The preventive approach: OPCAT and the prevention of violence and abuse of persons with mental disabilities by monitoring places of detention

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Abstract

Adopted in December 2002, the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment establishes a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment. The article explores how this collaboration between national and international bodies, with independent mandates to carry out such unannounced visits, represents an important effort in the process of protecting persons with mental disabilities who are detained and who are particularly exposed to exploitation and other forms of serious human rights violations, contrary to Article 16 of the Convention on the Rights of Persons with Disabilities.

Key words:

OPCAT,

NPMs,

Article 16 CRPD,

persons with mental disability,

prevention,

monitoring.

Introduction[1]

In his article entitled "*There must be some way out of here: Why the Convention on the Rights of Persons with Disabilities*[2] *is potentially the Best Weapon in the Fight Against Sanism*," Michael Perlin argues that the Convention on the Rights of Persons with Disabilities (CRPD) is the most revolutionary international human rights document - ever - that applies to persons with disabilities".[3] In addition, he observes that the CRPD "firmly endorses a social

[1] This article forms part of special issue of the journal entitled ' which can be accessed at **.

[2] United Nations, General Assembly, *The Convention on the Rights of Persons with Disabilities*, A/RES/61/106 (13 December 2006); Retrieved from http://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx

[3] M L Perlin (2013). "There must be some way out of here": Why the Convention on the Rights of Persons with Disabilities is potentially the best weapon in the fight against sanism. *New York Law School Legal Studies*; Research Paper Series 12/13#77. 2013. Retrieved from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2283279

model of disability and reconceptualises mental health rights as disability rights – a clear and direct repudiation of the medical model that traditionally was part and parcel of mental disability law".[4]

Especially when viewed alongside other core human rights documents, the UN CRPD strengthens the rights of persons with disabilities and, in particular, those with mental disabilities who are deprived of their liberty. The CRPD explicitly states that "the existence of a disability shall in no case justify a deprivation of liberty",[5] and the latter applies to contexts of criminal justice, of immigration and involuntary hospitalizations in health or care-giving settings, such as hospitals, treatment centres or social-care homes.

Through Article 16 of the CRPD, States parties to the Convention have committed themselves to protect and prevent all forms of exploitation, violence, and abuse, including gender-based discrimination. Paragraph 3 of the same Article underlines State obligation to ensure that independent authorities effectively monitor all facilities and programmes designed to serve persons with disability.

In this article, we will focus on the protection and prevention of such violence as required by Article 16 of the CRPD in the context of the prohibition against torture and ill-treatment, and the potential of the two major conventions aimed at eradicating torture, namely the CRPD and the UN Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment [6] (UNCAT) and its Optional Protocol[7] (OPCAT) to contribute to this objective. We will have a particular focus on the monitoring mandate under the OPCAT and how the work performed under this instrument can strengthen the prevention of torture, ill-treatment and forms of abuse and exploitation in places of detention. Perlin & Schriver (2013) have further highlighted the relevance of both conventions to prohibit and prevent torture in relation to persons with mental disabilities: "The ratification of the Convention (CRPD) must be read hand-in-glove with the United Nations Convention against Torture (UNCAT). Together, these documents make it more likely -- or should make it more likely -- that, for the first time, particular attention will be paid to the conditions of confinement, world-wide of this

[4] Ibid., p. 2.
[5] Article 14.1.b.
[6] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, New York, 10 December 1984, Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspxv
[7] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 entered into force on 22 June 2006. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx

population; to what extent those conditions regularly violate international human rights law; and how those who are in charge of these institutions do so with impunity".[8]

The question that will be addressed in this article is how torture and ill-treatment of persons with a mental disability can be prevented through the existing international legal framework and the measures that have been developed to strengthen prevention, in particular for persons deprived of their liberty. As independent monitoring through visits to places of detention constitutes one of the most established measures for prevention, and the OPCAT is adopted specifically with this as the main working method, the challenge is to understand how this protocol can make a difference in the field of disability rights. Given that the Committee Against Torture (CAT) has a visiting mandate limited to very specific conditions set forth in Article 20 of the UNCAT, and visits must never be unannounced, the OPCAT was adopted with the aim of allowing a more direct and proactive approach to prevention, through regular unannounced visits to *all places* where persons are held in detention.

Prevention of torture and ill-treatment of persons with disabilities

In the following section, the two main UN instruments to combat torture and ill-treatment will be described with a particular focus on how they relate to persons with mental disabilities.

Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

The UNCAT distinguishes between torture and cruel, inhuman or degrading treatment or punishment. Whereas torture is clearly defined in Article 1, other forms of ill-treatment are not, but the Convention expressly establishes that "each State party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in Article 1". Furthermore "the obligations contained in Articles 10, 11, 12 and 13 shall apply with the substitution for references to torture of references to other forms of cruel, inhuman or degrading treatment or

[8] M L Perlin & M Schriver (2013). 'You that Hide Behind Walls': The Relationship between the Convention on the Rights of Persons with Disabilities and the Convention Against Torture and the Treatment of Institutionalized Forensic Patients. *Torture and Ill-Treatment in Health-Care Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report, American University Center on Humanitarian Law, 2013.* *NYLS Legal Studies Research Paper No. 13/14 #76*. Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2412550, p. 12.

punishment".[9] In its General Comment No.3 to Article 14 on the right to redress, the CAT also notes that victims of cruel, inhuman and degrading treatment have rights to redress under the Convention.[10] Because "conditions that give rise to ill-treatment frequently facilitate torture" the measures that are required to prevent torture must be applied also to prevent ill-treatment, and the CAT has thus "considered the prohibition of ill-treatment to be likewise non-derogable under the UNCAT and its prevention to be an effective and non-derogable measure".[11]

In the first annual report of Subcommittee for the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment of Punishment (the SPT), which is the treaty body monitoring the OPCAT, the relationship between torture and ill-treatment was referred to in the following way: "The scope of preventive work is large, encompassing any form of abuse of people deprived or their liberty which, if unchecked, could grow into torture or other cruel, inhuman or degrading treatment or punishment".[12] This means that "when working within a preventive framework it is generally not necessary to distinguish between acts of torture and other forms of ill-treatment because both are absolutely prohibited under international law at all times".[13] This observation is particularly relevant when discussing the rights of persons with mental disabilities who may be deprived of their liberty. Since the detention of persons with mental disabilities primarily takes place within health-care/psychiatric units, torture and prohibition of torture is often not regarded as something directly relevant, since torture is often understood as or being limited to taking place in other kinds of settings, for example, prison or police cells, not hospitals. And the fact that torture is defined as the intentional infliction of pain leaves the sense that it does not necessarily relate to institutions that are locations for care and treatment. On the other hand, there may be somewhat greater willingness to look at the risk of ill-treatment taking place in such settings, and against those may be deprived of their liberty in these settings. Thus, by emphasizing the close and dynamic relationship between torture and

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[9] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, New York, 10 December 1984, *United Nations Treaty Series*, vol. 1465, p. 85, Retrieved from https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-9&chapter=4&lang=en; art. 16.

[10] United Nations, Committee against Torture, *General Comment No. 3 of the Committee against Torture: Implementation of Article 14 by States parties*, CAT/C/GC/3 (19 November 2012), Retrieved from http://www2.ohchr.org/english/bodies/cat/docs/GC/CAT-C-GC-3_en.pdf, para. 3.

