Tackling Torture

Victims with Disabilities in the COVID-19 Outbreak

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Litigating Emergency De-institutionalisation as Torture

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Challenging institutionalisation as torture has a long tradition in human rights advocacy, for obvious reasons – but with not so obvious consequences. Freedom from torture is a cornerstone of the international human rights protection system, and a finding of torture brings with it a serious moral condemnation. But litigators do not simply want to make a point by winning before courts. They are looking for remedies which help individual victims and those affected similarly, by transforming policies. They want change on the ground, not declarations. This chapter looks at the advantages and disadvantages of relying on the torture framework to challenge institutionalisation of persons with disabilities at the time of the COVID-19 pandemic.

1. Institutionalisation as Torture in International Law

Human rights organisations monitoring institutions of persons with disabilities have often described institutionalisation through the lens of ill-treatment.[1] They have reported on practices which have already been found to constitute elements of torture in other settings, such as prisons or asylum centres.[2] The reports established that dilapidated physical conditions, overcrowding, lack of privacy, lack of meaningful activities, poor access to healthcare, forced treatment, restraints, physical and sexual abuse are widespread in institutions for persons with disabilities.[3]

Despite the fact that the conditions in institutions are often worse than in prisons, it took a long time for international courts to recognise institutions as places of ill-treatment. This finally happened with the judgment of the European Court of Human Rights (European Court) in *Stanev v. Bulgaria*, which reviewed the conditions in the Pastra home, arguably the worst social care institution in Bulgaria.[4] However, this important precedent did not lead to a surge of successful litigation. It was followed by *Stankov v. Bulgaria*, but no other cases since then.[5] The European Court found other types of violations connected to institutions but did not classify these as ill-treatment.[6]

1 János Fiala-Butora, 'Disabling Torture: the Obligation to Investigate Ill-treatment of Persons with Disabilities' (2013) 45 Columbia Human Rights Law Review 214.
2 For examples of how the UN Human Rights Committee (HRC) and the Committee against Torture (CAT) addressed some aspects of torture affecting persons with disabilities, such as restraints and forced sterilizations, see Phil Fennel, 'Article 15: Protection against Torture and Cruel or Inhuman or Degrading Treatment or Punishment' in Ilias Bantekas, Michael Stein, and Dimitris Anastasiou (eds.), *Commentary on the UN Convention on the Rights of Persons with Disabilities* (Oxford University Press, Oxford, 2018), 426-465.
3 Janet E. Lord, 'Shared Understanding or Consensus-Masked Disagreement? The Anti-Torture Framework in the Convention on the Rights of Persons with Disabilities' (2010) 33 Loy. L.A. Int'l & Comp. L. Rev. 27.
4 *Stanev v. Bulgaria* App no 36760/06 (ECtHR, 17 January 2012).
5 *Stankov v. Bulgaria* App no 25820/07 (ECtHR, 17 March 2015).
6 For example *D.D. v. Lithuania* App no 13469/06 (ECtHR, 14 February 2012).

During the negotiations on the adoption of the Convention on the Rights of Persons with Disabilities (CRPD), disability advocates tried not simply to abolish certain practices harming persons with disabilities but to have them declared as torture. Involuntary treatment or the use of restraints are good examples. The text of the CRPD is not sufficiently clear on these practices, therefore advocacy continues since its adoption as well.

Institutionalisation was also argued to constitute torture. However, the Committee on the Rights of Persons with Disabilities (CRPD Committee) has not considered conditions in institutions as torture under Article 15 of the CRPD, only as abuse under Article 16. It found a violation of Article 16 on the account of poor living conditions,[7] insufficient nutrition,[8] neglect,[9] and violence in institutions.[10] None of these problems warranted an examination of institutionalisation *as* torture in the CRPD Committee's view.

2. The Advantages and Disadvantages of the Torture Framework

There are obvious advantages to recognising a practice not simply as a human rights violation, but specifically as torture or another form of ill-treatment. Torture is the most serious violation of the human right to personal integrity and dignity.[11] It is an absolute right which permits no derogations or limitations.[12] Resource constraints can justify the limitations of other rights, but not freedom from torture.[13] The state is obliged to provide redress to victims of torture, including by prosecuting perpetrators.[14]

Freedom from torture does not permit taking into account competing interests. If something is classified as torture, its use must not simply be limited or curtailed, but discontinued without debate. Not recognising involuntary treatment or restraints as torture would legitimise these coercive practices and provide wide discretion to states on how and to what extent to police their use. It would invite counter-interests and counterarguments, both legitimate and illegitimate, to be balanced against the rights of victims, and used as excuses to retain illicit practices.

