

European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP)

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ENUSP Shadow report 2015
Submission on CRPD implementation in the European Union,
CRPD-Committee, 14th session

This submission seeks to provide supplementary information to the Committee on implementation of the UN CRPD in the European Union for consideration in the constructive dialogue and the compilation of the Concluding Observations for the European Union at the 14th session of the Committee in August-September 2015.

The **European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP)**¹ is the grassroots, independent representative organisation of mental health service users and survivors of psychiatry at a European level. ENUSP's members are regional, national and local organisations and individuals based in European countries. Since its foundation in 1991, ENUSP has campaigned for the full human rights and dignity of mental health service users and survivors of psychiatry and the abolition of all laws and practices that discriminate against us. ENUSP is currently a consultant to the European Commission, the European Union Fundamental Rights Agency, and the World Health Organization-Europe. ENUSP is a member of European Disability Forum (EDF) and European Patients' Forum (EPF) and part of the World Network of Users and Survivors of Psychiatry (WNUSP).

This submission is following the *ENUSP Proposals for the List of issues on the European Union*² which was sent to the UN CRPD Committee for consideration at its 13th session.

!!! IMPORTANT NOTE !!!

In this submission of ENUSP, the Council of Europe (CoE) is mentioned repeatedly, in order to address the situation of the rights of persons with psychosocial disabilities within the EU, which is deeply impacted by the Council of Europe's treaties and standards.

Please note that the Council of Europe is not part of EU

The Council of Europe is founded in 1949 and is a body independent from EU, currently comprising 47 member states.



logo Council of Europe

Please note the difference with the *Council of the European Union*, and the *European Council* at the EU.

¹ www.enusp.org

² ENUSP proposals for the List of Issues on the European Union:
http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2fCRPD%2fICO%2fEUR%2f19778&Lang=en

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Annex 1: Situation overview of persons with psychosocial disabilities in EU and Member States

Summary:

ENUSP is deeply concerned about the absence of protection and promotion of the rights of persons with psychosocial disabilities on the EU level and in Member States. Persons with psychosocial disabilities across EU are exposed to a range of serious and systemic human rights violations, such as:

- Deprivation of legal capacity
- Deprivation of liberty
- Torture, ill-treatment, violation of the integrity and unnatural deaths
- Lack of access to justice

This remains the case while current human rights standards of the UN require a paradigm shift.

Despite the fact that ratification of the CRPD should also imply advancement of the rights of persons with psychosocial disabilities, and despite the fact that EU could take a variety of actions to remedy the human rights violations on persons with psychosocial disabilities within EU, the EU has not taken any action on these issues.

ENUSP urges the EU to take action to include the rights of persons with psychosocial disabilities in EU's human rights-agenda and remedy the widespread human rights violations against persons with psychosocial disabilities in the EU.

Key suggestions:

→ EU should ensure that the highest applicable standard of human rights applies in the EU, and ensure that CRPD standards supersede the conflicting (non-EU) Council of Europe standards in the EU and in Member States.

→ EU should ensure meaningful consultation and involvement of persons with psychosocial disabilities through their representative organizations in all decision-making processes of the EU, including by ensuring access to resources.

→ EU should take all possible action to end the widespread discriminatory practices and gross and systemic human rights violations against persons with psychosocial disabilities in the EU, particularly by taking measures to ensure that all EU member states repeal all forms of guardianship and substitute decision-making, forced institutionalization, and forced treatment, which should be solidified by framing it as a non-discrimination issue under EU policy and legislation.

→ EU should take all possible actions to ensure that all EU Member States realize an absolute ban on all forced psychiatric interventions, including a ban on the use of solitary confinement, restraints, non-consensual administration of electroconvulsive therapy (ECT) and non-consensual administration of psychiatric and other medication, forced strip search and body cavity search, forced abortion and forced sterilization, and outpatient forced treatment such as Community Treatment Orders (CTOs) in all EU Member States.

→ EU should take action to ensure legal accountability and remedies at the domestic and European level for acts that violate the human rights of persons with psychosocial disabilities, including widespread and severe violations of the rights to recognition before the law, liberty and security of the person, freedom from torture and ill-treatment, and the right to life.

→ EU should take action to ensure that all mental health services in EU's Member States are provided based on the free and informed consent of the person concerned, and that violation of this right is effectively prohibited in the EU, which should be solidified by framing it as a non-discrimination issue under EU policy and legislation.

→ EU should take all possible actions to ban the paternalistic biomedical paradigm of psychiatry from EU, and develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies aimed at promoting the paradigm shift away from the biomedical concepts of 'mental impairment' to a human rights based approach of psychosocial disability, and including actions to raise awareness of the human rights, dignity, autonomy and needs of persons with psychosocial disabilities across the EU.

→ EU should develop a coherent EU approach to guide and foster de-institutionalization, independent living and inclusion of persons with psychosocial disabilities in the community in all Member States of the EU, in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities.

→ EU should ensure that EU Funds cannot be used for ongoing human rights violations, such as segregation and institutionalization of persons with psychosocial disabilities without their free and informed consent.

→ EU should take all possible actions to ensure that all EU Member States develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, a variety of options for support in the community which respect the will and preferences of the person concerned and which are based on the free and informed consent of the person concerned.

→ EU should develop a coherent EU approach to guide and foster the implementation of the rights of persons with psychosocial disabilities in EU and all EU Member States, in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities. Installing a DG on Disability at the European Commission could be an idea.

Prologue : Human rights practices in EU are affected by Council of Europe

In this submission, the Council of Europe (CoE) is mentioned repeatedly.
Please note that the Council of Europe is not part of EU.

A. Council of Europe – European Convention on Human Rights - Article 5.1.e is discriminatory



In European history, since 1950 up to today, the rights of persons with psychosocial disabilities in Europe are largely defined by the Council of Europe.

As was also mentioned in the *ENUSP Proposals for the List of issues on the EU*:

Art 5 of the European Convention on Human Rights (ECHR, 1950) mentions:

“Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
(...) ECHR art 5.1.e: the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants.”

ECHR Art 5.1.e provides legitimate grounds for deprivation of liberty based on psychosocial disability and is contrary to CRPD Article 14 which prohibits all detention based on psychosocial disability³, and which the CRPD Committee has already applied to EU member states in its Concluding Observations⁴.

Although the EU is independent from the Council of Europe, the European Convention on Human Rights (ECHR) is binding law in all EU Member States, since signing the European Convention on Human Rights (ECHR) is a **condition for EU membership**⁵.

As a side note: Also **accession of the EU as a Party to the ECHR** is being considered⁶.

B. A large sequence of discriminatory policies and practices across EU needs to be combatted.

Since 1950, the stigmatizing language in this main European treaty (ECHR, art 5.1.e) has laid the basis for a larger sequence of discriminatory policies and practices across the EU, which has been largely implemented in **EU Member States’ legislation**.



Also several independent (non-EU) European mechanisms, such as the **European Court on Human Rights (ECtHR)**, the **Committee on the Prevention of Torture (CPT)**, and the **Council of Europe- Convention on Human Rights and Biomedicine (Oviedo Convention)** use, prescribe and enhance these stigmatizing standards that run contrary to the CRPD, and allow for substitute decision making and non-

consensual interventions, including acts that amount to torture and ill-treatment on persons with psychosocial disabilities [“mental disorder”].

The discrimination against persons with psychosocial disabilities in EU is widely embedded in practice, legislation, policy, courts and culture throughout the EU, and results in gross and systematic violations of human rights, and additionally prevents access to justice.

³ CRPD Committee’s statement on Article 14

⁴ CRPD Committee’s Concluding Observations on EU Member States: Austria, Belgium, Croatia, Czech Republic, Denmark, Germany, Hungary, Spain and Sweden

⁵ Article 6 of the Treaty on European Union (Maastricht Treaty) mentions that signing the European Convention on Human Rights (ECHR) is a condition for EU membership.

⁶ <http://echr.coe.int/Pages/home.aspx?p=court/accessioneu&c=>



Up to today, several developments at the Council of Europe still promote substitute decision-making, forced institutionalization and forced treatments, such as the ***Draft Additional Protocol to the Oviedo Convention***⁷ (June 2015), which is allowing for forced institutionalization and forced treatments embedded by “safeguards”, and runs contrary to the CRPD.

