The CPT at 25

Taking stock and moving forward

Strasbourg, France, 2 March 2015
Palais de l'Europe

Towards new standards in psychiatry

Veronica Pimenoff MD PhD

CPT standards have been developed and are used for the purpose of preventing torture, ill treatment and inhuman or degrading treatment or punishment in any places where persons are held who have been lawfully or unlawfully deprived of their liberty by the authorities. All CPT standards are developed in close connection to the field work of the Committee. The standards evolve from facts found and reflected upon on visits, the process being determined by the working methods of the CPT as spelled out in the Convention for the Prevention of Torture, particularly in Art 1 and Art 10.1.

Art 1 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.

Art 10 .1. After each visit, the Committee shall draw up a report on the facts found during the visit, taking account of any observations which may have been submitted by the Party concerned. It shall transmit to the latter its report containing any recommendations it considers necessary. The Committee may consult with the Party with a view to suggesting, if necessary, improvements in the protection of persons deprived of their liberty.

One encounter with a particular problem is as a rule not enough, standard recommendations are founded on broader experience gathered in the real world of places of detention in many countries and should be applicable in all member states. Collections of standards addressing specific fields of CPT work or particular types of places of detention can be extracted from a pool of standard recommendations and reflections emerging while considering the particular problems connected to them.

A crucial part of the experience gathered on the visits is the experience and are the views and opinions of the detained persons. The working methods stipulated in art 8, subsections 2,3 and 4 of the Convention make this approach possible.

2 A Party shall provide the Committee with the following facilities to carry out its task:

a access to its territory and the right to travel without restriction;

b full information on the places where persons deprived of their liberty are being held;

c unlimited access to any place where persons are deprived of their liberty, including the right to move inside such places without restriction;

d other information available to the Party which is necessary for the Committee to carry out its task. In seeking such information, the Committee shall have regard to applicable rules of national law and professional ethics.

3 The Committee may interview in private persons deprived of their liberty.

4 The Committee may communicate freely with any person whom it believes can supply relevant information.

The integrating of the expressed experience of detained persons into the development of standards has from the beginning been important and is paid constant attention to. Once emerged the standards become a tool used in the field work, as it has to be checked whether circumstances found at places of detention live up to these standards.

It goes without saying that CPT standards are developed in the framework of the European Convention for the Protection of Human Rights and other Human Rights documents. The CPT visits places where persons are deprived of their liberty by the authorities. Art 5 of ECHR spells out the conditions under which there can be a deprivation of liberty in accordance with a procedure prescribed by law.

Under art 5.1 f the lawful detention of persons of unsound mind, alcoholics or drug addicts is mentioned. (*I did not mention the persons spreading infectious diseases or vagrants as these are not directly related to psychiatry. Alcohol and drug dependence are psychiatric diagnoses and on visits the CPT every now and then meet "alcoholics and drug addicts" detained in psychiatric hospitals.)*

It is a well known fact, also grounded in the Convention and its explanatory report, that the CPT is no judicial body. It is the privilege of the European Court of Human Rights to define in a particular case what is torture, inhuman or degrading treatment or punishment. The Court might sometimes decide to look for guidance in CPT reports, but it still keeps its monopoly to set definitions. In the light of Art 5 of the ECHR even the Court would not have the possibility to state that detention in psychiatric institutions as such is degrading.

*(Would the CPT, referring to the UN Convention on the Rights of Persons with Disabilities, be of the opinion that detention of psychiatric patients as such is inhuman or degrading – which it as a non judicial body is not entitled to do – a complete abandoning of this group of persons would be the result, as the CPT could only ask for involuntary admittances to end. Psychiatric patients not admitted and kept involuntarily are not covered by the CPT mandate. The CPT is not allowed to overstep its mandate and say what can be done to them by the authorities and what not. The CPT is not a body for reforming psychiatry, not even a body for drafting guidelines of good practice. It is a*

*body for the prevention of ill treatment and inhuman conditions in the real existing places of detention of psychiatric patients. The CPT has a lot of necessary work to do under its mandate and should not be distracted by trying to call to abolish its field of activity (the mental hospitals detaining involuntary patients). If concentrating on launching the idea of closing down hospitals the CPT would completely neglect the persons under its mandate and abandon its working methods defined by the Convention.)*

The Committee has its power and its limits set by the Convention for Prevention of torture. The CPT's task is to examine issues under article 3 of the ECHR not under article 5 of the ECHR.

