# CHILDREN'S LAW CENTRE ANNUAL LECTURE 2014

## "Mental Health in Juvenile Detention: A Preventative and Human Rights Based Approach"

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**Law Society House,**
**Law Society of Northern Ireland**
**96 Victoria Street, Belfast**

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**SPECIAL RAPPORTEUR ON TORTURE AND OTHER CRUEL, INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT**

Distinguished Justices, Ladies and Gentlemen,

It is with great honor that I address this audience in my capacity as United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment. I welcome this opportunity to deliver the 2014 Annual Lecture and wish to thank the Children's Law Centre for having invited me to be with you this afternoon.

I have been asked to talk about "Mental Health in Juvenile Detention: A Preventative and Human Rights Based Approach". I will discuss this subject within the broad framework of conditions in deprivation of liberty, to encompass, in addition to the criminal law context, other institutions including health-care facilities, where juveniles may be held.

I have visited many countries, both in my capacity as UN Special Rapporteur and in my academic capacity as a Visiting Professor at the Washington College of Law in DC, but this is my first visit to Belfast. In preparation for this visit, I have been briefed about a number of children's rights issues that are currently being debated in Northern Ireland and I welcome this opportunity to learn more about these concerns during our the question and answer period that will follow my statement.

A number of these issues are regrettably prevalent in many other States and my Rapporteurship has been working for nearly 30 years, since the inception of the mandate on torture and other cruel, inhuman or degrading treatment or punishment in 1985, first under the Commission of Human Rights and, since 2006, under the auspices of the Human Rights Council.

My 2013 report to the General Assembly (A/68/295) evaluated the intergovernmental Expert Group review process, of The Standard Minimum Rules for the Treatment of Prisoners (SMRs), which is considered one of the most important soft law instruments for the interpretation of various aspects of the rights of prisoners. The ongoing review process is an opportunity to enhance understanding of the scope and

nature of the prohibition against torture and other ill-treatment, the contexts and consequences in which they occur and effective measures to prevent them.

My report targeted areas of review and offered a set of procedural standards and safeguards from the perspective of the prohibition of torture or other ill-treatment that should, as a matter of law and policy, be applied, at a minimum, to all cases of deprivation of liberty. Not only do certain areas of the Rules (adopted in 1955) require updating in the light of developments in international law, but Governments must renew their commitment to address adequately the needs of persons deprived of liberty, with full respect for their inherent dignity and their fundamental rights and guarantees, in order to enhance the implementation of the Rules and the minimum standards contained therein.

In my report, I advocate for the SMRs to apply to *all* places of deprivation of liberty. Regarding juveniles, there are additional guiding principles contained in the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, adopted in 1990 (GA Res 45/113), which state that these Rules apply to all types and forms of detention, including institutional settings, in which juveniles are deprived of their liberty (Rule 15).

The revision of Rule 55 of the SMRs creates an excellent opportunity to integrate the well- established, two-fold system of independent monitoring of places of detention. It allows for inspections to be carried out by governmental agencies and other competent authorities distinct from those directly in charge of the administration of the place of detention or imprisonment (see the Optional Protocol, arts. 5.6, 17 and 35, and the Body of Principles, principle 29).

The revised Rule 55 should make clear that the aforementioned inspection powers, as understood in the two-fold system, require judicial control to be in place. In this respect, the Rules should provide for the power of independent oversight mechanisms to have unimpeded access (on a regular and an ad hoc basis), without prior notice, to all places of deprivation of liberty, including police lock-ups, vehicles, prisons, pretrial detention facilities, security service premises, administrative detention areas, psychiatric hospitals and special detention facilities. They should be entitled to inquire about and

have access to information and documentation, including registries, and have private, unsupervised and confidential interviews with detainees of their own choosing. Finally, the monitoring bodies should be able to make their findings public and follow up on the outcome (United Nations Rules for the Protection of Juveniles Deprived of their Liberty, rule 74).

