The CPT and Mental Disability: The Next 25 Years

By Peter Bartlett
Nottinghamshire Healthcare NHS Trust Professor of Mental Health Law
School of Law and Institute of Mental Health
University of Nottingham

[For presentation to the conference celebrating the 25th anniversary of the European Committee for the Prevention of Torture, Strasbourg, 1 March 2015. Aspects of this paper draw on my paper 'A mental disorder of a kind or degree warranting confinement: examining justifications for psychiatric detention' (2012) International Journal of Human Rights, 16 (6). pp. 831-844. ISSN 1364-2987. A pre-publication version of that paper is available open access online at http://eprints.nottingham.ac.uk/1676/]

Congratulations (and the first challenge)

Thank-you for inviting me to take part in this auspicious occasion. The CPT has for two and a half decades been at the forefront of the fight against torture and inhuman and degrading treatment or punishment. While my comments below are intended to challenge, I am also a firm fan of the CPT, and I hope these will be understood as comments from a friend.

My instructions for today were to look forward, to where the CPT should go in the future, but it would be remiss not to acknowledge its considerable successes over the last twenty-five years.

The CPT standards are a benchmark referred to by courts and human rights scholars throughout the region and internationally, and the national reports are authoritative. Both these aspects can be seen in the judgments of the European Court of Human Rights. The Court frequently refers to CPT reports as part of its evidence gathering in psychiatric and related cases, but the influence is also jurisprudential, with the CPT standards influencing the direction of court decisions. My personal favourite is X v Finland, (Application no. 34806/04, judgment of 19 November 2012), which now makes it clear in the jurisprudence of the Court that compulsory admission to a psychiatric facility does not in itself allow for compulsory treatment – there have to be additional substantive and procedural safeguards, a view initiated in the CPT standards many years ago.

The CPT standards are also cited to considerable effect in domestic jurisprudence. In the United Kingdom, for example, they were instrumental in providing psychiatric patients with a right to a hearing to review their compulsory treatment (see *R (Wilkinson) v Broadmoor* [2001] EWCA Civ 1545). That turned out to be something of a damp squib in its application – a matter the CPT might want to consider next time it visits the UK – but the standards were influential in the Court of Appeal.

Perhaps most important, the CPT continues, stubbornly and unremittingly, to shed light in places where so many in society would prefer not to look, being a catalyst for change were change is so desperately needed.

In my original draft of this talk, I intended to thank you at this point on behalf of those people who could not be here to thank you themselves, the people who have benefitted from that CPT gaze. That does, however, raise my first critical observation: why is it that people with mental disabilities are not here today? In my country, it would be almost unthinkable that a conference of this nature would be held without significant service user involvement – much the same way it would be unthinkable for a bunch of men to get together to discuss women's rights, or a bunch of white people to get

together to discuss black people's rights. That is my first challenge to you: next time, people with mental disabilities should be here.

And that is the case not just for the conference. The Care Quality Commission in England uses service users as part of their inspection teams. The experience of the CQC is that the service users do see things that the experts do not, and that the detained service users will say things to other service users that they will not say to professional staff. This too is something that the CPT should consider. Certainly, the international nature of the CPT's work makes such involvement more complicated, but I am certainly not convinced that it is impossible. I would be happy to put the CPT in touch with relevant people at the CQC who could share advice and experience, if that would be helpful.

This is an occasion to celebrate the triumphs of the past, but it is more importantly a time to look forward. In this talk I certainly do not want to discourage you from continuing the work you have done in the past – far from it. Conditions in institutions matter, and it is clear from the national reports of visits by the CPT that there is still much to do on that score, throughout the Council of Europe. But the CPT's work is going in broadly the right direction on that, so I want instead to engage with some of the big questions and new directions raised by the background paper.

The Problem of Substance: A human issue

The question that must lurk in our minds is whether the institutions the CPT visits as part of its psychiatric and related mandates should exist at all, and if they should, who should be in them? I will of course be discussing the new United Nations Convention on the Rights of Persons with Disabilities (CRPD) in a few moments – there is a legal side to this question - but first, I would suggest to you that it is much more fundamentally a human problem.

