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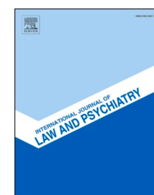

Unlocking the impact of the CRPD on Swedish mental health law

Anna Nilsson

Lund University, Faculty of Law, Lilla Gråbrödersgatan 4, Box 207, 221 00 Lund, Sweden

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ABSTRACT

The Convention on the Rights of Persons with Disabilities (CRPD) sets out a new vision for mental health care with equality and self-determination as its core standards. The CRPD fundamentally challenges long-standing practices in Sweden including the use of involuntary hospitalization, treatment without consent, and the use of restraints. This article discusses the impact of this new vision on Swedish mental health law and policy. An examination of mental health law inquiries from 2008 to 2023 reveals a notable lack of attention from policy-makers towards the CRPD. Nevertheless, the Convention has emerged as a vital advocacy instrument for disability organizations and others opposing proposals that seek to broaden doctors' authority to employ coercion. In addition, the many efforts undertaken to reduce the use of coercion and to enhance the involvement of individuals with psychosocial disabilities in policy development align seamlessly with the principles of the Convention. This article concludes with a reflection on why the CRPD has not assumed a more prominent role in shaping mental health law in Sweden and calls on the government to seriously consider the CRPD's call for equality.

1. Introduction

The Convention on the Rights of Persons with Disabilities (CRPD) sets a new vision for mental health care. The novelty lies in the Convention's emphasis on equal treatment and individual self-determination, and in the fact that it does not explicitly permit coercive psychiatric care. This signals a break from previous human rights standards, which, similar to many domestic mental health regulations, were crafted under the presumption that special rules governing this branch of healthcare and permitting the use of coercion are necessary to protect the health or life of persons with mental health problems. The European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) is perhaps the most obvious example here. It explicitly provides for the civil detention of people of 'unsound mind' (Article 5.1(e).[1] By contrast, Article 14 of the CRPD affirms that persons with disabilities enjoy the right to liberty on an equal basis with others. The existence of a disability shall never justify a deprivation of liberty, and states parties to the Convention must ensure that persons with psychosocial disabilities are not arbitrarily deprived of their liberty. Respect for individual autonomy, including the freedom to make one's own choices, is listed as the first of the general principles set out in Article 3 to guide the interpretation and application of the treaty. Article 12 reinforces the right to make decisions, acknowledging that individuals with psychosocial disabilities possess legal capacity on par with others in all facets of life, including within the context of mental health care. Additionally, Article 25 affirms that healthcare should be delivered without discrimination and based on free and informed consent.

Sweden ratified this treaty and its optional protocol on 15 December 2008 without making any reservations or interpretative declarations to its provisions. In contrast to a handful of other states parties (e.g., Australia, Canada, the Netherlands, and Norway), Sweden saw no need to clarify its position on the implications of Articles 12 and 14 on domestic policies for compulsory mental health care. In the official reports from the domestic ratification process, the government held that Swedish law was already consistent with the CRPD (Government bill

E-mail address: anna.nilsson@jur.lu.se.

[1] For a recent analysis of the European Court of Human Rights' jurisprudence on coercive psychiatric care and the steps taken to align it with the CRPD, see Nilsson, A. (2023). The European Court's incremental approach to the protection of liberty, dignity and autonomy. In B. D. Kelly and M. Donnelly (Eds.), *Routledge Handbook on Mental Health Law*, pp. 83–100. See also soft-law instruments such as the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, UNGA Res 46/119 (17 December 1991) principles 11 and 16, and its European equivalents. Council of Europe, 'Recommendation No R(99)4 of the Committee of Ministers to Member States' (23 February 1999), principles 22–26, and 'Recommendation No Rec(2004)10 of the Committee of Ministers to Member States' (22 September 2004), principles 10, 12, and 17–18.

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2008/09:28, pp. 42, 44, and 49). Some stakeholders expressed their doubts about whether this was correct. For example, the Swedish National Board of Health and Welfare (NBHW) indicated that coercive care under the Compulsory Mental Health Care Act (1991:1128), hereafter abbreviated CMHCA, may conflict with the right to self-determination and that this matter ought to be further investigated (ibid, p. 49f). Representatives from the disability movement also voiced their concern about possible conflicts between the CMHCA and Article 14 of the CRPD (ibid., p. 45). The government, however, deemed that Sweden could — and should — ratify the Convention without further analysis. Compulsory hospitalization is a measure of last resort and subject to strict regulations and court review. Such an arrangement, the government argued, is compatible with the CRPD. As we know, the Committee on the Rights of Persons with Disabilities (the CRPD Committee) takes a different position. It has consistently interpreted the CRPD to require states to abolish all forms of compulsory hospitalization and medical treatment without consent (CRPD Committee, 2014c, paras. 40–42). Mental health services are to be provided on a voluntary basis and in community settings.

This article will explore the impact of the CRPD on Swedish mental health law from 2008 onwards. Not every amendment of the law from 2008 to the present will be addressed. Rather, the focus will be on legal reforms and proposed reforms that either align with or potentially violate these rights. I will not attempt to provide a definitive answer to the intensely debated question of whether coercive mental health care is compatible with the CRPD. There is already a rich literature on this topic and sound legal arguments can be made both in favour of interpreting the CRPD to prohibit coercive care and in support of the treaty allowing such care under specific conditions (see e.g., Minkowitz, 2007, 2017; Bartlett, 2012; Morrissey, 2012; Szmukler, Daw, & Callard, 2014; Dawson, 2015; Arstein-Kerslake & Flynn, 2016; Brosnan & Flynn, 2017; Gooding, 2017; Stavert, 2018; Martin & Gurbai, 2019; Wilson, 2021; Nilsson, 2021).

