

# UKPTS Position and Guidance Paper on Torture, Coercive Interrogations and Cruel and Degrading Treatment

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## Introduction

We have produced this document for several reasons. Primarily, this is because to date we are unaware of any statement or guidance made with the benefits of being a multi-professional group specialising in psychological trauma. The UKPTS are a multi-disciplinary body where each profession has their own ethics codes, which may differ between professions. Whilst only some of our members are involved in the care and treatment of those who have been tortured we consider that the topic is important enough to warrant being explicit about the societies' view on this subject.

Production of this guidance involved a number of tasks. First, the UKPTS had to agree on a definition not just of torture but of what this means in practice, paying attention to specific and widely used practices that others have claimed do not constitute torture. Second, we formed our position regarding the involvement of our members in such practices. This included a brief examination of the efficacy of torture. Finally, we sought to offer guidelines for training and supervision of UKPTS members who may, involuntarily or unwittingly, find themselves in contact with torture.

To meet these aims this document includes an overview of other associations' ethical principles and the history of these. The existing guidance varies and appears to give a different weight to different ethical principles. Some (since revised) have resulted in allowing the active participation of their members in what the UKPTS regard as torture.

## Definition of Torture, Coercive Interrogation and Cruel and Degrading Treatment

Section 134 Criminal Justice Act 1988 defines and criminalises an act of torture as:

- *the intentional infliction of severe pain or suffering, in the UK or elsewhere,*

- *in the performance or purported performance of official duties; at the instigation of or with the consent or acquiescence of a public official or person acting in an official capacity.*

By subsection (3) it is immaterial whether the pain or suffering is physical or mental and whether it is caused by an act or an omission, and by subsection (6) person convicted of torture under section 134 is liable to imprisonment for life.

### *Alternative Definitions*

Definitions vary largely over the severity threshold needed to constitute torture and/or the need for state involvement or acquiescence. The definition under section 134 broadly reflects that under article 1 Convention against Torture. Both have severity threshold and a purposive or state sanctioned element.

However, Article 2 Inter-American Convention on Torture does away with any form of severity threshold, defining as torture any unjustified intentional infliction of pain or suffering attributable to the state:

*'For the purposes of this Convention, torture shall be understood to be any act intentionally performed whereby physical or mental pain or suffering is inflicted on a person for purposes of criminal investigation, as a means of intimidation, as personal punishment, as a preventive measure, as a penalty, or for any other purpose. Torture shall also be understood to be the use of methods upon a person intended to obliterate the personality of the victim or to diminish his physical or mental capacities, even if they do not cause physical pain or mental anguish.'*

One the other hand, international humanitarian law does away with the need for the presence of a state official or person of authority – the International Criminal Tribunal for the former Yugoslavia explaining that:

*'The definition of an offence is largely a function of the environment in which it develops.*

*'Article 1 of the Torture Convention makes it abundantly clear that its*

*definition of torture is limited in scope and was meant to apply only "for the purposes of this Convention...[T]he definition of torture under international humanitarian law does not comprise the same elements as the definition of torture generally applied under human rights law."<sup>1</sup>*

The definition adopted, of acts constituting torture, and so of acts *not* constituting torture, is legally significant in relation to:

- i. the concept of universal jurisdiction (the concept by which any state can investigate, arrest, charge and try perpetrators of torture regardless of where the alleged act(s) took place, the nationality of the perpetrator or the nationality of the victim(s)), and
- ii. in the operation of the rule prohibiting the admissibility of evidence extracted by torture in any proceedings.

Both are applicable – by (i) articles 4 et seq. 5 and (ii) article 15 Convention against Torture – only to acts said to constitute torture.

Beyond the above, a tiered or branched approach – in which torture is separated conceptually from less ‘cruel, inhuman or degrading treatment’ – is of less significance: both are absolutely prohibited and neither allow for any balancing between the suffering inflicted and the aim pursued (the infliction of a little ‘less than severe’ suffering is not permitted in for example any ‘ticking time-bomb’ scenario); a human rights claim can be bought for a breach of article 3 European Convention on Human Rights whether the treatment complained of is alleged to constitute torture or cruel, inhuman or degrading treatment, and the obligation on states under both the European Convention on Human Rights and the Convention against Torture 1983 is to prevent both.