Unimpeded access to all places of deprivation of liberty, private interviews and monitoring are critical elements on my mandate's working methods and are reinforced in the Terms of Reference for Fact-Finding Missions by Special Rapporteurs (E/CN.4/1998/45, Appendix V). To date, I have conducted country visits to Tunisia, Tajikistan, Kyrgyzstan, Morocco and Western Sahara, Uruguay and Ghana. I have always made a point of visiting at least one juvenile centre when visiting detention facilities. For the most part, the physical conditions of detention in youth facilities are of higher standards than the adult penitentiaries. However, the separation of juveniles from adults in the prison population, in compliance with international standards, especially when prisons may be overcrowded is often violated and can cause additional mental stress on juveniles who are held in these conditions during lengthy pre-trial detention.

*Deprivation of liberty of children must be a last resort*

Children in detention are particularly vulnerable as they are in their "formative years" and their vulnerability is exacerbated in those countries or situations in which children grow up in a climate of conflict.

It is therefore of utmost importance that deprivation of a child's liberty always remain a last resort, that it is restricted to the shortest time possible, and that children in detention are strictly separated from adults and treated with special care.

Although these principles seem self-evident, in practice they are all too often violated.

During my follow up visit to Uruguay (A/HRC/22/53/Add.3), I expressed concern that although the law provides for alternative measures, in practice, 70% of juvenile cases are subjected to measures of home arrest or temporary detention.

Deprivation of liberty of juveniles, and particularly pre-trial or preventive detention, should be used exclusively as measures of last resort. Alternative measures are not only more suitable to promote rehabilitation and prevent ill-treatment, but they also enable the Government to improve the conditions of those who require to be deprived of their liberty.

I am concerned about Uruguay's recent approval of reforms to its juvenile justice code to expand the use of preventive detention under various circumstances. Additionally, there is an ongoing effort within different sectors of Uruguay to reform the constitution to lower the age at which a minor can be charged as an adult and subsequently placed in adult detention facilities. I expressed concern about these two initiatives as they would exacerbate the deplorable conditions of detention and increase the risk of torture and ill-treatment.

During my visit to Tajikistan (A/HRC/22/53/Add.1) I expressed concern about Article 34 of their criminal procedure law, that provides for an exception to the separation of juveniles from adult detainees. When the prosecutor so decides, adolescents may be detained together with adults convicted for the first time for a crime not classified as serious or a felony. Further, I found that there was no strict separation between adults and juveniles in pre-trial detention facilities or police cells outside the capital.

During my visit to Morocco (A/HRC/22/53/Add.2), I noted that criminal legislation regarding juveniles provides for a juvenile system which operates with specially trained prosecutors and judges, but in practice any public prosecutor may be responsible for a juvenile case. Article 460 of the Code of Criminal Procedure provides that the judicial police officer in charge of juveniles may detain the juvenile in a dedicated place. However, in the police stations I visited, there were neither special places dedicated to juveniles nor specialized police officers assigned to such cases. I did not, however, receive any complaints regarding the treatment of juveniles during my inspection of police stations.

It appeared that, in practice, the General Prosecutor's Office rarely requests alternative measures of detention, as provided for in articles 501 to 504 of the Code of

Criminal Procedure. Juveniles often remain in custody for a long period before being admitted to a child protection centre.

I visited a child protection centre and observed decent living conditions and, in general, good treatment of the juveniles, aged between 12 and 17. However, I heard credible reports about corporal punishment (beating with sticks and electric cords) committed by one specific member of the staff. I received no further information as to whether the reported use of corporal punishment was an isolated case or if such treatment is more generally used in juvenile protection centres. The medical examination of one juvenile detainee, conducted by a Forensic Doctor who is always part of my team, resulted in findings consistent with such abuse. The Ministry of Youth and Sports indicated to me that no such treatment is tolerated and that complaints were investigated without undue delay.

With regard to treatment of juveniles in Morocco, I made a number of recommendations to the Government: police stations should be visited regularly with a specific focus on juvenile delinquents; hold juveniles *not* in regular prisons but reinforce the structure of child protection centres; investigate all complaints of torture and ill-treatment of juveniles, in particular allegations of corporal punishment; and provide specialized prosecutors and specialized judicial police officers for cases of juvenile offenders.

I also called for the amendment of article 473 of the Code of Criminal Procedure to raise the age at which a juvenile delinquent can be imprisoned from 12 to 18 years old, and stress that the imprisonment of juvenile delinquents is an exceptional measure.