Mental hospitals are among the places visited by the CPT and inside them the involuntarily admitted persons are under its mandate as spelled out in the Explanatory report to the Convention "…, the committee may carry out visits only in relation to persons who are deprived of their liberty by a public authority, and not voluntary patients. However, in the latter case, it should be possible for the committee to satisfy itself that this was indeed the wish of the patient concerned." This is standard practice on visits and does not call for particular comments.

Interestingly, mental hospitals are the only type of place finding particular attention in the explanatory report: "Visits to places where persons are deprived of their liberty because of their mental condition will require careful preparation and handling, for example as regards the qualifications and experience of those chosen for the visit and the manner in which the visit is conducted. In carrying out its visits, moreover, the committee will no doubt wish to have regard to any relevant recommendation adopted by the Committee of Ministers." The meaning of the last sentence has to my knowledge not been discussed. *Could it for instance mean that Rec 10, 2004 would be binding, although younger as the Convention?*

With regard to the demand of expertise it can be noted that during its 25 years the CPT has had to its disposal psychiatrists, psychologists and nurses as members and assisting experts on visits. There have been some ad hoc visits targeting psychiatry. The substantive sections of the 8th and the 16th annual report are on psychiatry. Psychiatrists have for years been represented in the Bureau and acted as chair of the medical group, and as heads of delegation or sub delegation, so nothing to complain there.

During the years the CPT has come across psychiatric units encountering extreme difficulties in feeding the patients and supplying them with heated accommodation, with an own bed and the most basic hygiene, out doors exercise and guaranteeing safety from being physically ill treated or

sexually abused by staff or co patients and being secluded or restrained for prolonged times without any effective means of improving their situation. Even worse when the hospital has been the legal guardian of a patient and there were no efficient review processes at hand. CPT visits and recommendations have on occasion played a crucial part in combating neglect and ill treatment. On the other hand delegations come across places with good material conditions and empowered patients, in many places genuine efforts are made to reduce any involuntary means.
There have been matters related to psychiatry which by the CPT have been assessed as amounting to ill treatment or degrading treatment. The most prominent ones are the prolonged use of mechanical restraint, the CPT has also called for prohibiting cage beds and abandoning the use of net beds in closed establishments. Unmodified electro convulsive therapy has been regarded as "as such degrading for patients and staff(sic)". Further, in the CPT's view, surgical castration of detained sex-offenders amounts to degrading treatment**.**

However, visits to psychiatric hospitals have been integrated into the programmes of CPT periodic visits only gradually. In Austria, the first ever by the CPT visited country, a psychiatric unit was on the programme only at the 3rd periodic visit in1999, when a single forensic ward was visited. A look at the visit programmes of the first 15 State Parties to the Convention reveals that there was no psychiatric unit visited on the first periodic visit to Ireland, the UK, Belgium, Spain, Cyprus or Norway. In Sweden in 1991 a completely unprepared delegation visited two psychiatric wards as they already were on the hospital campus looking for persons detained on grounds of communicable diseases.
Still psychiatric establishments are often not to be found on the programmes of periodic visits. As far as I can see recent periodic visits to Luxembourg, Bulgaria, Turkey, Ukraine, the Slovak Republic, Greece and Ireland did not include any visits to psychiatric units. Whether and how the decisions to skip psychiatry have been reasoned is not known to me.
For 25 years forensic psychiatric units have been preferred when choosing places to visit, whereas civil psychiatry containing child, adolescent, adult and gerontopsychiatry has received less attention.
This history might have had an impact on the developing of the standards in psychiatry. Some standards applied in psychiatry appear to be genuine prison standards like the recommendation of one hour daily outdoor exercise and the way in which something called "activities" is stressed. That has to be remedied, detaining patients does not turn hospitals into prisons.
I shall, however, focus on the obvious fact that whereas some prison standards have been applied to psychiatric hospitals where they do not fit, other standards developed in the police and prison

context have not been applied in psychiatry although it would be necessary. As such or with minor adaptations some core issues related to the prevention of ill treatment which are applied for criminal suspects at the police, for prisons and for detention centres of illegal migrants should be applied for psychiatric patients and institutions, too.

