- 2016

Monitoring psychiatric institutions

OUTCOME REPORT

association pour la prévention de la torture
asociación para la prevención de la tortura
association for the prevention of torture

Jean-Jacques Gautier NPM Symposium 2016

Monitoring psychiatric institutions

Outcome report

The Association for the Prevention of Torture (APT) is an independent non-governmental organisation based in Geneva, working globally to prevent torture and other ill-treatment.

The APT was founded in 1977 by the Swiss banker and lawyer Jean-Jacques Gautier. Since then the APT has become a leading organisation in the prevention of torture. Its expertise and advice is sought by international organisations, governments, human rights institutions and other actors. The APT has played a key role in establishing international and regional standards and mechanisms to prevent torture, among them the Optional Protocol to the UN Convention against Torture (OPCAT) and National Preventive Mechanisms.

The APT's vision is a torture free world where the rights and dignity of all persons deprived of liberty are respected.

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Abbreviations

APT	Association for the Prevention of Torture
CPT	European Committee for the Prevention of Torture
CRPD	UN Convention on the Rights of Persons with Disabilities
NGO	Non-Governmental Organisation
NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
SPT	United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment

About the third Jean-Jacques Gautier Symposium

This Symposium is the third in a series of meetings organised by the APT in Geneva with the aim of allowing National Preventive Mechanisms (NPM), the national monitoring bodies established under the Optional Protocol to the United Nations Convention against Torture (OPCAT), to discuss the challenges they face in the implementation of their preventive mandate and to identify good practices in relation to situations of vulnerability in detention. The Symposium offers a platform for discussion among peers and other experts. The first Symposium, organised in 2014, addressed children's vulnerabilities in detention, while the second, in 2015, discussed the situation of LGBT (lesbian, gay, bisexual and transgender) persons deprived of their liberty. The third Jean-Jacques Gautier Symposium focused on the monitoring of psychiatric institutions.

This series of meetings pay tribute to Jean-Jacques Gautier, the founder of APT, whose idea to introduce regular, unannounced visits to all places of detention is now a reality. The ratification of the OPCAT, which entails the establishment of a national (NPMs) and international (the Subcommittee on Prevention of Torture) independent visiting mechanism, has been in force since 2006 and includes 83 States Parties from around the world. As part of their mandates, NPMs visit any place where persons are or are likely to be deprived of their liberty.

In recent years, psychiatric institutions have received growing international attention, including from torture prevention bodies. To address situations of vulnerability of persons deprived of liberty in these institutions and to fulfil their preventive mandate, the NPMs have asked the APT to advise them in order to strengthen their capacity in this area.

This third Symposium was attended by representatives from 15 National Preventive Mechanisms from around the world and by international experts, including representatives of international and regional detention monitoring bodies, of non-governmental

organisations and intergovernmental bodies, as well as experts on disability rights and on mental health. The programme was divided into two parts. The first day and a half brought together all the participants who discussed the following main topics: involuntary placement and treatment; seclusion and means of restraints; respect for dignity and the right to privacy; the role and capacity of NPMs to evaluate treatment and, finally, the issue of alternatives to institutionalisation. Part one included a discussion on the standards relevant to monitoring work and the challenges of implementing these in practice. It also identified the risk factors experienced by persons deprived of liberty in psychiatric institutions.

Part two (last afternoon) brought together the representatives of NPMs and SPT only for an exchange among peers. The participants were able to share the challenges specific to monitoring psychiatric institutions and discuss good practices in order to address these challenges more effectively.

Objectives and structure of the report

This document is the outcome report of the third Jean-Jacques Gautier Symposium on monitoring psychiatric institutions. It does not provide a detailed account of the fruitful discussions which took place over two days, but aims to emphasise the issues and challenges of monitoring deprivation of liberty in psychiatric institutions, and to present certain points for consideration identified during the discussions on how to implement NPMs' preventive mandate.

The report contains a first **introductory part**, which presents the general framework and main definitions relating to the subject. **Part two** deals with the principles and standards relating to deprivation of liberty and treatment in psychiatric institutions, and the challenges of implementing them in practice. **Part three** identifies the main situations and risk factors for torture and other ill-treatment. Finally, the **fourth and last part** covers the role of NPMs in monitoring psychiatric institutions and their daily methodological questioning by identifying examples of good practices that emerged from these discussions.

Summary

Psychiatric institutions are places of deprivation of liberty, as defined in Article 4 of the Optional Protocol to the UN Convention against Torture (OPCAT), an international treaty adopted in 2002 that aims to prevent torture by establishing a system of regular visits to places of detention. These establishments therefore form an integral part of the mandate of the detention monitoring bodies created under the OPCAT: the Subcommittee on Prevention of Torture (SPT), an international body, and the National Preventive Mechanisms (NPM), national institutions that the States must establish when they ratify the treaty.

On 6 and 7 September 2016, the APT gathered in Geneva NPM representatives and international experts to explore the risk factors and situations that might contribute to abuse committed against persons deprived of liberty in psychiatric institutions, as well as the means of preventing these abuses. Over the two days, the participants tackled the following issues: international standards on the deprivation of liberty of persons with mental disabilities, involuntary treatment, seclusion and restraints (physical or chemical), the respect for dignity and the right to privacy, the risks of overmedication and the broader issue of deinstitutionalisation.

Deprivation of liberty in psychiatric institutions. In most countries, a person may be forced into a psychiatric institution, particularly if she/he is perceived to present a risk to her/his safety or that of others. The international standards governing this matter vary considerably and present a considerable challenge when developing national public policies. Several international human rights bodies (including the UN Human Rights Committee, UN Subcommittee on Prevention of Torture, and the European Committee for the Prevention of Torture) accept, as a measure of last resort, the involuntary placement of persons with mental disabilities, subject to the implementation of legal safeguards that prevent arbitrary detention and include review procedures in cases of abuse. Article 14 of the UN Convention on the Rights of Persons with Disabilities

(CRPD), ratified by 170 States, prohibits any deprivation of liberty on the basis of disability. This treaty, which has been in force since 2008, marks a paradigm shift by demanding an approach that is based on the person with a disability being a subject of rights and not as an "object" of medical treatment.

The Symposium shed light on the difficulty in implementing these international standards and the way in which, depending on the socio-political contexts in which they are operating, the NPMs approach involuntary placement and the right, as set forth in the CRPD, to live independently within the community.

Involuntary treatment. The participants held lengthy discussions on involuntary treatment and the deprivation of the right to legal capacity – a right enshrined in Article 12 of the CRPD – who often leads to involuntary placements and treatment of persons with disabilities. There remains a common perception that a person with mental disabilities is "incapable" of autonomous decision-making, and the principle of free and informed consent to treatment is therefore often not observed in practice. The participants emphasised that this consent should always be sought and that only exceptional circumstances, where the life of the person or that of others is in danger, could justify treatment without consent. It was pointed out that public policies cannot be based on these exceptional circumstances and that policies must guarantee the right of persons with mental disabilities to make autonomous decisions, in line with the paradigm shift embodied by the CRPD.

Situations and risk factors. The common practices of *seclusion and restraints* present an increased risk to the individual's physical and mental integrity. These measures should therefore only be used in exceptional circumstances, be tightly controlled, never imposed as a punishment and even completely abolished if they amount to torture or ill-treatment. Some NPMs gave examples of non-violent steps taken to manage crises and underlined the importance of having enough staff duly qualified in de-escalation techniques to prevent the use of these coercive measures.

The various daily restrictions imposed indiscriminately in many psychiatric establishments result in other risk situations that are often justified for safety reasons. These can seriously affect the *dignity, autonomy and right to privacy* of users of psychiatric services.

Finally, the *risks of overmedication*, including the use of chemical restraint, which often responds to a wish to control rather than to provide care, are some of the practices that require strict supervision to prevent abuse and should therefore be identified by monitoring bodies during their visits.

Monitoring psychiatric institutions and the role of NPMs. Monitoring bodies play a key role since, under international treaties (OPCAT or European Convention for the Prevention of Torture), state authorities are obliged to ensure unhindered access to places of detention. Despite their different approaches to monitoring psychiatric institutions, all NPMs at the Symposium acknowledged that non-discrimination is one of their main guiding principles. Some of them still encounter obstacles that are both internal (lack of NPM members' awareness and training on rights and needs of persons with disabilities) and external (lack of access to the institutions, questioning of their legitimacy to carry out this type of monitoring in "care settings"). However, most NPMs and the SPT now include this monitoring in their visit programmes (the CPT having already many years of expertise in this area).

The Symposium also gave NPMs the opportunity to discuss the challenges they face from a methodological point of view, in particular the need for multidisciplinary visiting teams and the role of health specialists (including psychiatrists) within those teams. A constructive dialogue with staff at the establishments being visited is also essential to enable the authorities to have a better understanding of NPMs' mandate and, where appropriate, be made aware of the changes that are needed in the institution. The importance of interviews in private with the persons deprived of liberty and the need for NPM members to receive specific training on how to handle these interviews was also discussed. Finally, several good practices were identified, in particular the experience of NPMs which integrate the perspective of former users of psychiatric services in their work, including during visits.

