COUNCIL OF EUROPE

CONSEIL DE L'EUROPE

Conference

2 March 2015
Strasbourg - France

Council of Europe
Palais de l'Europe

www.cpt.coe.int/25/

The CPT at 25: taking stock and moving forward

Background paper

Contents

Introduction

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has reached its 25-year milestone. Following the entry into force of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the Convention") on 1 February 1989, the setting up of a small secretariat and the election of its first members, the CPT held its inaugural meeting in November 1989. The first ever on-site monitoring activity took place half a year later, when a delegation visited Austria in May 1990.

The CPT has evolved significantly since those early days. The Committee's geographical scope has gradually expanded from an initial 15 states parties to the Convention to the current 47. Over the years, the CPT has progressively widened the range of places of privation of liberty it visits, covering not only police establishments and prisons, but also psychiatric hospitals, detention facilities for foreigners held under aliens legislation, juvenile and military detention centres and social care homes. The CPT has in recent years begun monitoring return flights and examining the treatment of foreign nationals during their deportation by air. In the course of its monitoring activities, the CPT has developed a corpus of standards on many issues covered by its work, such as safeguards against ill-treatment, conditions of detention, health care and combating impunity, to name just a few. Compared to the first decade of its existence, the CPT now makes much more use of the possibility it has to carry out ad hoc visits including, if necessary, visits organised at very short notice. All these developments underline the fact that it has been possible for the Convention mechanism to evolve considerably within the framework of the Convention and illustrate the foresight of its drafters.

It is a matter of concern to the Committee that, in respect of several states parties, it has been obliged to repeat recommendations made in the context of earlier visits, having found no significant improvement or, in some cases, even a worsening of the situation. In the same vein, the responses of some states parties limit themselves to merely invoking the domestic legislative framework, whereas the CPT's recommendations in question pointed to the need for practical improvements, policy changes or even the amendment of legislation. Clearly, the effectiveness of a preventive mechanism based on facts found during visits will depend very much on co-operation and meaningful dialogue with the states parties concerned. Fortunately, there are numerous examples of precisely that: of states parties taking CPT reports seriously and implementing concrete measures to remedy the problems found.

Co-operation with the national authorities is central to the Convention, since the aim is to strengthen the protection of persons deprived of their liberty from ill-treatment rather than to condemn states for abuses. Reports that are issued by the Committee are the starting point for an ongoing dialogue with the state concerned. Enhancing such a dialogue has become one of the key priorities for the CPT in recent years, through the organisation of high-level talks with Ministers of the country concerned and meetings with Permanent Representatives to the Council of Europe in Strasbourg. The Committee has also provided written feedback to governments regarding their responses and requested them to send, on a regular basis, follow-up information on their implementation of the CPT's recommendations.

In cases of failure to co-operate or to improve a serious situation, the CPT has the possibility to use its power under Article 10, paragraph 2, of the Convention to make a public statement. However, the CPT continues to believe that this power should be exercised only as a last resort. It much prefers that other ways and means be used to bring about the necessary changes. In particular, there should be no hesitation in requesting the expert assistance and other forms of targeted co-operation that the Council of Europe has to offer its member states in many of the areas covered by the CPT's mandate. The CPT stands ready to facilitate and accompany such efforts. Obviously, a speedy publication of CPT reports and responses by states parties will make it easier for potential beneficiaries, donors and implementers to launch well-designed projects that effectively address the objective needs identified in the Committee's reports. Further, publication will inform domestic debates on the issues covered by the CPT in the visit report.

It is probably not an exaggeration to say that after a quarter of a century and some 370 visits, the CPT has reached a certain level of maturity, in terms of accumulated experience and consolidated working methods. Maturity does not necessarily imply wisdom, however, and the Committee continues to welcome constructive criticism of its work and standards, as well as ideas and suggestions for its work in the future. In this context, the CPT has decided to organise a Conference to mark its 25th anniversary. It represents an opportunity to reflect on the work of the Committee thus far and to examine how best it can tackle the challenges ahead in cooperation with the State Parties and in partnership with other relevant monitoring mechanisms.

After a high-level opening session, the Conference will address the following topical subjects in five simultaneous panels:

- combating impunity in police and prison contexts;
- health care in prisons;
- juveniles in detention;
- solitary confinement; and
- CPT standards on psychiatry

These five topics were selected by the CPT as they each represent a significant challenge with regard to standard setting and/or the implementation of standards. The sections below provide an overview of each of the topics, highlighting a number of issues and considerations so as to stimulate discussion. At the end of each section there is a list of issues and questions which may be debated during the various sessions of the Conference.

Panel 1: Combating impunity in police and prison contexts

Combating impunity for torture and other ill-treatment is one of the obligations of a State in the implementation of the prohibition of torture. While the focus of the CPT is on preventing torture, assessing the effectiveness of action taken when ill-treatment has occurred constitutes an integral part of the Committee's mandate, given the implications that such action has for future conduct. The CPT discussed this topic in detail in its 14th General Report.

The credibility of the prohibition of torture and other forms of ill-treatment is undermined each time officials responsible for such offences are not held to account for their actions. In failing to take effective action, the persons concerned – colleagues, senior managers, investigating and prosecuting authorities – will ultimately contribute to the corrosion of the values which constitute the very foundations of a democratic society. Conversely, when officials who order, authorise, condone or perpetrate torture and ill-treatment are brought to justice for their acts or omissions, an unequivocal message is delivered that such conduct will not be tolerated. Apart from its considerable deterrent value, this message will reassure the general public that no one is above the law, not even those responsible for upholding it. The knowledge that those responsible for ill-treatment have been brought to justice will also have a beneficial effect for the victims.

Combating impunity must start within the agency (police or prison service, military authority, etc.) concerned. Too often the 'esprit de corps' within an agency leads to a willingness for its operatives to stick together and help each other when allegations of ill-treatment are made, and sometimes even cover up the illegal acts of colleagues. Positive action is required, through promoting a culture where it is regarded as unprofessional – and unsafe from a career path standpoint – to work and associate with colleagues who resort to ill-treatment, and where it is considered as correct and professionally rewarding to belong to a team which abstains from such acts.

Obligation to investigate allegations of torture and other ill-treatment

Acts of torture and ill-treatment in the performance of a duty, coercion to obtain a statement, abuse of authority, etc. should constitute specific criminal offences which are prosecuted *ex officio* (see Articles 4 and 12 of the UN Convention against Torture). However, the CPT has found that, in certain countries, prosecutorial authorities have considerable discretion with regard to the opening of a preliminary investigation when information related to possible ill-treatment of persons deprived of their liberty comes to light. Even in the absence of a formal complaint, such authorities are under an obligation to undertake an investigation whenever they receive credible information, from any source, that ill-treatment of persons deprived of their liberty may have occurred. This obligation has been confirmed by the European Court of Human Rights initially in 1997 as a result of the right to an effective remedy (Article 13 ECHR, see *Aksoy v. Turkey*) and, in 1999, as an obligation directly linked with the prohibition of torture (Article 3 ECHR, see *Assenov v. Bulgaria*). This obligation should be reflected in national law. The legal framework for accountability will also be strengthened if public officials (police officers, prison directors, etc.) are formally required to notify the relevant authorities immediately whenever they become aware of any information indicative of ill-treatment.

In order for the legal obligation to investigate to have effect, it is of great importance that the relevant authorities are sensitised to this obligation. They should be able to recognise the signs of ill-treatment cases and willing to act on any suspicion of ill-treatment. Further, victims of ill-treatment should be given a real opportunity to complain without fear of repercussions.

The principle of effective investigations

The CPT has had occasion, in a number of its visit reports, to assess the activities of the authorities empowered to conduct official investigations and bring criminal or disciplinary charges in cases involving allegations of ill-treatment.[1] In so doing, the Committee takes account of the case law of the European Court of Human Rights as well as the standards contained in a wide range of international instruments. It is now a well-established principle that effective investigations, capable of leading to the identification and punishment of those responsible for ill-treatment, are essential to give practical meaning to the prohibition of torture and inhuman or degrading treatment or punishment. Genuine endeavours by the competent authorities to meet these requirements and uphold the rule of law will have an important dissuasive effect on those minded to ill-treat persons deprived of their liberty.

Complying with this principle implies that the authorities responsible for investigations are provided with all the necessary resources, both human and material. Further, investigations must meet certain basic criteria.

The European Court of Human Rights set out certain standards for an investigation to be considered effective. The investigation into serious allegations of ill-treatment must be both prompt and thorough. That means that both the investigation and eventual legal proceedings must be conducted in a reasonably expeditious manner. Further, the authorities must always make a serious attempt to find out what happened and should not rely on hasty or ill-founded conclusions to close their investigation or to use as the basis of their decisions. They must take all reasonable steps available to them to secure the evidence concerning the incident, including, inter alia, eyewitness testimony and forensic evidence. Any deficiency in the investigation which undermines the ability to establish the cause of injuries or the identity of the persons responsible will risk falling foul of this standard. The investigation should be adequate, meaning that it should be capable of gathering evidence to determine whether official behaviour complained of was unlawful and to identify and punish those responsible. Furthermore, the investigation should be independent from the executive/the prison service. Independence of the investigation implies not only the absence of a hierarchical or institutional connection, but also independence in practical terms. Lastly, there should be an element of public scrutiny in the investigation on its results, including the involvement of the alleged victims in the procedures and the provision of information to the public on the status of ongoing investigations.

It goes without saying that no matter how effective an investigation may be, it will be of little avail if the sanctions imposed for ill-treatment are inadequate. When ill-treatment has

[1] See for example CPT/Inf (2013) 35, CPT/Inf (2013) 1, CPT/Inf (2013) 6 and CPT/Inf (2011) 3.

been proven, the imposition of a suitably severe penalty should follow. This will have a very strong dissuasive effect. Conversely, the imposition of light sentences can only engender a climate of impunity. Other impediments to combating impunity include the lack of adequate criminalisation of torture as a specific offence, as well as immunities, amnesties, statutes of limitation and the requirement of prior authorisation for investigations against public officials.

Guidelines for effective investigations

Several instruments have been developed to provide further guidance on how to ensure effective investigations. In 1999, for example, the Istanbul Protocol was developed by a group of experts, after which it was included in the official training materials of the UN Office of the High Commissioner for Human Rights and endorsed by international and regional human rights bodies. The manual includes principles for the effective investigation and documentation of torture, and other cruel, inhuman or degrading treatment or punishment, which outline minimum standards for States in order to ensure the effective documentation of torture. In the context of its cooperation work, the Council of Europe developed specific guidelines on the European standards in 2009, with a revised version being published in 2014.

In 2009, the Commissioner for Human Rights of the Council of Europe published the *Opinion of the Commissioner for Human Rights concerning Independent and Effective Determination of Complaints against the Police*. The Commissioner recalls the five principles of effective investigation and states these provide a useful framework for determining all complaints against police. The Opinion further promotes the establishment of an independent police complaints body (IPCB) with comprehensive responsibilities for oversight of the entire police complaints system in order to reinforce the independence principle.

Assessment of allegations of ill-treatment

Adequately assessing allegations of ill-treatment will often be a far from straightforward matter. Certain types of ill-treatment (such as asphyxiation or electric shocks) usually do not leave obvious marks. Similarly, making persons stand, kneel or crouch in an uncomfortable position for hours on end, or depriving them of sleep, is unlikely to leave clearly identifiable traces. Even blows to the body may leave only slight physical marks, difficult to observe and quick to fade. Consequently, when allegations of such forms of ill-treatment come to the notice of prosecutorial or judicial authorities, they should be especially careful not to accord undue importance to the absence of physical marks. The same applies *a fortiori* when the ill-treatment alleged is predominantly of a psychological nature (sexual humiliation, threats to the life or physical integrity of the person detained and/or his/her family, etc.). Furthermore, there are usually two versions of an incident, one by the prisoner and another one by staff. Credibility of the prisoner or suspect is often considered to be low, and third persons' observations are absent so that a judgment is difficult. Therefore, adequately assessing the veracity of allegations of ill-treatment may well require taking evidence from all persons concerned and arranging in good time for on-site inspections and/or specialist medical examinations.