The text is structured as follows: It commences, in section two, with a brief overview of Swedish mental health law and practice. This provides a contextual foundation for the coming analysis of the impact of the CRPD on mental health law. A more in-depth discussion of how well mental health care *practice* accords with the CRPD is, however, out of the scope of this text. Section three delves into the dialogue between the CRPD Committee and the Swedish government concerning mental health law. Since there are no individual complaints against Sweden in this regard, this section will concentrate on Swedish reports on the implementation of Articles 12, 14, and 17 along with the Committee's responses to this information. Section four proceeds with an examination of how the CRPD has influenced governmental inquiries on mental health law. The key question here is whether Swedish mental health law today is more in line with the CRPD than it was in 2008, and if so, in what specific aspects. Additionally, this section will compare the impact of the CRPD to that of other human rights treaties such as the ECHR and the Convention on the Rights of the Child (CRC). The article will conclude with a reflection on why the CRPD has not played a more prominent role in shaping the development of Swedish mental health law.

2. Mental health care in Sweden

2.1. Community-based care on a voluntary basis

Like many other western countries, Swedish mental health care has undergone significant reforms during the 20th century. In 1967, Sweden had among the highest number of beds for inpatient psychiatric treatment per capita in the world (~37,000 beds in state-run mental hospitals). This is nearly 5 beds/1000 inhabitant (Stefansson & Hansson, 2001, p. 82). Patients stayed in these hospitals for years and had little influence over the content of the care. Alternatives like counselling or outpatient medical treatment were almost non-existent. The situation today is the reverse. Large psychiatric hospitals have been closed, and the vast majority of those who seek help for mental health problems receive care on a voluntary basis at local healthcare centres or psychiatric clinics. The number of beds for psychiatric inpatient treatment for adults is about 3200, which is approximately 3 beds/10,000 inhabitants (Swedish Association of Local Authorities and Regions (SALAR), 2023a p. 5). Such inpatient care typically extends over a relatively short period. In 2022, the average length of in-patient psychiatric care was 8.7 days for adults and 9.2 days for people underage (SALAR, 2023a, p. 5, and 2023b, p. 5).

Swedish health law reflects this shift by stipulating that health services must respect patients' integrity and right to self-determination.[2] Healthcare — including mental healthcare — may not be provided without the patient's consent unless otherwise provided by law. It should be noted that Sweden currently lacks a system for supported or substituted decision-making in the healthcare context. It remains open to legal argumentation whether and, if so, to what extent the general system of administrators or legal representatives may be employed to support persons with psychosocial disabilities to make healthcare choices and/or whether such representatives may provide legally valid consent in situations in which a person with an intellectual or cognitive disability cannot do so for themselves (Fridström Montoya, 2020). This uncertainty about what Swedish law prescribes has prompted governmental investigations (Government report series 2015:80 and 2004:112, pp. 651–646) and multiple calls on the Parliament to adopt proper legislation on this matter. However, as of now, such legislation is still lacking. The only exceptions to the rule that healthcare interventions must be based on the patient's consent concern emergency care, substance abuse treatment, and psychiatric care. Patients have the right to receive emergency care when necessary to avert acute and serious threats to the patient's life or health, even if consent cannot be obtained due to unconsciousness or similar reasons.[3] Non-consensual medical care of persons with substance abuse problems and people with mental health problems is further provided for in two separate regulations: the Care of Substance Abusers (Special Provisions) Act (1988:870) and the CMHCA. An overview of the latter is provided in the next section.

Since the mental health reform in 1995, both left-wing and conservative governments have invested approximately 13 billion Swedish crowns (equivalent to slightly over 1 billion Euros) into various initiatives aimed at enhancing access to high-quality outpatient care and developing peer-to-peer support (Government report series 2018:90, p. 125ff). An oft-cited and highly regarded example of such an initiative is the personal ombudsman system that was initiated in 1995 as a pilot project. It may be described as a Swedish version of case management.[4] The ombudsman's primary task was to assist individuals with psychosocial disabilities in coordinating social, occupational, and healthcare services (Government bill 1993/94:218, p. 29ff). Today, the ombudsman system is an integral part of the welfare system.

2.2. Coercive care

According to the CMHCA (section 3), persons suffering from a "serious mental disorder" who have a pressing need for inpatient care at a psychiatric clinic and who refuse such care, or cannot express a decision on the matter, may be committed and treated in a closed psychiatric ward. During inpatient treatment, the patient may be subjected to restraints to secure the safety of the patient and/or others (sections

[2] The Patient Act (2014:821), chapter 4, sections 1 and 2.

[3] The Patient Act (2014:821), chapter 4, section 4.

[4] For a description of this service in English, see Klockmo, C. (2023). The role of personligt ombud in supporting the recovery process for people with psychiatric disabilities. PhD thesis, Mid Sweden University, p. 12–15. http://www.diva-portal.org/smash/get/diva2:663432/FULLTEXT01.pdf

19–20a). The patient may also be compelled to undergo medical treatment without consent (section 17). Such coercive interventions must, however, be used as a last resort and carried out as gently and respectful as possible (section 2a). Commitment to in-patient care is subject to legal safeguards including judicial review (section 32), and the administration of care and use of restraints is monitored by the Health and Social Care Inspectorate (the Care Inspectorate) — a government agency to which individuals may also submit individual complaints.

In practice, between 11,000 to 12,500 people have been committed for compulsory psychiatric care per year during the last decade (NBHW, 2023a). Official statistics also reveal significant variations across the country concerning the number of individuals subjected to coercive care and the frequency of restraints applied during such care. This suggests that certain regions and hospitals are more effective in preventing the need to intervene with coercion than others. To illustrate these differences, fewer than 20% of patients diagnosed with schizophrenia are committed for compulsory care in some regions, while in other regions this figure is closer to 60%, indicating unequal access to quality outpatient services for this group (NBHW, 2023b, pp. 22–24).

