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OFFENDERS WITH PSYCHO-SOCIAL AND INTELLECTUAL DISABILITIES
IDENTIFICATION, ASSESSMENT OF NEEDS AND EQUAL TREATMENT

PROCEDURAL RIGHTS OF SUSPECTS AND ACCUSED WITH PSYCHOSOCIAL OR INTELLECTUAL DISABILITIES

BELGIUM

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BELGIUM

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General legal framework

The Belgian Constitution contains a general equality rule and a general prohibition of discrimination, not a specific one for people with a mental illness.

Article 10 of the Constitution states: "All Belgians are equal before the law". Article 11 declares that "The enjoyment of all rights and freedoms has to be assured to all Belgians without discrimination". The courts have not developed any specific standards.

Belgium's preferential treatment arrangements in respect of mentally ill can be derived from the general equality and anti-discrimination rules.

These contain not only the principle that all people in the same circumstances should be treated in the same manner, but also the opposite principle that people in different circumstances should be treated differently. A person's specific situation always has to be taken into account. As a result, mentally ill should not be treated the same as mentally sane people in every single situation. Where and when needed, the constitutional equality and anti-discrimination rules provide a basis for preferential treatment of mentally ill. The courts apply the same reasoning.

The anti-discrimination legislation

Belgium has ratified the Convention on the Rights of Persons with Disabilities and the Optional Protocol on 2 July 2009, after approval by the Federal Parliament and by all Parliaments of the Regions and the Communities.[1]

Belgium also adopted a specific Act against certain forms of discrimination,[2] which had been further adapted to the European directives on the same issue, including provisions on reasonable

[1] Federal Parliament: Belgium/Act of 13.05.2009; Flemish Parliament: Flanders/decree of 08.05.2009; French Community Parliament: French Community/decree of 26.03.2009; Walloon Parliament: Walloon Region/decrees of 30.04.2009; Parliament of the German speaking Community: German speaking Community/decree of 11.05.2009; Parliament of the Region of Brussels-Capital: Brussels-Capital/ordinance of 26.03.2009; United Assembly of the Common Community Commission of Brussels: Brussels-Capital/decree of 14.05.2009; Assembly of the French Community Commission of Brussels: Brussels-Capital/decree of 15.01.2009.

[2] La loi du 25 février 2003 tendant à lutter contre la discrimination et modifiant la loi du 15 février 1993 créant un Centre pour l'égalité des chances et la lutte contre le racisme (M.B., 17 mars 2003) ; Loi du 10 mai 2007 tendant à lutter contre certaines formes de discrimination, M.B., 30 mai 2007. See also Protocole entre l'Etat fédéral, la Communauté flamande, la Communauté française, la Communauté germanophone, la Région wallonne, la Région de Bruxelles-Capitale, la Commission communautaire commune, la Commission communautaire française en faveur des personnes en situation de handicap (19/07/2007). - Protocole relatif au concept d'aménagements raisonnables en Belgique en vertu de la loi du 25 février 2003 tendant à lutter contre la

accommodations for persons with a handicap. This legislation is not only applicable in work situations. Article 5, which defines the scope of the law, mentions inter alia the access to and the offering of public goods and services, social protection (including social security and health care) and social benefits.

According to Directive 2000/78/EC, Belgium has to provide "reasonable accommodations" to meet the needs of disabled people. At the federal level as well as at regional and community level, specific policies aimed at ensuring integration of disabled persons have been adopted in the field of education and employment.

It is possible to bring a discrimination complaint before the Centre for Equal Opportunities and Opposition to Racism (now called UNIA). The Centre will try to bring about reconciliation between the parties. When reconciliation seems impossible or fails, the case can be brought before a court. In these cases, the Centre is competent to act on behalf of the discriminated person when this is considered useful. Other discrimination cases, or cases without the involvement of the Centre, can also be dealt with by Belgian courts and tribunals

The **social protection system** also guarantees other benefits for mentally ill, such as tax benefits and an additional child allowance (either because the parent is disabled, or because the child is disabled). There are also three types of allowances for disabled people. Factors such as degree of autonomy in daily activities, ability to work and degree of handicap are assessed. First of all, there is the allowance which replaces the income of a person who is not capable of working due to his or her disability. Secondly, disabled people can request an allowance to facilitate their integration. Lastly, elderly people can ask for an allowance when they have become less independent.

Specific fundamental rights

As previously said, the Constitution never explicitly foresees specific guarantees or safeguards for fundamental rights of mentally ill persons. However, at the legislative level, more attention is being paid to this vulnerable group.

For instance, both in civil and criminal law, the mental illness of the victim can be an aggravating factor for some offences. The right to liberty and security of mentally ill is explicitly defined in the laws regulating involuntary placement and internment.

discrimination et modifiant la loi du 15 février 1993 créant un Centre pour l'égalité des chances et de lutte contre le racisme (publication moniteur belge 20 septembre 2007).

In order to guarantee a fair trial, several special measures (mostly limited to provision of free legal laid) can be taken in procedures concerning mentally ill. Special attention is also being paid to the patient rights of people with mental illnesses. Their rights to marry and to have children cannot be easily restricted; this is usually only possible when they are subjected to a legal protective measure. The same goes for the restriction of property rights.

Criteria and definition of psycho-social or intellectual disabilities

In Belgium, there are a number of legal provisions that define a handicap. However, legislation and case law often lack uniform definitions.

With regard to the Act against certain forms of discrimination (Belgium/Act against certain forms of discrimination, 10.05.2007), the courts state that the interpretation of the European Court of Justice of, inter alia, the notion of "disability" has to be followed.

While, for instance, no definition of the concept of "mental illness" is provided in the civil law allowing for involuntary placement of mentally ill persons under certain conditions (see below Act of 1990), the concept of mentally ill offender ("geestesgestoorde dader" / "malfaiteur atteint d'un trouble mental") received definition in criminal law. Initially referring to an offender in a state of insanity, a serious state of mental disorder or mental deficiency which makes him incapable of controlling his actions,[3] a new law[4] defined this category as an offender who suffers from a mental disorder which annihilates or seriously affects his ability to judge or to control his actions.

Regarding the healthcare system, as already mentioned, a handicapped person may benefit from different types of assistance on condition that he or she meets a number of specific criteria, usually assessed by a medical examination. These include specific allowances paid by social security, as well as other measures such as access to employment, training, mobility.

Data collection and dissemination on mental health

In Belgium, health policy is organised by the federal authority as well as by the different regions and communities (he Flemish, the French Community, the German-speaking Community, the Walloon Region and the Brussels Capital Region). In the course of the 6th state reform, the health care sector has been reshaped resulting in the transfer of several responsibilities and competencies from the federal state to the different communities and regions.

[3] Belgisch Staatsblad-Moniteur belge 11.V.1930 / Act on the protection of society against abnormal people, habitual offenders and the perpetrators of certain sexual offences (09.04.1930), Art. 1 § 1.
[4] Belgisch Staatsblad-Moniteur belge 13.VII.2007 / Act on the internment of persons with a mental illness (21.04.2007), Art. 8, § 1.

Broadly, primary care, hospital care, long term rehabilitation, psychiatric care, elderly care, disability and prevention became community responsibilities, whereas tariffing, vaccination, pharmaceuticals, medical aids and regulations concerning the exercise of medical and paramedical professions remain federal responsibilities.

As far as mental health care is concerned, the Flemish-speaking and French-speaking communities are in charge of all non-hospital mental healthcare, such as sheltered housing and centres for mental health. The federal government is in charge of hospitals, location of psychiatric care and quality of hospital care. Mental health is a part of the primary health-care system and so the treatment of severe mental disorders is available at the primary care level. There is regular training in mental health for primary care professionals. Emergency facilities are geographically sectorised across the country, which offers immediate care at low rates, through subsidisation by the local centres.

This redistribution of powers also had an impact on the provision of health information. Some data information systems were closed down at national level and re-established at another level. Besides, both the French and Flemish communities develop their own health targets and indicators.

Therefore, despite the availability and collection of many health and health care data in Belgium, they are so far not integrated or aggregated into a real Health Information System. The actors involved in collecting these data, as well as obligations to provide information, vary from one database to another.

Furthermore, additional challenges include: a lack of a unique patient identification between all available databases; a lack of data concerning voluntary health insurance (VHI); difficulties with diagnosis and treatment data as far as validity is concerned, in particular for co-morbidity and complications; a lack of data concerning extramural health care; only moderately useful data concerning psychiatry and very limited data concerning homes for the elderly and nursing homes; a lack of data concerning technology used in health care; and a lack of data concerning non-reimbursed payments (Van de Sande et al. 2006).

Statistics on disabilities

In Belgium, there is no official database on persons with disabilities because on the one hand there has never been a census at the level of this population and on the other hand the criteria for establishing the degree of disabilities are not scrupulously identical from one region to another in Belgium.

For example, people with disabilities receiving allowances and integration benefits from the Federal Ministry of Social Affairs are counted according to their degree of autonomy and dependence. Statistical data by type of disability are not currently available. In 2015, the number of persons receiving such benefits or allowances were as follows: 175,416 adults less than 65 aged and 153,647 over 65.[5] According to certain –not recent – studies, the percentage of persons affected by a mental or psychological disorder benefiting from such allowances amounts to an average of 34 %.[6]

Data on prevalence

Surveys are also carried out by the Scientific Institute of Public Health (ISSP - Institut Scientifique de la Santé Publique), which are available online. The most recent one however was conducted in 2013[7] and data collected and treated through specific themes (health status, lifestyles and prevention, health care consumption, health and society, socio-economic inequalities) do not provide a clear picture on the number of persons affected by psycho-social or intellectual disabilities.

On the basis of an average prevalence, it is estimated that there are approximately 150,000 people with mental disabilities in Belgium, of which, according to the available data, around 50 000 people also suffer from psychiatric and/or behavioural disorders, hence the name of "Double Diagnostic" patients, that is to say people with a mental disability and a mental illness with behavioural disorders.[8]

Psychiatric registry

Another potential source of information at national level are the reports of the Minimal Psychiatric Dataset.

