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Legal capacity in international human rights law

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Chapter 8: Disability, torture and ill-treatment: taking stock and ending abuses

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1. Introduction

This special issue looks at the nexus of torture prevention and disability. While Volume 16, Issue 5 of this Journal focused on ‘Torture and the quest for justice’ focused on torture and the development of international law, this Special Issue looks at how law can be used to prevent future instances of torture, cruel, inhuman or degrading treatment or punishment. It focuses on a group which has been neglected by torture prevention actors, namely children and adults with psycho-social (mental health) disabilities or intellectual disabilities in places of detention.

This introduction briefly outlines the history of torture prevention and the development of international law focused on people with disabilities. The paper then looks at the segregation and human suffering of detainees with disabilities, the failure of monitoring mechanisms to integrate such places within their regular scheme of visits, as well as impunity and barriers to access to justice which flow from incarceration. The paper then outlines the aims of this Special Issue and provides an overview of the five papers which follow. Lastly, the paper looks ahead and makes four inter-related recommendations

to international, regional and national inspectorate bodies, recommendations intended to help increase their effectiveness with regards to preventing torture and ill-treatment against people with disabilities.

2. Torture prevention

Freedom from torture, cruel, inhuman and degrading treatment and punishment has been recognized as an absolute, non-derogable right since the wake of the global human rights movement in the 1950s. There exist today several bodies at regional and country-level, European and global-levels which seek to prevent or remedy torture and other forms of ill-treatment. The UN Committee against Torture sets standards, reviews State compliance and adjudicates as a quasi-judicial body when allegations of torture arise.⁶⁴¹ Others, such the UN Sub-Committee for the Prevention of Torture, are mandated to ensure prevention of torture and ill-treatment by means of periodic visits to “to any place [...] where persons are or may be deprived of their liberty”.⁶⁴² The logic of this is that detainees are exposed to a heightened risk of abuse,⁶⁴³ and that such ill-treatment often takes place with impunity and remains unaddressed.⁶⁴⁴ Yet, despite the combined efforts of these bodies, non-governmental organisations, and public campaigns, human rights in places of detention all around the world still continue to be violated.

⁶⁴¹ The UN Committee against Torture was established by the UN Convention against Torture in 1984. See Art. 17-24 of the Convention.

⁶⁴² UN Convention against Torture, Art. 4(1).

⁶⁴³ ‘Preventing Torture: An Operational Guide for National Human Rights Institutions’, Office of the High Commissioner for Human Rights. Sydney, May 2010. p.4.

⁶⁴⁴ Ibid., pp.6-7. In cases where the judiciary lacks independence, complaint mechanisms are ineffective, there is no access to free legal aid and legal assistance for detainees, allegations of torture and ill-treatment are not investigated, and those who breach the law are not punished, there is a heightened risk of impunity.

The Council of Europe's 1950 Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and United Nations' 1966 International Covenant on Civil and Political Rights (ICCPR), both human rights treaties, include an unconditional prohibition of all forms of torture, cruel and inhuman or degrading treatment or punishment. The mechanisms established by these treaties, however, have proved to lack sufficient effectiveness in preventing torture. The 1984 Convention against Torture (CAT) and the establishment of the Committee against Torture marked the next step of global efforts to prevent and prohibit such abuses and end impunity. Despite this, torture and ill-treatment continued to be carried out. Particularly worrisome was the situation of people who found themselves in situations of vulnerability, including in places of detention. To strengthen efforts in protecting detainees from torture and ill-treatment the Council of Europe established its own torture prevention body in 1989 – the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). This body's mandate is to carrying out monitoring visits to all places of detention in Council of Europe Member States.⁶⁴⁵ The UN established its own monitoring mechanism after the adoption of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) in 2002, which established the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). This global body comprised now of 25 members, was established in 2007. Under the OPCAT States Parties must establish National Preventive Mechanisms (NPMs), which are bodies independent from the State whose mandate it is to carry out preventive monitoring visits to places of detention.⁶⁴⁶

⁶⁴⁵ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), established by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Strasbourg, 26 November 1987.

⁶⁴⁶ Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). New York, 18 December 2002.

3. A disability-specific focus in international law

The UN Convention on the Rights of Persons with Disabilities (CRPD) was adopted in 2006.⁶⁴⁷ The treaty sets out basic international human rights norms specifically for children and adults with disabilities, including in the area of torture and ill-treatment prevention and in places of deprivation of liberty. The CRPD gathers in a comprehensive manner rights for people with disabilities, a term which is defined⁶⁴⁸ to include people with “mental” disabilities (“psycho-social disabilities” is the term used by the CRPD’s treaty bodies and which we use in this paper)⁶⁴⁹ and people with “intellectual disabilities”.⁶⁵⁰

The preamble of the CRPD refers to the international human rights infrastructure, including the ICCPR the CAT,⁶⁵¹ explaining that, “despite these various instruments and undertakings, persons with disabilities continue to face barriers in their participation as equal members of society and violations of their human rights in all parts of the world”.⁶⁵² To overcome these barriers the CRPD articulates a philosophy which is set out in its overarching “Principles”, which include respecting dignity and autonomy and

⁶⁴⁷ UN Convention on the Rights of Persons with Disabilities (CRPD), New York, 13 December, 2006.

⁶⁴⁸ CRPD, Art. 2 says that “[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

⁶⁴⁹ People with psycho-social disabilities are those who experience mental health issues, and/or who identify as “mental health consumers”, “mental health service users”, “psychiatric survivors”, or “mad”. These are not mutually exclusive groups.

⁶⁵⁰ People with intellectual disabilities generally have a long-term condition that is present at birth or before the age of eighteen. People have greater difficulty than others with intellectual and adaptive functioning as well as carrying out everyday activities such as communicating and interacting with others, managing money, doing household activities and attending to personal care. While the term “intellectual disability” is technically distinct from other “developmental disabilities” these terms are often used interchangeably.