## **Definition of Torture and Coercive Interrogation and Cruel and Degrading Treatment Adopted by the UKPTS**

While the UKPTS recognise the potential utility of adopting a particular definition

in other contexts, we see no utility in becoming embroiled in distinctions between torture and other forms of prohibited treatment for the purpose of this position statement. The UKPTS emphasise that there is no significant difference between the therapeutic needs of victims of ill-treatment received from state or non-state parties, or as between suffering inflicted for a specific purpose or no purpose.

The UKPTS consider the abuse of the clinician's specialist knowledge, combined with the vulnerability of the patient/detainee/victim particularly reprehensible where employed or exploited for the intentional infliction of any suffering.

The UKPTS adopt the prohibition as one on the unjustified infliction of suffering<sup>2</sup>. The UKPTS considers the abuse of the clinician's specialist knowledge, employed or exploited for the intentional infliction of any suffering, as inherently unjustified. At the same time the UKPTS endorse the view of the European Court of Human Rights in its opinion in *Nevmerzhitsky v. Ukraine* (Application no. 54825/00) 5 April 2005, para. 98 that:

*'...a measure which is of therapeutic necessity...cannot in principle be regarded as inhuman and degrading'*

## The Efficacy of Torture

Much has been written on the (in) efficacy of torture<sup>3</sup>. The US senate report found that the US practices of torture did not produce lifesaving information<sup>4</sup> and most experts agree that torture is not effective in extracting information<sup>5</sup>. Sleep deprivation and hostile interrogation have the increased potential to produce false memories that the individual incorrectly believes to be true<sup>6</sup>. Thus forcibly extracted confessions and information cannot be relied upon.

The use of torture has also had several supporters, and some have argued that it has revealed, or has the potential to reveal lifesaving information<sup>7</sup>. University Law Professor John Yoo, who was the key author granting legal opinion to use enhanced interrogation techniques, claims that information obtained through torture led to the death of Osama Bin Laden. Others argue that torture cannot be justified even in use in the ticking bomb scenario<sup>8</sup> not only due to the propensity for incorrect information, but also because the circumstances and limitations on

its use are undefinable. The proportionality of what is permissible is similarly difficult or impossible to define.

The UKPTS share the view that torture is often used as a means to intimidate, threaten, punish, act as a warning or deterrent to others or extract revenge, and that little or no importance may be ascribed to the acquired information. We highlight that in situations where torture has been used it has increased violence against the state resulting in dramatic increases in civilian casualties. For example, following the widespread use of hostile interrogation practices that included the use of sleep deprivation, hooding, sensory deprivation, stress positions, forced exercise, nakedness and other humiliation tactics, solitary confinement, reduced diet and extreme temperatures in Ireland in the first half of the 1970's, the level of violence intensified sharply, resulting in escalating civilian deaths<sup>9</sup>.

## The UKPTS Position on Torture, Coercive Interrogation and other forms of Cruel, Inhuman and Degrading Treatment

- **The UKPTS condemn all forms of physical or psychological techniques used in the exercise of torture, coercive interrogation and other prohibited treatment. Its members shall not attend, assist, cooperate or comply with, or condone the use of torture or coercive interrogation, or use their clinical and/or medical skills and expertise, either actively or passively, to facilitate the use of torture or coercive interrogation. The UKPTS unequivocally condemn the use of the strategy of 'extraordinary rendition' and so called "enhanced interrogation" techniques.**
- **Any member found to have engaged in these practices in any way will be barred from membership. Furthermore, any clinician whether or not they are a member of the UKPTS risks being prosecuted under Section 134 Criminal Justice Act 1998, for which the maximum prison sentence is life. Any involvement also risks exposure to civil liability.**

- **The UKPTS will do its utmost to support and assist members who find themselves involuntarily in situations of questionable ethical practices that may amount to torture or cruel and degrading treatment where they raise their concerns at an early stage.**
- **The UKPTS recognise its ethical obligation to alert its members to the risks they face when working in the field of interrogation, torture and other forms of prohibited treatment may be manifest or hidden. The UKPTS therefore urges its members to be cognisant of such considerations and to evaluate them fully before agreeing to undertake work that might expose them to such risks.**
- **The UKPTS hold that its members' practices must adhere to the highest ethical standards at all times. Members should be alert to possible conflicts between loyalty to their employers or to the organisation in which they serve and their professional Code of Practice. Members who work in governmental organisations who engage in, or rely upon information from interrogations, such as the Ministry of Justice, the Ministry of Defence, the Intelligence Services, or those who serve in the Armed Forces should be particularly aware of this. At every step of their work, they should reflect on the impact of their loyalty to their employers, and the influences of their personal and professional principles on their clinical work. The UKPTS acknowledge that dual loyalty to their employment organisation and their professional bodies or the UKPTS can place members in difficult situations that can impact on their careers and livelihood, irrespective of legality. However, the UKPTS believe that adopting its view will ultimately serves both members and their employers well.**
- **Members are obliged to assume responsibility for monitoring such risks. Where they have doubts, uncertainties, or misgivings about their work the UKPTS will do its utmost to assist in clarifying the relevant issues.**