Introduction: general framework and definitions

"*While the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognize that torture may also occur in other contexts.*"[1] As noted by the United Nations Special Rapporteur on Torture, psychiatric institutions are among the environments in which persons are at risk of abuse, which can amount to torture or other ill-treatment. To contribute to the capacity-strengthening of monitoring bodies in these types of establishment and to the better prevention of abuses, the APT dedicated its third Jean-Jacques Gautier Symposium to the realities of psychiatric institutions around the world and to the challenges related to monitoring these places of deprivation of liberty.

The monitoring of psychiatric institutions

Psychiatric institutions form an integral part of the mandate of the SPT and NPMs – the bodies established under the Optional Protocol to the United Nations Convention against Torture (OPCAT) whose mandate is to conduct regular visits to "*any place in which a person is deprived of liberty (in the sense of not being free to leave) (...) if it relates to a situation in which the State either exercises, or might be expected to exercise a regulatory function.*"[2] Privately-run healthcare settings, including care centres that use traditional healers, were discussed several times during the Symposium and are also places of detention as defined in the OPCAT.

Practice shows that, 10 years after the OPCAT came into force, visits to psychiatric establishments form an integral part of NPMs' activities

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[1] See the report of the UN Special Rapporteur on Torture, Juan E. Méndez, UN Doc. A/HRC/22/53, 1 February 2013, §15, http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf

[2] SPT, *Compilation of SPT Advice in response to NPMs' requests*, Advance unedited version, §3, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/C/57/4&Lang=en

in many countries, particularly in Europe and Latin America, but also in the Asia-Pacific region (New Zealand). Since 2011, the SPT has placed greater emphasis on monitoring psychiatric institutions and systematically conducts visits to this type of establishment as part of its field missions.

On a regional level, the European Committee for the Prevention of Torture (CPT) regularly monitors psychiatric hospitals and has been doing so for approximately 15 years. An integral part of the CPT's work involves raising their members' awareness, training them and conducting visits to psychiatric institutions. This is borne out by the statistics on visits carried out in 2015: 12 of the 17 missions in that year included visits to psychiatric hospitals.

Despite this clear mandate and the monitoring bodies' awareness of the need to visit these facilities, various internal and external obstacles to regular monitoring remain in place. Externally, limited access, in particular to private establishments, continues to present significant challenges to the monitoring bodies in some settings. Internally, some NPMs' visiting schedules still rarely prioritise these centres. This is in part the result of the members' lack of training and awareness on mental disability, which hinders NPMs' capacity to treat persons deprived of liberty in these institutions in an appropriate way and to respond to their needs. Members and staff of monitoring bodies (NPMs or SPT) are often still ill at ease during these visits due to prejudices surrounding mental disability, the discrimination that has historically prevailed towards persons with disabilities and a lack of training and awareness.

The aim and nature of psychiatric institutions differs from more "classic" detention centres, such as prisons. Unlike in the prison system, directors of health establishments are involved in the decision-making on involuntary placement, and are then responsible for implementing this decision, which is not always accompanied by the necessary guarantees to prevent arbitrariness and allow for review procedures in case of abuse. In addition, the attitude of care staff, who see themselves as vested with a therapeutic mission and are not used to being supervised by an independent external body may, initially, be wary. Often people do not know what these bodies do and their actions are therefore misunderstood and perceived to be an inappropriate challenge to the merit of medical decisions and interference in the therapeutic process. Against this background, it

is therefore essential for visiting teams to take the time, at the start of each visit, to explain why they are there, what they will be doing and to break down this initial resistance.

Towards a paradigm shift: the Convention on the Rights of Persons with Disabilities

For a long time, an exclusively medical approach to mental disability has prevailed and psychiatrists' opinions have never or rarely been questioned. This situation has led to the wishes of persons with mental disabilities being ignored as they were, and in practice still are, considered "incapable" of making independent decisions. The participants mentioned that there is a power game behind the medical community's reticence to be supervised by independent bodies protecting human rights, such as the NPMs, as the psychiatric body has a "monopoly" on care and, in some cases, has also been entrusted by the government authorities with the mission of "social control".

In many countries, this power is compounded by stigmatisation and discrimination towards persons with mental disabilities in a society that tends to accept the incarceration of persons who are assumed to be dangerous. The place and role of families in institutionalisation is an issue that was raised several times during the Symposium. Social stigma, as well as the absence of support and suitable structures in the community, contribute to families "abandoning" a relative with a disability in closed institutions. This situation is particularly serious in societies with strong superstitions, and in which families use traditional healers who offer treatments that can present serious risks to a person's physical and mental integrity and are not subject to any outside inspection. Nevertheless, it was pointed out that, in certain countries, such as Senegal, the family plays an integral role in the care, ensuring more compassionate treatment and a more humane environment, as well as an easier return to society following hospitalisation and thus avoiding a long-term separation from life in the community.

Based on these findings and traditional discrimination towards persons with mental disabilities, the Symposium's participants acknowledged the need for a change in their approach to accepting these individuals as subjects of rights and not as "objects" of medical

treatment. This approach is justified in light of the paradigm shift deriving from the CRPD, adopted in December 2006 and in force since May 2008, which has 170 States Parties from around the world.

This treaty aims to uphold the principle of non-discrimination, at the heart of the Convention, by promoting and protecting the full and equal enjoyment of all human rights by persons with disabilities. The Convention reaffirms the prohibition of torture and other ill-treatment towards persons with disabilities (Article 15) and forbids the deprivation of liberty on the basis of disability (Article 14). The CRPD Committee that supervises the implementation of the Convention has interpreted article 14 as an absolute prohibition on placement on the basis of (actual or perceived) disability and considers that any placement on the basis of disability constitutes a form of arbitrary detention.[3] In addition, article 19 of the Convention establishes the right of persons with disabilities to live independently in the community. This treaty therefore departs from a primarily medical approach towards disability and binds the States Parties to implement a range of services that enable persons with disabilities to be integrated into society on an equal basis with others.

On a national level, although 170 States are parties to the Convention, almost all existing legislation authorises involuntary placement and/or treatment based on criteria that include "mental disorder", but also the "risk" that the person presents to themselves or to others and "therapeutic necessity".

Main definitions and terminology

"**Psychiatric institution**" is a term used throughout this report, which we understand to mean public or private health institutions, specialised in the care of persons suffering from mental (or psychosocial) disabilities, such as psychiatric hospitals, psychiatric units within hospitals, but also secure units for persons in conflict with the law. Other facilities, such as social care homes in which thousands of people are institutionalised for years, while not formally psychiatric institutions, are often so *de facto* and were therefore included in discussions at the Symposium. In light of this definition, we must specify that persons with mental (or psychosocial)

[3] CRPD Committee, *Guidelines on the right to liberty and security of persons with disabilities*, 2015: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx

disabilities are found in many other places of deprivation of liberty that were not discussed at the Symposium, including prisons, police stations, homes for the elderly or orphanages.

Persons held in psychiatric institutions have a range of legal statuses, as they can be placed following either criminal or civil proceedings. In the first instance, the decision regarding placement as part of the criminal justice system is decided by a judge and the placement is involuntary. As part of the civil procedure, we find persons whose placement is involuntary (a placement also called "mandatory", "forced" or "without consent") and that, in some countries, is ordered by a judicial authority or subject to judicial review, as well as persons who have agreed to being placed in an institution.

A shift from voluntary to involuntary placement is nonetheless common, and in practice it is not unusual for individuals who have been voluntarily placed not to be free to leave the establishment and to be subject to the same conditions and measures restricting their freedom (e.g. placement in closed units, seclusion) as persons placed against their will. These so-called "volunteers" are particularly at risk as they do not enjoy the same legal safeguards as involuntary persons as they were initially placed in the institution on a "voluntary" basis.

> "*By definition, everyone detained in a prison, police station or an immigration detention centre is deprived of liberty. This is not the case in a health-care setting or care home, even though many patients or residents thought to be voluntary are not so in reality.*"
>
> Catherine Paulet, member, SPT

The terminology used to refer to people who are institutionalised in psychiatric hospitals varies enormously and includes: "persons with mental disorders", "persons with mental health problems", "persons with mental disabilities", or "persons with psychosocial disabilities". In this report, we favour the use of terms such as "persons with mental disabilities" or "persons with psychosocial disabilities" to reflect the historical paradigm shift embodied by the CRPD which, for the first time, enshrines in an international treaty the fact that

persons with disabilities are subjects of rights.[4] These two terms are often used interchangeably, but the UN Committee on the Rights of Persons with Disabilities (the CRPD Committee) favours the term "psychosocial" to reflect the concept that disability is a consequence of the interaction between a person's "impairment" and the social environment she/he lives in.

Finally, to conclude this introduction, we would like to emphasise that an intersectional approach should be applied when dealing with situations of vulnerability of persons with disabilities deprived of liberty. Indeed, certain groups or persons with disabilities (for example, women, LGBTI persons, children, the elderly, ethnic minorities or indigenous peoples), once institutionalised, are exposed to an increased risk of discrimination and ill-treatment as a result of, for example, their gender, sexual orientation, age or membership of a minority or indigenous people. Monitoring bodies are therefore asked to pay particular attention to these cases of multiple vulnerability in the context of deprivation of liberty.

[4] Article 1 of the CRPD defines persons with disabilities as "*those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others*". This definition distinguishes between two concepts: "impairment" (which is a personal characteristic) and "disability" (understood to be the effect of interaction between personal impairment and the social and material environment).

