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European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

8th General Report on the CPT's activities

covering the period 1 January to 31 December 1997

Strasbourg, 31 August 1998

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Preface

The European Committee for the prevention of torture and inhuman or degrading treatment or punishment (CPT) was set up under the 1987 Council of Europe Convention of the same name (hereinafter "the Convention"). According to Article 1 of the Convention:

> "There shall be established a European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment..... The Committee shall, by means of visits, examine the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment."

The work of the CPT is designed to be an integrated part of the Council of Europe system for the protection of human rights, placing a proactive non-judicial mechanism alongside the existing reactive judicial mechanisms of the European Commission and European Court of Human Rights.

The CPT implements its essentially preventive function through two kinds of visits - periodic and ad hoc. Periodic visits are carried out to all Parties to the Convention on a regular basis. Ad hoc visits are organised in these States when they appear to the Committee "to be required in the circumstances".

When carrying out a visit, the CPT enjoys extensive powers under the Convention: access to the territory of the State concerned and the right to travel without restriction; unlimited access to any place where people are deprived of their liberty, including the right to move inside such places without restriction; access to full information on places where people deprived of their liberty are being held, as well as to other information available to the State which is necessary for the Committee to carry out its task.

The Committee is also entitled to interview in private persons deprived of their liberty and to communicate freely with anyone whom it believes can supply relevant information.

Visits may be carried out to any place "where persons are deprived of their liberty by a public authority". The CPT's mandate thus extends beyond prisons and police stations to encompass psychiatric institutions, detention areas at military barracks, holding centres for asylum seekers or other categories of foreigners, and places in which young persons may be deprived of their liberty by judicial or administrative order.

Two fundamental principles govern relations between the CPT and the Parties to the Convention - co-operation and confidentiality. In this respect, it should be emphasised that the role of the Committee is not to condemn States, but rather to assist them to prevent the ill-treatment of persons deprived of their liberty.

After each visit, the CPT draws up a report which sets out its findings and includes, if necessary, recommendations and other advice, on the basis of which a dialogue is developed with the State concerned. The Committee's visit report is, in principle, confidential; however, almost all States have chosen to waive the rule of confidentiality and publish the report.

I. ACTIVITIES IN 1997

A. Visits

1. The CPT carried out seven **periodic visits** during 1997 to, in chronological order, the Czech Republic (16 to 26 February), Greece (25 May to 6 June), Estonia (13 to 23 July), Belgium (31 August to 12 September), Turkey (5 to 17 October), the Netherlands (17 to 27 November) and Albania (9 to 19 December). This was the first time the CPT had visited the Czech Republic, Estonia and Albania. As for the remaining countries, 1997 marked the second occasion on which the Committee had visited them on a periodic basis.

2. In addition, six **ad hoc visits** were organised: to Spain (17 to 18 January and 21 to 28 April), Norway (17 to 21 March), Luxembourg (20 to 25 April), the United Kingdom and the Isle of Man (8 to 17 September) and the Netherlands Antilles (7 to 11 December).

The visit to **Spain** in January 1997 was organised in order to examine the treatment received by a person who had very recently been detained by the Civil Guard, as well as to review the operation in his case of formal safeguards against the ill-treatment of detained persons. As for the second ad hoc visit, in April 1997, the CPT's delegation examined the treatment of immigration detainees in Ceuta, Málaga and Melilla.

The ad hoc visit to **Norway** focused on the detention in police establishments of persons remanded in custody and on the solitary confinement by court order of remand prisoners. Both of these questions had previously been the subject of recommendations by the CPT.

The main objective of the ad hoc visit to **Luxembourg** was to examine the situation of minors deprived of their liberty. In addition, the delegation reviewed the action taken in response to certain recommendations made previously with respect to Luxembourg Prison.

In the course of the ad hoc visit to the **United Kingdom**, the efficacity of existing legal remedies in cases involving allegations of ill-treatment by police officers was assessed. Further, the visit afforded an opportunity to review the measures being taken to tackle the problem of overcrowding in prisons in England and Wales. The CPT's delegation also examined conditions of detention in the **Isle of Man** Prison, about which the Committee had recently received information.

During the ad hoc visit to the **Netherlands Antilles**, the CPT's delegation made a detailed examination of the situation at Koraal Specht Prison, in order to ascertain whether the recommendations made by the Committee after the 1994 visit to that establishment had been implemented. The visit also afforded an opportunity to re-examine conditions in the police detention facilities and the Criminal Investigation Department in Rio Canario.

3. In all, some 120 days of visits were carried out during the year. A list of the places of detention visited by CPT delegations in 1997 is set out in Appendix 3.

4. With rare exceptions, the degree of cooperation displayed towards CPT delegations remained satisfactory, at both national and local level. This favourable situation is certainly due in part to the continuing practice of organising information seminars on the activities of the Committee in States which have recently become Parties to the Convention. In the course of 1997, such seminars were held in Kyiv, Prague and Tirana.[1]

5. It should be added, however, that on occasion the CPT was not supplied in good time with complete lists of places of detention. This was particularly the case as regards police establishments. In this respect, the Committee wishes to recall the obligation placed on Parties by Article 8, paragraph 2(b) of the Convention to provide full information on places where persons are deprived of their liberty.

B. Meetings and follow-up of visits

6. The CPT held three plenary sessions during 1997, in the course of which thirteen visit reports were adopted: on visits to Denmark, France, Greece, Italy, Portugal and Turkey in 1996 and to the Czech Republic, Estonia, Greece, Luxembourg, Norway and Spain (two visits) in 1997. The number of visit reports adopted increased substantially as compared to 1996, notwithstanding the reduction of the number of plenary sessions from four to three. In other words, the new accelerated procedure for the examination of visit reports referred to in the 7th General Report has proven a success.

There can be no question of reducing further the number of plenary sessions; for operational reasons, the existing four-month gap between sessions is the maximum tolerable. However, the CPT shall continue its efforts to streamline decision-making at plenary level, and to work increasingly in smaller groups during "plenary" sessions. Practically all pre-visit work by visiting delegations is already carried out in the context of plenary sessions, and more and more specific tasks are being assigned to working parties.

7. As regards the ongoing dialogue between the CPT and Parties to the Convention, the Committee indicated in the 7th General Report that it intended to give more life to this process, in particular by developing the practice of face-to-face discussions on matters of concern between State authorities and representatives of the Committee. There is no substitute for direct contact when it comes to settling issues which are often complex and sometimes very sensitive for the authorities concerned. Moreover, a short stay by a very small delegation, limited to discussions at Governmental level - and thus having very few financial implications - can achieve results which render a visit by the Committee unnecessary.