[11] GC 3 (n 24), para. 3.

[12] *First Annual Report of the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.* (February 2007 to March 2008; CAT/C/40/2;14 May 2008, Retrieved from file:///C:/Users/norasv_adm/Downloads/G0841828%20(1).pdf

[13] Association for the Prevention of Torture (APT) and Inter-American Institute of Human Rights. Geneva/Costa Rica (2010). *Optional Protocol to the UN Convention against Torture. Implementation Manual*, p. 28. Retrieved from http://www.apt.ch/content/files_res/opcat-manual-english-revised2010.pdf

ill-treatment, the need to apply torture-prevention mechanisms and strategies in the range of contexts for persons with mental disabilities is highly relevant and necessary.

The obligation to prevent

The obligation to prevent is defined in Article 2 of the UNCAT and further detailed in General Comment No.2: "The obligations to prevent torture and other cruel, inhuman or degrading treatment or punishment (hereinafter "ill-treatment") under Article 16, paragraph 1, are indivisible, interdependent and interrelated. The obligation to prevent ill-treatment in practice overlaps with and is largely congruent with the obligation to prevent torture".[14]

The responsibility of States parties to prevent torture and ill-treatment under the UNCAT, relates both to acts as well as omissions when these are done by officials, agents, private contractors, and others "acting in official capacity or acting on behalf of the State, in conjunction with the State, under its direction or control, or otherwise under colour of law".[15] In practice this means that the State obligation to prevent torture and ill-treatment, including protecting persons from violence, exploitation and abuse, extends to:

> *"all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm*".[16]

The obligation to prevent must be read in close conjunction with the obligation to provide redress to victims of torture and ill-treatment. In its General Comment No. 2, the CAT established that:

> *"States parties must ensure that, insofar as the obligations arising under the Convention are concerned, their laws are in practice applied to all persons, regardless of race, colour, ethnicity, age, religious belief or affiliation, political or other opinion, national or social origin, gender, sexual orientation, transgender identity, mental or other disability, health status, economic or indigenous status, reason for which the person is detained, including*

[14] United Nations, Committee against Torture, *General Comment No. 2: Implementation of article 2 by States parties*, CAT/C/GC/2 (24 January 2008) available from http://www.refworld.org/docid/47ac78ce2.html, para. 3.
[15] GC 2 (n 18) para. 15
[16] GC 2 (n 18) para. 15

persons accused of political offences or terrorist acts, asylum-seekers, refugees or others under international protection, or any other status or adverse distinction".[17]

The obligation to prevent, thus, is expansive and far-reaching: the jurisprudence of the CAT defines State responsibility in situations where lack of protection is reported and measures to prevent persons from suffering harm have not been put in place.[18] Action as well as inaction may be considered a breach of this obligation. The CAT has defined failure to protect and lack of due diligence in situations where the State has failed "to prevent and protect victims from gender-based violence, such as rape, domestic violence, female genital mutilation, and trafficking".[19]

In recent years, several situations which would not necessarily be regarded as issues under the purview of the CAT, have nevertheless been highlighted by it as examples of lack of State compliance. Relevant examples include violence against women and children; trafficking; and certain forms of harmful traditional practices. This position is based on the understanding that acts of violence by non-State actors can also be regarded as violations attributable to the State under Article 2 of the UNCAT, when the State has not carried out its obligations to prevent, protect, investigate, redress and hold the perpetrators responsible. This approach by the CAT to acts such as ill-treatment in institutions, hospitals, social care homes and even private homes strengthens the focus on protection and prevention of persons in vulnerable situations.[20] Seen in conjunction with the CRPD, this can be an important tool in the process of protecting the rights of groups historically subjected to discrimination, in particular, this recognises the right to self-determination and legal capacity and the need for adequately adapted conditions to meet individual needs. CAT recommendations to States regarding persons with mental and physical disabilities may include concerns, encouragement to act and urgently implement measures in cases related to persons with mental and physical disabilities in their homes; in institutions, including prisons, hospitals and other types of care providers, covering both involuntary and voluntary placements.

The CAT has not pronounced an absolute ban on involuntary hospitalization or treatment. Instead, it has advocated for the need to develop voluntary approaches to the treatment of all

[17] GC 2 (n 18) para. 21
[18] N Sveaass (2013). Gross human rights violations and reparation under international law: approaching rehabilitation as a form of reparation. *European Journal of Psychotraumatology*, (4): http://dx.doi.org/10.3402/ejpt.v4i0.17191
[19] United Nations, Committee against Torture, *General Comment No. 2: Implementation of Article 2 by States parties*, CAT/C/GC/2 (24 January 2008) available from http://www.refworld.org/docid/47ac78ce2.html, para. 18
[20] F Gaer (2008). Opening remarks: General Comment No. 2. *New York City Law Review, 2*, 187-201.

persons with mental disabilities, including by recommending alternative forms of treatment and care;[21] and speaking out against treatment methods which involve serious restrictions and carry a high risk of humiliation and/or inhumane treatment. It also urges States to enforce laws prohibiting such methods.[22] These will be discussed further below.

The Optional Protocol and the Preventive Approach

The UNCAT and the Optional Protocol to the Convention against Torture [23] have different mandates, so the two treaty bodies created by them consequently have distinct approaches and working methods. While the CAT considers reports by States and recommends legislative, administrative and other forms of measures to ensure compliance with obligations under the UNCAT, including follow-up procedures, the Optional Protocol was created as a result of a conviction:

> *"that the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment can be strengthened by non-judicial means of a preventive nature, based on regular visits to places of detention*".[24]

The Optional Protocol aims to prevent torture and cruel, inhuman and degrading treatment or punishment by visiting, reporting and collaborating with national and international bodies. The mandate relates to the obligation to prevent torture as well as ill-treatment. In the reports issued by the SPT, torture is always referred to in conjunction with ill-treatment, and tend to be referred to in conjunction with each other.[25] The relevance of the OPCAT in relation to the aims defined in Article 16 of the CRPD is evident: first, because contributing to the

[21] See United Nations, Committee against Torture, *Consideration of reports submitted by States parties under Article 19 of the convention: Concluding observations of the Committee against Torture: Moldova*, CAT/C/MDA/CO/2, 2010, para. 25
[22] See United Nations, Committee against Torture, *Consideration of reports submitted by States parties under Article 19 of the convention: Concluding observations of the Committee against Torture: Czech Republic*, CAT/C/CZE/CO/4-5; 2012, para. 21
[23] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* Adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199 entered into force on 22 June 2006. Retrieved from http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx
[24] Ibid, Preamble art. 4.
[25] See http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=12&DocTypeID=23&DocTypeCategoryID=9)

prevention of torture and ill-treatment is the primary objective of the OPCAT: secondly, because the OPCAT is about the rights of *all persons* who may be deprived of their liberty; and thirdly, because the SPT is mandated to enter, unannounced, all places of detention, including hospitals, psychiatric units and social care homes.

