Is Involuntary Placement and Non-Consensual Treatment Ever Compliant with UN Human Rights Standards?

A Survey of UN Reports (2006-2017)

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COMMENTS WELCOME

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Introduction

In recent years, the issues of involuntary placement and involuntary treatment for mental health conditions have been addressed on a number of different occasions within the UN system.[1] There is no unified UN position on the question of whether involuntary placement and treatment can be lawful under UN human rights standards; different positions have been taken in different reports. This Essex Autonomy Project report surveys recent UN statements on these matters. The authors welcome feedback on this document, particularly if there are relevant UN statements that have been overlooked here.[2] It is worth noting that even the terms involved ("involuntary placement," "involuntary treatment") do not have internationally accepted definitions.[3]

This document focuses on statements coming from

- the Office of the United Nations High Commissioner for Human Rights (which serves as the secretariat for the United Nations' human rights mechanisms) and the United Nations High Commissioner for Human Rights
- UN Treaty-based bodies, including
  - Human Rights Committee
  - Committee on the Rights of Persons with Disabilities
  - Committee against Torture
  - Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
  - Committee on Economic, Social and Cultural Rights
  - Committee on the Rights of the Child
  - Committee on the Elimination of Discrimination against Women[4]
- UN Charter-based bodies, including
  - Human Rights Council
  - Universal Periodic Review
  - Special procedures including Special Rapporteurs and the Working Group on Arbitrary Detention[5]

I. Office of the United Nations High Commissioner for Human Rights and the United Nations High Commissioner for Human Rights

I.1. Office of the UN High Commissioner for Human Rights

In its 2008 Information Note No. 4 on *Detention: Persons with Disabilities*, the Office of the United Nations High Commissioner for Human Rights (OHCHR) summarized the key human rights standards on the detention of persons with disabilities and reported that:

> The Convention on the Rights of Persons with Disabilities (CRPD) states clearly that deprivation of liberty based on the existence of a disability is contrary to international human rights law, is intrinsically discriminatory, and is therefore unlawful. Such unlawfulness also

[1] For an overview of the UN human rights bodies see: http://www.ohchr.org/EN/HRBodies/Pages/HumanRightsBodies.aspx.
[2] Contact: autonomy@essex.ac.uk. Please note that this document focuses only on those UN positions which were released after the adoption by the UN General Assembly of the UN Convention on the Rights of Persons with Disabilities (CRPD).
[3] European Union Agency for Fundamental Rights, 2012: *Involuntary placement and involuntary treatment of persons with mental health problems.* (Luxembourg: Publications Office of the European Union), 9.
[4] The order of the Treaty-based bodies reflects on to what extent involuntary placement and treatment are touched upon in the statements of the given treaty body. The order between the Human Rights Committee and the CRPD Committee is determined by seniority.
[5] The order of the Charter-based bodies reflects on the functioning (reporting order) of these entities.

> extends to situations where additional grounds—such as the need for care, treatment and the safety of the person or the community—are used to justify deprivation of liberty.[6]

The OHCHR reiterates this position in its 2009 Thematic Study on enhancing awareness and understanding of the CRPD (A/HRC/10/48) and distinguishes between the pre-CRPD and the post-CRPD era regarding the lawfulness of involuntary placement and treatment:

> A particular challenge in the context of promoting and protecting the right to liberty and security of persons with disabilities is the legislation and practice related to health care and more specifically to institutionalization without the free and informed consent of the person concerned (also often referred to as involuntary or compulsory institutionalization). *Prior to the entrance into force of the Convention, the existence of a mental disability represented a lawful ground for deprivation of liberty and detention under international human rights law. The Convention radically departs from this approach by forbidding deprivation of liberty based on the existence of any disability, including mental or intellectual, as discriminatory.* Article 14, paragraph 1 (b), of the Convention unambiguously states that "the existence of a disability shall in no case justify a deprivation of liberty". Proposals made during the drafting of the Convention to limit the prohibition of detention to cases "solely" determined by disability were rejected. As a result, unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14.[7]

The OHCHR calls for abolition of legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent. The OHCHR explains how this procedure should happen: All those provisions shall be repealed which give authorization for:

- institutionalization of persons with disabilities for their care and treatment without their free and informed consent, and
- preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.

However, the OHCHR also makes the point that this 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.[8]

The OHCHR took the same position in its 2012 Thematic study on the issue of violence against women and girls and disability (A/HRC/20/5), and highlighted that "a striking number of States have laws that authorize forced or involuntary treatment of persons with psychosocial disabilities when in their 'best interests'."[9] The OHCHR called for the prohibition of forced treatment of persons with

[6] Office of the United Nations High Commissioner for Human Rights, 2008: *Dignity and Justice for Detainees week. Information Note No. 4, Persons with Disabilities*, 2.
[7] Office of the United Nations High Commissioner for Human Rights, 2009: *Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities.* A/HRC/10/48, para 48. Emphasis added.
[8] Ibid, para 49.
[9] Office of the United Nations High Commissioner for Human Rights, 2012: *Thematic study on the issue of violence against women and girls and disability.* A/HRC/20/5, para 30.

disabilities and emphasized the importance of adequate procedural safeguards to protect the right to prior informed consent.[10]

I.2. UN High Commissioner for Human Rights

Zeid Ra'ad Al Hussein, UN High Commissioner for Human Rights emphasized in his 2017 Report on Mental health and human rights (A/HRC/34/32) that "substituted decision-making regimes commonly permit third parties to provide consent for treatment or admission for treatment on behalf of the person concerned. States should repeal legal frameworks allowing substitute decision makers to provide consent on behalf of persons with disabilities and introduce supported decision-making, ensuring its availability for those who request it. Health service providers should seek the free and informed consent of the person concerned by all possible means."[11]

The High Commissioner acknowledges that "in certain situations, the will of the person concerned might be difficult to determine"[12] and points out:

> Instruments such as advance directives or powers of attorney should be promoted and clearly formulated to prevent misunderstanding or arbitrariness by those executing them. Even when such instruments are in force, *persons with psychosocial disabilities must always retain their right to modify their will* and service providers should continue to seek their informed consent.[13]

The High Commissioner underlines that *fundamental changes* are necessary in current approaches to the protection of the rights of persons with mental health conditions and those with psychosocial disabilities and how that protection is implemented in policy. "Key to this is recognizing that the individuals concerned, including children, have agency, self-determination and rights, which should be protected and respected."[14]

II. United Nations Treaty Bodies

II.1. UN Human Rights Committee

In its 2014 General Comment No. 35 (Article 9 - Liberty and security of person, CCPR/C/GC/35), the **UN Human Rights Committee** (CCPR) called upon States Parties to the International Covenant on Civil and Political Rights "to revise outdated laws and practices in the field of mental health in order to avoid arbitrary detention."[15] The CCPR calls for the engagement of States parties in making "available adequate community-based or alternative social-care services for persons with psychosocial disabilities, in order to provide less restrictive alternatives to confinement." However, the treaty body of the International Covenant on Civil and Political Rights (ICCPR) allows for the possibility of involuntary placement and treatment, provided that:

[10] Ibid, para 53 (e).
[11] United Nations High Commissioner for Human Rights, 2017: *Mental health and human rights.* A/HRC/34/32. paras 25-26.
[12] Ibid, para 28.
[13] Ibid. Emphasis added.
[14] Ibid, para 34.
[15] UN Human Rights Committee, 2014: *General Comment No. 35, Article 9 (Liberty and security of person).* CCPR/C/GC/35, para 19.