Reference can be made in this context to talks held in Spain in July 1997 between a Government delegation led by the Secretary of State for Security and a CPT delegation led by the Committee's President. Talks of a similar nature were held in Rome in February 1998.

The initiative taken by certain Parties to forward draft laws or regulations to the CPT for its comments is another facet of the on-going dialogue process which could be further developed.

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[1] To date in 1998, similar information meetings have been held in Chişinău, Skopje and Zagreb.

8. Of course, the interim and follow-up responses by States to the CPT's visit reports remain the backbone of the on-going dialogue. Most States continue to forward their responses broadly within the time-limits set by the CPT.

However, the CPT wishes to stress the importance of States also responding in time - and in a detailed fashion - to immediate observations made by a delegation during a visit, pursuant to Article 8, paragraph 5, of the Convention. Immediate observations relate to matters considered to be particularly urgent; consequently, a failure to respond in an adequate manner to such observations constitutes a significant violation of the principle of cooperation set out in Article 3 of the Convention.

C. Publications

9. In the course of 1997, the CPT's reports on visits to Bulgaria, Cyprus (two visit reports), Denmark, Germany, Italy, Norway, Slovakia and Switzerland were published at the request of the Governments concerned, as were several interim and follow-up responses of Governments.[2] At the time of writing, 49 of the 70 visit reports so far drawn up by the CPT have been published. Many of the remaining twenty-one visit reports have only recently been forwarded to Governments and will in all likelihood be published in due course.

10. All visit reports which have been published, as well as the CPT's annual reports, are now accessible via the Internet (http://www.cpt.coe.fr); published responses by Governments are also accessible provided that they have been forwarded to the CPT in electronic format. The CPT's web site also contains information on recent developments, such as new signatures and ratifications of the Convention and its Protocols, visits which have recently been carried out (indicating the composition of the delegation and establishments visited) and updated lists of the names and abridged curricula vitae of the Committee's members.

11. 1997 also saw publication of the first volume of the *Yearbook of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.* Published by the Human Rights Law Centre of the University of Nottingham, in association with the Secretariat of the CPT, Volume 1 (1989 - 1992) includes the text of the Convention, the CPT's Rules of Procedure, the Committee's visit reports and the State responses which were published during that period, as well as other information about the CPT and the Convention. Successive volumes will be published in respect of each year of the Committee's activities. The CPT welcomes this initiative, which should serve to foster further awareness of its activities, particularly in academic circles.[3]

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[2] Moreover, to date in 1998 five additional visit reports have been published (concerning visits to Belgium, France, Portugal, Romania and Spain).

[3] The *Yearbook* may be ordered directly from: Human Rights Law Centre, Department of Law, University of Nottingham, Nottingham NG7 2RD, United Kingdom.

D. Parliamentary Assembly Recommendation 1323 and Order No. 530 (1997)[4]

12. The CPT is most grateful for the support for its work expressed by the Parliamentary Assembly in Recommendation 1323 and Order No. 530, on the strengthening of the machinery of the European Convention for the prevention of torture and inhuman or degrading treatment or punishment.

13. Various aspects of these two texts will be referred to in the chapter "Organisational issues". However, the CPT wishes at this point to welcome the emphasis placed in Recommendation 1323 on the importance of States ensuring that all the relevant authorities and personnel, at both national and local level, are made aware of the CPT's work and of its tasks and powers. Indeed, this is a sine qua non for the success of the Committee's activities.

The CPT also appreciates the measures adopted designed to promote cooperation between the Committee and the Assembly, and to have transmitted to the Committee relevant information gathered by the Assembly.

II. ORGANISATIONAL ISSUES

A. The Convention and its Protocols

14. In the course of 1997, the Convention was ratified by Andorra, Croatia, Moldova, "the former Yugoslav Republic of Macedonia" and Ukraine, and signed by Latvia. Taking into account subsequent ratifications in 1998[5], the Convention has now been ratified by 39 of the 40 member States of the Council of Europe, and has been signed by Lithuania[6]. From the standpoint of the maintenance of human rights, this is a very positive development. However, it also means that the tasks facing the CPT will continue to grow in magnitude.

15. The two Protocols amending the Convention[7] were also signed and/or ratified by a number of States during 1997[8]. However, neither of the Protocols has yet entered into force; in the case of each Protocol, entry into force requires ratification (or signature without reservation as to ratification) by all Parties to the Convention.

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4 These texts were adopted by the Parliamentary Assembly of the Council of Europe on 21 April 1997.

5 Latvia (10 February 1998) and the Russian Federation (5 May 1998).

6 See Appendix 1 A for the state of signatures and ratifications of the Convention.

7 Protocol No. 1 "opens" the Convention by providing that the Committee of Ministers may invite any non-member State of the Council of Europe to accede to it; Protocol No. 2 introduces amendments regarding the renewal of the CPT's membership and provides that members may be re-elected twice.

8 See Appendices 1 B and 1 C for the state of signatures and ratifications of the Protocols.

As has been pointed out on many previous occasions, the entry into force of Protocol No. 2 would greatly facilitate the CPT's work. The Committee must therefore once again express its disappointment and incomprehension that almost five years after its opening for signature, the Protocol has still not been ratified by five Parties to the Convention. In the previously-mentioned Recommendation 1323, the Parliamentary Assembly recommended that the Committee of Ministers "urge the States Parties to the Convention which have not yet done so to ratify its Protocols and, in particular, Protocol No. 2 without delay, thus allowing its entry into force" and "invite the authorities of States considering ratification of the Convention to ratify its Protocol No. 2 at the same time". The CPT trusts that the Committee of Ministers will take the measures proposed by the Assembly.

B. CPT membership

16. Important changes to the CPT's membership occurred in 1997. The terms of office of Mr Claude Nicolay, the President of the Committee (elected in respect of Luxembourg), Mrs Nadia Gevers Leuven-Lachinsky (Netherlands), Mr Rudolf Machacek (Austria), Mr Bent Sørensen (Denmark) and Mr Stefan Terlezki (United Kingdom) expired on 19 September 1997. All of these members had been with the CPT since the outset of its activities in 1989, and the Committee wishes to place on record its gratitude for their significant contributions to its work.

Seven new CPT members were elected by the Committee of Ministers in the course of 1997: Ms Silvia Casale (United Kingdom), Mrs Emilia Drumeva (Bulgaria), Mrs Renate Kicker (Austria), Mr Andres Lehtmets (Estonia), Mr Ole Vedel Rasmussen (Denmark), Mr Pierre Schmit (Luxembourg) and Mr Pieter Reinhard Stoffelen (Netherlands). During the same period, Mrs Ingrid Lycke Ellingsen (Norway), Mr Arnold Oehry (Liechtenstein), Mrs Gisela Perren-Klingler (Switzerland), Mr Safa Reisoğlu (Turkey), Mr Leopoldo Torres Boursault (Spain) and Mr Ivan Zakine (France) were re-elected.