EU Member States face conflicting obligations between the implementation of the UN CRPD on the one hand, and on the other hand, the still existing standards embedded in several binding Council of Europe Conventions and related jurisprudence by independent (non-EU) mechanisms.

Even when the EU has no legislative competence over the Council of Europe standards and reforms directly, still a variety of actions can be taken by the EU towards Member States, to deal with the conflicting obligations in favour of the CRPD, such as by class-actions towards the Council of Europe.

Recommendation:

→ EU should ensure that the CRPD standards supersede the outdated Council of Europe standards at conflicting articles, - and should either ensure harmonization of the Council of Europe-mechanisms with the CRPD, - or develop a legally binding declaration or a Code of Conduct with regards to the conflicting parts of the Council of Europe-mechanisms, such as on art 5.1.e of the European Convention on Human Rights, the Oviedo Convention (and the Draft Additional Protocol), and the independent (non-EU) European mechanisms which monitor and enforce human rights of people with psychosocial disabilities in EU Member States, such as the European Court on Human Rights (ECtHR) and the Committee on the Prevention of Torture (CPT), to ensure that within the EU, CRPD standards supersede any conflicting standard.

⁷ In June 2015, the Council of Europe’s Committee on Bioethics (DH-BIO) launched a public consultation on the ***Draft Additional Protocol to the Convention on Human Rights and Biomedicine (Oviedo Convention) concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment*** (ref: DH-BIO/INF (2015) 7, www.coe.int/bioethics)

Purpose, Definitions, General Principles and General obligations (art 1-4)

1. EU neglects the rights of persons with psychosocial disabilities also after CRPD ratification

Since the CRPD applies to all persons with disabilities, and one of the core fundamentals of EU is to realize full respect for human rights in EU, it would only have been appropriate if the rights of persons with psychosocial disabilities were included in EUs human rights-agenda, especially regarding the amount of exclusion that persons with psychosocial disabilities experience across EU. Yet, we must conclude that up to today (2015), almost 5 years after EUs ratification of the CRPD, the EU still leaves the exclusion and marginalization of persons with psychosocial disabilities unchanged, and makes no efforts to ban the gross and systematic human rights violations on persons with psychosocial disabilities from the EU, which is in direct **contradiction with the spirit of the CRPD**.

Recommendation on CRPD articles 1, 2 and 3:

→ **EU should take action to include the rights of persons with psychosocial disabilities in EUs human rights-agenda and remedy the widespread human rights violations on persons with psychosocial disabilities in the EU, including by developing specific programmes and policies aimed at the protection and promotion of the rights of persons with psychosocial disabilities in the EU, and measures to facilitate a paradigm shift and change of practices in EU Member States, in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities.**

2. Meaningful involvement of persons with psychosocial disabilities in EU policy making is not realized

Historically, persons with psychosocial disabilities have been excluded from participation in decision-making processes, since the **validity of opinions** of persons with psychosocial disabilities is often doubted. Policy makers are more likely to rely on **substitute opinions** of mental health service providers, family members and other caregivers who claim to speak in the 'best interest' of persons with psychosocial disabilities. The lack of value ascribed to the lived experience and expertise of people with psychosocial disabilities as compared to professional knowledge is a huge barrier to meaningful participation. Additionally, in policy making across the EU, the paternalistic medical model approach is still dominant. Within the **predefined margins** of the paternalistic medical model approach and its **impure scope and inappropriate concept of mental health care**, such as allowing for substitute decision-making, forced institutionalization and forced treatments, meaningful participation is also impossible.

The meaning of participation is to stop being regarded as 'objects' of the discussion, and to acquire different roles which enable persons with psychosocial disabilities and their representative organizations such as ENUSP, to enter the dialogue and shape the discussion and its outcomes. Yet, despite the ratification of the CRPD by the EU, ENUSP has experienced no changes in the systematic exclusion of persons with psychosocial disabilities from decision making processes across the EU and its Member States.

EU funding has the potential to empower organizations of persons with psychosocial disabilities. Yet in practice, the complexity of EU funding applications and the 20-80 ratio for EU funding⁸ constitute barriers for the respective organizations of persons with psychosocial disabilities, especially when they may not have any other resources.

⁸ EU funding requires that applicants have 20% of the total budget of the funding application themselves, and EU funding can supply the remaining 80% of the total budget of the funding application.

Recommendations on CRPD article 4:

→ EU should ensure meaningful consultation and involvement of persons with psychosocial disabilities through their representative organizations in all decision-making processes of the EU, and develop a Code of Conduct which should include specific measures to ensure that the views of persons with psychosocial disabilities are meaningfully included throughout all processes and not marginalized or substituted by the views of professionals or others.

→ Also, EU should ensure that persons with psychosocial disabilities have access to resources such as EU funding to organize and represent themselves through their respective local, regional, national and European organizations. And in addition, the EU should guarantee that the 20-80 ratio for European funding⁹ does not constitute a barrier for the respective organizations of persons with psychosocial disabilities, especially when they may not have any other resources.

Equality and non-discrimination (art 5)

3. EU makes no efforts to end discrimination against persons with psychosocial disabilities in EU

An actual or perceived psychosocial disability or diagnosis should not lead to a loss of rights. Yet, within EU and its Member States, **persons with psychosocial disabilities can still be stripped of their rights on the basis of an actual or perceived psychosocial disability**, either in itself or in combination with additional grounds, such as for example presumed dangerousness or so-called ‘need for treatment’, which is a blunt discriminatory practice, and is harmful, and not helpful nor “care”. It is a core violation of human rights and needs to be prohibited.

The EU has a clear duty to **combat discrimination and to ensure equality** as a fundamental step in the protection and promotion of human rights. Even when the EU has no legislative competence over the Member States legislation directly, still a variety of actions can be taken by the EU towards Member States, to ensure an end to discriminatory practices and gross and systemic human rights violations. Even when the current work domains of the EU may contain limited possibilities for taking EU action to remedy the violations of the rights of persons with psychosocial disabilities in Member States, the EU has a clear duty to advance human rights and to take all appropriate measures to ensure the full realization and implementation of human rights for all persons with disabilities in the EU, which includes taking measures to advance the rights of persons with psychosocial disabilities. Also the references to ‘shared competences’ or ‘supporting competence’ of EU mentioned at various work domains of the EU imply that EU is not powerless on these domains, and that the autonomy of Member States is not limitless, but **there is a meaningful role to play for the EU**.

The right to legal capacity for persons with psychosocial disabilities on an equal basis with others, can be solidified by framing it as a non-discrimination issue under EU policy and legislation.

Also the right to liberty, the right to be free from torture and other cruel inhuman or degrading treatment or punishment, and the right to respect for integrity of persons with psychosocial disabilities on an equal basis with others, can be solidified by framing it as a non-discrimination issue under EU policy and legislation.

⁹ EU funding requires that applicants have 20% of the total budget of the funding application themselves, and EU funding can supply the remaining 80% of the total budget of the funding application.

Recommendations on CRPD article 5:

→ EU should take all possible action to ensure equality and non-discrimination of all EU citizens, including persons with psychosocial disabilities on an equal basis with others, including all possible action to end the widespread discriminatory practices and gross and systemic human rights violations against persons with psychosocial disabilities in the EU, particularly by taking measures to ensure that all EU member states repeal all forms of guardianship and substitute decision-making, forced institutionalization, and forced treatment, which should be solidified by framing it as a non-discrimination issue under EU policy and legislation.

→ EU should develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific measures, programmes and policies aimed at ensuring that a perceived or actual psychosocial disability or diagnosis does not lead to a loss of fundamental human rights for EU citizens.

Women with disabilities (art 6)

4. Women with psychosocial disabilities in EU still at higher risk of violations

5 years after EUs ratification of the CRPD, women with psychosocial disabilities in institutions and in the community within EU and its Member States are still facing **double disadvantage** due to stigma and multiple discrimination, and are at higher risk of abuses, including being considered as ‘incapable’ in the views of others. A relatively very large number women with psychosocial disabilities in the EU¹⁰ is subjected to **forced abortion and forced sterilization**, based on presumptions of “incapacity”, while forced sterilization and forced abortion is considered illegal on persons without disabilities in the EU.

The EU has clear competences to ensure equality, and to ensure that women with psychosocial disabilities enjoy the same full set of human rights on an equal basis with other persons in the EU. Yet, no targeted measures have been taken by EU to alleviate the risks of human rights violations that women with psychosocial disabilities are confronted with within EU and its Member States.