Regrettably, rather than being subjected to preferential treatment, children are even at a higher risk of abuse and ill-treatment than adults.

In Tajikistan, I also learned that children in conflict with the law were often mistreated by police inquiry officers of the Ministry of the Interior during arrest and at various stages of detention. In the juvenile colony and in the basement of a special school for underage offenders, run by the Ministry of Education, children were kept in

disciplinary isolation cells for up to 15 days as a disciplinary measure for breaking the establishment's rules.

Despite the recently adopted child protection policy in Tunisia, that prohibits violence against children in closed institutions and establishes a complaint procedure, in practice, there is no accessible and effective complaint mechanism available to children in these facilities.

Juveniles are not afforded most procedural safeguards, including that of informing their family of their arrest without significant delay. It is unclear whether juvenile offenders are allowed to hold private interviews with court-appointed legal counsel and at what stage they are guaranteed access to legal counsel of their choice. I was alarmed to learn that cases of mistreatment for the purpose of extracting a confession from minors go unreported owing to fear of reprisal.

*Solitary confinement*

I am very concerned about placing juveniles in solitary confinement, and have held that children or minors should not be subjected to solitary confinement of any duration at all.

In Uruguay, the practice of solitary confinement as a disciplinary measure is allowed by regulations and practiced fairly frequently. Juveniles may be confined to their cell for up to 23 hours a day and for several weeks, without access to reading materials, cultural or recreational activities, or meaningful contact with other detainees or the outside world.

I advocate that the SMRs should prohibit the use and imposition of *indefinite* solitary confinement either as part of a judicially imposed sentence or a disciplinary measure, and alternative disciplinary sanctions should be introduced to avoid the use of solitary confinement. The Rules should also prohibit *prolonged* solitary confinement as well as frequently renewed measures that amount to prolonged solitary confinement. The Rules should establish a maximum term of days beyond which solitary confinement is considered prolonged.

The Rules should explicitly prohibit the imposition of solitary confinement of any duration for juveniles, persons with psychosocial disabilities or other disabilities or health conditions, pregnant women, women with infants and breastfeeding mothers (see the United Nations Rules for the Treatment of Women Prisoners, rule 22, and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty, rule 67).

*Corporal punishment*

Juveniles are more likely to be subjected to corporal punishment and abuse by fellow detainees. (A/HRC/13/39/Add.5)

In Ghana, I visited the country's only juvenile centre, and assisted by a Forensic Doctor from my team, we documented traumatic physical injuries on seven juveniles, resulting from a caning incident that had taken place within the last 24 hours as a disciplinary sanction. During my debriefing with the Ministry of Foreign Affairs I demanded that the Prisons Service conduct an immediate and impartial investigation to establish accountability for this act of torture. The Prisons Service did establish a formal inquiry, which is ongoing, and has dismissed the Chief Officer who directly flogged the juveniles with twelve lashes on the back as a disciplinary sanction. The Government admitted this caning of juveniles was in breach of the Convention of the Rights of the Child and their Constitution and national laws.

In Ghana, as there is only one juvenile centre based in Accra, the authorities reported that more than 50 per cent of juveniles do not receive family visits, either because the family lives too far away or the boy has been effectively abandoned by his family. This further isolation is detrimental to their mental and social development and, combined with the minimum level of rehabilitation services available, often results in deterioration rather than improvement of their mental health.

The positive obligation of States to prohibit and prevent corporal punishment, in all its forms, whether imposed by State authorities or by private actors, including schools and parents, has been confirmed by various monitoring bodies, including the Committee on the Rights of the Child, in relation to article 19 of the Convention on the Rights of the

Child (CRC) and the European Committee of Social Rights in relation to the explicit provision in article 17 of the revised European Social Charter.

Article 19(1) of the CRC states that "States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child".

In its pervasiveness and impact on the child, corporal punishment of children in the home and in educational settings is severely detrimental to the mental and physical health of the child. In Ghana, while there is an explicit prohibition of corporal punishment in the correctional services, this prohibition does not yet extend to all settings, including the home, schools and alternative care settings.