In any country the risk of ill treatment of an involuntary psychiatric patient is highest when being picked up by police or ambulance staff at home or in a public place and brought to hospital, directly or via a stop at the police station or a health care unit.
Psychotic persons can be dangerous and unpredictable and establishing contact with them may be difficult. Police has the obligation to assist but police is seldom trained to tackle these encounters with disturbed persons.
Force has sometimes to be used to get the person to stay with the police and be transported to the hospital. Patients report about excessive use of force, too.
Out of the 36 persons shot dead by German police in the years 2009 to 2013 two thirds were without any criminal background, they were mentally ill and confused persons in the street.

In some countries police might use dogs or electrical discharge weapons, their batons or pepper spray during these interventions. It seems not to be unusual in any country that involuntary patients arrive hand cuffed or hand and foot cuffed at the psychiatric hospital.
When visiting a mental hospital it should be routine for CPT delegations to ask newly arrived involuntary patients about their experience with the police and the somatic check by a doctor at arrival, just like remand prisoners are interviewed.

As a rule the injuries obtained by involuntary patients during the transport to the hospital can be treated at the psychiatric hospital if they they are in need of treatment. It appears that in most cases appropriate treatment is provided but nothing else happens: there is no recording or reporting.

There are psychiatric clinics where virtually no somatic check is made at admittance, in other hospitals there are thorough somatic checks. Psychiatrists interviewed in different countries as a rule state that they do not record detected injuries in a special way in the patients file or elsewhere and that it is not their duty to report if a patient displays injuries consistent with the allegations of ill treatment the patient is making.

Received allegations by psychiatric patients on ill treatment by ambulance staff or police or extensive use of force should in the CPT report be placed into the police section, where recommendations on the matter should be placed, too, when needed.

The standards for recording and reporting of injuries which psychiatric patients may have obtained when police used the power of the law to take and keep them and transport them to the mental hospital have to be the same as for persons detained by police or brought to prison. This should be checked during the visits and referred to in the reports.

I am now moving on to another issue, closely connected to ill treatment, the issue of impunity.

Let me quote some old psychiatric CPT standards, still valid phrasings used by the CPT:

“ The information at the CPT's disposal suggests that when deliberate ill-treatment by staff in psychiatric establishments does occur, ... auxiliary staff (orderlies and security) rather than medical or qualified nursing staff are often the persons at fault.” 8th Annual general report

”The CPT invites the management to regularly remind staff that patients should be treated with respect and that any form of ill treatment, including verbal abuse, is unacceptable and will not be tolerated” (2008) ”and will be punished accordingly” (2011)
In the reports the hospital management is as a rule only asked to supervise orderlies better and to remind them of that ill treatment is not acceptable.

I think that instead of moving on with constructing more detailed standards on treatment offers it would be a priority of the CPT to stick to the core of the mandate and make an effort to combat impunity in psychiatric hospitals in order to prevent ill treatment of patients. Even if it would be justified to assume that there is less ill treatment in mental hospitals than in prisons, combating impunity in psychiatric clinics is justified and necessary. If combating impunity at the police is an issue as it has to be, also the patients who make allegations on police ill treatment have to be taken seriously, not only the police detainees, prisoners or detained aliens.

Combating impunity has to be in place in psychiatric institutions like it is in other places of detention. In CPT standards psychiatric clinics shall not be hidden behind the abbreviation “etc.“
If one takes it seriously that “ culpability for ill treatment (and serious neglect, VP) extends beyond the actual perpetrators to anyone who knows, or should know, that ill treatment is occurring and fails to act to prevent or report it,” then it cannot be enough when the hospital management only reminds the orderlies. Then it is not sufficient to write etc, but the CPT has to apply the standard for psychiatric establishments, too.

“Combating impunity must start at home, that is within the agency (police or prison service, military authority, **etc**.) concerned. Too often the esprit de corps leads to a willingness to stick

together and help each other when allegations of ill-treatment are made, to even cover up the illegal acts of colleagues. Positive action is required, through training and by example, to promote a culture where it is regarded as unprofessional – and unsafe from a career path standpoint – to work and associate with colleagues who have resort to ill-treatment, where it is considered as correct and professionally rewarding to belong to a team which abstains from such acts.