Recommendation on CRPD article 6:

→ EU should develop in close and meaningful cooperation with the representative organizations of women with psychosocial disabilities, specific programmes and policies aimed at preventing abuse and discrimination on women with psychosocial disabilities, including an immediate end to forced abortion and forced sterilization, and targeted measures to combat stigma, and to support women with psychosocial disabilities in getting access to their rights.

Children with disabilities (art 7)

5. Children with psychosocial disabilities in EU remain excluded

Although in some EU Member States efforts are made for the de-institutionalization of children with psychosocial disabilities, children with psychosocial disabilities in the EU are still at a high risk of **disability-based segregation**, for example by special education and institutionalization.

¹⁰ Exact numbers on forced abortion and forced sterilization are unknown, but to our knowledge, the vast majority of reported cases of forced abortion or forced sterilization in the EU is related to women with psychosocial and/or intellectual disabilities.

Additionally, children with psychosocial disabilities in the EU are also at a high risk of being subjected to non-consensual and forced psychiatric interventions, including the administration of psychopharmaceutical medication and treatments aimed at **correcting a psychosocial disability** without the free and informed consent of the child concerned, which is in violation of the right to respect for inherent dignity, human differences and the acceptance of children with psychosocial disabilities as part of the human diversity and humanity.

On top of that, children with psychosocial disabilities face **numerous barriers regarding access to justice**, due to presumptions of ‘disability-based incapacity’ on top of age-discrimination, and additionally, a massive lack of information and support in executing their rights.

The promotion of children’s rights is an integral part of EU fundamental rights objectives set out by EU law ¹¹, implying that EU has a duty to take action to ensure that children with psychosocial disabilities enjoy all fundamental rights and freedoms on an equal basis with other children with or without disabilities. Yet, despite the fact that the CRPD has been ratified by the EU and virtually all its Member States¹², and despite the evident vulnerability of children with psychosocial disabilities, and taking into account the existing widespread and severe violations and deprivations of the rights of children with psychosocial disabilities across the EU, it is appalling that the EU has not developed a coherent EU-wide strategy to ensure an end to the violation of children’s rights. Even when the EU may not have direct legislative competence on children’s rights in EU Member States, still a variety of actions can be taken by the EU towards Member States to ensure a change of practices. For example, on the issue of eradicating Child Poverty the EU does not have legislative competence, but still has made a strong policy document on this theme (European Commission Recommendation “Investing in Children”, 2013).

Recommendations on CRPD article 7:

→ **EU should develop specific programmes and policies to protect the rights of children with psychosocial disabilities in EU, and ensure the realization of a prohibition of all forms of disability-based non-consensual interventions on children with psychosocial disabilities, including a prohibition of disability-based segregation, institutionalization and non-consensual treatments of children with psychosocial disabilities throughout all EU Member States, and ensure that any violation of this prohibition in the EU is sanctioned.**

→ **EU should take steps to ensure effective access to justice for children with psychosocial disabilities, including by developing specific programmes and policies aimed at supporting children with psychosocial disabilities in executing their rights, including prior to and during violations, and include prevention and timely remedies of injustices.**

→ **EU should develop ways to enable children and youth with psychosocial disabilities to participate in EU policy making meaningfully.**

Awareness raising (art 8)

6. EUs passive attitude infringes the rights of persons with psychosocial disabilities in EU

Despite the fact that as a regional body, the EU could do a lot on awareness-raising to promote the rights of persons with psychosocial disabilities across the EU, the EU has not taken action to promote awareness on the rights of persons with psychosocial disabilities.

¹¹ Children’s rights are mentioned in Article 3 of the TEU and Article 24 of the EU Fundamental Rights Charter.

¹² All EU member States are either Signatories (3) or State Parties (25) to the UN CRPD.

On the other hand, the non-EU guidelines for involuntary treatments prescribed by the Council of Europe-mechanisms (see Prologue) carry a wrong signal to Member States as if involuntary treatments could be a so-called “good practice”, instead of it being recognized as a core human rights violation. These guidelines invoke the practice of involuntary treatments.

Yet, the EU still has **not taken any action to nullify discriminatory provisions** of the Council of Europe-mechanisms and its provisions which affect all EU Member States, while for example, drafting a Code of Conduct to move away from discriminatory parts of Council of Europe standards (such as ECHR 5.1.e and the Oviedo Convention) is a relatively easy step to take for the EU, and which could be an effective way to raise awareness on the rights of persons with psychosocial disabilities in the EU, and provide a clear guidance to Member States to abide by the obligations set out under the CRPD instead of following the conflicting discriminatory parts of Council of Europe-mechanisms.

Also, EU shows **no resistance to violations of the CRPD by its Member States in the case of law reforms that allow for substitute decision-making, forced institutionalization and forced treatment of persons with psychosocial disabilities**, (see art 33), which is also contrary to awareness-raising.

EUs **passive attitude** towards grave violations upholds the wrongful suggestion as if the rights of persons with psychosocial disabilities are not important for the EU and its mission to secure human rights for all persons. In that way, the EU becomes part of the problem, instead of part of the solution. It is not a question of EUs competence on awareness raising, but it is a question of EUs willingness to promote the rights of persons with psychosocial disabilities in the EU.

Recommendations on CRPD article 8

→ **EU should take an active role to raise awareness on the rights of persons with psychosocial disabilities across the EU, in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities.**

→ **EU should develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies to raise awareness on the rights of persons with psychosocial disabilities, including the provision of information and training on the rights of persons with psychosocial disabilities, and including a Code of Conduct regarding the discriminatory provisions of the Council of Europe-mechanisms which conflict with the obligations set out under the CRPD.**

→ **EU should take effective measures to counter the profiling of stereotypes and stigmatization of persons with psychosocial disabilities, including by ending doctrines of “unsound mind”, “danger to self or others”, “need for treatment”, and “incapable of consenting”, across all layers of the EU and in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities.**

Accessibility (art 9)

7. EU leaves barriers for persons with psychosocial disabilities unchanged

A ‘barrier free EU’ for persons with psychosocial disabilities is far from realized.

Generally, EU citizens with psychosocial disabilities are either segregated from the community, or left without sufficient support in the community where they face a large amount of attitudinal and other barriers in regards to participation and inclusion in the community, such as stigma, prejudice, fear, discrimination and exclusion.

Despite EUs obligations on equality, non-discrimination, the fight against social exclusion and the promotion and protection of fundamental rights, EU is **not taking action** to ensure accessibility of

communities for persons with psychosocial disabilities, nor developing a coherent plan or strategy to ensure accessibility for persons with psychosocial disabilities, and leaves the barriers unchanged.

Yet, EU does intend to foster the de-institutionalization of persons with psychosocial disabilities. Obviously, de-institutionalization without investing in accessible communities and the availability of community-based support bears a high **risk** of resulting in other problematic situations.

Currently, the **austerity measures** have worsened the social-economic situation of persons with psychosocial disabilities and budget cuts have caused reduction in the provision of services in all EU Member States, resulting in **increased barriers** for the participation and inclusion of persons with psychosocial disabilities.

Even when the EU has no legislative competence over the Member States legislation directly, still a variety of actions can be taken by the EU, to ensure that barriers are removed and communities are accessible for the participation of persons with psychosocial disabilities. And even when the current work domains of the EU may offer limited possibilities for taking EU action to remedy the barriers and the lack of community-based support for persons with psychosocial disabilities in Member States, the EU has a clear duty to advance human rights and to take all appropriate measures to ensure the full realization of human rights in the EU, which includes taking measures to advance the rights of persons with psychosocial disabilities.

Recommendation on CRPD article 9:

→ **EU should take action and develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies aimed at ensuring accessibility for persons with psychosocial disabilities in all communities in the EU, the removal of barriers including stigma, the realization of community based support in line with the will and preferences of the person concerned including non-medical alternatives, and research and awareness-raising on accessibility-concepts and practices across the EU.**

Right to life (art 10)

8. EU is negligent to preventable deaths of persons with psychosocial disabilities in EU

ENUSP members report on dreadful practices throughout the EU, where institutionalization and forced psychiatric interventions, including the direct use of force, violence, restraints, medication and negligence has caused the death of persons with psychosocial disabilities. It appears that **deadly psychiatric interventions happen across the EU, and in some psychiatric institutions the mortality rates are shockingly high**. Some of these cases are reported in the media. Exact numbers are unknown. A unique research in the UK shows staggering numbers of unnatural deaths of persons with psychosocial disabilities while deprived of their liberty in the UK¹³.