⁶⁵¹ CRPD, Preamble para. (d).

⁶⁵² CRPD, Preamble para. (k).

independence,⁶⁵³ non-discrimination,⁶⁵⁴ and the ambition of “[f]ull and effective participation and inclusion in society”.⁶⁵⁵

In 2008 the CRPD entered into force and Manfred Nowak, the (then) Special Rapporteur on Torture, issued a thematic report on “Protecting Persons with Disabilities from Torture”. He suggested that the entry into force of the CRPD provided, “a timely opportunity to review the anti-torture framework in relation to persons with disabilities.”⁶⁵⁶ He did so knowing that there was much scope in the CRPD for people working in the torture prevention field, and that discussions needed to take place at that time to ensure a synthesis of standards, and coordinated actions. His observations remain true today.

The provisions in the CRPD which are relevant for torture prevention include the following. Article 15 repeats the classic prohibition of torture, cruel, inhuman or degrading treatment or punishment, and adds a prohibition on medical and scientific experimentation without consent. The second paragraph of Article 15 focuses on prevention, obliging States to take, “all effective legislative, administrative, judicial or other measures” to prevent torture and other forms of ill-treatment. This is a similar provision to that set out in the UN Convention against Torture which also places an obligation on States to prevent torture and ill-treatment, yet falls short of fleshing out operational requirements.⁶⁵⁷ Article 16 of the CRPD remedies this shortcoming by setting out in detail the right to be free from exploitation, violence, and abuse. After stating the prohibition, it establishes a State obligation to take, “all appropriate measures” to prevent such abuse, measures which include providing information to people with disabilities, families and caregivers on how to “avoid, recognize and report” such abuse.⁶⁵⁸

Article 16 of the CRPD goes on to include a very far reaching State obligation, that is to ensure that all facilities and programmes designed to serve

⁶⁵³ CRPD, Art. 3(a).

⁶⁵⁴ CRPD, Art. 3(d).

⁶⁵⁵ CRPD, Art. 3(c).

⁶⁵⁶ Manfred Nowak (July 2008), *Protecting Persons with Disabilities from Torture*, p. 9, para. 41.

⁶⁵⁷ UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. New York, 10 December 1984, Article 2(1).

⁶⁵⁸ CRPD, Art. 16(2).

disabilities are “effectively monitored by independent authorities” (a provision which is broader than OPCAT’s focus on places of detention).⁶⁵⁹ It also obliges States to ensure access to “recovery, rehabilitation and reintegration” of disabled victims of exploitation, violence or abuse.⁶⁶⁰ Lastly, Article 16 calls on States to appropriately investigate and prosecute allegations of exploitation, violence and abuse,⁶⁶¹ ensuring justice systems which are accessible to people with disabilities and which provide appropriate adjustments so as to neutralize the effect of someone’s impairment or disability.⁶⁶²

These innovative provisions are further bolstered by a new provision in international law, one of respect for “mental and physical integrity on an equal basis with others”, which is set out in Article 17 of the CRPD. In its concluding observations whereby it examines a particular State’s compliance with the CRPD, its treaty body, the Committee on the Rights of Persons with Disabilities (CRPD Committee), has begun to tease out the meaning of Articles 15 and 17. It has noted that Article 17 violations include forced treatment and surgery of people with disabilities,⁶⁶³ as well as forced sterilisation of women with disabilities.⁶⁶⁴ The CRPD Committee has also held that torture and ill-treatment may include, “the use of continuous forcible medication, including neuroleptics, and poor material conditions in psychiatric institutions [...] where some persons have been institutionalized for more than ten years without appropriate rehabilitation services”.⁶⁶⁵

⁶⁵⁹ CRPD, Art. 16(3).

⁶⁶⁰ CRPD, Art. 16(4). See also CRPD Art. 26 which sets out obligations to provide people with disabilities to services they may require “to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life”.

⁶⁶¹ CRPD, Art. 16(5).

⁶⁶² CRPD, Art. 13.

⁶⁶³ UN Committee on the Rights of Persons with Disabilities, Concluding Observations of the Committee: Tunisia, 13 May 2011, CRPD/C/TUN/CO/1, paras. 28-29,

⁶⁶⁴ UN Committee on the Rights of Persons with Disabilities, Concluding Observations of the Committee: Spain, 19 October 2011, CRPD/C/ESP/CO/1, paras. 37-38.

⁶⁶⁵ UN Committee on the Rights of Persons with Disabilities, Concluding Observations of the Committee: Peru, 9 May 2012, CRPD/C/PER/CO/1, paras. 30-31

4. From detention to the community

Of particular significance to our examination of disability and detention is that the CRPD provides that the existence of a disability “shall in no case justify a deprivation of liberty”.⁶⁶⁶ The CRPD Committee has hinted as to what this means, by stating that depriving someone of their liberty because of their actual or perceived disabilities is against the Convention.⁶⁶⁷ Deprivations of liberty can be short-term and it can happen in psychiatric wards of general hospitals or emergency rooms; and long-term when a person is placed in residential care. There are ample examples documented of people living their whole lives in such institutions.⁶⁶⁸ Such institutions are often in remote areas, segregated from society, where ill-treatment takes place with impunity and without any public oversight.

Whenever a person with a disability is detained, says the CRPD, the relevant state has an obligation to provide “reasonable accommodation”,⁶⁶⁹ a construct which is defined as any “necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms”.⁶⁷⁰ The Convention makes clear that a denying reasonable accommodation constitutes disability-based discrimination, which is prohibited.⁶⁷¹

⁶⁶⁶ CRPD, Art. 14(1)(b) which states that persons with disabilities, “[a]re not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.”

