University of BRISTOL

Human Rights Implementation Centre

Some reflections on issues emerging from the practice of the UN Subcommittee on Prevention of Torture (SPT) regarding mental health in detention.

The UN Subcommittee on Prevention of Torture (SPT) has noted that persons with acute medical or psychological dependencies or conditions are considered to be a vulnerable group and called for special expertise in order to lessen the likelihood of ill-treatment of such persons in detention.[1] The practice of the SPT itself however on issues of mental health in detention has been limited. The aim of this paper is to take stock of what the Subcommittee has done so far in relation to mental health issues in detention. It is hoped that this exercise will allow some light to be shed on gaps in the SPT's practice and assist towards suggesting some possible ways forward.

1. Some General Issues: scope of Article 4 of OPCAT and diversity of expertise

Article 4 is one the key provisions of the Optional Protocol to the United Nations Convention against Torture (OPCAT): it sets out the extent of and limits to the mandates for both National Preventive Mechanisms (NPMs) and the SPT in relation to the types of places of deprivation of liberty that these bodies are to visit. The crucial aspect here is proper interpretation and application of this provision as it is essential for proper adherence to the obligations undertaken by the States parties upon the ratification of OPCAT.[2]

Article 4(1) of OPCAT obliges States parties to allow visits by both the NPMs and SPT to any place under their jurisdiction and control where persons are or may be deprived of their liberty 'either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'. This is a very broad definition encompassing 'traditional' (e.g. prisons, remand centres and police cells) and less traditional places (e.g. transit points at international ports and psychiatric hospitals); public and private settings (including e.g. private hospitals, nursing homes and children homes

[1] 4th Annual Report of SPT, UN Doc CAT/C/46/2 of 3 February 2011, at para 23.
[2] For detailed analysis see: Murray, R., Steinerte, E., Evans, M. and Hallo de Wolf, A. *The Optional Protocol to the UN Convention against Torture* Oxford University Press, 2011,Chapter 4; See also' 'Deprivation of liberty' as per Article 4 of OPCAT: the scope', Policy Paper by the Human Rights Implementation Centre, University of Bristol, October 2011.

To date, SPT has conducted fourteen in-country visits and one follow-up visit.[3] Of these, there are six visits reports which have been made public in accordance with Article 16 of OPCAT. Examination of these six reports reveals that SPT has only visited three psychiatric institutions[4] and not a single social care home for persons with disabilities, for example, when compared to twenty five prisons and sixty one police cells that have been visited by SPT during the same six in-country visits. The practice of NPMs is also similar, with prisons and police cells receiving more attention. There are two concerns that flow from this:

(a) Firstly, that this may send a message, albeit unintentionally, that some places of deprivation of liberty are 'more important than others'.

(c) Secondly, to what extent does this have to do with the expertise and background of those undertaking the visits? Is medical expertise necessary when carrying out visits to places of deprivation of liberty in the context of mental health? According to the Institutional Treatment, Human Rights and Care Assessment project (ITHACA),[5] formal medical qualifications are not crucial for the ability of monitoring team to conduct visits to specialised mental health institutions.[6] Rather, what is more important is the credibility of team which can be enhanced by ensuring that team members have undergone specific training on the principles and methodology of monitoring as well as standards against which places of detention will be monitored.[7] They emphasize the need for a multi-disciplinary team and argue that this should include a person who is a user of mental health services or former user of services; a health care practitioner with specific knowledge of mental health or intellectual disability and someone with a background in human rights.[8] Could external experts provide a broader range of experience in this field, whether this is through the roster of experts for the SPT, which has been little used,[9] or for NPMs at the national level?

The practice of NPMs so far indicates two underlying issues in their engagement with mental health issues in detention.