In most cases access to justice is impossible, because national laws and the binding directives of the Council of Europe, which are enforced in all EU member states, allow for forced psychiatric interventions and involuntary treatment, resulting in **impunity** for psychiatric and other staff that perpetrates these acts of torture and ill-treatment, even in the case of acts directly resulting in the death of the person. Some of these horrific cases are reported in the media.

¹³ Preventing Deaths in Detention of Adults with Mental Health Conditions, An Inquiry by the Equality and Human Rights Commission, UK, 4 March 2015 <http://www.equalityhumanrights.com/publication/preventing-deaths-detention-adults-mental-health-conditions>

By ratifying the CRPD, the EU has taken up a responsibility to ensure human rights also for persons with psychosocial disabilities, which is not a new task, but rather a new focus.

Every person has the right to live and should not be unjustly killed by another person. EU claims that human rights are a central value. **There can be no excuse to ignore preventable deaths of persons with psychosocial disabilities in EU.**

Recommendations on CRPD article 10:

→ **EU should take immediate action and put in place measures to ensure protection of the lives of persons with psychosocial disabilities whose life is in danger and/or are at risk of dying by forced or otherwise harmful psychiatric interventions or other discriminatory violence in the EU Member States.**

→ **EU should take measures to ensure that persons who engage in actions, including psychiatric interventions, which result in the death of persons with psychosocial disabilities, including when they are psychiatric or other staff, are held responsible for these actions under domestic and EU law.**

Equal recognition before the law (art 12)

9. **EU skips the right to legal capacity of persons with psychosocial disabilities in EU**

Within EU Member States, an actual or perceived psychosocial disability or diagnosis can still lead to a tremendous loss of rights, such as deprivation of legal capacity and substitute decision-making.

Substitute decision-making and guardianship regimes for persons with psychosocial disabilities exist in all EU member states. Plenary or full substitute decision-making exists in at least 25 EU member states¹⁴. The CRPD calls for an end to substitute decision-making.

In many EU Member States, the domestic laws on substitute decision-making, forced institutionalization and forced treatments are in a process of being reviewed. Yet despite EU ratification of the CRPD, and despite the fact that all 28 EU Member States are either Signatories (3) or States Parties (25) to the CRPD, **none of the EU States Parties have abolished substitute decision-making and forced interventions by law**, but instead they maintain laws, or create new laws, authorizing for substitute decision-making, forced institutionalization and forced treatments, and thereby flagrantly violating their obligations as States Parties or Signatories to the CRPD.

EU shows no resistance to these violations of the CRPD by its Member States and takes no action.

Abolition of the offending laws is a necessary step to realize equality in the EU.

Deprivation of legal capacity of persons with psychosocial disabilities in the EU is inherently associated with discrimination and stereotyping of persons with psychosocial disabilities. A psychosocial disability or a need for support does not justify the deprivation of fundamental rights.

In line with the CRPD and EU's promises on equality, non-discrimination, the fight against social exclusion and the promotion and protection of fundamental rights, EU clearly has a responsibility to secure the right to legal capacity equally for all persons, including for persons with psychosocial disabilities. Actions are needed to close the gap and to realize that all persons with psychosocial disabilities in EU are enabled to make their own decisions.

¹⁴ Mental Health Europe (MHE): 2012 report: Mapping Exclusion, p22.

Even when the EU has no direct legislative competence over the law reforms of Member States, still **a variety of actions can be taken**¹⁵, such as awareness-raising, new policy making, resourcing, incentives and sanctions, to firmly influence developments in order to stop the violation of the right to legal capacity of persons with psychosocial disabilities in the EU.

Instead of substitute decision-making practices, it is needed to **create support** which respects the will and preferences of the person concerned. Adequate supportive systems to enable independent or supported decision-making by persons with disabilities, including the provision of information to enable free and informed consent including on alternatives to the medical model, and the provision of community-based support and supported decision-making practices still need development across all EU Member States, which is another area where the EU could take action to realization of the right to legal capacity persons with psychosocial disabilities and prevent substitute decision-making.

Yet EU is not making any efforts to ban substitute decision-making from the EU, nor makes any efforts to ensure the exercise of legal capacity of persons with psychosocial disabilities in the EU.

The EU has a clear duty to advance human rights and to take all appropriate measures to ensure the full realization and implementation of human rights for all persons with disabilities in the EU, which includes taking measures to advance the rights of persons with psychosocial disabilities. The references to 'shared competences' or 'supporting competence' of EU mentioned at various work domains of the EU imply that EU is not powerless on these domains, and that the autonomy of Member States is not limitless, but there is a meaningful role to play for the EU.

Recommendations on CRPD article 12:

→ **EU should take all possible actions to ensure that all EU Member States repeal all forms of guardianship and substitute decision-making, and that they promote and realize support systems.**

→ **The right to legal capacity for all EU citizens, including those with psychosocial disabilities on an equal basis with others, should be solidified by framing it as a non-discrimination issue under EU policy and legislation.**

→ **EU should ensure that CRPD standards supersede the outdated (non-EU) Council of Europe-standards within EU.**

→ **EU should take action towards Member States in case of clear violations of the CRPD, such as law reforms which maintain forms of guardianship and substitute decision making for persons with psychosocial disabilities.**

→ **EU should take action to adopt a legal framework that explicitly protects the right to legal capacity for all persons with psychosocial disabilities, and enforces a prohibition against deprivation of legal capacity.**

→ **EU should develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies aimed at the development of adequate supportive systems to enable independent or supported decision-making by persons with psychosocial disabilities in the EU, including by sharing knowledge on the provision of information, community-based support and supported decision-making practices which respect the will and preferences of the person concerned.**

→ **EU should make efforts to convince Member States to revoke any declaration on CRPD article 12**

¹⁵ For example: The EU has no legislative competence over education (only supportive competence), yet there is a DG Education at the European Commission, and several EU programmes to promote learning.

Access to justice (art 13)

10. EU is not resolving barriers to access to justice for persons with psychosocial disabilities in EU

Stigma and exclusion impose significant barriers on access to justice for persons with psychosocial disabilities across EU member states. The incapacity-approach towards persons with psychosocial disabilities generally results in a culture of procedures and attitudes that do not take persons with psychosocial disabilities seriously as litigants for the protection of their human rights in the courts, which prevents access to justice.

Additionally, the existence of legal norms contrary to the CRPD on substitute decision-making, forced institutionalization and forced psychiatric treatment is an insurmountable barrier to access to justice for people with psychosocial disabilities. Domestic laws in EU Member States and the binding directives of the Council of Europe (non-EU) which are enforced in all EU Member States, allow for forced psychiatric interventions and involuntary treatment, resulting in **impunity** for psychiatric and other staff that perpetrates these acts of torture and ill-treatment, even in the case of acts directly resulting in the death of the person.

Abolition of the offending laws is a first and necessary step in reparations, and **attitudinal barriers** need to be addressed and resolved. In addition, **reparations and remedies** for the harm that has already been committed must be provided as set out in the Basic Principles and Guidelines on the Right to a Remedy and Reparations for Victims of Gross Violations on Human Rights and Serious Violations of International Humanitarian law of 2006.¹⁶

The EU has shared competences in the area of freedom, security and justice (TFEU art 4,2(j)), which implies that EU is not powerless on these domains, and that the autonomy of Member States is not limitless, but there is a meaningful role to play for the EU. Even when the EU has no direct legislative competence over the laws and practices of Member States, still a variety of actions can be taken, such as awareness-raising, new policy making, resourcing, incentives and sanctions, to firmly influence development of access to justice for persons with psychosocial disabilities in the EU.

Recommendations on CRPD article 13:

→ **EU should take all possible actions to ensure repeal of all discriminatory norms on the domestic and international level which allow for substitute decision-making, forced institutionalization and forced treatments based on psychosocial disability and which prevent effective access to justice for persons with psychosocial disabilities.**

→ **EU should take all possible actions to ensure that all barriers to access to justice for persons with psychosocial disabilities are resolved in all EU Member States, and EU should support and stimulate access to justice for persons with psychosocial disabilities on an equal basis with others in the EU, which could be integrated into European non-discrimination frameworks and policies.**

→ **EU should take action to ensure legal accountability and remedies at the domestic and European level for acts that violate the human rights of persons with psychosocial disabilities, including widespread and severe violations of the rights to recognition before the law, liberty and security of the person, freedom from torture and ill-treatment, and the right to life.**

¹⁶ A/RES/60/147.