Deprivation of liberty and treatment in psychiatric institutions

International standards and perspectives

There is a set of international standards on involuntary placement and treatment of persons with mental disabilities. These standards and their interpretation vary considerably. Most international and regional human rights bodies accept deprivation of liberty and treatment without consent in certain circumstances (in particular the UN Human Rights Committee, the UN Committee against Torture, the UN Subcommittee on Prevention of Torture, the European Committee for the Prevention of Torture and the Inter-American Commission on Human Rights), while the UN Committee on the Rights of Persons with Disabilities recommends an absolute prohibition on deprivation of liberty based on disability, without exceptions. This position is supported by the UN Working Group on Arbitrary Detention in its *Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court*, adopted in 2015.[5]

Monitoring bodies such as the SPT and CPT accept involuntary placement, as a measure of last resort and subject to guarantees, that prevent arbitrary detention and ensure regular judicial review of the decision on deprivation of liberty.[6] Similarly, the SPT and CPT accept treatment without consent as a measure of last resort.

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[5] Principle 20, UN Doc. A/HRC/30/37, 6 July 2015. For a detailed analysis of the international standards on the right to liberty and security of persons with disabilities, see the document published in 2015 for a meeting of experts organised by the United Nations High Commissioner for Human Rights: http://www.ohchr.org/EN/Issues/Disability/Pages/deprivationofliberty.aspx

[6] See SPT, *Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment regarding the rights of persons institutionalised and treated medically without informed consent*, UN Doc. CAT/OP/27/2, 26 January 2016, §8, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/OP/27/2&Lang=en. See also CPT, *CPT Standards*, CPT/Inf/E (2002) 1-Rev.2015, §52: http://www.cpt.coe.int/en/docsstandards.htm

This treatment without consent should, however, have safeguards, including the possibility of appeal to an independent authority, which is often not available in practice. The CPT and SPT nevertheless consider that alternatives to involuntary placement must be put in place in accordance with article 19 of the CRPD, to minimise long-term institutionalisation and promote health-care services in the community.

As noted above, the CRPD proposes a paradigm shift, which prohibits deprivation of liberty based on disability. The Committee therefore believes that any placement based on disability constitutes a form of arbitrary detention and also calls for a total prohibition on medical procedures without the individual's free and informed consent.

Some participants expressed their concerns that this new paradigm embodied in the CRPD does not have sufficient support among states. Given the high number of ratifications of this treaty, they therefore recognised that it should become a key reference, including for torture prevention bodies. The participants in the Symposium, and in particular the NPMs, discussed at length these different international standards and interpretations and the difficulties this inconsistency presents to the work of monitoring bodies. The last chapter of this report will revisit this point.

Paraguay: Criteria on involuntary placement and treatment

The NPM requires four cumulative conditions to limit cases of involuntary deprivation of liberty:

1. As provided for the Paraguayan Health Code, the risk the person presents must be proven in written after evaluation by a panel of independent experts (minimum two health professionals) who have no interest in institutionalising the person.
2. This proven risk must involve a danger to the life or personal integrity of a third person or of the person herself/himself.
3. The absence of an emergency treatment in case of crisis will lead to irreversible harm.

4. The authorities have not considered the institutionalisation as the first and only measure but envisaged alternatives, including by exhausting non-custodial measures in the community.

If such conditions are met, the deprivation of liberty must be for the shortest time possible and be subject to regular review (every 24, 48 or 72 hours).

The principle of free and informed consent to treatment

The principle of free and informed consent to any medical treatment is enshrined in several international documents that precede the adoption of the CRPD in 2006.[7] Article 25 of the CRPD stipulates that the States Parties have the obligation to demand that health professionals *"provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent*." The CPT and SPT standards also enshrine this principle. The CPT specifies that *"Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances."*[8]

Placement in a psychiatric establishment, whether voluntary or not, should never be interpreted as authorising treatment without consent. Consent can be considered to be "free and informed" if the persons are notified of all the implications of the treatment, including any possible side effects, as well as of their right to refuse treatment or any other form of medical intervention. Moreover, obtaining consent should not be limited to a simple formality and therefore requires taking the time to talk to the person and discussing the treatment he/she is likely to receive. Finally, pursuing a treatment option should not be based exclusively on consent expressed at the start. Obtaining free and informed consent should be an ongoing process required for every medical intervention.

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[7] See, at the European level, the *Oviedo Convention on Human Rights and Biomedicine* that entered into force in 1999 and the *Charter of Fundamental Rights of the European Union* of 2000 (Art, 3, §2). See also, Council of Europe Committee of Ministers, *Recommendation Rec(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder.*

[8] *CPT Standards*, §41.

During the Symposium, the participants highlighted the significant gap between the legal framework for consent and its daily implementation in psychiatric institutions. Indeed, the visiting teams often found that the existence of a (real or perceived) mental impairment justified decisions being taken without even seeking to find out the will of the person involved, who is often ill-informed or not informed of his/her rights. In many cases, there is also a close correlation between deprivation of legal capacity and deprivation of liberty followed by involuntary treatments. Persons who are deprived of their legal capacity (and under full or partial guardianship) are indeed often placed without consent and are wrongly considered to be "voluntary" patients if the institution has obtained the consent of their guardian.

The CRPD proposes a paradigm shift that assumes a person has the capacity to make decisions on her/his treatment in every situation. The consent must therefore be sought even if the person does not *a priori* has the capacity to understand the information provided or to communicate effectively.

> "*We acknowledge that there are situations where people are not able to express their consent or decide on their will and preferences on treatments that would be life-saving. But we must embrace an approach that presumes capacity. We have witnessed over decades that, unless we take that approach, we presume that people are incapable of making decisions and giving consent. This is the paradigm shift we are talking about: we should presume capacity in any situation because every person has moments of clarity.*"
>
> Dragana Ćirić, Mental Disability Rights Initiative, Serbia

The CRPD Committee has begun to develop standards on the subject, which still require protocols for their implementation in practice. It recommends in particular a move from a system of "substitute decision-making" to one of "supported decision-making".[9] The former is based on appointing a third party who bases their decisions on the principle of the person's "best interests", sometimes even against their will. The latter allows the persons to express their will and preferences with someone else's support, if necessary. The Committee has identified examples of practices to guarantee this right, such as the possibility of obtaining the individual's prior consent or of resorting to a "personal ombudsman" or even to the testimonies of family members.

The principle of free and informed consent: practical challenges to its implementation

The issue of situations that justify circumventing an individual's consent was the subject of lively debate. The participants agreed on the need to differentiate between two very separate scenarios: emergency situations, which present an imminent risk to the life of the person or to others, in which the absence of treatment could cause irreparable harm, and long-term healthcare measures for which consent cannot be circumvented.

A consensus was reached in which situations of imminent danger to the life of a person could justify treatment without consent. The views and experiences of former service users illustrated the various positions and complexity of this issue. Some believed that forced treatment could be justified in order to save a life, while others were of the opinion that any forced treatment is a violation of the right not to be tortured since certain treatments can cause serious harm to the person's health in the medium or long-term, and should therefore be prohibited in favour of an ongoing attempt to seek consent and alternatives. Finally, it was clearly stated that crisis situations should be seen to be exceptional and cannot under any circumstances form the basis of public policy on this matter.

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[9] CRPD Committee, *General Comment N°1 on Article 12* (Equal recognition before the law), UN Doc. CRPD/C/GC/1, 19 May 2014, §3, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/1&Lang=en

> "*What is the alternative that allows us to continue saving lives, without establishing forced treatment and deprivation of legal capacity as a general rule? There lies the challenge. (...) It seems to me that focusing public policies on the exceptional situations basically ends up being a discussion that is not about public policies. We should think of systems that can cover 99.99% of cases, instead of concentrating on the minimum number of cases.*"
>
> Facundo Chávez,
> UN Office of the High Commissioner for Human Rights

In addition to the ethical arguments and the danger of administering involuntary psychiatric treatments, the participants also discussed the counter-productive nature of these treatments, as illustrated in a study published by the European Union Agency for Fundamental Rights in 2012.[10] This study highlights the fact that the persons' involvement in their treatment, and their support for the choice of treatment has a positive impact on their hospitalisation. Conversely, if the treatment is administered without consent and the person does not understand its implications, this causes suffering and has far greater long-term harmful consequences for the person's health.

The testimony of a victim of forced treatment also allowed to illustrate the negative effect of some treatments and the need to recognise the harm caused as an initial form of reparation and a necessary first step towards a change in practice. The principle of "medical necessity" of certain treatments was thus challenged as a vague notion that is not backed by clear scientific evidence, as stated by the UN Special Rapporteur on the Right to Health and the UN Special Rapporteur on the Rights of Persons with Disabilities: "*The concept of "medical necessity" behind non-consensual placement and treatment falls short of scientific evidence and sound criteria. The legacy of the use of force in psychiatry contravenes the "primum non nocere" (first do no harm) principle and should no longer be*

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[10] European Union Agency for Fundamental Rights, *Involuntary placement and involuntary treatment of persons with mental health problems*, 2012: http://fra.europa.eu/en/publication/2012/involuntary-placement-and-involuntary-treatment-persons-mental-health-problems

accepted."[11]

It was mentioned that in practice it is possible to reduce or even remove the use of involuntary treatment by learning de-escalation techniques that allow the person to regain lucidity without medication. When a treatment is administered, the calming effect can lead to difficulty communicating and result in treatment being pursued without consent. To avoid this vicious circle, all possible measures must be put in place to understand the will and preferences of the person and avoid any forced treatment. It is therefore essential to have enough medical staff with the appropriate training to anticipate risks and avoid crisis situations. It was also pointed out that access to activities, which are lacking in so many institutions, is a factor that can minimise restlessness and prevent crisis situations.