The Belgian federal Ministry of Public Health (FOD – SPF Public Health) requires all general and psychiatric hospitals to register all psychiatric intakes, both voluntary and involuntary. The MPD registration was put in place after laws on compulsory admission became active. These "Minimal

[5] SPF Sécurité sociale, Direction générale Personnes handicapées (2016), Rapport annuel 2015, https://handicap.belgium.be/docs/fr/rapport-annuel-2015-fr.pdf.
[6] Etude sur la compilation de données statistiques sur le handicap à partir des registres administratifs des Etats membreZ, Applica & Cesep & European Centre, rapport final, novembre 2007.
[7] For more information, see https://his.wiv-isp.be/fr/SitePages/Rapports.aspx.
[8] Proposition de résolution relative à la prise en charge de personnes handicapées souffrant en plus d'un trouble psychique ou d'un trouble grave du comportement, et en particulier de celles qui requièrent une hospitalisation (Déposée par M. André du Bus de Warnaffe et consorts), Sénat de Belgique, Document législatif n° 5-2201/1, 11 Juillet 2013, available at www.senate.be/www/?MIval=/publications/viewPub.html&COLL=S&LEG=5&NR=2201&VOLGNR=1&LANG=fr.

Psychiatric Data" (Minimale Psychiatrische Gegevens – Résumé Psychiatrique Minimal) are collected and centralised per year by the FOD – SPF Public Health.[9]

The MPD contains socioeconomic characteristics of the patient, diagnosis and pre-admission problems, treatment data, and diagnosis and residual problems at discharge. Psychiatric hospitals (and psychiatric departments of acute care hospitals), and psychiatric nursing homes and initiatives for sheltered living have recorded psychiatric data since 1996 and 1998 respectively.

Apart from general problems with accuracy of an obligatory administrative registration the MPD has a number of specific biases. Whether someone is compulsory admitted can only be registered at admission. The system does not provide registration of a change from voluntary to involuntary during an admission. So, patient who enters hospital as a voluntary patient and whom the treating physician judges that compulsory treatment is needed are not recorded. According to the available data, males are twice as frequently being involuntary admitted than females. The largest proportion of compulsory admissions is done in psychiatric hospitals. On a yearly basis, nearly 6 % of patients enter hospital with an involuntary admission and on any given day 15 % of all patients in hospital are involuntary admitted.[10]

Legal measures of protection in case of "incapacity"

Belgium has four legal systems of so-called protective measures which can apply to a mentally ill person: the declaration of incompetence, the extended minority, the designation of a legal adviser and the designation of a provisional administrator. According to the seriousness of the incapacities of the mentally ill person, a more or less restrictive measure is adopted. These measures have different consequences on the competence of the protected person with regard to his or her assets and/or with regard to his or her person. None of these measures have strict time limits, but last as long as needed. The normal appeal procedure applies.

The law of 17 March 2013 (Act reforming incapacity regimes and introducing a new protection status in accordance with human dignity[11]) reformed the whole of the Belgian regime for protection and representation of individuals who, for reasons of health, are not able to manage

[9] Other important data sets developed for hospital policy since the 1980s are: Minimal Clinical Data (MCD-MKG-RCM), Minimal Nursing Data (MND-MVG-RIM), Hospital Billing Data (HBD-SHA-AZV) and Mobile Urgency Group Data (MUG-SMUR). These data are mainly collected as tools for the measurement of hospital needs for public financing, and evaluation of the effectiveness and quality of hospital care (FPS Health, Food Chain Safety and Environment 2009c). Other objectives include the possibility of using the data for internal management and to determine population needs through epidemiological studies.

[10] For more information, see www.health.belgium.be/fr/sante/organisation-des-soins-de-sante/hopitaux/systemes-denregistrement/rpm/publications-rpm#niveaunational.

[11] Loi du 17 mars 2013 réformant les régimes d'incapacité et instaurant un nouveau statut de protection conforme à la dignité humaine, M.B., 14 June 2013, p. 38132. See also : F.-J. Warlet, "La capacité protégée", collections "Lois actuelles", Kluwer, 2014.

their patrimonial or non-patrimonial rights without assistance. These provisions apply whatever the cause of the individual's inability to manage his/her affairs.

Since the reform introduced by this new law, there are basically two regimes for protection of persons having difficulty in managing their affairs: (1) extra-judicial protection and (2) judicial protection accompanied by the appointment of an administrator pursuant to Article 492 of the Belgian Civil Code. Such an administrator can be given powers of proxy decision-making in relation to a person's assets and/or in relation to exercise of certain of a person's personal rights, such as choice of place of residence, exercise of patient's rights, etc. This is an enlargement of the old regime of Article 488bis under which proxy decision-making powers could only be conferred in relation a person's assets.

Pursuant to Article 488/1 of the Belgian Civil Code, the conditions for adopting protective measures in relation to an individual follow: "A person of full age who, due to his or her state of health, is completely or partially incapable, even temporarily, of managing his patrimonial or non-patrimonial affairs in the normal manner without assistance of other measure of protection, may be placed under protection if and to the extent that his interests so require".

When the Justice of the Peace makes an order for judicial protection, he must decide which personal legal acts the person concerned is incapable of carrying out, having regard for that person's personal circumstances and state of health. At the same time, or in the alternative, the Justice of the Peace may make an order for judicial protection of assets having regard for the nature of these, and the state of health of the person concerned. An order for judicial protection of assets determines which acts a person is incapable of carrying out in relation to his or her assets (see Article 492/1 of the Belgian Civil Code).

The making of an order for judicial protection pursuant to Article 492/1 formally "opens the administration" of the protected person (see Article 495 of the Belgian Civil Code). It is then incumbent on the Justice of the Peace to appoint an administrator ("administrateur"). The administrator can be given powers simply to "assist" the protected person in the accomplishment of certain acts, or to carry out those acts as the "representative" of the protected person.
It can be seen that the regime of judicial protection introduced by the law of 17 March 2013 provides for greater flexibility than the old regime under Article 488 bis of the Belgian Civil Code. The Justice of the Peace can protect a person's non-patrimonial rights and patrimonial rights. He/she can decide which rights the person can exercise without assistance, which acts can be exercised with the assistance of an administrator, and which acts must be carried out by an administrator. Certain acts are, in any event, subject to prior approval of the Justice of the Peace, or can be made subject to prior approval.

Certain patrimonial rights cannot be exercised by or with the assistance of the administrator at all – see Article 497/2 of the Belgian Civil Code. If a person is declared incapable of exercising these rights, there is no way they can be exercised.[12]

Procedure of adoption of protective measures

The person concerned ("the protected person") or any other person interested may request the Justice of the Peace to make an order for protection and to appoint an administrator. The Justice of the Peace may also take such measures as a matter of course when a petition has been made to place the person under observation. The petition must be supported by a medical certificate. The Justice of the Peace then collects all the necessary information and designates an expert doctor to give an opinion on the state of health of the person concerned. The person and his/her spouse or parents are summoned to court and are heard, if required in the presence of their lawyer. The Justice of the Peace may also decide to visit the person in his/her home, if necessary.

The Justice of the Peace usually appoints the spouse or partner, a member of the immediate family or, if necessary, a person in whom the person to be protected has confidence. Within 15 days the clerk of the court publishes details of the administrator in the Moniteur Belge / Belgisch Staatsblad. Any modification to or revocation of the powers of the administrator must also be published. The administrator must be informed that he/she has been appointed within three days of the decision and must reply in writing within eight days stating whether he/she accepts the appointment.

Duration of the measure

In principle, an administrator is appointed for an indefinite period, but he/she is obliged to submit an annual report on his/her management of the protected person's affairs. The appointment of the administrator may be revoked by the court and a new administrator appointed upon the petition of any person having an interest.

The right to appeal

[12] These rights are: consent to marriage; petitioning for annulment of marriage, divorce or separation; determination of the conjugal domicile; consent to dispose of the family dwelling; recognition of parenthood of a child or consent to such recognition; opposition to an action to determine maternity or paternity of a child; consent to adoption; exercise of parental authority over the person's child; declarations of commencement or termination of legal cohabitation; consent to sterilisation; consent to medically assisted pro-creation; declaration of firm conviction that sex is the opposite of that stated in birth certificate; request for euthanasia; request for an abortion; consent to acts affecting one's physical integrity or intimity; consent to use of embryos in vitro for research purposes; refusal of autopsy on one's child of less than 18 years of age; consent to taking of blood or blood derivatives; making of gifts inter vivos, except presents that are proportional to the assets of the protected person; the making or revocation of testamentary dispositions; the exercise of political rights listed in Article 8 § 2 of the Constitution.

A right of appeal exists from the decision of the Justice of the Peace to the Court of First Instance. The Court of First Instance ("Tribunal de première instance"/ "Rechtbank vaneerste aanleg") has jurisdiction to reconsider the matter de novo, that is to say, to re-examine both the facts and the law. From the Court of First Instance there is an appeal to the Supreme Court ("Cour de Cassation"/ "Hof van Cassatie") but only on a point of law.

While providing partial improvement in respect of the previous incapacity regime, this new Act is object of criticism both at national[13] and international level. In observations published in 2014, the CRPD[14] – although commending the Belgian State's efforts to reform legislation on legal capacity, raised concerns about the fact that the new law continues to adhere to a substitute decision-making model and does not provide for the right to supported decision-making. Recommendations issued included to take immediate steps to revise the 2013 Act as well as to allocate sufficient financial and human resources to provide for supported decision-making and enable justices of the peace to take decisions on a case-by-case basis, as required by the law.

Legal measures on involuntary placement and treatment

The law of 26 June 1990 concerning the protection of a person with mental illness is a civil law[15] defines the conditions and procedures for involuntary placement and involuntary treatment of mentally ill persons (both adults and minors) in Belgium.

Looking at the criteria and definitions provided in the law, it should be noted that no strict definitions on the concept of "mental disorder" is given (except by explicitely excluding in its Article 2 the "inadaptation to moral, social, religious, political or other values"). Although there are no specific psychiatric disorders named in the law, it is applicable only to people suffering from (severe) mental illness.