In the long run, the "correct" use of coercion, as opposed to its "abuse", would be a question determined individually, which domestic authorities are better placed to review than international bodies. This particularly empowers medical professionals, as they have

7 CRPD Committee, Concluding Observations: Serbia, UN Doc CRPD/C/SRB/CO/1 (23 May 2016) para 31.
8 CRPD Committee, Concluding Observations: Latvia, UN Doc CRPD/C/LVA/CO/1 (10 October 2017) para 28.
9 CRPD Committee, Concluding Observations: Armenia, UN Doc CRPD/C/ARM/CO/1 (8 May 2017) para 27, CRPD Committee, Concluding Observations: Republic of Moldova, UN Doc CRPD/C/MDA/CO/1 (18 May 2017) para 32.
10 CRPD Committee, Concluding Observations: Lithuania, UN Doc CRPD/C/LTU/CO/1 (11 May 2016) para 32.
11 Manfred Nowak, 'Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak' A/63/175 (28 July 2008) para 50.
12 Juan E. Méndez, 'Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez' A/HRC/22/53 (1 February 2013) para 82.
13 ibid., para. 83.
14 CRPD Committee, Concluding Observations: Slovenia, UN Doc CRPD/C/SVN/CO/1 (5 March 2018) para 26; CRPD Committee, Concluding Observations: Montenegro, UN Doc CRPD/C/MNE/CO/1 (22 September 2017) para 31; CRPD Committee, Concluding Observations: Serbia, UN Doc CRPD/C/SRB/CO/1 (23 May 2016) para 28.

the most direct first-hand information about each case, and their determinations necessarily involve the application of medical norms. It is easy to see why many victims would find this solution unacceptable. After all, in terms of power relations, it is not that different to what we had before the CRPD. It has led to significant suffering and abuses, which the CRPD aims to overcome, not preserve.

Freedom from torture is also an immediate obligation. That feature is particularly appealing to advocates who are no doubt frustrated by the slow progress in implementing rights which are subject to progressive realisation. The standards of progressive realisation are unclear, and thus difficult to review by international bodies. As such, progressive realisation has often been used by states as an excuse to delay honouring their obligations flowing from human rights treaties, although such excuses are unjustifiable.

Similar arguments have also been used in defence of institutionalisation. It has been explicitly recognised as a human rights violation some time ago, at least since the adoption of the CRPD, whose article 19 protects the right to independent living. States parties have been required to implement de-institutionalisation plans. Yet progress has often been unsatisfactory. States are both delaying the transformation of social services and are also questioning the goal itself by referring to competing interests, be those of staff, the community, the government providing funds, or residents of institutions who allegedly "like it" inside institutions and want to stay within them.

In the face of such resistance, framing institutionalisation as torture is undeniably quite appealing. It attaches a particular moral condemnation to the practice, which might be more difficult for states to own up to. It would send a clear message that transferring residents to the community is not up for debate, and that it cannot wait. However, portraying a practice as ill-treatment also has its disadvantages. Arguing and proving all attributes of torture can be problematic in the case of coercive practices, including institutionalisation.

Only those practices which achieve a particular level of severity can be classified as ill-treatment, and only the most severe of these can be considered torture. This might be too high a threshold to reach with institutionalisation alone. Some practices, some instances of institutional experience could no doubt meet the threshold, but declaring the practice of institutionalisation as ill-treatment per se might be too big of a step for courts to take, condemning this strategy to perpetual unsuccessfulness.

Since the prohibition of torture is absolute, no exceptions can be accepted under it. This means that if institutionalisation is identified as torture, the only legitimate goal would be to eliminate it immediately instead of gradually reducing its occurrence. This is contrary to what states are currently trying to achieve, and what many consider a laudable goal.[15] We must recognise that the need for immediate transformation of social services does have legitimate constraints, such as the need for resource allocations, staff

15 Brian O'Donoghue, 'Coercion: an understudied issue in mental health' (2017) 34 Irish Journal of Psychological Medicine 222; Bernadette McSherry & Ian Freckelton (Eds.) *Coercive care: Rights, law and policy* (New York, NY: Routledge, 2013).

training, rehabilitation of clients, etc. The absolute nature of the prohibition of torture does not provide space for such considerations to be taken into account. It is simply not a framework suited for balancing competing interests in a complicated policy framework. Torture requires states to take an immediate all or nothing approach, and if they are presented with that choice, states might be very tempted to opt for "nothing" if they see the alternative as impossible to implement.

