P.H.P.H.M.C. van Kempen & M.J.M. Krabbe (eds.)

Mental Health and Criminal Justice

International and Domestic Perspectives on Defendants and Detainees with Mental Illness

Santé mentale et justice pénale

Perspectives internationales et nationales sur les prévenus et les détenus atteints de maladie mentale

International Penal and Penitentiary Foundation
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More than 10.74 million people globally are detained in penal institutions. An estimated 40% to 90% of these detainees suffer from mental illness. This makes the prevalence of mental disorder in detainees extremely high compared with the general population (18% to 29%). As a consequence, defendants and detainees with mental illness are not 'yet another vulnerable group' that should be 'taken into account' in developing laws and policies. On the contrary, they are a dominant force and therefore a factor that should shape our criminal justice systems. This edited volume provides insight into the causes of the current situation, the human rights implications and other problems that this situation generates and possible solutions and best practices. The volume comprises an introductory chapter that provides a broad introduction to the topic, seven thematic chapters addressing mental health and criminal justice from various disciplines and fourteen national chapters describing the situation in individual countries. In all these chapters a variety of questions is addressed: Should we at all put mentally ill offenders in prison? Can the human rights perspective and the interests of society perspective on this issue be united? And are mentally ill offenders the responsibility of the health department or of the justice department? This edited volume presents a thorough discussion on these and many more questions with a broader aim of contributing to a continuous effort to place the alarming situation of mentally ill offenders on the international agenda.

Plus de 10,74 millions de personnes dans le monde sont détenues dans des établissements pénitentiaires. On estime que 40 à 90 % de ces détenus souffrent d'une maladie mentale. La prévalence des troubles mentaux chez les détenus est donc extrêmement élevée par rapport à la population générale (prévalence de 18 % à 29 %). Par conséquent, les prévenus et les détenus souffrant de troubles mentaux ne constituent pas « un autre groupe vulnérable » qui devrait être « pris en compte » lors de l'élaboration de lois et de politiques. Au contraire, ils constituent une force dominante, et donc un facteur qui devrait façonner nos systèmes de justice pénale. Ce volume édité donne un aperçu des causes de la situation actuelle, des implications en matière de droits de l'homme et des autres problèmes que cette situation génère, ainsi que des solutions possibles et des meilleures pratiques. L'ouvrage comprend une introduction circonstanciée du sujet, sept chapitres thématiques abordant la santé mentale et la justice pénale sous l'angle de diverses disciplines et quatorze chapitres nationaux décrivant la situation dans les différents pays. Diverses questions sont abordées dans chacun de ces chapitres, telles que : faut-il vraiment emprisonner les délinquants souffrant de troubles mentaux ? Est-il possible de concilier la perspective des droits de l'homme et celle des intérêts de la société sur cette question ? Et : les délinquants souffrant de troubles mentaux relèvent-ils de la responsabilité du ministère de la Santé ou du ministère de la Justice ? Outre la présentation d'un débat approfondi sur ces questions et bien d'autres encore, cet ouvrage vise à contribuer à un effort continu pour inscrire la situation alarmante des malades mentaux à l'ordre du jour international.

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Part I
Introductory Synthesis and Analyses

1ère Partie
Synthèse et Analyses Introductives

A legal perspective on the worldwide situation of defendants and detainees with mental illness

Maartje Krabbe[*]

1 Introduction to this volume

Worldwide, more than 10.74 million people are detained in penal institutions. An estimated 40% to 90% of these detainees is suffering from mental illness. This makes the prevalence of mental disorder in detainees extremely high compared with the general population (prevalence of 18% to 29%). Isolated information on mental illness in defendants who are not detained is sparse. However, the numbers on detained defendants may be indicative of the number of defendants who are not detained.[1] As a consequence, defendants and detainees with mental illness are not 'yet another vulnerable group' that should be 'taken into account' when developing laws and policies. On the contrary, they are a dominant force and therefore a factor that should shape our criminal justice systems.

This edited volume provides insight into the causes of the current situation, the human rights implications and other problems that this situation generates, and possible solutions and best practices. In this context, a variety of questions is addressed, such as: should we at all put mentally ill offenders in prison? Can the human rights perspective and the interests of society perspective on this issue be united? And: are mentally ill offenders the responsibility of the ministry of justice or the ministry of health? Apart from a thorough discussion on these and many other questions, this project aims to contribute to a continuous effort to put the alarming situation of mentally ill offenders on the international agenda.

Regarding the structure of this book: this volume contains seven thematic chapters by authorities on specific topics, fourteen national chapters describing the situation of mentally

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1 See Section 2 for the scientific underpinning of these numbers and a more thorough representation of the relevant statistics.

ill offenders in various countries and the present introductory chapter. This introductory chapter first provides an introduction to this volume. Several definitions, relevant to the clarification of the subtitle of this volume, are provided (Section 1.1). Next, an outline of the volume is presented (Section 1.2), offering a brief summary of the seven thematic chapters in part II (Section 1.2.1), explaining the structure of the national chapters in part III (Section 1.2.2.) and providing an introduction to the subsequent sections of the present chapter (Section 1.2.3.). These sections (Sections 2-7) aim to provide a broad introduction to the topic of defendants and detainees with mental illness: in the first place by offering an analysis of the national and thematic chapters, in the second place by discussing this analysis in the context of additional sources (international rules, scientific literature, reports by international organizations, statistics) and, in the third place by providing a legal analysis of the current situation. This chapter ends with recommendations in the form of four focus points for future law and policy.

1.1 Definitions

Several definitions are relevant to a clarification of the title of this volume. In what follows, the concepts of *mental illness*, *defendant* and *detainee* are provided with some context. For the purpose of this volume, a *mental illness* must be broadly understood as referring to a psychiatric condition that disturbs a person's behaviour, thinking or mood to such an extent that it causes suffering or a poor ability to function in life.[2] Throughout this book, concepts such as psychiatric disturbance, mental disturbance and mental disorder are used interchangeably. A *defendant* (synonym: accused) is a person charged with a crime, against whom criminal proceedings are directed. A defendant is thus a person who defends himself or herself in pre-trial procedures and at trial. A *detainee* is a person who is deprived of his

2 For an official clinical approach to mental illness see the DSM-5 definition: *A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behaviour (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above* (American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, fifth edition (DSM-V), 2013, p. 20. See also the WHO definition of mental disorders: *Mental disorders represent disturbances to a person's mental health that are often characterized by some combination of troubled thoughts, emotions, behaviour and relationships with others. Examples of mental disorders include depression, anxiety disorder, conduct disorder, bipolar disorder and psychosis* (WHO, *Mental health: Fact Sheet*, 2019, p. 1). And the WHO definition of 'mental health': *Mental health is a state of wellbeing, in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community* (WHO, *Mental health: Fact Sheet*, 2019, p. 1).

or her liberty by the authorities. Detainee is to be understood broadly, for it includes both persons in provisional detention and in prison. Provisional detention covers detainees who have not been definitively sentenced yet, i.e., persons in pre-trial detention – which, in turn, includes both police custody and detention on remand – and persons in trial detention, i.e., detention during trial but before final sentencing. Prisoners are detainees that have been definitively sentenced.

1.2 Outline of this volume

1.2.1 Thematic chapters

A thematic approach to mental illness and criminal law is presented in part II of this volume. In this part, seven professionals from various parts of the world present an expert opinion on the situation of defendants and detainees with mental illness.

The negative effects of deprivation of liberty on mental health are discussed by **Olivera Vulić Kralj**. Vulić Kralj argues that both prisoners with and without prior mental health problems experience negative psychological effects of imprisonment. Consequently, imprisonment often has the opposite effect of its intended purpose (prevent future recidivism and enhance public safety). Vulić Kralj demonstrates several international rules that protect prisoners with mental health problems. However, these rules are often not complied with. The author also discusses the adverse effects of disciplinary measures and the often inappropriate response to suicidal prisoners. The latter has on occasion resulted in violations of Article 2, 3 and/or 5 of the European Convention on Human Rights (ECHR). Vulić Kralj holds that alternatives to detention should be available to persons with mental disorders who do not pose a threat to public safety. She also underlines that all prisoners should be offered health services of an equivalent level to those in the community. The author further adds that mental health screenings should be performed on admission to prison and that a multidisciplinary staff should at all times be present. In general, Vulić Kralj concludes, prison conditions should *promote* the mental well-being of all those deprived of their liberty.

Oscar Bloem, **Robbert-Jan Verkes** and **Erik Bulten** present an international meta study on mentally disordered prisoners. The study focuses on the prevalence of mental illness, the development of symptoms and recidivism. Data demonstrate that prevalence of all types of mental disorders in prisoners is high compared with the general population. Also, the prevalence of mental disorders is, in general, higher in female than in male prisoners. According to the authors, improvement of mental health symptoms is found over time during imprisonment, especially where depressive and anxiety symptoms are concerned. Regarding the relation between mental disorders and recidivism, there is a

replicated finding on the existence of a relationship between substance-related disorders and recidivism. Throughout the article, the authors address explanations for the differences between studies on mental disorders. They conclude with recommendations for further research, especially in longitudinal studies, on the complex combination of personal and circumstantial factors that may be related to changes in mental health symptoms during imprisonment.

Authors **Taro Morinaga** and **Mana Yamamoto** share their thoughts on the fundamental question of how society should approach convicts suffering from mental illness. Should they stay in prison, or must they be submitted to a treatment program? The authors shed light on the different interests of criminal justice and healthcare and discuss how these interests can be balanced. They make several policy suggestions, taking into account the various actors within the field of criminal justice and the divergent budgets of states. The authors conclude their contribution by stressing that cooperation of various experts and institutions is an absolute prerequisite for evolving a better policy for prisoners with psychiatric problems.

Piet Hein van Kempen's contribution provides a human rights perspective on defendants with disturbed or limited mental abilities in the pre-trial and trial stage. His analysis is based on the ECHR, the American Convention on Human Rights (ACHR) and the International Covenant on Civil and Political Rights (ICCPR). The case law of several international and hybrid criminal tribunals is also included in the analysis. After demonstrating that few numbers are available on defendants with mental problems, Van Kempen addresses the fundamental principles underlying the rights of defendants with mental inabilities: adversariality, equality of arms and non-discrimination. Next, he discusses whether these principles allow for a different level of protection of defendants with mental inabilities in an adversarial system than in an inquisitorial system. The central sections of the contribution examine specific fair procedure rights for defendants with mental inabilities and obligations for authorities in such cases, namely guarantees for effective participation by defendants during trial and safeguards for fairness during police questioning. The contribution concludes with ten recommendations for securing the legal position of defendants with mental inabilities.

The human rights perspective on detention is provided by **Małgorzata Wąsek-Wiaderek**. The aim of this thematic chapter is twofold. In the first place, it provides an overview of the international human rights standards applicable to detainees with mental disabilities. Wąsek-Wiaderek particularly focuses on the right to life, the prohibition of inhuman or degrading treatment and the right to liberty. For this purpose, she presents a list of cases on these topics, mainly from the European Court of Human Rights (ECtHR). She also provides an inventory of soft law instruments. In the second place, Wąsek-Wiaderek's chapter discusses whether detention – instead of hospitalization – of persons with severe mental disabilities is in compliance with human rights standards. The

author concludes that the views on this question, on the one hand, of the ECHR and ICCPR and, on the other hand, of the Convention on the Rights of Persons with Disabilities (CRPD) may be incompatible. While the former two conventions permit deprivation of liberty of a person of 'unsound mind' when this person poses a threat to himself or to others, Article 14 of the CRPD provides that "existence of a disability shall in no case justify a deprivation of liberty". However, this incompatibility must be nuanced, since Article 14 of the CRPD has been interpreted in the light of the ECHR/ICCPR criterion. Likewise, the ECtHR has interpreted the relevant provisions of the Convention in the light of the CRPD, granting more autonomy to the mentally disabled. Wąsek-Wiaderek hopes that this development at the ECtHR will enhance procedural safeguards for persons deprived of liberty on the basis of their mental disability.

Celso Manata discusses two distinctive groups of prisoners that are suffering from psychiatric disturbances. The first group is composed of prisoners that have been found criminally responsible for their acts, despite their mental illness. The second group is composed of patients with psychiatric diseases that have been sentenced with a security measure to be executed by the penitentiary system. For each group, Manata describes the specific challenges, predominantly from a prison management perspective. Most of these challenges are related to striking a balance between treatment, on the one hand, and control, on the other. Manata ends his contribution with an overview of the different actions initiated in Portugal to bridge the gap between treatment and control. Most of these actions are based on cooperation between the ministry of justice and the ministry of health.

In order to provide a more adequate reaction to prisoners with severe mental health problems, France introduced, in 2012, specially equipped hospital units (*Unités Hospitalières Spécialement Aménagées*, UHSA for short). **Catherine Pautrat's** contribution provides an explanation and an evaluation of these UHSA. The UHSA are units within a health establishment, taking care of persons – initially placed under the care of justice – who require psychiatric care in the form of full hospitalization. These UHSA were founded on two basic principles: (a) the primacy of care (over punishment) and (b) the idea of dual care: detainees remain in custody during hospitalization and continue to serve their sentence. As a consequence, the costs of the UHSA are split between the ministry of health (90%) and the prison administration (10%). An evaluation of the UHSA reveals that: in 2014, 60% of the full hospitalizations were in UHSA; in the UHSA, primacy is given to care; in the UHSA, incidents justifying the intervention of prison personnel are rare; persons stay in UHSA for an average of 45 days, and the occupancy rates of the units vary between 82% and 93%. All in all, UHSA have been considered successful. Still, Pautrat holds there are several points for improvement. Owing to the high occupancy rates, there are waiting times for up to several weeks. Also, since some regions do not have UHSA yet, more UHSA should be created to avoid a breach of equality in the care of detainees. Finally,

the development of UHSA is meaningful only if this is accompanied by the strengthening of the healthcare system for detainees at all levels (outpatient treatment and day admissions).

1.2.2 National chapters

The national chapters in this volume are based on a questionnaire to which professionals from 14 countries responded during 2017-2021. The reporting states are Brazil, Chile, Germany, Greece, Hungary, Ireland, Japan, Kazakhstan, the Netherlands, New Zealand, Poland, Portugal, Spain and the USA. Each of the national reports contains a similar structure. After a brief introduction, the focus is on the situation of defendants with mental health problems during pre-trial inquiry and at trial. Next, detainees with psychiatric disturbances during provisional detention are discussed, following a presentation of issues related to mentally ill prisoners (convicted detainees). Before we turn to the end of the criminal justice chain – the community reintegration of prisoners with mental health problems – light is shed on the responsibility for the treatment of detainees with psychiatric disturbances. Should this be vested with the health or with the criminal justice department? In the final section of the report the authors offer conclusions based on the situation in their own countries.

1.2.3 Present chapter

The following sections of this chapter aim to provide a broad introduction to the worldwide situation of mentally ill defendants and detainees. First, an overview is provided of international studies on the *numbers* of mentally ill defendants and detainees (Section 2). These numbers are relatively high. Consequently, possible *causes* for this disproportionate number have to be addressed (Section 3). Section 4 is devoted to the *problems* generated by the disproportionate number of mentally ill in the criminal justice chain. Subsequently, these problems are translated into *human rights implications* (Section 5). Section 6 provides *recommendations* based on the foregoing. A summary of Sections 2-6 is provided in Section 7 (conclusion). The following introduction is based on the information provided in the national and thematic chapters in this volume and on supplementary materials (international rules, scientific literature, reports by international organizations, statistics).

2 Defendants and detainees with mental illness: the numbers

As mentioned in the introduction to this chapter, more than 10.74 million people worldwide are detained in penal institutions.[3]

3 Roy Walmsley, *World Prison Brief* (12th edition), 2018.

An estimated 40% to 90%[4] of these prisoners[5] is suffering from mental illness.[6] This makes the prevalence of mental disorder in detainees extremely high compared with the general population (prevalence of 18% to 29%).[7] What is more, prevalence of mental health problems in detainees could be even higher than reflected in these numbers for the following reasons. First, because not all cases of mental illness are reported, registered or available.[8] Second, because the impact of the ongoing Covid-19 pandemic is presumed to have an enormous impact on the mental health of detainees.[9] Third, because prison research tends

4 The rather wide margin – caused by differences in outcome – may be explained by the specific population studied (e.g. men and/or women, prisoners on remand and/or sentenced prisoners), a variation in methodology (e.g. a wide or narrow definition of 'mental disorder'), whether current or lifetime pathology is addressed, and by the specific mental health policy in the part of the world reflected in the research (the more mentally ill offenders are diverted from the criminal justice system, the lower the numbers of mentally ill in prison). See the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten, Sections 2 and 5.

5 Percentages are even higher among female prisoners. See the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten, Sections 2 and 5. See also the national chapters on New Zealand and Kazakhstan.

6 See the analysis of various studies in Section 2 of the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten. For an overview of largely other studies displaying similar numbers see: Alice Mills & Kathleen Kendall, 'Introduction', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical Perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, pp. 1-22, 1/2; Graham Duncan & Jan Cees Zwemstra, 'Mental health in prison', in: S. Enggist (ed.), WHO, *Prisons and Health*, 2014, pp. 87-95, p. 88 and the thematic chapter in part II of this volume by Van Kempen, Section 2. For the latest numbers reflecting the prevalence of mental illness in jails and prisons in the USA, see: E. Fuller Torrey *et al.*, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, Treatment Advocacy Center, 2014, p. 111 (at: www.treatmentadvocacycenter.org). Several national chapters also stress the relatively high prevalence of mental illness among prisoners. See, for example, the chapters on Brazil, Greece, Japan, Kazakhstan, New Zealand, Spain and the USA.

7 See the analysis of various studies in Section 2 of the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten and Alice Mills & Kathleen Kendall, 2018, p. 2.

8 Lack of accurate numbers is reported by Brazil, Chile, Germany, Hungary, New Zealand and Spain. The authors of the national chapter on Chile underline the importance of numbers: when numbers are lacking, a group is invisible. Consequently, a fitting policy will be hard to attain, and rights may not be protected. See also: HOSPICE Casa Sperantei Foundation, *MenACE: Mental health, aging and palliative care in European prisons*, 2018, p. 2 and Section 3 below on problems with screening.

9 Although research on the influence of Covid-19 on the mental health of *prisoners* is yet scarce (see for example: Jucier Gonçalves Júnior *et al.*, 'Analysis of the prison population's mental health in Sars-Cov-2 pandemic: Qualitative analysis', 296 *Psychiatry Research* (2021), pp. 1-6, 5) and somewhat ambiguous (See: Thomas Hewson *et al.*, 'The effects of COVID-19 on self-harm in UK prisons', 45 *BJPsych Bulletin* 3 (2020), pp. 131-133, 131. The article demonstrates, among other findings, a reduction of self-harm incidents during the pandemic.), studies have established the negative influence of the pandemic on the mental health of the *general* population (see for a summary of several studies: Geraldine Pearson, 'The mental health implications of Covid-19', 26 *Journal of the American Psychiatric Nurses Association* 5 (2020), pp. 443-444). What is more, many experts have expressed concerns about the impact of the pandemic on the mental health of prisoners. See, for example: Thomas Hewson *et al.*, 'Effects of the COVID-19 pandemic on the mental health of prisoners', 7 *The Lancet* 7 (2020), pp. 568-570; Lauren K. Robinson, Reuben Heymar-Kantor & Cara Angelotta, 'Strategies mitigating the impact of the COVID-19 pandemic on incarcerated populations', 110 *American Journal of Public Health* 8 (2020), pp. 1135-1136; A. Ogunwale *et al.*, 'Forensic mental health service implications of COVID-19 infection in Nigeria', 1 *Forensic Science International: Mind and Law*

to focus on the medicalized term of mental illness. However, there is also a group of detainees who is neither mentally ill, nor mentally healthy. This grey area of 'mental wellbeing' or 'mental distress' has rarely been measured.[10]

As to the worldwide prevalence of specific types of mental illness: about 4% of the detainees suffers from psychosis, 11% suffers from depressive disorder and 20% from anxiety disorders. Attention deficit hyperactivity disorder (ADHD) is found in about 25% of the detainees. Studies on substance abuse disorders display large differences, with prevalence rates up to 69%. Prevalence numbers on (anti-social) personality disorders also vary, with rates up to 80%. Studies on intellectual dysfunction and autism in detainees are sparse. However, the literature does suggest an over-representation of people with autism in prison.[11]

Suicide numbers in prison are high, compared with those in the general population.[12] Studies also show that these suicides have increased over the last few decades,[13] are more prevalent among younger detainees,[14] are often committed shortly after being detained[15] and are found in detainees with pre-existing mental health problems.[16]

The foregoing numbers refer to detainees on remand, detainees in trial detention and to prisoners. Numbers on mental illness of defendants in police custody and defendants that are not detained are limited. Based on four national studies, 29% to 75% of the persons

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(2020), pp. 1-3 and Claire Shiple & Pracha Peter Eamranond, 'Letter to Editor – The disproportionate negative impacts of COVID-19 on the mental health of prisoners', 66 *Journal of Forensic Sciences* 1 (2021), pp. 413-414.

10 Emily Tweed, Xanthippi Gounari & Lesley Graham, 'Mental wellbeing in prisoners in Scotland', 392 *The Lancet* supplement 2 (November 2018), p. S11. To the knowledge of the authors, this is the only reported study on mental well-being in a national prisoner population. See also Alice Mills & Kathleen Kendall, 2018, p. 4, for a broad perspective on mental health in prison.

11 For an overview of the different types of mental disorders in prisoners see Section 2 of the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten.

12 For a modest overview of international studies see: Stefan Fruehwald *et al*., 'Suicide in custody: case-control study', 185 *British Journal of Psychiatry* 6 (2004). pp. 494-498, 494. See also: UNODC, 'Prisoners with mental health care needs', in: *Handbook on Prisoners with Special Needs*, UN Publication, 2009, pp. 9-42, referring on page 16 to an Austrian worldwide review article on the topic; WHO, *Mental health and prisons* (information sheet), 2005, p. 1; HOSPICE Casa Sperantei Foundation, 2018, p. 1 (reporting suicides in prisons up to ten times higher than those in the general population). For domestic studies see: Seena Fazel, Ram Benning & John Danesh, 'Suicides in male prisoners in England and Wales, 1978-2003', 366 *The Lancet* 9493 (2005), pp. 1301-1302 (finding a five-fold excess of suicide in male prisoners); Alice Mills & Kathleen Kendall, 2018, p. 2 (referring to a ministry of justice report displaying an 8.6 greater risk of self-inflicted death in prison) and the national chapters on Chili, Kazakhstan and the USA.

13 Seena Fazel, Ram Benning & John Danesh, 2005, p. 1301; Alice Mills & Kathleen Kendall, 2018, p. 5 and UNODC, 2009, p. 16.

14 Seena Fazel, Ram Benning & John Danesh, 2005, p. 1301. See also the national chapter on Germany.

15 The Sentencing Project reports that 50% of the US suicides took place within the first 24 hours in jail. See: The Sentencing Project, *Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription*, USA, 2002, p. 18.

16 UNODC, 2009, p. 16.

in police custody has a mental health problem.[17] Nearly one fifth of those in police custody was found to be at risk for suicide.[18] Although isolated information on mental illness in defendants who are not detained does not seem to exist,[19] the statistics provided on detained defendants may be indicative of the number of defendants who are not detained.[20]

Overall, the data shows that defendants and detainees with mental illness make up a significant part of the detention population, and this is a global phenomenon. Consequently, these defendants are not a minor detail when designing policies but a dominant factor that should shape our criminal justice systems.[21]

3 Defendants and detainees with mental illness: the causes

This section addresses possible reasons for the disproportionate number of mentally ill defendants and detainees. These reasons are divided into systemic causes (Section 3.1.) and reasons for systemic causes (Section 3.2). Systemic causes are rooted in the criminal justice *system*. These causes are presented through two perspectives: how the system deals with mental illness (Section 3.1.1) and how defendants and detainees deal with the system (Section 3.1.2). Section 3.2 delves into the reasons behind the systemic causes, such as underlying political considerations and societal problems that may eventually contribute to the large number of mentally ill detainees. Some of these causes are substantiated by scientific evidence, while others represent observations of practitioners or hypotheses.

17 Gennady N. Baksheev, Stuart D.M. Thomas & James R.P. Ogloff, 'Psychiatric disorders and unmet needs in Australian police cells', 44 *Australian and New Zealand Journal of Psychiatry* 1 (2010), pp. 1043-1051, 1046 (finding a prevalence of 75%); Tina Dorn *et al*., 'Mental health and health - care use of detainees in police custody', 26 *Journal of Forensic and Legal Medicine* (2014), pp. 24-28, 25 (finding a prevalence of 49.8%); Iain G. McKinnon & Don Grubin, 'Health screening of people in police custody - evaluation of current police screening procedures in London, UK', 23 *The European Journal of Public Health* 3 (2013), pp. 399-405, 402 (finding a prevalence of 39%) and Chiara Samele *et al*., 'The prevalence of mental illness and unmet needs of police custody detainees', *Criminal Behaviour and Mental Health* 2 (2021), pp. 80-95, 88 (finding a prevalence of 29% to 39%).

18 Chiara Samele *et al*., 2021, p. 89.

19 Compare a similar finding on defendants in the thematic chapter in part II of this volume by Van Kempen, Section 2.

20 See thematic chapter in part II of this volume by Van Kempen, Section 2.

21 Compare the thematic chapter in part II of this volume by Van Kempen, Section 2, where the author asserts that defendants and detainees with mental illness are "so common that no criminal justice system can regard such incapacities of defendants as a minor detail that can be ignored in the larger scheme of criminal justice".

3.1 Systemic causes

3.1.1 How the system deals with mental illness

There is a general consensus that the mentally ill are a vulnerable party in the criminal process[22] and can often not be held fully accountable for their deeds.[23] Consequently, most of the reporting states have special rules and procedures for mentally ill defendants and detainees. However, despite these special procedures, there may be several aspects inherent to criminal justice systems that contribute to a disproportionate number of defendants and detainees with mental illness. A crucial factor seems to be the functioning of diversion mechanisms. Diversion mechanisms are provisions and policies that aim to divert the mentally ill defendant from the criminal justice system to a more care-focused division of the criminal justice system or to the (mental) health system. The total absence of a diversion system undoubtedly drives up the numbers of mentally ill detainees.[24] Also, flaws in the existing diversion mechanisms may contribute to a larger number of mentally ill persons in detention.[25] A major problem in many systems seems to be the lack of thorough screening for mental illness.[26] When mental illness is not detected at an early stage, this has several consequences. First, the mentally ill defendant is not diverted from the criminal justice system in cases where he should have been. Second, a defendant, not recognized as mentally ill, is not entitled to extra safeguards[27] to exercise his procedural rights (e.g., to remain silent, to legal representation),[28] potentially enhancing the chance of a confession and, ultimately, a (false) conviction.[29] Another diversion problem driving up numbers is that

22 See, for example, the thematic chapter by Van Kempen in part II of this volume, Sections 1 and 4.2.

23 See, for example, M.J.F. van der Wolf & H.J.C. van Marle, 'Legal approaches to criminal responsibility of mentally disordered offenders in Europe', in: K. Goethals (ed.), *Forensic Psychiatry and Psychology in Europe. A Cross-Border Study Guide*, Springer International Publishing, 2018, pp. 31-44.

24 See the national chapter on Japan. However, in Japan this deficiency is somewhat compensated by a decision not to prosecute in case of a mentally ill defendant.

25 See the national chapters on Germany, Ireland and the USA. See also the thematic chapter by Taro Morinaga & Mana Yamamoto in part II of this volume, Section 2.

26 UNODC, 2009, p. 14, and HOSPICE Casa Sperantei Foundation, 2018, p. 2. See also the national chapters on Germany, Poland and on the USA. Interestingly, the moment of the first screening of the defendant differs greatly, varying from within 24 hours (Germany) to before the decision to prosecute (see national chapter on Japan) to the prosecution stage (see national chapter on Hungary) to no screening at all (see national chapter on Greece). Lack of structural screening has also been mentioned as a problem (see national chapter on the Netherlands).

27 What is more, considering the existing extra safeguards for mentally ill defendants, there is also room for improvement. See national chapter on the Netherlands.

28 See the national chapter on the USA. In Sections 4.1 and 5.2 the procedural position of the mentally ill defendant is discussed more elaborately.

29 See the national chapters on Kazakhstan, the Netherlands and the USA. In Portugal one confession is sufficient evidence to impose a penalty of less than five years. See the national chapter on Portugal. In Ireland an insanity verdict is no longer possible in case of a guilty plea. See the national chapter on Ireland. The literature also demonstrates that vulnerable defendants (young defendants, defendants with mental problems)

although rules for diversion exist, there is a gap between the existing diversion policies and the law in action.[30] Diversion is also problematic when there is nowhere to divert to in specific situations, for example when arrest is the only possibility to deal with the situation[31] or when an effective policy for the 'lighter cases' is lacking.[32] Finally, delays in transfer to mental hospitals also add to the number of mentally ill people in detention.[33]

Sanctioning and sanction systems may also contribute to a disproportionate number of detainees with mental illness. In general, the 'legal fiction of free choice', on which our criminal justice system is based, has been proposed as a factor driving mentally ill people to prison.[34] This is particularly the case when a successful insanity plea is hard to achieve.[35] The same can be said for both considering mental illness as an aggravating factor[36] and for treating mental illness as a mitigating factor.[37] Reason: in both cases a penalty may be imposed instead of treatment. Also, when a court is forced by a system to choose between penalty and treatment, a court may opt for a penalty to avoid reoffending,[38] especially when few forensic facilities are available.[39] Finally, sentencing policies, imposing severe

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are more likely to confess. See, for example: Brandon L. Garrett, 'The substance of false confessions', 62 *Stanford Law Review* 4 (2010), pp. 1051-1191; Robert Perske, 'Perske's list: False confessions from 75 persons with intellectual disability', 49 *Intellectual and Developmental Disabilities* 5 (2011), pp. 365-373 and UNODC, 2009, p. 12. However, research has also established that 'normal people' are likely to confess when confronted with false incriminating evidence. See: Robert Horselenberg, Harald Merkelbach & Sarah Josephs, 'Individual differences and false confessions: A conceptual replication of Kassin and Kiechel (1996)', 9 *Psychology, Crime and Law* 1 (2003), pp. 1-8.

30 Alice Mills & Kathleen Kendall, 2018, p. 4/5. See also the national chapter on Poland. In the national chapters on Ireland and Portugal, this problem is also mentioned, without establishing a direct relation to numbers.

31 See Section 1 of the thematic chapter by Van Kempen in part II of this volume. Interestingly, Van Kempen also demonstrates that, in general, the chances of being arrested are significantly greater in case of persons with mental illness.

32 See HOSPICE Casa Sperantei Foundation, 2018, p. 2. See also the national chapters on Germany and Ireland.

33 See the national chapter on Ireland. See also the thematic chapter by Morinaga & Yamamoto in part II of this volume, Section 2.

34 Craig Haney, *Criminality in Context: A Psychological Foundation of Criminal Justice Reform*, American Psychological Association, 2020, p. 386.

35 See the thematic chapter by Morinaga & Yamamoto in part II of this volume, Section 2. See also the national chapter on Germany.

36 See the national chapter on the USA, where diminished responsibility can be an aggravating factor when the mental condition of the defendant enhances the risk of reoffending.

37 See the thematic chapter by Morinaga & Yamamoto, in part II of this volume, Section 2. See also the national chapter on Ireland, where it is argued that employing diminished responsibility and mental ill-health as a *mitigating factor* may be more effective when combined with an option for the court to order treatment.

38 See the national chapter on Brazil. See also the thematic chapter by Morinaga & Yamamoto in part II of this volume, Section 2.

39 See the national chapter on Ireland.

sentences on non-violent repeat offences or on drug use, may also drive up the number of prisoners suffering from mental illness.[40]

A systemic cause for a disproportional number of detainees with mental illness at *the end of the criminal justice chain* can first be found in the fact that detainees with mental illness seem to find it harder to withdraw from the system. Several factors play a role. Regarding detainees in psychiatric prisons, states report that these detainees are locked up for lengthy, indefinite periods.[41] Various reasons for these policies are mentioned, such as the legal options for – sometimes – endless prolongation of a stay in such institutions,[42] and the fact that people in these institutions often do not have a place to go, which makes officials reluctant to release them.[43] Another reason for lengthy stays can be found in the frequent imposition of disciplinary sanctions on detainees with mental illness. These detainees often do not understand or cannot comply with prison rules, which makes them more prone to disciplinary sanctions than the average detainee, which, in turn, may affect their parole.[44] A second factor driving up numbers related to this final stage is the lack of aftercare for detainees with mental illness, which increases the risk of reoffending.[45]

In short, when considering the way criminal justice systems deal with mental illness, it can be maintained that a combination of ineffective diversion policies, rigid rules on criminal liability and mechanisms that make mentally ill offenders 'stick to the system' all contribute to the relatively large number of mentally ill detainees.

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40 On punitive sentencing policies affecting people with mental disabilities, see: UNODC, 2009, p. 12. See also the national chapter on the USA, where high penalties for drug use drive up the number of prisoners suffering from substance abuse disorders.

41 See the national chapters on Germany, Hungary, New Zealand and Portugal. See also the thematic chapter by Morinaga & Yamamoto, Section 2. The possibility of a lengthy, indefinite period of commitment to a psychiatric prison has occasionally made these prisons a location to deal with political opponents. See the national chapter on Kazakhstan.

42 See the national chapters on Hungary and New Zealand.

43 See the national chapters on Hungary, Portugal, the thematic chapter by Morinaga & Yamamoto – in part II of this volume – Section 2 and UNODC, 2009, p. 38. See also the national chapter on Kazakhstan: in Kazakhstan this also applies to detainees with mental illness in regular prisons.

44 UNODC, 2009, p. 15/16. In general, mentally ill inmates are less likely to be paroled than non-mentally ill inmates. See: Lynette Feder, 'Psychiatric hospitalization history and parole decisions', 18 *Law and Human Behavior* 4 (1994), pp. 395-410 and Kelly Hannah-Moffat, 'Losing ground: Gendered knowledge, parole risk and responsibility', 11 *Social Politics* 3 (2004), pp. 363-385.

45 UNODC, 2009, p. 18. See also the national chapter on Hungary. Aftercare of mentally ill offenders is also a problem in the Netherlands. See national chapter on the Netherlands.

3.1.2 How defendants and detainees deal with the system

The literature indicates that detention and imprisonment may exacerbate and even cause mental illness.[46] Different triggers for (exacerbation of) mental illness[47] are mentioned, such as prison regimes,[48] abuse by prison staff,[49] prison architecture,[50] aggression,[51] bullying and abuse also by other prisoners,[52] the lack of meaningful activities,[53] the lack of exercise,[54] the use of disciplinary sanctions,[55] solitary confinement,[56] the separation from social contacts[57] (sometimes intensified by the remoteness of the detention location),[58] inadequate (mental) health services,[59] insecurities about the future (e.g. work, relationships),[60] poor

46 For an international perspective see: UNODC, 2009, p. 10; Eric Blaauw & Hjalmar J.C. van Marle, 'Mental health in prisons', in: WHO, *Health in Prisons: A WHO Guide to the Essentials in Prison Health*, 2007, pp. 133-145, 133. For domestic studies see: A. Goomany & T. Dickinson, 'The influence of prison climate on the mental health of adult prisoners: a literature review', 22 *Journal of Psychiatric and Mental Health Nursing* 6 (2015), pp. 413-422, p. 421; Craig Haney, 2020, p. 341, 386 and 387 and Alice Mills & Kathleen Kendall, 2018, p. 2. For a study on maximum security prisons, see: Craig Haney, 'A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons', 35 *Criminal Justice and Behaviour* 8 (2008), pp. 956-984, 957-959. See also the national chapters on Brazil, Chile, Kazakhstan, New Zealand, Spain and the USA and the thematic chapter by Vulić Kralj in part II of this volume, Section 2. For a specific study on the influence of police custody on mental health see: James Ogloff *et al.*, 'Psychiatric symptoms and histories among people detained in police cells', 46 *Social Psychiatry and Social Epidemiology* 9 (2011), pp. 871-880.

47 Sometimes resulting in suicide, see Section 2.

48 Alice Mills & Kathleen Kendall, 2018, p. 4.

49 UNODC, 2009, p. 15; WHO, 2005, p. 1; A. Goomany & T. Dickinson, 2015, pp. 413-422, 416. See also the national chapters on Chile, Kazakhstan and the USA.

50 Simon Cross &Yvonne Yewkes, 'The architecture of psychiatry and the architecture of incarceration', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical Perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, pp. 49-72.

51 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134. See also the national chapter on Chile.

52 UNODC, 2009, p. 15; A. Goomany & T. Dickinson, 2015, p. 417 and Alice Mills & Kathleen Kendall, 2018, p. 2.

53 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 and A. Goomany & T. Dickinson, 2015, p. 415/416. Lack of meaningful activities may also lead to illicit drug use (p. 417); WHO, 2005, p. 1 and Alice Mills & Kathleen Kendall, 2018, p. 2. See also the national chapters on Germany and Kazakhstan.

54 Alice Mills & Kathleen Kendall, 2018, p. 3.

55 See the national chapter on the USA.

56 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134; A. Goomany & T. Dickinson, 2015, p. 415 and WHO, 2005, p. 1. See also the national chapters on Chili, Ireland, Kazakhstan and the USA.

57 A. Goomany & T. Dickinson, 2015, p. 418; WHO, 2005, p. 1; Alice Mills & Kathleen Kendall, 2018, p. 2 and Graham Duncan & Jan Cees Zwemstra, 2014, p. 87. See also the national chapters on Kazakhstan and on the USA.

58 A. Goomany & T. Dickinson, 2015, p. 418. See also the national chapters on Brazil and Spain.

59 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134; A. Goomany & T. Dickinson, 2015, p. 419 and WHO, 2005, p. 1. See also the national chapters on Chili and Kazakhstan.

60 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 and WHO, 2005, p. 1.

living conditions[61] (such as bad hygiene,[62] lack of privacy,[63] a depressing environment and poor food[64]), harsh security measures,[65] loss of autonomy,[66] isolation from society,[67] availability of illicit drugs,[68] criminalization of behaviour that is symptomatic of mental illness (such as self-harm),[69] lack of protection for vulnerable groups such as LGBTIs[70] and overcrowding.[71] The latter – overcrowding – seems to be a root cause, since it triggers all kinds of organizational problems that may lead to, among other things, social disconnection, staff burden, solitary confinement, lack of meaningful activities, lack of (mental health) care, insecurity of future prospects[72] and poor reintegration.[73] More recently, the prison policy changes caused by the Covid-19 pandemic have also emerged as a factor negatively influencing the mental health of detainees.[74] What is more, the cumulative effect of the above factors is in itself a factor negatively influencing the mental health of prisoners. When the mental health of prisoners decreases owing to the above factors, incidents (e.g. aggression, bullying, self-harm) increase. This, in turn, negatively affects the mental health of both prisoners and staff.[75]

Research has also established that prison environments contribute to the self-harming behaviour of prisoners.[76] Prison characteristics that have been found to be related to suicide are: boredom, isolation, stressful events within prison such as intimidation and victimization and the increasing use of new psychoactive substances.[77]

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61 UNODC, 2009, p. 10 and 15 and Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134. See also the national chapter on Kazakhstan.

62 See the national chapter on Chili.

63 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134; WHO, 2005, p. 1 and Alice Mills & Kathleen Kendall, 2018, p. 2. See also the national chapters on Chili and Kazakhstan.

64 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134.

65 A. Goomany & T. Dickinson, 2015, p. 418.

66 A. Goomany & T. Dickinson, 2015, p. 419.

67 UNODC, 2009, p. 10.

68 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134. See also the national chapter on Germany.

69 UNODC, 2009, p. 17.

70 UNODC, 2009, p. 18 and Andrea Daley & Kim Radford, 'Queer and trans incarceration distress: considerations from a mad queer abolitionist perspective', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical Perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, pp. 285-307, 288/289. See also the national chapter on the USA, describing the abuse of LGBTI detainees and the effect of this abuse on their mental health.

71 UNODC, 2009, p. 10; Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134; WHO, 2005, p. 1 and A. Goomany & T. Dickinson, 2015, p. 420. See also the national chapters on Chile, Kazakhstan, Spain and the USA.

72 A. Goomany & T. Dickinson, 2015, p. 20. See also the national chapter on the USA.

73 See the national chapter on Hungary.

74 See Section 2.

75 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134.

76 For an overview of studies see: Alice Mills & Kathleen Kendall, 2018, pp. 1-22, 5. See also the national chapter on Chile.

77 Alice Mills & Kathleen Kendall, 2018, p. 2.

The negative influence of prisons on mental health has caused several researchers to label prisons as a manifestation of 'slow violence': a type of violence that is not quick and visible (like a blow on the nose) but continuous and invisible and therefore not engaging the public concern necessary to stop this violence.[78] This school of researchers advocates for alternatives to imprisonment, not only for the mentally ill.[79] On the other hand, there are also a fair number of studies that demonstrate a possible positive effect of imprisonment on mental health, such as an improvement of mental health symptoms over time[80] or female prisoners labelling prison as a place of respite, offering safety.[81]

As we have seen in this section, an abundance of research is available on the effects of imprisonment on the mental health of *detainees*. However, recent research on the effects of a criminal prosecution on the mental health of a defendant (not detainee) and on the influence of probation systems and aftercare programmes on mental health seems to be scarce.[82]

3.2 Reasons for systemic causes

While the previous sections address problems within the system that contribute to a disproportionate number of detainees with mental health problems, this section discusses possible causes for such a system. Why is this group of people not better acknowledged and treated according to their – and societies' – needs? The national chapters mention a diversity of causes for this, which can be grouped into the following three categories: (a) lack of budget to take care of defendants and detainees with mental health problems (b) *general* problems within the criminal justice system and (c) problems related to the functioning of the *general* mental health system.

An overarching reason for the current situation in prisons is a *lack of funding* to take care of defendants and detainees with mental health problems.[83] A possible reason for this

78 The term slow violence was introduced by Rob Nixon in: Rob Nixon, *Slow Violence and the Environmentalism of the P*oor, Harvard University Press, 2011.

79 Alice Mills & Kathleen Kendall, 'Care versus custody: Challenges in the provision of prison mental health care', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical Perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, pp. 105-129, 112.

80 See the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten, Section 5, which contains the conclusion of their meta study. Especially depressive and anxiety symptoms improve.

81 For an overview of studies see: A. Goomany & T. Dickinson, 2015, p. 417.

82 I could not find any such studies in a search (in the English language) in our Dutch national library system and in Google Scholar. Considering the mental effects of prosecution, research seems to focus on the mental health of the victim, not the defendant. The lack of research on defendants that are not detained is, however, not that surprising, since detainees are literary more of a 'fixed' group and therefore easier to research than defendants who are not detained.

83 See the national chapters on Germany and the USA.

is that prisoners with mental health problems are not high on the political agenda.[84] This may be explained by a general intolerance of societies to difficult or disturbing behaviour.[85]

General problems within the criminal justice system refer to problems, not specifically related to how the system deals with mental health patients, that do have an impact on defendants and detainees with mental illness. For example, when basic procedural rights are ineffective, this factor also negatively influences mental health patients caught up in the criminal justice system.[86] When prisons are overcrowded, it is hard to maintain a sufficient level of healthcare in those facilities, despite good plans and initiatives.[87] As described in Section 3.1.2, overcrowding also triggers many other factors that negatively influence mental health. When resocialization of prisoners is a general problem, this also affects the mentally ill prisoner, who needs more support in this process than the average detainee.[88]

In many countries in the world there is a lack of, or poor access to, mental healthcare services.[89] When *general mental healthcare is problematic*, this may affect the burden on the criminal justice system. For example, through an increase in the number of offences committed by mentally ill persons[90] or due to a lack of diversion possibilities to mental institutions.[91] What is more, when mental institutions are scarce, persons with mental illness who did *not* commit an offence or who were *not* criminally liable are occasionally also placed in detention.[92]

All in all, the foregoing causes for the disproportionate number of defendants and detainees with mental illness can be traced back to the existence of a group of people who are not acknowledged (enough) by the criminal justice system for what they are and are treated accordingly owing to insufficient budget and systemic problems within both the criminal justice system and the mental health system. Consequently, the ultimate causes of the disproportionate number of defendants and detainees with mental illness seem to lie within the functioning of the government and the way it shapes and finances its social policies.

84 See the national chapter on Hungary.
85 WHO, 2005, p. 1. See also the national chapters on Hungary and the USA.
86 See the national chapters on Hungary and Brazil.
87 See the national chapters on New Zealand and on the USA (on the policy of mass incarceration).
88 UNODC, 2009, p. 18. See also the national chapter on Brazil.
89 WHO, 2005, p. 1. See also the national chapter on the USA.
90 See the national chapter on Japan.
91 See the national chapters on Brazil and Ireland, where the reduction of mental hospital beds – with the aim of moving care to community services – has contributed to an increased number of mentally ill detainees. See also the national chapter on the USA, where it is stated that the mental health budget is so low that diversion is quite useless.
92 UNODC, 2009, p. 11 and WHO, 2005, p. 1. See also the national chapters on Japan, Poland and the USA.

4 Defendants and detainees with mental illness: the problems

The previous sections have demonstrated that on a global level there is a disproportionate number of defendants and detainees with mental illness and that the origins of this situation are complex and diverse. The present section discusses the complications that this situation generates. All these complications are rooted in the fact that the *criminal justice chain is not designed to accommodate people with mental illness*. This leads to the following problems, discussed below: defendants are not able to deal with the stress and/or complexity of criminal proceedings (Section 4.1), a lack of adequate professional treatment in detention (Section 4.2), accommodation of mentally ill people in an unsuitable environment (Section 4.3) and a lack of support for mentally ill people in the aftercare trajectory (Section 4.4). Please note that *reasons* for a disproportionate number of mentally ill people in the criminal justice system (Section 3) and *problems* caused by this large number (present section) may sometimes overlap. For example, a *reason* for large numbers of prisoners with mental illness may be *the negative effect of the prison environment on the mental health* of detainees. The nature of the prison environment causes the number of mentally ill people in prison to rise. This negative effect of the prison environment on the mental health of may, however, also be a *problem* arising when mentally ill persons end up in prison. The prison environment may negatively influence their mental health, exacerbating their condition.

4.1 Defendant is not able to deal with criminal proceedings

When a defendant or detainee with mental illness is not diverted and gets involved in the regular criminal justice system, this defendant – more than a regular defendant – may not be able to understand the system and its implications[93] and have the resilience to deal with authorities.[94] This may lead to the violation of defense rights[95] and other human rights.[96]

93 See, for example, the national chapters on Hungary and Poland. See also the thematic chapter by Van Kempen in part II of this volume, Section 1, on the possible problems when negotiating justice, such as in case of plea bargaining.

94 See E.M. Gremmen, *De kwetsbare psychisch gestoorde verdachte in het strafproces: regelgeving, praktijk en Europese standaarden*, Wolf Legal Publishers, 2018 (dissertation with summary in English), p. 39/40, discussing the fact that mentally ill defendants are more vulnerable and influenceable than the average defendant.

95 See Section 3.1.1. See also the national chapter on Brazil, reporting a general fair trial problem in case of mentally ill defendants, specifically in relation to undue delay.

96 See the national chapter on Greece, where ill treatment during police investigation is a general problem. See also the national chapters on New Zealand and the USA on the lengthy confinement of defendants that are unfit to stand trial and the thematic chapter by Van Kempen in part II of this volume, Section 1, on unnecessary and disproportionate use of force by the police in case of defendants with mental illness.

Ultimately, this may even cause false convictions,[97] including unfairly incurred death penalties.[98]

4.2 *Lack of treatment*

Once the mentally ill defendant enrols in the detention system, the main challenge is that prisons are not designed to accommodate people with mental illness. In the first place, because prisons lack options for *treatment* for this group of people.[99] This is largely due to a dearth of therapeutic staff (psychiatrists, psychologists, social workers).[100] This in turn can lead to a work overload of the operating therapeutic staff,[101] which may not only increase the risk of burnout among these staff members[102] but also influence the quality of the therapy offered. For example, the focus may be more on testing than on therapy,[103] while the focus of therapy is more on the everyday functioning in prison instead of on reintegration[104] and more on treatment of prisoners who ask for help[105] than on general prevention of mental illness in prison.[106] Other problematic phenomena related to a lack of quality treatment are: a policy of sedation to manage symptoms instead of treatment,[107] lack of variety in treatment for different disorders,[108] power imbalance between therapist

97 See Section 3.1.1.

98 Amnesty International, *Global Report: Death Sentences and Executions* 2016, p. 7. See also the national chapter on the USA. In the USA, people suffering from mental illness are more likely to unfairly incur death penalty charges than the average person. Currently, some states are considering a ban on the death penalty for mentally ill defendants. This is in line with the UN Safeguards guaranteeing protection of the rights of those facing a death penalty. Safeguard number 3 prohibits the imposition of the death penalty on insane persons, see: E/1984/50. The safeguard has been reiterated and redefined to cover a wider range of mental disabilities by other UN Bodies, see: E/2015/49, par. 84.

99 WHO, 2005, p. 1; Alice Mills & Kathleen Kendall, 2018, p. 6 and Adrian Grounds, 'Discrimination against offenders with mental disorder', 29 *Criminal Behaviour and Mental* Health 4 (2019), pp. 247-225. See also the national chapters on Brazil, Chili, Germany, Greece, Hungary, Ireland, New Zealand, Poland, Spain and the USA.

100 UNODC, 2009, p. 14 and Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 140. See also the national chapters on Chile, Germany, Greece, Hungary, Ireland, Kazakhstan, Poland, Portugal, Spain and the USA.

101 See the national chapter on Hungary.

102 See the national chapter on Hungary.

103 See the national chapter on Hungary.

104 See the national chapters on Hungary and the Netherlands (in relation to the Penitentiary Psychiatric Centers).

105 However, stigmatization of mental illness and treatment result in prisoners not addressing their problems. See WHO, 2005, p. 2 and the national chapter on Hungary.

106 See the national chapter on Hungary.

107 Alice Mills & Kathleen Kendall, 2018, p. 6 and UNODC, 2009, p. 13/14. See also the national chapters on Germany, Hungary, Poland and the USA.

108 See the national chapter on Hungary.

and patient,[109] lack of treatment based on the needs of specific groups, such as women[110] and elderly,[111] no treatment for people whose mental illness develops after being sentenced to prison,[112] maintaining continuity of treatment after replacement,[113] short duration of treatment[114] and lack of compulsory advanced training of therapeutic prison staff.[115]

4.3 Unsuitable environment

A second reason why prisons are not designed to accommodate people with mental illness is that the regular *prison environment* is not a suitable place for mental health patients. First, the – often minimal[116] – *regular* (non-therapeutic) *prison staff* is not trained to deal with mental illness.[117] This may cause anti-therapeutic conduct[118] towards prisoners and even human rights violations. Reported behaviour of prison staff, specifically towards mentally ill prisoners, include: imposing unnecessary disciplinary sanctions,[119] discrimination,[120] intimidation (sometimes aimed at making the prisoner an informer)[121] and general ill treatment,[122] occasionally causing deaths.[123] A situation where untrained staff has to work with mental health patients is harmful not only to the patients but also to the staff itself.[124] A second reason why the regular prison environment is not a suitable accommodation, is that *prison infrastructure* is not designed to accommodate people with mental illness. Although Article 109 of the Nelson Mandela Rules provides for the treatment

109 Alice Mills & Kathleen Kendall, 2018, pp. 1-22, 6. See also the national chapters on Germany and Hungary. In the latter chapter, the author points out that when diagnostics and therapy are performed by the same professional, this means that the person offering treatment is also the person who decides on the dismissal of the patient, which may contribute to an unsafe treatment environment.

110 See the national chapter on Greece.

111 See the national chapter on Ireland.

112 See the national chapter on Kazakhstan.

113 See the national chapter on Ireland.

114 See the national chapters on Poland and Spain. Observed in the national chapter on Ireland: sometimes treatment time depends on the length of the sentence. The end of the sentence, however, does not necessarily coincide with the end of treatment.

115 See the national chapter on Germany.

116 See the national chapters on Greece, the Netherlands and Spain.

117 See the national chapters on Chile, Hungary, Ireland, Kazakhstan and the USA.

118 Anti-therapeutic conduct refers to conduct opposite to therapy, often with a damaging psychological effect.

119 UNODC, 2009, p. 15. See also the thematic chapter by Vulić Kralj, in part II of this volume, Section 5, and the national chapter on Spain.

120 UNODC, 2009, p. 15.

121 UNODC, 2009, p. 15.

122 See the national chapters on Chile, Hungary and the USA.

123 See the national chapter on Chile.

124 See the thematic chapter by Vulić Kralj in part II of this volume, Section 4, on the effect of unqualified staff on the mental health of prisoners. The effect of negative staff attitudes on prisoners is also discussed in Section 3.1.2 of the present chapter.

of mentally ill detainees in specialized facilities, it does not require mentally ill defendants to be separated from other defendants.[125] Consequently, mentally ill detainees often inhabit the same spaces as regular detainees. This may undermine the safety of both parties.[126] Mentally ill detainees are particularly vulnerable, and it has been reported that they are more prone to (sexual) violence than regular detainees.[127] Also, the material conditions of prison facilities may be not suitable for mental health patients.[128] In addition, mental health patients may not always understand, or be able to adapt to prison rules, resulting in harsh disciplinary punishment[129] and delays in release.[130] A third reason why the regular prison environment is not a suitable accommodation for mental health patients, is that prison in itself may have a *negative effect on mental health*.[131] Since mentally ill persons have fewer coping mechanisms than regular inmates, they are more vulnerable to the psychological effects of the prison environment than regular prisoners.[132]

4.4 Aftercare problems

Reintegration systems also experience problems when confronted with mental health patients. Probation services are often unable to deal with mentally ill clients professionally.[133] What is more, the lack of treatment of mentally ill prisoners seriously complicates reintegration.[134] When treatment and reintegration of detainees with mental illness are not well organized, these people often stay in prison longer than necessary.[135] However, in many systems the organization of reintegration in general seems to be problematic.[136] As is the general level of mental healthcare outside prison.[137]

125 As is the case with, for example female, juvenile and untried detainees. See Rule 11 of the Nelson Mandela Rules.
126 See the national chapters on Germany, Ireland and Spain.
127 UNODC, 2009, p. 15.
128 See the national chapters on Greece and Hungary. The national chapter on Greece, for example, mentions the poor quality of isolation cells.
129 See thematic chapter by Vulić Kralj in part II of this volume, Section 5, and UNODC, 2009, p. 15/16.
130 See Section 3.1.1.
131 See Section 3.1.2.
132 UNODC, 2009, p. 13.
133 See the national chapters on Germany, Hungary, Japan, Kazakhstan, Portugal and the USA.
134 See the national chapter on New Zealand.
135 See Frank J. Porporino & Laurence L. Motiuk, 'The prison careers of mentally disordered offenders', 18 *International Journal of Law and Psychiatry* 1 (1995), pp. 29-44. See also the national chapters on Greece, Hungary and Portugal, all mentioning the lengthy detention of mentally ill defendants as a problem.
136 See the national chapters on Chile, Greece, Hungary and Poland. See also Section 3.2.
137 See the national chapter on Kazakhstan. See also Section 3.2.

The foregoing problems evoke the image of a mentally ill defendant – who for some reason is not recognized as such and/or diverted – being overwhelmed by the criminal justice system and sent to prison, where treatment is scarce and the environment is anti-therapeutic, eventually being delivered to probation services that have limited resources to deal with his or her problems. Not surprisingly, reoffending rates are generally high among mentally ill detainees.[138]

5 Human rights implications

The previous section demonstrated a variety of problems resulting from the regular criminal justice system not being designed to deal with mental health patients. This section explores the human rights implications of these problems. After briefly sketching the legal framework applicable to prisoners with mental illness (Section 5.1), this section turns to the particular legal implications of each of the problems addressed in Section 4: defendants that are unable to deal with the stress and/or complexity of criminal proceedings (Section 5.2.), absence of professional treatment in detention (Section 5.3), accommodation of mentally ill detainees in an unsuitable environment (Section 5.4) and a lack of support for mentally ill detainees in the aftercare trajectory (Section 5.5).

5.1 Legal framework

In general, persons deprived of their liberty should be able to enjoy the protection of human rights subject to the restrictions that are unavoidable in a closed environment ('minimum basic principle').[139] However, prisoners with mental illness are not only protected by human

138 See the thematic chapter in part II of this volume by Oscar Bloem, Robbert Jan Verkes & Erik Bulten, Section 4, on a replicated finding on the existence of a relationship between substance-related disorders and recidivism; Craig Haney, 2020, p. 387, on how re-traumatization in prison leads to recidivism; and UNODC, 2009, p. 18, on lack of aftercare as an important factor for reoffending by mental health patients. See also the national chapters on Brazil (recidivism rate of 70% among mental health patients), Germany (mentioning a link between mental disorders and recidivism) and the Netherlands (referring to studies on reoffending and the importance of treatment).

139 References to the 'minimum basic principle' can be found in numerous international sources: HRC, General Comment No. 21, 'Humane treatment of persons deprived of liberty' (Article 10), 10 April 1992, par. 3; Rule 3 of the Mandela Rules; Principle 5 of the UN Basic Principles for the Treatment of Prisoners; Rules 2 and 5 of the European Prison Rules; Principle 8 of the Principles and Best Practices the Protection of Persons Deprived of Liberty in the Americas and the Second Recommendation on Prison Conditions in the Kampala Declaration on Prison Conditions in Africa. Also, the 'minimum basic principle' has largely been affirmed in the international and regional case law on the main human rights conventions. See: Piet Hein van Kempen, 'Positive obligations to ensure the human rights of prisoners: safety, healthcare, conjugal visits and the possibility of founding a family under the ICCPR, the ECHR, the ACHR and the AfChHPR', in: Peter Tak & Manon Jendly (eds.), *Prison Policy and Prisoners' Rights: The Protection of Prisoners' Fun-*

rights as humans, but also as *prisoners* and as *mentally ill persons*. As a consequence, defendants and detainees with mental illness are protected by a patchwork of general human rights treaties, more specific human rights treaties (e.g. on persons with disabilities, torture) and soft law instruments (such as various UN prison rules). The next paragraph provides a brief inventory of the relevant rules with universal application. Regional instruments[140] are not included in analysis presented in this section.[141]

General human rights treaties of particular relevance to detainees with mental illness are the International Covenant on Civil and Political Rights (ICCPR, 1966) and the International Covenant on Social Economic and Cultural Rights (ICESCR, 1966). Relevant specific treaties are: the Convention on the Rights of Persons with Disabilities (CRPD, 2006)[142] and the Convention against Torture and Other Cruel and Inhuman or Degrading Treatment or Punishment (UNCAT, 1984). In addition to these treaties, there are several relevant soft law instruments: the Nelson Mandela Rules (2015, formerly known as the UN Standard Minimum Rules for the Treatment of Prisoners, 1955);[143] the Bangkok Rules (applicable to women in detention, 2010);[144] the Principles for the protection of persons with mental illness and the improvement of mental healthcare (1991);[145] the Basic principles for the treatment of prisoners (1990);[146] the Havana Rules (applicable to juveniles in detention, 1990);[147] the Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment (1982);[148] and the Code of conduct for law enforcement officials (1979).[149] Below an overview is provided of the rules

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damental Rights in International and Domestic Law/Politique pénitentiaires et droits des détenus, Wolf Legal Publishers, 2008, pp. 21-44, 24.

140 Such as: the African Charter of Human and People's Rights (AfChHPR, 1981), the European Convention on Human Rights (ECHR, 1950), the American Convention on Human Rights (ACHR, 1969) and the ASEAN Human Rights Declaration (2012).

141 For an analysis of the European Court of Human Rights case law on *detainees* with mental illness, see the thematic chapter by Wąsek-Wiaderek in part II of this volume. For an analysis of the *defense rights* in various regional and international systems, see the thematic chapter by Van Kempen in part II of this volume.

142 The CRPD is applicable to defendants and detainees with mental illness. Although the notion of 'disability' is not defined in the convention, Art. 1(2) of the CRPD refers to persons with disabilities with a non-exhaustive description, including mental disabilities. Accordingly, the convention has been interpreted as including the protection of persons with mental illness. See: Tina Minkowitz, 'The United Nations Convention of the Rights of Persons with Disabilities and the right to be free from non-consensual psychiatric interventions', 34 *Syracuse Journal of International Law and Commerce* 2 (2007), pp. 405-428, 407.

143 A/Res/70/175, 17 December 2015.

144 A/C.3/65/L.5, 6 October 2010.

145 A/Res/46/119, 17 December 1991.

146 A/Res/45/111, 14 December 1990.

147 A/Res/45/113, 14 December 1990.

148 A/Res/37/194, 18 December 1982.

149 A/Res/34/169, 17 December 1979.

derived from the above treaties and instruments relevant to the problems described in Section 4.

5.2 Procedural rights of defendants and detainees with mental illness

In Section 4.1 it was explained that a defendant or detainee with mental illness involved in the regular criminal justice system may be unable to understand the system and its implications or have the resilience to deal with authorities and that this can result in human rights violations. This section discusses the human rights protection of defendants with mental illness involved in criminal proceedings.

In the first place, defendants with mental illness involved in criminal proceedings are protected by the general human rights as contained in the ICCPR. These rights include, first and foremost, the right to a fair trial (Art. 14 ICCPR).[150] However, protection during proceedings is also offered through additional rights, such as the prohibition of torture and other cruel, inhuman or degrading treatment or punishment (Art. 7 ICCPR);[151] the right to liberty and security, including the prohibition of arbitrary detention (Art. 9); the right to humane treatment of detained persons (Art. 10); the right to privacy (Art. 17) and the prohibition of discrimination (Art. 26). The ICCPR does not set an explicit standard for fitness to stand trial. The Human Rights Committee holds that an 'effective defense' must be possible,[152] laying emphasis on the countermeasures to be taken in case of a defendant with restricted capabilities, instead of setting a boundary for a minimum level of mental capacity.[153]

Apart from the ICCPR catalogue, defendants with mental illness can also enjoy the protection offered by several provisions in the CRPD. Most relevant to criminal proceedings as a whole is Article 13 of the CRPD. This article obligates states to ensure effective access to justice for persons with mental illness. This effective access should be on an equal basis with others, through the provision of procedural accommodations, including at investigative and other preliminary stages. According to the UN High Commissioner for Human Rights, this obligation to provide procedural accommodations refers to the duty to ensure equality of arms.[154] In case of criminal proceedings, this means that the mentally ill defendant must

150 The Human Rights Committee has not elaborated on the right to a fair procedure specifically for persons with mental illness. The European Court of Human Rights, however, has interpreted Art. 6 ECHR to imply obligations of authorities to ensure effective participation in criminal procedures of defendants with mental inabilities. See the thematic chapter by Van Kempen in part II of this volume, Section 4.

151 Also contained in Art. 1 of the UNCAT. Art. 11 of the UNCAT obliges states to monitor interrogation rules and practices throughout the whole criminal justice process.

152 HRC, General Comment No. 32, 'Right to equality before courts and tribunals and to a fair trial' (Art. 14), 23 August 2007, par. 10 and 40.

153 See the thematic chapter by Van Kempen in part II of this volume, Section 4.

154 A/HRC/37/25, 27 December 2017, par 24.

have access to the information and support necessary to attain this equality of arms. This may include an obligation of the authorities to present all relevant information in an understandable way and an obligation to practice procedural flexibility (i.e. adapting the procedure to the capabilities of the defendant).[155] Legislation of state parties should explicitly include these procedural accommodations in criminal proceedings.[156] What is more, states should increase their efforts to guarantee free legal aid for persons with disabilities.[157] Article 13 of the CRPD also provides that states must promote training for those working in the field of administration of justice, including police and prison staff, to ensure equal access to justice for defendants with mental illness.

Other relevant provisions contained by the CRPD are the right to liberty and security, prohibiting arbitrary detention (Art. 14 CRPD), the obligation of states to prevent exploitation and abuse of and violence against persons with disabilities (Art. 16 CRPD),[158] and the prohibition of torture, obliging states to take all measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment (Art. 15 CRPD).[159]

Based upon the above, states are not only obliged to provide basic procedural guarantees to defendants with mental illness, as they are with every defendant. States should also take extra measures (e.g. accessible information, procedural flexibility, legal aid, trained staff) to ensure that the basic procedural rights of the mentally ill defendant are guaranteed. Failing to execute these measures may violate not only the general human rights in the ICCPR but also the more specific rights, mainly Article 13 of the CRPD. In order to offer defendants with mental illness this extra layer of protection, authorities are obliged to create and execute appropriate legislation.

5.3 The right to mental healthcare

Section 4.2 has demonstrated that prisons are not designed to accommodate people with mental illness because *treatment* options are often limited. This section discusses the right to mental healthcare of detainees, including the right to treatment.

155 A/HRC/37/25, 27 December 2017, par 24.
156 A/HRC/37/25, 27 December 2017, par 28.
157 A/HRC/37/25, 27 December 2017, par 40.
158 Also contained in Principle 1,3 of The Principles for the protection of persons with mental illness and the improvement of mental health care.
159 See also Art. 10 of the UNCAT, containing the obligation of states to educate police officers, prison personnel and medical personnel on the prohibition against torture.

5.3.1 General rules on the right to mental healthcare

Explicit reference to the right to health can be found in Article 12 of the ICESCR and Article 25 of the CRPD. Based on these provisions, detainees with mental illness[160] have a right to secure the highest attainable standard of health, including mental health,[161] subject to the restrictions that are unavoidable in a closed environment. This right to mental health also covers the responsibility of states to prevent mental illness,[162] the obligation to identify mental illness at an early stage and to prevent further mental illness,[163] the obligation to adopt a national public mental health strategy with particular attention to vulnerable and marginalized groups,[164] the obligation to organize care close to people's own communities,[165] the obligation to offer treatment based on free and informed consent[166] and the obligation to educate health professionals on ethical standards and human rights.[167]

5.3.2 Rules on mental healthcare in prison

Before we address the right to mental healthcare in prison, we need to note that international rules limit the categories of detainees with psychiatric disturbances that are allowed to be incarcerated. Persons who are found to be not criminally responsible or who are later diagnosed with severe mental health conditions, for whom staying in prison would mean an exacerbation of their condition, should not be detained in prison but in a mental health facility instead.[168] What is more, all juveniles suffering from mental illness should be treated in a specialized institution.[169]

160 A phrasing of the minimum basic principle discussed previously specifically applicable to detainees with mental illness can be found in principle 5 of the Principles for the protection of persons with mental illness and the improvement of mental healthcare.

161 Art. 12 ICESR, Art. 25 CRPD. See also Principle 1.1 of The Principles for the protection of persons with mental illness and the improvement of mental healthcare.

162 Art. 12(c) ICESCR and CESCR, General Comment No. 14, 'The right to the highest attainable standard of health' (Art. 12), 11 August 2000, par. 16.

163 Art. 25 CRPD.

164 CESCR, General Comment No. 14, 'The right to the highest attainable standard of health' (Art. 12), 11 August 2000, par. 43.

165 Art. 25 CRPD.

166 Art. 25 CRPD. Although treatment without consent is possible, it is often driven by inappropriate considerations; see: UNODC, 2009, pp. 33-35. See also on this matter the national chapters on Hungary and Kazakhstan.

167 Art. 25 CRPD.

168 Rule 109(1) of the Nelson Mandela Rules. See also the analysis in the thematic chapter by Wąsek-Wiaderek, where she argues that Art. 14 CRPD could be read as prohibiting the detention of mentally ill but later nuances that finding by demonstrating that Art. 14 of the CRPD has been interpreted in the light of a less restrictive ECHR/ICCPR criterion.

169 Rule 53 of the Havana Rules.

In general, prisons should have a health service where prisoners can receive healthcare[170] of the same standard as that available to the community outside prison.[171] Responsible for healthcare are members of a multidisciplinary team with 'sufficient expertise in psychology and psychiatry'.[172] Screening upon admission to prison should include a mental health check, including a suicide risk assessment.[173] Prisoners with mental health problems can be treated in specialized facilities,[174] but one way or the other psychiatric treatment[175] must be available to them.[176] The state has the duty to take adequate measures to protect a prisoner from suicide.[177] Healthcare professionals must have daily access to (mentally) ill prisoners.[178] This access should be free and should be guaranteed during all stages of detention.[179] Healthcare professionals must keep a confidential medical record.[180] States are required to know about the state of health of detainees as far as may be reasonably expected. Lack of financial means does not reduce this responsibility.[181] Prison staff should receive training on mental health issues.[182] In line with reintegration as a general purpose of imprisonment[183] – but also as a treatment purpose for mentally ill members of society

170 Rule 25(1) of the Nelson Mandela Rules and Principle 9 of the Basic Principles for the Treatment of Prisoners. In proceedings based on Art. 6, 7 and 10 of the ICCPR, the Human Rights Committee has held that adequate or most appropriate and timely medical care must be available to all detainees. This care must be offered even when not requested by the prisoner. See analysis of Arts 6, 7 and 10 ICCPR in: Piet Hein van Kempen, 2008, pp. 21-44, 31-33.

171 Rule 24 of the Nelson Mandela Rules; Rule 10(1) of the Bangkok Rule and Principle 1 of the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. According to the general comment to Art. 12, ICESCR states have a legal obligation to refrain from denying equal access to healthcare to detainees or prisoners or limiting such access for them. See: CESCR, General Comment No. 14, 'The right to the highest attainable standard of health' (Art. 12), 11 August 2000, par. 34.

172 Rule 25(2) of the Nelson Mandela Rules. If withholding mental healthcare in prison contravenes Arts 6 ICCPR (right to life), 7 ICCPR (prohibition on torture and degrading treatment) and 10 ICCPR (right to humane treatment of prisoners), authorities may be required to provide the necessary care. See: Piet Hein van Kempen, 2008, pp. 31-33.

173 Rule 30(c) of the Nelson Mandela Rules; Rule 6(b) of the Bangkok Rules and Rules 27 and 50 of the Havana Rules. There is no explicit reference to suicide risk assessment in the Havana Rules.

174 Rule 109(2) of the Nelson Mandela Rules.

175 A relevant matter, not addressed in the Nelson Mandela Rules, is to what extent treatment should be voluntary.

176 Rule 109(3) of the Nelson Mandela Rules and Rule 51 of the Havana Rules.

177 This conclusion was drawn by the Human Rights Committee on the basis of Arts 6 and 10 of the ICCPR. For an analysis of Arts 6 and 10 ICCPR on this issue, see Piet Hein van Kempen, 2008, pp. 26-27.

178 Rule 31 Nelson Mandela Rules.

179 See analysis of Arts 6, 7 and 10 ICCPR in: Piet Hein van Kempen, 2008, pp. 31-33.

180 Rule 26 of the Nelson Mandela Rules and Rule 21 of the Havana Rules.

181 See the analysis of Arts 6, 7 and 10 ICCPR in: Piet Hein van Kempen, 2008, pp. 31-33.

182 Art. 13(2) of the CRPD; Rules 75 and 76 of the Nelson Mandela Rules and Rules 13 and 35 of the Bangkok Rules.

183 See, for example, HRC, General Comment No. 21, 'Humane treatment of persons deprived of liberty' (Art. 10), 10 April 1992, par. 10: "[n]o penitentiary system should be only retributory; it should essentially

outside prison[184] – the focus of mental health treatment in prison should be on the reintegration[185] and must, if necessary, continue after release.[186]

5.3.3 Rules relevant to specific groups of prisoners

Instruments protecting particular groups of vulnerable prisoners (women, juveniles) endorse the general rules specified above but contain an extra focus on the specific mental health risks of the particular group. The Bangkok Rules (for women), for example, contain rules on detection and treatment of traumas caused by (sexual) violence,[187] the allocation of female prisoners with mental health problems[188] and extra rules on the prevention of suicide and self-harm.[189] In accordance with Section 12 of the preliminary observations to the Bangkok Rules, these rules may be equally applicable to prisoners that are male or gender non-conforming.[190] Also, the Havana Rules (for juveniles) contain an extra focus on mental vulnerability. They prescribe, for example, that juveniles should receive both preventative and remedial mental healthcare,[191] that psychologists and psychiatrists should be among the personnel,[192] that staff should have knowledge of child psychology[193] and that disciplinary sanctions are restricted in case of juveniles.[194]

From the above can be derived, that detainees with mental illness have a right to the highest attainable standard of mental health. To attain this standard, states are obliged to prevent mental illness, to screen for mental illness and to prevent exacerbation of mental illness. As to the quality of this care, prisoners should receive mental healthcare of the same standard as that available to the community outside prison, subject to the restrictions

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seek the reformation and social rehabilitation of the prisoner." See also: Rule 4 of the Nelson Mandela Rules; Rules 12 and 43 of the Bangkok Rules and Principle 10 of the Basic Principles for the Treatment of Prisoners.

184 Art. 16 of the CRPD imposes a general obligation on states to organize rehabilitation services for (mentally) disabled people. According to Principle 9 of the 'Principles for the protection of persons with mental illness and the improvement of mental health care', treatment of persons with mental illness, in general, should be directed towards preserving and enhancing personal autonomy.

185 Art. 10 Section 3 of the ICCPR states that the 'essential aim' of the treatment of prisoners is reformation and social rehabilitation. See also Rule 25 of the Nelson Mandela Rules and Rule 51 of the Havana Rules (prison healthcare services must pay particular attention to prisoners with healthcare needs that hamper their reintegration).

186 Rule 110 of the Mandela Rules; Rule 53 of the Havana Rules and Rule 47 of the Bangkok Rules.

187 See Rules 6(b), 7, 12, 20, 25 and 42 of the Bangkok Rules.

188 Rule 41(b) of the Bangkok Rules.

189 See Rules 16 and 35 of the Bangkok Rules.

190 Maartje Krabbe & Piet Hein van Kempen, 'Women in prison: A transnational perspective', in: Piet Hein van Kempen & Maartje Krabbe (eds.), *Women in Prison: The Bangkok Rules and Beyond*, Intersentia, 2017, pp. 3-34, 30. Considering medical services, Section 12 of the preliminary observations to the Bangkok Rules even makes an explicit reference to the equal applicability of these services.

191 Rule 49 of the Havana Rules.

192 Rule 81 of the Havana Rules

193 Rule 85 of the Havana Rules.

194 Rule 67 of the Havana Rules.

of a closed environment. This mental healthcare must be provided by professional healthcare staff, and treatment for mental illness must be available. Consequently, the absence of (sufficient) professional healthcare staff and treatment in prisons worldwide may – also depending on the situation outside prison – not be in accordance with international standards and may violate the reintegrative purpose of both prison sentences and treatment of the mentally ill in general. Finally, keeping mental health patients in prison, who are not criminally responsible or whose mental illness is later diagnosed and deteriorating, is not in accordance with international standards either.

5.4 *Human rights implications of the effect of the general situation in prisons on detainees with mental illness*

Section 4.3 demonstrated that prisons are not designed to accommodate people with mental illness, because the regular *prison environment* is not a suitable accommodation for them. Various factors contribute to this condition: prison staff attitudes towards mental health patients, an infrastructure that is not designed to accommodate these patients, and the general negative effect of imprisonment on mental health, which may impact prisoners with mental illness even more than regular detainees.

The above factors may all lead to violations of international human rights standards. For example, as explained in the previous section on mental health, operating a prison with staff who are not trained to deal with mental health issues is in itself a violation of international rules. When the use of untrained staff has undesirable consequences (in Section 4.3 various forms of ill treatment are mentioned), these consequences may amount to violations of rights and principles as contained in Article 6 ICCPR (right to life), Article 7 ICCPR (prohibition on torture and degrading treatment), Article 10 ICCPR (right to humane treatment of prisoners), Article 16 of the CRPD (the obligation of states to prevent exploitation and abuse of and violence against persons with disabilities), Article 26 ICCPR (prohibition of discrimination), Article 5 CRPD (prohibition of the discrimination of persons with mental disabilities) and Principle 4 of the Principles for the protection of persons with mental illness and the improvement of mental healthcare (prohibiting discrimination based on mental illness).

An infrastructure that is not created to accommodate mental health patients generates, in the first place, safety issues, for both the mentally ill and the regular detainees. When a prison fails to guarantee the safety of its inmates, this may raise issue under Article 6 ICCPR (right to life) and Article 10 ICCPR (right to humane treatment of prisoners).[195] In the

195 The Human Rights Committee has held that the rights in Arts 6 and 10 ICCPR imply a duty of the state to take adequate measures to protect the life of a prisoner from killing and assaults by other prisoners. For the relevant analysis of Arts 6 and 10 ICCPR, see Piet Hein van Kempen, 2008, pp. 26-27.

second place, the material conditions of a prison may be unsuitable for mental health patients. When these material conditions amount to degrading or inhumane treatment this may raise issue under Article 7 ICCPR (prohibition on torture and degrading treatment) and 10 of the ICCPR (right to humane treatment of prisoners). Non-compliance with prison rules due to mental illness and subsequent disciplinary punishment may also raise issue under the anti-discrimination provisions summed up in the previous paragraph.

As to the human rights implications of the negative effect of detention on mental health – especially on those who already suffer from mental illness upon entering the penitentiary system – the following can be maintained. If international standards prescribe that detainees that are not criminally responsible and detainees that develop symptoms later on, for whom staying in prison would mean an exacerbation of their condition, should not be detained in prison (Rule 109 Nelson Mandela Rules) and if detention generally negatively influences the mental health of detainees, it can be held that detention in these cases (unaccountable, symptoms develop later) is by default in violation of international rules. What is more, it could probably be successfully argued in some situations that detaining a person with mental illness in an unsuitable facility may raise issue under Article 7 of the ICCPR.[196] Apart from the human rights implications of the *effect* of imprisonment on the mentally ill, it is important to note that prison conditions causing the negative effect on mental health may *in themselves* amount to human rights violations. Examples of these conditions are provided in Section 3.1.2, e.g. different forms of aggression, lack of meaningful activities and exercise, solitary confinement,[197] harsh security measures, general poor living conditions (food, hygiene) and overcrowding.[198]

In short, because mental health patients may be more vulnerable to the negative effects of the prison environment and because prisons are often not designed (staff, allocation) to accommodate mental health patients, the risk of violations of international rules and standards seems to increase in case of detention of mental health patients.[199]

196 Compare the analysis of Thoonen on ECtHR cases on the equivalent Art. 3 ECHR: Eveline Thoonen, *Death in state custody*, Apeldoorn-Antwerp: Maklu, 2017, p. 116.

197 According to principle 7 of the Basic Principles for the Treatment of Prisoners, "Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged". The Nelson Mandela Rules also prescribe that the imposition of solitary confinement should be prohibited in case of prisoners with mental or physical disabilities when their conditions would be exacerbated by such measures (Rule 45).

198 See: Piet Hein van Kempen, 2008, p. 27, where Van Kempen argues that Art. 10 ICCPR implies a duty of states to resolve problems such as prison overcrowding. See also the national chapter on Greece, where overcrowding in Greek prisons has been found to be in violation of Art. 3 of the ECHR.

199 UNODC, 2009, p. 15.

5.5 Human rights implications of aftercare problems

As indicated in Section 4.4 on aftercare issues, many countries are dealing with problems related to both reintegration of detainees into society and mental healthcare *in general*. In case of mentally ill detainees, reintegration problems are aggravated by lack of treatment in prison and a shortage of mental health professionals working in probation. This may ultimately lead to extended stays in detention. The human rights implications of this situation are diverse. First, as was demonstrated in Section 5.3.2 (Rules on mental healthcare in prison), international rules prescribe that the focus of mental health treatment in prison should be on the reintegration and must, if necessary, continue after release. Consequently, when treatment and guidance for mental health patients is inadequate, both in detention and during the aftercare stage, this could amount to a violation of international rules. Second, keeping mental health patients in detention longer than necessary may raise issue under Article 9 of the ICCPR (right to liberty and security) and Article 14(1)(b) of the CRPD, which explicitly states that "the existence of a disability shall in no case justify a deprivation of liberty". In this respect, lengthy stays are particularly unjust when, on the one hand, recovery is a condition for release,[200] while, on the other hand, no, or poor, treatment is offered by the system. What is more, anti-discrimination provisions, such as Article 26 ICCPR and Article 5 of the CRPD,[201] could also be violated in case of extended stays in detention. For example, when the stay is based on the imposition of numerous disciplinary sanctions that were issued, even though the mentally ill detainees did not understand, or could not comply with, the prison rules.[202]

5.6 Conclusion

This section demonstrates that mentally ill detainees are protected by international human rights, both in their capacity as a defendant or detainee and in their capacity as a mental health patient. The problems caused by the disproportionate number of mentally ill people confronted with the criminal justice system has several human rights implications. Not offering an extra layer of protection to defendants suffering from a mental illness in the (pre-) trial stage is a violation of international standards. So is a lack of adequate professional

200 See, for example, the national chapter on Brazil. Currently, legal scholars move away from 'mental illness' as a criterion for treatment measures. They argue that 'danger' or 'risk' should be a (more) decisive criterion in such cases. See, for example: Michiel van der Wolf, *TBS: veroordeeld tot vooroordeel*, Oisterwijk: Wolf Legal Publishers, 2012, p. 729 (dissertation with summary in English), Maarten Beukers, *Over de grenzen van de stoornis* (The mental disorder in criminal law), 2017, p. 241 (dissertation with summary in English), not published but submitted to open access: https://repub.eur.nl/pub/102952 and Bijlsma et al., 'Legal insanity and risk', *International Journal of Law and Psychiatry* 66 (2019), p. 1-6, p. 5.

201 See also Principle 2 of Basic Principles for the Treatment of Prisoners.

202 See section 3.1.1.

treatment – when this treatment is not limited by the basic minimum principle and/or the principle of equivalence – in detention. The detention of unaccountable or later diagnosed and deteriorating mental health patients also contravenes international rules. Because mental health patients may be more vulnerable to the negative effects of the prison environment and because prisons are often not designed (staff, allocation) to accommodate mental health patients, there seems to be a significant risk of violations of international rules and standards if mental health patients are detained in standard prisons. Lack of support for the mentally ill in the aftercare trajectory may be not only violative of the right to liberty and the prohibition of discrimination, but also contrary to the purpose of reintegration, which is the ultimate aim of both prison sentences and of mental health treatment.

6 Recommendations

Although the worldwide situation of the mentally ill in the criminal justice system is alarming, it is encouraging to gather from the national chapters in this volume that stakeholders are aware of the magnitude of this problem and are working towards solutions on different levels. Several states report initiatives, such as active working groups, legislative reforms (conforming laws to both scientific findings and human rights standards) and successful (rehabilitation) programmes.[203] It is to be hoped that these initiatives will contribute to the improvement of the situation of the mentally ill in the criminal justice system. Still, a lot of work remains to be done. Therefore, this introduction ends with four focus points for future laws and policies, based on the contributions to this volume and the additional materials presented in this introduction. These focus points are**:** (A) diversion of the mentally ill from the criminal justice system, (B) a legal framework and policy to ensure effective participation of the mentally ill defendant in the criminal process, (C) the rethinking of sentencing laws and (D) a suitable accommodation for mentally ill detainees. There is some contradiction in these focus areas as the first, (A), is based on the situation where the defendant is taken out of the criminal justice system, while the others (B, C and D) are based on the situation where the defendant is still part of this system. However, since diversion is not always possible or even desirable (see further on), governments should both invest in possibilities for diversion and work on creating the best possible situation in cases where diversion is not an option. The final words of this section (E) are devoted to the question of departmental accountability. Who is responsible for mentally ill offenders: the ministry of health or the ministry of justice?

203 See the national chapters on Brazil, Germany, Greece, Hungary, Kazakhstan, New Zealand and the USA.

A. Diversion

Many of the arguments issued in the previous sections are made in support of diversion of the mentally ill defendant from the traditional criminal justice system: both the procedure and the sanctions imposed are not designed for the mentally ill offender. This leads to many problems, including human rights violations (both in the (pre-) trial stage and in prison) and recidivism. What is more, the detention of unaccountable or later diagnosed and deteriorating mental health patients contravenes international rules. Generally, it is for these reasons that contributors to this volume and other sources support the creation of more possibilities for diversion.[204]

While reflecting on improving the situation of mentally ill defendants and detainees through diversion, a more complex question arises: what does a solid diversion system look like? A first step to be taken would be to create a system *that acknowledges the presence of a mental illness as early as possible*. Consequently, early screening is paramount.[205] As Section 3.1.1 has demonstrated, screening is not always applied, and when it is, it is often at a later stage. This is unfortunate, for screening is not only crucial to enable diversion, it is also a first step in guaranteeing an effective defense in case of mental illness.[206] What is more, not only is early screening paramount, but failing to apply such an assessment even contravenes international rules.[207]

As to the further details of diversion, there are many possibilities and different views. Diversion can refer to a route out of the regular criminal justice system and into a special division of this system. It can also refer to diversion from the criminal justice system into the regular mental health system. When diversion happens within the criminal justice system, treatment in a special wing of a regular prison is an option.[208] Some argue in favour

204 Graham Duncan & Jan Cees Zwemstra, 2014, p. 87; UNODC, 2009, p. 23 and WHO, 2005, p. 3. See also the thematic chapters by Vulić Kralj (conclusion) and by Morinaga & Yamamoto Section 4. See also the national chapters on Chili and Spain.

205 Graham Duncan & Jan Cees Zwemstra, 2014, p. 91 and UNODC, 2009, p. 14. See also: P.R. Kranendonk, 'Verdachten met een LVB in het politieverhoor: de invloed van verhoormethoden op de inhoud van verklaringen', 43 *Justitiële verkenningen* 6 (2017), p. 74-91. This Dutch article specifically discusses the importance of screening in the context of police interrogation. The research results in this article will be included in Kranendonk's forthcoming dissertation on defendants with intellectual disability in English (2023).

206 For the latter reason, screening is especially important in adversarial systems, since the responsibilities of the defense are traditionally more extensive in this trial model. However, the general importance of early screening can also be underlined by the fact that trial systems in general are becoming more adversarial. See national chapter on the Netherlands and the thematic contribution by Van Kempen in part II of this volume, Section 3.

207 Art. 25 CRPD prescribes early screening at the police investigation stage, and various UN rules prescribe this in the context of detention. See Section 5.3.

208 See the national chapter on Poland.

of separate medical prisons,[209] while others strongly reject this idea.[210] In case of diversion to the mental health system, treatment can also be offered in different modalities, such as voluntary and involuntary, inpatient or outpatient.[211]

To list all the options for diversion and the pros and cons of these models in this introduction would be excessive. However, factors that determine the contours of a diversion system are enumerated. These contours largely depend on: (i) how we, as a society, value the concepts of fitness to stand trial and criminal responsibility, (ii) the existing national system for mental health and criminal justice, (iii) the existing human rights framework and (iv) the scientific views on resocialization. The first factor refers to normative questions: when are mental capacities so disturbed that it is unethical to let a person participate in a criminal trial or to impose criminal responsibility on a person? These questions determine whether a person ought to be dealt with by the criminal justice system or not. The answers to these questions will be partly informed by the next three factors. The second factor, the current national system, sets boundaries for the possibilities for diversion. When there is no mental health system, diversion is quite useless.[212] Also, the nature of the criminal justice system may be a factor determining possibilities. In more inquisitorial systems, the rather active courts often have more possibilities to find an appropriate solution within the criminal justice system for the mentally ill defendant. As a consequence, the criminal justice system contains all the expertise on forensic care, while the mental health system has no experience in this area.[213] In the more adversarial systems, where mental illness can have a larger impact on the outcome of the procedure because the litigants have greater responsibilities,[214] more solutions outside the criminal justice system are being created, such as the mental health courts.[215] The nature of the national criminal justice and mental health systems, and the relationship between these two, thus also determine the optimal place for a defendant with mental illness. The third factor, human rights, also sets boundaries, e.g. in situations where diversion is required or cannot be enforced. The fourth factor, scientific knowledge on resocialization, steers us towards

209 See the thematic chapter by Morinaga & Yamamoto, Section 4.

210 WHO, 2005, p. 2.

211 UNODC, 2009, p. 12. See also the national chapter on Spain, where it is argued that involuntary outpatient treatment is more effective than short-term confinements in psychiatric prisons.

212 See the national chapter on the USA.

213 See Michiel van der Wolf *et al*., 'Understanding and evaluating contrasting unfitness to stand trial practices', 9 *International Journal of Forensic Mental Health* 3 (2010), pp. 245-258, 256/257. See also the national chapter on the Netherlands.

214 See Michiel van der Wolf *et al*., 2010, p. 249. See also the thematic chapter by Van Kempen, Section 5.

215 See for an elaborate study on problem-solving courts: Suzan Verberk, *Probleemoplossend strafrecht en het ideaal van responsieve rechtspraak*, Den Haag: Sdu uitgevers, 2011 (dissertation with summary in English).

the most efficient system,[216] offering arguments in favour of the route that reduces reoffending and makes society safer. Although the optimal diversion system may look different in various parts of the world, the ultimate aim is to create a system that offers a humane place for the defendant with mental illness, where the highest level of resocialization – both as an offender and as a mental health patient – is possible.

B. Procedural measures

In order to avoid both human rights violations and miscarriages of justice, an adequate legal framework and policy is necessary to ensure effective participation of the mentally ill defendant in the criminal process.[217] This means, first, that legislation must prescribe under which conditions a defendant is at all to participate (fit to stand trial). On the basis of international human rights law, a defendant participating in a criminal trial must have a minimum level of understanding, enabling him or her to instruct counsel in a meaningful way.[218] Second, legislation and policy must be clear on the modalities of compensation available to guarantee effective participation for the mentally ill defendant participating in a criminal trial. This compensation may include, for example, fewer restrictions on access to a lawyer.[219]

The national chapters in this volume demonstrate that most national codes contain rules to protect defendants with mental illness, providing them with all kinds of procedural protection,[220] including better access to mandatory defense[221] and mental healthcare.[222] However, authors also indicate that there may be a difference between the law on paper and the law in action.[223] These concerns about the protection of defendants with mental illness in the principal stage of criminal procedures may be partly attributable to 'defendants with mental illness not in detention' being a rather invisible group. While there is an

216 See, for example, this recent publication arguing the economic benefits of diversion (potential fiscal savings of over 1 billion dollars): Darci Delgado *et al.*, 'Economics of decriminalizing mental illness: when doing the right thing costs less', 25 *CNS Spectrums* 5 (2020), pp. 566-570.

217 UNODC, 2009, p. 22.

218 For an analysis of the relevant rules, see the thematic chapter by Van Kempen in part II of this volume, Section 5.

219 For a more elaborate exposition of these procedural recommendations based on human rights law, see the thematic chapter by Van Kempen in part II of this volume, Section 5. See also: E.M. Gremmen, 2018, p. 346. Gremmen argues that mental vulnerability of a defendant should be compensated for during all stages of the criminal trial. Because mental vulnerability may fluctuate during the course of the trial, it must constantly be re-evaluated. See also Section 5.2 for the legal underpinning of these recommendations.

220 See, for example, the national chapters on Brazil, Hungary, Japan and Kazakhstan.

221 See the national chapters on Germany and Greece.

222 See the national chapter on Germany, specifically in case of juveniles.

223 See, for example, the national chapters on Brazil, Hungary, Ireland and Kazakhstan.

abundance of data on detainees with mental illness, few international studies are available on defendants in police custody and even fewer on defendants that are not detained.[224]

It is therefore submitted here that not only must special procedures for mentally ill defendants based on international human rights be implemented in our domestic systems, but that these rules must also be executed. Two ways to stimulate the execution of these rules could be:

(i) Training of police officers and other authorities active during the principal stage. These professionals should be instructed on the identification of mentally ill defendants, the legal framework applicable to them, and the interaction with these defendants in a respectful and effective way.[225]

(ii) Generating more research on defendants with mental illness who are not detained.[226] The latter may not only provide information on the compliance with special domestic procedures and international human rights in case of these defendants, but also, for example, data on the number of non-detained defendants with mental illness, the development of mental illness from the moment of arrest and on the effect of a criminal prosecution on mental health.

C. Sentencing

Sentencing systems must be re-evaluated for the purpose of reducing elements that increase the number of mentally ill people in prison. This re-evaluation should occur not only on a very fundamental level (e.g. how do we define criminal responsibility? Do we attach more weight to retribution or to resocialization? Can danger be a ground for imprisonment when fitness to stand trial or criminal guilt are absent?),[227] but also by repairing the elements that are mentioned in Section 3.1.1 on causes. For example, by abolishing sentencing policies imposing severe sentences on non-violent repeat offences and by creating guarantees to prevent endless stays in prison.

D. Accommodation

The previous sections on problems (Section 4) and human rights implications (Section 5) demonstrated that prisons are not designed to accommodate mental health patients. There is a general lack of treatment (and appropriate aftercare), and the environment itself is

224 See Section 2.

225 See the national chapter on the USA. See also Section 5.2 for the legal underpinning of these three recommendations.

226 Incidentally, during the preparatory work for this introduction I noticed that little information is available on the mental health of other principal actors in the criminal process such as witnesses, but, especially, informants, infiltrators and crown witnesses. What would be a minimum level of mental capacity for those to perform their often psychologically demanding duties?

227 See also the thematic chapter by Manata on the weighing of such interests.

anti-therapeutic. This may have negative consequences, such as human rights violations and recidivism. For these – and other – reasons it was argued under (A) that diversion out of the regular prison environment is the best option for mentally ill defendants. However, in case diversion is not conceivable, the best possible circumstances should be created for detainees with mental illness. Several suggestions to improve the circumstances of mental health patients in regular prisons are summed up below.

Availability of treatment

Treatment must be available in detention. From the overview of the relevant human rights framework in Section 5.3 it can be gathered that detainees with mental illness should receive mental healthcare according to the same standards as those that apply in the community outside prison, subject to the restrictions of a closed environment. This mental healthcare must be provided by professional healthcare staff, and treatment for mental illness must be available.[228] The observations in Section 4.2 demonstrate that the shortage of sufficient and trained healthcare staff, in particular, is a major obstacle in providing adequate treatment, which should have the immediate attention of governments.[229] As to the further implementation of quality treatment in accordance with international standards, several of the articles and reports referred to in this chapter carry detailed recommendations, to which the following footnote refers.[230] In general, it has been argued that treatment programs can best be established through a multi-departmental, inter-sectoral approach[231] and that these programmes should extend to the aftercare stage.[232] In terms of treatment design, it may be worthwhile to further explore the idea not only that mental illness in detention is an individual pathology brought in from the outside, but also that it may be – partially – seen as a response to the prison environment.[233]

Training of regular staff

228 These international rules are also reflected in WHO recommendations, see: WHO, 2005, p. 3.

229 See also recommendations in: UNODC, 2009, p. 26. According to the UNODC, the principle of equivalence should extend to the salaries and career opportunities of healthcare staff in prisons.