Case law led to further define this concept. For instance, mental debility can be constitutive of an illness.[16] On the other hand, simple personality disorders are not enough. Neither immaturity nor sexual hypersensitivity constitute a mental illness.[17] Senility is not necessarily a disease of the mind. The mere fact that an older person refuses to leave their home does not establish the existence of a mental illness.[18] Similarly, when an elderly person lives in unsanitary conditions and makes incoherent statements about money matters, it has not been established that he

[13] See for instance Avis 2018/34 du CNSPH (Conseil National Supérieur des persinnes Handicapées), available at http://ph.belgium.be/fr/avis/avis-2018-34.html.
[14] Committee on the Rights of Persons with Disabilities (2014), Concluding observations on the initial report of Belgium, (CRPD/C/BEL/CO/1), 28 October 2014.
[15] Loi 26 juin 1990 relative à la protection de la personne des malades mentaux, MB 27 juillet 1990.
[16] Civ. Namur, 6 février 1995, JLMB, 1996, 19, note P. Vanderlinden.
[17] J.P. Namur, 16 décembre 1994, JLMB, 1996, 20, note P. Vanderlinden.
[18] J.P. Anderlecht, 31 janvier 1992, JJP, 1992, 76.

suffers from a mental illness.[19] Isolation, self-neglected habits, aggression and anxiety behaviour are not enough to demonstrate the existence of mental illness.[20]

Article 1 of the law states clearly that limitation of freedom / involuntary placement is only possible through the application of the required legal administrative procedure provided by this law.

The central question of the law is: "who can and in which conditions be admitted to a psychiatric institution against his/her will?". The law is only applicable when there is no other adequate treatment option. In practice this bales down to a patient refusing voluntary treatment. The last criterion relates to a situation of danger. This covers both personal health and safety as well as the life or integrity of someone else. It must concern a present and real danger.

The law regulates two forms of procedures for involuntary or compulsory admission.

Normal procedure

The Judge of peace of the locality where a patient is staying is the responsible legal authority in the procedure.

A procedure can be started with a written request ("verzoekschrift") to the Judge of peace. This request can be made by all concerned (with the exception when a demand would be solely motivated by potential financial gains).

Joint to the request there needs to be an "extensive" medical report, based on medical evaluations not older than 15 days. "Extensive" means that it not only contains a psychiatric diagnosis but also a description of the specific problems, e.g. dangerousness of the situation and the lack of other treatment options. This report can be made by any physician who is not a relative of the patient or of the person making the request, or, in case of a hospitalised patient, does not work in the psychiatric ward where the patient is staying or is going to stay.

The Judge of peace will assess whether all conditions of the law apply. Within 24 hours he/she will decide whether this demand for compulsory admission is valid and whether the normal procedure will continue. When the demand is invalid the procedure stops.

When the demand is considered valid the Judge of peace will within 24 hours inform the patient or his/her legal representative, a lawyer is appointed either pro deo by the judge or chosen by

[19] J.P. Fosses-la-Ville, 13 décembre 1991, JLMB, 1992, 738, note C. Daubaton.
[20] J.P. Asse, 18 décembre 1992, JJP, 1994, 16.

the patient (see items on patient rights). The Judge can appoint an independent psychiatrist to assist him in his judgement, and the patient can appoint or choose an independent psychiatrist and "a trusted third person".

The judge will also set the date and timing when his ruling will take place. On that day, he/she will see and hear the patient and all concerned who the judge decides can provide relevant information. Within 10 days after the procedure started with the written request the Judge rules after having heard all concerned.

A transcript of the ruling is sent to: the patient, legal representatives of patient and those who made request, the personal physician of the patient, the appointed trusted person of the patient; the prosecutor.

If a compulsory admission is ruled, the judge appoints the psychiatric service where the patient needs to be hospitalised.

Period of observation of maximum 40 days

Upon arrival in hospital all compulsory admitted patients are entered in a logbook (personal demographic details, date of entry and discharge, each leave from hospital, all procedures of protection (e.g. isolation, use of restraints, etc.) by the director. This logbook is available for all persons involved with the control on the institution. Hospitalisation for observation is only possible in accredited hospital wards (psychiatric hospital or psychiatric ward of general hospital) of which the responsible psychiatrist has passed a specific exam. The period for observation should not exceed 40 days. In this period, the patient is 'guarded', thoroughly assessed and an appropriate treatment is started.

Urgency procedure

This procedure does not replace the normal procedure but is used in case of high urgency, as a preliminary step to the normal procedure.

The prosecutor can order an urgent admission of a patient on his own authority or on the request of someone, with a report from a physician. This report needs to show the urgency in a specific case as well as the other criteria for compulsory admission.

The prosecutor can rule for an immediate admission to a hospital in which case he informs the director of the psychiatric institution. Within 24 hours the prosecutor must start the normal procedure (written demand, medical report) with the Judge of peace.

Special case, compulsory admission to a family

The law also provides a special chapter for placement in a family. The procedure is similar to the normal procedure and stipulates compulsory placement in a family setting. In practice this procedure is rarely used.[21]

Patient rights

The law takes into account overall issues related to patient rights. During the procedure, the patient is heard and he/she has right to have independent legal support of a lawyer. The patient can appoint a personal physician and a trusted third person.

During hospitalisation, the law stipulates some general basis rights:

- Respect of freedom of speech and philosophical and religious conviction.
- Respect for social and cultural interests and right to have contacts with family.
- Right on privacy of personal mail.
- Right to have visits of a lawyer, personal physician and trusted third person. Other visits are dependent on psychiatric conditions and consultation with treating psychiatrist.

The chosen physician and the lawyer have access to the logbook to consult data on the patient. They can ask the treating psychiatrist for all relevant information needed to assess the patient's condition. The physician chosen by the patient can in the presence of the treating psychiatrist consult the patient file.

Appeal against rulings on compulsory admission is regulated within the law. Appeal is possible against the first ruling of the Judge of peace, questioning whether the demand for the procedure is valid, as well as all later rulings of the judge (e.g. ordering compulsory admission, prolongation of stay, etc.).

The lawyer of the patient is responsible for starting a procedure of appeal before the court of appeal with three judges. The ruling in higher appeal must be made within a month.

[21] A survey in the Flemish part of the country (Arteel, 2001) indicated that in the majority of cases (75 %) patients are being involuntary admitted by the emergency procedure. In the larger cities, the normal procedure is only followed in 15 % of cases. Admission to hospital with the emergency procedure is not confirmed by the judge of peace in 1 out of 3 cases. In 50 % of involuntary admissions the duration of forced treatment is less than 6 months. After an involuntary admission prolongation of stay is requested in 2 out of 3 cases. See Arteel P (2001), De wet van 26 juni 1990 betreffende de bescherming van de persoon van de geesteszieke (unpublished text, personal communication).

Legal status in the area of criminal law

Mentally ill offenders and criminal liability

Article 71 of the Belgian Penal Code states that "no crime shall have been committed where the accused or defendant was in a serious state of mental imbalance or debility rendering them incapable of controlling their actions, or was subject to an irresistible impulse".[22]

From the point of view of criminal law, people with mental disorders who make them unable to control their actions, even if they are the material authors of an offense, cannot be convicted and sentenced to a penalty. Mental disorders that have abolished or severely impaired one's mental faculties thus constitute a cause of "criminal incapacity".

The principle has been stated, in formal terms, by the Court of Cassation: "The act of a person who at the moment when he performs it is in a serious state of mental imbalance rendering him incapable of controlling his actions, cannot be regarded as having taken place by the fault of this person nor as committing, therefore, his responsibility".[23]

The assessment of mental illness is a question of fact. The status of the person concerned is not a determinant factor. Even if the person has been declared in a state of prolonged minority or is being subject to another protective measure (see Act of 1990), he or she can be held responsible for his/her acts if they have been carried out in an interval of lucidity. The same applies to the person who is under compulsory observation pursuant to the Act of 26 June 1990 on the protection of the person of the mentally ill.

Although Article 71 of the Criminal Code allows the judge to dismiss the case or order an acquittal, the law on social protection and internment allows judges to order the person to be interned if the mental state in which they were in at the time the crime was committed is still present at the time of the court investigation or judgment. Stricto sensu, such cases do not constitute imprisonment, but a security measure.

Law on social protection and internment

[22] "Il n'y a pas d'infraction lorsque l'accusé ou le prévenu était atteint, au moment des faits, d'un trouble mental qui a aboli sa capacité de discernement ou de contrôle de ses actes ou lorsqu'il a été contraint par une force à laquelle il n'a pu resister".
[23] Cass., 29 novembre 1984, Pas., 1985, I, 399.

The Belgian Act of 1964 on the Protection of Society against Abnormal and Recidivist Offenders[24]

In Belgium, mentally ill offenders who are deemed not criminally accountable for the offence they have committed can be placed under an "internment measure" as they are – at the same time – seen as a danger for society but also as persons who need treatment and care.

The internment measure is defined as a safety measure – rather than a punishment – to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires in view of his/her reintegration into society".

However, the main rationale and focus of the imposition of an internment measure in Belgium has traditionally been the protection of society against mentally ill offenders who are considered a danger to society.

Until the adoption of a new legislation that came into force in 2016, the law of 1964 on the Protection of Society against Abnormal and Recidivist Offenders stipulated that the internment measure could be imposed by a judge when the defendant 1) had committed a criminal offence 2) was deemed not criminally responsible at the moment of the trial due to insanity, a serious mental disorder or a serious mental deficiency which made the person incapable to (fully) control his or her acts, and 3) was considered a danger to society at the moment of the trial.

Under this act, a Commission for the Protection of Society (CPS – *Commission de Défense Sociale*) supervised the administration of the internment measure. A CPS was regionally organised corresponding to judicial districts, and chaired by a judge who was assisted by a psychiatrist and a lawyer. A public prosecutor was also present at the hearings. The CPS decided, amongst others, when and to which type of treatment setting the mentally ill offender would be initially referred to, any successive transfers to another establishment, to grant conditional release under specific conditions (into a (forensic) psychiatric hospital or the community), revoke or suspend the conditional release in case of lack of compliance, as well as to abrogate the internment measure.

The regime set up to protect society against mentally ill offenders was based on a twofold measure, both medical and legal.