Whenever detainees brought before prosecutorial or judicial authorities allege ill-treatment, those allegations should be recorded in writing, a forensic medical examination (including, if appropriate, by a forensic psychiatrist) should be immediately ordered, and the necessary steps taken to ensure that the allegations are properly investigated. Such an approach should be followed whether or not the person concerned bears visible external injuries. Even in the absence of an express allegation of ill-treatment, a forensic medical examination should be requested whenever there are other grounds to believe that a person could have been the victim of ill-treatment.

The role of health-care professionals

It is important that no barriers be placed between persons who allege ill-treatment (who may well have been released without being brought before a prosecutor or judge) and doctors who can provide forensic reports recognised by the prosecutorial and judicial authorities. For example, access to a doctor should not be made subject to prior authorisation by an investigating authority.

Health-care services in places of deprivation of liberty can and should make an important contribution to combating ill-treatment of detained persons, through the methodical recording of injuries and the provision of information to the relevant authorities. The accurate and timely documenting and reporting of such medical evidence will greatly facilitate the investigation of cases of possible ill-treatment and the holding of perpetrators to account, which in turn will act as a strong deterrent against the commission of ill-treatment in the future.

The CPT has paid particular attention to the role to be played by prison health-care services in relation to combating ill-treatment. Naturally, that role relates in part to possible ill-treatment of detained persons during their imprisonment, whether it is inflicted by staff or by fellow inmates. However, health-care services in establishments which constitute points of entry into the prison system also have a crucial contribution to make as regards the prevention of ill-treatment during the period immediately prior to imprisonment, namely when persons are in the custody of law enforcement agencies (e.g. the police or gendarmerie). In addition to ensuring adequate treatment and documentation of injuries following an incident in a place of deprivation of liberty, systematic medical screening of new arrivals to such places is crucial. The CPT has set out standards with regard to the documenting and reporting of medical evidence of ill-treatment, including a procedure that whenever injuries are recorded by a health-care professional which are consistent with allegations of ill-treatment made by a detained person, that information is immediately and systematically brought to the attention of the relevant authority, regardless of the wishes of the person concerned.

Policy against impunity

No one must be left in any doubt concerning the commitment of the State authorities to combating impunity. This will underpin the action being taken at all other levels. When necessary, those authorities should not hesitate to deliver, through a formal statement at the highest political level, the clear message that there must be “zero tolerance” of torture and other forms of ill-treatment.

Some challenges to combating impunity

Translating the standards for an effective investigation into a set of actions remains a great challenge. To begin with, there is a degree of uncertainty as to what exactly the standards mean: what constitutes independence, what is the definition of promptness and thoroughness, which level of involvement of the victim, his/her next of kin and the public fulfils the requirement? And, in practice, lack of will and/or resources can cause obstacles to implementation. This is illustrated in the number of cases where the European Court of Human Rights found violations of Articles 2 and 3 ECHR due to the lack of an effective investigation. In the 2000s, this number increased dramatically with a peak in 2011 with 90 cases each for Articles 2 and 3. In 2013, lack of effective investigations accounted for 8,6% of the total of violations of all articles.

So who should investigate allegations of ill-treatment by law enforcement officials? In the past 15 years, several countries have established independent police complaints bodies. However, although this is encouraged by the Council of Europe and considered good practice, the group of countries remains small, including for example Denmark, England and Wales, some German *Länder*, Ireland, Northern Ireland and Scotland. The mandate, role, set-up and available budget of these bodies differ per country. In Norway, the Bureau for the Investigation of Police Affairs (an independent body outside the police force or prosecuting authority) has a mandate that is limited to the investigation of cases in which persons serving in the police or prosecuting authorities are suspected of having committed a criminal offence. In most countries investigations are performed by regular prosecutors, while again some other countries, such as Armenia, Moldova and Russia, have set up separate investigative units led by specialised prosecutors. For independent bodies or investigative units to function properly it is in any case crucial that the necessary resources are made available.

There are further practical obstacles which the CPT has come across in various countries. In the police context, criminal suspects often feel they have to be cautious to lodge complaints because this might complicate their case (sometimes this is openly mentioned by the interrogating police officers, in other cases even lawyers advise suspects not to raise complaints).

In the prison context, there can be a culture of intimidation either by staff and/or by certain groups of prisoners which are not effectively controlled by the staff. This makes complaining a risky endeavour because it might trigger intimidation or even acts of violence in a number of countries.

Furthermore, police investigations of ill-treatment committed within a prison can often be complicated as a result of a certain “code of silence” among both prisoners and staff. Collection of sufficient evidence in order to effectively prosecute such offences can be seriously hampered when witnesses do not speak out due to such codes and negative attitudes from prisoners against the police and prosecutors, as well as a lack of trust. In order to break this wall of silence a prison complaints system must thus not only fulfil the criteria of effectiveness outlined above, but must also invest in building trust among prisoners and actively counteract any negative consequences linked to complaining.

List of discussion questions and topics (non-exhaustive):

- What are the requirements for an investigation into police ill-treatment to be sufficiently independent?
    - Can such investigations be led by regular prosecutors? Or perhaps by a special prosecutorial unit within the regular prosecution services?
    - Or should it be handled by an independent investigative body, functioning outside regular police and prosecution structures?
    - What are the obstacles to the creation of independent police complaints bodies (ICPBs) ?
    - Who evaluates the evaluator? Can an investigative body fall under the same ministry as police or should it report to another body, for example parliament or a human rights institution?

- Investigations into ill-treatment by public officials tend to take much longer than regular criminal investigations and cases often end up being dismissed. What are the reasons behind this and how can it be addressed?

- Which models of investigative structures in or outside of Europe can be considered best practices? Which best practices can be recommended to countries with particularly limited resources?

- It is clear that independence in investigations into police ill-treatment requires particular attention, given the close links within police structures and with the prosecutorial services. Other places of deprivation of liberty can face similar but perhaps also other challenges.
    - What are the challenges with regard to investigations into ill-treatment by prison staff?
    - What best practice models can be identified for ill-treatment investigations in prisons?
    - What are the challenges for other places of deprivation of liberty, such as youth or psychiatric institutions and immigration detention centres?

- Should investigative bodies be separate from more general complaints bodies and/or monitoring/oversight bodies with a preventative mandate, such as national preventive mechanisms set up in the framework of OPCAT?

Panel 2: Health care in prisons

The spectrum of health problems in prisons is wide and their prevalence generally greater behind bars than in the population at large. Special challenges to prison health care are substance abuse, mental health problems and communicable diseases alongside several other problems such as self-harm and suicide. The quality and accessibility of prison health-care services are therefore of particular importance for the overall quality of life of prisoners. This is all the more pertinent since prisoners usually do not have access to a doctor of their choice but are fully dependent on the health care services provided by the prison.

An inadequate provision of health care in prisons can rapidly lead to situations falling within the scope of the term "inhuman and degrading treatment" in the sense of Article 3 of the European Convention on Human Rights (ECHR). The European Court of Human Rights has in a number of cases where it found a violation of Article 3 emphasised that the mere fact that a detainee was seen by a doctor and prescribed a certain treatment does not automatically mean that the medical assistance provided was adequate. The Court has determined that the authorities have an obligation to ensure that the prisoner's state of health is regularly and systematically supervised, that a comprehensive record is kept of the prisoner's health condition and the treatment he/she received, that the diagnosis and care are prompt and accurate, and that, where necessary, a comprehensive therapeutic strategy is developed.

The CPT has emphasised the importance which it attaches to the principle of equivalence of care, i.e. that prisoners are entitled to the same level of medical care as persons living in the community at large. This principle is also recognised by many other organisations and is reflected in the legislation and policies of many states. In light of the disproportionately high level of health problems amongst prisoners, there is a growing body of opinion which questions whether the aim should not be rather to ensure the equivalence of objectives and end results. In many cases this would involve a higher standard of care for prisoners. Proponents of this principle of "equity of care" argue that, quite apart from the legal and ethical considerations, this is often the only real way to achieve larger public health objectives.

Special groups

In addition to treating sick patients, prison health care services may also be entrusted with responsibility for social and preventive medicine and address the specific needs of female and older prisoners and of those with disabilities. Studies have shown that women prisoners have many of the same problems as their male counterparts, but often to a greater extent. Pregnancy, especially where combined with mental health issues and drug dependency, is a particular problem for women prisoners. The reasons for women being incarcerated, which are clearly related to mental health, substance abuse and sexually transmitted diseases, show a different pattern to that of male prisoners. Women also face different problems in prison, so that programmes designed for men, such as for drug rehabilitation, may not be effective. The potentially "punitive environment" of prisons has been identified as being particularly difficult for women, even taking into account that some aspects of

incarceration, such as health care for substance abuse, may be better inside the prison than in the community (see Watson R. et al., p.124).*

Older prisoners also face specific problems, and a tendency to longer custodial sentences means that even young offenders (who commit the vast majority of crimes) may stay in prison long enough to join this category. As in the general population, older prisoners have greater health needs, and multipathology, including mental disorders, is common; palliative care is also an issue. Since older prisoners statistically are less likely to offend on release, their continued incarceration may represent an undue burden on prison services, particularly health-care facilities.

Basic principle of free healthcare

Health-care systems and the financial burden imposed on individuals for particular health services vary widely amongst Council of Europe member states. In view of the limitations imposed on any carceral population, the CPT stresses the need that health-care services should be provided free of charge in all prisons. The 2003 Moscow Declaration on Prison Health as part of Public Health recognises the vulnerability of prison populations and recommends "that all necessary health care for those deprived of their liberty is provided to everyone free of charge" and that strong integrated systems of health care are developed to deal with such problems as communicable diseases and mental illness. One body of opinion would favour a basic package of health-care services specifically designed for prison environments which would include treatment and prevention programmes for TB, HIV/AIDS and hepatitis as well as advanced treatment, prevention and rehabilitation programmes for both drug addiction and mental illness. Opponents of this approach point out that such packages can have negative consequences on health care in practice as they undermine the basic principle of equivalence of care, arguably the starting point of all health care in prisons.

Certainly, designing any health-care services for prison populations represents a considerable challenge, and an initial step would inevitably involve the evaluation of existing services. Despite the growing recognition of the importance of user participation in such evaluations, only a very limited number of studies of this nature have been carried out in prison environments. This situation begs the question of whether the evaluation of the level of satisfaction of prisoners in respect of health care services accessible to them could represent one element in determining necessary changes to health-care systems for prison populations.

Mental health

International studies have confirmed that mental health problems are more prevalent in prisons than in the general population and that the mental health situation in prisons is an international problem of increasing proportions. The lack of specialist training for doctors and nurses is an issue which has been noted in scholarly literature, and the CPT has recommended that "a doctor qualified in psychiatry should be attached to the health care service of each prison, and some of the nurses employed there should have had training in this field" (3rd General Report, paragraph 41). As with other health issues to which prisoners

are subject, early assessment of mental disorders is recognised as being key to addressing the problem. Specific standardised assessment protocols have been proposed as one part of a solution, since procedures and instruments used for the population at large may not be appropriate. Mental health promotion for prisoners is a focus for improving not only the situation of prisoners, but also that of the outside community: "In terms of mental health, prison could be the place where the cycle of jail and homelessness could be broken and where preventive strategies could be implemented to prevent the release of people with greater mental health problems than when they entered prison." (Watson R. et al., p. 125)

Communicable diseases

The prevalence of HIV/AIDS, hepatitis and tuberculosis (TB) among prisoners is another problem of international dimensions. Scholarly articles from around the world point to how prisons are conducive to the spread of TB, how mortality from TB is high and drug resistance prevalent, and how TB in prisons poses a threat to the general population. Syphilis and other sexually transmitted diseases are also problematic in many prisons. In terms of prevention, health education and health promotion have been identified as key elements in any programme aimed at the eradication of these and other communicable diseases, and some programmes also include the provision of condoms and clean needles for safe sex and safe drug use. However, a positive and progressive attitude towards such strategies by prison staff is essential for their successful implementation.