- 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.
- Forced measures must be applied only as a measure of *last resort* and for the *shortest appropriate period of time*, and must be accompanied by *adequate procedural and substantive safeguards established by law*.[16]

The view of the CCPR is rooted in its concluding observations[17] and also in the case of *Fijalkowska v. Poland* (CCPR/C/84/D/1061/2002) in which the CCPR "acknowledges that circumstances may arise in which an individual's mental health is so impaired that so as to avoid harm to the individual or others, the issuance of a committal order, without assistance or representation sufficient to safeguard her rights, may be unavoidable" (at para 8.3).[18] According to the treaty body of the ICCPR, Article 14 paragraph 1 (b) of the Convention on the Rights of Persons with Disabilities supports the approach of the CCPR.[19]

II.2. UN Committee on the Rights of Persons with Disabilities

In its 2014 General Comment on Article 12 (CRPD/C/GC/1), the **UN Committee on the Rights of Persons with Disabilities** (CRPD Committee) drew attention to the tension between involuntary placement/treatment and the right to legal capacity. The Committee stated that detention of persons with disabilities in institutions against their will (either without their consent or based on the consent of a substitute decision-maker) constitutes *arbitrary deprivation of liberty.* They held that such practices violate both Article 12 and Article 14 of the CRPD.[20] Regarding involuntary treatment, the CRPD Committee stated that States parties are obliged:

- 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;
- not to permit substitute decision-makers to provide consent on behalf of persons with disabilities.[21]

In contrast to the UN Human Rights Committee, the CRPD Committee stated in its 2015 Guidelines on Article 14 of the CRPD that CRPD Article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment. The CRPD Committee has reported that it is aware of the fact that legislation of several States parties, including mental health laws, provides instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others. According to the CRPD Committee, this practice is incompatible

[16] Ibid. Emphasis added.
[17] See Appendix 1.
[18] The case of *Fijalkowska v. Poland* predates the CRPD, but the same position can be seen reflected in more recent concluding observations. See for example the Committee's 2016 *Concluding Observations on Azerbaijan CCPR/C/AZE/CO/4*, para. 13, in which the Committee states that the State party "should ensure that psychiatric confinement is applied only as a measure of last resort and for the shortest appropriate period of time and that the confinement is strictly necessary and proportionate for the purpose of protecting the individuals in question from serious harm or from preventing injury to others. The State party should ensure that procedures for involuntary hospitalization and forced institutionalization respect the views of the individual and that any representative genuinely represents and defends the wishes and interests of the individual concerned. It should also ensure that such confinement is supported by adequate procedural and substantive safeguards established by law, including effective initial and periodic judicial review of the lawfulness of such deprivation of liberty and regular independent oversight of living conditions in such institutions."
[19] See footnote 50 of the General Comment No. 35 of the UN Human Rights Committee.
[20] UN Committee on the Rights of Persons with Disabilities, 2014: *General Comment No. 1 on Article 12: Equal recognition before the law*. CRPD/C/GC/1, para 40.
[21] Ibid, para 41.

with Article 14. Furthermore, the CRPD Committee states that this practice is discriminatory in nature and amounts to arbitrary deprivation of liberty.[22] The CRPD Committee goes further and states that:

> [t]he involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty.[23]

The Guidelines on Article 14 of the CRPD were issued 9 months after the release of the General Comment No. 35 of the UN Human Rights Committee and the CRPD Committee underlined, in what could be regarded as a response to its sister committee, that:

> During the negotiations of the Ad Hoc Committee leading up to the adoption of the Convention there were extensive discussions on the need to include a qualifier, such as *"solely" or "exclusively",* in the prohibition of deprivation of liberty due to the existence of an actual or perceived impairment in the draft text of article 14(1)(b). *States opposed it*, arguing that it could lead to misinterpretation and allow deprivation of liberty on the basis of their actual or perceived impairment in conjunction with other conditions, like danger to self or others. (…) Consequently, article 14(1)(b) prohibits the deprivation of liberty on the basis of actual or perceived impairment *even if additional factors or criteria are also used to justify the deprivation of liberty* (…).[24]

In its concluding observations the CRPD Committee has called on States parties to protect the security and personal integrity of persons with disabilities who are deprived of their liberty, including by eliminating the use of forced treatment, seclusion and various methods of restraint in medical facilities, including physical, chemical and mechanical restraints.[25] According to the CRPD Committee, these practices are in breach of the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with disabilities (Article 15 CRPD).[26]

II.3. UN Committee against Torture

In most of its concluding observations, the **UN Committee against Torture** (CAT Committee) is silent on whether involuntary placement and treatment must be based on free and informed consent of the person concerned in each and every case.[27] However in its Concluding Observations on the Czech Republic in 2012, it stated:

> Institutionalization and treatment should be based on free and informed consent and the persons concerned should be informed in advance about the intended treatment.[28]

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[22] UN Committee on the Rights of Persons with Disabilities, 2015: *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities.* para 6. These 2015 *Guidelines* elaborated on an earlier and shorter document issued by the same Committee in 2014: *Statement on article 14 of the Convention on the Rights of Persons with Disabilities.* CRPD/C12/2, Annex IV. 1.

[23] Guidelines, above n. 21, para 13; CRPD/C12/2, Annex IV. 2.

[24] Guidelines, above n. 21, para 7. Emphasis added. See also the concluding observations of the CRPD Committee including: CRPD/C/KOR/CO/1, para 29; CRPD/C/DOM/CO/1, para 27; CRPD/C/AUT/CO/1, para 30.

[25] See for example: CRPD/C/PER/CO/1, paras 30-31.; CRPD/C/HRV/CO/1, para 24.; CRPD/C/DOM/CO/1, para 31.; CRPD/C/SLV/CO/1, paras 33-34.; CRPD/C/SWE/CO/1, paras 37-38.; CRPD/C/NZL/CO/1, para 32.; CRPD/C/AUS/CO/1, para 36. For more Concluding observations from the CRPD Committee see Appendix 1.