The first aspect involved placing the offender in observation within the psychiatric wing of a prison (Article 1 LDS). Such wings existed in Belgium since 1920. These wards already contained prisoners and mentally ill criminals awaiting forensic investigation. This first measure, instating an observation period, evidenced the new importance of forensic psychiatry in the protection of

[24] La loi de défense sociale à l'égard des anormaux et des délinquants d'habitude (Law on the protection of society from abnormal and habitual delinquents of 1 July 1964).

society system. It aimed at improving the practical conditions surrounding the expert assessment of responsibility and dangerousness used to guide the defendant's future orientation.

The second measure prescribed by the law is an internment measure that may be ordered by investigating or court judges (Article 7). This measure is pronounced for a "relatively" indeterminate period of 5, 10 or 15 years depending on the seriousness of the act committed (Article 19). However, this period may be prolonged indefinitely, so that the goal pursued, that of preserving freedom and combating arbitrary confinement, is hardly achieved. The measure actually makes it possible to confine an individual who continues to represent a danger for society for his entire lifetime.

Mentally ill offenders could reside in prison, in a high secure forensic psychiatric centre, in a medium secure unit, or in a ward of a general psychiatric hospital. They could also receive psychiatric treatment or psychosocial support as an outpatient in several community (forensic psychiatric) mental health care and social services (including sheltered living projects and day hospitalisation).

The 2014 Act on the internment of mentally ill persons[25]

Since 1 October 2016 a new Law (the Act on the internment of mentally ill persons of 5 May 2014, amended by the Potpourri III-law of 4 May 2016) has come into force and brought several innovations in respect of the previous legal framework. In Article 2, it defines an "internment measure" as "a safety measure to protect society and that simultaneously aims to ensure that the mentally ill offender is provided with the care his/her condition requires according to human dignity in view of his/her reintegration into society". Broadly speaking, this new legislation is still characterized by the overall philosophy of the 1930-1964 Social Defence Acts as a system oscillating between security and care.

This Law states that persons can be subjected to an internment measure: (1) if their criminal offence harms the physical and psychological integrity of a third party; (2) if they have a mental illness at the time of the offence; and (3) if there is a danger of committing new offences.

Consequentially, only persons who have committed criminal offences harming the physical and psychological integrity of a third party can be "interned". The previous law did not require that the crime of offences committed be punishable by imprisonment. As a result, persons with disabilities were detained for minor offences which would not have resulted in imprisonment had they acted as ordinary defendants.

[25] Loi du 5 mai 2014 relative à l'internement de personnes, M.B., 9 July 2014, p. 52159.

The new law also adopts the new terminology of "mental disorder", a notion deemed to be more in adequacy with the evolution of contemporary psychiatry (Article 9).

The law makes psychiatric assessment compulsory prior to any decision on internment and sets the minimum content. The law also sets up a panel of experts (already regularly used in practice), and provides the assistance with other experts in behavioural science (also commonly used) while making the expertise potentially contradictory (Article 7).

In particular, the expert must decide on the person's "care path" by establishing "whether, where appropriate, the person can be treated and supported, and in what way, with a view to his reintegration into society". If needed, the expert can also request additional analysis from third parties or be assisted by behavioural science professionals.

From 2020, the expert may request observations in an institution provided for this purpose or he can obtain additional information during the two months of "observation" by a multidisciplinary team.

In response to the condemnations pronounced by the European Court of Human Rights, internment remains the basic measure of the regime but can no longer, in principle, be served in the psychiatric wing of ordinary prisons. Internment should be only served in an institution for the protection of society, in a social defence section, in a forensic psychiatric centre for internees at "high risk", or in an institution recognized by the competent authority organized by a private institution, a Community or a Region for internees at "low or moderate risk" (Article 3).

Another innovation is that the management and control over internment is no longer attributed to the "*Commission de Défense Sociale" but to a* Social Protection Chamber attached to the Sentence Implementation Court (*Tribunal d'application des peines*[26]), made up of a judge (the sentence implementation judge) who will sit as president, an assessor specialized in social rehabilitation and a specialist assessor in clinical psychology (Article 93, 2).

Once the verdict of internment is pronounced by the investigating judge on the basis of a psychiatric report, it is then the Chamber that decides at a first hearing the details of the internment (Articles 10, 11, 12). It determines the location where the internment will take place or opts for another modality (electronic surveillance, probation release, early release, exit permit, leave and limited detention). The execution is then put in place.

The law provides that the internee may have access to his court file to prepare for the hearing with his counsel 10 days before it. No decision can be taken if the internee and his counsel are

[26] A Law of 17 May 2006, partially in force as from 1 February 2007 and fully in force since 1 June 2008, has introduced new principles, among which the creation of Sentences Implementation Courts *Tribunaux d'application des peines*. Most release modalities, such as semi-detention, electronic monitoring, conditional release, are now granted and revoked by these courts.

not present. If the chamber is seized in writing by the public prosecutor, the victims, the lawyer, a caregiver or a prison director, the internee (and all parties involved) is always notified. These mechanisms (and the submission of opinions) have with very strict deadlines and are determined in a precise way.

Finally, the Act of May 5, 2014, maintains the various modalities of execution of internment measures but considerably softens them. Specifically, more leeway is given to the Social Protection Chamber to assess eligibility of a particular modality (transfer, furlough, leave, electronic surveillance, conditional release, etc.) in order to design a flexible "care path". In other words, one of the salient features of the new text is its evolutionary philosophy required by therapeutic action, the measure being likely to change according to the state of health of the interned citizen.

As part of this evolutionary process, mentally disordered offenders may, with the assistance of a legal counsel, apply for release or conditional release to the Social Protection Chamber. Such request can be submitted every six months. When considering this request, the Chamber may seek the advice of a doctor. If the Chamber assesses that the mental state of the mentally disordered offender had improved and conditions are met for his rehabilitation, this latter will be released.

If the mentally ill offender is granted conditional release, the role of control on the procedure and compliance of its conditions is carried out by the Houses of Justice.[27] As part of the process leading to a possible return to the free society, the justice assistant plays an important role and he can be mandated at any time to make an inquiry and evaluate the process or to ensure guidance and monitoring. The justice assistant can also meet the family with the agreement of the internee in the case of release under probation or electronic surveillance. The justice assistant (Houses of Justice) reports to the Chamber regarding the course of the guidance and the way the offender deals with the conditions imposed.

Internment ends with a probationary release or final release. Final release can only be pronounced after a probationary trial period of 3 years and every 2 years maximum if it has been

[27] Upon inception in 1999 (Act of 13 June 1999), the Houses of Justice were assigned to the execution and supervision of all community penalties or alternative penalties and measures to imprisonment (which includes probation tasks). Since 2006, their mandate has been extended so that the scope of their monitoring assignment includes work punishments, electronic monitoring, limited detention, probationary conditional or suspended sentences, conditional or custodial release of prison, supervised release, placing at the disposal of the government, as well as internment and conditional release of mentally disordered offenders. The Houses of Justice are administered by the federal Ministry of Justice (Directorate General Houses of Justice) and are funded 100 % by the central government (through the Ministry of Justice). From an organisational point of view, the Directorate-General Houses of Justice can be divided in two levels: a central and a decentralised (local) level. At local level, there is a House of Justice in every court district (in total 28). The actual fieldwork is carried out by approximately 1,100 justice assistants (probation workers, mediators, victim support workers, etc.). Justice assistants are trained at a higher education level as social workers, social advisors, social nurses or assistants in psychology, while others are trained at a university level as social scientists (i.e. criminologists, psychologists, sociologists and educationists).

refused, and as far as the state of health of the mentally ill offender has sufficiently improved and he/she is no longer dangerous (art. 66). Final release can also be subject to non-negotiable general conditions (not to commit new crimes, not to harass the victims) and other special conditions such as a post-cure obligation but the internee must agree with the stated conditions.

Although improvements have been made in comparison with the law of 1964, the new law is still subject to criticism and discussion, first on the transfer of competences to a body attached to Sentencing Courts which means that internment measure – although it should not be considered as a "punishment" – still falls within the remit of criminal law. Another critical aspect is the elimination of the Court of Appeal against decisions by the Sentencing Court, which may now only be appealed to the Supreme Court, to which only the lawyer of the detainee may lodge an appeal, within a very short time-frame.

The CRPD[28] also raised concerns about this new Act governing safety measures applicable to persons who have been deprived of legal capacity, stressing that it was not in conformity with the Convention on the Rights of Persons with Disabilities. The measures are forms of social punishment that are adopted not on the basis of the principle of proportionality, but rather in response to a person's perceived "dangerous" state. The procedure used to put in place safety measures for persons who have been deprived of legal capacity is not in accordance with the procedural guarantees established in international human rights law, such as, inter alia, the presumption of innocence, the right to a defence and the right to a fair trial.[29]

Persons with disabilities who have committed a crime should be tried under the ordinary criminal procedure, on an equal basis with others and with the same guarantees, although with specific procedural adjustments to ensure their equal participation in the criminal justice system.

[28] Committee on the Rights of Persons with Disabilities, Concluding observations on the initial report of Belgium, (CRPD/C/BEL/CO/1), 28 October 2014.

[29] The Committee also recommended that the Belgian State should guarantee the right to reasonable accommodation for all persons with disabilities who are detained in prison; ensure their access to health care on an equal footing with others, on the basis of their free and informed consent, and to the same level of health care as that provided in society at large; establish an independent formal complaints mechanism accessible to all persons detained in prisons or in forensic institutions; and repeal extrajudicial intervention programmes that involuntarily commit individuals to mental health establishments or force them to register with the mental health services. The provision of these services should be based on the free and informed consent of the person concerned. For more information see https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/BEL/CO/1&Lang=En.

Procedural rules and practices within the criminal justice system

Lack of appropriate procedural safeguards and accommodations

The United Nations Convention on the Rights of Persons with Disabilities prescribes that reasonable accommodation is necessary for people who are disabled. Within the context of legal proceedings, Article 13 of this Convention states that "States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages". In order to help to ensure effective access to justice for persons with disabilities, "States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff".[30]

Since the Federal Anti-Discrimination Act of 25 February 2003,[31] whose scope was further extended by the Act of 10 May 2007[32] (aimed at combating certain forms of discrimination), not providing for reasonable accommodations that would allow full access or participation of persons with disabilities in specific context is considered to be an act of discrimination in Belgium. The anti-discrimination legislation applies to the sector of goods and services, whether public or private, and therefore to public services such as courts and penitentiary facilities.[33]

Reasonable accommodations are defined as "appropriate measures taken as needed in a particular case, to enable a disabled person to access, participate and progress in the areas for

[30] United Nations Convention on the Rights of Persons with Disabilities and its optional protocol, 13.12.2006, available at www.un.org/disabilities/default.asp?navid=13&pid=150. The instrument was adopted by the United Nations General Assembly in 2006, opened for signature in 2007 and came into force in 2008, so – especially considering the preceding negotiations – around the same time as the developments leading up to the Roadmap on an EU level.