Liberty and security of person (art 14)

11. EU fails to restore liberty of persons with psychosocial disabilities

An actual or perceived psychosocial disability or diagnosis should not lead to deprivation of liberty. **Yet, deprivation of liberty based on actual or perceived psychosocial disabilities, either in itself or in combination with additional criteria such as supposed dangerousness or so-called need for treatment, is taking place in all EU Member States.**

Despite the significant shift in international law brought about by the CRPD, EU States Parties have not moved to abolish by law these violent practices, and face conflicting obligations between the implementation of the UN CRPD on the one hand, and on the other hand, the still existing standards embedded in several binding Council of Europe Conventions and related jurisprudence by independent (non-EU) mechanisms. EU shows **no resistance** to law reforms contrary to the CRPD by its Member States and takes **no action against the discriminatory domestic and international laws** which allow for deprivation of liberty on the basis of psychosocial disability.

The EU has shared competences in the area of freedom, security and justice (TFEU art 4,2(j)), which implies that EU is not powerless on these domains, and that the autonomy of Member States is not limitless, but there is a meaningful role to play for the EU. Even when the EU has no direct legislative competence over the laws and practices of Member States, still a variety of actions can be taken, such as awareness-raising, new policy making, resourcing, incentives and sanctions, to firmly influence the realization of the right to liberty for persons with psychosocial disabilities on an equal basis with other citizens in the EU. Yet despite having various options for taking action, **EU is not making any efforts to ban deprivation of liberty based on psychosocial disability from the EU.**

Additionally, **EU Funds** are still being used to fund institutionalization and ongoing deprivation of liberty of persons with psychosocial disabilities in the EU, which is amongst others in violation of CRPD art 14 and 19.

Instead of deprivation of liberty, it is needed to **create a variety of options for support in the community** which respects the will and preferences of the person concerned and is based on the free and informed consent of the person concerned. Adequate supportive systems in the community still need development across all EU Member States, which is another area where the EU could take action to realize the right to liberty and security of persons with psychosocial disabilities and to prevent deprivation of liberty.

Recommendations on CRPD article 14:

→ **EU should take all possible actions to ensure liberty of persons with psychosocial disabilities in the EU on an equal basis with others, including all possible actions to ensure that all EU Member States repeal legal provisions that authorize deprivation of liberty based on a psychosocial disability, and that they end institutionalization and treatment without the free and informed consent of the person concerned.**

→ **The right to liberty for all EU citizens, including persons with psychosocial disabilities on an equal basis with others, should be solidified by framing it as a non-discrimination issue under EU policy and legislation.**

→ **EU should ensure that EU Funds cannot be used for ongoing human rights violations, such as segregation and institutionalization of persons with psychosocial disabilities without their free and informed consent.**

→ **EU Funds which are applied to the institutionalization and segregation of persons with psychosocial disabilities should be ended.**

→ EU Funds should be used only for services which facilitate the enjoyment of the right to live in the community independently, including only these mental health services which are based on free and informed consent of the person concerned.

→ EU should take all possible actions to ensure that all EU Member States develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, a variety of options for support in the community which respect the will and preferences of the person concerned and which are based on the free and informed consent of the person concerned.

→ EU should ensure that CRPD standards supersede the outdated (non-EU) Council of Europe standards within EU.

→ EU should take action to adopt a legal framework that explicitly protects the right to liberty for all persons with psychosocial disabilities, and enforces a prohibition against deprivation of liberty based on psychosocial disability.

The right to be free from torture and other cruel, inhuman or degrading treatment and punishment (art 15)

12. EU ignores ongoing torture and ill-treatment of persons with psychosocial disabilities in EU

Torture and cruel inhuman or degrading treatment and punishment is taking place in all Member States of the European Union by **a large variety of forced psychiatric interventions**, including by forced institutionalization and segregation from the community, forced medication, forced electroconvulsive therapy (ECT), restraints such as belts and caged beds, solitary confinement, forced strip search and body cavity searches, and forced abortion and forced sterilization, and by outpatient forced treatment such as Community Treatment Orders (CTOs)¹⁷. This remains the case while current human rights standards of the UN require a ban on involuntary psychiatric treatments, as declared by the CRPD Committee in General Comment No. 1 paragraph 42, and by the Special Rapporteur on Torture in paragraph 89(b) of his 2013 thematic report¹⁸.

On top of that, in relation to article 15 of the CRPD, several EU Member States made **declarations on the interpretation of consent** as “consent in conformity with international standards that relate to human rights and biomedicine¹⁹, and national legislation²⁰” which refers to provisions allowing for forced interventions which constitute torture and ill-treatment on persons with psychosocial disabilities.

As a side-note, it is important to realize that the Council of Europe-mechanisms (non-EU), such as the European Court on Human Rights (ECtHR) and the Committee of the Prevention of Torture (CPT), which are applied to every EU country, use **other definitions of torture and ill-treatment which run contrary to the CRPD**, since they use standards based on the Council of Europe’s directives, and still allow for forced interventions based on psychosocial disability, contrary to the CRPD. A unified definition of torture and ill-treatment in line with the CRPD across EU is needed to ensure that

¹⁷ Community Treatment Orders (CTOs) are an extension of forced psychiatric treatments into community, which implies a conditional suspension of forced institutionalization on the condition of complying to forced psychiatric treatment regulations in the community, such as taking psychopharmaceutical medication.

¹⁸ A/HRC/22/53 Special Rapporteur on Torture (Mendez), 2013 thematic report: Torture in health care settings http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

¹⁹ Oviedo Convention on Human Rights and Biomedicine of the Council of Europe

²⁰ France (ratified) and the Netherlands (signatory)

violations of the right to be free from torture and other cruel inhuman degrading treatment or punishment on persons with psychosocial disabilities are recognized, prohibited and remedied in EU Member States.

Yet also in regards of preventing torture and ill-treatment, the EU has taken **no action** to secure the rights of persons with psychosocial disabilities and leaves the situation unchanged.

The prohibition of torture and other cruel, inhuman or degrading treatment or punishment is absolute. There can be no excuse to ignore the ongoing torture and ill-treatment of persons with psychosocial disabilities in EU.

Recommendations on CRPD article 15:

→ EU should declare that all forms of forced psychiatric interventions violate the right to be free from torture and ill-treatment, as declared by the CRPD Committee in General Comment No. 1 paragraph 42, and by the Special Rapporteur on Torture in paragraph 89(b) of his 2013 thematic report.

→ EU should take steps to ensure that a full ban on torture and ill-treatment applies in the EU, including by ensuring unified definitions of torture and ill-treatment in line with the CRPD in EU.

→ The right to be free from torture and other cruel inhuman or degrading treatment or punishment for all EU citizens, including persons with psychosocial disabilities on an equal basis with others, should be solidified by framing it as a non-discrimination issue under EU policy and legislation.

→ EU should ensure that CRPD standards supersede the outdated (non-EU) Council of Europe standards within EU,

→ EU should take all possible actions to ensure that all EU Member States realize an absolute ban on all forced psychiatric interventions, including a ban on the use of solitary confinement, restraints, non-consensual administration of electroconvulsive therapy (ECT) and non-consensual administration of psychiatric and other medication, forced strip search and body cavity search, forced abortion and forced sterilization, and outpatient forced treatment such as Community Treatment Orders (CTOs) in all EU Member States.

→ EU should make efforts to convince its Member States to revoke any declaration on CRPD article 15, and ensure that within the EU consent is interpreted according to the principles of the CRPD.

Freedom from exploitation, violence and abuse (art 16)

13. EU fails to protect persons with psychosocial disabilities at high risk of exploitation, violence and abuse in EU.

According to a WHO-study (2012) on Violence against adults and children with disabilities²¹, persons with psychosocial disabilities are at **much higher risk** of being exposed to exploitation, violence and abuse. Children with psychosocial disabilities appear among the most vulnerable, with 4.6 times the risk of sexual abuse than their non-disabled peers. Adults with psychosocial disabilities are at nearly 4 times the risk of experiencing violence. Factors which place people with disabilities at higher risk of violence include **stigma, discrimination, and ignorance about disability**, as well as a lack of social support for those who care for them. Placement of persons with psychosocial disabilities in institutions increases their vulnerability to violence.

