



Strasbourg, 09 November 2015

CommDH(2015)28

**Comments of the Council of Europe Commissioner for Human Rights on the
“Working document concerning the protection of human rights and dignity of persons with
mental disorder with regard to involuntary placement and involuntary treatment”**

1. The Commissioner for Human Rights would like to thank the Committee on Bioethics (DH-BIO) for having invited him to provide comments on the draft Additional Protocol to the Convention on Human Rights and Biomedicine concerning the protection of human rights and dignity of persons with mental disorders with regard to involuntary placement and involuntary treatment (hereinafter, “the draft Additional Protocol”).
2. The present comments are based on the Commissioner’s work, and in particular on two issue papers relating to the rights of persons with disabilities published by his Office, on the right to legal capacity¹ and the right to live in the community². The Commissioner also dealt with the issues falling under the scope of the draft Additional Protocol in a large number of country reports. In some recent reports, the Commissioner examined in more detail issues concerning the use of involuntary placement and treatment in psychiatry, for example in his latest reports on Denmark³ and Norway⁴.
3. The Commissioner was invited to comment on specific provisions in the draft Additional Protocol and to suggest drafting proposals, where possible. Having carefully examined the document and its draft explanatory report, however, the Commissioner came to the conclusion that he cannot subscribe to many of the basic assumptions underpinning the draft Additional Protocol and has serious misgivings about the compatibility of the draft’s approach with the UN Convention on the Rights of Persons with Disabilities (CRPD). The Commissioner finds that limited drafting proposals and amendments would not be sufficient to allay these fundamental concerns. The present document contains, instead of drafting proposals, a non-exhaustive description of the Commissioner’s main reservations about the draft Additional Protocol and his conclusions.

The aim of the draft Additional Protocol and its approach

4. The Commissioner would like to stress that he fully understands the concerns that prompted DH-BIO to work on this issue. Involuntary placement and involuntary treatment procedures give rise to a large number of human rights violations in many member states, as he himself witnesses first-hand in his various country visits.
5. As the Commissioner has already declared in 2014, human rights violations caused in the context of involuntary placements, and more generally in connection with the use of coercion in psychiatry:

¹ See the Commissioner’s Issue Paper [“Who gets to decide? Right to legal capacity for persons with intellectual and psychosocial disabilities”](#), 2012.

² See the Commissioner’s Issue Paper, [“The right of people with disabilities to live independently and be included in the community”](#), 2012.

³ Commissioner’s report following his visit to Denmark, [CommDH\(2014\)4](#), published on 24 March 2014.

⁴ Commissioner’s report following his visit to Norway, [CommDH\(2015\)9](#), published on 18 May 2015.

“have their roots in outdated legal frameworks, but also assumptions the validity of which are being increasingly challenged. The premise so far has been that involuntary placement of persons with mental health problems was an inevitable necessity, since they present a danger to themselves and others. The focus was very much on designing safeguards and controls, often judicial in nature. Well, very often these safeguards do not work. The case-law of the Strasbourg Court is now full of examples where national procedures have gone terribly wrong, where the person whose life is at stake has entirely lost his say in a process which has essentially been reduced to a dialogue between the judge and the psychiatrist. We need to shift the focus to how coercion can be avoided in the first place, and how the person can best be supported in making healthcare choices.”⁵