My Rapporteurship considers ill-treatment by non-State actors, especially domestic violence, to be part of my mandate in those circumstances in which the State knows or ought to know of the risk of such violence and does not exercise due diligence to protect the child from it.

When the European Convention was adopted in 1950, corporal punishment was widely accepted in European societies, in particular as chastisement in the family or as disciplinary punishment in schools, prisons, the military and similar institutions. In other words, these comparatively lenient forms of corporal punishment were not regarded as cruel, inhuman or degrading punishment by most European States, and were widely practiced.

This cultural attitude significantly changed, however, during the 1960s and 1970s. Consequently, the European Court of Human Rights, in the landmark judgment of Tyrer v. UK (1978), adopted a dynamic interpretation of article 3 of the European Convention on Human Rights and ruled that birching of a juvenile, a traditional punishment on the Isle of Man, was no longer compatible with a modern understanding of human rights in Europe. Referring to the European Convention as a "living instrument" that needed to be

"interpreted in light of present-day conditions", the Court considered birching degrading punishment.

In 1982, the Human Rights Committee, expressed the unanimous opinion that the prohibition of torture or ill-treatment extends to corporal punishment, including excessive chastisement as an educational or disciplinary measure. (Human Rights Committee, General Comment 7).

As far back as 1988, the Rapporteurship has examined questions relevant to torture and stated that it was international law, not domestic law, which ultimately determined whether a certain practice might be regarded as lawful, and that practices which might initially be considered lawful might become outlawed and viewed as the most serious violations of human rights (E/CN.4/1988/17, paras 42 and 44).

Corporal chastisement of juveniles as a disciplinary sanction, or as part of a judicial sentence, has been documented in many States visited by the Rapporteurship over the years (A/HRC/13/39/Add.5 paras 209-228). Without exception, corporal punishment has a degrading and humiliating component. It must therefore be considered to amount to cruel, inhuman or degrading punishment or torture in violation of international treaty and customary law. (A/HRC/13/39, para 63).

The legal norm has evolved so that corporal punishment is no longer considered a "lawful sanction" for purposes of the exception to the definition of torture, according to Article 1 of the Convention against Torture. That norm refers to sanctions that are lawful under *both* national and international law. In this sense, it is now widely accepted that corporal punishment at least amounts to cruel, inhuman or degrading treatment; it does not qualify as a lawful sanction and, accordingly, is not immune from being categorized as torture.

*Death penalty*

Over the years, the prohibition of cruel, inhuman or degrading punishment has been interpreted in a dynamic manner in relation to the question of corporal punishment. Corporal punishment may be compared to capital punishment in the sense that, even apart

from the physical pain and suffering it might cause, over the last decades it has evolved to be considered a direct assault on the dignity of a person and therefore prohibited by international law (A/HRC/10/44, para. 35)

In my 2012 report to the General Assembly (A/67/279, para. 58), I asserted that, like the evolution of the prohibition on corporal punishment, there is similar emergence of a customary norm may be emerging to consider the death penalty as running afoul of the prohibition of torture and cruel, inhuman and degrading treatment. A customary international law rule has already emerged to prohibit corporal punishment for persons who commit their crimes as minors or mentally disabled.

In Michael Domingues v. United States (2002), the Inter-American Commission canvassed international legal and political developments and State practice concerning the execution of juveniles and reached the conclusion that the state of international law had evolved so as to prohibit, as a *jus cogens* norm, the execution of persons who were under 18 years of age at the time of commission of their crimes. This is in line with the jurisprudence of the Human Rights Committee. In Roper v. Simmons (2005), the United States Supreme Court held that under the "evolving standards of decency" test, it is cruel and unusual punishment to execute a person who was under the age of 18 years at the time of the murder.

Remarkably, in January 2012, the Government of the Islamic Republic of Iran, one of the most persistent retentionist countries, adopted the Islamic Penal Code and established new measures to limit the sentencing to death of juveniles (A/HRC/21/29 and Corr.1, para. 8). The abolition of the death penalty for juveniles is based on the fact that their limited capacity has a direct impact on their effective exercise of the right to a fair trial and that it is inherently cruel to execute children.