230 Recommendations as to the quality of treatment can be found in: UNODC, 2009, pp. 26-36; WHO, 2005, 3 and Graham Duncan & Jan Cees Zwemstra, 2014, p. 91. These recommendations touch on topics such as consent to treatment, awareness of times of increased risk, continuity of care after transfers and suicide prevention programmes.

231 See UNODC, 2009, p. 25; WHO, 2005, p. 3 and the national chapter on Ireland.

232 Graham Duncan & Jan Cees Zwemstra, 2014, p. 92; UNODC, 2009, p. 25 and HOSPICE Casa Sperantei Foundation, 2018, p. 5. See also the national chapter on the USA.

233 Alice Mills & Kathleen Kendall, 2018, p. 8. In the latter case, according to Mills & Kendall, we are not dealing with mental illness but with a normal reaction to an abnormal environment. See: Alice Mills & Kathleen Kendall, 'Conclusion', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical Perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, pp. 355-364, 358/359.

In view of the considerable number of mental health patients in detention, and the risk of mistreatment or even human rights violations by regular prison staff members that this incurs, training of regular staff to deal with mental illness is paramount. Such training should focus on promoting mental health and reducing mental harm.[234] For example by including tools to recognize and handle mental illness, instructions on how to avoid negative attitudes towards detainees with mental health problems and basic knowledge of the human rights framework applicable to this population.[235]

Creating a therapeutic prison environment

In order to improve the accommodation of mental health patients in regular prisons, anti-therapeutic elements – other than those related to treatment and staff, discussed above – should be eliminated from the general prison environment. A first step would be to focus on the factors negatively influencing mental health identified in Section 3.1.2. Working on these factors will reduce the deterioration of mental health in prisons.[236] Also, when addressing these 'negative elements', fulfilling the basic needs of prisoners should simultaneously be high on the agenda. These basic needs are: personal development and support,[237] maintaining intimate relationships,[238] providing exercise and meaningful activities,[239] safety[240] and privacy[241].[242] Overall, the promotion of mental health should be a key element of prison management.[243]

Funding

234 Eric Blaauw & Hjalmar J.C. van Marle, 2007, pp. 139-141 and UNODC, 2009, p. 24.

235 See Graham Duncan & Jan Cees Zwemstra, 2014, p. 90; WHO, 2005, p. 3 and HOSPICE Casa Sperantei Foundation, 2018, p. 4. See also the thematic chapter by Manata in part II of this volume and the national chapters on Hungary, Kazakhstan and the USA. For some best practices see: Semyon Melnikov *et al.*, 'Nurses teaching prison officers: a workshop to reduce the stigmatization of prison inmates with mental illness', 53 *Perspectives in Psychiatric Care* 4 (2017), pp. 251-258.

236 For example, a shift from disciplinary punishment to preventative measures in case of mentally ill detainees is advised by the UNODC, since these detainees often have problems complying with prison rules. See UNODC, 2009, p. 36. See also Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 137.

237 See also the national chapter on Germany.

238 See recommendations in UNODC, 2009, p. 36. See also José Cid *et al.*, 'Does the experience of imprisonment affect optimism about re-entry?', 101 *The Prison Journal* 1 (2021), pp. 80-101, 96. This study demonstrates that experiencing harsh prison conditions makes prisoners more pessimistic about re-entry, while receiving family support during imprisonment has the opposite effect. See also the national chapter on Spain.

239 See recommendations in UNODC, 2009, p. 36. See also the national chapter on Germany.

240 See recommendations in the national chapter on the USA.

241 See the national chapter on Germany.

242 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 137, referring to a study by Toch (1977). According to Blaauw and Van Marle, deterioration of mental health can be prevented by adhering to the Mandela rules and by satisfying the basic needs of prisoners as identified by Toch.

243 UNODC, 2009, p. 10 and the thematic chapter by Vulić Kralj in part II of this volume. For a creative take on improving mental health in prisons see: Jana Söderlund & Peter Newman, 'Improving mental health in prisons through biophilic design', 97 *The Prison Journal* 6 (2017), pp. 750-772.

In general, more funding is needed, both for diversion programs and for mental healthcare in prison.[244] In Section 3.2 it was noted that a possible reason for the scarcity of funds is that prisoners with mental health problems are not high on the political agenda, because of a general intolerance of societies to difficult or disturbing behaviour. If this is the case, a first step in gaining adequate funding is lifting the taboo on mental illness. For, as Alastair Campbell once aptly said,[245] *as long as we are not open about mental health, as we are about physical health, we are not a civilized society*.[246] Creating public support for the advantages of good public mental health in general, and that of detainees in particular, will also be helpful in this respect.

Separate set of UN rules

International legal protection of mentally ill detainees could be further enhanced by drafting specific UN rules for this group, an idea that is supported by the following arguments: other major vulnerable groups, like women and juveniles, are also protected by specific UN rules; the rules applicable to mentally ill defendants and detainees are currently scattered and a specific set of UN rules would assemble and organize this framework; promotion of the applicable framework will be more effective when presented as a coherent set of rules; when international courts get familiar with a set of UN soft law rules, they may reinforce those rules, thereby increasing their legal weight. It is submitted here that a separate set of UN rules on defendants and detainees with mental illness should not only assemble and organize the existing legal framework, it should also introduce new provisions. For example, on the separation of mentally ill defendants and detainees for the purpose of safety,[247] on access to a psychiatrist,[248] on consent to treatment[249] and on restrictions considering disciplinary sanctions.[250]

E. Health or justice

244 UNODC, 2009, pp. 13 and 39.

245 Alastair Campbell (1957) is a British writer and strategist. During the 1990s he was Tony Blair's press secretary. Campbell has a history of serious mental illness.

246 Alastair Campbell on How to Fail, podcast by Elizabeth Day on Spotify (31 October 2018).

247 Although Art. 109 of the Nelson Mandela Rules mentions the possibility for treatment of mentally ill detainees in specialized facilities, it is not a requirement to separate mentally ill defendants from other defendants, as is the case with female, juvenile and untried detainees. See Rule 11 of the Nelson Mandela Rules.

248 Juveniles have access to a psychologist and psychiatrist (Rule 81 Havana Rules), while adults only have access to a mental health professional.

249 This issue is not addressed in the Nelson Mandela Rules, see Section 5.3.2.

250 In case of women and juveniles, disciplinary sanctions are restricted (see for example Rule 23 of the Bangkok Rules and Rules 67 of the Havana Rules). Since the ground for these restrictions lies within the specific vulnerabilities of these groups, a similar argument can be raised for mentally ill detainees.

A consideration of the above recommendations may lead to the following question: who would be responsible for implementing such recommendations, the ministry of health or the ministry of justice? Currently, the prevailing view seems to be that the responsibility for mentally ill offenders lies too heavily in the hands of justice[251] and that it ought to be at least a shared responsibility,[252] perhaps even a health responsibility, according to some.[253] The main argument for more health involvement, set out in Sections 4 and 5, is that the criminal justice system is generally not designed to accommodate mental health patients. As a consequence, committing mental health patients to the criminal justice systems generates many problems. Not only for the detainees themselves, but also for the people working with them and for society as a whole. Another, more theoretical, argument lies in the criminal accountability of mentally ill defendants. When people cannot be – fully – held responsible, the focus should be on care instead of punishment.[254] A tactical reason for more health involvement is that (partly) financing forensic care from health resources will generate a more stable budget. The reason: investments in 'criminals' are less easy to sell to the general public than investments in healthcare.[255]

In order to generate more health involvement, international organizations recommend the inclusion of prisoners' needs in national mental health policies and legislation[256] and a close cooperation between prison and health services.[257] However, a solid *general* mental healthcare policy seems to be a precondition for this cooperation to be successful.[258] What is more, a growing body of scholarship demonstrates that mental health problems are more prevalent among individuals who are socially marginalized owing to socio-economic difficulties.[259] This raises the question of whether the 'health or justice' debate may display

251 See the national chapters on Brazil (according to the law, a health responsibility; in practice, a criminal justice responsibility), Japan and Ireland.

252 UNODC, 2009, p. 22.

253 WHO, 2005, p. 2. See also the national chapters on Greece and Portugal. In Germany, psychiatric hospitals fall under the ministry of social affairs, and detainees are called patients and are treated by medical staff. See the national chapter on Germany.

254 This is also one of the founding principles of the UHSA. See the thematic chapter by Pautrat in part II of this volume, Section 2.

255 See the national chapter on the Netherlands.

256 UNODC, 2009, p. 22 and WHO, 2005, p. 3.

257 UNODC, 2009, p. 22, and HOSPICE Casa Sperantei Foundation, 2018, p. 2. See also the thematic chapters by Morinaga & Yamamoto and by Manata in part II of this volume and the national reports on Germany and Japan. In general, it would also be advisable to involve mental health experts not only in the execution of laws and policies but also in the design. A mental health expert can, for example, better estimate the effect of certain procedural rules (B) or sentencing rules (C) on people with mental illness.

258 Craig Haney, 2020, p. 387 and UNODC, 2009, p. 10.

259 See, for example: Anna Macintyre, Daniel Ferris, Briana Gonçalves & Neil Quinn, 'What has economics got to do with it? The impact of socioeconomic factors on mental health and the case for collective action', 4 *Palgrave Communications* 10 (2018), p. 1–5 and Manuela Silva, Adriana Loureiro & Graça Cardoso, 'Social determinants of mental health: A review of the evidence', 30 *European Journal of Psychiatry* 4 (2016), p. 259-292.

a false dichotomy, since the problem of detainees with mental illness is also rooted in social and economic policies, implying that these departments of the government also have a role to play in resolving the issue.

In addition to the question of the responsibilities of departments, a practical matter must also be addressed by each country willing to make improvements to their system. Namely: where is currently the best place for mentally ill offenders? Where is the funding and the expertise? The location of this place may very well not depend on theoretical arguments referring to the various branches of government but on the systems of health and justice in force.[260]

7 Conclusion

The *numbers* of defendants and detainees with mental illness are so disproportionately high that they should be considered a dominant factor shaping our criminal justice systems. The *causes* of these large numbers are complex and diverse. Some lie within the reaction of our criminal justice system to mentally ill offenders (diversion mechanisms, sanctioning systems, organization of aftercare), while others can be traced back to the reaction of these offenders to the system (negative effect on mental health). Lack of funding and general problems within both the criminal justice and the mental health system are also factors that have led to the current position of the mentally ill offender in the criminal justice system. Ultimately, the above causes can be traced back to the functioning of governments and the way they shape and finance social policies.

The plethora of mentally ill people caught up in the criminal justice chain causes many *problems*. These problems are all rooted in the inability of the system, given its design, to accommodate people with mental illness. This leads to the following difficulties: many defendants are unable to deal with criminal proceedings, there is a lack of adequate professional treatment in detention, mentally ill defendants are accommodated in an unsuitable environment and lack sufficient support in the aftercare trajectory. These factors may, ultimately, contribute to high recidivism among mentally ill detainees.

The problems caused by the current situation have *human rights implications*. Mentally ill persons in the criminal justice system enjoy dual human rights protection, both in their capacity as defendants or detainees and in their capacity as mental health patients. On the basis of these two frameworks, it is submitted that many of the problems generated by the large numbers of mentally ill people caught up in the criminal justice chain consist of

260 See point A (Diversion) above, where the difference between accusatorial and inquisitorial systems is discussed for the purpose of diversion. When justice has traditionally accommodated the mentally ill, mental health institutions lose their expertise.

situations that do not conform to international human rights standards. For example, not offering an extra layer of protection to defendants suffering from a mental illness in the (pre-) trial stage is a violation of international standards. So is a lack of adequate professional treatment – when this treatment is not limited by the basic minimum principle and/or the principle of equivalence – in detention. The detention of unaccountable or later diagnosed and deteriorating mental health patients also contravenes international rules. Because mental health patients may be more vulnerable to the negative effects of the prison environment and because prisons are often not designed (staff, allocation) to accommodate mental health patients, there seems to be a significant risk of violations of international rules and standards in case of detention of mental health patients in regular prisons. Lack of support for mentally ill people in the aftercare trajectory may not only violate the right to liberty and the prohibition of discrimination it is also contrary to the purpose of reintegration, which is the ultimate aim of both prison sentences and of mental health treatment.

In order to improve the situation of mentally ill offenders, four focus points for future law and policy are suggested:

(A) Diversion of the mentally ill from the criminal justice system
More options for diversion should be created. Early screening is an important first step of a solid diversion system. Although it is complex to argue which diversion system is 'the best', several determining parameters of a diversion system are provided: (i) the society's perspective on the concepts of fitness to stand trial and criminal responsibility, (ii) the current national system for mental health and criminal justice, (iii) the current human rights framework and (iv) the scientific views on resocialization.

(B) Ensuring effective participation of the mentally ill defendant in the criminal process
Putting in place special procedures for mentally ill defendants based on international human rights is not all that needs to be ensured in our domestic systems. The execution of these rules, which has proven to be problematic, must also be guaranteed. Two ways to promote the full execution of procedural rules are (i) to provide training for police officers, and other authorities active during the principal stage, in dealing with mental health patients and (ii) to encourage more research on defendants with mental illness who are not detained, to increase the visibility of this group.

(C) Rethinking sentencing laws
Sentencing systems must be re-evaluated for the purpose of reducing elements that increase the number of mentally ill people in prison, such as harsh penalties for several small offences.

(D) Creating suitable accommodations for mentally ill detainees

In case diversion is not conceivable, the best possible circumstances should be created for detainees with mental illness. Several suggestions have been offered to improve the circumstances of mental health patients in regular prisons: the availability of treatment, the training of regular prison staff to deal with mental health patients, the creation of a therapeutic prison environment, the availability of more funding and the drafting of specific UN rules.

On a global level, the responsibility for offenders with mental illness is currently too heavily concentrated in the hands of justice, overlooking the vital need for more health involvement. However, a solid general mental health policy seems to be a precondition for this cooperation to be successful. What is more, ministries of social and economic affairs may also have to play a part in improving the current situation. In the final analysis, the question of the best place for mentally ill detainees is not only a matter of 'whose responsibility?' it also depends on the systems of health and justice in force: this determines where the experts are and where the best care and treatment can be offered.

Ideally, governments should push the situation of mentally ill offenders up on their list of priorities and aim to create a humane place for mentally ill offenders, where professionals can work towards the highest possible level of resocialization, (financially) supported by all relevant branches of the government. This would not only be in the interest of the offenders themselves, but also of the people working with them and society as a whole.

Une perspective juridique sur la situation mondiale des prévenus et des détenus atteints de maladie mentale

Maartje Krabbe[*]

1 Introduction à ce volume

Plus de 10,74 millions de personnes dans le monde sont détenues dans des établissements pénitentiaires. L'on estime que 40 à 90 % de ces détenus souffrent d'une maladie mentale. La prévalence des troubles mentaux chez les détenus est donc extrêmement élevée par rapport à la population générale (prévalence de 18 % à 29 %). Les informations isolées sur les maladies mentales chez les prévenus qui ne sont pas détenus sont rares. Cependant, les chiffres concernant les prévenus détenus peuvent être indicatifs du nombre de prévenus qui ne sont pas détenus.[1] Par conséquent, les prévenus et les détenus atteints de maladie mentale ne constituent pas « un autre groupe vulnérable » dont il faudrait « tenir compte » lors de l'élaboration des lois et des politiques. Au contraire, ils constituent une force dominante, et donc un facteur qui devrait façonner nos systèmes de justice pénale.

Ce volume édité donne un aperçu des causes de la situation actuelle, des implications en matière de droits de l'homme et des autres problèmes que cette situation génère, ainsi que des solutions possibles et des meilleures pratiques. Dans ce contexte, diverses questions sont abordées, telles que : faut-il vraiment emprisonner les délinquants souffrant de troubles mentaux ? Est-il possible de concilier la perspective des droits de l'homme et celle des intérêts de la société sur cette question ? Et : les malades mentaux relèvent-ils de la responsabilité du ministère de la Justice ou du ministère de la Santé ? Outre un débat approfondi sur ces questions et bien d'autres, ce projet vise à contribuer à un effort continu pour mettre la situation alarmante des malades mentaux à l'ordre du jour international.

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1 Voir la section 2 pour les fondements scientifiques de ces chiffres et une représentation plus approfondie des statistiques pertinentes.

En ce qui concerne la structure de ce livre : ce volume contient sept chapitres thématiques rédigés par des autorités sur des sujets spécifiques, quatorze chapitres nationaux décrivant la situation des délinquants malades mentaux dans divers pays et le présent chapitre introductif. Ce chapitre introductif présente dans un premier temps une introduction à ce volume. Tout d'abord, plusieurs définitions, pertinentes pour la clarification du sous-titre de ce volume, sont fournies (section 1.1). Ensuite, un plan du volume est présenté (1.2) présentant un bref résumé des sept chapitres thématiques de la partie II (1.2.1), expliquant la structure des chapitres nationaux de la partie III (1.2.2.) et fournissant une introduction aux sections suivantes du présent chapitre (1.2.3.).Ces sections (section 2-7) ont pour but de fournir une large introduction au sujet des prévenus et des détenus atteints de maladie mentale : en premier lieu en présentant une analyse des chapitres nationaux et thématiques, en second lieu en évoquant cette analyse au regard de sources supplémentaires (règles internationales, littérature scientifique, rapports d'organisations internationales, statistiques) et en troisième lieu en fournissant une analyse juridique de la situation actuelle. Ce chapitre se termine par des recommandations sous la forme de quatre points d'attention pour la législation et la politique futures.

1.1 Définitions

Plusieurs définitions sont pertinentes pour clarifier le titre de ce volume. Les concepts de *maladie mentale*, de *défendeur* et de *détenu* sont présentés ci-dessous assortis d'un certain contexte. Aux fins du présent ouvrage, la *maladie mentale* doit être comprise au sens large, c'est-à-dire qu'il s'agit d'un état psychiatrique qui perturbe le comportement, la pensée ou l'humeur d'une personne à un point tel qu'il entraîne une souffrance ou une faible capacité à fonctionner dans la vie.[2] Tout au long de cet ouvrage, des concepts tels que la perturbation

2 Pour une approche clinique officielle de la maladie mentale, voir la définition du DSM-5 : *Un trouble mental est un syndrome caractérisé par une perturbation cliniquement significative de la cognition, de la régulation des émotions ou du comportement d'un individu qui reflète un dysfonctionnement des processus psychologiques, biologiques ou développementaux qui sous-tendent le fonctionnement mental. Les troubles mentaux sont généralement associés à une détresse ou à une incapacité significative dans les activités sociales, professionnelles ou autres activités importantes. Une réponse prévisible ou culturellement approuvée à un facteur de stress commun ou à une perte, comme la mort d'un être cher, ne constitue pas un trouble mental. Les comportements socialement déviants (par exemple, politiques, religieux ou sexuels) et les conflits qui opposent principalement l'individu à la société ne sont pas des troubles mentaux, à moins que la déviance ou le conflit ne résulte d'un dysfonctionnement de l'individu, tel que décrit ci-dessus* (American Psychiatric Association, *Diagnostic and statistical manual of mental disorders*, fifth edition (DSM-V), 2013, p. 20. Voir également la définition des troubles mentaux de l'OMS : *Les troubles mentaux représentent des perturbations de la santé mentale d'une personne qui se caractérisent souvent par une certaine combinaison de pensées, d'émotions, de comportements et de relations avec autrui perturbés. La dépression, les troubles anxieux, les troubles du comportement, les troubles bipolaires et les psychoses sont des exemples de troubles mentaux* (OMS, *Santé mentale : fiche d'information*, 2019, p. 1). Et la définition de la « santé mentale » de l'OMS :

psychiatrique, la perturbation mentale et le trouble mental sont utilisés de manière interchangeable. Un *défendeur* (synonyme : accusé) est une personne accusée d'un crime, contre laquelle une procédure pénale est dirigée. Un défendeur est donc une personne qui se défend dans les procédures préalables au procès et au procès. Un *détenu* est une personne qui est privée de sa liberté par les autorités. Le terme « détenu » doit être compris au sens large, car il englobe aussi bien les personnes en détention provisoire que celles en prison. La détention provisoire concerne les personnes qui n'ont pas encore été condamnées définitivement, c'est-à-dire les personnes en détention provisoire - qui comprend à la fois la garde à vue et la détention préventive - et les personnes en détention de jugement, c'est-à-dire les personnes détenues pendant le procès mais avant la condamnation définitive. Les prisonniers sont des personnes détenues qui ont été définitivement condamnées.

1.2 Aperçu du présent volume

1.2.1 Les chapitres thématiques

Une approche thématique de la maladie mentale et du droit pénal est présentée dans la deuxième partie de ce volume. Dans cette partie, sept professionnels de diverses régions du monde présentent un avis d'expert sur la situation des prévenus et des détenus atteints de maladie mentale.

Les effets négatifs de la privation de liberté sur la santé mentale sont abordés par **Olivera Vulić Kralj**. Vulić Kralj soutient que les détenus, qu'ils aient ou non des problèmes de santé mentale antérieurs, subissent les effets psychologiques négatifs de l'emprisonnement. Par conséquent, l'emprisonnement a souvent l'effet inverse de l'objectif visé (prévenir les récidives futures et renforcer la sécurité publique). Vulić Kralj met en avant plusieurs règles internationales qui protègent les prisonniers ayant des problèmes de santé mentale. Cependant, ces règles ne sont souvent pas respectées. L'auteur aborde également les effets néfastes des mesures disciplinaires et la réponse souvent inappropriée aux prisonniers suicidaires. Cette dernière a parfois entraîné des violations des articles 2, 3 et/ou 5 de la Convention européenne des droits de l'homme (CEDH). Vulić Kralj soutient que des alternatives à la détention devraient être disponibles pour les personnes atteintes de troubles mentaux, qui ne représentent pas une menace pour la sécurité publique. Elle souligne également que tous les détenus devraient se voir proposer des services de santé d'un niveau équivalent à ceux de la communauté. L'auteur ajoute en outre que des examens de santé

La santé mentale est un état de bien-être dans lequel un individu prend conscience de ses propres capacités, peut faire face aux stress normaux de la vie, peut travailler de manière productive et est capable d'apporter une contribution à sa communauté (OMS, *Santé mentale : fiche d'information*, 2019, p. 1).

mentale devraient être effectués lors de l'admission en prison et qu'un personnel pluridisciplinaire devrait être présent à tout moment. De manière générale, conclut Vulić Kralj, les conditions de détention devraient *favoriser* le bien-être mental de toutes les personnes privées de liberté.

Oscar Bloem, **Robbert-Jan Verkes** et **Erik Bulten** présentent une méta-étude internationale sur les détenus atteints de troubles mentaux. L'étude se concentre sur la prévalence de la maladie mentale, le développement des symptômes et la récidive. Les données démontrent que la prévalence de tous les types de troubles mentaux chez les détenus est élevée par rapport à la population générale. En outre, la prévalence des troubles mentaux est en général plus élevée chez les femmes que chez les hommes détenus. Selon les auteurs, on constate une amélioration des symptômes de santé mentale au fil du temps pendant l'incarcération, notamment en ce qui concerne les symptômes dépressifs et anxieux. En ce qui concerne la relation entre les troubles mentaux et la récidive, il existe un résultat répété sur l'existence d'une relation entre les troubles liés aux substances et la récidive. Tout au long de l'article, les auteurs abordent les explications des différences entre les études sur les troubles mentaux. Les auteurs concluent en recommandant des recherches supplémentaires - en particulier dans le cadre d'études longitudinales - sur la combinaison complexe de facteurs personnels et circonstanciels qui peuvent être liés aux modifications des symptômes de santé mentale pendant l'emprisonnement.

Les auteurs **Taro Morinaga** et **Mana Yamamoto** partagent leurs réflexions sur la question fondamentale de savoir comment la société doit aborder les condamnés souffrant de maladies mentales. Doivent-ils rester en prison ? Ou doivent-ils être soumis à un programme de traitement ? Les auteurs mettent en lumière les différents intérêts de la justice pénale et des soins de santé et abordent la question de l'équilibre entre ces intérêts. Ils font plusieurs suggestions de politiques, en tenant compte des différents acteurs dans le domaine de la justice pénale et des budgets divergents des États. Les auteurs concluent leur contribution en soulignant que la coopération de différents experts et institutions est une condition absolue pour parvenir à une meilleure politique pour les prisonniers ayant des problèmes psychiatriques.

La contribution de **Piet Hein van Kempen** apporte une perspective des droits de l'homme sur les accusés ayant des capacités mentales perturbées ou limitées au stade de la préparation du procès et du procès. Son analyse se fonde sur la CEDH, la Convention américaine relative aux droits de l'homme (CADH) et le Pacte international relatif aux droits civils et politiques (PIDCP). La jurisprudence de plusieurs tribunaux pénaux internationaux et hybrides est également incluse dans l'analyse. Après avoir démontré que peu de chiffres sont disponibles sur les défendeurs souffrant de problèmes mentaux, Van Kempen aborde les principes fondamentaux qui sous-tendent les droits des défendeurs souffrant d'incapacités mentales : l'adversité, l'égalité des armes et la non-discrimination. Ensuite, il examine si ces principes permettent un niveau de protection des défendeurs

atteints d'incapacités mentales dans un système accusatoire différent de celui d'un système inquisitoire. Les sections centrales de la contribution examinent les droits spécifiques à la procédure équitable pour les défendeurs atteints d'incapacités mentales et les obligations des autorités dans de tels cas, à savoir : les garanties de participation effective des défendeurs pendant le procès et les garanties d'équité pendant les interrogatoires de police. La contribution se termine par dix recommandations visant à sécuriser la situation juridique des prévenus atteints d'incapacité mentale.

La perspective des droits de l'homme sur la détention est fournie par **Małgorzata Wąsek-Wiaderek**. L'objectif de ce chapitre thématique est double. En premier lieu, il donne un aperçu des normes internationales en matière de droits de l'homme applicables aux détenus souffrant de handicaps mentaux. Wąsek-Wiaderek se concentre particulièrement sur le droit à la vie, l'interdiction des traitements inhumains ou dégradants et le droit à la liberté. À cette fin, elle présente une liste d'affaires sur ces sujets, provenant principalement de la Cour européenne des droits de l'homme. En outre, elle dresse également un inventaire des instruments de soft law. En second lieu, le chapitre de Wąsek-Wiaderek traite de la question de savoir si la détention - au lieu de l'hospitalisation - des personnes atteintes de graves handicaps mentaux est conforme aux normes des droits de l'homme. L'auteur conclut que les points de vue sur cette question, d'une part, de la CEDH et du PIDCP et, d'autre part, de la Convention relative aux droits des personnes handicapées (CDPH) peuvent être incompatibles. Alors que les deux premières conventions autorisent la privation de liberté d'une personne « non saine d'esprit » lorsque celle-ci représente une menace pour elle-même ou pour autrui, l'article 14 de la CDPH prévoit que « l'existence d'un handicap ne peut en aucun cas justifier une privation de liberté ». Toutefois, cette incompatibilité doit être nuancée, car l'article 14 de la CDPH a été interprété à la lumière du critère de la CEDH/du PIDCP. De même, la Cour européenne des droits de l'homme (CEDH) a interprété les dispositions pertinentes de la Convention à la lumière de la CDPH, accordant plus d'autonomie aux personnes handicapées mentales. Wąsek-Wiaderek espère que cette évolution à la CEDH renforcera les garanties procédurales pour les personnes privées de liberté en raison de leur handicap mental.

Celso Manata évoque deux groupes distincts de prisonniers souffrant de troubles psychiatriques. Le premier groupe est composé de prisonniers qui ont été jugés pénalement responsables de leurs actes, malgré leur maladie mentale. Le second groupe est composé de patients atteints de maladies psychiatriques qui ont été condamnés à une mesure de sécurité à exécuter par le système pénitentiaire. Pour chaque groupe, Manata décrit les défis spécifiques, principalement du point de vue de la gestion des prisons. La plupart de ces défis sont liés à la recherche d'un équilibre entre le traitement d'une part et le contrôle d'autre part. Manata termine sa contribution par un aperçu des différentes actions initiées au Portugal pour combler le fossé entre le traitement et le contrôle. La plupart de ces actions sont basées sur une coopération entre le ministère de la justice et le ministère de la santé.

Afin de proposer une réaction plus adéquate aux détenus souffrant de graves problèmes de santé mentale, la France a introduit en 2012 des *Unités Hospitalières* Spécialement *Aménagées* (UHSA en abrégé). La contribution de **Catherine Pautrat** fournit une explication et une évaluation de ces UHSA. Les UHSA sont des unités au sein d'un établissement de santé, prenant en charge des personnes - initialement placées sous la main de justice - qui nécessitent des soins psychiatriques sous forme d'hospitalisation complète. Ces UHSA ont été fondées sur deux principes fondamentaux : (a) la primauté des soins (sur la sanction) et (b) l'idée d'une double prise en charge : les détenus restent en détention pendant l'hospitalisation et continuent d'exécuter leur peine. En conséquence, les coûts de l'UHSA sont répartis entre le ministère de la santé (90 %) et l'administration pénitentiaire (10 %). Une évaluation des UHSA révèle qu'en 2014, 60 % des hospitalisations complètes ont eu lieu en UHSA ; dans les UHSA, la primauté est donnée aux soins ; dans les UHSA, les incidents justifiant l'intervention du personnel pénitentiaire sont rares ; les personnes séjournent en moyenne 45 jours dans les UHSA et les taux d'occupation des unités varient entre 82 % et 93 %. Dans l'ensemble, les UHSA sont considérées comme un succès. Toutefois, M. Pautrat estime qu'il existe plusieurs points à améliorer. En raison des taux d'occupation élevés, les délais d'attente peuvent atteindre plusieurs semaines. De plus, certaines régions n'ayant pas encore d'UHSA, il faudrait en créer davantage pour éviter une rupture d'égalité dans la prise en charge des détenus. Enfin, le développement des UHSA n'a de sens que s'il s'accompagne d'un renforcement du dispositif de prise en charge sanitaire des personnes détenues à tous les niveaux (traitement ambulatoire et admissions de jour).

1.2.2 Chapitres nationaux

Les chapitres nationaux de ce volume sont basés sur un questionnaire auquel les professionnels de 14 pays ont répondu au cours de la période 2017-2021. Les États déclarants sont : Brésil, Chili, Allemagne, Grèce, Hongrie, Irlande, Japon, Kazakhstan, Pays-Bas, Nouvelle-Zélande, Pologne, Portugal, Espagne et États-Unis. Chacun des rapports nationaux présente une structure similaire. Après une brève introduction, l'accent est mis sur la situation des prévenus souffrant de problèmes de santé mentale pendant l'enquête préliminaire et le procès. Ensuite, les détenus souffrant de troubles psychiatriques pendant la détention provisoire sont abordés, après une présentation des questions relatives aux détenus souffrant de troubles mentaux (détenus condamnés). Avant d'aborder la fin de la chaîne pénale - la réintégration dans la communauté des détenus souffrant de problèmes de santé mentale - un éclairage est apporté sur la responsabilité du traitement des détenus souffrant de troubles psychiatriques. Cette responsabilité doit-elle incomber au département de la santé ou à celui de la justice pénale ? Dans la dernière partie du rapport, les auteurs présentent des conclusions fondées sur la situation dans leur pays.

1.2.3 Présent chapitre

Les sections suivantes de ce chapitre visent à fournir une introduction générale sur la situation des prévenus et des détenus atteints de troubles mentaux dans le monde. Dans un premier temps, une vue d'ensemble des études internationales sur le *nombre d*'accusés et de détenus souffrant de troubles mentaux est présentée (section 2). Ces chiffres sont relativement élevés. Il convient donc d'examiner les *causes* possibles de ce nombre disproportionné (section 3). La section 4 est consacrée aux *problèmes* générés par le nombre disproportionné de malades mentaux dans la chaîne de la justice pénale. Ensuite, ces problèmes sont traduits en *implications pour les droits de l'homme* (section 5). La section 6 fournit des *recommandations*, basées sur ce qui précède. Un résumé des sections 2 à 6 est fourni dans la section 7 (conclusion). L'introduction ci-dessous est basée sur les informations fournies dans les chapitres nationaux et thématiques de ce volume et sur des documents complémentaires (règles internationales, littérature scientifique, rapports d'organisations internationales, statistiques).

2 Les prévenus et les détenus atteints de maladie mentale : les chiffres

Comme indiqué dans l'introduction de ce chapitre, plus de 10,74 millions de personnes sont détenues dans des établissements pénitentiaires dans le monde.[3] L'on estime que 40 à 90 %[4] de ces détenus[5] souffrent de troubles mentaux.[6] La prévalence des troubles mentaux

3 Roy Walmsley, *World Prison Brief* (12e édition), 2018.

4 La marge assez large - causée par les différences de résultats - peut s'expliquer par la population spécifique étudiée (par exemple, les hommes et/ou les femmes, les prisonniers en détention provisoire et/ou les prisonniers condamnés), une variation dans la méthodologie (par exemple, une définition large ou étroite des « troubles mentaux »), si la pathologie actuelle ou à vie est abordée, et par la politique de santé mentale spécifique dans la partie du monde étudiée dans la recherche (plus les délinquants malades mentaux sont détournés du système de justice pénale, plus le nombre de malades mentaux en prison est faible). Voir le chapitre thématique de la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten, sections 2 et 5.

5 Les pourcentages sont encore plus élevés chez les femmes détenues. Voir le chapitre thématique de la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten, sections 2 et 5. Voir également les chapitres nationaux sur la Nouvelle-Zélande et le Kazakhstan.

6 Voir l'analyse de diverses études dans la section 2 du chapitre thématique de la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten. Pour un aperçu de la plupart des autres études affichant des chiffres similaires, voir : Alice Mills & Kathleen Kendall, 'Introduction', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, p. 1-22, p. 1/2 ; Graham Duncan & Jan Cees Zwemstra, 'Mental health in prison', in: OMS, *Prisons et santé*, 2014, p. 87-95, p. 88 et le chapitre thématique de la partie II du présent volume par Van Kempen, section 2. Pour les derniers chiffres reflétant la prévalence des maladies mentales dans les prisons et les établissements pénitentiaires aux États-Unis, voir : E. Fuller Torrey *et al*, *The treatment of persons with mental illness in prisons and jails: A state Survey*, Arlington, VA: Treatment Advocacy Center, 2014, p. 111 (à l'adresse : https://www.treatmentadvocacycenter.org). Plusieurs chapitres nationaux

chez les détenus est donc extrêmement élevée par rapport à la population générale (prévalence de 18 % à 29 %).[7] Qui plus est, la prévalence des problèmes de santé mentale chez les détenus pourrait être encore plus élevée que ne le reflètent ces chiffres. Premièrement, parce que tous les cas de maladie mentale ne sont pas signalés, enregistrés ou disponibles.[8] Deuxièmement, parce que l'impact de la pandémie actuelle de Covid-19 est présumé avoir une incidence énorme sur la santé mentale des détenus.[9] Troisièmement, parce que la recherche sur les prisons a tendance à se concentrer sur le terme médicalisé de la maladie mentale. Cependant, il existe également un groupe de détenus qui n'est ni malade ni en bonne santé mentale. Cette zone grise de « bien-être mental » ou de « détresse mentale » a rarement été mesurée.[10]

Quant à la prévalence mondiale de certains types de maladies mentales, environ 4 % des détenus souffrent de psychose, 11 % de troubles dépressifs et 20 % de troubles anxieux. Le TDAH est présent chez environ 25 % des détenus. Les études sur les troubles liés à l'abus de substances présentent de grandes différences, avec des taux de prévalence allant jusqu'à

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soulignent également la prévalence relativement élevée de la maladie mentale chez les détenus. Voir par exemple les chapitres consacrés au Brésil, à la Grèce, au Japon, au Kazakhstan, à la Nouvelle-Zélande, à l'Espagne et aux États-Unis.

7 Voir l'analyse de diverses études dans la section 2 du chapitre thématique de la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten et Alice Mills & Kathleen Kendall, 2018, p. 2.

8 Le manque de chiffres précis est signalé par l'Allemagne, le Brésil, le Chili, l'Espagne, la Hongrie et la Nouvelle-Zélande. Les auteurs du chapitre national sur le Chili soulignent l'importance des chiffres : lorsque les chiffres font défaut, un groupe est invisible. Par conséquent, il sera difficile de mettre en place une politique adaptée et les droits risquent de ne pas être protégés. Voir aussi : Fondation HOSPICE Casa Sperantei, *MenACE : Santé mentale, vieillissement et soins palliatifs dans les prisons européennes*, 2018, p. 2 et section 3 ci-dessous sur les problèmes de dépistage.

9 Bien que les recherches sur l'influence du Covid-19 sur la santé mentale des *prisonniers* soient encore rares (voir par exemple : Jucier Gonçalves Júnior *et al*, 'Analysis of the prison population's mental health in Sars-Cov-2 pandemic: Qualitative analysis', 296 *Psychiatry Research* (2021), p. 1-6, p. 5) et quelque peu ambiguës (voir : Thomas Hewson *et al.* , 'The effects of COVID-19 on self-harm in UK prisons', 45 *BJPsych Bulletin* 3 (2020), p. 131-133, p. 131. L'article démontre, entre autres, une réduction des incidents d'automutilation pendant la pandémie), des études ont établi l'influence négative de la pandémie sur la santé mentale de la population *générale* (voir pour un résumé de plusieurs études : Geraldine Pearson, "The mental health implications of Covid-19", 26 *Journal of the American Psychiatric Nurses Association* 5 (2020), p. 443-444). Qui plus est, de nombreux experts ont exprimé leurs inquiétudes quant à l'impact de la pandémie sur la santé mentale des détenus. Voir par exemple : Thomas Hewson *et al*, "Effects of the COVID-19 pandemic on the mental health of prisoners", 7 *The Lancet* 7 (2020), p. 568-570; Lauren K. Robinson, Reuben Heymar-Kantor & Cara Angelotta, "Strategies mitigating the impact of the COVID-19 pandemic on incarcerated populations", 110 *American Journal of Public Health* 8 (2020), p. 1135-1136; A. Ogunwale *et al*, 'Forensic mental health service implications of COVID-19 infection in Nigeria', 1 *Forensic Science International: Mind and Law* (2020), p. 1-3 et Claire Shiple & Pracha Peter Eamranond, 'Letter to Editor - The disproportionate negative impacts of COVID-19 on the mental health of prisoners', 66 *Journal of Forensic Sciences* 1 (2021), p. 413-414.

10 Emily Tweed, Xanthippi Gounari & Lesley Graham, 'Mental wellbeing in prisoners in Scotland', 392 *The Lancet* supplement 2 (novembre 2018), p. S11. À la connaissance des auteurs, il s'agit de la seule étude rapportée sur le bien-être mental dans une population carcérale nationale. Voir également Alice Mills & Kathleen Kendall, 2018, p. 4 pour une large perspective sur la santé mentale en prison.

69 %. Les chiffres de prévalence des troubles de la personnalité (antisociale) varient également, avec des taux allant jusqu'à 80 %. Les études sur les dysfonctionnements intellectuels et l'autisme chez les détenus sont rares. Cependant, la littérature suggère une surreprésentation des personnes autistes en prison.[11]

Le nombre de suicides en prison est élevé, comparé à celui de la population générale.[12] Des études montrent également que ces suicides ont augmenté au cours des dernières décennies[13], qu'ils sont plus fréquents chez les jeunes détenus[14], qu'ils sont souvent commis peu de temps après la détention[15] et qu'ils sont constatés chez des détenus ayant des problèmes de santé mentale préexistants[16].

Les chiffres ci-dessus font référence aux détenus en détention provisoire et aux prisonniers. Les chiffres concernant les maladies mentales des prévenus en garde à vue et des prévenus qui ne sont pas détenus sont limités. D'après quatre études nationales, entre 29 et 75 % des personnes en garde à vue ont un problème de santé mentale[17]. L'on a constaté que près d'un cinquième des personnes placées en garde à vue présentaient un risque de suicide[18]. Bien qu'il ne semble pas exister d'informations isolées sur les maladies mentales

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11 Pour une vue d'ensemble des différents types de troubles mentaux chez les détenus, voir la section 2 du chapitre thématique de la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten.

12 Pour un aperçu modeste des études internationales, voir : Stefan Fruehwald *et al*, 'Suicide in custody: case-control study', 185 *British Journal of Psychiatry* 6 (2004). p. 494-498, p. 494. Voir également : UNODC, 'Prisoners with mental health care needs', in: *Handbook on prisoners with special needs*, UN Publication, 2009, p. 9-42, renvoyant à la page 16 à un article de synthèse mondial autrichien sur le sujet ; OMS, *Mental health and prisons* (information sheet), 2005, p. 1 ; HOSPICE Casa Sperantei Foundation, *MenACE: Mental health, aging and palliative care in European prisons*, 2018, p. 1 (faisant état de suicides en prison jusqu'à dix fois supérieurs à ceux de la population générale). Pour les études nationales, voir : Seena Fazel, Ram Benning & John Danesh, 'Suicides in male prisoners in England and Wales, 1978-2003', 366 *The Lancet* 9493 (2005), p. 1301-1302 (constatant un excès de suicide cinq fois supérieur chez les détenus masculins) ; Alice Mills & Kathleen Kendall, 2018, p. 2 (faisant référence à un rapport du ministère de la Justice affichant un risque de mort auto-infligée 8,6 fois plus élevé en prison) et les chapitres nationaux sur le Chili, le Kazakhstan et les États-Unis.

13 Seena Fazel, Ram Benning & John Danesh, 2005, p. 1301 ; Alice Mills & Kathleen Kendall, 2018, p. 5 et UNODC, 2009, p. 16.

14 Seena Fazel, Ram Benning & John Danesh, 2005, p. 1301. Voir aussi le chapitre national sur l'Allemagne.

15 Le Sentencing Project rapporte que 50 % des suicides aux États-Unis ont eu lieu au cours des 24 premières heures de détention. Voir : The Sentencing Project, *Mentally ill offenders in the criminal justice system: an analysis and prescription*, USA, 2002, p. 18.

16 UNODC, 2009, p. 16.

17 Gennady N. Baksheev, Stuart D.M. Thomas & James R.P. Ogloff, 'Psychiatric disorders and unmet needs in Australian police cells', 44 *Australian and New Zealand Journal of Psychiatry* 1 (2010), p. 1043-1051, p. 1046 (constatant une prévalence de 75 %) ; Tina Dorn *et al*., "Mental health and health-care use of detainees in police custody", 26 *Journal of Forensic and Legal Medicine* (2014), p. 24-28, p. 25 (constatant une prévalence de 49,8 %); Iain G. McKinnon & Don Grubin, 'Health screening of people in police custody-evaluation of current police screening procedures in London, UK', 23 *The European Journal of Public Health* 3 (2013), p. 399-405, p. 402 (constatant une prévalence de 39 %) et Chiara Samele *et al*, 'The prevalence of mental illness and unmet needs of police custody detainees', *Criminal Behaviour and Mental Health* 2 (2021), p. 80-95, p. 88 (constatant une prévalence de 29-39 %).

18 Chiara Samele *et al*. 2021, p. 89.

des prévenus qui ne sont pas détenus[19], les chiffres ci-dessus concernant les prévenus détenus peuvent être indicatifs du nombre de prévenus qui ne sont pas détenus[20].

Globalement, si l'on se base sur les chiffres, les prévenus et les détenus atteints de maladies mentales représentent une part importante de la population carcérale, et il s'agit d'un phénomène mondial. Par conséquent, ces défendeurs ne sont pas un détail mineur lors de la conception des politiques, mais un facteur dominant qui devrait façonner notre système de justice pénale[21].

3 Les prévenus et les détenus atteints de maladie mentale : les causes

Cette section traite des raisons possibles du nombre disproportionné de prévenus et de détenus souffrant de troubles mentaux. Ces raisons sont divisées en causes systémiques (3.1.) et en raison de causes systémiques (3.2). Les causes systémiques sont enracinées dans le *système de* justice pénale. Elles sont présentées selon deux perspectives : comment le système traite la maladie mentale (3.1.1) et comment les défendeurs et les détenus traitent avec le système (3.1.2). La section 3.2 plonge dans les raisons qui se cachent derrière les causes systémiques, telles que les considérations politiques sous-jacentes et les problèmes sociétaux qui peuvent éventuellement contribuer au nombre élevé de détenus atteints de maladie mentale. Certaines de ces causes sont étayées par des preuves scientifiques, tandis que d'autres sont plutôt des observations de praticiens ou des hypothèses.

3.1 Causes systémiques

3.1.1 Comment le système traite la maladie mentale

Il est généralement admis que les malades mentaux sont une partie vulnérable du processus pénal[22] et qu'ils ne peuvent souvent pas être tenus pleinement responsables de leurs actes[23].

19 Comparez à une conclusion similaire sur les défendeurs dans le chapitre thématique de la partie II de ce volume par Van Kempen, section 2.

20 Voir le chapitre thématique de la partie II de ce volume par Van Kempen, section 2.

21 Comparez au chapitre thématique de la partie II de ce volume par Van Kempen, section 2, où l'auteur affirme que les prévenus et les détenus atteints de maladies mentales sont « si courants qu'aucun système de justice pénale ne peut considérer ces incapacités des prévenus comme un détail mineur qui peut être ignoré dans le schéma plus large de la justice pénale ».

22 Voir par exemple le chapitre thématique de Van Kempen dans la partie II du présent volume, section 1. et 4.2.

23 Voir par exemple : M.J.F. van der Wolf & H.J.C. van Marle, 'Legal approaches to criminal responsibility of mentally disordered offenders in Europe', in: K. Goethals (ed.), *Forensic Psychiatry and Psychology in Europe. Un guide d'étude transfrontalier*, Bâle : Springer International Publishing, 2018, p. 31-44.

Par conséquent, la plupart des États ayant répondu au questionnaire disposent de règles et de procédures spéciales pour les accusés et les détenus atteints de maladie mentale. Cependant, malgré ces procédures spéciales, plusieurs aspects inhérents aux systèmes de justice pénale peuvent contribuer à un nombre disproportionné de prévenus et de détenus atteints de maladie mentale. Un facteur crucial semble être le fonctionnement des mécanismes de déjudiciarisation. Les mécanismes de déjudiciarisation sont des dispositions et des politiques qui visent à détourner le défendeur atteint de maladie mentale du système de justice pénale vers une division du système de justice pénale plus axée sur les soins ou vers le système de santé (mentale). L'absence totale de système de déjudiciarisation fait sans aucun doute augmenter le nombre de détenus souffrant de troubles mentaux[24]. De même, les failles des mécanismes de déjudiciarisation existants peuvent contribuer à augmenter le nombre de malades mentaux en détention[25]. Un problème majeur dans de nombreux systèmes semble être le manque de dépistage approfondi des maladies mentales[26]. L'absence de détection de la maladie mentale à un stade précoce a plusieurs conséquences. Premièrement, le défendeur atteint de maladie mentale n'est pas détourné du système de justice pénale dans les cas où il aurait dû l'être. Deuxièmement, un prévenu non reconnu comme malade mental ne bénéficie pas de garanties supplémentaires[27] pour exercer ses droits procéduraux (par exemple, le droit de garder le silence ou d'être représenté par un avocat)[28], ce qui peut augmenter les chances d'obtenir des aveux et, en fin de compte, une (fausse) condamnation.[29] Un autre problème de la déjudiciarisation qui fait augmenter les

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24 Voir le chapitre national sur le Japon. Toutefois, au Japon, cette carence est quelque peu compensée par la décision de ne pas engager de poursuites dans le cas d'un défendeur souffrant de troubles mentaux.

25 Voir les chapitres nationaux sur l'Allemagne, l'Irlande et les États-Unis. Voir également le chapitre thématique de Taro Morinaga & Mana Yamamoto dans la partie II de ce volume, section 2.

26 UNODC, 2009, p. 14 et HOSPICE Casa Sperantei Foundation, 2018, p. 2. Voir également les chapitres nationaux sur l'Allemagne, la Pologne et les États-Unis. Il est intéressant de noter que le moment du premier dépistage de la personne mise en cause diffère grandement, allant de 24 heures (Allemagne) à avant la décision d'engager des poursuites (voir le chapitre national sur le Japon), en passant par le stade des poursuites (voir le chapitre national sur la Hongrie), jusqu'à l'absence totale de dépistage (voir le chapitre national sur la Grèce). L'absence de contrôle structurel a également été mentionnée comme étant un problème (voir le chapitre national sur les Pays-Bas).

27 De plus, compte tenu des garanties supplémentaires existantes pour les accusés souffrant de troubles mentaux, des améliorations sont également possibles. Voir le chapitre national sur les Pays-Bas.

28 Voir le chapitre national sur les États-Unis. Dans les sections 4.1 et 5.2, la position procédurale du défendeur malade mental est discutée plus en détail.

29 Voir les chapitres nationaux sur le Kazakhstan, les Pays-Bas et les États-Unis. Au Portugal, un aveu est une preuve suffisante pour imposer une peine inférieure à cinq ans. Voir le chapitre national sur le Portugal. En Irlande, un verdict d'aliénation mentale n'est plus possible en cas de plaidoyer de culpabilité. Voir le chapitre national sur l'Irlande. La littérature démontre également que les accusés vulnérables (jeunes accusés, accusés souffrant de problèmes mentaux) sont plus susceptibles d'avouer. Voir par exemple Brandon L. Garrett, 'The substance of false confessions', 62 *Stanford Law Review* 4 (2010), p. 1051-1191 ; Robert Perske, 'Perske's list: False confessions from 75 persons with intellectual disability', 49 *Intellectual and developmental disabilities* 5 (2011), p. 365-373 et UNODC, 2009, p. 12. Cependant, la recherche a également établi que les « personnes normales » sont susceptibles d'avouer lorsqu'elles sont confrontées à de fausses preuves

chiffres est que, bien que des règles de déjudiciarisation existent, il y a un écart entre les politiques de déjudiciarisation existantes et la loi en vigueur[30] La déjudiciarisation est également problématique lorsqu'il n'existe aucun moyen de déjudiciarisation dans des situations spécifiques, par exemple lorsque l'arrestation est la seule possibilité de traiter la situation[31], une politique efficace pour les « cas plus légers » fait défaut[32]. Enfin, les retards dans le transfert vers les hôpitaux psychiatriques augmentent également le nombre de malades mentaux en détention[33].

Les *systèmes de sanctions et de punitions* peuvent également contribuer à un nombre disproportionné de détenus atteints de maladies mentales. D'une manière générale, le fait que notre système de justice pénale soit basé sur la « fiction juridique du libre choix » a été avancé comme un facteur poussant les malades mentaux vers la prison[34]. C'est particulièrement le cas lorsqu'il est difficile d'obtenir un plaidoyer d'aliénation mentale[35]. Il en va de même si l'on considère la maladie mentale comme une circonstance aggravante[36] ou comme une circonstance atténuante[37]. La raison : dans les deux cas, une peine peut être imposée au lieu d'un traitement. De plus, lorsqu'un système oblige un tribunal à choisir entre une peine et un traitement, celui-ci peut opter pour une peine afin d'éviter la récidive[38], surtout lorsque les structures médico-légales disponibles sont peu nombreuses[39]. Enfin, les politiques de condamnation, qui imposent des peines sévères en cas de récidive non

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incriminantes. Voir : Robert Horselenberg, Harald Merkelbach & Sarah Josephs, 'Individual differences and false confessions: A conceptual replication of Kassin and Kiechel (1996)', 9 *Psychology, crime and law* 1 (2003), p. 1-8.

30 Alice Mills & Kathleen Kendall, 2018, p. 4/5. Voir également le chapitre national sur la Pologne. Dans les chapitres nationaux sur l'Irlande et le Portugal, ce problème est également mentionné, sans établir de relation directe avec les chiffres.

31 Voir la section 1 du chapitre thématique de Van Kempen dans la partie II de ce volume. Il est intéressant de noter que Van Kempen démontre également qu'en général, les risques d'être arrêté sont nettement plus élevés dans le cas des personnes souffrant de maladies mentales.

32 Voir HOSPICE Fondation Casa Sperantei, 2018, p. 2. Voir également les chapitres nationaux sur l'Allemagne et l'Irlande.

33 Voir le chapitre national sur l'Irlande. Voir également le chapitre thématique de Morinaga & Yamamoto dans la partie II de ce volume, section 2.

34 Craig Haney, *Criminality in Context: A Psychological Foundation of Criminal Justice reform*, American Psychological Association, 2020, p. 386.

35 Voir le chapitre thématique de Morinaga & Yamamoto dans la partie II de ce volume, section 2. Voir également le chapitre national sur l'Allemagne.

36 Voir le chapitre national sur les États-Unis, où la responsabilité diminuée peut être une circonstance aggravante lorsque l'état mental du défendeur augmente le risque de récidive.

37 Voir le chapitre thématique de Morinaga & Yamamoto, dans la partie II de ce volume, section 2. Voir également le chapitre national sur l'Irlande, où l'on fait valoir que l'utilisation de la responsabilité atténuée et de la mauvaise santé mentale comme *facteur atténuant* peut être plus efficace lorsqu'elle est associée à une option permettant au tribunal d'ordonner un traitement.

38 Voir le chapitre national sur le Brésil. Voir également le chapitre thématique de Morinaga & Yamamoto dans la partie II de ce volume, section 2.

39 Voir le chapitre national sur l'Irlande.

violente ou de consommation de drogues, peuvent également faire augmenter le nombre de détenus souffrant de maladies mentales[40].

Une cause systémique du nombre disproportionné de détenus atteints de maladies mentales au *bout de la chaîne de la justice pénale* peut d'abord être trouvée dans le fait que les détenus atteints de maladies mentales semblent avoir plus de mal à se retirer du système. Plusieurs facteurs jouent un rôle en la matière. En ce qui concerne les détenus des prisons psychiatriques, les États rapportent que ces détenus sont enfermés pour des périodes longues et indéfinies[41]. Diverses raisons expliquent ces politiques, comme les possibilités légales de prolonger - parfois à l'infini - le séjour dans ces institutions[42] et le fait que les personnes qui y sont placées n'ont souvent aucun endroit où aller, ce qui rend les responsables réticents à les libérer[43]. Une autre raison des séjours prolongés réside dans l'imposition fréquente de sanctions disciplinaires aux détenus atteints de maladies mentales. Ces détenus ne comprennent souvent pas les règles de la prison ou ne peuvent pas s'y conformer, ce qui les rend plus sujets aux sanctions disciplinaires que la moyenne des détenus, ce qui, à son tour, peut affecter leur libération conditionnelle[44]. Un deuxième facteur d'augmentation des chiffres liés à cette dernière étape est le manque de suivi des détenus atteints de maladies mentales, qui augmente le risque de récidive.[45]

En résumé, si l'on considère la manière dont les systèmes de justice pénale traitent les maladies mentales, on peut affirmer que la combinaison de politiques de déjudiciarisation inefficaces, de règles rigides en matière de responsabilité pénale et de mécanismes qui font que les délinquants malades mentaux « collent au système » contribuent tous au nombre relativement élevé de détenus malades mentaux.

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40 Sur les politiques de condamnation punitive affectant les personnes atteintes de déficience mentale, voir : UNODC, 2009, p. 12. Voir également le chapitre national sur les États-Unis, où les peines élevées pour consommation de drogue font augmenter le nombre de détenus souffrant de troubles liés à l'abus de substances.

41 Voir les chapitres nationaux sur l'Allemagne, la Hongrie, la Nouvelle-Zélande et le Portugal. Voir également le chapitre thématique de Morinaga & Yamamoto, section 2. La possibilité d'un engagement de longue durée, à durée indéterminée, dans une prison psychiatrique, a parfois fait de ces prisons un lieu de traitement des opposants politiques. Voir le chapitre national sur le Kazakhstan.

42 Voir les chapitres nationaux sur la Hongrie et la Nouvelle-Zélande.

43 Voir les chapitres nationaux sur la Hongrie, le Portugal, le chapitre thématique de Morinaga & Yamamoto - dans la partie II de ce volume - section 2 et UNODC, 2009, p. 38. Voir également le chapitre national sur le Kazakhstan : au Kazakhstan, cela s'applique également aux détenus atteints de maladies mentales dans les prisons ordinaires.

44 UNODC, 2009, p. 15/16. En général, les détenus atteints de troubles mentaux ont moins de chances d'être libérés sur parole que les détenus non atteints de troubles mentaux. Voir : Lynette Feder, 'Psychiatric hospitalization history and parole decision', 18 *Law and Human Behavior* 4 (1994), p. 395-410 et Kelly Hannah-Moffat, 'Losing ground: Gendered knowledge, parole risk and responsibility', 11 *Social Politics* 3 (2004), p. 363-385.

45 UNODC, 2009, p. 18. Voir également le chapitre national sur la Hongrie. Le suivi des délinquants atteints de troubles mentaux est également un problème aux Pays-Bas. Voir le chapitre national sur les Pays-Bas.

3.1.2 Comment les prévenus et les détenus traitent avec le système

La littérature indique que la détention et l'emprisonnement peuvent exacerber, voire provoquer des maladies mentales[46]. Différents éléments déclencheurs de (l'exacerbation de) la maladie mentale[47] sont mentionnés, tels que les régimes pénitentiaires[48], les abus du personnel pénitentiaire[49], l'architecture de la prison[50], l'agression[51], les brimades et les abus également de la part d'autres prisonniers[52]. le manque d'activités significatives[53], le manque d'exercice[54], l'utilisation de sanctions disciplinaires[55], l'isolement cellulaire[56], la séparation des contacts sociaux[57] (parfois intensifiée par l'éloignement du lieu de détention)[58], les services de santé (mentale) inadéquats[59], les insécurités concernant l'avenir (par ex. le

46 Pour une perspective internationale, voir : UNODC, 2009, p. 10 et Eric Blaauw & Hjalmar J.C. van Marle, 'Mental health in prisons', in : OMS, La *santé en prison : A WHO guide to the essentials in prison health*, 2007, p. 133-145, p. 133. Pour les études nationales, voir : A. Goomany & T. Dickinson, 'The influence of prison climate on the mental health of adult prisoners: a literature review', 22 *Journal of Psychiatric and Mental Health Nursing* 6 (2015), p. 413-422, p. 421 ; Craig Haney, 2020, p. 341, 386 et 387 et Alice Mills & Kathleen Kendall, 2018, p. 2. Pour une étude sur les prisons de haute sécurité, voir : Craig Haney, 'A Culture of Harm: Taming the Dynamics of Cruelty in Supermax Prisons', 35 *Criminal Justice and Behaviour* 8 (2008), p. 956-984, p. 957-959. Voir également les chapitres nationaux sur le Brésil, le Chili, le Kazakhstan, la Nouvelle-Zélande, l'Espagne et les États-Unis, ainsi que le chapitre thématique de Vulić Kralj dans la partie II du présent volume, section 2. Pour une étude spécifique sur l'influence de la garde à vue sur la santé mentale, voir : James Ogloff *et al.* , 'Psychiatric symptoms and histories among people detained in police cells', 46 *Social Psychiatry and Social Epidemiology* 9 (2011), p. 871-880.

47 Débouchant parfois sur un suicide, voir section 2.

48 Alice Mills et Kathleen Kendall, 2018, p. 4.

49 UNODC, 2009, p. 15 ; OMS, 2005, p. 1 et A. Goomany & T. Dickinson, 2015, p. 413-422, p. 416. Voir également les chapitres nationaux sur le Chili, le Kazakhstan et les États-Unis.

50 Simon Cross & Yvonne Yewkes, 'The architecture of psychiatry and the architecture of incarceration', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, p. 49-72.

51 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134. Voir aussi le chapitre national sur le Chili.

52 UNODC, 2009, p. 15 ; A. Goomany & T. Dickinson, 2015, p. 417 et Alice Mills & Kathleen Kendall, 2018, p. 2.

53 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 et A. Goomany & T. Dickinson, 2015, p. 415/416. Le manque d'activités significatives peut également conduire à la consommation de drogues illicites (p. 417) ; OMS, 2005, p. 1 et Alice Mills & Kathleen Kendall, 2018, p. 2. Voir également les chapitres nationaux sur l'Allemagne et le Kazakhstan.

54 Alice Mills et Kathleen Kendall, 2018, p. 3.

55 Voir le chapitre national sur les États-Unis.

56 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 ; A. Goomany & T. Dickinson, 2015, p. 415 et OMS, 2005, p. 1. Voir également les chapitres nationaux sur le Chili, l'Irlande, le Kazakhstan et les États-Unis.

57 A. Goomany & T. Dickinson, 2015, p. 418 ; OMS, 2005, p. 1 ; Alice Mills & Kathleen Kendall, 2018, p. 2 et Graham Duncan & Jan Cees Zwemstra, 2014, p. 87. Voir également les chapitres nationaux sur le Kazakhstan et sur les États-Unis.

58 A. Goomany & T. Dickinson, 2015, p. 418. Voir également les chapitres nationaux sur le Brésil et l'Espagne.

59 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 ; A. Goomany & T. Dickinson, 2015, p. 419 et OMS, 2005, p. 1. Voir également les chapitres nationaux sur le Chili et le Kazakhstan.

travail, les relations)[60], les mauvaises conditions de vie[61] (mauvaise hygiène[62], manque d'intimité[63], environnement déprimant et mauvaise alimentation[64]), les mesures de sécurité sévères[65], la perte d'autonomie[66], l'isolement de la société[67], la disponibilité de drogues illicites[68], la criminalisation des comportements symptomatiques de la maladie mentale (comme l'automutilation)[69], le manque de protection des groupes vulnérables comme les LGBTI[70] et la surpopulation[71]. Ce dernier point - la surpopulation - semble être une cause fondamentale, puisqu'elle déclenche divers problèmes d'organisation susceptibles d'entraîner, par exemple, la déconnexion sociale, la charge de travail du personnel, l'isolement, le manque d'activités significatives, le manque de soins (de santé mentale), l'insécurité des perspectives d'avenir[72] et une réintégration inefficace[73]. Plus récemment, les changements de politique carcérale provoqués par la pandémie de Covid-19 sont également apparus comme un facteur influençant négativement la santé mentale des détenus[74]. Qui plus est, l'effet cumulatif des facteurs susmentionnés est en soi un facteur influençant négativement la santé mentale des détenus. Lorsque la santé mentale des détenus régresse en raison des facteurs susmentionnés, les incidents (par exemple, agressions, intimidations, automutilations) progresse, ce qui, à son tour, affecte négativement la santé mentale des détenus et du personnel[75].

60 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 et OMS, 2005, p. 1.
61 UNODC, 2009, p. 10 et 15 et Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134. Voir également le chapitre national sur le Kazakhstan.
62 Voir le chapitre national sur le Chili.
63 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 ; OMS, 2005, p. 1 et Alice Mills & Kathleen Kendall, 2018, p. 2. Voir également les chapitres nationaux sur le Chili et le Kazakhstan.
64 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134.
65 A. Goomany & T. Dickinson, 2015, p. 418.
66 A. Goomany & T. Dickinson, 2015, p. 419.
67 UNODC, 2009, p. 10.
68 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134. Voir aussi le chapitre national sur l'Allemagne.
69 UNODC, 2009, p. 17.
70 UNODC, 2009, p. 18 et Andrea Daley & Kim Radford, 'Queer and trans incarceration distress: considerations from a mad queer abolitionist perspective', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, p. 285-307, p. 288/289. Voir également le chapitre national sur les États-Unis, qui décrit les mauvais traitements infligés aux détenus LGBTI et l'effet de ces mauvais traitements sur leur santé mentale.
71 UNODC, 2009, p. 10 ; Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134 ; OMS, 2005, p. 1 et A. Goomany & T. Dickinson, 2015, p. 420. Voir également les chapitres nationaux sur le Chili, le Kazakhstan, l'Espagne et les États-Unis.
72 A. Goomany & T. Dickinson, 2015, p. 20. Voir également le chapitre national sur les États-Unis.
73 Voir le chapitre national sur la Hongrie.
74 Voir la section 2.
75 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 134.

La recherche a également établi que l'environnement carcéral contribue au comportement autodestructeur des détenus[76]. Les caractéristiques des prisons qui se sont avérées être liées au suicide sont : l'ennui, l'isolement, les événements stressants au sein de la prison tels que l'intimidation et la victimisation et l'utilisation croissante de nouvelles substances psychoactives[77].

L'influence négative des prisons sur la santé mentale a amené plusieurs chercheurs à considérer les prisons comme une manifestation de la « violence lente » : un type de violence qui n'est pas rapide et visible (comme un coup sur le nez) mais continue et invisible, et qui ne suscite donc pas l'intérêt du public nécessaire pour y mettre fin[78]. Cette école de chercheurs plaide en faveur d'alternatives à l'emprisonnement, et pas seulement pour les malades mentaux[79]. D'autre part, il existe également un bon nombre d'études démontrant un possible effet positif de l'emprisonnement sur la santé mentale, comme une amélioration des symptômes de santé mentale au fil du temps[80] ou des femmes détenues décrivant la prison comme un lieu de répit, offrant une sécurité[81].

Comme le montre la présente section, il existe une abondance de recherches sur les effets de l'emprisonnement sur la santé mentale des *détenus*. Cependant, les recherches récentes sur les effets d'une poursuite pénale sur la santé mentale d'un prévenu (et non d'un détenu), et l'influence des systèmes de probation et des programmes de suivi sur la santé mentale semblent rares[82].

3.2 Les raisons des causes systémiques

Alors que les sections précédentes traitent des problèmes au sein du système qui contribuent à un nombre disproportionné de détenus souffrant de problèmes de santé mentale, cette

76 Pour un aperçu des études, voir : Alice Mills & Kathleen Kendall, 2018, p. 1-22, p. 5. Voir également le chapitre national sur le Chili.

77 Alice Mills et Kathleen Kendall, 2018, p. 2.

78 Le terme de violence lente a été introduit par Rob Nixon dans : Rob Nixon, *Slow violence and the environmentalism of the* poor, Londres : Harvard University Press, 2011.

79 Alice Mills & Kathleen Kendall, 'Care versus custody: Challenges in the provision of prison mental health care', in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, p. 105-129, p. 112.

80 Voir le chapitre thématique dans la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten section 5, qui contient la conclusion de leur méta-étude. Les symptômes de dépression et d'anxiété, en particulier, s'améliorent.

81 Pour un aperçu des études, voir : A. Goomany & T. Dickinson, 2015, p. 417.

82 Je n'ai pas pu trouver de telles études lors d'une recherche dans notre système de bibliothèque nationale néerlandaise et dans Google Scholar, tous deux en langue anglaise. En ce qui concerne les effets mentaux des poursuites judiciaires, les recherches semblent se concentrer sur la santé mentale de la victime, et non sur celle du défendeur. L'absence de recherches sur les prévenus qui ne sont pas détenus n'est toutefois pas surprenante, car les détenus constituent littérairement un groupe plus « fixe » et donc plus facile à étudier que les prévenus qui ne sont pas détenus.

section examine les causes possibles d'un tel système. Pourquoi ce groupe de personnes n'est-il pas mieux reconnu et traité en fonction de ses besoins - et de ceux de la société ? Les chapitres nationaux mentionnent une diversité de causes à cela, qui peuvent être regroupées en trois catégories : (a) manque de budget pour prendre en charge les prévenus et les détenus ayant des problèmes de santé mentale ; (b) problèmes *généraux* au sein du système de justice pénale ; et (c) problèmes liés au fonctionnement du système *général* de santé mentale.

Une raison primordiale de la situation actuelle dans les prisons est le *manque de financement* pour prendre en charge les prévenus et les détenus souffrant de problèmes de santé mentale[83]. Cela peut s'expliquer par le fait que les détenus souffrant de problèmes de santé mentale ne figurent pas en bonne place dans l'agenda politique[84]. Cela peut s'expliquer par une intolérance générale des sociétés à l'égard des comportements difficiles ou dérangeants[85].

Les *problèmes généraux au sein du système de justice pénale* font référence à des problèmes, non spécifiquement liés à la façon dont le système traite les malades mentaux, qui ont un impact sur les prévenus et les détenus atteints de maladie mentale. Par exemple, lorsque les droits procéduraux fondamentaux sont inefficaces, cela a également une influence négative sur les malades mentaux pris dans le système de justice pénale[86]. Lorsque les prisons sont surpeuplées, il est difficile de maintenir des soins de santé corrects dans ces établissements, malgré de bons plans et de bonnes initiatives[87]. Comme décrit dans la section 3.1.2, la surpopulation déclenche également de nombreux autres facteurs ayant une influence négative sur la santé mentale. Lorsque la resocialisation des détenus est un problème général, elle affecte également le détenu malade mental, qui a besoin de plus de soutien dans ce processus que le détenu moyen[88].

Dans de nombreux pays du monde, les services de soins de santé mentale sont insuffisants ou peu accessibles[89]. Lorsque *les soins de santé mentale généraux posent problème*, cela peut avoir une incidence sur la charge du système de justice pénale. Par exemple, par une augmentation des infractions commises par des malades mentaux[90] ou en raison d'un manque de possibilités de détournement vers les établissements

83 Voir les chapitres nationaux sur l'Allemagne et les États-Unis.
84 Voir le chapitre national sur la Hongrie.
85 OMS, 2005, p. 1. Voir également les chapitres nationaux sur la Hongrie et les États-Unis.
86 Voir les chapitres nationaux sur la Hongrie et le Brésil.
87 Voir les chapitres nationaux sur la Nouvelle-Zélande et sur les États-Unis (sur la politique d'incarcération de masse).
88 UNODC, 2009, p. 18. Voir également le chapitre national sur le Brésil.
89 OMS, 2005, p. 1. Voir également le chapitre national sur les États-Unis.
90 Voir le chapitre national sur le Japon.

psychiatriques[91]. De plus, lorsque les établissements psychiatriques sont rares, les personnes atteintes de maladie mentale qui *n'ont pas* commis d'infraction ou qui *ne sont pas* pénalement responsables sont parfois placées en détention[92].

Dans l'ensemble, les causes susmentionnées du nombre disproportionné de prévenus et de détenus atteints de maladies mentales peuvent être ramenées à l'existence d'un groupe de personnes qui n'est pas (suffisamment) reconnu par le système de justice pénale pour ce qu'il est, et traité en conséquence en raison d'un budget insuffisant et de problèmes systémiques au sein du système de justice pénale et du système de santé mentale. Par conséquent, les causes ultimes du nombre disproportionné de prévenus et de détenus atteints de maladies mentales semblent résider dans le fonctionnement du gouvernement et dans la manière dont il façonne et finance ses politiques sociales.

4 Les prévenus et les détenus atteints de maladie mentale : les problèmes

Les sections précédentes ont démontré qu'au niveau mondial, il existe un nombre disproportionné d'accusés et de détenus souffrant de maladies mentales et que les origines de cette situation sont complexes et diverses. La présente section traite des complications que cette situation engendre. Toutes ces complications trouvent leur origine dans le fait que la *chaîne pénale n'est pas conçue pour accueillir les personnes atteintes de maladie mentale*. Cela entraîne les problèmes suivants, examinés ci-après : des prévenus qui ne sont pas en mesure de faire face au stress et/ou à la complexité des procédures pénales (section 4.1), un manque de traitement professionnel adéquat en détention (section 4.2), l'hébergement des malades mentaux dans un environnement inadapté (section 4.3) et un manque de soutien aux malades mentaux dans le parcours postcure (4.4). Veuillez noter que les *raisons* du nombre disproportionné de malades mentaux dans le système de justice pénale (section 3) et les *problèmes* causés par ce nombre élevé (présente section) peuvent parfois se chevaucher. Par exemple, l'une des *raisons* du nombre élevé de détenus atteints de maladie mentale peut être *l'effet négatif de l'environnement carcéral sur la santé mentale* des détenus. La nature de l'environnement carcéral entraîne une augmentation du nombre de malades mentaux en prison. Cet effet négatif de l'environnement carcéral sur la santé

91 Voir les chapitres nationaux sur le Brésil et l'Irlande, où la réduction des lits d'hôpitaux psychiatriques - dans le but de transférer les soins vers les services communautaires - a contribué à l'augmentation du nombre de détenus atteints de troubles mentaux. Voir également le chapitre national sur les États-Unis, où il est indiqué que le budget de la santé mentale est si faible que la déjudiciarisation est tout à fait inutile.

92 UNODC, 2009, p. 11 et OMS, 2005, p. 1. Voir également les chapitres nationaux sur le Japon, la Pologne et les États-Unis.

mentale des détenus peut toutefois également constituer un *problème* lorsque des malades mentaux se retrouvent en prison. L'environnement carcéral peut avoir une influence négative sur leur santé mentale et exacerber leur état.

4.1 Le défendeur n'est pas en mesure de faire face à la procédure pénale

Lorsqu'un prévenu ou un détenu souffrant de troubles mentaux n'est pas réorienté et se retrouve impliqué dans le système de justice pénale ordinaire, ce prévenu - plus qu'un prévenu ordinaire - peut ne pas être en mesure de comprendre le système et ses implications[93] et ne pas avoir la résistance nécessaire pour traiter avec les autorités[94]. Cela peut conduire à la violation des droits de la défense[95] et d'autres droits de l'homme[96]. En fin de compte, cela peut même entraîner de fausses condamnations[97], y compris des peines de mort injustement encourues[98].

4.2 L'absence de traitement

Une fois que le défendeur atteint de maladie mentale s'inscrit dans le système de détention, le principal défi est que les prisons ne sont pas conçues pour accueillir les personnes atteintes de maladie mentale. En premier lieu, parce que les prisons manquent de possibilités

93 Voir par exemple les chapitres nationaux sur la Hongrie et la Pologne. Voir également le chapitre thématique de Van Kempen dans la partie II de ce volume, section 1, sur les problèmes possibles lors de la négociation de la justice, comme dans le cas de la négociation de plaidoyer.

94 Voir E.M. Gremmen, *De kwetsbare psychisch gestoorde verdachte in het strafproces: regelgeving, praktijk en Europese standaarden*, Oisterwijk: Wolf Legal Publishers, 2018 (thèse avec résumé en anglais), p. 39/40, discutant du fait que les défendeurs souffrant de troubles mentaux sont plus vulnérables et influençables que le défendeur moyen.

95 Voir la section 3.1.1. Voir également le chapitre national sur le Brésil, qui fait état d'un problème général de procès équitable dans le cas des accusés souffrant de troubles mentaux, notamment en ce qui concerne les problèmes de délais excessifs.

96 Voir le chapitre national sur la Grèce. En Grèce, les mauvais traitements pendant les enquêtes de police sont un problème général. Voir également les chapitres nationaux sur la Nouvelle-Zélande et les États-Unis sur la détention prolongée de prévenus inaptes à être jugés et le chapitre thématique de Van Kempen dans la partie II de ce volume, section 1, sur l'usage inutile et disproportionné de la force par la police dans le cas de prévenus atteints de maladie mentale.

97 Voir la section 3.1.1.

98 Amnesty International, *Rapport mondial : Condamnations à mort et exécutions* 2016, p. 7. Voir également le chapitre national consacré aux États-Unis. Aux États-Unis, les personnes souffrant de maladies mentales sont plus susceptibles d'être injustement condamnées à la peine de mort que la moyenne. Actuellement, certains États envisagent d'interdire la peine de mort pour les accusés souffrant de maladies mentales. Cette mesure est conforme aux garanties des Nations unies pour la protection des droits des personnes passibles de la peine de mort. La garantie numéro 3 interdit l'imposition de la peine de mort aux personnes aliénées, voir : E/1984/50. Cette garantie a été réitérée et redéfinie pour couvrir un plus large éventail de handicaps mentaux par d'autres organes de l'ONU, voir : E/2015/49, par. 84.

de *traitement* pour ce groupe de personnes[99]. Cela est dû en grande partie à un manque de personnel thérapeutique (psychiatres, psychologues, travailleurs sociaux)[100]. Ce manque de personnel thérapeutique peut entraîner une surcharge de travail pour le personnel thérapeutique opérationnel[101], ce qui peut non seulement augmenter le risque d'épuisement professionnel de ces membres du personnel[102], mais aussi influencer la qualité de la thérapie offerte. Par exemple, l'accent peut être mis davantage sur les tests que sur la thérapie[103], tandis que la thérapie est davantage axée sur le fonctionnement quotidien en prison que sur la réinsertion[104] et davantage sur le traitement des détenus qui demandent de l'aide[105] que sur la prévention générale des maladies mentales en prison[106]. D'autres phénomènes problématiques liés à un manque de traitement de qualité sont : une politique de sédation pour gérer les symptômes au lieu d'un traitement[107], un manque de variété dans le traitement des différents troubles[108], un déséquilibre de pouvoir entre le thérapeute et le patient[109], un manque de traitement basé sur les besoins de groupes spécifiques, tels que les femmes[110] et les personnes âgées[111], aucun traitement pour les personnes dont la maladie mentale se développe après avoir été condamnées à la prison[112], le maintien de la continuité du

99 OMS, 2005, p. 1 ; Alice Mills & Kathleen Kendall, 2018, p. 6 et Adrian Grounds, 'Discrimination against offenders with mental disorder', 29 *Criminal Behaviour and Mental* Health 4 (2019), p. 247-225. Voir également les chapitres nationaux sur le Brésil, le Chili, l'Allemagne, la Grèce, la Hongrie, l'Irlande, la Nouvelle-Zélande, la Pologne, l'Espagne et les États-Unis.

100 UNODC, 2009, p. 14 et Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 140. Voir également les chapitres nationaux sur le Chili, l'Allemagne, la Grèce, la Hongrie, l'Irlande, le Kazakhstan, la Pologne, le Portugal, l'Espagne et les États-Unis.

101 Voir le chapitre national sur la Hongrie.

102 Voir le chapitre national sur la Hongrie.

103 Voir le chapitre national sur la Hongrie.

104 Voir les chapitres nationaux sur la Hongrie et les Pays-Bas (en relation avec les CPP).

105 Cependant, la stigmatisation de la maladie mentale et du traitement a pour conséquence que les détenus ne s'occupent pas de leurs problèmes. Voir OMS, 2005, p. 2 et le chapitre national sur la Hongrie.

106 Voir le chapitre national sur la Hongrie.

107 Alice Mills & Kathleen Kendall, 2018, p. 6 et UNODC, 2009, p. 13/14. Voir également les chapitres nationaux sur l'Allemagne, la Hongrie, la Pologne et les États-Unis.

108 Voir le chapitre national sur la Hongrie.

109 Alice Mills & Kathleen Kendall, 2018, p. 1-22, p. 6. Voir également les chapitres nationaux consacrés à l'Allemagne et à la Hongrie. Dans ce dernier chapitre, l'auteur souligne que lorsque le diagnostic et la thérapie sont effectués par le même professionnel, cela signifie que la personne qui propose le traitement est également celle qui décide du renvoi du patient, ce qui peut contribuer à un environnement de traitement peu sûr.

110 Voir le chapitre national sur la Grèce.

111 Voir le chapitre national sur l'Irlande.

112 Voir le chapitre national sur le Kazakhstan.

traitement après le remplacement[113], la courte durée du traitement[114] et le manque de formation avancée obligatoire du personnel thérapeutique de la prison[115].

4.3 Environnement inadapté

Une deuxième raison pour laquelle les prisons ne sont pas conçues pour accueillir des personnes atteintes de maladies mentales est que l'*environnement carcéral* ordinaire ne convient pas aux malades mentaux. Tout d'abord, parce que le *personnel pénitentiaire ordinaire* (non thérapeutique) - souvent minimal[116] - n'est pas formé pour traiter les maladies mentales[117]. Cela peut entraîner un comportement antithérapeutique[118] envers les détenus, voire des violations des droits de l'homme. Les comportements signalés du personnel pénitentiaire, en particulier à l'égard des prisonniers souffrant de maladies mentales, comprennent l'imposition de sanctions disciplinaires inutiles[119], la discrimination[120], l'intimidation, parfois dans le but de faire du prisonnier un informateur[121], et un mauvais traitement général[122], causant parfois la mort[123]. Une situation dans laquelle un personnel non formé doit travailler avec des malades mentaux est non seulement préjudiciable aux patients, mais aussi au personnel lui-même[124]. Une deuxième raison pour laquelle l'environnement carcéral ordinaire ne convient pas est que l'*infrastructure des prisons* n'est pas conçue pour accueillir des personnes atteintes de maladies mentales. Cela génère des problèmes de sécurité. Bien que l'article 109 des Règles Nelson Mandela mentionne la possibilité de traiter les détenus atteints de maladie mentale dans des établissements spécialisés, il n'est pas obligatoire de séparer les accusés atteints de maladie mentale des autres accusés[125]. Par conséquent, les détenus malades mentaux occupent

113 Voir le chapitre national sur l'Irlande.
114 Voir les chapitres nationaux sur la Pologne et l'Espagne. Observé dans le chapitre national sur l'Irlande : parfois la durée du traitement dépend de la durée de la peine. Cependant, la fin de la peine ne coïncide pas nécessairement avec la fin du traitement.
115 Voir le chapitre national sur l'Allemagne.
116 Voir les chapitres nationaux sur la Grèce, les Pays-Bas et l'Espagne.
117 Voir les chapitres nationaux sur le Chili, la Hongrie, l'Irlande, le Kazakhstan et les États-Unis.
118 C'est-à-dire un comportement opposé à la thérapie, ayant un effet psychologique néfaste.
119 UNODC, 2009, p. 15. Voir également le chapitre thématique de Vulić Kralj, dans la partie II de ce volume, section 5 et le chapitre national sur l'Espagne.
120 UNODC, 2009, p. 15.
121 UNODC, 2009, p. 15.
122 Voir les chapitres nationaux sur le Chili, la Hongrie et les États-Unis.
123 Voir le chapitre national sur le Chili.
124 Voir le chapitre thématique de Vulić Kralj dans la partie II du présent volume, section 4, sur l'effet du personnel non qualifié sur la santé mentale des détenus. L'effet des attitudes négatives du personnel sur les détenus est également abordé dans la section 3.1.2 du présent chapitre.
125 Comme c'est le cas, par exemple, pour les femmes, les jeunes et les détenus non jugés. Voir la règle 11 des Règles Nelson Mandela.

souvent les mêmes espaces que les détenus ordinaires, ce qui peut entraîner des situations dangereuses pour les deux parties[126]. Les détenus souffrant de troubles mentaux sont particulièrement vulnérables et il a été signalé qu'ils sont plus enclins à la violence (sexuelle) que les détenus ordinaires[127]. En outre, les conditions matérielles des établissements pénitentiaires peuvent ne pas convenir aux malades mentaux[128]. Les malades mentaux ne comprennent par ailleurs pas toujours les règles de la prison ou n'ont pas toujours la capacité d'adapter leur comportement à ces règles, ce qui entraîne des sanctions disciplinaires sévères[129] et des retards dans la libération[130]. Une troisième raison pour laquelle l'environnement carcéral ordinaire ne convient pas aux malades mentaux est que la prison en elle-même peut avoir un *effet négatif sur la santé mentale*[131]. Comme les malades mentaux ont moins de mécanismes d'adaptation que les détenus ordinaires, ils sont plus vulnérables aux effets psychologiques de l'environnement carcéral que ces derniers[132].

4.4 Problèmes de suivi

Les systèmes de réinsertion connaissent également des problèmes lorsqu'ils sont confrontés à des patients souffrant de troubles mentaux. Les services de probation ne sont souvent pas en mesure de traiter les clients souffrant de troubles mentaux de manière professionnelle[133]. De plus, l'absence de traitement des détenus souffrant de maladies mentales complique sérieusement la réintégration[134]. Lorsque le traitement et la réinsertion des détenus atteints de maladie mentale ne sont pas bien organisés, ces personnes restent souvent en prison plus longtemps que de nécessaire[135]. Cependant, dans de nombreux systèmes, l'organisation de la réinsertion en général semble être problématique[136]. Tout comme le niveau général des soins de santé mentale à l'extérieur de la prison.[137]

126 Voir les chapitres nationaux sur l'Allemagne, l'Irlande et l'Espagne.
127 UNODC, 2009, p. 15.
128 Voir les chapitres nationaux sur la Grèce et la Hongrie. Le chapitre national sur la Grèce, par exemple, mentionne la mauvaise qualité des cellules d'isolement.
129 Voir le chapitre thématique de Vulić Kralj dans la partie II de ce volume, section 5 et UNODC, 2009, p. 15/16.
130 Voir la section 3.1.1.
131 Voir la section 3.1.2.
132 UNODC, 2009, p. 13.
133 Voir les chapitres nationaux sur l'Allemagne, la Hongrie, le Japon, le Kazakhstan, le Portugal et les États-Unis.
134 Voir le chapitre national sur la Nouvelle-Zélande.
135 Voir Frank J. Porporino & Laurence L. Motiuk, 'The prison careers of mentally disordered offenders', 18 *International Journal of Law and Psychiatry* 1 (1995), p. 29-44. Voir également les chapitres nationaux sur la Grèce, la Hongrie et le Portugal, qui mentionnent tous le problème de la détention prolongée des accusés atteints de troubles mentaux.
136 Voir les chapitres nationaux sur le Chili, la Grèce, la Hongrie et la Pologne. Voir également la section 3.2.
137 Voir le chapitre national sur le Kazakhstan. Voir également la section 3.2.

L'examen des problèmes évoqués ci-dessus fait naître l'image d'un prévenu souffrant de troubles mentaux - qui, pour une raison ou une autre, n'est pas reconnu comme tel et/ou n'est pas réorienté - dépassé par le système de justice pénale et envoyé en prison, où les traitements sont rares et l'environnement antithérapeutique, pour être finalement remis aux services de probation qui disposent de ressources limitées pour traiter ses problèmes. Il n'est pas surprenant que les taux de récidive soient généralement élevés chez les détenus souffrant de troubles mentaux[138].

5 Les implications en matière de droits de l'homme

La section précédente a démontré une variété de problèmes découlant du fait que le système de justice pénale ordinaire n'est pas conçu pour traiter les malades mentaux. Cette section explore les implications de ces problèmes en matière de droits de l'homme. Après une brève esquisse du cadre juridique applicable aux détenus atteints de maladie mentale (section 5.1), cette section se penche sur les implications juridiques particulières de chacun des problèmes abordés dans la section 4 : des défendeurs qui ne sont pas en mesure de faire face au stress et/ou à la complexité des procédures pénales (section 5.2.), un manque de traitement professionnel adéquat en détention (section 5.3), l'hébergement des détenus atteints de maladie mentale dans un environnement inadapté (section 5.4) et un manque de soutien aux détenus atteints de maladie mentale dans le parcours de postcure (5.5).

5.1 Cadre juridique

En général, les personnes privées de liberté doivent pouvoir bénéficier de la protection des droits de l'homme, sous réserve des restrictions inévitables dans un environnement fermé (« principe de base minimum »).[139] Cependant, les détenus atteints de maladie mentale ne

138 Voir le chapitre thématique de la partie II de ce volume par Oscar Bloem, Robbert Jan Verkes & Erik Bulten, section 4, sur une constatation répétée de l'existence d'une relation entre les troubles liés aux substances et la récidive ; Craig Haney, 2020, p. 387 sur la façon dont la retraumatisation en prison conduit à la récidive et UNODC, 2009, p. 18 sur le manque de suivi comme facteur important de récidive chez les patients atteints de troubles mentaux. Voir également les chapitres nationaux sur le Brésil (taux de récidive de 70 % chez les patients atteints de troubles mentaux), l'Allemagne (mentionnant un lien entre les troubles mentaux et la récidive) et les Pays-Bas (faisant référence à des études sur la récidive et l'importance du traitement).

139 Des références au « principe de base minimum » peuvent être trouvées dans de nombreuses sources internationales : Observation générale sur l'article 10 du Pacte international relatif aux droits civils et politiques : HRC, Observation générale n° 21, « Traitement humain des personnes privées de liberté » (article 10), 10 avril 1992, paragraphe 3. 3 ; Règle 3 des Règles Mandela ; Principe 5 des Principes fondamentaux des Nations Unies pour le traitement des détenus ; Règles 2 et 5 des Règles pénitentiaires européennes ; Principe 8 des Principes et pratiques optimales relatifs à la protection des personnes privées de liberté dans les Amériques et Deuxième recommandation sur les conditions de détention dans la Déclaration de Kampala sur les

sont pas seulement protégés par les droits de l'homme en tant qu'êtres humains, mais aussi en tant que *détenus* et *en* tant que *malades mentaux*. Par conséquent, les prévenus et les détenus atteints de maladie mentale sont protégés par un ensemble disparate de traités généraux sur les droits de l'homme, de traités plus spécifiques sur les droits de l'homme (par exemple, sur les personnes handicapées, la torture) et d'instruments non contraignants (tels que les diverses règles pénitentiaires des Nations Unies). Le paragraphe suivant dresse un bref inventaire des règles pertinentes d'application universelle. Les instruments[140] régionaux ne sont pas inclus dans l'analyse de cette section[141].

Les traités généraux relatifs aux droits de l'homme qui présentent un intérêt particulier pour les détenus atteints de maladie mentale sont le Pacte international relatif aux droits civils et politiques (ICCPR, 1966) et le Pacte international relatif aux droits sociaux, économiques et culturels (ICESCR, 1966). Les traités spécifiques pertinents sont : la Convention sur les droits des personnes handicapées (CRPD, 2006)[142] et la Convention contre la torture et autres peines ou traitements cruels, inhumains ou dégradants (UNCAT, 1984). En plus de ces traités, il existe plusieurs instruments de soft law pertinents : les Règles Nelson Mandela (2015, anciennement connues sous le nom d'Ensemble de règles minima des Nations Unies pour le traitement des détenus, 1955)[143], les Règles de Bangkok (applicables aux femmes en détention, 2010)[144], les Principes pour la protection des personnes atteintes de maladie mentale et l'amélioration des soins de santé mentale

conditions de détention en Afrique. De même, le « principe de base minimum » a été largement affirmé dans la jurisprudence internationale et régionale relative aux principales conventions des droits de l'homme. Voir : Piet Hein van Kempen, 'Positive obligations to ensure the human rights of prisoners: safety, healthcare, conjugal visits and the possibility of founding a family under the ICCPR, the ECHR, the ACHR and the AfChHPR', in: Peter Tak & Manon Jendly (eds.), *Prison policy and prisoners' rights: the protection of prisoners' fundamental rights in international and domestic law/Politique pénitentiaire et droits des détenus*, Nijmegen: Wolf Legal Publishers, 2008, p. 21-44, p. 24.

140 Par exemple, la Charte africaine des droits de l'homme et des peuples (AfChHPR, 1981), la Convention européenne des droits de l'homme (CEDH, 1950), la Convention américaine des droits de l'homme (ACHR, 1969) et la Déclaration des droits de l'homme de l'ASEAN (2012).

141 Pour une analyse de la jurisprudence de la Cour européenne des droits de l'homme sur les *détenus* atteints de maladies mentales, voir le chapitre thématique de Wąsek-Wiaderek dans la partie II de ce volume. Pour une analyse des *droits de la défense* dans divers systèmes régionaux et internationaux, voir le chapitre thématique de Van Kempen dans la partie II de ce volume.

142 La CDPH est applicable aux prévenus et aux détenus atteints de maladie mentale. Bien que la notion de « handicap » ne soit pas définie dans la convention, l'article 1(2) de la CDPH fait référence aux personnes handicapées et en donne une description non exhaustive, y compris les handicaps mentaux. Par conséquent, la convention a été interprétée comme incluant la protection des personnes atteintes de maladie mentale. Voir : Tina Minkowitz, 'The United Nations Convention of the Rights of Persons with Disabilities and the right to be free from non-consensual psychiatric interventions', 34 *Syracuse Journal of International Law and Commerce* 2 (2007), p. 405-428, p. 407.

143 A/Res/70/175, 17 décembre 2015.

144 A/C.3/65/L.5, 6 octobre 2010.

(1991)[145], les Principes fondamentaux relatifs au traitement des détenus (1990)[146], les Règles de La Havane (applicables aux mineurs en détention, 1990)[147], les Principes d'éthique médicale relatifs au rôle du personnel de santé, en particulier des médecins, dans la protection des prisonniers et des détenus contre la torture et autres peines ou traitements cruels, inhumains ou dégradants (1982)[148], et le Code de conduite pour les responsables de l'application des lois (1979)[149]. L'on trouvera ci-dessous un aperçu des règles découlant des traités et instruments susmentionnés qui sont pertinentes pour les problèmes décrits dans la section 4.

5.2 Droits procéduraux des accusés et des détenus atteints de maladie mentale

Dans la section 4.1, il a été expliqué qu'un défendeur ou un détenu atteint de maladie mentale impliqué dans le système de justice pénale ordinaire peut ne pas être en mesure de comprendre le système et ses implications ou avoir la résilience nécessaire pour traiter avec les autorités et que cela peut entraîner des violations des droits de l'homme. Cette section traite de la protection des droits de l'homme des défendeurs atteints de maladie mentale impliqués dans des procédures pénales.

En premier lieu, les défendeurs atteints de maladie mentale, impliqués dans des procédures pénales, sont protégés par les droits de l'homme généraux contenus dans le PIDCP. Ces droits comprennent, avant tout, le droit à un procès équitable (article 14 du PIDCP)[150]. Cependant, la protection au cours de la procédure est également assurée par des droits supplémentaires, tels que l'interdiction de la torture et des autres peines ou traitements cruels, inhumains ou dégradants (article 7 du PIDCP)[151], le droit à la liberté et à la sécurité, y compris l'interdiction de la détention arbitraire (article 9), le droit à un traitement humain des personnes détenues (article 10), le droit à la vie privée (article 17) et l'interdiction de la discrimination (article 26). Le Pacte international relatif aux droits civils et politiques ne fixe pas de norme explicite concernant l'aptitude à être jugé. Le

145 A/Res/46/119, 17 décembre 1991.
146 A/Res/45/111, 14 décembre 1990.
147 A/Res/45/113, 14 décembre 1990.
148 A/Res/37/194, 18 décembre 1982.
149 A/Res/34/169, 17 décembre 1979.
150 Le Comité des droits de l'homme ne s'est pas étendu sur le droit à une procédure équitable spécifiquement pour les personnes atteintes de maladie mentale. La Cour européenne des droits de l'homme a toutefois interprété l'article 6 de la CEDH comme impliquant l'obligation pour les autorités de garantir la participation effective aux procédures pénales des prévenus atteints d'incapacité mentale. Voir le chapitre thématique de Van Kempen dans la partie II de ce volume, section 4.
151 Figurant également à l'article 1 de l'UNCAT. L'article 11 de l'UNCAT oblige les États à contrôler les règles et les pratiques d'interrogatoire tout au long du processus de justice pénale.

Comité des droits de l'homme estime qu'une « défense effective » doit être possible[152], mettant l'accent sur les contre-mesures à prendre dans le cas d'un défendeur aux capacités limitées, au lieu de fixer une limite pour un niveau minimum de capacité mentale[153].