Further, two new CPT members have already been elected in the course of 1998: Mr Aurel Kistruga (Moldova) and Mr Davor Strinović (Croatia).

As a result, the CPT presently has 30 members[9]. The seats in respect of Albania, Andorra, Germany, Latvia, Portugal, Slovenia, "the former Yugoslav Republic of Macedonia" and Ukraine are vacant, and a seat in respect of the Russian Federation shall have to be filled as from 1 September 1998.

17. The current membership is arguably the most balanced and specialised that the CPT has ever enjoyed. The number of members with a medical background is now on a par with that of lawyers in the Committee. Further, the CPT's wish to have more persons with specialist practical knowledge of penitentiary systems and more forensic doctors within the Committee is gradually being met. The proportion of women among the CPT's membership (nine out of 30) has also improved slightly.

In Recommendation 1323 and Order No 530, the Parliamentary Assembly spelt out the criteria (professional background, gender, age, availability) to which attention should be paid when national parliamentary delegations nominate candidates for the CPT, when the Bureau of the Assembly draws up the lists of candidates and when the Committee of Ministers subsequently proceeds to elect members. The CPT fully agrees with those criteria and would add, as regards professional background, that it would be very helpful if the Committee's membership were also to include some persons with specialist practical knowledge of police work.

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[9] See Appendix 2 A for the full list of CPT members. Abridged curricula vitae of the members can be obtained from the CPT's Secretariat.

18. During its meeting in November 1997, the CPT elected its new Bureau for a period of two years. The Committee elected Mr Ivan Zakine (Presiding Judge at the Court of Cassation in France) as President, renewed the mandate of Mrs Ingrid Lycke Ellingsen (a Norwegian psychiatrist) as First Vice-President and elected Mr John Olden (former Assistant Secretary in the Irish Department of Justice) as Second Vice-President.

C. Administrative and financial questions

19. In its 7th General Report, the CPT set out a number of measures designed to ensure that the Committee can meet the challenge of the widening circle of Parties to the Convention (increase in the number of visit days; rationalisation of the Committee's working methods; reinforcement of the Committee's Secretariat). In particular, the CPT indicated that it wished to be in a position to organise 200 days of visits per year as from the year 2000, which would enable the Committee to ensure that the average period between periodic visits to a given country does not exceed four years.

As a result of the difficult budgetary climate, the number of visit days in 1998 has had to be limited to 135 (an increase of 15 days as compared to 1997). The CPT remains confident that the 200-day target will be attained, though reaching it will probably take one or two years longer than had initially been hoped.

20. The CPT is grateful to the Secretary General and Committee of Ministers for having made provision in the 1998 Budget for a further grade A4 post in its Secretariat. This has made it possible to reorganise the Secretariat into three operational units responsible for visits, supported by a central section (cf. Appendix 2B).

The CPT is also very pleased that the retainer system previously applicable only to members of the Bureau has now been extended to cover all Committee members. This is a major step towards meeting the objective of ensuring that CPT members are in a position to carry out their functions effectively.

21. As in the past, the CPT shall strive to be modest in its future budgetary requests, and continue to seek ways to enhance the cost-effectiveness of its operating procedures. Nevertheless, in view of the significant geographical expansion of its activities, the CPT will be obliged to request in due course that the resources placed at its disposal be further augmented.

In this connection, the CPT appreciates the support expressed in Parliamentary Assembly Recommendation 1323 concerning requests for increases of the Committee's resources. Moreover, the declaration made by the Heads of State and Government of the Member States of the Council of Europe at the Second Summit in October 1997, in which they proclaimed their determination "to reinforce the means to prevent and combat torture and inhuman or degrading treatment or punishment", reassures the CPT about the future.

D. Implementation of the CPT's recommendations

22. As is well known, the CPT monitors the action taken upon its recommendations through an ongoing dialogue with the States concerned. However, in recent times, as the CPT's activities have spread throughout the European continent, the Committee has begun to reflect on whether a more proactive approach might be adopted as regards the implementation of its recommendations. Indeed, the prevailing economic circumstances in at least certain States visited by the CPT render it difficult to meet all of the Committee's requirements, notwithstanding the goodwill of the authorities concerned. The CPT is anxious to avoid this state of affairs leading to a hiatus in the process of combatting ill-treatment. In appropriate cases, positive measures intended to assist States to implement the Committee's recommendations could contribute to resolving this problem.

23. In some areas, such as the training of law enforcement officials, prison officers and health-care staff in prisons and psychiatric hospitals, there may be scope to enhance the interface between the CPT's activities and existing Council of Europe programmes of assistance for developing and consolidating democratic security (ADACS). Further, the CPT is keen to explore the idea of developing channels through which certain of its recommendations with substantial financial implications - in particular those relating to a country's infrastructure - could be submitted for the consideration of international organisations which may have the requisite funds at their disposal.

24. Similarly, the CPT can on occasion encounter situations calling for a humanitarian response (such as the provision of emergency food aid or medication to persons deprived of their liberty) which the Committee is not itself able to furnish. In this respect it should be underlined that although the CPT, by virtue of its powers under the Convention, is in a position to identify needs which might otherwise not be readily apparent, the Committee has neither the mandate nor the organisational capacity and resources to distribute aid. Procedures need to be developed by virtue of which, when necessary and having due regard to the principles of cooperation and confidentiality, relevant organisations can be alerted to such situations without delay.

III. INVOLUNTARY PLACEMENT IN PSYCHIATRIC ESTABLISHMENTS

A. Preliminary remarks

25. 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 mental 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.

26. When examining the issue of health-care services in prisons in its 3rd General Report (cf. CPT/Inf (93) 12, paragraphs 30 to 77), the CPT identified a number of general criteria which have guided its work (access to a doctor; equivalence of care; patient's consent and confidentiality; preventive health care; professional independence and professional competence). Those criteria also apply to involuntary placement in psychiatric establishments.

In the following paragraphs, some of the specific issues pursued by the CPT in relation to persons who are placed involuntarily in psychiatric establishments are described.[10] The CPT hopes in this way to give a clear advance indication to national authorities of its views concerning the treatment of such persons; the Committee would welcome comments on this section of its General Report.

B. Prevention of ill-treatment

27. In view of its mandate, the CPT's first priority when visiting a psychiatric establishment must be to ascertain whether there are any indications of the deliberate ill-treatment of patients. Such indications are seldom found. More generally, the CPT wishes to place on record the dedication to patient care observed among the overwhelming majority of staff in most psychiatric establishments visited by its delegations. This situation is on occasion all the more commendable in the light of the low staffing levels and paucity of resources at the staff's disposal.