Substance abuse

The World Health Organization has recognised illegal substance abuse as a major problem in prisons, and international studies have identified the relationship between substance abuse and crime, mental health problems and communicable diseases. The success rate of drug rehabilitation programmes in prisons is notoriously low: for example, in some cases mandatory testing of prisoners has led to the use of harder drugs with a shorter half-life and which are therefore less detectable (for example, opiates replacing marijuana). Promotion and education programmes are considered essential, not only in terms of reducing substance abuse among prisoners, but also for the prevention of recidivism and the reduction of substance abuse in the general population. In this regard, any successful programme for the eradication of substance abuse must be part of a national strategy and should include the following elements: the elimination of the illegal supply of drugs; the identification of substance abuse and the organisation of effective treatment, harm reduction, and prevention programmes; the development of standards on the above and the training of staff in their application.

Suicide and self-harm

Prison is recognised as a high-risk environment with regard to suicide. Likewise, self-harm is a growing phenomenon in prison environments. There are clear links between mental health, self-harm and suicide. Self-harm rates are generally higher in female prisoners than in their male counterparts, and women in custody are also a high risk category with respect to suicide (especially in pre-trial detention where they attempt suicide more often than both their female counterparts in the community and their incarcerated male counterparts). The

CPT has recommended that prison authorities put in place a comprehensive suicide and self-harm prevention and management approach. Such an approach needs to involve effective procedures for the identification of prisoners who may be at risk, starting with the initial medical screening, which should include a suicide risk assessment using an identified screening tool. All prison staff who interact with inmates, and particularly those working in the reception and admissions units, should receive special training in this regard. Where a risk is identified, steps should be taken to ensure a proper flow of information within the establishment, and all persons identified as being at risk should as a first step benefit from counselling and appropriate support. Where necessary, persons at risk should be subject to special precautions (placement in a ligature-free room and provision of suicide-proof clothing). In high-risk cases the prisoner should be under constant observation by a member of staff who should attempt to establish a dialogue. The need for enhanced external contacts (i.e. family visits and telephone calls) should also be considered on a case-by-case basis. The CPT has identified the establishment of constructive relations between staff and inmates, and amongst the inmates themselves, as being key elements in any successful approach for addressing issues of suicide and self-harm.

Prevention of ill-treatment

A prison health-care service should further play an important role in combatting ill-treatment, both in the establishment itself, and elsewhere (in particular at police stations). As from an early stage of its activities, the CPT has emphasised the important contribution which health-care services in all places of deprivation of liberty can and should make to combat ill-treatment through the methodical recording of injuries and the provision of information to the relevant authorities. The duty of prison health-care staff to record and report any sign or indication of violent treatment is also stipulated in the European Prison Rules. The accurate and timely documenting and reporting of such medical evidence greatly facilitates the investigation of cases of possible ill-treatment and the holding of perpetrators to account, which in turn can act as a strong deterrent against ill-treatment in future.

Professional independence

The professional independence of prison health-care professionals is of crucial importance not only for facilitating their role in combatting ill-treatment but also for enabling a confidential doctor/patient relationship unimpaired by the real or perceived dual loyalty of health-care staff to both patients and prison management. As long as health-care professionals are subordinate to the prison administration, their task to care for their prisoner patients may often come into conflict with considerations of prison management and security. They might be exposed to pressures to serve other purposes than patient care, giving rise to difficult ethical questions and potentially undermining the quality of care provided.

According to the rules of ethics for health-care staff working in prisons as established by numerous international organisations, the sole duty of health-care professionals in prisons is care for the physical and mental health of the prisoners. Medical activities which are not in the prisoner's interest should not be undertaken by professionals who provide health care to prisoners, as stated clearly in principle 3 of the UN Resolution on Principles of Medical

Ethics. The CPT shares this position and recommends that such personnel should be aligned as closely as possible with the mainstream of health-care provision in the community at large instead of being subordinate to an authority responsible for prison administration. A greater participation of Health Ministries in prison health-care services (including recruitment of health-care staff, their in-service training, evaluation of clinical practice, and certification and inspection) may not only enable the undivided loyalty of health-care staff to their prisoner patients, but also help to ensure a better quality of health care for prisoners and the implementation of the general principle of equivalence of health care in prison with that in the wider community.

A policy trend in Europe has indeed favoured prison health-care services being placed to a great extent, or entirely, under the responsibility of the Ministry of Health: for example, in France, Norway, the United Kingdom, most regions of Italy, and three Swiss cantons (Geneva, Waadt and Vallis) prison health-care services are completely independent of prison authorities. The integration of prison health-care services into the community system, often as a result of the transfer of such services to health-care authorities, also facilitates continuity of medical care and prevention measures after release from prison.

Health promotion and health of the community

Health promotion and health of the community are cross-cutting issues with respect to the problems outlined above. The lack of effective assessment procedures on entry to any prison facility is a major problem in this regard: “if the health needs and problems of prisoners are not known then how can action be effective?” (Watson R. et al., p.125) The CPT has recommended appropriate medical assessment and screening procedures from the outset of imprisonment, particularly with respect to the early detection of psychiatric ailments. Likewise, health promotion is recognised as integral to any health-care models in prison settings. It may be an obvious point, however, it is worth emphasising how close the relation is between health in prisons and health in the community. As one study states: “health problems in prisons largely reflect, but magnify, the problems present in the communities which the prisons serve” resulting in “an inevitable interplay in terms of health between prisons and the communities” (Watson R. et al., p. 125). Prison services and community services therefore have a particular interest in working together to ensure that adequate prevention and treatment are provided to patients on both sides of the prison walls.

List of discussion questions and topics (non-exhaustive):

- Is it possible to identify the reasons for the increasing proportion of prisoners with mental health problems? How should this phenomenon be addressed?
- What essential elements should a comprehensive mental health policy for prisoners include? What range of institutions should be involved? What kind of (standard) assessment policies should be put in place?
- The problem of substance abuse in prisons is notoriously difficult to address. Why do substance-abuse eradication approaches, even where established along the lines outlined in this paper, fail? Which aspects are particularly liable to failure and why?
- What are the minimum requirements for a policy to reduce the incidence of suicide and self-harm in prisons? To what extent is a comprehensive policy to address these problems dependent on cultural and/or other factors particular to a given country?
- In cases of high risk of suicide or self-harm, is it sufficient that the prisoner be under observation by a member of staff, or should it necessarily be a member of the health care staff? Why?
- How might a strategy for prevention of self-harm in female prisoners differ from that for their male counterparts?
- Should the principle of "equivalence of health care" in prisons be replaced by a principle of "equity of health care" owing to the proportionally poorer health conditions of prisoners compared to the population at large?
- What are the advantages and disadvantages of introducing a basic health-care package for prisons in any given country? To what extent could the effectiveness of such a package depend on the level of health services outside the prison system?
- What are the advantages and disadvantages of integrating prison health-care services into the public health system rather than subordinating them to prison authorities?
- Smaller prison establishments often do not provide for a 24-hour presence of health-care staff. Is such a round-the-clock presence of health-care staff in all prison establishments indispensable or could exceptions be envisaged? If so, under what conditions (for example, the presence of someone competent to provide first aid, possibilities either to contact external health-care staff quickly or to effect emergency transfers to a nearby health-care facility)?
- Is it acceptable for medication – including psychotropic drugs and antiviral therapy – to be distributed to prisoners by non-health-care staff? If so, under what conditions? What are the risks?

Panel 3: Juveniles in detention

In February 2012 the Council of Europe adopted the Strategy for the Rights of the Child 2012-2015 focusing on four strategic objectives, including the elimination of all forms of violence against children and guaranteeing the rights of children in vulnerable situations, objectives which are particularly relevant to the situation of children deprived of their liberty. In its 24th General Report the CPT has set out the revised criteria applicable to its work in respect of juveniles in detention. These follow on from those standards published in its 9th General Report in 1998[2] and should be viewed as complementary to the standards set out in international instruments, notably the 1989 United Nations Convention on the Rights of the Child, and Recommendation CM/Rec (2008) 11 of the Committee of Ministers of the Council of Europe to member states on the European Rules for juvenile offenders subject to sanctions or measures ("European rules for young offenders"), which provides a detailed set of rules for the treatment of juvenile offenders in Europe.[3] The Committee subscribes wholeheartedly to the cardinal principles enshrined in Articles 3 and 37.b of the Convention on the Rights of the Child and in Rules 5 and 10 of the European Rules for juvenile offenders, namely that in all action concerning juveniles, their best interests shall be a primary consideration and that they should only be deprived of their liberty as a last resort and for the shortest possible period of time.

The circumstances in which juveniles are deprived of their liberty vary widely in the different Council of Europe member states. Areas of concern most frequently evoked in CPT reports include the lack of separation of juveniles from adults in detention, conditions and duration of police detention, and conditions and treatment in detention centres (especially as regards protection from ill-treatment, material conditions, regime, solitary confinement, and visits). The CPT is also concerned with the problems confronting children in social care homes, children of parents in prison and irregular migrant children.

The conclusions and recommendations of the CPT are frequently referred to by non-governmental organisations working in the area of child protection, in scholarly literature and, increasingly, in the judgments of the European Court of Human Rights.

Juveniles held in police custody

In line with its mandate the CPT's priority during visits to juveniles in police custody is to seek to establish whether they have been subjected to ill-treatment. In this connection the CPT has paid particular attention to procedural safeguards which prevent ill-treatment and to the assertion of the rule of law for children in police custody, including recommending stronger standards than for adults: that law enforcement officials should be under a formal

[2] See also the CPT's 18th General Report which contains comments on the draft European Rules on Juvenile Offenders Subject to Sanctions and Measures (CPT/Inf (2008) 25, and the 19th General Report (CPT/Inf (2009) 27) containing a substantive section on irregular migrants deprived of their liberty, which addresses also the question of additional safeguards for children in such situations.

[3] See also the 1985 United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("Beijing Rules"), the 1990 United Nations Rules for the Protection of Juveniles Deprived of their Liberty ("Havana Rules"), the 1990 United Nations Guidelines for the Prevention of Juvenile Delinquency ("Riyadh Guidelines") and the 2010 Guidelines of the Committee of Ministers of the Council of Europe on child friendly justice.

obligation to ensure that a relative or other adult person trusted by the juvenile is notified of the detention (regardless of the juvenile's wishes); that a lawyer should always be called when a juvenile is taken into police custody and he/she should never be subjected to police questioning or be requested to make any statement or sign any document without the presence of a lawyer; that a specific child-friendly information sheet in the relevant language should be provided to each juvenile entering custody setting out the applicable safeguards and, in this connection, that special efforts be made to ensure that the child has understood the information.

Unfortunately, the phenomenon of ill-treatment of juveniles by law enforcement officials is still a concern in a number of European countries. The CPT considers that law enforcement establishments are generally unsuitable for prolonged periods for any detained person, and this is all the more true in respect of juveniles. The CPT recommends that juveniles should not be held in police establishments for more than 24 hours. Further, every effort should be made to avoid police cells altogether and to hold juveniles in a more appropriate environment. To this end, separate police units should be established providing juvenile-friendly surroundings and treatment, staffed by law enforcement officials who have received special training in the handling of juveniles.

In any case, the vulnerability of juveniles to different forms of abuse dictates that they should be held as a matter of principle separately from adults. The documenting, reporting and investigating of allegations of ill-treatment should be particularly rigorous in the case of juveniles, and special attention should be devoted to ensuring that their allegations are taken seriously and reach the appropriate authorities.