⁶⁶⁷ CRPD Committee’s Concluding Observations on Spain (op cit), paras. 35-36.; Concluding Observations on Tunisia (op cit), paras. 24-25.; Concluding Observations on Peru (op cit), paras. 28-29.

⁶⁶⁸ See “Out of Sight: Human Rights in Psychiatric Hospitals and Social Care Institutions in Croatia”, Mental Disability Advocacy Center, 2011, in which MDAC documented that lifelong institutionalization is often the norm in Croatian facilities for people with disabilities. See also monitoring reports of the Hungarian Civil Liberties Union which reveal the same pattern in social care institutions in the Hungarian county of Tolna. 2010-2012.

⁶⁶⁹ CRPD, Art. 13.

⁶⁷⁰ CRPD, Art. 2.

⁶⁷¹ CRPD, Art. 5.

The Optional Protocol to the UN Convention against Torture (OPCAT) was conceived because places of detention are incubators of torture and ill-treatment. It is hardly surprising that the disability movement has campaigned for many years that disability institutions should be done away with. The independent living movement has consistently called for a social policy of de-institutionalisation and the establishment of services in community-based settings,⁶⁷² not merely because of the horrors of what happens inside institutions, but how institutions by their very nature segregate people from our – their – communities.

It is only within the last decade that the mainstream human rights community has embraced the quite obvious notion that desegregation applies in the field of disability on an equal basis to other domains such as race and ethnicity. Article 19 of the CRPD solidifies this concept, providing for the “the equal right of all persons with disabilities to live in the community, with choices equal to others”, in order to “prevent segregation from the community”.⁶⁷³ Importantly, there is nothing in the Convention to suggest that the right to live in the community is dependent on the nature of severity of a person’s impairment; indeed, the Convention’s preamble emphasises the universality of the rights set out in the Convention, specifying the need for rights to be implemented for those “who require more intensive support”.⁶⁷⁴

In 2009 and as Commissioner for Human Rights of the Council of Europe, Thomas Hammarberg was one of the first human rights officials to point out that the CRPD, “questions the very existence of these large institutions”.⁶⁷⁵ Thus community living, with appropriate support, should no longer be described (as the CPT does) merely as “a favourable development”, but rather, as an human right established under binding international law.

⁶⁷² There is a rich literature on this. See, for example Jerry Alan Winter, “The Development of the Disability Rights Movement as a Social Problem Solver”, *Disability Studies Quarterly*, 23(1)(2003): 33-61.

⁶⁷³ CRPD, Art. 19(b).

⁶⁷⁴ CRPD Preamble para. (j).

⁶⁷⁵ Thomas Hammarberg, “Inhuman treatment of persons with disabilities in institutions”, October 2010. See also his extended Issue Paper, “The rights of people with disabilities to live independently and be included in the community”, March 2012, CommDH/IssuePaper(2012)3.

In many jurisdictions, a person can be placed in a psychiatric hospital⁶⁷⁶ or social care institution⁶⁷⁷ because someone else - their guardian – has taken the decision to put them there. Guardianship is a system whereby an expert deems an individual to lack the competence/capacity to make decisions (in the case of total guardianship) or a specific decision (in the case of partial guardianship) and a substitute decision maker is appointed to act on the adult's behalf. Guardianship systems are intended to protect the interests of the person under guardianship and in some jurisdictions the guardian is obliged to respect the wishes of the person and consult them when making decisions. However, the removal of legal capacity deprives people of aspects of their personhood, rendering them prohibited from exercising some fundamental rights, such as the right to work, to marry, to bring-up children, to control their own money or property interests, to associate and join political parties and NGOs, and to make independent decisions about where and with whom they want to live. Even the right to vote and stand for election – emblematic rights of humanity for which people have fought and died – are denied.

Article 12 of the CRPD establishes that everyone is entitled to legal capacity on an equal basis with others, and that States should ensure access to the supports a person may need in exercising this right. Under guardianship people have little access to systems of justice. In many cases complaints systems are non-existent as are lay advocacy services, domestic monitoring bodies do not visit places of disability detention, and there is no state-funded legal advice, assistance and representation available for people under guardianship to challenge their status, and regain their legal capacity. Article 13 of the CRPD sets out access to justice rights including a state obligation to

⁶⁷⁶ See, for example, *Shtukaturov v. Russia*, judgment of the European Court of Human Rights, Application No. 44009/05, 27 March 2008.

⁶⁷⁷ See for example, *Stanev v. Bulgaria*, judgment of the Grand Chamber of the European Court of Human Rights, 17 January 2012, Application no. 36760/06, and *DD v. Lithuania*, judgment of the European Court of Human Rights, 14 February 2012, Application No. 13469/06.

ensure their effective role as direct and indirect participants in all legal proceedings.⁶⁷⁸

The social and political invisibility of people detained inside disability institutions results in a heightened risk of ill-treatment taking place. Given the fact that in many jurisdictions these institutions are not – or inadequately or infrequently – monitored, these violations take place with impunity. Silence perpetuates violence.

5. Why monitoring matters

This section explores the pervasive invisibility of persons with disabilities within human rights bodies and monitoring mechanisms in particular. In pitching our critique at such bodies our wish and intention is that they urgently take measures to change tack. The section starts by giving a some examples from our organisations and other bodies to illustrate the human suffering which flows from segregation. Evidence will be provided about how persons with disabilities have been left off the monitoring radar, including by the global leader UN Subcommittee on Prevention of Torture. The section ends by pointing out how the lack of monitoring has contributed to human rights abuses being carried out with impunity in particular when the access to justice of persons with disabilities in places of deprivation of liberty is rendered virtually impossible.