Reports from disability organizations and research studies informs us of the harms of coercive care in Sweden. Being forced to undergo certain treatments and/or subjected to restrains can be physically and emotionally painful, degrading, stigmatizing, and terrifying (e.g., Ejneborn Looi, Engström, & Sävenstedt, 2015; Gerle, Fischer, & Lundh, 2019; Kjellin et al., 2004; Pelto-Piri & Kjellin, 2021). The use of coercion also harms the therapeutic alliance between the patient and the physician (Sjöstrand et al., 2015). Consequently, numerous projects and training initiatives have been implemented to reduce the reliance on coercion. During 2010–2013, for example, the government invested approximately 16 million Euros in a project named "Better care – less coercion". This project aimed to develop new methodologies for mental health professionals to avoid resorting to restraints in psychiatric hospitals. Other initiatives to reduce the use of coercion include the introduction of patient-controlled admissions to in-patient care[5] in many hospitals, (NBHW, 2021), the implementation of the Safeward Model[6] for conflict prevention (Pelto-Piri & Strandberg, 2022), and the funding of systematic reviews designed to identify and assess evidence-based alternatives to coercion (Ministry of Health and Social Affairs, 2022, 2023). Although these initiatives were not specifically motivated by the need to align with the CRPD, they do reflect an ambition to minimizing the use of coercion within psychiatric care. The aforementioned statistics indicate that these initiatives have not resulted in a significant reduction in the overall use of coercive care in the country. However, they have contributed to positive developments in specific regions and psychiatric hospitals.

3. The dialogue between the Swedish government and the CRPD Committee

3.1. The initial reporting cycle (2011–2014)

3.1.1. The issue of compulsory care

Sweden submitted its initial report on measures taken to fulfil to its obligations under the CRPD in January 2011. This is before the CRPD Committee adopted its first concluding observations recommending states parties to abolish coercive care.[7] In that report, the government explained that health services, in principle, are provided on a voluntary basis but that persons with psychosocial disabilities may be subject to coercive mental health care in accordance with CMHCA (Ministry of Health and Social Affairs, 2011, pp. 24–25). The government emphasized that coercive care is subject to efficient supervision and surrounded by legal safeguards. The government also mentioned that a comprehensive review of the system was underway.

The Committee asked the government to provide more detailed information on the type and nature of treatment that may be imposed on persons with disabilities without consent and to describe the safeguards in place to prevent abuse (CRPD Committee, 2013, para. 26). The government adhered to this request by spelling out the admission criteria for compulsory care, the legal safeguards surrounding the process, and the supervisory role of the Care Inspectorate. The Care Inspectorate is a government agency responsible for monitoring healthcare and social services, conducting on-site visits and investigating individual complaints of malpractices (CRPD Committee, 2014a, para. 101–104). This did not, however, prevent the Committee from expressing its concern over the fact that Swedish law provided for coercive care of persons with psychosocial disabilities who are considered to be a danger to themselves or to others, or from recommending the government to take all necessary legislative, administrative, and judicial measures to ensure that no one is detained on the basis of actual or perceived disability (CRPD Committee 2014b, paras. 35–36). Both the expression of concern and the recommendation of abolition are now standard formulations in the Committee's concluding observations regarding the issue of coercive care. The Committee also recommended the government to ensure that all mental health services are provided on the basis of free and informed consent from the person concerned and to allocate more financial resources to community-based outpatient services. These too are part of the Committee's repertoire of standard recommendations in relation to mental health care policies.

3.1.2. The administration of ECT

During the reporting process, the Committee took an interest in the use of electroconvulsive therapy (ECT). This may be because ECT is used more frequently in Sweden than in other countries (Wingralek, Banaszek, Nowak, & Próchnicki, 2022) and/or because it may be administrated without consent. This type of treatment is not subject to specific regulations, which means that it may be provided without consent during compulsory in-patient care if deemed necessary to protect the patient's health or life. In addition, the Swedish Disability Federation (the Federation)[8] had voiced its worry over what appeared to be a significant rise in the use of ECT (150%) and about the lack of efficient monitoring (the Federation, 2011, p. 57).

The Committee asked the Swedish government to provide data regarding the frequency of ECT treatments and to explain who authorizes and oversees their administration (CRPD Committee, 2013, para. 27). At this time, Sweden had not yet set up the national quality registry for the administration of ECT. A pilot study from the NBHW, however, indicated that approximately 39,500 sessions were administered in 2010

[5] Such admissions include a brief admission to psychiatric inpatient care upon the patient's request. The patient is the one to decide, within clearly prearranged frameworks, when inpatient care is called for.

[6] The Safewards Model describes how conflict and self-harm may be prevented without resort to coercive interventions through modification of risk factors in six domains: the physical environment, the staff team, the patient community, patient characteristics, outside hospital, and the regulatory framework. Bowers, L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. *Journal of Psychiatric and Mental Health Nursing*, 21, 499–508.

[7] The Committee issued its first such recommendation in May 2011 to the Tunisian government. In October of the same year, the Committee delivered similar recommendations in its dialogue with Spain. CRPD Committee, CRPD/C/TUN/CO/1, paras. 24–25 and 28–29; and CRPD/C/ESP/CO/1, paras. 35–38.

[8] The Federation is a national umbrella for organizations of persons with disabilities founded in 1942 with 41 member organizations representing approximately 400,000 persons with physical, intellectual, and psychosocial disabilities. It works for a society for all and is characterized by solidarity, equality, and participation. It coordinates the CRPD reporting from civil society.

(CRPD Committee, 2014a, para. 107). The Committee was deeply concerned about the high number of ECT treatments and of reports suggesting that this treatment was more often performed on women than men (CRPD Committee, 2014b, paras. 37). Current data indicate that ECT was administered ~36,500 times to ~3500 individuals in 2022. Of note, most recipients (59%) were women. This gender distribution is attributed to the fact that ECT is primarily employed to treat severe depression, a condition that is more prevalent among women than men (Elvin & Nordenskjöld, 2022).

Regarding the issue of consent, the Swedish government argued that even though the law provided for administration of ECT without consent, this was not feasible in practice. The necessary preparations for this therapy demand the patient's cooperation (CRPD Committee, 2014a, para. 107). However, the Committee was not convinced by this explanation and reiterated its recommendation to put an end to all forms of non-consensual practices within the mental health care (CRPD Committee, 2014b, paras. 38).