[31] Law of 25 February 2003 Combating Discrimination, Amending the Law of 15 February 1993 Founding the Centre for Equal Opportunities and Opposition to Racism. The Belgian Anti-Discrimination Act of 2003 broadened the concept of criminal "discrimination to every "discrimination" on the grounds of "gender, so-called race, colour, descent or national or ethnic origin, sexual preference, marital status, birth, wealth, age, religion or philosophy, present or future state of health, handicap or physical characteristic".

[32] Three new anti-discrimination laws were issued on 10 May 2007: the Racism Act, which modifies the Act of 30 July 1981 on Combating Certain Acts Inspired by Racism and Xenophobia; the Gender Act, which aims to eliminate discrimination between men and women; and the Anti-discrimination Act 2007, which aims to eliminate certain forms of discrimination. These new legislations set out prohibited grounds of discrimination as follows: nationality; racial identity; skin colour; ancestry; or national or ethnic origin; gender; age; sexual orientation; marital status; family background; financial status; religious or other belief; political opinion; language; current or future state of health; disability; physical or genetic characteristics; or social origin.

[33] The Anti-discrimination Federal Acts provide for protection in large areas of public life: the provision of goods or services when these are offered to the public; access to employment, promotion, conditions of employment, dismissal and remuneration, both in the private and in the public sector; the nomination of a public servant or his/her assignment to a service; the mention in an official document of any discriminatory provision; and access to and participation in, as well as exercise, of an economic, social, cultural or political activity normally accessible to the public.

which this law applies, unless such measures would impose in respect of the person who should them adopt a disproportionate burden" (Article 4, § 12).

Despite this general legal framework, Belgian criminal justice procedures applied to mentally disordered defendants, both in theory and in practice, are unsatisfactory in the light of international standards to which it should abide. We can even assert that regulations in Belgium concerning the identification of mentally disordered defendants do not have a "fair-trial-rights-finality".

When there are reasons to believe that a person is suffering from a mental disorder that could have an impact on, or nullify, the control of his/her actions, and in respect of whom there is a risk of reoffending because of this mental disorder, the Belgian prosecution authorities or courts may order a psychiatric expert report. In essence, this psychiatric report aims to establish whether or not the defendant is criminally accountable for the act(s) he/she committed. In other words, the aim of this report is to establish whether or not this individual should be referred to a (secure) forensic psychiatry setting, instead of applying the Criminal Code to his/her case.

Of course, defendants with a mental disability are now always entitled to free legal aid.[34] However, neither the identification by the police, prosecuting authorities or the courts, nor the identification by the psychiatrist, of a severe mental disorder is made with the aim of granting the defendant additional extra-legal assistance in order to be able to participate in the proceedings properly. The regulations do not mention the possibility of instigating extra-legal procedural protection involving a relative, a social worker or a healthcare professional in order to safeguard the fairness of the proceedings. Similarly, no specific provision is made to ensure appropriate access to documents for persons with cognitive disabilities. The person therefore has no other choice than to rely solely on their lawyer. In this regard, communication between the lawyer and the client is extremely important. If some lawyers are specialised in dealing with cases involving mentally ill defendants, there is no procedural guarantee that these latter would be represented by such specialists.

[34] Royal Decree setting the conditions for full or partial freedom of charge for legal aid of the second line and for court costs (18.12.2003). It should be noted that in a procedure for an involuntary placement, a state-funded independent counsel is automatically appointed, regardless of the means of the mentally ill. There was no similar legal provision for a mentally ill offender involved in a procedure leading to his or her punishment or internment. However, the Constitutional Court has recognised the importance of a lawyer in such cases. Therefore, it has annulled certain parts of the Act on the internment of persons with a mental illness in order to assure the full assistance of a lawyer throughout the whole of the procedure (Constitutional Court, No. 154/2008, 06.11.2008). Not only the interned person but also his or her lawyer has to automatically receive any relevant advice concerning the implementation of his or her internment and they both have to have the right to receive a copy of the file, since an interned person is not always capable of handling it on his or her own.

Lack of appropriate training of the entire justice sector

Furthermore, there is a clear lack of training – aimed at ensuring appropriate communication and interaction with mentally ill persons at all stages of the process for all justice stakeholders from the police to the judicial and prison staff:[35] this lack of awareness concerns all types disabilities (motor, sensory and cognitive).

Contacts with the police is an important element as it constitutes the first stage of the process in which mentally ill offenders or not might be involved.

Pursuant to the Belgian law, police services have among their tasks the supervision of mentally disordered persons who seriously endanger their health and safety or who pose a serious threat to the life and physical integrity of others.[36] They can prevent their straying, seize them and immediately notify the public prosecutor.[37]

Police services should also seize those who are reported to them as having escaped from the psychiatric ward where they were put under observation or placement in accordance with the law and keep them at the disposal of the competent authorities.[38]

Finally, the police services are also tasked to supervise the internees to whom the sentencing court has granted one of the methods of execution of the internment referred to in Articles 20,

[35] The lack of understanding of disability among staff is nowhere as dramatic as in the prison system. Persons with disabilities in the prison system are there 24/7. Not hearing or understanding what is being said can have catastrophic consequences for the person. While the principle of reasonable accommodation has been enshrined in law, there are no measures expressly intended for persons with disabilities in the prison regulations. The training of prison staff does not include any official information or specific guidelines on this subject either. Having said that, certain actors within the prison system do promote the "natural" practice of making such accommodations, particularly in the case of staff working within prison psychiatric units. In response to the Federal Ombudsman inspections or following the intervention of the Centre for Equal Opportunities and Opposition to Racism (now called UNIA; www.unia.be), the prison administration use to solve the problem individually (such as providing for an ergonomic chair in the cell). However, such way of addressing special needs of disabled inmates is not sufficient nor appropriate. The Belgian penitentiary administration should integrate the concept of "reasonable accommodations" organically within its policy, staff training and infrastructure design.

[36] Article 18. (Les services de police) surveillent les malades mentaux qui mettent gravement en péril leur santé et leur sécurité ou qui constituent une menace grave pour la vie et l'intégrité physique d'autrui. (Ils) empêchent leur divagation, s'en saisissent et en avisent immédiatement le procureur du Roi, L 1998-12-07/31, art. 174, 005; En vigueur: 01-01-2001, L 1999-04-19/50, art. 23, 006; En vigueur: 01-01-2001.

[37] The police services can thus inform the public prosecutor of the arrest of a person whose state suggests that it could present mental disorders justifying the start of an emergency observation procedure. In this case, the public prosecutor invites the police to present the arrested person to the doctor he has designated so that he can prepare a detailed medical report. This detailed medical report is most often drawn up by one of the doctors attached to the psychiatric emergency services of a hospital. These services operate 7 days a week and have a multidisciplinary team that can work 24 hours a day.

[38] "(Ils) se saisissent de ceux qui leur sont signalés comme étant évadés du service psychiatrique où ils avaient été mis en observation ou maintenus conformément à la loi et les tiennent à la disposition des autorités compétentes. L 1998-12-07/31, art. 174, 005; En vigueur: 01-01-2001.

21, 23, 24, 25 and 28 of the law of 5 May 2014 on the internment of persons. They also monitor compliance with the conditions communicated to them for this purpose.[39]

The police intervention must, in all cases, meet the principles of legality, subsidiarity, proportionality and opportunity. These principles include, on the one hand, that priority should be given to the least coercive and radical dialogue and intervention techniques and, on the other hand, that the modalities of intervention must be adapted both to the objective and the circumstances of that intervention, which, for example, depend on the behaviour and state of vulnerability of the person to whom the police intervention is taking place.

Respect for the aforementioned principles conditions the legality of police interventions, and in particular the use of binding measures. Police who do not respect these principles incur criminal, civil and disciplinary liability.

To this purpose, the basic training of police officers includes a module dedicated to intervention in situations involving mentally ill persons. More specifically, this training covers the following aspects: the identification of the situation, the legal bases of the police intervention, the role of the various services and institutions involved in this issue, the management of a crisis situation involving a person suffering from mental/physical problems. Specific advanced trainings also address this issue (e.g. “Mental illnesses and police attitudes”[40]).

However, despite these initiatives, associations representing people with disabilities and promoting respect of their rights consider that these training are not sufficient to ensure appropriate communication and interaction of police officers with mentally ill persons.

When law enforcement personnel carrying out identity checks and administrative or judicial arrests, it is not uncommon for a person with a disability to be deemed to be a delinquent whereas a proper understanding of their experience would lead to the situation being managed with respect for the person and their mental state. For example, people are sometimes arrested on the street, not on the basis of an offense they have committed, but on the basis of a behaviour they display, or simply because they did not have the capacity to express oneself or to make oneself understood.

[39] Article 19. [2 Les services de police surveillent les personnes internées à qui le tribunal de l'application des peines a octroyé une des modalités d'exécution de l'internement visées aux articles 20, 21, 23, 24, 25 et 28 de la loi du 5 mai 2014 relative à l'internement des personnes. Ils contrôlent également le respect des conditions qui leur ont été communiquées à cet effet.] L 2014-05-05/11, art. 129, 033; En vigueur : 01-10-2016 (L 2016-05-04/03, art. 250). Dispositions transitoires: art. 134 et 135.
[40] Fomation Maladies mentales et attitudes policières (DA 3071).

Police authorities are also aware of this knowledge's gap and, given the increase in the number of cases requiring police intervention with respect to persons in a vulnerable psychological or mental state, they have taken steps to improve the situation.[41]

Perceptions of rules and measures by mentally ill offenders

The lack of appropriate procedural safeguards or the inadequacy of procedures in respect of their specific situation is also confirmed by mentally ill persons who have been subject to an internment measure. As demonstrated by recent surveys and studies, interned mentally ill offenders also utter many procedural difficulties regarding the internment measure and the law that regulates the internment measure. These procedural difficulties are related to different aspects of the internment procedure, namely to the psychiatric expertise, the courts, and the administration of the internment measure.