- **The UKPTS undertake to do its utmost to assist members in whistleblowing and reporting of any practices they become aware of they feel may constitute torture, cruel, inhumane or degrading treatment.**
- **To be clear, torture and cruel, inhuman and degrading punishment or treatment is wrong in all circumstances irrespective of any arguments regarding efficacy.**
- **Furthermore, the use of torture or cruel, inhuman and degrading punishment or treatment is highly unlikely to result in useful information and is likely to lead to false confessions and information.**
- **The use of torture or cruel, inhuman and degrading punishment or treatment results in the psychological harm of the victims and has the great potential to increase the risk of harm or casualties that its proponents claim to seek to protect.**

### *Specific Techniques*

For the avoidance of doubt the following are considered as torture. This is not an exhaustive list and contains elements that some do not immediately consider to be torture:

1. Deliberate prolonged sleep deprivation or interrupting of sleep. Detainees should normally be allowed a reasonable duration (e.g. eight hours) of uninterrupted rest during each 24 hour period. Sleep disturbance is sometimes disguised by guards banging on doors, playing loud music or films, position of a generator, placing inmates on unnecessary enhanced and intrusive observation schedules and cell searches. These may be introduced at a systemic level and those enforcing them may be unaware of the harm they cause.
2. Extended solitary confinement. Particularly lasting more than 15 days.
3. Stress positions, for any reason at any time. This includes enforced standing.

4. Enforced exercise.
5. Sensory deprivation such as blackened goggles, hooding and ear defenders and constantly dark cells.
6. Sensory overload such as constant music playing or lights always on.
7. Purposely reduced water or calorific intake.
8. Extreme temperatures such as very cold or very hot cells. Sitting in the sun in hot climates.
9. Humiliation tactics such as photographing naked detainees, enforced nudity, sexual positions,
10. Unnecessary medical interventions and examinations. For example, blood taking, rectal examinations and forced feeding (orally or anally).

## Sample Clinical and Ethical Dilemmas

### ***Case Scenario 1: Removal to a country known engage in torture***

You are asked by the lawyers defending a foreign national to prepare an expert report on his mental health to be used in evidence at SIAC (the Special Immigration Appeals Commission). You are told that the Home Office are asking the Court to deport defendant on the grounds of national security. The United Kingdom has signed a Memorandum of Understanding with the defendant's country which gives assurances that those deported will not be tortured. However, you know that many of those sent back have been tortured and that the Memorandum is a diplomatic paper exercise.

You meet with the detainee for the purposes of assessment. Your clinical opinion is that many of his symptoms are not genuine, and that he is malingering. What do you do?

#### **The Legal Response:**

You are being asked to act as an expert witness and in those circumstances your duty is to the court, not either party in the litigation. The Civil Justice Council's Guidance for the instruction of experts in civil claims includes at 23(d): '*Where an expert advisor is approached to act as an expert witness they will need to consider carefully whether they can accept a role as expert witness*'. If a clinician is holding themselves out as ready to act as an independent expert witness, they need to be aware that their duty is going to be to the court, to assist the court in the area they are being asked to give their opinion on, and there may be instances where that turns out to be uncomfortable for them, whether by reason of the likely consequence of their evidence, or their being cross examined and having to defend their view in the face of opposing opinion.

The Civil Justice Council's Guidance for the instruction of experts in civil claims does include:

*23. Experts should inform those instructing them (whether on initial*

*instruction or at any later stage) without delay if:*

*c. they become aware that they may not be able to fulfil any of the terms of appointment;*

*d. the instructions and/or work have, for any reason, placed them in conflict with their duties as an expert.*

And:

*27. Where experts' instructions are incompatible with their duties, through incompleteness, a conflict between their duty to the court and their instructions, or for any other reason, the experts may consider withdrawing from the case. However, experts should not do so without first discussing the position with those who instruct them and considering whether it would be more appropriate to make a written request for directions from the court. If experts do withdraw, they must give formal written notice to those instructing them.*

And in the scenario above *if* you are able to argue that the work has placed you in conflict with your duties to the court you could approach your instructing solicitors accordingly

However, whether in this scenario the expert's instructions are really 'incompatible with their duties' is questionable, and the expert should consider whether in fact they are approaching the instruction as the 'independent' expert they are holding themselves out to be. If an expert is only ever going to proceed where the facts and likely conclusion align with their ethical stance that is arguably not an independent expert.