A. Segregation and human suffering

There are no global figures about people with disabilities in institutions, but one study in 2007 estimated that there were 1.2 million children and adults in

⁶⁷⁸ Article 14(2) states that States need to “ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation”.

disability institutions in the European Union.⁶⁷⁹ The figure included Turkey (which is not a member of the EU) but not Germany or Greece (for which no data were available: that governments do not count people in such institutions is itself revealing). Manfred Nowak's 2008 report examined the nexus between torture and disability.⁶⁸⁰ His is one of the first reports to recognise that people with disabilities in psychiatric and social care institutions are subjected to torture and ill-treatment due to poor living conditions, severe and prolonged forms of mechanical, chemical, and physical restraints, seclusion and solitary confinement, forced medical and psychiatric interventions, as well as the denial of reasonable accommodations (as outlined above and defined in Article 2 of the CRPD). Of critical importance to the development of global understanding of these issues, Nowak pointed out that involuntary confinement and treatment can themselves constitute torture.⁶⁸¹

Abuses happen everywhere. They often stem from an institutional culture rather than a lack of available resources. Sometimes these abuses are revealed by investigative journalism: in June 2011 BBC reporters uncovered serious physical abuse in a privately-owned social care institution for adults with intellectual disabilities in Bristol, the United Kingdom.⁶⁸² Evidently, the residents had been slapped, beaten, pinned down, left outside in the cold, put in the shower with clothes on, and dragged out of their beds. Sometimes abuses are highlighted by UN treaty bodies – but only when NGOs bring evidence before them and invite them to make findings. In 2012 the Committee against Torture (CAT) documented the widespread use of cage beds in the Czech Republic,⁶⁸³ and in 2011 with respect to Ghana,⁶⁸⁴ found that the main psychiatric hospital was severely overcrowded, lacked appropriate treatment and had poor material and hygienic conditions. The CAT also noted

⁶⁷⁹ Mansell J, Knapp M, Beadle-Brown J and Beecham J (2007) "Deinstitutionalisation and community living – outcomes and costs: report of a European Study", Canterbury: Tizard Centre, University of Kent.

⁶⁸⁰ Manfred Nowak, "Protecting Persons with Disabilities from Torture", Office of the UN High Commissioner for Human Rights, July 2008, para. 41.

⁶⁸¹ Manfred Nowak (op cit), para. 65.

⁶⁸² "Government condemns 'shocking' Winterbourne View abuse". BBC. 1 June 2011. <http://www.bbc.co.uk/news/uk-13617196>.

⁶⁸³ UN Committee against Torture, Concluding Observations of the Committee: Czech Republic, 14 May 2012, CAT/C/CZE/CO/4-5 para. 21.

⁶⁸⁴ UN Committee against Torture, Concluding Observations of the Committee: Ghana, 15 June 2011, CAT/C/GHA/CO/1, para. 17.

that in lack of alternatives in the community, and that residents were kept in the hospital long after they could have been discharged had these community alternatives existed. As well as investigative journalism and treaty bodies, mechanisms which inspect institutions can also uncover abuses. During its 2009 visit to Ukraine, the CPT visited a psychiatric hospital and found that that staff verbally and physically abused patients.⁶⁸⁵

Non-governmental organisations, however precarious their existence, play a valuable role in scratching beneath the State surface and holding governments to account for their international human rights commitments. Access to justice (a topic which is addressed below) is often compromised for people in institutions and it is only when NGOs support individuals in taking their cases to court that the judiciary has an opportunity to comment on allegations of ill-treatment. Of considerable significance, in February 2012 the Grand Chamber of the European Court of Human Rights held unanimously that the applicant in the case of *Stanev v. Bulgaria* had been subjected to degrading treatment in violation of Article 3 of the ECHR (which sets out the prohibition of torture, inhuman and degrading treatment or punishment) by being forced to live for more than seven years in unsanitary and unlivable conditions, and that domestic law did not provide him any remedy for such violations.⁶⁸⁶ This was the first case in which the Court has found a violation of Article 3 in a social care setting.

Mr Stanev was lucky. The European Committee for the Prevention of Torture (CPT) carried out a periodic visit to Bulgaria in December 2003 and visited the institution where Mr Stanev was being held: likely a minor curiosity for Mr Stanev at the time, but a major blessing for his international litigation. The CPT found that the indoor temperature at midday on a December day was 12 degrees Celsius.⁶⁸⁷ The residents clothes were bundled together and handed out

⁶⁸⁵ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Preliminary Observations: Ukraine, 23 November 2011, CPT/INF/2011.

⁶⁸⁶ *Stanev v Bulgaria*, op cit.

⁶⁸⁷ Findings on Pastra social care home for “adults with mental disorders”, from “Report to the Bulgarian Government on the visit to Bulgaria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 16 to 22 December 2003”, CPT/Inf (2004) 23, 24 June 2004 (hereinafter “CPT report”), para. 26. In Block 3, where Mr Stanev was held, the CPT

randomly to the residents, a situation which the European Court found “was likely to arouse a feeling of inferiority in the residents”.⁶⁸⁸ The CPT found that residents had access to the bathroom once a week, and that which Mr Stanev had access was “rudimentary and dilapidated”.⁶⁸⁹ Mr Stanev’s case is merely illustrative of abuses which take place in many jurisdictions, the difference being that most other cases do not find themselves before the European Court of Human Rights.⁶⁹⁰

The Mental Disability Advocacy Center supported Mr Stanev throughout his international litigation, and has been involved in this field since its inception in 2002. The organisation has been concerned how in many countries, children and adults are abandoned into institutions in the name of treatment and care, segregated from families, communities, and chances to become active participants of society. As an illustration, again in Bulgaria, a reported 238 children with disabilities died in State-run institutions in the past ten years as a result of neglect, starvation, poor hygiene, and violence.⁶⁹¹ Deaths are not so prevalent in other countries, but the funding structure makes institutionalisation and ill-treatment more likely. In Hungary, for example, the funding available for a parent with disabilities makes often economically non-viable for the family to keep the child: instead the child is placed into an institution where the accumulated costs are far greater than would be necessary to keep the family intact.