[26] Guidelines, above n. 21, para 12.

[27] See for example: CAT/C/KOR/CO/3-5, CAT/C/AZE/CO/4, CAT/C/FRA/CO/7, CAT/C/DNK/CO/6-7. For more relevant Concluding observations from the CAT Committee see Appendix 1.

[28] UN Committee against Torture, 2012: *Concluding observations of the Committee against Torture, Czech Republic.* CAT/C/CZE/CO/4-5, para 21 (b).

A recommendation similar to that made to the Czech Republic in 2012 was made in 2017, when the Committee called upon Finland to "strengthen the right to self-determination for persons with mental and psychosocial disabilities and ensure that their placement in psychiatric hospitals and social institutions is based on their free and informed consent… ."[29]

In other concluding observations,[30] the CAT Committee adopted a standard identical to the CCPR's approach. In its 2014 Concluding Observations on Croatia, the CAT Committee did not criticise the practice of involuntary commitment,[31] but recommended that

> [M]eans of restraint should be used [in psychiatric establishments] only as a last resort to prevent the risk of harm to the individual or others and only when all other reasonable options would fail to satisfactorily contain that risk...[32]

In 2017, the CAT Committee followed this path and pointed out in its Concluding Observations on the Republic of Korea that involuntary psychiatric hospitalization can be acceptable if it is "strictly necessary, proportionate, applied as a measure of last resort and under the effective supervision and independent monitoring of judicial organs."[33]

II.4. UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

The **UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment** (SPT) highlights in its 2016 document called Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent that States parties to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), "should revise outdated legislation and practices in the field of mental health in order to avoid arbitrary detention."[34] The SPT, similarly to the CCPR, suggests that "States should develop and make available alternatives to confinement such as community-based treatment programmes, which are particularly appropriate for avoiding hospitalization and for providing care for persons upon their discharge from hospitals."[35] The treaty body of the OPCAT, like the CCPR, allows States to use involuntary placement and treatment under the following conditions:

- Any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the person in question from harm or preventing injury to others.

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[29] UN Committee against Torture, 2017: *Concluding observations on the seventh periodic report of Finland.* CAT/C/FIN/CO/7, para 23.

[30] For example, UN Committee against Torture, 2016: *"Concluding observations on the seventh periodic report of France."* CAT/C/FRA/CO/7, para 30,; UN Committee against Torture, 2016: *"Concluding observations on the fourth periodic report of Azerbaijan."* CAT/C/AZE/CO/4, para 27.; UN Committee against Torture, 2016: *"Concluding observations on the combined sixth and seventh periodic reports of Denmark."* CAT/C/DNK/CO/6-7, paras. 40-41.

[31] For the practice of involuntary commitment see UN Committee against Torture, 2013: *"Consideration of reports submitted by States parties under article 19 of the Convention pursuant to the optional reporting procedur, Combined fourth and fifth periodic reports of States parties due in 2008, Croatia."* CAT/C/HRV/4-5, paras 114-120.

[32] UN Committee against Torture, 2014: *"Concluding observations on the combined fourth and fifth periodic reports of Croatia."* CAT/C/HRV/CO/4-5, para 17.

[33] UN Committee against Torture, 2017: *"Concluding observations on the combined third to fifth periodic reports of the Republic of Korea."* CAT/C/KOR/CO/3-5, para 32(a). Further safeguards are mentioned in subparas (c)-(d).

[34] UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 2016: *Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent.* CAT/OP/27/2, para 11. Cf. UN Human Rights Committee, 2014: *General Comment No. 35, Article 9 (Liberty and security of person).* CCPR/C/GC/35, para 19.

[35] Ibid, para 5.

- Forced measures must take into consideration less restrictive alternatives, and must be accompanied by adequate procedural and substantive safeguards established by law.[36]

When it comes to involuntary placement, the SPT explicitly talks about persons who "suffer serious mental disorders". In the opinion of the SPT, "placement in a psychiatric facility may be necessary to protect the detainee from discrimination, abuse and health risks stemming from illness."[37] The SPT suggests:

> [P]lacement in a psychiatric facility may be necessary […], provided that all guarantees are respected and that *the treatment offered is equal to that offered to other patients* and corresponds to the health needs of the person and that the placement of the person is subject to constant judicial review. *As specified in article 14 (b) of the Convention on the Rights of Persons with Disabilities, the existence of a disability should not be the justification for a deprivation of liberty*.[38] (Emphases added)

Regarding involuntary treatment, the SPT's standpoint is that it "must be a last resort to avoid irreparable damage to the life, integrity or health of the person concerned."[39] Under the same approach, the SPT recognizes that "[r]estraints, physical or pharmacological […] should be considered only as measures of last resort for safety reasons."[40] The SPT report goes on to elaborate on these circumstances of "last resort" as follows:

> Exceptionally, it may be necessary to medically treat a person deprived of liberty without her or his consent if the person concerned is not able to:
>
> (a) Understand the information given concerning the characteristics of the threat to her or his life or personal integrity, or its consequences;
>
> (b) Understand the information about the medical treatment proposed, including its purpose, its means, its direct effects and its possible side effects;
>
> (c) Communicate effectively with others.[41]

Finally, the SPT claims the *withholding* of forced treatment in such circumstances can itself become a human rights *violation*, since failure to provide forced treatment could:

- constitute inappropriate practice and
- amount to a form of cruel, inhuman or degrading treatment or punishment, and
- constitute a form of discrimination.[42]

II.5.UN Committee on Economic, Social and Cultural Rights

In its General Comment No. 14 (2000) on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), the **UN Committee on Economic, Social and Cultural Rights** (CESCR Committee) underlined that states should refrain from "applying coercive medical treatments, *unless on an exceptional basis for the treatment of mental illness* … . Such exceptional cases should be subject to specific and restrictive conditions,

[36] Ibid. para 11.
[37] Ibid, para 8.
[38] CAT/OP/27/2, above n. 33, para 8.
[39] Ibid, para 15. Further guaranties are listed in the same paragraph.
[40] Ibid, para 9.
[41] CAT/OP/27/2, above n. 33, para 14.
[42] Ibid, para 15.

respecting best practices and applicable international standards, including the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care."[43]

In its 2011 Concluding Observations on Moldova, the CESCR Committee suggested "that the State party take measures to provide alternative forms of mental health treatment, in particular outpatient treatment."[44] The CESCR Committee recommended that:

> "[t]he State party incorporate into the law the abolition of violent and discriminatory practices against children and adults with disabilities in the medical setting, including deprivation of liberty, the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electro convulsive therapy (ECT). […]"[45]

In 2013, the CESCR Committee addressed a similar recommendation to Norway.[46] Although the treaty body of the ICESCR called upon Norway to make sure that treatment of persons with psychosocial disabilities in a psychiatric institution is based on the free and informed consent of the individual concerned, the CESCR added that this consent may also come from the legal representative of the person concerned.