> "*Violent medical practices, such as forced electroshocks and forced drugging do not constitute help or care, nor do they have a legitimate purpose. They are discriminatory and harmful practices that can cause severe injury, pain and suffering as well as deep fear and trauma for the victims. There is an urgent need to recognise the severe harm done and the suffering inflicted on the victims.*"
>
> Hege Orefellen,
> World Network of Users and Survivors of Psychiatry

[11] *"Dignity must prevail" – An appeal to do away with non-consensual psychiatric treatment*, World Mental Health Day, 10 October 2015, http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583&LangID=E

Situations and risk factors in psychiatric institutions

Several rights are affected by placement and involuntary treatment in psychiatric institutions. This chapter first examines the use of measures such as seclusion and restraint, which pose the greatest risks to physical and mental well-being. It then tackles other measures, such as various restrictions the individuals are subjected to as part of their daily life in the institution and that violate their dignity and privacy. Finally, it will deal with the risks of overmedication.

Seclusion and means of restraints

Placing someone in seclusion is understood here to be confining someone in an enclosed space that the person cannot leave at his/her own free will, whether this be his/her own room or any other room used for this purpose. Restraint aims to limit the person's mobility and can take several forms: physical or mechanical restraint (straitjacket, fasteners, including restraint on a bed with straps on four or five fixation points) and chemical restraint (injecting medication, often with the aim of sedating the person). Other means of restraint include the use of cage beds, including in Europe, and shackles, which have been reported in traditional healing centres in Africa and Asia.[12]

The participants described the situation in various parts of the world and expressed huge concerns about the use of practices that constitute a "*deprivation of liberty within deprivation of liberty*". The CPT in particular has underlined a trend towards an increase in the use of seclusion and restraint in various European countries, both in terms of duration and frequency, as well as the danger of combining

[12] See the recent report by Human Rights Watch on the use of shackles in Indonesia: *Living in Hell, Abuses against People with Psychosocial Disabilities in Indonesia*, https://www.hrw.org/news/2016/03/20/living-hell-people-mental-health-conditions-indonesia. Other reports that document the situation in other countries are available here: https://www.hrw.org/topic/disability-rights. See also the reports of Disability Rights International: http://www.driadvocacy.org/media-gallery/our-reports-publications/

various forms of restraint (physical and chemical). This reality calls for action, especially as existing international standards tend to limit, and even prohibit - in the case of the CRPD Committee - the use of such practices. The CPT standards on psychiatry only provide for the use of seclusion and restraint in exceptional circumstances, as a last resort, for the shortest time possible, and under the constant supervision of qualified medical staff. The CPT specifies that the use of such practices should never be applied as a punishment and that each instance of seclusion or restraint should follow a procedure that enable the use of these practices to be recorded and properly traced.[13]

In May 2016, the French NPM published a report on seclusion and restraint in France, following visits conducted in more than 100 healthcare establishments over the last few years.[14] This report highlights the fact that no scientific study confirms the therapeutic effectiveness of restraint and seclusion and reveals a huge disparity in the use of these practices in France, a disparity also observed by NPMs in other countries:

- variations in the use of seclusion and restraint depending on the establishment (use sometimes widespread and completely commonplace or practically absent), even within the same establishment where significant differences were sometimes found from one unit to the next;
- a variety of reasons given to justify the measure: “risk” posed by the individual, therapeutic purpose, but also often “disciplinary” reasons;
- variation in the duration of the measures, from a few hours to several months.

The Paraguayan NPM has observed non-violent practices in crisis situations in certain institutions, such as the “hug” method (*abrazo*) or restraint using sheets.

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[13] *CPT Standards*, §§ 47-50.

[14] General Controller of Places of Deprivation of Liberty (CGLPL), *Isolement et contention dans les établissements de santé mentale*, éditions Dalloz, Paris, 2016: http://www.cglpl.fr/2016/isolement-et-contention-dans-les-etablissements-de-sante-mentale/.

> *"My experience in one psychiatric unit was that the first method used for a person who has just been admitted is a method of restraint called the "hug" or "restraint using sheets". This method is more humane than others such as confinement, shackling or seclusion."*
>
> Carlos Portillo, NPM, Paraguay

Participating monitoring bodies agreed on the need to identify how widespread these practices are in order to establish if they are used routinely and therefore part of an institution's culture. For these bodies to be able to verify that other means (substitute measures to seclusion or restraint) have indeed been attempted and failed, each establishment must keep a register of these measures to ensure traceability, not only for independent external bodies such as NPMs but also for the authorities, or even families and users' associations. The families must always be notified when their relative has been placed in seclusion and of the restraint measures they have been subjected to.

France: register of seclusion and restraint and new remedy

A law dated 26 January 2016 has implemented some of the NPM's recommendations on the use of seclusion and restraint in France. The law stipulates that these practices should only be applied as a last resort subject to a doctor's decision, and no longer based on a medical prescription, and that they must be recorded in a register. Seclusion is therefore now outside the scope of a medical prescription (in other words, outside the scope of an alleged therapeutic measure that is prescribed), which opens the possibility of challenging this medical decision before a judge. The effects of this recent provision have not yet been evaluated.

The participants highlighted the need to identify alternative measures that respect the integrity and dignity of individuals, offer better prevention against crisis situations and break the vicious circle brought about by seclusion and restraint. These practices are often linked to a shortage of nursing staff in the institution as well

as to a lack of training on de-escalation techniques for managing agitation. Reference was therefore made to the importance of NPMs' role in identifying situations liable to result in crises, such as: lack of access to carers, lack of activities, limited visitor access, few or no opportunities to smoke.

> *"I always remember the story of a young man, who admitted himself to hospital. He felt he needed support. He came voluntarily and he was administered medication immediately. He was given a drug before he had talked to anyone. The drug caused him to have involuntary movements. That behaviour was then recognised as agitation when he was simply trying to communicate. After that, he was given an injection and he then lost the ability to speak and was perceived as not consenting to treatment, so they started treating him involuntarily by restraining him on the bed."*
>
> Dragana Ćirić, Mental Disability Rights Initiative, Serbia

The NPMs and other experts who were present questioned what approach should be adopted in these circumstances. While some advocated better training (for example, giving written instructions to professionals) and more control of these practices to provide greater safeguards for users, others stated that the only approach that ensures human rights are respected is to prohibit these practices, as recommended by the UN Committee on the Rights of Persons with Disabilities.

Dignity and respect for the right to privacy

Living conditions in psychiatric institutions and the restrictions imposed on persons who are hospitalised also affect the protection and respect for their right to privacy. Situations that were identified often included a total absence of privacy: being unable to lock their room's door (provided that such private rooms exist) and to keep one's personal belongings including one's own clothes. There is often an obligation to wear pyjamas for alleged safety reasons: to stop individuals from running away. Access to a mobile phone can also be restricted or even prohibited throughout the duration of the

stay in the institution, depriving the person of private contacts with people on the outside (public telephones, when they exist, are often in the common areas of the institution and therefore do not allow for any privacy). Access to visitors is also difficult and even prohibited for persons who are in seclusion or under physical restraint. Contact between users is also sometimes prohibited. Other restrictions are imposed such as a ban on smoking. Sexual relations, while not necessarily prohibited, remain a taboo in a number of institutions, leading to a total absence of any preventive measures, specifically against unwanted pregnancies or sexually transmitted infections.

Sometimes, constant supervision, such as in seclusion rooms, either via video surveillance systems, or by the nursing staff directly, also violates the person's privacy. In extreme cases, supervision is also carried out in private areas such as the showers and toilets, and prevents the person from turning their bedroom light off, even at night. The testimony of one Symposium participant, who underwent the profoundly humiliating experience of permanent supervision, illustrated this problem.

> *"In order to prevent me from leaving the hospital and from harming myself, I was put under close observation and had a nurse within arm's reach every minute of every day for seven weeks of the four months I was a patient. I was not allowed to turn the lights off in my room, I was not allowed to have parts of my body out of sight of the nurse, I had to go to the toilet in front of the nursing staff. Any possession I had that I might use to harm myself with was removed and at one point, after I had tried to hang myself, nearly every single possession I had was taken away."*
>
> Graham Morgan, Mental Welfare Commission for Scotland, part of the UK NPM

The justification given for these restrictions is generally safety or medical reasons (including prevention of suicides). This requires NPMs to call the authorities' attention to the need to question the validity of certain practices commonly used by the staff. These various restrictions should never take the form of general rules imposed on all institutionalised persons, but rather should be the

result of an individual analysis to evaluate the need for such measures on a case-by-case basis as part of each person's treatment.