Detention centres for juveniles

In keeping with the "last resort" principle, there should be a range of community-based measures available as alternatives to deprivation of liberty for juveniles remanded or sentenced for criminal offences. Furthermore, remand custody should be strictly regulated, and used only when, and for the minimum period, necessary. Political support for such measures is essential, as is appropriate judicial education and training. Where deprivation of liberty is deemed necessary, the CPT has long advocated that detention centres for juveniles should be specially adapted to their needs, offering an environment that is "non-prison-like" and staffed by persons trained in dealing with the young. All too often, the lack of trained staff and of adequate material conditions and meaningful activities mean that juveniles do not benefit from training in life skills which are essential for reintegration into the community upon release.

Some countries do, however, have centres adapted for juveniles and composed of small well-staffed units, each comprising a limited number of single rooms (usually no more than ten) as well as a communal area. Such centres provide a range of purposeful activities during the day accompanied by devoted staff who promote a sense of community within the unit. The CPT has noted with concern the impoverished regime often witnessed in pre-trial detention, where juveniles are particularly vulnerable on account of the uncertainty surrounding their situation. On the basis that a lack of purposeful activities is particularly detrimental to the wellbeing of juveniles, that CPT has determined that they should be

provided with a full range of education, sport, vocational training, recreation and other purposeful out-of-cell activities. The CPT pays particular attention to ensuring that female juveniles do not receive less attention, protection, assistance and training than their male counterparts.

Health-care services for juveniles should form part of an integrated multidisciplinary programme of care. Under such a programme all juveniles should benefit on admission from a comprehensive needs assessment at the medical, psychological and social levels, and the health-care team should always work closely with other relevant professionals, including specialised educators, social workers and teachers who work regularly with juvenile inmates. The goal should be to ensure that the health care delivered to juveniles forms part of a seamless web of support and therapy. Female juveniles should have access to gynaecological care and health education. Pregnancy and motherhood are issues which require particular care: at the very least appropriate support and medical care should be provided, and wherever possible alternatives to detention should be found for young mothers. Female juveniles should also benefit fully from the standards applicable in this context to women deprived of their liberty as set out in the CPT's 10th General Report.

Appropriate and flexible opportunities for visits from family and other trusted persons are essential to the development of social skills and the process of rehabilitation, and juveniles in detention should have frequent access to telephones and be able to freely avail themselves of means of correspondence. Juveniles' contact with the outside world should never be denied or restricted as a disciplinary measure, except where the restriction is imposed as a proportionate response to a disciplinary infraction involving such contact. Furthermore, such measures should only be imposed for a specified period. Finally, the parents or legal representative of a juvenile should always be informed without delay of transfers, release, disciplinary sanctions and protective and security measures, as well as of any illness, injury or death.

- *Protection from ill-treatment*

Juveniles in detention are particularly vulnerable to physical and verbal ill-treatment at the hands of staff and other inmates; self-harm is also an issue of concern. The CPT has highlighted in particular the link between the protection of juveniles from inhuman or degrading treatment and their separation from adults in detention. Where, exceptionally, juveniles are held in prisons for adults, they should always be accommodated separately in a distinct unit. Out-of-cell activities together with adult prisoners can, in some circumstances, be permitted or even beneficial, however on the strict condition that there be appropriate supervision by staff.

The use of restraints for juveniles is also of concern to the CPT, particularly in the light of the undue stress and the potential injuries arising out of handcuffing and certain manual restraint techniques. Corporal punishment and all forms of collective punishment must be strictly prohibited.

- *Solitary confinement*

Solitary confinement as a disciplinary measure should only be imposed for very short periods and never for more than 3 days. Juveniles subject to solitary confinement should receive socio-educational support, medical treatment where necessary and regular human contact (including at least once per day by a member of health-care staff). In very rare cases solitary confinement may be required for protection or preventive purposes where no other solution is available. Every such measure should be subject to the following safeguards: it should be decided by a competent authority based on a clear procedure specifying the nature of the confinement, its duration, and the grounds on which it may be imposed and providing for a regular review process and for the possibility for the juvenile to appeal against the decision to an independent external authority.

Likewise, the placement of a violent and/or agitated juvenile in a calming-down room should be a highly exceptional measure, lasting no longer than a few hours and never imposed as an informal punishment. Mechanical restraint is never appropriate in such circumstances. Every such measure should immediately be brought to the attention of a doctor and should also be recorded in a central file as well as in the juvenile's individual file.

Children in social care homes

Children in social care homes also attract the particular attention of the CPT both because of their vulnerability and because of the often inadequate conditions in which they are accommodated. Many children in such homes suffer from different degrees of learning disabilities or physical and/or mental illness. As in other types of establishment, such children should never be accommodated with adults, and their special needs should be addressed. The use of means of restraint is of particular concern in such cases, and the CPT has determined that, in this respect, stronger safeguards are required than for adults subjected to means of restraint. Many countries are now moving towards the de-institutionalisation of persons placed in social care homes, including children, and their transfer to community-based support structures. The CPT welcomes such initiatives, subject to appropriate measures to safeguard the best interests of the children concerned, and follows closely the progress of such initiatives in the countries concerned.

Children with parents in custody

The CPT is aware of the detrimental impact on children of having parents in custody and, particularly, the effect on family relationships of restricted visit regimes and inappropriate conditions during visits. In many prisons, the area for holding visits is inappropriate for children, impeding quality contact between children and imprisoned parents. In more than one case, the CPT has reported that parents had chosen to abandon visits by their children because of the traumatic experience the inappropriate conditions represented for the prisoners themselves and for their young children.[4]

[4] Report on CPT's visit to Italy CPT/Inf (2010) 12, paragraphs 76-78; Report on CPT's visit to Greece CPT/Inf (2010) 33, paragraph 143.

It is recognised that early maternal separation causes long-term difficulties, including impairment of attachments to others, emotional maladjustment and personality disorders. As set out in the CPT's 10th General Report, the CPT considers that babies should not be born in prison, and the usual practice in Council of Europe member states is to transfer expectant mothers to external hospitals at the appropriate time.

Many women in prison are primary carers for children, and the question of the length of time which children should be allowed to stay with their imprisoned mothers is a difficult one. In the view of the CPT the governing principle in all cases must be the welfare of the child, and the goal should be to provide as "normal" and child-friendly an environment as possible. Studies have shown that fostering better family relations between imprisoned parents and their children can improve both staff-prisoner relations and the general prison environment. It is also widely acknowledged that fostering prisoner-family relations contributes towards reintegration and reduces recidivism.

Safeguards for irregular migrant children

The CPT concurs with the United Nations Committee on the Rights of the Child which considers that "[i]n application of article 37 of the Convention [on the Rights of the Child] and the principle of the best interest of the child, unaccompanied or separated children[5] should not, as a general rule, be detained. Detention cannot be justified solely on the basis of the child being unaccompanied or separated, or on their migratory or residence status, or lack thereof".[6] Further, other Council of Europe bodies, such as the Parliamentary Assembly[7] or the Commissioner for Human Rights,[8] have stated that unaccompanied minors should not be detained. In case of doubt over whether the individual is over 18, there should be a presumption that he/she is a minor until the contrary is proven. Unaccompanied or separated migrant children should also have prompt and free access to legal and other appropriate assistance, including the assignment of a guardian or other legal representative. The ongoing quality of the guardianship should be subject to regular review.

The placement of minors with their parents in a detention centre should only occur as a last resort, and if, in exceptional circumstances, such placement cannot be avoided, its duration should be as short as possible. Every possible effort should be made to avoid separation of children from their parent(s).

---

[5] "Unaccompanied children" (also called unaccompanied minors) are children who have been separated from both parents and other relatives and who are not being cared for by an adult who, by law or custom, is responsible for doing so. "Separated children" are children who have been separated from both parents, or from their previous legal or customary primary carer, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.

[6] Committee on the Rights of the Child, General Comment no. 6 (2005) on the Treatment of unaccompanied and separated children outside their country of origin, CRC/GC/2005/6, 1 September 2005, paragraph 61.

[7] Parliamentary Assembly of the Council of Europe, Resolution 1707 (2010) on detention of asylum seekers and irregular migrants in Europe, 28 January 2010, paragraph 9.1.9, and Resolution 2020 (2014) on the alternatives to immigration detention of children, 3 October 2014, paragraph 3.

[8] Commissioner for Human Rights, Positions on the rights of minor migrants in an irregular situation, CommDH/Position Paper (2010)6, 25 June 2010.

List of discussion questions and topics (non-exhaustive):

- This paper was drafted primarily on the basis of the substantive section on juveniles in the CPT's latest General Report and shortened for the purposes of this background document. Are any crucial issues left unaddressed with regard to the deprivation of liberty of juveniles?

- What is the best model for accommodating children remanded or sentenced for a criminal offence? Should children's establishments be placed under an authority other than the prison service? If so, which one?

- What are the major obstacles to creating a child-centred approach towards detention facilities? How best could these obstacles be overcome?

- In what ways could direct references to relevant international instruments in CPT reports reinforce the work of the Committee?

- While acknowledging that detention of juveniles should only ever be used as a last resort, what best practice examples with regard to juvenile detention facilities can be identified?

- It can be challenging to ensure that juveniles are kept separate from adults in environments with very limited resources and where very few juveniles are deprived of their liberty. In this scenario, what are feasible solutions for specialised juvenile facilities or for protection of and adequate conditions for juveniles held in adult facilities?

- What might be the minimum criteria for visits of children to their parents in custody to be considered as taking place under acceptable conditions? To what extent should the CPT incorporate these into its standards?

- How can the CPT convey a more child-centred message, in light of the Council of Europe and United Nations standards on children's rights?

- What kind of additional safeguards might the CPT consider in respect of children in social care homes? Should the CPT be more specific about what kind of community-based structures are appropriate for children with learning/physical disabilities and/or mental illness? What might be the disadvantages of de-institutionalisation for such children?

- What is the major obstacle to ensuring that no irregular migrant child is deprived of his/her liberty? Could one argue that, in some cases, detention is justified?

- Does the CPT need to devote more attention to the specific problems of female children deprived of their liberty? What might be some of the special vulnerabilities of this group which the CPT should address more clearly?

Panel 4: Solitary confinement

The CPT understands the term "solitary confinement" as meaning whenever a prisoner is ordered to be held separately from other prisoners, for example, as a result of a court decision, as a disciplinary sanction imposed within the prison system, as a preventative administrative measure or for the protection of the prisoner concerned. Solitary confinement has a well-documented negative impact on mental health and wellbeing and may amount to cruel, inhuman or degrading treatment or punishment, particularly when used for a prolonged time. If used intentionally for purposes such as intimidation, coercion or obtaining information or a confession, or for any reason based on discrimination, and if the resulting pain or suffering is severe, solitary confinement may even amount to torture.

In its 21st General Report, the CPT set out standards on the issue of solitary confinement with the aim to minimise its use in prisons, not only because of the mental, somatic and social damage it can do to prisoners but also given the opportunity it can provide for the deliberate infliction of ill-treatment. The CPT considers that solitary confinement should only be imposed in exceptional circumstances, as a last resort and for the shortest possible time.

Prisoners undergoing solitary confinement should be accommodated in decent conditions. Further, the measure should involve the minimum restrictions on prisoners consistent with its objective and the prisoner's behaviour, and should always be accompanied by strenuous efforts on the part of staff to resolve the underlying issues. More specifically, regimes in solitary confinement should be as positive as possible and directed at addressing the factors which have made the measure necessary. In addition, legal and practical safeguards need to be built into decision-making processes in relation to the imposition and review of solitary confinement. Ensuring that solitary confinement is always a proportionate response to difficult situations in prisons will promote positive staff-prisoner interaction and limit the damage done to the very persons who are often already among the most disturbed members of the inmate population.