States Parties are bound by the CRPD, but they have possibilities not to comply with a norm which they consider impossible to implement. They can resort to wilful non-compliance. If there is consensus among them, it will be hard for the CRPD Committee to overcome their resistance, especially since it is the states that are parties to the CRPD, and their subsequent agreements and practices are a source of its interpretation.[16] They can also create exceptions by reclassifying some forms of institutionalisation as not-torture. This seems impossible due to the absolute nature of prohibition of torture, but in fact it is not without precedent in international law. A very similar approach was adopted by the European Court in the *Herczegfalvy* case,[17] where the prolonged use of restraints, which would be otherwise considered ill-treatment, was considered not to constitute ill-treatment if medically necessary. Medical necessity might not be accepted as a justification under the CRPD, but other similar similar justifications could be. States would only need to find a disability-neutral way of phrasing the conditions for permissible institutionalisation, and thereby remove them from the CRPD's scope. This neutrality would only be formal, although the impact would still disproportionally affect persons with disabilities. Nevertheless, it might be seen by many as a viable option if the alternative is portrayed as seeking the impossible. Interestingly, such a disability-neutral approach formally avoiding violation of the CRPD has already been proposed under other articles of the CRPD.[18]

Also, it seems to be clear that notwithstanding differences in pace across states, de-institutionalisation will take some time. At least for a temporary period, institutions are here to stay, and some persons will be moved to the community faster than others.[19] The absolute prohibition of torture is not the best framework to deal with such temporary situations. Due to its absolute nature, it requires immediate implementation.[20] States cannot legitimately experiment with safeguards and regulation in order to monitor and limit the practices which are recognised as torture.[21] This means that at least for a temporary period, victims staying in institutions would enjoy less protection in a torture framework than they might in a different one.

16 Article 31(3) b) and c) of the Vienna Convention on the Law of Treaties (VCLT), 1155 U.N.T.S. 331 (27 January 1980).
17 *Herczegfalvy v. Austria* App no 10533/83 (ECtHR, 24 September 1992).
18 Wayne Martin, Sabine Michalowsky, Timo Jütten, Matthew Burch, 'Achieving CRPD Compliance, Is the Mental Capacity Act of England and Wales Compatible with the UN CRPD? If not, what next?' An Essex Autonomy Project Position Paper (22 September 2014).
19 Peter Bartlett and Marianne Schulze, 'Urgently awaiting implementation: The right to be free from exploitation, violence and abuse in Article 16 of the Convention on the Rights of Persons with Disabilities (CRPD)' (2017) 53 International Journal of Law and Psychiatry 9.
20 CRPD Committee, Concluding Observations: Slovakia, UN Doc CRPD/C/SVK/CO/1 (17 May 2016) para 46.
21 Juan E. Méndez (n 12) para 89 b).

The CRPD Committee has recognised similar temporary adjustments to otherwise applicable rules under other articles. For example, under Article 14, while it requires the abolition of involuntary hospitalisation, "until as such time as these provisions have been amended", it has required Latvia to implement court review of hospitalisations.[22] Similarly, while the Committee rejects the practice of sheltered workshops, it required Hong Kong to raise the daily allowance for persons in sheltered workshops to protect them from exploitation under Article 16.[23] The Committee and States Parties do not enjoy such flexibility under the torture framework, which might leave victims worse off, at least in the short run.

Lastly, the torture framework might also not offer the most effective remedies to victims. I have argued elsewhere that criminal law is not an appropriate solution for many victims with disabilities suffering from ill-treatment in institutions due to, among others, accessibility problems, the violations' systemic nature, and criminal law's focus on the perpetrator rather than the victim.[24] In the case of institutionalisation, the picture is even more complicated. Who is the perpetrator in this case? Is a criminal sanction such as prison time for a nurse or social care worker an adequate response? Maybe there is a legitimate point to make about how and under what conditions it might be, but it is very difficult to imagine how members of the care professions would participate in such a discussion. And without their involvement, it is hard to develop alternative services. Other articles of the CRPD are more suited to introduce a different range of remedies that aim at reducing unwanted practices, such as educational, administrative and social measures.[25]

3. How does the Pandemic Change the Calculus?

The above general reasons apply in usual times. However, the global COVID-19 pandemic creates extraordinary circumstances. How does it change the relevance of the torture framework in respect of institutionalisation?