Autistic persons in psychiatric hospitals

It was noted that, in some settings, autistic persons who are deprived of liberty are at particular risk and have all their personal possessions removed as they are wrongly perceived as being a danger to themselves and to others. Their difficulties in communicating are perceived as a psychosocial disability that justifies treatment without seeking to obtain their consent. Despite the risk of violent behaviour initially being low, these individuals have their freedom and privacy severely curtailed. They perceive the deprivation of liberty and the treatment they are given as a threat and this only exacerbates the problem. Measures can escalate to include seclusion and restraint – a direct result of a lack of understanding of the needs and specific characteristics of these persons.

Evaluating treatment and the risks of overmedication

Drug treatment, and in particular overmedication and the combination of different substances, pose serious risks to a person's integrity. Various monitoring bodies observed that, too often, the treatment consists primarily in drug therapy, which is not tailored to the individual, and that essential components of effective treatment (such as therapeutic activities, including access to occupational therapy, art, music or sport but also individual psychotherapy) are rarely explored or completely absent. The situation, as noted by the CPT, "*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*."[15] Overmedication is therefore generally the result of an institutional environment that does not aim to encourage the person's autonomy and capacity to make his/her own decisions. It can constitute inhuman or degrading treatment and participants stressed the harmful effects of an overdose of medication or drug interaction. They also discussed the issue of clinical trials without the consent of individuals, as well as the deaths potentially linked to this research.

[15] *CPT Standards*, §37.

Several participants underlined the fact that medication often has no clear therapeutic purpose and that it is used for disciplinary and punitive purposes. To prevent abuse where possible, it is essential that individuals give their consent to treatment, that they are duly involved in the choice of medication and that they understand its possible side effects. This requires informing them and presenting alternatives, including a drug-free therapeutic option.

Monitoring bodies often face the difficulty of evaluating the merit of a medical treatment. When they do not have medical expertise, some are occasionally powerless as they feel neither qualified nor entitled to judge the therapeutic value of a particular treatment.

NPMs vary in their opinions on their capacity and legitimacy to challenge the relevance and content of treatments. Some believe it is their responsibility to evaluate each treatment systematically and question certain overmedication practices, which are often the result of insufficient or poorly trained staff. It is advisable to consider the content and duration of the treatment, whether or not alternatives have been suggested and the institution's resources, including whether or not they propose alternative therapies without any medication.

> "*The issue of medicine in the hospital is: what is it used for? Very rarely is it used for treatment, much more often it is used for discipline, sedation and punishment. And this is what I believe the role of the NPM is: to observe and decide whether these medicines are not being used for their purpose, which means they are not being used for treatment.*"
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> Vladimir Jovic, NPM, Serbia

The NPMs must also be trained to be able to identify signs of potential overmedication from the presence of side effects (such as drowsiness) which can easily be identified, but also to evaluate the potential effects of interaction between various medicinal products and the use of substances for disciplinary purposes. The institution's death rate should also be monitored to identify the causes.

To be able to implement this aspect of their mandate, it is essential that NPM (including any non-medical staff) and SPT members have

access to all medical documentation, as provided for in the OPCAT. In several countries, this is often still a challenge, particularly owing to the confidential nature of medical information.

NPMs' role regarding overmedication: the Georgian experience

The Georgian NPM has been active since 2010 as part of the Public Defender's Office. It considers that it is qualified to evaluate treatment from a pharmacological (type and dosage) and legal (whether or not this constitutes a form of ill-treatment) perspective. Based on the premise that all treatments must be adapted to each individual, who should be involved in the whole process, it underlines the need to check that there is a therapeutic value to any treatment and that it is never administered as a punishment.

The NPM verifies whether guidelines governing medication exist or not and whether doctors are free to prescribe the type and dose of medication. It also checks that the medication is not the only method of management used and identifies any potential side effects.

The NPM also suggests evaluating a treatment by: ascertaining if the medication and dose are correct; finding out if the person's condition is stable or has even improved and if side effects are being managed. If there are no positive results, the prescription should be reviewed.

From a methodological point of view, it recommends that NPMs:

- acquire specialised knowledge of existing pharmacological treatments;
- ascertain the systemic use of overmedication;
- pay close attention to risk factors that may result in overmedication, including: staff training and numbers; living conditions in the establishment; the absence of personalised psychosocial treatment; the absence of strategies for prevention and de-escalation and the lack of any proper communication between patients and staff.

Monitoring psychiatric institutions: what role for NPMs?

In response to the many risks identified, NPMs can play a key role in strengthening the protection of persons placed in psychiatric institutions. Their preventive mandate allows them to visit these places of deprivation of liberty to observe the treatment of persons deprived of liberty and the conditions in the establishment, with the aim of identifying the causes of torture and other ill-treatment and, based on their findings, to engage in a dialogue with the state authorities to improve laws and practices. It is thus incumbent upon them to guide the authorities towards adopting legislative frameworks and public policies based on non-discrimination and the respect for human rights. The NPMs also play a significant role in raising awareness among the general public by publishing reports or statements on their findings.

To achieve this, it is essential that everyone within each NPM is aware of the standards that govern the deprivation of liberty of persons with mental disabilities, including the principles enshrined in the CRPD. It is, moreover, essential that NPMs be trained on the specificities of monitoring psychiatric institutions and that they define the scope and limits of their monitoring mandate.

Scope and limitations of NPMs' preventive mandate

How do NPMs tackle the issue of international standards on deprivation of liberty of persons with mental disabilities, but also in connection with the use of restraint or seclusion? Should they question the deprivation of liberty as such and encourage alternatives to institutionalisation and the right of persons with mental disabilities to live independently within the community?

Most NPMs recognise that the CRPD standards are a reference and that the principle of non-discrimination and recognition of persons with disabilities as subjects of rights must govern their action. Nevertheless, they have identified major obstacles to the implementation of these principles, in particular the reassessment

of "substitute decision-making" systems and the goal of deinstitutionalisation, as a result of the profound societal reforms underlying the paradigm shift deriving from the Convention.

In addition to the issue of applicable standards, NPMs discussed their role in the implementation of these standards and the challenges they face for their actions and recommendations to help reduce the gap between legislation and practice.

> *"Our role as NPM is to address recommendations that the institutions can implement and not just to reiterate standards that they know, or are supposed to know. We have to bridge this gap between the standards and the very challenging practice, dealing with these difficult situations on a daily basis. That, I think, is our biggest challenge as NPM: to have practical recommendations for the institutions, and convince them that this is the right approach so that they then implement these recommendations."*
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> Sandra Imhof, NPM, Switzerland

In terms of the deprivation of liberty itself, some NPMs and the SPT believe that to prevent arbitrary detention, it is in their remit to evaluate the legality of deprivation of liberty in a psychiatric context, and to verify if the person has indeed been placed "voluntarily".

During the discussions, some of the participants stated that it is not enough to call for an improvement to institutional practices. In light of NPMs' various practices, they discussed whether deinstitutionalisation is a necessary precondition for respecting the rights of persons with disabilities. Under the CRPD, providing care without resorting to institutionalisation is a requirement that the States Parties must pursue immediately. However, what should the NPMs' role be? Should they take a position on a particular health model or does this exceed their mandate?

Even though most of the NPMs present subscribed to the key principles of the Convention (non-discrimination, autonomy), not all of them approached implementation in the same way in practice. Some mechanisms actively promote deinstitutionalisation as an immediate requirement, believing it is the most effective

way of preventing torture. In Brazil, the NPM operates within the framework of a reform of the psychiatric system (Law 10216 of 2001), which recommends replacing psychiatric hospitals with services in the community. The Paraguayan NPM has also given the example of a rural indigenous community, which does not use institutionalisation, to illustrate that the perception of the risks related to mental disability can also be culturally conditioned. Other NPMs see deinstitutionalisation as a long-term goal and adopt a more "pragmatic" approach that consists of questioning cases of arbitrary detention and checking that all guarantees are in place to prevent ill-treatment, in particular the application of the principle of free and informed consent to treatment.

Finally, if NPMs and other monitoring bodies can be led to call for the closure of psychiatric establishments and promote community care, there remains the issue of ensuring appropriate measures are in place in the community. It is clear that the absence of community services cannot, under any circumstances, justify institutionalisation, but monitoring bodies' concern about the future of persons with mental disabilities is legitimate. Several participants expressed their concerns about the lack of health-care services in the community and highlighted the need for states to develop such services instead of renovating long-term stay institutions. In the case of persons in conflict with the law, they also alerted their peers to the need to ensure that the closure of psychiatric establishments does not result in an increase in the number of persons with mental disabilities in prison.

Main methodological challenges

Participating NPMs debated the specificities and methodological challenges of monitoring psychiatric institutions, in particular: the composition of the visiting team, issues related to the staff of the establishments and interviews in private with the users of psychiatric services.

Composition of the visiting team

When states create their NPM, the OPCAT requires they ensure NPM staff and members form a multidisciplinary team. This allows the mechanism to benefit from a range of points of view according to each person's area of expertise. During the Symposium, the NPMs

and the SPT discussed the role of psychiatrists within the team and the advantages and disadvantages of their presence within visiting teams.