The question that needs to be raised is, of course, how the OPCAT mechanism has contributed to and impacted on prevention in general and, in particular, for persons with mental disabilities. A recent study by Carver and Handley explores what we know about the effects of torture prevention and what seems to be the most effective mechanism to obtain this. [26] The study includes a thorough analysis based on country specific reports and a critical approach to preventive mechanisms, with a view to determining what, in fact, reduces the risk of torture. The research summarizes the key findings with respect to the most effective measures as follows:[27] the provision of safeguards in the first hours and days after arrest/detention; effective investigation and criminalisation of allegations of torture; visits to monitor places of detention; and finally, effective complaint procedures and mechanisms. In other words, ensuring that the rights of persons who are detained, including the right to see a doctor; a lawyer; to notify family and to be interviewed according to human rights standards seem to be effective means of preventing torture, and the other approaches are important with regards to detecting any gaps between the legal standards and implementation on the ground. The findings in the study are significant and have general application to the work of prevention and implementation, although there are few direct references to the measures specifically aimed at persons with mental disabilities or to the places where they may be detained. Nevertheless, the measures of prevention analysed both in this study and in earlier studies[28] are directly applicable and relevant to persons in detention with disabilities. In particular, the basic safeguards in the period immediately following apprehension or loss of liberty are very relevant, whether it is at a police station, hospital or other care-unit. FrightMoreover, monitoring places of detention through regular visits and individual private interviews and ensuring that effective complaint mechanisms are in place must be developed and strengthened in places of detention for persons with mental disabilities, be they part of the criminal, health, social or immigration system.

[26] R Carver & L Handley, (2016). "Does Torture Prevention Work?", Liverpool: Liverpool University Press.
[27] Ibid. p. 2 – 4.
[28] E Delaplace & M Pollard, (2006). Torture prevention in practice. *Torture*, 16 (03), 220 – 246**. (NBBBBB with or without period after first initial? I have left out the period and also reduced the first name some places to only first initial**

In the following sections, we will outline both the potential and actual role of the OPCAT in the prevention of torture/ill-treatment of persons deprived of their liberty, and, in particular for the protection of persons with mental disabilities from exploitation, violence and abuse. We will conclude with some observations about the need to strengthen the essential preventive work in this particular field.

A brief historical overview

Both the CRPD and the OPCAT are relatively new mechanisms. One of the central initiators of the Optional Protocol, the Swiss banker Jean-Jacques Gautier, argued that torture is most likely to occur in places out of the public eye.[29] A system of unannounced visits to such places could therefore constitute one way of detecting and preventing torture. The establishment in 1977 of the Swiss Committee against Torture (Comité Suisse contre la torture), which would later become the Association for the Prevention of Torture, proved to be an important platform for the work to promote an international convention that would create a universal system of visits to places of detention. This process resulted in the OPCAT, which, when adopted, made possible a strengthened focus on prevention. The adoption of the European Convention for the Prevention of Torture in 1987 as a regional tool for prevention led to the establishment of a similar mechanism at the international level.

The OPCAT was adopted by the General Assembly in 2002. With its entry into force on 22nd June 2006, a new system for regular and unannounced visits to prisons, police cells and all other places of detention was established. The OPCAT is based on the principle that the preventive mandate is assigned simultaneously to an international body (the SPT) and to National Preventive Mechanisms (NPMs), established domestically pursuant to the obligations under the Protocol. The OPCAT provides direct monitoring by visits by the two bodies and including joint visits in collaboration between the two bodies.

The OPCAT sets out that the objective of the Protocol is to "establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment".[30] In addition to direct monitoring, the activities under the

[29] http://www.apt.ch/en/jean-jacques-gautier/

[30] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* art. 1

Protocol include advisory work and capacity building carried out both by the SPT and the designated NPMs.

The institutional pillars of the OPCAT: the SPT and the NPM

As explained above, the OPCAT creates two fundamental institutional pillars: an international treaty body, the SPT, and the numerous national preventive mechanisms (NPMs).

The SPT is composed of 25 members appointed by the Conference of States parties to the Optional Protocol with the mandate of visiting the places (referred to in Article 4) and making recommendations to States Parties concerning the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment. Article 11 of the OPCAT establishes a relation between the SPT and the NPMs, through which the SPT is mandated to advise State parties on the designation and establishment of NPMs and how to strengthen their capacities and competencies. Most importantly, once the NPMs have been created, the OPCAT creates an innovative line of communication between the international and national bodies that may, "if necessary", be confidential. This is a highly significant and distinctive feature of the system created under OPCAT: the ability to maintain separate, and if necessary, confidential communications allows the SPT to consider and adopt actions to support NPMs, for example if the body is subjected to any undue influence or interference from the State.

At the national level, NPMs should be established within one year after ratification of the OPCAT.[31] The State designates or establishes the NPM based on its evaluation as to what body or institution is best suited to perform this duty, or whether a new institution should be created. Under OPCAT it is required that the mechanism must be fully and functionally independent; contain the required capabilities and professional knowledge; and have the necessary resources to undertake the work. Members must be independent experts and a multi-disciplinary composition and approach is strongly recommended. Article 18 highlights the importance of giving due consideration to the Paris Principles,[32] that is, the principles relating to the status of national institutions for the promotion and protection of human rights. The OPCAT does not establish a separate system of accreditation of the NPMs, in the way that this is established for the national human rights

[31] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* art. 17.
[32] Ibid.art. 18.

institutions. However, a set of guidelines has been developed by the SPT to guide the work of the national bodies and with the aim of ensuring that it is within the remit of the OPCAT.[33]

Like the SPT, the NPMs have unrestricted access to any place where persons are, or may be, deprived of their liberty, and the right to confidential individual interviews with detainees to enable the visiting body to examine and evaluate treatment and conditions. Places of deprivation of liberty are wide ranging and include involuntary hospitalization in health or care-giving settings, such as psychiatric and social care institutions; psychiatric wards; prayer camps; secular and religious-based therapeutic boarding schools; boot camps; private residential treatment centres; or traditional healing centres.[34]

Unrestricted access means access to *all parts* of the facilities, including entry records/ registries and medical files. In that respect, the imperative of having a multi-disciplinary visiting group becomes clear: at a minimum, medical health professionals must be present to adequately examine medical files, medical services and options, as well as evaluating the conditions from the perspective of mental and physical health. It is in this context that the provision of Article 14.1.b of the CRPD has acquired particular importance for the discussion on possible intersections on the rights of persons with disabilities, arbitrary deprivation of liberty and prevention of torture and ill-treatment. This has already been noted by the United Nations Special Rapporteur on Torture in his Annual Report in 2013, in which he voiced the opinion that "the effects of institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight, raise particular questions under prohibition of torture and ill-treatment".[35]

It is important that visits are regular and unannounced, and that there is an effective system for follow-up to enable the NPM to evaluate the implementation of recommendations and willingness on the part of the relevant State to set in motion the recommendations in the NPM reports.

There is regular contact between the SPT and NPMs worldwide. In addition, it is a requirement that the SPT shall work to strengthen its preventive mandate with all relevant bodies, both within the UN and with external regional mechanisms. Other regional oversight/monitoring bodies in particular can provide important input to the SPT's visiting mandate and be significant

[33] http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/OP/12/5&Lang=en
[34] This catalogue identified by the UN Special Rapporteur against Torture in his Annual Report for 2013, cfr. A/HRC/22/53, par. 57.
[35] A/HRC/22/53, par. 70

partners in the prevention of torture work. This is true for the European Committee for the Prevention of Torture (CPT), the Inter-American Commission on Human Rights (IACHR), and the African Commission on Human and Peoples' Rights (ACHPR).