As well as its case-work and policy analysis, MDAC staff have conducted monitoring in various countries in the Council of Europe region. While the conditions in some institutions are still alarming, the routine stripping of fundamental human rights is also of grave concern. In Moldova MDAC has found instances of conditions amounting to degrading treatment, such as a

found “somewhat better heating”, although “residents indicated that it had been on all the time since the delegation’s arrival.” This tells us more about the institution’s management cynical attitude to human rights inspectors than it does about the extra pitiful degrees of warmth.

⁶⁸⁸ *Stanev* judgment para. 209.

⁶⁸⁹ CPT Report on Bulgaria, para. 27.

⁶⁹⁰ For an analysis of this case, see Oliver Lewis, “*Stanev v. Bulgaria: On the Pathway to Freedom*”, *Human Rights Brief*, American University Washington College of Law, Vol. 19, Winter 2012.

⁶⁹¹ “Neglected, Abused, and Starved to Death”, Bulgarian Helsinki Committee, Sofia, 20 September 2010.

lack of toilet paper, sanitary pads, and tampons on the women's wards in a psychiatric institution where women are (on any objective criteria) needlessly forced to spend many months – and in some cases years – locked up against their will. In a number of psychiatric facilities in that country the use of restraint is common. Residents are injected with sedation against their will, restrained with bed sheets, tied to their beds, forced to spend significant periods in isolation rooms, effectively in solitary confinement.

In a long-term institution for people with intellectual disabilities in Kosovo, MDAC has found appalling conditions in the residents' living area. There, residents had no personal belongings. They had no bed sheets, no towels, no toothbrushes, and no soap. Their rooms often had no doors and no curtains. In Croatia, female residents in the institutions visited reported undergoing forcible abortions.⁶⁹² MDAC has documented how physical restraints are used arbitrarily. Such restraints include straps (usually leather or canvas) that are fastened with buckles or magnetic locks that cannot be undone without a key, thereby attaching patients to beds. Limbs are restrained by using straps on the shoulders, waist, thighs, hands and feet. In one of the facilities monitored, staff told MDAC that patients were restrained with belts for an average of, "one day or less". The staff member went on to add, "but in exceptional circumstances for two to three days".

B. Off the monitoring radar

In the past few years torture has been at the forefront of global concern, thanks in part to torture being carried out after the terrorist events in the USA on 11 September 2001 as part of the secret rendition program of the US government and the use of unlawful detention and ill-treatment in Guantanamo Bay.⁶⁹³ This has been uncovered and debated by the media, human rights organisations, national parliaments and inquiries, and the

⁶⁹² "Out of Sight: Human Rights in Psychiatric Hospitals and Social Care Institutions in Croatia", Mental Disability Advocacy Center, 2011.

⁶⁹³ See for example, Marjorie Cohn, "Introduction to the United States of Torture: Interrogation, Incarceration, and Abuse", Thomas Jefferson School of Law, 3 February, 2011; Richard Jacson, "Language, policy and the construction of a torture culture in the war on terrorism", 2007, *Review of International Studies*, 33, pp. 353-371.

international community. A focus on these scandals has trickled down into the operations of the small and insular UN torture prevention community, which since its beginnings in 2007 has focused on abuses carried out by police, security forces and prison officers in traditional places of detention.

Any piece of work needs to start somewhere. Priorities need to be set. One advantage of starting with police stations and prisons is that these abuses have wide public resonance. Police stations are drilled in our consciousness from a young age via crime programmes on TV and detective novels. The torture prevention community largely emanates from the prison world: it is inevitable that people stay within their comfort zones. Each decision has its down sides, and a focus on prison torture is ill-treatment which occurs in places other than police lock-ups and prisons have been neglected.

One of the “groups” which has been neglected are those who are detained – de jure or de facto – in psychiatric hospitals, psychiatric wards of general hospitals, social care institutions, elderly people’s homes, group homes⁶⁹⁴ and nursing homes. Inside these facilities people labeled with psycho-social disabilities⁶⁹⁵, intellectual disabilities⁶⁹⁶, autism, brain injury and dementias are detained via formal mental health legislation or through a private arrangement by the person’s relative or guardian and the institution or local municipality – as happened to Mr Stanev.

People with disabilities and in particular those with labels of psycho-social disabilities also make up a considerable subgroup of the general prison population, and are often left without any reasonable accommodations and are exposed to human rights violations in the criminal justice system. A 2010 study about the prison population in New South Wales, Australia, for

⁶⁹⁴ Group homes are small, residential facilities located within a community and designed to serve children or adults with chronic disabilities.

⁶⁹⁵ People with psycho-social disabilities are those who experience mental health issues, and/or who identify as “mental health consumers”, “mental health service users”, “psychiatric survivors”, or “mad”. These are not mutually exclusive groups.

⁶⁹⁶ People with intellectual disabilities generally have a long-term condition that is present at birth or before the age of eighteen. People have greater difficulty than others with intellectual and adaptive functioning as well as carrying out everyday activities such as communicating and interacting with others, managing money, doing household activities and attending to personal care. While the term “intellectual disability” is technically distinct from other “developmental disabilities” these terms are often used interchangeably.

example, has found that 75 per cent of prisoners had mental health problems.⁶⁹⁷ Another study from 2007 revealed that 9 out of 10 prisoners in England and Wales met their criteria for at least one “mental disorder”.⁶⁹⁸

There is thus a growing body of research evidence of the scale and nature of suffering inside disability institutions, as well as advocacy calling for an end to congregated care itself. With this backdrop the SPT has noted that “an essential element for preventing torture and ill-treatment is the existence of a fully developed system of independent inspection visits to all places where people may be deprived of their liberty”.⁶⁹⁹ The SPT has not followed its own advice.