**The Clinician Response:** It is likely that you would be asked to consider current mental health, risk of suicide or self-harm upon return or awaiting deportation. You may also be asked about mental health needs when arriving in the other country. It is likely that you will be asked how their mental health will be affected in particular circumstances. These may not be what you expect them to be. For example, you may believe that the person will be tortured and the instructions

may direct you to state your opinion on the basis that the person is held in similar conditions as in the UK, without threat of torture.

As the legal response states above, your duty is to the court. In this scenario it is likely that there will be others, far more expert than you, in determining the risk of torture or harsh conditions. Your duty is to provide an impartial opinion, regardless of what you believe may happen. It will be more difficult to do this, and not have your opinion swayed. You may be under greater pressure from your instructing solicitors, which should be resisted. It will be helpful to seek supervision on why you believe the level of risk or severity to be as you believe. In this case it would be helpful to discuss your opinion with someone who does not know the circumstances and your beliefs of possible torture. Taking extra precautions not to exaggerate severity and risk, means that those who really are at the highest risk are more likely to be accepted as such by the court. The danger is that too many people are deemed as high risk, or very severe, and thus the court no longer places much merit on expert opinion.

In stating your opinion, you should also consider what the client believes. If they believe they will be tortured, irrespective of reality, then risk to self may be increased.

In the unlikely event that you have good reason to believe that the court is not fair, you should exclude yourself and not provide an opinion. It is never acceptable to exaggerate or provide false opinion.

### *Case Scenario 2: Fitness to Fly*

You are asked to assess an immigrant in a detention centre to see if he is fit to be flown back to his country of origin. It is clear that he has no right to stay and the Home Office view is that he comes from a country that does not engage in oppression or torture and that he is clearly an economic migrant. You are impressed by his story and know from other individuals you have treated that torture does occur. There is absolutely no medical or psychiatric reason that he is unfit to fly.

## **The Legal Response:**

In this scenario it is not really clear in what capacity you are being instructed: as either an expert for the legal team (to advise and assist them in their planning a strategy) or as an expert witness for court proceedings.

If you are being instructed as the former you should simply advise the instructing solicitors that there is no medical or psychiatric reason that he would be unfit to fly; any advice from an expert on which the parties do not intend to rely upon in litigation is very likely going to be either confidential or legally privileged. This approach will allow the instructing legal team to divert their resources towards alternative strategies to resist removal. You can of course also then relay your concerns over the use of torture in the country of return, and if you have first-hand knowledge, from for example having treated client's having fled that country offer to be a witness of fact for them.

If you are being instructed as an independent expert witness for court proceedings your duty is to the court, not either party in the litigation. Any evidence you do give is highly likely to be tested by at least counsel for the other side, who may well have an expert of their own, and the court. As an expert witness you risk: a fine or imprisonment on a finding of contempt by the court were you to give false evidence; criminal sanctions if you perjure yourself and a costs order directly against you if found in flagrant and reckless disregard of your duties to the court or that you have caused significant expense to be incurred.

The independence of an expert holding themselves out to be that is of paramount importance. The Civil Justice Council's Guidance for the instruction of experts in civil claims for example includes, at 23(d) that '*Where an expert advisor is approached to act as an expert witness they will need to consider carefully whether they can accept a role as expert witness*'. If a clinician is holding themselves out as ready to act as an expert witness, they should be aware that their duties are going to be to the court to assist the court in the area they are being asked to give an expert opinion on.

**The Clinician Response:** As above, your duty is always to the court. Extra

precautions should be taken to remain impartial. It is never correct to provide an opinion that you know to be false or exaggerated.

### *Case Scenario 3: Treating Torturers*

You are in the middle of a course of treatment of an undercover agent who had worked for many years in Northern Ireland. You agree to take the case on the understanding that he was being retired and this was part of his post-service rehabilitation. You know that he has been involved in the torture both of IRA members and, in his undercover role, of British soldiers. Treatment goes very well and it becomes clear that this man would like to return to active duty and has approached his employers about this.