Nevertheless, the CPT's own on-site observations and reports received from other sources indicate that the deliberate ill-treatment of patients in psychiatric establishments does occur from time to time. A number of questions will be addressed subsequently which are closely-linked to the issue of the prevention of ill-treatment (e.g. means of restraint; complaints procedures; contact with the outside world; external supervision). However, some remarks should be made at this stage as regards the choice of staff and staff supervision.

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[10] As regards psychiatric care for prisoners, reference should also be made to paragraphs 41 to 44 of the Committee's 3rd General Report.

28. Working with the mentally ill and mentally handicapped will always be a difficult task for all categories of staff involved. In this connection it should be noted that health-care staff in psychiatric establishments are frequently assisted in their day-to-day work by orderlies; further, in some establishments a considerable number of personnel are assigned to security-related tasks. The information at the CPT's disposal suggests that when deliberate ill-treatment by staff in psychiatric establishments does occur, such auxiliary staff rather than medical or qualified nursing staff are often the persons at fault.

Bearing in mind the challenging nature of their work, it is of crucial importance that auxiliary staff be carefully selected and that they receive both appropriate training before taking up their duties and in-service courses. Further, during the performance of their tasks, they should be closely supervised by - and be subject to the authority of - qualified health-care staff.

29. In some countries, the CPT has encountered the practice of using certain patients, or inmates from neighbouring prison establishments, as auxiliary staff in psychiatric facilities. The Committee has serious misgivings about this approach, which should be seen as a measure of last resort. If such appointments are unavoidable, the activities of the persons concerned should be supervised on an on-going basis by qualified health-care staff.

30. It is also essential that appropriate procedures be in place in order to protect certain psychiatric patients from other patients who might cause them harm. This requires inter alia an adequate staff presence at all times, including at night and weekends. Further, specific arrangements should be made for particularly vulnerable patients; for example, mentally handicapped and/or mentally disturbed adolescents should not be accommodated together with adult patients.

31. Proper managerial control of all categories of staff can also contribute significantly to the prevention of ill-treatment. Obviously, the clear message must be given that the physical or psychological ill-treatment of patients is not acceptable and will be dealt with severely. More generally, management should ensure that the therapeutic role of staff in psychiatric establishments does not come to be considered as secondary to security considerations.

Similarly, rules and practices capable of generating a climate of tension between staff and patients should be revised accordingly. The imposition of fines on staff in the event of an escape by a patient is precisely the kind of measure which can have a negative effect on the ethos within a psychiatric establishment.

C. Patients' living conditions and treatment

32. The CPT closely examines patients' living conditions and treatment; inadequacies in these areas can rapidly lead to situations falling within the scope of the term "inhuman and degrading treatment". The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment. This is of importance not only for patients but also for staff working in psychiatric establishments. Further, adequate treatment and care, both psychiatric and somatic, must be provided to patients; having regard to the principle of the equivalence of care, the medical treatment and nursing care received by persons who are placed involuntarily in a psychiatric establishment should be comparable to that enjoyed by voluntary psychiatric patients.

33. The quality of patients' living conditions and treatment inevitably depends to a considerable extent on available resources. The CPT recognises that in times of grave economic difficulties, sacrifices may have to be made, including in health establishments. However, in the light of the facts found during some visits, the Committee wishes to stress that the provision of certain basic necessities of life must always be guaranteed in institutions where the State has persons under its care and/or custody. These include adequate food, heating and clothing as well as - in health establishments - appropriate medication.

living conditions

34. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.

Particular attention should be given to the decoration of both patients' rooms and recreation areas, in order to give patients visual stimulation. The provision of bedside tables and wardrobes is highly desirable, and patients should be allowed to keep certain personal belongings (photographs, books, etc). The importance of providing patients with lockable space in which they can keep their belongings should also be underlined; the failure to provide such a facility can impinge upon a patient's sense of security and autonomy.

Sanitary facilities should allow patients some privacy. Further, the needs of elderly and/or handicapped patients in this respect should be given due consideration; for example, lavatories of a design which do not allow the user to sit are not suitable for such patients. Similarly, basic hospital equipment enabling staff to provide adequate care (including personal hygiene) to bedridden patients must be made available; the absence of such equipment can lead to wretched conditions.

It should also be noted that the practice observed in some psychiatric establishments of continuously dressing patients in pyjamas/nightgowns is not conducive to strengthening personal identity and self-esteem; individualisation of clothing should form part of the therapeutic process.

35. Patients' food is another aspect of their living conditions which is of particular concern to the CPT. Food must be not only adequate from the standpoints of quantity and quality, but also provided to patients under satisfactory conditions. The necessary equipment should exist enabling food to be served at the correct temperature. Further, eating arrangements should be decent; in this regard it should be stressed that enabling patients to accomplish acts of daily life - such as eating with proper utensils whilst seated at a table - represents an integral part of programmes for the psycho-social rehabilitation of patients. Similarly, food presentation is a factor which should not be overlooked.

The particular needs of disabled persons in relation to catering arrangements should also be taken into account.

36. The CPT also wishes to make clear its support for the trend observed in several countries towards the closure of large-capacity dormitories in psychiatric establishments; such facilities are scarcely compatible with the norms of modern psychiatry. Provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes.

Similarly, the CPT favours the approach increasingly being adopted of allowing patients who so wish to have access to their room during the day, rather than being obliged to remain assembled together with other patients in communal areas.

treatment

37. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.

The CPT all too often finds that these fundamental components of effective psycho-social rehabilitative treatment are underdeveloped or even totally lacking, and that the treatment provided to patients consists essentially of pharmacotherapy. This situation can be the result of the absence of suitably qualified staff and appropriate facilities or of a lingering philosophy based on the custody of patients.

38. Of course, psychopharmacologic medication often forms a necessary part of the treatment given to patients with mental disorders. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed. The CPT will also be on the look-out for any indications of the misuse of medication.

39. Electroconvulsive therapy (ECT) is a recognised form of treatment for psychiatric patients suffering from some particular disorders. However, care should be taken that ECT fits into the patient's treatment plan, and its administration must be accompanied by appropriate safeguards.

The CPT is particularly concerned when it encounters the administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants); this method can no longer be considered as acceptable in modern psychiatric practice. Apart from the risk of fractures and other untoward medical consequences, the process as such is degrading for both the patients and the staff concerned. Consequently, ECT should always be administered in a modified form.

ECT must be administered out of the view of other patients (preferably in a room which has been set aside and equipped for this purpose), by staff who have been specifically trained to provide this treatment. Further, recourse to ECT should be recorded in detail in a specific register. It is only in this way that any undesirable practices can be clearly identified by hospital management and discussed with staff.

40. Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will inter alia enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment.

A personal and confidential medical file should be opened for each patient. The file should contain diagnostic information (including the results of any special examinations which the patient has undergone) as well as an ongoing record of the patient's mental and somatic state of health and of his treatment. The patient should be able to consult his file, unless this is unadvisable from a therapeutic standpoint, and to request that the information it contains be made available to his family or lawyer. Further, in the event of a transfer, the file should be forwarded to the doctors in the receiving establishment; in the event of discharge, the file should be forwarded - with the patient's consent - to a treating doctor in the outside community.

41. Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

Of course, consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition and the treatment proposed; to describe ECT as "sleep therapy" is an example of less than full and accurate information about the treatment concerned. Consequently, all patients should be provided systematically with relevant information about their condition and the treatment which it is proposed to prescribe for them. Relevant information (results, etc.) should also be provided following treatment.

D. Staff

42. Staff resources should be adequate in terms of numbers, categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), and experience and training. Deficiencies in staff resources will often seriously undermine attempts to offer activities of the kind described in paragraph 37; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service.

43. In some countries, the CPT has been particularly struck by the small number of qualified psychiatric nurses among the nursing staff in psychiatric establishments, and by the shortage of personnel qualified to conduct social therapy activities (in particular, occupational therapists). The development of specialised psychiatric nursing training and a greater emphasis on social therapy would have a considerable impact upon the quality of care. In particular, they would lead to the emergence of a therapeutic milieu less centred on drug-based and physical treatments.

44. A number of remarks concerning staff issues and, more particularly, auxiliary staff, have already been made in an earlier section (cf. paragraphs 28 to 31). However, the CPT also pays close attention to the attitude of doctors and nursing staff. In particular, the Committee will look for evidence of a genuine interest in establishing a therapeutic relationship with patients. It will also verify that patients who might be considered as burdensome or lacking rehabilitative potential are not being neglected.

45. As in other health-care services, it is important that the different categories of staff working in a psychiatric unit meet regularly and form a team under the authority of a senior doctor. This will allow day-to-day problems to be identified and discussed, and guidance to be given. The lack of such a possibility could well engender frustration and resentment among staff members.

46. External stimulation and support are also necessary to ensure that the staff of psychiatric establishments do not become too isolated. In this connection, it is highly desirable for such staff to be offered training possibilities outside their establishment as well as secondment opportunities. Similarly, the presence in psychiatric establishments of independent persons (e.g. students and researchers) and external bodies (cf paragraph 55) should be encouraged.

E. Means of restraint

47. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The restraint of patients should be the subject of a clearly-defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.

Staff in psychiatric establishments should receive training in both non-physical and manual control techniques vis-à-vis agitated or violent patients. The possession of such skills will enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

48. Resort to instruments of physical restraint (straps, straight jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment.

The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.

49. Reference should also be made in this context to the seclusion (i.e. confinement alone in a room) of violent or otherwise "unmanageable" patients, a procedure which has a long history in psychiatry.

There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.

Seclusion should never be used as a punishment.

50. Every instance of the physical restraint of a patient (manual control, use of instruments of physical restraint, seclusion) should be recorded in a specific register established for this purpose (as well as in the patient's file). The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

This will greatly facilitate both the management of such incidents and the oversight of the extent of their occurrence.

F. Safeguards in the context of involuntary placement

51. On account of their vulnerability, the mentally ill and mentally handicapped warrant much attention in order to prevent any form of conduct - or avoid any omission - contrary to their well-being. It follows that involuntary placement in a psychiatric establishment should always be surrounded by appropriate safeguards. One of the most important of those safeguards - free and informed consent to treatment - has already been highlighted (cf. paragraph 41).

the initial placement decision

52. The procedure by which involuntary placement is decided should offer guarantees of independence and impartiality as well as of objective medical expertise.

As regards, more particularly, involuntary placement of a civil nature, in many countries the decision regarding placement must be taken by a judicial authority (or confirmed by such an authority within a short time-limit), in the light of psychiatric opinions. However, the automatic involvement of a judicial authority in the initial decision on placement is not foreseen in all countries. Committee of Ministers Recommendation N° R (83) 2 on the legal protection of persons suffering from mental disorder placed as involuntary patients allows for both approaches (albeit setting out special safeguards in the event of the placement decision being entrusted to a non-judicial authority). The Parliamentary Assembly has nevertheless reopened the debate on this subject via its Recommendation 1235 (1994) on psychiatry and human rights, calling for decisions regarding involuntary placement to be taken by a judge.

In any event, a person who is involuntarily placed in a psychiatric establishment by a non-judicial authority must have the right to bring proceedings by which the lawfulness of his detention shall be decided speedily by a court.

safeguards during placement

53. An introductory brochure setting out the establishment's routine and patients' rights should be issued to each patient on admission, as well as to their families. Any patients unable to understand this brochure should receive appropriate assistance.

Further, as in any place of deprivation of liberty, an effective complaints procedure is a basic safeguard against ill-treatment in psychiatric establishments. Specific arrangements should exist enabling patients to lodge formal complaints with a clearly-designated body, and to communicate on a confidential basis with an appropriate authority outside the establishment.

54. The maintenance of contact with the outside world is essential, not only for the prevention of ill-treatment but also from a therapeutic standpoint.

Patients should be able to send and receive correspondence, to have access to the telephone, and to receive visits from their family and friends. Confidential access to a lawyer should also be guaranteed.

55. The CPT also attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body (eg. a judge or supervisory committee) which is responsible for the inspection of patients' care. This body should be authorised, in particular, to talk privately with patients, receive directly any complaints which they might have and make any necessary recommendations.

discharge

56. Involuntary placement in a psychiatric establishment should cease as soon as it is no longer required by the patient's mental state. Consequently, the need for such a placement should be reviewed at regular intervals.

When involuntary placement is for a specified period, renewable in the light of psychiatric evidence, such a review will flow from the very terms of the placement. However, involuntary placement might be for an unspecified period, especially in the case of persons who have been compulsorily admitted to a psychiatric establishment pursuant to criminal proceedings and who are considered to be dangerous. If the period of involuntary placement is unspecified, there should be an automatic review at regular intervals of the need to continue the placement.

In addition, the patient himself should be able to request at reasonable intervals that the necessity for placement be considered by a judicial authority.

57. Although no longer requiring involuntary placement, a patient may nevertheless still need treatment and/or a protected environment in the outside community. In this connection, the CPT has found, in a number of countries, that patients whose mental state no longer required them to be detained in a psychiatric establishment nevertheless remained in such establishments, due to a lack of adequate care/accommodation in the outside community. For persons to remain deprived of their liberty as a result of the absence of appropriate external facilities is a highly questionable state of affairs.