The principle pillars of the OPCAT: access and confidentiality

The OPCAT enshrines two fundamental principles that enable the preventive approach: access and confidentiality. The access principle enables the SPT to observe places where persons are or may be deprived of their liberty and, if relevant, provide advice to the State in relation to the measures that must be adopted to give full effect to the duty of prevention. The principle of access is a cornerstone of the OPCAT and extends to the open invitation to the SPT to visit the territory of any State party, and to all relevant information that the SPT may request to evaluate the needs and measures necessary to ensure the protection of persons deprived of liberty within that territory. [36]

Article 2 of the OPCAT guarantees access for the SPT to all places of detention within the control and authority of the States parties.[37] Visits can be either announced or unannounced and the SPT must not be denied access to any relevant detention facilities. Should the SPT be refused entry/access, measures can be taken to obtain entry, and if it is not resolved, the SPT can suspend its mission. The principle of access also extends to the opportunity to have private interviews with the persons deprived of their liberty without witnesses. If necessary, interviews with detainees can be carried out with an interpreter, appointed by the SPT, and the SPT can conduct interviews with any other person whom it believes may supply relevant information.[38] The SPT has complete discretion as to the choice of places to visit and the persons it wishes to interview.[39]

The State parties must as part of their commitment, provide all relevant information about the number of persons deprived of their liberty in places of detention as defined in Article 4, as well as the number of such places and their location.[40] Further, States must provide all the necessary information about the treatment of those persons and the conditions of detention.[41]

Therefore, the OPCAT places under the scrutiny of the SPT and the NPM any public or private custodial setting under the jurisdiction and control of the State party, where persons may be

[36] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* art. 12.a & b
[37] Association for the Prevention of Torture (APT) and Inter-American Institute of Human Rights. Geneva/Costa Rica (2010). *Optional Portocol to the UN Convention against Torture. Implementation Manual,* p. 28. Retrieved from http://www.apt.ch/content/files_res/opcat-manual-english-revised2010.pdf
[38] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* art 14.d
[39] Ibid., art 14.e.
[40] Ibid., art 14.a.
[41] Ibid., art 14.b.

deprived of their liberty, either by an order given by a judicial, administrative or other authority, or at its instigation or with its consent or acquiescence. The formulation of the OPCAT also implies that these provisions should be interpreted as expansively as possible, in order to maximise the preventive impact of the work. This means that persons who may be detained in places which are not formally designated as places of detention, (for example, so-called "black sites", illegal places of detention or places under where no official order exists), may still be included in the OPCAT mandate, because there is some form of acquiescence or consent by the State. The SPT only communicates its observations and recommendations directly to the State party[42] and the report is only published upon the request of the relevant State.[43] In fact, the OPCAT principles of confidentiality, impartiality, non-selectivity, universality and objectivity (as defined in Article 2), underline the importance given to co-operation with State parties in implementing the protocol.

It is important to note, especially in the SPT's collaboration with civil society organizations which are an important source of knowledge and input into its work, that confidentiality does not mean impunity, or a lack of willingness to bring about change. The principle of confidentiality is based on an understanding that this mechanism, with a mandate to visit any place of detention, at any time, without prior notice, requires that change must be achieved through close collaboration with the State Parties, in a confidential manner. Nevertheless, the SPT is keen to promote and open and transparent approach through contact with the States and at their discretion.

Another aspect of confidentiality relates to the fact that, during visits, private conversations or interviews with detained persons are a priority. This means that such conversations must be conducted in situations where there are no staff present and that any detainees who wish to speak to the visiting delegation (be they from the SPT or NPM) should be able to do so without any undue hindrance, in the knowledge that the information obtained will not be transmitted to the staff or detaining authorities.

The principle of confidentiality under which the SPT carries out its mandate is comparable to that of the work of the International Committee of the Red Cross, although, arguably, the latter is even more limited in its ability to make its findings and recommendations public.

The scope of the OPCAT

[42] Ibid.,art. 16.1.
[43] Ibid.,art. 16.2

The combination of national and international efforts to combat and prevent torture and ill-treatment makes the OPCAT a rather innovative treaty. Both monitoring bodies play important and complementary roles in the process of strengthening preventive measures, through visits, and as a result of recommendations for legal reform and changes to conditions and practices that may contribute or amount to torture.

The work of the SPT under the OPCAT is operational and practically oriented. In contrast to other treaty bodies, it is not directly involved in standard setting not does it have the ability to pronounce and make critical comments in public. The work is carried out through direct contact, both during visits and active consultations, with authorities as well as NPMs. There are no procedures for submitting considerations or receiving communications from individuals.

Given the mandate to visit "places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment,[44] there are a wide range of places that can be visited, both by the SPT and the NPMs. We will briefly outline below the different types of visits and methods of operating during such visits, with a focus on the approaches to preventing and protecting against violence, abuse and exploitation of persons with a mental disability.

Places of detention.

The monitoring bodies have authority to visit places where persons are held against their will, that is, they are deprived of their liberty based on judicial or administrative orders by State institutions. This includes police stations and prisons; pre-trial detention facilities; security forces stations; military facilities; centres for juveniles and administrative detention; detention centres for asylum seekers and immigrants; as well as mental health institutions or hospitals, social care homes, and any other place where persons may be held against their will. A major part of the monitoring is conducted in places where persons are held by decisions based on criminal law, including sentenced prisoners, those under preventive detention or remand and those who have served their sentence but not yet released, as well as persons whose legal status may be unclear. Among them are inmates with a range of different challenges related to mental and physical health, including disabilities. There may also be persons who find themselves in difficult situations because they belong to groups historically subjected to discrimination and

[44] *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,* art. 1

marginalization, such as LGBTI persons. There is a wealth of information about the risks of exposure to torture and ill-treatment, exploitation and other forms of violence for people from these particular groups.[45]

The question of reprisals is particularly relevant in this context. It is the duty of visiting bodies to do everything possible to ensure that the persons who are providing information to the visiting bodies are not exposed to reprisals following the visit. It is also important to be aware of the "do no harm" principle and avoid interaction, questioning or forms of engagement with those who find themselves deprived of liberty and who may, as a result, face reprisals.

Prison visits. Visits to prisons of different kinds constitute the most frequent type of visit by monitoring bodies such as the SPT and NPM, and also the CPT. Such visits may be announced or unannounced, but in all cases there are special procedures to be followed and aspects of the facility which will always be explored. One of the major points of investigation during visits is related to access to the registries. Monitors must conduct thorough reviews of these records to check whether persons are properly registered at arrival/ entry; whether medical entry examinations have been completed, which also includes assessment and documentation of possible injuries on entry to the institution. Evidence of inadequate registration/documentation could imply torture or ill-treatment prior to the prison transfer, such as violence in connection with apprehension, interrogation and/or the holding cells. In the context of persons with a mental disability, proof of an initial medical examination is vital in order to evaluate and recommend any special needs and conditions.