Outre le catalogue du PIDCP, les défendeurs atteints de maladie mentale peuvent bénéficier de la protection offerte par plusieurs dispositions de la CDPH. L'article 13 de la CDPH est le plus pertinent pour les procédures pénales dans leur ensemble. Cet article oblige les États à assurer un accès effectif à la justice pour les personnes atteintes de maladie mentale. Cet accès effectif à la justice doit se faire sur la base de l'égalité avec les autres, par le biais d'aménagements procéduraux, y compris lors de l'enquête et des autres étapes préliminaires. Selon le Haut-Commissaire des Nations Unies aux droits de l'homme, cette obligation de fournir des aménagements procéduraux renvoie au devoir d'assurer l'égalité des armes[154]. Dans le cas de procédures pénales, cela signifie que le défendeur souffrant de troubles mentaux doit avoir accès aux informations et au soutien nécessaires pour atteindre cette égalité des armes. Cela peut inclure l'obligation pour les autorités de présenter toutes les informations pertinentes d'une manière compréhensible et l'obligation de pratiquer la flexibilité procédurale (c'est-à-dire d'adapter la procédure aux capacités du défendeur)[155]. La législation des États parties devrait inclure explicitement ces aménagements procéduraux dans les procédures pénales[156]. De plus, les États devraient accroître leurs efforts pour garantir une aide juridique gratuite aux personnes handicapées[157]. L'article 13 de la CDPH prévoit également que les États doivent promouvoir la formation des personnes travaillant dans le domaine de l'administration de la justice, y compris la police et le personnel pénitentiaire, afin de garantir l'égalité d'accès à la justice pour les défendeurs atteints de maladie mentale.

D'autres dispositions pertinentes contenues dans la CDPH sont le droit à la liberté et à la sécurité, interdisant la détention arbitraire (article 14 de la CDPH), l'obligation des États de prévenir l'exploitation, les abus et la violence à l'égard des personnes handicapées (article 16 de la CDPH)[158], et l'interdiction de la torture, obligeant les États à prendre toutes les mesures nécessaires pour empêcher que les personnes handicapées, sur la base de

152 HRC, Observation générale n° 32, « Droit à l'égalité devant les tribunaux et les cours de justice et à un procès équitable » (article 14), 23 août 2007, par. 10 et 40.

153 Voir le chapitre thématique de Van Kempen dans la partie II de ce volume, section 4.

154 A/HRC/37/25, 27 décembre 2017, par. 24.

155 A/HRC/37/25, 27 décembre 2017, par. 24.

156 A/HRC/37/25, 27 décembre 2017, par. 28.

157 A/HRC/37/25, 27 décembre 2017, par. 40.

158 Figurant également dans le Principe 1.3 des Principes pour la protection des personnes atteintes de maladie mentale et pour l'amélioration des soins de santé mentale.

l'égalité avec les autres, ne soient soumises à la torture ou à des peines ou traitements cruels, inhumains ou dégradants (article 15 de la CDPH)[159].

Sur la base de ce qui précède, les États ne sont pas seulement obligés de fournir des garanties procédurales de base aux défendeurs atteints de maladie mentale, comme ils le font pour tout autre défendeur. Ils doivent également adopter des mesures supplémentaires (par exemple, des informations accessibles, une flexibilité procédurale, une aide juridique, un personnel formé) pour s'assurer que les droits procéduraux de base du défendeur atteint de maladie mentale sont garantis. Ne pas exécuter ces mesures peut non seulement violer les droits de l'homme généraux du PIDCP, mais aussi les droits plus spécifiques, principalement l'article 13 de la CDPH. Afin d'offrir aux défendeurs atteints de maladie mentale cette couche supplémentaire de protection, les autorités sont tenues de créer et d'appliquer une législation appropriée.

5.3 Le droit aux soins de santé mentale

La section 4.2 a démontré que les prisons ne sont pas conçues pour accueillir les personnes atteintes de maladie mentale car les options de *traitement* sont souvent limitées. Cette section traite du droit aux soins de santé mentale, y compris le droit au traitement.

5.3.1 Règles générales sur le droit aux soins de santé mentale

L'article 12 du PIDESC et l'article 25 de la CDPH font explicitement référence au droit à la santé. Sur la base de ces dispositions, les détenus atteints de maladie mentale[160] ont le droit de jouir du meilleur état de santé possible, y compris de la santé mentale[161], sous réserve des restrictions inévitables dans un environnement fermé. Ce droit à la santé mentale recouvre également la responsabilité des États de prévenir les maladies mentales[162], l'obligation d'identifier les maladies mentales à un stade précoce et de prévenir les maladies mentales ultérieures[163], l'obligation d'adopter une stratégie nationale de santé mentale

159 Voir également l'article 10 de l'UNCAT, qui prévoit l'obligation pour les États de former les policiers, le personnel pénitentiaire et le personnel médical à l'interdiction de la torture.

160 Une formulation du principe fondamental minimum discuté ci-dessus, spécifiquement applicable aux détenus atteints de maladie mentale, se trouve dans le principe 5 des Principes pour la protection des personnes atteintes de maladie mentale et pour l'amélioration des soins de santé mentale.

161 Article 12 ICESR, article 25 CRPD. Voir également le principe 1.1 des Principes pour la protection des personnes atteintes de maladie mentale et pour l'amélioration des soins de santé mentale.

162 Article 12(c) du Pacte international relatif aux droits économiques, sociaux et culturels et du Comité des droits économiques, sociaux et culturels, Observation générale n° 14, « Le droit au meilleur état de santé susceptible d'être atteint » (article 12), 11 août 2000, par. 16.

163 Article 25 de la CDPH.

publique en accordant une attention particulière aux groupes vulnérables et marginalisés[164], l'obligation d'organiser des soins à proximité de la communauté des personnes[165], l'obligation d'offrir un traitement fondé sur le consentement libre et éclairé[166] et l'obligation de former les professionnels de la santé aux normes éthiques et aux droits de l'homme[167].

5.3.2 Règles relatives aux soins de santé mentale en prison

Avant de nous plonger dans le droit aux soins de santé mentale en prison, il est important de noter que les règles internationales limitent les catégories de détenus souffrant de troubles psychiatriques qui sont autorisés à être incarcérés. Les personnes qui ne sont pas pénalement responsables ou qui sont diagnostiquées par la suite comme souffrant de graves problèmes de santé mentale, et pour qui rester en prison signifierait une exacerbation de leur état, ne doivent pas être détenues en prison, mais dans un établissement de santé mentale[168]. De plus, tous les mineurs souffrant de maladies mentales devraient être traités dans une institution spécialisée[169].

En général, les prisons doivent disposer d'un service de santé où les détenus peuvent recevoir des soins de santé[170] selon les mêmes normes que dans la communauté hors de la prison[171]. Les responsables des soins de santé sont les membres d'une équipe pluridisciplinaire possédant « une expertise suffisante en psychologie et en psychiatrie »[172].

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164 CESCR, Observation générale n°14, « Le droit au meilleur état de santé susceptible d'être atteint » (article 12), 11 août 2000, par. 43.

165 Article 25 de la CDPH.

166 Article 25 de la CDPH. Bien que le traitement sans consentement soit possible, il est souvent motivé par des considérations inappropriées, voir : UNODC, 2009, p. 33-35. Voir également à ce sujet les chapitres nationaux sur la Hongrie et le Kazakhstan.

167 Article 25 de la CDPH.

168 Règle 109(1) des Règles Nelson Mandela. Voir également l'analyse de Wąsek-Wiaderek dans le chapitre thématique, où elle soutient que l'article 14 de la CDPH pourrait être lu comme interdisant la détention des malades mentaux, mais nuance ensuite cette conclusion en démontrant que l'article 14 de la CDPH a été interprété à la lumière d'un critère moins restrictif de la CEDH/du PIDCP.

169 Règle 53 des Règles de la Havane.

170 Règle 25(1) des Règles Nelson Mandela et Principe 9 des Principes fondamentaux relatifs au traitement des détenus. Dans le cadre de procédures fondées sur les articles 6, 7 et 10 du Pacte international relatif aux droits civils et politiques, le Comité des droits de l'homme a estimé que des soins médicaux adéquats ou les plus appropriés et opportuns doivent être disponibles pour tous les détenus. Ces soins doivent être proposés même si le détenu ne les demande pas. Voir l'analyse des articles 6, 7 et 10 du PIDCP dans : Piet Hein van Kempen, 2008, p. 21-44, p. 31-33.

171 Règle 24 des Règles Nelson Mandela ; Règle 10(1) de la Règle de Bangkok et Principe 1 des Principes d'éthique médicale relatifs au rôle du personnel de santé, en particulier des médecins, dans la protection des prisonniers et des détenus contre la torture et autres peines ou traitements cruels, inhumains ou dégradants. Selon l'observation générale de l'article 12, les États parties au Pacte international relatif aux droits économiques, sociaux et culturels ont l'obligation légale de s'abstenir de refuser l'égalité d'accès aux soins de santé aux détenus ou prisonniers ou de limiter cet accès pour eux. Voir : CESCR, Observation générale n°14, « Le droit au meilleur état de santé susceptible d'être atteint » (article 12), 11 août 2000, par. 34.

172 Règle 25(2) des Règles Nelson Mandela. Si la rétention des soins de santé mentale en prison contrevient aux articles 6 PIDCP (droit à la vie), 7 PIDCP (interdiction de la torture et des traitements dégradants) et

Le dépistage à l'admission en prison doit inclure un examen de la santé mentale, y compris une évaluation du risque de suicide[173]. Les détenus souffrant de problèmes de santé mentale peuvent être traités dans des établissements spécialisés[174], mais d'une manière ou d'une autre[175], ils doivent pouvoir bénéficier d'un traitement psychiatrique[176]. L'État a le devoir de prendre des mesures adéquates pour protéger un détenu contre le suicide[177]. Les professionnels de la santé doivent avoir un accès quotidien aux prisonniers (mentalement) malades[178]. Cet accès doit être gratuit et doit être garanti à tous les stades de la détention[179]. Les professionnels de la santé doivent tenir un dossier médical confidentiel[180]. Les États sont tenus de connaître l'état de santé des détenus dans la mesure où l'on peut raisonnablement s'y attendre. Le manque de moyens financiers ne réduit pas cette responsabilité[181]. Le personnel pénitentiaire doit recevoir une formation sur les questions de santé mentale[182]. Conformément à la réintégration en tant qu'objectif général de l'emprisonnement[183] - mais aussi en tant qu'objectif de traitement des membres de la société souffrant de troubles mentaux en dehors de la prison[184] - le traitement de la santé

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10 PIDCP (droit au traitement humain des prisonniers), les autorités peuvent être tenues de fournir les soins nécessaires. Voir : Piet Hein van Kempen, 2008, p. 31-33.

173 Règle 30(c) des Règles Nelson Mandela ; Règle 6(b) des Règles de Bangkok et Règles 27 et 50 des Règles de La Havane. Les Règles de La Havane ne contiennent aucune référence explicite à l'évaluation du risque de suicide.

174 Règle 109(2) des Règles Nelson Mandela.

175 Une question pertinente, non abordée dans les Règles Nelson Mandela, est de savoir dans quelle mesure le traitement doit être volontaire.

176 Règle 109(3) des Règles Nelson Mandela et Règle 51 des Règles de la Havane.

177 Cette conclusion a été tirée par le Comité des droits de l'homme sur la base des articles 6 et 10 du PIDCP. Pour l'analyse des articles 6 et 10 du PIDCP sur cette question, voir Piet Hein van Kempen, 2008, p. 26-27.

178 Règle 31 Règles de Nelson Mandela.

179 Voir l'analyse des articles 6, 7 et 10 du PIDCP dans : Piet Hein van Kempen, 2008, p. 31-33.

180 Règle 26 des Règles Nelson Mandela et règle 21 des Règles de la Havane.

181 Voir l'analyse des articles 6, 7 et 10 du PIDCP dans : Piet Hein van Kempen, 2008, p. 31-33.

182 Article 13(2) de la CDPH ; Règles 75 et 76 des Règles Nelson Mandela et Règles 13 et 35 des Règles de Bangkok.

183 Voir par exemple : HRC, Observation générale n° 21, « Traitement humain des personnes privées de liberté » (article 10), 10 avril 1992, par. 10 : « [a]ucun système pénitentiaire ne saurait être axé uniquement sur le châtiment ; il devrait essentiellement viser le redressement et la réadaptation sociale du prisonnier ». Voir également : Règle 4 des Règles Nelson Mandela ; Règles 12 et 43 des Règles de Bangkok et Principe 10 des Principes fondamentaux relatifs au traitement des détenus.

184 L'article 16 de la CDPH impose aux États une obligation générale d'organiser des services de réadaptation pour les personnes (mentalement) handicapées. Selon le principe 9 des « Principes pour la protection des personnes atteintes de maladie mentale et pour l'amélioration des soins de santé mentale », le traitement des personnes atteintes de maladie mentale en général doit viser à préserver et à renforcer l'autonomie personnelle.

mentale en prison doit être axé sur la réintégration[185] et il doit, si nécessaire, se poursuivre après la libération[186].

5.3.3 Règles applicables à des groupes spécifiques de détenus

Les instruments protégeant des groupes particuliers de prisonniers vulnérables (femmes, mineurs), approuvent les règles générales ci-dessus, mais se concentrent davantage sur les risques spécifiques de santé mentale du groupe en question. Les Règles de Bangkok (pour les femmes), par exemple, contiennent des règles sur la détection et le traitement des traumatismes causés par la violence (sexuelle)[187], la répartition des détenues ayant des problèmes de santé mentale[188] et des règles supplémentaires sur la prévention du suicide et de l'automutilation[189]. Conformément à la section 12 des observations préliminaires des Règles de Bangkok, ces règles peuvent être également applicables aux détenus de sexe masculin ou de genre non-conforme[190]. Les Règles de La Havane (pour les mineurs) mettent également l'accent sur la vulnérabilité mentale. Elles prescrivent, par exemple, que les mineurs doivent recevoir des soins de santé mentale à la fois préventifs et curatifs[191], que des psychologues et des psychiatres doivent faire partie du personnel[192], que le personnel doit avoir des connaissances en psychologie de l'enfant[193] et que les sanctions disciplinaires sont limitées dans le cas des mineurs[194].

De ce qui précède, on peut déduire que les détenus atteints de maladie mentale ont le droit de jouir du meilleur état de santé mentale possible. Pour atteindre ce niveau, les États sont tenus de prévenir les maladies mentales, de dépister les maladies mentales et de prévenir l'exacerbation des maladies mentales. En ce qui concerne la qualité de ces soins, les détenus doivent recevoir des soins de santé mentale selon les mêmes normes que la communauté hors de la prison, sous réserve des restrictions liées à un environnement fermé. Ces soins de santé mentale doivent être dispensés par un personnel de santé

185 L'article 10, section 3, du Pacte international relatif aux droits civils et politiques stipule que le « but essentiel » du traitement des détenus est leur amendement et leur reclassement social. Voir également la règle 25 des Règles Nelson Mandela et la règle 51 des Règles de La Havane (les services de santé pénitentiaires doivent accorder une attention particulière aux détenus dont les besoins en matière de soins de santé entravent leur réinsertion).

186 Règle 110 des Règles Mandela ; règle 53 des Règles de la Havane et règle 47 des Règles de Bangkok.

187 Voir les règles 6(b), 7, 12, 20, 25 et 42 des Règles de Bangkok.

188 Règle 41(b) des Règles de Bangkok.

189 Voir les règles 16 et 35 des Règles de Bangkok.

190 Maartje Krabbe & Piet Hein van Kempen, 'Women in Prison: A transnational perspective', in: Piet Hein van Kempen & Maartje Krabbe (eds.), *Women in Prison: The Bangkok Rules and Beyond*, Anvers : Intersentia, 2017, p. 3-34, p. 30. En ce qui concerne les services médicaux, la section 12 des observations préliminaires des Règles de Bangkok fait même une référence explicite à l'applicabilité égale de ces services.

191 Règle 49 des Règles de la Havane.

192 Règle 81 des Règles de la Havane

193 Règle 85 des Règles de la Havane.

194 Règle 67 des Règles de la Havane.

professionnel et un traitement pour les maladies mentales doit être disponible. Par conséquent, l'absence de personnel de santé professionnel (en nombre suffisant) et de traitement dans les prisons du monde entier peut - en fonction également de la situation à l'extérieur de la prison - ne pas être conforme aux normes internationales et violer l'objectif de réinsertion des peines de prison et du traitement des malades mentaux en général. Enfin, le maintien en prison de malades mentaux qui ne sont pas pénalement responsables ou dont la maladie mentale est diagnostiquée ultérieurement et se détériore, n'est pas non plus conforme aux normes internationales.

5.4 Implications pour les droits de l'homme de l'incidence de la situation générale dans les prisons sur les détenus atteints de maladie mentale

La section 4.3 a démontré que les prisons ne sont pas conçues pour accueillir les personnes atteintes de maladie mentale, car l'*environnement carcéral* ordinaire ne leur convient pas. Différents facteurs contribuent à cette situation : l'attitude du personnel pénitentiaire à l'égard des patients atteints de maladie mentale, une infrastructure qui n'est pas conçue pour accueillir ces patients et l'effet négatif général de l'emprisonnement sur la santé mentale, qui peut avoir un impact sur les prisonniers atteints de maladie mentale encore plus important que sur les détenus ordinaires.

Les facteurs ci-dessus peuvent tous conduire à des violations des normes internationales en matière de droits de l'homme. Par exemple, comme expliqué dans la section précédente sur la santé mentale, faire fonctionner une prison avec un personnel qui n'est pas formé pour traiter les problèmes de santé mentale constitue en soi une violation des règles internationales. Lorsque le recours à un personnel non formé a des conséquences indésirables (dans la section 4.3, diverses formes de mauvais traitements sont mentionnées), ces conséquences peuvent constituer des violations des droits et principes contenus dans l'article 6 du PIDCP (droit à la vie), l'article 7 du PIDCP (interdiction de la torture et des traitements dégradants), l'article 10 du PIDCP (droit à un traitement humain des prisonniers), l'article 16 de la CDPH (obligation pour les États de prévenir l'exploitation, les abus et la violence à l'égard des personnes handicapées), l'article 26 du PIDCP (interdiction de la discrimination), l'article 5 de la CDPH (interdiction de la discrimination à l'égard des personnes atteintes d'un handicap mental) et le principe 4 des Principes pour la protection des personnes atteintes de maladie mentale et pour l'amélioration des soins de santé mentale (interdiction de la discrimination fondée sur la maladie mentale).

Une infrastructure qui n'est pas créée pour accueillir les patients atteints de troubles mentaux génère, en premier lieu, des problèmes de sécurité, tant pour les malades mentaux que pour les détenus ordinaires. Lorsqu'une prison ne parvient pas à garantir la sécurité de ses détenus, cela peut soulever des questions au titre de l'article 6 du PIDCP (droit à la

vie) et de l'article 10 du PIDCP (droit au traitement humain des prisonniers)[195]. En second lieu, les conditions matérielles d'une prison peuvent être inadaptées aux patients souffrant de troubles mentaux. Lorsque ces conditions matérielles équivalent à un traitement dégradant ou inhumain, cela peut soulever des questions au titre de l'article 7 du Pacte international relatif aux droits civils et politiques (interdiction de la torture et des traitements dégradants) et de l'article 10 du Pacte international relatif aux droits civils et politiques (droit au traitement humain des prisonniers). Le non-respect des règles de la prison en raison d'une maladie mentale et les sanctions disciplinaires qui en découlent peuvent également soulever des problèmes au regard des dispositions antidiscriminatoires résumées dans le paragraphe précédent.

En ce qui concerne les implications en termes de droits de l'homme de l'effet négatif de la détention sur la santé mentale - en particulier sur ceux qui souffrent déjà d'une maladie mentale à leur entrée dans le système pénitentiaire - on peut soutenir ce qui suit. Si les normes internationales prescrivent que les détenus qui ne sont pas pénalement responsables et les détenus qui développent des symptômes ultérieurement, pour lesquels rester en prison signifierait une exacerbation de leur état, ne devraient pas être détenus en prison (règle 109 des Règles Nelson Mandela) et si la détention influence généralement négativement la santé mentale des détenus, l'on peut affirmer que la détention dans ces cas (non responsable, symptômes se développant plus tard) constitue par défaut une violation des règles internationales. Qui plus est, l'on pourrait probablement faire valoir avec succès dans certaines situations que la détention d'une personne atteinte de maladie mentale dans un établissement inadapté peut soulever un problème au titre de l'article 7 du PIDCP[196]. Outre les implications en matière de droits de l'homme de l'*effet de* l'emprisonnement sur les malades mentaux, il est important de noter que les conditions de détention à l'origine de l'effet négatif sur la santé mentale peuvent *en soi* constituer des violations des droits de l'homme. Des exemples de ces conditions sont mentionnés dans la section 3.1.2, par exemple, différentes formes d'agression, le manque d'activités et

195 Le Comité des droits de l'homme a estimé que les droits énoncés aux articles 6 et 10 du PIDCP impliquent l'obligation pour l'État de prendre des mesures adéquates pour protéger la vie d'un détenu contre les meurtres et les agressions commis par d'autres détenus. Pour une analyse pertinente des articles 6 et 10 du PIDCP, voir Piet Hein van Kempen, 2008, p. 26-27.

196 Comparer l'analyse de Thoonen sur les affaires de la CEDH sur l'article 3 équivalent de la CEDH : Eveline Thoonen, *Death in state custody*, Apeldoorn-Anvers : Maklu, 2017, p. 116.

d'exercices significatifs, l'isolement cellulaire[197], les mesures de sécurité sévères, les mauvaises conditions générales de vie (nourriture, hygiène) et le surpeuplement[198].

En bref, parce que les malades mentaux peuvent être plus vulnérables aux effets négatifs de l'environnement carcéral et parce que les prisons ne sont souvent pas conçues (personnel, affectation) pour accueillir les malades mentaux, le risque de violation des règles et normes internationales semble augmenter en cas de détention de malades mentaux[199].

5.5 Implications des problèmes de postcure sur les droits de l'homme

Comme indiqué dans la section 4.4 sur les questions de suivi, de nombreux pays sont confrontés à des problèmes liés à la fois à la réintégration des détenus dans la société et aux soins de santé mentale *en général*. Dans le cas des détenus souffrant de troubles mentaux, les problèmes de réinsertion sont encore intensifiés par le manque de traitement en prison et la pénurie de professionnels de la santé mentale travaillant en probation. Cela peut finalement conduire à des séjours prolongés en détention. Les implications de cette situation en matière de droits de l'homme sont diverses. Tout d'abord, comme cela a été démontré dans la section 5.3.2 (Règles relatives aux soins de santé mentale en prison), les règles internationales prescrivent que le traitement de la santé mentale en prison doit être axé sur la réinsertion et qu'il doit, si nécessaire, se poursuivre après la libération. Par conséquent, lorsque le traitement et l'orientation des malades mentaux sont inadéquats, tant en détention que pendant la phase de postcure, cela peut constituer une violation des règles internationales. Deuxièmement, le fait de maintenir les malades mentaux en détention plus longtemps que de nécessaire peut soulever des problèmes au regard de l'article 9 du PIDCP (droit à la liberté et à la sécurité) et de l'article 14(1)(b) de la CDPH, qui stipule explicitement que « l'existence d'un handicap ne peut en aucun cas justifier une privation de liberté ». À cet égard, les séjours prolongés sont particulièrement injustes lorsque, d'une part, la guérison est une condition de la libération[200], alors que, d'autre part, aucun

197 Selon le principe 7 des Principes fondamentaux relatifs au traitement des détenus, « les efforts visant à abolir l'isolement cellulaire en tant que peine, ou à en restreindre l'usage, doivent être entrepris et encouragés ». Les Règles Nelson Mandela prescrivent également que l'imposition de l'isolement cellulaire doit être interdite dans le cas de prisonniers souffrant de handicaps mentaux ou physiques lorsque leur état serait exacerbé par de telles mesures (Règle 45).

198 Voir : Piet Hein van Kempen, 2008, p. 27, où Van Kempen soutient que l'article 10 du PIDCP implique le devoir des États de résoudre des problèmes tels que la surpopulation carcérale. Voir également le chapitre national sur la Grèce, où il a été constaté que la surpopulation dans les prisons grecques constitue une violation de l'article 3 de la CEDH.

199 UNODC, 2009, p. 15.

200 Voir par exemple le chapitre national sur le Brésil. Actuellement, les juristes s'éloignent de la « maladie mentale » comme critère pour les mesures de traitement. Ils affirment que le « danger » ou le « risque »

traitement n'est proposé par le système, ou seulement un traitement médiocre. Qui plus est, les dispositions anti-discrimination, telles que l'article 26 du PIDCP et l'article 5 de la CDPH[201], pourraient également être violées en cas de séjours prolongés en détention. Par exemple, lorsque le séjour est basé sur l'imposition de nombreuses sanctions disciplinaires qui ont été prononcées, malgré le fait que les détenus malades mentaux ne comprenaient pas ou ne pouvaient pas se conformer aux règles de la prison.[202]

5.6 Conclusion

La présente section démontre que les détenus malades mentaux sont protégés par les droits de l'homme internationaux, tant en leur qualité de défendeur ou de détenu qu'en leur qualité de patient de santé mentale. Les problèmes causés par le nombre disproportionné de malades mentaux confrontés au système de justice pénale ont plusieurs implications en matière de droits de l'homme. Le fait de ne pas offrir une protection supplémentaire aux défendeurs souffrant d'une maladie mentale au stade du (pré)procès constitue une violation des normes internationales. Il en va de même pour l'absence de traitement professionnel adéquat - lorsque ce traitement n'est pas limité par le principe du minimum vital et/ou le principe d'équivalence - en détention. La détention de patients souffrant de troubles mentaux non justifiés ou diagnostiqués ultérieurement et dont l'état se détériore est également contraire aux règles internationales. Parce que les malades mentaux peuvent être plus vulnérables aux effets négatifs de l'environnement carcéral et parce que les prisons ne sont souvent pas conçues (personnel, affectation) pour accueillir des malades mentaux, il semble y avoir un risque important de violation des règles et normes internationales si les malades mentaux sont détenus dans des prisons standard. Le manque de soutien aux malades mentaux dans le parcours de postcure peut non seulement violer le droit à la liberté et l'interdiction de la discrimination, mais il est également contraire à l'objectif de réinsertion, qui est le but ultime tant des peines de prison que du traitement de la santé mentale.

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devrait être un critère (plus) décisif dans de tels cas. Voir par exemple Michiel van der Wolf, *TBS: veroordeeld tot vooroordeel*, Oisterwijk: Wolf Legal Publishers, 2012, p. 729 (thèse avec résumé en anglais), Maarten Beukers, *Over de grenzen van de stoornis* (Les troubles mentaux en droit pénal), 2017, p. 241 (thèse avec résumé en anglais), non publié mais soumis en accès libre : https://repub.eur.nl/pub/102952 et Bijlsma et al, 'Legal insanity and risk', *International Journal of Law and Psychiatry* 66 (2019), p. 1-6, p. 5.

201 Voir également le principe 2 des Principes fondamentaux relatifs au traitement des détenus.

202 Voir la section 3.1.1.

6 Recommandations

Bien que la situation mondiale des malades mentaux dans le système de justice pénale soit alarmante, il est encourageant de constater, à la lecture des chapitres nationaux de ce volume, que les parties prenantes sont conscientes de l'ampleur du problème et s'efforcent de trouver des solutions à différents niveaux. Plusieurs États font état d'initiatives, telles que des groupes de travail actifs, des réformes législatives (mise en conformité des lois avec les normes scientifiques et celles relatives aux droits de l'homme) et des programmes (de réhabilitation) couronnés de succès[203]. Il faut espérer que ces initiatives contribueront à l'amélioration de la situation des malades mentaux dans le système de justice pénale. Cependant, il reste encore beaucoup de travail à faire. C'est pourquoi cette introduction se termine par quatre points d'attention pour les lois et politiques futures, basés sur les contributions à ce volume et les matériaux supplémentaires présentés dans cette introduction. Ces points focaux sont les suivants : (A) la déjudiciarisation des malades mentaux du système de justice pénale, (B) un cadre juridique et une politique visant à garantir la participation effective du défendeur malade mental au processus pénal, (C) la refonte des lois sur la détermination de la peine, et (D) un hébergement approprié pour les détenus malades mentaux. Il y a une certaine contradiction dans ces domaines d'action car le premier, (A), est basé sur la situation où le défendeur est retiré du système de justice pénale, tandis que les autres (B, C et D) sont basés sur la situation où le défendeur fait toujours partie de ce système. Cependant, comme la déjudiciarisation n'est pas toujours possible ou même souhaitable (voir ci-dessous), les gouvernements devraient à la fois investir dans les possibilités de déjudiciarisation et s'efforcer de créer la meilleure situation possible dans les cas où la déjudiciarisation n'est pas une option. Les derniers mots de cette section (E) sont consacrés à la question de la responsabilité des ministères. Qui est responsable des délinquants atteints de troubles mentaux : le ministère de la Santé ou le ministère de la Justice ?

A. Diversion

Nombre des arguments avancés dans les sections précédentes plaident en faveur de la déjudiciarisation du défendeur malade mental du système de justice pénale traditionnel : tant la procédure que les sanctions imposées ne sont pas conçues pour le délinquant malade mental. Cela entraîne de nombreux problèmes, notamment des violations des droits de l'homme (tant au stade du (pré)procès qu'en prison) et la récidive. Qui plus est, la détention de patients souffrant de troubles mentaux non justifiés ou diagnostiqués et qui se sont détériorés ultérieurement est même contraire aux règles internationales. D'une manière

203 Voir les chapitres nationaux sur le Brésil, l'Allemagne, la Grèce, la Hongrie, le Kazakhstan, la Nouvelle-Zélande et les États-Unis.

générale, c'est pour ces raisons que les contributeurs à ce volume et d'autres sources soutiennent la création de nouvelles possibilités de déjudiciarisation.[204]

Lorsqu'on réfléchit à l'amélioration de la situation des prévenus et des détenus souffrant de troubles mentaux par le biais de la déjudiciarisation, une question plus complexe se pose : à quoi ressemble un système de déjudiciarisation solide ? Une première étape à franchir serait de créer un système *qui reconnaîtrait la présence d'une maladie mentale le plus tôt possible*. Par conséquent, le dépistage précoce est primordial.[205] Comme l'a démontré la section 3.1.1, le dépistage n'est pas toujours appliqué, et souvent à un stade ultérieur. Ceci est regrettable, car le dépistage n'est pas seulement crucial pour permettre la déjudiciarisation, il est aussi une première étape pour garantir une défense efficace en cas de maladie mentale[206]. Qui plus est, le dépistage précoce est non seulement primordial, mais le fait de ne pas appliquer une telle évaluation contrevient aux règles internationales[207].

En ce qui concerne les détails de la déjudiciarisation, il existe de nombreuses possibilités et différents points de vue. La déjudiciarisation peut faire référence à une voie de sortie du système de justice pénale ordinaire, vers une division spéciale de ce système. Elle peut également faire référence à la déjudiciarisation du système de justice pénale vers le système de santé mentale ordinaire. Lorsque la déjudiciarisation a lieu au sein du système de justice pénale, le traitement dans une aile spéciale d'une prison ordinaire est une possibilité[208]. Certains plaident en faveur de prisons médicales séparées[209], tandis que d'autres rejettent fermement cette idée[210]. Dans le cas d'une réorientation vers le système de santé mentale, le traitement peut également être proposé selon différentes modalités, telles que le traitement volontaire ou involontaire, le traitement hospitalier ou ambulatoire[211].

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204 Graham Duncan & Jan Cees Zwemstra, 2014, p. 87 ; UNODC, 2009, p. 23 et OMS, 2005, p. 3. Voir également les chapitres thématiques de Vulić Kralj (conclusion) et de Morinaga & Yamamoto section 4. Voir également les chapitres nationaux sur le Chili et l'Espagne.

205 Graham Duncan & Jan Cees Zwemstra, 2014, p. 91 et UNODC, 2009, p. 14. Voir également : P.R. Kranendonk, 'Verdachten met een LVB in het politieverhoor: de invloed van verhoormethoden op de inhoud van verklaringen', 43 *Justitiële verkenningen* 6 (2017), p. 74-91. Cet article néerlandais traite spécifiquement de l'importance du dépistage dans le contexte des interrogatoires de police. Les résultats de la recherche dans cet article seront inclus dans la thèse à venir de Kranendonk sur les défendeurs ayant une déficience intellectuelle en anglais (2023).

206 Pour cette dernière raison, l'examen préalable est particulièrement important dans les systèmes contradictoires, car les responsabilités de la défense sont traditionnellement plus étendues dans ce modèle de procès. Cependant, l'importance générale du dépistage précoce peut également être soulignée par le fait que les systèmes de procès en général deviennent plus accusatoires. Voir le chapitre national sur les Pays-Bas et la contribution thématique de Van Kempen dans la partie II de ce volume, section 3.

207 L'article 25 de la CDPH prescrit un dépistage précoce au stade de l'enquête policière et diverses règles de l'ONU le prescrivent dans le contexte de la détention. Voir section 5.3.

208 Voir le chapitre national sur la Pologne.

209 Voir le chapitre thématique de Morinaga & Yamamoto, section 4.

210 OMS, 2005, p. 2.

211 UNODC, 2009, p. 12. Voir également le chapitre national sur l'Espagne où il est affirmé que le traitement ambulatoire involontaire est plus efficace que l'enfermement à court terme dans des prisons psychiatriques.

Il serait trop long d'énumérer toutes les options de déjudiciarisation et les avantages et inconvénients de ces modèles dans cette introduction. Cependant, quelques mots sont consacrés aux facteurs qui déterminent les contours d'un système de déjudiciarisation. Ces contours dépendent largement : (i) de la manière dont nous apprécions, en tant que société, les concepts d'aptitude à être jugé et de responsabilité pénale, (ii) du système national existant en matière de santé mentale et de justice pénale, (iii) du cadre existant des droits de l'homme et (iv) des points de vue scientifiques sur la resocialisation. Le premier facteur renvoie à des questions normatives : quand les capacités mentales sont-elles si perturbées qu'il est contraire à l'éthique de laisser une personne participer à un procès pénal ou d'imposer une responsabilité pénale à une personne ? Ces questions déterminent si une personne doit être traitée par le système de justice pénale ou non. Les réponses à ces questions seront en partie éclairées par les trois facteurs suivants. Le deuxième facteur, le système national actuel, fixe les limites des possibilités de déjudiciarisation. En l'absence d'un système de santé mentale, la déjudiciarisation est tout à fait inutile[212]. De même, la nature du système de justice pénale peut être un facteur déterminant les possibilités. Dans les systèmes plus inquisitoriaux, les tribunaux plutôt actifs ont souvent plus de possibilités de trouver une solution appropriée au sein du système de justice pénale pour le défendeur malade mental. Par conséquent, le système de justice pénale possède toute l'expertise en matière de soins médico-légaux, alors que le système de santé mentale n'a aucune expérience dans ce domaine[213]. Dans les systèmes plus contradictoires, où la maladie mentale peut avoir un impact plus important sur l'issue de la procédure parce que les plaideurs ont des responsabilités plus importantes[214], davantage de solutions en dehors du système de justice pénale sont créées, comme les tribunaux de santé mentale[215]. La nature des systèmes nationaux de justice pénale et de santé mentale, et la relation entre les deux, déterminent donc également le lieu optimal pour un défendeur atteint de maladie mentale. Le troisième facteur, les droits de l'homme, fixe également des limites, par exemple, dans les situations où la déjudiciarisation est nécessaire ou ne peut être appliquée. Le quatrième facteur, les connaissances scientifiques sur la resocialisation, nous oriente vers le système le plus efficace[216], offrant des arguments en faveur de la voie qui réduit la récidive et rend la société

212 Voir le chapitre national sur les États-Unis.

213 Voir Michiel van der Wolf *et al*, "Understanding and Evaluating Contrasting Unfitness to Stand Trial Practices", 9 *International Journal of Forensic Mental Health* 3 (2010), p. 245-258, p. 256/257. Voir également le chapitre national sur les Pays-Bas.

214 Voir Michiel van der Wolf *et al.* 2010, p. 249. Voir également le chapitre thématique de Van Kempen, section 5.

215 Voir pour une étude élaborée sur les tribunaux axés sur les solutions : Suzan Verberk, *Probleemoplossend strafrecht en het ideaal van responsieve rechtspraak*, Den Haag: Sdu uitgevers, 2011 (thèse avec résumé en anglais).

216 Voir par exemple cette récente publication arguant des avantages économiques de la déjudiciarisation (économies fiscales potentielles de plus d'un milliard de dollars) : Darci Delgado *et al*, 'Economics of

plus sûre. Bien que le système de déjudiciarisation optimal puisse être différent dans diverses parties du monde, l'objectif ultime est de créer un système qui offre un lieu humain pour le défendeur souffrant de maladie mentale, où le plus haut niveau de resocialisation - à la fois en tant que délinquant et en tant que patient de santé mentale - est possible.

B. Mesures procédurales

Afin d'éviter à la fois les violations des droits de l'homme et les erreurs judiciaires, un cadre juridique et une politique adéquats sont nécessaires pour garantir la participation effective du défendeur souffrant de troubles mentaux au processus pénal[217]. Cela signifie en premier lieu que la législation doit prescrire dans quelles conditions un défendeur peut participer à la procédure judiciaire (apte à être jugé). En vertu de la législation internationale des droits de l'homme, un défendeur participant à un procès pénal doit avoir un niveau minimum de compréhension, lui permettant de donner des instructions à son avocat de manière significative[218]. En second lieu, la législation et la politique doivent être claires sur les modalités de compensation disponibles pour garantir la participation effective du défendeur malade mental participant à un procès pénal. Cette compensation peut inclure, par exemple, une réduction des restrictions d'accès à un avocat[219].

Les chapitres nationaux de ce volume montrent que la plupart des codes nationaux contiennent des règles visant à protéger les défendeurs atteints de maladie mentale, en leur offrant diverses protections procédurales[220], y compris un meilleur accès à la défense obligatoire[221] et aux soins de santé mentale[222]. Toutefois, les auteurs indiquent également qu'il peut y avoir une différence entre la loi sur le papier et la loi en action[223]. Ces préoccupations concernant la protection des défendeurs atteints de maladie mentale au stade principal des procédures pénales peuvent être dues en partie au fait que les « défendeurs atteints de maladie mentale qui ne sont pas en détention » constituent un groupe plutôt invisible. Alors qu'il existe une abondance de données sur les détenus atteints

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decriminalizing mental illness: when doing the right thing costs less', 25 *CNS Spectrums* 5 (2020), p. 566-570.

217 UNODC, 2009, p. 22.

218 Pour une analyse des règles pertinentes, voir le chapitre thématique de Van Kempen dans la partie II du présent volume, section 5.

219 Pour une exposition plus élaborée de ces recommandations procédurales fondées sur la législation des droits de l'homme, voir le chapitre thématique de Van Kempen dans la partie II de ce volume, section 5. Voir également : E.M. Gremmen, 2018, p. 346. Gremmen soutient que la vulnérabilité mentale d'un défendeur devrait être compensée à toutes les étapes du procès pénal. Comme la vulnérabilité mentale peut fluctuer au cours du procès, elle doit constamment être réévaluée. Voir également la section 5.2 pour les fondements juridiques de ces recommandations.

220 Voir par exemple les chapitres nationaux sur le Brésil, la Hongrie, le Japon et le Kazakhstan.

221 Voir les chapitres nationaux sur l'Allemagne et la Grèce.

222 Voir le chapitre national sur l'Allemagne, notamment en ce qui concerne les mineurs.

223 Voir par exemple les chapitres nationaux sur le Brésil, la Hongrie, l'Irlande et le Kazakhstan.

de maladie mentale, peu d'études internationales sont disponibles sur les défendeurs en garde à vue et encore moins sur les défendeurs qui ne sont pas détenus[224].

Il est donc proposé ici que non seulement des procédures spéciales pour les accusés souffrant de troubles mentaux, basées sur les droits de l'homme internationaux, soient mises en œuvre dans nos systèmes nationaux, mais que ces règles soient également exécutées. Deux façons de stimuler l'exécution de ces règles pourraient être :

(iii) la formation des officiers de police et des autres autorités actives lors de la phase principale. Ces professionnels doivent recevoir des instructions sur l'identification des prévenus atteints de troubles mentaux, le cadre juridique qui leur est applicable et l'interaction avec ces prévenus de manière respectueuse et efficace[225].

(iv) Produire davantage de recherches sur les défendeurs atteints de maladie mentale qui ne sont pas détenus[226]. Ces dernières peuvent non seulement fournir des informations sur le respect des procédures nationales spéciales et des droits de l'homme internationaux dans le cas de ces défendeurs, mais aussi, par exemple, des données sur le nombre de défendeurs non détenus atteints de maladie mentale, sur l'évolution de la maladie mentale à partir du moment de l'arrestation et sur l'effet d'une poursuite pénale sur la santé mentale.

C. Condamnation

Les systèmes de condamnation doivent être réévalués dans le but de réduire les éléments qui augmentent le nombre de malades mentaux en prison. Cette réévaluation ne doit pas seulement se faire à un niveau très fondamental (par exemple : comment définissons-nous la responsabilité pénale ? Accordons-nous plus de poids à la répression ou à la resocialisation ? Le danger peut-il être un motif d'emprisonnement lorsque l'aptitude à être jugé ou la culpabilité criminelle sont absentes ?)[227], mais aussi en réparant les éléments qui sont mentionnés dans la section 3.1.1 sur les causes. Par exemple, en abolissant les politiques de condamnation imposant des peines sévères pour les récidives non violentes et en créant des garanties pour éviter les séjours interminables en prison.

224 Voir la section 2.

225 Voir le chapitre national sur les États-Unis. Voir également la section 5.2 pour les fondements juridiques de ces trois recommandations.

226 Cependant, au-delà de la question qui nous occupe, j'ai remarqué, au cours des travaux préparatoires de cette introduction, que peu d'informations sont disponibles sur la santé mentale des autres acteurs principaux du processus pénal, tels que les témoins, mais surtout les informateurs, les infiltrés et les témoins à charge. Quel serait le niveau minimum de capacité mentale pour que ces personnes puissent accomplir leurs tâches souvent psychologiquement exigeantes ?

227 Voir également le chapitre thématique de Manata sur la pondération de ces intérêts.

D. Hébergement

Les sections précédentes sur les problèmes (section 4) et les implications en matière de droits de l'homme (section 5) ont démontré que les prisons ne sont pas conçues pour accueillir des patients atteints de troubles mentaux. Il y a un manque général de traitement (et de suivi approprié) et l'environnement lui-même est antithérapeutique. Cela peut avoir des conséquences négatives, telles que des violations des droits de l'homme et la récidive. Pour ces raisons - et d'autres - il a été affirmé au point (A) que la déjudiciarisation hors de l'environnement carcéral ordinaire est la meilleure option pour les accusés souffrant de troubles mentaux. Toutefois, si la déjudiciarisation n'est pas envisageable, il convient de créer les meilleures conditions possibles pour les détenus atteints de maladie mentale. Plusieurs suggestions visant à améliorer la situation des malades mentaux dans les prisons ordinaires sont résumées ci-dessous.

Disponibilité du traitement

Le traitement doit être disponible en détention. L'aperçu du cadre pertinent des droits de l'homme présenté à la section 5.3 permet de comprendre que les détenus atteints de maladie mentale doivent recevoir des soins de santé mentale selon les mêmes normes que celles qui s'appliquent à la communauté en dehors de la prison, sous réserve des restrictions liées à un environnement fermé. Ces soins de santé mentale doivent être dispensés par un personnel de santé professionnel et un traitement pour les maladies mentales doit être disponible[228]. Les observations de la section 4.2 montrent que la pénurie de personnel de santé formé et en nombre suffisant est un obstacle majeur à la fourniture d'un traitement adéquat, qui devrait retenir l'attention immédiate des gouvernements[229]. Quant à la poursuite de la mise en œuvre d'un traitement de qualité conforme aux normes internationales, plusieurs des articles et rapports mentionnés dans le présent chapitre ont émis des recommandations détaillées, auxquelles renvoie la note de bas de page suivante[230]. D'une manière générale, il a été avancé que la meilleure façon d'établir des programmes de traitement est d'adopter une approche multi-départementale et intersectorielle[231] et que ces programmes devraient s'étendre à la phase de postcure[232]. En termes de conception du

228 Ces règles internationales sont également reflétées dans les recommandations de l'OMS, voir : OMS, 2005, p. 3.

229 Voir également les recommandations dans : UNODC, 2009, p. 26. Selon l'UNODC, le principe d'équivalence devrait s'étendre aux salaires et aux opportunités de carrière du personnel de santé dans les prisons.

230 Des recommandations quant à la qualité du traitement peuvent être trouvées dans : UNODC, 2009, p. 26-36 ; OMS, 2005, p. 3 et Graham Duncan & Jan Cees Zwemstra, 2014, p. 91. Ces recommandations abordent des sujets tels que le consentement au traitement, la sensibilisation aux périodes de risque accru, la continuité des soins après les transferts et les programmes de prévention du suicide.

231 Voir UNODC, 2009, p. 25 ; OMS, 2005, p. 3 et le chapitre national sur l'Irlande.

232 Graham Duncan & Jan Cees Zwemstra, 2014, p. 92 ; UNODC, 2009, p. 25 et Fondation HOSPICE Casa Sperantei, 2018, p. 5. Voir également le chapitre national sur les États-Unis.

traitement, il peut être utile d'explorer davantage l'idée que la maladie mentale en détention n'est pas seulement une pathologie individuelle apportée de l'extérieur, mais qu'elle peut aussi être - partiellement - considérée comme une réponse à l'environnement carcéral[233].

Formation du personnel permanent

Compte tenu du grand nombre de patients souffrant de troubles mentaux en détention et du risque de mauvais traitements, voire de violations des droits de l'homme par le personnel pénitentiaire permanent, la formation de ce personnel à la prise en charge des maladies mentales est primordiale. Cette formation doit être axée sur la promotion de la santé mentale et la réduction des atteintes à la santé mentale[234]. Par exemple, en y incluant des outils pour reconnaître et traiter les maladies mentales, des instructions sur la manière d'éviter les attitudes négatives envers les détenus ayant des problèmes de santé mentale et des connaissances de base sur le cadre des droits de l'homme applicable à cette population[235].

Créer un environnement carcéral thérapeutique

Afin d'améliorer l'accueil des malades mentaux dans les prisons ordinaires, les éléments antithérapeutiques – autres que ceux liés au traitement et au personnel, examinés ci-dessus – devraient être éliminés de l'environnement carcéral général. Une première étape consisterait à se concentrer sur les facteurs influençant négativement la santé mentale mentionnés dans la section 3.1.2.[236]. Un travail mené sur ces facteurs réduira la détérioration de la santé mentale dans les prisons[237]. En outre, lorsque l'on s'attaque à ces « éléments négatifs », la satisfaction des besoins fondamentaux des détenus devrait également figurer en tête des priorités. Ces besoins fondamentaux sont les suivants : le développement et le soutien

233 Alice Mills & Kathleen Kendall, 2018, p. 8. Dans ce dernier cas, selon Mills & Kendall, nous n'avons pas affaire à une maladie mentale mais à une réaction normale à un environnement anormal. Voir : Alice Mills & Kathleen Kendall, "Conclusion", in: Alice Mills & Kathleen Kendall (eds.), *Mental Health in Prisons: Critical perspectives on Treatment and Confinement*, Palgrave Macmillan, 2018, p. 355-364, p. 358/359.

234 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 139-141 et UNODC, 2009, p. 24.

235 Voir Graham Duncan & Jan Cees Zwemstra, 2014, p. 90 ; OMS, 2005, p. 3 et Fondation HOSPICE Casa Sperantei, 2018, p. 4. Voir également le chapitre thématique de Manata dans la partie II du présent volume et les chapitres nationaux sur la Hongrie, le Kazakhstan et les États-Unis. Pour quelques bonnes pratiques, voir : Semyon Melnikov *et al.* , "Nurses teaching prison officers: a workshop to reduce the stigmatization of prison inmates with mental illness", 53 *Perspectives in Psychiatric Care* 4 (2017), p. 251-258.

236 Plusieurs de ces facteurs ont été mentionnés dans les recommandations des organisations internationales. L'UNODC conseille de passer des sanctions disciplinaires aux mesures préventives dans le cas des détenus souffrant de troubles mentaux, car ces derniers ont souvent du mal à se conformer aux règles de la prison. Voir UNODC, 2009, p. 36.

237 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 137.

personnels[238], le maintien de relations intimes[239], l'exercice et les activités significatives[240], la sécurité[241] et l'intimité[242, 243]. Globalement, la promotion de la santé mentale devrait être un élément clé de la gestion des prisons[244].

Financement

De manière générale, un financement plus important est nécessaire, tant pour les programmes de déjudiciarisation que pour les soins de santé mentale en prison[245]. Dans la section 3.2, il a été indiqué que l'une des raisons possibles de la rareté des fonds est que les prisonniers souffrant de problèmes de santé mentale ne sont pas prioritaires dans l'agenda politique, en raison d'une intolérance générale des sociétés aux comportements difficiles ou dérangeants. Si tel est le cas, une première étape pour obtenir un financement adéquat consiste à lever le tabou sur la maladie mentale. Car, comme l'a si bien dit Alastair Campbell[246], *tant que nous ne serons pas ouverts sur la santé mentale, comme nous le sommes sur la santé physique, nous ne serons pas une société civilisée*[247]. Créer un soutien public pour les avantages d'une bonne santé mentale publique sera également utile à cet égard.

Un ensemble distinct de règles de l'ONU

La protection juridique internationale des détenus atteints de troubles mentaux pourrait être renforcée par l'élaboration de règles spécifiques de l'ONU pour ce groupe. Les arguments en faveur de cette idée sont les suivants : d'autres groupes vulnérables importants, comme les femmes et les mineurs, sont également protégés par des règles spécifiques de l'ONU ; les règles applicables aux accusés et aux détenus atteints de maladie mentale sont actuellement dispersées et un ensemble spécifique de règles de l'ONU permettrait de

238 Voir également le chapitre national sur l'Allemagne.

239 Voir les recommandations de l'UNODC, 2009, p. 36. Voir également José Cid *et al*, 'Does the experience of imprisonment affect optimism about re-entry?', 101 *The Prison Journal* 1 (2021), p. 80-101, p. 96. Cette étude démontre que l'expérience de conditions de détention difficiles rend les détenus plus pessimistes quant à leur réinsertion, tandis que le fait de recevoir un soutien familial pendant l'emprisonnement a l'effet inverse. Voir également le chapitre national sur l'Espagne.

240 Voir les recommandations dans UNODC, 2009, p. 36. Voir également le chapitre national sur l'Allemagne.

241 Voir les recommandations dans le chapitre national sur les États-Unis.

242 Voir le chapitre national sur l'Allemagne.

243 Eric Blaauw & Hjalmar J.C. van Marle, 2007, p. 137, faisant référence à une étude de Toch (1977). Selon Blaauw et Van Marle, la détérioration de la santé mentale peut être évitée en adhérant aux règles de Mandela et en satisfaisant les besoins fondamentaux des détenus tels qu'identifiés par Toch.

244 UNODC, 2009, p. 10 et le chapitre thématique de Vulić Kralj dans la partie II de ce volume. Pour une approche créative de l'amélioration de la santé mentale dans les prisons, voir : Jana Söderlund & Peter Newman, 'Improving mental health in prisons through biophilic design', 97 *The Prison Journal* 6 (2017), p. 750-772.

245 UNODC, 2009, p. 13 et 39.

246 Alastair Campbell (1957) est un écrivain et stratège britannique. Dans les années 90, il était l'attaché de presse de Tony Blair. Campbell a des antécédents de maladie mentale grave.

247 Alastair Campbell sur How To Fail, podcast d'Elizabeth Day sur Spotify (31 octobre 2018).

rassembler et d'organiser ce cadre ; la promotion du cadre applicable sera plus efficace si elle est présentée comme un ensemble cohérent de règles ; lorsque les tribunaux internationaux se familiarisent avec un ensemble de règles non contraignantes de l'ONU, ils peuvent renforcer ces règles et augmenter de la sorte leur poids juridique. Nous soutenons ici qu'un ensemble distinct de règles de l'ONU sur les prévenus et les détenus atteints de maladie mentale devrait non seulement rassembler et organiser le cadre juridique existant, mais aussi introduire de nouvelles dispositions. Par exemple, sur la séparation des accusés et des détenus atteints de maladie mentale pour des raisons de sécurité[248], sur l'accès à un psychiatre[249], sur le consentement au traitement[250] et sur les restrictions concernant les sanctions disciplinaires[251].

E. Santé ou Justice

En considérant les recommandations ci-dessus, la question suivante peut se poser : qui serait responsable de la mise en œuvre de ces recommandations, le ministère de la santé ou le ministère de la justice ? À l'heure actuelle, l'opinion dominante semble être que la responsabilité des délinquants souffrant de troubles mentaux incombe trop à la justice[252], alors qu'elle devrait être au moins une responsabilité partagée[253], voire, selon certains, une responsabilité sanitaire[254]. Le principal argument en faveur d'une plus grande implication de la santé, exposé dans les sections 4 et 5, est que le système de justice pénale n'est généralement pas conçu pour accueillir les malades mentaux. Par conséquent, confier des malades mentaux au système de justice pénale génère de nombreux problèmes, non seulement pour les détenus eux-mêmes, mais aussi pour les personnes qui travaillent avec eux et pour la société dans son ensemble. Un autre argument, plus théorique, réside dans la responsabilité pénale des accusés malades mentaux. Lorsque des personnes ne peuvent pas être - pleinement - tenues pour responsables, l'accent devrait être mis sur les soins

248 Bien que l'article 109 des Règles Nelson Mandela mentionne la possibilité de traiter les détenus atteints de troubles mentaux dans des établissements spécialisés, il n'est pas obligatoire de séparer les accusés atteints de troubles mentaux des autres accusés, comme c'est le cas pour les femmes, les mineurs et les détenus non jugés. Voir la règle 11 des Règles Nelson Mandela.

249 Les mineurs ont accès à un psychologue et à un psychiatre (règle 81 des Règles de La Havane), tandis que les adultes n'ont accès qu'à un professionnel de la santé mentale.

250 Cette question n'est pas abordée dans les Règles Nelson Mandela, voir section 5.3.2.

251 Dans le cas des femmes et des mineurs, les sanctions disciplinaires sont limitées (voir par exemple la règle 23 des Règles de Bangkok et la règle 67 des Règles de La Havane). Puisque le motif de ces restrictions réside dans les vulnérabilités spécifiques de ces groupes, un argument similaire peut être avancé pour les détenus souffrant de troubles mentaux.

252 Voir les chapitres nationaux sur le Brésil (selon la loi, une responsabilité en matière de santé ; en pratique, une responsabilité en matière de justice pénale), le Japon et l'Irlande.

253 UNODC, 2009, p. 22.

254 OMS, 2005, p. 2. Voir également les chapitres nationaux sur la Grèce et le Portugal. En Allemagne, les hôpitaux psychiatriques relèvent du ministère des affaires sociales, les détenus sont appelés patients et sont traités par le personnel médical. Voir le chapitre national sur l'Allemagne.

plutôt que sur la sanction[255]. Une raison tactique en faveur d'une plus grande implication de la santé est que le financement (partiel) des soins médico-légaux à partir des ressources de santé générera un budget plus stable. La raison : les investissements dans les « criminels » sont moins faciles à vendre au grand public que les investissements dans les soins de santé[256].

Afin de susciter une plus grande implication des services de santé, les organisations internationales recommandent que les besoins des détenus soient inclus dans les politiques et la législation nationales en matière de santé mentale[257], et que les services pénitentiaires et les services de santé collaborent étroitement[258]. Toutefois, une solide politique *générale* de soins de santé mentale semble être une condition préalable à la réussite de cette coopération[259]. Qui plus est, un nombre croissant d'études démontre que les problèmes de santé mentale sont plus fréquents chez les personnes socialement marginalisées en raison de difficultés socio-économiques.[260] Cela soulève la question de savoir si le débat « santé ou justice » n'est pas une fausse dichotomie, puisque le problème des détenus souffrant de maladies mentales est également ancré dans les politiques sociales et économiques, ce qui implique que ces départements du gouvernement doivent également jouer un rôle dans la solution.

Outre la question des responsabilités des départements, une question pratique doit également être abordée par chaque pays désireux d'apporter des améliorations à son système. À savoir : quel est actuellement le meilleur endroit pour les délinquants souffrant de troubles mentaux ? Où sont le financement et l'expertise ? La localisation de ce lieu peut très bien ne pas dépendre d'arguments théoriques faisant référence aux différentes branches du gouvernement, mais des systèmes de santé et de justice en vigueur[261].

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255 C'est également l'un des principes fondateurs de l'UHSA. Voir le chapitre thématique de Pautrat dans la partie II de ce volume, section 2.

256 Voir le chapitre national sur les Pays-Bas.

257 UNODC, 2009, p. 22 et OMS, 2005, p. 3.

258 UNODC, 2009, p. 22 et HOSPICE Casa Sperantei Foundation, 2018, p. 2. Voir également les chapitres thématiques de Morinaga & Yamamoto et de Manata dans la partie II du présent volume et les rapports nationaux sur l'Allemagne et le Japon. D'une manière générale, il serait également judicieux d'associer des experts en santé mentale non seulement à l'exécution des lois et des politiques, mais aussi à leur conception. Par exemple, un expert en santé mentale peut mieux estimer l'effet de certaines règles de procédure (B) ou de condamnation (D) sur les personnes atteintes de maladie mentale.

259 Craig Haney, 2020, p. 387 et UNODC, 2009, p. 10.

260 Voir par exemple : Anna Macintyre, Daniel Ferris, Briana Gonçalves & Neil Quinn, 'What has economics got to do it? The impact of socioeconomic factors on mental health and the case for collective action', 4 *Palgrave Communications* 10 (2018), p. 1-5 et Manuela Silva, Adriana Loureiro & Graça Cardoso, 'Social determinants of mental health: A review of the evidence', 30 *European Journal of Psychiatry* 4 (2016), p. 259-292.

261 Voir le point A. DIVERSION ci-dessus, où la différence entre les systèmes accusatoire et inquisitoire est discutée aux fins de la déjudiciarisation. Lorsque la justice a traditionnellement accueilli les malades mentaux, les institutions de santé mentale perdent leur expertise.

7 Conclusion

Le *nombre d'*accusés et de détenus souffrant de maladies mentales est si disproportionné qu'il devrait être considéré comme un facteur dominant qui façonne notre système de justice pénale. Les *causes* de ces chiffres élevés sont complexes et diverses. Certaines sont liées à la réaction de notre système de justice pénale face aux délinquants atteints de maladie mentale (mécanismes de déjudiciarisation, systèmes de sanction, organisation de l'assistance postpénale), d'autres peuvent être attribuées à la réaction de ces délinquants face au système (effet négatif sur la santé mentale). Le manque de financement et les problèmes généraux au sein de la justice pénale et du système de santé mentale sont également des facteurs qui contribuent à la position actuelle du délinquant malade mental dans le système de justice pénale. *In fine*, les causes susmentionnées peuvent être ramenées au fonctionnement des gouvernements et à la manière dont ils façonnent et financent les politiques sociales.

Le nombre élevé de malades mentaux pris dans la chaîne de la justice pénale pose de nombreux *problèmes*. Ces problèmes trouvent tous leur origine dans le fait que le système n'est pas conçu pour accueillir les personnes atteintes de maladies mentales. Cela entraîne les difficultés suivantes : de nombreux prévenus ne sont pas en mesure de faire face aux procédures pénales, il n'y a pas de traitement professionnel adéquat en détention, les prévenus souffrant de troubles mentaux sont hébergés dans un environnement inadapté et ne bénéficient pas d'un soutien suffisant dans le cadre de la trajectoire de suivi. Ces facteurs peuvent finalement contribuer à un taux élevé de récidive chez les détenus souffrant de troubles mentaux

Les problèmes causés par la situation actuelle ont des *répercussions sur les droits de l'homme*. Les personnes atteintes de maladies mentales dans le système de justice pénale bénéficient d'une double protection des droits de l'homme, à la fois en leur qualité de défendeur ou de détenu et en leur qualité de patient de santé mentale. Sur la base de ces deux cadres, il est avancé que bon nombre des problèmes générés par le nombre élevé de malades mentaux pris dans la chaîne de la justice pénale consistent en des situations qui ne sont pas conformes aux normes internationales en matière de droits de l'homme. Par exemple, le fait de ne pas offrir une protection supplémentaire aux accusés souffrant d'une maladie mentale au stade du (pré)procès constitue une violation des normes internationales. Il en va de même pour l'absence de traitement professionnel adéquat - lorsque ce traitement n'est pas limité par le principe du minimum vital et/ou le principe d'équivalence - en détention. La détention de patients souffrant de troubles mentaux non justifiés ou diagnostiqués ultérieurement et dont l'état se détériore est également contraire aux règles internationales. Parce que les malades mentaux peuvent être plus vulnérables aux effets négatifs de l'environnement carcéral et parce que les prisons ne sont souvent pas conçues (personnel, allocation) pour accueillir des malades mentaux, il semble qu'il existe un risque significatif de violations des règles et normes internationales en cas de détention de malades

mentaux dans des prisons ordinaires. Le manque de soutien aux malades mentaux dans le parcours de postcure peut non seulement violer le droit à la liberté et l'interdiction de la discrimination, mais il est également contraire à l'objectif de réintégration, qui est le but ultime des peines de prison et du traitement de la santé mentale.

Afin d'améliorer la situation des délinquants atteints de troubles mentaux, quatre points d'attention sont suggérés pour les lois et politiques futures :

(A) Détournement des malades mentaux du système de justice pénale
Il convient de créer davantage d'options de déjudiciarisation. Le dépistage précoce est une première étape importante d'un système de déjudiciarisation solide. Bien qu'il soit complexe d'argumenter pour savoir quel système de déjudiciarisation est « le meilleur », plusieurs paramètres déterminants d'un système de déjudiciarisation sont avancés : (i) le point de vue de la société sur les concepts d'aptitude à être jugé et de responsabilité pénale, (ii) le système national actuel de santé mentale et de justice pénale, (iii) le cadre actuel des droits de l'homme et (iv) les points de vue scientifiques sur la resocialisation.

(B) Assurer la participation effective du défendeur malade mental au processus pénal
Il ne suffit pas de mettre en œuvre, dans nos systèmes nationaux, des procédures spéciales pour les accusés souffrant de troubles mentaux, fondées sur les droits de l'homme internationaux. L'exécution de ces règles, qui s'est avérée problématique, doit également être garantie. Deux moyens de stimuler l'exécution précise des règles de procédure sont : (i) la formation des officiers de police et des autres autorités actives au cours de la phase principale, pour qu'ils apprennent à traiter les patients atteints de maladie mentale et (ii) davantage de recherches sur les défendeurs atteints de maladie mentale qui ne sont pas détenus, afin d'accroître la visibilité de ce groupe.

(C) Repenser les lois de condamnation
Les systèmes de condamnation doivent être réévalués dans le but de réduire les éléments qui augmentent le nombre de malades mentaux en prison, comme les peines sévères pour plusieurs petits délits.

(D) Créer des logements appropriés pour les détenus souffrant de troubles mentaux
Si la déjudiciarisation n'est pas envisageable, il convient de créer les meilleures conditions possibles pour les détenus atteints de maladie mentale. Plusieurs suggestions sont faites pour améliorer les conditions de vie des malades mentaux dans les prisons ordinaires : la disponibilité de traitements, la formation du personnel des prisons ordinaires à la prise en charge des malades mentaux, la création d'un environnement carcéral thérapeutique, la disponibilité de fonds supplémentaires et la rédaction de règles spécifiques de l'ONU.

Au niveau mondial, la responsabilité des délinquants atteints de maladie mentale est actuellement trop largement entre les mains de la justice. Par conséquent, une plus grande implication de la santé est vitale. Toutefois, une solide politique générale de santé mentale semble être une condition préalable à la réussite de cette coopération. En outre, les ministères des Affaires sociales et économiques pourraient également avoir un rôle à jouer dans l'amélioration de la situation actuelle. En définitive, la question de savoir quel est le meilleur endroit pour les détenus souffrant de troubles mentaux n'est pas seulement une question de « responsabilité », elle dépend aussi des systèmes de santé et de justice en vigueur qui déterminent où se trouvent les experts et où les meilleurs soins et traitements peuvent être apportés.

Dans l'idéal, les gouvernements devraient placer la situation des délinquants souffrant de troubles mentaux en tête de leur liste de priorités et s'efforcer de créer un lieu de vie humain pour les délinquants souffrant de troubles mentaux, où les professionnels peuvent travailler au niveau de resocialisation le plus élevé possible, avec le soutien (financier) de toutes les branches concernées du gouvernement. Cela irait dans l'intérêt non seulement des délinquants eux-mêmes, mais aussi des personnes qui travaillent avec eux et de la société dans son ensemble.

Part II
Themes

2ème Partie
Thèmes

The effects of the criminal process and deprivation of liberty on mental health

Olivera Vulić Kralj[*]

> *To deny people their human rights is to challenge their very humanity (Nelson Mandela).*

1 Introduction

The constitution of the World Health Organization (WHO) defines **health** as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[1] In the standard-setting definition of the WHO, **mental health** is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.[2] The expression **poor mental health** is used to describe the absence of well-being but also means that someone can have poor mental health without a clinical diagnosis of mental disorder. Poor mental health is associated with rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, physical ill-health and human rights violations.[3] **Mental disorders** are health conditions characterized by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others.[4] The course and outcome of mental disorders varies depending on different factors, i.e. the disorder per se, the individual as a whole and the social circumstances. Some disorders are acute and transient in nature, while others may be chronic. In some cases the limitation is confined, whereas in other cases it may involve disability.

Let us take a close look at the foregoing definition of mental health and oppose it to any state of deprivation of liberty, and *a minori maius* imprisonment, and assess the following two questions:

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1 Constitution of WHO: Principles.

2 WHO, *Fact file, Mental Health: A State of Well-being*, updated August 2014.

3 WHO, *Fact sheet, Mental Health: Strengthening Our Response*, updated March 2018.

4 WHO, *Fact sheet, Mental Disorders*, reviewed in April 2017.

1) Considering the definition, is it possible at all to *maintain* mental well-being during a state of imprisonment?
2) What effect(s) do(es) deprivation of liberty have on persons already diagnosed with mental disorder(s) prior to deprivation of liberty?

2 Effects of deprivation of liberty

The term 'prisonization' describes the process by which inmates are shaped and transformed by the institutional environments in which they live. In fact, it is the shorthand expression for the negative psychological effects of imprisonment.[5] It could be argued that recidivists (more) easily comply with the strict prison rules imposed by the authorities as they had previous experiences of imprisonment. In reality, the adaptation to imprisonment is difficult (almost always) for any kind of prisoner. The psychological effects of incarceration do vary from individual to individual. The effects are often reversible, and not everyone who is incarcerated is disabled or psychologically harmed by it. However, the atypical patterns and norms of living and interacting with others may – and more often than not actually do – have long-term consequences.[6]

One inevitable consequence of imprisonment, even in the most humane prisons, is the *deprivation of choices* that are taken for granted on freedom. The discipline, imposed by others, must be obeyed. People are no longer able to freely decide where to live, with whom to associate and how to fill their time.[7] Some of the powerful factors causing significant harmful effects on the mental health of most prisoners could be avoided with more emphasis on rehabilitation. It appears, however, that the current (global) trends are going more in the other direction, namely emphasizing retribution over rehabilitation. The WHO and the International Committee for the Red Cross (ICRC) identify the following factors as having particularly harmful effects on the mental well-being of (most) prisoners: overcrowding, violence of all sorts, enforced solitude or lack of privacy, lack of meaningful activity, isolation from social networks, inadequate health services, especially mental health services.[8]

Prisoners with mental disorders are at increased risk of acute mental harm and deterioration in an environment offering no privacy, purposeful activities or mental health support. They are ill-equipped to survive in the often harsh prison environment. Moreover,

5 C. Haney, *The Psychological Impact of Incarceration: Implications for Post-Prison Adjustment*, University of California, Santa Cruz, December 2001, p. 4.

6 *Ibid*., p. 3.

7 E. Blaauw & H.J.C. van Marle, *Mental Health in Prisons, Health in Prisons, A WHO Guide to the Essentials in Prison Health*, pp. 133-145.

8 WHO, *ICRC Information Sheet, Mental Health and Prisons*, p. 1 (at: www.euro.who.int/Document/MNH/WHO_ICRC_InfoSht_MNH_Prisons.pdf).

discrimination and stigmatization often encountered among the general public (such as mental disorder is a weakness; they are un-predictable; violent, and many other misconceptions) are ongoing and even magnified in the closed environment of prisons. Other prisoners are often unwilling to associate with them, often refuse to share cells or take part in joint activities, all of which cause such prisoners to remain isolated and their symptoms to deteriorate further.[9] Prisoners with intellectual disabilities are commonly subjected to abuse by their fellow inmates and by prison guards too. In the course of my professional experience as prison psychiatrist, I used to sense that such prisoners were sometimes sexually exploited by their fellow inmates who would subsequently claim that the abused fellow inmate consented to sexual acts (Note: as a rule in such cases, the capacity to make informed choices is questionable, to say the least.) Fitting into the pattern, prison guards more often than not did not comply with the legal duties of their profession, sometimes resorting to blackmailing victims to serve as informers in return for protection from further abuse. Thus, the victims are re-punished, and perpetrators feel encouraged to believe that they can easily continue their acts with impunity. Prisoners with mental disorders are in need of increased and specific care and protection. Apart from adequate mental health treatment, vigilant supervision is a necessity.

3 Challenges prior to imprisonment

What are the challenges concerning contact and interaction with law enforcement officials and during court proceedings? The European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment[10] considers access to a lawyer during police custody as a fundamental *safeguard against ill-treatment* and a means of ensuring a fair trial.[11] In order to be fully effective, this right must be granted *from the very outset* of a person's deprivation of liberty. The right of access to a lawyer should be enjoyed by everyone deprived of their liberty, no matter how 'minor' the offence of which they are suspected.[12]

In some jurisdictions, the law allows for police interrogation in the absence of a lawyer in cases of minor offences. But even in societies guaranteeing the right to a lawyer for all persons detained by the police, people with mental disorders are often questioned by the police in the absence of a lawyer. They may not be sufficiently aware of that right (had not been properly informed) or may be unable to gain access to legal counsel without assistance.

9 *Handbook on Prisoners with Special Needs, Criminal Justice Handbook Series*, United Nations Office on Drugs and Crime, 2009, pp. 11-13 .

10 Hereinafter referred to as CPT.

11 21st General Report, CPT/Inf (2011) 28, para. 23.

12 21st General Report, CPT/Inf (2011) 28, para. 18, 19, 20.

Owing to their social status, many of them are in need of free legal aid, which may not be offered.[13]

Persons with a mental impairment appear to be disproportionately represented among false confession cases. Many of them, both guilty and innocent ones, are more likely to confess than persons without mental disorders.[14] Those with intellectual disabilities are particularly highly suggestible and easy to manipulate. They lack self-confidence and good problem-solving abilities. They have tendencies to mask or disguise their cognitive deficits and to look to others, particularly to authority figures, for appropriate cues to behaviour. It is therefore easy to get them to agree with the misleading statements, even incriminating ones.[15] People with intellectual disabilities have characteristics that render them utterly vulnerable to law enforcement officials: desire to please persons with authority; being quick to take the blame; the inability to abstract from concrete thoughts. Consequently, they are vulnerable to arrest, incarceration and possibly execution (in some jurisdictions), even if they committed no crime.[16] Moreover, the state of mental disorder may affect the capacity of a person to understand the legal proceedings being initiated against him/her and to prepare a proper defence and other related matters.[17]

4 The presence of prisoners with mental and behavioural disorders

The presence of prisoners with mental and behavioural disorders in penal institutions is disproportionately high compared with their percentage in the community. A systematic review of 62 surveys of the incarcerated population from 12 Western countries showed that among the men:

- 3.7% had psychotic disorders
- 10% had major depression
- 65% had a personality disorder (including 47% with antisocial personality disorder).

In addition, a significant number suffered from anxiety disorders, suicidal behaviours, distress associated with all forms of abuse, attention deficit hyperactivity disorder (ADHD),

13 *Handbook on Prisoners with Special Needs, Criminal Justice Handbook Series*, United Nations Office on Drugs and Crime, 2009, p. 12.

14 A.D. Redlich, 'Mental illness, police interrogations, and the potential for false confession', 55 *Law & Psychiatry* 1 (2004), pp. 20-21.

15 R.A. Leo, 'False Confessions: Causes, Consequences, and Implications', 37 *Journal of the American Academy of Psychiatry and the Law Online* 3 (2009), pp. 332-343.

16 R. Perske, 'Observations of a water boy', 41 *Mental Retardation* 1 (2003), pp. 61-64.

17 R.K. Chadda, 'Forensic evaluations in psychiatry', 55 *Indian Journal of Psychiatry* 4 (2013), pp. 393-399.

mental retardation, etc. Approximately 70% had primary or comorbid substance abuse disorders.[18]

The large numbers of prisoners with mental and behavioural disorders have been explained from different angles. Some theories put the 'blame' on society, saying that "… prisons are used as dumping grounds for people with mental disorders because of the lack of mental health services in community".[19] Some theories show the significantly enhanced risk of violence in people who suffer from schizophrenia, through additional substance abuse, comorbidity with personality disorders, absence of treatment and social disintegration.[20]

On the basis of my experience, prisoners diagnosed with antisocial personality disorders pose the greatest challenge for managing in a correctional setting. Their behaviour is often manipulative, they are impulsive and disrespectful of social norms and rules imposed by the authorities, as well as ignorant of the needs and rights of others. They are susceptible to self-harm incidents and suicide attempts, but also to violence against others. However, when diagnosing prisoners with antisocial personality disorders, it so happens that the clinical descriptions and diagnostic guidelines are not always followed (according to ICD-10 or DSM-5).[21] The diagnosis is sometimes used as a default diagnosis for anyone repeatedly breaking social rules and seeming to have mental problems of some sort without having a psychosis. In such cases, the diagnosis of antisocial personality disorder becomes, in fact, a moral rather than clinical judgment, meaning that prisoners are 'bad, not mad'.[22] Sometimes mental health treatment in correctional settings is offered only to prisoners with serious mental disorders (psychosis), and prisoners diagnosed with personality disorders are not considered eligible for transfer to a psychiatric hospital, even when the clinical presentation calls for it.

The failure to properly attend to prisoners' personality disorders can lead to inappropriate responses by correctional staff, thereby aggravating prisoners' conduct and increasing incidents of self-mutilation and suicide attempts.[23] Hence, we may conclude that all prisoners with mental health needs require increased care and protection in prisons, including those diagnosed with non-psychotic disorders.

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18 S. Fazel & J. Danesh, 'Serious mental disorder in 23,000 prisoners: a systematic review of 62 surveys', 359 *The Lancet* 9306 (2002), pp. 545-550.

19 WHO Europe, *WHO and ICRC: Information sheet Mental Health and Prisons*, October 2005.

20 R. Haller, I. Dittrich & E. Kocsis, 'How dangerous are patients with mental disorders?', 154 *Wien Med Wochenschr*. 15-16 (2004), pp. 356-365.

21 ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the WHO; The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association (APA).

22 S. Abramsky, *Ill-equipped: U.S. Prisons and Offenders with Mental Illness*, Human Rights Watch, 2003, p. 32.

23 Human Rights Watch, *Who Are the Mentally Ill in Prison*, October 2003.

5 Prisons: theory versus reality

Ideally, the main goal of imprisonment should be to prevent future recidivism and guarantee public safety. Although it is a difficult task, it can be achieved if all means are used to improve the general conditions of detention and adequately respond to the mental health needs of prisoners. The programmes offered should be tailored to the individual needs of prisoners.

As stated previously, deprivation of liberty is stressful per se, always and for everybody. But the detrimental effects could be minimized by providing decent conditions of life and the full range of purposeful activities. For those with mental disorders – especially for those who were leading a chaotic lifestyle before imprisonment and did not have contacts with community mental health services prior to their imprisonment – a well-organized prison system managed according to pertinent human rights standards and principles could also offer an opportunity to connect with the proper services, all with the desired goal of giving a person the chance to recover and to retrain in order to adapt to society after discharge.

Article 10 of the International Covenant on Civil and Political Rights establishes that "[a]ll persons deprived of liberty shall be treated with humanity and with respect for the inherent dignity of the human person". The consequent translation of this legal (and civilizational) norm, standard and principle, by which at least the signatory and ratifying states should feel bound, means that prison conditions and treatment, including services, should be designed in a way that protects and promotes the mental well-being of all prisoners.[24] In reality, the reports from many monitoring bodies worldwide frequently show huge discrepancies between theory and practice; between international standards and the facts found in monitoring missions; little to inexistent respect for human dignity; prisoners living in the poorest of conditions, in environments unable to promote their physical and mental well-being. In many countries around the world, prisoners are accommodated in overcrowded, poorly ventilated and unsanitary prisons, in an atmosphere charged with the perceived or real risk of violence and abuse. Such conditions induce stress, depression and anxiety, which may develop into more serious mental disabilities if appropriate action is not taken.[25]

The UN Standard Minimum Rules for the Treatment of Prisoners[26] state that persons who are held not to be criminally responsible shall not be detained in prisons and that arrangements shall be made without further delay to transfer them to mental health

24 WHO Regional Office for Europe, *Health in Prisons Project, Consensus Statement on Mental Health Promotion in Prisons*, 1998.

25 *Handbook on Prisoners with Special Needs, Criminal Justice Handbook Series*, United Nations Office on Drugs and Crime, 2009, p. 19.

26 Hereinafter referred to as 'the Nelson Mandela rules'.

facilities.[27] However, monitoring bodies often reveal that patients with court-imposed security measures of mandatory psychiatric treatment in a healthcare facility are nevertheless found in ordinary prison sections, i.e. in settings where their basic mental and physical healthcare needs could not be adequately taken care of as required by internationally agreed norms and standards.[28] In deference to all security considerations, the care of persons subject to security measures should be based on treatment and rehabilitation.

In the third General Report, the CPT said that a mentally ill prisoner should be kept and cared for in a hospital facility adequately equipped and with appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system.[29] In any case, transfer to an adequate facility shall be organized without delay. During monitoring visits to Council of Europe member states, the CPT had met prisoners whose mental care needs were disrespected in ways that obliged the CPT delegation to make an 'immediate observation' pursuant to Article 8 para. 5 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment[30] and to recommend the prompt transfer to appropriate hospital facilities.[31] However, the transfer from a prison to a hospital does not automatically equate to actual provision of adequate care: hospitals may be poorly equipped and unable to offer material conditions conducive to the adequate treatment and welfare of patients; treatment for psychiatric patients may also be based exclusively on pharmacological treatment; there may be an absence of individual treatment plans tailored to the special needs of different categories of patients indicating the goals of treatment, the therapeutic means and the staff member responsible; occupational therapy and recreational activities may be non-existent; patients may be spending 23 hours a day locked up in their rooms in a state of total idleness.[32]

Taking into account the high incidence of psychiatric symptoms among prisoners, a doctor qualified in psychiatry should be attached to the healthcare service of each prison, and some of the nurses should have had training in this field.[33] The interdisciplinary team should act with full clinical independence and possess sufficient expertise in psychology and psychiatry.[34] The prison authorities are responsible for the healthcare of all prisoners and should ensure that a precise diagnosis is promptly established and that adequate

27 UN Standard minimum rules for the treatment of prisoners (the Nelson Mandela rules), rule 109.
28 CPT/Inf (2016) 17, para. 73.
29 3rd General Report, CPT (1992), para. 43.
30 See also the CPT Explanatory Report, European Treaty Series No. 126 Art. 8.5: *If necessary, the Committee may immediately communicate observations to the competent authorities of the Party concerned.*
31 CPT/Inf (2016) 31, para. 87.
32 All of these are examples of actual findings by CPT missions to COE member States; see also e.g. CPT/Inf (2016) 16, para. 115.
33 3rd General Report, CPT (1992), para. 43.
34 UN Standard Minimum Rules for the treatment of Prisoners (the Nelson Mandela rules), rule 27.

treatment pertinent to the state of health of the person concerned is provided. In the field, the situation is frequently far from ideal: low wages for specialist staff employed in prisons, their low social status, unpleasant and often extremely difficult and challenging working environments, inadequate support, etc. One of the consequences observed by the monitoring bodies is a clear shortage of medical staff found in many prison systems.[35] The CPT missions found that some prisons do not benefit from a psychiatrist's presence and that even prisoners diagnosed with serious mental disorders are not visited by a psychiatrist regularly. Such situations are described as *therapeutic abandonment*. An inadequate level of healthcare can lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment'.[36] Moreover, "untreated psychiatric illness in a prison setting leads to ad hoc measures which may easily constitute inhuman and degrading treatment".[37]

It is impossible to overemphasize the importance of medical screenings of newly arrived prisoners, particularly in establishments that constitute points of entry into the prison system (i.e. remand prisons). Every newly admitted prisoner should be properly interviewed and physically examined by a medical doctor as soon as possible after their admission.[38] All signs of psychological or other stress brought on by imprisonment per se, including the risk of suicide or self-harm and withdrawal symptoms resulting from the use of drugs, medication or alcohol should be identified on admission to prison.[39] The CPT visited many prisons where medical examinations were not being carried out within the first 24 hours after arrival at the institution. The procedure (screening) is often conducted with significant delays, often limited to a few general questions, and even more often under conditions not guaranteeing medical confidentiality.[40] Apart from constituting clear violations of the international standards regarding prison/health management, the consequences are obvious: neither are mental health problems diagnosed timely on admission to prison, nor are potential suicide risks recognized and possible deaths prevented. Many of those undiagnosed on admission are consequently left untreated during their imprisonment term.

As a group, inmates have higher suicide rates than their community counterparts.[41] The WHO identified young males, persons with mental disorders, indigent, socially isolated, people with substance use problems and those who have previously engaged in suicidal

35 *Handbook on Prisoners with Special Needs, Criminal Justice Handbook series*, United Nations Office on Drugs and Crime, 2009, p. 14.
36 3rd General Report (1992), para. 30.
37 CPT/Inf (2005) 18, par. 83.
38 CPT/Inf (2003) 6, para. 144.
39 UN Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), rule 30.
40 CPT/Inf (2015) 36, para. 50.
41 L. Snow, J. Paton, C. Oram & R. Teers, 'Self-inflicted deaths during 2001: an analysis of trends', 4 *The British Journal of Forensic Practice* 4 (2002), pp. 3-17.

behaviours as being at higher risk of suicide in prison setting.[42] Experts identify two key issues that need to be implemented to reduce the impact of suicide and self-harming behaviours among convicts: better identification of those individuals suffering from mental disorders and reduction of prison overcrowding.[43] The limited availability of psychiatric, psychological and educator staff – coupled with the absence of meaningful activities – undermines overall efforts at a systematic, multidisciplinary approach towards the prevention of self-harm and the associated risk of suicide.[44] *Conditio sine qua non* for any successful prison policy for prevention of suicide is adequate training of all prison staff coming into contact with inmates in recognizing indications of suicidal risk.[45]

When a suicide risk is recognized (with or without a previous suicide attempt), the prison authorities often resort to isolation of the prisoner concerned, and efforts are directed solely towards death prevention. Beside preventive measures, the authorities should take proactive measures, beginning with adequate mental health support. De facto isolation resulting from a combination of confinement to a cell for most of the day, little or no contact with staff and a poor regime, is the exact opposite of the care required. Prisoners presenting a risk of suicide or self-harm should be afforded increased contacts with other persons. Indeed, isolation may well increase the risk of suicide rather than decrease it.[46] It goes without saying that prisoners showing severe signs of suicidal or (auto)-aggressive behaviour should be immediately transferred to an acute mental health unit.[47] Yet in some jurisdictions instances of self-harm are considered to be disciplinary offences and are punished accordingly, causing further distress and leading, inevitably, to the worsening of any mental disorder. The acts of self-harm in prisons can be associated with personality disorders, drug dependence, a history of alcoholism and being a victim of violence, all of which require therapeutic responses.[48] The acts of self-harm frequently reflect problems and conditions of a psychological nature and should be approached from a therapeutic rather than from a punitive standpoint. All cases of self-harm ought to be assessed medically immediately after the incident to evaluate the extent of lesions and to assess the

42 *Preventing Suicide in Jails and Prisons*, Co-produced by WHO and IASP, the International Association for Suicide Prevention, WHO 2007, p. 4.

43 A. Preti & M. Tereso Cascio, 'Prison suicides and self-harming behaviors in Italy, 1990-2002', 46 *Medicine, Science, and the Law* 2 (2006), pp. 127-134.

44 CPT/Inf (2013) 30 part 1, para. 22.

45 *Preventing Suicide in Jails and Prisons*, Co-produced by WHO and IASP, The International Association for Suicide Prevention, WHO 2007, p. 9.

46 CPT/Inf (2013) 30 part 1, para. 23.

47 CPT/Inf (2011) 5, para. 136.

48 J. Borrill, R. Burnett, R. Atkins, S. Miller, D. Briggs, T. Weaver, & A. Maden, 'Patterns of self-harm and attempted suicide among white and black/mixed race female prisoners', 13 *Criminal Behaviour and Mental Health* 4 (2003), pp. 229-240.

psychological state of the prisoner.[49] Prisoners who harm themselves may be considered at higher risk of attempting suicide than others.

Prisoners with mental health problems are sometimes subjected to disciplinary procedures, although the underlying reason for the disciplinary offence committed has stemmed from their mental disorder. Prisoners with serious mental health disorders, particularly if the disorder has psychotic features, may find it next to impossible to abide by, or, in more extreme cases, even to understand, prison regulations. Sometimes prisoners refuse to follow orders because hallucinations and delusions have impaired their connection with reality. An inmate may resist being taken from his cell because, for example, they think the officers want to harvest their organs or because they cannot distinguish the officer's commands from what other internal voices are telling them.[50] Some may demonstrate disruptive behaviour, aggression and violence and refuse to follow routine orders, for no apparent reason. As a consequence, frequent disciplinary offences and punishment lead to the accumulation of misconduct reports, which have a negative impact on the prospects of early release of prisoners with mental disabilities – the very prisoners who should benefit from parole as a priority.[51]

Strategies need to be developed to reduce or eliminate the use of administrative segregation or any other potentially harmful punitive measures, by emphasizing preventative approaches. An overview of disciplinary measures relating to prisoners with mental disabilities is an urgent need in almost all prison systems. Criteria that are different from those that apply to the general prison population should be developed to respond to disciplinary offences committed by prisoners with mental disabilities, taking into account their treatment and social reintegration needs.[52] Use of disciplinary sanctions against psychiatric patients aim at sanctioning patients' behaviour, which is often likely to be related to a psychiatric disorder and should be approached from a therapeutic rather than a punitive standpoint.[53] Prisoners considered to be dangerous as a result of serious mental disorders should not be placed in high-security units. These prisoners should have access, in a hospital environment, to treatment and appropriate therapeutic activities, administered by a sufficient number of qualified staff to provide them with the assistance they require.[54] Special attention is needed when a placement in a solitary confinement cell is imposed on prisoners with mental disorders. The psychological effects of solitary confinement can

49 CPT/Inf (2009) 35, para. 92.

50 Human rights Watch, *Use of Force against Inmates with Mental Disabilities in US Jails and Prisons*, May 2015.

51 *Handbook on Prisoners with Special Needs, Criminal Justice Handbook series*, United Nations Office on Drugs and Crime, 2009, p. 16.

52 *Handbook on Prisoners with Special Needs, Criminal Justice Handbook series*, United Nations Office on Drugs and Crime, 2009, p. 36.

53 CPT/Inf (2017) 1, para. 113.

54 CPT/Inf (2008) 33, para. 138.

include anxiety, depression, anger, cognitive disturbances, perceptual distortions, obsessive thoughts, paranoia and psychosis.[55] The adverse effects of solitary confinement are especially significant for persons with serious mental disorders, in view of the possibility that the overall conditions (i.e. stress, lack of meaningful social contact and unstructured days) can exacerbate symptoms of illness or provoke recurrence.[56] The use of solitary confinement should be absolutely prohibited for mentally ill prisoners.[57]

The role of healthcare staff is particularly important in all disciplinary procedures. In many prisons, medical doctors are requested to sign 'a fit for punishment' certificate. Medical practitioners working in prisons act as personal doctors of prisoners. Ensuring a positive doctor-patient relationship is a major factor in safeguarding the health and well-being of prisoners. To oblige prison doctors to certify that prisoners are fit to undergo punishment is scarcely likely to promote that relationship. Prison doctors should be very attentive to the situation of prisoners placed in disciplinary isolation/segregation cells and should report to the prison director whenever a prisoner's health is exposed to serious risk by subjecting the prisoner to disciplinary isolation/segregation.[58]

6 The jurisprudence of the ECtHR

The European Court of Human Rights (ECtHR) is the best reference point for assessing the extent to which individual European states implement international standards in terms of complying with the ECHR. As stated previously, suicide is the most common cause of death in correctional institutions. Therefore, correctional institutions face a big challenge when a tragic event of suicide takes place, because of legal consequences. The following judgments are good illustrations of state failure to protect life, prohibit torture and ensure detention in accrdance with international human rights standards (Arts 2, 3 and 5 of the ECHR).

55 P.S. Smith, 'The effects of solitary confinement on prison inmates: a brief history and review of the literature', 34 *Crime and Justice* 1 (2006), pp. 441-568.

56 S. Abramsky & J. Fellner, *Ill-equipped: US Prisons and Offenders with Mental Illness*, Human Rights Watch, 2003, pp. 145-168.

57 The Istanbul statement on the use and effects of solitary confinement, Adopted on 9. December 2007 at the International Psychological Trauma Symposium, Istanbul.

58 Committee of Ministers' Recommendation Rec (2006)2 on the revised European Prison Rules (rule 43.2 and 42.3).

6.1 De Donder and De Clippel v. Belgium[59]

A young man diagnosed with paranoid schizophrenia before imprisonment committed suicide in the ordinary section of the prison, despite the prosecutor's decision to place him in the psychiatric wing of the Ghent Prison. The circumstances of the case were as follows: Tom De Clippel was arrested on suspicion of attempted theft. A psychiatric expert appointed by the investigating judge attested in the report that both when the alleged offence was committed and during the examination Tom De Clippel had been in a state of severe mental disturbance, making him incapable of controlling his actions. The expert explained that the accused needed to be placed in a secure therapeutic environment to undergo treatment. The Committals Division of the Ghent Court of First Instance found that Tom De Clippel had committed the offence with which he had been charged and ordered his detention under section 7 of the Social Protection Act. It held that, both at the time of its decision and at the time of the offence, the accused had been in a state of severe mental disturbance that made him incapable of controlling his actions and that he posed a danger to himself or society, within the meaning of the Act. It specified that Tom De Clippel would be temporarily detained in the psychiatric wing of Ghent Prison until the Mental Health Board designated an appropriate psychiatric institution. In accordance with the Mental Health Board's decisions, Tom De Clippel was placed in an institution specializing in drug-dependence treatment. After some time, his status was changed from resident status to living away from the centre at weekends. After a negative report from the social worker concerned, the deputy public prosecutor, finding that Tom De Clippel still posed a danger to society, ordered his return to the psychiatric wing of Ghent Prison. Tom De Clippel was readmitted to Ghent Prison, not to the psychiatric wing but to the section for ordinary prisoners. On 6 August 2001, Tom De Clippel hanged himself in his cell.

The court found a substantive violation of Article 2 ECHR (right to life) concerning the death of Tom De Clippel in prison and a violation of Article 5 § 1 (right to liberty and security) in respect of his detention in a prison environment. Tom De Clippel should never have been held in the ordinary section of a prison. Although he had not given any warning signs, the authorities should have been aware that there was a real risk that a young man suffering from mental disorders might attempt suicide while in an ordinary prison environment in Ghent Prison. The Social Protection Act clearly indicated that the detention was not to take place in an ordinary prison environment but in a specialized institution, or, as an exceptional measure, in a prison psychiatric wing. Furthermore, the deputy public prosecutor's decision had specified that he was to be placed in the psychiatric wing of Ghent Prison. The Court thus concluded that the detention in a prison environment had been in breach of domestic law. The 'detention' of a person as a mental health patient is

59 Application number: 8595/06, final on 3 June 2012.

'lawful' for the purposes of Article 5 *only* if effected in a hospital, clinic or other appropriate institution.

6.2 Keenan v. the UK[60]

A young prisoner committed suicide in segregation in the punishment block of Exeter prison. He was known to be at risk of suicide yet was not provided with adequate specialist medical supervision. He was punished for an offence, by way of segregation, which put him at further risk. The circumstances of the case are as follows: Mark Keenan had been receiving intermittent anti-psychotic medication since the age of 21, and his medical history included symptoms of paranoia, aggression, violence and deliberate self-harm. He was admitted to Exeter prison, initially to the prison healthcare centre, to serve a four-month prison sentence for assault on his girlfriend. Various attempts to move him to the ordinary prison were unsuccessful, as his condition deteriorated whenever he was transferred. After the question of being transferred to the main prison was repeatedly raised with him, Mr. Keenan assaulted two hospital officers, one seriously. He was placed in a segregation unit of the prison punishment block on the same day and consequently found guilty of assault, and his overall prison sentence was extended by 28 days (effectively delaying his release date from 23 May to 20 June), including seven extra days in segregation in the punishment block. On 15 May 1993, he was discovered hanging from the bars of his cell by a ligature made from a bed sheet.

The court found a violation of Article 3 ECHR (prohibition of torture).The lack of effective monitoring of Mark Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk. The belated imposition on him in those circumstances of a serious disciplinary punishment – seven days' segregation in the punishment block and 28 days added to his sentence imposed two weeks after the event and only nine days before his expected date of release – which may well have threatened his physical and moral resistance, is not compatible with the standard of treatment required in respect of a mentally ill person.

7 Conclusion

Alternatives to detention should be provided to persons with mental disorders who do not pose a threat to public safety. Effective interventions are possible at several stages in the criminal justice process, but the success of these programmes relies on strong

60 Application number: 27229/95, final on 4 March 2001.

community-based services. The most cost-effective strategy is to provide accessible treatment that keeps people with mental illness out of the criminal justice system in the first place.[61] As a minimum standard, all prisoners should be offered health services of an equivalent level to those in the community. Apart from mandatory comprehensive health screening on admission, ongoing care should be offered by properly trained multidisciplinary staff. The overall prison conditions should promote the mental well-being of all those deprived of their liberty.