An atmosphere must be created in which the right thing to do is to report ill-treatment by colleagues; there must be a clear understanding that culpability for ill-treatment extends beyond the actual perpetrators to anyone who knows, or should know, that ill-treatment is occurring and fails to act to prevent or report it. This implies the existence of a clear reporting line as well as the adoption of whistle-blower protective measures."

The CPT has already developed standards saying that "Independent and impartial 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. The investigation should be thorough, comprehensive, prompt, expeditious,with a sufficient element of public scrutiny. Criminal/disciplinary proceedings should be followed by suitable sanctions."

In cases of allegations of ill treatment there have to be independent investigations also in psychiatric hospitals holding involuntary patients. The police might conduct an investigation when hospital staff is suspected, but police cannot investigate when the allegation of ill treatment made by a patient concerns the police. Here it should be borne in mind that police is in most countries not only taking persons to psychiatric hospitals, police may also – in some establishments not quite infrequently – be called in to the psychiatric wards when staff and security staff cannot manage.

A standard CPT text reads."The authorities should be under a legal 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. In this connection, the legal framework for accountability will 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."

If we put "hospital management" or "head of clinic" for "etc." the psychiatric hospitals are already integrated here. As of course also the social care homes should be.

In some countries a judge or a judicial committee turns up at the hospital to decide on the involuntary placement of a patient. At reviews of their placement patients may be present at

hearings of the court . Thus the following CPT standards are applicable for psychiatry as well and could then read: “Whenever a patient brought before judicial authorities alleges ill-treatment 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.

Even in the absence of an expressed 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.”

In the CPT's opinion the Health Care Unit of a prison can have a crucial role in preventing and detecting ill- treatment of detained persons. It has to be borne in mind that in a psychiatric hospital injuries can be treated even by the perpetrator. Thus there might be less protection in the closed hospital than in the prison where the wing relies on the assistance of the health care unit. Further, on occasion medical staff may value confidentiality higher than reporting or even whistle blowing.

There is a further need for developing standards. Although the CPT has paid attention to measures of restraint there are not yet standards on seclusion as a security measure in psychiatry.
There are published CPT standards on solitary confinement and the subject is being discussed at a special panel just now. Seclusion is a type of solitary confinement. Appropriate statements on seclusion on psychiatric grounds should be added to the standards on solitary confinement.

There are five parallel panels running for the moment. Ours is about psychiatry, the four others are about general subjects: combating impunity, health care in prison, juveniles in detention, and solitary confinement. With the exception of Health Care in Prison all seem – at least in their background papers - to completely forget psychiatric patients. As if there would not be impunity to combat in mental hospitals, no juveniles detained in psychiatric and forensic psychiatric establishments, no solitary confinement (seclusion) in mental hospitals. This neglect of attention seems to be general, and this state of affairs needs to be remedied.

Let me now move on to another issue concerning CPT standards on psychiatry. It was a great achievement 18 years ago to have a first compilation of CPT standards for psychiatry written and published. It is also no bad sign that standards gradually need to be revised, it is indicating that

there has been some progress.  The following section is one candidate for change.

The existing CPT standards on psychiatry contain phrases like the following. ”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.”

I want first to pick up the issue with the outdoor exercise, which is not outdated at all and goes for any kind of psychiatric establishment for in patients. I think that a lot needs to be done and can be done on visits and in reports to achieve that patients can exercise this right of theirs. In the overwhelming majority of psychiatric units for in patient care in all countries there are serious problems with out door exercise for newly arrived, for chronic patients, for challenging patients, sometimes even for all patients. The issue needs to be taken care of more effectively by the CPT. It has to be thoroughly explored during visits and suitable recommendations made, but the prison model should not be used in this context.

The recommended individual approach is also not outdated and goes for every patient.

But this is not the point I want to make about CPT standards in psychiatry. My point is that the quote shows that some CPT standards concerning psychiatry are too undifferentiated  and therefore they loose all effect. They are also not convincing, and they are not applicable everywhere.