#### **The Legal Response:**

This probably depends on what a 'return to active duty' necessarily, or even preferably for the client, entails, and specifically whether it entails their further involvement in torture. If not, there might not be enough to break confidentiality and would depend on how likely the risk of the individual causing harm has to be before the clinician breaks confidentiality.

**The Clinician Response:** The duty of a clinician is to break confidentiality if there is a risk to others. At the beginning of the treatment, he did not pose a risk, there is a potential risk to others. You therefore have a duty to report the potential risk. The judgement of risk rests on whether or not he is going to become re-involved in torture. If there is a clear intention and likelihood to torture, then it your duty is to break confidentiality. The assessment of risk should be taken in supervision and with the assistance of relevant people. A difficult question to address is also who to report/expose the person to?

However, by exposing him or reporting him there may be a threat to national security and you may be the product of a gagging order by the security services. Your position is extremely difficult and it is likely to place a huge personal and

professional burden on you that will have far reaching consequences. The way forward will require support from your professional organisations such as the UKPTS, the RCP or the BPS.



## Summary of Positions Adopted by Other Regulatory and Advisory Bodies of Health Professionals

We have taken the clear and unequivocal view that members must not engage in, facilitate, develop, advise upon or condone torture, coercive interrogation, or other cruel, inhuman or degrading treatment under any circumstances. Since we are a multidisciplinary organisation we offer below a review of relevant position statements from international and national professional and regulatory organisations and institutions to provide context for the UKPTS statement.

### *American Psychological Association*

The APA is one of the largest psychological bodies in the world. In 2007 its policy-making council voted against a proposal to ban psychologists from taking part in any interrogations at U.S. Military prisons *'in which detainees are deprived of their human rights'*. The APA approved a resolution that reaffirmed the Association's opposition to torture and restricted members from taking part in torture. However it specifically allowed members to participate in interrogations that dozen specific practices that included sleep deprivation and forced nakedness.

The APA Resolution cites the McCain Amendment<sup>10</sup> (2005) to the Detainee Treatment Act and adopted a definition of torture that departed from the UNCAT definition (see above). The amendment stated that the condition that a detainee has been charged for a criminal act did not apply to non-US citizens located outside the U.S. It did not issue prohibitions against participation in highly coercive interrogation. It did not require its members to adhere to international human rights law. It did not adequately protect confidentiality with respect to detainee health information.

In **February 2010**, the APA's Council of Representatives amended their Ethics Code to clarify psychologists' ethical responsibilities in situations where conflicts arise between psychology ethics and the law or ethics and organizational demands. Previously, it appeared that if psychologists could not resolve such conflicts, they could adhere to the law or demands of an organization without further consideration. That language has been deleted and a new sentence was added that stated *"Under no circumstances may this standard be used to justify*

*or defend violating human rights.”*

In 2010 the APA ethical standards committee revised the code of conduct to state that if there is a conflict between psychologists' ethical responsibilities and the law or governing authority they must *“make known their commitment to the Ethics Code and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code.”* However, *‘If the demands of an organization with which psychologists are affiliated or for whom they are working are in conflict with this Ethics Code, psychologists clarify the nature of the conflict, make known their commitment to the Ethics Code, and take reasonable steps to resolve the conflict consistent with the General Principles and Ethical Standards of the Ethics Code. Under no circumstances may this standard be used to justify or defend violating human rights.’*

The APA stance at this time allowed psychologists to continue to work with the CIA using enhanced interrogation techniques. In 2014 the APA were accused by a New York Times journalist of working with the Bush administration to endorse and collude in torture.<sup>11</sup> The APA strenuously denied this and commissioned an independent review<sup>12</sup> by an independent law firm who concluded that the APA colluded with the Defense Department and the CIA to allow psychologists to facilitate torture. By contrast the American Psychiatric Association did not allow its members to participate in the same practices. The investigation found that that the Ethics Director, Stephen Behnke, in particular was colluding with the military and others to allow psychologists to engage in and facilitate what most other organisations considered to be torture. The report identified significant collusion but found little consideration of the ethical position to adopt. The author identifies *“...the special skill that psychologists possess regarding how our minds and emotions work—a special skill that presumably allows psychologists to be especially good at both healing and harming.”*

The report states:

*‘From 2001 through 2004, there was a great deal of interaction on issues related to interrogations between key CIA psychologists and both APA staff and prominent psychologists, who were considered elder statesmen in psychology or were former*