²¹ WHO (2012) Violence against adults and children with disabilities <http://www.who.int/disabilities/violence/en/>

EU has a clear competence to combat discrimination and ensure equality for all EU citizens, and should take action to ensure that persons with psychosocial disabilities are free from exploitation, violence and abuse on an equal basis with others. Yet, while a variety of actions could have been taken by EU to combat exploitation, violence and abuse on persons with psychosocial disabilities in the EU, sadly, we conclude that **EU does not make any effort to protect persons with psychosocial disabilities and to prevent exploitation, violence and abuse.**

Recommendations on CRPD article 16:

→ **The right to be free from exploitation, violence and abuse for all EU citizens, including persons with psychosocial disabilities on an equal basis with others, should be solidified by framing it as a non-discrimination issue under EU policy and legislation.**

→ **EU should take all possible actions to prevent occurrence of exploitation, violence and abuse against persons with psychosocial disabilities in all EU Member States, and develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies aimed at preventing exploitation, violence and abuse against persons with psychosocial disabilities throughout EU, and including the realization of support and access to justice for persons with psychosocial disabilities who are victims of exploitation, violence or abuse in the community and in institutions within EU and Member States.**

Protecting the integrity of the person (art 17)

14. EU makes no efforts to protect the integrity of persons with psychosocial disabilities in EU

The medical model-approach of “persons of unsound mind” gave rise to a biomedical industry, which has developed many harmful, invasive and irreversible treatments, such as electroconvulsive therapy (ECT), neuroleptics and other harmful psychopharmaceutical drugs, with the aim to correct the disability. Within the EU and its Member States, the biomedical explanation of **the word ‘dignity’** is often misused against persons with psychosocial disabilities in order to promote **non-consensual invasive and irreversible interventions aimed at repairing, correcting or alleviating a psychosocial disability without free and informed consent of the person concerned**, instead of the human rights based approach to dignity as the lived experience of the person.

In this way, the right to respect and protection of bodily and psychosocial functioning of persons with psychosocial disabilities on an equal basis with others, is violated and even nullified on the basis of the existence of a psychosocial disability or diagnosis, which is **a clear form of discrimination.**

EU clearly has competences to combat discrimination, and additionally, EU has shared competences in the area of freedom, security and justice (TFEU art 4,2(j)), which implies that EU is not powerless on these domains, and that the autonomy of Member States is not limitless, but there is a **meaningful role** to play for the EU. Even when the EU has no direct legislative competence over the laws and practices of Member States, still **a variety of actions can be taken**, such as awareness-raising, new policy making, resourcing, incentives and sanctions, to firmly influence the realization of protection of the integrity for persons with psychosocial disabilities on an equal basis with other citizens in the EU. Yet despite having various options for taking action, **EU is not making any efforts to protect the integrity of persons with psychosocial disabilities in the EU.**

Recommendations on CRPD article 17:

→ **The right to integrity for all EU citizens, including persons with psychosocial disabilities on an equal basis with others, should be solidified by framing it as a non-discrimination issue under EU policy and legislation.**

→ EU should take all possible actions to promote the human rights based concept of dignity of a person with psychosocial disabilities, and to prohibit the wrongful biomedical paradigm of 'dignity' depending on health status.

→ EU should ensure that all non-consensual invasive and irreversible interventions aimed at repairing, correcting or alleviating a psychosocial disability without free and informed consent of the person concerned are prohibited within EU.

Living independently and being included in the community (art 19)

15. EUs approach to de-institutionalization of persons with psychosocial disabilities needs to be broadened.

As a result of history up to today, persons with psychosocial disabilities have traditionally not been part of diversity in the communities across the EU so far. Generally, EU citizens with psychosocial disabilities are either segregated from the community by institutionalization, or left without sufficient support in the community where they face a large amount of attitudinal and other barriers in regards to participation and inclusion in the community, such as stigma, prejudice, fear, discrimination, exclusion, violence and abuse.

As already mentioned, **EU does intend to foster the de-institutionalization** of persons with psychosocial disabilities, which is a positive move.

Yet, **EU Funds** are still being used to fund institutionalization and ongoing deprivation of liberty of persons with psychosocial disabilities in the EU, which is amongst others in violation of CRPD art 14 and 19, and runs counter to the goal of de-institutionalization.

Additionally, de-institutionalization **without investing in accessible, inclusive communities and the availability of community-based support** bears a high risk of resulting in other problematic situations.

Currently, under the flag of de-institutionalization initiatives, several institutional habits are finding a way into the community, such as segregation in smaller-sized institutions, sheltered unpaid /underpaid work, and **outpatient forced treatment such as Community Treatment Orders (CTOs)**. Community Treatment Orders (CTOs) are an extension of forced psychiatric treatments into community, which implies **a conditional suspension of forced institutionalization on the condition of complying to forced psychiatric treatment regulations in the community, such as taking psychopharmaceutical medication**. Outpatient involuntary treatment in form of Community Treatment Orders has been introduced in various EU Member States (Scotland and Wales (2005), Netherlands (2004), England (2008), Denmark (2010), Sweden (2008) and appear to be spreading.

EU shows no reaction to these violations of the CRPD by its Member States. However, like any other form of forced psychiatric treatment, Community Treatment Orders should be regarded as acts of torture and other cruel, inhuman or degrading treatment or punishment, and should be absolutely prohibited in EU. And because it is a form of discrimination on the basis of a psychosocial disability, there is a role to play for EU, especially when considering the fact that EU already makes efforts to foster the de-institutionalization of persons with psychosocial disabilities in the EU.

EU has shared competence for the promotion of independent living and inclusion in the community, and has a clear competence to combat discrimination, has a shared competence in the area of freedom, security, justice, and on common safety concerns in public health matters, and has supporting competence in health protection, which means that the **EU can and should complement Member States' policies in various ways**.

Even when the EU has no direct legislative competence over the laws and practices of Member States, still a variety of actions can be taken to ensure an immediate end to forced outpatient treatment and Community Treatment Orders, and to develop **a coherent EU approach to foster de-institutionalization, independent living and inclusion** of persons with psychosocial disabilities in the community.

Recommendations on CRPD article 19:

→ **EU should take all possible actions to combat and prohibit outpatient forced treatment such as Community Treatment Orders (CTOs) and to ensure that all mental health services in EU are provided based on the free and informed consent of the person concerned, which should be solidified by framing it as a non-discrimination issue under EU policy and legislation.**

→ **EU should ensure that EU Funds cannot be used for ongoing human rights violations, such as segregation and institutionalization of persons with psychosocial disabilities without their free and informed consent, and not for initiatives that maintain social inequality and segregation of persons with psychosocial disabilities, including Community Treatment Orders.**

→ **EU Funds which are applied to the institutionalization, segregation or any other violation of the rights of persons with psychosocial disabilities should be ended.**

→ **The EU Funds should be used only for services which facilitate the enjoyment of the right to live in the community independently, including only these mental health services which are based on free and informed consent of the person concerned.**

→ **EU should develop a coherent EU approach to guide and foster de-institutionalization, independent living and inclusion of persons with psychosocial disabilities in the community in all Member States of the EU, in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities.**

Respect for home and family (art 23)

16. EU makes no efforts to prevent forced separation of persons with psychosocial disabilities and their families in EU

Across the EU and its Member States, persons with psychosocial disabilities and their families can be **forcefully separated from each other on the basis of psychosocial disability**, such as by forced institutionalization, or by forced outplacement of children of an adult with psychosocial disabilities. Also forced abortion and forced sterilization without the free and informed consent of the person happens in several EU Member States. Yet, EU takes no action ensure respect for home and family of persons with psychosocial disabilities.

Most matters related to home and family fall under the competence of Member States. However, the EU is competent on judicial cooperation in civil and criminal matters, and since forced family separation generally is done by a procedure prescribed in domestic law, and generally accompanied by a court order, there is a role to play for EU.