*Involuntary detention in the health-care context*

I now discuss the mental health of juveniles who are placed in involuntary detention in the health-care context.

During country visits, I also make a point of visiting psychiatric hospitals or other institutions where individuals, including children, may be held against their will.

In Ghana I visited two prayer camps, of which there are hundreds scattered about the country. These camps are privately owned religious institutions that play a large role in Ghanaian society. It is estimated that 70 per cent of the population turn first to a prayer camp to receive spiritual healing in order to deal with any type of illness, in particular mental illness. These prayer camps are essentially alternative residential facilities for those with mental disabilities, but they currently operate with little oversight and no State regulation.

Children are taken to prayer camps by family members and left with the prophets to be "healed". They are shackled to walls or trees and forced to fast. I saw persons with mental disabilities or in some cases with neurological problems, including a number of children, treated in that way. In one of the prayer camps, women and children were chained to the walls or floors of their cells, including a 14 year-old girl and a 7 year-old boy, who exhibited symptoms not of a mental illness but of a neurological disease that clearly required specialized treatment and medication. In my report to the Government, presented to the Human Rights Council in Geneva this week, I called upon the Government to enact laws to prohibit the admission and treatment of children in prayer camps and ban inhumane practices involving chaining and restraint of any duration, mandatory fasting, treatment without free and informed consent and denial of medication.

*Applicability of the torture and ill-treatment framework in health-care settings*

Until recently, mistreatment in health-care settings (hospitals, public and private clinics, hospices and institutions) has received little specific attention from the perspective of my mandate, as denial of health-care has often been understood as essentially interfering with the "right to health". I have engaged this issue because there are practices in many States that are harmful to patients and, if they are under age, these practices are not in the "best interests of the child" and are in fact detrimental to both the mental development and physical health of juveniles. In some cases, they constitute ill-treatment and even amount to torture.

My 2013 report to the Human Rights Council (A/HRC/22/53) focused on certain forms of abuse in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment. My report aimed to shed light on often undetected and unrecognized forms of abusive practices that occur under the guise of health-care practice. I emphasized how certain treatments run afoul of the prohibition on torture and ill-treatment. I examined the scope of the State's obligation to regulate, control and supervise health-care practices requiring strict medical or therapeutical necessity, absence of less painful alternatives, and free and informed consent. I called for the recognition of practices that violate those standards and for an absolute ban on them as well as for monitoring and accountability.

Both the European Court of Human Rights (ECHR) and the Inter-American Court of Human Rights (IACHR) have stated that the definition of torture is subject to ongoing reassessment in light of present-day conditions and the changing values of democratic societies.[1]

The conceptualization of abuses in health-care settings as torture or ill-treatment is a relatively recent phenomenon. In my capacity as Special Rapporteur I must examine practices within this ongoing paradigm shift, which is applicable as well to various forms of abuse in health-care settings and brings them within the discourse on torture. 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.

The Committee against Torture interprets State obligations to prevent torture as indivisible, interrelated, and interdependent with the obligation to prevent cruel, inhuman, or degrading treatment or punishment because "conditions that give rise to ill-treatment frequently facilitate torture" (General comment No. 2 (2007), para.3). It has established that "each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, institutions that

[1] IACHR, Cantoral-Benavides v. Peru, Series C, No. 69 (2000) para. 99; ECHR, Selmouni v. France, Application No. 25803/94 (1999), para. 101.

engage in the care of children, the aged, the mentally ill or disabled, in military service, and other institutions as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm" (General comment No. 2 (2007), para. 15).

Indeed, the State's obligation to prevent torture applies not only to public officials, such as law enforcement agents, but also to doctors, health-care professionals and social workers, including those working in private hospitals, other institutions and detention centres (A/63/175, para. 51). As underlined by the Committee against Torture, the prohibition of torture must be enforced in all types of institutions and States must exercise due diligence to prevent, investigate, prosecute and punish violations by non-State officials or private actors (General comment No. 2, (2007) paras 15, 17 and 18.)[2]

*Legal capacity, informed consent, powerlessness and the doctrine of "medical necessity"*

The legality or illegality of certain practices, in particular with respect to juveniles, depends on interpretative principles (regarding, for example, consent, medical necessity and existence of therapeutic alternatives) that are not fully settled; indeed, both the progress of science and recent developments in domestic and international law are rapidly changing the landscape of what is permissible and appropriate as health care "treatment." More detailed criteria for certain concepts need to be worked out.