*or current APA Presidents. These interactions were occurring precisely during the time that the CIA was using "enhanced interrogation techniques"—including waterboarding—in vigorous fashion against certain detainees, and had given a key role in the development and implementation of the enhanced interrogation techniques to contract psychologists Jim Mitchell and Bruce Jessen. These interactions clearly raise the question whether APA was providing direct and important support to the CIA's interrogation program and the enhanced interrogation techniques.'*

At time of writing Jim Mitchell and Bruce Jensen are named in a civil lawsuit by men who allege that they were tortured by them<sup>13</sup>. It was widely reported that the APA permitted psychologists to participate in torture and therefore exonerate others from wrong doing while putting a veneer of apparent ethical and quasi scientific respectability upon the practices<sup>14</sup>.

The report named the leaders of the APA colluded to allow psychologists to permit participation in torture. The CEO, communications officer and chief executive officer all tendered resignations or took early retirement and are no longer associated with the APA.

Since the report was published there have been several revisions and developments. At time of writing all of the APA's etic and procedures are being reviewed. The APA now unequivocally oppose torture, although it is understood that the US Defense Department are objecting to some of the revisions and the process is ongoing. In October 2015 the APA sent letters to key individuals, including President Obama, The Attorney General and the CIA Director making clear that APA members are prohibited in participation in national security interrogations.

These letter and a timeline and review can be viewed at <http://www.apa.org/news/press/statements/interrogations.aspx>

The APA state on their website:

*'The American Psychological Association's (APA) position on torture is clear and unequivocal: Any direct or indirect participation in any act of torture or other forms of cruel, inhuman or degrading treatment or punishment by psychologists is strictly prohibited. There are no exceptions. Such acts as waterboarding, sexual*

*humiliation, stress positions and exploitation of phobias are clear violations of APA's no torture/no abuse policy.'*

***American Psychiatric Association (2006):***

- No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere.

***Royal College of Psychiatrists***

The RCP unanimously passed a resolution at their 2006 AGM reaffirming its condemnation of psychiatric participation in the interrogation of detainees, whether in military or civilian settings. Additionally, the Royal College's statement, *Psychiatric Participation in Interrogation of Detainees* reaffirmed its support for:

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- Principles of Medical Ethics in the Protection of Prisoners and Detainees –against Torture and other Cruel, Inhuman or Degrading Treatment resolution of the U.N. General Assembly (Resolution 37/194, New York, 1982)
- Royal College of Psychiatrists' Statement on torture and psychiatry (October 1998);
- Madrid Declaration on Ethical Standards for Psychiatric Practice of the World Psychiatric Association.

***British Psychological Society<sup>15</sup>:***

The BPS released a statement in 2005 stating that psychologists must ensure that they can discharge their duty of care and exercise independent professional judgment concerning any person for whom they are responsible.

'Psychologists shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty,

and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.'

Psychologists shall not knowingly provide any premises, instruments, substances or knowledge that facilitates the practice of torture or other forms of cruel, inhuman or degrading treatment or that diminishes the ability of the victim to resist such treatment.

Psychologists shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.

In 2009 the BPS issued a statement in the British Medical Journal distancing themselves from the position of the American Psychological Association and condemning any use of psychologists in torture<sup>16</sup>.

In 2014 the BPS officially responded to the US senate report into 'excessive and brutal interrogation techniques that *techniques did **not** deliver life-saving intelligence to the US.*'<sup>17</sup> They noted with deep regret *'that some members of the profession and discipline of psychology were involved in developing some of these techniques.'* The BPS took the opportunity

- to condemn and repudiate those practices
- to reiterate their 'long standing and principled stance' in torture
- to repeat the overriding ethical responsibility of all psychologists and other healthcare professionals to protect and defend fundamental human rights
- and furthermore to note the extensive psychological research concluding that torture and coercive interrogation is ineffective, especially in comparison to rapport-based approaches

*United Kingdom Council for Psychotherapy Statement on Torture (December 2010)*<sup>18</sup>:

UKCP produced a position statement that was critical of some professional body's stance on torture and working with organisations who torture. They produced a set of ten guiding principles:

1. Help registrants/members become aware of International law and their link to professional requirements that relate to torture, mistreatment and interrogation.
2. Establish mechanisms to ensure that human rights breaches involving mistreatment are investigated by professional bodies and criminal prosecutions assisted where relevant.
3. Promote the documentation of torture and abuse that supports evidence, especially when it might involve health professionals or psychologists.
4. Set up systems that will assist professionals who know about or suspect mistreatment to act morally, even when they have divided loyalties.
5. Share professional knowledge with care in order to avoid assisting torturers or training people likely to pass on information to others who may abuse.
6. Promote within training and education of members the limitations of intelligence gathering using duress and factors contributing of human rights abuses by professionals.
7. Promote understanding of the impact of mental and physical torture on the health of individuals and their families, including the special needs of women and children survivors and those who come from groups with history oppression.
8. Research the effectiveness of treatments and responses to those who have been tortured.
9. Work with other agencies to identify people who have been tortured and appropriate responses to their complex needs.
10. Ensure that survivors and people at risk of torture in other countries are not returned there.

*The World Medical Assembly Declaration of Tokyo* provided guidelines for physicians concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment (adopted 1975, editorially

revised 2005, 2006). These:

- Prohibits physician from being present at, condoning or participating in practice of torture or other forms of cruel, inhuman or degrading procedures.
- Prohibits physician from providing premises, instruments, substance or knowledge to facilitate such practices, or to diminish the ability of the victim to resist such treatment.
- Enjoins physicians to ensure confidentiality of all personal medical information.
- Forbids use of medical knowledge or skills, or health information specific to the individual to aid interrogation.
- Urge complete clinical independence
- Charges physician to report any breach of the Geneva Conventions to the relevant authorities.

*World Medical Association Declaration (1997)* affirmed support for medical doctors refusing to participate in, or to condone, the use of torture or other forms of cruel, inhuman or degrading treatment. It detailed the rights and duties expected from physicians in a torture-related situation and reaffirmed that there is never any justification for violating human rights

*Physicians for Human Rights, 2002: Dual loyalties and human rights in health professional practice stated:*

- A Physician shall not limit or deny medical treatment or information related to an individual's treatment related to treatment of an individual in order to effectuate policy or practice of the state or other third party.
- A Physician shall not disclose confidential information to state authorities or other third parties in circumstances that violate human rights.

*International Council of Nurses (1998, revised 2006):*<sup>19</sup>

- Interrogation procedures and any act or behaviour harmful to mental and physical health, including denial of treatment and care during detention must be condemned.
- Prisoners and detainees, including those on hunger strike have a right to clear and sufficient information; to consent for or refusal of treatment or diagnostic procedures; and to a dignified and peaceful death.
- Nurses have a role in making sure informed consent and capacity to consent is established, particularly for vulnerable groups and those with mental health problems or learning disabilities.
- Nurses working in prison systems must observe the *Standard Minimum Rules for the Treatment of Prisoners*, which require that health services must be available to prisoners without discrimination.
- The ethical obligations of health professionals are addressed in the *Principles of Medical Ethics Relevant to the Role of Health Personnel, in the Protection of Prisoners and Detainees Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment*. These and other instruments such as the Istanbul Protocol make clear that health professionals have a moral duty to protect the physical and mental health of prisoners and detainees.
- Nurses who are aware of abuse and maltreatment take appropriate action to safeguard the rights of detainees and prisoners.
- *'Violations of human rights are pervasive and scientific advances have brought about sophisticated forms of torture. ICN supports the United Nations Universal Declaration of Human Rights and advocates upholding the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Istanbul Protocol on Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment'*

However, the guidelines appear to permit nurses to attend torture sessions. The position statement also states:

*'The ICN Code of Ethics for Nurses states that ...the fundamental responsibility of the nurse is to promote health, prevent illness, to restore health and to alleviate suffering. However we recognise that nurses are sometimes called upon to*



*perform physical examinations before prisoners' interrogation and torture, to attend torture sessions in order to provide care, and/or to treat the effects of torture.'*

## UKPTS Board

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<sup>1</sup> *Prosecutor v. Kunarac et al., Case No.IT-96-23-T & IT-96-23/1-T* Judgement of the International Criminal Tribunal for the former Yugoslavia 22 February 2001, para. 469 et seq