With respect to the **psychiatric expertise**, they especially question and raise concerns about its quality. They argue that the quality of the psychiatric report was hampered by their state of mind at the time of the expertise as well as the way the psychiatrist performed the expertise. Participants indicate that when the psychiatric assessment was carried out, they were experiencing (severe) symptoms of mental illness or were intoxicated, which obstructed having a normal conversation or cooperating with the assessment in a serious manner. They also indicate they met only once with the court psychiatrist for a short amount of time, and that the assessment lacked scrutiny.

The circumstances that produce the low quality of the psychiatric expertise in reports in Belgium have already received a lot of attention and national criticism. These circumstances are the low remuneration for a psychiatric court assessment and the shortage of available psychiatric experts, the lack of a formal statute and training for forensic (expert-)psychiatrists, the lack of quality criteria for a psychiatric court assessment report, and the lack of a forensic clinical observation centre. Magistrates call on only a small number of psychiatrists, who are already overburdened. Therefore, they cannot respond to the request within a reasonable period. The result is that, in the majority of cases, the psychiatrists only see the defendant once and can only give a short amount of time to them.

[41] In 2015, a working group has been created within the federal police to address this issue with a view to developing a particular training focused on: the legal framework for police interventions, the typology of the main cases of mental disorders and the symptoms detectable and identifiable by the police, modalities to avoid stigmatization, as well as the development of appropriate dialogue and intervention techniques. This study is done in consultation with professionals from the mental health sector and include the exchange of good practices with police services from other countries. See Question écrite n° 6-141 de Bert Anciaux (sp.a) du 23 octobre 2014 au vice-premier ministre et ministre de la Sécurité et de l'Intérieur, chargé de la Régie des bâtiments – *Police – Contact avec les personnes souffrant d'une maladie mentale*, available at www.senate.be/www/?MIval=/Vragen/SchriftelijkeVraag&LEG=6&NR=141&LANG=fr.

The act on Internment of 2014 creates preconditions for a better quality of psychiatric court assessment reports. In April 2016, the regulation regarding the formal recognition of the special professional competence in forensic psychiatry was implemented. This formal recognition is associated with a theoretical and practical training. In addition, the numeration for performing a psychiatric court assessment has been adapted to the standard rate for psychiatric consultation and a formal template for a psychiatric court assessment report has been implemented. It has been announced that a forensic clinical observation centre will probably open in 2020.

With respect to **court proceedings**, participants believe the internment measure is imposed too quickly, i.e. without a necessary thorough consideration. For instance, they disagree with imposing the internment measure for minor offences since in these cases the severity of the internment measure is not in accordance with the seriousness of the offence(s) committed. As already mentioned, pursuant to the new Act on internment, this measure cannot be imposed anymore in case of minor offences. In addition, some indicate not attending the court hearing(s). Reasons for not attending the court hearing(s) were, for example, being dissuaded by their lawyer, not being notified of the hearings or feeling uncomfortable at these hearings. When this non-attendance was primarily induced by others, participants felt unsatisfied or ambiguous about it because they were not able to defend themselves.

In addition, participants experienced difficulties in **understanding what was happening,** in terms of not understanding certain professional language during hearings as well as in terms of not being fully aware of the seriousness of the impending internment measure.

Finally, and contrary to the objective of the law stating that the internment measure is a safety measure instead of a punishment, mentally ill offenders also experience the internment as a punishment. Furthermore, considering its indeterminate duration, they experience the internment as “a maximum sentence”, “a life sentence”, or “a sentence to death”.

Custodial and non-custodial measures in practice

The indeterminate period of internment

As already mentioned, mentally ill offenders who are subject to an internment measure are **interned for unspecified periods** and their release depends on assessment of the risk of reoffending.

Despite the new act of 2014, the measure of internment is still not limited in time, even though the detainee and their lawyer are entitled to appear every six months before the Commission for the social protection, either to modify the detention conditions or request release,

Release, either on a trial basis or permanently, is only possible where the mental state of the person has sufficiently improved, a reintegration plan has been drawn up and the reintegration conditions are fulfilled. Upon release, the person is sent to an open residence which meets to their specific needs, on the condition that such an establishment exists and there is a place available. So far, such cases were few and far between and extremely unlikely. Persons were often held for a number of years and left in a permanent state of uncertainty, trapped in a cycle of anticipation and disappointment that repeats itself every six months in view of a hearing before the jurisdictional body (commission/chamber) mandated to decide on their possible (conditional) release.

It is too soon to verify and assess if the new provisions established by the Act on internment of 2014 (which entered into force in 2016) have changed the game in the balance between security and care and in allowing internees – who oscillate between a status of patient and offender – to be less "voiceless" and mainly subjected to a managerial and risk-reduction logic that threats their reintegration into society. Certainly, this would imply a significant shift in culture within Social Protection Chambers, a larger access to the intermediate (outpatient and community) structures for internees and probably increased resources to enable these actors responsible for intermediate housing to set up and apply appropriate care paths.

The quality of health care in penitentiary psychiatric wards

The basic principles of health care in prison are legally embedded within the law of 12 January 2005 concerning the internal legal position of detainees (the Act on Principles of Prison Administration and Prisoners' Legal Status, commonly referred to as the "Dupont Act"[42]), which provides in its Article 88 that all prisoners must have access to health care of the same quality as

[42] Loi de principes du 12 janvier 2005 concernant l'administration pénitentiaire ainsi que le statut juridique des détenus, available at www.ejustice.just.fgov.be/cgi_loi/change_lg.pl?language=fr&la=F&cn=2005011239&table_name=loi

in the free community and that is suited to their specific needs. Until the adoption of this law, most aspects of life in detention, including prisons, were left to the discretion of the prison authorities or based on a variety of guidelines and circulars issued by the executive power. However, several of its provisions regarding health care and health protection, medical expertise and medico-psychosocial expertise, and right to social assistance and services relating to the detention plan, so far have not been implemented. Royal Decrees have to be issued for the coming into force of several articles. In the absence of full implementation of this law, the General Regulations of the Penitentiary Institutions of 1965,[43] still rules today significant aspects of the internal legal status of detainees.

Structurally and legally speaking, prison health care is a competence of the Minister of Justice as persons incarcerated in a penal institution (be it internees, pre-trial detainees, convicted inmates) are by law excluded from the benefits of the Social Security system. The Prison Health Care Service, on central level, as part of the Directorate-general of Penitentiary Institutions, is the service provider for the *"improvement, determination, preservation and improvement of physical and mental health"* (Article 87, § 1, Dupont Act of 2005).[44]

While internees as well as ordinary sentenced prisoners with mental health difficulties are entitled to appropriate care and treatment whose quality should commensurate to the type of care available for people with similar mental health difficulties in the community, these requirements are not fulfilled in Belgium. This is due to different factors.

Firstly, the delay in the implementation of many of the relevant health care related provisions of the Dupont Act entails that the rights afforded to prisoners in this sector are in effect more restrictive than the legislation would suppose. As a result, the principle of equivalent medical care is still not a priority among the prison management.

Secondly, the complex Belgian state structure and the consequent fragmentised division of competencies between different ministerial portfolios have an impact on the organisation of services in the Belgian prison system. This compartmentalisation has disastrous results when it comes to meeting the specific needs of people in prison with mental and psychological disabilities, particularly when persons with disabilities are held under internment orders.

Thirdly, the situation de facto reveals organisational and practical shortcomings in the provision of health care due to an inadequate infrastructure of medical care, a lack of qualified or

[43] Royal Decree of 21 May 1965 laying down General Regulations of Penitentiary Institutions.
[44] It is responsible for the global management of health care, the medical management (cure and prevention), internal management (quality standards and inspection), staff management, educational management, financial management, development and management of electronic databases, consultation and cooperation with internal health services (service for prevention and protection at work, service for labour medicine) and external services (health promotion, control of tuberculosis, drug-aid).

specifically trained staff, dilapidated and unsanitary facilities and insufficient resources. Prisoners continue to be reportedly confronted with long waiting times for specialized care, delayed medical interventions, lack of continuity of medical care and dissatisfaction with the access to minimum health care services on weekends and public holidays.

Shortage of places and appropriate care

Receiving **appropriate treatment** is vital for mentally ill offenders who are subject to an internment measure. However, the shortage of places in suitable facilities means that they are often held in prisons psychiatric wards, where they sometimes remain for lengthy periods while waiting to be transferred to a social protection unit (*établissement de défense sociale*), occasionally together with ordinary prisoners. In these circumstances adverse to appropriate care, their state of health tends to deteriorate rather than improve, and there is therefore very little likelihood to establish social reintegration plans leading to their release.

In 2007, a ministerial memorandum[45] set out two measures: 1. the establishment of multidisciplinary care teams in the prison psychiatric units and social protection institutions. Teams are composed of a psychiatrist, a psychologist, a social worker, an occupational therapist, a psychiatric nurse, a physical therapist, and an educational therapist. These teams provide practical and emotional support to mentally ill offenders. They focus on motivating them for treatment, doing pre-therapeutic work and limiting detriment related to detention; 2. placing specifically trained and selected security personnel in the psychiatric units to assist the care team.

However, during the visit to the psychiatric prison units in Lantin, Jamioulx and Forest, the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment (CPT) reported that the care team although well-qualified were insufficient in number, particular for psychiatric care, in relation to the needs reported on the ground. While conditions have improved considerably, substantial efforts must be made in order to achieve the primary objective set out in the memorandum of June 2007, i.e. to provide detainees with “an equivalent standard of care as that provided in free society”.

[45] FPS Justice, DG Correctional Facilities, Prisons Health Care Service, Circular No. 1800: “Equipes soignantes des sections psychiatriques dans les prisons, les sections ou dans les établissements de défense sociale: objectifs, composition, fonctionnement”, 7 June 2007. The creation of these teams went hand in hand with the decision to separate the task of care (assigned to a treatment team) and that of expertise (assigned to a psycho-social team) in the psychiatric wings of prisons and in the Paifve EDS. The improvement in care since 2007 has proved quite not satisfactory due to the insufficient involvement of psychiatrists (who are employed as independent workers and work part-time in several prisons), the difficulty in recruiting trained personnel for jobs (that are neither professionally nor financially stimulating) as well as the lack of specific training for caregivers.