6. The Commissioner is therefore unable to share DH-BIO’s assessment of the main cause of the violation of the human rights and dignity of persons in the context of such coercive practices set out in the letter inviting the Commission to comment, i.e. “legal gaps in certain member states, in particular concerning legal provisions governing measures for involuntary placement and treatment of persons with mental disorders”. In the opinion of the Commissioner, the problem is not only the lack of adequate safeguards and legal frameworks for the use of involuntary measures. While violations due to such legal gaps do occur in some member states, many of these are clearly already illegal under the established case law of the European Court of Human Rights and represent the worst forms of a far larger phenomenon. In the Commissioner’s experience, the larger problem is rather that the legal safeguards prove often inadequate in practice, owing to the shortcomings of existing legal systems and their inherently discriminatory nature. The Commissioner considers that human rights of persons with psychosocial disabilities are routinely violated while respecting the letter of existing legal safeguards, including some that are very similar to those proposed in the draft Additional Protocol. In other cases, the persons lack any reasonable prospect of challenging the non-respect of the safeguards, because of numerous legal and practical impediments.
7. In the opinion of the Commissioner, a system which gives extensive powers to the medical professional, while the opinion of the person concerned is only “taken into account” and where the latter bears the burden of proving (despite often facing serious impediments, for example, in relation to legal capacity) that they do not constitute a “significant risk of serious harm” to themselves or others builds an inherent imbalance into the procedure. The medical authority will always enjoy a privileged position, since in practice the judge will need to rely on the professional expertise of the doctor in assessing the existence of the danger involved, there being no precise legal definition of and criteria for establishing “significant risk of serious harm”. The person concerned also must prove, against the doctor’s assessment, that her or his ability to decide on placement is not “severely impaired” (Article 10 of the draft Additional Protocol) – this would be a daunting challenge for anyone, with or without mental disorder. It should also be borne in mind that involuntary treatment in many cases involves the use of psychoactive substances which affect the mental state and decision-making capacity of the persons concerned, and could potentially interfere with their ability to challenge decisions affecting them.
8. The letter inviting the Commissioner to comment on the draft Additional Protocol states that the aim of the text is to protect the human rights and fundamental freedoms of all persons with mental disorder with regard to the use of involuntary measures, and that it does so by promoting the use of alternatives to involuntary measures and by ensuring that the latter are only used as a last resort. However, as far as the Commissioner can see, the only relevant provision in the draft Additional Protocol, apart from the preamble, is Article 5 which provides that “Parties to this Protocol shall promote the development and use of alternatives to involuntary placement and involuntary treatment”. Compared to the numerous, detailed provisions setting out a procedure for involuntary measures, this is a rather vague provision, programmatic in nature, the assessment of which is presumably left to the national authorities. The Commissioner has doubts therefore that the drafting choices serve the avowed aims.

⁵ See the [keynote speech](#) on “Monitoring the Human Rights of Persons with Disabilities in Europe”, delivered by the Commissioner at the International Symposium “Human Rights and Disability” in Vienna on 10 April 2014.

Compatibility with the CRPD and the Commissioner's approach

9. In his work on disability, the Commissioner consistently refers to the UN CRPD as the international benchmark and legal reference point in all matters pertaining to disability, including psychosocial disability. "Psychosocial disability" is a term which describes the experience of persons with impairments relating to mental health conditions and which puts the emphasis not on a medical diagnosis, but on the interaction between these impairments and society and the potential violation of the basic human rights of the persons concerned as a result of that interaction. In the opinion of the Commissioner, one can no more dissociate persons with psychosocial disabilities from persons with mental disorder than, for example, people with sensory disabilities from persons who have a disorder affecting their vision or hearing. The Commissioner therefore prefers to refer to "persons with mental disorders" as "persons with psychosocial disabilities".
10. The Commissioner notes that the Committee on Social Affairs, Health and Sustainable Development of the Parliamentary Assembly of the Council of Europe considered at its meeting in Paris on 24 March 2015 an Introductory Memorandum entitled "Involuntary Placement and treatment of people with psychosocial disability: need for a new paradigm". It decided to make this Introductory Memorandum available to DH-BIO and the Commissioner's Office, in order to ensure that the Assembly's views and concerns are heard at an early stage of the drafting process. The Rapporteur of this Introductory Memorandum, Ms Guguli Magradze, described the paradigm shift in the approach to disability which was enshrined in international law by the CRPD, and raised her concerns about the draft Additional Protocol.
11. The Commissioner fully shares the views of Ms Magradze, both in terms of her initial negative assessment as to whether the Council of Europe should be drawing up an Additional Protocol which will give legal sanction to involuntary measures imposed on people with "mental disorders", as well as her concerns regarding its elaboration process with no involvement of the disability rights organisations beyond one consultation meeting. Both of these conclusions were, in the Commissioner's opinion, based on a sound understanding of the CRPD and the paradigm shift it embodies. More specifically on the latter aspect, Ms Magradze rightly pointed out the requirement set out in the CRPD that disability rights organisations be involved as an integral part, rather than merely consulted, in all decision-making processes concerning issues relating to persons with disabilities. Council of Europe bodies are no exception, the drafting process of the Additional Protocol therefore raises certain concerns in view of Article 4, paragraph 3 of the CRPD.
12. The Commissioner finds that the current draft does not seem to have taken account of some of the legitimate concerns regarding the Protocol contained in this Introductory Memorandum. The Commissioner furthermore notes that DH-BIO took as its starting point the Recommendation(2004)10 concerning the protection of human rights and dignity of persons with mental disorder, and that the draft Additional Protocol remains remarkably close, both in letter and spirit, to this text. However, four years after the adoption of this Recommendation, the CRPD entered into force, challenging some of the basic assumptions underpinning the approach in the 2004 Recommendation.
13. One of these is the assumption, which seems to be corroborated by the actual title of the draft Additional Protocol, that the existence of a mental disorder is the determining pre-condition for the possibility to consider involuntary placement and treatment, although other subsidiary conditions relating to risk or impaired decision-making capacity are also required. This must, however, be contrasted with the absolute prohibition contained in the CRPD of discrimination on the basis of an impairment, such as a mental disorder. The draft explanatory report clearly sets out the view that involuntary measures imposed on persons with mental disorder pose no problem of discrimination, and hence compatibility with the CRPD, since it is not the existence of the mental disorder, in itself, which justifies the use of involuntary measures.
14. It is difficult to reconcile this view with either the letter and spirit of the CRPD, nor its authoritative interpretation by the Committee on the Rights of Persons with Disabilities, the Committee set up under the CRPD in order to examine periodic reports of the States Parties, as well as receive individual communications under the Optional Protocol to the CRPD. The Commissioner notes, in