3.1.3. *The use of restraints against children*

The last point of critique from the Committee was on coercive care of patients under 18 years — especially the use of straps, belts, and seclusion. In 2014, when representatives from the Swedish government met committee members in Geneva, the Swedish Ombudsman for Children had recently released a report giving voice to boys' and girls' experiences of despair, resignation, and helplessness during in-patient mental health care (Ombudsman for Children, 2014). The Ombudsman called for a review of the CMHCA with the goal to craft new rules adapted to children's needs. The use of restraints should be reserved for situations in which they are necessary to protect the life of the patient (ibid., pp. 79–91 and 123). The CRPD Committee echoed the Ombudsman's criticism and urged Sweden to implement the ombudsman's recommendations (CRPD Committee, 2014b, paras. 39–40). The Committee's recommendation appears somewhat ambiguous because the Ombudsman did not advocate for the elimination of restraints under all circumstances. It raises questions of whether the Committee simply advised the government to curtail the use of restraints. Given the Committee's consistent stance against all forms of coercive measures, a more reasonable interpretation could be that the recommendation is to abolish coercive care for children and align with the Ombudsman's recommendations in other relevant areas towards this goal.

By the end of this first reporting round, it was clear that the Swedish government and the CRPD Committee had different visions for the future of mental health care. While the Swedish government maintained that the Swedish system was in harmony with the CRPD, the CRPD Committee expressed quite harsh criticism and recommended comprehensive reforms. Surprisingly, the Committee's critique did not generate significant debate in Sweden, which is unusual because criticisms from UN treaty bodies typically prompt discussion in Swedish media. This was not the case in 2014.[9]

3.2. *The second round (2018–)*

During the second round of communication between the Committee and the Swedish government, the Committee followed up on the recommendations made 2014. The Committee asked what measures had been taken to repeal legislation permitting forced institutionalization (which I take to include civil commitment in a psychiatric hospital)[10] and medical treatment without consent. They further pressed on action to eliminate such violations in practice including the use of ECT without consent and the use of restraints on children (CRPD Committee, 2018, paras. 10–11). In addition, the Committee asked for information about resource allocation for community-based outpatient services. The Swedish government replied that "no specific measures have been carried out to repeal legislation on forced institutionalisation" (CRPD Committee, 2020, para. 143). However, it highlighted several initiatives aimed reducing the use of coercion and increase patients' influence on their treatment during in-patient mental health care.

At the time of writing, the Committee is scheduled to meet with government representatives and other stakeholders in spring 2024. One can only speculate about how the dialogue concerning mental health law will evolve. It is, however, reasonable to assume that the Committee will acknowledge the positive strides taken to diminish the use of coercion within mental health care but repeat its position that coercive care violates the CRPD and recommend Sweden to cease such practices.[11] Conceivably the Committee will also clarify its position in relation to use of restraints against children and recommend Sweden to prohibit such practices as well. On this point, the Committee has gained support from the Committee on the Rights of the Child (CRC Committee), which made such recommendations in 2015 and 2023 (CRC Committee, 2015, paras. 25–26, and 2023, para. 23).[12] In relation to the administration of ECT, the Committee may wish to join forces with the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), which have repeatedly urged Sweden to take the necessary measures to ensure that patients' free and informed consent is always sought and documented in writing before resorting to this form of therapy (CPT, 2016, para. 110, and 2021, para. 67).

4. Mental health law inquiries and reforms (2008–2022)

4.1. *The mental health law inquiry*

As noted above (section 3.1.1), the CMHCA was under review when Sweden decided to ratify the CRPD. The inquiry had a broad mandate to consider the suitability of the current criteria for compulsory hospitalization and the rules governing the use of coercion during in-patient care. The rationale behind this review was not to ensure compliance with the CRPD. Rather, it stemmed from the recognition that the CMHCA was crafted in the early 1990s and hence based on medical knowledge and care ethics from the 1980s. Since then, our view of persons with mental health problems and our knowledge of how to best assist this group has advanced (Government offices, 2008, pp. 4–5). The inquiry's terms of reference did, however, refer to the CRPD together

[9] The implications of the CRPD on Swedish mental health law has been discussed by a few legal scholars, including myself, Nilsson (2018), Litins'ka, Y. (2018). *Assessing capacity to decide on medical treatment – On human rights and the use of medical knowledge in the laws of England, Russia and Sweden* (PhD thesis, Uppsala University), 544 f. and 565ff; and Kindström Dahlin, M. (2014). *Psykiatrirätt – Intressen, rättigheter och principer* [Swedish mental health law – Interests, rights, and principles] (PhD thesis, Stockholm University) Jure, 2014 p. 345 f.

[10] It may be discussed whether "forced institutionalization" appropriately describes compulsory hospitalization in a closed ward in the Swedish context. In view of the formulation of the Committee's recommendation in 2014, i.e., to take all necessary measures to ensure that no one is detained against their will in any medical facility on the basis of actual or perceived disability. I believe that it makes sense to interpret forced institutionalization to include compulsory in-patient mental health care.

[11] The Committee has adopted this approach in its concluding observations on other states parties. See, for example, concluding observations on the combined second and third periodic reports of Hungary, 20 May 2022, CRPD/C/HUN/CO/2–3, paras. 29–32.

[12] It may be noted that the UN Committee Against Torture also expressed its concern about the continued use of physical restraints and solitary confinement against young patients in 2021. It did not, however, ask Sweden to abolish such practices but to ensure that they are employed as measures of last resort for the shortest possible time and effectively monitored. See Concluding observations on the eighth periodic report of Sweden, 20 December 2021, CAT/C/SWE/CO/8, para. 27.

with other human rights conventions such as the ECHR and the CRC. The government declared that these treaties clarified the state's obligations towards persons with mental health problems and psychosocial disabilities (ibid.).

The inquiry delivered its report in 2012, and it is reasonable to conclude that the CRPD had a limited, if any, impact on the outcome. The report exceeds 1000 pages, of which less than one full page is devoted to the CRPD (Government report series 2012:17, p. 285f). While it briefly mentions the CRPD's focus on non-discrimination, it does not discuss how this norm impacts mental health law services. In contrast, the report dedicates twelve pages to discussing relevant provisions in the ECHR (ibid., pp. 270–281). The inquiry's proposals for CMHCA amendments further reinforce the notion that the CRPD had limited impact on its work. One such proposal suggested lowering the threshold for compulsory hospitalization, thus enabling psychiatrists to intervene at an earlier stage. The inquiry also proposed new forms of restrains (e.g., mobile belts). None of these proposals became law. It is, however, worth noting that whilst the report discusses whether many of their proposals are compatible with European human rights standards, it presents no such discussion with regard to the CRPD (ibid., pp. 381, 389, 682–687).