<sup>2</sup> This is in line with the following: '*...there may be some purposes for which deliberately causing severe suffering is justified and, therefore, is not inhuman...*' Manfred Nowak, *What Practices Constitute Torture?: US and UN Standards*, 28 (no. 4) Human Rights Quarterly 809 (2006), at 821; '[a]ny use of force that is not strictly necessary to ensure proper behavior on the part of the detainee constitutes an assault on the dignity of the person... in violation of Article 5 of the American Convention' [emphasis added] Loayza Tamayo, 1997, Inter-Am.Ct.H.R. Series C No.33, para. 57; *Castillo-Petruzzi*, Judgment of May 30, 1999, Inter-Am. Ct. H.R. (Ser. C) No. 52 (1999) para.197; *Cantoral-Benavides*, Judgment of August 18, 2000, Inter-Am. Ct. H.R., (Ser. C) No. 69 (2000) para. 96; '*in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3*' [emphasis added], *Bati and Others v. Turkey*, nos. 33097/96 and 57834/00, judgment of 3 June 2004 at para. 118.

<sup>3</sup> Shane O'Mara (2015) *Why Torture Doesn't Work: The Neuroscience of Interrogation*. Harvard University Press.

<sup>4</sup> <https://www.amnestyusa.org/pdfs/sscistudy1.pdf>

<sup>5</sup> McCoy, A. (2006): *A Question of Torture: CIA Interrogation, From the Cold War to the War on Terror*: New York: Metropolis

<sup>6</sup> Frenda et al (2014). Sleep Deprivation and False Memories. *Psychological Science* Vol 25 (9)1674-1681

<sup>7</sup> Yoo, J (2014). "Yoo: The Feinstien Report Cannot Deny a Clear Record of Success" Time, December 9<sup>th</sup>.

<http://time.com/3626957/yoo-senate-torture-report-feinstein/>

<sup>8</sup> Why I'm glad Torture Works Huffington Post July 9<sup>th</sup> 2011. [http://www.huffingtonpost.com/bruce-ledewitz/why-im-glad-that-torture-\\_b\\_859269.html](http://www.huffingtonpost.com/bruce-ledewitz/why-im-glad-that-torture-_b_859269.html)

<sup>9</sup> See Bob Brecher (2007) *Torture and the Ticking Bomb*: Blackwell Ltd London

<sup>9</sup> Cobain, I (2012) *Cruel Britannia: A Secret History of Torture*. Portobello Books

<sup>10</sup> The McCain Amendment (2005) World Medical Association Declaration concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment (1997):

<sup>11</sup> James Risen (2014) *Pay Any Price: Greed, Power, and Endless War* Houghton Mifflin Harcourt

<sup>12</sup> <http://www.apa.org/independent-review/APA-FINAL-Report-7.2.15.pdf>

<sup>13</sup> <https://www.aclu.org/legal-document/salim-v-mitchell-complaint>

<sup>14</sup> See for example <http://www.economist.com/blogs/democracyinamerica/2015/07/terror-torture-and-psychology> and <http://www.theguardian.com/us-news/2015/jul/14/apa-senior-officials-torture-report-cia> and <http://www.theguardian.com/law/2015/jul/10/us-torture-doctors-psychologists-apa-prosecution>

<sup>15</sup> [http://www.bps.org.uk/system/files/Public%20files/declaration\\_on\\_torture\\_2005.pdf](http://www.bps.org.uk/system/files/Public%20files/declaration_on_torture_2005.pdf)

<sup>16</sup> <http://www.bmj.com/rapid-response/2011/11/02/british-psychologists-repudiation-torture>

<sup>17</sup> <http://www.bps.org.uk/news/bps-reponse-us-torture-report>

<sup>18</sup> [http://www.psychotherapy.org.uk/UKCP\\_Documents/policy/12\\_UKCP\\_Statement\\_on\\_Torture.doc](http://www.psychotherapy.org.uk/UKCP_Documents/policy/12_UKCP_Statement_on_Torture.doc).

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[http://www.ordemenfermeiros.pt/relacoessinternacionais/gri\\_documentacao/ICN\\_TomadasdePosicao\\_versaoINGePT/TP\\_versao\\_ING/E13\\_Torture\\_Death\\_Penalty\\_Executions.pdf](http://www.ordemenfermeiros.pt/relacoessinternacionais/gri_documentacao/ICN_TomadasdePosicao_versaoINGePT/TP_versao_ING/E13_Torture_Death_Penalty_Executions.pdf)

[http://www.icn.ch/images/stories/documents/publications/position\\_statements/A13\\_Nurses\\_Role\\_Detainees\\_P\\_risoners.pdf](http://www.icn.ch/images/stories/documents/publications/position_statements/A13_Nurses_Role_Detainees_P_risoners.pdf)