This was brought home to me forcefully over three years when I was teaching mental disability law at a summer school in a Council of Europe country. Part of the programme involved a visit to an institution for people with learning disabilities. There is one person in particular that I remember. He was a young man, admitted shortly before our first visit. I remember him as engaged, curious about us and about what we were doing, tagging along with the group, laughing and joking. When we returned a year later, he had started to fade, and by the third year, he was sitting silently as part of a group. It appeared that his personality – indeed, his personhood – was essentially gone, eroded by institutional life (and quite possibly by sedating medications). I would emphasise that this was a 'good' institution – the food was fine, people could go outside into a rather nice fenced-in area, staff were certainly not horrible. It was not a place that would have triggered concern under the present CPT standards. But for the man I refer to, that misses the point. His personhood had disappeared; he had faded to grey.

This is not an isolated case, and we all know it. We have all seen first-hand the systems of 'care' to which people are admitted as children, under-stimulated while they are there, so that there is not much to do but pass them to an institution for adults, where they will remain until they reach 65 (if they do not die first), when they will be moved to an institution for old people. These are lives destroyed, and if 'inhuman and degrading treatment' means anything, surely it means this life course. A focus on the conditions of care in the institution colossally misses this fundamental point.

We need to start asking why people are in these institutions, not just what happens to them when they are there.

Let me be clear – I do understand the principle of subsidiarity, and the role of Council of Europe institutions vis-à-vis states parties. I appreciate that it is not the CPT's role to

dictate terms to member states. It is however time for the CPT to say that the failure to provide meaningful alternatives to institutional care is no longer an option. How community alternatives are provided is a matter for the states; but I do believe that we have reached the time when we have to say that the states have to do it.

I started this section with a depressing story; let me end it with an encouraging one. In the UK, as elsewhere, a large number of admissions to psychiatric facilities come through the police. My local news last Tuesday reported that Nottinghamshire police have reduced their Mental Health Act admissions by 39 per cent in less than a year, and reduced the number of people with mental health problems in police cells by fifty-four per cent in that period. It was done by a new programme of having community nurses available to go out with officers on the beat – an easy, cheap, and it would seem very effective approach.

Two messages come from that. First, even in countries with long histories of moving away from institutional care towards community alternatives, there is still work to be done. None of us should be complacent about this. And second, the picture can change, often with remarkably simple and affordable interventions. Change is possible; it is time to ensure that it happens.

Now is the Time: Article 14 of the CRPD

The CRPD is a radical document in many ways. You will no doubt know all about it already – non-discrimination, challenge to compulsion based on disability (including, of course mental disability[1]), the requirement of a move to supported decisionmaking rather than substituted decisionmaking, and profound challenges to traditional guardianship régimes. Those are tremendously important, and no doubt we will return to them over time, but they are not the focus of today's discussion.

For present purposes, it is the Article 14 point that requires consideration. The challenge is stated concisely in the background paper: it would seem that the CRPD says that detention based on disability (and according to the CRPD Committee, that is in whole or in part on disability) is a violation of Article 14. The debate has framed these arguments in terms of legal analysis relating to discrimination. I support those arguments (and have indeed made my fair share of them myself), but for the moment, I would ask you to remember the human case I made a moment ago. I think that gives a good sense of where the advocates of this seemingly radical reading of Article 14 are coming from.

There are of course those that are appalled by this. Accommodation in hospitals and social care homes, they claim, is protection rather than abuse; and there is in any event no practical alternative for the foreseeable future. I do not question the practical difficulties posed by Article 14, particularly in cases of crisis, but I do wonder how far the objections are underlaid by a cultural issue: we have for hundreds of years detained people with mental disabilities; it feels normal and right, and a move away from that, like any major cultural shift, feels unsettling. While I do not question the reality of the cultural norm, I believe that it cannot serve as an argument against the provision of meaningful rights to people with mental disabilities.