Between its first visit in October 2007 and May 2011, the SPT visited a total of 227 places of detention during 13 missions to 12 States. Of those only three were psychiatric facilities⁷⁰⁰ and one was to a hospital.⁷⁰¹ This hospital may have a psychiatric ward which the SPT visited, but due to the confidentiality of the report and the vagueness of information published by the SPT, this cannot be confirmed. It is only since May 2011 that the SPT has paid more attention to visiting such facilities.⁷⁰² Of considerable alarm, is that SPT has not visited a social care institution in the course of six-year existence.

The tide seems to be turning, if slowly. In its Fifth Annual Report the SPT states that it will visit more facilities where persons with disabilities may be deprived of their liberty.⁷⁰³ It is also promising that the SPT held thematic

⁶⁹⁷ Leila Kavanagh, Donald Rowe, Jolyn Hersch, Kylie J. Barnett, Robert Reznik, “Neurocognitive deficits and psychiatric disorders in a NSW prison population”, p. 1. *International Journal of Law and Psychiatry*, 33 (2010) 20-26

⁶⁹⁸ See for instance “Prison psychiatry: adult prisons in England and Wales” *Royal College of Psychiatrists*, College Report CR141, February 2007, p. 15.

⁶⁹⁹ See for instance the SPT’s 2010 report on Mexico, following its visit in September 2008. UN Subcommittee on Prevention of Torture, Report on Visit: Mexico, 31 May 2010, CAT/OP/MEX/1, para. 12.

⁷⁰⁰ The SPT visited two psychiatric hospitals in Mexico between 27 August- 12 September 2008 and one in Paraguay between 10-16 March 2009.

⁷⁰¹ The SPT visited Liberia between 6 -13 December 2010.

⁷⁰² In Brazil (mission 19-30 September 2011) the SPT visited one psychiatric hospital, and in Argentina (mission 18-27 April 2012) it visited four psychiatric facilities. The SPT’s press release about its visit to Mali mission (5-14 December 2011) stated that such facilities were visited, but numbers were not made public.

⁷⁰³ UN Subcommittee on Prevention of Torture, Fifth Annual Report, 19 March 2012 CAT/C/48/3 .

discussions at its 16th Session and an internal training at its 17th Session with the involvement of international experts at the intersection of torture prevention and disability. Representatives of the OPCAT Contact Group – a cluster of international NGOs working to assist the SPT – were excluded from the consultation and training itself. The SPT is currently working on a thematic paper on mental health and detention to set its own standards in this area. The SPT is to be commended in taking these steps towards increasing its effectiveness in preventing torture against persons with disabilities, but the lack of transparency is of continuing concern.

Whatever the reason for the SPT's initial focus (and there is no publicly-available explanation), the consequences are unfortunate as they are serious. Whether intended or not, the message conceptually is clear: society values people in disability institutions less than those in prisons. More concretely, the SPT as the global torture prevention leader has silently said that national-level monitoring bodies need not monitor disability institutions. Had the SPT chosen to visit a more holistic set of detention facilities, the trickle-down effect to the national level would have stopped some human rights abuses against people with disabilities, as NPMs would have followed their global master, visited disability institutions in their countries and taken appropriate actions.

C. Impunity and access to justice

Human rights violations are often carried out with impunity in psychiatric and social care institutions, as they are elsewhere. An authoritative UN document has defined impunity as, “the impossibility, de jure or de facto, of bringing the perpetrators of violations to account – whether in criminal, civil, administrative or disciplinary proceedings – since they are not subject to any inquiry that might lead to their being accused, arrested, tried and, if found guilty, sentenced to appropriate penalties, and to making reparations to their victims”.⁷⁰⁴

⁷⁰⁴ “Updated Set of principles for the protection and promotion of human rights through action to combat impunity”, United Nations, E/CN.4/2005/102/Add.1, 8 February 2005.

The reasons why disability abuses take place with impunity include the following generalisations, to which there are of course exceptions. There is a lack of public monitoring of such institutions (as noted above); there are insufficiently effective complaints systems; access to free legal aid and assistance is absent; professional psychiatric and nursing bodies fail to discipline their members for breaches of law and professional ethics (in human rights language: perpetrators are not punished); and investigative journalists rarely attempt to uncover abuses in disability institutions.

Procedures for reviewing detention mandated by law (for example, under Article 5(4) of the European Convention on Human Rights) are often inaccessible for people in places of detention. As an illustration, the applicant in the *Shtukaurov v Russia* case before the European Court of Human Rights had his legal capacity removed, and as a result he was treated as a voluntary patient (his guardian had voluntarily placed him there, despite the fact that he made it abundantly clear that did not wish to be in the psychiatric hospital). The Strasbourg Court in this case held that even people whose legal capacity has been restricted, has the right to effectively pursue a legal review of the necessity of their detention.⁷⁰⁵ Some jurisdictions have complaints mechanisms available for residents as well as patients' rights advocates and Ombudsperson's offices, which can carry out reactive investigations of abuses. In MDAC's experience (no comprehensive data is available) these complaints mechanisms exist in a few jurisdictions only, and such mechanisms have few resources to deal with complaints and to access institutions which may be located many hundreds of miles outside the capital city where the ombudsman office is located. While non-governmental organisations can be helpful in uncovering abuses and helping bring perpetrators to justice, their access to institutions is often at the mercy of the very ministry against which they are advocating.

In Hungary, for example, every resident in a disability institution has the right to launch a complaint to the director, the Ombudsperson's Office,⁷⁰⁶ or a

⁷⁰⁵ *Shtukaurov v Russia*, op cit, para 125.

⁷⁰⁶ 18. §, 2011./CXI. Ombudsperson Act. Törvény az alapvető jogok biztosáról.