The objective during visits is to bring as much as possible out in the open, including possible disciplinary measures, inter-prisoner violence, abuse by prison personnel and evidence of withholding of any rights and privileges.The need to collect information about individuals and groups that may be in especially vulnerable situations or historically exposed to discrimination and marginalization is a priority for the visiting bodies. This may be related to a wide range of different situations, such as disability - mental and somatic; chronic illness (HIV, TB etc.); persons young of age; gender identity/LGBT; being non-nationals; belonging to groups in conflict with other groups in the prison, either related to religion or gangs for example. Making recommendations to remedy the conditions and/or treatment during detention

[45] ACHR, *Ximenes Lopes v. Brazil,* in extensor; Available on https://iachr.lls.edu/cases/ximenes-lopes-v-brazil; IACHR, *Precautionary Measures in the Matter of the Neuropsychiatric Hospital of Paraguay,* in extensor: Available on http://www.oas.org/en/iachr/decisions/precautionary.asp .

represent an important part of the visits and will form the basis of the recommendations made to the detaining authority after the visit.

In general, the observations made by the SPT/NPMs relating to the conditions of detention cover a wide range of issues. These may include comments about the standards of hygiene; access to food and drinking water, air, exercise and movement; the availability of education activities, health services and medical care; and the procedures for dealing with contagious diseases, etc. Any serious gaps or failings in any of these areas may constitute evidence of ill-treatment and even torture. Occupancy rates which far exceed the maximum number of inmates often creates the biggest risk of ill-treatment. In situations of serious overcrowding, it goes without saying that those with particular needs and vulnerabilities, including those with mental disabilities, will be among those at greatest risk of ill-treatment, violence, abuse and/or exploitation.

Juvenile detention settings are also the focus of visits, stemming from the concerns about their particular risk to vulnerability. Discussions with States about the possibility of alternative placements, legal safeguards and access to education, activities, and contact with family and networks are particularly central in these cases.

Police stations and holding cells. The risk of exposure to violence and ill-treatment seems especially high in the early stages of detention, that is, during the period immediately following apprehension /arrest, such as during interrogation at police stations and holding cells.[46] As mentioned earlier, the endeavours to secure basic safeguards at this early stage are considered to be some of the most important measures for prevention.[47] It is essential for monitoring bodies to be given full access to all parts of police stations, including spaces that are not readily opened for inspection. Inspecting interrogation rooms and checking whether CCTV is operational and available are also important. A particular focus is on persons in vulnerable situations, and especially persons who may need particular support or assistance due to a disability or language/communication barriers. Health other forms of psychiatric care and support will be evaluated in the same way as in the prison.

[46] European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment, *the CPT Standards, Substantive Sections of the CPT's General Reports*, Council of Europe, October 2001, CPT/Inf/E(2002), p.12, para. 41

[47] See Carver and Handley, 2006.

Preventive detention settings. Detention is often an overused option and many people remain in preventive detention for far too long, often without access to a judge, to legal counsel or any complaints processes. It is often the case that persons in preventive detention are not usually provided with the range of services that are available in regular prisons for sentenced inmates.

Immigration detention. Over the last few years, the practice of detaining persons who are crossing borders has become more frequent and today there are immigration detention centres in many countries all over the world. Whilst some of them are difficult to access and visit, in OPCAT State parties there is no legitimate reason to deny access to the SPT or NPMs. These detention centres can be highly problematic and, in many cases, could be regarded as forms of arbitrary detention, as no crime has been committed (other than crossing borders) and access to legal assistance is often limited.[48] The conditions in these centres for persons who may be particularly vulnerable must be reviewed very carefully. Immigration centre detainees are often seeking protection from violence/abuse or imprisonment in their home countries and frequently they may have been exposed to different forms of torture, including rape. The conditions for persons with special vulnerabilities, including mental disabilities must be subjected to scrutiny and form part of the visiting body's recommendations.

Psychiatric units in prisons. Many countries have separate forensic psychiatric units within prisons or separate institutions/units/hospitals. There may be different categories of patients/ inmates in such units: some may be subject to forensic compulsory treatment, i.e. persons who have committed violent crimes but are not criminally liable. There may also be persons who, during their period of imprisonment have developed a serious mental disorder and are placed in the hospital unit as an alternative placement. Thirdly, there may be observation units for persons who have committed crimes, but where there is some doubt as to their legal capacity. Some of the conditions in these units/hospitals pose serious threats to the health and well-being of the patients/inmates and may constitute ill-treatment and torture.

Health care institutions, including psychiatric hospitals. There has been a growing focus over the last few years on the risks of torture and ill-treatment in health care settings. The need to

[48] See for ex Hungary Helsinki committee on detention of all asylum seekers; http://www.helsinki.hu/en/hungary-law-on-automatic-detention-of-all-asylum-seekers-in-border-transit-zones-enters-into-force-despite-breaching-human-rights-and-eu-law/

strengthen approaches to monitoring of health related institutions is clear. Persons who are deprived of their liberty in health institutions might be there under legal provisions that can be criminal or civil in nature, but in practice, arbitrary detention is commonplace. The CPT has for many years focused on mental health, and persons with serious mental health issues. However, the main focus has been on the conditions for severely mentally ill prisoners.[49] There is a need to strengthen visits to all psychiatric hospitals/units where patients are deprived of their liberty and subjected to compulsory treatment. The SPT as well as the NPMs are increasingly focusing on visiting the broad range of such psychiatric/ health care settings.

Care homes including social care institutions and drug-rehabilitation centres. Numerous reports from monitoring bodies in the UN and European systems have documented instances of ill-treatment, also amounting to torture, in places where persons are held in order to receive care, treatment or even rehabilitation.[50] Examples have been found of ill-treatment of adults as well as children with mental and/or physical disabilities where "forceful internment and long-term restraint used in institutions (…) amount to torture or cruel, inhuman and degrading treatment or punishment".[51] Monitoring such places and investigating allegations of abuse/ill-treatment is therefore paramount and in line with the OPCAT and Article 16 of the CRPD.

Persons with disabilities deprived of their liberty

In all types of institutions where persons are held against their will, a wide variety of disabilities may be encountered, and the underlying questions are whether the conditions under which they live are acceptable; whether any special needs are being met; whether they are at risk from violence or threats; and whether their detention is lawful. A failure to provide support/conditions that are suitable for individual needs may be considered ill-treatment and, at times, amount to torture. Likewise, the failure to protect persons in vulnerable situations may constitute torture and ill-treatment.

[49] See f.ex. CPT visit to UK, 2016 https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168070a773

[50] See United Nations, Committee against Torture, *Consideration of reports submitted by states parties under article 19 of the convention: Concluding observations of the Committee against Torture: Cambodia,* CAT/C/KHM/CO/2, 2011, para. 20; retrieved from http://www2.ohchr.org/english/bodies/cat/docs/CAT.C.KHM.CO.2_en.pdf;

[51] *Consideration of reports submitted by states parties under article 19 of the convention: Concluding observations of the Committee against Torture; Serbia,* CAT/C/SRB/CO/1,2008, para. 16; Retrieved from http://www2.ohchr.org/english/bodies/cat/docs/CAT.C.SRB.CO.2.pdf.

In visits to places where persons are deprived of liberty because of infractions of the law, the focus of the visiting bodies is on the treatment of individuals and whether there is risk of torture and ill-treatment of individuals, or the group as a whole. Further, the visiting body will also examine whether legal safeguards have been respected both on arrival and at later stage of the detention period. In some instances, inadequate provision of information about legal safeguards is observed, such as no access to legal counsel, no appearance before a judge, and sentences that have been served by the person has not been released. The persons in detention are usually serving time in prison pursuant to a legal decision by a court/judge and this will not usually be questioned. However, that does not authorise forms of excessive punishment, such as torture or ill-treatment, be it through direct application or due to the nature of the physical conditions which amount to treatment prohibited under the conventions. In addition, detention facilities manage disciplinary regimes, and there may be forms of disciplinary action as well as reasons for implementing these that may be contrary to the prohibition against torture and ill-treatment.