On a ward treating involuntary acute psychotic patients who during their short stay of for instance a week or two are in a bad condition it is not in place to ask for all the activities listed in the standard text. It is not even suitable to ask for group therapy or even individual psychotherapy.  A person needs to have a minimum health condition for an individual psychotherapy, psychotherapy needs first an assessment then an agreement on goals etc. and then it  lasts for at least some weeks, usually for months, sometimes for years. Thus it is not indicated for a short stay involuntary patient.  Some patients may be in therapy outside the hospital, no other psychotherapy should be intruded on them during the hospital stay. Something deserving the name of psychotherapy is not to be recommended for a short stay civil acute ward, any way it as a rule belongs to out patient care.

Education and suitable work might be in place in a long stay forensic clinic. Work offered to long stay civil patients easily turns into exploitation, and having psychiatric patients kept in hospitals for years on end, is not the goal. Education should on the other hand be offered at a children's

psychiatric ward and usually for adolescent patients, too.

The CPT has recommended all kind of therapies and activities, but although it has preferred to visit forensic units and also has since recent years mentioned the need for programmes addressing offending behaviour to my knowledge no particular standards concerning forensic psychiatry have found their place in the source book.

In my view there is an urgent need to develop different standards for different types of establishments

acute short stay civil in patient treatment of adults,

chronic long stay civil in patient treatment of adults,

forensic psychiatry,

psychiatric wards inside the prison system,

psychogeriatric wards, acute and long stay,

adolescent wards,

children's wards,

wards for treating substance dependence

taking into account the purpose of the ward, the particular needs of the patients and the length of the stay. Also gender specific issues have to be addressed. One should not apply programmes for alcoholics or drug addicts or forensic patients developed to meet the needs of male patients when treating female patients whose situation and needs considerably differ from those of their male co patients. Further there are procreational health questions to look into in many places.

The CPT standards tell that “an introductory brochure setting out the establishment's routine and patients' rights *(in this order VP)* should be issued to each patient on admission. It might be time to get more specific on the rights: notifying relatives, legal aid, somatic check at admittance, external medical opinion, informed consent and legal issues on refusing treatment/being treated against the will.

Approaching the end of the presentation I want to mention some needs of developing standards in psychiatry. Of course no comprehensive list.

As long as there are long stay clinics there should be a somatic health care and screening offered at least of the same standard and frequency as in the outside society. It is known, that severely mentally ill persons suffer from more serious somatic diseases, do not seek a doctor as easily as others and their diseases are out of many grounds not detected and taken as seriously as diseases of persons who are mentally better off.

The CPT has some guidelines on hunger strikes in closed institutions. They say that at the beginning it should be assessed whether the person refusing food does this out of reasons grounded in a mental illness and if yes the person should be transferred to a psychiatric hospital. There the guidelines end, the food refuser is abandoned by the guideline writers and handed over to psychiatry...

(Long stay) patients should not be excluded from sexual rights and patients should be protected from any form of sexual harassment and abuse. This is a complicated and delicate issue. Hospitals could begin with trying to make masturbation less problematic.

There are always some sanctions for disobeying rules. In hospitals there are no (and should not be) disciplinary proceedings. The field needs investigation. At least it should be ruled out that corporal punishment, restraint, deprivation of food and outdoor exercise are sanctions, and that completely arbitrary sanctions are not used in places where involuntary psychiatric patients of any age are held.

Difficult to detect on short visits are ongoing degrading practices by staff and co patients towards some patients, bullying, diminishing, excluding, humiliating which can amount to psychological ill treatment, something that according to the mandate should be prevented.

Restraints are of course always on the agenda. *I did not include a discussion in this presentation. I can deliver comments to the revised standards on restraint which in my view do not stress the means for diminishing frequency and duration of restraint cases and means of preventing stress and suffering potentially connected to the measures, but instead present bureaucratic rules on duration and outside experts which hardly are applicable in the clinic (like calling in an outside expert in the small hours) and in no way advisable (like waking up a secluded – and perhaps heavily sedated - patient in the small hours to check whether the seclusion can be ended. The adopters of such standards have not taken into account that sleep is as a rule a relief for a suffering, often desperate, severely ill patient and that ending a restraint measure often calls for an immediate after care plan which cannot be implemented in the middle of the night when there is extremely low staffing. A six hours limit should not be established to produce a lot of damage.)*

Technical developments which have a crucial impact on the life style of people in European

societies have of course intruded the hospital wards, too. The CPT cannot on the long run avoid to deal with the issue, and it can not deal with it like in a prison setting. There should not be any principal objection to psychiatric patients keeping their mobile phones, iphones, ipads and laptops at the hospital ward.