Recommendations on CRPD article 23:

→ **The right to respect for home and family of persons with psychosocial disabilities on an equal basis with others, should be solidified by framing it as a non-discrimination issue under EU policy and legislation.**

→ **EU should take steps to prevent forced family separation on the basis of psychosocial disability, and steps to promote support for parenthood for persons with psychosocial disabilities.**

Health (art 25)

17. EU fails to protect the health of persons with psychosocial disabilities

Within the EU and its Member States, the biomedical explanation of “persons of unsound mind”²² and the word ‘health’ is often misused against persons with psychosocial disabilities in order to promote non-consensual interventions aimed at repairing, correcting or alleviating a psychosocial disability [‘unsound mind’, ‘mental disorder’] without free and informed consent of the person concerned, instead of the human rights based approach to health and dignity as the lived experience of the person.

Within the biomedical model, psychosocial disabilities are viewed as impairments, and not as a dynamic disabilities, and **a set of standardized interventions, including forced psychiatric interventions** is promoted as so-called ‘necessary treatment’. Institutionalization and medication, either voluntary or involuntary, are the main interventions in the biomedical model, and are applied to any type of psychosocial disability. The harmfulness of institutionalization is widely documented²³, as well as the harmfulness of psychopharmaceutic medication which includes a higher risk of organ failures, sudden death, and a shortened life span.

In most EU Member States, **no alternative** to the medical model of psychiatry is available, and persons with psychosocial disabilities have no choice in mental health care on the basis of free and informed consent, and are forced to comply with the medical model, while in fact non-consensual psychiatric interventions are in violation of a range of fundamental rights and freedoms and should be classified as acts of discrimination, ill-treatment and torture.

EU is **not taking action to ban the paternalistic biomedical paradigm of psychiatry** from the EU and its Member States, and takes no action to promote a shift to a human rights based approach, nor any action to raise awareness of the human rights, dignity, autonomy and needs of persons with psychosocial disabilities across the EU.

Instead of forcing persons with psychosocial disabilities to comply to a set of standardized interventions under the biomedical model, it is needed to **create a variety of options for support** which respect the will and preferences of the person concerned and is based on the free and informed consent of the person concerned. Adequate supportive systems for persons with psychosocial disabilities in the community still need development across all EU Member States, which is an area where the EU could take action to promote the health of persons with psychosocial disabilities. Yet, EU also takes **no action to remedy the lack of adequate support** for the psychosocial needs of persons with psychosocial disabilities across the EU.

Additionally, also in general health care systems relating to physical health and wellbeing, EU citizens with psychosocial disabilities continue to face **discrimination and stigma**, and may not get the care and support that they need on an equal basis with others.

In the health field, the EU shares competence with EU Member States. The EU complements Member States’ policies to improve public health. EU can and should take action to ensure good quality health care for persons with psychosocial disabilities on an equal basis with others within EU and fully in line with the principles of the CRPD.

²² See Prologue on Council of Europe-mechanisms, which are enforced in every EU Member State

²³ EU Fundamental Rights Agency (FRA), 2012 report: Involuntary placement and involuntary treatment of persons with mental health problems, http://fra.europa.eu/sites/default/files/involuntary-placement-and-involuntary-treatment-of-persons-with-mental-health-problems_en.pdf

Recommendations on CRPD article 25:

→ EU should take action to ensure that all mental health services in EU Member States are provided based on the free and informed consent of the person concerned, and that violation of this right is effectively prohibited in the EU, which should be solidified by framing it as a non-discrimination issue under EU policy and legislation.

→ EU should take all possible actions to ban the paternalistic biomedical paradigm of psychiatry from EU, and develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies aimed at promoting the paradigm shift away from the biomedical concepts of 'mental impairment' to a human rights based approach of psychosocial disability, and including actions to raise awareness of the human rights, dignity, autonomy and needs of persons with psychosocial disabilities across the EU.

→ EU should ensure that CRPD standards supersede the outdated (non-EU) Council of Europe standards within EU.

→ EU should take action to remedy the lack of adequate support for persons with psychosocial disabilities in the EU, and develop in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities, specific programmes and policies aimed at the development of a variety of options for support which respect the will and preferences of the person concerned and is based on the free and informed consent of the person concerned in all EU Member States,

→ EU should take steps to combat discrimination of EU citizens with psychosocial disabilities in general health care systems relating to physical health and wellbeing in all EU Member States.

National implementation and monitoring (art 33)

18. EU omits to take action against developments in violation of the CRPD

The lack of attention for the rights of persons with psychosocial disabilities in the implementation process of the CRPD at the EU level, combined with the controversial and backward developments by several Council of Europe-mechanisms (non-EU, see Prologue), has consequences.

In many EU Member States, we notice that the domestic laws on substitute decision-making, forced institutionalization and forced treatments are in a process of being reviewed. Yet, despite EU's ratification of the CRPD, and despite the fact that all 28 EU Member States are either Signatories (3) or States Parties (25) to the CRPD, none of the EU States Parties have abolished substitute decision-making and forced interventions by law, but instead they maintain laws, or create new laws, authorizing for substitute decision-making, forced institutionalization and forced treatments, and thereby flagrantly violating their obligations as States Parties or Signatories to the CRPD, including art 4.1.d to refrain from engaging in any act or practice that is inconsistent with the CRPD and to ensure that public authorities and institutions act in conformity with the CRPD.

EU clearly has competences to combat discrimination, and additionally, EU has shared competences in the area of freedom, security and justice (TFEU art 4,2(j)), which implies that EU is not powerless on these domains, and that **the autonomy of Member States is not limitless**, but there is a meaningful role to play for the EU.

The EU has competences²⁴ to influence the situation of fundamental human rights in Member States, and should take firm action in regards to the **violation of the CRPD in the case of law reforms that authorize for forced psychiatric treatments**. Even when the EU has no direct legislative competence over the law reforms of Member States, still **a variety of strategic actions can be taken**²⁵, such as awareness-raising, new policy making, resourcing, incentives and sanctions, to firmly influence developments in order to secure the realization of human rights for all persons in the EU, including persons with psychosocial disabilities.

Recommendations on CRPD article 33:

→ **EU should develop a coherent EU approach to guide and foster the implementation of the rights of persons with psychosocial disabilities in EU and all EU Member States, in close and meaningful cooperation with the representative organizations of persons with psychosocial disabilities. Installing a DG on Disability at the European Commission could be an idea.**

→ **EU should ensure that CRPD standards supersede the outdated (non-EU) Council of Europe standards within EU.**

→ **EU should take action to ensure that EU Member States act in conformity with the CRPD and take action to install appropriate measures to enforce that violations of the CRPD are also a violation of EU standards.**

Several ENUSP members contributed input for this report. Annex 1 on the next pages will present an overview of the situation of persons with psychosocial disabilities within EU and its Member States.

For any questions, remarks or information, please contact enusp.info@gmail.com

²⁴ The EU has a clear competence to combat discrimination, has a shared competence in the area of freedom, security, justice, on common safety concerns in public health matters, and has supporting competence in health protection, which means that EU can and should complement Member States' policies in various ways.

²⁵ For example: The EU has no legislative competence over education (only supportive competence), yet there is a DG Education at the European Commission, and several EU programmes to promote learning.

Annex 1 : Situation overview of persons with psychosocial disabilities in EU and Member States

Persons with psychosocial disabilities across EU are exposed to a range of serious and systemic human rights violations, especially on CRPD articles 12 (legal capacity), 14 (liberty), 15 (freedom from torture) and 17 (integrity). We are subject to discrimination, including in health services, because we tend to be treated less favorably than patients' groups with other types of diagnoses. Our somatic health problems are not taken seriously, but attributed to psychological problems. Complaints are dismissed as part of pathology. The right to read your own treatment record is rejected. Patients are threatened with discharge, separation, forced treatment or enhancement of the psychiatric drugs' dose, if they do not accept the offered treatment.²⁶ Psychiatric drugs are prescribed without informed consent. Professionals customarily do not inform their clients of the side-effects of medications prescribed and of the danger of dependence from medication. Other options, beyond medication, are usually not mentioned or offered.

Emergency and crisis situations very negatively affect persons with psychosocial disabilities. For example according to the report of ENUSP member organization in Greece, due to the current socioeconomic crisis there have been large scale closure of public mental health services and laying off of mental health staff, resulting in the shrinking of the mental health service system to in-patient acute wards with an exclusively biomedical orientation and discarding any psychosocially oriented services. In terms of available treatment and support, medication is almost exclusively the only option offered. Over-medication, through prescribing extremely high dosages or combinations of drugs, is the norm. The inadequacy of public mental health services has led to the concentration of people with severe and chronic psychosocial problems in private psychiatric clinics, with terrible living conditions, lack of any treatment or care, everyday practices of coercion and violence, and complete disregard for basic human rights.