Many of the inquiry's proposals, including those mentioned earlier, encountered significant opposition. Representatives from mental health service user organizations expressed their criticism in separate opinions attached to the report (ibid., p. 1099ff) and during the referral procedure[13] (National Association for Social and Mental Health (RSMH),[14] 2012; Swedish Partnership for Mental Health,[15] 2012; the Federation, 2012). The NBHW (2012), the Swedish Psychiatric Association (2012), the National Council on Medical Ethics (2012), ombudsmen, and scholars also voiced their concerns. Some of these critical voices referenced the CRPD in their remarks, contending that certain proposals from the inquiry violated or posed a risk of violating, the Convention (Equality Ombudsman, 2012; RSMH, 2012; Gothenburg University, 2012; Lund University, Faculty of Law, 2012). Others highlighted the issue of discrimination without direct reference to the CRPD. It seems reasonable to assume that this resistance contributed to the proposals not advancing further in the legislative process.

4.2. *The work of the national coordinator for mental health services*

4.2.1. *Inclusion of persons with mental health problems in policy development and follow-up*

In 2015, the government appointed a national coordinator for the development and coordination of mental health services to work for three years.[16] The coordinator's main task was to support and coordinate the work of authorities, municipalities, and county councils in the field of mental health. Lack of coordination has been, and still is, a longstanding problem preventing persons with psychosocial disabilities from accessing adequate care and social services (Government offices, 2015). Thus, the rationale behind this initiative was not to better align Swedish practices with the CRPD or to address criticism from the CRPD Committee. In fact, the terms of reference for the coordinator's role did not make any reference to the Convention or other human rights treaties.

The coordinator decided to perform this work in close collaboration with representatives from the Swedish mental health service user movement — a working method she considered to be pivotal. The final report emphasized that active engagement of mental health service users in policy and service development is crucial to address current challenges (Government report series 2018:90, pp. 18 and 248). The report also outlined a series of recommendations designed to facilitate such involvement in future work on the organization, implementation, and monitoring of mental health services. This included support for so-called user-boards[17] and involvement of persons with psychosocial disabilities in quality assessments and research (ibid., pp. 238f, 296ff and 303). While none of these recommendations were explicitly tied to the CRPD — the Convention is mentioned in the coordinators' report (pp. 56–57) but not discussed or referred to in the sections outlining the coordinators' proposals — these proposals strongly resonate with the general principle of participation outlined in Article 3(c) of the CRPD as well as the specific obligation to involve persons with disabilities in the implementation of the Convention as articulated in Article 4.3. According to this provision, state parties shall closely consult with persons with disabilities and actively involve them through their representative organizations in the development and implementation of legislation and policies to implement the CRPD.

4.2.2. *New legal provisions strengthening children's rights*

In 2016, the coordinator received an additional assignment: to review the use of coercion against children committed for compulsory mental health care (Government offices, 2016). One might think that this review connects to the CRPD Committee's criticism of the use of restraints against children (section 3.1.1). The terms of reference, however, informs us that the review was prompted by a similar critique expressed by the CRC Committee (Government offices, 2016, p. 2). Like the CRPD Committee, the CRC Committee had recommended banning the use of restraints against children and stressed the importance of effective monitoring and training in non-coercive care methods (CRC Committee, 2015, paras. 25–26).

The review was conducted in close collaboration with children and adolescents who have been exposed to compulsory mental health interventions. This group largely agreed on the necessity of reducing restraint use because they often felt that restraints were imposed without first trying alternative methods to assist the child or to persuade him or her to accept a certain treatment. Some children reported instances of abuse, including use of restraints for punitive or controlling purposes (Government report series 2017:111 (2017), pp. 122–123). However, they did not align with the UN Committees' stance that restraining belts and seclusion should be entirely banned. They believed that such interventions might be necessary in extraordinary situations when there were no less restrictive measures available to preserve the patients' lives. This would, for example, be the case when a child with a severe eating disorder refuses nourishment despite extensive efforts to persuade the patient. In such situations, administering nutrition against the child's will could be imperative to prevent starvation. Another example would be the temporary separation of a child experiencing psychosis (ibid.).

Like prior mental health law inquiries, this report devoted little attention to the CRPD. While the Convention was briefly mentioned in

[13] A referral procedure is a common feature of the Swedish legislative process. Before the government takes up a position on recommendations from an inquiry, its report is referred for consideration to the relevant bodies. More information in English is available here: https://www.government.se/how-sweden-is-governed/swedish-legislation—how-laws-are-made/

[14] RSMH is a national federation of local associations that bring together individuals with psychosocial disabilities, focusing on peer support and advocacy. It is a part of the international mental health service user/survivor movement and the Federation.

[15] Partnership for Mental Health is an umbrella organization of user and family organizations in the mental health field. Its advocates for increased influence in policymaking, recognizing mental health care users and their families as invaluable resources with unique knowledge and experiences.

[16] Similar initiatives aim to improve coordination among agencies and service providers have been recurring since the mental health reform in 1995.

[17] User boards are representative bodies that aim to provide individuals who use mental health services with a platform for influencing and participating in the decisions, policies, and practices within psychiatric care settings. These boards typically consist of users of mental health services and the goal is to promote the rights, well-being, and interests of this group.

the section summarizing current law, it did not acknowledge the concerns expressed by the CRPD Committee. In contrast, descriptions of relevant provisions in the CRC — along with general comments and concluding observations by the CRC Committee — feature extensively in the report. These texts include sections in which the inquiry deliberated on the pros and cons of prohibiting restraint use on children and provided rationale for its stance (e.g., pp. 60–62, 124–126, 193–201, 325–329). Although the inquiry did not follow the CRC Committee's advice to ban restraint use on children, it certainly gave it careful consideration (pp. 122–126 and 228).