Epidemiological and judicial profile of mentally ill offenders

Belgium suffers from an extreme lack of epidemiological judicial data, due to limited, non-systematic and inconsistent electronic data registration in national databases (Dheedene, Seynnaeve, & Van der Auwera, 2015). Moreover, Belgium currently does not use internationally standardized screening and assessment procedures in its prisons that would more accurately identify the prevalence of mentally ill offenders. The absence of (evidence-based) treatment protocols leads to additional difficulties, including wrongful clinical diagnoses of mental health problems at the start of a person's incarceration, and consequently inadequate treatment and care. This shortcoming is particularly relevant, considering that a majority of mentally ill offenders have dual or multi-diagnoses, including substance disorders, psychotic disorders, personality disorders, impulse control disorders, and other severe mental disorders.

To date, this shortage of general and accurate descriptive information also regards mentally ill offenders subject to an internment measure.[46] For instance, cross-sectional demographic, psychiatric and judicial information was till recently only available for mentally ill offenders residing in prisons at specific moments in time.[47]

According to the result of these studies,[48] the majority of mentally ill offenders residing in Flemish prisons in 2013 (amounting to 713) were men (93.1 %) and had the Belgian nationality. Median age of these PSIM was 41.64 years. Comorbidity between mental disorders was common (73.41 %). Most common psychiatric diagnoses were (cluster-B) personality disorders (28.4 %), substance use disorders (21.1 %), psychotic disorders (15.7 %), mental disability (12.3 %) and sexual disorders (9.8 %). Regarding judicial characteristics, the study found that most common criminal offence categories were violent offences (including sex offences) (41.6%), property offences (including scams and arson) (29 %), drug related offences (5.4 %) and jeopardizing public safety (such as illegal possession of weapons and hostage) (5.3 %).

As a useful tool of comparison and evaluation, a more recent study[49] focused on the clinical and judicial profile of mentally ill offenders who were treated in medium secure units between 2001 and 2010 (531 profiles). As for mentally ill offenders residing in prison, the majority of them were men (94.9 %) and had the Belgian nationality (90.1 %). Mean age on admission was 36.5 years. Comorbidity between axis-I and axis-II diagnoses was assessed in about two out five of them (42

[46] Jaspis, P. (2018), What's up, Doc? Twee jaar toepassing van de wet van 5 mei 2014 betreffende de internering, paper presented at the Internering: praktijken, onderzoek en wetgeving; welke veranderingen?, Brussels.
[47] Cosyns, P., D'Hont, C., Janssens, D., Maes, E., & Verellen, R. (2007), Geïnterneerden in België: De cijfers. Panopticon, 28(1), 46-61; Dheedene, J., Seynnaeve, K., and Van der Auwera, A. (2015), De geïnterneerdenpopulatie in Vlaamse gevangenissen: Enkele cijfergegevens. Fatik, 32(145), 4-9.
[48] Dheedene, J., Seynnaeve, K., and Van der Auwera, A. (2015), *op. cit.*
[49] Jeandarme, I., Saloppé, X., Habets, P., and Pham, T.H. (2018), Not guilty by reason of insanity: clinical and judicial profile of medium and high security patients in Belgium, The Journal of Forensic Psychiatry & Psychology, 1-15.

%). Most common psychiatric diagnoses were (cluster-B) personality disorders (55.2%), psychotic disorders (43.9 %), and mood and anxiety disorders (6.4 %). Substance misuse was present in 56.7 % of mentally ill offenders. Most of them were subjected to the internment measure due to violent offences (including sex offences) (77.2 %). The majority (84.4 %) had a (violent) criminal history before the imposition of the internment measure.

Geography of internment

Generally, internees are first sent to psychiatric wings of prisons, in theory for a preliminary and temporary observation stage. However, since these wings are overpopulated, some are sent to prison wards for sentenced prisoners. Only 12 out of 35 Belgian prisons are equipped with special psychiatric sections for mentally ill offenders and detainees with psychiatric disease.

In addition to the psychiatric wings of prisons, the French-speaking region has an Institute for Social Defense (*Établissements de Défense Sociale – EDS*) located in Paifve, with a capacity of 208,[50] while the Flemish Region has a high-security section for treatment ("De Haven") at the Merksplas prison, with a capacity of 60. The latter two facilities are subjected to the correctional authorities' rules and correspond to the prison/mental asylum model.

In French-speaking Belgium, two other EDSs (*établissements de défense sociale*) have been created in Mons (30 places) and Tournai (376 places), but these "legal psychiatry centres" are attached to the Ministry of Health. They correspond to the mental asylum/prison model and are theoretically more medically oriented than punitive.

Until recently, there was no equivalent institution, in Flanders. Responding to critiques pointing out the lack of healthcare and specific institutions for internees, the Masterplan adopted by the Ministry of Justice led to the construction of two top-security legal psychiatry centres for medium and high-risk internees was planned in Ghent and Antwerp (with a total capacity of 390).

The Gent's institution opened its doors in May 2014. This facility focuses on medium to high risk mentally ill offenders diagnosed with personality disorders, psychotic disorders, developmental disorders, mental disability, emotional hypersensitivity and psycho-motoric problems who hold a high risk of reoffending and require treatment in a high secure setting. A second high secure facility opened in 2017 in Antwerp.

[50] The situation is hardly better at the Paifve EDS. This facility, which is attached to the ministry of Justice. The Paifve EDS encounters the same difficulties observed in psychiatric wings of prisons. In reality, the priority given to security in the detention regime, the lack of hospital staff and the wardens' lack of specific training leave little room for care.

In addition, some general psychiatric hospitals, both public and private, accept medium risk internees or those on probation who are felt to represent a lesser risk.

In 2001, the development of a forensic psychiatric care circuit for mentally ill offenders in Flanders started with the implementation of three medium secure units at the premises of three general psychiatric hospitals. The initial target population of these units were mentally ill offenders who were diagnosed with psychotic and personality disorders considered unsuitable for treatment in general psychiatric hospitals or the community and who did not require care in a high secure forensic psychiatric setting.

Last, there is also a network of general psychiatric inpatient and outpatient care facilities (psychiatric hospitals, homes, and sheltered living services) offering ambulatory support for low-risk internees, or those on probation.

The variety of care facilities ranging from prison structures to ambulatory care networks illustrates the ambiguity of the internment measure, caught between risk management and treatment.

Internment figures and rates

Over the past decade, Belgian prisons have accommodated over 25 % additional detainees on a daily basis. Over a long period, the number of mentally ill offenders detained in prison psychiatric wings has risen sharply, with an increase of 72 %, not counting residents in social protection institutions in Wallonia in Mons and Tournai, or outside the prison system. There has been a comparable increase across the three regions.

Until recently, the average daily number of internees[51] subjected to a penitentiary custodial regime represented 10 % of the total prison population.

For instance, in absolute figures, there were 1,131 internees in psychiatric wings of prisons and in the Paifve EDS[52] as of 27 August 2013, for a prison population of 11,475.

Figures and percentage were similar until 2016. Due to the development of a forensic psychiatric care circuit in Flanders (with facilities in Gent and Antwerp), the number of mentally ill offenders

[51] Mentally ill offenders sentenced to an internment measure should not be confused with prison inmates suffering from mental disorders, who usually were considered being criminally responsible for their offences, and whose mental disorder – if at all prevalent prior to the prison sentence – was not found to be associated with the committed crime. The Belgian penitentiary administration does not provide any public statistical data related to this specific category of prisoners and does not take it into account in its annual report.

[52] The statistics of the FPS Justice do not count the internees placed in the two other social protection institutions (EDS) in the Walloon Region (in Mons and Tournai), or the population of non-prison structures in the three Regions.

residing in Belgian prisons declined on that year[53] and in 2018 approximately halved (530 internees counted on 30 May 2018[54]) (Jaspis, 2018).

If we look at the total number of mentally ill offenders subjected to an internment measure, we can observe that it is approximatively four times higher than the number of internees residing in prison wings. For instance, in 2012 Belgium counted 4093 "mentally ill offenders" subjected to an internment measure (indicating an increase of 24% over the six previous years). In 2013, there were 3,820[55] and in 3,792 in 2015.[56] Around 60% are conditionally released into (forensic) inpatient or outpatient care in the community (2,311 in 2015 and 2,450 in 2016).

Average yearly number of internees in prison[57]					
2011	2012	2013	2014	2015	2016
1,096	1,133	1,139	1,088	907	784

Number of internees entering prison facilities per year					
2011	2012	2013	2014	2015	2016
370	425	328	310	368	278

Number of internees released from prison per year					
2011	2012	2013	2014	2015	2016
468	442	422	437	715	492

Houses of justice – number of new social enquiry reports prior to conditional release of internees[58]					
2011	2012	2013	2014	2015	2016
290	305	288	285	225	166

[53] Directorate-General of Penitentiary Institutions (2018), 2017 Annual Report.
[54] Jaspis, P. (2018), *op cit.*
[55] Dheedene, J., Seynnaeve, K., and Van der Auwera, A. (2015).
[56] Présentation de Donatien Macquet, "Vers la mise en place de meilleurs soins en santé mentale par la réalisation de circuit et de réseau de soins", SPF Santé Publique – CIFAS Charleroi.
[57] Service Publique Federal Justice (SPF) (2016), Justice en chiffres 2011 – 2016, p. 58, available at https://justice.belgium.be/sites/default/files/jic_fr-2016.pdf.
[58] The number of investigations or social enquiries carried out by the assistants of justice to prepare for conditional release of internees has declined relatively significantly. This decline might be explained by the creation of social protection chambers (SPC) attached to the sentence implementing courts, replacing former Social Defence Commissions. The introduction of the SPC is part of the modification of the legislation on internment (the law of 5 May 2014 which entered into force on 23 May 2016). However, it is too early to draw reliable conclusions on the effect of this evolution.