G. Final remarks

58. The organisational structure of health-care services for persons with psychiatric disorders varies from country to country, and is certainly a matter for each State to determine. Nevertheless, the CPT wishes to draw attention to the tendency in a number of countries to reduce the number of beds in large psychiatric establishments and to develop community-based mental health units. The Committee considers this is a very favourable development, on condition that such units provide a satisfactory quality of care.

It is now widely accepted that large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff, the more so if they are situated in isolated locations. This can have a detrimental effect on patient treatment. Care programmes drawing on the full range of psychiatric treatment are much easier to implement in small units located close to the main urban centres.

APPENDIX 1

A. Signatures and ratifications of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (*) (as at 1 August 1998)

MEMBER STATES	Date of signature	Date of ratification	Date of entry into force
ALBANIA	02.10.96	02.10.96	01.02.97
ANDORRA	10.09.96	06.01.97	01.05.97
AUSTRIA	26.11.87	06.01.89	01.05.89
BELGIUM	26.11.87	23.07.91	01.11.91
BULGARIA	30.09.93	03.05.94	01.09.94
CROATIA	06.11.96	11.10.97	01.02.98
CYPRUS	26.11.87	03.04.89	01.08.89
CZECH REPUBLIC	23.12.92	07.09.95	01.01.96
DENMARK	26.11.87	02.05.89	01.09.89
ESTONIA	28.06.96	06.11.96	01.03.97
FINLAND	16.11.89	20.12.90	01.04.91
FRANCE	26.11.87	09.01.89	01.05.89
GERMANY	26.11.87	21.02.90	01.06.90
GREECE	26.11.87	02.08.91	01.12.91
HUNGARY	09.02.93	04.11.93	01.03.94
ICELAND	26.11.87	19.06.90	01.10.90
IRELAND	14.03.88	14.03.88	01.02.89
ITALY	26.11.87	29.12.88	01.04.89
LATVIA	11.09.97	10.02.98	01.06.98
LIECHTENSTEIN	26.11.87	12.09.91	01.01.92
LITHUANIA	14.09.95		
LUXEMBOURG	26.11.87	06.09.88	01.02.89
MALTA	26.11.87	07.03.88	01.02.89

MOLDOVA	02.05.96	02.10.97	01.02.98
NETHERLANDS	26.11.87	12.10.88	01.02.89
NORWAY	26.11.87	21.04.89	01.08.89
POLAND	11.07.94	10.10.94	01.02.95
PORTUGAL	26.11.87	29.03.90	01.07.90
ROMANIA	04.11.93	04.10.94	01.02.95
RUSSIA	28.02.96	05.05.98	01.09.98
SAN MARINO	16.11.89	31.01.90	01.05.90
SLOVAK REPUBLIC	23.12.92	11.05.94	01.09.94
SLOVENIA	04.11.93	02.02.94	01.06.94
SPAIN	26.11.87	02.05.89	01.09.89
SWEDEN	26.11.87	21.06.88	01.02.89
SWITZERLAND	26.11.87	07.10.88	01.02.89
"THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA"	14.06.96	06.06.97	01.10.97
TURKEY	11.01.88	26.02.88	01.02.89
UKRAINE	02.05.96	05.05.97	01.09.97
UNITED KINGDOM	26.11.87	24.06.88	01.02.89

(*) The Convention is open for signature by the member States of the Council of Europe.

B. Signatures and ratifications of Protocol No. 1 to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (as at 1 August 1998)

MEMBER STATES	Date of signature	Date of ratification	Date of entry into force
ALBANIA	02.10.96	02.10.96	
ANDORRA		***	
AUSTRIA	04.11.93	30.04.96	
BELGIUM	04.11.93	12.09.96	
BULGARIA	04.03.97	27.10.97	
CROATIA		***	
CYPRUS	02.02.94	10.09.97	
CZECH REPUBLIC	28.04.95	07.09.95	
DENMARK	04.11.93	26.04.94	
ESTONIA	28.06.96	06.11.96	
FINLAND	04.11.93(*)	04.11.93(*)	
FRANCE	04.11.93	***	
GERMANY	04.11.93	13.12.96	
GREECE	04.11.93	29.06.94	
HUNGARY	04.11.93(*)	04.11.93(*)	
ICELAND	08.09.94	29.06.95	
IRELAND	10.04.96(*)	10.04.96(*)	
ITALY	30.10.96	***	
LATVIA	11.09.97	10.02.98	
LIECHTENSTEIN	04.11.93	05.05.95	
LITHUANIA	14.09.95		
LUXEMBOURG	04.11.93	20.07.95	
MALTA	04.11.93(*)	04.11.93(*)	

MOLDOVA	02.10.97	02.10.97	
NETHERLANDS	05.05.94	23.02.95	
NORWAY	04.11.93(*)	04.11.93(*)	
POLAND	11.01.95	24.03.95	
PORTUGAL	03.06.94	20.03.98	
ROMANIA	04.11.93	04.10.94	
RUSSIA	28.02.96	05.05.98	
SAN MARINO	04.11.93	05.12.96	
SLOVAK REPUBLIC	07.03.94	11.05.94	
SLOVENIA	31.03.94	16.02.95	
SPAIN	21.02.95	08.06.95	
SWEDEN	07.03.94(*)	07.03.94(*)	
SWITZERLAND	09.03.94(*)	09.03.94(*)	
"THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA"	14.06.96	06.06.97	
TURKEY	10.05.95	17.09.97	
UKRAINE	26.01.98	***	
UNITED KINGDOM	09.12.93	11.04.96	

(*) Signature without reservation as to ratification

*** State whose ratification is necessary for the entry info force of the Protocol

C. Signatures and ratifications of Protocol No. 2 to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (as at 1 August 1998)

MEMBER STATES	Date of signature	Date of ratification	Date of entry into force
ALBANIA	02.10.96	02.10.96	
ANDORRA		***	
AUSTRIA	04.11.93	30.04.96	
BELGIUM	04.11.93	12.09.96	
BULGARIA	04.03.97	27.10.97	
CROATIA		***	
CYPRUS	02.02.94	10.09.97	
CZECH REPUBLIC	28.04.95	07.09.95	
DENMARK	04.11.93	26.04.94	
ESTONIA	28.06.96	06.11.96	
FINLAND	04.11.93(*)	04.11.93(*)	
FRANCE	04.11.93	14.08.96	
GERMANY	04.11.93	13.12.96	
GREECE	04.11.93	29.06.94	
HUNGARY	04.11.93(*)	04.11.93(*)	
ICELAND	08.09.94	29.06.95	
IRELAND	10.04.96(*)	10.04.96(*)	
ITALY	30.10.96	***	
LATVIA	11.09.97	10.02.98	
LIECHTENSTEIN	04.11.93	05.05.95	
LITHUANIA	14.09.95		
LUXEMBOURG	04.11.93	20.07.95	
MALTA	04.11.93(*)	04.11.93(*)	