The review resulted in new rules for the use of isolation and belts on children, which became law in 2020. Under this law, a patient under 18 years can be restrained with a belt if there is an immediate risk of serious harm to the patient, and other measures are deemed to be insufficient (CMHCA, section 19a). A restraint decision is valid for a maximum of one hour and extendable one hour at a time. This provision is stricter than the corresponding one for adults: Belts may only be used on children if there is a danger to the child's own health and safety, not the safety of others. Additionally, the provision for adults is less specific about time limits, stating that belts should be used for "a short period of time", which according to the NBHW (2008, p. 51) should not exceed four hours unless there are extraordinary reasons to prolong the intervention. Neither the rule for children nor the one for adults specify a maximum limit on extensions, however. The new rule on separation of children also prescribes shorter time frames for children than adults. The decision to separate a child applies for a maximum of two hours and the decision to separate an adult may last up to eight hours (CMHCA, sections 20 and 20a).

Most referral bodies endorsed the amendments of the CMHCA during the referral process. Disability organizations such as the Federation (2018) and RSMH (2018), however, had preferred a prohibition on the use of restraints against children. Equally important as these new rules restricting the use of restraints against children, I believe, was the inquiries work on restraint monitoring. In her report, the coordinator argued that the Care Inspectorate, responsible for overseeing restraint use in coercive care, lacked comprehensive and reliable information about the use of restraints, and put forth a set of proposals to improve the situation (Government report series 2017:111, pp. 262–265). The Parliamentary Ombudsman has followed up on this critique, which has resulted in subsequent changes in the inspectorate's working methods to enhance data accuracy, increase the number of on-site visits, and improve the patient dialogue (Care Inspectorate, 2023).

Still, the impact of these initiatives on practice remains uncertain. There are no official statistics regarding the use of restraints against children prior to 2020, i.e., before the new rules entered into force. Available statistics on the current use of restraints are unreliable but suggest that in 2020, children were restrained with belts on 562 occasions — remarkably, this was 555 times on girls (NBHW, 2023a). The same year children were subjected to isolation on 108 occasions. In 2022, the reported instances of belt use had risen to 640, with girls still being overrepresented; in 609 of these cases, the restrained patient was a girl. The number of seclusions had also increased to 103. It is unclear if this reflects a genuine rise in the use or restraints or improved reporting.

4.3. Proposals for future reforms

4.3.1. Access to court review of the use of coercion?

Since the national coordinator ended her work in 2018, two governmental inquiries have presented proposals for future reforms. None of these proposals have yet made it into law, but they have been circulated for consultation. Examining these proposals and the reactions they provoked give us, I believe, a hint of the direction that mental health law is taking. Here, I will begin with the inquiry addressing issues of legal review, daily activities, and children's rights. The next section (4.3.2) explores reform proposals concerning coercive care for people with comorbidities.

In 2021, the government appointed an inquiry to address specific issues related to coercive psychiatry. In contrast to the mental health inquiry from 2012, which had a broad mandate to make a comprehensive analysis of mental health law and policy, this inquiry's mandate was limited to a few specific questions concerning judicial review of coercive interventions, separation of children and adults during in-patient care, and access to daily activities and outdoor exercise. The terms of reference framed these issues as human rights concerns and emphasized the ECHR as particularly important (Government offices, 2021, p. 2). The CRPD and the CRC were also mentioned, and the inquiry was instructed to consider the views expressed by the CRC Committee and the CPT (ibid., p. 16). As noted by the government, the CPT has stressed the importance of access to daily outdoor activities. In addition, this committee has repeatedly recommended that Sweden grant patients the right to appeal against medical treatment without consent (CPT, 2016, para. 123; 2021, para. 77).

The inquiry grappled with whether patients should have the right to seek court review of decisions to impose treatment without consent. Indeed, these decisions require significant clinical judgment, and judges are not medical experts. Thus, there is a risk that legal review of medical decisions may uncritically accept healthcare providers' arguments and evidence (Government report series 2022:40, pp. 154–158). The inquiry argued that monitoring bodies with medical experts such as the Care Inspectorate are better equipped to assess such material. After weighing the pros and cons of different alternatives, the inquiry recommended that patients should have the right to appeal decisions related to restraints but left it to policymakers to decide whether patients should enjoy the same right to court review of decisions regarding non-consensual medical treatment.

The response to the inquiry's recommendations has been mixed. There was large agreement in favour of extending the rights to daily activities and outdoor exercise for adults following the precedent set for patients under 18 years in 2020. Similarly, the proposal to separate children from adults during in-patient care received widespread support. However, the suggestion to grant patients the right to appeal the use of straps and seclusion to a court sparked controversy. Disability organizations such as the Federation (2022b) and RSMH (2022b) supported the proposal along with the NBHW (2022), the Care Inspectorate (2022), and three organizations for healthcare professionals. They emphasized the importance of providing effective remedies for human rights violations. In contrast, the Swedish Association for Psychiatrists (2022) opposed court review as did many local authorities responsible for coercive care. They argued that court involvement might harm the doctor-patient relationship and be of limited benefit to patients, given that the coercion would likely have ended by the time the case reached court. Administrative courts also expressed doubts about the added value of court review versus the existing system of monitoring by the Care Inspectorate. Furthermore, most referral bodies resisted court review of decisions related to medical treatment without consent, citing the clinical nature of such decisions, which they considered unsuitable for legal review. A few academics pointed out the potential conflicts between the CMHCA and the CRPD, emphasizing the need for further reforms to align with the Convention's principles of self-determination and equality (Lund University, 2022; Uppsala University, 2022; and National Council on Medical Ethics, 2022).

In view of the above, we may anticipate future amendments to the CMHCA concerning daily activities, outdoor exercise, and the separation of children and adults. This would enhance the rights protection for persons with psychosocial disabilities receiving coercive care and may thus be seen as a positive development from the perspective of the CRPD.