61 D. Cloud & C. Davis, *Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications*, Vera Institute of Justice, February 2013.

Mentally disordered in prison? Prevalence, development of symptoms and recidivism

Oscar Bloem, Robbert-Jan Verkes & Erik Bulten[*]

1 Introduction[1]

This chapter provides an overview of studies on the prevalence of mental disorders[2] and the course of symptoms of mental disorders in prisoners across the world. It then describes how mental disorders may be related to recidivism after prison release. Issues of methodology, such as the number of prisoners in the study and how the assessment of mental disorders or symptoms took place, are addressed. Differences in the prevalence between countries are evaluated in terms of the local prison policies and circumstances. Judicial guidelines concerning prison mental health services and the way mentally disordered offenders should be dealt with differ considerably between countries. Furthermore, mental health is addressed in relation to minority subgroups of prisoners such as females.

2 Prevalence

Prisons worldwide face a high prevalence of mentally disordered prisoners. In general, this prevalence is much higher than in the regional general population (Andersen, 2004; Baranyi et al., 2019; Bebbington et al., 2017; Butler, Indig, Allnutt, & Mamoon, 2011; Di Lorito, Völlm, & Dening, 2018; Fazel & Danesh, 2002; Vicens et al., 2011). See Table 1 for

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1 This chapter is partly based on a recently published chapter on mental disorders and prison with a reflection on Belgian and Dutch penal mental healthcare system within prison (Bloem, Bulten, & Cosyns, 2019).

2 Mental disorders are defined and described in the Diagnostic and statistical manual of mental disorders (5th ed.) (American Psychiatric Association [APA], 2013).

an overview. According to previous overview studies, about 40 to 90% of all prisoners suffer from mental disorders, including substance-related disorders and (antisocial) personality disorders (Andersen, 2004; Blaauw, Roesch, & Kerkhof, 2000). In regard to differences between studies, the overall findings are more or less stable over time and across different parts of the world. Differences may result from methodology, such as measurement instruments used and inclusion or exclusion criteria, and may depend on whether lifetime or current pathology is addressed. In comparison, findings in the general population are much lower. A review and meta-analysis of 174 surveys about mental disorders (in which personality disorders were not included) in the general population was conducted (Steel et al., 2014). They described the overall past year prevalence in the population is about 18%. And up to 29% of the general population fulfil the criteria for a mental disorder at any time during their life (Steel et al., 2014).

Recently, Al-Rousan, Rubenstein, Sieleni, Deol, and Wallace (2017) studied 8,574 imprisoned males and females in the United States and found that almost 48% were diagnosed with a mental disorder. These findings were based on the official penitentiary files, including DSM-IV (Diagnostic and statistical manual of mental disorders, 4th edition) or ICD-9 (International Classification of Diseases, 9th revision) classifications as assessed by professionals from the penitentiary institution itself. As regards major mental disorders, such as psychosis or depression, females reported higher prevalence rates than men (Al-Rousan et al., 2017). A Spanish study among 707 regular imprisoned men, which included substance-related disorders, described a 41% presence of current mental disorder, assessed by the Structured Clinical Interview for DSM-IV (SCID) (Vicens et al., 2011). An Australian study of 1,208 newly detained men described a prevalence of 37% over the previous year, measured by the Composite International Diagnostic Interview (CIDI) (Butler et al., 2011). In this study substance-related disorders and personality disorders were excluded. Of the 207 females in the same study, 61% suffered from a mental disorder, which is considerably higher than the prevalence of 37% in men (Butler et al., 2011). An American study found a rather higher prevalence (91%) of current mental disorders in 56 newly detained women than that (85%) in 264 men. This was measured by the Mini International Neuropsychiatric Interview (MINI) and included substance-related disorders (Gunter et al., 2008). A Dutch study in 191 male prisoners on regular wards found that 68% suffered from a mental disorder (MINI), including antisocial personality disorders (Bulten, Nijman, & Van der Staak, 2009). A recent Dutch study of 226 newly detained men awaiting trial, which also used the MINI, reported a prevalence of 77%, which included substance-related disorders and antisocial personality disorders (Bloem, Bulten, & Verkes, 2019). In line with this finding, in French Guiana, a high prevalence of mental disorders in prisoners was reported. Among 647 newly detained men and 60 newly detained women 72% were classified with a MINI mental disorder, including substance-related disorders and antisocial personality disorders (Nacher et al., 2018). Findings for men and women

in this study were not displayed separately. An exception to the findings of rather high prevalence of mental disorders in prisoners was reported in a Taiwanese study. The official files from 82,650 Taiwanese prisoners (of which 10.3% were female) were studied. A prison psychiatrist classified an ICD-9 disorder in 11% of all prisoners, more often in women (18%) than in men (11%; Tung, Hsiao, Shen, & Huang, 2019), comparable to the differences that Butler et al. (2011) found between male and female prisoners in Australia.

Specifically, the official prison file diagnoses may under-represent the actual prevalence of mental disorders, because of possible barriers to reporting oneself for mental evaluation or lack of mental health services within prison. Later in this chapter we focus on the prevalence of specific mental disorders in prisoners.

2.1 Psychotic disorders

A meta-analysis based on 109 studies found that about 4% of all prisoners worldwide suffer from a psychotic disorder, such as schizophrenia. Studies display differences, with a higher prevalence reported in low- and middle-income countries, but, overall, this finding is stable over time (Fazel & Seewald, 2012). A recent meta-analysis on 23 studies specific from low- and middle-income countries reported a prevalence of 6% psychotic disorders in prisoners (Baranyi et al., 2019). In line with Fazel and Seewald (2012), a Spanish study found a prevalence of psychotic disorders in 4% of 707 male prisoners (Vicens et al., 2011). A review of nine studies in older prisoners (age above 50) described the presence of a psychotic disorder in about 5.5% of this subpopulation (Di Lorito et al., 2018). A recent English study, however, reported a higher prevalence of psychosis, measured by the Schedules for Clinical Assessment in Neuropsychiatry (SCAN), in 14% of 197 incarcerated men and 10% of 171 incarcerated women (Bebbington et al., 2017). An American study, using the official diagnosis from the prison professionals, described a psychotic disorder in 9% of 8,574 incarcerated men and women. Specifically, schizophrenia was reported to be prevalent in 3% of this population (Al-Rousan et al., 2017). A Dutch study found a current psychotic disorder in only 1% of 191 regularly imprisoned men, but a lifetime diagnosis was classified in 4% (Bulten et al., 2009). A recent study in 226 newly detained men in the Netherlands reported a psychotic disorder in 7% of the studied population (Bloem, Bulten, & Verkes, 2019). Some studies referred to a higher prevalence of psychotic disorders in prison than in the general population (Bebbington et al., 2017; Di Lorito et al., 2018). In comparison, a systematic review of 188 studies concludes that schizophrenia is diagnosed in the general population in about 5 of 1,000 (0.5%) individuals (Saha, Chant, Welham, & McGrath, 2005). A Finnish study on 8,028 persons from the general population

Table 1 Overview of prevalence of mental disorders in prisoners across studies

Study	Population	Number	Mental disorder	Psychotic disorder	Depressive disorder	Anxiety disorder	Substance use disorder	Attention deficit hyper-activity disorder	Antisocial personality disorder	Any personality disorder	Intellectual Dysfunction
Al-Rousan et al. (2017)	Men and women	8.574	48%	9%	18%	16.5%	26%			11%	
Andersen (2004)	Men and women	Review	37-94%	2-5%	2-3%; 10-14%	6-41% (10-20%)	29-86%		50-75%		
Baggio et al. (2018)	Men and women	Meta-analysis						26%			
Baranyi et al. (2019)	Men and Women	Meta-analysis		6%	16%		31%				
Bebbington et al. (2017)	Men	197		14%	20%	29%	55%			35.5%	
	Women	171		10%	25%	24%	60%			33%	
Blaauw et al. (2000)	Not specified	Review	37-89%	1-9%	6-29%***	6-29%	19-56%				
Bloem et al. (2019)	Men (remand)	226	77%	7%	13%***	19%	45%	8%	32%		
Bulten et al. (2009)	Men (prison)	191	61%	1%	9%	12%	30%	4%	37%		
Butler et al. (2011)	Men (remand)	1,208	37%	8%	18%***	31%	52%				
	Women (remand)	207	61%**	11.5%	29%***	31% 55%	69%				
Coid et al. (2009)	Men and women,	496			18%	11%			50%	65%	

Study	Population	Number	Mental disorder	Psychotic disorder	Depressive disorder	Anxiety disorder	Substance use disorder	Attention deficit hyper-activity disorder	Antisocial personality disorder	Any personality disorder	Intellectual Dysfunction
	remanded and sentenced										
Dias et al. (2013)	Men and women	1279									9%
Di Lorito et al. (2018)	Older prisoner (>50 yr)	Review	38%**	5.5%	28%	14%				23%	
Fazel and Danesh (2002)	Men, detained, sentenced	Meta-analysis		4%, 3%	9%, 11%				46%, 48%	65%	
	Women, detained, sentenced	Meta-analysis		4%, 4%	13%, 11%				20%, 21%	42%	
Fazel and Seewald (2012)	Men	Meta-analysis		4%	10%						
	Women	Meta-analysis		4%	14%						
Fazel et al. (2008)	Men	Meta-analysis									0.9%
	Women	Meta-analysis									1.4%
Fazel et al. (2017)	Men	Meta-analysis					30%				
	Women	Meta-analysis					51%				

Study	Population	Number	Mental disorder	Psychotic disorder	Depressive disorder	Anxiety disorder	Substance use disorder	Attention deficit hyper-activity disorder	Antisocial personality disorder	Any personality disorder	Intellectual Dysfunction
Gunter et al. (2008)	Men (remand)	264	85%*	10%	17%	36%	75%	23%	37%		
	Women (remand)	56	91%*	12.5%	14%	46%	68%	14%	27%		
Haysom et al. (2014)	Boys and girls (av. age 17)	295	87%*	3%	17%	22%		29.5%			14%
Nacher et al. (2018)	Men and women (remand)	707	72%	8%	14%		33%		35%		
Tung et al. (2019)	Men	82.650	11%								
	Women		18%								
Vicens et al. (2011)	Men (regular imprisoned)	707	41%*	4%	8%	23%	17.5%		23%	80%	
Young et al. (2015)	Men and women	Meta-analysis						25%			

*Notes: * (antisocial) personality disorders are excluded.*
*** substance use disorders and (antisocial) personality disorders are excluded.*
**** affective disorders, which include depressive disorder.*
Blank boxes indicate data was not reported.

found a lifetime prevalence of any psychotic disorder in about 3 to 3.5%, including schizophrenia in 0.9% (Perälä, Kuoppasalmi, Partonen, & Kieseppä, 2007).

2.2 Depressive disorders

About 11% of all prisoners suffer from a depressive disorder; a non-significant difference was found between men (10%) and women (14%). Despite differences between studies, these findings are stable over time for both men and women in (remand) prison (Fazel & Seewald, 2012). In low- and middle-income countries a recent meta-analysis reported a little higher prevalence of 16% in men and 19% in women (Baranyi et al., 2019). A review of older prisoners (over 50 years of age) described a prevalence of depression of 28% (Di Lorito et al., 2018), which is higher than that (11%) reported in Fazel and Seewald's (2012) meta-analysis. Recent studies in the United States and England also observed a relatively higher prevalence of 18% (Al-Rousan et al., 2017) and 22% (Clinical Interview Schedule; CIS) (Bebbington et al., 2017). A Spanish study reported a depressive disorder in 8% of 707 incarcerated men (Vicens et al., 2011). A Dutch study found a depressive disorder in 9% of 191 incarcerated men (Bulten et al., 2009). More recently, 13% of 226 newly detained Dutch men were diagnosed with an affective disorder (Bloem et al., 2019). Studies vary in the prevalences found, but most studies show higher prevalence rates for affective and depressive disorders in prisoners compared with the general population (Andersen, 2004; Di Lorito et al., 2018). A recent meta-analysis of 148 studies in the general population found an affective disorder in about 5%, more often in females (7%) than in males (4%) (Steel et al., 2014).

2.3 Anxiety disorders

In general, anxiety disorders are frequently found among prisoners, with a prevalence of approximately 10 to 20% (Andersen, 2004). The variance is influenced by, among other things, the inclusion criteria used, considering the broad spectrum of anxiety disorders. A Dutch study found anxiety disorders to be prevalent in 12% of 191 male prisoners (Bulten et al., 2009). In a more recent Dutch study of newly detained men awaiting trial, 19% suffered from an anxiety disorder (Bloem, Bulten, & Verkes., 2019). An American study of all 8,574 men and women in prison reported a prevalence of 16.5% (Al-Rousan et al., 2017). Studies on the prevalence of anxiety disorders in older prisoners (age > 50) described

findings of 14% (Di Lorito et al., 2018). Other studies found a higher prevalence of anxiety disorders than that cited previously. An English study found the prevalence in 196 incarcerated men and 169 women to be rather equal to each other, at 29% and 24%, respectively, as assessed by the CIS (Bebbington et al., 2017). An Australian study, however, reported a higher prevalence of anxiety disorders in 270 newly detained women than in the 1,208 included men: 55% versus 31% respectively (Butler et al., 2011). The prevalence of post-traumatic stress disorder (PTSD) was found to be 6% in the large American study among 8,574 men and women cited earlier (Al-Rousan et al., 2017). A systematic review of PTSD containing 56 studies over 20 different countries described the presence in 6% of all incarcerated men and in 21% of all incarcerated women (Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018). This represents a higher prevalence of approximately 5-fold for men and 8-fold for women, compared with the general population (Baranyi et al., 2018). Anxiety disorders in the broader range have been diagnosed in about 7% in the general population, on the basis of 122 studies (Steel et al., 2014). Anxiety disorders are generally more common in females (9%) than in males (4%) (Steel et al., 2014). A comparison between the prevalence of anxiety disorders among older prisoners and that among their counterparts in the general population showed no difference (Di Lorito et al., 2018).

2.4 Substance-related disorders

Many prisoners suffer from the problematic use of substances in life. The substances can be as diverse as alcohol, soft drugs or hard drugs. A recent review of 24 publications from 10 countries, which included studies on alcohol and/or substance use disorders in the past twelve months, found an alcohol use disorder in 24% of all prisoners (Fazel, Yoon, & Hayes, 2017). Drug addiction was present in 30% of all male prisoners and in 51% of all females. Large differences were reported between studies, with prevalence rates rising up to 69% (Fazel et al., 2017). Also in low- and middle-income countries lifetime prevalence of alcohol (28%) and substance (31%) use disorders in prisoners were in the same high ranges (Baranyi et al., 2019). All findings exceed the prevalence in the general population (Fazel et al., 2017). A meta-analysis of 104 studies found an overall prevalence in the general population of about 4%, higher in males (7.5%) than in females (2%) (Steel et al., 2014). Older people may form an exception to this finding, since alcohol use disorders in older prisoners do not seem to differ from those in older people in the general population (Di Lorito et al., 2018).

2.5 Attention Deficit Hyperactivity Disorders (ADHD)

A meta-analysis, containing 42 studies, reported attention deficit hyperactivity disorders (ADHD) to be present in around 25% of all prisoners (Young, Moss, Sedgwick, Fridman, & Hodgkins, 2015). These findings were independent of age or gender. This means that ADHD is ten times more common in prison than in the overall adult population (Young et al., 2015). In 2018, Baggio et al. published a meta-analysis on 102 studies from 28 countries on ADHD in different prison settings. They found a prevalence rate of 26% for ADHD in all prisoners. In retrospect, 41% were classified for ADHD during childhood (Baggio et al., 2018). A Dutch study in 191 adult male prisoners reported a 4% prevalence of ADHD in adulthood, but, retrospectively, about 38% would have classified for ADHD in childhood (Bulten et al., 2009). In a recent Dutch study of 226 adult male detainees too, only 8% fulfilled the criteria for ADHD (Bloem, Bulten, & Verkes, 2019).

2.6 (Antisocial) Personality disorders[1]

A meta-analysis of 28 surveys described the presence of a personality disorder in about 65% of all male prisoners and 42% in females. In particular, about 47% of the men fulfil the criteria for an antisocial personality disorder, compared with 21% in women (Fazel & Danesh, 2002). In contrast to other disorders, fewer imprisoned women seem to suffer from personality disorder than men. The overall prevalence rates were replicated in later studies. Coid et al. (2009) found that 65% of the 391 incarcerated men and 105 women that were studied by means of the SCID-II met the criteria for a personality disorder. However, no specifications were described in the findings between men and women in this study. In 50% of all these prisoners an antisocial personality disorder was classified (Coid et al., 2009). A Spanish study even reported that more than 80% of the 707 studied men in prison suffered from a personality disorder, measured by the International Personality Disorders Examination (IPDE), but the prevalence of an antisocial personality disorder was 'only' 23% (Vicens et al., 2011). A more recent English study found no differences between men and women concerning personality disorders: it also used the SCID-II and reported a personality disorder in 35.5% of the 197 incarcerated men and in 33% of the 171 incarcerated women (Bebbington et al., 2017). American research reported the presence of any personality disorder in 'only' 11% of 8,574 male and female prisoners (Al-Rousan et al., 2017). A recent Dutch study described the presence of an antisocial

1 The DSM-5 defines 10 specific types of personality disorders. Personality disorders are long-term patterns of behaviour and inner experiences that differ significantly from what is expected. The pattern of experience and behaviour begins by late adolescence or early adulthood and causes distress or problems in functioning (APA, 2013).

personality disorder in 32% of 226 newly detained men in remand prison (Bloem, Bulten, & Verkes, 2019). Personality disorders may fade out with age. In line with this, a review of older prisoners (age >50) found a personality disorder to be present in 23% of this subgroup (Di Lorito et al., 2018). Personality disorders in the general population are less common (Bebbington et al., 2017; Di Lorito et al., 2018). For example, a British study of 626 individuals in the general population found that about 4% fulfilled the criteria for any personality disorder (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006).

2.7 Intellectual dysfunction

Over the past few years more insight into and recognition of the presence of intellectual dysfunction (ID) in a larger group of prisoners has been provided. In 2008, Fazel, Xenitidis and Powell concluded from their meta-analysis that intellectual dysfunction with an IQ < 70, measured by validated and reliable psychodiagnostic testing, was present in about 0.5 to 1.5% of all prisoners. Australian researchers estimated the presence of ID with an IQ score of below 85 at 24% of 1,005 incarcerated men and 274 incarcerated women. ID was confirmed in 9% of this group of prisoners (Dias, Ware, Kinner, & Lennox, 2013). In another Australian study conducted in a group of 295 incarcerated youth (257 boys and 38 girls) with an average age of 17, ID (IQ < 80) was found present in 46% of all participants. In 14% an IQ of below 70 was measured (Haysom, Indig, Moore, & Gaskin, 2014). With reference to the general population it should be noted that the build-up of IQ scores reflects a normal distribution, with about 16% of the population scores <85 and around 2% below 70. Studies on intellectual dysfunction in prisoners are still sparse, and publications have recently been restricted to Australia. Since findings are inconsistent, more research is needed.

2.8 Autism Spectrum Disorders (ASD)

Prison conditions are not helpful in the diagnostic evaluation of autism spectrum disorders (ASD). ASD is a developmental disorder, a proper diagnosis of which requires information about development in childhood. This information is mostly lacking in prison or is very hard to obtain. It is therefore unsurprising that studies on the prevalence of autism in prisoners are sparse. The literature does suggest that people with autism are over-represented in prison, compared with the general population (Cashin & Newman, 2009; King & Murphy, 2014). In line with this, an American study of 431 male prisoners observed a possible presence of ASD in 4.4%, based on the autism spectrum quotient (AQ) (Fazio, Pietz, & Denney, 2012). Similarly, a recent Portuguese study among 101 male prisoners reported a higher risk of autistic traits compared with a control group, also

measured by the AQ (Loureiro et al., 2018). In the general population, any form of ASD is estimated to be present in about 0.4-0.6% (Fombonne, 2005). Lai, Lombardo, and Baron-Cohen (2014) reported a worldwide prevalence of about 1%.

3 Development of symptoms

Given these high prevalence rates of mental disorders in prisoners, the question arises as to how the symptoms of these disorders develop during imprisonment. The following part of this chapter provides an overview of the literature on this topic.

3.1 Symptom changes in the overall prison population

A review of fifteen longitudinal studies revealed that the highest levels of mental health problems are commonly reported during the first phase of imprisonment (Walker et al., 2014). In general, symptoms of primary depression and anxiety seem to decline over time (Walker et al., 2014). On the other hand, 15 to 28% (depending on the prison setting) of 228 remand prisoners in Denmark developed new mental disorders according to the Present State Examination (PSE) – mainly adjustment disorders, followed by depressive disorders – in the initial weeks of remand imprisonment (Andersen et al., 2000). Recently, Dirkzwager and Nieuwbeerta (2018) found an overall decrease on the Brief Symptom Inventory (BSI) over an 18-month period in 1,664 Dutch male prisoners from prisons all over the Netherlands. But self-reported mental health problems remained higher than in the general population (Dirkzwager & Nieuwbeerta, 2018). Also, in 75 Portuguese adolescents (17-22 years of age), a decline in symptoms on the BSI was reported over the first six months from admission, but not yet after the first three months (Gonçalves, Endrass, Rossegger, & Dirkzwager, 2016). An English study of 133 male adolescent remanded and sentenced prisoners measured depressive and anxiety symptoms using the Middlesex Hospital Questionnaire (MHQ) and found a decline in symptoms over the first two months of imprisonment (Brown & Ireland, 2006). An American study of 325 male prisoners displayed different findings. Depressive symptoms on the Beck Depression Inventory (BDI) increased from reception onwards but remained mild from a clinical perspective (Reitzel & Harju, 2000). Considering the effects of long-term imprisonment, a German study of 87 prisoners with an average stay of 14.6 years in prison reported a decrease in mental disorders over time, but the prevalence remained high compared with that in the general population (Dettbarn, 2012). She concluded that long-term imprisonment had no damaging effect on mental health.

3.2 Symptom change in specific mental disorders

The relationship between symptom changes during imprisonment with regard to specific mental disorders has been studied for more than thirty years. Harding and Zimmermann (1989) described, in their study of 208 male remand prisoners in Switzerland that prior mental health problems per se were not related to the symptom levels during imprisonment. Gibbs (1987) even found that higher symptom levels on the Symptom Checklist-90 (SCL-90) were reported in 102 newly detained prisoners (in America) without a reported history of a mental health disorder, in contrast to those with prior mental health problems. Studies display different results concerning symptoms during imprisonment in relation to mental disorders. More recently, according to an English study of 980 prisoners, those with a depressive disorder reported 'case' reduction on the general health questionnaire (GHQ) in the first two months of incarceration (Hassan et al., 2011). Also, prisoners without a mental disorder showed symptom reduction after two months in prison. Other prisoners in this study showed no symptom changes during the same time. A Dutch study followed 61 male prisoners with a psychotic disorder in the first twelve weeks of remand imprisonment. Most prisoners' psychotic symptoms remained stable, as measured by the Brief Psychiatric Rating Scale (BPRS), or even improved (Blaauw, Roozen, & Van Marle, 2007). A Danish study of 228 male and female prisoners on remand indicated that a substance-related disorder was associated with a lower incidence of new disorders during imprisonment (Andersen et al., 2000). Also for remand prisoners with drug and alcohol-related disorders, the Global Assessment Scale (GAS) scores remained unchanged within the subgroup of prisoners in solitary confinement (SC) (isolation), while those without such disorders got worse on the GAS (Andersen, Sestoft, Lillebæk, Gabrielsen, & Hemmingsen, 2003). Furthermore, symptom improvement, as measured by the GHQ, was steeper among remand prisoners with substance-related disorders than without (Andersen et al., 2003). Recently, a large Dutch study of 1,664 prisoners reported that prisoners with a history of mental health problems and/or substance-related problems experienced higher symptom levels at the start of remand imprisonment and seemed to improve in mental health, as measured by the BSI (Dirkzwager & Nieuwbeerta, 2018). An older study of 208 remand prisoners in Switzerland also indicated that prior alcohol and drug abuse was associated with low stress levels, which again was related to lower symptom levels on the GHQ, during remand imprisonment (Harding & Zimmermann, 1989). In a longer term follow-up study in Chile, 79 prisoners, both male and female, remanded and sentenced, with a major depression were followed up during imprisonment, one year after the first measurement. After this year, 67% improved in mental health according to the SCL-90 (Baier, Fritsch, Ignatyev, Priebe, & Mundt, 2016), while 44% still fulfilled the criteria for a depressive disorder. Previous imprisonment, being female and suffering from PTSD, were predictors of a prolongation of depression over time. Only 27% of these 79

depressive prisoners had consulted mental health services during imprisonment (Baier et al., 2016). An American study of 43 mentally disordered male prisoners, assigned to a special treatment unit within prison, showed an overall decline in symptoms on the BPRS and a decline in negative affect as measured by the Positive and Negative Affective Schedule (PANAS) between admission and discharge (Leidenfrost et al., 2016).

3.3 Symptom changes in relation to other prison or personal circumstances

Apart from mental disorders, mental health and symptom changes over time may be related to other prison or personal circumstances as well. A review of 15 longitudinal studies reported that symptoms most likely decline in sentenced prisoners but not in prisoners on remand per se (Walker et al., 2014). More deprived prison circumstances, specifically isolated prison conditions, can be seen as ultimate deprivation. Isolated prison conditions are related to more severe mental health symptoms, which are more likely to remain present over time within that prison context (Andersen et al., 2003). In Denmark a group of 133 remand prisoners in SC were compared with 95 non-SC remand prisoners. No differences were found for overall symptoms measured by the GHQ, since both groups experienced a decrease in symptoms and no differences were evident after transferral to a non-SC prison setting (Andersen et al., 2003). However, considering more specific symptoms of anxiety and depression, as measured by the Hamilton Anxiety Scale (HAS) and the Hamilton Depression Scale (HDS), differences were displayed. In a more deprived prison setting (SC) no changes were found, whereas in the less deprived setting (non-SC) symptoms of anxiety and depression improved, as well as after transferral to the less deprived prison setting (Andersen et al., 2003). In a Canadian study that included 23 segregated (isolated) and 37 non-segregated prisoners, segregation was associated with more severe depressive and anxiety symptoms on the BDI, BSI and State-Trait Anxiety Inventory (STAI), but mental health improved over time regardless of prison setting (Zinger, Wichmann, & Andrews, 2001). Two independent meta-analytic reviews reported that a highly deprived prison setting (segregation) related to higher anxiety levels but that segregation per se did not seem to produce lasting emotional damage (Morgan et al., 2016). An American study found that, on the basis of one year's population of 17.393 prisoners (92% male), prisoners with a mental disorder were more likely to be segregated than others with an odds ratio of 1.8 (O'Keefe, 2007). And within the subgroup of mentally disordered prisoners, those who were in segregation displayed significantly more severe symptom levels on the BPRS than those with a mental disorder who were in regular wards (O'Keefe, 2007).

Walker et al. (2014) reported in their review some evidence that larger prisons are associated with poorer mental health than smaller prisons. Furthermore, a record of

previous imprisonments was related to a lower risk of developing an incident mental disorder during the first phase of remand imprisonment in 228 male and female prisoners in Denmark (Andersen et al., 2000). Higher age, on the other hand, was associated with a higher incidence of mental disorders (Andersen et al., 2000). Differences in the development of mental health in prison were also found in gender. An English study described a decline in the number of cases on the GHQ for the 469 partaking men but not in the 146 women (Hassan et al., 2011). Considering relationships and social contacts, it was reported that of all the 208 remand prisoners, those who had a loved one and therefore loss of intimacy, were more likely to experience mental health problems measured by the GHQ (Harding & Zimmermann, 1989). Also, a review by De Claire and Dixon (2017) reported that receiving visits during imprisonment has a positive effect on prisoners, specifically on the reduction of depressive symptoms in adolescent prisoners and in female prisoners. A large Dutch study in 1,664 prisoners showed that those who were unemployed or non-participant regarding employment prior to imprisonment reported higher symptom levels on the BSI shortly after arrival in remand prison but no longer during further (remand) imprisonment (Dirkzwager & Nieuwbeerta, 2018). Finally, staff treatment of prisoners may be related to mental health. From the same large Dutch study, data was retrieved from 824 remand prisoners, in which it was found that fair and respectful treatment of prisoners was related to better psychological well-being on the BSI during imprisonment (Beijersbergen, Dirkzwager, Eichelsheim, Van der Laan, & Nieuwbeerta, 2014).

4 Recidivism

Policies on detention between countries may be different, but an important objective of imprisonment should be to prevent criminal behaviour. However, recidivism rates after detention are high throughout the world. Different studies describe rates from around 25% to 69%, depending on the type of prison population, time span in question and potential interventions after prison release (Baillargeon, Binswanger, Penn, Williams, & Murray, 2009; Baillargeon et al., 2010; Bunting, Staton, Winston, & Pangburn, 2019; Håkansson & Berglund, 2012; Hall, Miraglia, Lee, Chard-Wierschem, & Sawyer, 2012; Nacher et al., 2018; Skeem, Manchak, & Montoya, 2017; Wermink, Nieuwbeerta, Ramakers, de Keijser, & Dirkzwager, 2018; Wilson, Draine, Barrenger, Hadley, & Evans, 2014; Wilson, Draine, Hadley, Metraux, & Evans, 2011). Next we describe the risk factors behind these recidivism rates, paying closer attention to the presence of mental disorders.

4.1 Mental disorders and recidivism

Employing a large sample of 79,211 male and female prisoners in the United States, a retrospective study was conducted on previous incarcerations over the past six years. It was found that prisoners with any mental disorder, in particular bipolar disorder, were more likely to have been incarcerated more times over the past years (Baillargeon et al., 2009). Also, a recent study in French Guiana on newly incarcerated males (647) and females (60) found that any mental disorder, measured by the MINI, was related to previous imprisonment (Nacher et al., 2018). A more comprehensive study on 61,248 American male and female prisoners included more differentiating analyses on mental disorders and substance use disorders. This study found that repeated offending was higher in dually diagnosed (mental disorder and substance use disorder) prisoners compared with those with a single mental disorder, over the past six years prior to the current imprisonment (Baillargeon et al., 2010).

Prospective studies have also been performed. A Swedish study followed 4,152 male and female prisoners after release for a maximum of 4.7 years (Håkansson & Berglund, 2012). During follow-up, 69% were found to have reoffended. Mental health problems in themselves were unrelated to recidivism, but there was a relationship with amphetamine, heroin and poly substance use. Furthermore, the risk increased when drugs were injected (Håkansson & Berglund, 2012). A longitudinal study in the United States followed all 2,185 male and female prisoners leaving with a major mental disorder (psychotic or affective disorder). They were followed up on for a maximum of 3.9 years (1,410 days), and 46% were rearrested (Hall et al., 2012). Treatment participation and parole supervision reduced the risk of rearrest within this group of mentally disordered prisoners. None of the mental disorders related to an elevated risk for recidivism, but substance use disorder (SUD), in addition to a mental disorder, was associated with a higher risk of rearrest (Hall et al., 2012). Also, another large US study on 20,112 male and female prisoners reported that prisoners with dual diagnosis were most likely to reoffend and that substance use disorders accounted for the difference. During a four-year follow-up, major mental disorders did not differ from prisoners without a mental disorder on reoffending rates (Wilson et al., 2011). Another study by Wilson et al. (2014) described prisoners with co-occurring substance use disorder as reoffending more quickly. This American study sample contained 16,434 male and female prisoners who were followed up for a three-year period (Wilson et al., 2014). In this study too, rates of recidivism were not different between prisoners with a major mental disorder and those without one (Wilson et al., 2014). A Swedish study in 318 mentally disordered male offenders in different settings concluded that prisoners and offenders with non-custodial sentences were more likely to reoffend during a two-year follow-up than offenders who were placed in a forensic treatment facility (Lund, Forsman, Anckarsäter, & Nilsson, 2012). Offenders with substance use disorders or personality

disorders were more likely to reoffend than offenders with any other single mental disorder (Lund et al., 2012). In a study that looked at a subgroup of 1,272 American prisoners with a substance use disorder, who followed a six-month SUD treatment programme after an average stay of two years in prison, it was found that after one-year follow-up, (only) 25% were reincarcerated. Relapse into substance usage was significantly related to recidivism (Bunting et al., 2019).

4.2 Other factors that may be related to recidivism

Apart from the relationship between mental health and risk for recidivism, other factors may also be influential in ensuring successful reintegration into the community. We discuss these factors briefly. The most cited factor is the higher risk of reoffending among former prisoners that are homeless and unemployed (Baillargeon et al., 2010; Bunting et al., 2019; Håkansson & Berglund 2012; Hancock, Smith-Merry, & Mckenzie, 2018; Lund et al., 2012). Furthermore, barriers or access to mental healthcare or special (parole) programmes seem to be related to reoffending, especially among former prisoners who were mentally disordered (Baillargeon et al., 2010; Hall et al., 2012; Hancock et al., 2018; Skeem et al., 2017). Factors of interest during imprisonment are segregation and receiving visits. Segregation during imprisonment was associated with a small increase in post-release recidivism. It is, however, unclear whether this relationship is direct or moderated by other related criminogenic factors that may influence both segregation and recidivism separately (Morgan et al., 2016). Prisoners that receive (more frequent) visits, specifically visits made closer to their release from prison, may be at a lower risk of reoffending after being released (De Claire & Dixon, 2017). This may support the hypothesis that receiving visits is related to a more protective social network to help reintegration after prison release. Some studies found a relationship between short stay in prison and recidivism (Hall et al., 2012; Håkansson & Berglund, 2012), whereas others did not find a relationship between time spent in prison and reoffending (Wermink et al., 2018). Finally, younger age, especially at the start of the criminal career, and the number of previous arrests and incarcerations are related to a higher risk of reoffending (Hall et al., 2012; Lund et al., 2012).

5 Conclusion

Despite differences between studies, the prevalence of all types of mental disorders in prisoners is high compared with that in the general population and, in general, higher in female than male prisoners. Differences in the prevalence reported over different studies may be attributable to the specific population studied, such as remanded or sentenced prisoners. Methodology can also be a factor and may include differences in the instruments

used to assess mental disorders or the focus on particular disorders and the neglect of other types of mental disorders. Also, there are differences between current versus lifetime disorders, but these are not always displayed well in studies. Differences across the world on how to manage mentally disordered offenders may be reflected in the prison population too. If mentally disordered offenders are filtered out and placed in specific units or treatment facilities, the prevalence of mental disorders among prisoners will turn out differently. Despite these factors, the findings on the prevalence of mental disorders seem rather consistent over time and across the world.

Overall, mental health symptoms, especially depressive and anxiety symptoms, have been found to improve over time during imprisonment, more so in sentenced than in remand prisoners. Prisoners with mental disorders do not seem to respond differently to prison conditions. In fact, prisoners with substance-related disorders seem to display less elevating symptoms and/or to improve progressively and quickly in their mental health during imprisonment. For this specific group of prisoners, the contrast with their daily living circumstances before incarceration may explain these findings (Harding & Zimmermann, 1989; Van Ginneken, 2015).

In general, prisoners' mental health seems to react differently in an isolated prison environment in comparison with regular prison wards. Specifically, elevated and non-improving symptoms of depression and anxiety were reported in SC. However, it should be noted that this result may reflect a selection bias of prisoners with mental disorders, as O'Keefe (2007) suspected.

Concerning the relationship between mental disorders and recidivism, the most striking and replicated finding in several studies is the relationship between substance-related disorders and recidivism. Other factors in reoffending, such as homelessness and unemployment, are relevant but not uniquely related to mental disorders.

6 Closing remark

The societal relevance of the prevalence of mental disorders in prisoners, specifically in relation to the development of mental health problems and recidivism after release from prison, is clearly reflected in a growing interest in the scientific literature. Yet the complex combination of personal and circumstantial factors that may be related to changes in mental health during imprisonment needs further attention. Apart from mental disorders, other personal, prison and behavioural factors may influence mental health and risk of recidivism. The relationship between the development of mental health problems during imprisonment and recidivism of delinquency after prison release needs further attention in longitudinal studies.

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On the treatment of prisoners with psychiatric disturbances: a matter of health or justice?

Taro Morinaga & Mana Yamamoto[*]

1 Introduction

Treatment of offenders with psychiatric disturbances seems to be almost an eternal issue. For the general public, offenders with psychiatric disturbances are nothing but a frightening existence, and they may wonder why it takes such a complicated discussion just to keep scary offenders out of society. For them, it would matter less whether a mentally disturbed offender goes to prison or to a psychiatric hospital, as long as he is properly locked up and kept away. But from the human rights perspective on one side and the need for the safety of society on the other, this issue needs more careful consideration. It seems that, in many countries, prisons accommodate too many inmates with psychiatric disturbances and are criticized as being an easy replacement for mental hospitals. Given the fact that mentally handicapped people have the tendency to come more frequently in conflict with criminal law, it is quite understandable that the percentage of mentally disturbed persons in prison is higher than that in society as a whole. But if this ratio reaches an extreme level, then we will have to start considering whether there is anything wrong with the system or its execution.

2 Causes

If it is observed that a prison of a certain country is overcrowded with mentally disturbed inmates, there may be multiple reasons behind it that need to be considered.

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One contributing factor may be how the insanity defence works. If it is generally difficult to successfully advance an insanity defence, more defendants with serious psychiatric disturbances will end up in prisons. Similarly, cases of diminished mental capacity will also result in the imprisonment of many convicts with psychiatric disturbances, if the law does not permit the judge to lower the sentence beyond a certain level, making the defendant eligible for non-institutional punishment.

Another factor to be considered may be diversion at an early stage, where the prosecutor weighs all the relevant elements, such as the seriousness of the committed offence and a social stigma against the mental handicap of the suspect and opts for non-prosecution while looking for alternatives.[1] But if prosecutors are in general reluctant to drop cases or if the law does not allow them to do so, more persons with psychiatric disturbances will end up in prisons.

Almost the same can be said about courts. If the courts are reluctant to grant suspension of sentencing or punishment, or release on parole or probation, this will also lead to an increased population of mentally ill prisoners.

The problem will grow even bigger once the prosecutors or judges become tilted towards populism or become too much affected by the emotion of victims or their families. Especially in situations where there is no appropriate institution or facility to deal with or accommodate persons with mental disturbances who have been diverted or acquitted, prosecutors and judges may become quite reluctant to divert or acquit such persons in conflict with the law, wanting to avoid criticism that they set 'a dangerous culprit' free.

Further, a quite ironic situation may arise owing to different understandings with respect to the role of medical care. For medical practitioners, the first priority is to heal or cure their patients, and thus it is a presupposition for them that they can expect medical treatment to have some effect, i.e. the patient is responsive to medical treatment. In other words, if the results of psychiatric and medical examination of a certain person with a psychiatric disturbance show that there is no hope for the person to cure or improve his condition, doctors would say that there is no use continuing any treatment. They would say, "Our task is to cure patients, not to simply lock them up; we're not a detention facility". In such a situation, it is easily imaginable that the prosecutor or the judge feels the need to put the defendant in jail because they think it would be inappropriate just to let him go free. Here, the prison may indeed become a replacement for a psychiatric hospital.

In some developing countries, the problem may be much more serious, because such countries may not be able to afford sufficiently equipped hospitals or clinics. They may

1 Here the authors use the term 'diversion' in its broadest sense. 'Diversion' often refers to a system or practice under which the suspect or defendant is led to an optional treatment other than the formal criminal disposition on the condition that the suspect or defendant successfully completes a certain kind of rehabilitation programme. Here, however, the term is used just to mean the avoidance of a full-fledged criminal procedure and a formal incarceration judgment.

lack proper financial and human resources to deal with mentally disabled patients. Under such circumstances, the authorities may have no other choice than to send a convicted felon with psychiatric disturbance to prison. For such countries, diversion of an offender to a mental hospital may be a luxury they cannot afford. Here, prisons indeed serve as mental hospitals.

3 Criminal justice versus medical care

Offenders should be treated as offenders and patients as patients. If an offender has fulfilled all the elements of a crime, including the subjective elements such as *mens rea* and sanity, it is the responsibility of the justice sector to handle such a person. If the person is found in a state of insanity at the time of the commission of the alleged offence, and is still suffering from a psychiatric disturbance, it is the health sector that has to take care of him as a patient. But the problem arises from the reality that many persons coming in conflict with criminal law have both characteristics – they are offenders and patients at the same time. These are the people that the justice system cannot find legally insane, but from the viewpoint of psychiatrics they are in dire need of medical treatment. The fundamental difference between the criminal justice response and medical treatment concerning their respective ideas and purposes adds more complexity to the issue.

The mandate for a prison is to keep prisoners safely incarcerated and make them diligently serve the sentence rendered by the court, while the first priority for medical care is to cure, or at least avoid deterioration of, the convicts' health and mental conditions. These values or interests sometimes come into conflict with each other. How we can balance these countervailing values and interests, or determining which value or interest we should prioritize, is a very difficult issue.

We believe that the starting point or the bottom line is to remind ourselves that an incarceration sentence rendered by the court orders the convict to be confined in a penal institution and, in some jurisdictions, to do certain work but nothing more. Deprivation of health or life is not a part of the sentence. Thus, if there is a probability that imprisonment causes serious damage to the convict's health that is beyond the ability of the particular prison or any other prison in the country to cope with, the convict has to be released and placed under medical care. And this may apply also to the prosecution stage, where the prosecutor is considering whether to prosecute or not. The prosecutor has to predict such a situation and act accordingly within his authority.

However, on the other hand, the risk of setting a prisoner with psychiatric disturbances free – the danger to society – must also be properly taken into account. Although it looks quite humane to release an inmate with deteriorating health conditions from the viewpoint that his health has priority over punishment, there will be no justice if the released person

commits another heinous offence, say, killing three people. So we may have to recognize that there are situations under which the authorities should not release a particular inmate with a serious mental disorder merely by reason of deteriorating health conditions, unless the risk of harm to society can be avoided, by such means as transferring the inmate in question directly to a high-security psychiatric hospital.

Obviously, there is a need to strike a balance between, or even try to harmonize, the seemingly countervailing interests – criminal justice and healthcare. One easily imaginable solution would be the medical prison. A properly operating medical prison is equipped with resources and staff capable of handling not only physical but also mental disturbances. In such a facility, prisoners can serve their sentences while, at the same time, receiving proper medical care including treatment by psychiatrists just as they would if they were in society. But medical prisons also have their limits and disadvantages. First of all, the cost of building and maintaining a medical prison is significant. Second, it may be quite difficult to secure a sufficient number of physicians, psychiatrists and other trained personnel. And, third, since medical prisons are still prisons, i.e. they are facilities where inmates serve their sentences, a medical prison has to release an inmate when his imprisonment term elapses, no matter how sick he still is and no matter the risk of damaging himself or hurting others.

There may be something more that we have to consider before deciding to send a mentally disturbed person to prison. Going back to the very beginning – to the investigation and prosecution stage – it may be better if the criminal justice system has some leeway to divert suspects with psychiatric disturbances from criminal justice at an early stage to medical treatment or welfare or other community-based treatment, taking into account and balancing the gravity of the offence and the severity of the mental disturbance of the suspect. By way of such screening, the entire criminal justice system could be relieved from overburdening and may be enabled to concentrate on much more serious cases. At the adjudication stage, two options are conceivable, again, depending on the seriousness of the offence and the severity of the mental disturbance. One is, again, diversion to community-based treatment by rendering a suspended sentence and ordering the defendant to undergo appropriate medical care, including hospitalization, if necessary. The other would be to adopt the 'dualistic' approach in the criminal justice system, as is followed in Germany and, upon an order by the judiciary, have high-security psychiatric hospitals accommodate persons with severe psychiatric disturbances who cannot be held criminally liable but pose a serious risk to society.[2]

At any stage of criminal justice, we should be reminded that parole and probation, if properly equipped with knowledge and skills, can also be effective tools for the treatment of offenders with psychiatric disturbances. Although the function of parole and probation

2 See German Penal Code (*Strafgesetzbuch*) Art. 63.

officers may differ to some extent from country to country, they are, in general, given the task of supervising and supporting offenders and leading them towards rehabilitation and social reintegration. With such mandate and function, parole and probation officers could also handle mentally ill offenders as part of their community-based correctional activities as long as the offenders are not so severely affected by mental disorder that it is inappropriate to let them stay in society.

4 A way towards fair and adequate treatment of offenders with psychiatric disturbances

So far, we have discussed the issue of treatment of offenders with psychiatric disturbances on the basis of the perception that in many jurisdictions there are prisons that accommodate too many prisoners with mental disorders and that proper treatment of such prisoners becomes impossible. In addition, this overload leads to serious disregard of or even infringement of their basic human rights, which otherwise should have been properly protected even under incarceration. We have reason to believe that such situations are actually happening. We therefore tend to think that we should, as much as possible, refrain from sending such offenders to prisons, resulting in a binary decision: 'imprisonment versus hospitalization'.

However, when this issue is viewed from a different angle, it looks fairly reasonable to argue, "Is it really a matter of '*versus*'?" Is it not possible to have offenders with psychiatric disturbances serve sentences they deserve and at the same time have them receive necessary medical, psychiatric or psychological treatments? Is it not just that we have to have a sufficient number of prisons adequately equipped that can treat offenders with psychiatric disturbances with the same level of treatment they would receive anyway if they had not been sentenced to imprisonment?

When considering such an argument, of course we have to stand on certain premises. Maybe we should consider the following elements:

i) The bottom line is that, as a matter of course, alleged offenders should not be wrongly or unfairly adjudicated, no matter whether they have psychiatric disturbances or not. Courts must, following just and fair procedure, seriously consider each element of the alleged crime, including the mental state of the defendant at the time of the alleged commission of the specific crime and make sure that no one is found guilty despite complete insanity.[3] And if the defendant is found guilty, but diminished capacity at

3 We suppose that, in reality, there is always a risk that judges and prosecutors will somehow 'bend' this basis once they face a tough decision in extreme cases. As already briefly mentioned, when the crime committed is so heinous, brutal and damaging to society, and the mental state of the defendant is not necessarily clear-

the time of the offence is in question, courts must not overestimate or underestimate the level thereof and must render an appropriate sentence of an adequate length if it is incarceration or, if any sort of diversion at this stage is available, hand down an appropriate ruling to that effect. If this basic capability of the judiciary is impaired, it will no longer be an issue of whether imprisonment or hospitalization is appropriate; it will be just a matter of whether the judiciary is functioning correctly or not.

ii) What is more complicated and what may raise different thoughts and opinions would be whether and how the mental state of the convict with psychiatric disturbance (which does not reach the level of insanity that would grant acquittal or release) would affect the capacity to serve an imprisonment sentence. Here, the classic debate on the purpose of criminal punishment still has its effect. If, in a certain jurisdiction, retribution and general deterrence are still the main purposes of punishment – and in the recent atmosphere in many parts of the world preferring 'tough criminal responses'-, there will be a tendency not to consider the convict's mental state in the context of assessing the punitive needs. The judiciary will be of the view that once the mental state of the convict has been duly considered in the course of deciding guilt, the convict has to pay his due anyway and that his mental state after the conviction will play little role. In contrast, if the entire justice system of a country focuses much more on special deterrence or, further, correction or rehabilitation of the individual as an important purpose of criminal penalties, the courts will be more interested in the mental state of the convict at and after the sentencing and will regard it as a very important factor in deciding what kind of treatment should be given to him and for how long.

iii) A different type of element we should not forget when discussing the issue of prison or hospital would be the availability of resources. This poses a much more real and practical issue. If there are sufficient human, physical and financial resources, it will be relatively easy for a country or jurisdiction to make imprisonment and psychiatric treatment compatible. But if not, it will be forced to prioritize one over the other and consider alternative measures.

Having set out these premises, let us now discuss solutions. As already mentioned, if the judiciary as well as the prosecution are working properly, the best measure could perhaps be, as already mentioned, to build enough medical prisons that can provide at least an average level of psychiatric treatment, despite their inherent limitations and disadvantages. This would, at least primarily, satisfy the believers of retribution and general deterrence because the punishment is implemented, and the supporters of special deterrence and

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cut, indisputable insanity, temptation to arbitrarily raise the threshold or criteria for finding insanity may be very strong.

rehabilitation would not have major objections because proper treatment to correct and rehabilitate can be done in prisons that have the same capability as psychiatric hospitals. Here, the question 'justice or health responsibility?' becomes merely an organizational matter of which authority takes care of those medical prisons. Or maybe it could be treated as a practical matter of whether to turn a prison into a hospital or a hospital into a prison – and possibly whether a PFI (private finance initiative) scheme could be utilized.

But not every country or jurisdiction can mobilize abundant resources. There are limits, necessitating some compromise. If the prisons do not have adequate capacity to treat inmates with psychiatric disturbances properly and are only capable of arranging for outside psychiatrists to come and treat them once in a while, then there will be no choice other than to treat the convicts somewhere outside the prison, except for those with less severe illness who can be satisfactorily treated by the visiting psychiatrists. Such convicts, although it was proven in court that they deserve punishment by incarceration, will have to undergo treatment outside the prison. In such a situation, parole and probation or any other means of community-based treatment combined with medical care might be an alternative. It would, at least to some level, satisfy both interests, because they are undergoing alternative punishment, albeit nominally, during the period of state intervention while being subject to compulsory medical treatment.

One specific problem would be that convicts whose mental state deteriorates while the procedure is pending (e.g. if a convict was legally sane or just had diminished capacity at the time the offence was committed but later got worse, the sentence cannot be retroactively nullified, can it?) and are at the moment so sick that there is a clear and imminent danger of grave harm to others. For those people, we would surely need a system that allows forcible hospitalization regardless of the offence committed. Such a system may be administrative or judicial.

5 Conclusion

Solving the problems of offenders with psychiatric disturbances needs multifaceted approaches and efforts that can provide diverse treatments to them according to the seriousness of their mental illness and its state as well as the nature and gravity of the crime they committed. As we have already seen, we need a properly functioning judiciary, well-equipped prisons both in terms of human resources and facilities, and effective community-based treatment combined with medical care. Out of the criminal justice area, we need administrative intervention both in the public security and welfare area, and, needless to say, considerable help from psychiatric experts and institutions. Also, while the criminal justice side has to establish a firm, common understanding both in the theoretical and in the practical areas, all those stakeholders have to cooperate and collaborate

with each other while at the same time diligently playing their individual roles. So the question 'a matter of health or justice?' may be responded to by a rather unexciting, but appropriate, 'it's the responsibility of both'.

Finally, we may have to add one more thing: the victims' and public's perceptions. Victims and the public may sometimes be frustrated by what the criminal justice does with respect to this issue. Although the criminal justice system should take into account these perspectives, views, opinions and emotions as much as possible, there are occasions when the system has to go against them. Justice and other professionals must refrain from responding to unreasonable demands of the victims or yielding to populism. However, they also have to be accountable and transparent, and it is surely their responsibility to sincerely explain their decisions and dispositions to the victims and the public, telling them why criminal justice, psychiatric medicine or welfare interventions are done. Although not easy, it is definitely necessary to ultimately obtain trust in the system and the way that it works.

Defendants with psychiatric disturbances or otherwise limited mental abilities

Fair procedure during pre-trial inquiry and at trial

Piet Hein van Kempen[*]

1 Introduction

Several years ago *The New York Times* reported on the growing number of people with severe mental disorders who, in the absence of adequate mental health services, are coming in contact with the criminal justice system.[1] The reason for the article was the killing by the police of James Boyd, a homeless man with a history of mental illness who was camping illegally somewhere in the foothills when he was shot dead.[2] Indeed, the police are often the front-line response to many citizens with mental illnesses.[3] Research shows that citizens with mental illness are perceived as a threat by the police,[4] while there is clear evidence that the large majority of people with mental disorders do not engage in violence against others, and it is estimated that only approximately 4% of overall violence is attributable to those with mental illness.[5] This may, under certain circumstances, cause a risk of

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1 Fernanda Santos & Erica Goode, 'Police Confront Rising Number of Mentally Ill Suspects', *New York Times*, 2 April 2014.

2 See Wikipedia for background information on the shooting of James Boyd, which took place on 16 March 2014 (at: https://en.wikipedia.org/wiki/Shooting_of_James_Boyd). The (shocking) video of the occurrence is available at YouTube (at: www.youtube.com/watch?v=6tpAZObNZfI).

3 G.P. Alpert, 'Police Use of Force and the Suspect with Mental Illness. A Methodological Conundrum', 14 *Criminology & Public Policy* 2 (2015), pp. 277-283, p. 277. See also Jerneja Sveticic, *Law enforcer or social worker? Exploration of the role of police in responding to persons with mental illness* (PhD thesis), Brisbane: Griffith University, 2020.

4 M.S. Morabito & K.M. Socia, 'Is Dangerousness a Myth? Injuries and Police Encounters with People with Mental Illnesses', 14 *Criminology & Public Policy* 2 (2015), pp. 253-276.

5 J.W. Swanson, E.E. McGinty, S. Fazel & V.M. Mays, 'Mental Illness and Reduction of Gun Violence and Suicide: Bringing Epidemiologic Research to Policy', 25 *Annals of Epidemiology* 5 (2015), pp. 366-376. Cf. with further references A.G. Robertson, 'Building on the Evidence Guiding Policy and Research on Police Encounters with Persons with Mental Illnesses', 14 *Criminology & Public Policy* 2 (2015), pp. 285-293, pp. 287-288.

unnecessary or disproportionate use of force by the police,[6] although it does not necessarily have to result in injuries for either the subject or the police.[7] Furthermore, there is evidence to suggest that the probability of being arrested is significantly greater for persons with mental illness, only partly because the police are often left with arrest as the only practical means to deal with a situation ('mercy bookings')[8] or a greater likelihood of arrest generating behaviour.[9] Discrimination or, at least, incapability to adequately deal with suspects' disturbed or limited mental abilities may be a factor of relevance too.

Within the criminal justice system, a person's mental illness not only has to be taken into account by the police and in the prison system, but may also be of considerable concern during pre-trial inquiry and at trial or, for example, when negotiating justice procedures like plea bargaining. A defendant's mental illness or limited mental abilities puts him or her in a particular vulnerable position during the criminal process, and it may challenge the system itself in guaranteeing fair procedure. The same applies if the defendant is not so much suffering from psychiatric disturbances but has otherwise limited mental abilities. This article therefore focuses on adult[10] defendants with psychiatric disturbances or otherwise limited mental abilities. It first sketches the scope of the problem on the basis of various statistics. It then briefly addresses the question of which fundamental principle requires special attention for a defendant's disturbed or limited mental abilities during the criminal process. With a view to a fair pre-trial inquiry and a fair trial for such defendants, this article then continues to explain their specific human rights as well as relevant human rights obligations of the authorities. This will lead me to present ten recommendations for what may be considered essential to sufficiently secure the legal position of defendants who possess insufficient abilities to adequately participate in criminal proceedings or who are even unfit to stand trial. At the end a conclusion is offered.

The basis of the analyses is, in particular, the European Convention on Human Rights (ECHR) and the associated case law of the European Court of Human Rights (ECtHR) and, furthermore, the American Convention on Human Rights, including the case law of the Inter-American Court of Human Rights (I-ACtHR), the International Covenant on Civil and Political Rights (ICCPR) and the jurisprudence of the Human Rights Committee (HRC), and case law of several international criminal tribunals, i.e. the International

6 P. Mulvey & M. White, 'The Potential for Violence in Arrests of Persons with Mental Illness', 37 *Policing: An International Journal of Police Strategies & Management* 2 (2014), pp. 404-419, pp. 414-415.

7 M.S. Morabito & K.M. Socia, 'Is Dangerousness a Myth? Injuries and Police Encounters with People with Mental Illnesses', 14 *Criminology & Public Policy* 2 (2015), pp. 253-276.

8 See with further references P. Mulvey & M. White, 'The Potential for Violence in Arrests of Persons with Mental Illness', 37 *Policing: An International Journal of Police Strategies & Management* 2 (2014), pp. 404-419, p. 406.

9 F.E. Markowitz, 'Mental Illness, Crime, and Violence: Risk, Context, and Social Control', 16 *Aggression and Violent Behavior* 1 (2011), pp. 36-44, p. 41.

10 Defendants who are minors will be excluded from this analysis.

Criminal Court (ICC), the International Criminal Tribunal for the former Yugoslavia (ICTY) and the Dili District Court's Special Panels for Serious Crimes (SPSC or East Timor Panel).[11]

2 Scope of the problem: various statistics

Everyone who works in the criminal justice system, for example as a judge, prosecutor or lawyer must notice on a day-to-day basis that many defendants have psychiatric disturbances or limited mental abilities. Exact statistics on defendants with psychiatric disturbances or limited mental abilities, however, are hard to find. However, there is quite a bit of statistical information that indicates that a substantial percentage of people that end up as defendants in criminal proceedings have disturbed or limited mental abilities, even though numbers may vary considerably between different studies. For example, studies of offenders with intellectual disabilities report a large range of estimates, varying worldwide from 2% to 40%, depending on methodology, diagnostic approach and applied criteria, definitions and classifications.[12] Nevertheless, most studies include the three major criteria for intellectual impairment (in general, IQ below 70): significant limitations in intellectual functioning and in adaptive behaviour and onset before the age of 18.

Since individuals who are in prison will have gone through pre-trial inquiry and a trial or, for example, negotiating justice procedures like plea bargaining, while people in pre-trial detention will usually have at least been involved in police questioning and in many cases also in other stages of preliminary inquiry, numbers on prisoners and detainees with psychiatric disturbances or limited mental abilities are indicative of the number of defendants with such mental disabilities. It is important to stress that these numbers are not more than that, i.e. they are indicative. One reason for this is that many defendants do not end up in prison or detention, as result of which it remains somewhat obscure what percentage of this category of defendants suffer from psychiatric disturbances or limited mental abilities.

A systematic review of the prevalence of psychosis and depression in prisoners based on 81 publications covering 24 different countries found an overall prevalence of 3.7% of

11 The description and analysis of the ECHR and the ECtHR's case law, as well as the recommendation at the end of this article, are largely derived from P.H.P.H.M.C. van Kempen, 'The Right to Fair Preliminary Investigation and Trial for Vulnerable Defendants: The Case of the Netherlands', in: R. Mackay & W. Brookbanks (eds), *Fitness to Plead: International and Comparative Perspectives*, Oxford: Oxford University Press, 2018, pp. 231-253.

12 See with further explanation and reference to sources J. Jones, 'Persons with Intellectual Disabilities in the Criminal Justice System: Review of Issues', 51 *International Journal of Offender Therapy and Comparative Criminology* 6 (2007), pp. 723-733, pp. 724-725.

male and female prisoners with a psychotic illness and 11.4% with major depression.[13] So, one in seven prisoners has psychosis or depression. The reviewers conclude that these overall prevalences have not changed materially since a 2002 review[14] based on 56 publications of mental illness. The study, furthermore, finds that the rates of psychosis in prisoners were significantly higher in low- and middle-income countries than in high-income ones (5.5% in low-middle versus 3.5% in high) and that there were no significant differences in rates of psychosis and depression between male and female prisoners or between detainees (or remand) and sentenced prisoners. Recent research that has been able to include the effects of the Covid-19 pandemic on prisoners suggests a significant adverse impact on their mental health and well-being because of the fear of Covid-19, the impact of isolation, discontinuation of prison visits and reduced mental health services.[15]

In the Netherlands it is estimated that 15-25% of the detainees (detention and prison) have a mental disability.[16, 17] Interviews with 355 prisoners pointed out that 14% of them had psychiatric problems to the extent that they have had long-standing serious psychological problems related to the offence, have long been depressed and are medically treated for one or more of the following illnesses: depression, anxiety disorders, obsessions, phobias and psychoses. This study found that 5% of them lack basic skills (for example, not being able to understand the newspaper, to fill out forms, to make sense of the schedule at the bus stop or to read maps).[18] From several studies it can, furthermore, be deduced

13 S. Fazel & K. Seewald, 'Severe Mental Illness in 33,588 Prisoners Worldwide: Systematic Review and Meta-Regression Analysis', 200 *The British Journal of Psychiatry* 5 (2012), pp. 364-373, p. 367.

14 S. Fazel & J. Danesh, 'Serious Mental Disorder in 23,000 Prisoners: A Systematic Review of 62 Surveys', 359 *The Lancet* 9306 (2002), pp. 545–550.

15 See L. Johnson, K. Gutridge, J. Parkes, *et al*., 'Scoping Review of Mental Health in Prisons through the COVID-19 Pandemic', 11 *BMJ Open* 5 (2021), pp. 1-8.

16 This is estimated by the Council for the Administration of Criminal Justice and Protection of Juveniles: Raad voor Strafrechtstoepassing en Jeugdbescherming, *Gedetineerden met een verstandelijke beperking: Advies*, Den Haag: RSJ, 2008; see also Raad voor Strafrechtstoepassing en Jeugdbescherming, 'Advies gedetineerden met een licht verstandelijke beperking', brief van 7 januari 2013 aan de Staatssecretaris van Veiligheid en Justitie.

17 H.L. Kaal, M.M.J. van Ooyen-Houben, S. Ganpat & E. Wits, *Een complex probleem; Passende zorg voor verslaafde justitiabelen met co-morbide psychiatrische problematiek en een lichte verstandelijke handicap*, Den Haag: WODC, 2009, pp. 42-43 (summary in English pp. 103-105). See furthermore H. Kaal, *Prevalentie licht verstandelijke beperking in het justitiedomein*, Leiden: Expertisecentrum Jeugd, Hogeschool Leiden, 2016, p. 19, on detainees with a mild mental disorder (i.e. IQ between 50 and 85 in combination with limited adaptability and additional problems): the prevalence of a mild mental disorder in regular detention (diagnosed) is around 10%, in special units about 15-20%, and in forensic psychiatric institutions 20-25%. The prevalence determined by screening or with Raven's Coloured Progressive Matrices is significantly higher. For example, within regular detention/imprisonment, the SCIL (Dutch abbreviation for intelligence assessment method) found percentages of 30-45%.

18 B.O. Vogelvang, A. van Burik, L.M. van der Knaap & B.S.J. Wartna, *Prevalentie van criminogene factoren bij mannelijke gedetineerden in Nederland*, Woerden/Den Haag: Adviesbureau van Montfoort/WODC, 2003.

that roughly 23% to 52% of the persons subject to judicial measures are faced with problematic drug use, that 30% to 65% of them have co-morbid psychiatric problems, while 15% to 39% of the drug users among those subject to judicial measures may have limited mental capacity.[19]

As for the United States of America, one still frequently quoted study from 1999 estimates that up to 16% of persons in jails and prisons may have a mental illness, many of whom have committed serious offences.[20] A later study estimates that 64% of jail inmates, 56% of state prisoners and 45% of federal prisoners have a mental health problem, with 50-60% reporting current symptoms.[21] Female inmates had higher rates of mental health problems than male inmates (in local jails 75% of females and 63% of males, in state prisons 73% of females and 55% of males).[22] On the basis of several other studies it has been reported that around the year 2000 about 10% to 15% of people in jails and federal and state prisons in the USA were even having severe mental illness.[23] According to another study, of the number of adults who face criminal charges, 4-10% are intellectually disabled, a number that is held to be likely lower than it should be.[24] Interestingly, some older studies show that defendants with retardation are more easily convicted and receive longer terms than offenders without disabilities, confess more readily, provide more incriminating evidence to authorities and are less successful in plea-bargaining.[25]

Even though the numbers between studies, between countries and between psychological disturbances and limited mental abilities may vary considerably, the foregoing statistics make clear that the problem of defendants with disturbed or limited mental abilities is real

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19 H.L. Kaal, M.M.J. van Ooyen-Houben, S. Ganpat & E. Wits, *Een complex probleem; Passende zorg voor verslaafde justitiabelen met co-morbide psychiatrische problematiek en een lichte verstandelijke handicap*, Den Haag: WODC, 2009, pp. 42-43 (summary in English pp. 103-105).

20 P.M. Ditton, *Mental health and treatment of inmates and probationers*, Special Report, Bureau of Justice Statistics, July 1999, NCJ 174463, for example cited in V.A. Hiday & M.E. Moloney, 'Mental Illness and the Criminal Justice System', in: W.C. Cockerham, R. Dingwall & S.R. Quah (eds), *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society*, John Wiley & Sons, 2014, pp. 1-5, p. 1.

21 See for percentages regarding female prisoners in other countries: P.H.P.H.M.C. van Kempen & M.J.M. Krabbe (eds), *Women in Prison. The Bangkok Rules and Beyond/Femmes en prison. Les règles de Bangkok et au-delà*, Cambridge/Antwerp/Portland: Intersentia, p. 226 (Australia, by K. Armstrong & K. Farrar), p. 404 and p. 409 (Germany, by R. Haverkamp & A. Boetticher), p. 457 (Greece, by E. Lambropoulou), p. 488 (Ireland, M. Rogan & M. Reilly), p. 541 and p. 556 (the Netherlands, by P.J.P. Tak), and pp. 740-741 (Switzerland, by A. Vallotton & M. Jendly).

22 D.J. James & L.E. Glaze, *Mental health problems of prison and jail inmates*, Special Report, Bureau of Justice Statistics, September 2006, NCJ 213600.

23 See with further references H.R. Lamb, L.E. Weinberger & B.H. Gross, 'Mentally Ill Persons in the Criminal Justice System: Some Perspectives', 75 *Psychiatric Quarterly* 2 (2004), pp. 107-126, p. 108.

24 See H. Reisman, 'Competency of the Mentally Ill and Intellectually Disabled in the Courts', 11 *Journal of Health & Biomedical Law* 2 (2015), pp. 199-234, p. 224 (note 139), with reference to B.W. Wall & P.P. Christopher, 'A Training Program for Defendants With Intellectual Disabilities Who are Found Incompetent to Stand Trial', 40 *Journal of the American Academy of Psychiatry and the Law* 3 (2012), pp. 366-373, p. 366.

25 See with further references J. Petersilia, *Doing Justice? Criminal Offenders with Developmental Disabilities*, University of California, California Policy Research Center, 2000, p. 13.

and frequent and should not be underestimated. It is actually so common that no criminal justice system can regard such incapacities of defendants as a minor detail that can be ignored in the larger scheme of criminal justice.

3 General bases: adversarial procedure, equality of arms, equality – relevance of systems' adversariality or inquisitoriality?

The provisions on the right to a fair trial in Article 6 ECHR, Article 8 ACHR and Article 14 ICCPR do not hold anything about the abilities of the defendant as a prerequisite for a fair procedure. These articles, however, recognize the right to a fair hearing of the case as well as the right to defend oneself or to be assisted by legal counsel. It is here where various international judicators derive various rights for defendants and obligations for the authorities that are relevant if a defendant owing to mental inabilities is not or is insufficiently capable of adequately contributing to looking after his or her interests in criminal proceedings. Before examining these specific rights and obligations more closely in the next section, it is useful to examine the basic principles on which they are based, in order to better understand their scope, their content and how their functioning may depend on the nature of a particular criminal procedural system in terms of adversariality and inquisitoriality or, perhaps better, in terms of rights and responsibilities of the defence.

For the European Court the underlying right is the right to effective participation, which, first of all, follows from the basic principle of adversarial procedure:

> The right of an accused under Article 6 to effective participation in his or her criminal trial generally includes, inter alia, not only the right to be present, but also to hear and follow the proceedings. Such rights are implicit in the very notion of an adversarial procedure and can also be derived from the guarantees contained, in particular, in sub-paragraph (c) of paragraph 3 of Article 6 – 'to defend himself in person'.[26]

The basic principle of adversarial procedure is fundamental to a fair trial. The ECtHR defines it as follows:

> The right to an adversarial trial means, in a criminal case, that both prosecution and defence must be given the opportunity to have knowledge of and comment

26 See e.g. ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2(a); ECtHR, Judgment of 9 February 2010, *Pylnev v. Russia*, Appl. 3038/03, para. 3(b).

> on the observations filed and the evidence adduced by the other party. Various ways are conceivable in which national law may meet this requirement. However, whatever method is chosen, it should ensure that the other party will be aware that observations have been filed and will get a real opportunity to comment on them.[27]

Adversarial argument also implies that the defence has "the opportunity to call witnesses and respond to the testimony heard"[28] and is able "to submit arguments in their defence and to state their view on the appropriate punishment".[29] Meanwhile, the adversarial principle is closely linked to the principle of equality of arms, according to the European Court. In combination they require:

> A 'fair balance' between the parties: each party must be afforded a reasonable opportunity to present his case under conditions that do not place him at a substantial disadvantage vis-à-vis his opponent or opponents.[30]

Also, the HRC uses the principles of fairness and of equality of arms to recognize that defendants must be able to 'defend themselves effectively'. More generally, it apparently sees an effective defence also as part of the right to equality before courts and tribunals.[31]

Interestingly, also the I-ACtHR's case law does recognize the relevance of the principle of equality of arms here[32] but lays the emphasis mainly on the general principles of equality and non-discrimination relative to suspects with disadvantages. The I-ACtHR holds:

> To accomplish its objectives, the judicial process must recognize and correct any real disadvantages that those brought before the bar might have, thus observing the principle of equality before the law and the courts and the corollary principle prohibiting discrimination. The presence of real disadvantages necessitates countervailing measures that help to reduce or eliminate the obstacles and deficiencies that impair or diminish an effective defense of one's interests. Absent those countervailing measures, widely recognized in various stages of the proceeding, one could hardly say that those

27 ECtHR (GC), Judgment of 12 May 2005, *Öcalan v. Turkey*, Appl. 46221/99, para. 146.
28 ECtHR (GC), Judgment of 29 November 2016, *Lhermitte v. Belgium*, Appl. 34238/09, para. 76.
29 ECtHR (GC), Judgment 24 January 2017, *Khamtokhu and Aksenchik v. Russia*, Appl. 60367/08, para. 76.
30 ECtHR (GC), Judgment of 23 May 2016, *Avotiņš v. Latvia*, Appl. 17502/07, para. 119.
31 HRC, General Comment No. 32. Art. 14: Right to equality before courts and tribunals and to a fair trial, U.N. doc. CCPR/C/GC/32, 23 August 2007, paras. 40 and 7-14.
32 I-ACtHR, 1 October 1999, *The Right to Information on Consular Assistance in the Framework of the Guarantees of the Due Process of Law*, paras. 117-124: "for 'the due process of law' a defendant must be able to exercise his rights and defend his interests effectively and in full procedural equality with other defendants."

> who have the disadvantages enjoy a true opportunity for justice and the benefit of the due process of law equal to those who do not have those disadvantages.[33]

There is no reason to assume that this case law is inapplicable to defendants with psychiatric disturbances or otherwise limited mental abilities. They, in principle, fully qualify as persons that are brought before the bar and who may have real disadvantages in that situation.

How do the procedural principles of adversariality and equality of arms and the general principles of equality and non-discrimination relate to the nature of a particular criminal procedural system in terms of adversariality and inquisitoriality and the rights and responsibilities of the defence? Unlike jurisdictions with a predominantly adversarial system such as the United Kingdom, Australia, Canada, New Zealand and the United States of America, most non-English-speaking European countries and South American nations used to recognize a system that was largely inquisitorial. However, this dichotomy is helpful only as a first characterization, as neither of these systems exists in a pure form. There are many differences among inquisitorial systems, and some stages of a country's criminal procedure may be more inquisitorial than others. Moreover, for varying reasons, countries have developed their systems. For example, many continental European and South American systems became more adversarial under the influence of the human right to a fair trial and the defence rights derived thereof.[34] As a result, many systems contain both adversarial and inquisitorial elements, although the emphasis may be on one or the other.

Particularly relevant here is the extent to which a system expects the defendant and his or her counsel to be active and take responsibility on pain of forfeiture of rights, relative to, for example, invoking their rights, assessing whether the inquiry is complete and adequate, gathering and assessing evidence, steering the course of the process, guarding its fairness and veracity and submitting requests and pleas.

The more responsibilities the defence holds, the higher the importance of the qualities of defendant and counsel. The capabilities of defendant and counsel cannot be seen in isolation. What matters is the combination: the quality of the defence will increasingly often depend on the capabilities of both counsel and his or her client and the cooperation between the two. Shortcomings in the capabilities of the defendant or counsel or in their combination are more likely to be detrimental to the defendant in a system that leans more heavily on adversarial principles and responsibilities than in a modern inquisitorial system. Where the defendant is concerned, adversarial systems assume that he or she is genuinely

33 I-ACtHR, 1 October 1999, *The Right to Information on Consular Assistance in the Framework of the Guarantees of the Due Process of Law*, para. 119.

34 For an overview regarding South American countries, see M.G. Andía, 'The Uphill Battle of Justice Reform', *Americas Quarterly* (Issue: Gender Equality: Political Backrooms, Corporate Boardrooms and Classrooms), Summer 2012.

(thus not merely ideally) autonomous, legally capable, assertive and a fully-fledged participant in the proceedings. A chiefly inquisitorial system expects less activity from the defendant and his or her counsel and is therefore less dependent on their capabilities. Consequently, in rather adversarial systems much more consideration is traditionally given to the fitness of the defendant to plead or to stand trial than in inquisitorial systems. Intensification of adversariality in the criminal process – as has been or is taking place in many European and South American jurisdictions – might therefore mean that the powers and responsibilities of the defence are or need to be strengthened also. This seems less necessary in systems that remain predominantly inquisitorial in nature, also with respect to the rights and responsibilities of the defence. Therefore, a few remarks on the question of whether the procedural principles of adversariality and equality of arms and the general principles of equality and non-discrimination may allow for such differences.

The principle of adversariality seems to entail rather absolute requirements, in the sense that those apply no matter what the exact nature of the particular system is. The principle of adversariality implies that the defendant and his or her counsel have the possibility to respond to all observations filed, evidence adduced and statements made by witnesses and experts and to submit evidence, arguments and views in their defence. Whether a procedure is rather of an adversarial or an inquisitorial nature, in all instances the defence – defendant and counsel – must be sufficiently capable of exercising these possibilities, in order not to deprive the adversariality principle of its meaning.

As for the principle of equality of arms, it is useful to make a distinction between formal equality and material equality. Formal equality is of a relative nature. It intends to ensure equality between two equally situated parties; this corresponds to 'a level playing field', where the advantage of one party would lead to an unfair outcome.[35] In rather inquisitorial systems the judge is very active at trial, while the prosecution and the defence have roles that are quite passive compared with those of their counterparts in adversarial processes. In an inquisitorial system formal equality will thus imply fewer rights and possibilities for the defence than in an adversarial trial. This is not so as regards material equality, which entails the idea that a state should ensure some level of equality between the stronger and a weaker party. Where the prosecutor will be a professional with legal schooling while the defendant is not, material equality requires that measures are taken to compensate for the unequal capacities of the defendant, which, for example, might be realized by providing counsel.[36] Material equality of arms is thus of particular importance in the case of defendants

35 See M.I. Fedorova, *The Principle of Equality of Arms in International Criminal Proceedings*, Cambridge/Antwerp/Portland: Intersentia, 2012, p. 11.

36 Cf. ECtHR, Judgment of 24 September 2009, *Pishchalnikov v. Russia*, Appl. 7025/04, which holds that the suspect is, per definition, in a vulnerable position within the criminal process.

with psychiatric disturbances or otherwise limited mental abilities, in principle regardless of the nature of the system.

The relevance of the general principles of equality and non-discrimination for defendants with limited capabilities is less straightforward. It seems that the I-ACtHR presupposes that, if a defendant owing to his or her incapability, is in a really less favourable position than defendants without such incapacities, this may amount to discrimination. In that case positive obligations arise to take countervailing measures to correct the real disadvantages. It seems to me that compensation instead of real correction – which will in most cases not be possible – may also be acceptable. Still, this ground implies that if correction or compensation of a defendant's psychiatric disturbances or otherwise limited mental abilities is insufficiently possible, the violation of the general principles of equality and non-discrimination remains. As a result, it seems that defendants' capabilities must at least meet a certain level, i.e. a level with which measures can still be sufficiently effective. However, since the comparison here is with fully capable defendants in the process and it is only required that incapable defendants are brought on an equal footing with capable defendants, the measures that need to be taken will also depend on the nature of the process. The more rights and possibilities that capable defendants in a system have, the more must be done to bring incapable defendants up to that level.

4 The specific fair procedure rights for defendants with psychiatric disturbances or otherwise limited mental abilities

In light of the principles of adversariality, equality of arms, equality and non-discrimination, human rights monitoring bodies hold that the right to a fair procedure – more specifically, the right to a fair hearing and the right to defend oneself or to be assisted by legal counsel – imply the right for the defendant to effective participation or effective defence in the criminal proceedings.[37] On the basis of the principle of effective participation in particular, the European Court and several international criminal judicators have developed various rights for defendants and obligations for the authorities that are relevant if a defendant, owing to mental inabilities, is not or is insufficiently capable of contributing adequately to looking after his or her interests in criminal proceedings. Although the HRC and the I-ACtHR have not elaborated on the right to a fair procedure for defendants with limited

37 See, among other sources, with further references ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2(a); ECtHR, Judgment of 9 February 2010, *Pylnev v. Russia*, Appl. 3038/03, para. 3(b). HRC, General Comment No. 32. Art. 14: Right to equality before courts and tribunals and to a fair trial, U.N. doc. CCPR/C/GC/32, 23 August 2007, paras. 10 and 40. I-ACtHR, Judgment of 24 September 2009, *Dacosta Cadogan v. Barbados*, para. 84; I-ACtHR, 1 October 1999, *The Right to Information on Consular Assistance in the Framework of the Guarantees of the Due Process of Law*, paras. 117-124.

mental abilities, both seem to imply a requirement that defendants must be sufficiently fit to stand trial.[38] The case law of the latter, in particular, offers some relevant notions, as has already been discussed in the previous section.

4.1 Guarantees for effective participation by defendants during trial

Thus, it is, first and foremost, the European Court that developed the notion of effective participation in its case law. More precisely, it concerns the following with respect to the required capabilities:

> 'Effective participation' in this context presupposes that the accused has a broad understanding of the nature of the trial process and of what is at stake for him or her, including the significance of any penalty which may be imposed. The defendant should be able, inter alia, to explain to his own lawyer his version of events, point out any statements with which he disagrees and make them aware of any facts which should be put forward in his defence.[39]
>
> It also requires that he or she, if necessary with the assistance of, for example, an interpreter, lawyer, social worker or friend, should be able to understand the general thrust of what is said in court.[40]

The standard applied by the European Court with regard to the degree of understanding that the defendant needs to achieve is not particularly rigorous. It only concerns a broad awareness or a general insight[41] into the nature of the trial, what it will deal with and what is at stake. Yet this minimum requirement for the level of understanding is strict in the sense that there can be no effective participation if the defendant does not meet this requirement. Such a lack of understanding on the part of the defendant cannot be compensated for by adequate legal aid from competent and experienced counsel, for

38 Cf. Björn Elberling, *The Defendant in International Criminal Proceedings: Between Law and Historiography*, Oxford/Portland: Hart Publishing, 2012, p. 26, with reference to HRC 15 March 2000, *Bech/Norway*, Comm. 882/1999: inadmissibility of the complaint that the author's medical condition impaired his functioning in such a way as to impede the presentation of his appeal.

39 See e.g. ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2(a); ECtHR, Judgment of 9 February 2010, *Pylnev v. Russia*, Appl. 3038/03, para. 3(b).

40 In this sense, see ECtHR, Judgment of 20 January 2009, *Güveç v. Turkey*, Appl. 70337/01, para. 124; see also ECtHR, Judgment of 15 June 2004, *SC v. UK*, Appl. 60958/00, para. 29: "The defendant should be able to follow what is said by the prosecution witnesses."

41 Sometimes the following wording is used: "that the accused understands in general the character of the proceedings"; in that sense ECtHR, Judgment of 31 October 2013, *Tarasov v. Ukraine*, Appl. 17416/03, para. 98.

example.[42] A fair criminal procedure is simply not feasible in that situation. The defendant will then be found unfit to stand trial[43] and the criminal proceedings discontinued under those circumstances. Nevertheless, the ECtHR opts for a fairly general and flexible approach with the aforementioned standard.

The HRC and the I-ACtHR rather pose 'an effective defence' as the ultimate standard to decide whether the proceedings can be qualified as being fair. The HRC recognizes that defendants must be able to 'defend themselves effectively' and participate in the proceedings 'in a meaningful way' whether it be with legal assistance or not.[44] The I-ACtHR holds:

> Specifically, Article 8(2)(c) of the Convention requires that individuals are able to adequately defend themselves.[45]

> [F]or 'the due process of law' a defendant must be able to exercise his rights and defend his interests effectively and in full procedural equality with other defendants.[46]

This seems to entail a broader and therefore less strict standard than the ECtHR's effective participation standard. Whereas the latter demands that the defendant can participate effectively, the 'effective defence' standard may require only that the defence as such is effective. With that, the HRC and the I-ACtHR would accept that the impossibility for the defendant to participate effectively can be compensated by counter measures that make the defence on a whole sufficiently effective. In fact, neither the HRC nor the I-ACtHR expressly requires that defendants' capabilities meet at least a certain level; it firmly put the emphasis on countermeasures in case of incapability of the defendant. Still, as was shown previously, the principles of equality and non-discrimination that, particularly, the I-ACtHR puts to the fore imply that if correction or compensation of a defendant's psychiatric disturbances or otherwise limited mental abilities is insufficiently possible, the violation of the general principles of equality and non-discrimination remains. As a result,

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42 See ECtHR, Judgment of 16 December 1999, *T v. UK*, Appl. 24724/94, paras. 88-89; ECtHR, Judgment of 15 June 2004, *SC v. UK*, Appl. 60958/00, paras. 25, 29-30, 34 and 37. Also, when a defendant has an insufficient command of the language in which the trial is conducted and in the absence of an interpreter, this obstacle to effective participation cannot be compensated for by the presence of counsel; see ECtHR, Judgment of 24 September 2002, *Cuscan v. UK*, Appl. 32771/96, paras. 34-40.

43 Also see P. Bal & F. Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces* (The psychological inability to stand trial. Safeguard or obstacle to the right to a fair trial), Den Haag: Boom Juridische Uitgevers, 2004, pp. 53-54.

44 HRC, General Comment No. 32. Art. 14: Right to equality before courts and tribunals and to a fair trial, U.N. doc. CCPR/C/GC/32, 23 August 2007, paras. 10 and 40.

45 I-ACtHR, Judgment of 24 September 2009, *Dacosta Cadogan v. Barbados*, para. 84.

46 I-ACtHR, 1 October 1999, *The Right to Information on Consular Assistance in the Framework of the Guarantees of the Due Process of Law*, paras. 117-124.

it seems that defendants' capabilities must meet at least a certain level, i.e. a level at which measures can still be sufficiently effective. Although what this exactly entails is unclear, this implicit level requirement seems to be significantly lower than the more absolute level requirement of the ECtHR.

International criminal courts and tribunals show that other, perhaps firmer and, in any event, more precise approaches are possible.[47] For example, the ICC holds:

> [F]rom the catalogue of fair trial rights, contained in article 67(1) of the Statute, a number of relevant capacities can be discerned which are necessary for the meaningful exercise of these rights. As indicated in the "Order to conduct a medical examination", they include the capacities: (i) to understand in detail the nature, cause and content of the charges; (ii) to understand the conduct of the proceedings; (iii) to instruct counsel; (iv) to understand the consequences of the proceedings; and (v) to make a statement.[48]

The ICTY Appeals Chamber explains that:

> [T]he applicable standard is that of meaningful participation which allows the accused to exercise his fair trial rights to such a degree that he is able to participate effectively in his trial, and has an understanding of the essentials of the proceedings.[49]

As a non-exhaustive set of rights that are essential for the determination of an accused's fitness to stand trial and that are thus to be evaluated when assessing an accused's fitness to stand trial, the ICTY Appeal Chamber reiterates the Trial Chambers list, which includes the capacity:

> [T]o plead, to understand the nature of the charges, to understand the course of the proceedings, to understand the details of the evidence, to instruct counsel,

47 In relation to several international courts, see also I. Freckelton & M. Karagiannakis, 'Fitness to Stand Trial under International Criminal Law: Challenges for Law and Policy', 12 *Journal of International Criminal Justice* 4 (2014), p. 722. An extensive overview of international and national case law is furthermore provided in ICTY, Appeals Chamber, 17 July 2008, *Prosecutor v. Pavle Strugar*, no. IT-01-42-A, para. 55.

48 ICC, Pre-Trial Chamber I, 2 November 2012, *The Prosecutor v. Laurent Gbagbo*, no. ICC-02/11-01/11, para. 50.

49 ICTY, Appeals Chamber, 17 July 2008, *Prosecutor v. Pavle Strugar*, no. IT-01-42-A, para. 55.

> to understand the consequences of the proceedings, and to testify (dashes omitted).[50]

As a final illustration, Judge Rapoza of the Dili District Court's Special Panels for Serious Crimes (SPSC or East Timor Panel) has established the following criteria for the determination of defendants' capability to stand trial:[51]

> As defined by this Court, the test of whether the Defendant is competent to stand trial requires that he have certain capacities. In that respect, he must have a rational and a factual understanding of both the charges and the criminal proceedings pending against him. He must also have a present ability to consult with his lawyer and to assist in the preparation of his own defense. A failure to have adequate capacity as to any one of these elements of competency would be fatal to a defendant's fitness to stand trial.[52]

Although much less specific, ultimately the level of guarantee required by the ECtHR is actually more in line with these approaches than appears at first sight. As with the international tribunals, the European Court puts the emphasis on the defendant's effective participation rather than on the effectiveness of the defence (defendant and counsel). Moreover, it appears from the ECtHR case law quoted previously, that the defendant will have to be able to understand the case to such a degree that he can instruct his or her counsel in a meaningful way about essential parts of the case. If the defendant is incapable of doing that, he does not meet the required minimum level of understanding. As a result, the case law of international criminal tribunals may perhaps be viewed as further specification of what the European Court's case law requires, rather than as stricter case law.

The list of capacities does, meanwhile, not alter the fact that, according to the ECtHR, it will not be necessary for the defendant to understand fully all legal and evidential complexities and all exchanges during the proceedings.[53] The ICC stresses that "the meaningful exercise of one's fair trial rights does not require that the person be able to

50 *Ibid*., paras. 55 and 41.

51 I. Freckelton & M. Karagiannakis, 'Fitness to Stand Trial Under International Criminal Law: The Ramifications of a Landmark East Timor Decision. Deputy General Prosecutor for Serious Crimes v Josep Nahak 1 March 2005, Judge Rapoza, Special Panels for Serious Crimes, Dili District Court, Democratic Republic of East Timor', 21 *Psychiatry, Psychology and Law* 3 (2014), pp. 321-332.

52 SPSC, Judge Rapoza, 1 March 2005, *Deputy General Prosecutor for Serious Crimes v. Josep Nahak*, no. 01A/2004, para. 135.

53 ECtHR, Judgment of 15 June 2004, *SC v. UK*, Appl. 60958/00, para. 29.

exercise them as 'if he or she were trained as a lawyer or judicial officer'."[54] Or as Judge Rapoza sitting in the East Timor Panel put it:

> In determining whether or not a particular defendant is competent to stand trial, a court need not determine whether the individual operates at the highest level of functioning. Rather the test is whether the defendant satisfies certain minimum requirements without which he cannot be considered fit for trial.[55]

Which capacities of the defendant are relevant for effective participation? The capacities required by the ECtHR include his or her physical condition,[56] mental state,[57] hearing,[58] language competence[59] and intellectual abilities,[60] so that the defendant's immaturity,[61] age and social background can also play a part.[62] Also relevant are the possibilities of using resources such as notes they may have prepared, regardless of whether the defendant has legal aid or not.[63] With regard to shortcomings in these abilities, the defence must have

54 ICC, Pre-Trial Chamber I, 2 November 2012, *The Prosecutor v. Laurent Gbagbo*, no. ICC-02/11-01/11, para. 52.

55 SPSC, Judge Rapoza, 1 March 2005, *Deputy General Prosecutor for Serious Crimes v. Josep Nahak*, no. 01A/2004, para. 121.

56 ECtHR, Judgment of 31 October 2013, *Tarasov v. Ukraine*, Appl. 17416/03, paras. 98-101 (violation regarding a defendant who was unable to walk and sit and had to be brought in on a stretcher and lie there during the entire trial and who was unable to deliver a closing statement); ECtHR, Judgment of 27 January 2011, *Bortnik v. Ukraine*, Appl. 39582/04, para. 43 (violation in the case of an alcoholic defendant with a physical handicap, from a disadvantaged group); ECtHR, Judgment of 9 February 2010, *Pylnev v. Russia*, Appl. 3038/03, para. 3(b) (no violation).

57 ECtHR, Judgment of 20 January 2009, *Güveç v. Turkey*, Appl. 70337/01, paras. 123-133 (violation involving a minor with psychological problems without counsel); ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2(a) (no violation involving a depressed defendant under the influence of medication).

58 See with further references ECtHR, Judgment of 9 April 2009, *Grigoryevskikh v. Russia*, Appl. 22/03, paras. 78-94 (violation); ECtHR, Judgment of 14 October 2008, *Timergaliyev v. Russia*, Appl. 40631/02 (violation).

59 See e.g. ECtHR, Judgment of 14 October 2014, *Baytar v. Turkey*, Appl. 45440/04, paras. 46-59 (violation because of the absence of an interpreter during police questioning); ECtHR, Judgment of 24 September 2002, *Cuscan v. UK*, Appl. 32771/96, paras. 34-40 (violation because of the absence of an interpreter, as a consequence of which the defendant could not be fully involved in the criminal proceedings).

60 ECtHR, Judgment of 15 June 2004, *SC v. UK*, Appl. 60958/00, paras. 26-37 (violation involving an 11-year-old with limited intellectual abilities); ECtHR, Judgment of 30 January 2001, *Vaudelle v. France*, Appl. 35683/97, paras. 50-66 (violation involving a defendant who had been deemed to be unfit to defend himself in earlier civil proceedings).

61 See e.g. ECtHR, Judgment of 14 November 2013, *Blokhin v. Russia*, Appl. 47152/06, para. 157.

62 See ECtHR, Judgment of 27 January 2011, *Bortnik v. Ukraine*, Appl. 39582/04, para. 43.

63 ECtHR, Judgment of 14 June 2011, *Mościcki v. Poland*, Appl. 52443/07, para. 42 (violation); ECtHR, Judgment of 15 June 2000, *Pullicino v. Malta*, Appl. 45441/99, para. A(3) (no violation, because the procedure as a whole was fair, thanks to the assistance from counsel, among other things).

the opportunity to demonstrate effectively – and with sufficient substantiation[64] – that the defendant is unable to stand trial.[65]

However, this is not to say that each limitation of the aforementioned abilities must immediately be considered an obstacle to effective participation.[66] The authorities will have to assess to what extent effective participation is compromised and whether compensatory measures are therefore required.[67] In general, it falls to the state to decide how – within its national legal system – the possibility of effective participation is ensured.[68] This, however, will have to be done in a genuinely effective manner.[69] The authorities and the judge, in particular, can therefore be required to take positive measures in a specific case, which will truly enable the defendant to participate effectively in the proceedings.[70]

This may involve both remedial and compensatory measures. Measures that can counteract shortcomings in abilities include the provision of medicines to suppress pain or psychoses, for example (of course, with respect to the patient's rights), an interpreter, extra explanation for the defendant, shorter court sessions and closing the doors (in camera) so that effective participation is not rendered impossible as a consequence of intimidation by the public. Compensation can consist of providing aid by counsel, provided that – as discussed previously – the defendant at least meets the required minimum level of understanding. In the final analysis, the benchmark is whether the defendant can sufficiently participate effectively. For defendants who are sufficiently capable of doing so, but

64 See e.g. ECtHR, Judgment of 13 March 2014, *Andrey Yakovenko v. Ukraine*, Appl. 63727/11, para. 117 (insufficient substantiation); ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2 (*ibid.*); and the more general ECtHR, Judgment of 26 July 2012, *Vasiliy Ivashchenko v. Ukraine*, Appl. 760/03, para. 88.

65 It also follows from the fact that – as we have seen above – a fair trial is not possible against a defendant who is not sufficiently capable of effective participation; see among other sources ECtHR, Judgment of 15 June 2004, *SC v. UK*, Appl. 60958/00, paras. 26-37. Also compare ECtHR, Judgment of 6 January 2015, *Aswat v. UK*, Appl. 62176/14, para. 30, where the Court, in its conclusion that extradition does not contravene Art. 3 ECHR, also takes into consideration that "Although there is currently no suggestion that the applicant is unfit to plead, concerns regarding his fitness to plead have been answered in that it would be open to him to immediately challenge his fitness to stand trial"; ECtHR, Judgment of 23 September 2003, *Kerr v. UK*, Appl. 63356/00 (requirements regarding fairness for persons who cannot participate effectively carry more weight in criminal cases than in civil cases).

66 ECtHR, Judgment of 9 February 2010, *Pylnev v. Russia*, Appl. 3038/03, para. 3(b) (poor health and distraction caused by pain did not impede effective participation).

67 Cf. e.g. ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2(a). The necessity to take compensating measures when a defendant is fit to stand trial but not fully capable, is also recognized by, e.g. ICC, Pre-Trial Chamber I, 2 November 2012, *The Prosecutor v. Laurent Gbagbo*, no. ICC-02/11-01/11, paras. 102-104.

68 ECtHR, Judgment of 24 April 2012, *Gennadiy Medvedev v. Russia*, Appl. 34184/03, para. 30.

69 *Ibid.*

70 See e.g. ECtHR, Judgment of 8 January 2008, *Liebreich v. Germany*, Appl. 30443/03, para. 2(a); ECtHR, Judgment of 9 February 2010, *Pylnev v. Russia*, Appl. 3038/03, para. 3(b).

nevertheless have limited mental or intellectual abilities, the authorities may be obliged to provide such assistance. This applies even if the defendant declines such assistance.[71]

In addition, the authorities' duty to take positive measures to ensure the right to effective participation is supported by Article 13 of the UN Convention on the Rights of Persons with Disabilities.[72] This provision states, among other things, that state parties must ensure that persons with disabilities can play an effective part as direct and indirect participants in all legal proceedings, including at investigative and other preliminary stages.