The European Court of Human Rights has found that complete sensory isolation, coupled with total social isolation, can destroy the personality and constitutes a form of inhuman treatment which cannot be justified by the requirements of security or any other reason.[9] Other forms of solitary confinement may also violate Article 3 ECHR, but the Court has found that prohibition of contact with other prisoners does not in itself amount to inhuman treatment or punishment.[10]

The United Nations Special Rapporteur on Torture (SRT) has also advocated for strict standards and highlighted a number of general principles to help to guide States to re-evaluate and minimise the use of solitary confinement. He also called for the exclusion of certain categories of prisoners from placement in solitary confinement. Similar calls were

[9] See *Van der Ven v. the Netherlands*, no. 50901/99, 4 February 2003, paragraph 51.
[10] See *Babar Ahmad and Others v. UK*, nos. 24027/07, 11949/08, 36742/08, 66911/09 and 67354/09, 10 April 2012, paragraph 208; *Messina v. Italy* (no. 2) (dec.), no. 25498/94, 10 April 2012, quoted with approval by the Grand Chamber in *Ramirez Sanchez v. France [GC]*, no. 59450/00, 4 July 2006, paragraph 12; and *Öcalan v. Turkey* [GC], no. 46221/99, 12 May 2005, paragraph 191.

made in the review process of the Standard Minimum Rules for the Treatment of Prisoners (SMR), where proposals were made to consider including a prohibition on solitary confinement for the following categories of prisoners:

- Juveniles;
- pregnant women, women with infants and breastfeeding mothers;[11]
- prisoners with mental disabilities;
- life-sentenced prisoners and prisoners sentenced to death merely by virtue of their sentence; and
- pretrial detainees as an extortion technique.

Duration of solitary confinement

The SRT has called for an absolute prohibition of prolonged (in excess of 15 days) solitary confinement, while the CPT has stated it considers that the maximum period of solitary confinement *as a punishment* should be no higher than 14 days for a given offence, and preferably lower. The CPT has further noted that this maximum should certainly be lower in respect of juveniles, no more than three days.

The European Court of Human Rights has found that whilst prolonged removal from association with other people is undesirable, whether such a measure falls within the ambit of Article 3 ECHR depends on the particular conditions, the stringency of the measure, its duration, the objective pursued and its effects on the person concerned.[12] The Court has never laid down precise rules governing the operation of solitary confinement and has never specified a maximum period of time.[13] It has, however, emphasised that solitary confinement cannot be imposed on a prisoner indefinitely.[14] While not setting a concrete maximum period to forms of solitary confinement other than punishment, the CPT holds that the longer the measure of solitary confinement is continued, the stronger must be the reason for it and the more must be done to ensure that it achieves its purpose. The safeguards in place should also increase with the length of the confinement, including for example court reviews and additional medical attention, notably psychological and/or psychiatric care.

Material conditions

The cells used for solitary confinement should meet the same minimum standards as those applicable to other prison accommodation. This is, however, very often not the case. Disciplinary cells are often dark, small and poorly ventilated and prisoners often do not have access to adequate exercise areas.[15]

---

[11] Rule 22 of the United Nations Rules for the treatment of women prisoners and non-custodial measures for women offenders (the Bangkok Rules) also prohibits punishment by close confinement or disciplinary segregation of pregnant women, women with infants and breastfeeding mothers in prison.
[12] See *Rohde v. Denmark*, no. 69332/01, 21 July 2005, paragraph 93.
[13] See *Babar Ahmad and Others v. UK*, paragraph 210.
[14] See *Ramirez Sanchez v. France [GC]*, paragraphs 136 and 145.
[15] See for example CPT/Inf (2013) 3, paragraph 41; CPT/Inf (2013) 4, paragraph 81; and CPT/Inf (2012) 32, paragraph 56.

Solitary confinement as the result of a court decision

The CPT considers that solitary confinement should never be imposed as part of a sentence. In the context of remand custody, clearly there may be justification, in an individual case and based on sufficient evidence, for keeping a given prisoner apart from other prisoners. This should, however, only be done to guard against a real risk to the administration of justice and must be subject to safeguards.

Prolonged solitary confinement of remand prisoners has particularly been an issue in Scandinavian countries. The situation has evolved in recent years with a significant decrease in the use of this form of isolation in for example Norway[16] and Denmark.[17] Nevertheless, some prisoners continue to be isolated for prolonged periods of time and in its reports the CPT has recommended increased out-of-cell activities and contact with the outside world.

Solitary confinement as a disciplinary sanction

Withdrawal of a prisoner from contact with other prisoners may be imposed under the normal disciplinary procedures specified by the law, as the most severe disciplinary punishment. Given the potentially very damaging effects of solitary confinement, the CPT considers that the principle of proportionality requires that it be used as a disciplinary punishment only in exceptional cases and as a last resort, and for the shortest possible period of time; the CPT advocates for a maximum period of 14, and preferably lower. Further, prisoners sentenced to consecutive terms of solitary confinement as a disciplinary punishment should always have a break of several days between each period.

The CPT has stressed that prisoners should never be totally deprived of contacts with the family and any restrictions on such contacts should be imposed only where the offence relates to such contacts. This approach is adopted in more and more countries; however, the practice of depriving prisoners of all contacts persists in a number of jurisdictions.[18]

Long periods of solitary confinement are often a reaction to serious or repeated disciplinary offences by prisoners. In this context, the CPT holds that serious offences which call for more severe sanctions should be dealt with through the criminal justice system and not just through internal disciplinary procedures.

Solitary confinement for preventative purposes

Solitary confinement is often used to separate prisoners who have caused, or are judged likely to cause, serious harm to others or who present a very serious risk to the safety or security of the prison. This may be for as short as a few hours, in the case of an isolated incident, or for as long as a period of years in cases involving prisoners who are considered as particularly dangerous and to continue to pose an imminent threat. As discussed above, safeguards should increase with the length of the isolation.

---

[16] CPT/Inf (2011) 33, paragraphs 71-77.
[17] CPT/Inf (2014) 25, paragraphs 33-39.
[18] See for example CPT/Inf (2013) 18, paragraph 54; CPT/Inf (2012) 32, paragraph 55; CPT/Inf (2012) 17, paragraph 100; CPT/Inf (2010) 16, paragraph 113; CPT/Inf (2009) 28, paragraph 53.

The CPT considers that if it becomes clear that solitary confinement is likely to be required for a longer period of time, a body external to the prison holding the prisoner, for example, a senior member of headquarters staff, should become involved. A right of appeal to an independent authority should also be in place. When an order is confirmed, a full interdisciplinary case conference should be convened and the prisoner invited to make representations to this body. A major task for the review team is to establish a plan for the prisoner with a view to addressing the issues which require the prisoner to be kept in solitary confinement. Among other things, the review should also look at whether some of the restrictions imposed on the prisoner are strictly necessary – thus it may be possible to allow some limited association with selected other prisoners. The prisoner should receive a written, reasoned decision from the review body and an indication of how the decision may be appealed. After an initial decision, there should be a further review at least after the first month and thereafter at least every three months, at which progress against the agreed plan can be assessed and if appropriate a new plan developed. The longer a person remains in this situation, the more thorough the review should be and the more resources, including resources external to the prison, made available to attempt to (re)integrate the prisoner into the main prison community. The prisoner should be entitled to require a review at any time and to obtain independent reports for such a review. The prison director or senior members of staff should make a point of visiting such prisoners daily and familiarise themselves with the individual plans. Medical staff should also pay particular attention to prisoners held under these conditions.

Prisons with high levels of inter-prisoner violence and/or gang activity have the difficult task of separating prisoners who represent a threat to each other. While segregation of dangerous prisoners appears to be an effective measure in the short term, it is important that prison management and staff work to reduce as much as possible the need for such a measure. This usually requires a change of the prison culture, involving targeted training and activities for both staff and prisoners.[19]

In cases when complete segregation from the rest of the prison population is inevitable, it is important that material conditions are at least the same as those for other prisoners and that an individual regime plan is in place. This plan should attempt to maximise contact with others and provide as full a range of activities as is possible to fill the days.[20]

Solitary confinement for protection purposes

States have an obligation to provide a safe environment for those confined to prison and should attempt to fulfil this obligation by allowing as much social interaction as possible among prisoners, consistent with the maintenance of good order. Resort should be had to solitary confinement for protection purposes only when there is absolutely no other way of ensuring the safety of the prisoner concerned. Protective segregation can take place on both a voluntary and an involuntary basis. It is indeed a primary duty of the prison authorities to prevent harm coming to the prisoners under their care, and the need to take protective measures in favour of certain inmates may inevitably have negative

[19] See for example CPT Standards concerning inter-prisoner violence, CPT/Inf/E (2002) 1 - Rev. 2011, paragraph 27.
[20] See for example CPT/Inf (2014) 11, paragraphs 68-71.

repercussions on the activities they can be offered. However, the prisoners concerned should never be left to languish in their cells for up to 21 hours or more a day. Purposeful activities should be offered, as well as psychological support.[21]

The role of health-care staff in solitary confinement

A prison doctor acts as a patient's personal doctor. Consequently, in the interests of safeguarding the doctor/patient relationship, this doctor should not be asked to certify that a prisoner is fit to undergo punishment. While health-care staff should never participate in any part of the decision-making process resulting in any type of solitary confinement of prisoners (expect when applied for medical reasons), they should be very attentive to the situation of such prisoners. This includes daily visits, providing prompt medical care as required and reporting to the prison director whenever a prisoner's health is being put seriously at risk as a result of this confinement. Long-term isolation further requires adequate mental health support.

Solitary confinement and counter-terrorism

Counter-terrorism efforts have seen an increase in the use of strict and often prolonged solitary confinement practices in detention systems in various jurisdictions across the world.[22] The CPT holds that the placement of a prisoner under particularly restrictive conditions on the sole basis of the sentence/possible sentence is unacceptable. Any such measure should be taken on a case-by-case basis, in the light of an individual risk and needs assessment.[23] While the CPT can only inspect conditions of detention under the jurisdiction of the Council of Europe member states, the CPT has on various occasions examined member states' respect for the principle of non-refoulement, particularly in the context of expulsions, forcible removals and push-back operations.[24]

The question of whether the prospect of prolonged solitary confinement might contravene Article 3 of the European Convention on Human Rights and therefore serve as a ground to stop the extradition of a person to another country was one of the issues examined by the European Court of Human Rights in the case *Babar Ahmad and others v. the United Kingdom (2012)*. At issue, was whether the so-called Supermax ADX Florence Federal Prison in Arizona where prisoners could expect to spend at least three years, and possibly many more years, alone in a cell with no physical contact with other prisoners and limited social interaction with staff could result in a breach of Article 3.The Court concluded:

---

[21] See for example CPT/Inf (2012) 15, paragraph 45; CPT/Inf (2012) 1, paragraph 80; and CPT/Inf (2011) 24, paragraph 97.

[22] See for example the Joint study on global practices in relation to secret detention in the context of countering terrorism, UN Doc A/HRC/13/42, 19 February 2010.

[23] See the Recommendation Rec(2003)23 of the Committee of Ministers to member states on the management by prison administrations of life sentence and other long-term prisoners, under 7, states that consideration should be given to not segregating life sentence and other long-term prisoners on the sole ground of their sentence (non-segregation principle). See also, for example, CPT/Inf (2012) 32, paragraph 59 and CPT/Inf (2012) 23, paragraph 32.