In its 2016 Concluding Observations on Poland, the CESCR Committee called on the State Party to

- "Guarantee full respect for the human rights of patients in psychiatric institutions, including through independent and effective monitoring of treatment and through effective judicial review of orders for confinement to psychiatric institutions."[47]
- "Ensure that treatment is provided on the basis of free and informed consent."[48]

II.6. UN Committee on the Rights of the Child

Age is an important factor when it comes to involuntary placement and treatment, and the **UN Committee on the Rights of the Child** (CRC Committee) has expressed its view on this issue in its Concluding Observations on Costa Rica. The treaty body of the UN Convention on the Rights of the Child urged the State party to:

> Ensure that all health services provided to children and adolescents with disabilities, including mental health services and, in particular, the administration of psychotropic substances, are based on the free and informed consent of the children concerned, according to their evolving capacities.[49]

The principle of evolving capacities of children, which appears in Article 3(h) of the CRPD as well, is rooted in Article 5 of the Convention on the Rights of the Child and is coupled with the obligation to

[43] UN Committee on Economic, Social and Cultural Rights, 2000: *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights).* E/C.12/2000/4, para 34. The "Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care" is also known as MI Principles. UN General Assembly, 1991: *Resolution 46/119 on the protection of persons with mental illness and the improvement of mental health care.* A/RES/46/119. It should be noted here that according to Manfred Nowak, former UN Special Rapporteur on Torture, the CRPD overrides the MI Principles (NOWAK, M., 2008: *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.* A/63/175, para 44)

[44] UN Committee on Economic, Social and Cultural Rights, 2011: *Concluding observations of the Committee on Economic, Social and Cultural Rights, Republic of Moldova.* E/C.12/MDA/CO/2, para 24.

[45] Ibid.

[46] UN Committee on Economic, Social and Cultural Rights, 2013: *Concluding observations on the fifth periodic report of Norway.* E/C.12/NOR/CO/5, para 19.

[47] UN Committee on Economic, Social and Cultural Rights, 2016: *Concluding observations on the sixth periodic report of Poland.* E/C.12/POL/CO/6, para 52(b).

[48] Ibid, para 52(c).

[49] Committee on the Rights of the Child, 2011: *Concluding observations: Costa Rica.* CRC/C/CRI/CO/4, para 56(d).

respect the views (Article 12)[50] and to secure the best interests (Article 3)[51] of the child. In the General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), the CRC Committee "recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality."[52]

II.7. UN Committee on the Elimination of Discrimination against Women

There are indications that the **UN Committee on the Elimination of Discrimination against Women** (CEDAW Committee) has been moving towards the CRPD Committee's position. Although in 2011, the CEDAW Committee called upon Kuwait to "adopt a law on mental health to regulate the detention and treatment of mentally ill patients in psychiatric hospitals in accordance with international standards, including a determination of detention and its duration by the court,"[53] in its 2014 Concluding Observations on India, the treaty body urged the State Party:

> To enact the bill on the rights of persons with disabilities without delay and incorporate a specific section (…) to repeal laws regarding and prohibit disability-based detention of women, including involuntary hospitalization and forced institutionalization.[54]

The CEDAW Committee does not say anything specific either in favour or against of the possibility of consent coming from a substitute decision-maker. However, the prohibition of disability-based detention of women, including involuntary hospitalization and forced institutionalization is clear and explicit.

III. UN Charter-based Bodies

III.1. UN Human Rights Council

In its 2017 Resolution on Mental Health and Human Rights (A/HRC/36/L.25), the Human Rights Council (HRC) calls, inter alia, for protecting, promoting and respecting all human rights and fundamental freedoms and ensuring that policies and services related to mental health comply with international human rights norms.[55] The HRC

[c]alls upon States to abandon all practices that fail to respect the *rights, will and preferences of all persons*, on an equal basis, and that lead to power imbalances, stigma and discrimination in mental health settings.[56]

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[50] Similar obligation can be found in Article 7(3) of the CRPD.
[51] Securing the best interests of the child is also a key obligation under Article 7(2) of the CRPD.
[52] Committee on the Rights of the Child, 2013: *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24).* CRC/C/GC/15, para 21.
[53] UN Committee on the Elimination of Discrimination against Women, 2011: *Concluding observations of the Committee on the Elimination of Discrimination against Women: Kuwait.* CEDAW/C/KWT/CO/3-4, para 43(c).
[54] UN Committee on the Elimination of Discrimination against Women, 2014: *Concluding Observations on India.* CEDAW/C/IND/CO/4-5, para 37.
[55] UN Human Rights Council, 2017: *"Resolution on Mental Health and Human Rights."* A/HRC/36/L.25, para 4.
[56] Ibid, para 8. Emphasis added.

In relation to this, the Resolution urges States not to perform "inappropriate treatments" in the field of clinical practice.[57] Although inappropriate treatments are not defined in the Resolution, it is stated that the *autonomy, will and preferences of all persons* shall be respected in this regard. In addition, States are called to provide mental health services for persons with mental health conditions or psychosocial disabilities on the same basis as to those without disabilities, including on the basis of free and informed consent.[58]

III.2. Universal Periodic Review

The Universal Periodic Review (UPR)[59] rarely addresses the issues of involuntary placement and treatment. In 2011, the Working Group on the UPR recommended that Lithuania shall review the procedures of involuntary hospitalization.[60] In 2014, in its A/HRC/27/3 report, the Working Group on the UPR recommended that Norway should

> Take further concrete steps to *reduce* the use of coercion in the treatment and detention of persons with mental health issues or intellectual disabilities, including by improving the monitoring of mental health care institutions and developing voluntary alternatives to coercive interventions,[61] and
> Ensure that coercive measures in mental health institutions are only applied when *necessary* and in a *proportionate* manner.[62]

In the same year, the Working Group on the UPR urged Kazakhstan to "ensure that involuntary detention on mental health grounds should only be possible in *exceptional circumstances* clearly defined in law, and based on a determination by qualified health care professionals."[63]

However in 2016, the UPR called upon Latvia to

> Prepare an appropriate normative framework for mental health institutions and social care facilities, ensuring that it *prohibits the nonconsensual use of coercive practices* such as psychiatric medication or electroconvulsive therapy.[64]

III.3. UN Special Procedures

III.3.1. UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

Manfred Nowak, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (2004-2010) underscored in his A/63/175 interim report in 2008 that:

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[57] Ibid, para 9.
[58] Ibid, para 10.
[59] For basic facts about the UPR, please visit http://www.ohchr.org/EN/HRBodies/UPR/Pages/BasicFacts.aspx.
[60] UN Human Rights Council, 2011: *Report of the Working Group on the Universal Periodic Review: Lithuania.* A/HRC/19/15, para 89.33.
[61] UN Human Rights Council, 2014: *Report of the Working Group on the Universal Periodic Review: Norway.* A/HRC/27/3, para 131.165. Emphasis added.
[62] Ibid., para 131.166. Emphases added.
[63] UN Human Rights Council, 2014: *Report of the Working Group on the Universal Periodic Review: Kazakhstan.* A/HRC/28/10, para 126.32. Emphasis added.
[64] UN Human Rights Council, 2016: *Report of the Working Group on the Universal Periodic Review: Latvia. A/HRC/32/15, para* 120.65. Emphasis added.

> Many States, with or without a legal basis, allow for the detention of persons with mental disabilities in institutions without their free and informed consent, on the basis of the existence of a diagnosed mental disability often together with additional criteria such as being a "danger to oneself and others" or in "need of treatment". The Special Rapporteur recalls that article 14 of CRPD prohibits unlawful or arbitrary deprivation of liberty and the existence of a disability as a justification for deprivation of liberty.[65]

Regarding the link between involuntary placement and treatment and the prohibition of torture and other cruel, inhumane or degrading treatment or punishment, Mr Nowak highlighted that:

> In certain cases, arbitrary or unlawful deprivation of liberty based on the existence of a disability might also inflict severe pain or suffering on the individual, thus falling under the scope of the Convention against Torture.[66]

Note that the language of this 2008 interim report is identical to the content of Article 14, para 7 of the CRPD Committee's Guideline on Article 14.

A similar approach was taken by Juan E. Méndez (2010-2016), the successor to Manfred Nowak. In his 2013 A/HRC/22/53 report, the then Special Rapporteur called for an absolute ban on restraints and seclusion:

> It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities should apply in all places of deprivation of liberty, including psychiatric and social care institutions.[67]

However Mr Méndez went on to emphasize that "criteria that determine the grounds upon which treatment can be administered in the absence of free and informed consent should be clarified in the law, and no distinction between persons with or without disabilities should be made."[68] Mr Méndez also relied on the A/HRC/10/48 Thematic Study of the OHCHR and emphasized:

- The CRPD forbids deprivation of liberty based on the existence of a disability, including mental or intellectual, as discriminatory.
- Legislation authorizing the institutionalization of persons with disabilities on the grounds of their disability without their free and informed consent must be abolished. This must include the repeal of provisions authorizing institutionalization of persons with disabilities for their care and treatment without their free and informed consent, as well as provisions authorizing the preventive detention of persons with disabilities on grounds such as the likelihood of them posing a danger to themselves or others, in all cases in which such grounds of care, treatment and public security are linked in legislation to an apparent or diagnosed mental illness.[69]

Finally, there are two paragraphs in the report which seem to support the view according to which *disability with other factors may justify involuntary placement and treatment*. In paragraph 69, the report analyses the jurisprudence of the European Court of Human Rights and comes to the following conclusion:

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[65] NOWAK, M., 2008: *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment.* A/63/175, para 64.
[66] Ibid, para 65.
[67] MÉNDEZ, J. E., 2013: *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez.* A/HRC/22/53, para 63.
[68] Ibid, para 66.
[69] Ibid, para 68.

> Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention. *The Special Rapporteur believes that the severity of the mental illness is not by itself sufficient to justify detention*; the State must also show that detention is necessary to protect the safety of the person or of others. […][70]

Mr Méndez also refers to the *Winterwerp v. the Netherlands*[71] case, which was decided by the European Court of Human Rights and continues his report in this way:

> […] Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind". As detention in a psychiatric context may lead to non-consensual psychiatric treatment, the mandate has stated that deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering could fall under the scope of the Convention against Torture […]."[72]

Furthermore, when Mr Méndez calls upon all States to review the anti-torture framework in relation to persons with disabilities in line with the Convention on the Rights of Persons with Disabilities as authoritative guidance regarding their rights in the context of health-care and to impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, he also stresses that:

> The obligation to end forced psychiatric interventions *based solely on grounds of disability* is of immediate application and scarce financial resources cannot justify postponement of its implementation.[73]

In the same year, in 2013, Mr Méndez interpreted his own A/HRC/22/53 report in a publication in a way which is in line with the CRPD Committee's approach and explained:

> Deprivation of liberty on grounds of mental illness is unjustified if its basis is discrimination or prejudice against persons with disabilities. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention. The severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. *In the ECtHR jurisprudence*, except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of "unsound mind." […] In my report, the reference to the European Court of Human Rights' decision in Winterwerp v. The Netherlands (at para. 69 and footnote 88) was meant to be critical. I disagree with that judgment because justifying non-consensual treatment on the fact that the patient is "of unsound mind" raises a discriminatory basis for the treatment, which is impermissible (see para. 68 of my report, citing CRPD).[74]

In these interpretative sentences, the then Special Rapporteur made two changes regarding his A/HRC/22/53 report:

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[70] Ibid, para 69. Emphasis added.
[71] *Winterwerp v. the Netherlands* (European Court of Human Rights, App. no. 6301/73, 24 October 1979).
[72] A/HRC/22/53, above n. 66, para 69.
[73] Ibid, para 89.
[74] MÉNDEZ, J. E., 2013: "Introduction", in *Torture in health-care settings: reflection on the Special Rapporteur on Torture's 2013 thematic report,* Center for Human Rights and Humanitarian Law, xviii. Emphasis added. We note that this statement is not itself a UN document, and so strictly does not fall within the scope of the survey undertaken here. We have included it nonetheless because of its unique relevance for interpreting the tensions within the 2013 report.

- He deleted the phrase of "[t]he Special Rapporteur believes that" from the beginning of the sentence which continues with "the severity of the mental illness is not by itself sufficient to justify detention."
- He added the words of "[i]n the ECtHR jurisprudence" to the sentence of "except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind.'"