There are important interpretative and guiding principles on such issues as legal capacity, informed consent, and the doctrine of "medical necessity" as well as the concept of stigmatized identities which provide useful guidance in understanding the breadth of the problem and the underlying causes that are paramount to most of these abusive practices.

It is important for States to bring domestic laws on legal capacity into compliance with the Convention on the Rights of the Child (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD).

[2] See also Committee against Torture, communication No. 161/2000, Dzemajl et al. v. Serbia and Montenegro, para. 9.2; Human Rights Committtee, general comment No. 20 (1992), para 2.)

Paramount is Article 3 of the Convention on the Rights of the Child (CRC) (also reflected in Article 7(2) of the CRPD) that states "the best interests of the child must be a primary consideration in all actions concerning children".

Article 12 of the CRC states that "that the child's views must be considered and taken into account in all matters affecting him or her."

Article 7(3) of the CRPD obliges States Parties "to ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right".

Article 5 of the Convention on the Rights of the Child says that "States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians or other persons legally responsible for the child, to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention".

Article 24 (1) of the CRC calls on States Parties "to recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health".

Under Article 25 of the CRC, States Parties "recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement".

Free and informed consent should be safeguarded on an equal basis for all individuals, and in particular children and juveniles without any exception, through the legal framework and judicial and administrative mechanisms, including through policies and practices to protect against abuses. Medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose or when aimed at correcting or

alleviating a disability, may constitute torture or ill-treatment when enforced or administered without the free and informed consent of the person concerned. Any legal provisions to the contrary, such as provisions allowing confinement or compulsory treatment in mental health settings, including through guardianship and other substituted decision-making, must be reviewed and updated.

*Compulsory detention for medical conditions*

Young people with substance abuse issues are over represented in the criminal justice system. My research has shown that in numerous countries, notwithstanding the commitment to increase the availability of methadone treatment and evidence-based treatment as opposed to punitive approaches, in practice, the vast majority of those remanded to compulsory treatment continue to be subjected to punitive treatment programmes, and there only a few programmes worldwide that deliver evidence-based treatment for drug dependence.

In Uruguay, the use of psycho-pharmaceutical medication on juveniles is a serious problem. For instance, psycho-pharmaceuticals are widely used in juvenile detention centers and I was informed that they are used by more than 50% of the detainees. I was informed that it is the children who request them to help them sleep and combat anxiety. This is of concern, given the possibility of excessive use of these drugs, the risk that juveniles will become dependent on them, and the obstacle that this treatment poses for rehabilitation of the juvenile. This is compounded by the lack of rehabilitation and recreational activities.

In my work as Special Rapporteur, I continue to engage with States and call on Governments to close compulsory drug detention and “so called” rehabilitation centres without delay and to implement voluntary, evidence-based and rights-based health and social services in the community. All harm-reduction measures and drug-dependence treatment services, particularly opioid substitution therapy, should be available to all who use drugs, including juveniles in particular who are incarcerated.

*Denial of pain treatment*

In 2012, WHO estimated that 5.5 billion people live in countries with low or no access to controlled medicines and have no or insufficient access to treatment for moderate to severe pain. Despite the repeated reminders to States of their obligations made by the Commission on Narcotic Drugs, 83 per cent of the world population has either no or inadequate access to treatment for moderate to severe pain. Many countries fail to make adequate arrangements for the supply of these medications. Although relatively inexpensive and highly effective medications such as morphine and other narcotic drugs have proven essential "for the relief of pain and suffering", these types of medications are virtually unavailable in more than 150 countries. A majority of these countries are in the "less or least developed category" in which the youth population (aged 10 to 24 years) comprises between 27-32%[3] of the world's total population.

Ensuring the availability and accessibility of medications included in the WHO Model List of Essential Medicines is not just a reasonable step but a legal obligation under the 1961 Single Convention on Narcotic Drugs. When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall foul of the right to health but may also violate an affirmative obligation under the prohibition of torture and ill-treatment.