(a) The national legal frameworks on NPMs may not duly reflect the scope and breadth of Article 4 of OPCAT which may negatively impact or even prevent NPMs from engaging with specialised mental health institutions where they exist. Equally, national legal frameworks on mental health generally can be inadequate or lacking

[3] See: http://www2.ohchr.org/english/bodies/cat/opcat/spt_visits.htm .
[4] These were two psychiatric hospitals in Mexico (see: CAT/OP/MEX/1 Annex I) and one in Paraguay (See: CAT/OP/PRY/1 Annex II).
[5] For further details see: http://www.ithaca-study.eu/
[6] See: 'The ITHACA Toolkit for monitoring Human Rights and General Health Care in mental health and social care institutions'; The ITHACA Project Group, 2010; at p. 26.
[7] Ibid.
[8] Ibid.
[9] According to the public reports on SPT visits, external experts have been used on only three visits: two external experts accompanied the SPT on its visit to the Maldives and one to Sweden. See: First Annual Report of SPT, UN Doc CAT/C/40/2 of 14 May 2008, at para 63; One expert accompanied the SPT on its visit to Benin; See Benin Visit Report, UN Doc CAT/OP/BEN/1 of 15 March 2011, at para 8.

altogether;[10] this includes also legislative frameworks guaranteeing the rights of mentally disabled patients deprived of their liberty and/or under treatment against their will.[11]

(b) As noted above, specialised expertise may also be an issue, given that the large proportion of NPMs around the world are existing institutions. Many NPMs overcome this by increasingly using external experts[12] and, when this is not possible, the visits to specialised mental health institutions tend to focus generally on checking that the applicable legal standards are properly adhered to and a general inspection of conditions of detention.[13]

2. Mental health in places of deprivation of liberty generally

Notwithstanding the limited number of occasions on which the SPT has engaged with mental health issues during its in-country visits, as reflected by the six visit reports that have been made public to date, there are some aspects in relation to general places of deprivation of liberty concerning mental health issues that arise from the SPT's reports:

(a) Firstly, underlining the responsibility of States to protect the physical and mental integrity of persons ,[14] the SPT has:

(i) requested that adequate healthcare, including in relation to mental health, is ensured in prisons;[15]

(j) reminded states parties that prisoners are entitled to the right to health as ensured in international human rights treaties;[16]

[10] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 237.
[11] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 292.
[12] For example, the Estonian NPM has increasingly relied on the use of external experts, including psychologists and psychiatrists when conducting visits to psychiatric institutions: two in 2008, three in 2009 and eight in 2010. See: The Chancellor of Justice of Estonia, *2008 Overview of the Chancellor of Justice: Activities for the prevention of torture and other cruel, inhuman or degrading treatment or punishment. Statistics of proceedings*, (Tallin: Office of the Chancellor of Justice, 2009) at p. 7; The Chancellor of Justice of Estonia, *2009 Overview of the Chancellor of Justice: Activities for the prevention of torture and other cruel, inhuman or degrading treatment or punishment. Statistics of proceedings*, (Tallin: Office of the Chancellor of Justice, 2010) at p. 7; The Chancellor of Justice of Estonia, *2010 Overview of the Chancellor of Justice activities for the prevention of ill-treatment. Statistics of proceedings*, (Tallin: Office of the Chancellor of Justice, 2011) at p. 8
[13] See: The Human rights Ombudsman of the Republic of Slovenia, *2009 Report: National Preventive Mechanism under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;* The Human rights Ombudsman of the Republic of Slovenia, *2010 Report: National Preventive Mechanism under the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*
[14] See Mexico Visit Report, UN Doc CAT/OP/MEX/1 of 31 May 2010, at paras 34, 59, 119 and 258; Honduras Visit Report, UN Doc CAT/OP/HND/1 of 10 February 2010, at para 61.
[15] See Benin Visit Report, UN Doc CAT/OP/BEN/1 of 15 March 2011, at para 131.
[16] See Mexico Visit Report, UN Doc CAT/OP/MEX/1 of 31 May 2010, at para 204

(k) noted that the level of health care offered in prison should be equivalent to that of the population in general, and free of charge;[17]

(l) and reiterated the right of prisoners to the highest attainable standard of physical and mental health.[18]

The SPT has specified that all this includes such specific aspects access to doctors,[19] including specialists such as psychiatrists.[20]

Secondly, in relation to places of deprivation of liberty, the SPT has noted the lack of adequate training of prison staff on health[21] and mental health issues specifically[22] and especially underlined the importance of such training in countries where the availability of specialist psychiatric expertise outside places of deprivation of liberty is limited.[23] The lack of adequate training of staff on appropriate use of force and disciplinary procedures on prisoners with mental health issues has also been emphasized.[24]