Patient's Advocate.⁷⁰⁷ MDAC has seen how in most institutions residents can complain by putting a complaint note into a message box, but the physical accessibility of the box is undermined by the people in the institutions being generally uninformed: uninformed of their rights, of how to make a complaint, and of what will happen if they do complain.⁷⁰⁸ During monitoring visits to psychiatric institutions in Moldova, MDAC has spoken to patients who launched a complaint and as a result were forcibly injected with psychiatric medication as punishment.⁷⁰⁹

Prejudicial attitudes towards people with disabilities can also contribute to low reporting. The credibility of persons with psycho-social disabilities is often questioned by the assumption that they are crazy, dangerous or suspicious, while persons with intellectual disabilities are often viewed as children whose claims are highly questionable and can easily be dismissed. Complaints procedures can be particularly difficult to access for persons with multiple or severe disabilities, who might need assistance in communicating their assertions and who are therefore often in the most vulnerable positions. As noted above, Article 13 of the CRPD speaks to these instances, by setting out that people with disabilities should have effective access to justice as direct participants (which presumably includes being the complainant) in all legal proceedings, including at investigatory stages.

Without regular independent monitoring, as well as taking actions to combat impunity and ensuring effective access to justice, including complaints mechanisms for detainees/patients/residents, it is unlikely that abuses will be uncovered, perpetrators held to account, and ill-treatment prevented.

⁷⁰⁷ 94/E, F, K.; 99 § (14), Law no. 1993./III on Social Administration and Social Benefits, Chapter 'The rights of persons receiving personal care in social care home'. (Törvény a szociális igazgatásról és szociális ellátásokról, A személyes gondoskodást nyújtó szociális intézményekben ellátottak jogairól).

⁷⁰⁸ Data from Hungarian Civil Liberties Union (TASZ), monitoring reports of social care institutions in Tolna county, 2010-2012.

⁷⁰⁹ Unpublished monitoring report to Chisinau psychiatric hospital, December 2010, on file at MDAC.

6. The aims of this special issue

The aim of this Special Issue is to examine the interface between torture, detention and disability. It is our intention that the Special Edition will contribute to the dialogue within and outside the torture prevention community and the disabilities movement, by highlighting key issues and suggesting solutions to entrenched problems. MDAC's work on freedom from torture and ill-treatment aims to contribute to global efforts to prevent torture and ill-treatment against persons with disabilities and in the Council of Europe region in particular. Our work has strengthened the capacity of international, European, and various national inspectorates in an effort to mainstream disability in their work. In particular, we suggest to these bodies to engage with the standards of the UN Convention on the Rights of Persons with Disabilities (CRPD) and ensure that these standards are duly applied in torture prevention and remedying functions.

With the Human Rights Implementation Centre at the University of Bristol (UK) and the Centre for Disability Law and Policy at the National University of Ireland, in November 2011 the Mental Disability Advocacy Center organised and hosted a one-day roundtable discussion entitled, 'Evolving Standards in Preventing Torture and Ill-treatment against Persons with Disabilities', which was funded by Zennström Philanthropies. The seminar brought together experts working at the intersection of torture and ill-treatment prevention and disability.

The objectives of the event were to contribute to the cooperation among key stakeholders to further increase the effectiveness of their work, to highlight the importance of visiting psychiatric and social care institutions, and to discuss evolving standards of the Convention on the Rights of Persons with Disabilities (CRPD) that inspectorates should apply.

The participants of the event included members of the UN Subcommittee on Prevention of Torture (SPT), the European Committee for the Prevention of Torture (CPT) as well as the UN Committee on the Rights of Persons with Disabilities. Representatives of key civil society groups also attended, namely

the European Network of Users and Survivors of Psychiatry (ENUSP), and the International Disability Alliance (IDA).⁷¹⁰

Draft papers were presented by academics and advocates on issues that MDAC had, through a process of outreach to various organisations, identified as unexplored. These included why psychiatric and social care institutions should be inspected at all; why and how mental health service users should be included as inspectors/monitors; the limits and justifications of mental health detention; the link between legal capacity and detention; medical treatment and ill-treatment in psychiatric and social care institutions; the meaning of reasonable accommodation in places of detention; and how inspectorates can promote the right to live in the community. This Special Edition contains some of the papers which were presented at the November 2011 roundtable, and these papers have benefitted greatly from comments from discussants and peer reviewers, all of to whom we are grateful.

7. Overview of papers

Peter Bartlett's paper on "Mental disorder of a kind or degree warranting confinement: Standards for psychiatric detention under the ECHR" discusses the jurisprudence of the European Court of Human Rights with regards to mental health detention. Bartlett analyses the Court's case-law looking at criteria of detention, and provides examples for the status approaches, dangerousness, treatment, least restrictive alternative, and capacity tests. He looks at the CRPD from various vantage points, from detention based solely on disability to other models in which detention is allowed if reasons for it are de-linked from disability. He finds that the line between the two can be rather blurry and could lead us down a slippery slope. Bartlett points out that Article 5 of the ECHR now represents a clear conflict to the CRPD, and that all Council of Europe and EU instruments must recognise the new standards to be applied. Bartlett concludes that in light of the CRPD more guidance is needed in Council of Europe instruments defining appropriate standards regarding detention.

⁷¹⁰ The authors of this paper also attended: DK coordinated the seminar, and OL chaired.

Anna Lawson's paper "Disability equality, reasonable accommodation and the avoidance of ill-treatment in places of detention: What role for monitoring and inspection bodies?" points out that little attention has been given to disability equality issues in the monitoring of places of detention, although neglect of disability equality considerations in these settings can have serious implications for detainees with disabilities, and can cause suffering amounting to cruel, inhuman or degrading treatment and possibly even torture. The paper focuses on reasonable accommodation duties by plotting the history of the concept, and placing it in the context of ill-treatment in detention. Lawson discusses relevant international case-law and points out serious discrepancies between inspectorate reports and the CRPD's standards. Lawson adds her voice to those calling for an updating of monitoring bodies' standards.