MOLDOVA	02.10.97	02.10.97	
NETHERLANDS	05.05.94	23.02.95	
NORWAY	04.11.93(*)	04.11.93(*)	
POLAND	11.01.95	24.03.95	
PORTUGAL	03.06.94	***	
ROMANIA	04.11.93	04.10.94	
RUSSIA	28.02.96	05.05.98	
SAN MARINO	04.11.93	05.12.96	
SLOVAK REPUBLIC	07.03.94	11.05.94	
SLOVENIA	31.03.94	16.02.95	
SPAIN	21.02.95	08.06.95	
SWEDEN	07.03.94(*)	07.03.94(*)	
SWITZERLAND	09.03.94(*)	09.03.94(*)	
"THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA"	14.06.96	06.06.97	
TURKEY	10.05.95	17.09.97	
UKRAINE	26.01.98	***	
UNITED KINGDOM	09.12.93	11.04.96	

(*) Signature without reservation as to ratification
*** State whose ratification is necessary for the entry into force of the Protocol

APPENDIX 2

A. Members of the CPT listed in order of precedence (as at 1 August 1998)*

Name	Nationality	Term of office expires
Mr Ivan ZAKINE, President	French	20.09.2001
Mrs Ingrid LYCKE ELLINGSEN, 1st Vice-President	Norwegian	20.09.2001
Mr John OLDEN, 2nd Vice-President	Irish	21.03.1999
Mrs Pirkko LAHTI	Finnish	20.06.1999
Mr Constantin ECONOMIDES	Greek	30.11.1999
Mr Jón BJARMAN	Icelander	26.03.2000
Mr Arnold OEHRY	Liechtensteiner	13.01.2001
Mr Leopoldo TORRES BOURSAULT	Spanish	03.05.2001
Mr Safa REISOĞLU	Turkish	20.09.2001
Mrs Gisela PERREN-KLINGLER	Swiss	20.09.2001
Mr Florin STĂNESCU	Romanian	21.03.1999
Mr Mario BENEDETTINI	San Marinese	21.03.1999
Mr Vitaliano ESPOSITO	Italian	21.06.1999
Mrs Jagoda POLONCOVÁ	Slovakian	21.06.1999
Mrs Christina DOCTARE	Swedish	19.09.1999
Mr Demetrios STYLIANIDES	Cypriot	30.11.1999
Mr Adam ŁAPTAŚ	Polish	30.11.1999
Mr Lambert KELCHTERMANS	Belgian	08.01.2000
Mrs Maria SCIBERRAS	Maltese	09.01.2000
Mr Miklós MAGYAR	Hungarian	03.04.2000
Mr Zdeněk HÁJEK	Czech	11.09.2000
Mrs Emilia DRUMEVA	Bulgarian	17.03.2001
Mr Pieter Reinhard STOFFELEN	Dutch	20.09.2001
Mr Ole Vedel RASMUSSEN	Danish	20.09.2001
Mrs Renate KICKER	Austrian	20.09.2001
Mr Pierre SCHMIT	Luxemburger	20.09.2001
Mrs Silvia CASALE	British	18.12.2001
Mr Andres LEHTMETS	Estonian	18.12.2001
Mr Davor STRINOVIĆ	Croatian	04.06.2002
Mr Aurel KISTRUGA	Moldovan	04.06.2002

* At this date, the seats in respect of Albania, Andorra, Germany, Latvia, Portugal, Slovenia, "the Former Yugoslav Republic of Macedonia" and Ukraine were vacant. A seat in respect of the Russian Federation shall have to be filled as from 1 September 1998.

B. Secretariat of the CPT

Mr Trevor STEVENS	Committee Secretary
Mrs Geneviève MAYER	Deputy Committee Secretary
Secretariat:	Ms Mireille MONTI
	Ms Violaine JOUANIN

Central section

Mrs Florence CALLOT-DURING,	administrative, budgetary and staff questions
Mr Patrick MÜLLER,	Head of the documentation and information centre
Ms Mireille MONTI,	archives and publications

Units responsible for visits

Unit 1

Mrs Geneviève MAYER, Head of Unit
Mr Edo KORLJAN
.....

Secretariat: Ms Violaine JOUANIN

Unit 2

Mr Fabrice KELLENS, Head of Unit
Mrs Petya NESTOROVA
Mr Borys WÓDZ

Secretariat: Mrs Janey MASLEN

Unit 3

Mr Mark KELLY, Head of Unit
Mr Jan MALINOWSKI
Ms Bojana URUMOVA

Secretariat: Ms Susan BRADBURY-KIN

APPENDIX 3

Places of detention visited by CPT delegations in 1997

I. PERIODIC VISITS

A. Albania

Police establishments

- Elbasan Police Headquarters
- Fier Police Headquarters
- Tirana Police Headquarters
- Police Station N° 4, Tirana

Prisons

- Burrel Prison
- Lushnjë Prison
- Prison N° 313, Tirana
- Prison N° 325, Tirana
- Prison Hospital, Tirana

Psychiatric establishments

- Elbasan Psychiatric Hospital.

B. Belgium

Police establishments

- Communal Police Stations, Lange Nieuwstraat and Noordlaan, Antwerp
- Communal Police Headquarters, rue du Collège, Ixelles
- Police Headquarters, rue Natalis, Liège
- Communal Police Stations, rue des Palais and place Colignon, Schaerbeek
- Communal Police Station, rue de l'Athénée, Tournai

Gendarmerie establishments

- Gendarmerie Brigade, Korte Vlierstraat, Antwerp
- Gendarmerie Brigade and the Surveillance and Investigation Brigade, rue de la Croix de Fer, Brussels
- Gendarmerie Services at the Palais de Justice, Brussels
- Gendarmerie Brigade, rue du Rossignol, Mons
- Gendarmerie Brigade, rue de la Citadelle, Tournai
- Gendarmerie Brigade, Wilrijk
- Security Unit and Repatriation Service of the Gendarmerie, Brussels-National Airport, Zaventem

Prisons

- Merksplas Prison
- Mons Prison
- Lantin Prison
- St-Gilles Prison

Holding centres for foreigners

- Centre for Illegal Aliens, Merksplas
- Repatriation Centre 127 "bis", Steenokkerzeel
- "INADS" Centre, Brussels-National Airport, Zaventem
- Transit Centre 127, Brussels-National Airport, Zaventem