Thirdly, SPT has stressed the importance of proper record keeping[25] and highlighted the importance of an initial medical examination, including a mental health assessment, upon admission to a prison[26] and recommended that it is carried out by independent doctors[27] and in a manner that respects medical confidentiality.[28]

Fourthly, in relation to detention regimes, the SPT has emphasized the negative effects of solitary confinement[29] and prolonged isolation,[30] as well as of overcrowding for prisoners with mental health issues[31] and noted that not all disciplinary procedures should be used in relation to prisoners with mental health problems.[32]

[17] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 227.
[18] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 170.
[19] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 154; See Benin Visit Report, UN Doc CAT/OP/BEN/1 of 15 March 2011, at para 131.
[20] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 228.
[21] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at paras 153-154.
[22] See Sweden Visit Report, UN Doc CAT/OP/SWE/1 of 10 September 2008, at para 127; See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 237.
[23] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 161.
[24] See Sweden Visit Report, UN Doc CAT/OP/SWE/1 of 10 September 2008, at para 127.
[25] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 181; Mexico Visit Report, UN Doc CAT/OP/MEX/1 of 31 May 2010, at para 119.
[26] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 181; Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 171.
[27] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 98.
[28] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 111.
[29] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 295.
[30] See Sweden Visit Report, UN Doc CAT/OP/SWE/1 of 10 September 2008, at para 127.
[31] See Honduras Visit Report, UN Doc CAT/OP/HND/1 of 10 February 2010, at para 188; Mexico Visit Report, UN Doc CAT/OP/MEX/1 of 31 May 2010, at para 205.
[32] See Benin Visit Report, UN Doc CAT/OP/BEN/1 of 15 March 2011, at para 246.

Finally, the SPT has scrutinised the issue of continuity of care, emphasizing that this must be ensured.[33]

3. Mental health in specialised places of deprivation of liberty

There are a number of points that the SPT has raised in relation to specialised mental health institutions specifically:

(a) The Subcommittee has expressed concern over lack of specialised facilities for those with mental health issues[34] and to this end has also criticised states parties for lack of clear legislation in relation to prisoners with mental health issues who due to inadequate legislation are frequently transferred from prison to a specialised mental health institution.[35] The SPT has thus requested that prisoners with mental health issues are transferred to specialised mental health institutions where proper care can be provided.[36]

(b) In relation to existing institutions, the SPT has scrutinised the physical conditions of detention and hygiene in specialised mental health institutions.[37]

(c) The SPT has engaged with issues of violence and use for force by requesting states parties to take measures against inter-patience violence[38] as well as ensure adequate surveillance in specialised mental health facilities so as to protect the patients from external violence.[39] The SPT has also requested that use of force by staff be legitimate and proportionate.[40]

(d) The SPT has recommended that patients are given greater opportunities to take part in rehabilitation activities[41] and has welcomed initiatives such as the provision of various workshops and gardens, where detainees could engage in various activities.[42]

4. Some reflections on methodological issues

There is very little advice available from the Subcommittee regarding the methodology of conducting visits to mental health institutions or to other places of detention where mental

[33] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 237.
[34] See Maldives Visit Report, UN Doc CAT/OP/MDV/1 of 26 February 2009, at para 237.
[35] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 181.
[36] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 292.
[37] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 219; Mexico Visit Report, UN Doc CAT/OP/MEX/1 of 31 May 2010, at para 205.
[38] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 220.
[39] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 219.
[40] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 220.
[41] See Paraguay Visit Report, UN Doc CAT/OP/PRY/1 of 7 June 2010, at para 224.
[42] See Mexico Visit Report, UN Doc CAT/OP/MEX/1 of 31 May 2010, at para 202.

health may be an issue. However, in its Second Annual Report the SPTdid promote the use of the Istanbul Protocol, which includes psychiatric examinations) as a methodological tool.[43]

In general NPMs equally have not developed detailed methodological tools and there is little beyond a checklist of items to be observed while touring the inspected establishments.[44]

Human Rights Implementation Centre

February, 2012

[43] 2nd Annual Report of SPT, UN Doc CAT/C/42/2 of 7 April 2009, para 24; see also Annex VII of the same report.
[44] See e.g. The Chancellor of Justice of Estonia, *2010 Overview of the Chancellor of Justice activities for the prevention of ill-treatment. Statistics of proceedings*, (Tallin: Office of the Chancellor of Justice, 2011) at p. 8.