4.2 Safeguards for fairness during police questioning of defendants with limited abilities

Where the position of the defendant in the preliminary enquiry is already vulnerable, in general, this is all the more so relative to police questioning. This is one of the reasons for the recognition of the right to legal assistance prior to questioning.[73] Such vulnerability exists a fortiori in the case of a defendant with insufficient abilities. For such defendants, states are therefore required to provide additional safeguards with respect to the right of access to counsel. In principle, the obligation on this point can apply to limitations of all the aforementioned abilities: physical condition, mental state, hearing, language competence, intellectual abilities and maturity. Vulnerabilities in these areas may also be present because the defendant is blind,[74] under the influence of alcohol, for example, or addicted.[75]

It is important to note that the limitations of abilities of the defendant may be such that he is not allowed to be questioned by the police without the assistance of legal counsel. This also means that if the defendant, having been informed of his or her right to legal aid, decides not to exercise this right, it cannot be assumed as easily as usual that the right to legal counsel was waived in a legally valid way.[76] In the case of serious incapacitation of

71 ECtHR, Judgment of 15 October 2009, *Prezec v. Croatia*, Appl. 48185/07, paras. 25-32 (defendant with serious and permanent personality disorder with paranoid personality disorder, schizophrenic disorder and a distinctly narcissistic pathology, as well as a strong tendency towards destructive and self-destructive behaviour); compare ECtHR, Judgment of 27 January 2011, *Bortnik v. Ukraine*, Appl. 39582/04, paras. 43-44. See also Supreme Court, 20 November 2011, ECLI:NL:HR:2011:BT6406, *NJ* 2012/29.

72 *Convention on the Rights of Persons with Disabilities*, New York, 13 December 2006, U.N. doc. A/RES/61/106 Annex I.

73 See ECtHR (GC), Judgment of 27 November 2008, *Salduz v. Turkey*, Appl. 36391/02, paras. 54-55.

74 ECtHR, Judgment of 12 January 2012, *Todorov v. Ukraine*, Appl. 16717/05, paras. 74-81.

75 ECtHR, Judgment of 31 March 2009, *Plonka v. Poland*, Appl. 20310/02, para. 38; ECtHR, Judgment of 27 January 2011, *Bortnik v. Ukraine*, Appl. 39582/04, para. 43.

76 ECtHR, Judgment of 17 July 2014, *Omelchenko v. Ukraine*, Appl. 34592/06, para. 49 (written and signed declaration of waiver by a vulnerable arrested suspect not legally valid); ECtHR, Judgment of 31 March 2009, *Plonka v. Poland*, Appl. 20310/02, paras. 37-42 (no legally valid waiver by an arrested alcoholic suspect

the defendant, it must even be assumed that a conscious and intelligent choice of 'waiver' is not possible.[77] Consequently, the authorities will, in principle, have to actively ensure that the right to counsel during questioning is effected in the case of less capable and/or vulnerable defendants.[78] That obligation is indeed not necessarily limited to defendants who have been deprived of their liberty. It may also apply to persons who have not formally been arrested and even those who have not formally been designated as suspects.[79]

According to the European Court, the requirement that persons who are unable to defend themselves on account of physical or mental limitations be legally represented as soon as the authorities are aware of the limitation is consistent with Article 6 ECHR.[80] This also means that the aforementioned obligations only actually arise if the suspect or defendant informs the questioning authorities of his or her limitation or if there are indications because of which the authorities have to assume that they are dealing with someone with limited abilities.[81]

4.3 No right to terminate the trial and no impediment to fair proceedings by suspension

As previously observed, it follows from Article 6 ECHR that a criminal procedure cannot continue if the defendant does not meet the required minimum level of understanding and consequently cannot participate effectively. As a result, and only to this extent, a right to suspension of the criminal proceedings ensues from the ECHR, which can be exercised, for example, by suspending the prosecution or the trial inquiry. However, there is no right to a definitive termination of the criminal proceedings on the grounds that the defendant is insufficiently able to stand trial.[82]

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who had been drinking heavily the day before being questioned and who had been informed of her right to legal aid and had subsequently not requested such aid).

77 See ECtHR, Judgment of 24 June 2014, *Kravchenko v. Ukraine*, Appl. 23275/06, paras. 60-62 (waiver by a schizophrenic suspect who had been declared legally incapacitated was voluntary but not conscious or intelligent).

78 See also ECtHR, Judgment of 25 June 2013, *Kaçiu and Kotorri v. Albani*a, Appl. 33192/07, para. 120.

79 ECtHR, Judgment of 17 December 2015, *Sobko v. Ukraine*, Appl. 15102/10, paras. 12-13 and 54-62 (violation of Art. 6(3)(c) ECHR versus a suspect of low intelligence who was originally interviewed as a witness and who was interviewed further at the police station without having been arrested and without having been told that he was a suspect).

80 In ECtHR, Judgment of 24 June 2014, *Kravchenko v. Ukraine*, Appl. 23275/06, para. 68 (in connection with 39).

81 ECtHR, Judgment of 24 June 2014, *Kravchenko v. Ukraine*, Appl. 23275/06, paras. 63-70 (therefore in this case no violation of Art. 6(3)(c) ECHR).

82 ECtHR, Judgment of 10 May 2012, *Krakolinig v. Austria*, Appl. 33992/07, para. 27; ECtHR, Judgment of 13 May 2003, *Antoine v. UK*, Appl. 62960/00, para. 1(B). Nevertheless, for a critical take on the fact that proceedings cannot be terminated definitively if the defendant is permanently insufficiently capable of standing trial, see: ECtHR, Judgment of 15 October 2009, *Nichitaylov v. Ukraine*, Appl. 36024/03, para. 36.

Justifiable or necessary suspension of the criminal proceedings because of genuine incapacity of the defendant does not lead to a violation of the requirement regarding a reasonable time either.[83] That is clear. After all, a state would otherwise find it hard to escape a violation of the convention with an incapable defendant: suspending the proceedings would soon cause a violation of the principle of a reasonable time, whereas continuing the proceedings would be incompatible with the right to effective participation. Moreover, in principle, Article 6 ECHR – on account of the 'criminal charge' requirement – does not apply to procedures taking place after the defendant has been declared unfit to stand trial.[84]

This does not alter the fact that if it is clear that there is no realistic prospect that the defendant will become sufficiently fit to stand trial, fairness requires – perhaps even the principles of due process – that the prosecuting authorities formally make a decision to abstain from further prosecution.[85]

4.4 Preliminary conclusion: task for legislature and legal practice

The gist of the case law of particularly the ECtHR and various international criminal adjudicators is that each defendant must be able to participate sufficiently effectively in the criminal proceedings against him. Moreover, according to the ECtHR, each defendant must be able to safeguard his or her own interests sufficiently during questioning in the preliminary enquiry.

First, this means that the system of criminal procedure must be set up and applied such that each defendant actually – not merely defendants in general – has that opportunity. The ECtHR is concerned primarily about participation during trial in this respect. However, not in all jurisdictions does the immediacy principle (the principle that holds that all evidence has to be produced and discussed at trial in the presence of the defendant and of

83 ECtHR, Judgment of 10 May 2012, *Krakolinig v. Austria*, Appl. 33992/07, paras. 18-28. However, in those cases where a defendant becomes increasingly less capable there may be an obligation for the authorities to speed up the proceedings, and failure to do so could cause a violation of the principle of reasonable time; according to ECtHR, Judgment of 15 October 2009, *Nichitaylov v. Ukraine*, Appl. 36024/03, para. 39.

84 See ECtHR, Judgment of 13 May 2003, *Antoine v. UK*, Appl. 62960/00, para. 1(B); ECtHR, Judgment of 23 September 2003, *Kerr v. UK*, Appl. 63356/00, para. B. In my opinion, the same applies almost certainly to procedures to assess the defendant's fitness to stand trial, in view of this case law, the Engel criteria (ECtHR, Judgment of 8 June 1976, *Engel v. Netherlands*, Appl. 5100/71, para. 82), the decision of the *Mosbeux v. Belgique* (1991) 71 DR 269 and the type of procedures, which, according to the ECtHR, do not concern a criminal charge; see the list in D. Harris *et al.* (eds), *Harris, O'Boyle & Warbrick: Law of the European Convention on Human Rights*, 3rd edn, Oxford: Oxford University Press, 2014, p. 373.

85 See also P. Bal & F. Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces* (The psychological inability to stand trial. Safeguard or obstacle to the right to a fair trial), Den Haag: Boom Juridische Uitgevers, 2004, pp. 46, 71, 82.

the judges who decide the case[86]) have a strong position. In some criminal justice systems – e.g. those of Belgium, France, Italy[87] and the Netherlands – the emphasis is on the preliminary inquiry. If the presentation and discussion of the evidence cannot or will not take place during trial, it must, in principle, be guaranteed that the defendant's participation in the investigation will be possible prior to the trial. The considerations of the ECtHR quoted previously show, for example, that effective participation also applies to witness examinations. When witnesses are examined in the preliminary enquiry rather than at trial, this means that, in principle, the defendant will have to be able to follow the witness examination during the preliminary enquiry. Therefore, it is appropriate for modernization to result in defendants being able to attend the examination of witnesses more often than is currently the case.[88]

Second, the principles in the case law of, especially, the European Court and the I-ACtHR imply that when the abilities of defendants are less than optimal for effective participation or defence, the system of criminal procedure needs to offer the possibility to take measures to remedy or compensate for the lack of abilities. It will, in principle, be the responsibility of the examining magistrate, and the trial court, in particular, to see to this.[89] Compensation for limitations regarding effective participation is not possible, however, if the defendant does not at least meet the required minimum level of understanding. This appears to be different in the case of limited abilities on the part of the defendant when questioned during the preliminary enquiry. At that point, compensation must be provided through the assistance of counsel.

86 See, e.g. M. S. Groenhuijsen & H. Selçuk, 'The Principle of Immediacy in Dutch Criminal Procedure in the Perspective of European Human Rights Law', 126 *Zeitschrift für die Gesamte Strafrechtswissenschaft* 1 (2014), pp. 248-276. See also ECtHR, Judgment of 2 December 2014, *Cutean v. Romania*, Appl. 53150/12, paras. 60-61; ECtHR, Judgment of 9 July 2002, *PK v. Finland*, Appl. 37442/97, para. 1(a).

87 See, e.g. M. Panzavolta, 'Of Hearsay and Beyond: Is the Italian Criminal Justice System an Adversarial System?', 20 *The International Journal of Human Rights* 5 (2016), pp. 617-633, p. 620.

88 *Ibid*., pp. 31, 37.

89 See also ICC, Pre-Trial Chamber I, 2 November 2012, *The Prosecutor v. Laurent Gbagbo*, no. ICC-02/11-01/11, para. 56; SPSC, Judge Rapoza, 1 March 2005, *Deputy General Prosecutor for Serious Crimes v. Josep Nahak*, no. 01A/2004, para. 61 *et seq*. See for a different approach ICTY, Appeals Chamber, 17 July 2008, *Prosecutor v. Pavle Strugar*, no. IT-01-42-A, para. 56.

5 The need for protection of the legal position of insufficiently capable defendants

5.1 Conclusions on defendants who are unfit to stand trial

The defendant must display a minimum level of understanding that enables him to comprehend, in a general sense, the nature of the trial, its subject matter and what is at stake, to such an extent that he is able to instruct his or her counsel meaningfully about the essential aspects of the case. This requirement appears to be the minimum from an international point of view.

Recommendation I. It is desirable that national criminal systems display a criterion for barring or suspension of prosecution, which does not limit the causes of unfitness to stand trial to situations where a defendant suffers from a mental illness to such an extent that he is no longer capable of understanding the gist of the prosecution instituted against him but will also encompass serious physical illness and limitations as a cause therefor. The foundation for the possibility of suspension is the fairness of the trial. If a fair trial is not compatible with the prosecution of incapacitated persons, the question of why they are incapacitated is irrelevant. Although deficient development or a pathological disorder of mental faculties are the most important categories, there can be more physical causes for an inability to defend oneself, for example if the defendant is a terminal patient and exhausted or has gone both deaf and blind. After all, as we have seen before, the defendant's capacities for effective participation as required by the ECtHR include not only his or her mental state, intellectual abilities and maturity but also his or her physical condition and hearing.

Recommendation II. From the point of view of the right to effective participation, it is not relevant when the unfitness to stand trial came about. However, it is sometimes argued that the possibility of suspension needs to exist only in those cases where the unfitness to stand trial came about after the commission of the offence, because the offence in cases where that unfitness existed at that time will not be attributed to the defendant, by virtue of the applicability of the excuse of insanity. The view that the possibility of suspension can be limited to cases where the unfitness to stand trial came about after the commission of the offence is problematic in my opinion. First of all, there may be other causes for unfitness to stand trial than insanity. Furthermore, before one arrives at the point where an excuse of insanity can be applied, in many jurisdictions there will first have to be a fair trial concerning the criminal charge.

This can, however, be circumvented if arranged roughly as follows. It should be possible, first, to declare the defendant to be unfit for trial. Subsequently, the trial should be able to continue, but in the first instance primarily for the purpose of answering the question whether the defendant is accountable for his or her actions. The judge must then declare the defendant to be wholly criminally unaccountable in an interim ruling. If this happens – in which case it is no longer possible to impose a punitive penalty – then, as we have seen before, there is no longer a criminal charge.[90] The procedure cannot be allowed to end in a conviction.[91] However, it can establish the non-punitive measure to which the person involved must be subjected, given his or her insanity (severe psychiatric disturbances or severe limited mental abilities) that underlay his or her unaccountability. Thus, the foregoing is meaningful only for defendants who are both unfit to stand trial and unable to be held accountable for the act. (The fact that the defendant is wholly unaccountable for the offence does not always mean that that he or she will also be unfit to stand trial.) In my opinion, it would be advisable for national jurisdictions to include this possibility in their system.

Recommendation III. Finally, I believe it is desirable that the defendant who is unfit to stand trial after a certain period should be able to request a definitive end to prosecution if it is no longer possible, taking into account the incapability of the defendant, to initiate further proceedings that may serve any interest protected by enforcement of criminal law. This may happen, for example, in the case of the defendant who is actually definitively unfit to stand trial (or in whose case the procedure described previously has been applied). While Article 6 ECHR (strictly speaking) does not require this, as became apparent earlier, this does not alter the fact that it is a suitable element of decent criminal procedure, also because it creates clarity for any victims and for the defendant's relatives.

5.2 *Conclusions on defendants with limited capacity for effective participation during trial*

The fact that a defendant can meet the required minimum level of understanding and therefore qualifies as sufficiently fit to stand trial does not necessarily mean that he is also able to exercise his or her right to effective participation sufficiently – let alone doing that well. Defendants who are fit to stand trial but who nevertheless do have limited – mental or physical – abilities, may require remedial or compensatory measures to be taken.

90 See para. 4(1) above.

91 See ECtHR, Judgment of 13 May 2003, *Antoine v. UK*, Appl. 62960/00, para. 1(B); ECtHR, Judgment of 23 September 2003, *Kerr v. UK*, Appl. 63356/00, para. B.

Recommendation IV. As discussed in more detail previously, it may be necessary for the realization of the right to effective participation that other limitations of the defendant – of a physical or gerontological nature, for example – are compensated for. After all, it is not relevant in the context of international human rights law what the exact cause of the limitation is. That is why the law should also recognize 'physical and gerontological diseases and limitations' as possible causes of limited abilities to defend oneself.

Moreover, the notions of psychiatric disturbances or otherwise limited mental abilities must, in principle, be broadly interpreted here. For example, compensatory measures will also need to be taken for defendants who are so less intelligent, alert or sharp than the average person that they cannot independently conduct an essential active defence for themselves. With respect to this last category, action will usually have to be taken to ensure that at least legal aid is provided.

Recommendation V. Apart from the foregoing, national criminal justice systems should not be restricted to compensation through – if necessary: mandatory – legal aid. If there is reason to believe that the defendant can exercise his or her right to effective participation independently only to a limited extent, national law must make sure that the court assesses what remedial and compensatory measures are called for, in light of the specific limitations of the defendant and given the nature of the case. The case law of the ECtHR referred to earlier contains measures such as the provision of medicines to suppress pain or psychoses (with respect for patients' rights), extra explanation for the defendant and closing the doors (in camera), so that effective participation is not rendered impossible as a consequence of intimidation by the public. This may be particularly relevant in cases in which defendants are especially vulnerable because of their psychiatric disturbances or otherwise limited mental abilities. One could also think of providing the assistance of a social worker or psychologist to the defendant. In my opinion, it is therefore desirable that the law offer an explicit, non-limitative list of measures so that the judge can implement them or have them implemented. In view of this, there will have to be room in the procedure for the court to have an investigation carried out into the nature and seriousness of the defendant's limitations, unless the extent of the measures that need to be taken and what measures they need to be are established.

5.3 Conclusions on defendants with limited capacity during police questioning and preliminary inquiry

According to international human rights law, both defendants who have been arrested and those who have not are, in principle, entitled to access to a lawyer *before* they are questioned by the police. Furthermore, under international human rights law, in certain

circumstances there is a right to assistance from counsel *during* police questioning. Particularly with respect to less capable and/or vulnerable defendants, the authorities, will in principle, have to actively ensure that the right to counsel during questioning is effectuated.[92] That obligation may also apply to persons who have not formally been arrested and even those who have not formally been designated as suspects.

Recommendation VI. The law should recognize a fairly wide category of defendants as being vulnerable. At least the following persons should qualify as vulnerable: persons with psychiatric disturbances or otherwise limited mental abilities, i.e. persons with a mental handicap or a disorder of cognitive functions, such as Parkinson's or Alzheimer's disease, or a disorder affecting perception, memory, thinking, language/speech, attention, concentration and executive functions and motor skills. In view of international human rights law – particularly Article 6 ECHR – this will also have to include people with a temporary functional disorder, for example as a result of the influence of medicines, alcohol or drugs.

Of course, none of this means that each imperfection in a defendant should lead to the measures discussed further on, or any other ones. The main point is whether the limitation entails that the defendant be qualified as insufficiently capable. As far as the interview is concerned, the criterion ought to be whether the limitation is such that the defendant is incapable of adequately and independently looking after his or her own interests, participating in the interview and deciding whether or not to use his or her right to remain silent. For other investigative acts during the preliminary enquiry the criterion is whether the limitation impedes effective participation.

Recommendation VII. The interview of a defendant with limited abilities who has been arrested, and for whom access to counsel has not explicitly been realized, may contravene Article 6 ECHR. The same may be the case if the defendant has not been arrested.[93] That is hardly surprising, since the first police interview may be crucial for the subsequent course and outcome of the case. That is exactly why it is appropriate to recognize in national law the right to assistance during questioning and to have counsel assigned to vulnerable defendants, if they are insufficiently aware of it and/or insufficiently capable of functioning adequately during the interview in cases where they have not been arrested. This should, for example, also mean that a waiver of the right to legal assistance can validly take place only if the defendant has first spoken to a lawyer and then only in the presence of that lawyer.

92 See para. 4.2 above.
93 See for information on this para. 4.2 above.

Recommendation VIII. Of course, in order to be able to take measures that during the police interview can sufficiently compensate a defendant's inabilities, the interviewing authorities will need to have reasonable cause to believe that they are dealing with someone with limited capability. However, to ensure that the police recognize psychiatric disturbances or otherwise limited mental abilities whenever possible, it is necessary that the police are properly trained and that policy is developed.

Recommendation IX. In cases of more serious offences – for example, offences that are punishable by a high prison sentence, acts where the victim died or suffered grievous bodily harm and the more serious sexual offences – it is desirable that the defendant with limited abilities – regardless of whether he or she has been arrested – can also have an assigned counsel at other times during the preliminary enquiry. This is the case, for example, when important investigative acts such as examining witnesses are carried out, where the defendant has a right to attend and legal counsel is needed to safeguard the defendant's right to effective participation.[94] The law should therefore also provide for this.

Recommendation X. According to the EU Directive on the right to information,[95] 'any particular needs' must be taken into account in the case of vulnerable defendants when they are furnished with information – orally or in writing – about their rights (the right to legal advice and aid, information about the charges, interpretation and translation and the right to remain silent). Clear and understandable information is indispensable for defendants to effectively exercise their rights. It is therefore of universal importance that it is clear for authorities around the world how this obligation is fulfilled in the case of adult vulnerable defendants. It is desirable to integrate this obligation in the law so that it is clear that it should be part of normal practice to consider insufficiently capable defendants. To this end, policies must also be developed so that information can be furnished to various categories of vulnerable defendants meaningfully.

6 Final remarks

The principles of fairness, truthfulness, effectiveness and humanity all require that criminal procedures take into consideration every defendant with no or limited abilities to participate sufficiently independently in police interviews, the preliminary inquiry and the inquiry at the trial (or, alternatively, negotiating justice procedures like plea bargaining). Relative to

94 For information on the defendant's presence during the witness examination in the preliminary enquiry, see also para. 4(4) above.

95 European Parliament and Council Directive 2012/13/EU of 22 May 2012 on the right to information in criminal proceedings [2002] OJ L142/1, Art. 3(2).

the protection of defendants with psychiatric disturbances or otherwise limited mental abilities, ten substantiated recommendations have been made previously. There lies an important task for legislators. Ultimately, however, it is up to legal practice to give effective attention to the legal position of defendants with no or only limited capabilities. This means that police officers, prosecutors, judges and lawyers will need to be vigilant to ensure that the fairness, truthfulness, effectiveness and integrity of the criminal justice process are not jeopardized, notably when defendants who are unfit to stand trial still end up being tried, or because insufficient measures were taken for defendants with limited abilities in order for them to participate effectively enough. In other words, there is an important task here for all professional key participants in criminal justice.

Healthcare and human rights requirements as regards detainees with psychiatric disturbances

Małgorzata Wąsek-Wiaderek[*]

1 Introduction

In accordance with Article 14 para. 2 of the UN Convention on the Rights of Persons with Disabilities, detainees with mental disturbances shall be entitled, on an equal basis with others, to guarantees, in accordance with international human rights law and shall be treated in compliance with the objectives and principles of the Convention, including the provision of reasonable accommodation.

The aim of this article is to present international human rights requirements applying to detainees with mental disabilities, in particular those stemming from their right to life, the prohibition of inhuman or degrading treatment and their right to liberty. The analysis will focus on guarantees provided in the European Convention on Human Rights (ECHR), the UN Covenant on Civil and Political Rights (ICCPR) and the UN Convention on the Rights of Persons with Disabilities (CRPD) mentioned previously. The article will also address the question of whether detention instead of hospitalization of persons with severe mental disabilities is in compliance with their human rights. There is a lack of consistency in international human rights' standards with reference to this issue. While ECHR permits deprivation of liberty of persons of 'unsound mind' (Art. 5, para. 1 (e) of the ECHR), Art. 14 of the CRPD provides that the "existence of a disability shall in no case justify a deprivation of liberty".

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2 The right to obtain adequate healthcare in prison/detention centre

The right to healthcare for prisoners is provided neither in the ECHR nor in the ICCPR. However, both at the European and at the universal level, positive obligations to address special needs of detainees with mental disabilities can be derived from their right to life (Art. 2 of the ECHR; Article 6 of the ICCPR) and the right to humane treatment (Art. 3 ECHR; Art. 7 of the ICCPR). Apart from the general prohibition of inhuman treatment, the Covenant offers an additional legal basis for the protection of human rights of prisoners. Article 10 of the ICCPR provides that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person". Additionally, the standard of healthcare that should be guaranteed to mentally disordered detainees is identified by the European Court of Human Rights (ECtHR) in its jurisprudence under Article 5 of the ECHR. Furthermore, provisions concerning the right to adequate healthcare for mentally disordered prisoners can be found in regional and universal soft law instruments, like CPT[1] standards or two Recommendations of the Committee of Ministers: European Prison Rules (EPR)[2] and Recommendation No. R (98) 7 concerning the ethical and organizational aspects of healthcare in prison. At the universal level, special attention should be paid to the Revised UN Standard Minimum Rules for Treatment of Prisoners.[3]

It is a commonly recognized rule of the international human rights law that prisoners shall retain all their rights except the right to liberty,[4] which has been confirmed by the jurisprudence of the Human Rights Committee (HRC) under Articles 7 and 10 of the ICCPR and the case law of the ECtHR. According to the HRC, persons deprived of their liberty shall enjoy all the rights set forth in the ICCPR, subject to the restrictions that are unavoidable in a closed environment.[5] Thus, in reference to healthcare, people in prison shall have a right to a standard of medical assistance equivalent to that available outside prison ('principle of equivalence').[6] Although the ICCPR does not guarantee the general right to properly functioning medical service for people at liberty, it sets a minimum

1 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

2 Recommendation Rec(2006)2 of the Committee of Ministers to member states on the EPR.

3 Resolution of the General Assembly of the UN adopted on 17 December 2015, thereafter referred as 'the Nelson Mandela Rules'.

4 P.H.P.H.M.C. van Kempen, 'Positive Obligations to Ensure the Human Rights of Prisoners. Safety, Healthcare, Conjugal Visits and the Possibility of Founding a Family under the ICCPR, the ECHR, the ACHR and the AfChHPR', in: P.J.P. Tak & M. Jendly (Eds), *Prison Policy and Prisoners' Rights. The Protection of Prisoners' Fundamental Rights in International and Domestic Law*, Nijmegen: Wolf Legal Publishers, 2008, pp. 23-26.

5 General comment No. 21: Art. 10 (Human treatment of persons deprived of their liberty), 1992, para. 3.

6 See, R. Lines, 'From equivalence of standards to equivalence of objectives: The entitlement of prisoners to health care standards higher than those outside prisons,' 2 *International Journal of Prisoner Health* 4 (2006), p. 269.

standard that extends to incarcerated persons by virtue of Articles 6 and 7 of the ICCPR.[7] In *Williams v. Jamaica* the HRC found that the applicant's mental condition deteriorated seriously during his incarceration on death row. Having established that the applicant did not receive any or received inadequate medical treatment for his mental condition while in detention, the HRC found a violation of Articles 7 and 10 para. 1 of the ICCPR. In the opinion of the HRC the applicant was subjected to inhuman treatment and was not treated with respect for the inherent dignity of his person.[8]

The HRC emphasizes that "appropriate and timely medical care must be available to all detainees".[9] It also stressed that "free access to doctors" should be guaranteed in practice immediately after arrest and during all stages of detention.[10] As it transpires from the *Fabrikant v. Canada* case, the state party to the Covenant "remains responsible for the life and well-being of its detainees". In this case, the HRC refrained from considering the issue whether a detainee has a right to choose or refuse a particular medical treatment but indicated that authorities shall provide the applicant with "the most appropriate treatment in accordance with professional standards".[11] As it is stressed in the literature, prisoners are not free to choose particular medical treatment, and the positive obligation to take proactive measures in order to preserve the health of detainees compels the state to offer professional medical healthcare.[12]

The obligation to offer adequate healthcare for prisoners can also be inferred from their right to life. In accordance with the general standards stemming from Article 6 of the ICCPR, state authorities are responsible for failure to take adequate measures to protect

7 *Ibid*., p. 275.

8 Human Rights Committee, View of 4 November 1997, *Nathaniel Williams v. Jamaica*, Comm. No. 609/1995, para. 6.5.

9 See, Human Rights Committee Concluding Observations, Portugal, CCPR/CO/78/PRT, 17 September 2003, para. 11; see also: Human Rights Committee Concluding Observations, Ukraine, CCPR/C/UKR/CO/6, 28 November 2006, para. 11; HRC Concluding Observation, Mongolia, CCPR/C/79/Add/120, 25 April 2000, para. 12; Human Rights Committee Concluding Observations, Georgia, CCPR/CO/74/GEO, 12 April 2002, para. 7.

10 Human Rights Committee Concluding Observations, Ukraine, CCPR/CO/73/UKR, 12 November 2001, para. 15. See also: P.H.P.H.M.C. van Kempen, 'Positive Obligations to Ensure the Human Rights of Prisoners. Safety, Healthcare, Conjugal Visits and the Possibility of Founding a Family under the ICCPR, the ECHR, the ACHR and the AfChHPR', in: P.J.P. Tak & M. Jendly (eds), *Prison Policy and Prisoners' Rights. The Protection of Prisoners' Fundamental Rights in International and Domestic Law*, Nijmegen: Wolf Legal Publishers, 2008, p. 33 and other Human Rights Committee Concluding Observations referred therein.

11 Human Rights Committee, View of 6 November 2003, Comm. 970/2001, CCPR/C/79/D/970/2001, para. 9.3.

12 See, P.H.P.H.M.C. van Kempen, 'Positive Obligations to Ensure the Human Rights of Prisoners. Safety, Healthcare, Conjugal Visits and the Possibility of Founding a Family under the ICCPR, the ECHR, the ACHR and the AfChHPR', in: P.J.P. Tak & M. Jendly (eds), *Prison Policy and Prisoners' Rights. The Protection of Prisoners' Fundamental Rights in International and Domestic Law*, Nijmegen: Wolf Legal Publishers, 2008, p. 33.

the right to life of inmates.[13] As the HRC highlighted in the *Lantseva v. Russia* case, "state party by arresting and detaining individuals takes the responsibility to care for their life. It is up to the State party by organizing its detention facilities to know about the state of health of the detainees as far as may be reasonably expected. Lack of financial means cannot reduce this responsibility". The applicant's son was provided with medical care only during the last few minutes of his life. Before the situation of life emergency, prison authorities refused to ensure necessary medical care for the applicant's son. This outright negligence resulted in his death. The HRC stressed that properly functioning medical services within the detention centre could and should be aware of the dangerous change in the state of health of the applicant's son and take appropriate measures to protect his life.[14]

Human rights of persons with mental disabilities are also protected by the CRPD. Although the notion of 'disability' is not defined in the Convention, it refers to persons "with long term mental, intellectual or sensory impairments" (Art. 1 (2) of the CRPD). Thus, there are no doubts that persons with psychosocial disabilities are covered by the CRPD.[15]

The 'principle of equivalence' with reference to detainees with a mental disorder should be extracted from Article 14 of the CRPD, read in conjunction with Article 25 of the CRPD. The latter provision obliges the state parties to the CRPD to recognize the right of persons with disabilities to enjoy the highest attainable standard of health without discrimination on the basis of disability. States shall take appropriate positive measures in order to ensure access to health services for persons with disabilities. Moreover, Article 25 of the CRPD contains a non-exhaustive list of obligations of state authorities, including, in particular, the duty to provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons. The list further indicates the right to early identification and intervention, as appropriate, and services designed to minimalize and prevent the gradual development of those disabilities. Article 25 of the CRPD expresses 'the principle of equivalence' with regard to the general access to healthcare: medical services should be equally accessible to persons with and without disabilities. Under Article 14 of the CRPD 'equal access' to medical services shall be granted to prisoners with mental disabilities.[16]

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13 Human Rights Committee, View of 21 October 1982, *Barbato v. Uruguay*, Comm. No. 84/1981, CCPR/C/OP/2 at 20 (1985), para. 9.2.

14 Human Rights Committee, View of 26 March 2002, *Lantsova v. Russian Federation*, Comm. No. 763/1997, para. 9.2.

15 T. Minkowitz, 'The United Nations Convention of the Rights of Persons with Disabilities and the Right to be Free from Nonconsensual Psychiatric Interventions', 34 *Syracuse Journal of International Law and Commerce* 2 (2007), p. 407 (electronic copy available at: http://ssrn.com/abstract=1481512) (last visited: 2 May 2018).

16 See Committee on the Rights of Persons with Disabilities, Guidelines on Art. 14 of the CRPD (The right to liberty and security of persons with disabilities) adopted at 14th Session in September 2015, para. 18.

The ECHR, like the Covenant, does not provide the general right to healthcare. However, a positive obligation to preserve the mental health of prisoners stems from their right to life (Art. 2) and the right not to be subjected to torture, inhuman or degrading treatment (Art. 3). The ECtHR has examined the question of whether denial of healthcare or inadequacy of medical assistance in detention facilities constitutes a violation of the right to life or the prohibition of inhumane treatment on many occasions.

In accordance with the standing case law of the ECtHR, Article 3 of the Convention cannot be construed as laying down a general obligation to release detainees on health grounds. However, it imposes a duty to protect the physical well-being of persons deprived of their liberty by providing them, among other things, with the requisite medical assistance.[17] The lack of appropriate medical care may amount to treatment contrary to Article 3 of the ECHR. In the case of mentally disordered persons, the ECtHR underlines that an assessment of whether the particular conditions of detention are incompatible with Article 3 must take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment.[18] Thus, three elements should be considered in order to evaluate whether deprivation of liberty of a person with mental disturbances does not contravene Article 3 of the ECHR: (a) the medical condition of the prisoner, (b) the adequacy of the medical assistance and care provided in detention, and (c) the advisability of maintaining the detention measure in view of the state of health of an applicant.[19] The ECtHR also stresses that it is not enough for detainees with mental disabilities to be examined and to obtain a diagnosis. Instead, it is essential that proper treatment for the problem diagnosed and suitable medical supervision also be provided.[20]

In several cases the Court stated that the lack of specialized treatment and constant medical care in a psychiatric facility of a detainee suffering from serious psychiatric disabilities amounted to a violation of Article 3 of the ECHR. In *Dybeku v. Albania* the ECtHR established that the applicant suffering from a chronic mental disorder was placed in an ordinary prison and received in-patient treatment in the prison hospital only when his health worsened and only for a few weeks. Moreover, the applicant was kept in a shared cell with inmates who were in good health and received the same treatment as they did, notwithstanding his state of health. The Court considered that the applicant's regular visits

17 See, inter alia, ECtHR (Grand Chamber), Judgment of 26 October 2000, *Kudła v. Poland*, Appl. 30210/96; ECtHR (Grand Chamber), Judgment of 26 April 2016, *Murray v. the Netherlands*, Appl. 10511/10, para. 105.

18 ECtHR, Judgment of 18 December 2007, *Dybeku v. Albania*, Appl. 41153/06, para. 41; ECtHR, Judgment of 20 January 2009, *Sławomir Musiał v. Poland*, Appl. 28300/06, para. 87; ECtHR, Judgment of 23 February 2012, *G. v. France*, Appl. 27244/09, para. 39; ECtHR (Grand Chamber), Judgment of 26 April 2016, *Murray v. the Netherlands*, Appl. 10511/10, para. 106.

19 See, for instance, ECtHR, Judgment of 18 December 2007, *Dybeku v. Albania*, Appl. 41153/06, para. 42; ECtHR, Judgment of 17 November 2015, *Bamouhammad v. Belgium*, Appl. 47687/13, paras. 121-123.

20 ECtHR, Judgment of 21 December 2010, *Raffray Taddei v. France*, Appl. 36435/07, para. 59.

to the prison's hospital could not be viewed as a solution since the applicant was serving a sentence of life imprisonment. Thus, the cumulative effect of the entirely inappropriate conditions of the detention to which the applicant was subjected clearly had a detrimental effect on his health and well-being and consequently amounted to a violation of Article 3 of the ECHR.[21]

The lack of constant and specialized medical supervision of a detainee suffering from chronic and severe mental disorders (including schizophrenia) was also found in the *Sławomir Musiał v. Poland* case. During his nearly three and a half years of detention the applicant, for the most part, has been detained with healthy inmates in ordinary detention facilities. On three occasions he received short-term emergency treatment in a psychiatric hospital. In addition, he was under regular pharmacological treatment, which comprised the administration of psychotropic drugs. He had access to prison in-house medical staff and, on appointment, to specialist doctors, including psychiatrists. However, the Court found that the applicant was not a subject of regular psychiatric supervision, although almost all doctors who examined him suggested that he remain under regular specialized medical supervision, in the absence of which he faced major health risks.[22]

Even if a detainee with mental disturbances is placed in a special psychiatric wing of a prison, it may not suffice for his treatment to be found in conformity with Article 3 of the ECHR. In the *W.D. v. Belgium* case the applicant was detained in a special unit of a prison, dedicated for persons with psychiatric disturbances, since he could not be criminally responsible for his acts owing to the state of his mental health *tempore criminis*. In accordance with the psychiatrists' reports, he should have been committed to the psychiatric institution (the Flemish Agency for People with Disabilities – VAHP). However, owing to organizational deficiencies, he was not admitted to VAHP and spent nine years in the social protection unit of the ordinary prison. The medical assistance offered to the applicant was limited to few consultations with psychiatrists who prescribed him antidepressants and antipsychotic medications.[23] The ECtHR found that the absence of an adequate medical treatment had a negative impact on the applicant's mental health since he needed stronger therapeutic supervision. This lack of adequate medical assistance constituted an obstacle to his reintegration into society. He suffered distress and hardship amounting to a violation of Article 3 of the ECHR.[24] The judgment in *W.D. v. Belgium* was delivered as a pilot

21 ECtHR, Judgment of 18 December 2007, *Dybeku v. Albania*, Appl. 41153/06, paras. 43-51.
22 ECtHR, Judgment of 20 January 2009, *Sławomir Musiał v. Poland*, Appl. 28300/06, paras. 89-96.
23 ECtHR, Judgment of 6 September 2016, *W.D. v. Belgium*, Appl. 73548/13, paras. 19, 107-116.
24 *Ibid*., paras. 113-116.

judgment,[25] revealing systemic and structural deficiencies in Belgium in providing appropriate medical treatment to mentally disordered detainees.[26]

Treating a mentally ill defendant in prison or in the psychiatric institutions and simultaneously detaining him in prison may be contrary to Article 3 ECHR. In *G. v. France* the Court was struck by the frequent and repetitive nature of the applicant's stays in a psychiatric hospital. The applicant was taken there whenever his state of health was incompatible with detention. On improvement, he returned either to the prison's psychiatric unit or to an ordinary cell until his health declined again. As the Court underlined "in these conditions no purpose was served by alternating periods in the psychiatric hospital, which were too short and haphazard, with periods in prison, which were incomprehensible to and distressing for the applicant, particularly as he presented a danger to himself and to others". Thus "alternately treating the applicant – in prison or in a psychiatric institution – and detaining him in prison clearly impeded the stabilization of his condition, demonstrating that he was unfit to be detained from the standpoint of Article 3 of the Convention".[27]

The access to adequate specialized assistance for mentally disordered detainees was also a key issue in cases concerning inmates with suicidal tendencies. Under Article 2 of the ECHR, prison authorities shall take positive operational measures to protect such inmates from themselves.[28] However, not every claimed risk to life should impose a burden on the authorities to take preventive actions. The Court indicates that "for a positive obligation to arise regarding a prisoner with suicidal tendencies, it must be established that the authorities knew, or ought to have known at the time, of the existence of a real and immediate risk to the life of an identified individual and, if so, that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to prevent that risk from materializing".[29]

The basic precautionary measure to prevent suicide is a medical screening of an inmate on his admission to prison.[30] It is of particular importance to apply such procedure with reference to inmates admitted to a detention facility for the first time. In the *Isenc v. France* case the applicant's son committed suicide 12 days after admission to a prison and one

25 *Ibid*., para. 166.

26 See 'Pilot judgment for mentally ill detainees in Belgium', *European Human Rights Law Review* no. 1 (2017), pp. 84-85.

27 ECtHR, Judgment of 23 February 2012, *G. v. France*, Appl. 27244/09, para. 45.

28 ECtHR, Judgment of 3 April 2001, *Keenan v. UK*, Appl. 27229/95, para. 89; ECtHR, Judgment of 16 October 2008, *Renold v. France*, Appl. 5608/05, para. 81.

29 ECtHR, Judgment of 9 October 2012, *Çoşelav v. Turkey*, Appl. 1413/07, para. 54; ECtHR, Judgment of 3 April 2001, *Keenan v. UK*, Appl. 27229/95, para. 90; ECtHR, Judgment of 1 June 2010, *Jasińska v. Poland*, Appl. 28326/05, para. 59.

30 See, E. Thoonen, *Death in State custody. Obligations to prevent premature death of detainees and to investigate deaths of detainees pursuant to the European Convention on Human Rights*, Apeldoorn – Antwerp: Maklu, 2017, p. 152.

day after he was placed in a cell shared with two other prisoners. He was identified as suicidal during the interview conducted by the police one day after his admission to the detention centre. He was not given medical consultation on admission owing to the lack of appropriate collaboration of medical and supervising staff of the prison. The ECtHR found that the authorities should have known that there was a real and immediate risk to life of the applicant's son and should have taken appropriate preventive measures. In this case a violation of Article 2 of the ECHR resulted from the lack of appropriate psychiatric screening and suicide risk assessment of the detainee.[31]

In the *Jasińska v. Poland* case the information about the deterioration of the prisoner's mental health and his previous suicide attempts was neglected by the prison authorities. Despite the long history of mental problems, he was not supervised by prison staff and was able to gather a lethal dose of medicines to commit suicide. The medical assistance offered to the applicant's grandson was limited to prescription of medicines without any consideration of other means of monitoring his mental condition. The ECtHR emphasized that the duty to provide mentally disturbed inmates with adequate medical care should not be confined to prescribing appropriate medicines, without also ensuring that their dosage was properly supervised.[32]

Disciplinary measures may be ordered in respect of detainees with mental disabilities and suicide risk only if they are absolutely necessary and conducted under strict medical supervision. In a few cases the ECtHR found that placing a detainee with mental disturbances in a solitary confinement or disciplinary cell, despite objective appearances of immediate and real suicide risk may constitute a breach of positive obligations to protect the right to life of an inmate. In *Renolde v. France* the applicant was placed in a punishment cell only three days after a suicide attempt. The ECtHR pointed out that no consideration had been given to his mental state, although he had made incoherent statements during the inquiry into the incident and had been described as 'very disturbed'. Considering the admissibility of applying disciplinary measures to mentally disturbed detainees, the Court referred to the Recommendation No. R (98) 7 concerning the ethical and organizational aspects of healthcare in prison, which provides that "[i]n those cases where the use of close confinement of mental patients cannot be avoided, it should be reduced to an absolute minimum and be replaced with one-to-one continuous nursing care as soon as possible". The Court also relied on the EPR, which state, that "[t]he medical practitioner shall report to the director whenever it is considered that a prisoner's physical or mental health is being

31 ECtHR, Judgment of 4 February 2016, *Isenc v. France*, Appl. 58828/13, paras. 39-47.

32 ECtHR, Judgment of 1 June 2010, *Jasińska v. Poland*, Appl. 28326/05, paras. 63-79. See also other cases concerning suicide of inmates in Polish penitentiary facilities: ECtHR, Decision of 24 January 2017, *Jagiełło v. Poland*, Appl. 21782/15; ECtHR, Decision of 17 January 2017, *Molga v. Poland*, Appl. 78388/12.

put seriously at risk … by any condition of imprisonment, including conditions of solitary confinement".[33]

Healthcare and human rights' requirements with reference to mentally disordered detainees are also precisely defined in the international soft law. Although not binding, this law very often serves as a point of reference for the creation of binding standards in the jurisprudence of the ECtHR or the HRC. The Strasbourg Court frequently refers to the EPR, the CPT reports or, as mentioned previously, to Recommendation No. R (98) 7. The EPR, in its part III, comprise all the standards that are derived by the ECtHR from Articles 2 and 3 of the ECHR. In particular, Rule 42 (1) of the EPR provides for medical screening of every prisoner on his/her admission. His/her physical and mental health conditions shall be recorded immediately on admission (the Rule 15.1. (f) of the EPR). It is worth stressing that medical screening may be done by "the medical practitioner or a qualified nurse reporting to such a medical practitioner". The EPR further outlines that specialized prisons or sections under medical control shall be available for the observation and treatment of prisoners suffering from mental disorder or abnormality who do not necessarily fall under the provisions of Rule 12. As discussed in the following section of this contribution, Rule 12 of the EPR provides that persons suffering from mental illness and whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for mental healthcare. In accordance with Rule 47 (2) of the EPR, the prison medical service shall ensure that the psychiatric treatment of all prisoners in need of such treatment pay special attention to suicide prevention.

Similar standards are expressed in the Nelson Mandela Rules. Rule 30 provides for medical screening on admission. The screening should include appropriate assessment to determine mental illness and the undertaking of all measures necessary for its treatment with the consideration of existing medical treatment. The examination shall be conducted by qualified medical professionals. Like the EPR, the Nelson Mandela Rules also do not require that medical examination be administered by a psychiatrist.

3 The right to liberty of persons of unsound mind – an absolute ban on deprivation of liberty based partly on mental disorder?

Article 5 para. 1 (e) of the ECHR allows for 'the lawful detention' of 'persons of unsound mind', if it is done 'in accordance with the law'. In the context of criminal law, this provision was accepted by the ECtHR as a valid legal basis for the application of isolation as a preventive measure towards offenders with unsound mind who cannot be held criminally

33 ECtHR, Judgment of 16 October 2008, *Renolde v. France*, Appl. 5608/05, paras. 97-110; see also: ECtHR, Judgment of 19 July 2012, *Ketreb v. France*, Appl. 38447/09, paras. 75-99.

responsible for criminal acts in view of their state of mental health *tempore criminis* and who pose a danger to the general public.[34] Furthermore, a 'preventive detention' applied to convicts with severe mental disorder following the execution of prison sentence (the so-called 'post-penal preventive measure') was also assessed as falling within the ambit of Article 5 para. 1 (e) of the ECHR.[35]

The ECtHR lists three minimum conditions that must be fulfilled in order for a person to be legally deprived of liberty on the basis of Article 5 para. 1 (e) of the ECHR: (1) he must be reliably shown to be of unsound mind; that is, a true mental disorder must be established before a competent authority on the basis of objective medical expertise; (2) the mental disorder must be of a kind or degree warranting compulsory confinement, and (3) the validity of continuing confinement depends on the persistence of such a disorder.[36] For the second condition to be satisfied, it must be found that "the confinement of the person concerned is necessary as the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him from, for example, causing harm to himself or other persons".[37]

It is also evident in the ECtHR case law that, in principle, the detention of a person of unsound mind will be 'lawful' for the purposes of Article 5 § 1 (e) of the ECHR only if effectuated in a hospital, clinic or other appropriate institution authorized for that purpose.[38] Thus, psychiatric detention may be assessed as arbitrary and illegal under Article 5 para. 1 of the ECHR if a person (offender of unsound mind) is detained in accommodation ill-suited to his needs, for example in the psychiatric wing of a prison without the provision of appropriate psychiatric treatment. In such cases a link between the purpose of his detention, which is medical treatment, and the practical conditions of detention, which amount to mere execution of penalty, is broken. Hence, such detention can neither be justified as therapeutic deprivation of liberty under Article 5 para. 1 (e) of the ECHR, nor be classified as imprisonment for the purpose of Article 5 para. 1 (a) ECHR since the offender cannot be held criminally responsible.[39] Furthermore, the ECtHR case law requires

34 See, inter alia, ECtHR, Judgment of 6 November 2007, *Mocarska v. Poland*, Appl. 26917/05, para. 42; ECtHR, Judgment of 21 December 2010, *Witek v. Poland*, Appl. 13453/07, paras. 39-48.

35 ECtHR, Judgment of 28 June 2012, *S. v. Germany*, Appl. 3300/10, para. 80; ECtHR, Judgment of 7 January 2016, *Bergmann v. Germany*, Appl. 23279/14, paras. 103-134.

36 See, inter alia, ECtHR, Judgment of 24 October 1979, *Winterwerp v. Netherlands*, Appl. 6301/73, para. 39; ECtHR, Judgment 28 November 2017, *N. v. Romania*, Appl. 59152/08, para. 144. See also: S. Trechsel & S.J. Summers, *Human Rights in Criminal Proceedings*, Oxford, New York: Oxford University Press, 2006, p. 448.

37 ECtHR, Judgment 28 November 2017, *N. v. Romania*, Appl. 59152/08, para. 145.

38 See, for instance, ECtHR (Grand Chamber), Judgment of 17 January 2012, *Stanev v. Bulgaria*, Appl. 36760/06, para. 147.

39 See, ECtHR, Judgment of 10 January 2013, *Claes v. Belgium*, Appl. 43418/09, paras. 110-121; ECtHR, Judgment of 6 September 2016, *W.D. v. Belgium*, Appl. 73548/13, paras. 122-135; ECtHR, Judgment of 12 February 2008, *Pankiewicz v. Poland*, Appl. 34151/04, paras. 38-46.

a qualified medical assessment based on the person's actual state of mental health and not solely on past events.[40]

Although Article 9 of the ICCPR does not indicate the specific grounds for lawful deprivation of liberty, it is also interpreted as permitting detention of a person with mental disability who poses a threat to himself or to society. The HRC states that "the existence of a disability shall not in itself justify a deprivation of liberty but rather any deprivation of liberty must be necessary and proportionate, for the purpose of protecting the individual in question from serious harm or preventing injury to others".[41]

It is further emphasized that such deprivation of liberty must be applied as a measure of last resort and for the shortest appropriate time and accompanied by adequate procedural and substantive safeguards established by law.[42] It should be executed in psychiatric hospitals or other institutions offering adequate psychiatric care or rehabilitation programmes.[43] The HRC condemned the practice of keeping mentally ill people in prisons and psychiatric annexes to prisons for months before transferring them to social protection establishments and found it inconsistent with Articles 7 and 9 of the CCPR.[44]

In accordance with Article 5 para. 4 of the ECHR, every person of unsound mind compulsorily detained in a psychiatric institution for an indefinite or lengthy period is, in principle, entitled to initiate review proceedings at reasonable intervals before a court to question the 'lawfulness' of his detention.[45] Such periodic review may also take place ex officio, since in many legal systems automatic periodic review of indefinite psychiatric detention is provided by law. Moreover, medical assessment must be sufficiently recent to enable the authorities to assess the mental health of the person concerned at the time when the request for discharge is examined. For instance, in *Ruiz Rivera v. Switzerland*, the applicant was refused release on the basis of the report of two psychologists, which referred to the psychiatric opinion dating back three years and seven months. The Court found a violation of Article 5 para. 4 of the ECHR, underlining that fresh psychiatric opinion shall be issued by a neutral expert, not involved in the constant medical treatment of the applicant.[46] In *Musiał v. Poland* the domestic court's decision concerning the applicant's continued psychiatric detention was based on a medical opinion obtained eleven months earlier. The outdated character of this opinion, combined with the lack of

40 ECtHR, Judgment of 5 October 2000, *Verbanov v. Bulgaria*, Appl. 31365/96, para. 47; ECtHR, Judgment of 21 December 2010, *Witek v. Poland*, Appl. 13453/07, paras. 40-44.

41 HRC, General Comment No. 35, adopted on 16 December 2014, CCPR/C/GC/35, para. 19.

42 *Ibid.* See also Human Rights Committee, View of 26 July 2005, *Fijalkovska v. Poland*, Comm. 1061/200; Reports of the Human Rights Committee, vol. II, A/60/40, para. 8.2.

43 See, inter alia, Concluding Observations, Bulgaria, CCPR/C/BGR/CO/3, 25 July 2011, para. 10.

44 Human Rights Committee, Concluding Observations, Belgium, CCPR/CO/81/BEL, 12 August 2004, para. 18.

45 ECtHR (Grand Chamber), Judgment of 25 March 1999, *Musiał v. Poland*, Appl. 24557/94, para. 43; ECtHR, Judgment of 21 December 2010, *Witek v. Poland*, Appl. 13453/07, paras. 55-56;

46 ECtHR, Judgment of 18 February 2014, *Ruiz Rivera v. Switzerland*, Appl. 8300/06, paras. 60-66.

ex officio review of the applicant's detention during the period in question, resulted in finding a violation of Article 5 para. 4 of the ECHR.[47]

In international soft law distinction is made between inmates/detainees suffering from mental illness or severe mental disabilities and those who suffer from various less severe psychiatric disturbances. Such distinction, although not sharp, is also visible in the international human rights jurisprudence. In accordance with the EPR, inmates belonging to the first group whose state of mental health is incompatible with detention in a prison should be detained in an establishment specially designed for this purpose (Rule 12.1. of the EPR). As further stated in the Rule 12.2., such detainees may be held in prison only exceptionally. However, if this is the case, special regulations shall be developed to take account of their status and needs. The same standard is provided in Recommendation No. R (98) 7, which states that "prisoners suffering from a serious mental disturbance should be kept and cared for in a hospital facility which is adequately equipped and possesses appropriately trained staff. The decision to admit an inmate to a public hospital should be made by a psychiatrist, subject to authorization by the competent authorities" (para. 55).

The aforementioned distinction between inmates based on type and degree of mental disturbance is also indicated in the Nelson Mandela Rules. In accordance with Rule 109, persons who are found not to be criminally responsible (previous wording of the Rule spoke about 'insane persons') and persons who are later diagnosed with severe mental disability, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to a mental health facility as soon as possible.

To sum up, the ECHR and the Covenant permit deprivation of liberty of persons of unsound mind if they pose a threat to themselves or to others. A rather different approach stems from Article 14 para. 1 (b) of the CRPD, which stipulates that "the existence of a disability shall in no case justify a deprivation of liberty". It is worth mentioning that during the negotiations of the CRPD some states proposed adding the term 'solely' or 'exclusively' to the aforementioned sentence in order to allow deprivation of liberty based on the risk and dangerousness of a person suffering from mental illness.[48] Although this option was eventually rejected, there is still room for divergent interpretation of Article 14 para.1 (b) of the CRPD.

47 ECtHR (Grand Chamber), Judgment of 25 March 1999, *Musiał v. Poland*, Appl. 24557/94, paras. 50-53.

48 See Committee on the Rights of Persons with Disabilities, Guidelines on Art. 14 of the Convention on the Rights of Persons with Disabilities. The right to liberty and security of persons with disabilities, adopted during the Committee's 14th session, held in September 2015, para. 7 (at: www.ohchr.org/EN/HRBodies/CRPD/Pages/Guidelines.aspx) (last visited: 1 May 2018); thereafter referred to as 'the CRPD Guidelines'. See also: E. Flynn, 'Disability, Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches', *International Journal of Mental Health and Capacity Law* 22 (2016), p. 81.

In accordance with the approach adopted by the Committee on the Rights of Persons with Disabilities, this provision "does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment". Thus, national provisions still prescribing instances in which persons may be detained on the grounds of their actual or perceived impairment, provided there are other reasons for their detention, including that they are deemed dangerous to themselves or others, are incompatible with Article 14 of the CRPD. In the opinion of the Committee, such legislation is discriminatory and amounts to arbitrary deprivation of liberty.[49] Applying this standard, the Committee criticized national law, specifying that persons unfit to stand trial on account of their impairment should not be punished but should be 'sentenced to treatment' in an appropriate psychiatric institution.[50]

A similar interpretation was proposed by the Office of UN High Commissioner for Human Rights in its thematic study on the CRPD. It emphasizes that "unlawful detention encompasses situations where the deprivation of liberty is grounded in the combination between a mental or intellectual disability and other elements such as dangerousness, or care and treatment. Since such measures are partly justified by the person's disability, they are to be considered discriminatory and in violation of the prohibition of deprivation of liberty on the grounds of disability, and the right to liberty on an equal basis with others prescribed by article 14".[51]

It is further argued that this interpretation does not exclude lawful detention for care and treatment or a preventive detention. However, "legal grounds upon which restriction of liberty is determined must be de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis".[52] Also, the UN Special Rapporteur on Disability argued that involuntary transfer to mental health facility within or outside prison or the

49 CRPD Guidelines, para. 7.

50 "The Committee is concerned at the distinction made by the State party between punishment and treatment, according to which persons considered 'unfit to stand trial' on account of their impairment are not punished but are sentenced to treatment. Treatment is a social control sanction and should be replaced by formal criminal sanctions for offenders whose involvement in crime has been determined. The procedure applied when determining whether a person should be sentenced to treatment is not in accordance with the safeguards that a criminal procedure should have if it may result in a sanction being imposed on a person. Sentencing a person to treatment is therefore incompatible with article 14." – see: CRPD Committee, Concluding Observations on the initial report of Denmark, 30 October 2014, CRPD/C/DNK/CO/1, part B.

51 Annual Report of the United Nations High Commissioner for Human Rights and reports of the Office of the High Commissioner and the Secretary General. Thematic Study by the Office of the United Nations High Commissioner for Human Rights on enhancing awareness and understanding of the CRPD, A/HRC/10/48, adopted on 26 January 2009, para. 48.

52 *Ibid*., para. 49. See also G. Szmukler, R. Daw & F. Callard, 'Mental health and the UN Convention on the rights of persons with disabilities', 37 *International Journal of Law and Psychiatry* 3 (2014), p. 246; *Mental health and human rights, Report of the United Nations High Commissioner for Human Rights*, 31 January 2017, A/HRC/34/32, para. 29.

imposition of mental health treatment as a condition of probation or parole violates Article 14 of the CRPD. In his opinion, legal provisions authorizing the involuntary transfer to mental health facilities of individuals subject to criminal proceedings shall be repealed.[53]

The absolute ban on deprivation of liberty on the basis of impairment seems to be widely supported in the literature.[54] There are some authors who disagree with the interpretation of Article 14 para. 1 (b) of the CRPD described previously. In 2011 the Council of Europe's Steering Committee on Bioethics (CDBI) analysed whether Articles 14, 15 and 17 of the CRPD are compatible with the possibility to subject a person who has a serious mental disorder to involuntary placement or involuntary treatment, as foreseen in other national and international texts. It found such compulsory treatment and placement permissible under certain circumstances. It may only be justified, in connection with a serious mental disorder, if, from the absence of treatment or placement, serious harm is likely to result to the person's health or to a third party. In addition, these measures may be taken only subject to protective conditions prescribed by law, including supervisory, control and appeal procedures.[55] A similar understanding of Article 14 of the CRPD was declared by some state parties when ratifying the Convention.[56]

As rightly noticed in the literature, an absolute ban on disability-linked deprivation of liberty is difficult to reconcile with European standards, in particular with the jurisprudence of the ECtHR. As was stressed previously, Article 5 of the ECHR *expressis verbis* permits disability-linked deprivation of liberty. Post-penal preventive measures or preventive measures applied instead of criminal sanction with reference to persons who cannot be held criminally responsible are usually based on an assessment of the mental health of an offender and the risk he or she may pose to others as a result of mental conditions. Thus, they are interconnected with a criminal act but also with a mental disability of an offender. Moreover, a preventive measure, such as deprivation of liberty 'delinked' from disability,

53 Shuaib Chalken, UN Special Rapporteur on Disability, Urgent request to amend the Human Rights Committee's draft version of General Comment No. 35 (CCPR/C/107/R.3) on Art. 9 (Right to liberty and security of person) bringing it in line with the UN Convention on the Rights of Persons with Disabilities, 27 May 2014 (at: www.ohchr.org/Documents/HRBodies/CCPR/GConArticle9/Submissions/SRDisability.doc) (last visited: 29 April 2018).

54 See E. Flynn, 'Disability, Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches', *International Journal of Mental Health and Capacity Law* 22 (2016), pp. 81-82 and literature referred to in footnote 36 on p. 82.

55 *Involuntary placement and involuntary treatment of persons with mental health problems*, Union Agency for Fundamental Rights, 2012, p. 21 (at: http://fra.europa.eu/en/publication/2012/involuntary-placement-and-involuntary-treatment-persons-mental-health-problems) (last visited: 3 May 2018).

56 See, inter alia, declaration of Australia: "Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards." Similar declarations were submitted by Ireland and Netherlands.
Full list of declarations available at: https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en#10 (last visited: 3 May 2018).

would not be permitted under Article 5 para. 1 (e) of the ECHR.[57] Neither would it be justified as falling within the ambit of other grounds for lawful detention indicated in Article 5 para. 1 of the ECHR.

Prima facie, the standard stemming from Article 14 para. 1 (b) of the CRPD cannot be reconciled with the ECtHR case law concerning Article 5 of the ECHR. As rightly stated by some authors, it is unrealistic to expect that the Council of Europe member states will be ready to repeal specialist mental health legislation authorizing detention on grounds of unsoundness of mind.[58] It is also unrealistic to hope that the use of preventive measures (instead of penalty, after or prior to it) in order to protect society will be abolished in European countries. However, increased reliance on UN international standards, including Article 14 of the CPRD, in complaints to the ECtHR, began to influence the Court's interpretation of Article 5 of the ECHR. In *N. v. Romania* judgment, it was emphasized that it is for the Court to decide which international instruments and reports it should consider relevant and how much weight it should attribute to them. Having said that, the ECtHR thoroughly examined whether the applicant's detention under the preventive measures scheme was applied 'in accordance with the domestic law'. The Court found it contrary to domestic procedural requirements but noticed, at the same time, that "such detention is open to question, particularly in the light of the provisions of Article 14 § 1(b) CRPD, which lays down that the existence of disability shall in no case justify a deprivation of liberty".[59]

In other cases the CRPD is invoked as a point of reference for additional arguments in the process of interpretation of Article 5 of the ECHR. In *M.S. v. Croatia* the Court found a violation of Article 5 para. 1 (e) of the ECHR owing to the lack of appropriate procedural safeguards for the applicant's compulsory placement in psychiatric detention. In order to support this ruling, the Court referred to the right to effective access to justice for persons with disabilities guaranteed in Article 13 of the CRPD.[60]

Additionally, the ECtHR's jurisprudence concerning Article 2 of the ECHR seems to be influenced by the CRPD. As mentioned previously, state parties to the ECHR have a positive obligation to protect the right to life of persons within their jurisdiction if there

57 See, P. Fennell & U. Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law', *European Human Rights Law Review* 6 (2011), p. 666. See also the jurisprudence of the ECtHR mentioned in note 39.

58 P. Fennell & U. Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law', *European Human Rights Law Review* 6 (2011), p. 674.

59 ECtHR, Judgment of 28 November 2017, *N. v. Romania*, Appl. 59152/08, para. 159.

60 ECtHR, Judgment of 19 February 2015, *M.S. v. Croatia (No. 2)*, Appl. 75450/12, paras. 157-162; See also *Partly concurring and partly dissenting opinion of judge Pinto de Albuquerque* attached to the judgment of the ECtHR of 16 July 2015, *Kuttner v. Austria*, Appl. 7997/08.

is an immediate and real threat from identified individuals.[61] In some instances deprivation of liberty should be administered to protect persons with mental disabilities at risk of suicide from themselves. In the case of *Hiller v. Austria*, the applicant complained that the authorities failed to assure the protection of her son's life by transferring him from a closed to an open ward of a psychiatric hospital. As a result of the transfer, the applicant's son escaped from a hospital and committed suicide. The ECtHR, by a majority vote of six to one, found no violation of Article 2 of the ECHR. The Court made reference to the international standards, including Article 14 of the CRPD, and stated that "today's paradigm in mental healthcare is to give persons with mental disabilities the greatest possible personal freedom in order to facilitate their re-integration into society. The Court considers that from a Convention point of view, it is not only permissible to grant hospitalized persons the maximum freedom of movement but also desirable in order to preserve as much as possible their dignity and their right to self-determination".[62]

This judgment marks a shift in the ECtHR jurisprudence towards standards deriving from Article 14 of the CRPD. The Court seems to be ready to reinterpret its own jurisprudence concerning positive obligations derived from Article 2 of the ECHR with reference to mentally disordered persons who pose a danger to themselves. I support the criticism of this 'shift' expressed by Judge Sajó in his concurring opinion. We must be aware of its consequences. The approach, based on Article 14 of the CRPD, "resulted in the tragic loss of the applicant's son['s] life, and it is now endorsed by the Court". As rightly stated by Judge Sajó, the Court should differentiate between precaution and redundant paternalism.[63]

In the recent case *Fernandes de Oliveira v. Portugal*, concerning a positive obligation to protect the right to life of mentally disordered patients, the Court was more reluctant to accept new trends. It underlined the negative implications they may have for the right to life of persons with serious mental disabilities. The Court ruled that "treatment under an 'open door' regime cannot exempt the State from its obligations to protect mentally ill patients from the risks they pose to themselves, in particular when there are specific indications that such patients might commit suicide. Accordingly, a fair balance must be struck between the State's obligations under Article 2 of the Convention and the need to provide medical care in an 'open door' regime, having in account the individual needs of special monitoring of suicidal patients".[64]

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61 See E. Flynn, 'Disability, Deprivation of Liberty and Human Rights Norms: Reconciling European and International Approaches', *International Journal of Mental Health and Capacity Law* 22 (2016), pp. 85-89.

62 ECtHR, Judgment of 22 November 2016, *Hiller v. Austria*, Appl. 1967/14, para. 54.

63 Concurring opinion of Judge Sajó attached to the *Hiller v. Austria* judgment (para. 3).

64 ECtHR, Judgment of 28 March 2017, *Fernandes de Oliveira v. Portugal*, Appl. 78103/14, para. 73.

4 Conclusions

While European and universal standards have converged on the subject of access to healthcare for mentally disordered persons, their right to liberty is approached differently by the ECHR and ICCPR, on the one hand, and the CRPD, on the other. The incompatibilities between Article 5 of the ECHR and Article 14 para. 1 (b) of the CRPD are difficult to reconcile. In my opinion, there is no chance that the ECtHR's jurisprudence would rule out the use of preventive measures as incompatible with Article 5 para. 1 of the ECHR. However, Article 14 of the CRPD may and should stimulate the ECtHR to strengthen the procedural guarantees of persons deprived of liberty on the basis of their mental disability and the risk they pose to others. There is no doubt that such offenders shall have access to justice and the right to initiate diligent and thorough judicial examination of the compulsory placement in a psychiatric institution or other places of execution of preventive measures. Given the vulnerability of individuals suffering from mental disorder, they should be provided with effective procedural guarantees, including access to legal assistance,[65] to avoid arbitrary detention. Although currently the application of preventive measures is based extensively on the discretion of psychiatrists and, as rightly noted in the literature,[66] there is no credible alternative to that, more insightful judicial examination of the necessity to apply these measures may prevent many cases of arbitrary detention resulting from negligent assessment of the risk that is posed to society by a person suffering from a serious mental disorder.

65 See, ECtHR judgment in the case *M.S. v. Croatia (No. 2)*, paras. 147, 153.

66 See, P. Fennell & U. Khaliq, 'Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English Law', *European Human Rights Law Review* 6 (2011), p. 674.

Prisoners with psychiatric disturbances in detention and in prison

Celso Manata[*]

1 Introduction

During the last 26 years a lot of things have changed in prisons, especially in regard to the problems related to the new criminal profile and the needs of offenders, as well as the new challenges that some specific prison populations present to the management of the system. However, very many chronic problems still remain, such as the lack of financial and human resources, namely in some specific and specialized areas of intervention. Prisoners and detainees with mental health problems belong to one of those sectors of the prison population that need more attention and special care. The following observations are from a manager's perspective, although an effort is also made to highlight and discuss some topics that raise a high degree of concern from a human rights point of view.

2 Dilemmas in relation to two different groups of prisoners

To begin with, I would say that a substantial proportion of the inmate population is in need of mental health treatment and that that situation represents formidable challenges to the criminal and penitentiary systems. Generally, these systems are not adequately prepared or equipped to address mental health treatment. Historically, they have been more security and control oriented. For this reason, and because several indicators show us that the situation may be getting worse, both the prison and correctional authorities and the monitoring bodies have been paying more attention to this problem and redoubling efforts to find more solutions to deal with mentally ill inmates. In short, some of the topics currently being discussed are those related to the nagging 'conflict' between the needs of treatment and security/control, the requirements of allocation to an adequate therapy, the use of medication and isolation, or the role of correctional officers in mental health treatment.

However, before addressing those topics there is a need to clarify and distinguish two groups of prisoners: the first is composed of the prisoners that, despite having a mental

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illness, have been considered criminally responsible and given a prison sentence; the other, smaller but not less complex, group comprises patients with psychiatric diseases who have been sentenced with a security measure to be executed by the penitentiary system.

The **first group** of prisoners – those who have a mental disorder but who are responsible for their criminal acts – present highly complex challenges in different terms, such as those related to the healthcare resources and treatment programmes needed to address their needs, with their vulnerability towards other prisoners and with their resettlement process. With regard to the allocation of these prisoners, their mental condition demands a secure and safe environment in order to control their symptoms. This control is necessary not only in order to provide treatment conditions specific to the personal needs of these prisoners but also to ensure that their disruptive behaviour does not cause serious problems in the daily routine of the prison, which could easily lead to breaches in the order and security of the establishment.

The aforementioned secure and safe environment must also be flexible in order to create the possibility of a close and individualized medical treatment, which must be aligned with other types of therapeutic approaches (such as programmes and occupational activities). On the other hand, the rehabilitation programmes used in a prison setting are not sensitive enough to address the specific needs of these prisoners. In addition, the medical care setting is designed to respond to the generic health needs of an adult population and is not adequate to the specific needs of these kinds of prisoners.

The lack or inadequacy of these responses often leads to the isolation or segregation of these prisoners, which is very counterproductive to their treatment and future resocialization. This scenario demands permanent attention to the conditions and treatment offered to this kind of population – more focused on a treatment perspective instead of a purely security approach – and must always take into consideration the need for allocation to a psychiatric setting.

Finally, at the end of the sentence the resettlement process is also very complex, particularly for those without family or social support. In fact, it is very difficult to find social institutions to provide them with safe housing and medical supervision and support, which is essential to prevent another cycle of active psychiatric symptoms that can easily lead to the practice of further crimes and imprisonment. From the foregoing, it is clear that any prison system in the world faces the daunting challenge of providing the perfect conditions to take care of this constantly growing and very complex group of prisoners and that all countries must strive to reach the standards needs to address this population.

The **second group** is composed of people with psychiatric diseases who have been sentenced with a security measure to be executed by the penitentiary system. In general terms there is a link between mentally ill prisoners and the commitment of violent acts, making it necessary to address all factors involved in the violent act (such as the type of disease, the use of alcohol/drugs or the process that led to the act) in order to more

comprehensively understand the reasons that led to the violence and prevent new acts from happening. Although violence and mental illness are not a direct cause-effect dialogue, they should be addressed as an integrated process with both control and treatment perspectives aligned and balanced. In fact, violence is also currently considered an issue of public health rather than a criminal problem alone, and hence the prevention of violent acts is a shared responsibility between the health and justice sectors. The relationship between treatment (health) and control (justice) and the appropriate balance between the two objectives are critical management issues. Appropriate and effective treatment serves a behavioural management function that enhances the overall operation of the prison institution. Likewise, effective behavioural management can facilitate treatment.

The relationship between treatment and control is not always easy to grasp as it is also very difficult to reach the appropriate balance between these two important objectives. Managing inmates with psychiatric disorders implies dealing with an inherent and permanent tension between security and healthcare considerations. The formal and informal rules and codes of conduct in a prison reflect the state, management and staff's concerns about security, safety, power and control. Coordinating the acts and the needs of the mentally ill prisoners with those rules and goals is nearly impossible. For this reason, a delicate balance must be achieved by management and staff between maintaining order and security and abstaining from punishing inmates for behaviours that are beyond their control because of their mental illness, especially when these inmates are unable to understand the rules or even to comprehend that they have been broken.

On the other hand, the aim of any psychiatric establishment should be to offer material conditions that are conducive to the treatment and welfare of patients (in psychiatric terms, a positive therapeutic environment). Creating a positive therapeutic environment involves, primarily, the provision of all basic needs of housing and living conditions, as well as treatment and healthcare services. This positive therapeutic environment is best achieved by small structures that promote the provision of care encompassing the full range of psychiatric and psycho-emotional treatment. In fact, large capacity psychiatric wings or large prison facilities entail a major risk of institutionalization for both patients and staff that may have adverse effects on a patient's treatment.

The psychiatric treatment should be based on an individualized approach, under which a plan is drawn up for each patient, taking into account the special needs of acute, long-term and forensic patients (including the need to reduce any risk they may pose) and indicating the goals of the treatment, the therapeutic resources that should be used and the staff member responsible for that treatment. This kind of treatment should involve a wide range of therapeutic, rehabilitative and recreational activities, as well as access to appropriate medication and medical care. Especially for those long-term patients, there should be an integrated approach to prepare them for adequate return and reintegration in their families or an independent life, which demands motivation, the improvement of self-esteem and

self-image, the acquisition of specific competences and the development of personal and social relation skills.

The role of correctional officers as members of the multidisciplinary team required to assist this group of people is another issue to be developed and enhanced. In general, mental health training for 'normal' correctional officers tends to be infrequent, although research has suggested that even short training courses can produce important results in terms of improved skills management. However, in the context of psychiatric treatment, there is a need for specially trained correctional officers who would participate as members of the aforementioned multidisciplinary treatment team, and that of kind profile is much more demanding in terms of training. Overall, there is a need for a firm commitment to reorient the paradigm of correctional officers to serve as specially trained members of a coherent multidisciplinary team instead of mainly security-oriented personnel. Such reorientation will lead to a major leap in the management of mentally ill offenders in correctional settings.

3 Recent developments

The nature, dimensions and complexity of the intervention required to address the aforementioned challenges posed by the prisoners and patients that need mental health treatment provided by the prison service demands a national plan and the active and intense cooperation between the ministries of justice and healthcare. In Portugal this approach is being implemented since 2016 with very good results.

The first step was the creation by those two governmental departments of a permanent working group – composed of representatives of the general directorates and also of members of the respective ministry cabinets – namely making an inventory, area by area, of the several healthcare needs of the people that are inside the prison system and advancing proposals to address them. The hybrid composition of the permanent working group has demonstrated its importance. On the one hand, it provides a technical approach, while, on the other it guarantees the political commitment to obtain the resources required to implement the respective proposals.

Another important step was the creation of another working group – with the same composition but led by an academic from the Law School – that elaborated the draft of the law that shall be applied to the facilities of the healthcare sector that will provide treatment, in outsourcing, to people with psychiatric diseases who have been sentenced with a security measure to be served in the penitentiary system.

A third working group, also created by the ministries of justice and healthcare and led by the director of a civil mental hospital, was charged with the evaluation of patients with psychiatric diseases who are allocated to a psychiatric clinic that belongs to the ministry

of justice. This working group assesses whether an individual patient must be kept inside the facility or whether the patient's release must be proposed to the competent judge.

Les unités hospitalières spécialement aménagées, un dispositif spécifique de prise en charge des personnes détenues atteintes de troubles mentaux

Catherine Pautrat[*]

La France, comme tous les pays industrialisés,[1] est confrontée à une prévalence des pathologies et troubles mentaux en milieu carcéral. Pour y faire face, les pouvoirs publics français ont mis en place des dispositifs particuliers offrant des réponses thérapeutiques adaptées et graduées. La création des Unités Hospitalières Spécialement Aménagées (UHSA) constitue l'une des réponses à la prise en charge des détenus atteints des pathologies les plus lourdes.

1 Une forte présence de personnes atteintes de troubles mentaux en prison justifiant une politique de prise en charge adaptée

1.1 La prévalence des troubles mentaux en prison

Au 1er mai 2017, 69 679[2] personnes, dont 96 % d'hommes, étaient détenues dans 188 établissements pénitentiaires. Si la consommation de soins somatiques des personnes incarcérées est inférieure à celle observée dans la population générale, en raison d'une moyenne d'âge relativement jeune de 34,6 ans contre 40,9 ans pour la moyenne nationale, on observe en revanche chez les personnes détenues des prévalences plus élevées en matière

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1 Seena Fazel & John Danesh, 'Serious mental disorder in 23 000 prisoners: a systematic review of 62 surveys', 359 *The Lancet* 9306 (2002), p. 545-550.

2 Statistiques mensuelles des personnes écrouées et détenues en France au 1er mai 2017, direction de l'administration pénitentiaire, bureau des statistiques et des études.

de santé mentale. Deux enquêtes réalisées en 2001[3] et 2004[4] et une étude en date de 2003[5] établissent ainsi que :

- 55 % des entrants présentent au moins un trouble psychiatrique de gravité plus ou moins importante ;
- Un entrant sur cinq a déjà été suivi dans un secteur de psychiatrie ;
- Un suivi psychiatrique est préconisé pour la moitié des entrants ;
- Les troubles psychotiques concerneraient 8 % des patients suivis ;
- 35 à 42 % d'entre eux sont considérés comme manifestement malades ou gravement malades ;
- Le taux de recours des détenus aux soins psychiatriques est de 271 pour 1000, soit un taux dix fois supérieur à celui observé en population générale (25 pour 1000 en 2000) ;
- La proportion des personnes atteintes des troubles mentaux les plus graves (schizophrénie ou autres formes de psychose) est estimée à 10 %.

Globalement, un détenu entrant sur 10 est orienté vers une consultation de psychiatrie, d'autant que le taux de suicide est sept fois supérieur à la moyenne nationale dans la population libre française. La prise en charge médicale revêt donc une importance essentielle, non seulement sous l'angle thérapeutique mais également sous celui de la sécurité de l'environnement carcéral des codétenus comme des personnels de surveillance.

1.2 Les principes d'une prise en charge spécifique

La nécessité de prendre en charge cette population pénale particulière s'inscrit depuis 2012[6] dans une logique d'offre de soins graduée à trois niveaux : **le premier niveau** concerne les soins ambulatoires somatiques et psychiatriques effectués dans des unités sanitaires au nombre de 86 (USMP anciennement appelées UCSA) ; ce sont des unités installées dans l'établissement pénitentiaire et dépendantes de l'hôpital de rattachement. Ces unités sont anciennes et remontent à 1945, lorsque la charte de la réforme pénitentiaire préconisait

3 Étude de la direction de la recherche, des études, de l'évaluation et des statistiques (Drees, https://drees.solidarites-sante.gouv.fr/) réalisée en 2001, concernant l'ensemble des détenus entrants sur un mois donné (juin 2001) et l'ensemble des patients suivis au cours de ce même mois. Drees, Études et Résultats, n°181, juillet 2002.

4 Enquête épidémiologique conduite en 2003 et 2004 sur un échantillon de 1000 personnes, publiée en 2006, conduite à la demande du ministère de la Justice et du ministre de la Santé, sous la direction scientifique de Bruno Falissard avec Frédéric Rouillon, Anne Duburcq et Francis Fagnani.

5 La santé mentale et le suivi psychiatrique des détenus accueillis par les services médico-psychologiques régionaux, étude de la Drees, Études et Résultats, n°181, juillet 2002.

6 Circulaire interministérielle du 30 octobre 2012 relative à la publication du guide méthodologique sur la prise en charge sanitaire des personnes placées sous main de justice.

la mise en place dans chaque établissement pénitentiaire d'un service spécifique chargé de fournir une assistance aux détenus des maisons d'arrêt.

Une deuxième étape intervient en mars 1986[7] avec la création d'un secteur de psychiatrie en milieu pénitentiaire. Sont ainsi installés dans chaque région pénitentiaire un ou plusieurs services médico-psychologiques régionaux (SMPR), au nombre total de 26. Situés dans les maisons d'arrêt les plus importantes, ils sont individuellement rattachés à un établissement hospitalier public et composés d'une équipe pluridisciplinaire placée sous l'autorité d'un psychiatre, praticien hospitalier. Ils permettent **l'hospitalisation à temps partiel de jour**, constituant ainsi le 2e niveau d'intervention de l'offre de soins psychiatriques.

La réforme de janvier 1994[8] introduit une évolution dans le dispositif en prévoyant que les personnes détenues doivent bénéficier d'une prise en charge identique à celle proposée à l'ensemble de la population. Elle introduit ainsi le droit commun de la santé dans les établissements pénitentiaires et met fin à la médecine pénitentiaire. Toutefois, le parallèle complet est difficile à respecter puisque les fortes contraintes carcérales ne permettent pas de suivi médical continu des patients atteints de pathologies mentales. Aussi, la loi du 9 septembre 2002[9] conjugue ce principe d'égal accès aux soins avec des paramètres de sécurité nécessaires à la prise en charge des détenus atteints de troubles mentaux. Sont ainsi créées les unités sécurisées psychiatriques en établissement de santé (UHSA) qui constituent **le dernier niveau** de l'offre de soins permettant les hospitalisations complètes en milieu hospitalier.

2 Les UHSA : un dispositif innovant de prise en charge des détenus atteints de troubles mentaux nécessitant une hospitalisation

2.1 Un dispositif novateur répondant à des besoins spécifiques

Les UHSA sont, au sein d'un établissement de santé, des unités prenant en charge des personnes placées sous main de justice nécessitant des soins psychiatriques en hospitalisation complète. Elles ne prennent pas en charge des malades dont l'hospitalisation relève d'un motif exclusivement somatique. Le fonctionnement des UHSA relève d'une circulaire du 18 mars 2011.[10] Elle énonce que les soins aux personnes détenues sont

7 Décret 86-602 du 14 mars 1986 relatif à la lutte contre les maladies mentales et à l'organisation de la sectorisation psychiatrique.

8 Loi n°94-43 du 18 janvier 1994 relative à la santé publique et à la protection sociale.

9 Loi n° 2002-1138 du 9 septembre 2002 d'orientation et de programmation pour la justice.

10 Circulaire interministérielle DGOS/R4/PMJ2/2011/105 du 18 mars 2011 relative à l'ouverture et au fonctionnement des UHSA.

dispensés dans les mêmes conditions que dans les autres unités d'hospitalisation de l'établissement de santé, rappelant ainsi les principes posés en 1994 et 2002 puis confortés par la loi pénitentiaire du 24 novembre 2009.[11]

Ces structures reposent sur **deux principes fondamentaux** :

- *La primauté du soin* ;
- *Une double prise en charge à la fois sanitaire et pénitentiaire* afin d'assurer un accès aux soins dans un cadre sécurisé. Les personnes détenues restent sous écrou durant leur hospitalisation et continuent d'exécuter leur peine. Elles sont soumises, d'une part, à des règles particulières restreignant leur liberté de circuler et de communiquer et d'autre part à la réglementation pénitentiaire, notamment en matière de discipline. Les UHSA sont organisées de façon à limiter autant que possible les déplacements des personnes. En conséquence, ce sont les praticiens de l'établissement hospitalier de rattachement qui se rendent à l'unité pour examiner et suivre les patients, sauf quand les déplacements sont inévitables pour des examens particuliers.

Elles accueillent des personnes détenues des deux sexes, par exception aux principes habituels de séparation des hommes et des femmes. De même, les mineurs peuvent y être hospitalisés par exception au principe de séparation des détenus mineurs et majeurs. Il convient alors d'éviter des contacts réciproques et de faire preuve de vigilance en cas de partage d'activités thérapeutiques.

2.2 Deux cas d'admission sont prévus

- *Avec consentement du patient* : l'admission est demandée par un médecin intervenant dans l'établissement pénitentiaire et décidée par un médecin de l'UHSA ;
- *Sans consentement du patient* : l'admission est demandée par un médecin intervenant dans l'établissement pénitentiaire, qui doit établir un certificat médical circonstancié indiquant la nécessité de l'hospitalisation sans consentement. L'admission est décidée par arrêté préfectoral. Le patient sort à la suite d'un arrêté préfectoral de levée d'hospitalisation pris sur avis du psychiatre intervenant dans l'UHSA.

Le programme initial de déploiement prévoyait la construction de 17 unités pour une capacité totale de 705 places réparties en deux tranches : la première de neuf unités pour 440 places et la seconde de huit pour 265 lits. A ce jour, huit unités ont été mises en place depuis 2012 (à Lyon, Toulouse, Nancy, Orléans, Bordeaux, Rennes, Lille et Villejuif) tandis

11 Art. 46 de la loi n° 2009-1436 du 24 novembre 2009 pénitentiaire : « la qualité et la continuité des soins sont garanties aux personnes détenues dans des conditions équivalentes à celles dont bénéficie l'ensemble de la population ».

que la neuvième ouvrira fin 2017 à Marseille. C'est un total de 380 places qui seront donc globalement disponibles à la fin de l'année. Les coûts d'investissement et de fonctionnement d'une unité de 40 lits s'élèvent à 18 millions d'euros, 27 millions d'euros pour une unité de 60 lits. Ces coûts, hors ceux en personnels, sont répartis entre le ministère de la Santé à hauteur de 90 % et l'administration pénitentiaire. Chaque UHSA fait l'objet d'une convention spécifique signée par l'ensemble des représentants des autorités sanitaires, administratives et pénitentiaires. Selon les dernières données, **1 985 admissions** avaient été effectuées **en 2014** dans 7 UHSA contre **874** dans 5 d'entre elles **en 2013**. Le nombre d'admissions a donc été multiplié par 2,2 en un an avec deux nouvelles unités supplémentaires.

2.3 Un dispositif pertinent et efficace

Une évaluation du programme est réalisée par le ministère de la Santé en association avec le ministère de la Justice au fur et à mesure de l'ouverture des unités, afin de vérifier les conditions de fonctionnement, procéder aux ajustements éventuels et les intégrer pour la mise en place des unités suivantes. Cette évaluation est assortie d'indicateurs d'activité, populationnels et relatifs au séjour des patients détenus. Ces résultats croisés avec une évaluation complémentaire réalisée en novembre 2015[12] ont mis en exergue **quatre points forts** induits par l'ouverture de ces structures :

- Seules les UHSA permettent d'assurer l'hospitalisation complète des personnes détenues avec leur consentement. En 2014, 60 % des hospitalisations étaient réalisées sous ce mode, permettant ainsi la construction d'un projet thérapeutique avec le patient dont l'adhésion aux soins est essentielle ;
- La primauté effective donnée aux soins. « *Les dispositifs de sécurité périmétrique et la présence périphérique des personnels pénitentiaires autorisent des conditions de vie à la fois sécurisées et propices aux soins,* » permettant aux patients de circuler librement dans les espaces communs. Les incidents justifiant l'intervention des personnels pénitentiaires sont très rares ;
- La durée moyenne de séjour reste raisonnable pour une moyenne de 45 jours en 2014. Le temps d'hospitalisation est compris entre 27 et 75 jours selon les UHSA et les pathologies.
- Les besoins de soins psychiatriques sont confirmés puisque les taux d'occupation varient entre 82 et 93 %.

12 Rapport d'évaluation du plan d'actions stratégiques 2010-2014 relatif à la politique de santé des personnes placées sous main de justice, novembre 2015, inspection générale des affaires sociales, inspection générale des services judiciaires et inspection des services pénitentiaires.

Il s'avère toutefois que ces taux d'occupation élevés peuvent entrainer des délais d'attente de plusieurs semaines pour des hospitalisations programmées et rendre difficiles, même si elles sont plus rares, des hospitalisations en urgence. L'éloignement géographique entre les unités et certains établissements pénitentiaires ou encore l'absence d'UHSA dans certains territoires traduisent manifestement une insuffisance du nombre de lits en UHSA, entrainant ainsi une rupture d'égalité dans la prise en charge des détenus.

Il est ainsi regrettable que la seconde tranche de construction des cinq nouvelles unités qui aurait dû être mise en œuvre en 2014 n'ait pas été initiée, privant ainsi un parc de 265 places supplémentaires réparties en France métropolitaine et en outre-mer. Il devient en effet urgent d'accélérer l'évaluation des besoins géographiques afin de finaliser le choix des futurs sites d'implantation.

3 Conclusion

Les UHSA sont une réussite. L'ensemble des intervenants en dressent un bilan largement positif conforté par les différentes instances de contrôle telles que la Cour des comptes ou le Contrôleur général des lieux de privation de liberté. Ces unités ont en effet permis, d'une part, d'améliorer incontestablement l'offre et la qualité des soins psychiatriques des personnes détenues et d'autre part, d'offrir des conditions d'accueil et de prise en charge s'effectuant dans le respect des droits des patients. De telles conditions d'accueil s'avèrent nettement supérieures à celles offertes dans les hôpitaux psychiatriques de rattachement au point que malgré leurs coûts, leur existence ne saurait être mise en cause. Cependant, le développement de ces structures n'a de sens et de cohérence que s'il s'accompagne d'un renforcement à tous les niveaux du parcours de soins en psychiatrie et d'une amélioration de l'offre de soins ambulatoires et des hospitalisations de jour qui sont actuellement insuffisamment développées.

Part III
National Reports

3ème Partie
Rapports Nationaux

Defendants and prison inmates with mental disabilities in the criminal justice system in Brazil

Edmundo Oliveira & Silvio Gemaque[*]

1 Introduction

Analysis of the situation of defendants and prison inmates with mental disabilities in Brazil is limited by the scarcity of data reflected in specialized literature on the subject matter and in the database of the National Council of Justice (CNJ). This study starts from the point where defendants find themselves in a provisional situation, that is when the criminal procedure has not yet been closed, in which the defendant is carrying out some form of temporary injunction that entails segregation from social interaction. The following step is the analysis of those with mental disorders who have already been subjected to a definitive decision to, finally, deal with the egressing ones and with their necessary resocialization. The objective here is to provide an overview of the situation pertaining to the treatment of defendants and convicts suffering from mental disabilities, whether they are considered criminally responsible or not in Brazil.

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2 Defendants with mental disabilities during the investigation stage and the trial stage: the fair process

The fair process or *giusto processo* is simply the law for all, or *la legge per tutti*, which means that the "constitution imposes on the criminal law legislator the safeguarding of the due process, in which the defense warranties of the defendant be respected and that the decision reached be based on an absolutely neutral judgment to be dispensed to the individuals in question" under the terms of Article 111 of the Italian Constitution. Accepted by Brazilian doctrine and jurisprudence, the fair trial, however, hardly corresponds to an effective reality in the Brazilian criminal procedural system, as is clearly reflected by the treatment of defendants with mental disabilities. Articles 149 through 159 of the Brazilian Code of Criminal Procedure prescribe the procedures to be followed in the eventuality of the defendant being mentally ill. Such procedures, according to §1, Article 149, may occur as early as the investigation stage (police inquiry), at the request of a police authority to a competent judge, without the need to suspend the investigations. In the judicial stage, a court-ordered criminal responsibility examination suspends the progress of the criminal action (§ 2, Art. 149). If the mental illness has occurred after the crime, the criminal proceedings will remain postponed until the defendant's mental health is restored, except for urgent procedures (Art. 152 'caput'). In this case, the defendant may be committed to a psychiatric institution controlled by the judicial system or to another appropriate facility, as provided in § 1, Article 152 of the CPP.

The set of Facilities for Custody and Psychiatric Treatment (ECTPs) in Brazil consists of 23 Custody and Psychiatric Treatment Hospitals (HCTPs) and 3 Psychiatric Treatment Wards (ATPs), located in penitentiary complexes.[1] In 2011, 3,989 people were committed or under treatment at the ECTPs; of these, 1,033 were in a temporary situation; 34% (353) were committed for mental health examination, and 35% (362) had a mental health report and were awaiting a judicial decision to proceed to the juridical process.[2] Of the 353 individuals waiting for a mental health report, 27% (97) were waiting within the legal deadline equivalent to 45 days, pursuant to Article 150, § 1, of the CPP, and 69% (244) were waiting for a period that extended the deadline previously mentioned.[3] The average time that the people undergoing temporary hospitalization spent waiting for the preparation of the mental health report was found to be ten months.[4]

1 Débora Diniz, *A custódia e o tratamento psiquiátrico no Brasil – Census 2011*, Brasilia: UNB, 2013, p. 35.
2 *Ibid*., p. 41.
3 *Ibid.*
4 *Ibid.*

3 Prisoners with mental disabilities during provisional arrest: needs, problems, possible solutions

Of the 3,989 defendants committed or in treatment in ECTPs, 1,033 were in a temporary situation, that is, they were under provisional arrest (pre-trial detention, *in flagrante delicto* or as a result of an appealable criminal verdict) or waiting for a mental health evaluation report; 362 (35%) had received the mental health evaluation report and were waiting for a judicial decision to put in motion the procedural process.[5] According to Débora Diniz: "Among the temporary population of ECTPs, 59% (612) were committed less than one year, 31% (324) were committed between one and three years, 3% (30) were committed between four and five years, 3% (26) were committed between six and ten years, 1% (10) were committed between eleven and fifteen years, and 0.3% (3) were committed between sixteen and twenty years. There was only one patient between the ages of 21 and 25, and two individuals who had been committed for more than thirty years. Comparing the male and female population confined to a mental health facility, it was found that there were no women in confinement for over a period of eleven years, whereas there was 1.6% (16) of men in this situation".[6]

There are two paradigmatic cases in the Federal Criminal Court of São Paulo, specifically in the 9th Court, which can be used to illustrate the way provisional prisoners are treated in the Brazilian justice system. One of the co-authors of the present study serves in the previously mentioned court and chaired both cases. The names and data of the proceedings have been preserved to ensure the safety of the defendants, who are referred to here as A.F.S and W.R.C. From what has been observed, it can be said with certainty that the Brazilian administrative system is far from meeting the necessary conditions for a dignified treatment of prisoners in situations involving mental disorders. In the case of both A.F.S. and W.R.C., there was no vacancy for the prompt treatment of the prisoners, so they had to wait for a vacancy under imprisonment for some time until they were granted provisional freedom, considering that an indefinite wait for a vacancy to be committed to a mental health facility or to receive treatment as an outpatient was simply not an option.

In the first case, A.F.S., he had been arrested *in flagrante delicto* while trying to steal a Samsung television set, owned by the Caixa Econômica Federal Bank, forcing open the glass doors of an agency and pulling out the television that was fixed to the wall. In the second case, that of W.R.C., he was arrested in the act of attempting to steal a copper cable from the parking lot belonging to an agency of the Caixa Econômica Federal Bank. In A.F.S.'s prosecution case, an official letter was sent to the Municipal Department of Social Assistance and Development. A meeting was also held among those involved, so as to

5 *Ibid.*

6 *Ibid.*, p. 42.

enable the defendant to obtain adequate treatment, taking into account the fact that he is homeless and refractory to constant contact with social care. Initially, the arrangement worked, and the defendant appeared in court to communicate his activities, for he had been granted alternative precautionary measures as opposed to imprisonment. However, in due course, he stopped going to court, confirming later that the safety net provided by the City Hall did not work properly. The defendant, on having his retarded mental development attested to by expert agents and on recognition of his inability to understand the unlawful nature of the act he committed, was summarily acquitted. He then received outpatient treatment, despite the provision of Article 97 of the Criminal Code. It is important to note that Law 10.216, of 6 April 2001, Article 4, states that "institutionalization, in any of its modalities, will only be recommended when the extra-hospital resources are insufficient". According to Fernando Balvedi Damas "confinement in mental health institutions would only be warranted when extra-hospital resources have proven to be insufficient, and would only happen upon a detailed medical review. He advises comprehensive, multidisciplinary treatment, based on non-confinement, with a service network that is diversified, community oriented, and as less restrictive as possible".[7]

In W.R.C's case, although the case has not yet gone to trial, the expert conclusion is that the defendant "was not mentally capable to understand the unlawful nature of the act on June 07/06/2017. The defendant was incapable of exercising self-determination to avoid the crime, [o]n the occasion, by virtue of chemical dependency".

In the foregoing case, it should be noted that there was failure even on the part of the federal police, responsible for the custody of the prisoner, by not ensuring that W.R.C., in view of his special condition, had immediate contact with members of his family, which is a constitutional right set forth in Article 5, sections LXII and LXIII, of the Brazilian Federal Constitution. The failure was observed by the court, which issued an official letter to the judge inspector responsible for overseeing custody matters in that district, stating the need for concrete observance of the individual rights and warranties provided for in the Federal Constitution and in international covenants.[8]

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7 Fernando Balvedi Damas, *Saúde Mental no Sistema Prisional: As Prisões Catarinenses: Perspectiva da Saúde Coletiva*, USCS / SC, 2011, p. 45.