Social Defence establishments

- Paifve Social Defence establishment
- Tournai Social Defence establishment

C. Czech Republic

Police establishments

- Police holding facilities, Bratislavská 13-15, Brno
- Police Headquarters, Kongresová 2, Prague 4
- Jižní Město I Police Station, Steinerova 604, Prague 4
- Košíře Police Station, Ostrovského 3, Prague 5
- Smíchov Police Station, Štefánikova 13, Prague 5
- District Investigation Department, Františka Křižka 24, Prague 7
- Police Headquarters, Havlíčkova 10, Šumperk

Prisons

- Mírov Prison
- Prague-Pankrác Remand Prison

Juvenile institutions

- Brno-Hlinky Diagnostic Institute for Children
- Moravský Krumlov Educational Institute for Children and Minors

D. Estonia

Police and Border Guard establishments

- Elva Police Station
- Harju Police Headquarters, Saue
- Ida-Viru Police Headquarters, Kohtla-Järve
- Jõgeva Police Headquarters
- Laane-Viru Police Headquarters, Rakvere
- Narva Police Headquarters
- Tallinn Police Headquarters (Arrest Houses Nos. 1 and 2)

- Lasnamäe Police Station, Tallinn
- Tartu Police Headquarters
- Viljandi Police Headquarters

- Border Guard detention facilities, Narva

Prisons

- Central Prison, Tallinn
- Tallinn Prison
- Viljandi Juvenile Prison

Psychiatric and Social Welfare establishments

- Forensic Unit at the Tallinn Psychiatric Hospital
- Tartu University Psychiatric Hospital
- Valkla Social Welfare House, Kiiu

Military establishments

- Military detention facility, Tallinn

E. Greece

Police establishments

Athens
- Police Headquarters, Alexandras Avenue
- Drapetzona Police Station, Piraeus
- Police Station No.2, East Terminal, Athens Airport
- Holding Areas at Athens Airport
- Hellenikon Holding Centre for Aliens
- Piraeus Holding Centre for Aliens, Asklepiou Street
- Piraeus Transfer Centre for Prisoners, Notara Street

Corfu
- Police Headquarters, Alexandras Street
- Police Station, Samartzi Street

Ioanina
- Police Headquarters, 28 October Street
- Perama Centre for Illegal Immigrants

Thessaloniki
- Police Headquarters
- Police Station, Democracy Square

Prisons

- Korydallos Prison Complex, Athens
- Corfu Prison
- Diavata Judicial Prison, Thessaloniki

Psychiatric establishments

- Attica State Mental Hospital, Athens
- Thessaloniki State Mental Hospital

Other establishments

- Detention facilities of the Courts of First Instance, Evelpidon, Athens

F. Netherlands

Police

- Amsterdam Police Headquarters
- Police Station, Warmoesstraat 44-50, Amsterdam
- Koninklijke Marechaussee (Royal Gendarmerie) facilities, Schiphol International Airport
- Emmen Police Headquarters
- Groningen Regional Police Headquarters
- Tilburg Regional Police Headquarters
- Police Station, Stationsstraat 14, Tilburg
- Registration Centre of the Central Reception Organisation for Asylum Seekers (COA) at Schiphol International Airport

Prisons

- Over-Amstel Prisons (Demersluis and Het Veer)
- Nieuw Vosseveld Prison (EBI and TEBI)

Psychiatric establishments

- Dr S. van Mesdag Clinic

Holding centres for foreigners

- Ter Apel Departure Centre for Foreigners
- King Willem II Detention Centre for Foreigners, Tilburg

G. Turkey

Police establishments

- Adana Police Headquarters
- Istanbul:
    - · Police Headquarters
    - · Beyoğlu District Central Police Station
    - · Küçükçekmece District Central Police Station
- Izmir Police Headquarters
- Mersin Police Headquarters
- Samsun Police Headquarters
- Ünye Police Headquarters

Prisons and reformatories

- Izmir (Buca) Closed Prison
- Izmir Reformatory for Juveniles
- Mersin E-Type Prison
- Ünye Closed Prison

Psychiatric establishments

- Bakırköy Mental and Psychological Health Hospital, Istanbul
- Psychiatric Observation Unit of the Institute of Forensic Medicine, Istanbul
- Samsun Regional Psychiatric Hospital

II. AD HOC VISITS

A. Netherlands (Netherlands Antilles)

- Koraal Specht Prison
- Police detention facilities and the Criminal Investigation Department in Rio Canario

B. Norway

- Prison ("Landsfengsel") and Police Headquarters, Bergen
- Prison ("Kretsfengsel") and Police Headquarters, Oslo

C. Luxembourg

Juvenile institutions

- State Socio-Educational Centre for Boys, Dreiborn
- State Socio-Educational Centre for Girls, Schrassig

Police, Gendarmerie and Customs and Excise establishments

- Luxembourg Central Police Station
- Custodial Unit of the Luxembourg Gendarmerie Brigade
- Special Service of the Gendarmerie at Luxembourg - Findel Airport
- Criminal Investigation Service of the Gendarmerie (Aliens' Police and Gaming Section)
- Holding room of the Gendarmerie at the Luxembourg Palais de Justice
- Intervention Brigade of the Drugs and Controlled Products Directorate, Rumelange

Prisons

- Luxembourg Prison, Schrassig

D. Spain (January 1997)

- General Directorate of the Civil Guard, Madrid
- Madrid V Prison

E. Spain (April 1997)

Centres for foreigners

- Calamocarro Camp, Ceuta
- Detention Centre for Foreigners, Plaza de Capuchinos, Málaga
- Premises at La Granja, Carretera de Alfonso XIII, Melilla

National Police and Civil Guard establishments

- Headquarters of the National Police, Paseo de Colón, Ceuta
- Headquarters of the Civil Guard, Nuestra Señora del Otero, Ceuta
- Holding facilities at the Port of Ceuta

- Headquarters of the National Police, Plaza de Manuel Azaña, Málaga
- Headquarters of the National Police, Actor Tallavi, Melilla

Military Establishments

- Disciplinary Unit, Infantry Regiment No. 52, Melilla
- Disciplinary Unit of the Gran Capitán Regiment of the Legion, Melilla
- Remand detention facilities of the Military Police, Melilla

Prisons

- Ceuta Prison, Los Rosales

F. United Kingdom and the Isle of Man

Police establishments

London

- Brixton Police Station
- Notting Hill Police Station
- Peckham Police Station
- Streatham Police Station

Isle of Man

- Headquarters of the Isle of Man Constabulary, Douglas
- Castletown Police Station
- Peel Police Station
- Ramsey Police Station

Prisons

England

- HM Prison, Dorchester
- HM Prison The Weare

Isle of Man

- Isle of Man Prison, Douglas