Houses of justice – number of new guidance and probation mandates as modality of execution of internment measures					
2011	2012	2013	2014	2015	2016[59]
396	410	309	306	345	248

Case law on internment measures

The critical situation of mentally ill offenders in Belgian prisons is well documented by the media, NGO's (particularly the Belgian Human Rights League) and international bodies (such as the European Committee for the Prevention of Torture), and is generally acknowledged to be one of country's major human rights issues.

These issues have been underlined by the Belgian judicial power itself. Over the last decade in particular, several condemnations have been pronounced by Belgian jurisdictions that have forced Belgian authorities to remove and transfer an internee from the psychiatric wing of a prison to an Institute for the Protection of Society.[60] Additionally, trial judges, the Belgian Civil Supreme Court as well as the Constitutional Court have raised the same issues.[61]

However, the harshest reactions have come from European authorities. Both the Committee for the Prevention of Torture and the European Court of Human Rights have been really concerned with the legal inappropriateness of internees' incarceration in the psychiatric wings of Belgian prisons without sufficient and timely treatment and the consequent violations of their fundamental rights. Belgium has been condemned again repeatedly by the European Court of Human Rights for violation of Articles 3 and 5 of the European Convention of Human Rights.[62] The Strasbourg Court has clearly underlined several times the inadequacy of psychiatric wings for therapeutic and medical ends and the existence of a structural problem in Belgium regarding the management of offenders suffering from mental illness and disorders.[63]

On 6 September 2016, the European Court of Human Rights condemned Belgium once more, after 22 previous convictions, for its internment policy. This time, however, the Court delivered

[59] Probationary release of internees (delivered by SPC from 2016) is a sector that has decreased by 28 % (from 345 new terms in 2015 to 248 in 2016). This decrease is linked to the introduction of the new law on internment, following which many cases in progress have been closed.
[60] See for instance Civ. Charleroi (ref.), 25 February 2005, Journal des Tribunaux, 2005, 308, note L. Brackman, "De la décision d'internement à son execution"; Civ. Liège (ref.), 17 September 2007, 1409 ; Civ. Namur, 18 March 2011, J. L.M.B., 2013, 450.
[61] Cass. 26 March, R. G. n°C.09.0330.F; C.C., 17 September 2009, n°142/2009.
[62] ECHR, 10 January 2013, Claes v. Belgium; ECHR, 6 December 2011, De Donder and De Clippel vs. Belgium; ECHR, 10 January 2013, Duffort vs. Belgium; ECHR, 10 April 2013, Sweenen v. Belgium; ECHR, 9 January 2014, Saadouni vs. Belgium; ECHR, 9 January 2014, Gelaude vs. C. Belgium; ECHR, 9 January 2014, Lankaster vs. Belgium; ECHR, 9 January 2014, Van Meroye vs. Belgium; ECHR, 9 January 2014, Plaisier vs. Belgium; ECHR, 9 January 2014, Oukili v. Belgium; ECHR, 9 January 2014, Moreels vs. Belgium; ECHR, 9 January 2014, Caryn vs. Belgium.
[63] ECHR, 9 January 2014, Saadouni vs. Belgium, § 56 and 61.

a "pilot judgement", classifying Belgium's internment policy as systematically and structurally dysfunctional and imposing an obligation upon it to address these problems within a limited amount of time. The Court gave Belgium a deadline of two years.

Selected list of ECHR case law on Belgium[64]

L.B. v. Belgium (no. 22831/08) - 2 October 2012

This case concerned the virtually continuous detention, between 2004 and 2011, of a man suffering from mental health problems in psychiatric wings of two prisons, despite the authorities' insistence on the need for placement in a structure adapted to his pathology. The applicant complained mainly that the institution in which he was held was ill-adapted to the situation of people with mental-health problems.

The Court held that there had been a violation of Article 5 § 1 (right to liberty and security) of the Convention, finding that, as a result of the maintaining of the applicant for seven years in a prison institution, when all the medical and psychiatric or social workers' opinions and competent authorities agreed that it was ill-adapted to his condition and re-adaptation, the conditions of the detention had been incompatible with its purpose. The Court emphasised in particular that the maintaining in a psychiatric wing was supposed to be temporary, while the authorities looked for an institution that was better adapted to the applicant's condition and re-adaptation. An inpatient placement had in fact been suggested by the authorities as early as 2005. It further found that the place of detention was inappropriate and noted in particular that the applicant's therapeutic care was very limited in the prison.

Claes v. Belgium - 10 January 2013

This case concerned the confinement of a mentally-ill sexual offender who had been found not to be criminally responsible in the psychiatric wing of an ordinary prison, without appropriate medical care, for more than fifteen years.

The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, finding that the national authorities had not provided the applicant with adequate care and that he had been subjected to degrading treatment as a result. The Court observed in particular that the applicant's continued detention in the psychiatric wing without the appropriate medical care and over a significant period of time, without any realistic prospect of change, had constituted particularly acute hardship causing distress which went beyond the suffering inevitably associated with detention. Whatever obstacles may have been

[64] ECHR (2019), Factsheet – Detention and mental health, Press Unit, January 2019.

created by the applicant's own behaviour, they did not dispense the State from its obligations in his regard by virtue of the position of inferiority and powerlessness typical of patients confined in psychiatric hospitals and even more so of those detained in a prison setting. In this judgment, the Court further stressed that the applicant's situation stemmed in reality from a structural problem: on the one hand, the support provided to persons detained in prison psychiatric wings was inadequate and placing them in facilities outside prison often proved impossible either because of the shortage of places in psychiatric hospitals or because the relevant legislation did not allow the mental health authorities to order their placement in external facilities. See also: Lankester v. Belgium, judgment of 9 January 2014.

Bamouhammad v. Belgium - 17 November 2015

Suffering from Ganser syndrome (or "prison psychosis"), the applicant alleged that he had been subjected while in prison to inhuman and degrading treatment which had affected his mental health. He also complained about a lack of effective remedies.

The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, finding that the level of seriousness required for treatment to be regarded as degrading, within the meaning of Article 3, had been exceeded in the applicant's case. The Court noted in particular that the need for a psychological supervision of the applicant had been emphasised by all the medical reports. However, his endless transfers had prevented such supervision. According to the experts, his already fragile mental health had not ceased to worsen throughout his detention. The Court concluded that the prison authorities had not sufficiently considered the applicant's vulnerability or envisaged his situation from a humanitarian perspective. The Court also held that there had been a violation of Article 13 (right to an effective remedy) taken together with Article 3, finding that the applicant had not had an effective remedy by which to submit his complaints under Article 3.

W.D. v. Belgium (application no. 73548/13) - 6 September 2016

This case concerned a sex offender suffering from mental disorders who was detained indefinitely in a prison psychiatric wing. The applicant complained that he had been detained in a prison environment for more than nine years without any appropriate treatment for his mental condition or any realistic prospect of reintegrating into society. He also complained that his deprivation of liberty and continued detention were unlawful. He lastly submitted that he had had no effective remedies by which to complain of the conditions of his detention.

The Court held that there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, finding that the applicant had been subjected to degrading treatment by having been detained in a prison environment for more than nine years, without

appropriate treatment for his mental condition and with no prospect of reintegrating into society; this had caused him particularly acute hardship and distress of an intensity exceeding the unavoidable level of suffering inherent in detention. The Court also held that there had been a violation of Article 5 § 1 (right to liberty and security) of the Convention, finding that the applicant's detention since 2006 in a facility ill-suited to his condition had broken the link required by Article 5 § 1 (e) between the purpose and the practical conditions of detention, noting that the reason for the applicant's detention in a prison psychiatric wing was the structural lack of alternatives.

The Court further held that there had been a violation of Article 5 § 4 (right to speedy review of the lawfulness of detention) and a violation of Article 13 (right to an effective remedy) of the Convention in conjunction with Article 3, finding that the Belgian system, as in operation at the time of the events, had not provided the applicant with an effective remedy in practice in respect of his Convention complaints – in other words, a remedy capable of affording redress for the situation of which he was the victim and preventing the continuation of the alleged violations. Lastly, finding that the applicant's situation had originated in a structural deficiency specific to the Belgian psychiatric detention system, the Court, in accordance with Article 46 (binding force and execution of judgments) of the Convention, held that Belgium was required to organise its system for the psychiatric detention of offenders in such a way that the detainees' dignity was respected.

Rooman v. Belgium - 31 January 2019 (Grand Chamber)

This case concerned the question of the psychiatric treatment provided to a sex offender who had been in compulsory confinement since 2004 on account of the danger that he poses and the lawfulness of his detention. The applicant complained that he had not received the psychological and psychiatric treatment required by his mental-health condition. He also alleged that the lack of treatment was depriving him of the prospect of an improvement in his situation and that, as a result, his detention was unlawful.

The Grand Chamber held that from the beginning of 2004 until August 2017 there had been a violation of Article 3 (prohibition of inhuman or degrading treatment) of the Convention, and that from August 2017 onwards there had been no violation of Article 3. It found in particular that the national authorities had failed to provide treatment for the applicant's health condition from the beginning of 2004 to August 2017, and that his continued detention without a realistic hope of change and without appropriate medical support for a period of about thirteen years had amounted to particularly acute hardship, causing him distress of an intensity exceeding the unavoidable level of suffering inherent in detention. In contrast, the Court held that since August 2017 the authorities had shown a real willingness to remedy the applicant's situation by undertaking tangible measures, and that the threshold of severity required to bring Article 3 into

play had not been reached. The Grand Chamber also held that from the beginning of 2004 until August 2017 there had been a violation of Article 5 (right to liberty and security) of the Convention and that from August 2017 onwards there had been no violation of Article 5. In that regard, the Court decided in particular to refine its case-law principles, and to clarify the meaning of the obligation on the authorities to provide treatment to persons placed in compulsory confinement. The Court then held that the applicant's deprivation of liberty during the period from the beginning of 2004 to August 2017 had not taken place in an appropriate institution which was capable of providing him with treatment adapted to his condition, as required by Article 5 § 1. In contrast, it found that the relevant authorities had drawn the necessary conclusions from the Chamber judgment of 18 July 2017 and had put in place a comprehensive treatment package, leading it to conclude that there had been no violation of this provision in respect of the period since August 2017.

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