[24] See for example CPT/Inf (2010) 14, paragraphs 26-33; CPT/Inf (2002) 8, paragraph 58;

Although inmates are confined to their cells for the vast majority of the time, a great deal of in-cell stimulation is provided through television and radio channels, frequent newspapers, books, hobby and craft items and educational programming. The range of activities and services provided goes beyond what is provided in many prisons in Europe…the services provided by ADX are supplemented by regular telephone calls and social visits and by the ability of inmates, even those under special administrative measures, to correspond with their families….While inmates are in their cells talking to other inmates is possible, admittedly only through the ventilation system. During recreation periods (ed. ten hours per week alternating between indoor and outdoor yards*) inmates can communicate without impediment. All of these factors mean that the isolation experienced by ADX inmates is partial and relative.* See paragraph 222 of the judgment.

List of discussion questions and topics (non-exhaustive):

- How should solitary confinement be defined?
- What are alternative solutions to solitary confinement?
- Should solitary confinement be prohibited for certain categories of prisoners? If so, which ones?
- The imposition of court ordered solitary confinement in the pretrial context has decreased in certain countries where this practice used to be widespread. What are currently the main issues of concern in Europe with regard to this form of isolation?
- With regard to solitary confinement as a punishment, is a maximum of 14 days for adults and three days for juveniles correct, too high or too low? And what should be the minimum standard of contact with the family?
- Prolonged solitary confinement occurs often in the context of segregating certain prisoners who are considered to pose a very serious risk to the safety or security of the prison.
    - What should be the minimum requirements for long-term segregation to be acceptable?
    - Which are the most feasible ways of increasing meaningful social contact for detainees while in solitary confinement?
    - What constitutes an effective review?
- What are the main challenges regarding solitary confinement for protection purposes and how can these be addressed?
- What role, if any, should health professionals play in the context of solitary confinement?

Panel 5: Towards new CPT standards on psychiatry

In its work, the CPT is called upon to examine the treatment of all categories of persons deprived of their liberty by a public authority, including persons with mental health problems. Consequently, the Committee is a frequent visitor to psychiatric establishments of various types. Establishments visited include psychiatric hospitals accommodating, in addition to voluntary patients, persons who have been hospitalised on an involuntary basis pursuant to civil proceedings in order to receive psychiatric treatment. The CPT also visits facilities (special hospitals, distinct units in civil hospitals, etc.) for persons whose admission to a psychiatric establishment has been ordered in the context of criminal proceedings. Psychiatric facilities for prisoners who develop a mental illness in the course of their imprisonment, whether located within the prison system or in civil psychiatric institutions, also receive close attention from the CPT.

In assessing the treatment of persons with mental health problems who are deprived of their liberty, the CPT will examine in particular the following issues: ill-treatment; living conditions and treatment; staff; use of means of restraint; and safeguards in the context of involuntary placement.

In view of its mandate, the CPT's first priority when visiting any establishment is to ascertain whether there are any indications of the deliberate ill-treatment of persons deprived of their liberty. The CPT has noted that the overwhelming majority of staff in most psychiatric establishments is dedicated to ensuring good patient care, and this despite the low staffing levels and paucity of resources which can exist in many countries. Nevertheless, deliberate ill-treatment can occur and is often closely linked to issues of staffing and procedures for the use of means of restraint, among other aspects of deprivation of liberty. In addition, staff shortages, lack of proper management or ignorance of acceptable (international) standards and lack of material resources can lead to situations falling within the scope of the term "inhuman and degrading treatment" in the sense of Article 3 of the European Convention on Human Rights (ECHR).

Revision of CPT standards on psychiatry

In 2011 the CPT decided to review its standards in the light of the Convention on the Rights of Persons with Disabilities (CRPD), which entered into force on 3 May 2008. As of 12 January 2015 the convention has been ratified by 41 Council of Europe member states. The CRPD includes in its definition of persons with disabilities (Article 1) "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". In 2008 the UN Special Rapporteur on Torture issued a report which stated that the CRPD "complements other human rights instruments on the prohibition of torture and ill-treatment by providing further authoritative guidance".[25]* Article 34 of the convention provides for monitoring of its implementation by a Committee on the Rights of Persons with Disabilities, which has to date issued concluding observations in respect of initial reports from

[25] Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, UN General Assembly document no. A/63/175, paragraph 44.

20 states parties. The Optional Protocol to the convention, which provides for an individual complaints mechanism, has to date been ratified by 28 Council of Europe member states.
With a view to developing its standards, the CPT has devoted increasing attention to the issues of involuntary placement, involuntary treatment, and the use of means of restraint. These issues have also attracted the attention of academics and practitioners external to the CPT.

Involuntary placement and involuntary treatment

Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder and the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Oviedo Convention) clearly establish the principle that medical treatment may only be administered on the basis of free and informed consent by the patient. Both instruments also contain provisions on the conditions under which persons may be subjected to the exceptional measures of involuntary placement and involuntary treatment.

The Council of Europe Steering Committee on Bioethics (CDBI) carried out an examination of the implementation of the provisions of Recommendation Rec(2004)10 and found "legal gaps in certain Member States in particular concerning legal provisions governing measures for involuntary placement and involuntary treatments of persons with mental disorders". A new Additional Protocol to the Oviedo Convention, with a particular focus on involuntary treatment and involuntary placement is being elaborated under the auspices of the Committee on Bioethics (DH-BIO).[26] This initiative is supported by the Steering Committee for Human Rights (CDDH) and the CPT. The drafting of the new protocol involves consultation with international non-governmental organisations representing patients and their families, health professionals, human rights defenders and specialists in the defence of persons with mental disorders. This work is being carried out "in the light of the United Nations Convention on the Rights of Persons with Disabilities" and on the basis of "the relevant provisions of Rec(2004)10 of the Committee of Ministers and the standards of the CPT".[27]

- *Involuntary placement*

The CRPD has provoked considerable debate on the issue of involuntary placement in psychiatric institutions in the light of the provision at Article 14, paragraph 1(b) "that the existence of a disability shall in no case justify a deprivation of liberty". Based on the concluding observations of the Committee on the Rights of Persons with Disabilities in respect of the initial reports submitted to it thus far, it would seem that the Committee's position is that legislation which allows involuntary placement of persons with mental health problems is

[26] Since January 2012 the responsibilities of the CDBI under the Convention have been transferred to the Committee on Bioethics.
[27] See Council of Europe website, web page "Psychiatry and Human Rights" at http://www.coe.int/t/dg3/healthbioethic/Activities/08_Psychiatry_and_human_rights_en/default_en.asp. In November 2011 the CDBI adopted a statement of compatibility concerning CRPD rights *vis-à-vis* Council of Europe standards.

incompatible with Article 14[28], and this view is also reflected in some of the scholarly literature. In the light of the general acknowledgment that the prevention of discrimination is at the heart of the CRPD, the UN Office of the High Commissioner for Human Rights has stated that Article 14 "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 so as to apply to all persons on an equal basis."[29] How this can be applied in practice remains to be clarified.

The European Court of Human Rights has addressed the issue of involuntary placement primarily in terms of violations of Article 5 (Right to liberty and security - with respect to the placement itself) and/or Article 8 (Right to respect for private and family life – with respect to deprivation of legal capacity) of the European Convention on Human Rights. In *Winterwerp* the court set out criteria for involuntary placement requiring that "a true mental disorder" be present ("unsound mind"), and that it be of a kind or degree "warranting compulsory confinement". Furthermore, the validity of continued confinement depends on the persistence of such a disorder.[30] The Court has also determined that the decision on placement must issue from and be executed by a proper authority, that the person concerned should have access to a court and the opportunity to be heard in person or through a representative, and that an automatic deprivation of legal capacity on admission to a psychiatric institution falls foul of Article 6 of the Convention since it does not afford the applicant a fair hearing on the issue by a court. In *Winterwerp,* the Court also recognised that the term "unsound mind" cannot be given a definitive interpretation in the light of the constantly evolving research in psychiatry, the development of more flexible treatments, and changes in society's attitude to mental illness. In a 2012 decision – *D.D. v. Lithuania* – the Court determined that even where a person is deprived of legal capacity, he or she must be afforded the possibility of contesting an involuntary placement decision before a court with separate legal representation. Finally, in *Stanev v. Bulgaria*, the Court, with reference to the CRPD, recognised that international instruments for the protection of people with mental disorders are attaching increasing importance to ensuring that such people are granted as much legal autonomy as possible.

The current CPT standards include, *inter alia,* that the initial placement decision must offer guarantees of independence and impartiality as well as of objective medical expertise, that patients should be informed on admission of their rights, that they should benefit from an effective complaints procedure and from contacts with the outside world, that any involuntary placement should be reviewed at regular intervals or as requested by the patient and should cease when it is no longer necessary, and that persons subjected to involuntary placement must have the ability to challenge the decision. Further, patients no longer requiring involuntary placement should be able to enjoy adequate care and accommodation in the outside community. One issue which might be the object of further consideration is

---

[28] See for example, the committee's concluding observations in respect of the initial report by Australia, CRPD/C/Aus/CO/1, 21 October 2013.

[29] *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,* Annual Report, A/HRC/10/48, 26 January 2009, paragraph 49.

[30] *Winterwerp v. Netherlands,* no. 6301/73, 24 October 1979, paragraph 39.

whether an order for involuntary placement may only be issued by a judicial authority. Currently the CPT standards accept involuntary placement, even by non-judicial authorities, but stipulate that the person involved must have the right to bring proceedings by which the lawfulness of his/her detention is decided speedily by a court.

During its visits the CPT has frequently encountered patients deemed "formally" to be voluntary patients (and therefore technically not covered by the CPT's mandate), but who are nevertheless subjected to restrictive and coercive measures, including accommodation in closed wards and involuntary treatment (sometimes on the basis of their signature on forms "waiving" their rights in this regard). In legal terms, such persons are not protected by the same safeguards as involuntarily placed patients, a situation which is of considerable concern to the CPT. In its reports the CPT has recommended that authorities review the status of voluntary patients subject to restrictive or coercive measures, and that legislation be adopted accordingly. In *Stanev* the European Court of Human Rights determined that the "voluntary" placement of the applicant in a social care home because of his psychiatric problems amounted to a deprivation of liberty, *inter alia,* on the basis of the rules on leave of absence, the duration of the placement and the applicant's lack of consent. A similar ruling was made by the Court in *Storck v. Germany.*

In the light of the debate surrounding the compatibility of some of the current standards of the Council of Europe concerning involuntary placement with Article 14 of the CRPD, it is expected that the adoption of the Additional Protocol to the Oviedo Convention will provide some guidance on the extent to which the Council of Europe is prepared to develop its standards in line with the new direction heralded by the CRPD.

- *Involuntary treatment*

Both the Oviedo Convention and Recommendation Rec(2004)10 clearly establish the principle of free and informed consent for any medical treatment. Both instruments stipulate that in the case of persons without legal capacity, authorisation must be obtained from the person's representative or from an authority, person or body provided for by law. Recommendation Rec(2004)10 also establishes detailed safeguards under which a person may be subjected to involuntary treatment.

In the landmark 1992 case *Herczegfalvy v. Austria* the European Court of Human Rights ruled that where measures which included the forced administration of psychiatric medication, including sedatives, constituted "a "therapeutic necessity" on the basis of the medical practice of the time, they could not be regarded as inhuman or degrading. Many of the therapeutic measures referred to in that judgment would now be considered as measures of restraint (see below under "The use of means of restraint"); the principle however, still stands more or less intact. In a 2004 decision- *Gennadiy Naumenko v. Ukraine* - the Court reaffirmed its position, determining in a case involving the question of involuntary treatment using psychiatric medication that therapeutic treatment could not in principle be regarded as contravening Article 3 of the Convention if it was persuasively shown to be necessary, even without the consent of the person. More recently, in *Schneiter c. Suisse* the Court acknowledged that the "legitimate aim" of forced medication could include the protection of the rights and freedoms of others.