8 Official Letter No. 743/2017 – IAF: "It is not excessive to point out that Decree No. 592 of July 6, 1992, which internalized the International Covenant on Civil and Political Rights, provides in its Art. 10, item 1. Every person deprived of freedom must be treated with humanity and respect for the inherent dignity of the human person. In this same sense, the Pact of San José, Costa Rica, in its Art. 5, item 2, final part, according to which every person deprived of freedom must be treated with respect due to the inherent dignity of the human being. For no other reason, the Federal Constitution, in Art. 5, para. LXII, ascertain[s] as a fundamental guarantee that "the arrest of any person and the place where they are will be immediately communicated to the competent judge and to the family of the prisoner or person indicated by him and, in clause LXII of the same article, that "the prisoner shall be informed of his rights, including that of remaining silent, with the assistance of the family and of a defense lawyer. Likewise, Art. 8 of CNJ Resolution 213, in regulating the procedure of custody hearings, established that: "Article 8 – At the custody hearing,

Both cases portray the merely formal fulfilment of constitutional guarantees for provisional prisoners with mental disorders. It is imperative that the organs of the executive, and also of the judiciary, work effectively towards the material fulfilment of the aforementioned constitutional guarantees.

4 Prison inmates with mental disabilities: needs, problems, possible solutions

Brazilian prisons are, with few exceptions, veritable human hells, so much so that the Federal Supreme Court has ruled that the Brazilian penitentiary system is in a state of permanent unconstitutionality, as seen in the Direct Action of Non-Compliance with Fundamental Precept (ADPF-347):

> Widespread and systemic violation of fundamental rights; passivity or persistent inability by public authorities to change the situation; transgressions requiring the performance not only of an administrative unit but of a plurality of authorities … c) that took into consideration, in a fundamental way, the dramatic picture of the Brazilian penitentiary system in the moment of implementation of criminal precautionary measures, in the application of the sentence and during the carrying out of penal procedures … The Plenary noted that in the Brazilian prison system there is general violation of prisoners'

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the police authority shall interview the person arrested in flagrante delicto, and shall: … IV – question whether he has been given information and an effective opportunity to exercise the constitutional rights inherent to his condition, in particular the right to consult with a lawyer or public defender, to be treated by a doctor and to communicate with their relatives. "Thus, the communication by prison agents to the family is not a mere formal requirement, but a fundamental guarantee of the prisoner, also associated with the guarantee of family assistance, to which effective exercise must be ensured. And, on this treadmill, it is the duty of the magistrate who presides over the custody hearing to adopt any measures necessary for their guarantee if they find evidence of violation. This was the case on the screen … In the present case, the need is aggravated because the prisoner questioned reported being a drug user, possibly suffering from mental disorders, and claimed that he received outpatient treatment of drugs, which he was not taking because he was in prison. The fact that the family was unaware of the arrest, being unable to provide the necessary assistance to the prisoner, was extremely serious and deserved [the] attention of the Court. Accordingly, the ex officio was ordered to be sent to custody, so that the prisoner's contact with his family or a person appointed by him may be opportune, in the strict terms of the above mentioned Art. 8, IV, Resolution 213 of 15 December 2015 of the National Council of Justice, and in light of the principle of the dignity of the human person also mentioned in subsections LXII and LXIII of Art. 5 of the Federal Constitution. Obviously, the prisoner's contact with the family must be carried out in accordance with the legal and regulatory precepts applicable in the police or custody office, which this magistrate does not ignore, and in no way does the determination made by this court imply disrespect for legal proceedings. On the other hand, it must be ensured that the opportunity for contact is effective and not merely protocol, under penalty of complete emptying of the fundamental guarantee ….".

> fundamental rights regarding dignity, physical health and psychological integrity. Freedom depriving sentences carried out in prisons become cruel and inhumane. In this context, various constitutional provisions (Arts 1, III, 5, III, XLVII, XLVIII, XLIX, LXXIV, and 6), international rules recognizing the rights of prisoners (the International Covenant on Civil and Political Rights, the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment and Punishment, and the American Convention on Human Rights) and infra-constitutional norms such as LEP and LC 79/1994, which created the Funpen, have been transgressed … pointed out that the situation is frightening: within prisons, systematic violations of human rights; outside them, increased crime and social insecurity. It mentioned that responsibility for this situation could not be attributed to a single and exclusive power but to the thereof them: the Legislative, the Executive and the Judiciary, and not only those of the Union, but also those of the Member States and the Federal District. It assessed that there are problems in the formulation and implementation of public policies as well as in the interpretation and application of criminal law. In addition, there is a lack of institutional coordination … the judiciary is also responsible, as approximately 41% of prisoners are in provisional custody and research shows that, when judged, the majority reach acquittal or alternative sentences.

The condemnation by the Supreme Court of the many violations of rights and fundamental precepts occurring in the penitentiary system in Brazil speaks volumes for the chaotic situation of prisons in the country and opens up a range of problems, many of which fall outside the scope of this study. However, it can be pointed out that: (a) this problematic situation directly contributes to the increase in the number of prisoners with mental disorders in the Brazilian prison system and (b) requires from the judiciary a more rigorous stance on the requirements of precautionary imprisonment in the Brazilian criminal procedural law. The need for a more rigorous analysis of the Brazilian judicial system pertaining to precautionary imprisonments is even more urgent in light of the Federal Supreme Court's adoption, after the judgment of Habeas Corpus 126.292/SP, the stance that demands the immediate fulfilment of freedom depriving sentences after all the chances for appeal have been exhausted, that is provided that the double degree of jurisdiction is fulfilled. If the arrest as a result of a sentence occurs faster, once the review of the Court of Appeal has been exhausted, it seems logical that the precautionary imprisonment should not be used as an alternative or subterfuge to meet social expectations regarding general prevention. In other words, the cessation of the possibility for multiple appeal resources that might lead to a sine die postponement situation should bring about a more responsible

application of precautionary imprisonments, which, it should be said, is responsible for much of the overcrowding of the Brazilian prison system.

A study by the Brazilian Federal Public Defense bureau on mental health in federal prisoners[9] found that the rules on isolation in federal prisons and the impossibility of carrying out sentences near relatives have caused a significant increase in the number of suicide attempts and mental problems among such prisoners: 12% have already resorted to suicide and 60% suffer from mental disorders. In this sense, *constrainment in solitary confinement tends to trigger or exacerbate symptoms or cause the recurrence of mental disorders; however, the rules of the prison system for these detainees restrain their access to mental health services*.[10]

Data from the National Justice Council (CNJ) reveal that hundreds of prison inmates with mental disorders are incarcerated when they should indeed be receiving psychiatric treatment, either committed to a mental health facility or as an outpatient.[11] The CNJ also cites non-compliance with Resolution 35 of the institution, which sets out the rules to be observed by the country's judiciary regarding the treatment of judicial patients and the enforcement of security measures. The aforementioned Resolution updated the guidelines of the agency after Law 10.216 / 2001, which instituted an anti-mental asylum policy in the country. It is interesting to note Taborda & Bins' position in this regard: "It is possible that one of the reasons for the high prevalence of mental patients in prison lies in the official policy of dealing with mental health in Brazil, as such policies are permeated by strong bias derived from theorists of what became known as the Psychiatric Reform. According to the predominant orientation among health authorities, mental illness is considered as being the result of policies of 'social exclusion' and, therefore, should be

9 At: www.gazetaonline.com.br/noticias/brasil/2017/12/defensoria-aponta-problemas-de-saude-mental-em-presos-federais-1014112497.html (last visited: 30 April 2018).

10 Damas, *Saúde Mental no Sistema Prisional*, p. 53. Still Negrelli Andréia Maria, *Suicídio no Sistema Carcerário: Analysis from the biopsychosocial profile of the prisoner in the prison institutions of Rio Grande do Sul*, Master's thesis presented to the Graduate Program, Faculty of Law of the Pontifical Catholic University of Rio Grande do Sul, obtaining the title of Master in Criminal Sciences. Advisor: Alfredo Cataldo Neto. Porto Alegre, 2006; Damas, *Saúde Mental no Sistema Prisional*, p. 53: "Incarcerated individuals may also be at greater risk of suicide than the general population". Negrelli (2006) identified the demographic and criminological characteristics of inmates who committed suicide in the prison system of the state of Rio Grande do Sul from 1995 to 2005. Suicides averaged 5.79% of all deaths. The suicide rate was 2.98% times the suicide rate of the state of Rio Grande do Sul, the third cause of death in the prison system, second only to infectious diseases and homicide. As a suicide profile, the male gender was identified; aged 20 to 29 years; White color; single; coming from the metropolitan region; Catholic religion; incomplete first degree and low professional qualification. The suicide act was characterized by hanging, during the day, mainly, in the months of December, January and February. Other associated characteristics were the closed regimen; first time offender, time served from one to four years; expectation of penalty to be served, from 5 to 10 years; perpetration of crime against life, especially homicide. 68.8% of individuals who committed suicide were diagnosed with mental illness (Negrelli, 2006).

11 At: www.cnj.jus.br (last visited: 30 April 2018).

basically treated with measures of 'inclusion' … Hospital beds were progressively eliminated without the creation of alternative community networks. As a result, the number of mentally ill people roaming the streets of large cities increased, and several of them reportedly ended up in prison".[12]

Lastly, it should be emphasized that Brazilian prisoners are on the margin of the Unified Health System (SUS), since the expenses of penitentiary healthcare facilities are not compensated by the SUS and are financed from out of the scarce funds of the penitentiary system.[13] The presence of the mentally ill in inadequate incarceration facilities is also very common, causing disruption and revolt among inmates and officials.[14]

In practice, rights are constantly violated and legal guarantees provided for carrying out sentences fail to be observed. Yet there are numerous administrative acts that tend to regulate the situation of prison inmates, whether they have mental disabilities or not, such as Administrative Rule 628, 2 April 2002 and Rule 1777 of 9 September 2003, which instituted the National Health Plan in the Penitentiary System, in addition to Resolutions CNPCP 05, of 4 May 2004, and CNPCP 04, of 2010; Resolution 113, of 20 April 2010; and Recommendation CNJ 35, of 7 December 2011.[15]

5 Treatment of prison inmates with mental disabilities: a matter of health or justice responsibility?

Brazil follows the biopsychological criterion regarding criminal incompetence, under the terms of Articles 26 and 27 of the Brazilian Criminal Code:

> Article 26 – An agent who, due to mental illness or incomplete or delayed mental development, was at the time of the action or omission thereof, wholly incapable of understanding the unlawfulness of the act or incapable of self determination according to that understanding. (Redaction provided by Law 7.209, dated 11 July 1984)
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> The penalty may be reduced from one to two thirds if the agent, due to mental health disturbance or incomplete or retarded mental development, was not entirely capable of understanding the unlawful nature of the act or incapable

12 José Geraldo Taborda & Helena Dias de Castro Bins, 'Assistência em Saúde e o Sistema Prisional no Brasil', 21 *Journal of Psychiatry* (2008), pp. 164-170; Damas, *Saúde Mental no Sistema Prisional*, p. 55.

13 José Geraldo Taborda & Helena Dias de Castro Bins, 'Assistência em Saúde e o Sistema Prisional no Brasil', p. 49.

14 Damas, *Saúde Mental no Sistema Prisional*, pp. 49 and 50.

15 *Ibid*., p. 40.

> of self determination according to this understanding. (Redaction provided by Law 7.209, dated 11 July 1984)
>
> Article 27 – Minors under the age of 18 (eighteen) are criminally incompetent, subject to the norms established in the special legislation. (Redaction provided by Law 7.209, dated 11 July 1984).

Another characteristic of our system, following the amendment of the Criminal Code of 1984, pertains to the vicarious being, replacing the dual binary system, according to what is seen in Article 98 of the Criminal Code. Thus, it is not possible to cumulate the penalty and cautionary measure or outpatient treatment; it must be either one or the other.

The paradigm for the maintenance in treatment of the defendant with mental disorders hinges on the analysis of the dangerousness of the patient. As long as the dangerousness has not ceased, it is not possible to speak of discharge or termination of outpatient treatment. In these terms:

> Article 97 – If the agent is incompetent, the judge will determine his commitment to a mental institution (Art. 26). If, however, the act deemed as an offense is punishable by detention, the judge may submit the individual to outpatient treatment. (Redaction provided by Law 7.209, dated 11 July 1984)
>
> § 1 – The institutionalization, or outpatient treatment, shall be for an indeterminate period of time, lasting as long as medical determination of dangerousness is not ascertained. The minimum term should be from 1 (one) to 3 (three) years. (Redaction provided by Law 7.209, dated 11 July 1984).

Therefore, after it has been verified by expert evaluation that the patient has ceased to be dangerous, his or her confinement to a mental institution or outpatient treatment is ended. Thus, it does not matter that the penalty for the crime committed by the inpatient or the outpatient is greater than the time spent in incarceration or in treatment; once the dangerousness has ceased to exist, his or her release is strictly necessary.

The minimum period is from one (01) to three (three) months (Art. 97, § 1, of the CP), but a maximum duration for the security measure was not foreseen, and cases of people being arrested for life have occurred in the past. However, currently, as the Federal Constitution prohibits life sentences (Art. 5 XLVII, "b", of the CF) and there is no custodial sentence that can be carried out for more than thirty (30) years (Art. 75 of the CP), the jurisprudence established the period of 30 (thirty) years as the parameter to be followed. There is also the prescription parameter. Thus, if the patient held in a mental facility committed a crime whose sentence is lower than this parameter, the patient could, in

theory, still be institutionalized for 30 (thirty) years; however, the Brazilian Supreme Court has already established an understanding to the effect that institutionalized patients need to be treated, and in the case of crimes whose penalties do not reach the aforementioned threshold, they must receive the treatment of the progressive discharge, as provided for in Article 5, Law 10.216 / 2001 (HC 102.489 Rio Grande do Sul, DJe 01/02/2012, Judge Luiz Fux).

Both the deinstitutionalization and the discharge will always be conditional, and, following the provisions of Article 178 of the Penal Enforcement Law (LEP), the agent is put on probation for a year: "in case they practice any act indicative of dangerousness – which need not be a typical and illegal act – they may return to the previous situation".[16] The agent is also subject to the conditions of the conditional release, submitting to its stipulations, which are as follows: obligatory: (a) obtain legal occupation; inform their occupation to the judge periodically; do not move from the district area; (b) optional: do not change residence without previous communication; obey a curfew; avoid going to certain places.

Another notable point is that criminal law treats the conversion from outpatient to inpatient treatment as an option for treatment purposes. However, there is no mention of the opposite direction taking place. But according to what has been understood by doctrine and jurisprudence, it is perfectly possible that the outpatient treatment be applied, even for those circumstances where the inpatient treatment was the applicable choice, provided that the absence of dangerousness has been ascertained.[17]

The Brazilian criminal procedural system, therefore, treats the defendant with mental problems as someone who must receive decent treatment, that is, as a health issue. However, data reveals a gap between what the law aims at and what actually happens in the overburdened Brazilian prison system, as well as the scarce instruments for the treatment of the mentally ill in the country in need of help.

6 Reintegration of prisoners with mental disabilities to the community: needs, problems, solutions

The excess or the injustice of the treatment offered to prison inmates or to those committed to a mental facility can result in a feeling of justification of the criminal conduct or a desire for revenge, as pointed out by Foucault, indicating the maintenance of a mechanism for the perpetuation of an interaction of power.[18] Often a pattern of repetition is observed in

16 Guilherme de Souza Nucci, 'Leis Penais e Processuais Penais Comentadas', 2 *Forensics* 10 (2017), p. 413.
17 *Ibid*. Exactly what occurred in the aforementioned case of A.F.S., in light of Law No. 10.216, of 6 April 2001.
18 Damas, *Saúde Mental no Sistema Prisional*, p. 48.

which the egressing prisoner, once free, ends up repeating the treatment or customs experienced during their stay in prison or mental facility:[19]

> The transformations undergone by the prisoner vary and they affect the egress at different levels, such as the habit of eating and behaving, and language structures. Such impact can occur in much larger dimensions, ranging from increased aggressiveness to extreme passivity. One of the consequences of this is the high number of people who relapse into crime; according to INALUD / Brazil it is equivalent to 70%.[20]

The process of reintegration is complex in that it involves different specialties and abilities:

> The process of deinstitutionalization is seen as the reconstruction of the complexity of the object; the emphasis is no longer placed on the healing process but on the production of life, of meaning, of sociability and the coexistence of the individual … The reform of mental health services in various places of the world in general, was based primarily on the practice of de-hospitalization. It is observed that in most of these countries the discharge of patients from psychiatric institutions was not accompanied by the creation of substitutive services, and that society in general was not able to follow such a radical change. Several studies demonstrate the 'phenomenon of the revolving door', and the increase of marginalization and criminality among the people who are discharged from mental institutions.[21]

The reintegration process is undoubtedly very difficult and turns out successful only if it can count on the participation of society, in general, as a facilitating agent for the resocialization of the egress.

A formidable problem, rooted in material needs and in the absence of the state and of public policies, is that many of those egressing have at no time in their lives enjoyed any form of socialization. So there is no means of enabling resocialization if there is no kind of socialization. Most of the time, however, it is possible to establish a guiding thread, like the one used by Ariadne, in order to seek a path that leads to resocialization. However, there is an overall lack of government policy and of social participation.

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19 *Ibid*., p. 48.

20 Mariana Leonesy da Silveira Barreto, 'Depois das Grades: Um Reflexo da Cultura Prisional em Indivíduos Libertos', 26 *Psicologia: ciência e profissão* 4 (2006), pp. 582-593; Damas, *Saúde Mental no Sistema Prisional*, p. 48.

21 Damas, *Saúde Mental no Sistema Prisional*, pp. 60 and 61.

7 Conclusion

Although the Brazilian procedural system has evolved with regard to the treatment of prisoners with mental illnesses, as seen in the Criminal Enforcement Law, the Criminal Code itself and Law 10.216 / 2001, it should be noted that it is a mere formal development of legislation, without the necessary materialization of the individual rights and guarantees inherent in the condition of prisoners with mental problems.

Thus, not infrequently, the prisoner with mental disorders gets mixed in with the other prisoners and does not receive the necessary treatment fundamental to his health condition. It was also observed that there are failures in both the executive and in the judiciary itself in safeguarding these rights and guarantees. There is no adequate treatment in the provisional prison stage, not even in the hospitalization stage, let alone in the period following treatment, that is, in the social reintegration stage of the egress. The existing efforts eventually available are not enough to ensure the required readaptation that is often essential for the full recovery of mental health patients. There is no coordination between the spheres in government for the creation and application of public policies in this sense. The treatment principles adopted by the Brazilian system hold that, regardless of the seriousness of the criminal act, the main purpose of committing them to a mental facility is to allow them to receive proper treatment. This policy was reinforced with the advent of Law 10.216/2001. However, there is a gap between what the law aims to accomplish and what actually happens.

In the face of all these issues, one hopes for the mobilization of the necessary will by the public authorities and the participation of society, in general, for the realization of the rights of the defendants with mental problems.

The criminal justice system, mental health and human rights

The situation of defendants and detainees in Chile

Francisca Figueroa San Martín & Francisco Molina Jerez[*]

1 Introduction

In 2008 the Chilean state ratified the Convention on the Rights of Persons with Disabilities (CRPD), currently the highest standard rights enforcement tool for people with mental or psychosocial disabilities. The convention also has a significant impact on the criminal justice arena.[1] According to the current human rights definition (Art. 1 CRPD), disability results from the interaction of a person with long-term mental impairments and surrounding sociocultural barriers, preventing them from fully and effectively participating in social life.[2]

The UN High Commission Office, in its mental health and human rights report, has extended CRPD standards for non-disabled people suffering from mental health difficulties or using mental health or psychiatric services.[3] Thus, the CRPD has become the most advanced and accurate regulatory framework to approach the main subject of this study – persons with mental health disturbances or psychosocial disabilities who enter the

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1 Tina Minkowitz, 'Rethinking criminal responsibility from a critical disability perspective: The abolition of insanity/incapacity acquittals and unfitness to plead, and beyond', 23 *Griffith Law Review* 3 (2014), p. 459.

2 Agustina Palacios, *El modelo social de discapacidad: orígenes, caracterización y plasmación en la Convención Internacional sobre los Derechos de las Personas con Discapacidad*. Madrid: Ediciones Cinca, 2008, pp. 103-106; Ministerio Público de la Defensa de la República Argentina, *Protocolo para el Acceso a la Justicia de las personas con Discapacidad*, 2nd ed. Buenos Aires: EUROSOCIAL, 2015, pp. 20-23.

3 Report of the United Nations High Commissioner for Human Rights, UN doc. A/HRC/32/32 (2017), *Mental Health and Human Rights*, 34th session, 27 February-24 March 2017, para. 5.

criminal justice system either as a defendant or as a detainee – as it enforces the rights to equal recognition before the law (Art. 12 CRPD), the access to justice on an equal basis with others (Art. 13 CRPD), the liberty and security of a person (Art. 14 CRPD) and the freedom of torture or cruel, inhuman or degrading treatment or punishment (Art. 15 CRPD). The CRPD includes many other guarantees, such as recognizing people with mental disabilities and psychiatric disturbances as rightful people before the law, recognizing their individual decision-making autonomy and freedom; promoting accessibility of information for adequate comprehension; ensuring the full exercise of their legal capacity in criminal procedures; providing support and safeguards to protect their will and preferences in this context; assuring the right of liberty and security of person without discrimination based on disability; protecting each person from inhuman, degrading or cruel treatment and torture; and guaranteeing access to health during confinement.

Owing to lack of accurate data regarding people with mental health problems taking part in criminal procedures,[4] in Chile the current situation of people in the criminal justice system affected by mental health issues can be defined as invisible. The limited internal regulatory framework promotes the social stigmatization of inabilities and dangerousness, undermining the person's individual freedom of choice, and their incarceration in jails or forensic psychiatric institutions.[5] From a systemic approach, access to criminal justice for people with mental health problems and psychosocial disabilities in Chile remains attached to an inadequate paradigm of the current human rights model, in which identifying the condition of the person is essential to remove barriers to the individual's effective and full participation in legal procedures, promoting their autonomy and equal conditions for the exercise of rights.[6]

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

In 2000, Chile introduced Law 19.696, which reforms the criminal justice system, establishing a Criminal Procedure Code (from now on CPP), which establishes an accusatory, oral, public and contradictory model, safeguarding the general guarantees of due process through diverse tools that, by principle of equality before the law, are applicable to all defendants in a criminal process in the country. This implies that, among other rights,

4 Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016), *Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 63.

5 Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016), *Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 29-30.

6 Ministerio Público de la Defensa de la República Argentina, *Protocolo para el Acceso a la Justicia de las personas con Discapacidad*, 2nd ed, Buenos Aires: EUROSOCIAL, 2015, p. 19.

the person is covered by the presumption of innocence during the whole procedure and has access to a free technical defence, that there is independent and impartial judicial control during the investigation and trial phase and that the person has access to mechanisms that safeguard their rights in various stages of the procedure.[7]

The Chilean legislation – which pre-dates the CRPD – despite the universal recognition of guarantees and human rights in the criminal justice framework, does not provide specific guidelines to favourably adjust procedures of intervention for people with psychiatric disturbances or mental disabilities under investigation. Neither does it provide specific guarantees for accessibility, support and safeguards in their favour. On the contrary, when there is a background of mental impairment that could prevent the person under investigation from taking full legal responsibility in the investigation[8] or from standing trial,[9] the case is put on hold until a psychiatric report about the condition and dangerousness of the defendant is issued, designating a *curator ad litem* to execute the rights of the defendant.[10]

During the investigation phase, the current norms in our legislation focus on determining whether the existence of a psychiatric disturbance compromises the responsibility of the person for the facts investigated and whether the psychiatric disturbance may cause danger in the future. This information is used to determine the modality of continuation of the procedure, that is, whether it will be in accordance with the general rules of due process or according to the special procedure for the imposition of security measures of hospitalization in a psychiatric establishment or through custody and treatment.[11] Within this framework, if on the basis of the forensic psychiatric report the mental capacity of the suspect or detainee to be held legally responsible is not compromised, the procedure will follow fair trial's general regulations and guarantees, and no specialized support to those requiring special assistance, such as those with diminished criminal responsibility, will apply.

On the other hand, if, the forensic report states that the mental condition of the detainee compromises their criminal liability in the investigation, the dismissal of the case could be requested by the *Ministerio Público* once the investigation concludes. The procedure

7 With regard to the protection of the suspect's rights in a legal procedure, specific mechanisms are relevant and include the caution of guarantees (Art. 10 CPP), the protection of one's rights before the guarantee judge (Art. 95), the control of the pre-trial detention (Art. 150), and certain other mechanisms established in the Chilean Criminal Justice Code.

8 Art. 458 CPP.

9 Art. 465 CPP.

10 Art. 459 CPP.

11 Art. 457 CPP. Diego Falcone, 'Una mirada crítica a la regulación de las medidas de seguridad en Chile', 29 *Revista de Derecho de la Pontificia Universidad Católica de Valparaíso* (2007), p. 236; María Inés Horvitz, 'El tratamiento del inimputable enajenado mental en el proceso penal chileno', 10 *Revista de Estudios de la Justicia* (2008), pp. 105-109.

could also continue by following the current special regulations for safety measurements regarding qualified background information risks due to mental conditions that could lead the suspect to presumably become a threat to themselves or others and therefore prevent the suspect from successfully completing the regular trial process.[12] Although during the execution of this procedure the general fair trial hearing guarantees are extended, certain limitations are applicable, depending on the condition of the subject: the exception to the principle of disclosure, the possibility to go to trial in the absence of the defendant, and the substitution of the person exercising their right to fair trial for the person of the curator.[13]

With regard to this normative model, which enables the imposition of the security measures of hospitalization in a psychiatric establishment and custody and treatment for people with psychiatric problems and psychosocial disability, it is necessary to indicate that there is a fundamental question concerning its constitutionality. The security measures are not regulated, either in the political constitution or in substantive criminal law, even though they constitute real mechanisms restricting fundamental rights.[14] This debate is deepened today by the ratification of the CRPD by the state of Chile and the commitments made by virtue of such instrument, where it is urged to abolish such practices because they are anchored in discrimination on the basis of disability.[15] This was warned about in April 2016 when the CRPD committee observed the country, instigating the elimination of limitations on the exercise of legal capacity during trial, so as to guarantee, adjust and support each person's effective performance and to revise the dangerousness risks criteria, which determine restrictions to fair trial and the forced institutionalization of people due to mental disabilities.[16]

In the Chilean regulatory framework, when the detainee presents psychiatric issues, the general instructions issued by the *Ministerio Público* for the investigation and criminal prosecution require that the person be taken away from other detainees, brought before

12 Art. 455, 460 and 461 CPP.

13 Art. 459 and 463 CPP.

14 Diego Falcone, 'Una mirada crítica a la regulación de las medidas de seguridad en Chile', 29 *Revista de Derecho de la Pontificia Universidad Católica de Valparaíso* (2007), p. 248.

15 Committee on the Rights of Persons with Disabilities, *Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities*, 14th session, 17 August-14 September 2015, para. 16, 20; Diana Sheinbaum & Sara Vera, Hacia un sistema de justicia incluyente. Proceso penal y discapacidad psicosocial. *Análisis y acción para la Justicia Social*. Mexico City: Documenta, 2016, pp. 50-52; María Florencia Hegglin, 'Las medidas de seguridad en el sistema penal argentino: su contradicción con principios fundamentales del Derecho penal y de la Convención sobre los Derechos de las Personas con Discapacidad', in: Documenta. Análisis y acción para la Justicia Social (eds), *Inimputabilidad y medidas de seguridad a debate: Reflexiones desde América Latina en torno a los derechos de las personas con discapacidad*. Mexico City: Ubijus Editorial S.A., 2017, pp. 46-50.

16 Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016), *Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 27-32.

the presiding judge as soon as possible and be allowed to make a statement before a legal defender, preferably the district attorney.[17] The *Defensoría Penal Pública*, on the other hand, is putting together a specialized defence model for defendants with mental health issues under investigation. For such work, it has established collaboration agreements with the *Fundación Gente de la Calle*, in order to facilitate the appointment of institutional curators in cases where the person does not have someone to whom their representation can be appointed.[18]

However, despite such initial efforts, the right to access criminal justice and fair trial guarantees without discrimination for persons with psychosocial disabilities has not yet been guaranteed in Chile. The Chilean system responds to a normative paradigm that pre-dates the current human rights model – a biomedical model where the identification of the person's impairment determines their segregation rather than identifying the condition of the person in order to articulate procedural adjustments, supports and safeguards that promote the exercise of their autonomy in the framework of criminal proceedings.

However, there are examples of good practices around the region that are worth promoting in Chile. In Mexico, for instance, the NGO *Documenta* is articulating teams of facilitators to support people with mental disabilities under investigation in criminal proceedings.[19] Argentina, Paraguay and Costa Rica are other examples where inter-institutional efforts have been made to establish formal protocols to ensure access to justice for people with disabilities in line with the CRPD, the latter two pointing specifically to people with psychosocial disability.[20]

17 Ministerio Público de Chile, Oficio FN Nº 286/2010, *Instructivo general que imparte criterios de actuación para los procedimientos especiales del Libro IV del Código Procesal Penal*, 31 May 2010, p. 7.

18 Defensoría Penal Pública, *Aseguran curaduría ad-litem para imputados con problemas mentales*, 28 August 2015 (at: www.dpp.cl/sala_prensa/noticias_detalle/6396/aseguran-curaduria-ad-litem-para-imputados-con-problemas-mentales) (last visited: 10 August 2017); Defensoría Penal Pública, *Fundación Gente de la Calle formalizó apoyo a imputados con discapacidad mental*, 21 January 2016 (at: www.dpp.cl/sala_prensa/noticias_detalle/6723/fundacion-gente-de-la-calle-formalizo-apoyo-a-imputados-con-discapacidad-mental) (last visited: 10 August 2017).

19 Documenta website, Discapacidad y Justicia (at: http://documenta.org.mx) (last visited: 18 August 2017).

20 Ministerio Público de la Defensa de la República Argentina, *Protocolo para el Acceso a la Justicia de las personas con Discapacidad*, 2nd ed. Buenos Aires: EUROSOCIAL, 2015; Ministerio de Justicia, República del Paraguay, *Protocolo de atención para el efectivo Acceso a la Justicia de personas con Discapacidad Sicosocial*, Asunción: EUROSOCIAL, 2014; Poder Judicial de Costa Rica, *Protocolo de atención para el efectivo Acceso a la Justicia de personas con Discapacidad Psicosocial*, Costa Rica: EUROSOCIAL, 2013.

3 Detainees with psychiatric disturbances during provisional detention: needs, problems, screening tools

Provisional detention during investigation and trial can occur through pre-trial detention and provisional internment in a healthcare establishment. The second option happens when general requirements for pre-trial detention are met and a psychiatric report concludes that the detainee suffers from serious mental disturbances or insufficiency in their mental faculties, thereby increasing the risk of the detainee becoming a potential threat to themselves or others.[21]

With respect to the barriers faced by people with psychiatric disturbances and psychosocial disabilities in detention centres, we first noticed a serious issue regarding identification and registration of those who are in such a condition, which seriously hinders the articulation of public policies that could meet their specific needs as there is no related national data.[22] This lack of information makes it difficult to guarantee and protect the rights of people under imprisonment, where gaps related to access to healthcare and lack of training of custody personnel have resulted in cases of mistreatment, negligence and even deaths of persons during pre-trial detention[23] and have led the state of Chile to be under specific observation because of the absence of police and security forces protocols regarding this group.[24]

In addition, regarding provisional internment there is a regulatory barrier in the form of the exception to the right to free and informed consent regarding medical interventions in the context of psychiatric hospitalization, which exposes people to forced treatment, including invasive or irreversible treatment, which may even be considered as constituting torture.[25] Regarding this, the state of Chile has specifically been observed to accomplish the duty to guarantee, without exception, the right of free and informed consent of people with mental disabilities, even when institutionalized.[26] From that perspective, in our opinion, it is necessary for the agents of the system to get trained and sensitized with regard to the human rights model and the specific needs affecting this group.

21 Art. 140 CPP y 464 CPP.

22 Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016), *Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 63.

23 See case: 7º Juzgado de Garantía Santiago, RIT 4938-2013, RUC 1300058684-0.

24 Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016), *Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 35-36.

25 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, UN doc. A/HRC/22/53, 1 February 2013.

26 Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016), *Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 25, 26, 41, 42.

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

As we have previously explained, in Chile, invisibility of people with psychiatric problems or mental disabilities who are incarcerated in criminal proceedings is a serious issue. During 2004, the *Fondo Nacional de la Discapacidad*, together with the *Instituto Nacional de Estadísticas*, prepared the first National Study on Disabilities. This work was an important step forward in raising awareness of this problem, applying the International Classification from the Functioning of Disability and Health (ICF), adopted by the World Health Organization (WHO) in May 2001. This tool was developed by WHO to provide a scientific basis for the understanding and study of health and related conditions, outcomes and determinants, establishing a common language to improve communication between different users, such as professionals, researchers, designers of public policies and the general population, allowing data between countries to be compared and providing a systematized coding scheme to be applied in health information systems.[27] However, this first inter-institutional effort focused its application on the country's households[28] and did not consider people under imprisonment. Consequently, the latter group was not included in the statistics.

In 2010, following the promulgation of the 20.422 Law – known as the law that establishes regulations on equal opportunities and social inclusion for people with disabilities – the *Servicio Nacional de Discapacidad* was created in Chile.[29] One of its initiatives since then was the preparation and application of the 2nd National Disability Study, which materialized in 2015, updating the Model Disability Survey methodology, developed by WHO and the World Bank in 2011. The problem with this second study lies in the fact that, along with preserving biases from the biomedical model, which is prior to the social model, it includes neither people incarcerated nor people institutionalized.[30] Thus, information is still missing, as there were no publications, public police records or *Ministerio Público nor Defensoría Penal Pública information on the matter*.

The *Poder Judicial de la República de Chile* has started to develop a line of work that exposes indicators in this regard. In April and August of 2014, two reports focusing on

27 World Health Organization, Report 2001, *Clasificación Internacional del Funcionamiento, de la Discapacidad y de la Salud*. Edición: Ministerio de Trabajo y Asuntos Sociales, España, 2001, p. 16.

28 Using the Integrated Program for Household Surveys (PIDEH), using the information linked to the 1992 census.

29 Published in the Official newspaper on 10 February 2020 after five years of processing in the National Congress.

30 Instituto Nacional de Derechos Humanos, 'Informe Anual 2016. *Capítulo 2 Igualdad y No Discriminación: Derechos de las Personas con Discapacidad*', 2016, p. 61; Committee on the Rights of Persons with Disabilities, UN doc. CRPD/C/CHL/CO/1 (2016*), Final observations on the initial report from Chile*, 15th session, 29 March-21 April 2016, para. 63

people with disabilities were issued, one on *The Quality of Justice* linked to disabilities and the other on *Users of a Quality Justice System*. We consider this a major initiative, and, as the report itself says, this is the first step towards bringing us closer to the issue.[31] As a result, there are no official up-to-date or standardized national data on people with psychiatric disorders who are in state custody or, more specifically, in prison. This lack of information implies a deficient construction of public policies addressing this matter, which could be compensated if the correctional establishments had records on the matter. However, *Gendarmería de Chile* has not yet elaborated on and published any information to identify this population in its custody and the specific needs regarding possible interventions. In that sense, the questioning is not only about the lack of reports about transferring people to get medical attention at a health centre in emergencies, neither is it about prisons that currently provide medical attention within them, but it is about the lack of systematization of information, which happens to be the only way to generate accurate public policies with respect to this issue.

As an example of the foregoing, we can say that during the current investigation through the Transparency Law, the *Gendarmería de Chile* was requested to indicate the total number of people with mental and intellectual disability currently in its custody at the national level, broken down by region and prison.[32] The answer provided by the institution, based on the information available with the Health Department of the *Gendarmería of Chile*, is that nationally only 17 people with disabilities are in its custody, disaggregating the information as follows:

Prison facility	**Type of disability**
CCP Curicó	Communication and language impairment
CCP Cauquenes	Intellectual disability
CDP Santiago Sur – Ovalo	Behavioural plus other mental disabilities
CDP Angol	Intellectual disability
CDP Angol	Behavioural plus other mental disabilities
CP Valdivia (Conceded)	Intellectual disability
CP Valdivia (Conceded)	Intellectual disability
CP Valdivia (Conceded)	Intellectual disability
CP Valdivia (Conceded)	Intellectual disability
CP Valdivia (Conceded)	Intellectual disability
C. Esp. Punta Peuco	Behavioural plus other mental disabilities
C. Esp. Punta Peuco	Behavioural plus other mental disabilities

31 Poder Judicial de la República de Chile (at: www.pjud.cl) (last visited: 18 August 2017).

32 Requested role AK006T0004513. Information received on 6 May 2017.

Prison facility	Type of disability
C. Esp. Punta Peuco	Communication and language impairment
C. Esp. Punta Peuco	Communication and language impairment
CDP Puente Alto	Intellectual disability
CDP Puente Alto	Intellectual disability
CDP Santiago Sur – Modules	Neurological damage, motoric and language impairment

The information provided by *Gendarmería de Chile* raises several questions, but the most important ones for us are as follows: are there really no more cases of people with mental disabilities in the Chilean penitentiary system? Or does this information reflect the permanent fact of the non-identification or inadequate and insufficient registration of people with mental disabilities imprisoned? We will see, in what follows, that the answer leans consistently towards the second case.

The deficiency of the government's institutions in Chile in furnishing numbers and providing visibility in regard to imprisoned people with psychiatric disturbances and psychosocial disabilities contrasts with the work done in the academic world. The School of Public Health of the University of Chile has carried out two investigations on this subject, one in 2007 and the other in 2010. In 2007, in a sample of 1008 incarcerated people (as a projection of the entire adult prison population of the country) under the administration of the *Gendarmería de Chile*, the third version of the Composite International Diagnostic Interview was applied with the objective of identifying any kind of mental disorder presented in that population during the last twelve months. The study found that 26.6% of the sampled population presented at least one type of mental disorder in the last twelve months, as the following data shows:[33]

Mental disorders	Nr. of cases	Prevalence (%)
Emotional disorders	82	8.1
Anxiety disorders	84	8.3
Substance abuse disorders	123	12.2
Possible psychotic episode	8	0.8
Other mental disorders	73	7.2
Total	**268**	**26.6**

33 Escuela de Salud Pública de la Universidad de Chile, Report 2010, *Evaluación de necesidades de atención por problemas de salud mental en la población de condenados, en cárceles de las regiones V y Metropolitana. Informe final*, 2010, pp. 4-6.

Difference by sex		
Mental disorders	**Men (%)**	**Women (%)**
Emotional disorders	7.6	11.1
Anxiety disorders	8.2	9.2
Substance abuse disorders	12.9	8.5
Possible psychotic episode	0.7	1.3
Other mental disorders	7	8.5
Total	**26.5**	**26.8**

In 2010, the study also included convicts aged 18 or older and applied the tools on the population that inhabited the prisons of the Santiago Metropolitan Region and the Region of Valparaiso.[34] The work was done in two stages, screening, followed by interviews. In the first stage, the General Questionnaire on Health (GHQ-12) was applied to the population under study (11,342 men and 1,089 women), and the main objective of the sifting through process was to identify potential cases of people with mental health problems. Sifting through identified 3,155 cases of people (2,260 men and 895 women) with potential mental health problems. The results of the analysis revealed that out of 3155 people to whom GHQ-12 was applied, 634, or 20.1%, tested positive for mental disorders. Dividing by gender yields 412 (18.2%) men and 24.8% in the case of women. In the second stage, out of the total number of possible cases of inmates with mental health disorders, 493 people randomly selected were interviewed (304 men and 189 women). This group of people were subjected to a standardized psychiatric interview, which showed that the total number of people with some type of mental health disorder goes up to 245 men and 150 women.[35] The main objective of this study was to create diagnostic profiles, differentiating between major depressive disorder (MDD), generalized anxiety disorder (GAD) and substance abuse disorder (SUD), revealing comorbidity in case studies among the people studied.

Mental health disorders profiles	**Men**		**Women**	
	N.	%	N.	%
Only MDD	28	11.4	11	7.3
Only GAD	26	10.6	19	12.7
Only SUD	22	9.0	12	8.0

34 At that date, according to the Gendarmería de Chile statistics database, the population was 41,152, of which 93.1% were men and 6.9% women (at: www.gendarmeria.gob.cl) (last visited: 1 August 2017).

35 Escuela de Salud Pública de la Universidad de Chile, Report 2010, *Evaluación de necesidades de atención por problemas de salud mental en la población de condenados, en cárceles de las regiones V y Metropolitana. Informe final*, 2010, p. 21.

Mental health disorders profiles	Men	Women		
MDD + GAD	61	24.9	44	29.3
MDD + SUD	20	8.2	19	12.7
TAG + SUD	20	8.2	7	4.7
MDD + GAD + SUD	68	27.8	38	25.3
TOTAL	245	100.0	150	100.0

Another indicator elaborated on the basis of this 2010 investigation relates to people who tested positive for mental health disorders in the study and their risk of suicide. The results are displayed in the following table:

Suicidal risk profile	Men	Women		
	N.	%	N.	%
No Risk	79	32.2	31	20.7
Low Risk	66	26.9	47	31.3
Moderate Risk	26	10.6	16	10.7
High Risk	74	30.2	56	37.3
TOTAL	245	100.0	150	100.0

These studies are key to allow a first approximation to the matter of study, quantifying the population affected by psychiatric problems in Chilean prisons, although it is still not possible to identify the number of people who also have mental disabilities due to such conditions.

In regard to the specific needs of this population, the situation seems alarming. In Chile the number, location, identity and needs of incarcerated people with mental health problems and mental disabilities are unknown. The foregoing prevents serious public policies from being formulated to guarantee and protect the rights of people in confinement. As previously explained, at least a quarter of the imprisoned population has some kind of psychiatric disturbance, making it necessary to take action and clarify their identity. In addition, the results of the studies already show *special needs* to which immediate intervention could apply. For example, in men, disorders associated with the problematic use of alcohol or drugs predominate; in women emotional disorders are highest; and about one-third of this population is at risk of suicide.

Regarding the tools for evaluating and identifying psychiatric disturbances in the incarcerated population, the work carried out during 2012 and 2013 in Concepción, Bío Bío Region, is representative. Osses-Paredes and Riquelme-Pereira investigated the health

conditions of convicts in El Manzano prison,[36] evaluating a total of 141 people over the age of 18, including detainees under investigation and inmates. To collect background information, they used a form with registered prison and health information of the inmates, applying the Preventive Medical Exam – a plan for monitoring and evaluating the health of people along their lifespan – promoted by the Ministry of Health. The focus was on lowering morbidity or the suffering associated with preventable or controllable conditions, to the person with the condition, their family and society.[37] The investigation revealed that of the 141 people evaluated, 15 showed some kind of condition associated with a psychiatric diagnosis category.

Gendarmería de Chile has started training its officials on the right approach to be adopted to deal with people with disabilities. This initiative has been developed in two regions of the country and on three different occasions. In August 2014 in the Los Lagos Region, in August 2015 and in August 2016 in the Aysén Region, a total of 57 officials from across the country were trained.[38] Although this progress is appreciated, the number of officials trained is still alarming, considering that the Chilean penitentiary system currently reaches 42,039 incarcerated people, 38,382 men and 3,657 women.[39] The lack of training for custody officers directly affects the imprisoned population. However, the problem is much more far-reaching in terms of the number of professionals for mental health or psychosocial support in the country.

Gendarmería de Chile reported that to cater to the needs of the Santiago Metropolitan Region there are five professionals, four of whom are psychologists and one of whom is a psychiatrist. Three psychologists are assigned to work in the National Office, and the remaining two professionals are in charge of the Penitentiary Hospital of Santiago.[40]

In Chile, neither the State Constitution of the Republic nor the Constitutional Organic Law of the *Gendarmería de Chile* nor the Establishments Regulations of the Penitentiary establish regulations to measure the adverse effects of imprisonment on people's mental health.[41] Moreover, in Chile, isolation is still in use as a disciplinary sanction, although there is abundant literature evidencing the serious consequences it has for the physical and psychic integrity of persons and recommending against its application to individuals

36 C. Osses-Paredes & N. Riquelme-Pereira, 'Situación de salud de reclusos de un centro de cumplimiento penitenciario, Chile', 15 *Revista Española de Sanidad Penitenciaria* (2013), pp. 98-104.

37 Ministerio de Salud, *Guía Clínica Auge: Examen Medicina Preventiva*, p. 5 (at: http://web.minsal.cl/sites/default/files/files/GPC%20Medicina%20Preventiva.pdf) (last visited: 18 August 2017).

38 Requested role AK006T0005471. Information received on 6 May 2017.

39 *Gendarmería de Chile* statistics database (at: www.gendarmeria.gob.cl) (last visited: 10 August 2017).

40 Requested role AK006T0005471. Information received 6 May 2017.

41 In Chile, the basic rules of Penitentiary Law are regulated by a simple regulation (Supreme Decree No. 518 dated 22 May 1998), issued by the Ministry of Justice. To date, no progress has been made in creating a law, nor is this envisaged in the near future. The only attempts to reform pertain to the present insufficient regulation.

with a psychiatric disturbance.[42] This does not prevent judges, the *Gendarmería de Chile* or the Penitentiary Public Defender from using the possibility to intervene in the enforcement stage of the penal sanction and to take steps to reverse this situation.

For example, in 2015 in the Punta Arenas prison, a convict complained against the officials of the *Gendarmería de Chile* before the Appeals Court of Punta Arenas regarding persistent aggressions and mistreatment. According to the Court's opinion, this qualified as "cruel and degrading treatment"[43]. The Court ordered, among other measures, a psychological intervention to be carried out by an external professional to repair the damage suffered. Subsequently, in March 2016, the convict appealed again, stating that he had not received the psychological treatment that had been ordered and that he should be treated with respect by the officials. However, the Appeals Court, despite finding that the psychological treatment had not been provided, rejected the appeal and determined "an evaluation of the mental health of the appellant [be carried out] by specialists from outside the institution".[44] This case highlights an issue concerning access to mental health support that was later revised by the Supreme Court, which rejected the action but also left the measure ordered by the Appeals Court ineffective.[45] The right to access to health is provided in our legislation as a state obligation: the state needs to adopt effective measures for its enforcement, including for persons in prison.

5 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

Convicts and detainees during pre-trial or serving their sentence are in the custody of the *Gendarmería de Chile*, which depends on the Ministry of Justice. It is the duty of such authority to manage the resources for people in prison. However, the Ministry of Health is in charge of both public policies regarding mental health and the use of mental health resources. In this context, the *Gendarmería de Chile* is responsible for ensuring inmates with appropriate healthcare, following the normalcy principle that inspires the penitentiary mission, according to which, despite the judge's decision to deprive the convict of certain rights, their legal status remains identical to that of any free citizen.[46]

42 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, UN doc. A/63/175, 28 July 2008, Annex, pp. 22-25.

43 See case: Corte de Apelaciones de Punta Arenas. Cause Role 89-2015. Resolution 2 April 2015.

44 See case: Corte de Apelaciones de Punta Arenas. Cause Role 41-2016. Resolution 4 March 2016.

45 See case: Corte Suprema. Cause Role 17.541-2016. Resolution 26 April 2016.

46 Regulation of Penitentiary Establishments, Art. 2: "It is the guiding principle of this activity, the background that the inmate is granted the public rights agreed to [be given] by the State, so that apart from the rights lost or limited by his arrest, preventive detention or condemnation, his legal status is identical to that of a free citizen."

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

The need to focus on public policies and interventions for people who have mental health problems and who have been involved in the penitentiary system has been expressed in Chile. They were sought to be implemented particularly through resocialization programmes within prisons and within the post-penitentiary, with the objective of avoiding return to the criminal justice system after committing a new offence.[47] *Gendarmería de Chile* has launched lines of work within both: the execution phase of the criminal sentence and the post-penitentiary system. According to the information requested for this study, the institution counts on a 'Program for the prevention of violence', with the objective of intervening in the most recurrent conflicts that are associated with people with mental health problems. Also, *Gendarmería* is elaborating the implementation of a 'Program promoting health: drugs and alcohol'.[48] This last programme addresses an urgent need, as the problematic consumption of alcohol and drugs selectively affects people who are deprived of their liberty. According to the findings of Sánchez Cea and Piñol Arriagada, close to 12% of the people deprived of freedom at the national level suffered from an addiction problem to either alcohol or some type of drug.[49] As stated by Villagra:

> In the field of mental health, evidence indicates that schizophrenia, psychosis, major depression, bipolar disorder and posttraumatic stress disorder are the most prevalent mental disorders within prisons and are overrepresented within prisons compared to the general population. A lack of medical treatment increases the chances that a person will commit a crime. The population that exhibits these types of disorders, usually has a comorbidity of pathologies of mental health and addiction problems, both of which are strong predictors of relapse.[50]

In addition to this, prison conditions will affect any possible advance because, as Jiménez Fernández noted, there exist factors that affect the morbidity of prisoners. These are as follows:[51]

47 Carolina Villagra, *Hacia una política postpenitenciaria en Chile*. Santiago de Chile: Centro de Estudios de Seguridad Ciudadana, RIL Editores, 2008, p. 46.

48 Requested role AK006T0005471. Information received 6 May 2017.

49 Carolina Villagra, *Hacia una política postpenitenciaria en Chile*. Santiago de Chile: Centro de Estudios de Seguridad Ciudadana, RIL Editores, 2008, p. 39.

50 Carolina Villagra, *Hacia una política postpenitenciaria en Chile*. Santiago de Chile: Centro de Estudios de Seguridad Ciudadana, RIL Editores, 2008, p. 189.

51 Gustavo Jiménez, *El funcionamiento de la cárcel como exclusión en Chile*. Santiago de Chile: División de planificación, estudios e inversión. Departamento de Estudios MIDEPLAN, 2007, pp. 20-21.

- The same prison triggers suicides.
- The relationship between the prisoners that, aggravated by overcrowding and a lack of activity, leads to quarrels and aggressive behaviours of different types.
- The relationship between agents of the state and detainees deteriorated by excessive punishments and torture reported by prisoners, both adults and minors.
- The material conditions of the place where the criminal sentence is being served, especially in the Santiago Penitentiary, where not even minimal shelter and hygienic conditions prevail, and where particularly severe conditions obtain in punishment cells.

On this issue, Carolina Villagra emphasizes comparative good practice in Canada,[52] like the Community Forums Programs, where its purpose is to link the penitentiary system with non-profit organizations, which receive state subsidies, increasing the coverage of activities delivered by the system, in order to improve or generate the reintegration of convicts. One of these programmes focuses on providing continued mental health treatment for people in prison. Appealing to the cooperation of non-profit external entities would allow human and material resources to be optimized in certain areas, but this is not enough if the means of reintegration are not injected and reorganized in the way it is currently done. The key is to adequately reorganize or administer resources, given that programmes exist from the Interior Ministry, the Social Development Ministry, the Ministry of Justice and the Health Ministry, which could be utilized to coordinate and jointly achieve better results.

7 Conclusions

Chile is in the initial phase of implementation of the CRPD, symbolized by the first test before the CRPD Committee in 2016, where the progress in this process was shown and observations and recommendations were received for the upcoming challenges. In this context, we observe that, at the level of the criminal justice and penitentiary system, sociocultural, normative and material barriers persist with respect to people with psychiatric disturbances and psychosocial disabilities, obstructing their ability to exercise their right to equal access to justice, favouring the deprivation of their liberty owing to their condition, and neglecting the specific needs of this group in the context of confinement. Among the main barriers that we identified with respect to this group were the invisibility of this population in relation to the penal and penitentiary system, accompanied by the lack of

52 Carolina Villagra, *Hacia una política postpenitenciaria en Chile*. Santiago de Chile: Centro de Estudios de Seguridad Ciudadana, RIL Editores, 2008, p. 57.

statistics and official data at the national level that allows for the identification of gaps as well as the creation of public policies that promote the safeguarding of rights without discrimination in the context of the penal process and the execution phase of the sentence being served. In addition, there are important normative and attitudinal barriers from the side of justice agents, accompanied by the effect of a model of criminal responsibility that associates the mental health problem and psychosocial disabilities with the concepts of illness and dangerousness, undermining the access of such persons to due process. In relation to the situation in prisons, there are important barriers to inmate access to health services and a lack of safeguards to protect the population, which, owing to their condition, find themselves selectively exposed to torture, violence and abuse.

The criminal system institutions are beginning to develop lines of intervention that are focused on this group of people. However, these lines of intervention must be appropriately framed in relation to the challenges assumed by the state in order to ensure greater protection of the rights of people with mental health problems and psychosocial disabilities. This can be achieved by adapting existing protocols and practices to the current social model on human rights, promoting adjustments to penal proceedings, eliminating restrictions on the exercise of rights, providing support and safeguards that protect the will and preferences of defendants and prisoners with mental problems and guaranteeing their right to liberty and security without discrimination based on their impairment or disability.

Defendants and detainees with psychiatric disturbances in Germany

Rita Haverkamp & Thomas Galli[*]

1 Introduction

The growing number of prisoners with psychiatric disturbances has come to the fore of crime policy in Germany in recent years. In June 2014 the Conference of the Ministers of Justice of the German federal states resolved to improve psychiatric care for prisoners.[1] The reason for this decision is the higher prevalence of mental disorders among inmates than among the general population – a state of affairs that is closely connected to drug addiction and violence, thereby increasing the risk of recidivism. At the level of the German federal states, the persons in charge are to support prisons' commitment to treat mentally ill prisoners on the basis of guidelines and integrate them into suitable care systems after release.

Not only is there increasing awareness of the special needs of detainees with psychiatric disturbances in the German states, new initiatives are also being undertaken.[2] In North Rhine-Westphalia, the commissioner responsible for the correctional system established an interdisciplinary working group to optimize both the diagnosis of mental disorders and the performance of emergency procedures without undue delay.[3] In 2014, a psychologically disturbed prisoner starved to death in Baden-Württemberg before the eyes of prison staff.[4] As a consequence, an expert commission was set up, and its recommendations attracted

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1 Konferenz der Justizministerinnen und Justizminister, *Beschluss der 85. Konferenz der Justizministerinnen und Justizminister am 25. Und 26. Juni 2014 im Ostseebad Binz auf Rügen*, 25/26 June 2014 (at: www.regierung-mv.de/Landesregierung/jm/justizministerium/Justizministerkonferenz/Beschl%C3%BCsse-2014) (last visited: 9 October 2017).

2 For example, in Schleswig-Holstein a correctional facility opened a psychiatric day-care hospital in the autumn of 2016: Holsteinischer Courier website, *Modellprojekt: Hilfe für psychisch kranke Gefangene*, 2 November 2016 (at: www.shz.de/lokales/holsteinischer-courier/hilfe-fuer-psychisch-kranke-gefangene-id15232886.html) (last visited: 26 April 2017).

3 Michael Kubink, 'Der Umgang mit psychisch auffälligen Strafgefangenen. Perspektive des Justizvollzugsbeauftragten des Landes Nordrhein-Westfalen', 65 *Forum Strafvollzug* 4 (2016), p. 250.

4 More details about the circumstances under: Der Spiegel website, *Strafvollzug: Tod in Zelle 1129*, 27 October 2014 (at: www.spiegel.de/spiegel/print/d-129976906.html) (last visited: 26 April 2017).

attention at various levels.[5] For one, their implementation was included in the newly formed state government's coalition agreement in May 2016. Furthermore, implementation measures are already taking place, including the hiring of additional personnel, the obtaining of specialist advice and the establishment of two working groups for structural improvements. This chapter starts by providing information about defendants with psychiatric disorders during pre-trial inquiry and at trial before presenting the situation of mentally disordered persons during imprisonment and after their release.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

Some special provisions for defendants with psychiatric disturbances exist during the pre-trial inquiry and at trial. During the first examination,[6] the mentally disordered defendant enjoys the following general guarantees: first of all, information about his or her offence with the relevant provisions, advice about the right to respond to the charges, the right to remain silent and the right to a counsel of his or her own choosing as well as the instruction to request evidence to be taken in his or her defence (sec. 136(1) German Code of Criminal Procedure, hereafter abbreviated as StPO). If a defendant is not able to understand the advice due to his or her psychological condition, he or she may be still questioned.[7] However, his or her testimony is only admissible on his or her account if the accused allows the evidence to be used during the main hearing.[8] Certain methods of examination are prohibited[9] (sec. 136a StPO) to protect the accused's freedom to make up his or her own mind, and the examination of an accused person who is not in a condition to be questioned is forbidden even if the interrogator does not consciously exploit the situation or has nothing to do with it.[10] The provision covers induced fatigue and the impaired freedom to make up one's mind and manifest one's will due to alcohol or drug

5 Rüdiger Wulf, 'Expertenkommission "Umgang mit psychisch auffälligen Gefangenen". Die Empfehlungen und ihre Umsetzung', 65 *Forum Strafvollzug* 4 (2016), p. 243.

6 In German: erste Vernehmung.

7 Herbert Diemer, '§ 136 Erste Vernehmung', in: Rolf Hannich (ed), *Karlsruher Kommentar zur Strafprozessordnung*, Munich: Verlag C.H. Beck, 2013, 7th edition, mn. 12; Jan C. Schuhr, '§ 136 Erste Vernehmung', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, München: Verlag C.H. Beck, 2014, mn. 59.

8 BGH, Judgment of 12 October 1993, 'Beweisverwertungsverbot bei Nichtverstehen der Belehrung über Aussagefreiheit (geistig-seelische Störung), 1 StR 475/93', 47 *Neue Juristische Wochenschrift* 5 (1994), p. 333; on the resulting requirements for the defence counsel Walter H. Kiehl, 'Neues Verwertungsverbot bei unverstandener Beschuldigtenbelehrung', 47 *Neue Juristische Wochenschrift* 19 (1994), p. 1267 *et seq*.

9 In German: Verbotene Vernehmungsmethoden.

10 LG Dortmund, Judgment of 19 August 1994, 'Notwendigkeit einer qualifizierten Belehrung, Ks 9 Js 4/92', 17 *Neue Zeitschrift für Strafrecht* 7 (1997), p. 357 (358).

consumption or withdrawal symptoms, but does not include reduced mental and physical ability.[11] Any violation means that the evidence[12] gained from such a testimony becomes inadmissible.[13]

Defendants with psychiatric disturbances have better access to mandatory defence.[14] Pursuant to sec. 140(1) StPO a defence counsel must be involved if the accused is in provisional placement[15] (sec. 126a StPO) (described later in this section), has been in an institution for at least three months based on a judicial order or with the approval of the judge,[16] is considered for placement in order to prepare an opinion[17] on his or her mental condition (sec. 81 StPO) (described later in this section) or is involved in a procedure for measures of correction and prevention[18] because of his or her lack of criminal responsibility or his or her unfitness to stand trial.[19] The general clause in sec. 140(2) StPO comprises two further variants: the difficult factual situation and the accused's apparent inability to defend him- or herself. The first alternative is relevant if the court file includes psychological or psychiatric expert opinions or if such an expert opinion or the statement of an expert is introduced during the main proceedings.[20] If criminal responsibility is an issue, the accused's inability to defend him- or herself must be assumed.[21] This also often applies in cases of addiction and the related repercussions as well as when intellectual and other cognitive disabilities are present. For the latter, pathological findings are not necessary: low or no school education and a legal guardian are sufficient indications of cognitive impairment.[22] With respect to psychological distress, its kind and degree are crucial: an

11 LG Mannheim, Judgment of 24 October 1975, 'Vernehmung eines unter Rauschgift stehenden Zeugen, 3 KLs 22/75', 30 *Neue Juristische Wochenschrift* 8 (1977), p. 346; OLG Hamm, Judgment of 26 November 1998, '3 Ss 1117/98', *BeckRS* 1998, p. 12899; Herbert Diemer, '§ 136a [Verbotene Vernehmungsmethoden]', in: Rolf Hannich (ed), *Karlsruher Kommentar zur Strafprozessordnung*, Munich: Verlag C.H. Beck, 2013, 7th edition, mn. 13, 16.

12 In German: Beweisverwertungsverbot.

13 Mannheim, Judgment of 24 October 1975, 'Vernehmung eines unter Rauschgift stehenden Zeugen, 3 KLs 22/75', 30 *Neue Juristische Wochenschrift* 8 (1977), p. 346; OLG Hamm, Judgment of 26 November 1998, '3 Ss 1117/98', *BeckRS* 1998, p. 12899; Herbert Diemer, '§ 136a [Verbotene Vernehmungsmethoden]', in: Rolf Hannich (ed), *Karlsruher Kommentar zur Strafprozessordnung*, Munich: Verlag C.H. Beck, 2013, 7th edition, mn. 13, 16.

14 In German: notwendige Verteidigung.

15 In German: einstweilige Unterbringung.

16 And will not be released from such an institution at least two weeks prior to commencement of the main hearing.

17 In German: Unterbringung des Beschuldigten zur Vorbereitung eines Gutachtens.

18 In German: Sicherungsverfahren (sec. 413 *et seq*. StPO).

19 Translation partly: juris GmbH website, The StPO, 2014 (at: www.gesetze-im-internet.de/englisch_stpo/englisch_stpo.html#p1048) (last visited: 2 May 2017).

20 Sven Thomas & Simone Kämpfer, '§ 140 Notwendige Verteidigung', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2014, mn. 38 with further references.

21 *Ibid*.

22 *Ibid*.

inability to defend oneself is present, inter alia, in dissocial personality disorder and schizophrenia.[23]

The defendant is obliged to be present during the trial (sec. 231(1) StPO). Pursuant to sec. 231(2) StPO the main hearing may be concluded without the defendant if he or she absents him- or herself or fails to appear when an interrupted main hearing is continued. This assumes that the defendant has already been examined concerning the indictment and the court does not consider his or her further presence to be necessary.[24] According to case law, unauthorized absence[25] can be assumed in the case of suicide attempts and of falling into a state of depression[26] or pathological mental excitement.[27] With respect to mental disorders, the question arises as to the extent to which the defendant is able to control his or her condition, especially if the person concerned is no longer able to rid themselves of the mental disorder at a certain point.[28] In the case of serious suicide attempts, the prevailing literature denies unauthorized absence,[29] while the Federal Supreme Court[30] affirms this attribute in certain circumstances.[31] Criticism of this decision rightly targets the interpretation of 'interference'[32] by means of 'culpable'[33] based on insanity[34] and diminished responsibility[35] (sec. 20, 21 German Criminal Code, hereafter abbreviated as StGB). The Court's view is misleading because interference concerns areas of responsibility in a formal sense and therefore a procedural solution is preferable.[36] Pursuant to sec. 247 third sentence StPO, the defendant may be removed for the duration of discussions concerning the defendant's condition and his or her treatment prospects if substantial

23 *Ibid.*

24 Translation partly: juris GmbH website, *The StPO*, 2014 (at: www.gesetze-im-internet.de/englisch_stpo/englisch_stpo.html#p1048) (last visited: 2 May 2017).

25 In German: eigenmächtiges Entfernen bzw. Fernbleiben.

26 OLG Düsseldorf, Judgment of 17 May 1996, '1 Ws 442 und 444 – 445/96', *Strafverteidiger Forum* 2 (1996), p. 154 (155).

27 BGH, Judgment of 22 April 1952, *Untersuchungsrichter. Richterliche Zeugenvernehmung im fremden Rechtsbereich. Vom Angeklagten herbeigeführte Verhandlungsunfähigkeit. Verjährung als Verfahrenshindernis*, BGHSt 2, 300 (305).

28 Ulrich Eisenberg, 'Sich-Entfernen bzw. Fernbleiben während der Hauptverhandlung (§ 231 II StPO)', 32 *Neue Zeitschrift für Strafrecht* 2 (2012), p. 66.

29 *Ibid.*, p. 67.

30 In German: Bundesgerichtshof (BGH).

31 BGH, Judgment of 25 July 2011, 'Hauptverhandlungs-Abwesenheit nach Suizid-Versuch – Anforderungen an steuerrechtliche Selbstanzeige', 64 *Neue Juristische Wochenschrift* 44 (2011), p. 3249.

32 In German: Eigenmacht.

33 In German: Schuldhaft.

34 In German: Schuldunfähigkeit.

35 In German: verminderte Schuldfähigkeit.

36 Olaf Arnoldi, '§ 231 Anwesenheitspflicht des Angeklagten', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2016, mn. 17; Gerson Trüg, 'Anmerkung', 64 *Neue Juristische Wochenschrift* 44 (2011), p. 3256.

detriment to his or her health is to be feared.[37] The provision grants the court a wide margin of discretion.[38] The mentally disordered defendant's right to be heard before the court must be weighed against the protection of his or her mental health.[39] Any removal must be based on the substantive opinion of an expert given in the absence of the defendant.[40]

If placement in a forensic psychiatric hospital or to preventive detention may be ordered or reserved,[41] an expert shall be examined at the trial on the defendant's condition and his or her treatment prospects (sec. 246a(1) StPO).[42] A qualified opinion before trial requires that the defendant is examined by an expert (sec. 246a(3) StPO). Due to its significance, the examination can be ordered against the defendant's will (sec. 81, 81a StPO).[43] But the defendant has the right to a refusal to be examined; that's why in exceptional cases the expert must prepare the opinion on the file.[44] Pursuant to sec. 81 StPO, in cases of urgent suspicion placement for observation in a psychiatric hospital may be ordered to prepare an opinion on the accused's mental condition, after an expert and the defence counsel have been heard; such a placement may last a total of six weeks. The principle of proportionality demands that a placement only occurs in exceptional cases, that the prohibition of excessiveness is taken into account and that the placement is indispensable and all other measures have been exhausted.[45] Otherwise provisional placement in a psychiatric hospital or in a custodial addiction rehabilitation facility may be ordered by the court to guarantee public safety if urgent grounds exist to assume that the accused has committed an unlawful act in a state of insanity or diminished responsibility (sec. 20, 21 StGB) and that one of the mentioned measures of correction and prevention will be ordered on account of the offence (sec. 126a StPO).[46] This provision supplements the provisions

37 Translation: juris GmbH website, The StPO, 2014 (at: www.gesetze-im-internet.de/englisch_stpo/englisch_stpo.html#p1048) (last visited: 2 May 2017).

38 Herbert Diemer, '§ 247 [Entfernung des Angeklagten]', in: Rolf Hannich (ed), *Karlsruher Kommentar zur Strafprozessordnung*, Munich: Verlag C.H. Beck, 2013, 7th edition, mn. 12.

39 *Ibid.*

40 *Ibid.*

41 The possibility is sufficient, Christoph Krehl, '§ 246a Ärztlicher Sachverständiger', in: Rolf Hannich (ed), *Karlsruher Kommentar zur Strafprozessordnung*, 2013, 7th edition, mn. 1.

42 Translation partly: juris GmbH website, *The StPO*, 2014 (at: www.gesetze-im-internet.de/englisch_stpo/englisch_stpo.html#p1048) (last visited: 2 May 2017).

43 More details: Gerson Trüg & Jörg Habetha, '§ 246a Vernehmung eines Sachverständigen vor Entscheidung über eine Unterbringung', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2016, mn. 25.

44 Thomas Trück, '§ 81 Unterbringung zur Beobachtung des Beschuldigten', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2014, mn. 6.

45 Section 81(2) StPO; Lothar Senge, '§ 81 Unterbringung zur Beobachtung des Beschuldigten', in: Rolf Hannich (ed), *Karlsruher Kommentar zur Strafprozessordnung*, 2013, 7th edition, mn. 5.

46 For more information on provisional placement: Klaus Michael Böhm & Eric Werner, '§ 126a Einstweilige Unterbringung', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2014, mn. 1-22.

concerning pre-trial detention (sec. 112, 112a StPO) and has a purely preventive, controlling function.[47] An accused person with diminished responsibility (sec. 21 StGB) raises the question of how the dividing line to pre-trial detention can be drawn. The court shall assess whether provisional placement is the more proportionate measure on a case-by-case basis. Provisional placement will usually be chosen if medical treatment is available and legally appropriate in the court's provisional assessment and can be executed in a legally permissible way.[48] During the trial, the public may be excluded from the main hearing or a part thereof if the subject of the proceedings is the placement of the accused in a psychiatric hospital or a custodial addiction rehabilitation facility in lieu of or in addition to a penalty (sec. 171a German Courts Constitution Act).[49]

3 Detainees and prisoners with psychiatric disturbances during provisional detention: needs, problems, screening tools

3.1 Introduction

Rita Haverkamp draws attention to a large number of important issues related to detainees and prisoner needs, problems and screening in her eloquent and persuasive discussion of the subject(s) in Sections 2, 4 and 5 of this chapter. Therefore, in Section 1, Thomas Galli focuses on those same needs, problems, tools and so forth pertaining to both detainees (in provisional detention) as well as inmates (in prison) from a different perspective – namely by drawing heavily on the first-hand experiences gathered personally throughout more than 15 years of operational/management employment in the German Prison Service. I will attempt to highlight the differences and similarities in both contexts (detention and prison), referring to selected published findings, as well as to some original, even unconventional initiatives at the institutions I have been responsible for. Doing so aims to serve as complementary to Haverkamp's remarks. Furthermore, I hope that some of

47 Klaus Michael Böhm & Eric Werner, '§ 126a Einstweilige Unterbringung', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2014, mn. 1 *et seq*.

48 Klaus Michael Böhm & Eric Werner, '§ 126a Einstweilige Unterbringung', in: Christoph Knauer, Hans Kudlich & Hartmut Schneider (eds), *Münchener Kommentar zur StPO*, Munich: Verlag C.H. Beck, 2014, mn. 3.

49 Pursuant to sec. 246a(1) second sentence StPO, the same shall apply where the court is considering an order committing the defendant to a rehabilitation facility; translation partly: juris GmbH website, *The German Courts Constitution Act*, 2014 (at: www.gesetze-im-internet.de/englisch_gvg/englisch_gvg.html#p0788) (last visited: 2 May 2017); Section 71 StGB allows the court to order stand-alone placement in a psychiatric hospital; a procedure for measures of correction and prevention replaces criminal proceedings in case of initial or subsequent inability to stand trial (sec. 413 *et seq*. StPO).

the positive, practical examples, drawn from the institutions I have been in charge of, may offer themselves for adaptation elsewhere.

3.2 Context

According to Germany's Federal Statistical Office,[50] in 2010 the incarceration rate in Germany was 95 prisoners per 100,000 members of the general population. Compared to other countries in Europe and around the world, this places Germany roughly at the mid-point. In absolute numbers the 2010 German prison population, including all prisons and provisional detention centres, was 76,629. This number includes 4,066 women. While reliable, hard, statistical data about numbers of inmates with psychiatric disturbances is notoriously conspicuous by its absence, it can be reliably estimated that in excess of 50% of all detainees and prisoners in Germany suffer from some or multiple forms of mental illness. These figures suggest that the German detainee and inmate population in need of qualified support, treatment and therapy could be in excess of 38,000. Statistics of 31 March 2011 from the Bavarian State Prison Service quote 146 social workers, 87 psychologists and 28 prison chaplains as being responsible for a total of 12,504 detainees and inmates, or a little over 2 per 100. One can safely assume that this ratio is reflected nationwide. This very 'thin' layer of professional coverage therefore places an even greater emphasis on the appropriate deployment of our often underrated uniformed officers, especially in the context of standardized screening methods and day-to-day occupational therapy. This is of particular importance in the context of detainees in provisional detention.

3.3 Needs

It is essential to have early access to a psychiatrist within 12-24 hours of arrival. A detainee/prisoner assessment is indispensable, in particular to identify any potential threat of self-mutilation or even suicide. Urgency is particularly relevant in provisional detention. Accurate assessment is required, and if a psychiatric disturbance is diagnosed, the following question arises: has that condition been 'imported' into the detention centre/prison or has it developed as a result of incarceration? In an article published in the United States in 2004,[51] Robert H. Potter of the University of Central Florida examines this question and comes to some interesting conclusions. The study that he cites correlates length of adult life spent in prison/length of time served in current sentence and found them to be inversely

50 In German: Statistisches Bundesamt, Deutschland.

51 William T. Edwards & Roberto Hugh Potter, 'Psychological Distress, Prisoner Characteristics, and System Experience in a Prison Population', 10 *Journal of Correctional Health Care* 2 (2004), pp. 129-149.

related to levels of psychiatric distress. His findings therefore suggest that a low number of years spent in prison and a shorter time served made younger prisoners particularly vulnerable to significant distress. This supports my own observations that young and first-time detainees need regular visits from a psychiatrist during the 'early days' of incarceration.

A safe and secure environment should be kept in mind as a need of detainees and prisoners. Detainees and prisoners, especially in provisional detention, should be assigned a personal mentor (staff member or trusted older prisoner) whenever a suitable 'candidate' is available, e.g. under a 'Trustee Programme'. Quiet, rest and privacy (rare) should not be forgotten – a library, a reading room and a park-like outdoor environment enhance living conditions. Sport and exercise are key activities for detainees and prisoners: several studies (including Zschucke, Gauditz, Ströehle 2013[52]) have indicated that exercise and physical activity can help prevent or delay the onset of psychiatric disturbances, and can have therapeutic benefits when used as treatment. Sport can engender social competence – team games in particular. Furthermore, athletic success can help the individual to increase self-respect. Studies report positive results of distance running, for example, among those with psychiatric disturbances. Resulting weight loss in the seriously obese can also help develop self-esteem.

Between 2013 and 2016, we successfully employed sport and exercise in Zeithain Prison (JVA Zeithain) in Saxony as part of an integration programme to draw prisoners showing signs of depression out of their self-inflicted isolation and to encourage a generally healthier lifestyle. Furthermore, Zschucke et al. suggested that regular exercise can result not only in higher health-related quality of life but can also help weight loss and encourage participants to quit smoking. In the Zeithain example, we offered controlled access to football (soccer), volleyball, table tennis and other sports. One group even began a programme of distance running which, while somewhat monotonous since the participants just ran many times around the football field (!), enabled them to measure their increased fitness levels and faster times against each other.

3.4 Problems

There is a shortage of trained and qualified staff. Fear, panic and threat of suicide are common phenomena – especially during early days among young and 'first-time' detainees/prisoners.

52 Elisabeth Zschucke, Katharina Gaudlitz & Andreas Ströhle, 'Exercise and Physical Activity in Mental Disorders: Clinical and Experimental Evidence', 46 *Journal of Preventive Medicine & Public Health* Suppl. 1 (2013), pp. 12-21.

Drugs are, of course, also available in temporary detention centres' structures, but the hierarchy for distribution and 'payment' has become more sophisticated – and thus less penetrable – over time in prisons, where mafia-like organizations have developed. The elimination of drugs from detention centres and prisons is a universal (political) problem. Germany is not alone. Furthermore, so-called drug 'barons' continuously find new methods of smuggling illegal substances into institutions. One drug that has caused enormous problems in recent years is crystal meth. Crystal meth-addicted detainees as well as inmates with psychiatric disturbances are particularly vulnerable. Crystal meth itself is not new. In fact, it was first developed (in Germany) over 100 years ago. But measures designed to tackle addiction to this low-priced, easily available commodity within a prison environment are underway. In Zeithain Prison (JVA Zeithain), a centre for treating addiction to crystal meth was opened in 2014.[53] Success rates were slow at first but are gradually improving. Today 20 inmates are being treated.

There is a danger of violence from other detainees or prisoners, many of whom are suffering from huge and sometimes multiple psychiatric disturbances themselves.

A lack of meaningful or rewarding pastimes and occupations can be observed. Occupational therapy, such as gardening projects and caring for an animal, have been tried in numerous prisons. In 2015 an original concept was (successfully) introduced in Zeithain Prison: snail husbandry.[54] At the outset more than 50 snails were acquired – a number that over time grew naturally to 150! Selected inmates took full responsibility for the animals' care and feeding as well as cleaning and maintaining the compounds under the guidance of the resident garden therapist. The long-term goal is to sell snails to gourmet restaurants.

There is a lack of exercise opportunities and sports facilities (see above on sports and exercise).

Non-enforceable diagnosis can be noticed – what a psychiatrist may see as medically essential is often illegal and therefore impossible to implement.

One can observe medically coercive treatment practices for persons who suffer from no apparent disease (e.g. paranoid schizophrenia).

3.5 Screening tools

Initial screening/arrival assessment occurs within 24 hours. Uniformed officers on the ground observe and report back on an ongoing basis: their importance and willingness to be trained cannot be overestimated. A standardized questionnaire is essential: the use of

53 JVA Zeithain (at: www.justiz.sachsen.de) (last visited: 10 October 2017).

54 WELT N24, *Schneckentherapie hinter Gittern*, 3 July 2015 (at: www.welt.de/regionales/sachsen/article143477563/Schneckentherapie-hinter-Gittern.html) (last visited: 24 May 2017).

a simple, standardized questionnaire on a regular basis allows qualified health-care professionals, prison management and uniformed officers to interact with detainees and prisoners and track their development/progress in a non-intrusive way (thus encouraging higher compliance levels). Detainees and prisoners complete the questionnaire themselves in their own time, in most cases returning it in a sealed envelope. The standard Patient Health Questionnaire (PHQ) is a nine-question report (copyrighted by Pfizer Inc.). It is available in German as well as in approximately 60 other languages.

3.6 Conclusion

While the majority of issues and problems in provisional detention and prisons referred to in this section such as understaffing (shortage of psychologists in prisons), underfunding or drug trafficking can only be addressed and solved at an (inter)national political level, others lie firmly in the hands of domestic prison services themselves. I would therefore encourage colleagues, despite the restraints imposed by bureaucratic convention, to adopt fresh and creative approaches with an open and optimistic mind. The question of the extent to which punishment benefits society and harms the individual is particularly relevant in cases of psychiatric disorders. Handling such diseases will always be a dilemma for the judiciary, and the results will never be completely satisfactory. Moreover, the focus on dealing with detainees' psychiatric problems should not distract from the fact that members of staff themselves also suffer disproportionately from psychiatric problems. This cannot be addressed in greater detail within the context of this chapter; however, in the longer term, psychiatric science could also prove to be a starting point for criticism of the prison system which, according to my impression, it currently tends to support.

4 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

In Germany, the so-called 'twin-track sanction system' differs between 'penalties' and 'measures of correction and prevention'[55] as reactions towards offenders. While penalties are based on the guilt of the offender and entail a strong retributive component, measures of correction and prevention are linked to the assumed future threat that he or she poses. The measure of correction and prevention – 'placement in a psychiatric hospital'[56] (sec. 63 StGB) – comes into question in cases of unlawful acts without or with diminished responsibility. As a consequence, the person concerned is deprived of his or her liberty in

55 In German: Maßregeln der Besserung und Sicherung.
56 In German: Unterbringung in einem psychiatrischen Krankenhaus.

a forensic psychiatric facility. According to sec. 63 StGB, the court shall order placement in a psychiatric hospital if a person has committed an unlawful act in a state of insanity (sec. 20 StGB) or diminished responsibility (sec. 21 StGB) and if the overall assessment of the offender and his or her act leads to the conclusion that as a result of his or her condition, future serious unlawful acts can be expected of him or her that substantially harm or endanger the victims physically or psychologically or cause considerable economic damage, and that he or she, therefore, poses a threat to the general public.[57] Placement in a psychiatric hospital is considered only when the state of insanity or diminished responsibility is based on a long-term mental defect.[58] The state of insanity or diminished responsibility must be present when the person commits the offence due to his or her inability to appreciate its unlawfulness (sec. 20, 21 StGB). This premise is the reason that other offenders with psychiatric disturbances are sentenced to penalties and, in cases of unconditional imprisonment, serve their sentence in prison. The Ministries of Social Affairs in the German federal states are responsible for the forensic psychiatric hospitals; the detainees are called patients and treated by medical staff. In contrast to imprisonment, placement in a psychiatric hospital is open-ended and can last a lifetime (sec. 67d StGB). In 2014, a total of 6,540 persons were held in forensic psychiatric facilities; the numbers have risen considerably from 4,098 in 2000, peaking at 6,750 persons in 2012.[59] A 2016 amendment tightened the possibilities of ordering placement in a forensic psychiatric facility and restricted lifelong placements.[60]

Another measure of correction and prevention is 'placement in a custodial addiction rehabilitation facility'[61] (sec. 64 StGB). Alcohol or other drug addicts are the target group of this measure. Placement in a rehabilitation facility shall be imposed when the person concerned committed the unlawful act with complete or diminished responsibility or in a state of insanity. The order of placement in a rehabilitation facility depends on a sufficiently certain prospect of successful treatment (sec. 64 second sentence StGB). If the addict persistently refuses to cooperate during detention, his or her chances of rehabilitation

57 Cf. also the translation: juris GmbH website, *StGB*, 2016 (at: www.gesetze-im-internet.de/englisch_stgb/englisch_stgb.html#p0416) (last visited: 26 April 2017).

58 BGH 2 StR 430/98, judgment 1999/01/08, HRRS-database (at: www.hrr-strafrecht.de) (last visited: 26 April 2017), mn. 8 *et seq*.

59 Statistisches Bundesamt, Strafvollzugsstatistik: Im psychiatrischen Krankenhaus und in der Entziehungsanstalt aufgrund strafrichterlicher Anordnung Untergebrachte (Maßregelvollzug) 2013/2014, 26 June 2015 (at: www.destatis.de) (last visited: 26 April 2017), table 2, p. 8.

60 "Gesetz zur Novellierung des Rechts der Unterbringung in einem psychiatrischen Krankenhaus gem. § 63 des Strafgesetzbuches und zur Änderung anderer Vorschriften" (BGBl. I 2016, p. 1610); critically on this issue Johannes Kaspar & Philipp Schmidt, 'Engere Grenzen nur in Grenzen – zur Novellierung des Rechts der Unterbringung gem. § 63 StGB', 11 *Zeitschrift für internationale Strafrechtsdogmatik* 11 (2016), p. 761 *et seq*.

61 In German: Unterbringung in einer Entziehungsanstalt.

vanish and the conditions of the measure no longer exist, so that the court has to declare the placement in a rehabilitation facility terminated (sec. 67d(5) StGB).

If the addict takes drugs as a result of a long-term mental disorder, the conditions for placement in a rehabilitation facility as well as in a psychiatric hospital are fulfilled. The placement in a rehabilitation facility takes priority because the measure may not exceed a period of two years (sec. 67d(1) first sentence StGB)[62] and thus represents the least burden on the offender (sec. 72(1) first sentence StGB). The court can impose both measures of correction and prevention to protect the community when the requirements of both are fulfilled and neither is sufficient to achieve the intended purpose on its own (sec. 72(1) first sentence StGB).[63] An accumulation is possible when several mental disorders coincide (comorbidity).[64] Only in exceptional cases of addiction will the court merely impose placement in a psychiatric hospital: one example is drug taking as self-medication in order to reduce the consequences of psychosis.[65] As with the placement in a psychiatric hospital, the Ministries of Social Affairs in the German federal states are in charge of the placement in rehabilitation facilities. There are no accurate figures of addicted persons with psychiatric comorbidity, but according to estimates the overwhelming majority present further psychiatric disturbances in addition to their addiction.[66] Similarly to placement in a psychiatric hospital, the numbers of placements in rehabilitation facilities have increased continuously from 1,774 patients in 2000 to 3,822 patients in 2014.[67]

Despite these two measures of correction and prevention, offenders with psychiatric disturbances sentenced to imprisonment are held in prisons.[68] In contrast to the

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62 The maximum period can last much longer according to sec. 67d(1) third sentence StGB and may amount to 12 years in case of accompanying imprisonment of 15 years; see Gerhard van Gemmeren, '§ 64 Unterbringung in einer Entziehungsanstalt', in: Wolfgang Joecks & Klaus Miebach (eds), *Münchener Kommentar zum StGB*, Munich: Verlag C.H. Beck, 2nd edition, 2012, mn. 140.

63 Walter Stree & Jörg Kinzig, '§ 63 Unterbringung in einem psychiatrischen Krankenhaus', in: Adolf Schönke & Horst Schröder (eds), *Strafgesetzbuch Kommentar*, Munich: Verlag C.H. Beck, 29th edition, 2014, mn. 27; whereas the order of placement in a psychiatric hospital is mandatory, placement in a rehabilitation facility shall be ordered: Gerhard van Gemmeren, '§ 64 Unterbringung in einer Entziehungsanstalt', in: Wolfgang Joecks & Klaus Miebach (eds), *Münchener Kommentar zum StGB*, Munich: Verlag C.H. Beck, 2nd edition, 2012, mn. 140.

64 Helmut Pollähne, '§ 64 Unterbringung in einer Entziehungsanstalt', in: Urs Kindhäuser, Ulfrid Neumann & Hans-Ullrich Paeffgen (eds), *Strafgesetzbuch Kommentar*, Baden-Baden: Nomos Verlag, fourth edition, 2013, mn. 85.

65 Van Gemmeren (see footnote 60), mn. 140. Gerhard van Gemmeren, '§ 64 Unterbringung in einer Entziehungsanstalt', in: Wolfgang Joecks & Klaus Miebach (eds), *Münchener Kommentar zum StGB*, Munich: Verlag C.H. Beck, 2nd edition, 2012, mn. 140.

66 Norbert Scherbaum & Michael Specka, 'Komorbide psychische Störungen bei Opiatabhängigen', 15 *Suchttherapie* 1 (2014), p. 22.

67 Statistisches Bundesamt, *Strafvollzugsstatistik: Im psychiatrischen Krankenhaus und in der Entziehungsanstalt aufgrund strafrichterlicher Anordnung Untergebrachte (Maßregelvollzug) 2013/2014*, 26 June 2015 (at: www.destatis.de) (last visited: 26 April 2017), table 2, p. 8.

68 The German Law on the Treatment and Placement of Violent Offenders Suffering from a Mental Disorder, enacted in January 2011, addresses a particular group: sexual offenders sentenced to preventive detention

aforementioned measures of correction and prevention, where the Ministries for Social Affairs hold responsibility, it is the Ministries of Justice in the German federal states that are responsible for inmates with psychiatric disturbances.[69] The objective or task[70] of enforcement is to produce a socially responsible way of life without re-offending. In order to encourage rehabilitation, therapeutic treatment measures should be offered to inmates in need of such support.[71] Forced therapy is prohibited, but prison staff should encourage the willingness to participate of the persons concerned.[72] Transfer to a social-therapeutic facility within the prison is another option for the correctional treatment of mentally ill prisoners in addition to the therapeutic measures offered by the psychological and social services.[73] The focus is on the correctional treatment of sexual and violent offenders, who quite often exhibit psychiatric disturbances. Due to limited capacity only a minority of prisoners is able to benefit from social therapy.[74] Psychiatric facilities within prisons or in prison hospitals are a further alternative,[75] but once again only a few inmates with

prior to 1998 who would have to be released due to the decision of the European Court of Human Rights in December 2009 (*M. v. Germany*, Judgment of 17 December 2009, 5th section, App. No. 19359/04). According to sec. 1 of the German Therapy Placement Act, the court shall order therapy placement if psychiatric experts attest to mental disorder and if reasons of public security require further detention. In July 2013 the German Federal Constitutional Court found the German Therapy Placement Act to be constitutional, but stated that the principle of proportionality was disregarded with respect to the individual cases of the complaints (BVerfG, Judgment of 11 July 2013, 2 BvR 2302/11, 2 BvR 1279/12). Subsequently all persons were dismissed from therapy placement, and since then the instrument has lost its relevance in practice; see also Rita Haverkamp & Gunda Wößner, 'New Responses to Sexual Offenders. Recent developments in legislation and treatment in Germany', 97 *Monatsschrift für Kriminologie und Strafrechtsreform* 1 (2014), p. 33.

69 The Ministries of Justice are also concerned with the enforcement of preventive detention (Sicherungsverwahrung). Preventive detention (sec. 66 StGB) is the most rigorous measure of correction and prevention; the German states have their own Laws on Preventive Detention.

70 In accordance with the different Prison Acts of the German states; preventive detainees often have serious mental disorders, see Rita Haverkamp, 'Übergangs- und Risikomanagement bei entlassenen Sicherungsverwahrten', in: Johannes Kaspar (ed), *Sicherungsverwahrung 2.0? Bestandsaufnahme – Reformbedarf – Forschungsperspektiven*, Baden-Baden: Nomos Verlag, 2017, p. 115.

71 Klaus Laubenthal, *Strafvollzug*, Heidelberg/New York/Dordrecht/London: Springer, 2015, 7th edition, p. 410.

72 All Prison Acts in Germany contain related provisions: e.g. sec. 3(1) Third Code of the Correctional System Baden-Württemberg, Art. 6(1) Bavarian Prison Act.

73 E.g. sec. 8 Third Code of the Correctional System Baden-Württemberg, Art. 11 Bavarian Prison Act.

74 In Germany a total of 2,396 prisoners were accommodated in social-therapeutic facilities at the reporting date (31 March 2016), see Sonja Etzler, *Sozialtherapie im Strafvollzug 2016. Ergebnisübersicht zur Stichtagserhebung zum 31.03.2016*, Wiesbaden: Eigenverlag Kriminologische Zentralstelle e.V., 2016, p. 11; in contrast, a total of 50,858 persons were in prison (31 March 2016): Statistisches Bundesamt, *Strafvollzug – Demographische und kriminologische Merkmale der Strafgefangenen zum Stichtag 31.03. – Fachserie 10, Reihe 4.1 – 2016*, 15 March 2017 (at: www.destatis.de) (last visited: 27 April 2017), table 1, p. 11.

75 Only some German states have such a hospital (e.g. Baden-Württemberg, North Rhine-Westphalia, Lower Saxony).

psychiatric disturbances can be accommodated there.[76] The need for correctional treatment is likely to far exceed the available options. In Germany, several studies on the prevalence of psychiatric disturbances among prison inmates have been produced.[77] These studies draw the conclusion that mental disorders occur more frequently among detainees than among the average population, with between 40% and 70% of all prisoners showing some form of mental disorder.[78] Although the small samples restrict the data's reliability, there is undeniably a great demand for correctional treatment. However, this demand cannot be met due to general shortcomings in correctional treatment, a lack of staffing and deficiencies in organization and infrastructure.[79] Suggested improvements include expanding both inpatient psychiatric treatment for severely ill patients in specialized facilities and a decentralized range of psychiatric and psychotherapeutic programmes.[80] Cooperative and synergetic opportunities should be strengthened by involving the expertise of forensic psychiatric hospitals in order to improve the treatment situation for mentally ill prisoners.[81]

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76 On one example in North Rhine-Westphalia Joachim G. Witzel & Udo Gubka, 'Ergebnisse der stationären Akutbehandlung psychisch kranker Häftlinge in einer als Modellprojekt speziell eingerichteten psychiatrischen Behandlungsabteilung in der JVA Werl', in: Heinrich Duncker, Bernd Dimmek & Ulrich Kobbé (eds), *Forensische Psychiatrie und Psychotherapie*, Lengerich *et al*.: Pabst Science Publishers, 2002, p. 22 *et seq*.; however, today there is a different structure: Justiz-online website, *Justizvollzugsanstalt Werl – Besondere Behandlungsmaßnahmen*, 2017 (at: www.jva-werl.nrw.de/aufgaben/besondere_behandlungsmassnahmen/zt_5/index.php#GMBH) (last visited: 27 April 2017); psychiatric facilities can be found in Bavaria, e.g. one prison in Würzburg: Justizvollzugsanstalt Würzburg, *Beilage zum Jahresbericht 2015 – Kurzinformation über die Justizvollzugsanstalt Würzburg*, 31 March 2016 (at: www.justiz.bayern.de) (last visited: 27 April 2017).

77 Luciano Missoni, Friedrich M. Utting & Norbert Konrad, 'Psychi(atri)sche Störungen bei Untersuchungsgefangenen. Ergebnisse und Probleme einer epIbid.iologischen Studie', 53 *Zeitschrift für Strafvollzug und Straffälligenhilfe* 6 (2003), pp. 323-332; concerning prisoners on remand; C.-E. von Schönfeld, F. Schneider, T. Schröder, B. Widmann, U. Botthof & M. Driessen, 'Prävalenz psychischer Störungen, Psychopathologie und Behandlungsbedarf bei weiblichen und männlichen Gefangenen', 77 *Nervenarzt* 7 (2006), pp. 830-841; Manuela Dudeck, Daniel Kopp, Philipp Kuwert, Kristin Drenkhahn, S. Orlob, H. Lüth, Harald Freyberger & Carsten Spitzer, 'Die Prävalenz psychischer Erkrankungen bei Gefängnisinsassen mit Kurzzeitstrafe', 36 *Psychiatrische Praxis* 5 (2009), pp. 219-224; D. Kopp, Kristin Drenkhahn, Frieder Dünkel, Harald J. Freyberger, C. Spitzer, S. Barnow & M. Dudeck, 'Psychische Symptombelastung bei Kurz- und Langzeitgefangenen in Deutschland', 82 *Nervenarzt* 7 (2011), pp. 880-885.

78 An overview of the studies in Germany as well as the estimates are included in the report of the Justizministerium Baden-Württemberg (ed), *Umgang mit psychisch auffälligen Gefangenen. Abschlussbericht der Expertenkommission*, Stuttgart: Justizministerium Baden-Württemberg, 2015, p. 22.

79 Justizministerium Baden-Württemberg (ed), *Umgang mit psychisch auffälligen Gefangenen. Abschlussbericht der Expertenkommission*, Stuttgart: Justizministerium Baden-Württemberg, 2015, p. 89; Hans Joachim Salize & Harald Dressing, 'Psychiatrische Versorgung im europäischen Strafvollzug', 4 *Forensische Psychiatrie, Psychologie, Kriminologie* 1 (2010), p. 76.

80 C.-E. von Schönfeld, F. Schneider, T. Schröder, B. Widmann, U. Botthof & M. Driessen, 'Prävalenz psychischer Störungen, Psychopathologie und Behandlungsbedarf bei weiblichen und männlichen Gefangenen', 77 *Nervenarzt* 7 (2006), p. 840.

81 The expert commission of the Justizministerium Baden-Württemberg (ed), *Umgang mit psychisch auffälligen Gefangenen. Abschlussbericht der Expertenkommission*, Stuttgart: Justizministerium Baden-Württemberg,

5 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

Neither the term 'prisoners with psychiatric disturbances' nor related terms are to be found in the prison laws of the German federal states. However, provisions concerning medical services, disciplinary measures and special precautions are relevant for mentally disordered inmates. Several prison laws emphasize that mental and/or psychological health shall be maintained,[82] some of them expressly include psychotherapy as treatment measure,[83] and others contain no definitive provision for the scope of medical services.[84] Be this as it may, the principle of equivalence guarantees that prisoners have the same access requirements and the same treatment standards as extramural patients.[85] In particular, striking differences between the German states arise with regard to healthcare for drug addicts.[86] Due to an overall drug-free ideal, drug substitution therapy is only granted in exceptional cases in prisons, once again differing across the federal states.[87] In September 2016, the European Court of Human Rights (ECtHR) found that a violation of Art. 3 (prohibition of torture) of the European Human Rights Convention (ECHR) had occurred because a long-term addict without any realistic chance of overcoming his addiction had been denied drug substitution therapy in prison, although he had previously received substitution treatment.[88]

2015 was made up of participants from the Ministries of Justice and Social Affairs as well as of experts from forensic psychiatric hospitals and correctional treatment experts; C.-E. von Schönfeld, F. Schneider, T. Schröder, B. Widmann, U. Botthof & M. Driessen, 'Prävalenz psychischer Störungen, Psychopathologie und Behandlungsbedarf bei weiblichen und männlichen Gefangenen', 77 *Nervenarzt* 7 (2006), p. 840.