There are nevertheless some concerns about the placement of persons in detention, in particular for minors and persons with disabilities. A special focus is placed by monitors on the conditions, special needs and protection of persons in such situations, and it may often seem clear that the placement in a regular prison is unacceptable and amounts to ill-treatment or worse.

On the other hand, when visiting places where persons are detained, such as hospitals and social care homes, or centres of detention for immigrants/ asylum seekers, the justification for detention is seldom related to the criminal law, but to national mental /health law and practices. In the case of asylum seekers and immigrants, the basis is national immigration or asylum laws. When persons are held deprived of liberty in hospitals and social care home, the decision for these interventions is related to the disability itself, to level of functioning and to behaviours or reactions that may be destructive to themselves or others. The focus of the scrutiny here should therefore be both on the legal justification for the deprivation of liberty, as well as on the legal safeguards, the conditions of detention and treatment methods, bearing in mind that these can, in themselves, constitute forbidden acts or conditions that are conducive to torture and ill-treatment. With regard to the detention of persons in the context of immigration, a special focus must be placed on the legal basis for the detention, as well as the conditions of detention.

Non-consensual treatment in a preventive context.

The stronger focus on the rights of persons with disabilities under the CRPD has raised issues relating to involuntary treatment and hospitalization, that is, care without free and informed consent and to legal capacity on equal basis with others.[52] The claim that involuntary treatment may constitute ill-treatment and even torture represents a special challenge to visiting bodies. Involuntary treatment includes both the act of committing a person to a hospital or health institution by an order of the court or a decision by a doctor, without the free and informed consent of the person, as well as the compulsory treatment measures that take place within the facility. In addition, it is well documented that persons in psychiatric settings are frequently exposed to other kinds of traumatic or harmful experiences. [53]

The argument to abolish disability-specific forms of deprivation of liberty, including forced institutionalisation in psychiatric hospital, has been raised in the context of the CRPD and by the Special Rapporteur on Torture[54]. This is closely related to the right to legal capacity, found in Article 12 of the CRPD, as well as to the right not to be detained unlawfully or arbitrarily.

The need for a shift in practice in relation to involuntary psychiatric care was voiced by the UN Special Rapporteur on Torture Report entitled "Torture in Health Care Settings" in 2013.[55] He called for "(a)n absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics, the use of restraint and solitary confinement, for both long- and short-term application".[56] This resulted in an important debate, and his position was strongly supported by advocates of disability rights.[57] However, professional organizations such as the American Psychiatric Association (APA) and

[52] CRPD, art. 12

[53] BC Frueh, Knapp RG, Cusack KJ, Grubaugh AL, Sauvageot JA, Cousins VC, Yim E, Robins CS, Monnier J, Hiers TG (2005). *Psychiatr Serv.* 56(9):1123-33. Patients' reports of traumatic or harmful experiences within the psychiatric setting.

[54] Expert meeting on the deprivation of liberty of persons with disabilities on the basis of disability, Palais de Nations, Geneve, Sept. 7, 2015.

[55] United Nations, General Assembly, *Report submitted by the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez,* A/HRC/22/53; Retrieved from http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/AHRC.22.53_English.pdf

[56] Ibid., para 89 b.

[57] World Network of Users and Survivors of Psychiatry (2013). ***Comments*** *to the* ***Committee against Torture*** *on* ***standards applicable*** *to* ***psychiatric institutions*** *and mental health services*. Document submitted to the UN Committee Against Torture, 2013

the World Psychiatric Organization (WPO) adopted the contrary view and were critical of the Special Rapporteur's position.[58]

This discussion is important and embraces a wide range of perspectives from users of psychiatry, their relatives/carers, health professionals, human rights activists and lawyers, as well as the relevant health care systems/providers of care. The views are often strong and polarised, and there is no space to elaborate on them in detail here. Our focus in the following section will be to consider the responses from the relevant treaty bodies, in particular, the CAT and SPT.

The CAT and SPT on involuntary placements in health and social care.

The CRPD General Comment No. 1 to Article 14 reminds States of their obligation to respect the right to legal capacity of persons with disabilities on an equal basis with others: "(T)he denial of the legal capacity of persons with disabilities and their detention in institutions against their will, either without their consent or with the consent of a substitute decision-maker, is an ongoing problem". [59] The General Comment further argues that, "This practice constitutes arbitrary deprivation of liberty and violates Articles 12 and 14 of the Convention".

Whereas this advocates for an absolute prohibition on detention or placements in residential settings without the consent of the person concerned, the Human Rights Committee, in its General Comment No. 35,[60] advises of the need to avoid arbitrary detention; and that States should make adequate community-based or alternative social–care services available for persons with psychosocial disabilities. Furthermore, it states that disability does not justify any deprivation of liberty but, rather, that it must be necessary and proportionate, and as a measure of last resort and for the shortest appropriate period of time. Procedural and substantive safeguards must be established.[61]

As referred to earlier, the CAT has likewise refrained from taking a general position with respect to involuntary hospitalization as a violation of the prohibition against torture in and of itself. Instead, the CAT has recommended that voluntary forms of treatment must be given

[58] Psychiatric News; Retrieved from http://psychnews.psychiatryonline.org/topic/news-residents?sortBy=Ppub
[59] General comment No 1, to CRPD art. 12, para 40, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement
[60] General comment No 35 to CCPR art. 9, para 19. http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fGC%2f35&Lang=en
[61] Ibid, para 19

priority and, if treatment, is involuntary, it should be for the shortest possible time;[62] restraints should only be used as a measure of last resort and under supervision, based on professional evaluation and for the shortest possible time.[63] The CAT has also recommended that persons should not be held in isolation; that forced medication should be avoided,[64] and that alternatives to hospitalization must be developed.[65] Furthermore, States are urged to limit or even consider forbidding enforced administration of intrusive and irreversible treatments such as neuroleptic drugs [66] and the use of isolation, diet reduction and means of restraints as a measure of discipline.[67]

The CAT has frequently expressed concern about the lack of legal safeguards for those deprived of their liberty in health care settings, with limited or no access to legal counsel, inadequate appeal possibilities and a lack of information. States have been urged to ensure that "effective judicial control over involuntary treatment and placement, as well as effective appeals mechanisms are established and.. effective legal safeguards are respected in all places of deprivation of liberty, including psychiatric and social care institutions", and finally that ".. access to effective complaint mechanisms is strengthened".[68] The need to initiate investigations "where excessive use of such restrictive measures result in injuries of the patient; complaints regarding torture and ill-treatment in health facilities"[69] has been underlined. This means that there is no unified or clear approach at the UN level about the need to abolish all forms of disability-specific forms of deprivation of liberty.