Nell Munro's paper "Define acceptable: how can we ensure that treatment for mental disorder in detention is consistent with the UN Convention on the Rights of Persons with Disabilities?" suggests that the CRPD provides a way forward based on a multi-dimensional assessment of the factors that need to be present in order for the practice of medical treatment in detention to be deemed acceptable. Munro further argues that since people with mental disabilities are rarely empowered to pursue individual complaints, domestic and supranational monitoring bodies have a key role to play in defining standards and ensuring their compliance.

Charles O'Mahony's paper "Legal capacity and detention: Implications for the CPT Standards", considers the implications of the CRPD for the operation of the European monitoring body, the Committee for the Prevention of Torture. O'Mahony suggests that standards should be reformulated to reflect the so-called paradigm shift in thinking on legal capacity as set out in Article 12 of the CRPD. He goes on to posit that the CPT should examine disability detention as an unjustifiable interference with people's legal capacity. O'Mahony introduces the term "clinical guardianship" and suggests an inconsistency with the CRPD, calling for the CPT to direct States away from this form of substitute decision-making and instead towards supported-decision making.

Finally, the paper on “Monitoring those deprived of their liberty in psychiatric and social care institutions: international and national practice” by Judy Laing, Rachel Murray and Elina Steinerte of Bristol University, discusses the importance of monitoring visits to non-traditional places of detention where people with disabilities may be detained. The paper looks at issues pertinent to independent monitoring of psychiatric institutions and social care institutions by international and national monitoring bodies, the obligations of states that are party to the OPCAT, drawing in particular on the experience in the UK. The paper finds that disability institutions are often of secondary importance when it comes to visits and reveals the problems of lack of expertise in monitoring bodies as well as the lack of clearly articulated substantive standards.

8. Recommendations for action

Academics, advocates, and activists can and should take distinct action to stop torture and ill-treatment. However, this Special Edition focuses on the role of international, regional and national inspectorate bodies, and to them we recommend the following four inter-related actions.

A. Recognise the range of human rights violations

The jurisprudence of the European Court of Human Rights and the Standards of the CPT establish that admission to a psychiatric or a social care institution can amount to a deprivation of liberty, which can be unlawful. The former UN Special Rapporteur on Torture further recognised that people with disabilities in psychiatric and social care institutions are often subject to torture and ill-treatment due to conditions, treatment, violence, and discrimination. Monitoring bodies at international, regional, and national levels should also now publicly acknowledge these new (to them rather than the victims) forms of torture and ill-treatment which arise in the context of facilities for persons with disabilities.

B. Visit non-traditional places of detention

It is probably true to assert that most people with disabilities around the world have never been visited by any human rights monitoring body. As this paper has illustrated, in many countries, torture prevention actors do not visit psychiatric or social care institutions or psychiatric wards of general hospitals, and do not report human rights abuses being carried out there. Monitoring bodies have for long focused on visiting traditional places of detention, such as prisons and police custody and the recognition of the need to visit other detention facilities only came later – as pointed out by Laing, Murray and Steinerte in their paper in this Special Edition.

As noted above, while the CPT visits a range of non-traditional detention settings, other monitoring bodies, such as the SPT and various domestic inspectorates do not. Inspectorates need to do justice to their mandate by inspecting the full range of places where people can be detained, and this includes psychiatric hospitals, social care institutions, nursing homes and so on. In other contexts it includes immigration centres, deportation custody suites, children's homes and so on. Civil society must play its part to monitor the monitors.

C. Valourise the CRPD

There is a growing need to harmonise the array of human rights standards established by international treaties across UN bodies. While the advantage of having various human rights mechanisms is that particular 'groups' and pressing issues can be discussed, there is also a risk that universalism and a streamlined approach is abandoned as bodies retrench to their silos. Communication and cooperation are crucial.

As Bartlett, Lawson, Munro, and O'Mahony highlight in their papers in this Special Edition, the CRPD not only prohibits torture and ill-treatment, exploitation, violence, and abuse, but it also obliges States to ensure that persons with disabilities enjoy legal capacity on an equal basis with others and are provided with the supports which may be necessary to achieve this in

order that everyone can meaningfully participate in the community. Monitoring bodies will themselves benefit from using these standards; indeed anything else opens them to criticism that they are not fulfilling their obligations under international human rights law.

D. Ensure participation

Participation has been described as the “lifeblood” of the CRPD.⁷¹¹ We suggest that monitoring bodies include people with disabilities (including users and survivors of psychiatry, as well as people with intellectual disabilities) in their work, including in planning, execution, and evaluation of monitoring. The reason for this is that beneficiary participation can enhance the effectiveness of torture prevention work. Mental health service users are experts by experience and have a particular role to play during visits, picking up on ill-treatment which may be invisible to monitors who have not been through the system. In the same way, ex-prisoners can add a depth and range to the quality of any prison monitoring. Mental health service users can establish trust between monitor and patient/resident in a more sophisticated way than those who have not used mental health services, and can often approach residents/patients who are quieter and less open to be interviewed by monitors who are perceived as part of the system. Mental health service users can also provide a positive example to the residents in showing that there is a way out of the system of institutions. The involvement of service users as monitors will mean that resultant reports are more relevant to needs, and because of a connection with civil society and disabled people’s organisations, can ensure a connection between the monitoring report and the community.⁷¹²

⁷¹¹ “Building the Architecture for Change: Article 33 of the UN Convention on the Rights of Persons with Disabilities”, Mental Disability Advocacy Center, 2011.

⁷¹² See Oliver Lewis and Nell Munro, “Civil Society Involvement in Mental Health Law and Policy Reform”, in *Mental Health and Human Rights*, edited by Michael Dudley et al, Oxford University Press, 2012.