States should adopt a human rights-based approach to drug control as a matter of priority to prevent the continuing violations of rights stemming from the current approaches to curtailing supply and demand.

*Psychosocial disabilities*

Despite the significant strides made in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment, severe abuses continue to be committed in health-care settings where choices by people with disabilities are often overridden based on their supposed "best

[3] Population Reference Bureau, World'sYouth Data Sheet, 2013.

interests", and where serious violations and discrimination against persons with disabilities may be masked as "good intentions" of health-care professionals.

My predecessors have advanced the mandate on torture and made significant strides in the development of norms for the abolition of forced psychiatric interventions on the basis of disability alone as a form of torture and ill-treatment (see A/63/175). The Convention on the Rights of Persons with Disabilities provides authoritative guidance on the rights of persons with disabilities and prohibits involuntary treatment and involuntary confinement on the grounds of disability, superseding earlier standards such as the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991 Principles).

Severe abuses, such as neglect, mental and physical abuse and sexual violence, continue to be committed against people with psychosocial disabilities and people with intellectual disabilities in health-care settings (In November 2012, the Inter-American Commission on Human Rights approved precautionary measures to protect 300 individuals in Guatemala City's psychiatric facility, where unspeakable forms of abuses were documented).

There are several areas where I believe we must press forward and beyond what has already been examined under my Rapporteurship in an effort to ensure a new normative paradigm that upholds the international standards under the Convention against Torture and the Convention on the Rights of the Child, which entered into force in 1987 and 1990 respectively, and the more recent standards contained in the Convention on the Rights of Persons with Disabilities which entered into force in 2008. All these international instruments call for measures to combat impunity.

United Nations Rules for the Protection of Juveniles Deprived of their Liberty provide guidelines regarding limitations of physical restraint and the use of force and state in Rule 63 that recourse to instruments of restraint and to force for any purpose should be prohibited, except as set forth in Rule 64, which provides that: "Instruments of restraint and force can only be used in exceptional cases, where all other control methods have been exhausted and failed, and only as explicitly authorized and specified by law

and regulation. They should not cause humiliation or degradation, and should be used restrictively and only for the shortest possible period of time. By order of the director of the administration, such instruments might be resorted to in order to prevent the juvenile from inflicting self-injury, injuries to others or serious destruction of property. In such instances, the director should at once consult medical and other relevant personnel and report to the higher administrative authority".

The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint constitute torture and ill-treatment. In my report (A/66/88) I addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment. Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions.

Laws and regulations should allow for non-consensual measures only under conditions similar to Rule 64 of the UN Rules for the Protection of Juveniles Deprived of their Liberty, though I would argue that they should be limited to cases of serious risk of harm to self or others, and for the time and methods strictly required to prevent such harm. The environment of patient powerlessness and abusive treatment of persons with disabilities, in which restraint and seclusion is used, can lead to other non-consensual treatment, such as forced medication and electroshock procedures.

*Forced interventions*

I receive reports of the systematic use of forced interventions worldwide. Both my mandate and United Nations treaty bodies have established that involuntary treatment and other psychiatric interventions in health-care facilities are forms of torture and ill-treatment. Forced interventions, often wrongfully justified by theories of incapacity and therapeutic necessity inconsistent with the Convention on the Rights of Persons with Disabilities, are legitimized under national laws, and may enjoy wide public support as being in the alleged "best interest" of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment (A/63/175, paras. 38, 40, 41). I urge revision of domestic legislation allowing for forced interventions out of concern for the autonomy and dignity of persons with disabilities.

*Involuntary commitment in psychiatric institutions*

In many States where mental health policies and laws exist, they focus on confinement of people with mental disabilities in psychiatric institutions but fail to safeguard their human rights effectively.

Deprivation of liberty on grounds of mental illness is unjustified. Under the European Convention on Human Rights, mental disorder must be of a certain severity in order to justify detention. The severity of the mental illness is not by itself sufficient to justify detention; the State must also show that detention is necessary to protect the safety of the person or of others. Except in emergency cases, the individual concerned should not be deprived of his liberty. In a decision with which I strongly disagree, the European Court of Human Rights allowed for such a deprivation of liberty if the person has been reliably shown to be of "unsound mind".