Other chapters in this volume have shown that a direct correlation between institutionalisation and death from COVID-19 have emerged in several countries. The consequences of contracting the virus go beyond a high chance of dying. Many patients describe the illness as very painful, no doubt reaching the required level of severity to constitute ill-treatment. To be sure, it is not the authorities causing pain to the victims – but by keeping them in settings where they have a very high chance of contracting the virus, they are knowingly exposing them to a high risk of suffering. This goes contrary to their obligations, which is to protect persons from suffering.

Those who might not get infected are also suffering the psychological effects of being exposed to the high risk of undergoing a severe illness and dying from it. This psychological suffering is especially pronounced in the case of residents of institutions

22 CRPD Committee, Concluding Observations: Latvia, UN Doc CRPD/C/LVA/CO/1 (10 October 2017) para 25. (b).
23 CRPD Committee, Concluding Observations: China, UN Doc CRPD/C/CHN/CO/1 (15 October 2012) para 68.
24 János Fiala-Butora (n 1).
25 Bartlett and Schulze (n 19) 7.

where the virus has already been detected. Not being able to take the only safe option and leave the place, they are essentially trapped in a room with death itself. Even if they survive, psychological suffering is inevitable. The European Court has recognised the concept of psychological torture and would likely be able to understand it in these circumstances as well.[26]

An important consequence of the pandemic is that care staff are no longer the ones causing the suffering – they are also the victims of it. This is very different than involuntary treatment and restraints, where they take on the roles of perpetrators. They might be much more supportive of disability advocates' arguments describing the situation as torture, and many might share the goal as well: release residents to settings where they are safer.

4. Conclusion – How to Choose the Best Way to Proceed

Litigators are not restricted to rely only on freedom from torture when challenging institutionalisation. They can use other provisions of international law in addition to the prohibition of torture. The right to independent living and the right to private life are amenable to review and oversee the different questions related to effective implementation of deinstitutionalisation strategies, such as resource constraints, priority settings, and temporary situations. Torture is not an effective framework for these tasks, and the pandemic has not changed that.

However, the pandemic has changed some other aspects of the relevance of the torture framework and has made it a more effective avenue to argue for urgent solutions. If freedom from torture had some attractive features before, it has become an almost unavoidable element in an effective strategy to respond to the pandemic.

As explained above, the pandemic helps us overcome some of the shortcomings of the torture framework which would otherwise caution us against resorting to it. With regard to the others, it depends on the precise remedies asked for. Governments might argue that emergency de-institutionalisation requires difficult policy decisions to be made which are resource- and time-intensive. That is true. However, coming up with a clear emergency plan with reasonable timelines is neither resource- nor time-intensive: it can be done in a short time, and can rely on the existing administrative capacities of the state. If litigators asked for this remedy, courts could be sympathetic, and governments could have a hard time explaining why they are unwilling to comply with such a request.

Governments might argue that an obligation to de-institutionalise is not new, it existed before the pandemic as well. That argument could be reversed by litigators. The fact that governments had such an obligation before the pandemic means that they should have closed the institutions already. The fact they have not done that has exposed and subjected a large number of persons with disabilities to excruciating physical and mental suffering. They did not intend that, nobody did, but it nevertheless happened because of their failure to act. And it will happen again, unless they finally honour their obligations.

26 Irfan Neziroglu, 'A Comparative Analysis of Mental and Psychological Suffering as Torture, Inhuman or Degrading Treatment or Punishment under International Human Rights Treaty Law' (2007) 4 Essex Hum. Rts. Rev. 1.

The pandemic is proof that institutionalisation as a cause of ill-treatment is no longer a speculation, a fanciful argument: it has become provable fact. Overcoming it has become more important and urgent than ever. When the next pandemic comes (because it will come, the question is only when), governments should no longer be able to argue that they did not know the impacts on persons with disabilities in institutions. They do now.