Psychiatrists have the benefit of specialised medical knowledge and are able to assess the relevance of the care, the quality of the proposed treatment and can therefore add more legitimacy to the NPM. However, their presence can also be perceived with suspicion by the users as it has strong associations with their experience in the institution. Moreover, it is not necessarily apparent to psychiatrists that their role as members of a human rights monitoring body should prevail over their role as a doctor in the interests of the persons who are deprived of liberty. The psychiatrist's point of view should therefore be contrasted with that of their non-specialist peers to allow for a discussion within the team before, during and after the visits, and establish a common approach to the monitoring between specialists and non-specialists.

> "*Non-psychiatrists play an essential role to counteract the professional biases of psychiatrists. Non-psychiatrists are more sensitive to the dehumanising effects of some psychiatric institutions and ask sensible questions about patients' everyday living conditions. They also understand how important private interviews with patients are conducted to probe for possible abuses, even with acutely disturbed, psychotic patients and patients in seclusion and/or physically restrained.*"
>
> Timothy Harding, Expert-psychiatrist, CPT

In practice, several NPMs lack medical expertise in their team. To make up for this, psychiatrists are often included as external experts and only join the NPM team for visits. This offers the aforementioned benefits but also provides an additional challenge: a shared common vision/understanding of the preventive mandate of monitoring that transcends the professional background of each of the members of the visiting team. The discussions led to the conclusion that, while a psychiatrist's presence in the NPM brings added value, one does not need to be a specialist to evaluate the merit of certain practices and their potential negative impact on human rights.

Finally, a good practice of certain NPMs is to include former users, either as full members of the mechanism's team, or as external experts. The presence and experience of these persons facilitates contacts with the users but also with their families, and even with the staff of the visited institution. Their personal experience sheds a different light on the establishments visited and the aspects to consider during the monitoring, increases the visiting teams' awareness and broadens the NPM's perspective, placing it in a position to better respond to the specific needs of persons with mental disabilities deprived of liberty.

United Kingdom: integrating the users' perspective in monitoring

In the United Kingdom, several institutions that are part of the NPM have a specific mandate to monitor healthcare institutions. The Mental Welfare Commission for Scotland is one of them. This Commission includes the perspective of former users of mental health services.

In 2015, the Commission created an "engagement and participation" department made up of three people, including a former user and a former carer. Their role is to be fully fledged members of the visiting team. During the visits, they focus on the meetings with patients and carers and are also involved in drafting reports after the visits. They also meet users' associations regularly to introduce the Commission, consult them on issues to better inform the Commission's work and to facilitate contacts between various groups of users in Scotland.

Staff-related issues

Establishing a constructive rapport with the management and staff of institutions being visited is an essential starting point for NPMs. They must therefore adopt a constructive approach, assuming that the staff and management are willing to improve the quality of the service and care.

It has already been mentioned that it can be difficult for the NPMs to deal with carers who fail to understand their aim and mandate as an institution preventing torture and other ill-treatment. In some cases,

however, the staff are willing to share their doubts and discuss the constraints in their working conditions. The monitoring mandate and the aims of the visits must be clearly explained so that the staff view the NPM's observations as a valuable contribution to improve the running of the establishment, including the staff conditions – one of the aspects that the NPM is required to observe. In many cases, the NPMs acknowledged that the use of methods violating the integrity of the individuals was in part the result of staff shortages and a lack of appropriate staff training.

> *"The inspectors have met teams who are equally concerned about the rights of patients and ask questions about how to treat them humanely. They query the merit of using seclusion and are open to discussion on their practices but are short of time and take these practices for granted. They say that in the beginning they were shocked, but now they no longer think about it."*
>
> Anne Lecourbe, NPM, France

Private interviews with the users

The NPMs highlighted the importance of having private interviews with many persons placed in psychiatric institutions, as well as taking all the necessary precautions to maintain their anonymity and prevent the risk of reprisals. However, as part of each visit and depending on the establishment's specific characteristics, it is important that the NPMs draft selection criteria for these private interviews. During the Symposium, the NPMs identified the following selection criteria: meeting people who would like to see the NPM but also those who have just been admitted to the institution, will soon be leaving it, are or have been in seclusion, as well as persons in particular situation of vulnerability (e.g. children, the elderly).

Meeting users who are under physical restraint raises ethical questions. Indeed, these persons are in a particularly vulnerable and degrading situation and having an unknown person visiting them can be an added humiliation. The CPT shared their experience on this matter by underlining the importance of meeting these people regardless, if they consent to it, since the aim of the meeting is to

obtain information liable to improve their conditions and minimise, or even eliminate, the use of these methods. A practice that was highlighted, and that aims to avoid too much exposure and protect the sensitivity of the persons being interviewed while being restrained, consists of meeting them one-to-one. It is a set-up that the person is not used to and does not therefore remind him/her of his/her contacts with usually two persons at a time: a doctor and a carer.

To guarantee the dignity of the users, experience has shown that it is essential that NPMs train their members and staff properly on how to handle private interviews with persons with mental disabilities. It is crucial to have an open approach that does not question the person's word. In Serbia, the NPM unit within the Ombudsman's Office is an example of good practice as their staff have been able to benefit directly from training on the specificities of monitoring institutions with persons with disabilities. This training was facilitated by civil society organisations (in particular the NGO Mental Disability Rights Initiative), who are specialised on disability rights and form an integral part of the NPM's structure.

Finally, during private interviews, one fundamental principle of the monitoring bodies' mandate should always be borne in mind and respected: the "do no harm" principle. It is therefore essential that NPMs remain vigilant and are always transparent about the aim of their visits and the limitations of their mandate so as not to create expectations regarding the solutions they can offer in each person's individual situation.

Conclusion

Almost anywhere in the world, persons with mental disabilities can be placed in an institution, whether voluntarily or not, based on criteria that include “mental disorder”, the “risk” that the persons present to themselves or to others and a “therapeutic need”. In these institutions, they run the risk of being subjected to different forms of ill-treatment that, in some cases, can amount to torture. Despite some progress, both on a normative and practical level, thousands of persons with disabilities are still institutionalised for longer or shorter periods depending on the contexts, at the expense of alternatives that would favour their (re-)integration in society by providing care services in the community.

The Symposium allowed representatives of monitoring bodies and other international experts to examine crucial issues related to the deprivation of liberty, as well as the treatment and conditions that persons with mental disabilities are subjected to during their institutionalisation. The participants underlined the need to move away from a primarily medical approach to disability, in line with the spirit of the UN Convention on the Rights of Persons with Disabilities. This means acknowledging that persons with mental disabilities are subjects of rights who must be supported, if needed, to exercise their rights effectively, including the right to live independently in the community.

Reference was also made to the fact that public policies on involuntary treatment must be based not on exceptional emergency situations, which may require overriding the individual’s consent in the event of an imminent risk to their life or that of others, but rather on the overwhelming majority of non-urgent situations, where seeking consent must always prevail.

To implement the paradigm shift embodied by the Convention, the UN Special Rapporteur on the Right to Health underlined the importance of developing a network of psychiatrists who are prepared to debate current practices and challenge them if these

amount to ill-treatment or torture, with the aim of better protecting the rights of persons with disabilities.

Monitoring bodies, and NPMs in particular, have a central role to play in protecting the rights of individuals deprived of liberty in psychiatric institutions – a monitoring role increasingly exercised in several regions around the world. Their preventive mandate under the OPCAT, which ensures privileged access to all places of deprivation of liberty - both public and private - (in the broad sense of the definition contained in article 4 of the OPCAT), places them in a unique position to report on the reality of deprivation of liberty and to question it with a view to improving practices.

Despite the diversity of the social, political and cultural contexts in which NPMs operate, and the diverging practices pertaining to the treatment of persons with mental disabilities, these bodies face similar challenges in the monitoring of psychiatric institutions, both on fundamental substantive issues and on the methodological approach to be adopted before, during and after the visits.

In light of the diverging international standards governing involuntary placement and treatment of persons with mental disabilities, which renders their implementation all the more difficult, NPMs' main governing principle should be non-discrimination. This principle includes an acknowledgement of the paradigm shift, which assumes that the individual has the capacity for independent decision-making. In other words, the move from a system of "substitute" decision-making to a system of "supported" decision-making.

At the end of the Symposium, it was concluded that NPMs (and other monitoring bodies) should be encouraged to consider the following issues to better protect persons with mental disabilities and promote alternatives to institutionalisation in favour of life in the community:

- check that the treatment is always individualised and question practices (such as the use of seclusion and physical or chemical restraint) that may amount to torture or other forms of ill-treatment;
- ensure visiting teams are multidisciplinary and made up of healthcare specialists but also non-specialists, in order to benefit both from medical expertise but also from a range of points of view on the methods of treatment observed;

- Include the perspective of former users in the NPM's work (either as members of the team or as external experts);
- adopt a sympathetic approach towards staff in the institution being visited and dedicate enough time to explain to them the aim of the visit so they can better understand NPMs' mandate;
- train and raise awareness of NPM members, to ensure they adequately respond to the specific needs of persons with mental disabilities and adopt an open and respectful attitude towards them during private interviews. The "do no harm" principle must be applied at all times.