The CRPD makes no explicit reference to involuntary treatment[31], however, some academic discussion situates this issue within the scope of Article 17 (Right to integrity), which states: "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others." The concluding observations of the Committee on the Rights of Persons with Disabilities in respect of initial reports by states parties have found medical treatment without consent (including in respect of persons deemed to lack legal capacity) to violate the Convention (whether under Article 17 or under other Articles). The UN Special Rapporteur on Torture has also stated that the "acceptance of involuntary treatment and involuntary confinement runs counter to the provisions of the" CRPD.[32] Some scholarly literature has taken the view that, in the light of the anti-discrimination basis of the CRPD, it is "likely to be the case that it will allow compulsory treatment of mental disorders if compulsion would also be allowed for physical disorders of comparable seriousness, and in cases of people without mental or other disabilities".[33] Once again, the practical implementation of such an approach remains to be defined.

The CPT has consistently made the point in its reports that involuntary placement should not be considered as a blanket justification for involuntary treatment and that, in principle, consent to treatment should be obtained from all legally capable ("competent") persons. Such consent should systematically be recorded in writing, and any derogation from this rule must be based upon law with respect to clearly and strictly defined circumstances. In addition, the CPT has insisted that every patient be provided with "full, accurate and comprehensible information" and that relevant information following treatment also be provided.

One aspect of the CPT standards which may require further consideration in the light of the CRPD is the exception to the general principle of consent where it concerns persons who are not "competent" (i.e. without legal capacity). The Committee on the Rights of Persons with Disabilities has up to now been quite consistent in stating its position that psychiatric treatment without consent should no longer be permitted in law or practice, even when it concerns persons deemed to lack legal capacity. This position is in line with the underlying intent of the CRPD that "substituted decision-making" (i.e. the exercising of a person's rights by a legally acknowledged guardian) should be replaced with "supported decision-making" (a new concept, the practicalities of which are not yet clear), so that all medical treatment, including psychiatric treatment should only be administered on the basis of the free and informed consent of the person concerned. As indicated in the previous section, the European Court of Human Rights has also acknowledged the growing tendency in this direction at the international level.

---

[31] Article 25(d) of the Convention does, however, make the point that states are obliged to provide the same quality of health services to persons with disabilities as to others "including on the basis of free and informed consent".

[32] Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, UN General Assembly A/63/175, paragraph 44.

[33] Bartlett P. (2013), "Re-Thinking *Herczegfalvy*: The ECHR and the Control of Psychiatric Treatment", in E. Brems (ed.), *Diversity and European Human Rights: Rewriting Judgments of the ECHR,* Cambridge University Press, Cambridge, p. 368.

The use of means of restraint

The need for a revision of the CPT standards regarding the use of means of restraint in psychiatric institutions has been acknowledged for some time. In the preliminary remarks to its 16th General Report the CPT welcomed "the comments of practitioners" on the issue, by way of establishing a "constructive dialogue, with a view to assisting health-care staff in performing their arduous tasks and providing patients with appropriate care." The different means of restraint (physical, mechanical, pharmaceutical, seclusion) are used in most Council of Europe member states, however, there is considerable variation between states in terms of the types of restraint most used, frequency of use, and duration. All the different types involve a degree of risk to the patient, and it would appear that mechanical restraint causes the most fatalities. The adverse effects on the patient and the risks of the different types of restraint have been increasingly acknowledged, and many countries have reduced the maximum duration permitted for mechanical restraint and seclusion in particular.

There are no binding human rights instruments which directly address the use of restraint, nor does the CRPD address this issue directly. Relevant non-binding instruments include Recommendation Rec(2004) 10, which provides that mechanical restraint can be used "to prevent imminent harm to the person concerned or others", and United Nations Resolution 46/119 on the protection of persons with mental illness and the improvement of mental health care, which provides that methods of restraint should only be used when necessary to prevent immediate or imminent harm to the patient or others.

In line with developments in psychiatry and changes in society's attitude towards mental illness, many of the "therapeutic measures" considered by the European Court of Human Rights in *Herczegfalvy v. Austria* - the forcible administration of sedatives on repeated occasions (sometimes resulting in bruising, loss of teeth and broken ribs to the applicant), seclusion, being strapped to a security net-bed for 2 days, remaining handcuffed with a belt around the ankles for over 2 weeks – would today be considered to be measures of restraint, rather than part of the medical treatment. Likewise, there is increasing scrutiny of such measures with respect to Article 3 of the European Convention on Human Rights. In two recent cases the Court determined that the attachment of a person suffering from a psychiatric disorder to a bed for hours on end amounted to a violation of Article 3 as being inhuman and degrading treatment.[34]

In its 8th General Report (published only a few years after *Herczegfalvy*) the CPT stated unequivocally that the application of restraint for a period of days "cannot have any therapeutic justification and amounts…to ill-treatment". Regrettably, such measures are still regularly applied in a number of countries. In its 16th General Report the CPT elaborated more detailed standards on the use of restraint in psychiatric institutions. At its 78th meeting in July 2012, the CPT approved the revisions to the standards on the use of restraint set out in the document entitled *The use of restraints in psychiatric institution (*CPT (2012) 28). These revisions concern in particular: the legal basis for the use of restraints; duration in respect of the different types of restraint; guidelines for the practical application of mechanical restraints; guidelines for the use of pharmaceutical restraint; the CPT's position on the

[34] See *Bureš v. the Czech Republic*, no. 37679/08, 18 October 2012, and *Koroviny v. Russia,* no. 31974/11, 27 February 2014.

different types of restraint; standards on the use of restraint in respect of children and adolescents; standards on the use of restraint in respect of patients who are voluntarily admitted or who themselves request to be restrained; supervision and complaint procedures; guidelines on situations where it is considered necessary to continue restraint for prolonged periods.[35]

The CPT recognises the complexity of the issues in question and has attempted to incorporate legal, practical and ethical requirements into its reconsideration of the issues outlined in this paper. The discussions which are part of the 25th Anniversary Conference of the CPT are welcomed as part of this ongoing process.

[35] Høyer G. (2012), *The use of restraints in psychiatric institutions,* CPT (2012) 28, available at http://www.cpt.coe.int/en/workingdocs.htm.

List of discussion questions and topics (non-exhaustive):

General

- To what extent should the CPT standards distinguish between institutions for psychiatric patients and facilities for persons with mental disabilities? Would the same principles apply to both categories of patients?

Restraint

- Should resort to or prolongation of some/all restraint measures require the involvement/approval of a second, independent doctor? Should in some/all cases involvement or approval by a judicial authority be necessary?

- It is recognised that minors under the age of 16 should never be subject to means of restraint except in exceptional cases where physical (manual) restraint - involving holding the child - can be applied. What about older children - should standards on the use of restraint for minors between the ages of 16 and 18 differ substantially from those in respect of adults?

- How should the standards deal with the rare cases of persons who are persistently and unpredictably violent, and at the same time resistant to treatment? Can there ever be a justification for fixating a person for prolonged periods? Should measures in such cases alternate between fixation, seclusion and medication? Might there be alternatives to using means of restraint?

Involuntary placement

- To what extent should the CPT review its position on involuntary placement in the light of Article 14 of the CRPD? Is it practical/possible to envisage the eradication of involuntary placement and of deprivation of legal capacity?

- Is there a common understanding of what constitute unacceptable or defective legal safeguards to prevent arbitrary and unjustified admissions to mental health institutions? Should the CPT attempt to define minimum standards in this regard (including, for example, procedures, time limits, etc.)?

- To what extent and on what issues should advance directives given by an individual who is subsequently deprived of his/her legal capacity be taken into consideration by a psychiatric establishment?

- The CPT frequently comes across “voluntary” patients who have not given their valid consent to being hospitalised, or who are otherwise subject to coercive or restrictive measures incompatible with their “voluntary” status. They may not, however, fulfil all the legal criteria to be considered as “involuntarily placed”. How should the CPT deal with such cases?

- Given the tendency internationally to move away from institutionalised care to community-based approaches, should the CPT reinforce its position on this issue (recent reports suggest that the CPT increasingly expects states to devote more resources to the provision of community-based care)? What reasons might be put forward against such an approach?

Involuntary treatment

- Should decisions for involuntary treatment of psychiatric patients involve the approval of a second, independent doctor? Should such decisions additionally require approval by a court, or notification to a public prosecutor? What other safeguards might be important in terms of involuntary treatment?

- Given the recognition that even a person deprived of his/her legal capacity may nevertheless be capable of understanding and consenting to/refusing a given medical treatment, should the CPT standards include safeguards in respect of such cases? Or is it sufficient that the legally appointed guardian take decisions on medical treatment on behalf of the person (see paragraph 41 of the 8th General Report)?

- What safeguards could be envisaged to ensure that a legally incapacitated person may challenge his/her involuntary treatment?

References

The following documents were consulted for the drafting of this paper (in the light of the restricted distribution of this background paper, sources of information have only been referenced in the text in the case of direct quotations and where required for clarity):

Panel 1: Combating impunity in police and prison contexts:

CPT reports: 14th General Report on the CPT's activities, CPT/Inf (2004) 28; 23rd General Report on the CPT's activities, CPT/Inf (2013) 29; CPT's reports on its 2013 visit to Portugal, CPT/Inf (2013) 35, on its 2011 visit to the Russian Federation, CPT/Inf (2013) 1, on its 2011 visit to Spain, CPT/Inf (2013) 6, and on its 2010 visit to Ireland, CPT/Inf(2011) 3.

Judgements of the European Court of Human Rights:
Aksoy v. Turkey, no. 21987/93, 18 December 1996
Assenov v. Bulgaria, no. 24760/94, 28 October 1998
El-Masri v. Macedonia, no. 39630/09, 31 December 2012.

Commissioner for Human Rights, *Police abuse – a serious threat to the rule of law*, 25 February 2014, Council of Europe.

Istanbul Protocol: *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, OHCHR Professional Training Series No.8/Rev.1 (2004).

Svanidze E. (2014), *Effective investigation of ill-treatment: Guidelines on European standards*, Council of Europe.

Smith G. (2015), "The interface between human rights and police complaints in Europe," chapter to be included in Prenzler, T. & G. den Heyer (eds) *Civilian Oversight of Police: International Perspectives*, CRC Press.

Panel 2: Health care in prisons

CPT reports: 3rd General Report on the CPT's activities CPT/Inf (93) 12; 23rd General Report on the CPT's activities CPT/Inf (2013) 29; CPT's reports on its 2010 visit to Italy, CPT/Inf (2013) 30, on its 2012 visit to Bulgaria, CPT/Inf (2012) 32, and on its 2013 visit to Cyprus CPT/Inf (2014) 31.

Judgments of the European Court of Human Rights:
Logvinenko v. Ukraine, no. 13448/07, 14 October 2010
A.B. v. Russia, no. 1439/06, 14 October 2010
Vasyukov v. Russia, no. 2974/05, 05 April 2011
Iacov Stanciu v. Romania, no. 35972/05, 24 July 2012.

The European Prison Rules (Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules).

Recommendation No. R (98) 7 of the Committee of Ministers of the Council of Europe to member states concerning the ethical and organisational aspects of health care in prison.

World Health Organization documents: *Preventing Suicide: A Resource for Prison Officers* (2000), *Declaration on Prison Health as part of Public Health (Moscow Declaration) (2005), Status Paper on Prisons, Drugs and Harm Reduction* (2005), *Preventing Suicide in Jails and Prisons* (2007).

UN General Assembly Resolution A/RES/37/194 of 18 December 1982 on Principles of Medical Ethics available at http://www.un.org/documents/ga/res/37/a37r194.htm.

Bennett L. and Dyson J. (2014), "Deliberate self-harm among adults in prison", *Mental Health Practice,* Vol. 18, No.1, pp. 14-20.

Bjørngaard, J.H., Rustad A.B., Kjelsberg E. (2009), "The prisoner as patient – a health services satisfaction survey", *BMC Health Services Research*, 9:176, available at http://www.biomedcentral.com/content/pdf/1472-6963-9-176.pdf.