82 E.g. sec. 77(1) Correctional System Act Brandenburg, sec. 75(1) Correctional System Act Rhineland-Palatinate.

83 E.g. sec. 58(1) Act on the Enforcement of Imprisonment Hamburg, sec. 26(2) Hessian Prison Act.

84 E.g. Art. 60 second sentence Bavarian Prison Act.

85 But no choice of doctor that causes problems in the relationship between the inmate and the doctor, see Heino Stöver, 'Gesundheitsversorgung und Gesundheitsförderung im Gefängnis', in: Heiner Bögemann, Karlheinz Keppler & Heino Stöver (eds), *Gesundheit im Gefängnis. Ansätze und Erfahrungen mit Gesundheitsförderung in totalen Institutionen*, Weinheim/Munich: Juventa-Verlag, 2010, p. 15; the principle is based on the legal mandate to approximate life in prison to general living conditions as far as possible and to counteract the detrimental effects of imprisonment; an overview of the different prison laws is given by Frank Neubacher, 'III. Gestaltung des Vollzugs', in: Klaus Laubenthal, Nina Nestler, Frank Neubacher & Torsten Verrel (eds), *Strafvollzugsgesetze*, Munich: C.H. Beck, 2015, 12th edition, pp. 46-58.

86 On female inmates Rita Haverkamp, *Frauenvollzug in Deutschland. Eine empirische Untersuchung vor dem Hintergrund der Europäischen Strafvollzugsgrundsätze*, Berlin: Duncker & Humblot, 2011, pp. 292-298.

87 Substitution treatment of 0.4% of all prisoners in Bavaria and 20% in Bremen, retrieved from Süddeutsche Zeitung, *Bayern verwehrt drogensüchtigen Häftlingen Therapie*, 28 August 2016 (at: www.sueddeutsche.de/bayern/justiz-bayern-verwehrt-drogensuechtigen-haeftlingen-therapie-1.3137020) (last visited: 3 May 2017); Heino Stöver, 'Drogenkonsum und Infektionskrankheiten: Grundsätzliche Herausforderungen für Gesundheit in Gefängnissen', in: Heiner Bögemann, Karlheinz Keppler & Heino Stöver (eds), *Gesundheit im Gefängnis. Ansätze und Erfahrungen mit Gesundheitsförderung in totalen Institutionen*, Weinheim/Munich: Juventa-Verlag, 2010, pp. 89-90.

88 ECtHR, Judgment of 1 September 2016, *Wenner v. Germany*, Appl. 62303/13 (at: https://lovdata.no/static/EMDN/emd-2013-062303.pdf) (last visited: 3 May 2017).

The Court highlighted that "the authorities failed to examine with particular scrutiny and with the help of independent and specialist medical expert advice, against the background of a change in the medical treatment, which therapy was to be considered as appropriate".[89] Intramural medical services have deficiencies in regard to mental health among other areas due to a lack of psychiatrists and psychologists, a lack of compulsory advanced training and falling behind latest developments.[90] Moreover, no precise information on the physical and psychological health of prisoners is available.[91]

In past years, cognitive-behavioural treatment programmes have been established in the correctional treatment of mentally disturbed prisoners throughout Germany.[92] The Risk Need Responsivity (RNR) Model[93] as well as the Good Lives Model (GLM)[94] are now widespread.[95] The 'Treatment Programme for Sexual Offenders'[96] was developed in Germany and is the most commonly used such programme in social-therapeutic facilities today: one of its parts can be used for all sorts of offenders.[97] The main problems encountered in the treatment of mentally disturbed prisoners are dissimulation, missing 'illness insight' as well as treatment preparedness, comorbidity, double stigmatization (imprisonment plus psychiatric illness) and pre-release assistance.[98] Inmates with dissocial personality disorder, denial of offence or low societal integration before imprisonment are considered difficult to treat; where rehabilitation is concerned, antisocial behaviour and poor social integration are recognized as indicators for relapse.[99] Psychoeducation is

89 ECtHR, *Wenner v. Germany* (see footnote 59), p. 22 mn. 80. ECtHR, Judgment of 1 September 2016, *Wenner v. Germany*, Appl. 62303/13 (at: https://lovdata.no/static/EMDN/emd-2013-062303.pdf) (last visited: 3 May 2017).

90 Heino Stöver, '"Healthy prisons". Gesundheit und Gesundheitsversorgung Gefangener', 11 *Prävention und Gesundheitsförderung* 4 (2016), p. 252.

91 *Ibid*., p. 251.

92 Rudolf Egg, 'Konzepte der Straftäterbehandlung im Wandel der Zeit', 43 *Kriminalpädagogische Praxis* 50 (2015), p. 25.

93 Donald A. Andrews & James Bonta, *The psychology of criminal conduct*, New Providence: Routledge, 2010, 5th edition.

94 Tony Ward & Shadd Maruna, *Rehabilitation*, London *et al*.: Routledge, 2007.

95 Johann Endres & M. Florian Schwanengel, 'Straftäterbehandlung', 62 *Bewährungshilfe* 4 (2015), p. 304 *et seq*.; a critical perspective: Stefan Suhling & Johann Endres, 'Deliktorientierung in der Behandlung von Straftätern. Bestandsaufnahme und Kritik', 2 *Rechtspsychologie* 3 (2016), pp. 346-363.

96 In German: Das Behandlungsprogramm für Sexualstraftäter.

97 Rudolf Egg, 'Konzepte der Straftäterbehandlung im Wandel der Zeit', 43 *Kriminalpädagogische Praxis* 50 (2015), p. 26 *et seq*.; in detail: Ulrich Rehder, Bernd Wischka & Elisabeth Foppe, 'Das Behandlungsprogramm für Sexualstraftäter (BPS)', in: B. Wischka, W. Pecher & H. van den Boogaart (eds), *Behandlung von Straftätern. Sozialtherapie, Maßregelvollzug, Sicherungsverwahrung*, Freiburg im Breisgau: Centaurus Verlag & Media, 2012, pp. 418-453.

98 Norbert Konrad, 'Entlassungssituationen von psychisch kranken Straftätern', in: DBH-Fachverband für Soziale Arbeit, Strafrecht und Kriminalpolitik (ed), *Kriminalpolitik gestalten. Übergänge koordinieren – Rückfälle verhindern*, Norderstedt: Books on Demand, 2010, p. 169.

99 Stefan Suhling, 'Behandlung "gefährlicher" und "schwieriger" Straftäter', 60 *Forum Strafvollzug* 5 (2011), p. 277.

taught in several prison units for psychiatry and psychotherapy in order to improve the compliance of mentally disordered prisoners and their acceptance of their mental illness.[100] The power imbalance between therapist and patient also causes difficulties in correctional treatment: a prisoner's complaints about his or her therapist could be interpreted as an insufficient willingness to be therapized or a lack of treatability, even if the therapist is not fully qualified or is unable to build a relationship to the person concerned.[101] In addition, tendencies "for a confrontative, if not humiliating approach, which undermines the self-esteem of the client and exploits the disparity in power between therapist and perpetrator" are observed.[102] Progress could be achieved by not abusing power, by transparency with regard to perceptions, by objectives as well as impending decisions and by respectful interaction.[103]

Transition-oriented release structures have been recognized as crucial for all prisoners in the vulnerable phase before release, but especially so for long-term and high-risk prisoners.[104] The prisons acts of the German states include different legal provisions for the resettlement of prisoners.[105] Pre-release assistance[106] is addressed in all prison acts, but some of them contain the term 'continual support',[107] understanding reintegration as a long-lasting process that begins with admission to prison and continues after release from prison; aftercare[108] is also an important issue in a number of prison acts.[109] Should crisis intervention be necessary, several prison acts stipulate that the prisoner may stay in prison or the released offender may be admitted to return to overcome his or her crisis, both on a voluntary basis.[110] Intensive transition management is especially important for prisoners

100 E.g. in Berlin, in detail: Elisabeth Quendler & Norbert Konrad, 'Therapeutische Behandlungskonzepte zur Verbesserung der Compliance psychisch kranker Häftlinge', 58 *Forum Strafvollzug* 1 (2009), pp. 33-37.

101 Hans-Ludwig Kröber, 'Transparenz und Fairness in der Therapie von Sexualstraftätern in Haft und Maßregelvollzug', 7 *Forensische Psychiatrie, Psychologie, Kriminologie* 1 (2013), p. 40 *et seq*.

102 *Ibid*., p. 37.

103 *Ibid*., p. 43.

104 Cf. the work by Eduard Matt, *Übergangsmanagement und der Ausstieg aus Straffälligkeit. Wiedereingliederung als gemeinschaftliche Aufgabe*, Herbolzheim: Centaurus Verlag & Media, 2014; including the European context Frieder Dünkel, Jörg Jesse, Ineke Pruin & Moritz von der Wense (eds), *European Treatment, Transition Management, and Re-Integration of High-Risk Offenders*, Mönchengladbach: Forum Verlag Godesberg, 2016.

105 An overview is provided by Ineke Pruin, 'Prisoner Resettlement in Germany – New Approaches?', 11 *Revista de Asistență Socială* 3 (2012), pp. 67-84; Elke Bahl & Helmut Pollähne, '§ 42 LandesR', in: Johannes Feest, Wolfgang Lesting & Michael Lindemann (eds), *Strafvollzugsgesetze Kommentar*, Cologne: Wolters Kluwer, 2017, 7th edition, mn. 1 *et seq*.

106 In German: Hilfe zur Entlassung, e.g. sec. 16(1) Act on the Enforcement of Imprisonment Hamburg as well as Hessian Prison Act.

107 In German: durchgängige Betreuung; sec. 68(3) Correctional System Act Lower Saxony.

108 In German: Nachsorge.

109 E.g. sec. 52 Correctional System Act Brandenburg, sec. 18 Act on the Enforcement of Imprisonment Hamburg.

110 In German: Verbleib oder Aufnahme auf freiwilliger Grundlage; e.g. Sec. 45 Correction System Act Mecklenburg-Vorpommern, sec. 51(1) Correctional System Act Rhineland-Palatinate; more information by

with psychiatric disturbances, who were often not part of the general psychiatric system before their imprisonment.[111] This target group is in need of an extramural support network that works on an individual basis, although the person concerned is often not willing to accept his or her mental disorder and attempts should aim to convince him or her of his or her assistance needs.[112] In practice, shortcomings arise in connection with the organization of aftercare because the actors involved do not take responsibility for the released offender with psychiatric disturbances and fail to work together.[113] One problem is that the probation service is often not able to deal with mentally disordered clients professionally and some probation officers try to avoid this client base.[114] In order to resolve these shortcomings, cross-functional and interdisciplinary cooperation is necessary, involving case-related sharing of experience about the client and clear and unambiguous arrangements.[115] The effective aftercare of mentally disturbed offenders must comprise outreach and active aid combined with social control and the occasional application of force in situationally appropriate forms (e.g. constant medication intake).[116] In recent years, aftercare for sexual and violent offenders released from social-therapeutic facilities has improved.

Social therapy serves the correctional treatment of prisoners in order to change the inmates' personality structures.[117] However, inmates do not need to have a medically certified illness to be transferred to a social-therapeutic facility,[118] and therefore this should

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Nina Nestler, 'III. Hilfe zur Entlassung' and 'V. Nachsorge', in: Klaus Laubenthal, Nina Nestler, Frank Neubacher & Torsten Verrel (eds), *Strafvollzugsgesetze*, Munich: C.H. Beck, 2015, 12th edition, pp. 803-810, 816-822.

111 Justizministerium Baden-Württemberg (ed), *Umgang mit psychisch auffälligen Gefangenen. Abschlussbericht der Expertenkommission*, Stuttgart: Justizministerium Baden-Württemberg, 2015, p. 30, 80 *et seq*.; Norbert Konrad, 'Entlassungssituationen von psychisch kranken Straftätern', in: DBH-Fachverband für Soziale Arbeit, Strafrecht und Kriminalpolitik (ed), *Kriminalpolitik gestalten. Übergänge koordinieren – Rückfälle verhindern*, Norderstedt: Books on Demand, 2010, p. 169.

112 Norbert Konrad, 'Entlassungssituationen von psychisch kranken Straftätern', in: DBH-Fachverband für Soziale Arbeit, Strafrecht und Kriminalpolitik (ed), *Kriminalpolitik gestalten. Übergänge koordinieren – Rückfälle verhindern*, Norderstedt: Books on Demand, 2010, p. 169.

113 Roland Freese, 'Ambulante Versorgung von psychisch kranken Straftätern im Maßregel- und Justizvollzug', 21 *Recht & Psychiatrie* 2 (2003), p. 55 *et seq*.; Michael Stiels-Glenn, 'Ist die Bewährungshilfe auf psychisch kranke Probanden gut vorbereitet? Eine kritische Bestandsaufnahme', 52 *Bewährungshilfe* 1 (2005), p. 42.

114 Michael Stiels-Glenn, 'Ist die Bewährungshilfe auf psychisch kranke Probanden gut vorbereitet? Eine kritische Bestandsaufnahme', 52 *Bewährungshilfe* 1 (2005), p. 46.

115 *Ibid*., p. 49.

116 Roland Freese, 'Ambulante Versorgung von psychisch kranken Straftätern im Maßregel- und Justizvollzug', 21 *Recht & Psychiatrie* 2 (2003), p. 55; Michael Stiels-Glenn, 'Ist die Bewährungshilfe auf psychisch kranke Probanden gut vorbereitet? Eine kritische Bestandsaufnahme', 52 *Bewährungshilfe* 1 (2005), p. 49.

117 OLG Karlsruhe, Judgment of 14 February 1997, 'Psychotherapeutische Behandlung durch Diplompsychologin, 2 Ws 221 u. 222/95', 17 *Neue Zeitschrift für Strafrecht* 6 (1997), p. 302, 304; in detail on social therapy: Michael Alex & Gerhard Rehn, '§ 17 LandesR', in: Johannes Feest, Wolfgang Lesting & Michael Lindemann (eds), *Strafvollzugsgesetze Kommentar*, Cologne: Wolters Kluwer, 2017, 7th edition, mn. 1 *et seq*.

118 In German: Verlegung in eine sozialtherapeutische Anstalt.

not be equated with medical care.[119] The legislator decided to refrain from committing to a scientifically based and universal model of therapy to instead allow a variety of methods, reflecting the current state of research.[120] Unless the German federal states have particular provisions, social therapy facilities – structurally independent prison units or separate wards inside a prison – are free to design treatment and use this leeway. Social therapy targets in particular inmates who have committed specific sexual offences or serious violent crime.[121] If a sexual or violent offender is in need of treatment, not incapable of therapy and has no therapy alternatives,[122] transfer to social therapy often is mandatory. In all other cases prisoners may be transferred to social therapy if specific therapeutic measures and social services support their resocialization.[123] Social therapy consists of an integrative treatment approach with vocational and educational training, work within prison, social work and different forms of therapy.[124] Psychotherapeutic interventions are dominated by cognitive-behavioural principles; a lot of internationally proven treatment approaches are applied and often particular programmes are used for the most important clientele, sexual offenders (e.g. Sexual Offender Treatment Programme).[125] In 2016, a total of 49.4% of prisoners in social-therapeutic facilities (n = 2,076) were sexual offenders and 22.3% were homicide offenders.[126] A recent evaluation of social therapy in the German state of Saxony suggests that the treatment is more promising for serious violent offenders than for sexual offenders.[127] Depending on the federal state, the inmate-staff ratio is much better in social-therapeutic facilities than in prisons: whereas one social worker and psychologist

119 Stephan Anstötz, '§ 9 Verlegung in eine sozialtherapeutische Anstalt', in: Jürgen-Peter Graf (ed), Beck'scher Online-Kommentar Strafvollzugsrecht Bund, Munich: C.H. Beck, 2016, 10th edition, mn. 5 *et seq*.

120 Deutscher Bundestag, *Entwurf eines Gesetzes zur Änderung des Strafvollzugsgesetzes (StVollzÄndG) – BT-Drs. 10/309*, 18 August 1983 (at: http://dipbt.bundestag.de) (last visited: 3 May 2017), p. 10.

121 E.g. Art. 11(1) Bavarian Prison Act, sec. 104(1) Correctional System Act Lower Saxony; a completely different approach is to be taken according to sec. 8(1) Third Code of the Correctional System Baden-Württemberg: every prisoner is admissible if social therapy is required and promising, the person concerned is expected to relapse and commit substantial offences without treatment, and the head of the social therapy institution consents.

122 When the prison considers transferring an inmate to social therapy, there is a margin of discretion with regard to the elements of the provision; Stephan Anstötz, '§ 9 Verlegung in eine sozialtherapeutische Anstalt', in: Jürgen-Peter Graf (ed), *Beck'scher Online-Kommentar Strafvollzugsrecht Bund*, Munich: C.H. Beck, 2016, 10th edition, mn. 20.

123 E.g. sec. 104(2) Correctional System Act Lower Saxony; more restrictive Art. 11(2) Bavarian Prison Act; the provisions in the German federal states differ considerably from one another in detail.

124 Rita Haverkamp & Gunda Wößner, 'New Responses to Sexual Offenders. Recent Developments in Legislation and Treatment in Germany', 97 *Monatsschrift für Kriminologie und Strafrechtsreform* 1 (2014), p. 34.

125 *Ibid*., p. 36 *et seq*.

126 Sonja Etzler, *Sozialtherapie im Strafvollzug 2016. Ergebnisübersicht zur Stichtagserhebung zum 31.03.2016*, Wiesbaden: Eigenverlag Kriminologische Zentralstelle e.V., 2016, p. 17, 34; the percentage of sexual offenders peaked in 2008 (62.5%) and has steadily fallen since then.

127 Gunda Wößner & Andreas Schwedler, 'Correctional Treatment of Sexual and Violent Offenders: Therapeutic Change, Prison Climate, and Recidivism', 41 *Criminal Justice and Behavior* 7 (2014), p. 873 *et seq*.

are responsible for six prisoners on average in social-therapeutic facilities,[128] in prisons one social worker cares for 38 to 50 prisoners and one psychologist for 72 to 86 prisoners.[129]

Many offenders in social-therapeutic treatment still have a need for continuing treatment after release. In recent years, there has been progress concerning transition-oriented release structures for inmates in social-therapeutic treatment and the capacities of forensic outpatient services in the framework of supervision[130] have been expanded (sec. 68 *et seq*. StGB).[131] Supervision is an outpatient measure of correction and prevention for released prisoners who have served their full sentence of at least two years for premeditated offences or not less than one year for specific sexual offences (sec. 68f(1) StGB). The court may order that a psychotherapist or a forensic outpatient service be visited regularly (sec. 68b(1) no. 11 StGB) or issue a therapy direction (sec. 68b(2) StGB). The reform of supervision in 2007 led to a vast increase in the number of persons under supervision:[132] while in 2008 a total of 24,818 persons under supervision were registered, numbers rose to 37,018 in 2015.[133]

Another special group consists of perpetrators assessed as dangerous held in preventive detention (sec. 66 StGB), which is the strictest measure of correction and prevention. Following a famous ECtHR decision[134] in December 2009, German legislature created a

128 Sonja Etzler, *Sozialtherapie im Strafvollzug 2016. Ergebnisübersicht zur Stichtagserhebung zum 31.03.2016*, Wiesbaden: Eigenverlag Kriminologische Zentralstelle e.V., 2016, p. 51.

129 Prison places: Statistisches Bundesamt, '*Strafvollzug – Demographische und kriminologische Merkmale der Strafgefangenen zum Stichtag 31.03.* – Fachserie 10. Reihe 4.1.2015', 28 April 2016 (at: www.destatis.de); numbers of qualified personnel in the most populous German states Baden-Württemberg (2015), Bavaria (2015) and North Rhine-Westphalia (2013) Justizministerium Baden-Württemberg, *Daten und Fakten – Personal*, 1 January 2015 (at: www.jum.baden-wuerttemberg.de/pb/,Lde/Startseite/Justiz/datenundfakten#anker2013025); Bayerisches Staatsministerium der Justiz, *Personalsituation*, 31 March 2015 (at: www.justiz.bayern.de); Justizministerium Nordrhein-Westfalen, *Personalübersicht (Stellenzahl) im Justizvollzug*, 2014 (at: www.justiz.nrw.de/Gerichte_Behoerden/zahlen_fakten/statistiken/justizvollzug/personal/personaluebersicht.pdf) (last visited: 15 May 2017).

130 In German: Führungsaufsicht.

131 Thereto Deutscher Bundestag, *Entwurf eines Gesetzes zur Reform der Führungsaufsicht – BT-Drs. 16/1993*, 28 June 2006 (at: http://dip21.bundestag.de) (last visited: 3 May 2017), p. 17.

132 Concerning forensic outpatient services for persons released from placement in a forensic psychiatric hospital or rehabilitation facility Roland Freese, 'Zum Stand der forensischen und forensisch-psychiatrischen Nachsorge in der Bundesrepublik Deutschland (Daten aus der sog. Pfingstabfrage 2013)', 8 *Forensische Psychiatrie, Psychologie, Kriminologie* 2 (2014), pp. 137-144.

133 Peter Reckling, *Aktuelles in der Führungsaufsicht: Übersicht über die Zahlen 2015*, 3/4 February 2016 (at: www.dbh-online.de/fa/FA-Zahlen-Bundeslaender-2015.pdf) (last visited: 15 May 2017); this database is an initiative by the German Probation Service and is not a nationwide uniform statistical record; Alexander Baur, *Problembereiche in der Führungsaufsicht*, 20 September 2012 (at: www.jura.uni-tuebingen.de) (last visited: 15 May 2017).

134 ECtHR, Judgment of 17 December 2009, *M. v. Germany*, Appl. 19359/04. In contrast to the German government, the ECtHR stated that preventive detention was a punishment, and therefore the retroactive extension from a limited to an unlimited application violated the right to liberty and security (Art. 5 ECHR) as well as the prohibition of retroactivity (Art. 7(1) ECHR).

host of new legal amendments to reorganize, inter alia, the enforcement of the measure[135] and, in addition, the German Federal Constitutional Court.[136] One Federal Constitutional Court judgment of 2004[137] resulted in the German Federal Act on the Implementation of the Difference Requirement concerning the Law of Preventive Detention[138] and the laws of the German federal states on the execution of preventive detention.[139] In its judgment, the Court stated that while preventive detainees have a right to an opportunity for release by considering treatment and pre-release preparations on the one hand, it is necessary to establish a distinction between preventive detention and imprisonment on the other hand,[140] because of the dissimilar purposes and bases of legitimation of each sanction. The Court underlined the importance of a therapeutic approach during the execution of preventive detention that draws up a treatment programme and uses all available therapeutic services with the aim of motivating preventive detainees; furthermore, the execution of the measure should relate to release. Meanwhile, the legislative efforts and changes in practice had an impact on the ECtHR: the Court rejected further complaints of preventive detainees related to the new legal framework or their placement in a centre of psychiatric treatment.[141] With regard to preventive detainees, a recent study on socialization and delinquency shows "a strong dissocial influencing factor beyond the individual moulding process, which only differed from other prisoners in the intensity".[142] The authors suggest prosocial milieu and social therapy based on motivating conversations; the preventive detainee should practice behavioural changes every day to internalize them and gather new and encouraging prosocial skills for an emotionally corrective relationship experience.[143] Aftercare for released preventive detainees – who are difficult, personally disordered, hospitalized and embittered – is a complex task, and the building of reliable

135 For an overview, see Kirsten Drenkhahn, Christine Morgenstern & Dirk van Zyl, 'What Is in a Name? Preventive Detention in Germany in the Shadow of European Human Rights Law', *Criminal Law Review* 3 (2012), pp. 167-187.

136 In German: Bundesverfassungsgericht; for more details: Kirsten Drenkhahn, 'Secure Preventive Detention in Germany: Incapacitation or Treatment Intervention', 31 *Behavioral Sciences and the Law* 3 (2013), p. 314 *et seq*.

137 Bundesverfassungsgericht, Judgment of 5 February 2004, *BVerfGE 109, 133*, Appl. 2 BvR 2029/01.

138 In German: Gesetz zur bundesrechtlichen Umsetzung des Abstandsgebotes im Recht der Sicherungsverwahrung (BGBl. I No. 57, 2012, p. 2425 *et seq*.).

139 All laws entered into force on 1 June 2013 due to the deadline of the German Federal Constitutional Court.

140 In German: Abstandsgebot; critical: Katrin Höffler & Johannes Kaspar, 'Warum das Abstandsgebot die Probleme der Sicherungsverwahrung nicht lösen kann. Zugleich ein Beitrag zu den Aporien der Zweispurigkeit des strafrechtlichen Sanktionssystems', 124 *Zeitschrift für die gesamte Strafrechtswissenschaft* 1, pp. 87-131.

141 ECtHR, Judgment of 7 January 2016, *Bergmann v. Germany*, Appl. 23279/14 and ECtHR, Judgement of 2 February 2017, *Ilnseher v. Germany*, Appl. 10211/12 and 27505/14.

142 Hans-Ludwig Kröber & Anja Bauer, 'Vorgeschichte und Merkmale der Berliner Sicherungsverwahrten. Marker von Gefährlichkeit?', 11 *Forensische Psychiatrie, Psychologie, Kriminologie* 1 (2017), p. 3.

143 *Ibid*., p. 12.

networks is crucial.[144] In this context, forensic outpatient services have a key function in implementing a supportive external daily structure within a reliable and continuous therapeutic relationship.[145] Therapist and patient should work on the individual risk factors of a relapse scenario in order to enable the patient to comply with directions and to control the behaviour in question on his or her own. A crisis plan drawn up in agreement with other actors is essential to establishing precise strategies for combatting recidivism. First experiences indicate that the implementation of a close support system seems to support a crime-free start after preventive detention.[146]

6 Conclusion

Some highly publicized cases have led to reforms concerning mentally disturbed offenders both in prisons and in forensic psychiatric hospitals. Gustl Mollath is the best-known figure in this respect. Mollath was held in a forensic psychiatric hospital for more than seven years: in August 2014 he was acquitted and was awarded financial compensation from the state for his unlawful confinement in a forensic psychiatric hospital.[147] The Federal Constitutional Court stated as early as in August 2013 that the continuation of long-term confinement in a forensic psychiatric hospital did not meet the strict standards that follow from the principle of proportionality.[148] A resulting amendment in 2016 substantiated the

144 Tatjana Voß, Julia Sauer & Hans-Ludwig Kröber, 'Entlassene Problemfälle in der ambulanten Nachsorge von langzeitinhaftierten und langzeituntergebrachten Patienten', 5 *Forensische Psychiatrie, Psychologie, Kriminologie* 4 (2011), p. 259; Tatjana Voß, Julia Sauter & Hans-Ludwig Kröber, 'Ambulante Betreuung von aufgrund des BVerfG-Urteils entlassenen Sicherungsverwahrten', in: Jürgen L. Müller, Norbert Nedopil, Nahlah Saimeh, Elmar Habermeyer & Peter Falkai (eds), *Sicherungsverwahrung – wissenschaftliche Basis und Positionsbestimmung. Was folgt nach dem Urteil des Bundesverfassungsgerichts vom 04.05.2011?*, Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft, 2012, p. 151.

145 Tatjana Voß, Julia Sauer & Hans-Ludwig Kröber, 'Entlassene Problemfälle in der ambulanten Nachsorge von langzeitinhaftierten und langzeituntergebrachten Patienten', 5 *Forensische Psychiatrie, Psychologie, Kriminologie* 4 (2011), p. 259.

146 Tatjana Voß, Julia Sauter & Hans-Ludwig Kröber, 'Ambulante Betreuung von aufgrund des BVerfG-Urteils entlassenen Sicherungsverwahrten', in: Jürgen L. Müller, Norbert Nedopil, Nahlah Saimeh, Elmar Habermeyer & Peter Falkai (eds), *Sicherungsverwahrung – wissenschaftliche Basis und Positionsbestimmung. Was folgt nach dem Urteil des Bundesverfassungsgerichts vom 04.05.2011?*, Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft, 2012, p. 161; Rita Haverkamp, 'Übergangs- und Risikomanagement bei entlassenen Sicherungsverwahrten', in: Johann Kaspar (ed), *Sicherungsverwahrung 2.0? Bestandsaufnahme – Reformbedarf – Forschungsperspektiven*, Baden-Baden: Nomos, 2017.

147 See the book on the case by Mollath's defence lawyer Gerhard Strate, *Der Fall Mollath. Vom Versagen der Justiz und Psychiatrie*, Zürich: orell füssli Verlag, 2014, p. 268; concerning the court's judgment.

148 Abstract of the German Federal Constitutional Court's order of 26 August 2013, 2 BvR 371/12, [GER-2013-2-020] (at: www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/EN/2013/08/rk20130826_2bvr037112en.html) (last visited: 28 May 2017).

requirements for orders of transfer to a forensic psychiatric hospital (see also Section 4).[149] In order to avoid disproportionate confinement, orders are restricted to serious cases of mentally disturbed offenders (sec. 63 StGB), are limited in cases of less severe danger by specifying the requirements for confinement longer than six and ten years (sec. 67d(6) StGB); furthermore, procedural safeguards have been expanded (sec. 463(4),(6) StPO). The reasons for this reform are a continuous increase in the number of patients in forensic psychiatric hospitals as well as a remarkable rise in the lengths of confinements.[150]

Despite progress, the quality of psychiatric expertise remains an essential issue with respect to the assessment of a mental illness. Although the certificate of forensic psychiatry issued by the German Society for Psychiatry, Psychotherapy and Mental Health[151] has contributed to improving the formal accuracy of expertise, complaints about professional deficiencies have increased.[152] Therefore, there is still an ongoing need to improve quality, raising the question of how the crucial internal quality can be ensured.[153] Once again, the Mollath case has raised concerns regarding the reliability of forensic psychiatric prognosis even by recognized experts.[154] Suggestions for improving quality include the gathering of feedback in order to monitor quality and intervision.[155] Measures for quality assurance include reacting to strikingly inadequate expertise, establishing a contact point for judges and other clients that assesses the quality of doubtful expertise and stabilizing further training.[156]

According to mentally disturbed detainees and prisoners, different shortcomings can be identified. Common problems relate to understaffing, especially a shortage of psychologists, underfunding and drug trafficking. While the German two-track system allows for the treatment of mentally disturbed offenders whose crime is a result of their

149 Deutscher Bundestag (2016), Gesetzentwurf der Bundesregierung. Entwurf eines Gesetzes zur Novellierung des Rechts der Unterbringung in einem psychiatrischen Krankenhaus gemäß § 63 des Strafgesetzbuches und zur Änderung anderer Vorschriften, pp. 1-2 (at: http://dipbt.bundestag.de) (last visited: 28 May 2017).

150 Deutscher Bundestag (2016), Gesetzentwurf der Bundesregierung. Entwurf eines Gesetzes zur Novellierung des Rechts der Unterbringung in einem psychiatrischen Krankenhaus gemäß § 63 des Strafgesetzbuches und zur Änderung anderer Vorschriften, p. 1 (at: http://dipbt.bundestag.de) (last visited: 28 May 2017).

151 In German: Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde (DGPPN).

152 Jürgen L. Müller & Nahlah Saimeh, 'Das DGPPN-Zertifikat Forensische Psychiatrie. Entwicklung, gegenwärtige Situation, Perspektive', 6 *Forensische Psychiatrie, Psychologie, Kriminologie* 4 (2011), p. 270.

153 *Ibid.*

154 Marie E. Fick, 'Die Rolle der Ärzte im Fall Gustl Mollath', p. 102 *et seq.* and Arnold Torhorst, 'Der Fall Mollath und das Zusammenspiel von Psychiatrie und Justiz', p. 120 *et seq.*, both in: Sascha Pommrenke & Marcus B. Klöckner (eds), *Staatsversagen auf höchster Ebene. Was sich nach dem Fall Mollath ändern muss*, Frankfurt am Main: Westend 2013; Gerhard Strate, *Der Fall Mollath, Vom Versagen der Justiz und Psychiatrie*, Zürich: orell füssli Verlag, 2014, p. 151 *et seq.*; also critical Thomas Galli, *Die Gefährlichkeit des Täters*, Berlin: Verlag Das Neue Berlin, 2017.

155 Jürgen L. Müller & Nahlah Saimeh, 'Das DGPPN-Zertifikat Forensische Psychiatrie. Entwicklung, gegenwärtige Situation, Perspektive', 6 *Forensische Psychiatrie, Psychologie, Kriminologie* 4 (2011), pp. 270-271.

156 *Ibid.*, p. 271.

disorder in forensic psychiatric hospitals, other convicts with psychiatric disturbances are incarcerated in prison. Only the most serious cases are accommodated in specific prison hospitals or in special units, whereas many mentally disordered offenders find themselves in usual prisons, though the last-mentioned practice is not in accordance with Rule 109 of the Nelson Mandela Rules. In prisons (e.g., social therapy) and in forensic psychiatric hospitals a variety of treatment programmes and measures are offered to prisoners and patients with psychiatric disturbances. Transition management has recently gained more and more importance in criminal justice and prison policy: release measures should be taken into account as early as possible and attention is also paid to aftercare. Evidence-based treatment has increasingly become a focus in practice; however, more emphasis could be placed upon evaluating the programmes and measures applied as well as upon implementing proven methods and approaches. In this respect, stronger exchange between representatives of prisons and forensic psychiatric hospitals would help to increase the quality of care and treatment for mentally disturbed offenders.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system in Greece

Calliope Spinellis & Athanassios Douzenis[*]

1 Introductory remarks

In Greece as in most Western countries, individuals accused of a crime who are suffering – or claim they are suffering – from a mental illness are dealt with in a special way. The questions to be answered in such cases concern the defendants' fitness to be questioned, to plead and to stand trial as well as whether the perpetrator of the established act(s) was criminally responsible.

In 2017, Greece was in a transitional period from quasi-bankruptcy to the dawn of growth. Strangely enough, the provisions of the Greek Penal Code (GPC) referring to the defendants and detainees with psychiatric disturbances[1] are also in a transitional stage. The GPC, an enactment of almost 70 years ago,[2] is in the process of being harmonized in accordance with the recommendations of: (i) the Council of Europe Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), (ii) the Committee of the United Nations Convention against Torture (UNCAT) and (iii) the new psychiatric terminology (*DSM-5*). A Draft Law amending the relevant legislation will soon be presented to the Greek Parliament for adoption.

The initial remarks that follow will cover three levels of approach: the law in the books of the year 1950 (Section 1.1), the 1950 law in action (Section 1.2) and the main provisions

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1 In this chapter the terms 'psychiatric disturbances', 'mental health problems', 'mental disturbance', 'mental disability', 'mental disorders', etc. are used interchangeably.

2 With respect to the historical and theoretical foundations of the Greek Penal Code, see Emmanouil Billis, 'Introduction to the basic characteristics and fundamental principles of the criminal law and Penal Code of Greece', in: E. Billis (ed), *The Greek Penal Code. English translation by Vasiliki Chalkiadaki and Emmanouil Billis. Introduction by Emmanouil Billis*, Berlin: Duncker & Humblot, 2017, pp. 1-62.

of the Draft Law (Section 1.3). Next this chapter addresses the following subjects: defendants with psychiatric disturbances during pre-trial inquiry and at trial (Section 2), detainees with psychiatric disturbances in provisional detention (Section 3), prisoners with psychiatric disturbances in prison (Section 4), whether treatment of prisoners with psychiatric disturbances is a Health or Justice responsibility (Section 5) and the community reintegration of prisoners with psychiatric disturbances (Section 6).

1.1 The law in the books of the year 1950

The terminology used in the GPC of 1950[3] referring to offenders with psychiatric disturbances are obsolete and complicated. A few clarifications are pertinent. The GPC in force provides for two basic categories of offenders with mental health problems:

a) those who are considered *non-imputable/unaccountable*,[4] e.g. deaf mute persons under certain circumstances (Art. 33 GPC),[5] generally, persons with a disturbance of mental functions or consciousness (Art. 34 GPC);
b) those with *diminished capacity for imputability/accountability* (Art. 36 GPC).

In Article 34 GPC the disturbance of mental functions or consciousness is defined:

> The act shall not be imputed to the perpetrator if, at the time of acting, due to a morbid disturbance of the mental functions or due to a disturbance of consciousness, he did not have the ability to understand the wrongfulness of his act or to act in accordance with his perception of this wrongfulness.[6]

The term 'imputable /accountable' is crucial. It is an element of the criminal act, as defined in Article 14 § 1 GPC: "a criminal offence is a wrongful act that is imputable to the perpetrator and punishable by law". Additional terms used in the aforementioned penal provisions request specification. A 'morbid disturbance of the mental functions' exists in

3 *Ibid.*

4 In the Swedish criminal justice system the term 'unaccountable' is used, see: Christer Syennerlind, Thomas Nilsson, Nora Kerekes *et al.*, 'Mentally disordered criminal offenders in the Swedish criminal justice', 33 *International Journal of Law and Psychiatry* 4 (2010), pp. 220-226.

5 In Art. 33 GPC it is stated: "1. Any act committed by a deaf-mute person shall not be imputed to him, if it can be established that he did not have the required mentality to understand the wrongfulness of his act or to act in accordance with his perception of this wrongfulness. 2. If the previous paragraph does not apply, the deaf-mute person shall be subject to a mitigated punishment." (Art. 83)

6 Throughout this chapter the very recent English translation of the Greek Penal Code published in the series (band G 124) of the Max-Planck-Institut fuer auslaendishes und internationales Strafrecht is used: Emmanouil Billis (ed), Vasiliki Chalkiadaki & Emmanouil Billis (trans.), *The Greek Penal Code. Introduction by Emmanouil Billis*, Berlin: Duncker & Humblot, 2017.

case of all forms of 'lunacy' or 'insanity' (e.g. psychiatric disorder) or mental retardation, while in the 'disturbance of consciousness' belong all psychological disturbances that are not directly linked to pathological states of the brain and are temporary (e.g. intoxication, drug abuse, panic, psychosis due to alcoholism, traumatic brain injury, arteriosclerosis, brain tumours, psychosis due to somatic causes). These disturbances should be present at the time the act took place.[7]On the other hand, diminished capacity for imputability/accountability exists:

> If, due to a mental condition of these mentioned in article 34, the capacity for imputability required by this article has been significantly reduced, yet not entirely abolished, a mitigated punishment shall be imposed (Art. 83).[8]

Finally, in Article 69 entitled 'Custody of non-imputable offenders' (or offenders not guilty by reasons of insanity – NGRIs) it is stated that:

> If a person, due to a morbid disturbance of his mental functions (art. 34) or due to deaf-muteness (art. 33 § 1) has been exempted from punishment or prosecution for a felony or misdemeanor for which the law imposes a punishment exceeding six months, the court shall order his custody in a public therapeutic facility, provided that the court is of the opinion that the offender presents danger to public safety.

1.2 The 1950 law in action

It should be noted at the outset that as of October 2010 the Forensic Psychiatric Unit of the Second Psychiatry Department of the National and Kapodistrian University of Athens Medical School (hereinafter the Forensic Psychiatry Unit, University of Athens) is providing clinical input at the Korydallos Prison Psychiatric Unit. Initially, a protocol was signed by the aforementioned Psychiatry Department and the Ministry of Justice, Transparency and Human Rights (hereinafter the Ministry of Justice) formalizing this cooperation which, at a later stage, included the Ministry of Health as well. A Presidential Decree is to be implemented regulating the transfer of care of the Korydallos Psychiatric Unit patients

7 M. Anagnostaki & C. Papakonstantinou, 'The detainment of criminally unaccountable offenders in public psychiatric hospitals', in: T. Vidalis (ed), *The Age of Autonomy. A Guide to Rights in Mental Health*, Athens: Society of Social Psychiatry & Mental Health, Hellenic League for Human Rights, Institute of Mental Health for Children and Adults, 2016, pp. 65-76 and esp. p. 70 quoting case law (in Greek).

8 Emmanouil Billis (ed), *The Greek Penal Code. Introduction by Emmanouil Billis*, Berlin: Duncker & Humblot, 2017, p. 73.

from the Ministry of Justice to the Ministry of Health and the Forensic Psychiatry Unit of the University of Athens. Thus, this Unit is now included in the organizational structure of 'Attikon' Hospital of the University of Athens.

On 1 May 2017 in the Korydallos Psychiatric Unit – the main establishment in the area of Attica, within the Greek prison system designed to hold mentally ill prisoners[9] – there were 233 detainees with psychiatric disturbances in a prison population of 9,573 individuals (see Table 1). An additional number of around 150 offenders with severe psychiatric disturbances (Art. 69 GPC) are in public psychiatric facilities.[10] In the special institution of Eleona are drug addicts who have committed drug-related offences, and in the prison of Tripoli are kept some sexual offenders with psychiatric disturbances (see Table 1). One should also bear in mind that sexual offenders with or without mental disabilities serving sentences are kept in separate prison settings because they are at risk from attacks by other prisoners.

Considering that in the Korydallos Psychiatric Unit the prison's conditions appear unchanged, a somewhat outdated report describing the profile of the detainees in this Unit prepared by the Special Control Committee for the Protection of the Rights of Persons with Psychiatric Disturbances[11] seems to sketch a reliable picture of the law in action. On 31 January 2012, 295 male detainees and 4 women were kept in this Unit. Allegations regarding sexual harassment of female prisoners with psychiatric disorders and lack of space resulted in their transfer to Eleona (see Table 1). Ninety-five detainees were awaiting trial and the remaining were serving sentences of imprisonment. Seventy-eight inmates were serving sentences 15 years and above, and 105 inmates in this facility had more than 12 months and 151 had more than 6 months to serve. Ninety-one detainees out of the 299 were non-Greek nationals. Nearly half of the detainees were in the Psychiatric Unit because of drug addiction or psychosis.[12] Others were transferred from various prisons because they presented mental health problems or needed evaluation and treatment, or because

9 CPT/Inf(94) 20, para. 277.

10 For instance, in 2011, there were 148 offenders in various psychiatric facilities. From those, 3 were in Dromokaiteio, 15 in Dafni, 56 in psychiatric facility of Thessaloniki and the remaining 74 in other psychiatric hospitals. 'Evaluation during the ongoing enforcement of the National Plan of Action "Psychargos" from 2011 to 2015', p. 199. With respect to Thessaloniki, we are informed that in the main prison of Diavata there is no non-accountable prisoner. Every year, however, some 15 detainees with mental health problems from the prison of Diavata are transferred to Korydallos Psychiatric Unit. On the other hand, 50 defendants or convicted persons (43 males and 7 females) are detained in the public psychiatric facility [hospital] of Thessaloniki (personal communication with professor A. Pitsela and with the Hospital).

11 This Committee is functioning under the auspices of the Ministry of Health and is established by virtue of Art. 2 of Law 2716/1999 (at: www.moh.gov.gr/articles/health/domes-kaidraseis-gia-thn-ygeia/1398eidikh-epitroph-elegxoy-prostasias-twn-dikaiwmatwn-twn-atomwn-me-psychikes-diataraches) (last visited: 21 July 2017) (in Greek). More on said Committee in: V. Karydis & E. Fytrakis (eds), *Penal Custody and Rights, The perspective of the Synigoros tou Politi* [Ombudsman], and especially, the chapter on a mentally ill prisoner filing a complaint with the Greek Ombudsman, Nomiki: Vivliothiki, 2011, pp. 16-21 (in Greek).

12 According to relevant inside information this might not be a reliable diagnosis.

they were serving a mitigated sentence due to diminished capacity for accountability (Art. 36 GPC) but were in need of special care (Art. 37 GPC) or were dangerous to public safety (Art. 38 GPC) or were habitual/professional offenders (Art. 41 GPC). At the time of the visits, approximately 100 detainees were working in the kitchen, in the cleaning service, etc. and their work was rewarded with reduced days of imprisonment according to Greek law.

According to this Report no full-time psychiatrists were working at the Unit, while, in general, this Unit was (and still is) functioning with inadequate number of medical doctors and health-care personnel. The Committee recommended to the relevant Ministry (a) to give priority, inter alia, to therapy rather than to imprisonment; (b) to improve the so-called intense care cells, *alias* isolation cells, and the life conditions of persons in them; and (c) to provide for a female section and female guards.[13] A reliable study in a random sample of 495 male prisoners found that 40.06% of them were diagnosed with mental disorders.[14] In both establishments there was overcrowding,[15] under-staffing and lack of therapeutic programmes. With respect to therapy both the Special Control Committee of 2012 and the CPT (1993[16] and 2001 visits especially to the Psychiatric Unit) made relevant recommendations to the Greek Government. The CPT emphasized the need to "develop the psychiatric prison facility of Korydallos into a fully resourced psychiatric hospital".[17] Further, CPT stated that "the suicide prevention policy of stripping patients and leaving them naked in an isolation cell is not necessary".

One should underline that persons who are found not guilty by reason of insanity (NGRI) are facing a double stigmatization from both the justice and the health systems. Initially, they are met with fear and later with indifference, since no therapy is offered but only surveillance. They are also facing a unique judicial and psychiatric situation.[18] They are in a disadvantaged position, compared to either convicted criminals or psychiatric patients. Offenders who are not found NGRI are punished with a prison sentence for a specific period of time. They have the right to appeal and possibly see their sentence reduced and even be granted early release. In contrast, individuals found to be NGRI are hospitalized for an indefinite period of time. In fact, they will not be allowed to leave the psychiatric

13 Report of the Special Control Committee for the Protection of the Rights of Persons with Psychiatric disturbances, pp. 3-7 (in Greek). See also above footnote 10.

14 Giorgos Alevizopoulos & Artemis Igoumenou, 'Psychiatric disorders and criminal history in male prisoners in Greece', 47 *International Journal of Law and Psychiatry* (2016), pp. 171-175.

15 The official capacity of the Korydallos Prison is 800. On 1 May 2017 there were 1,585 prisoners. The capacity of the Korydallos Psychiatric Unit is 160. On 1 May 2017 there were 233 prisoners. Data provided by the Ministry of Justice, Transparency and Human Rights.

16 In 1993 CPT visited for the first time the Psychiatric Unit of Korydallos. A second visit took place in 1997, and in 1999 and 2001 more visits followed up the situation. The last visit to this establishment was in 2005.

17 CPT/Inf (94) 20, para. 175, see also CPT/Inf (2002) 31.

18 Citizen's advocate. Guarding not guilty by reasons of insanity patients in Psychiatric Hospitals, March 2005.

unit until assessed by a judge with no psychiatric knowledge who decides that they have ceased to be dangerous. These problems are aggravated by the dysfunctions of the Greek justice system.

1.3 The new law: main points

The Draft Law entitled *Therapeutic measures for persons who are not punished due to psychological or mental disturbance* will soon be enacted.[19] With it a number of provisions of the GPC[20] and the Greek Code of Penal Procedure (GCPP) will be amended.[21] The intention of the legislator is to ensure the harmonization of the provisions regulating mentally ill offenders with the contemporary developments in psychiatry, emphasizing the human rights perspective in order to effectively address the needs of these offenders. The notion of dangerousness, the practice of indefinite incarceration and the focus on public safety will be replaced by pertinent therapeutic measures and social reintegration. It is worth mentioning certain salient points of this draft legislation:

- Adoption of non-stigmatizing terminology.
- Provision for a special Prosecutor and other independent bodies which will guarantee the human rights of detainees with psychiatric disorders.
- Recognition of the right to appeal, to have an appointed counsel in many instances and to take leave of absence or to live in supervised apartments. Measures of security can be imposed by a Court only, under certain conditions, depending on the crime committed.
- Provision for two expert opinions to assess the mental health of the person involved in the criminal justice system: one at the time of arrest and a second as close as possible to the day of the court hearing.
- Adoption of pertinent therapeutic measures and other non-custodial measures instead of 'deprivation of liberty in public therapeutic facilities'.
- Abolition of detention for an indefinite period.
- Yearly re-evaluation of each case.
- Emphasis is placed upon: therapeutic measures, improvement of mental health, psychosocial rehabilitation and social reintegration of the NGRI offenders.

19 See the Draft Law (in Greek) in: www.opengov.gr/ministryofjustice/? P=8246 (last visited: 21 July 2017). At the time this piece went to the publisher this draft law has entered into force (law 4509/2017 of 22 December 2017).

20 The changes refer to Arts. 69 and 70 GPC. Moreover, a new Art. 70A and 11 new articles on the rules which will govern the execution of the therapeutic measures are added. Finally, Arts. 38-41 GPC are repealed.

21 The changes refer to Art. 282 § 2 GCPP, Art. 313 GCPP where a new subparagraph is added, Art. 315 GCPP where a new paragraph 5 is added, a new Art. 486A GCPP which is added, Art. 500 GCPP where a new subparagraph is added and Art. 555 GCPP which is amended.

– Supervision and evaluation of the psychiatric facilities by officials of the Ministries of Health, Justice and Education.

At the time of writing this contribution it is expected that a Presidential Decree will be issued. This Decree will establish a partnership between the Ministry of Justice under whose jurisdiction is the Korydallos Psychiatric Unit and the Ministry of Health which will be providing medical-psychiatric care. Last but not least, training of the correctional personnel in mental health issues is under way as well as a pilot programme providing telepsychiatry[22] services in three prisons.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

The European Convention on Human Rights (Art. 6), the Greek Constitution (Arts. 6 and 7) and the GCPP (Arts. 96-108A GCPP) – among other biding international and national documents – provide guarantees for *all* defendants involved in criminal proceedings. Thus, a criminal case referring to psychiatrically disturbed offenders follows a number of stages in order to reach a fair trial.

The police and the prosecution are informed that a crime has been committed. In case the suspect has mental health problems he/she may be examined by a psychiatrist at any stage of the proceedings. This examination, which will establish whether or to what extent these problems affected the behaviour of the suspect, is either ordered by the officials of the criminal justice system or takes place upon the petition of the counsel for the defence. In rare cases some persons with psychiatric disturbances have already a 'judicial supporter'[23] who will take the necessary steps in order to safeguard their rights during the proceedings.[24]

22 American Psychiatric Association, *What Is Telepsychiatry?*, January 2017 (at: www.psychiatry.org/patients-families/what-is-telepsychiatry) (last visited: 23 July 2017).

23 A 'judicial supporter' is the person who, according to the Greek Civil Code (Arts. 1666 *et seq*.) supports individuals with low IQ, physical disability, mental health problems, alcoholism or toxicomania, who are unable to care of themselves, of their property and/or their interests, who might harm themselves or others and who are assisted in various instances of their life, including when involved in a crime. The 'judicial supporter' is appointed by the court upon a petition of the subject in need of support or of his/her parents or the public prosecutor. In a report drafted by a social worker the need for judicial support and the appropriateness of the person who will assist temporarily or permanently the person in need of such support are evaluated.

24 See Jannis Alexakis , *The institution of judicial support* (at: www.mentalheath-law.blogspot.gr) (in Greek) (Last visited: 29 July 2017). J. Alexakis is attorney-at-law specializing in the rights of mentally ill.

The police might conduct a pre-investigation (Art. 33 § 1 GCPP). According to a detailed Hellenic Police Circular[25] the traditional rights of *all* persons[26] who are apprehended or are detained by police are spelled out. Namely, police officers should: (i) inform the detained persons in writing and orally about the reasons and the place where they are detained and about their rights as well. This information should be given in a language they understand and they may have an interpreter, etc., (ii) allow the detainees to communicate with a lawyer personally or via telephone and the non-Greek nationals with diplomatic services, international bodies and NGOs protecting human rights, (iii) see that the detainees receive medical care by a doctor of their choice or be transferred to a therapeutic facility and (iv) inform detainees about all the rights to which they are entitled during the period of detention in accordance with paragraph 3(b) of the aforementioned Police Circular. Despite the existence of this Circular the CPT stated "that formal safeguards against ill-treatment (notably, the right to have the fact of one's detention notified to a relative or another third party and the rights of have access to a lawyer and a doctor) do not apply from the very outset and generally, remain ineffective in practice. Furthermore, persons deprived of their liberty were not always informed of their rights". In summary, the situation has not changed since the CPT's 2009, 2011[27] or 2013 visits.[28] In a later report of CPT it is stressed that "formal safeguards against ill-treatment...do not for the most part apply in practice" and that "in spite of the fact that the presence of a lawyer is established in most stages of the criminal and administrative proceedings … criminal suspects [seem not to enjoy this right] … at the initial period of incarceration and particularly prior to or during questioning by police officers i.e. when the risk of intimidation and physical ill-treatment is greatest. This is mainly due to the fact that legal aid is not available at the stage of police investigation or when criminal suspects are questioned by the police".[29] There are no indications that suspects with psychiatric disturbances are treated differently during the following process:

- The **police** sends the case to the Prosecutor.
- The **Prosecutor** examines the case, and he/she may have the defendant assessed by a **psychiatrist** in order to have an expert opinion, if no psychiatric examination took place at the police level. In general, defendants at any stage of the proceedings – from the pre-trial inquiry to the main trial – may have an *ex officio* expert psychiatrist who will be invited to answer questions referring to: (i) the accountability of the defendant, (ii) the existence of mental health problems when committing the offence, (iii) the

25 Circular 4803/22/44 Rights of persons detained by Police authorities (at: http://eaynh.gr/index.php/blog/item/247-nomothesia-4) (Last visited 21 July 2017).

26 There are no indications that suspected criminals with mental health problems do not enjoy these rights.

27 CPT/Inf (2014) 26, p. 19, para. 26 (at: https://rm.coe.int/1680696620) (Last visited: 18 November 2020).

28 *Ibid*.

29 CPT/Inf (2016) 4, p. 40, para. 47.

relationship between the psychiatric disturbance and the offence committed and (iv) the degree to which the mental health problems influenced the defendant's actions. Defendants at the inquiry stage have the right to have their own psychiatrist (**technical expert** according to Art. 204 GCPP) which is paid by them. Furthermore, the officer responsible for the interrogation may order the admission of the defendant to a state psychiatric unit for **observation** in order to have a**n expert opinion** regarding the mental health of the defendant (Art. 200 § 1 GCPP). Hospitalization, however, requires the consent of the Prosecutor and that of the expert psychiatrists and is effectuated after hearing the counsel for the defence or the *ex officio* counsel. In any case, the defendant may remain for observation in this facility for no more than six months (Art. 200 § 3).[30] The Prosecutor then has three options: (i) to place the case in the archives, (ii) to proceed with the prosecution or (iii) to transfer the case directly to Court. If the defendant is unaccountable (Art. 33, 34 and 69 GPC, see Section 1.1) he/she either is exempted from punishment or is committed to a public therapeutic facility. If, on the other hand, the defendant is of diminished capacity (Art. 36 GPC) the case is transferred either to the Judicial Council or to the Court directly.

- If the case is transferred to the **Judicial Council**, the Council decides either to acquit or to send the case to the Court for a hearing. A possibility of an appeal to an Appellate Judicial Council also exists.[31]
- If a **Criminal Court** hearing follows, and during the trial the need for **psychiatric assessment** arises, the Court orders the referral for assessment in a psychiatric facility (Art. 80 § 2 GCPP). Another provision ensures a fair treatment of the defendant who cannot adequately participate in the proceedings due to the disturbance of his/her mental functions (Art. 80 GCPP). The court either acquits the defendant because he/she is found unaccountable or it orders the suspension of the hearing. If the defendant is detained in prison on provisional detention, the court orders the referral to a public psychiatric facility (Art. 80 GCPP).
- Subsequently an appeal can be placed to an Appellate Court and, following this, another appeal to the Supreme Court (Areios Pagos). Lastly, the convicted person with psychiatric disturbances may, as any other citizen, lodge an appeal to the European Court of Human Rights in Strasbourg. However, a study on the cases against Greece which stemmed from petitions of persons with disabilities (e.g. HIV positive, cancer patients, etc.) did not include any offenders with psychiatric disturbances.[32]

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30 For a detailed discussion of the provisions on psychiatric expert opinion of Art. 200 GCPP see Nik. K. Androulakis, *Fundamental Concepts of the Penal trial*, 2nd edition, Athens/Komotini: Ant.N.Sakkoulas, 1994, pp. 256-258 (in Greek).

31 C.D. Spinellis, *Criminology*, Athens/Komotini: Ant.N.Sakkoulas, 1985, p. 33 (in Greek).

32 See, E. Tsounakou-Roussia, 'The Greek prisons as an area of violation of Article 3 ECHR', in: *Theartofcrime.gr*/May-2017/ (In Greek) (at: https://theartofcrime.gr).

3 Detainees with psychiatric disturbances in provisional detention: needs, problems, screening tools

The Council of Europe repeatedly recommended that provisional detention should be the *ultimum refugium*.[33] In accordance with this recommendation, provisional detention is the exception and not the rule in Greece. In Article 282 § 3 CPP, which *is not specifically covering mentally disturbed persons*, it is mentioned that only under certain specific conditions provisional detention may be imposed instead of alternative, non-custodial measures. If, under such conditions, a suspected offender who suffers from psychiatric disturbances is arrested and held in police custody or if a defendant is in provisional detention, the Greek legislation provides for the transferring of this person to a public, if possible, psychiatric facility in order to protect: (a) his health and well-being and (b) the health of others who are near him/her (Art. 80 § 3 GCPP). A discrepancy between law in theory and law in action is noticed in this area. Detainees possibly suffering from psychiatric disturbances, during provisional detention, do not undergo a screening for diagnostic purposes and their needs for care and treatment are not usually met. The proposed Greek legislation, inter alia, requires a diagnosis of the state of mental health of the accused at the time of arrest and provides for defendants with psychiatric disturbances a series of alternative measures to provisional detention (see Section 1.3).

Recent recommendations of the CPT are lacking. In the visit of 2015[34] the delegation repeated that the ill-treatment of criminal suspects detained by police has been a long-standing concern of the CPT since its first visit to Greece in 1993. Nevertheless, this is a general statement which makes *no reference to detainees with mental health problems*. The CPT also acknowledged that the rights of notification of custody and of access to a lawyer and to a doctor remain ineffective in practice despite the existence of clear rules.[35] (See Section 2 the Police Circular.)

The handling of detainees with psychiatric problems who are in provisional detention raises a number of ethical and legal issues. Yet, in Greek prisons or in other facilities, usually these individuals are not treated according to their needs. They are treated like all convicted inmates, often sharing the same cells. The lack of a full psychiatric assessment for prisoners who do not ask for psychiatric help is a worldwide phenomenon. For this purpose, general screening tools have been developed but they are never used on a regular basis. Tools like the Brief Jail Mental Health Screen (BJMHS) or Correctional Mental

33 See also Recommendation Rec(2006)13 of the Committee of Ministers to member states on the use of remand in custody, the conditions in which it takes place and the provision of safeguards against abuse.

34 CPT/Inf(2016) 4 part (at: www.coe.int/da/web/cpt/greece?desktop=true) (last visited: 21 July 2017).

35 CPT/Inf(216) 4, p. 14.

Health Screen for Men and Women (CMHS-M and CMHS-W) have not been standardized for Greek prisoners and have been used only for research projects.

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

For the purposes of this section, the term 'prisoners with psychiatric disturbances' refers to six categories of prisoners. Persons:

i) with diminished capacity for accountability who are punished with a mitigated sentence (Art. 36 GPC), and therefore they end up in prison;
ii) with diminished capacity for accountability who need special care and are committed either to a special psychiatric facility or to a prison section (Art. 37 GPC). In Greece there is no such special facility. The Korydallos (Prison) Psychiatric Unit is used for that purpose (see Section 1.2);
iii) with diminished capacity for accountability (Art. 36 GPC) who are deaf mute – and are not considered unaccountable – (Art. 33 § 2 GPC) and have committed serious crimes and are also dangerous to public safety (Art. 38 GPC) who have been convicted to deprivation of liberty either in a psychiatric facility or in a prison section (Art. 38 § 1 GPC), i.e. in the Korydallos Psychiatric Unit;
iv) for whom the confinement in a psychiatric facility was converted to imprisonment or incarceration[36] (Art. 40 GPC);
v) habitual or professional offenders with diminished capacity whose confinement in a psychiatric facility was converted to incarceration for an indefinite period (Art. 41 GPC);
vi) individuals who present psychiatric problems that either were not detected before or were caused by the system itself.

A recent study which aimed at the exploration of the psychiatric disorders and the criminal behaviour of male prisoners in Greece[37] revealed that nearly half (45.06%) of the 495 randomly selected prisoners of the Korydallos Prison who were interviewed[38] were diagnosed with some form of a psychiatric disorder. Despite methodological shortcomings of this study, data suggests that the prevalence of psychiatric disorders in male prisoners

36 Incarceration is executed in prisons.

37 Giorgos Alevizopoulos & Artemis Igoumenou, 'Psychiatric disorders and criminal history in male prisoners in Greece', 47 *International Journal of Law and Psychiatry* (2016), pp. 171-175.

38 The Iowa Structured Psychiatric Interview (ISPI) and the Personality Disorders Questionnaire (PDQ-4) were administered in: Giorgos Alevizopoulos & Artemis Igoumenou, 'Psychiatric disorders and criminal history in male prisoners in Greece', 47 *International Journal of Law and Psychiatry* (2016), pp. 171-175.

was higher than in the general population. This holds true for both other Greek and international studies.[39] Personality disorder and substance misuse were the most common types of mental disorder among prisoners (79 prisoners or 15.96% and 72 or 14.54% respectively). Other psychiatric disorders were also diagnosed: depression (22 prisoners or 4.44%), anxiety disorder (18 or 3.64%), schizophrenia-like psychosis (13 or 2.63%), organic mental disorder (7 or 1.41%), mania (5 or 1.01%) and dual diagnosis: substance misuse and major psychiatric disorder (7 or 1.41%).[40] The criminal history of the prisoners interviewed revealed that 40.7% were involved in non-violent offences, 30.3% in drug-related offences and less than one-third of them (28.0%) with violent offences.[41] Violent offences were related to personality disorder. The absence of sex offences among the crimes mentioned above is due to the fact that sex offenders are usually transferred to the prison of Tripolis (total of 89 inmates on 1 May 2017).[42] Prisoners belonging to the categories 1-4 above are kept in the Korydallos Psychiatric Unit. In Table 1, the Greek prison structure and the identification of certain special needs of the prisoners with psychiatric disturbances are elucidated. With a population of 10,816,286 (5,303,223 males and 5,513,063 females) and a prison population of 9,573, in Greece around 3% of the prison population is in the Korydallos Psychiatric Unit due to mental health problems.[43]

Female inmate population is growing in greater speed than the male population. In Greece as of 2012 the national media showed the faces and personal details of 27 female street sex workers that were found to be HIV positive. The Hellenic Centre of Disease Control and Prevention (HCDCP), in the framework of an intervention for epidemic surveillance in a prostitution house in Athens, has detected HIV-positive sex workers. Thus, the HCDCP announced the results of their investigation in order to 'inform and protect people'. The circle of stigmatization that emerged through the stories of these women is not an isolated social phenomenon related only to prostitution and drug use or mental illness, but it may be nurtured by societies which suffer from profound financial and humanistic crisis.[44] In the past the vast majority of female prisoners served their

39 M. Fotiadou *et al*., 'Prevalence of mental disorders and deliberate self-harm in Greek male prisoners', 29 *International Journal of Law and Psychiatry* 1 (2005), pp. 68-73; Seena Fazel & Katharina Seewald, 'Severe mental illness in 33 588 prisoners worldwide: Systematic review and meta-regression analysis', 200 *British Journal of Psychiatry* 5 (2012), pp. 364-373.

40 Giorgos Alevizopoulos & Artemis Igoumenou, 'Psychiatric disorders and criminal history in male prisoners in Greece', 47 *International Journal of Law and Psychiatry* (2016), pp. 171-175.

41 *Ibid*.

42 According to data of the Ministry of Justice, Transparency and Human Rights.

43 The 3% stems from the fact that: (a) in the main Psychiatric Unit of Korydallos 233 individuals or 2.4% of the Korydallos prison population were detained on 1 May 2017 (see Table 1) and (b) some additional 50 prisoners from other prisons eventually will end up in the main and largest prison of Korydallos.

44 G. Kalemi, S. Gkioka, P. Tsapatsari, G. Tzeferakos, T. Kandri, M.L. Psarra, F. Konstantopoulou & A. Douzenis, 'Stigma and self-esteem: a case of HIV positive sex workers', 28 *Psychiatriki* 1 (2017), pp. 67-74.

sentence in Korydallos Women's prison but currently most of them reside in Eleona female prison. It is striking that there are no mental health services for imprisoned women except rare visits from a psychiatrist. If a female prisoner suffers from a psychiatric disorder that requires psychiatric admission, the prison cannot accommodate this need. These women are sent (under guard) to the nearest on-call psychiatric unit where they are treated for a very brief period of time as the presence of such a patient (escorted by policemen on duty) is disrupting for the whole unit. In this respect, one can argue that a mentally ill female prisoner is not suffering 'double' but 'triple' stigmatization as mentally ill, as a criminal and as woman not being offered treatment because of their sex. This undoubtedly embarrassing state for Greece will hopefully stop with the expected Presidential Decree that will transfer the care of mentally ill prisoners to the health system and the Forensic Psychiatry Department of the Second Department of Psychiatry of the National and Kapodistrian University of Athens (see Section 1.3).

Table 1 Prisons in Greece[45]

Kind of Prison	Prisons	Capacity	Prisoners (1 May 2017)
Therapeutic facilities	'Eleona' (for drug addicts)	96	64
SAME	Korydallos Hospital	253	169
SAME	Korydallos Psychiatric Unit	200	233
Prisons type A'*	Amfissa	102	129
SAME	Thessaloniki	358	521
SAME	Ioannina	66	213
SAME	Komotini	162	213
SAME	Korinthos	46	14
SAME	Korinthos [military]	-	1
SAME	Korydallos (prison for males)	1,222	1,585
SAME	Korydallos [females]	174	136
SAME	Ko	56	95
SAME	Larissa	554	623
SAME	Nafplio	273	320
SAME	Neapoli	45	83

45 This table is adapted from a Greek table of the Ministry of Justice, Transparency and Human Rights containing additional information in a Press Release justifying the changes in the capacity of Greek prisons according to the Council of Europe Recommendations (at: www.ministryofjustice.gr) (last visited: 23 July 2017).

Kind of Prison	Prisons	Capacity	Prisoners (1 May 2017)
SAME	Tripoli	53	89
SAME	Chania	480	308
SAME	Chios	82	128
Prisons type B'**	Alikarnassos	210	157
SAME	Grevena	600	536
SAME	Domokos	600	437
SAME	Thiva [females]	655	375
SAME	Kerkyra	138	166
SAME	Malandrino	431	390
SAME	Nigrita	360	324
SAME	Patra	446	623
SAME	Trikala	600	534
SAME	Chalkida	127	200
TOTAL		**9,815**	**9,573**

* According to Law 4322/2015 Art. 1, Prisons Type A' are prisons where (i) individuals are on provisional detention, (ii) individuals convicted for debts and (iii) individuals sentenced to imprisonment are detained.
** The sentences of all other convicted offenders (e.g. incarceration, life sentence, etc.) are executed in Prisons Type B'.

From the preceding it follows that in Greek prisons inmates with psychiatric disturbances have three basic needs that are not met: the need for: (i) a hygienic and not overcrowded cell, (ii) psychiatric treatment and (iii) being submitted to screening procedures. Despite the legislative and prison building policy of the Greek government overcrowding remains a problem in Korydallos Prison where 45.06% of the prisoners, as already stated, were diagnosed with psychiatric disorders, pre-existing or caused during imprisonment.[46] The ECtHR in many instances underlined that overcrowding coupled usually with unhealthy hygienic conditions amounts to degrading treatment and thus a violation of Article 3 of the ECHR (e.g. *Peers v. Greece and Varga* and *Others v. Hungary*).[47] The Ministry of Justice on 22 May 2017 re-calculated the capacity of each Greek prison according to the White paper on prison overcrowding of the Council of Europe[48] and indicated that overcrowding exists in 14 prisons, while overall there are 9,573 inmates in a capacity of 9,815. On the other hand, psychiatric and/or psychological therapy offered to prisoners is minimal.

46 Giorgos Alevizopoulos & Artemis Igoumenou, 'Psychiatric disorders and criminal history in male prisoners in Greece', 47 *International Journal of Law and Psychiatry* (2016), pp. 171-175.

47 ECtHR, Judgment of 19 April 2001, *Peers v. Greece*, Appl. 28524/951 and ECtHR, Judgment of 10 March 2015, *Varga and others v. Hungary*, Appls. 14097/12, 45135/12, 34001/13, 44055/13, and 64586/13.

48 European Committee on Crime Problems (CDPC) *White Paper on Prison Overcrowding*, P-CP (2015) 6 rev 7 (at: https://rm.coe.int/16806f9a8a) (last visited: 25 July 2017).

Consequently, deprivation of liberty and security prevails over therapy. This, inter alia, is due to the fact that psychiatrists are visiting the Unit twice a week and there are no psychiatrists in residence, in violation of the relevant law. Moreover, three (instead of six) healthcare individuals, one psychologist and four social workers are employed.[49] The under-staffing creates problems that the Prosecutor of the Supreme Court (Areios Pagos) attempted to solve. It was stated that when mentally disturbed offenders are kept in public psychiatric hospitals, the personnel of the public therapeutic facility is only responsible for the therapy of these prisoner-patients and not for their detainment. Detainment is the responsibility of the Ministry of Justice.[50] Finally, although screening is a critical component of a correctional mental health policy,[51] it does not seem, until now, to be within the priorities of the Greek Ministry of Justice. Nevertheless, the administration of diagnostic tools like the Iowa Structured Psychiatric Interview (ISPI) and the Personality Disorders Questionnaire (PDQ-4) was used in several occasions.[52]

5 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

Offenders with psychiatric disorders may more easily be involved in the criminal justice system and they may stay within the system for a longer period of time than other citizens.[53] In Greece, these phenomena may be understood on the basis of certain articles of the GPC and the Code of Penal Procedure which provide for: a) an indefinite period of deprivation of liberty for persons with diminished capacity for accountability (Art. 38 § 2 GPC), b) conversion of confinement in a psychiatric facility to imprisonment or incarceration (Art. 40 GPC), c) postponement of the execution of punishment in case the convicted individual, after the conviction, was found to suffer from 'psychopathy' (Art. 555 § 1 GCPP); in this case the release of the prisoner from the facility is delayed (Art. 560 § 3 GCPP).

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49 See Report of the Special Control Committee for the Protection of the Rights of Persons with Psychiatric Disturbances (at: www.moh.gov.gr/articles/health/domes-kaidraseis-gia-thn-ygeia/1398-eidikh-epitroph-elegxoy-prostasias-twn-dikaiwmatwn-twn-atomwn-me-psychikes-diataraches) (last visited: 21 July 2017).

50 Opinion of the Public Prosecutor of the Areios Pagos 8/2007.

51 Michael S. Martin, *et al.*, 'Mental health screening tools in correctional institutions: a systematic review', 13 *BMC Psychiatry* (2013).

52 Giorgos Alevizopoulos & Artemis Igoumenou, 'Psychiatric disorders and criminal history in male prisoners in Greece', 47 *International Journal of Law and Psychiatry* (2016), pp. 171-175. Yet, the most promising tools, according to Michel S. Martin *et al.*, are meta-analysis studies (see footnote 51 above) such as BjMHS, EMHS, CMH S-M, CMH S-W and jSAT.

53 Mark R. Munetz, Thomas P. Grande & Margaret R. Chambers, 'The incarceration of individuals with severe mental disorders', 37 *Community Mental Health Journal* 4 (2001), pp. 361-372 (DOI: 10.1023/A:1017508826264).

The fact that the law regulates all matters concerning forensic patients and that the Ministry of Justice is responsible for the surveillance and care of this category of offenders creates a number of issues. The most important of them is the emphasis on 'the justice and security model' rather than on the 'therapeutic and welfare model'. This is one of the problems that the proposed Draft Law aims at tackling.[54]

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

Recently, the CPT delegation did not make a follow-up visit to Korydallos Psychiatric Unit, which is the only place for treatment of forensic patients in Greece.[55] Most of the recommendations made in 2005 were not followed. However, overcrowding does not seem currently to be a major problem (see Table 1), but the staff levels and therapy have not improved considerably despite the partnership with the Forensic Unit of the University of Athens. The delegation at that time noted that "there has been no progress in developing the facility into a fully resourced psychiatric hospital". In 2005 there were also problems with the isolation cells. To date, the isolation rooms are rarely used and seclusion is of a short duration.

Reintegration of patients into society has had few chances until the Psychargos psychiatric reform programme. This programme is aimed at *all* psychiatric patients. Supported by the EU, it was started in 1983 (Law 1397/1983) and continued from 1999 (Law 2716/1999) through 2010.[56] Although Psychargos has helped a lot in developing psychiatric services in the community and leads the way in de-institutionalization and the closure of some psychiatric asylums, its impact on the mental health of prisoners and their aftercare was minimal. Reports on the reintegration of psychiatric prisoners are missing and what exists is often controversial and anecdotal. Up until 2010 there was no Special Forensic Outpatient Unit or established Forensic Psychiatric Unit. The first Forensic Psychiatry Unit was established in the Second Department of Psychiatry of the University of Athens Medical School. The outpatient clinic associated with the long-acting antipsychotic clinic was established as already mentioned in 2010. The second Forensic Outpatient Unit was established in 2013 in Thessaloniki. Up until then prisoners suffering from mental illness were discharged with no referral and it was up to them to find a psychiatrist that would accept to treat them, an almost impossible task because of the

54 For more information on the issue of 'health or justice responsibility' see Section 4.

55 CPT/Inf (94) 20, para. 117.

56 See, inter alia, Health & Consumer Protection Directorate-General, doc. COM(2005)484, 14 October 2005 (at: http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf) (last visited: 21 July 2014).

double stigmatization (being mentally ill and having served a prison sentence). In the revised Psychargos C programme for the years 2011-2020, a chapter is devoted to prisoners with mental health disturbances. It is expected that certain inmates with psychiatric disorders will be supported to live in the community and some of their needs will be met.[57] However, to date these changes are not visible. The most important change that will occur within the next year is the placing of the Korydallos Forensic Unit under the jurisdiction of the Ministry of Health instead of that of the Ministry of Justice. This will underline the commitment to 'treat' the mentally ill prisoners instead of keeping them imprisoned. As stated in the draft proposal of a Presidential Decree: "the current plan consists of a well-rounded proposal for updating […] the therapeutic services of the Korydallos Prison Psychiatric Unit (PPU)", while placing emphasis on the following characteristics:

- The therapeutic approach will be prioritized over imprisonment. An attempt has been made to conserve the independence of the Scientific Committee, to underline the role of the Medical Director and to supervise all available scientific personnel (nurses, psychologists, social workers) in the University Hospital 'Attikon' and the Ministry of Health.
- The responsibility of the security of the prison unit, the daily management and functioning will remain with the Ministry of Justice. Regarding the specification of issues concerning the duties and responsibilities of the head of the prison unit and the head of the Scientific committee, there will be a need of a new internal system.
- Care will be provided for the social reintegration of prisoners released from the PPU with the recommendation of post-release therapeutic follow-ups. This new system will be responsible for recommending patients to medical professionals in the area in which they live, follow-up meetings and care, allowing the patients to receive continual care and the networking with charities, organizations and associations that support patients' induction into the communities of both those with mental health issues and the community of former prisoners.
- Under the new scientific director of the PPU, new measures will be adopted for the immediate abolishment of the so-called blue (isolation) cells that can be found in the basement of the prison unit, and the replacement of these with specially designed areas of increased care which will be in line with modern psychiatric practice.

While the European Prison Rules reaffirm that "[a]ll prisoners shall have the benefit to arrangements designed to assist them in returning to the society after release", aftercare

57 Jim Mansell, Martin Knapp, Julie Beadle-Brown & Jennifer Beecham (2007), *Deinstitutionalization and community living – outcomes and costs: report of a European Study. Volume 2: Main Report*, Canterbury: Tizard Centre, University of Kent, p. 2 (at: www.kent.ac.uk/tizard/research/DECL_network/documents/DECLOC_Volume_2_Report_for_Web.pdf (last visited: 30 July 2017).

for the Greek prisoners is at an embryonic stage. Only somewhat recently, with the Presidential Decree 300/2003, the non-profit organization Epanodos supervised by the Ministry of Justice was set up in order to prepare and assist all inmates, including mentally ill, to return to society. However, Epanodos is operating in Athens and the overwhelming majority of prisons (see Table 1) are scattered all over Greece. Therefore, prisoners cannot fully benefit from the services of Epanodos.

7 Conclusion

The Commission's Green Paper, inter alia, paints an alarming picture of detainees with mental and psychological disorders in all institutions of the EU.[58] Although this is lamentably true for Greece, this is expected to change. A draft Law is in process of being enacted. The GPC and the GCPP date back to 1950. However, the inadequate handling of defendants and detainees with psychiatric disturbances is not only caused by the anachronistic legal regulations. The discrepancy between law in theory and law in practice and the inappropriateness of the structures of the psychiatric establishments as well as their under-staffing are responsible for the predominance of the 'justice, surveillance and security model' rather than of the desired 'therapeutic-welfare model'.[59]

From the preceding panoramic analysis of the issues related to defendants and detainees with psychiatric disturbances we may learn some lessons. First: the 'patchwork approach' of solving problems existing in the relevant law with casual interventions is ineffective. A well-planned holistic approach and new, modern legislation is needed. Second lesson: in certain cases medical and psychiatric screening upon the first contact of the suspect with the law enforcement agencies and, subsequently, periodic reviews will prevent future inextricable situations. The aim should be for all individuals arrested for a serious violent crime (murder, grievous bodily harm, rape) to undergo a psychiatric/psychological assessment. Third lesson: partnerships between the Ministry of Justice which has the exclusive competence of the criminal justice system, on the one hand, and the local public health services or the forensic psychiatrists/psychologists and faculty members of nearby universities, on the other, will improve the health care and therapy of the mentally ill offenders. Fourth lesson: defendants and detainees with latent, obvious or claimed psychiatric disturbances, in addition to their rights to a psychiatric evaluation and to an

58 Official Journal of the European Union, C 168 E/84, 14 June 2013 (at: https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52011IP0585&from=EN) (last visited: 30 July 2017).

59 See, the following evaluation report for the years 2011-2015 of the "Psychargos" programme, where the inadequacy of the buildings for treatment purposes and the surveillance of the mentally ill are underlined: www.psychargos.gov.gr/Documents2/ON-%20GOING/Eval_Report_2014.pdf, p. 200 (in Greek) (last visited: 2 August 2017).

expert opinion report,[60] shall be granted an appointed counsel upon their first contact with the police or the prosecution or a 'judicial supporter' (see footnote 23). This is justified by the vulnerability of these persons and, in some cases, their inability to complain coherently.[61] Finally: the psychiatric reform and de-institutionalization will be conducive to reintegration of criminal patients in the community, and will solve the problems of (a) institutional ill-treatment, (b) unneeded long-term hospitalizations[62] and (c) overcrowding in public establishments where offenders with psychiatric disorders are usually kept. The unmet needs of the mentally ill criminals shall be addressed not only in the prison or in the forensic psychiatric setting but most importantly in the community.

In short, currently in Greece, the most pressing unmet needs include continuity of mental healthcare, therapy and support, housing and work experience in order to enhance community reintegration and reduce recidivism.

60 For a general overview on the topic see: A. Douzenis, 'Psychiatric expert opinion', in: A. Douzenis & L. Lykouras (eds), *Forensic Psychiatry*, Athens: Paschalidis Publishers, 2008, pp. 276-286 (in Greek).

61 See, para. 106 *Murray v. the Netherlands*. A research in the Greek case-law reveals that during the years 2003-2016 no detainee with psychiatric problems has lodged an application to the ECtHR against Greece on the basis of violation of Art. 3 ECHR. (see footnote 31).

62 Cf. ECtHR, *Murray v. the Netherlands*, Judgment of 26 April 2016, Appl. 10511/10. Quoting an exploratory memorandum: "The execution of a custodial sentence that gives no hope of returning to society can result in an inhuman situation", para. 56.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system in Hungary

Katalin Ligeti[*]

1 Introduction

The UN Convention on the Rights of Persons with Disabilities[1] (CRPD) guarantees "access to justice for all persons with disabilities, including persons with mental and/or intellectual impairment". According to the wording of the CRPD:

> State Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural … accommodations, in order to facilitate their effective role as direct and indirect participants, … 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.

The CRPD foresees accessibility of all procedures of a judicial or an administrative nature – regarding our focus: also the criminal procedure, implying investigation, court procedure and the execution of penalty – for all participants in the procedure, including defendants.

The main obstacles of accessibility of the criminal procedure and the subsequent imprisonment or psychiatric treatment can be identified as:

- lack of accessible information (principally on rights and duties);
- communicational barriers (e.g. difficulties in giving evidence);
- lack of required psychological support (or voluntary medical treatment on demand);
- Lack of disability-specific knowledge and negative attitudes of staff members.

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1 Adopted on 13 December 2006 at the sixty-first session of the United Nations General Assembly by resolution A/RES/61/106.

The CRPD aims to ensure accessibility through accommodation and training, which means that it envisages the modification of the physical as well as the social environment. It was a hopeful sign to persons with disabilities that Hungary ratified the CRPD, the first country in Europe to do so, in 2007.[2] It soon became clear, however, that changes in the legislation, and particularly in everyday practice, come slowly, and that making criminal justice accessible for persons with mental disorders or mental disabilities is not high on the agenda.

In this chapter I divide defendants with psychiatric disturbances into two groups:

a) Defendants called to account for a criminal offence under the general rules of the Act on the Criminal Code[3] (CC) and the Code on Criminal Procedure[4] (CCP),
b) Defendants considered insane[5] under the CC and undergoing special procedures under the CCP.

The *former group* includes defendants whose mental disorder did not have any impact on committing the crime and did not, therefore, affect their criminal responsibility. In this case, even if the 'impairment of the perpetrator's mind'[6] is of such a character that it is difficult for him/her to understand the nature and consequences of his/her acts, the criminal procedure is conducted under the general rules of substantive and procedural law. The penalty, however, may be reduced without limitation.[7] *Insanity*, on the contrary, constitutes a full exemption from criminal responsibility. The insane person commits a 'criminal act', but not a 'crime' under the CC. The procedure against such persons is therefore conducted under special rules of the CC and the CCP. Paying attention to the differences in the criminal procedure and the possible sanctions in most of the subchapters, I examine the two groups separately.

Insanity is not defined in the Hungarian criminal law. The new CC does not enlist any type of mental disorders when referring to exclusion of criminal responsibility. The former CC,[8] however, highlighted a few mental disorders – such as insanity, imbecility, diminished mental capacity, disorientation and personality disorder[9] – establishing the application of special rules. The current CC leaves the question open, enabling a more competent and flexible evaluation of the defendant's mental state.

2 Act XCII of 2007 on the proclamation of the Convention on the Rights of Persons with Disabilities and its Optional Protocol.
3 Act C of 2012 on the Criminal Code.
4 Act XIX of 1998 on the Criminal Procedure.
5 According to § 17 (1) CC, any person who has committed a criminal act in a state of impairment of the mind of a character such that it is impossible for the person so afflicted to understand the nature and consequences of his acts shall not be prosecuted.
6 § 17 (2) CC.
7 § 17 (2) CC.
8 Act IV of 1978 on the Criminal Code.
9 § 24 (1) Act IV of 1978.

As the questionnaire outlining the framework of the study refers to 'psychiatric disturbances', I generally use this expression as well, with the meaning of 'mental disorder' in the sense of the DSM-5.[10] Although 'insanity' might be an outdated expression, the Hungarian criminal law and criminal procedural law still apply the concept, together with the expression of 'state of impairment of the mind', in referring to specific mental disorders, usually a psychotic state. Even if these expressions are not justifiable from a psychological point of view, I hold to these to facilitate the traceability of my text in the legal material.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

Analysing the CCP currently in force through the looking glass of the rights of persons with disabilities, we see an outdated and excluding legal regulation. Special guarantees in connection with psychiatric disturbances are scattered in a few articles, referring mostly to the establishment of the 'insanity' or 'mental disorder' defence. The guarantees of fair procedure concerning defendants with psychiatric disturbances do not go far beyond the general rules of fair procedure. Yet there are some provisions that aim to formulate 'inclusive' proceedings and provide effective access to justice for persons with disabilities, particularly for defendants with psychiatric disturbances.

Before addressing these issues, however, it is important to mention that a new Code on Criminal Procedure (nCCP) was adopted in June 2017.[11] The nCCP foresees a number of procedural safeguards for persons with disabilities taking part in the investigation and the trial. The new provisions will regulate the use of language, addressing persons with severe communication impairments or the inability to communicate. The nCCP requires that the authorities ensure an adequate method of communication in all stages of the procedure.[12] An even more important provision of the nCCP is the introduction of the category of *persons in need of special treatment*.[13] Although, as a general rule, victims and witnesses can qualify as persons in need of special treatment, the nCCP authorizes the court, the pubic prosecution and the investigation authority to apply certain safeguards for persons in need of special treatment on alleged offenders as well, in order to ensure the exercise of rights and fulfilment of duties.[14] This may be the case if the defendant is (or might be regarded as) a person with disability as defined in the Act on the Rights and

10 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, 2013.

11 Act XC of 2017 on the Criminal Procedure (entering into force on 1 July 2018).

12 § 78 (5) nCCP.

13 § 81 (1) nCCP.

14 § 96 (1) b) nCCP.

Equality of Chances of Persons with Disabilities.[15] Special safeguards for persons in need of special treatment include the following:

- ensuring the exercise of rights and fulfilment of duties despite his/her special circumstances;
- special caution in maintaining contact with the outside world and concerning the private life of the concerned;
- extra protection for personal data (specifically on health condition);
- enabling contribution of special assistants;
- taking the special needs of the person into consideration;
- avoiding the repetition of certain procedural elements, unnecessary meetings with other persons involved;
- using special facilities (e.g. interrogation rooms), voice and video recording;
- ensuring the presence of the person at procedural actions via telecommunication tools.[16]

The provisions of the nCCP are explicitly ambitious, and we can only hope that the everyday practice of authorities and the attitudes of the officials contribute to their success. Returning to the regulation in force, I address the main issues where special regulation takes the psychological state of the defendant into consideration.

2.1 Providing information for defendants with psychiatric disturbances

According to the provisions of the CCP, a legal representative has to be appointed if the defendant is mentally disabled/insane[17] within the scope of the CC. Defendants shall be informed of their rights and duties, although, until 2015 no provision of the CCP contained any specific instruction to the authorities on providing the necessary information. The November 2015 amendment of the CCP, implementing the relevant EU legislation,[18] explicitly provides that courts (judges), public prosecutors and investigation authorities should endeavour to communicate – orally as well as and in writing – in a 'simple and commonly comprehensible' way. Information provided on the rights as well as warnings on the duties shall be communicated with regard to the state and personal characteristics of the defendant. The court, the public prosecutor and the investigation authority shall ascertain during the oral communication that the addressee has taken the meaning, and if not, the public authorities have the duty to explain the instruction or warning. If the

15 Act XXVI of 1998.
16 § 85 (1) nCCP.
17 § 46 c) CCP.
18 Directive 2012/13/EU of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings.

person is mentally disabled – without any regard to his/her accountability – his/her state shall be taken into account with special care.[19]

According to recent qualitative findings, the simplicity and comprehensibility of the information provided is jeopardized in the everyday practice of the police. Approximately one-third of the legal representatives state that at the investigative stage of the criminal procedure the information provided is not easily and commonly understood. The everyday practice of courts is somewhat better: almost half of the legal representatives confirm the comprehensibility of the information on rights and duties.[20] Only 6 of the interviewed 12 legal representatives stated that the manner in which the information is provided by the investigation authorities satisfies the special needs of vulnerable defendants. The picture is once again more appealing at the courts (10 out of 14 legal representatives confirmed that the manner of informing the defendant complied with the special needs).[21]

In my opinion, it is important to note that the text of the CCP itself does not comply with the requirements of the 2012/13/EU directive (hereinafter: the Directive), if we take the following into consideration. According to the Directive, information shall be given in 'simple and accessible language'. Observing the relevant legal context of international as well as European law, the word *accessibility* generally refers to the availability of the physical environment or information to persons with disabilities. Article 9 (Accessibility) of the CRPD states that "[t]o enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, … to information and communications". The recent proposal for the *EU Accessibility Act*[22] explicitly defines accessible products and services as "products and services that are perceptible, operable and understandable for persons with functional limitations, including persons with disabilities, on an equal basis with others".[23]

Although neither of the aforementioned legal texts refer explicitly to criminal matters, it is perhaps not too far-fetched to conclude that accessibility, as a measure aimed at improving independent living shall also be interpreted as such in the context of access to justice. If we accept this conclusion, 'accessible language' within the framework of the

19 CCP 62/A. §.

20 Hungarian Helsinki Committee, *EU-irányelvek a gyakorlatban: A büntetőeljárás során a tájékoztatáshoz való jogról szóló EU-irányelv átültetésének vizsgálata, Magyar országjelentés, 2015* (EU directives in practice. Analysing the implementation of the directive on the right to information in criminal proceedings. Hungarian national report) (at: www.helsinki.hu/wp-content/uploads/HHC_Measure_B_National_Report_on_Hungary_2015_HUN.pdf) (last visited: 30 June 2017), p. 14.

21 *Ibid*., p. 14.

22 Proposal for a Directive of the European Parliament and of the Council on the approximation of the laws, regulations and administrative provisions of the member states as regards the accessibility requirements for products and services. COM(2015) 615 final.

23 Art. 2 (1).

Directive shall also mean a language that is accessible for persons with intellectual and psychosocial disabilities, i.e. an *easy to read* language. Applying the foregoing to the Hungarian wording of the act implementing the Directive, we have to note that a language that qualifies as *commonly understandable/comprehensible* is not the same as a language qualified as *accessible*. The Hungarian legislative shall, therefore, modify the current wording of the CCP to comply with the requirements of the Directive.

2.2 Acquiring evidence on the mental state

It is a statutory requirement of the CCP to "employ an expert if the fact to be proven or the issue to be decided on is the mental disability/insanity of a person or if the fact to be proven or the issue to be decided on is the necessity of involuntary medical treatment".[24] The observation of the mental state is an exception from the general rule of using only one expert: when the subject of the examination is the mental state of a person, two experts shall be employed.[25] If the expert opinion concludes that the assessment of the mental state of the defendant requires a longer time, the court shall order the observation of the defendant's mental state.[26] Detained defendants shall be referred to the central Forensic Psychiatric and Mental Institution (IMEI), defendants at liberty to a psychiatric in-patient institution specified by law.[27] The observation lasts for one month at the longest, although the court may extend the duration by one month on the opinion of the institution performing the observation. In the course of the observation of the mental state of a defendant at liberty, the personal freedom of the defendant may be restricted in compliance with the provisions of the Act on Health Care (HCA).[28] If the defendant evades the observation, the psychiatric institution shall forthwith notify the court ordering the diagnosis.[29]

The Commentary of the CCP emphasizes that although the observation of a mental state involves a certain degree of coercion, as it realizes a deprivation of liberty, it shall not be confused with any coercive measure under the CCP. The aim of coercive measures is to ensure the success of the criminal proceeding by restricting certain fundamental rights, whereas the observation of a mental state aims to deliver evidence. Consequently, defendants who are not observed under detention are entitled to leave the institution at their own will.

24 § 99 CCP.
25 § 101 (2) CCP.
26 According to the relevant case law, ordering the observation of the mental state, the court shall proceed as a council of three judges. BH 1944.176.
27 According to the commentary of the CCP, in the latter case, the physician of the in-patient institution may also be involved in the criminal procedure as an expert.
28 Act CLIV of 1997.
29 § 107 CCP.

Although as they are regarded as unwilling to participate in the examination, coercive measures – such as apprehension – may be inflicted on them.

Despite the explanation provided by the Commentary, observation of the mental state and (involuntary) emergency treatment – under the HCA – are often confused in practice, especially in regard to the nature and extent of observation and treatment within the in-patient psychiatric institution. The incoherence of the legislation has been addressed by the Commissioner for Fundamental Rights as well.[30] By ordering the observation of the mental state, the criminal court only commands the defendant to enter the psychiatric institution and stay there in order to be observed. The extent of this presence is, however, not clarified on a statutory level. As the court order does not refer to specific duties of the defendant, it is, in practice, the physician, who decides whether the observed person shall stay in the institution during the observation or whether he or she is free to leave (e.g. on weekends).

It is also unclear what medical interventions and/or restraints are allowed to be inflicted on the defendant. The CCP states that if the defendant is not in pre-trial detention, his/her liberty may only be restricted under the HCA, that is, only if the defendant exhibits dangerous or immediately dangerous behaviour.[31] In this case, however, the institution shall initiate the emergency or mandatory treatment of the defendant,[32] both of which are ordered by a civil court. The relationship between the criminal court and civil court procedures are not regulated in the legislation either. The report of the Commissioner for Fundamental Rights concludes that if the observation of the mental state is carried out on a defendant at liberty, his/her liberty may be restricted only in the case of dangerous or immediately dangerous behaviour. This means that if the defendant does not exhibit any danger but is merely not willing to stay at the psychiatric institution, neither physical nor chemical or biological restrictions are permitted to ensure his or her presence. In this latter case, the psychiatric institution is obliged to inform the criminal court that it is entitled to order a coercive measure against the defendant. Although the Commissioner recommended the amendment of the CCP and the HCA in order to include the necessary clarifications, no changes have been made to either of the acts.

30 Report of the Commissioner for Fundamental Rights, AJB-5564/2010.
31 § 192 HCA.
32 § 196 HCA.

3 Detainees with psychiatric disturbances in provisional detention: needs, problems, screening tools

Pre-trial detention of defendants with psychiatric issues is carried out in a prison facility, or – in the case of severe mental disturbances – in the IMEI. At the admission procedure the defendant shall be informed of his or her rights and be subjected to medical examination.