The CAT's jurisprudence on psychiatric treatment without consent has been criticised for being too legalistic and moderate, and not in line with the aims of the CRPD. The World Network for Survivors of Psychiatry summarizes it in the following way: "The Committee has

[62] See e.g. CAT/JPN/CO/2 (CAT, 2013), para. 22; Retrieved from http://www.nichibenren.or.jp/library/ja/kokusai/humanrights_library/treaty/data/torture_report_en2013.pdf
[63] See e.g. CAT/HRV/CO/4-5 (CAT, 2014); para 17. Retrieved from file:///C:/Users/norasv_adm/Downloads/G1424639%20(1).pdf
[64] See e.g. CAT/JPN/CO/2 (CAT, 2013), para 22 e.
[65] Ibid. para 22 e
[66] See e.g. CAT/C/BGR/CO/4-5 (CAT, 2011), para 19 b; Retrieved from http://www2.ohchr.org/english/bodies/cat/docs/CAT.C.BGR.CO.4-5_en.pdf
[67] See e.g.CAT/C/SLE/CO/1 (CAT, 2014), para 27; Retrieved from file:///C:/Users/norasv_adm/Downloads/G1405801.pdf
[68] See e.g. CAT/C/JPN/CO/2 (CAT, 2013), para 22, a,c & d.
[69] See e.g.CAT/C/JPN/CO/2 (CAT, 2013), para 22, para. f

for most part adopted an approach calling for legal standards and procedural safeguards, rather than outright abolition of institutional confinement and compulsory treatment". [70]

The SPT, with its visiting and preventive mandate, has ongoing discussions about involuntary hospitalization and treatment. The SPT is mindful of the obligations under Article 14 of the CRPD and the prohibition to deprive persons of their liberty based solely on disability,[71] but it has not adopted an absolute position on the prohibition of non-consensual treatment. Nor has the SPT adopted a policy in relation to exceptions to the requirement of informed consent. What seems evident is that the treaty bodies referred to above have different interpretations and thereby different approaches regarding these issues. That said, the discussion as to whether the detention is arbitrary is often not within the capacity of the SPT to evaluate or determine. Nevertheless, assessment and inquiry into legal safeguards, and a systematic approach to what conditions may constitute ill-treatment or torture, including the conditions and forms of treatment provided whilst in detention, be it hospitals or settings under criminal law, are major objectives for the SPT visiting mandate.

As a way of responding to the challenges observed in places where people are deprived of their liberty because of their health status, the SPT has produced a paper on the approach of the CAT "regarding the rights of persons institutionalized and treated medically without informed consent".[72] The SPT adopted this paper in November 2015. The paper argues that informed consent is fundamental, but there are exceptions to this principle, though not with respect to medication. It states that even "if involuntary confinement seems to be appropriate and proportional on a legal bases, such confinement should never directly include the formal right for medication to be administered without informed consent".[73] The paper points to restraints being used as measures of last resort for safety reasons and that solitary confinement must never be used.[74] The paper stresses the need for legal safeguards to be respected at all times and that States must review their mental health legislation, including by developing restrictive criteria for involuntary interventions and guidelines for support when needed in relation to the exercise of legal capacity.[75] The paper does

[70] World Network of Users and Survivors of Psychiatry (2013). *Comments to the Committee against Torture on standards applicable to psychiatric institutions and mental health services*. Document submitted to the UN Committee Against Torture, 2013
[71] CRPD art 14
[72] United Nations (2016). *Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalized and treated medically without informed consent*. CAT/OP/27/2. Retrieved from https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/011/96/PDF/G1601196.pdf?OpenElement
[73] Ibid. para. 7
[74] Ibid. para. 10
[75] Ibid. para 20 a

not, as noted, voice a ban on all forms of non-consensual treatment, including non-consensual forms of treatment within the hospitals, such as the use of restraints. This is even though the SPT has on numerous occasions criticized the application of these forms of treatment as part of the treatment regime. The position paper has been commented on by some, including the WNSUP, who argue that the document may "legitimate the existence of practices contrary to the UN Convention on the Rights of Persons with Disabilities (CRPD), including psychiatric institutionalization, involuntary commitment, involuntary interventions a, and physical and chemical restraint". [76] The SPT has a constant focus on basic rights, health, conditions and special needs when monitoring places of detention, but as the above reflections indicate, there is a clear need to further develop the positions and practice about these important issues.

SPT recommendations on Prevention of Violence and Exploitation

Even though the visiting obligations extend to all places of detention, and as such include hospitals, social care homes etc. the focus on the protection of persons with mental disabilities in prison has been more visible in the work of the SPT to date than the focus on those with disabilities detained in other types of facilities. This is acknowledged by the SPT itself and attempts at rectifying this are a priority. The SPT has highlighted that there "should be no exclusivity in the preventive endeavour" and that it must be multifaceted and interdisciplinary.[77] The need to enhance and improve working methods for monitoring people with mental disabilities in psychiatric institutions has been expressed by the SPT. The SPT is collaborating with the Association for the Prevention of Torture (APT) with this objective in mind and important steps have already been taken with a special focus on preventing abuses in psychiatric hospitals.[78]

By way of example, some of the recommendations to States from reports (based on visits, collaboration with States and regular contact with the NPMs) which are in the public domain and relate to the protection of persons with disability in detention will be outlined below.

[76] WNUSP statement: SPT should consult with organizations of persons with disabilities its position paper in relation to mental health treatment. Nov. 5, 2014.
[77] The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishnment(2010) http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/OP/12/6&Lang=en
[78] APT (2016). Monitoring psychiatric institutions. http://www.apt.ch/content/files/JJG%20Symposium/Concept%20note_JJG%20Symposium%202016_EN.pdf

Observations and recommendations with regards to health, both somatic and mental health form central parts of the visiting mandate and collaboration with the NPMs. State Parties are urged to ensure access to mental health services for persons in all forms of detention, provide sufficient human and financial resources to ensure the quality of these services, as well as appropriate training to staff. [79] States are often also encouraged to monitor the psychological effects of detention conditions and the treatment of persons deprived of their liberty, since these could produce mental health consequences that amount to torture and ill-treatment. [80] There is also focus on the systems of mental health assessments on admission to psychiatric places of detention and scrutiny of the records regarding early assessment, health care needs and treatments, and medical records more generally to ensure the rules on confidentiality are respected. It is also important to check that there is a regular system of reporting and documentation of any injuries, both on admission and throughout the period of detention. The systems for regular monitoring of detainees' general health, including through visits and interviews by the NPMs are highlighted as measures to reduce the risks of abuse, torture and ill-treatment.[81] The use of restraints has been commented on in reports based on visits, although this has related more clearly to persons in prison than hospital. Greater focus on and developing methodology on what happens while in non-consensual care seems central.