Hawton K. et al. (2014), "Self-harm in prisons in England and Wales: an epidemiological study of prevalence, risk factors, clustering, and subsequent suicide", *The Lancet*, Vol. 383, pp. 1147-1154.

Lehtmets A. and Pont J. (2014), *Prison health care and medical ethics: A manual for health-care workers and other prison staff with responsibility for prisoners' well-being,* Council of Europe, Strasbourg.

Lines R. (2006), "From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons", *International Journal of Prisoner Health*, Vol.2 Issue 4, pp. 269-280.

Pont J., Stöver H., Wolff H. (2012), "Dual Loyalty in Prison Health Care", *American Journal of Public Health,* Vol. 102, No. 3, pp. 475-480.

Watson R., Stimpson A., Hostick T. (2004), "Prison health care: a review of the literature", *International Journal of Nursing Studies 41,* pp. 119-128.

Panel 3: Juveniles in detention

CPT reports: 9th General Report on the CPT's activities, CPT/Inf (99) 12; 10th General Report on the CPT's activities, CPT/Inf (2000) 13; 18th General Report on the CPT's activities, CPT/Inf (2008) 25; 19th General Report on the CPT's activities, CPT/Inf (2009) 27; 24th General Report on the CPT's activities, CPT/Inf (2015) 1; CPT's reports on its 2008 visit to Italy CPT/Inf (2010) 12 and on its 2009 visit to Greece CPT/Inf (2010) 33.

Ayre L., Philbrick K. and Reiss M. (eds) (2006), *Children of Imprisoned Parents: European Perspectives on Good Practice,* EUROCHIPS, Paris.

Hammarberg, T. (2009), *Children and Juvenile Justice: Proposals for Improvements,* Commissioner for Human Rights Issue Paper, Council of Europe, Strasbourg.

Kilkelly U. (2012), *Children's rights and the European Committee for the Prevention of Torture*, Council of Europe, Strasbourg.

Kilkelly U. (2013), "Rewriting V v. United Kingdom: building on a ground-breaking standard", in *Diversity and European Human Rights: Rewriting Judgments of the ECHR*, Cambridge University Press, Cambridge.

Malmberg F. (2013), *From the Inside: Children and Young People on Life in Police Cells and in Remand Prisons,* The Ombudsman for Children in Sweden, Stockholm.

Children and Detention, ICRC (2014), Geneva.

Guidelines of the Committee of Ministers of the Council of Europe on child friendly justice, adopted 17 November 2010.

Recommendation CM/Rec (2008) 11 of the Committee of Ministers to member states on the European Rules for juvenile offenders subject to sanctions or measures, adopted 5 November 2008.

Recommendation 1469 (2000) of the Parliamentary Assembly of the Council of Europe on the subject of mothers and babies in prison, adopted 30 June 2000.

Resolution 2020 (2014) of the Parliamentary Assembly of the Council of Europe on the subject of the alternatives to immigration detention of children, 3 October 2014.

United Nations Committee on the Rights of the Child General Comment No. 6 (2005), *Treatment of Unaccompanied and Separated Children outside their Country of Origin,* CRC/GC/2005/6, adopted 1 September 2005.

United Nations Committee on the Rights of the Child General Comment No. 10 (2007), *Children's rights in juvenile justice*, CRC/C/GC/10, adopted 25 April 2007.

United Nations Convention on the Rights of the Child, General Assembly A/RES/44/25, adopted 20 November 1989.

United Nations Standard Minimum Rules for the Administration of Juvenile Justice, ("Beijing Rules"), General Assembly A/RES/40/33, adopted 29 November 1985.

United Nations Rules for the Protection of Juveniles Deprived of their Liberty ("Havana Rules"), General Assembly A/RES/45/113, adopted 14 December 1990.

United Nations Guidelines for the Prevention of Juvenile Delinquency ("Riyadh Guidelines"), General Assembly A/RES/45/112, adopted 14 December 1990.

Panel 4: Solitary confinement

CPT reports: 21st General Report on the CPT's activities CPT/Inf (2011) 28; 24th General Report on the CPT's activities CPT/Inf (2015) 1; CPT's reports on its 2001 visit to Turkey, CPT/Inf (2002) 8; its 2008 visit to Azerbaijan, CPT/Inf (2009) 28; its 2009 visit to Italy, CPT/Inf (2010) 14; its 2009 visit to Hungary, CPT/Inf (2010) 16; its 2010 visit to Armenia CPT/Inf (2011) 24; its 2011 visit to Armenia, CPT/Inf (2012) 23; its 2011 visit to Bosnia and Herzegovina, CPT/Inf (2012) 15; its 2011 visit to Greece CPT/Inf (2012) 1; its 2011 visit to Serbia, CPT/Inf (2012) 17; its 2012 visit to Denmark (Greenland), CPT/Inf (2013) 3; its 2012 visit to Portugal, CPT/Inf (2013) 4; its 2012 visit to Bulgaria, CPT/Inf (2012) 32; its 2012 visit to Georgia, CPT/Inf (2013) 18; and its 2012 visit to the United Kingdom, CPT/Inf (2014) 11.

Judgments of the European Court of Human Rights:

Van der Ven v. the Netherlands, no. 50901/99, 4 February 2003
Öcalan v. Turkey [GC], no. 46221/99, 12 May 2005
Rohde v. Denmark, no. 69332/01, 21 July 2005
Ramirez Sanchez v. France [GC], no. 59450/00, 4 July 2006
Babar Ahmad and Others v. UK, nos. 24027/07, 11949/08, 36742/08, 66911/09 and 67354/09, 10 April 2012
Messina v. Italy (no. 2) (dec.), no. 25498/94, 10 April 2012.

Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc A/68/295, 9 August 2013.

Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, UN Doc A/66/268, 5 August 2011.

Istanbul Statement on the Use and Effects of Solitary Confinement, adopted on 9 December 2007 at the International Psychological Trauma Symposium in Istanbul.

Working paper prepared by the Secretariat for the second meeting of the open-ended intergovernmental expert group on the Standard Minimum Rules for the Treatment of Prisoners, UNODC/CCPCJ/EG.6/2012/2, 6 November 2012.

Shalev S. (2008), *Sourcebook on solitary confinement*, Mannheim Centre for Criminology, LSE: London, available online at: www.solitaryconfinement.org/sourcebook.

Scharff Smith P. (2006), "The Effects of Solitary Confinement on Prison Inmates. A Brief History and Review of the Literature" in *Crime and Justice*, Vol. 34, pp. 441-528.

Panel 5: Towards new CPT standards on psychiatry

CPT reports: CPT standards, CPT/Inf/E (2002) 1 - Rev. 2013; 3rd General Report on the CPT's activities, CPT/Inf (93) 12; 8th General Report on the CPT's activities, CPT/Inf (98) 12; 16th General Report on the CPT's activities, CPT/Inf (2006) 35.

Judgments of the European Court of Human Rights:
Bureš v. the Czech Republic, no. 37679/08, 18 October 2012
D.D. v. Lithuania, no. 13469/06, 14 February 2012
Gennadiy Naumenko v. Ukraine, no. 42023/98, 10 February 2004
Herczegfalvy v. Austria, no. 10533/83, 24 September 1992
Ketreb c. France, no. 38447/09, 19 July 2012
Koroviny v. Russia, no. 31974/11, 27 February 2014
Lashin v. Russia, no. 33117/02, 22 January 2013
Schneiter c. Suisse, no. 63062/00, 31 March 2005 (inadmissible)
Shtukaturov v. Russia, no. 44009/05, 27 March 2008
Stanev v. Bulgaria, no. 36760/06, 17 January 2012
Storck v. Germany, no. 61603/00, 16 June 2005
Winterwerp v. Netherlands, no. 6301/73, 24 October 1979.

European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, CPT/Inf/C (2002) 1, adopted in Strasbourg, 26 November 1987.

United Nations Convention on the Rights of Persons with Disabilities, General Assembly A/RES/61/106, adopted 13 December 2006.

Optional Protocol to the United Nations Convention on the Rights of Persons with Disabilities, General Assembly A/RES/61/106, adopted 13 December 2006.

Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (Oviedo Convention), CETS No. 164, available at http://conventions.coe.int/Treaty/en/Treaties/Html/164.htm.

Council of Europe website http://www.coe.int/en/.

Concluding observations of the Committee on the Rights of Persons with Disabilities in respect of initial reports of states parties, available at http://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx.

General Comment No. 1 of the Committee on the Rights of Persons with Disabilities, *Article 12: Equal recognition before the law*, CRPD/C/GC/1, 19 May 2014.

Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder.

Recommendation No. R (99) 4 of the Committee of Ministers to Member States on Principles Concerning the Legal Protection of Incapable Adults.

United Nations Resolution 46/119 on the protection of persons with mental illness and the improvement of mental health care, General Assembly A/RES/46/119, adopted 17 December 1991.

Bartlett P. (2013), "Re-Thinking *Herczegfalvy*: The ECHR and the Control of Psychiatric Treatment", in E. Brems (ed.), *Diversity and European Human Rights: Rewriting Judgments of the ECHR,* Cambridge University Press, Cambridge.

Bartlett P. (2012), "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law", *Modern Law Review,* Vol. 75, Issue 5, pp. 752-778.

Dierck de Casterlé B., Goethals S., Gastmans C. (2014), "Contextual influences on nurses' decision-making in cases of physical restraint", *Nursing Ethics,* 06 August 2014, 1477-0989.

Freeman M. et al. (2005), *WHO Resource Book on Mental Health, Human Rights and Legislation,* WHO, Geneva.

Høyer G. (2012), *The use of restraints in psychiatric institutions,* CPT (2012) 28, available at http://www.cpt.coe.int/en/workingdocs.htm.

Høyer G. (2011), *The use of restraint and seclusion in the treatment of persons with mental disorders (Discussion paper prepared for the medical group by Mr. Georg Høyer*), CPT (2011) 27 available at http://www.cpt.coe.int/en/workingdocs.htm.

Høyer G. (2010) 100, *How to approach cases of prolonged use of mechanical restraint in mental health care facilities – Guidelines for visiting delegations)*, CPT (2010) 100 available at http://www.cpt.coe.int/en/workingdocs.htm.

Kontio R. et al. (2010), "Patient restrictions: Are there ethical alternatives to seclusion and restraint?", *Nursing Ethics,* vol.17 no.1, pp. 65-76.

Lehtmets A. and Hauksson P., *Checklist for the evaluation of a psychiatric hospital*, CPT (2009) 56, available at http://www.cpt.coe.int/en/workingdocs.htm.

Lehtmets A. and Pimenoff V., *Means of restraint in a psychiatric hospital*, CPT (2006) 22 available at http://www.cpt.coe.int/en/workingdocs.htm.

Ortakov V. (2010), *Proposal for the substantive section of the 21st Annual General Report on involuntary psychiatric treatment and alternatives to the institutional treatment,* CPT (2010) 67, available at http://www.cpt.coe.int/en/workingdocs.htm.

Prinsen E.J.D. and Delden J.J.M. (van)(2009), "Can we justify eliminating coercive measures in psychiatry?", *Journal of Medical Ethics* No. 35(1), pp. 69-73.

Restellini J.-P. (2008), *Enforced somatic treatment of detained persons,* CPT (2008) 87, available at http://www.cpt.coe.int/en/workingdocs.htm.

Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, UN General Assembly A/63/175, 28 July 2008.

Interim Report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, UN General Assembly A/66/268, 05 August 2011.

Involuntary placement and involuntary treatment of persons with mental health problems, report of the European Union Agency for Fundament Rights, 2012.

Recommendations by the Mental Disability Advocacy Center to the European Committee for the Prevention of Torture, on Aligning Standards to the UN Convention on the Rights of Persons with Disabilities, unpublished document, 02 March 2010.

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, Annual Report, A/HRC/10/48, 26 January 2009.