As highlighted by many NPMs present at the Symposium, their mandate is not limited to visits and to verifying material conditions – a well-intentioned approach but one that, in some cases, has contributed to the renewal or creation of new infrastructures that perpetuate long-term institutionalisation. NPMs' function is, where appropriate, to challenge practices but also legislation and regulations – including by checking that all guarantees are in place to prevent arbitrary detention, and that individuals are duly informed of their rights. In the case of arbitrary detention, this function includes questioning the decision of deprivation of liberty itself. They must also evaluate the overall management and culture of the institution, identify the deep-rooted causes of ill-treatment and, through a constructive dialogue with the authorities, offer solutions to prevent new abuses.

Finally, it is crucial for this monitoring to also include actions to raise awareness among users' relatives but also within the society as a whole on the rights and needs of persons with mental disabilities, with a view to ending discriminatory practices and preventing their prolonged institutionalisation.

Annex I: Agenda

Tuesday, 6 September 2016

Objectives of Part 1 of the Symposium:

- Explore the risk factors and situations which contribute to abuse and ill-treatment of persons held in psychiatric institutions and ways to address them.
- Examine standards applicable to psychiatric institutions and identify NPM strategies to address challenges related to their implementation in practice.
- Enable interaction between NPMs and other key actors to share and identify good practices and reinforce cooperation.

Time	Session
8:30 – 9:00	Registration and welcome coffee
9:00 – 9:30	**Introductory session** • Opening remarks *Mark Thomson, APT Secretary General* • Objectives, scope and methodology *Isabelle Heyer, APT* • "Tour de table" (introduction of participants)

9:30 – 11:00	**Session 1 – Deprivation of liberty in psychiatric institutions: international perspectives** • The SPT's approach to involuntary placement in psychiatric institutions *Catherine Paulet, UN Subcommittee on Prevention of Torture* (8 min.) • The UN CRPD and the right to liberty and security *Silvia Quan, Vice-Chair, UN Committee on the rights of persons with disabilities* (8 min.) Moderated discussion: all participants (~1h.) Moderator: *Barbara Bernath, APT*
11:00 – 11:30	Coffee break
11:30 – 13:00	**Session 2 – Involuntary treatment** • The right to legal capacity in the context of psychiatric institutions *Facundo Chávez, Disability Rights Advisor, OHCHR* (8 min.) • The principle of free and informed consent to treatment: a perspective from medical practice *Dainius Puras, UN Special Rapporteur on the right to health* (8 min.) • Rights and remedies for an effective protection against non-consensual treatment *Hege Orefellen, Member, World Network of Users and Survivors of Psychiatry* (8 min.) Moderated discussion: all participants (~1h.) Moderator: *Isabelle Heyer, APT*
13:00 – 14:15	Lunch

14:15 – 15:45	**Session 3 – Seclusion and means of restraints** • The CPT's experience in monitoring psychiatric institutions: current challenges related to the use of seclusion and restraints in Europe *Timothy Harding, Expert, CPT* (8 min.) • The French NPM's experience and approach *Anne Lecourbe, CGLPL, France* (8 min.) • Perspectives from Ghana, India and Indonesia on the use of restraints in psychiatric institutions *Shantha Barriga, Director, Disability Rights Division, Human Rights Watch* (8 min.) Moderated discussion: all participants (~1h.) Moderator: *Jean-Sébastien Blanc, APT*
15:45 – 16:15	Coffee break
16:15 – 17:45	**Session 4 – Respecting dignity and the right to privacy** • Dignity and privacy of persons held in psychiatric institutions: a perspective from civil society *Oliver Lewis, Directeur exécutif, Mental Disability Advocacy Center* (8 min.) • Privacy and dignity in a psychiatric hospital *Graham Morgan, Engagement & Participation Officer (Lived experience), Mental Welfare Commission for Scotland* (8 min.) • The situation of persons in conflict with the law in psychiatric facilities: a perspective from the Costa Rica NPM *Lorna Elizondo, Social worker, NPM, Costa Rica* (8 min.) Moderated discussion: all participants (~1h.) Moderator: *Sylvia Dias, APT*

17:45 – 18:00	Wrap up and close of meeting – *Isabelle Heyer, APT*
18:30	Reception at the APT

Wednesday, 7 September 2016 (morning)

Time	Session
8:30 – 9:00	Welcome coffee
9:00 - 10:30	**Session 5 – Assessing treatment and the risk of overmedication** • The Georgian NPM approach and experience *Nika Kvaratskhelia, Head of the NPM, Georgia* (8 min.) • Challenges related to assessing treatment and the risk of overmedication: a perspective from the Mauritius NPM *Vijay Ramanjooloo, Commissioner, National Human Rights Commission (NPM), Mauritius* (8 min.) Moderated discussion: all participants (~1h.) Moderator: *Veronica Filippeschi, APT*
10:30– 11:00	Coffee break
11:00 – 12:30	**Session 6 – De-institutionalisation and community-care: challenges and good practices** • The role of civil society organisations in NPMs' approach to de-institutionalisation *Dragana Ćirić, Director, Disability Rights International/MDRI-Serbia* (8 min.) • Alternatives to institutionalisation in psychiatric institutions from a monitoring perspective: the experience of the Paraguayan NPM *Carlos Portillo, NPM Commissioner, Paraguay* (8 min.)

	Moderated discussion: all participants (~1h.) Moderator: *Barbara Bernath, APT*
12:30 - 12:45	Wrap-up of first part of the Symposium – *Isabelle Heyer, APT*
12:45 – 14:00	Lunch at the IPU

Wednesday, 7 September 2016 (afternoon)[16]

Objectives of part 2 of the Symposium:

- Discuss among peers about the main challenges for NPMs in carrying out their preventive mandate with regard to the issues discussed during the first part of the Symposium.
- Exchange good practices in relation to working methods to develop NPMs skills in monitoring psychiatric institutions.
- Strengthen cooperation among NPMs and with the SPT.

Time	Session
14:00 – 15:30	**Session 1 – Applicable standards in monitoring psychiatric institutions** • NPMs' feedback on issues discussed during part 1 of the Symposium, including possible unaddressed issues (30 min.) • NPMs' strategies to address existing different standards in practice (1h.) Moderated discussion: all participants Moderator: *Isabelle Heyer, APT*
15:30 – 16:00	Coffee break

[16] This last afternoon was a closed meeting only for representatives of National Preventive Mechanisms (NPMs) and the UN Subcommittee on Prevention of Torture (SPT).

16:00– 17:30	**Session 2 – Methodological challenges** This last session will address challenges, including: • Composition of visiting teams: ensuring multidisciplinarity and adequate skills of monitors as well as common approach/ understanding of monitoring; role of external experts, incl. integration of "experts by experience" in the visiting team • Staff-related issues: number, skills, training, how to build a rapport with staff • Handling private interviews with persons held in psychiatric institutions Moderated discussion: all participants (1h30) Moderator: *Jean-Sébastien Blanc, APT*
17:30 – 18:00	Wrap up and closing of the Symposium *Isabelle Heyer, APT* *Mark Thomson, Secretary General, APT*

Annex II: List of participants

National Preventive Mechanisms (NPMs)

	Name	Title	Institution and Country
1.	Mr Nurlan ADBYRAIMOV	Senior expert	National Centre of the Kyrgyz Republic on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, Kyrgyzstan
2.	Ms Ariadna CHERONI	Psychologist	National Preventive Mechanism, National Institute of Human Rights, Uruguay
3.	Mr Lucio COSTA	Member	National Mechanism for the Prevention and Fight against Torture, Brazil
4.	Mr Hamet Saloum DIAKHATE	External observer	Observatoire National des Lieux de Privation de Liberté –ONLPL, Senegal
8.	Ms Sandra IMHOF	Secretary	Commission Nationale pour la Prévention de la Torture –CNPT, Switzerland
9.	Mr Vladimir JOVIC	Member	National Preventive Mechanism - Protector of Citizens, Serbia

10.	Mr Nika KVARATSKHELIA	Head of Department of Prevention and Monitoring	National Preventive Mechanism - Public Defender of Georgia, Georgia
11.	Ms Anne LECOURBE	Controller	Contrôleur Général des Lieux de Privation de Liberté - CGLPL, France
12.	Mr Colin McKAY	Chief Executive	Mental Welfare Commission for Scotland (part of NPM), United Kingdom
13.	Mr Graham MORGAN	Engagement & Participation Officer (Lived experience)	Mental Welfare Commission for Scotland (part of NPM), United Kingdom
14.	Mr Carlos PORTILLO	Commissioner	National Mechanism for the Prevention of Torture, Paraguay
15.	Mr Vijay RAMANJOOLOO	Member	National Preventive Mechanism – National Human Rights Commission, Mauritius
16.	Ms Iisa SUHONEN	Legal advisor and OPCAT coordinator	National Preventive Mechanism – Parliamentary Ombudsman, Finland

International experts

1.	Ms Shantha BARRIGA	Director, Disability Rights	Human Rights Watch, Brussels
2.	Mr Facundo CHÁVEZ PENILLAS	Human Rights and Disability Advisor	Office of the United Nations High Commissioner for Human Rights (OHCHR), Geneva