The SPT recommended that the Maldives should "adopt mental health legislation to ensure that deprivation of liberty of persons suffering of psychiatric conditions is given a firm legal basis" following a country visit. [82] Again, this highlights some of the points raised above. The SPT has also advocated for the development of comprehensive mental health reforms of involuntary hospitalization procedures, including for the elimination of solitary confinement for persons with mental disabilities, as necessary measures in several settings.[83]

The SPT has also raised the problem of corruption as a major issue concerning the right not to be subjected to torture or ill-treatment in detention. The fact that persons deprived of their liberty must pay bribes to prison officers to obtain what should be automatic rights

[79] See, e.g., CAT /OP/NZL/1 paras. 58-63; CAT/OP/SWE/1, para. 137; CAT/OP/MLI/1, para. 69; CAT/OP/PRY/1, paras. 181-182; CAT/OP/KGZ/1, paras. 111-120.
[80] See, e.g., CAT/OP/SWE/1, paras. 127, 163.
[81] See, e.g., CAT/OP/HND/1, paras. 190-191, 196; CAT/OP/MLI/1, paras. 37-38; CAT /OP/NZL/1, paras. 62-67; CAT/OP/DEU/1, paras. 33-34.
[82] See e.g. CAT/OP/MDV/1 para 237
[83] See, e.g., CAT/OP/KGZ/1, paras. 111-123720; CAT/OP/PRY/1, paras. 182, 185, CAT/OP/27/2.

constitutes a serious human rights concern. Based on a visit to Paraguay, the SPT said that it considers:

> "that corruption is both the cause and the consequence of torture and ill-treatment. People enter into the system of corruption and privileges under duress and become corrupt so as not to suffer abuse. If they do not go along with the system, they are subjected to ill-treatment even torture. Corruption also ensures silence, blocks complaints and guarantees impunity. A system of corruption as hermetic and complex as the one observed by the SPT would seem to offer no choice as regards entering it and no way of escape from it. The SPT also considers that the low salaries of the prison guards serve to exacerbate the phenomenon". [84]

The Special Rapporteur on Torture has raised similar concerns to the same State Party in 2010.[85] The problem of corruption in cases of detention may represent a very special risk, both of exploitation of and violence committed to persons deprived of their liberty, and to persons in vulnerable situations or those who are subjected to discrimination and marginalization.

NPMs recommendations on prevention of torture, violence and exploitation

The NPMs are much closer to public authorities than any international body and, as such, have a unique opportunity to conduct follow-up visits to places of particular concern. A recently published report from the NPM in Norway contained specific criticism and recommendations to the health authorities on issues regarding the rights of persons hospitalized for reasons of mental health /disabilities. After a visit to a major psychiatric hospital, the NPM published its findings, which included serious concerns and deficits. Among these were the lack of meaningful activities for patients and the lack of therapeutic assistance in the acute phase of hospitalization. Furthermore, there the NPM also found that there was a lack of legal safeguards, in particular regarding complaints by patients. Injuries among patients were not reported or registered, in violation of existing rules. And the excessive use of power was described in some cases in connection with involuntary hospitalization, and the practice of non-consensual care in cases where alternative treatment methods had not been exhausted. Some

[84] Paraguay CAT/OP/PRY/1 (2009;163)
[85]Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishmesnt, Manfred Nowak, Mission to Paraguay, A/HRC/7/3/Add.3, para. 68.

patients spent far too long in belts and other forms of mechanical restrictions were used for unacceptably long periods and without any clear legal basis. Finally, there was inadequate information provided to patients, especially regarding coercive methods of treatment and, related to this, was the lack of proper registration or recording of such measures. In addition, forced medication was found to be a major concern. Based on this, the Norwegian NPM has made several recommendations to the hospital and those responsible authorities in the health system.[86]

Similar criticisms about psychiatric detention have been made by other NPMs in relation to persons with mental disabilities, focusing on unacceptable conditions in hospitals, social care homes and other places where people with mental disabilities are deprived of their liberty. The legal basis for detention has also been questioned in many cases. One clear example of such abuse was the process before the Inter-American Commission on Human Rights (IACHR) concerning the Neuropsychiatric Hospital of Paraguay. In July of 2008, the IACHR began to monitor the allegations of physical violence and sexual abuse against patients in the hospital. For a period of two years, the IACHR monitored the situation and followed-up on the implementation of the measures adopted by the State to remedy it.

Conclusions and Recommendations

This article has focused on how the work under OPCAT can be a tool to help to fulfil the rights laid down in Article 16 of the CRPD, and in what way this objective corresponds with the preventive mandate under OPCAT. Despite some of the positive aims and practices that have been described above, it seems correct to say that the monitoring work that has been made possible under the OPCAT is still in its infancy and that a systematic and strengthened strategy, in particular with regard to monitoring the rights of persons with mental disabilities, is yet to be developed. The mandate defines preventive visits in places of detention with the aim of observing, disclosing and commenting on conditions and regulations that may

[86] Sivilombudsmannen, 2016. National Preventive Mechanism against Torture and Ill-Treatment. Retrieved from https://www.sivilombudsmannen.no/aktuelt/sivilombudsmannen-etter-besok-til-psykiatriske-avdelinger-ved-unn-har-informert-ledelsen-om-alvorlige-funn-article4522-2865.html

be conducive to torture and ill-treatment with a view to changing these. In this context, persons who are deprived of their liberty, and with different forms of mental disabilities, should have a prioritized focus to bring the law and practice in line with the obligations to prevent torture and ill-treatment. For some persons who are detained under mental health laws (rather than criminal provisions), the human rights violation may be the actual hospitalization/detention itself, when this is carried out without the free and informed consent of the person. In such cases, the SPT is looking at forms of deprivation related to mental disability. The question is therefore, how monitoring bodies can respond to these issues, that is, in what way the legitimacy of such practices can be met. The Norwegian NPM did not adopt a position against involuntary treatment as such in its report, but nevertheless it did criticise the procedures in relation to hospitalization, treatment as well as the legal safeguards.

This, along with other examples mentioned in this article highlight the need for greater reflection and dialogue on policy and approaches about preventing abuse, violence, ill-treatment and torture, and how to respond to questions regarding mental disability and the risk of discrimination when deprivation of liberty is based on mental disability. This dilemma was encapsulated by the United Nations High Commissioner for Human Rights in the 2009 Annual Report:

> "Legislation authorizing the institutionalization of persons with disability on the grounds of their disability without their free and informed consent must be abolished……this should not be interpreted to say that persons with disabilities cannot be lawfully subject to detention for care and treatment or to preventive detention, but that the legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined as to apply to all persons on an equal basis". [87]

Despite the many examples of clear and harsh criticism by the SPT and NPMs in a variety of situations where rights have not been respected, these monitors under OPCAT are not denouncing bodies. The mandate is very much one of prevention in collaboration and co-operation with the States Parties to the OPCAT. As described above, the reports are confidential

[87] OHCHR (2009). *Annual Report of the United Nations High Commissioner for Human Rights and Reports of the Office of the High Commissioner and the Secretary General.* Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities. A/HRC/10/48; para 49)

to the States concerned, and not made public in the same way as the reports from other UN human rights bodies and Rapporteurs. Although the SPT does strongly encourage publication of reports to States, the report may only be published when the State so decides. It is only then that other bodies, including civil society organizations, can effectively examine the SPT's observations, recommendations and findings, to ensure that they are actioned and implemented by the relevant State.

Capacity building is a priority for the future, and this is true both for national and international bodies. There must be a stronger focus on disseminating information, research findings and reports, as well as of reports from different bodies and NGOs engaged in the rights of persons with disability. The enhancement of methods of monitoring, for those places of detention that fall outside the remit of the criminal/penal system is needed. This includes developing appropriate methods for interviewing persons with mental disabilities who are deprived of their liberty that foster trust and do not add to any feelings of marginalisation and/or ill-treatment. This may enhance both the frequency and outcome of monitoring visits, as well as contributing to the growing body of knowledge and promote strong human rights approaches to strengthen the rights of persons with mental disabilities.

As noted above, prevention is a comprehensive endeavour and is dependent on effective co-operation and an ongoing dialogue between States, human rights mechanisms and civil society[88] to identify problems, find solutions and carefully oversee their implementation on the ground.

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[88] See Delaplace & Pollard, 2006.

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