After this self-interpretation, Mr Méndez sums up his position the following terms:

> I want to put the burden on States to show that involuntary commitment is necessary under very strict and narrow circumstances: a) when the patient is a danger to him or herself or others; b) in emergency circumstances; c) in both cases for a limited time and with limited means, strictly sufficient only to prevent the risk of major harm.[75]

III.3.2. UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Anand Grover, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2008-2014) also addressed the issue of involuntary placement and treatment in 2009, in his A/64/272 Report. Mr Grover, on the one hand, pointed out that the "CRPD reaffirms that the existence of a disability is not a lawful justification for any deprivation of liberty, including denial of informed consent,"[76] but, on the other hand formulated a sentence, which might be in collision with the position taken by the CRPD Committee:

> Policies and legislation sanctioning *non-consensual treatments lacking therapeutic purpose* or aimed at correcting or alleviating a disability, including sterilizations, abortions, electro-convulsive therapy and unnecessarily invasive psychotropic therapy, *violate the right to physical and mental integrity and may constitute torture and ill-treatment.*[77]

This sentence may be read in a way according to which only those non-consensual treatments that lack therapeutic purpose violate the right to physical and mental integrity and may constitute torture and ill-treatment. This might be taken to imply that non-consensual treatments, which do not lack (i.e., do have) therapeutic purpose, do not violate the right to physical and mental integrity and do not constitute torture and ill-treatment.

In its A/HRC/35/21 Report (2017) to the Human Rights Council, Dainius Pūras, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2014-) pointed out that there was no agreement among UN entities regarding the absolute ban on involuntary placement and treatment.[78] Mr Pūras is concerned about the current situation and points out:

> At present, there is an impasse over how obligations in relation to non-consensual treatment are implemented in the light of the provisions of the Convention on the Rights of Persons with Disabilities, given the different interpretation by international human rights mechanisms. The Special Rapporteur has followed these developments and hopes that consensus can be reached to start the shift towards strengthened mental health policies and services without

[75] MÉNDEZ, J. E., 2013, p. xviii.
[76] GROVER, A., 2009: *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* A/64/272, para 72.
[77] Ibid, para 73. Emphasis added.
[78] PŪRAS, D., 2017: *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.* A/HRC/35/21, para 33.

> delay. He seeks to participate actively in these processes and potentially report again on the progress achieved.[79]

Later in his report, the Special Rapporteur underscores that "[because] the right to health is now understood within the framework of the Convention on the Rights of Persons with Disabilities, immediate action is required to radically reduce medical coercion and *facilitate the move towards an end to all forced psychiatric treatment and confinement*. In that connection, *States must not permit substitute decision-makers to provide consent on behalf of persons with disabilities on decisions that concern their physical or mental integrity*; instead, support should be provided at all times for them to make decisions, including in emergency and crisis situations."[80]

Although Mr Pūras is well aware of the concerns of various stakeholders, particularly within the medical communities, regarding the absolute ban on all forms of non-consensual measures, he thinks that there is agreement about the unacceptably high prevalence of human rights violations within mental health settings and that change is necessary. The Special Rapporteur concludes:

> Failure to take immediate measures towards such a change is no longer acceptable and the Special Rapporteur proposes five deliberate, targeted, and concrete actions as follows:
> (a) Mainstream alternatives to coercion in policy with a view to legal reform;
> (b) Develop a well-stocked basket of non-coercive alternatives in practice;
> (c) Develop a road map to radically reduce coercive medical practices, with a view to their elimination, with the participation of diverse stakeholders, including rights holders;
> (d) Establish an exchange of good practices between and within countries;
> (e) Scale up research investment and quantitative and qualitative data collection to monitor progress towards these goals.[81]

III.3.3. UN Special Rapporteur on Disability and UN Special Rapporteur on the rights of persons with disabilities

In 2014, Shuaib Chalklen, UN Special Rapporteur on Disability (2009-2014) expressed concerns about the UN Human Rights Committee's draft version of General Comment No. 35 (CCPR/C/107/R.3) on Article 9 (Right to liberty and security of person) and asked the UN Human Rights Committee to bring it in line with the CRPD and the position taken by the CRPD Committee.[82]

Catalina Devandas-Aguilar, the first Special Rapporteur on the Rights of Persons with Disabilities has expressed particular concerns about the practice of forced placement and non-consensual administration of psychiatric treatment on grounds of mental or intellectual disabilities and recommended that Republic of Moldova:

> (a) In accordance with its obligations under article 14 of the Convention on the Rights of Persons with Disabilities, *immediately stop the deprivation of liberty of persons with disabilities on the basis of an actual or perceived disability*, and take prompt action to revise the legal provisions that currently allow detention on mental health grounds or in mental health facilities;

[79] Ibid, para 34.
[80] Ibid, para 65. Emphasis added.
[81] Ibid, para 66.
[82] CHALKLEN, S., 2014: *Urgent request to amend the Human Rights Committee's draft version of General Comment No. 35 (CCPR/C/107/R.3) on Article 9 (Right to liberty and security of person) bringing it in line with the UN Convention on the Rights of Persons with Disabilities*.

(b) Immediately halt any coercive intervention or treatment in mental health or any other settings without the free and informed consent of the persons concerned.[83]

III.3.4. UN Working Group on Arbitrary Detention

At its very first session in 1991, the UN Working Group on Arbitrary Detention (WGAD) "deliberately refrained from taking a position in the abstract on measures involving the deprivation of liberty of mentally disabled persons placed in a closed establishment. It held that it is more appropriate to examine this issue later."[84]

In its E/CN.4/2005/6 report in 2004, relying on pre-CRPD documents,[85] the WGAD arrived at the conclusion that "in some cases confinement of psychiatric patients in closed institution *may prove necessary to prevent the harm which the patient might cause to others or to himself*."[86] The WGAD took the position that it would apply the criteria according to which the "law shall provide the conditions of the deprivation of liberty of persons of unsound mind, as well as the procedural guaranties against arbitrariness…"[87]

More than 10 years later, in 2015, in Guideline 20 (Specific measures for persons with disabilities) of the United Nations Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of Their Liberty to Bring Proceedings Before a Court (A/HRC/30/37), the WGAD proposed the following step to be taken:

> Individuals who are currently detained in a psychiatric hospital or similar institution and/or subjected to forced treatment, or who may be so detained or forcibly treated in the future, must be informed about ways in which they may effectively and promptly secure their release, including injunctive relief.[88]

According to the WGAD, injunctive relief has multiple aims:

> Injunctive relief should consist in an order requiring the facility to release the person immediately and/or to cease immediately any forced treatment and any systemic measures, such as those requiring mental health facilities to unlock their doors and to inform persons of their right to leave, and establishing a public authority to provide for access to housing, means of subsistence and other forms of economic and social support in order to facilitate de-institutionalization and the right to live independently and be included in the community. Such assistance programmes should not be centred on the provision of mental health services or treatment, but free or affordable community-based services, including alternatives that are

[83] DEVANDAS-AGUILAR, C., 2016: *Report of the Special Rapporteur on the rights of persons with disabilities on her mission to the Republic of Moldova.* A/HRC/31/62/Add.2, para 67. Emphasis added. Cf. DEVANDAS-AGUILAR, C., 2016: *Report of the Special Rapporteur on the rights of persons with disabilities on her visit to Paraguay.* A/HRC/34/58/Add.1, para 84(d).; DEVANDAS-AGUILAR, C., 2016: *Report of the Special Rapporteur on the rights of persons with disabilities on her visit to Zambia.* A/HRC/34/58/Add.2, para 88.