3.	Ms Dragana ĆIRIĆ	Executive Director	European Regional Office of Disability Rights International (DRI)/Mental Disability Rights Initiative (MDRI-S), Serbia
4.	Ms Lucía DE LA SIERRA	Human Rights Officer	Mandate of the SR on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health Office of the United Nations High Commissioner for Human Rights (OHCHR), Geneva
5.	Mr Timothy HARDING	Expert	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)
6.	Mr Oliver LEWIS	Executive Director	Mental Disability Advocacy Center (MDAC), UK
7.	Ms Cristina MICHELS	Human Rights Officer	Mandate of the SR on the Rights of Persons with Disabilities – Office of the United Nations High Commissioner for Human Rights (OHCHR), Geneva
8.	Ms Hege OREFELLEN	Member	World Network of Users and Survivors of Psychiatry (WNUSP)
9.	Ms Catherine PAULET	Member	United Nations Sub-Committee on Prevention of Torture (SPT)
10.	Mr Dainius PURAS	Special Rapporteur	UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

11.	Ms Silvia QUAN	Vice-Chair	United Nations Committee on the Rights of Persons with Disabilities (CRPD)
12.	Ms. Emilie THAGE	Associate Human Rights Officer	SPT Secretariat, Office of the United Nations High Commissioner for Human Rights (OHCHR), Geneva

Association for the Prevention of Torture

	Name	Title
1.	Ms Barbara BERNATH	Chief of Operations
2.	Mr Jean-Sébastien BLANC	Detention Adviser
3.	Ms Sylvia DIAS	National delegate (Brazil)
4.	Ms Veronica FILIPPESCHI	OPCAT Adviser
5.	Ms Isabelle HEYER	Americas Programme Officer
6.	Ms Caroline MOUCHET	Intern
7.	Mr Mark THOMSON	Secretary General

Annex III: Concept note

Monitoring psychiatric institutions
3rd Jean-Jacques Gautier NPM Symposium

6-7 September 2016, Geneva, Switzerland

Overview

"*While the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognise that torture may also occur in other contexts.*"[17] Psychiatric institutions fall within these "other contexts", where persons are at risk of abuses that can amount to torture or other forms of ill-treatment. The involuntary placement and the specific exposure to abuses in such institutions have received increased attention in the last decade, especially following the adoption of the UN Convention on the rights of persons with disabilities, which states that "*the existence of a disability shall in no case justify a deprivation of liberty.*" (art. 14)

Objectives

Part 1: NPMs and international experts

- Explore the risk factors and situations which contribute to abuse and ill-treatments of persons held in psychiatric institutions and ways to address them.
- Examine standards applicable to psychiatric institutions and identify NPM strategies to address challenges related to their implementation.
- Enable interaction between NPMs and other key actors to share and identify good practices and reinforce cooperation.

[17] See Report of the UN Special Rapporteur on torture, Juan E. Méndez, UN Doc A/HCR/22/53, 1 February 2013.

Objectives

Part 2: NPMs and the SPT

- Discuss among peers about the main challenges for NPMs in carrying out their preventive mandate with regard to the issues addressed during Part 1.
- Exchange working methods to develop NPMs skills in monitoring psychiatric institutions.
- Strengthen cooperation among NPMs and with the SPT.

National Preventive Mechanisms (NPM) established under the Optional Protocol to the UN Convention Against Torture (OPCAT) have the mandate to monitor all places of deprivation of liberty, including public or private psychiatric institutions where persons are held and treated involuntarily.

This Symposium will therefore focus on psychiatric institutions, understood as any public or private health establishment providing medical treatment to persons with mental or intellectual impairments (e.g. psychiatric hospitals, psychiatric wards in general hospitals, secure units/hospitals or other places that are de facto psychiatric institutions).

Symposium Organisation

The September 2016 meeting is the third of a series of ***Jean-Jacques Gautier Symposiums***. The Symposium is an international forum, unique in its kind, allowing the exchange of knowledge and practices between NPMs and other experts on the issue of vulnerabilities in detention. In 2014, the first symposium focused on the vulnerability of children in detention.[18] The second edition looked at the situation of LGBT persons deprived of their liberty. This third edition will address the issues and challenges related to deprivation of liberty and human rights violations in psychiatric institutions.

Participants at this event will include around fifteen NPMs from all regions of the world, as well as representatives from regional and international monitoring bodies (including the Subcommittee on Prevention of Torture, SPT) and other international experts with extensive knowledge of the issue. The limited number of

[18] The outcome reports of the first and second Jean-Jacques Gautier Symposiums are available here: http://www.apt.ch/en/jean-jacques-gautier-npm-symposium/

participants is intended to create an environment which enables exchange and discussion among participants.

Each session will begin with a few brief presentations addressing specific issues and will be followed by discussions in plenary among all participants, allowing them to share good practices as well as challenges. Simultaneous interpretation will be available in English, French and Spanish.

Outcomes and outputs

- Participants will have a clear understanding of risk situations faced by persons held in psychiatric institutions.
- NPMs will have identified strategies to address these issues in carrying out their preventive mandate.
- Contacts between participants will help build future collaboration.
- Working methods of NPMs will be adapted to address key issues in psychiatric institutions.
- The 3rd NPM Symposium outcome report will be made public.

Part 1 (6 September and morning of 7 September)

The first day and a half will gather all participants with multidisciplinary expertise and diverse backgrounds: NPM representatives, experts from regional and international monitoring bodies as well as NGOs specialised on disability rights. This first part will aim at exploring the main risk factors found in psychiatric institutions in different contexts and highlight ways of addressing them in order to identify strategies for NPMs and other monitoring bodies to effectively address these issues in their daily work. Finally, the meeting will be an opportunity for NPMs and other stakeholders to develop or strengthen existing cooperation.

Part 2 (afternoon of 7 September)

The last afternoon of the Symposium will gather NPM representatives and the SPT member in a smaller setting to facilitate increased cooperation among NPMs and between NPMs and the SPT. The working meeting will focus on an exchange among peers on the issues identified during Part I. It will also allow participants to share working methods and further develop their skills and strategies with regard to NPMs' role in monitoring psychiatric institutions.

Annex IV: Useful references

International and regional standards

- UN Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security* (art. 14), 2015: www.ohchr.org/Documents/HRBodies/CRPD/GC/GuidelinesArticle14.doc
- UN Working Group on Arbitrary Detention, *Basic Principles an Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court*, 2015: http://www.ohchr.org/EN/Issues/Detention/Pages/DraftBasicPrinciples.aspx
- OHCHR, *Compilation of international standards on the right to liberty and security of persons with disabilities* (Background note for OHCHR expert meeting of 8-9 September 2015): http://www.ohchr.org/EN/Issues/Disability/Pages/deprivationofliberty.aspx
- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), *CPT standards* (for standards related to psychiatric establishments, see pages 48 onwards): http://www.cpt.coe.int/en/docsstandards.htm
- Inter-American Commission on Human Rights, *Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas* (see especially Principle III.3 on special measures for persons with mental disabilities): http://www.oas.org/en/iachr/mandate/Basics/principlesdeprived.asp
- African Commission on Human and Peoples' Rights, *Draft protocol to the African Charter on Human and Peoples' Rights on the rights of persons with disabilities in Africa* (adopted by the Commission in 2016 but pending adoption by the States of the African Union): http://www.achpr.org/files/news/2016/04/d216/disability_protocol.pdf

Reports and documents from intergovernmental mechanisms and institutions

- UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, (SPT), *SPT's approach regarding the rights of persons institutionalised and treated medically without informed consent*, UN Doc CAT/OP/27/2, 26 January 2016: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT/OP/27/2&Lang=en
- UN Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, UN Doc A/HRC/22/53, 1 February 2013: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf
- EU Fundamental Rights Agency, *Involuntary placement and involuntary treatment of persons with mental health problems*, 2012: http://fra.europa.eu/en/publication/2012/involuntary-placement-and-involuntary-treatment-persons-mental-health-problems

NGO websites

- Association for the Prevention of Torture (APT): www.apt.ch
- Disability Rights International (DRI): www.driadvocacy.org
- Human Rights Watch (HRW): www.hrw.org/topic/disability-rights
- International Disability Alliance (IDA): www.internationaldisabilityalliance.org
- Mental Disability Advocacy Centre (MDAC): http://mdac.info/en
- World Network of Users and Survivors of Psychiatry (WNUSP): www.wnusp.net

association pour la prévention de la torture
asociación para la prevención de la tortura
association for the prevention of torture

Psychiatric institutions are places of deprivation of liberty, as defined in Article 4 of the Optional Protocol to the UN Convention against Torture (OPCAT). These establishments therefore form an integral part of the mandate of the detention monitoring bodies created under the OPCAT: the Subcommittee on Prevention of Torture (SPT) and the National Preventive Mechanisms (NPM).

To explore the risk factors, the situations that might lead to abuse committed against persons deprived of liberty in psychiatric institutions, as well as the means of preventing these abuses, the Association for the Prevention of Torture (APT) organised on 6 and 7 September 2016 the ***Jean-Jacques Gautier Symposium on monitoring psychiatric institutions***. This meeting gathered in Geneva international experts and representatives of National Preventive Mechanisms (NPMs) from all regions of the world.

This Symposium is the third in a series of meetings organised by the APT to allow NPMs and other experts to exchange their knowledge and practices in relation to situations of vulnerability in detention.

This document is the outcome report of the Symposium. It does not provide a detailed account of the fruitful discussions which took place over two days, but aims to emphasise the issues and challenges of monitoring deprivation of liberty in psychiatric institutions. It also presents certain points for consideration identified during the discussions on how to implement NPMs' preventive mandate.

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