particular, the Guidelines on article 14 CRPD (the right to liberty and security of persons with disabilities) adopted by the Committee in September 2015, which state the following:

“6. [...] legislation of several States Parties, including mental health laws, still provide 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. This practice is incompatible with article 14; it is discriminatory in nature and amounts to arbitrary deprivation of liberty.

7. 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. Furthermore, discussions were held on whether to include a provision for periodic review of the deprivation of liberty in the text of draft article 14(2). Civil society also opposed the use of qualifiers and the periodic review approach. 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. The issue was settled in the seventh meeting of the Ad Hoc Committee.”⁶

15. The Commissioner observes that this interpretation clearly contradicts DH-BIO’s interpretation of the relevant articles of the CRPD.
16. DH-BIO’s position on this issue is also difficult to reconcile with the Commissioner’s own approach so far, who stressed on several occasions that there is a clear European trend towards reinforcing the rights and self-determination of patients and their participation in decisions about care, and that people with psychosocial disabilities should not be excluded from this development. All people with disabilities have the right to enjoy the highest attainable standard of health without discrimination and the care provided to them should be based on free and informed consent in line with Article 25 of the CRPD.
17. More specifically, in his report on Norway, for example, the Commissioner urged the authorities to “reform legislation on involuntary placements in a way that it applies objective and non-discriminatory criteria which are not specifically aimed at people with psychosocial disabilities, while ensuring adequate safeguards against abuse for the individuals concerned”.⁷ The Commissioner also stated that medical treatment should be based on free and fully informed consent with the exception of life-threatening emergencies when there is no disagreement about the absence of decision-making capacity.⁸
18. Another crucial matter is the restriction of the legal capacity of persons with intellectual and psychosocial disabilities, despite the fact that the right to legal capacity is guaranteed on an equal basis to persons with disabilities under Article 12 of the CRPD. Most Council of Europe member states clearly lag behind the CRPD standards in this area.⁹ Restriction of legal capacity, substitute decision-making and the non-provision of adequate supports for decision making are in the Commissioner’s opinion at the core of the issues covered by the draft Additional Protocol: not only are persons who are deprived of their legal capacity often unable to formulate or withhold their free and informed consent in the first place, in a way that is recognised by the legal system, but they are also frequently not in a position to challenge satisfactorily any involuntary measure affecting them.
19. In the opinion of the Commissioner, the draft Additional Protocol deals with this crucial question only peripherally, by requiring for example that courts “take into account” the opinion of the person concerned and by allowing for a person of trust. At the same time, the draft Additional Protocol takes substitute decision-making (the “representative”) and deprivation of legal capacity,

⁶ Committee on the Rights of Persons with Disabilities, Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities, adopted during the Committee’s 14th session, held in September 2015.