There is the problem of loosing and damaging the devices, the problem with the use of the integrated camera and putting pictures of co patients on the net(which has to be prevented), the problem of harassing other persons by phone and the problem of (especially paranoid or maniac patients) causing personal and financial damage by messages and on line shopping. Still, any restriction of the use of the devices should be based upon law and only relate to clearly and strictly defined exceptional circumstances.
These are art 8 and art 10 issues,though, but dealing only with visits, access to TV and newspapers does not any longer hit all essentials of the contact to the outside world.

There are many matters which deserve a never ending reflection, like Psychological evidence of torture and inhuman and degrading treatment, What should psychiatric care in prisons or holding centres for aliens be about (including a gender sensitive approach to substance abuse and self harm issues)

The members professionally involved in psychiatry should participate with members representing other professions in developing standards for instance on indefinite detention which is reality under different circumstances like in civil psychiatry, in forensic psychiatry, in preventive detention and for real life-prisoners.

The CPT can fall back on a wealth of experience of more than 25 years in the field of psychiatry. It has developed a valuable body of standards. However, psychiatric establishments have often been totally lacking in the programmes of periodic visits including in countries where serious ill-treatment, bad conditions and neglect had been found on previous visits. There is not always sufficient time available when visiting psychiatric units. I would claim that there is at least as much to do in a big hospital as in a prison of equal capacity.
In any civil psychiatric in patient unit the delegation has the obligation to convince itself that the de jure voluntary patients also are de facto voluntary, not only that they say so but that they would be able to leave if they so wished. Accommodation building, rooms/cells, yards, out doors exercise , privacy, food, clothing, hygiene, addiction, visits, complaints are similarly checked in both kind of

places. The medical check at admittance is always checked in prisons but the somatic check must not neglected to check in psychiatry.

In a prison you have not to look into the sentences, in a psychiatric hospital you have to look into the admission procedure and check that the process of involuntary placement has been properly done. The question of consent to treatment is marginal in prison, but has to be focused on in the hospital. In a prison there are decisions on release on probation, but in psychiatry there are the frequent reviews, and in forensic psychiatry the relaxations of the regime to check.

You might meet adult persons, children and very old persons of both sexes, these person are mentally disturbed and in many places you find mentally retarded persons. There are persons who cannot speak. But also those who cannot be interviewed are under the mandate!! their situation needs to be assessed and it has to be done by other means than interviews.

There are no disciplinary measures to check but a tricky issue on punishments. The question of outdoors exercise is simpler to explore in the prison than in a hospital, presumably there are far more persons staying inside for days, weeks and months although they would wish to go out in a hospital than in a prison and I am not speaking of bed ridden persons. Guardianship issues might need attention. Restraint issues and forced medication are of great importance in psychiatry, marginal in prisons. There are special programmes for forensic patients to examine, as there can be special issues of quite small children, adolescents and old patients, male and female.

There has been a preference for visiting forensic units, but no body of standards for them have been developed. Since a few years it is at least recognised that there should also be programmes aiming at preventing reoffending in the future. But there is no body of standards.

During recent years units holding persons in preventive detention have been visited in several countries. The policy of preventive detention is in some countries closely linked to psychiatric treatment, in other countries it might constitute a pause in treatment. After fact finding the time has come to reflect on the issues.

Although the CPT's mandate is defined by art 3 ECHR, the Committee has developed standards touching art 5 and also other articles and in psychiatry it has sometimes acted like a medical body not only issuing fragments of guidelines of good practice but also interfering in clinical details.

The Committee should however prioritise its core mandate of preventing ill treatment and focus on developing its working methods: the visiting of establishments, issuing recommendations and cooperating with the State Parties in order to assure their implementation.

There is not data from all countries available and State Parties have different policies, but there are many countries where more persons are every year involuntarily admitted to a psychiatric hospital than sent to prison. For old people, women and minors psychiatric detention is far more frequent than detention on criminal grounds. The CPT should not be mirroring the general avoidance and neglect of mentally ill persons found in society. Involuntary psychiatric patients need the attention of the CPT and should constantly be included when developing the means for preventing ill treatment and inhuman and degrading treatment.