[84] UN Working Groupon Arbitrary Detention, 2004: "Deliberation no. 7 on issues related to psychiatric detention", in *Civil and political rights, including the question of torture and detention, Report of the Working Group on Arbitrary Detention.* E/CN.4/2005/6, para 48.

[85] Ibid, para 50.

[86] Ibid, para 55.

[87] Ibid, para 58.

[88] UN Working Group on Arbitrary Detention, 2015: "Guideline 20 - Specific measures for persons with disabilities", in *Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court,* A/HRC/30/37, para 107 (d).

> free from medical diagnosis and interventions. Access to medications and assistance in withdrawing from medications should be made available for those who so decide.[89]

Furthermore, the WGAD calls for providing persons with disabilities with compensation, as well as other forms of reparations, in the case of arbitrary or unlawful deprivation of liberty.[90]

Regarding the question whether there could be any possibility for consent of a substituted decision-maker, the WGAD clearly states:

> The denial of legal capacity of persons with disabilities and detention in institutions against their will, without their consent or with the consent of a substituted decision-maker constitutes arbitrary deprivation of liberty in violation of international law.[91]

Conclusion

It is fair to conclude that the UN system is currently divided when it comes to formulating views and taking positions on involuntary placement and treatment of persons with psychosocial disabilities (mental health problems). The two principal positions are those that have been elaborated by the CCPR and CRPD Committees respectively; these two positions are inconsistent with one another. But we also find UN-level reports that seem to be working towards a reconciliation of the two.

The various documents reviewed in this overview can be usefully grouped under four headings.

i.) Some permit, or may even require, "necessary and proportionate" involuntary placement and non-consensual treatment of persons with disabilities as a last resort;
ii.) Some call for an absolute ban thereon;
iii.) Some are framed in language that avoids committing one way or another on the question of whether involuntary placement and treatment of persons with disabilities can ever be justified;
iv.) Some look to reconcile the conflict by developing a schema for disability-neutral policies that permit involuntary placement and treatment.

In April 2014, the UN General Assembly adopted a resolution concerning the effective functioning of the human rights treaty body system.[92] It emphasised the importance of "accelerating the harmonization of the treaty body system" (para. 38) while also reaffirming the independence of the members of such bodies (para. 35). It is within the constraints of these two fundamental principles that work towards a unified position on involuntary placement and treatment continues.[93]

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[89] Ibid, para 107 (e).
[90] Ibid, para 107 (f).
[91] Ibid, para 106 (b).
[92] This was recognised by the adoption of the UN General Assembly Resolution 68/268 on strengthening and enhancing the effective functioning of the human rights treaty body system, A/RES/68/268.
[93] We are grateful to colleagues who provided helpful feedback on earlier drafts of this document. Many of those who reviewed earlier drafts encouraged us to address various questions of interpretation raised by the survey we have undertaken here. We have also been encouraged to produce a table in which we sort different UN documents into the four categories we enumerate in the conclusion. We are grateful for these suggestions, but after consideration have decided not to take them up here. Our purpose in this document has been quite narrow in seeking to generate a comprehensive factual record of positions taken in the reports surveyed here. Our hope is that doing so may be useful for researchers, activists, and policy makers

working in this area. We plan in future work to take up issues of interpretation, to consider whether and how different positions might be reconciled, and to address the first-order question posed in our title.

Appendix 1. Some concluding observations of UN treaty bodies regarding involuntary placement and treatment

Treaty Body	Year	Country concerned	Document ID	Paras
CAT	2017	Republic of Korea	CAT/C/KOR/CO/3-5	31-32
	2017	Finland	CAT/C/FIN/CO/7	22-23
	2016	Azerbaijan	CAT/C/AZE/CO/4	26-27
	2016	France	CAT/C/FRA/CO/7	29-30
	2016	Denmark	CAT/C/DNK/CO/6-7	40-41
	2015	Romania	CAT/C/ROU/CO/2	14
	2015	Serbia	CAT/C/SRB/CO/2	18
	2014	Lithuania	CAT/C/LTU/CO/3	23
	2014	Sweden	CAT/C/SWE/CO/6-7	13
	2014	Croatia	CAT/C/HRV/CO/4-5	17
	2013	Mozambique	CAT/C/MOZ/CO/1	17
	2013	Japan	CAT/C/JPN/CO/2	22
	2013	Kingdom of the Netherlands	CAT/C/NLD/CO/5-6	21
	2013	Estonia	CAT/C/EST/CO/5	20
	2012	Russian Federation	CAT/C/RUS/CO/5	22
	2012	Czech Republic	CAT/C/CZE/CO/4-5	23 (lack of data)
	2012	Norway	CAT/C/NOR/CO/6-7	14
	2011	Bulgaria	CAT/C/BGR/CO/4-5	19
	2011	Finland	CAT/C/FIN/CO/5-6	11
	2011	Kuwait	CAT/C/KWT/CO/2	20
	2011	Slovenia	CAT/C/SVN/CO/3	14
	2011	Ireland	CAT/C/IRL/CO/1	28
	2011	Ghana	CAT/C/GHA/CO/1	17
	2011	Bosnia and Herzegovina	CAT/C/BIH/CO/2-5	20
	2010	Liechtenstein	CAT/C/LIE/CO/3	29 (social welfare)
	2010	Republic of Moldova	CAT/C/MDA/CO/2	26
	2009	Slovakia	CAT/C/SVK/CO/2	20
	2009	Azerbaijan	CAT/C/AZE/CO/3	15-16
	2008	Latvia	CAT/C/LVA/CO/2	15
	2008	Estonia	CAT/C/EST/CO/4	24
CCPR	2016	Azerbaijan	CCPR/C/AZE/CO/4	12-13
	2016	Argentina	CCPR/C/ARG/CO/5	21-22
	2016	Denmark	CCPR/C/DNK/CO/6	25-26
	2015	Republic of Korea	CCPR/C/KOR/CO/4	28-29
	2015	Suriname	CCPR/C/SUR/CO/3	37-38
	2015	Croatia	CCPR/C/HRV/CO/3	16
	2014	Japan	CCPR/C/JPN/CO/6	17
	2014	Ireland	CCPR/C/IRL/CO/4	12
	2014	United States of America	CCPR/C/USA/CO/4	18
	2014	Latvia	CCPR/C/LVA/CO/3	16
	2013	Czech Republic	CCPR/C/CZE/CO/3	14
	2011	Norway	CCPR/C/NOR/CO/6	10