4.3.2. A proposal to fuse mental health and substance abuse law

Inadequate coordination between healthcare and social services for individuals with co-occurring mental health and substance use problems has long been a barrier to proper access to such services in Sweden

(Government report series 2021:93, p. 518ff). In 2020, an inquiry was established to propose a new system geared to provide "well-coordinated, needs-based and person-centred" services to this group (Government offices, 2020). There was no talk of the CRPD in the inquiry's instruction, but a strong emphasis on the principle of participation. The inquiry was tasked to work in close collaboration with individuals who had experiences of mental health problems and substance use, as well as with their representative organizations. It faithfully adhered to this instruction and conducted interviews, dialogues, and workshops with these groups (Government report series 2021:93, p. 22f and 65–67, and 2023:5, p. 24). During the consultation phase, numerous disability organizations, including the Federation (2022a), RSMH (2022a), and Swedish Partnership for Mental Health (2022), praised the inquiry for its exemplary efforts in this regard.

It is not possible to present the reform in full here, but one element is of particular interest to the discussion of the impact of CRPD on mental health law. That is the proposal to fuse current legislation on coercive care for substance use problems with the CMHCA, and thus expand mental health care providers responsibility to provide care for persons with serious substance use problems. Such a reform, the inquiry argued, would ensure that people with substance use problems entailing an indispensable need for in-patient care can access such care. Under the current system, there is a significant risk that this group fall through the cracks. An untreated psychiatric condition may make it difficult for them to maintain and benefit from social services and break an addiction. Concurrently, a serious addition is an obstacle to access in-patient care in many psychiatric clinics.

Most referral bodies have cautiously welcomed this fusion proposal but emphasized the need for significant investments to equip psychiatric hospitals to provide professional, evidence-based and person-centered care for this new patient group. Several organizations have raised concerns about the risk that people with substance abuse would be exposed to more coercion compared to the current system,[18] underscoring the importance of continued efforts to minimize coercion within psychiatry. The Federation (2023) and RSMH (2023) referred to the CRPD to support this point. Others have questioned the appropriateness of imposing treatment on this group arguing that they will often be competent to make decisions about their healthcare (Lund University, 2023; National Council on Medical Ethics, 2023).

From a CRPD perspective, the proposed fusion represents an expansion of psychiatrists' authority to use coercion. This contradicts the CRPD Committee's general stance against coercive care of persons with disabilities, though the Committee has not elaborated its position in relation to people with disabilities who also have substance use problems. On the other hand, the proposal aims to ensure better and more equal access to health care for this group. This could be viewed as a step towards better adherence to the Convention. In addition, the proposal forms part of a larger reform that includes various CRPD-aligned initiatives aimed at combating substance use-related stigma, facilitating access to personal ombudsmen, and enhancing access to community-based care, thereby reducing the reliance on coercion within mental health care. Whether this fusion proposal — viewed alone or as part of a larger package — represents a step in the right or wrong direction depends on how we interpret the CRPD and value the adverse effects of expanding psychiatrists' mandate to use coercion. Notably, the inquiry did not discuss its proposals in relation to the CRPD. Nevertheless, the final report contains the most extensive discussion of these norms and recommendations from the CRPD Committee found in preparatory works on mental health law in Sweden to date (Government report series 2023:5, pp. 223–226). Here, the inquiry also expressed the view that the CRPD does not explicitly prohibit coercive care (p. 225). There is no further discussion on what this means, why it is difficult to pin down what the inquiry meant to say with its statement. Did the inquiry mean to say that coercive care, as provided for in the CMHCA is compatible with the CRPD? Or that coercive care may be compatible with the CRPD under certain circumstances? Or did the inquiry mean to say something else? The statement ends with a footnote that references the government bill (2008/09:28, p. 44) on the ratification of the CRPD asserting that Sweden could ratify the Convention without amending the CMHCA. The same footnote, however, also cites an article in which I argue that Swedish mental health law still has an urgent need of reform to comply with the Convention (Nilsson, 2018), which further complicates the interpretation of the statement.[19]

4.4. Summing up the CRPD's impact on mental health law reforms

As the discussion above illustrates, the CRPD has not played a leading role in the development of Swedish mental health law. None of the inquiries discussed in section 4 were initiated to better align the law with the CRPD or to address criticisms from the CRPD Committee. While the CRPD is mentioned in the terms of reference and briefly described in the sections of the reports that explain "current law," it is conspicuously absent in the discussions concerning the future shaping of mental health law. More prominence is given to other human rights treaties such as the ECHR and the CRC as well as to the views of the CRC Committee. As discussed in section 4.2.2, review of the use of coercion against children was prompted by criticism from the CRC Committee, a critique which was given careful thought during the review.

Does this imply that the CRPD has had zero impact Swedish on mental health law? I would argue otherwise. First, the CRPD played a role in stopping the Mental Health Law Inquiry's proposals to expand psychiatrists' discretionary power to restrain and coerce patients at psychiatric wards. Many critics opposed such an expansion and supported their stance with references to the CRPD (see section 4.1). Second, efforts have been made to reduce the use of coercion, to mitigate its adverse effects on patients' well-being, and to improve monitoring of coercive psychiatric care. Much of this work has been in the form of projects and trainings as discussed in section 2.2, but a few legal reforms also aim to contribute to these aims. This includes the introduction of new stricter rules governing the use of restraints against children and the new right to a post-restraint debriefing session for patients exposed to these forms of coercion. In addition, proposals for court review of the use of restraints and administration of non-consensual medical treatment are currently under government consideration.

We can also discern some shifts in the discourse around ECT over time. The Mental Health Law Inquiry deliberated on the necessity of distinct regulations governing the administration of ECT in 2012. The inquiry recognized the distress associated with administering ECT without consent, which spoke in favour of stricter regulations granting patients more influence. Nevertheless, the inquiry opted not to propose such regulations and referred to the proven effectiveness of ECT in alleviating specific psychiatric conditions. The report also stressed the

[18] Within current regulations, there are slight differences between the type of restraints that may be use within coercive mental health care and coercive care for substance abuse.

[19] In the mentioned article, I critique the (mental) health law in Sweden for its inconsistency in addressing the consequences of a lack of decision-making capacity and the potential for violent behaviour. The law mandates medical treatment for individuals with mental health problems due to their diminished decision-making ability, but not for those lacking capacity due to factors like a brain injury, advanced stages of dementia, or being in shock. Likewise, only individuals with mental health problems can be subject to preventive detention based on their anticipated 'dangerousness' to others. This constitutes disability-based discrimination that is challenging to justify and, therefore, amounts to a violation of the CRPD.

importance of not hindering doctors from treating critically ill patients who are considered to lack the capacity to provide informed consent (Government report series 2012:17, pp. 399–400). A decade later, the inquiry focusing on specific mental health law issues advised the government to modify the rules applicable to the administration of ECT although it was not explicitly within its mandate (Government report series 2022:40, p. 151). The inquiry referred to the Danish and Norwegian systems as models to consider. These systems contain stricter rules for the use of ECT, such as a period of reflection and observation before ECT can be administered without consent.