As detention in a psychiatric context may lead to non-consensual psychiatric treatment, my Rapporteurship has stated that deprivation of liberty that is based on the grounds of a disability and that inflicts severe pain or suffering falls under the scope of the Convention against Torture (A/63/175, para. 65). In making such an assessment, factors such as fear and anxiety produced by indefinite detention, the infliction of forced medication or electroshock, the use of restraints and seclusion, the segregation from family and community, should be taken into account.

Moreover, the effects of institutionalization of individuals who do not meet appropriate admission criteria, as is the case in most institutions which are off the monitoring radar and lack appropriate admission oversight, raise particular questions under the prohibition of torture and ill-treatment. Inappropriate or unnecessary non-consensual institutionalization of individuals may amount to torture or ill-treatment as use of force beyond that which is strictly necessary.

The CRPD offers the most comprehensive set of standards on the rights of persons with disabilities and it is important that States review the anti-torture framework in relation to persons with disabilities in line with the CRPD. States should impose a ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual administration of psychosurgery, electroshock and mind-altering drugs, for both long- and short- term application. The obligation to end forced psychiatric interventions based on grounds of disability is of immediate application and scarce financial resources cannot justify postponement of its implementation.

Forced treatment and commitment should be replaced by services in the community that meet needs expressed by persons with disabilities and respect the autonomy, choices, dignity and privacy of the person concerned. States must revise the legal provisions that allow detention on mental health grounds or in mental health facilities and any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned.

*Juveniles with disabilities*

Children and juveniles who suffer mental or psycho-social disabilities should be afforded special protection as a critical component of the obligation to prevent torture and ill-treatment. The State must, *inter alia*, invest in and offer a wide range of voluntary support to enable them to exercise their legal capacity and that fully respect their individual autonomy, will and preferences. States should repeal any law allowing intrusive and irreversible treatments when enforced or administered without the free and informed consent of the person concerned.

Juveniles with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices (A/63/175, para. 40). In the case of children in health-care settings, an actual or perceived disability may diminish the weight given to the child's views in determining their best interests, or may be taken as the basis of substitution of determination and decision-making by parents, guardians, carers or public authorities. Girls living with disabilities, with psychiatric labels in particular, are at risk of multiple forms of discrimination and abuse in health-care settings. Forced sterilization of girls and women with disabilities has been widely documented. National law in Spain, among other countries, allows for the sterilization of minors who are found to have severe intellectual disabilities.

*Conclusions and Recommendations*

All States should ratify the Optional Protocol to the Convention against Torture and establish effective and independent national preventative mechanisms with the task of carrying out preventive visits to *all* places of deprivation of liberty, including juvenile centres and psychiatric hospitals.

All States should enforce the prohibition of torture, beyond the criminal law context, into all health-care institutions, both public and private by regulating health-care practices with a view to preventing mistreatment under any pretext; and integrating the provisions of prevention of torture and ill-treatment into health-care policies.

The significance of categorizing abuses in health-care settings as torture and ill-treatment and examining abuses in health-care settings from a torture protection framework lies in the fact that it provides the opportunity to solidify an understanding of these violations and highlight the positive obligations that States have to prevent, prosecute and redress such violations. Furthermore, by reframing violence and abuses in health-care settings as prohibited ill-treatment, victims and advocates are afforded stronger legal protection and redress for violations of human rights.

In this respect, the recent general comment No. 3 (2012) of the Committee against Torture on the right to a remedy and reparation offers valuable guidance regarding proactive measures required to prevent forced interventions. Notably, the Committee considers that the duty to provide a remedy and reparations extends to all acts of ill-treatment, so that it is immaterial for this purpose whether abuses in health-care settings meet the criteria for torture per se. This framework opens new possibilities for holistic social processes that foster appreciation of the lived experiences of persons, including measures of satisfaction and guarantees of non-repetition, and the repeal of inconsistent legal provisions.

Distinguished Justices, Ladies and Gentlemen,

I thank you for your attention and look forward to a fruitful exchange.