How is the CPT to deal with this? On the one hand, virtually all members of the Council of Europe have signed the CRPD (the exception being Lichtenstein). Certainly it is a separate treaty from the 1987 Convention that is the founding document of the CPT, and is administered by the United Nations not the Council of Europe. Nonetheless, the fact that the overwhelming number of Council of Europe states that have signed the CRPD does suggest a significant consensus. It is a marker that the world has moved on.

---

[1] In this talk, 'mental disabilities' is taken to include learning disabilities, mental health problems, and mental disabilities related to old age such as dementia.

I am aware of no country that complies fully with the orthodox interpretation of Article 14 – that is, I am aware of no country that has entirely abolished psychiatric and other detention based on mental disability. This raises the practical problem of how we approach this. On the one hand, the transformative potential of the CRPD matters. Post-CRPD, we cannot look forward to a world of 'business as usual' in detaining people with mental disabilities. The CRPD must be taken to make a difference, and that cannot be lost. At the same time, there is the reality question of what can be sold on the ground to individual governments and those involved in the administration of people with mental disabilities in individual states.

Judging by their reports, he CRPD Committee would seem to think compliance is easy. I think complete implementation will be very difficult, not just because it will be difficult to sell on the ground, but also because, for the most difficult cases, it really is hard. It will be difficult even in countries with financial resources and backgrounds in disability rights; it will be increasingly problematic in countries where those financial and experiential resources do not exist. I am not convinced that we will progress if we pretend this is easy – it is not.

As a way forward, I would propose that we acknowledge that the CPT standards are themselves a moving target. The psychiatric standards are now being re-designed; they will no doubt be re-designed again in the future. If we understand each iteration of the CPT standards to have a life of, say, 15 years, the question becomes what can we reasonably accomplish in the next 15 years. In that time, it is certainly possible to insist that states institute programmes that promote non-institutional alternatives, getting people integrated into the community for all but the most difficult and compelling cases (mainly, I suspect, people in crisis). Rather than insisting on full implementation immediately, it becomes a policy that requires states to move towards full implementation.

That is in my view saleable and practical. It also suggests a parallel with many of the other CPT standards. No doubt there are many elements of the CPT standards that we would really rather see imposing much stronger requirements on states; in the short term, we move forward with what we can in practice do. It is not an ideal approach by any means, but it has the potential to bring about real improvement without watering down the terms of the CRPD.

The CPT and the Move to the Community

If this approach is adopted (and even if it is not, since many countries in the Council of Europe are moving independent of the CPT to systems of community care), we will see a diversification of sites of care. This raises practical challenges for the CPT. A quarter of a century ago, people with mental disabilities overwhelmingly lived in a relatively small number of buildings, each containing a large number of people. That is increasingly not the case, and the CPT has already started to take account of this by visits to an increasingly diverse range of accommodation. As we move to community alternatives, however, detention and inhuman or degrading treatment will no longer be so clearly based in traditional institutional environments, but also in smaller community facilities and, in the extreme, in the individual's own home.[2]

From the perspective of the CPT, this will involve questions of whether the state has responsibility for the care and accommodation provided. In the past, this line has been

---

[2] On this point, see the recent case of the United Kingdom Supreme Court*, P v Cheshire West and Chester Council; P and Q v Surrey County Council* [2014] UKSC 19, where a deprivation of liberty of a person with mental disability is taken to occur in an environment similar to a foster home.

relatively easy to draw, but as service provision moves increasingly into the community, it will be more complex: increasingly, the state will no longer be about big institutions. That creates practical problems. Traditionally, CPT visits have focused on a relatively small number of very large institutions. In a decentralised system, how does the CPT decide where to visit?

On that point I shall stop. The future presents new challenges, but the history of the CPT leaves me optimistic that they will be met. May I close by offering my heartiest best wishes on your twenty-fifth birthday, and my best hopes for the quarter century to come.