⁷ Commissioner’s report following his visit to Norway, [CommDH\(2015\)9](#), published on 18 May 2015, paragraph 41.

⁸ See the [press release](#) on the aforementioned report.

⁹ For more details on the Commissioner’s approach to legal capacity, see the aforementioned Issue Paper.

including the capacity to consent, as a given, despite their clear incompatibility with Article 12 CRPD. Furthermore, it does not address the very serious problem the Commissioner observed in several countries of conflicts of interest between the person and the legal representative, for example when a staff member of the psychiatric institution assumes this role,¹⁰ or the impossibility for persons put in this position to contact a lawyer, let alone retain one through a valid legal act, or obtain legal aid. In addition, Article 10 of the draft Additional Protocol, while defining the condition that the person's "ability to decide is severely impaired", does not address the right of the person to supports which would reduce or neutralise such impairment.

20. The concept of "person of trust", introduced with Article 6 of the draft Additional Protocol is admittedly a novelty. However, the Commissioner has misgivings as to whether this new entity would be sufficient to satisfy the requirements necessary to be considered as supported decision-making, in accordance with Article 12 of the CRPD. It seems, for example, that the person of trust, while chosen by the person whose placement is at stake, can act independently of the latter's will. This is particularly apparent under Article 12, paragraph 2, of the draft Additional Protocol which provides that the court or other competent body shall "take into account" the opinion of the person concerned (iii) and consult, "according to law, his or her person of trust" (v). In a true supported decision-making system, the support must be there to help enable the person concerned to understand the stakes, reach a decision and communicate it to others; thus "taking into account" the opinion or wishes of the person should already imply the provision of support, for example by the person of trust. The fact that the consultation of the person of trust is considered a separate legal act within the proposed legal framework suggests to the Commissioner that the draft Additional Protocol is still operating under an implicit substitute decision-making paradigm, also when it comes to the person of trust.
21. The Commissioner considers that this approach is not only in conflict with the CRPD, but would also undermine the purported goal of the draft Additional Protocol to reduce involuntary placement and treatment. As the Commissioner observed in his aforementioned report on Norway, "the availability of supported decision-making alternatives and reasonable accommodation measures can contribute significantly towards the development of alternatives to coercion" and support the ultimate objective of "drastically reducing and progressively eliminating" coercive practices in psychiatry.¹¹

Potential contribution of the draft Additional Protocol to legal certainty concerning involuntary measures

22. Regardless of the observations made above, the Commissioner is of the view that one of the added values of the draft Additional Protocol could have consisted in creating more legal certainty for the use of coercive measures in psychiatry, thereby limiting cases of abuse. However, the Commissioner considers that the draft Additional Protocol leaves an unduly large margin of appreciation to national authorities, judges and medical professionals, by ruling out clearly only the most egregious forms of abuse, i.e. where involuntary measures are ordered without regard to due process and the minimum guarantees under Article 5 of the European Convention of Human Rights, or administered by unqualified personnel. The Commissioner is concerned that this margin of appreciation is so large that it could potentially appear to sanction in international law entirely unacceptable limitations of basic human rights.
23. One of the most worrying aspects in that regard is the extraordinarily large scope of the definition of "mental disorder" "in accordance with internationally accepted medical standards" (Article 2). The draft Additional Protocol does not define what these standards are, but its explanatory report cites as an example Chapter V of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems*, which concerns *Mental and Behavioural Disorders* (ICD-10). The Commissioner observes that in its last iteration, ICD-10 covers a vast array of disorders such as, for example, mild depressive episode, various neurotic disorders, nonorganic insomnia, sexual dysfunction, or even abuse of non-dependence-producing substances such as vitamins or herbal remedies. Even more problematically, transsexualism and

¹⁰ See, for example, the Commissioner's report on his visit to Romania, [CommDH\(2014\)14](#), published on 8 July 2014.

¹¹ Commissioner's report following his visit to Norway, [CommDH\(2015\)9](#), published on 18 May 2015, paragraph 42.

gender identity disorder of childhood are considered to be “mental disorders” according to this nomenclature. In short, the list is extremely open-ended and might potentially increase, rather than decrease, the risk of abuse.