Laws in some EU countries still employ derogatory terminology that is not in line with the current standards, set by the UN CRPD. For example the legislation in Portugal uses the term "handicap" when referring to persons with psychosocial disabilities, which is quite vague and highly offensive.

Though user-run advocacy organizations exist and in some countries are somewhat supported, their actual influence is questionable, as pharmaceutical and physicians associations have large impact on policies, and involvement of user-run organizations, if any, is very superficial and meaningless. Additionally, our places in decision making are often substituted with service providers and family organizations. Organizations of persons with psychosocial disabilities in many EU countries are active enough and ready to be truly and meaningfully involved in the decision making processes that affect lives of persons with psychosocial disabilities. However this meaningful involvement remains a dream, in spite of the requirement of the UN CRPD to involve DPOs in the decision making processes.

Persons with psychosocial disabilities throughout the EU face forced hospitalization and forced treatment. According to the existing laws, they may be confined without consent using involuntary institutionalization in mental health facilities, if they are perceived to be a danger to themselves or others or if their guardian thinks their health would deteriorate if they were not incarcerated. The damage to property is often the reason for such forced measures too. For example, there is an article in Lithuanian Civil Code that states that: "person can be hospitalized if he causes serious damage to property". Hospitals and institutions are often obliged to free a patient before the limited time if her/his condition gets better, because the law sets a maximum time for involuntary placement and treatment, but this limit can be prolonged if a court decides so.

Sometimes people are released but have to comply with specific rules e.g. take x amount of medication, go to therapy sessions etc. (Community Treatment Orders). Many people with

²⁶ <http://www.peter-lehmann-publishing.com/articles/enusp/questions-english.pdf>

psychosocial disabilities report, that the best way to regain freedom is to do exactly what professionals want, be completely docile and then hide, change one's identity.

Solitary confinement, forced medication and restraints are used in psychiatry on a day to day basis. Our member in Slovenia reports that usage of high doses of medication is allowed as a means of restriction and there are no public records regarding use and overuse of these measures. Our member in Germany says that also there is no forced ECT as such in this country, but violations of the patients' rights still may happen, because it is possible to obtain non-informed consent of the patient, if hospital personnel, guardian and perhaps family members think it is a good idea and give or withhold information accordingly. It is even easier to do so, because the already incarcerated patient has no access to true information about ECT and may be incapacitated by psychotropic drugs. The same situation of risk may lead to the situation when people with psychosocial disabilities can become subject to medical, scientific or psychiatric experimentation.

The problem of institutionalization and forced treatment is a reality not only for adults, but also for children. Children with psychosocial disabilities too often are placed in institutional care and deprived of a family environment. Non-medical, family-and community-based care options for children with psychosocial disabilities, if any, are not sufficient. In some EU countries there are no special mental health services developed for children. Sometimes, like in the case of Slovenia, children with psychosocial disabilities even have to be confined to mental wards together with adult patients.

Persons with psychosocial disability may lose not only their place in society as a result of institutionalization and forced treatment, but also their lives. ENUSP member in Germany reports that there have been documented cases in Germany where persons died directly at the hands of psychiatry. Action has been taken in some cases, but it usually addressed family members. Often the family is estranged or if there is no family, nothing happens. Cases are not publicized, so it is hard to know whether there have been successful cases. In Czech Republic there are several known cases of deaths related to the use of caged beds. A unique research in the UK shows staggering numbers of unnatural deaths of persons with psychosocial disabilities while deprived of their liberty in the UK²⁷. There were some cases of accidental death in Slovenia, media exploited these deaths, but none of them made it to the court. There have been such cases also in Portugal, when people have died but nothing was done about it. In Belgium, and the Netherlands (Signatory Party to CRPD) cases are known where courts fail to address responsibility of perpetrators even despite shocking video evidence of cases of death by so-called "authorized use of force" of staff on persons with psychosocial disabilities. In 2014, the European Court of Human Rights for the first time recognized a violation of the Right to Life due to inadequate psychiatric treatment, in the case of *Câmpeanu v. Romania*. ENUSP hopes that this judgement will result in a better protection of the lives of persons with psychosocial disabilities.

Because of the lack of coverage and the closed nature of psychiatric institutions it is hard to estimate the actual scale of the problem in the EU, however the fact that the problem is hidden and as a rule there is no adequate reaction on such cases speaks for itself, meaning unwillingness of the governments to take action to protect lives of people with psychosocial disabilities and provide them with necessary protection.

Guardianship is wide spread. Some members of ENUSP describe it as a "booming industry". Guardians of persons with psychosocial disabilities are allowed to give their authorization for psychiatric or other interventions without the consent of the person, and psychiatric treatment is often the main reason why people are placed under guardianship. Change to the supported decision making doesn't happen, and as a rule only NGOs strive to promote such change.

²⁷ Preventing Deaths in Detention of Adults with Mental Health Conditions, An Inquiry by the Equality and Human Rights Commission, UK, 4 March 2015 <http://www.equalityhumanrights.com/publication/preventing-deaths-detention-adults-mental-health-conditions>

Regarding the access to justice, members of ENUSP report about barriers when accessing it. For example our member in Slovenia mentions that although persons with psychosocial disabilities have access to justice and legal aid in form of free legal aid, but this right is not easy to obtain when someone is disabled in many ways. Our member from Germany reports about the same difficulties, saying that people placed under guardianship in Germany can appeal against the guardianship or the person who is the guardian, but this requires a lot of stamina and competence.

In case of Portugal, our member organization in this country reports, that persons with psychosocial disabilities can resort to lawyers designated by Social Security, however because of the lack of money they cannot pay for the court appeal. The same situation holds for appeals against deprivation of the legal capacity: the disqualified or interdicted person (Portugal analogue of the guardianship) has no financial resources to pay for such court appeals.

In terms of the freedom of expression and opinion, people who are closed in psychiatric hospitals naturally have little freedom to speak out. But due to discrimination and stigma people often cannot openly express their opinion even when they leave institutions. Our member organization in Portugal mentions that people with mental illness experience cannot speak out in Portugal because there are still laws in favor of institutionalizing people with mental illness experience.

As a rule, communities are not accessible and inclusive for persons with psychosocial disabilities. Society is still largely uninformed and misinterprets people with mental illness experience. Among the main barriers that prevent persons with psychosocial disabilities from participating equally in the community are poverty, stigma and discrimination and side effects of the psychotropic drugs. People with psychosocial disabilities who live in the community are struggling to find and become involved in a meaningful social activity. Absence of such meaningful social outlet for this group of people leads to their frustration and functional isolation from society and prevents their full recovery. Governments do little to promote inclusion of people with psychosocial disabilities, raise awareness and reduce stigma in society. Usually these tasks are being done by few active NGOs that try to raise awareness in society on the issues of mental health and human rights, and promote the inclusion of persons with psychosocial disabilities in the community. But their efforts as a rule are not systemic and not enough to solve the problem on the country level.

Because of the widespread stigma and discrimination persons with psychosocial disabilities do not have access to employment on an equal basis with others. Often people lose their jobs because of their diagnosis. Sometimes they work and/or are coerced to work for very little money doing extremely boring and repetitive jobs. Our members say that there have been cases of discrimination of persons with psychosocial disability in employment, education and housing in their countries. ENUSP members from Portugal and Germany report that there have been cases where persons with psychosocial disabilities, including women, boys, girls and older persons, have been victims of exploitation, abuse and violence.

Because persons with psychosocial disability do not have well paid jobs, they cannot enjoy an adequate standard of living and social protection. Support for persons with psychosocial disabilities to achieve an adequate standard of living and social protection is given to some people, but not to all who need it. Support with employment is sometimes provided by NGOs, but not the governments, so this cannot solve a problem of unemployment and poverty. Due to poverty and stigma persons with psychosocial disabilities cannot enjoy cultural, recreational, leisure and sports activities on an equal basis with others.

Based on the CRPD and also in line with the general EU obligations on equality, non-discrimination, the fight against social exclusion and the promotion and protection of fundamental rights, EU has a duty to take all appropriate measures to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities, to ensure the full realization and implementation of the rights of persons with disabilities, recognized in this treaty.

For any questions, remarks or information, please contact enusp.info@gmail.com