CRPD	2017	Morocco	CRPD/C/MAR/CO/1	30-31
	2017	United Kingdom of Great Britain and Northern Ireland	CRPD/C/GBR/CO/1	34-37
	2017	Republic of Moldova	CRPD/C/MDA/CO/1	28-31
	2015	Qatar	CRPD/C/QAT/CO/1	27-28
	2015	Gabon	CRPD/C/GAB/CO/1	32-33
	2015	Mauritius	CRPD/C/MUS/CO/1	25-26
	2015	Brazil	CRPD/C/BRA/CO/1	28-29
	2015	Croatia	CRPD/C/HRV/CO/1	19-20, 23-24
	2015	Germany	CRPD/C/DEU/CO/1	29-30, 37-38
	2015	Kenya	CRPD/C/KEN/CO/1	27-28
	2015	Cook Islands	CRPD/C/COK/CO/1	10, 27-28
	2015	Turkmenistan	CRPD/C/TKM/CO/1	25-26
	2015	Dominican Republic	CRPD/C/DOM/CO/1	26-31
	2014	Azerbaijan	CRPD/C/AZE/CO/1	28-29
	2014	Sweden	CRPD/C/SWE/CO/1	35-40
	2014	New Zealand	CRPD/C/NZL/CO/1	29-32
	2013	Republic of El Salvador	CRPD/C/SLV/CO/1	31-34
	2013	Paraguay	CRPD/C/PRY/CO/1	33-36
	2013	Australia	CRPD/C/AUS/CO/1	31-36
	2012	China	CRPD/C/CHN/CO/1	25-28, 37-38, 48
	2012	Argentina	CRPD/C/ARG/CO/1	23-24
	2012	Peru	CRPD/C/PER/CO/1	28-31
	2011	Spain	CRPD/C/ESP/CO/1	35-36
CESCR	2016	Poland	E/C.12/POL/CO/6	51-52
	2013	Norway	E/C.12/NOR/CO/5	19
	2011	Germany	E/C.12/DEU/CO/5	35 (request for info)
	2008	Sweden	E/C.12/SWE/CO/5	24 (request for info)
CRC	2015	Sweden	CRC/C/SWE/CO/5	25-26
	2011	Costa Rica	CRC/C/CRI/CO/4	56
CEDAW	2014	India	CEDAW/C/IND/CO/4-5	36-37
	2011	Kuwait	CEDAW/C/KWT/CO/3-4	42-43
CERD	2014	United States of America	CERD/C/USA/CO/7-9	26 (request for info)

Apendix 2. Treaty bodies' recommendations Matrix

Treaty bodies' recommendations on involuntary measures for Azerbaijan

CAT (2016) CAT/C/AZE/CO/4	CCPR (2016) CCPR/C/AZE/CO/4	CRPD Committee (2014) CRPD/C/AZE/CO/1
27. The State party should take measures to ensure that verbal and physical abuse of patients is eradicated and perpetrators are adequately punished, that all psychiatric facilities provide decent living conditions to all patients, that all patients are provided with a sufficiently nutritious diet and the proper amount of food, that each patient has his or her own treatment plan and access to a full range of rehabilitative psychosocial activities, that **detailed instructions on the use of any type of restraint is issued and that any use of such restraints is properly registered and monitored, that the provisions of the National Mental Health Act are duly followed, and that every patient whose involuntary placement is sought has access to free legal aid, is heard in person by a competent judge before deciding on placement and is provided a copy of the court decision.**	13. The State party should step up its efforts towards the deinstitutionalization of persons with disabilities by making available adequate community-based or alternative social care services for persons with psychosocial disabilities. **It should ensure that psychiatric confinement is applied only as a measure of last resort and for the shortest appropriate period of time and that the confinement is strictly necessary and proportionate for the purpose of protecting the individuals in question from serious harm or from preventing injury to others. The State party should ensure that procedures for involuntary hospitalization and forced institutionalization respect the views of the individual and that any representative genuinely represents and defends the wishes and interests of the individual concerned. It should also ensure that such confinement is supported by adequate procedural and substantive safeguards established by law, including effective initial and periodic judicial review of the lawfulness of such deprivation of liberty and regular independent oversight of living conditions in such institutions. The Committee brings the State party's attention to its general comment No. 35 (2014) on liberty and security of person.**	29. The Committee urges the State **party to repeal laws and prohibit disability based detention of children and adults with disabilities, including involuntary hospitalization and forced institutionalization, and ensure that all relevant legislation and policies in this area are in line with the Convention. It should also develop support services in the community and accelerate deinstitutionalization strategies based on the human rights model of disability in consultation with organizations of persons with disabilities.**

Treaty bodies' recommendations on involuntary measures for Croatia

CAT (2014) CAT/C/HRV/CO/4-5	CCPR (2015) CCPR/C/HRV/CO/3	CRPD (2015) CRPD/C/HRV/CO/1
17. The Committee recommends that: **means of restraint should be used only as a last resort to prevent the risk of harm to the individual or others and only when all other reasonable options would fail to satisfactorily contain that risk**; the staff of psychiatric establishments should receive appropriate training; **any resort to means of restraint should always be either expressly ordered by a doctor or immediately brought to the attention of a doctor; and the application of means of restraint should be for the shortest possible time.**	Persons with disabilities 16. In the light of the Committee's general comment No. 35 (2014) on liberty and security of person, the State party should ensure that **deprivation of liberty is applied only as a measure of last resort and for the shortest appropriate period of time and that it is accompanied by adequate procedural and substantive safeguards established by law.** The State party should ensure **respect for the views of the individual and ensure that any representative genuinely represents and defends the wishes and interests of the individual.** Furthermore, the State party should establish an independent monitoring and reporting system, and ensure that **abuses are effectively investigated and prosecuted and that redress is provided to the victims and their families**. The State party should promote psychiatric care aimed at preserving the dignity of patients, both adults and minors, and **develop a plan for deinstitutionalization, including appropriate outpatient and community-based care programmes.**	20. The Committee recommends that **legal provisions that permit involuntary commitment on the basis of impairment be repealed and that laws**, including the Act on the Protection of Persons with Mental Disorders, be aligned with the Convention. 24. The Committee urgently recommends that immediate steps be taken to address the poor living conditions in institutions, **to end involuntary treatment and to put a stop to the use of restraint measures**. It also recommends that the relevant legislation be brought into line with the Convention, and that **all human rights violations be investigated and the perpetrators prosecuted.**