24. The Commissioner finds that the definitions of a number of other legal concepts and the formulation of some of the Parties’ obligations are similarly vague or problematic. Thus, “therapeutic purpose” includes “management” of the disorder (Article 2) for example, which could be understood as sanctioning an open-ended placement. The draft Additional Protocol also provides that persons subject to involuntary placement and/or treatment (Article 4) shall be cared for in the “least restrictive environment available and with the least restrictive or intrusive treatment available”. The non-availability of less restrictive measures for whatever reason, for example owing to material shortcomings, would appear to justify the use of more restrictive measures if the text is interpreted literally.
25. The Commissioner already stated above that he considers that Article 5 on the promotion of alternative measures is too weak to contribute to a real improvement of the situation on the ground. Similarly, Article 8 provides that care should be delivered in accordance with “professional obligations and standards by staff having the requisite competence and experience” and Article 9 provides that involuntary measures take place in an “appropriate environment”. Both these articles appear overly broad and circular to the Commissioner, the precise content of what constitutes “requisite competence and experience” or “appropriate environment” being left entirely to the discretion of the Parties, with only very little guidance on the matter provided in the non-binding explanatory report.
26. As regards the provisions at the heart of the draft Additional Protocol, the Commissioner already expounded above on his concerns regarding the lack of certainty around the notions used in Article 10 of “significant risk of serious harm”, and impairment of the ability to decide on placement. In the absence of a clearer indication, for example a life-threatening situation, the assessment of the significance of the risk and the seriousness of the harm is entirely left to the discretion of the doctor, whose examination provides the basis on which the entire procedural system established under Articles 12 to 15 rests.
27. The Commissioner already addressed above the issue of why legal safeguards are not in themselves a sufficient guarantee against the violation of the human rights of persons with psychosocial disabilities owing to, *inter alia*, the presumption in favour of the medical professional, and the fact that the person is merely consulted in the process. In any case, the Commissioner considers that these guarantees, possibly with the exception of the person of trust (the consultation of whom is however qualified as being required only “according to law”), are already firmly established in the case-law of the European Court of Human Rights. Three aspects are, nonetheless, particularly worrying to the Commissioner:
 - that a decision of involuntary treatment of a person already subject to placement can be unilaterally taken by the doctor (Article 12, para. 3);
 - that the emergency procedure provided for under Article 13 allows for the bypassing of a court or even the prior consultation of the person;
 - that the draft Additional Protocol does not set a specific statutory limit, not even an indicative one in the explanatory report, as to the maximum time period beyond which the placement decision must be reviewed (while “48 or 72 hours” is mentioned as an example in the explanatory report in relation to the emergency procedure). The length of this period is thus entirely left to the Parties’ discretion.
28. In view of these elements, the Commissioner is not persuaded that the draft Additional Protocol would bring a significant added value in comparison to safeguards already clearly established in the case-law of the European Court of Human Rights and in the national legislation of the vast majority of member states. On the other hand, the Commissioner is concerned that its adoption would present a certain number of risks.