The third and final positive development pertains to the increased involvement of individuals with mental health issues and their representative organizations in policy development and in decisions regarding their own care and treatment. This shift is most visible in the work of the national coordinator and the inquiry responsible for coordinating services for people with psychosocial disabilities and substance use problems.

5. Concluding reflections

One might wonder why the CRPD has not had a more significant impact on Swedish mental health law and policy. Initially, this could be attributed to a certain level of unawareness or ignorance. As noted above, the Swedish government held in 2008 that no amendments to the CMHCA were needed to align it with the CRPD — a stance put forward with little justification. There is presently an increased recognition of the Convention. Nevertheless, policymakers have yet to undertake a comprehensive analysis of how the obligations to ensure equal enjoyment of legal capacity, freedom of liberty, and respect for physical and mental integrity set forth in Articles 12, 14, and 17 affect mental health law. As this article has illustrated, the discrimination perspective is conspicuously absent from the official documents addressing this matter.

Other scholars have noted that the abstract nature of the CRPD's norms may have contributed to their limited impact on domestic mental health law. The treaty text does not provide detailed answers to the classic dilemma between the interest to protect health and life and the duty to respect individuals' autonomy and self-determination, including the freedom to make one's own choices, as specified in the Convention's guiding principles (Article 3 (a)). It presents a vision but leaves it unclear how states parties should go about creating a workable legal framework to implement this vision (Alexandrov & Schuck, 2021, p. 10; Aluh, Onu, & Caldas-de-Almeida, 2022, p. 6). This is inconvenient for those responsible for its practical implementation.

The lack of consensus among UN treaty bodies further complicates matters. There is an ongoing debate regarding (1) whether coercive mental health care is ever compatible with human rights law and (2) whether restrictions of freedom of liberty and legal agency that are directly or indirectly associated with intellectual, cognitive, or psychosocial disability — and hence meet standard definitions of discrimination — may ever be justified (Gurbai & Martin, 2018; Martin & Gurbai, 2019; Gurbai, 2020). On one side, the Human Rights Committee (2014, para. 19) contends that coercive mental health care that meets the definition of prima facie discrimination may be justified if certain criteria are met. Conversely, the CRPD Committee insists that such care violates the prohibition of disability-based discrimination, thus demanding its complete abolition. A similar disagreement is visible in the European context between the European Court of Human Rights—which like the Human Rights Committee, maintains that coercive care may be justified—and the Council of Europe Commissioner for Human Rights (2018, paras. 92–102) who rely significantly on the outputs of the CRPD Committee in its recommendations to governments.[20] While these disagreements can serve as a constructive force, thus ultimately strengthening the protection of human rights for mental health care service users, they may also undercut the immediate impact of the disputed norms. It is indeed unfortunate if states parties to the CRPD use this controversy as an excuse to delay mental health law reforms while awaiting clearer guidance. In my view, the debate on the proper interpretation of the Convention emphasizes the need for the Swedish government to engage in the debate and conduct its interpretative analysis of how these provisions should be understood, preferably in close dialogue with the disability and human rights movement.

It must be acknowledged that the dispute over coercive care extends beyond whether the CRPD imposes a *legal* duty to abolish such care. Indeed, it reflects ethical and political disagreement about the moral acceptability of using coercion to protect health and prevent self-harm. In the Swedish context, there is little advocacy for the complete abolition of coercive care. Disability organizations have repeatedly called for a reduction in the use of compulsion and for the elimination of specific forms of coercion, such as the use of restraints on children and the administration of ECT without consent. They, however, rarely advocate for the closure of coercive psychiatry. A mental health care system free from coercion is seen as an ideal to pursue, but it is rarely depicted as a practical possibility in the current context (e.g., RSMH, 2012 and 2022b; Swedish Partnership for Mental Health, 2012 and 2023; the Federation, 2012 and 2023).

Looking ahead, it is time for the Swedish government to initiate a serious analysis of the implications of the CRPD on the CMHCA. This law clearly treats patients with psychosocial disabilities differently than other patients including patients with intellectual and cognitive disabilities. As explained in section 2.1, only psychiatric treatment may be imposed without consent, and questions related to decision-making capacity are underdeveloped in Swedish health law. The CRPD's focus on equality and self-determination challenges us to find new ways of thinking about mental health law. The debate over the lawfulness and legitimacy of coercive care, which began during the drafting of the Convention, continues at international and domestic arenas. There is now a growing body of literature offering insights into how to assess and revise mental health law including proposals for how to improve compliance with the CRPD without abolishing coercive care altogether (Szmukler et al., 2014; Gooding & Flynn, 2015; Flynn & Arstein-Kerslake, 2017; Brosnan & Flynn, 2017; Nilsson, 2018, 2021; Wilson, 2018, 2021). I urge the next Swedish mental health inquiry to engage with this literature to unleash the transformative potential of the CRPD to develop a fairer mental health care system.

CRediT authorship contribution statement

Anna Nilsson: Conceptualization, Formal analysis, Methodology, Writing – original draft, Writing – review & editing.

Declaration of competing interest

None.

[20] When the Commissioner visited Sweden in 2018, he repeated the CRPD Committee's concern about Swedish mental health law and recommended a drastic reduction and progressive elimination of the use coercion in psychiatry. The Commissioner also asserted that medical treatment must be based on free and fully informed consent, with the exception of life-threatening emergencies when there is no disagreement regarding the ability to consent. In *Rooman*, the European Court held that the ECHR does not contain a prohibition of detention in a psychiatric hospital in contrast to what is proposed by the CRPD Committee. *Rooman v Belgium* [GC], app no. 18052/11, 31 January 2019, para. 205.

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