Potential risks in case of the adoption of the draft Additional Protocol

29. The Commissioner is concerned that, if the draft Additional Protocol is adopted, the broadness of some of the provisions examined above may lead to a situation in which a legally binding international treaty appears to sanction practices which were not intended by the drafters and which are indisputable violations of human rights. He is of the view that, in the absence of clear and precise legal definitions, the draft Additional Protocol leaves a great deal of margin of appreciation to the national legislation, which will eventually be filled with the prevailing ethical standards and approaches of the psychiatric profession in the country in question, or failing that, the views and practices of doctors in individual cases.
30. Unfortunately, the history of psychiatry is riddled with examples which appear completely unethical today: to give a provocative example, in the not-too-distant past, electroconvulsive therapy was used to treat what was seen as “disorders” of sexual orientation or gender identity (the latter is still considered a mental disorder by WHO, as mentioned above). The Commissioner wonders if such practices would have necessarily been discouraged, had one applied the legal safeguards contained in the draft Additional Protocol, since the general consensus at the time was that these “disorders” constituted a “significant risk of serious harm”, thereby justifying involuntary placement (for an undefined maximum period) and involuntary treatments which appear barbaric today but which at the time were believed to serve a “therapeutic purpose”.
31. The Commissioner reiterates that severe violations of the human rights of persons with psychosocial disabilities occur today, in many countries in Europe, despite the existence of safeguards similar to the ones foreseen in the draft Additional Protocol. Today, thanks to the impetus given by the disability rights movement, which includes associations of users of psychiatry, as well as the paradigm shift embodied in the CRPD, such practices are being increasingly challenged by national and international human rights mechanisms, including the Commissioner himself. However, the adoption of the draft Additional Protocol now would send a mixed message and risk giving the semblance of legitimacy to such violations, including practices that the Commissioner severely criticised in the past, such as the use of non-consensual electroconvulsive therapy.¹² It would also render the awareness-raising work of the Commissioner on these issues considerably more difficult.
32. The Commissioner already pointed to the risk of an explicit conflict between international norms at the global and European levels, owing to the divergence of interpretation between the DH-BIO and the Committee on the Rights of Persons with Disabilities. He considers that such a situation would be detrimental both to the CRPD system, but also to the work of the Council of Europe. If the *only* binding legal instrument specifically targeting persons with disabilities of the Council of Europe were to be on such a controversial topic, seeking to regulate an exception to general principles of human rights, this would render it vulnerable to accusations of being discriminatory and reactionary *vis-à-vis* the CRPD system. This situation would be all the more striking since the key instrument of the Council of Europe on disability, the Council of Europe Disability Action Plan 2006-2015, is not legally binding. Furthermore, the explicit and implicit power accorded to the medical professionals in the procedures foreseen in the draft Additional Protocol, coupled with the insufficient involvement of concerned disability rights groups in its drafting process, may prompt criticism of bias in favour of the former over the latter.

Conclusion

33. For these reasons and based on his experience with country monitoring work on the subject, the Commissioner thinks that DH-BIO should not adopt the draft Additional Protocol: however well-intentioned the aim behind it, the Commissioner is not convinced that the draft is capable of fulfilling this aim, ensure compatibility with the CRPD, and present sufficient added value to make it worthwhile taking a number of significant risks in terms of the protection of the human rights and dignity of persons with psychosocial disabilities, as well as the Council of Europe’s and Commissioner’s work on disability.

¹² See the Commissioner’s aforementioned report on Norway.

34. This is not to say, however, that DH-BIO could not fulfil an important gap in this field, and the Commissioner would like to make a suggestion in this respect. In his opinion, while it becomes increasingly clear what member states are not allowed to do under the CRPD, there is a great need for guidance for filling out their positive obligations and further awareness-raising. There are also extreme differences between member states: there are states which clearly operate under a medical paradigm where the individual has very little to no voice in decisions affecting her/him, including healthcare choices, and others which are much further advanced in terms of ensuring that treatment happens in the vast majority of cases with free and informed consent, with very narrowly defined exceptions limited to short periods of time. There is a clear need to promote an information exchange and sharing of best practices, and better guidance with a view to reducing the need for coercion in psychiatry in the first place and fighting against discrimination of persons with psychosocial disabilities.
35. Such guidance could include, *inter alia*, the views of the DH-BIO on the following issues, accompanied by examples of good practices from different member states:
- How to develop non-discriminatory criteria for assessing risk to one's health or others, as well as impairment of decision-making capacity;
 - How to promote alternative measures and reduce recourse to coercion in psychiatry, as well as an excessive use of restraints or medication;
 - How to better involve patients in treatment decisions;
 - How to ensure access to adequate supports for decision-making over healthcare choices for persons with psychosocial disabilities;
 - How to involve persons with psychosocial disabilities and their representative organisations in policy-making and relevant procedures.
36. The explanatory report of the draft Additional Protocol already includes several valuable elements which could be expanded on through a comprehensive examination of practices in member states and thorough engagement with civil society. In the Commissioner's opinion, the resulting document, even if it is non-binding, would much better serve the DH-BIO's ultimate goal to protect the dignity of persons with psychosocial disabilities and promote alternatives to involuntary measures.
37. The Commissioner once more would like to emphasise his appreciation for the opportunity to comment on the draft Additional Protocol and remains at DH-BIO's disposal for any clarification of his views.