Empirical studies on the psychological disturbances of detainees are rarely to be found, and, even if available, their scope is very limited. Findings of research from 2009, carried out at a county prison in Hungary, showed that *more than half of the defendants were struggling with mental health problems*, even if the symptoms were 'only' anxiety, attention and sleep disturbances, depressive mood or the feeling of personal worthlessness. Approximately 56.43% of the first-time offenders and 60.64% of the recidivists reported on psychological issues.[33]

3.1 Providing information for defendants with psychiatric disturbances

One of the basic needs of detainees is knowledge of their rights and duties. Similarly to the requirements during trial, the Prison Code of Hungary[34] foresees that the defendant shall be informed of the rights in a language that is understood by him/her and is furthermore clear and commonly understandable.[35] Information on the rights and duties shall also be provided in writing, once again in clear and understandable language.[36] A sample text on the information to be provided is included in Annex no. 11 of the Rules of Police Detention Facilities[37] (for persons detained at police stations) and in Annex no. 2/A. of the Sample Rules of the House of the Hungarian Prison Service (for persons serving their pre-trial detention in prisons). Empirical research of the Helsinki Committee shows that both of the documents – especially Annex no. 11 – are excessively long and include superfluous information with citations from legal texts. Neither the form nor the wording of Annex no. 11 can, therefore, qualify as commonly comprehensible. Legal representatives emphasize that whether they understand the document or not depends mostly on the personal skills and education of the defendants.

33 Balázs Mihály – Lantos Zsuzsanna, 'Az egészség és az életmód összefüggései a Veszprém Megyei Bv. Intézet előzetesei körében' ('Relation of health and lifestyle at the Veszprém County Penitentiary Institution among pre-trial detainees'), *Börtönügyi Szemle* 4 (2009), p. 56.

34 Act CCXL of 2013 on the execution of punishments, criminal measures, certain coercive measures and confinement for administrative offences.

35 § 12 (4) Prison Code.

36 § 12 (5) Prison Code.

37 In English at: www.helsinki.hu/wp-content/uploads/3-2015_ORFK_utasitas_11_melléklet_ENG.pdf (last visited: 30 June 2017).

The Prison Code, furthermore, explicitly states that "detainees with long-term sensory, communicational, physical, intellectual or psychosocial disabilities shall receive information with special regard to their state, capacity and situation".[38] In practice, however, there are no alternative or accessible documents available. It is up to the preparedness and attitude of the police/prison staff to decide whether providing information to the aforementioned persons complies with the regulation.[39]

3.2 Assessing and meeting the needs in 'standard' places of detention

Medical examination of the defendant shall be carried out within 72 hours from admission.[40] All injuries shall be documented. If the defendant has any injuries or the probability of physical abuse arises, gathered evidence should be included in a medical statement immediately.[41] Screening tools of the medical examination are not specified in any piece of legislation, orders or protocols of the police or prison service.

Suicide prevention[42] is one of the most important focal points during the examination of the psychological status of the defendant. The reason for this is that the suicide rate among detainees is always much higher than among the non-detained population.[43] Statistics also show that suicide attempts occur predominantly in the pre-trial, pre-judgement period.[44] The prison physician and psychologist shall, therefore, focus on signs of suicidal behaviour. Besides documenting former suicide attempts, the medical staff shall also document former psychiatric disturbances and treatments with the emphasis on depression, bipolar disorders, anxiety disorders, alcohol and drug abuse, schizophrenia,

38 § 12 (9) Prison Code.

39 *Ibid*., p. 19.

40 § 3 (5) decree no. 8/2014. (XII. 12.) IM of the minister of justice on the healthcare of convicted and other detainees in prisons.

41 § 3 (5) decree no. 8/2014. (XII. 12.) IM.

42 Regulated by decree no. 11/2010. (III. 26.) IRM of the minister of justice and law enforcement on the methods of prevention and treatment of suicide attempts among detainees and order no. 27/2017 (II. 5.) OP of the director general of the Hungarian Prison Service on the tasks in connection with suicidal actions of detainees.

43 According to current statistics, there were 5 suicides in 2015 and 1 in the first half of 2016. The number of suicide attempts was 42 in 2015 and 6 in the first half of 2016. The number of suicides and attempted suicides mentioned above mark only cases with real suicidal crises behind the incidents. This means cases where exploration, tests and other methods used in psychology indicate a direct suicide risk situation. Inside the prisons and penitentiary institutes self-harm is not necessarily connected to a real death wish but can also be caused by tension release (intentional self-injury) or by issues connected to imprisonment. (E.g.: 'manipulative' self-inflicted wounds to achieve potential benefits). These cases are not indicated. *Review of Hungarian Prison Statistics* 2016/2, Budapest: Hungarian Prison Service Headquarters, 2016, p. 8.

44 Csiszér Nóra, 'Szakértői vélemény a fogvatartottak szuicid cselekményeinek csökkentésére irányuló intézkedésekhez' ('Expert opinion on the measures aiming to diminish suicidal actions of detainees'), *Börtönügyi Szemle* 4 (2004), p. 89.

personality disorders and ADHD. Data of particular importance relates to former (violent) suicide attempts, especially in the past year and severe self-harm without suicidal intent. The prison psychologist gives a statement on the risk of suicidal behaviour based on the available data; the statement shall be taken into account by the Admission and Detention Committee (ADC) during the risk assessment of the detainee.[45]

If the prison physician observes any symptoms of psychological disturbance, the defendant shall immediately be referred to the IMEI.[46] If the symptoms of the defendant are severe but do not constitute insanity (requiring treatment at the IMEI), the defendant shall be provided with adequate medical assistance on the spot: he/she shall be referred to the prison psychiatrist (psychologist) or to the local psychiatric ambulance or in-patient institution. If the detainee shows signs of psychological imbalance but no prison physician is present at the time, security officers shall specify the particular tasks in connection with the detainee and the frequency of his/her observation. In this case, detainees shall be placed in a cell that is fully observable.[47]

Although – as we see – legal provisions ensure the thorough examination of detainees and oblige the prison staff to meet the medical need of such persons, results of the monitoring activity of the Commissioner for Fundamental Rights acting as the National Preventive Mechanism (NPM) under the Optional Protocol for the UN Convention Against Torture[48] and the Hungarian Helsinki Committee clearly show that detainees with psychological disturbances are not treated according to their needs. One of the reasons for this is the lack of qualified staff,[49] although counselling and special treatment would be most crucial to defendants in pre-trial detention because of the aforementioned risk of suicide or self-harm. Defendants in pre-trial detention can also be placed in so-called 'curative-therapeutic units' or 'psychosocial units'.[50] As these units qualify as suitable for reintegration purposes, detainees may – as an exception to the general rule – be placed together with convicted prisoners.[51]

In recent years two cases have been brought before the European Court of Human Rights (ECtHR), in which the applicants complained about the prison staff ignoring their

45 Sections 2, 3.2. and 5.6 order no. 27/2017 (II. 5.) OP.

46 § 16 (3) decree no. 8/2014. (XII. 12.) IM.

47 Section 9-10. order no. 27/2017 (II. 5.) OP.

48 Adopted on 18 December 2002 at the fifty-seventh session of the United Nations General Assembly by resolution A/RES/57/199.

49 For illustration: 1 psychologist for 138 inmates at the Somogy County Prison, 4 psychologists for 762 inmates at the Tököl Juvenile Prison, 1 psychologist for 372 inmates at the Prison of Kalocsa. See report nos. AJB-3865/2016 and AJB-1423/2015 of the Commissioner for Fundamental Rights and the *Report on the monitoring visit of the Hungarian Helsinki Committee on the 11-12th of June 2012 at the Kalocsa Prison* (at: http://helsinki.hu/wp-content/uploads/kalocsa_bv_jelentes_fin_anonim.pdf) (last visited: 30 June 2017).

50 See the more detailed description of these special units in Section 4.2.

51 § 185 decree no. 16/2014. (XII. 19.) IM.

special needs as persons with mental disturbances. In the case of *Z.H. v Hungary*[52] the deaf and dumb applicant, who had an intellectual disability and was illiterate, has been detained for multiple offences at a police department and later at the county prison. He used a special sign language and could only communicate with his mother. The police interrogated him in the mother's absence with the help of an official sign language interpreter. The authorities argued that the applicant had understood the charges brought against him but made no complaint about it and admitted to having committed the offence by signing the minutes of the interrogation. The applicant denied this, arguing that the sign language used by him and the one used by the interpreter were different and that thus no comprehension had been possible between them. The applicant stated that the conditions of detention were inapt to his condition and that he had been molested, sexually and otherwise, by the other inmates. The ECtHR observed that "the authorities decide to detain a person with disabilities, they should demonstrate special care in guaranteeing such conditions as correspond to the person's individual needs resulting from his disability"[53] and concluded that there had been a breach of Article 3 of the European Convention of Human Rights (ECHR).

In the case of *X.Y. v. Hungary*[54] the applicant was detained without grounds in 2007 for car theft. During his detention he underwent medical examination resulting in a psychiatric opinion, according to which he suffered from a personality disorder, including fear of crowds and of being locked up, which was susceptible to deterioration due to detention. A further expert opinion specified that the applicant had suffered a sexual assault from fellow inmates while in detention, which had aggravated his psychological imbalance. Despite these facts, his pre-trial detention continued until 2009. The ECtHR noted that over the period of detention no consideration had been given to the possibility of a less stringent measure, even though the authorities became aware of the applicant's psychological problems. The ECtHR found it regrettable that "domestic authorities paid no heed to the fact that with the passage of time and given the applicant's deteriorating health, it became more and more acutely obvious that keeping him in detention no longer served the purpose of bringing him to trial within a reasonable time"[55] and, accordingly, concluded that there had been a violation of Article 5 § 3 of the ECHR.

52 ECtHR, Judgement of 8 November 2012, *Z. H. v. Hungary*, Appl. 28973/11.
53 *Ibid*., para. 29.
54 ECtHR, Judgement of 19 May 2013, *X. Y. v Hungary*, Appl. 43888/08.
55 *Ibid*., para. 41.

3.3 *Temporary involuntary treatment – assessing and meeting the needs in the IMEI*

Temporary involuntary treatment is a form of deprivation of liberty in a psychiatric institution. It may be ordered by a court, when there is reasonable cause to assume that an order for the involuntary treatment of the defendant in a psychiatric institution will be required at the end of the criminal procedure.[56] The necessity of the treatment shall be supported by the expert opinion and the circumstances of the case.[57] Temporary involuntary treatment can be used against defendants that bear no criminal responsibility but not against defendants with limited responsibility. Conditions of temporary involuntary treatment are therefore the same as involuntary treatment:

- the defendant committed a violent crime or an offence causing collective danger;
- he or she is not punishable because of mental disturbance (insanity);
- there is a likelihood of further offences in the future;
- a punishment more severe than one-year imprisonment.[58]

Temporary involuntary treatment in a mental institution ordered prior to filing the indictment may continue up to the decision of the court of first instance.[59] Until the filing of the indictment, the court reviews the necessity of the temporary involuntary treatment 6 months after its commencement and thereafter every 6 months.[60] The treatment is carried out at the IMEI. It shall be terminated if its term has expired, if the investigation has been terminated, if its maximum period has expired or if the procedure has come to a final conclusion. It shall be terminated if the cause of ordering the treatment has ceased to exist.[61]

Since the amendment of the CCP in 2007, pre-trial detention can also be executed in the IMEI. This is the case when the psychiatric treatment of the person under pre-trial detention is necessary[62] but the requirements of ordering a temporary involuntary treatment are not fulfilled.[63] This provision aims at providing the appropriate environment and the necessary treatment also for such defendants with psychiatric disturbances who have full criminal responsibility (or limited criminal responsibility). According to the statistics of

56 § 140 CCP.
57 Antal Albert – Laczkó János – Kardon László, 'A kényszergyógykezelés és az ideiglenes kényszergyógykezelés büntetőjogi és büntető-eljárásjogi problematikája' ('Issues of criminal substantive and procedural law of involuntary treatment and temporary involuntary treatment'), *Börtönügyi Szemle* 4 (2002), p. 108.
58 Commentary to Act C of 2012 on the Criminal Code.
59 § 142 (1) CCP.
60 § 142 (2) CCP.
61 § 145 CCP.
62 § 66 (4) CCP.
63 §141 CCP.

June 2016, 21 persons were treated at the IMEI in the form of temporary involuntary treatment.[64]

Unfortunately, recent cases show that meeting the needs of defendants with psychiatric disturbances is not high on the IMEI agenda.[65] In a case brought before the Budapest Court of Appeal[66] the claimant requested just satisfaction for the breach of his right to physical and mental health, self-determination, freedom of movement and human dignity by the treatment he suffered at the IMEI during his pre-trial detention. He complained that his medical examination had been formal and that the prescribed treatment had only worsened his health condition. The court observed that the claimant had been treated without any evidence-based diagnosis, medication plan or control of the effects of medication. As a result of the medication, the claimant came to such a state in which the observation of his original problem was impossible. The claimant has practically been sedated throughout his stay at the IMEI. The court emphasized that the IMEI had no legal authorization to act arbitrarily – invoking its own prison psychiatry practice – and sedate the patients instead of treating them according to their health condition. The arguments of the IMEI – namely the lack of personnel or necessary devices – cannot justify a practice that does not intend to ameliorate the psychological state of the defendant but that is used only to "make the inmates less trouble for the staff".

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

4.1 Proportion of prisoners with psychiatric disturbances

The number of prisoners with psychiatric disturbances cannot be specified, as no official disaggregated data is publicly available on the subject. One possible reason for this is the lack of a (legal) definition of a prisoner with psychiatric disturbance. Statistics can be found only on the number of persons referred to the IMEI. As of June 2016, *164 persons were involved in – permanent – involuntary treatment* at the institution.[67] Statistics on convicted persons held at the IMEI on other grounds than permanent involuntary treatment can be found only in the recent report of the Commissioner for Fundamental Rights. According to this, the IMEI accommodated *13 convicted persons who were not involuntarily treated*:

64 *Review of Hungarian Prison Statistics* 2016/2, p. 22.
65 See a more detailed evaluation of the functioning of the IMEI in Section 4.3.
66 Budapest Court of Appeal 7.Pf.21.908/2012/7.
67 *Review of Hungarian Prison Statistics* 2016/2, p. 6.

- 2 convicted prisoners, who became 'insane' in prison;
- 2 convicted prisoners under examination of their mental state;
- 8 convicted prisoners with neurological symptoms, and
- 1 convicted prisoner with personality disorder.[68]

Occasional data based on non-representative estimations – perceptions of prison psychologists – suggest that the proportion of detainees with psychological issues is high among the convicted population of penitentiary institutions, although in some cases the directors and non-medical personnel of prisons deny the presence of such prisoners.[69]

4.2 Psychiatric disturbances in prison

4.2.1 Screening and detecting psychiatric disturbances

One of the biggest innovations of the new Prison Code is the establishment of the risk assessment and management system. The system aims to identify the risks of recidivism, the foreseeable development and changes as well as the reintegration potential of the convicted. The new system's goal is to categorize the prisoners according to the risk they pose to fellow prisoners and to the order of the prison and to provide the prisoners with individual treatment fashioned according to their individual needs.[70] Prisoners are assessed with the help of predictive screening tools measuring the likelihood of self-harm, aggression, escape, substance abuse and the social status of the person in the prison subculture.[71] As already mentioned previously, with regard to the traditionally high suicide rate in Hungary,[72] special attention shall be given to the signs of (future) suicidal behaviour.[73] The new system is, however, criticized by experts as aiming to measure an *expected* and not an *actual*

68 See report of the Commissioner for Fundamental Rights, AJB-766/2017, *Monitoring visit to the IMEI*.

69 Report of the Hungarian Helsinki Committee, *Monitoring visit at the Hajdú-Bihar County Penitentiary Institution on the 11-12 of May 2015* (at: http://helsinki.hu/wp-content/uploads/MHB_jelentes_HBMBVI_final_2015.pdf) (last visited: 30 June 2017), p. 15.

70 Schmehl János, 'Az új szabályozás főbb szakmai elemei és üzenetei' ('Major elements and messages of the new regulation'), *Börtönügyi Szemle* 4 (2013) pp. 19-20; Schmehl János, 'A fogvatartottak kockázatelemzési és kezelési rendszere' ('Risk-assessment and -management System of detainees'), *Börtönügyi Szemle* 1 (2014) p. 33.

71 Vig Dávid – Fliegauf Gergely, 'A szabadságvesztés és az elkövetők reintegrációja' ('Imprisonment and the reintegration of offenders'), in: Borbíró Andrea – Gönczöl Katalin – Kerezsi Klára – Lévay Miklós (eds), *Kriminológia (Criminology)*, Budapest: Wolters Kluwer, 2016; Schmehl János – Pallo József (eds), *Korszakváltás a büntetés-végrehajtásban. Útmutató a 2013. évi CCXL. (Bv.) törvény megismeréséhez*. Budapest: A Büntetés-végrehajtás Tudományos Tanácsa kiadványai, 2015, p. 45.

72 See Section 3.2.

73 See 11/2010. (III. 26.) IRM.

behaviour of the prisoner, a criticism that can be disputed from an evidence-based scientific point of view.[74]

Screening is carried out by the Central Examination and Methodological Institute (CEMI) if the prisoner is sentenced to more than one and the half-year imprisonment and there is more than one year left to serve.[75] Screening tools are not specified in the legal framework, and the relevant provisions refer only to interviewing, psychodiagnostic testing, questionnaires and somatic health diagnostics.[76] The 30-day-long observation and examination is concluded with a summary report that includes the foreseen health and mental healthcare, security and reintegration tasks, which are necessary to diminish the risks in connection with the specific prisoner.[77] Risk assessment is carried out once again if an extremely high-risk prisoner is to be re-categorized for a change of imprisonment regime.[78]

Taking a look at the practice of the risk-assessment procedure, a recent report of the Commissioner for Fundamental Rights as the NPM observed that prisoners are placed under depressing conditions at the CEMI. During the 30 days of assessment they have no access to any programmes, television, etc., nor do they receive any treatment.[79]

All prisons operate an ADC. If the prisoner has not been assessed in the CEMI, the ADC is required to carry out the necessary risk assessment.[80] Focusing on the duties that can relate to defendants with psychiatric disturbances, the ADC has the following tasks:[81]

- classification of the convicted into one of the regimes according to the results of the risk-assessment and revisiting the original classification if needed;
- initiating/terminating the participation of the convicted in a reintegration programme, evaluation of the results of the programme;
- decision on the involvement of the convicted in work-therapy on the basis of the recommendation of the prison physician;
- placement/termination of placement in a curative-therapeutic unit;
- placement in a psychosocial unit.

74 Vig – Fliegauf, *ibid.*

75 § 92 (2) Prison Code.

76 § 30 (2) of the decree no. 16/2014. (XII. 19.) IM of the minister of justice on the detailed regulation of the execution of imprisonment, custody, pre-trial detention and custody substituting fine.

77 § 92 (3) Prison Code.

78 The regime means an execution environment – established by the principals of the institutions of the prison service in accordance with the law – that is adjusted to the principle of individualization and that aims to fulfil the reintegration aims concerning the convicted person (§ 82 point 6. Prison Code). Different regimes mean differences in isolation from the outside world, surveillance and control, daily plans, rewarding and discipline, etc.

79 Report of the Commissioner for Fundamental Rights, AJB-776/2017, *Monitoring visit to the IMEI*, pp. 26-27.

80 § 95 (4) Prison Code.

81 § 96 (1) Prison Code.

4.2.2 Special units and mental healthcare for persons with psychiatric disturbances in prisons

The prisoner shall be placed in a *curative-therapeutic unit* – after an examination at the IMEI – if he/she:[82]

- has a limited criminal responsibility;
- has been treated at the IMEI during the execution of imprisonment because of his or her insanity but his or her mental state has improved in a measure that enables the imprisonment to continue;
- Suffers from a personality disorder, the nature or severity of which indicates the placement in this unit.

The reintegration[83] of prisoners placed in a curative-therapeutic unit shall be carried out in the form of a complex therapeutic programme. They shall be provided with work therapy, education and psychological support.[84] Curative-therapeutic units are used to accommodate prisoners with severe personality disorders (e.g. antisocial, schizoid, borderline) and prisoners with (mild or moderate) intellectual disabilities. Recently, the number of prisoners diagnosed with schizophrenia has been increased in these units as well. The prisoner is referred to the curative-therapeutic unit if his or her psychological disturbances exceed the more simple symptoms, which are usually treated with medication.[85] The curative-therapeutic unit can be operated both as a closed and as an open-door regime, although it is more common to operate in the latter.[86] Curative-therapeutic units currently operate in 14 prisons throughout the country.[87]

The curative-therapeutic unit is operated by a multidisciplinary working group, consisting of a prison physician, a clinical psychologist, a psychiatrist, the reintegration officer of the unit and other professionals providing support in the form of social work. According to the legal framework, reintegration and security officers shall have the necessary empathy to work with this special group of prisoners. It is desirable that the unit involve professionals from civil organizations, religious groups and charity organizations to facilitate

82 § 106 (1) Prison Code.

83 Under the new Prison Code the whole process of carrying out the imprisonment is referred to as 'reintegration'. For a narrower use of the concept, see subchapter VI.

84 § 106 (4)-(5) Prison Code.

85 Schmehl – Pallo (eds), *ibid*., p. 55.

86 *Ibid*.

87 Order no. 57/2016. (XII. 16.) OP of the General Director of the Prison Service Headquarters on the execution of decree 55/2014. (XII. 5.) BM of the minister of interior on the rules of the appointment of penitentiary institutions executing imprisonment, custody, custody substituting fine, pre-trial detention and custody for an administrative offence.

the reintegration programmes. Prisoners not fit for work shall participate in work therapy provided by certain companies or the prison itself.[88]

The prisoner shall be placed in a *psychosocial unit* if he or she suffers from personality disorder or if his or her mental state requires specific care, but the requirements of the placement in a curative-therapeutic unit are not fulfilled. Regarding the severity of psychological disturbances, the psychosocial unit is a transition between the general units and the curative-therapeutic unit.[89] The defendant can also be placed in a psychosocial unit if it is required because of his or her personal circumstances or the nature of the committed offence or because he or she is endangered for any other reasons and his or her detention can be realized securely only in this unit.[90] For example, in case of advanced age, frail physique or poor health condition.[91]

The reintegration of prisoners placed in a curative-therapeutic unit shall also be carried out in the form of a complex therapeutic programme.[92] Psychological counselling is provided on the demand of the prisoner or on the initiative of prison staff members. The programmes provided for the prisoners of the unit shall focus on the utilization and development of existing skills.[93]

Observing the relevant practice, there are prisons where curative-therapeutic or psychosocial units would be needed for the adequate treatment of vulnerable prisoners. These special units are, however, not available in all facilities. Special needs of prisoners are, therefore, not met everywhere. Facilities lacking special units place their prisoners in the infirmary or in cells preserved unofficially for persons with special needs. This means that the required therapy is not ensured in these prisons, although it would be obviously needed. The most probable reason for this is the lack of qualified staff at the facility. On the other hand, the prison cannot differentiate between prisoners beyond the explicit requirements of the legal regulation because of the overcrowding (i.e. no other special units or different levels of regimes can be organized). This causes a significant work overload for the staff.[94]

The professional work of psychologists is specified in the Methodological guidelines (hereinafter: Guidelines) for prison service psychologists on the activity with the persons

88 Order no. 24/2017. (II. 14.) OP of the general director of the Prison Service Headquarters on the execution of reintegration tasks in connection with prisoners placed in units designed for prisoners requiring special treatment and in other special units.

89 Schmehl – Pallo (eds), *ibid*., p. 56.

90 § 70 (1) decree no. 16/2014. (XII. 19.) IM.

91 Schmehl – Pallo (eds), *ibid*., p. 56.

92 § 107 (2) Prison Code.

93 Order no. 24/2017. (II. 14.) OP.

94 Report of the Hungarian Helsinki Committee, *Monitoring visit at the Hajdú-Bihar County Penitentiary Institution on the 11-12 of May 2015* (at: http://helsinki.hu) (last visited: 30 June 2017), pp. 7-8.

in detention[95] issued by the director general of the prison service. According to the Guidelines, the goal of the prison service is that one psychologist should look after a maximum of 150-200 persons in detention. Furthermore, if the detained are placed in special units (juveniles, long-term convicted, prisoners at curative-therapeutic units, HIV units, etc.) a psychologist should look after a maximum of 50-70 persons in detention. A comparison of the aims and goals of the prison service with everyday reality yields results that are exasperating. According to the reports of the Commissioner for Fundamental Rights and the Hungarian Helsinki Committee on the monitoring of Hungarian prisons, it can be generally stated that we find a huge lack of psychologists or staff members who can give psychological support to prisoners.[96] Psychologists are often responsible for counselling 200-plus or even 300-plus prisoners. They usually have consulting hours for private counselling but also organize support groups or specific group therapy.[97] Experience also shows that detainees seek support from the medical staff of prisons as well.[98] The reason for this might be twofold: on the one hand, they cannot have a private appointment with the psychologist within a reasonable time because of the psychologist's limited working capacity, while, on the other hand, visiting a psychologist may still result in stigmatization in Hungarian (prison) society, while visiting a doctor is widely accepted. An important example of involving the staff in the support of prisoners is the initiative of the Psychological Department[99] of the Tököl Juvenile Penitentiary Institution, which organizes training for the staff members of the prison on providing psychological support for the detainees.[100]

The Commissioner for Fundamental Rights recommended an increase in the number of psychologists in each of the visited institutions.[101] It is important to note that psychologists should be employed also in order to detect early signs of psychiatric disturbances and prevent decompensation (losing the ability of normal psychological functioning) of detainees. In the Hungarian system psychologists do not enter into contact with all prisoners of the facility because of their workload; they usually give appointments to those who ask for counselling and have very limited time even for these prisoners. The idea of prevention is, therefore, very much neglected in the Hungarian prison system (similarly to the general health system).

95 Annex no. 1. of order no. 89/2015. (XII. 18.) OP of the director general of the Prison Service on the issue of the methodological guidelines for prison service psychologists on activities with the persons in detention.

96 See the reports of the Commissioner for Fundamental Rights, AJB-679/2017, *Monitoring visit at the Sátoraljaújhely Prison*, AJB-3865/2016, *Monitoring visit at the Somogy County Penitentiary Institution* and AJB-1423/2015, *Monitoring visit at the Juvenile Penitentiary Institution of Tököl*.

97 *Ibid*.

98 AJB-1423/2015, p. 19 and AJB-3865/2016, p. 26.

99 A Psychological Department can be organized if 3 or more psychologists work in full-time employment of the institution. See Annex no. 1. of order no. 89/2015. (XII. 18.) OP.

100 AJB-1423/2015, p. 17.

101 E.g. AJB-679/2017, p. 15.

4.3 Treatment and involuntary treatment at the IMEI

The IMEI as an in-patient healthcare institution carries out:[102]
- involuntary treatment and rehabilitation;
- examination and treatment of patients referred to temporary involuntary treatment (see previously);
- treatment and rehabilitation of persons convicted for imprisonment who became 'insane';
- psychiatric examination of detainees, whose pre-trial detention has been ordered to be executed at the IMEI;
- observation of the mental state of persons referred to the IMEI (see Section 2.2);
- psychiatric and neurological examination of prisoners referred to the IMEI by the prison physician;
- examination of prisoners preliminary to placement in the curative-therapeutic unit (see Section 4.2.2).

The IMEI also operates as an ambulance, and as such, it carries out:
- psychiatric care of prisoners;
- the tasks of a neurological ambulance;
- the tasks of an addictology ambulance.

A person engaged in a violent crime or in a criminal offence that endangers the public shall be subjected to involuntary treatment if he cannot be prosecuted owing to his mental condition and if there is reason to believe that he will commit a similar act. The crime shall carry a penalty of imprisonment of one or more years. Involuntary treatment in a mental institution is terminated if it is not necessary any more.[103] The person undergoing involuntary treatment is a detainee but also a mentally ill patient. The primary aim of involuntary treatment is therefore to cure, while the secondary aim is to prevent further criminal acts.[104]

The person (patient) undergoing involuntary treatment disposes over the same rights, protection of rights and enforcement of rights as a convicted prisoner. Concerning the rights in connection with the treatment itself, however, the patient enjoys all patients' rights defined in the HCA, unless they are incompatible with the nature and aim of the involuntary treatment.[105] Regarding the execution, the patient has no right to refuse the

102 § 2 (1) decree no. 13/2014 (XII. 16.) IM of the minister of interior on the execution of involuntary treatment and temporary involuntary treatment and on the tasks of the IMEI.
103 § 78 CC.
104 Commentary of the CC.
105 § 325 (2)-(3) Prison Code.

involuntary treatment ordered by a court. He or she is only entitled to refuse a certain treatment method and the specific medical interventions. Self-determination shall otherwise be interpreted according to the HCA.[106] A closer look at this regulation shows that the provisions are quite difficult to interpret. It is not clear to what extent patients can refuse certain treatment methods or medical interventions if the treatment as a whole is obligatory. This always raises the question of alternative treatment and provides no answer to the issue where no alternative treatments are available. Similar concerns are raised in the literature.[107] Restraints can be used only in cases defined in healthcare regulations, and only the methods of restraint defined in these regulations are lawful.[108]

The therapy at the IMEI is carried out by a professional team, including security officers, nurses, reintegration officers,[109] psychologists and psychiatrists. The individual and group therapy is primarily the task of the Clinical Psychology Department.[110] The therapy focuses on the treatment of the mental disorder – mostly schizophrenia or other disorders resulting in a psychotic state – with the main aim of minimizing the risk of reoffending. The patients are treated with a combination of medication and psychotherapy.[111] Case discussions are organized in order to provide insight for all members of the multidisciplinary team into a certain patient's treatment.[112] Group programmes are led by the professional team, using the tools of work, art and community therapy. According to staff professionals, problems of the involuntary treatment arise from the dichotomy of treatment and punishment: patients rarely perceive the deprivation of liberty as therapy, more often experiencing this deprivation as punishment for a crime. This may lead to a lack of motivation for cooperation. Additionally, psychologists providing therapy and carrying out the evaluation required for discharge are the same professionals, and this often results in resistance, mistrust and hiding. While diagnostics requires neutrality and objectivity, the therapeutic setting needs trust, acceptance and a supportive attitude.[113]

The group therapy system of the IMEI follows the needs of the patients from admission to discharge. The starting stage of the therapy is the group supporting integration into the institution, specifically designed for patients under temporary involuntary treatment. After the integration phase, various therapy groups are offered for the patients: psychoeducation

106 § 330 (2) Prison Code.

107 Kovács Zsuzsa Gyöngyvér, 'A kényszergyógykezelés végrehajtása a nemzetközi dokumentumok és a hazai gyakorlat tükrében' ('The execution of involuntary treatment in the light of international documents and domestic practice'), *JURA* 2 (2013), p. 95.

108 § 336 (1) Prison Code.

109 See Section 6.1.

110 Hamula János – Uzonyi Adél, 'Az Igazságügyi Megfigyelő és Elmegyógyító Intézet csoportterápiás rendszerének bemutatása' ('Introducing the group therapy system of the Forensic Psychiatric and Mental Institution'), *Börtönügyi Szemle* 4 (2015), p. 35.

111 *Ibid*., pp. 36-37.

112 *Ibid*., p. 37.

113 *Ibid*., p. 39.

group for patients and family members, thematic groups and group therapy aiming at skill development.[114]

The most recent information on the everyday operation of the IMEI is available in the 2017 report of the Commissioner for Fundamental Rights.[115] Unfortunately, the report reveals serious deficiencies in the functioning of the IMEI, with regard to both the unsatisfactory material conditions of the facility but also the lack of professionals and human rights violations during treatment:

- patients reported on ill-treatment (beatings and verbal aggression) by staff members;[116]
- no easily accessible information material for patients;[117]
- detrimental conditions of the facility itself;[118]
- personal space of patients falls below the statutory minimum: bedrooms are so large that they do not allow any private space (this goes against the recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT));[119]
- low number of professional staff: psychologists are involved mainly in testing and assessment instead of in providing therapy, resulting in work overload and risk of burnout;[120]
- no efforts are made to involve all patients in therapeutic activities.[121]

All of these anomalies cause an infringement of fundamental rights or the risk thereof. The work overload of psychologists and the lack of time for psychotherapy are also confirmed by other sources. According to statistics, approximately 87% of the working time of a psychologist is used for diagnostics, which leaves only 13% for therapy.[122]

The length of the treatment is not specified in the CC. It shall be terminated, if it is not necessary any more, according to the opinion of medical experts. This indefinite length of the treatment has been criticized by the literature and human rights organizations.[123] The indefinite length of treatment is contrary to the *nulla poena sine lege* principle, which

114 *Ibid*., pp. 41-44.
115 Report of the Commissioner for Fundamental Rights, AJB-766/2017, *Monitoring visit to the IMEI*.
116 AJB-766/2017, p. 34.
117 *Ibid*., p. 11.
118 *Ibid*., p. 13.
119 *Ibid*., p. 16.
120 *Ibid*., pp. 18-19.
121 *Ibid*., p. 27.
122 Hamula – Uzonyi, *ibid*., p. 38.
123 See Tóth Mihály, 'Az új Btk. bölcsőjénél' ('At the cradle of the new Criminal Code'), *Magyar Jog* 9 (2013); Nagy Ferenc, 'A szabadságelvonással járó szankciókról az új Btk.-ban' ('Sanctions with deprivation of liberty in the new Criminal Code'), *Börtönügyi Szemle* 4 (2014); Report of the Hungarian Helsinki Committee, *Monitoring visit to the IMEI on the 7-9 August 2013*.

requires the exact definition of criminal sanctions.[124] It may also be contrary to the principle of non-discrimination in that persons referred to the IMEI may serve a much longer time than prisoners because the review of their treatment is unsuccessful. Some authors explicitly state that the reason for the reintroduction of the indefinite duration has very practical reasons, namely that psychiatric hospitals in Hungary are not prepared to receive more patients.[125] Others emphasize that the indefinite length of the treatment is clearly a method of trying to mask a medical problem as a criminal policy one.[126]

Trying to comply with human rights standards despite the indefinite length of deprivation of liberty, the regulation foresees a periodic review of the involuntary treatment. During the third month of treatment, the director of the IMEI sends a comprehensive report on the current health state of the patient to the competent court to review the necessity of the treatment. This procedure shall be repeated every 6 months. The director of the IMEI decides – according to the mental state – whether the patient shall attend the review procedure before the court.[127] In the procedure the court examines the following questions:

- Has the patient recovered?
- Is there a risk of reoffending?
- Is it necessary to uphold the treatment to protect society?[128]

A somewhat older study of the Mental Disability Advocacy Centre (MDAC) examined whether the periodic review of involuntary treatment corresponds to the requirements of the ECHR.[129] The study found that at first glance hearings by the competent court fulfil the mandate of Article 5 (4) of the ECHR but that there are major deficiencies in the regulation and practice.[130]

a) The director of the IMEI has the right to decide about the patient's attendance at court. This is significantly more problematic, as a new Prison Code has been adopted since the study. The same *unchecked discretionary administrative power*, however, has been included in the new legal regulation as well, although the provision has been

124 Nagy Ferenc, *ibid*., p. 14.

125 Tóth Mihály, *ibid*., p. 534.

126 Pallo József, 'Büntetéstől menten (Gondolatok a kényszergyógykezelés néhány sarokpontjáról)' ('Without penalty. Thoughts on the main elements of involuntary treatment'), in: Deák Ferenc – Dr. Pallo József (eds), *Börtönügyi kaleidoszkóp. Ünnepi kötet Dr. Lőrincz József 70. születésnapja tiszteletére*, Budapest: Büntetés-végrehajtás Tudományos Tanácsa, 2014, p. 168.

127 § 329 (1) and (3) Prison Code.

128 Commentary of the CC.

129 Mental Disability Advocacy Centre, *Liberty denied – Human rights violations in criminal psychiatric detention reviews in Hungary*, Budapest: MDAC, 2004.

130 In connection with the MDAC study, it has to be noted that new empirical studies should be conducted in order to have topical information on probable changes.

criticized by the Hungarian Supreme Court already in connection with the former regulation.[131]

b) There are *no clear legal criteria* specifying the grounds on which the judge shall maintain or terminate involuntary treatment: "Judges are free to make arbitrary decisions or to show total subservience to the psychiatrist-expert."[132]

c) In the 60 hearings that the MDAC observed, the *average length of a hearing was about 7 minutes*. In this time frame judges had to hear the prosecutor, the patient, the attorney (and other possible participants), analyse the medical opinion, announce the judgment and give reasons. Considering the extreme brevity of the procedure, MDAC evaluated the hearings as extremely superficial.[133]

d) Judges *did not have a comprehensive report on the relevant social circumstances* of the patients. If the patient requires release, the judge does not have any information on the possible alternatives to involuntary treatment.[134]

e) Attorneys representing the patients *do not provide meaningful representation* as they "do not meet the client before the hearing; say things to the court which they have not been instructed to say by their clients; they do not challenge evidence even when their clients have said to the court that they do not agree with the evidence; and they do not challenge any aspect of the treating psychiatrist's or the court-appointed psychiatrist's report".[135]

f) *Judges accept psychiatric opinions without any further questions* or clarification. One reason for this could be that experts were not present at any hearings and that, consequently, if the judge wanted to ask a question, he or she would have to adjourn the case, instruct the psychiatrist to attend and resume the case later.[136]

Summarizing the foregoing reports of the Commissioner for Fundamental Rights and the MDAC brings us to conclude that the facility of the IMEI itself, as well as the treatment provided by the institution and the review of its necessity has to be subjected to major changes in the future in order to adequately meet current human rights standards and the needs of patients. It is, however, not easy to realize any changes in either dimension, as persons under involuntary treatment are still strongly stigmatized and their issues are, therefore, not high on the political agenda.

131 In 3 cases the patient's presence at such hearings was denied by IMEI for 'practical' or 'expediential' reasons. The Supreme Court found these procedures to be unlawful and ordered new review procedures. See court decisions: BH 1977.537., BH 1978.12., and BH 1989.437. *ibid*., p. 20.

132 *Ibid*., p. 21.

133 *Ibid*., p. 22.

134 *Ibid*., p. 23.

135 *Ibid*., p. 24.

136 *Ibid*., p. 28.

5 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

The report on the visit at the IMEI of the Commissioner for Fundamental Rights as the NPM under OPCAT[137] addresses the issue of placing the patients in other mental or social care facilities in detail. As a general observation, the report emphasizes that the number of patients allowed on adaptation leave[138] is extremely low. It is, of course, important to examine the measure of protectiveness of the environment receiving the patient – this plays a significant role in making the decision on adaptation leave. To explore the characteristics of the receiving environment, the IMEI introduced a special form of family therapy consultation.[139]

Nonetheless, patients of the IMEI could, in the long run, be placed in residential social care institutions for psychiatric patients. According to the law, adaptation leave may be spent with any person suitable for taking care of the patient and accepting this task. The commissioner advocates the wide interpretation of this provision, namely that if the residential institution accepts the patient from the IMEI, it should be permissible for the patient to spend the adaptation leave in his or her future environment.[140]

In this context the commissioner refers to the discrepancies of the deinstitutionalization process in Hungary. Indisputably, institutionalization of persons with disabilities leads to isolation and stigmatization. It is also contrary to Articles 12 and 19 of the CRPD. The Commissioner for Fundamental Rights of the Council of Europe advocated the cessation of new placements in institutions along with ensuring for persons with disabilities the conditions based on effective support of the right to live in the community. Interpreting this issue in the context of the discharge of patients of the IMEI, the Commissioner for Fundamental Rights highlights the fact that obstacles to the deinstitutionalization process make the placement of IMEI patients significantly more difficult and the CRPD-compatible placement of the patients clearly impossible.[141]

According to the director of the IMEI, the number of patients treated at the institution practically stagnates, and although the number of admissions decreased recently, this was not followed by an increase in the number of discharges. The reason for this is the lack of a protective environment where patients could be discharged. It can be honestly stated that some patients are in the IMEI only because they have no other place to go to. The family is unable or unwilling to receive them, general social care institutions or social care institutions for psychiatric patients do not have the necessary number of places available.

137 Optional Protocol to the Convention against Torture (2006).
138 See Section 6.3.
139 AJB-766/2017, p. 28.
140 *Ibid.*
141 AJB-776/2017, p. 29.

In some cases, patients have to wait for a place for more than 5 years. Stigmatization is once again a problem, as social care institutions are not eager to accept former patients of the IMEI. A further problem is that if a social care institution has a vacancy, the interest of the institution is to fill it as fast as possible. Patients from the IMEI, however, cannot be discharged quickly enough, because a court needs to review the necessity of involuntary treatment.[142]

Considering all these circumstances, it is not surprising that according to psychologists interviewed during the monitoring by the commissioner approximately 10-20%(!) of the patients reside in the IMEI only because they "have nowhere to go". The treatment of patients who (a) are in need of involuntary treatment and who (b) are not in need of involuntary treatment any more does not differ significantly.[143]

The Commissioner for Fundamental Rights concludes – very accurately – that the deprivation of liberty of such persons who are not in need of involuntary treatment any more constitutes a breach of the right to liberty and security of the person as defined in Article IV Section (2) and the prohibition of torture, inhuman or degrading treatment as defined in Article III Section (1) of the Fundamental Law of Hungary.[144]

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

6.1 General remarks

A discussion of the issues of reintegration essentially includes three central concepts: resocialization, rehabilitation and reintegration. According to the traditional Hungarian definition, rehabilitation and reintegration are the two pillars of resocialization.[145] Rehabilitation in this context means the preservation or amelioration of the defendant's physical and mental health through the provision of healthcare, psychological support, harm reduction practices, etc.[146] Reintegration, on the other hand, means the re-entry of the prisoner into society or into the personal environment, the re-acceptance of the general roles as a citizen and the cessation of offending (desistance).[147] Although the Prison Code

142 *Ibid.*, p. 30.
143 *Ibid.*
144 *Ibid.*
145 Borbíró Andrea – Szabó Judit, 'Harmadlagos megelőzés a magyar büntetés-végrehajtási intézetekben a nemzetközi kutatások fényében' ('Tertiary prevention in Hungarian prisons in the light of international research'), in: Vókó György (ed), *Kriminológiai Tanulmányok 49 (Studies in Criminology 49)*, Budapest: OKRI, 2012, p. 160.
146 Vig – Fliegauf, *ibid.*
147 Vig – Fliegauf, *ibid.*

refers only to the reintegration of offenders explicitly, this term is often interpreted as resocialization by the literature. The reason for this is that the general reasoning of the Prison Code defines the development of the prisoner's personality as a primary aim of correctional facilities, in the sense of not only desisting from crime but also striving to be a useful member of society.[148]

The entire reintegration process – under the Prison Code – should aim to ensure that the prisoner recognizes the dangerousness of his or her criminal offence towards society and strives after the mitigation of its consequences. Defendants shall participate in education or vocational training and the director of the prison decides whether they can be supported in participating in higher education.[149] The prisons shall provide the opportunity of regular work to all defendants.[150] For an effective reintegration prisons shall promote family contacts and other contacts with the outside world and shall enable the participation of the Prison Pastor Service in the reintegration process. Cultural programmers, sports and religious activities shall be enabled in order to spend leisure time usefully.[151]

Evaluating the new 2013 Prison Code, the literature emphasizes the paradigm shift of the prison service in comparison with the former aims and goals of the system. Reintegration is now a central concept of the prison service, as reflected even by the terminology of the law. Officers formerly known as 'instructors' or 'educators' are now called 'reintegration officers', the 'instruction' or 'education' of prisoners is now the 'reintegration process', the former 'curative-instructive unit' is now a 'curative-therapeutic unit'.[152] The integration process hallmarks the whole duration of the sentence, not only its final stage before the release. The Prison Code and the prison service see work as a key element of reintegration and as a tool to improve responsibility, self-esteem and autonomy.[153] A new form of deprivation of liberty is introduced by the Prison Code under the name 'reintegration custody',[154] where the prisoner regains a limited liberty as far as he or she can leave the prison but can stay only in a home appointed by the court.[155]

As we see, on the normative level, reintegration is a priority in the Hungarian prison system. There is a consensus, however, in empirical research that everyday attitudes and practices may differ greatly from this framework.[156] A somewhat older empirical study

148 Katalán Gergely Tamás, 'Reszocializáció és reintegráció – dogmatikai vagy terminológiai különbségek az új Bv. Kódexben' ('Resocialisation and reintegration – a dogmatic or a terminological difference in the new Prison Code'), *Arsboni* 2015, (at: http://arsboni.hu) (last visited: 30 June 2017).

149 § 164 (1) Prison Code.

150 § 164 (5) Prison Code.

151 § 164 (6)-(8) Prison Code.

152 Schmehl, 'Az új szabályozás főbb szakmai elemei és üzenetei', *Börtönügyi Szemle* 4 (2013) p. 18.

153 *Ibid*., p. 19.

154 §§ 61/A-61/D Prison Code.

155 *Ibid*., p. 21.

156 Albert Fruzsina – Bíró Emese, 'A sikeres reintegráció' ('Successful reintegration'), in: Albert Fruzsina (ed), *Életkeretek a börtönön innen és túl. Szubjektív reszocializációs esélyek (Life frameworks in the prison and*

from 2011[157] – based on individual and focus group interviews – discovered that according to prison professionals, resocialization should be the main focus and goal of the prison. There are, however, objective obstacles to reaching this goal in terms of lack of (trained) personnel, poor material conditions and infrastructure in prisons, overcrowding, etc.[158] Another – probably more interesting – result of the study is that prison psychologists are generally expected to ensure the everyday secure functioning of the prison. No one – not even the psychologists themselves – defines the prevention of reoffending or the change in the behaviour of prisoners as the goal of their work. Desistance is usually bound up with the concept of structural readaptation of the prisoners to society, in terms of increasing their chances in the labour market. The most important tools for reintegration are therefore – as seen previously – work, education and training. Only a couple of interviewees regarded psychological support as a means of reintegration.[159] Professionals also emphasize that it is a great disadvantage that society does not take any responsibility for the reintegration of prisoners. Reintegration is expected from the prison service alone. This is problematic, on the one hand, because possibilities of the prison service are very limited and, on the other hand, because it indicates that society has still not realized its own basic interest in reintegrating its criminals.[160]

A hopeful sign is that after a successful project in 2010-2012, 'Establishing methodological grounds for crime prevention and reintegration programmes strengthening social cohesion',[161] a new reintegration project 'Reintegration of prisoners' has been launched in 2016 and will last until 2020 in the most underdeveloped regions of Hungary.[162] The project provides the following services to prisoners:[163]

- developing competencies (personality, skills and capacities);
- vocational training (acquiring a marketable profession according to competencies and the demands of the labour market);
- human services and services promoting reintegration (support groups, counselling, labour market information, support in finding a home and having the required documents for healthcare);

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beyond. Subjective chances of resocialization), Budapest: Magyar Tudományos Akadémia Társadalomtudományi Kutatóközpont, 2015, p. 144.

157 Borbíró – Szabó, *ibid.*

158 *Ibid.*, pp. 174 and 179.

159 *Ibid.*, pp. 175-176.

160 *Ibid.*, p. 187.

161 A társadalmi kohéziót erősítő bűnmegelőzési és reintegrációs programok módszertani megalapozása ('Establishing methodological grounds for crime prevention and reintegration programs strengthening social cohesion'), TÁMOP 5.6.2-10/1-2010-0001 Project, Financed by the European Social Fund.

162 Fogvatartottak reintegrációja ('Reintegration of prisoners') EFOP 1.3.3-16-2016-00001 Project.

163 Tettekkel az eredményes társadalmi beilleszkedésért. Az EFOP 1.3.3-16-2016-00001 azonosító számú, Fogvatartottak reintegrációja című projekt nyitó kiadványa, (at: www.tettprogram.hu) (last visited: 30 June 2017).

- strengthening the natural support network of the prisoner and preparation of the local community to receive the former prisoner;
- restorative justice techniques (re-establishing family contacts, repairing the harm caused by the criminal offence);
- follow-ups.

6.2 *Reintegration in the curative-therapeutic and psychosocial unit*

As mentioned previously,[164] the Prison Code foresees the reintegration of prisoners placed in the curative-therapeutic or psychosocial group as a complex therapeutic programme. Prisoners shall receive work therapy, education and psychological support.[165] The project 'Establishing methodological grounds for crime prevention …' made an explicit reference to prisoners in curative-therapeutic and psychosocial units and offered, primarily, the preparation of social integration/reintegration and, secondarily, the labour market integration/reintegration. The project accepted the special significance of trainings and skill development, the promotion of autonomy and positive changes in the way of living. The description emphasized, however, that these services are *not* of therapeutic nature and are detached from the curative tasks.[166] In this regard, the project, once again, did not aim directly at resocialization in the sense of achieving changes in the personality of the prisoners but focused on the therapeutic effects of work and training – regarding changes in the personality as a probable side effect. As the new 'Reintegration of prisoners' project began only on 1 October 2016[167] and is currently taking its first steps, no detailed information is available on the methodology for reintegrating prisoners with special needs at special units. But if the new project is based on the aims of the former, the same lack of resocialization aims can be identified in this one as well.

6.3 *Reintegration at the IMEI*

The last stage of the therapy at the IMEI is carried out in a rehabilitation group. Participants in this group are patients in a stable, compensated state with the necessary reality control and motivation. The group uses verbal and nonverbal methods and helps patients to integrate negative memories of the former social environment into their personality and articulate fears and expectations in connection with discharge. Although efficacy has not

164 See Section 4.2.2.

165 § 106 (4)-(5) and § 107 (2) Prison Code.

166 *A fogvatartottak többszakaszos, társadalmi és munkaerőpiaci reintegrációja és az intenzív utógondozás modellje* Projektismertető (at: http://tettprogram.hu), p. 20.

167 Tettekkel az eredményes társadalmi beilleszkedésért.

been measured, after 31 sessions the group could be defined as a cohesive group, and 9 of the 12 participants could be discharged from the IMEI in the following year. The aforementioned family therapy consultation also encompasses the preparation of the receiving (family) environment of the patient for the discharge. Family members of the patient are required to take part in such consultations before the adaptation leave of the patient.[168]

After 6 months of involuntary treatment, the patient may be allowed on adaptation leave – on the recommendation of the adaptation committee of the IMEI – in order to facilitate his or her recovery. The 30-days' adaptation leave can be extended by another 30 days. Adaptation leave may be granted again and yet again in the course of the treatment.[169] As we have seen in the previous analysis,[170] however, adaption leave is practically a non-functioning institution of the Prison Code.

Discharge is decided by the court.[171] The court decision is practically based only on the expert opinion of the IMEI physician and two independent psychiatrists. Discharge is possible if the patient is in an adequately compensated state, has an insight into his or her mental disorder and is, consequently, capable of cooperating for a further voluntary treatment.[172] The aforementioned 'Establishing methodological grounds for crime prevention …' aimed at the social reintegration of those IMEI patients, whose placement in a social care institution was not foreseen. For those who were expected to live in an institution, the main aim of the project was to prepare the patient for the stay at a social care home and the maintenance of the remaining social contacts.[173]

7 Conclusion

Access to justice is a human right anchored in numerous international and national instruments and guaranteed also for persons with disabilities in the CRPD. This means that defendants with psychiatric disturbances should have the opportunity to participate in criminal procedures on an equal basis with others. Furthermore, special needs of defendants with psychiatric disturbances should be taken into consideration during pre-trial detention, imprisonment and involuntary treatment.

The current Hungarian criminal justice and prison system is in most cases still 'blind' to psychiatric disturbances of defendants and not sensitive enough to treat different types

168 Hamula – Uzonyi, *ibid*., pp. 44-45 and 47.
169 § 338 Prison Code.
170 See chapter V.
171 As seen above at the analysis of reviewing the necessity of the treatment in Section 4.3.
172 Hamula – Uzonyi, *ibid*., pp. 36-37.
173 *A fogvatartottak többszakaszos, társadalmi és munkaerőpiaci reintegrációja és az intenzív utógondozás modellje* Projektismertető, p. 21.

of mental disorders differently. The system operates on a more or less binary basis. If the defendant shows acute symptoms of a severe psychiatric disturbance, he or she is referred to the IMEI. Even the IMEI has only two types of patients: a high-security patient in need of treatment and 'cured' patients ready to discharge.[174] Defendants with other, less striking mental disorders, however, are given psychological support only on an ad hoc basis.

Although curative-therapeutic units and psychosocial units are decidedly designed for prisoners with psychiatric disturbances, they do not differ much from regular units in terms of providing psychotherapy or counselling for inmates. This is hardly surprising as the aim of the reintegration process (i.e. the whole period of imprisonment) is centred on actual work and training or work therapy but not psychotherapy. Although prisoners undergo a risk assessment during the admission procedure, the assessed risks are taken into consideration only as security issues but not as individual psychological characteristics in need of particular methods of reintegration. These needs are rarely met in the prison setting.

This is no less unsurprising if we take a look at the number of trained personnel able to give psychological support for defendants (primarily, psychologists but also psychiatrists, reintegration officers and other professional helpers). It is doubtful whether psychologists can provide for individualized, regular and effective counselling or therapy in an adequate length of time if they are responsible for literally hundreds of prisoners in one institution. The Commissioner for Fundamental Rights as the NPM under OPCAT recommended increasing the number of psychologists in every single report published on his visits to prisons. Although the recommendations were met in some cases, psychological support still does not appear to be a primary goal of the prison service in Hungary.

Patients at the IMEI deserve special attention not only because of their unusual defencelessness but also because of the indefinite period of involuntary treatment. This clearly leads to serious human rights violations, particularly if the two major deficiencies of the practical functioning are taken into consideration. On the one hand, the review procedure – according to empirical data – proves to be insufficient to effectively evaluate the necessity of further treatment, while, on the other hand, there is a lack of residential care or family environment that can receive the patient. Both elements result in the unnecessary, and therefore unlawful, deprivation of liberty of the patients.

Finally, I would like to highlight the importance of disaggregated statistical data, particularly that of quantitative as well as qualitative empirical research in the field. I have indicated in more subchapters that the proportion of psychological disturbances among defendants remains unclarified. Statistical data on the prevalence of psychiatric disturbances, the sociological characteristics of prisoners with psychological disturbances, the applied therapy and its results, the chances of reoffending, etc. are either non-existent or inaccessible

174 Hungarian Helsinki Committee, *Report on the monitoring visit at the IMEI on the 7-9 August 2013*, p. 18.

to the public.[175] This makes it impossible to fully capture the dimensions of the problem. As the existing empirical data suggests, the issues concerning defendants with psychiatric disturbances are surely not marginal.

Using the study of Borbíró and Szabó as a source of inspiration, *society has to realize its own basic interest in reintegrating its criminals*,[176] an ideal that is impossible to realize without changing the conditions of reintegration, i.e. imprisonment or involuntary treatment. Detailed knowledge about the relevant issues and sensitivity to the significance of psychological phenomena would certainly contribute to the adoption of adequate legislation and policies on criminal justice and imprisonment in the future.

175 I personally think that data exists and is gathered by single prisons and also by the prison headquarters on the country level, but it is never analysed or evaluated.

176 Borbíró – Szabó, *ibid*., p. 187.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system in Ireland

Mary Davoren & Mary Rogan[*]

1 Introduction

Ireland, as with many other European countries, witnessed periods of great expansion, as well as rapid decline, in the number of mental health admission beds over the past 200 years. During the 1700s and early 1800s, psychiatric hospitals were almost non-existent in the country. But in the late 1800s asylums began to be built, and by the early 1900s Ireland had one of the largest numbers of mental health beds per head of population in Europe. Since then the number of psychiatric beds has steadily declined in Ireland, and mental health beds sharply so over the past three decades. Penrose law states that there is an inverse relationship between the numbers of psychiatric admission beds available in a jurisdiction and the numbers of individuals detained in prison settings. Brennan[1] argues that there has been a transfer of populations that would otherwise have been detained in mental health settings in Ireland into the prison population, a view echoed by the director general of the Irish Prison Service.[2] As the provision of mental health admission and longer stay beds decreases, many vulnerable, mentally disordered individuals instead find themselves detained in prison settings, in a process known as trans-institutionalization.

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1 Damien Brennan, *Irish Insanity 1800-2000*, Abingdon: Routledge, 2014.

2 Oireachtas Debates, Committee of Public Accounts, 2 February 2017.

In some cases, this may be appropriate and necessary, but in many cases placement of mentally disordered individuals in prison may be disproportionate to the offence committed and detrimental to their mental health and human dignity. As with many countries, people with mental illness are disproportionately represented in contemporary Ireland's prison population.

Recent decades have seen changes in legislation and policy concerning the treatment of people with mental disorders who come into contact with the criminal justice system. New laws were introduced to regulate this area in the form of the Criminal Law (Insanity) Act 2006, amended in 2010, and the Mental Health Act 2001. In 2006, the Report from the Expert Group on Mental Health Policy, called *A Vision for Change*, also recommended that "every person with serious mental health problems coming into contact with the forensic system should be afforded the right of mental healthcare in the non-forensic mental health services unless there are cogent and legal reasons why this should not be done".[3] However, *A Vision for Change* also advocated moving mental health services into the community accompanied by a reduction in the provision of mental health admission beds and a significant reduction in the provision of longer stay mental health beds. This reduction in bed provision is considered a factor in the increased numbers of mentally disordered individuals in prison settings. The extent to which this document's aspirations in the area of criminal justice has been realized is therefore unclear. This report examines Irish law and practice in this area.

2 Therapeutic security and the provision of mental health beds appropriate for the needs of mentally disordered offenders

In most developed countries, mental health services provide care and treatment in various inpatient settings. Forensic mental health services provide care and treatment in conditions of therapeutic security – providing beds at high, medium and low levels of security. In Ireland all forensic mental health admission beds are provided in one centre, the Central Mental Hospital (CMH) Dundrum, Dublin. This offers care and treatment to mentally disordered offenders at medium and low security levels, with one ward providing higher levels of relational security, although not in conformity with the international criteria for physical and procedural security that would be required for a true high secure hospital setting. The CMH Dundrum has a total of 94 beds, of which ten are for female patients and 84 for males. This gives a ratio of two forensic mental health beds per 100,000 of the population, significantly below the European and International averages. The UK, for example, has ten beds per 100,000 population, the Netherlands 14 beds per 100,000

3 Expert Group on Mental Health Policy, Report 2016, *Mental Health – A Vision for Change*, 2016, p. 137.

population. There are at present no low secure units around the country, although plans are in place to build these, and therefore the only admission beds available to those in contact with the criminal justice system are either the medium secure beds at the CMH Dundrum or open wards in the community settings. The lack of provision of low secure psychiatric beds in Ireland has a direct effect on the provision of care and treatment to individuals coming into contact with the criminal justice system in Ireland. For a coherent system of diversion to take place, low secure beds are needed as many such individuals, while not requiring the medium secure conditions of the CMH Dundrum, would not be safe to manage in an open ward in the community setting. Also, the lack of low secure locked units directly accessible to patients in community units that exceed the capacity of those units to safely care for them puts heavy pressure on the scarce CMH admission beds, which might be more appropriately utilized for mentally disordered individuals on transfer from sentenced prisons.

3 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedures

During the 2000s, two pieces of legislation altered the law governing the treatment of people with mental illness in the criminal justice system and more generally. The Mental Health Act 2001 changed the governance structures and mechanisms for voluntary and involuntary detention in healthcare settings. The Criminal Law (Insanity) Act 2006, which was amended in 2010, sought to modernize the law on fitness to be tried and verdicts where a person is suffering from a mental disorder as defined in that legislation. Under Section 1 of that act, a mental disorder includes mental illness, mental disability, dementia or any disease of the mind but does not include intoxication. The act deems the CMH a 'designated centre', that is the place for the reception, detention and care or treatment of those committed or transferred under the operation of the Criminal Law (Insanity) Act 2006.

Under Section 4 of the Criminal Law (Insanity) Act 2006, a person is deemed unfit to be tried in circumstances where the person, by reason of a mental disorder, is unable to understand the nature and course of the proceedings so as to:

(a) Plead to the charge;
(b) Instruct a legal representative;
(c) Elect for trial by jury in the case of an indicatable offence that can be tried in either the District Court or before a jury;
(d) Make a proper defence;

(e) Challenge a juror in the case of a jury trial; or
(f) Understand the evidence.

The defendant, the prosecution or the court may raise the issue of fitness to be tried (section 4(1) of the act). The definition of mental disorder that must apply in such a situation is that generally applicable under the 2006 Act and includes a mental illness, a mental disability, dementia or other disease of the mind.

The procedure that is involved depends on whether the person is being tried in the District Court or in the higher courts. The District Court in Ireland deals with minor offences; a judge sits alone without a jury. When a person is being tried before the District Court, that court will deal with any matters raised concerning the person's fitness to be tried. If the District Court holds that the person is not fit to be tried, it must adjourn the proceedings. The court may commit the person as an patient to a hospital setting or order that the person receive outpatient treatment as appropriate. The court may base this decision on the evidence of an 'approved medical officer', defined as a consultant psychiatrist.[4] Where the person is deemed unfit to be tried, it is possible, under Sections 4(7) and 4(8) of the act that he or she be acquitted or discharged. It is also possible for the court to commit the accused person to a designated centre for a maximum of 14 days and direct that the person receive a medical examination, or direct the person to attend such a centre as an outpatient, so as to decide whether a treatment order should be made. During this period, under Section 4(6) of the act, the medical officer must provide his or her opinion to the court as to whether the person is suffering from a medical disorder and whether inpatient or outpatient treatment is necessary. Furthermore, it is possible to appeal a decision concerning fitness to plead.

If the person is being tried on indictment, i.e. for a serious offence, it is for the trial court to decide whether or not the person is fit to be tried. An interdepartmental group has argued that such a trial should be mandatory where a person is deemed unfit to be tried and the court wishes to order inpatient care or treatment.[5] When a court commits an accused person as an inpatient to a specified centre for treatment, this detention will be subject to clinical review of the need for further detention, conducted by the Mental Health (Criminal Law) Review Board, which must ensure that the detention is reviewed at least once every six months. The patient is provided with funded legal assistance. The

4 Under Section 1 of the Criminal Law (Insanity) Act 2006, referring to the Mental Health Act 2001.
5 Interdepartmental group to examine issues relating to people with mental illness who come into contact with the criminal justice system, *Report of the interdepartmental group to examine issues relating to people with mental illness who come into contact with the criminal justice system*, 2014.

case of *FX v Director of the Central Mental Hospital*[6] held that the two-step procedure was an important protection for vulnerable persons.

Concern has been expressed regarding the proportionality of the possibility of indefinite detention in the CMH when the matter that gave rise to that detention was a minor offence. Plans are currently in place to develop four regional low secure units around provincial Ireland, known as intensive care regional units (ICRUs), and in the event these were to develop, and were named designated centres under the Criminal Law Insanity Act, an option would be available to the courts to detain an individual found unfit to stand trial in either conditions of medium therapeutic security, at the CMH Dundrum, or low therapeutic security at a regional ICRU. This would be an important development in least restrictive practice as well as freeing up beds at the CMH Dundrum for mentally disordered offenders who present a higher risk to the public.

There is no mechanism at present whereby a trial can be adjourned to allow for assessment and treatment when an issue arises as to the mental health of an accused person that is short of the standard required to make an application for unfitness to be tried. Such a power was recommended in the Implementation Plan for the recommendations of the Report of the Commission of Investigation into the death of Gary Douch.[7] Gary Douch was the victim of homicide perpetrated by a mentally disordered offender, and the review into the case highlighted the difficulties in managing such individuals in a prison environment. This recommendation has, however, been rejected by the interdepartmental group formed to examine issues relating to people with mental illness who come into contact with the criminal justice system, which argues that such a provision would add an additional layer to criminal proceedings. However, the group further argues that the courts should have the power to order an assessment from a prison in-reach service in such circumstances and that this service should have the power to notify the relevant court that a psychiatric assessment is necessary.[8]

The report into the death of Gary Douch reflects many concerns about the treatment of people with mental disorders in the current criminal justice system. One of the main themes of the report into the killing of Gary Douch was the difficulty of managing the care and treatment of prisoners in a system that has a very high level of movement of individuals between various wings within prisons as well as between different prisons. For example, prisoners are regularly transferred between units, when on remand, when sentenced, to attend court or other appointments and when placed on protection. This can lead to a

6 Ireland High Court, judgment of 3 July 2012, IEHC 271; Ireland Supreme Court, judgment of 23 January 2014, IESC 1.

7 Commission of Investigation into the Death of Gary Douch, Report 2014, *Report of the Commission of Investigation into the Death of Gary Douch*, 2014.

8 Interdepartmental group to examine issues relating to people with mental illness who come into contact with the criminal justice system, Report 2014, *First Interim Report*, 2014, p. 25.

breakdown in care provision unless there are very tight systems in place, as was the case in the aforementioned report authored by Gráinne McMorrow SC.

When a person is in police custody, the police have a general obligation to make sure that they are well treated and receive medical attention if necessary. The Custody Regulations of 1987[9] state that if a person in police custody inter alia fails to respond normally to questions or conversation (for reasons other than the influence of intoxicating liquor alone), or appears to be suffering from mental illness, then a doctor must be called, unless the person's conditions appear such as to necessitate removal to a hospital or other suitable place. Such medical examinations should be entered into the custody record, and if the person is taken to hospital then an immediate relative should be informed as soon as practicable. The Custody Regulations also contain a provision on what is described as the 'mentally handicapped', with special protections to be put in place during questioning.[10] These antiquated provisions need reform. Since 2014, the director of public prosecutions has instructed the gardaí (police) to permit solicitors to attend police interviews when the detained person so requests.

While this is the formal position in the law, it is by no means clear whether people with mental health difficulties are receiving the care they require while in police custody in all cases, and there is evidence that people who should be diverted to mental health treatment settings are still being processed by the police into the criminal justice system. McInerney and others have described the frustration of judges of the District Court at the repeated appearances of "visibly disturbed individuals charged with minor crimes, for whom there appeared to be no coherent system of rapid referral to psychiatric services for assessment".[11] These authors also reported police difficulties in obtaining medical assessments in police stations and long delays when those in their custody were brought to emergency departments or to psychiatric hospitals. Consideration has been given by policymakers and practitioners to the development of a diversion programme at the point of arrest or in police stations. Because of Ireland's predominantly rural population and the large number of police stations in local areas, it was decided that it would be unviable to establish such a service and that, instead, it should be placed within a prison dealing with pre-trial detainees.[12] As previously mentioned, however, without sufficient provision of low secure

9 Regulation 21 of the Custody Regulations S.I. No. 119 of 1987.

10 Regulation 22 of the Custody Regulations S.I. No. 119 of 1987.

11 Clare McInerney, Mary Davoren, Gráinne Flynn, Diane Mullins, Mary Fitzpatrick, Martin Caddow, Fintan Caddow, Sean Quigley, Fergal Black, Harry G. Kennedy, and Conor O'Neill, 'Implementing a court diversion and liaison scheme in a remand prison by systematic screening of new receptions: a 6 year participatory action research study of 20,084 consecutive male remands', 7 *International Journal of Mental Health Systems* 1 (2013), 18, p. 21.

12 *Ibid.*

admission beds throughout the country, the effectiveness of any court diversion service will remain limited.

The Mental Health Act 2001 governs civil committals to psychiatric care. Section 12 of the act allows the police to divert a person away from the prosecution system and into a mental health setting through the commencement of an application for assessment of the person.[13] The High Court has interpreted Section 12 in *A.B v. Commissioner of An Garda Síochána*[14] to the effect that the legislation suggests that the powers to detain a person civilly may not be exercised when a person is already in custody, i.e. after the power of arrest has been used. This is quite limiting. The interdepartmental group has recommended that where a person is admitted to an approved centre, they should still be able to benefit from the diversionary policies of the police.

Another judgment brings the pressures on the system into sharp relief. In *DPP and another v. Burlega*[15] the accused person was charged with two counts before the District Court. An issue arose as to whether the person was fit to be tried. The District Court then ordered that the person be assessed at the CMH to determine the question of fitness to be tried. However, when the person came to the hospital, its clinical director advised that there were no beds and that the person could not be detained there. The person was then brought to a garda (police) station. The person's lawyers then argued that there was no power to detain the person in the police station, and the person was released by way of an application under Article 40.4.2 of the Constitution, which provides for habeas corpus procedures.

Another issue concerns situations where a person has a mental illness but does not meet the criteria for involuntary admission. No official policy is in place to divert such individuals away from the criminal justice system. A policy to govern such a scenario has been proposed by the interdepartmental group. It recommended that diversion should apply when the person is aged 18 or over, when the offence involved is minor and sufficient prima facie evidence for prosecution exists in circumstances where the person has a mental disorder as defined in the Mental Health Act 2001, when the public interest does not require a prosecution, and when there is an offending pattern. The other conditions proposed are that treatment of the person may be more effective in preventing repeat offending than prosecution or punishment and that the person consents to assessment, treatment or care. The interests of the victim should be taken into account in such a decision. The group considered that only certain minor offences should be included in such a scheme, such as intoxication in a public place, disorderly conduct in a public place,

13 Figures indicate this accounts for 20% of all such admissions. Interdepartmental group to examine issues relating to people with mental illness who come into contact with the criminal justice system, *First Interim Report*, 2014, p. 8. This group is due to issue its second report in 2018.

14 Ireland High Court, judgment of 8 February 2013, IEHC 88.

15 Ireland High Court, judgment of 14 November 2013, IEHC 499.

theft of a value of less than €1,000, minor assaults and damaging property up to a value of €1,000. It is submitted that a more extensive and systematic approach to diverting people with mental illness away from the criminal justice system is needed. More training for the police in recognizing mental health problems is also necessary.[16]

The Mental Health Commission stated in 2011 that priority must be given to the establishment of diversion programmes.[17] It stated that mental health professionals, the police, lawyers and the courts in all regions should have a "comprehensive range of legislative and service options available to them in relation to mentally disordered people involved in criminal proceedings" and that there should be a national policy of diversion towards treatment and recovery options.[18] This reiterated a similar call by the Expert Group on Mental Health Policy in the *Vision for Change* document of 2006. However, for the successful implementation of systematic court diversion across the country, admission beds must be available in sufficient numbers to accept these referrals. Indeed, it is one of the contradictions of *A Vision for Change* that while recommending diversion for mentally disordered offenders where possible, the document also led to a dramatic reduction in psychiatric bed provision, and, indirectly, to increased numbers of mentally unwell individuals being detained in prison settings.

4 Detainees with psychiatric disturbances during provisional detention: needs, problems, screening tools

Since 2006 a well-regarded service has been in place that provides a full-time mental health team to coordinate screening of people remanded to Cloverhill prison, the main prison for pre-trial detention in Ireland. The Prison In-reach and Court Liaison Service (PICLS), provided by the National Forensic Mental Health Service and the Health Service Executive, supports diversion to mental health treatment. Medical and nursing staff attend the remand prison and screen all those newly remanded for major mental illness. A multidisciplinary mental health team is provided from Monday to Friday.[19] The team also takes referrals from prison staff. Those who are identified as severely mentally ill or who otherwise require

16 See further, Noel Baker, '100 remand prisoners a year referred for mental health treatment', *The Irish Examiner* (2014).

17 Mental Health Commission, *Position Paper – Forensic Mental Health Services for Adults in Ireland*, 2011.

18 *Ibid.*, p. 20; see also p. 24.

19 Conor O'Neill, Damian Smith, Martin Caddow, Fergal Duffy, Philip Hickey, Mary Fitzpatrick, Fintan Caddow, Tom Cronin, Mark Joynt, Zetti Azvee, Bronagh Gallagher, Claire Kehoe, Catherine Maddock, Benjamin O'Keeffe, Louise Brennan, Mary Davoren, Elizabeth Owens, Ronan Mullaney, Laurence Keevans, Ronan Maher, and Harry G. Kennedy, 'STRESS-testing clinical activity and outcomes for a combined prison in-reach and court liaison service: a 3 year observational study of 6177 consecutive male remands', 10 *International Journal of Mental Health Systems* 67 (2016).

considerable support from nursing and medical staff are placed on a landing for vulnerable prisoners. General practitioners and general nurses do rounds there each day, and the staff of the psychiatric in-reach team attend on five days per week. Multidisciplinary and interdisciplinary meetings are held. The full staff complement comprises a consultant psychiatrist, two to three psychiatric doctors in training, three forensic mental health nurses and a social worker, although not all posts have been filled at all stages.[20]

O'Neill *et al*. report that, during the currency of their longitudinal study, all those remanded to Cloverhill Prison were screened on committal, usually within two hours of their reception by prison nursing staff using a standardized tool. This generates automatic referrals. All committals were also seen within 24 hours by a prison general practitioner. Where concerns existed about the person's acute mental or physical health, the person would be transferred to a vulnerable persons' unit and placed under special observation. On the first working morning following committal, a member of the PICLS team reviews the screening results and GP's assessment, as well as electronic case note of previous committals, along with any referrals. Those identified as needing a psychiatric assessment were then seen by pairs of interviewers from the team and a detailed history taken. Any additional information is also reviewed, and if admission to a mental health unit is deemed appropriate, a structured assessment of need for security and urgency of need for admission using the DUNDRUM tool was completed. This tool is designed to assist with appropriate diversions by allocating patients to the appropriate level of security, for example differentiating those that need admission to the medium secure hospital in CMH Dundrum from those that can manage in an open community ward and triaging the waiting list according to urgency.[21]

The service provides medical reports to the courts on topics such as whether the person is fit to be tried, the diagnosis, if any, and treatment arrangements that could be put in place should the person be given a custodial or non-custodial sanction. The defendant/patient, in the majority of cases, attends outpatient treatment services on a voluntary basis. When this happens, the court adjourns the case to allow the person to access the treatment, and the court may grant bail on that condition. The person may also be sent to an approved centre for assessment and possible admission. The court may grant bail or, where the person is found guilty, impose a non-custodial sanction to allow for treatment in such a centre. When involuntary inpatient treatment is recommended by the medical staff, members of the team will prepare the relevant documentation and attend court with the defendant to provide oral evidence if called upon to do so by the judge. For women, a consultant psychiatrist leads a team to provide in-reach to the women's prison in Dublin.

20 *Ibid*.

21 For more information, see: Conor O'Neill *et al*., n. 20.

This scheme has resulted in thousands of screenings and hundreds of diversions of people away from the criminal justice system and into healthcare settings. Based on figures provided by the scheme, the interdepartmental group reports that during 2012-2014, there were 6,177 committals on remand to Cloverhill prison for pre-trial detention, representing 5,472 people. All were screened. A further 2,197 sentenced committals were also screened in the same period. Of this total of 8,374 committals, 1,205 (14.4%) were identified as requiring mental health assessment. The types of primary diagnoses (patients may have multiple diagnoses) within this group are outlined in Table 1.[22]

Table 1 Diagnostic breakdown for 1,205 committals assessed by PICLS at Cloverhill Prison 2012-2014

Diagnostic Group	Number	Percentage
Organic Mental Disorders	21	1.7
Substance Use Disorders	460	38.3
Schizophrenia, Schizotypal and Delusional Disorders	279	23.2
Bipolar Affective Disorder	49	4.1
Other mood disorders	74	6.1
Neurotic Disorders	6	0.5
Personality Disorders	222	18.4
Intellectual Disability	15	1.2
Childhood and Developmental Disorders	9	0.8
No Mental Illness or Adjustment Reaction only	70	5.8

Source: Interdepartmental Group to examine issues relating to people with mental illness who come into contact with the criminal justice system, *First Interim Report*, 2014.

Reflecting the complicated and multifaceted nature of the profiles of those sent to prison: 64% of this group had a history of deliberate self-harm, 35% were homeless and 86% of those assessed had a history of substance misuse disorders.

O'Neill *et al.* report that of 6,177 remands committed and screened, 1,109 were taken on by the scheme. About 251 were identified as having active psychotic symptoms (4.1% of all remands). A total of 60 people were admitted to a forensic hospital (0.97% of all remands), 81 to a general hospital (1.31% of all remands) and 208 were diverted to community outpatient facilities.[23] The numbers being diverted had increased from a

22 Interdepartmental group to examine issues relating to people with mental illness who come into contact with the criminal justice system, Report (2014), *First Interim Report*, 2014, p. 17.

23 Conor O'Neill *et al.*, n. 20.

2006-2011 review. The numbers identified as homeless had also increased during this period. McInerney *et al.* and O'Neill *et al.* have found that the performance of this court diversion service has been consistent and sustained over a 6-year review period.[24] This service is not nationwide, and the interdepartmental group has recommended it to be made available to prisoners remanded in custody in two additional prisons. It is also notable that this service does not have a basis in statute, something which the Group has recommended to continue, as it allows for a flexible, accessible and responsive service.

4.1 The 'special verdict' or not guilty by reason of insanity

Irish law provides for what is known as a special verdict of 'not guilty by reason of insanity'. Section 5(1) of the Criminal Law (Insanity) Act provides that where a court (a judge or a jury, depending on the format of the trial) finds, following the evidence provided by a consultant psychiatrist, that a person was suffering from a mental disorder at the time of the offence such that s/he ought not to be held responsible for the act because s/he: (i) did not know the nature and quality of the act; or (ii) did not know that what s/he was doing was wrong; or (iii) was unable to refrain from committing the act, then a verdict of not guilty by reason of insanity must be returned. When a person receives such a verdict, they may be detained for the purpose of inpatient care or treatment where the court considers this necessary. This will be in a designated centre, currently the CMH, Dundrum. It is for the court to consider the mental condition of the person to determine whether s/he should be released or detained for care or treatment. When the court is making this decision, it must apply the criteria for civil detention under the Mental Health Act 2001. The purpose of the committal in such circumstances is to allow the accused person to be examined by an approved medical officer at the centre, who must advise the court on his or her opinion as to whether the person has a mental disorder and is in need of inpatient care or treatment in a designated centre. The court will then have to consider whether to commit the person to the designated centre. Although silent on the matter, the legislation has been interpreted to mean that there must be a hearing before such a decision is made.[25] Where the court is satisfied that the person is suffering from a mental disorder, it must commit the person to the CMH. The review procedure conducted by the Mental Health (Criminal Law) Review Board then applies. The Review Board will then decide on whether the person can be discharged and on the form of that discharge.

Although a relatively rare finding, the verdict of not guilty by reason of insanity is more common in Ireland than in the UK, where the finding of diminished responsibility is more

24 Clare McInerney *et al.*, n. 11; Conor O'Neill, *et al.*, n. 20.

25 Dermot Walsh, *Walsh on Criminal Procedure*, Dublin: Round Hall, 2016, p. 1442.

common, even for individuals who were suffering from a significant level of mental disorder at the time of the offending behaviour. This is due to the presence of the third limb of the insanity legislation, which is not present in UK legislation, whereby the individual can be found not guilty by reason of insanity if he or she was unable, by reason of a mental disorder, to refrain from committing the act.

In *DPP v. Redmond*,[26] the Supreme Court dealt with a situation where the accused person was fit to plead and pleaded guilty. While the special verdict was potentially open to the defendant, he chose to plead guilty as he preferred to be the subject of a definite sentence of imprisonment rather than, possibly, an indefinite detention under mental health legislation. The Supreme Court was asked to consider whether the court had the power or duty to refuse a plea of guilty where it was satisfied that the person was 'insane' at the time of the act. The court held, by a majority, that there was no such duty in the particular circumstances of the case as it was not certain that the special verdict would have been returned. The court left open the possibility, however, that if it seemed certain that the special verdict would be returned, the judge may be under a duty to require a change of plea.

Some figures exist on the operation of the special verdict. By way of example, the Central Criminal Court (the name for the High Court when dealing with criminal matters) dealt with 734 offences in 2016, 17 of which resulted in a verdict of not guilty by reason of insanity.[27] In the same year, the Mental Health (Criminal Law) Review Board held 115 review hearings on the detention of people found not guilty by reasons of insanity.[28]

It is notable that Section 5 of the Criminal Law (Insanity) Act 2006 makes no provision to manage the situation where a person is found not guilty by reason of insanity but does not require inpatient treatment in the CMH. In these circumstances, the person must be released, even where they have a mental illness in need of some treatment.[29]

There has been criticism of the procedural safeguards available to those detained under the special verdict compared with others detained under mental health legislation. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has recommended that the Irish authorities introduce legally binding safeguards to govern consent to treatment and the use of means of restraint and seclusion in such circumstances.[30] Such concern has also been forthcoming from the High Court in

26 Ireland Supreme Court, judgment of 6 April, 2006, IESC 25.

27 See further, Annual report of the Courts Service 2016 (at: www.courts.ie/acc/alfresco/6ca3d890-65b0-4974-87ff-271c68ad7c18/Courts%20Service%20Annual%20Report%202016.pdf/pdf#view=fitH) (last visited: 2 April 2018).

28 Annual Report of the Mental Health (Criminal Law) Review Board 2016 (at: www.mhclrb.ie) (last visited: 2 April 2018).

29 See further, Dermot Walsh, *Walsh on Criminal Procedure*, Dublin: Round Hall, 2016.

30 Report to the Government of Ireland on the visit to Ireland carried out by the CPT from 16 to 26 September 2014 (last Visited: 1 March 2018).

DPP v. B.[31] According to a study of the predictors of length of stay in the CMH, being found not guilty by reason of insanity tended to predict a longer length of stay.[32] The Criminal Law (Insanity) Act 2010 also provided, for the first time, a power for mental health review boards to grant conditional discharge to people detained following a verdict of not guilty by reason of insanity or a finding that the person is unfit to stand trial.

In addition to the verdict of not guilty by reason of insanity, Irish law also provides for a verdict of diminished responsibility where the offence involved is murder. Where a finding of diminished responsibility is made, a finding that the person is guilty of manslaughter rather than murder is returned. This applies under Section 6 of the Act of 2006. The limitation of this finding to the case of murder means that it is of relatively narrow application. Ireland does not provide for 'hospital orders' of the kind found in the United Kingdom or other countries. Such a sanction was recommended by the Commission of Investigation into the death of Gary Douch and also by the interdepartmental group. Where a mandatory sentence does not apply (such as the sentence of life imprisonment for the offence of murder), a court may take into account the presence of mental ill-health as a mitigating factor, but there are no specific sanctions or options available for a court to order a course of treatment. On an informal basis, a court may impose a sentence of imprisonment but suspend it on condition that the person access treatment or care. This means that the sentence of imprisonment will not activate should the conditions be complied with. A court may also impose a probation order in such circumstances. Should imprisonment be ordered, the court may recommend that the person receive treatment. As the interdepartmental group has candidly stated "these options are basically aspirational".[33]

5 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

Duffy *et al.*[34] and Linehan *et al.* 2006 have found high levels of mental illness within the Irish prison population. Kennedy *et al.* found prevalence rates for psychosis of 5.1% for

31 Ireland High Court, 2011, IECCC 1.

32 Mary Davoren, Orla Byrne, Paul O'Connell, Helen O'Neill, Ken O'Reilly, and Harry G. Kennedy, 'Factors affecting length of stay in forensic hospital setting need for therapeutic security and course of admission', 15 *BMC Psychiatry* 301 (2015).

33 Interdepartmental group to examine issues relating to people with mental illness who come into contact with the criminal justice system, Report 2014, *First Interim Report*, 2014, p. 32.

34 Dearbhla Duffy, Sally Linehan, and Harry G. Kennedy, 'Screening prisoners for mental disorders', 27 *Psychiatric Bulletin* (2003), pp. 241-242; Dearbhla Duffy, Sally Linehan, and Harry G. Kennedy, 'Psychiatric morbidity in the male sentenced Irish prisons population', 23 *Irish Journal of Psychological Medicine* 2 (2006), pp. 54-62; Sally Linehan, Dearbhla Duffy, Brenda Wright, Katherine Curtin, Stephen Monks, and

prisoners on remand and 2.6% within the population serving sentences. For major depressive disorders, the prevalence rate was 4.5% for the remand population and 4.6% for the sentenced population. The authors estimated that 3.7% of male committals, 7.5% of men on remand, 2.7% of sentenced men and 5.4% of female prisoners should be diverted to psychiatric services, with 20% of male committals and 32% of female committals needing to be seen by a consultant psychiatrist. The number of men with severe mental illness within the remand population was found by these authors to exceed international averages.[35] Mohan *et al*. have also found a high level of psychiatric morbidity among women prisoners in Ireland.[36] O'Sullivan *et al*. have also found significantly higher depression scores in a sample of prisoners surveyed in an Irish prison when compared with community samples.[37]

The provision of mental health treatment for prisoners in Ireland has been criticized by the CPT, which found, in its 2014 visit, prisoners with psychiatric disorders too severe to be properly cared for in prisons, as well as prison officers without the training to deal with prisoners suffering from serious mental disorders, even in high support units. The delegation also expressed concern that people with psychiatric illnesses were being placed in special observation cells for long periods.[38]

Once a person is committed to prison, he or she may be transferred to the CMH for treatment. This process, however, is not straightforward. Delays in transfer are commonplace because of a lack of space in the CMH, which is the only psychiatric hospital designated to receive prisoners. Kennedy argues that the closure of psychiatric institutions without an accompanying policy to manage those who need acute inpatient care has led to prisons becoming a 'dumping ground' for the mentally ill.[39] Where a person is transferred from prison to the CMH, they must be released from the hospital at the expiration of their sentence, which may not coincide with the best time in terms of their treatment. This is in contrast to the UK where provision is made in the Mental Health Act 1983, as amended, to allow a mental health patient to be detained under a 'notional section 37' on the expiry of their sentence if they continue to require care and treatment in hospital. Transfers back to prison during the currency of the sentence may also lead to relapse and interruptions

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Harry G. Kennedy, 'Psychiatric morbidity in a cross-sectional sample of male remanded prisoners', 22 *Irish Journal of Psychological Medicine* 4 (2005), pp. 128-132.

35 Harry G. Kennedy, Stephen Monks, Katherine Curtin, Brenda Wright, Sally Linehan, Dearbhla Duffy, Conor Teljeur, and Alan Kelly, *Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners*, Dublin: National Forensic Mental Health Service (2006).

36 Damian Mohan, Paul Scully, Claire Collins and Charles Smith, 'Psychiatric disorder in an Irish female prison', 7 *Criminal Behaviour and Mental Health* 3 (1997), pp. 229-235.

37 Danny J. O'Sullivan, Maura E. O'Sullivan, Brendan D. O'Connell, Ken O'Reilly, and Kiran M. Sarma, 'Attributional style and depressive symptoms in a male prison sample', 13 *PLOS One* 2 (2018), pp. 1-14.

38 Report to the Government of Ireland on the visit to Ireland carried out by the CPT from 16 to 26 September 2014 (at: https://rm.coe.int/pdf%20/1680727e23) (last visited: 1 March 2018).

39 Harry Kennedy, 'Opinion: Prisons now a dumping ground for mentally ill young men', *The Irish Times* (2016).

in treatment. In 2016, 36 prisoners were transferred on an involuntary basis from prison to the CMH.[40] It is expected that some of the problems concerning the capacity of the CMH to deal with people being transferred from prison will be addressed by the opening of a new hospital on a site in north county Dublin, which will have increased bed capacity. This development has long been anticipated and will increase the number of adult beds in the National Forensic Service from 94 to 130. However, ten of these additional beds will be for females (giving a total of 20 female beds), and twenty for a newly developed learning disability forensic service. This will increase the number of male forensic beds from the current provision of 84 to 90, or 1.95 male beds per 100,000 population to 2.0 male beds per 100,000 population. Both figures are much too short of the international average of eight to ten forensic beds per 100,000 population. Therefore, without the development of the ICRUs around the country it is unlikely that the development of the new Medium Secure Unit in Dublin will be able to greatly affect waiting times for admission. In the event the new ICRUs were to develop in a timely manner and appropriately triage their admissions, this would provide low secure admission options around the country, allowing the CMH to specialize in offering care and treatment to individuals who pose a significantly higher security risk and higher risk of violence.

In-prison psychiatric care is provided by a combination of prison-employed medical staff and in-reach mental health services, provided by the staff of the National Forensic Service, CMH Dundrum. Mountjoy Prison in the centre of Dublin was home to the first high support unit for people with mental health problems; its capacity is an ongoing problem. In-reach mental health services are provided through collaboration with the Health Service Executive and the National Forensic Mental Health Service in Dublin, Portlaoise and Castlerea prisons, with weekly forensic mental health sessions provided in these prisons. In two others, Cork and Limerick, consultant-led psychiatric services are provided, with arrangements also in place for Castlerea. For other prisons, the National Forensic Mental Health Service provides an assessment and liaison service for those in need of a forensic assessment or possible admission to the CMH. These resources are, however, limited.[41]

6 Special populations within the prison setting

Personality disorder (PD) is very common among prisoners and is associated with high levels of morbidity. However, in Ireland, patients cannot be involuntarily admitted to hospital on the grounds of PD under the civil Mental Health Act. The mainstay of treatment

40 Annual Report of the Mental Health (Criminal Law) Review Board, 2016.
41 *Dáil Debates*, Written Answers 88, 30 March 2017.

for prisoners with primary PD is the psychology provision within the prison settings, which, as mentioned previously, struggle with quite limited resources. There is currently no inpatient unit in the National Forensic Service Dundrum to offer inpatient care and treatment to individuals with primary PD, likely because of the MHA issues. In the UK, specialized units exist within prison settings for individuals with primary PD, such as Therapeutic Communities and Psychologically Informed Planned Environments (PIPEs); however, these have yet to develop in Ireland and remain an unmet need.[42] In regard to older prisoners, significant evidence exists that this category represents the fastest growing group in the prison estate of most developed countries and that they have significant mental and physical health needs. This has been found both internationally and in Ireland. Again, a specialized service for older prisoners does not yet exist in Ireland and they are managed by the in-reach services of the National Forensic Service. Given the often low profile of older prisoners within prisons, this can lead to de-prioritization of their care as documented in the recent report by HMPPS 'No problems old and quiet'.[43] A young offender institution (YOI) that existed in St Patricks on the Mountjoy Campus Dublin to provide a secure setting for adolescent males has now been replaced by a secure residential facility, Oberstown House. This is supported with weekly in-reach clinics by the mental health team at the CMH Dundrum; an inpatient forensic child and adolescent unit is planned for the development of the new Medium Secure Unit in Dublin.

It is well known that solitary confinement exacerbates mental illness. Sufficient staffing levels and allocation of appropriate levels of funding to the prison service is vital to reducing the hours spent in segregation by more challenging prisoners, since these individuals may need multiple members of staff to safely support them spending time out of their cells. This is necessary both for the prisoners' health and well-being and for their support when moving forward to less restrictive regimes. In the recent past, the Irish Prison Service has reduced the numbers of people on 22- and 23-hour lock-up considerably, although long periods of lock-up remain a feature of the Irish prison system.[44] There is also now a commitment by the Irish Prison Service in its Strategy Statement to bring forward proposals to comply with the Mandela Rules, which prohibit the use of solitary confinement, defined

42 See further, Seena Fazel, Tim Hope, Ian O'Donnell, and R. Jacoby, 'Unmet treatment needs of older prisoners: a primary care survey', 33 *Age and Ageing* 4 (2004), pp. 396-398; Seena Fazel, Tim Hope, Ian O'Donnell, Mary Piper, and Robin Jacoby, 'Health of elderly male prisoners: worse than the general population, worse than younger prisoners', 30 *Age and Ageing* 5 (2001), pp. 403-407; Mary Davoren, Mary Fitzpatrick, Fintan Caddow, Martin Caddow, Conor O'Neill, and Harry Kennedy, 'Older men and older women remand prisoners: mental illness, physical illness, offending patterns and needs', 27 *International Psychogeriatrics* 5 (2015), pp. 747-755.

43 H.M. Inspectorate of Prisons, *Older Prisoners in England and Wales: A Follow up to the 2004 Thematic Review by H.M. Chief Inspector of Prisons*, London: HMSO, 2008.

44 *Census of Restricted Regime Prisoners July 2017* (at: www.irishprisons.ie/wp-content/uploads/documents_pdf/July-2017-Restriction.pdf) (last visited: 30 March 2018). At the time of writing, some concerns about the accuracy of some figures have been expressed, and caution should be exercised.

as 22 hours or more in a cell, for more than 15 days. This activity has culminated in the introduction of an amendment to the Prison Rules 2007, through Statutory Instrument 276 of 2017, which requires all prisoners to receive a minimum of two hours out of their cells or rooms with an opportunity for meaningful human contact, including contact with other prisoners. While the numbers on very long periods of lock-up have been falling, concerns remain about the numbers of people spending 19 hours or more per day in their cells and the impact of this environment.[45] As previously stated, appropriate resourcing is particularly needed in such environments.

Some research has been conducted on the prevalence of mental illness among people on probation in Ireland. Cotter has found, however, that 33.7% of those assessed by the Probation Service (who are not trained medical professionals) under the Level of Service Inventory – Revised (LSI-R) Assessments process in 2012 responded that they had had mental health treatment in the past, with 15.8% engaging in some form of psychiatric treatment at the time of the assessment.[46] Cotter recommends more research into this area as well as mental health awareness training for Probation Service staff. Protocols between the Probation Service and community mental health clinics are also needed.

7 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

Provision of medical care in Irish prisons is the responsibility of the Irish Prison Service. Ireland does not have a system whereby the general national health services are responsible for in-prison medical services. It is submitted that this should be amended to align with international best practice. The Irish Prison Service recruits doctors, mainly General Practitioners and substance misuse specialists, as well as nurses, who are employees of the Irish Prison Service. These individuals provide the bulk of in-prison care. Psychiatry services are provided by the National Forensic Mental Health Service from the CMH Dundrum, who are employees of the Health Service Executive. Prisoners are, however, referred to medical services and hospitals within the community for all specialized general medical or surgical services as required. Under the Prison Rules 2007[47] and from decisions of the courts, prisoners are entitled to the same level of healthcare that is available in the community. This means that prisoners are entitled to all services under the 'medical card'

45 Irish Penal Reform Trust, *Behind the Door: Solitary Confinement in the Irish Penal System*, Dublin, 2018.

46 Laura Cotter, 'Are the Needs of Adult Offenders with Mental Health Difficulties being met in Prisons and on Probation?', 12 *Irish Probation Journal* (2015), pp. 57-78.

47 S.I. No. 252 of 2007.

scheme, which provides state-funded medical care to those below a certain income threshold.[48]

The Irish Prison Service also has a psychology service. Its current Strategy Statement (2016-2018) has set the goal of improving links with in-reach psychiatry colleagues across all prisons, including developing the potential for direct referral procedures between the two services.[49] The service underwent a review (the Porporino Review) in 2015, which found that the psychology services had overemphasized their role as helping professionals and had not focused sufficiently on their role as scientist-experts in designing moral and rehabilitation-focused prison environments.[50] A particular recommendation was for the appointment of a senior clinical psychologist for the women's prison in Dublin who has a background in supporting women with vulnerabilities and multiple needs. Following this review, the recruitment of additional staff has taken place.

8 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

The reintegration of prisoners in Ireland has undergone a significant change in the past five to seven years, with a greater focus being put in place on sentence management and through care. Severe challenges remain, particularly in the areas of housing and linking with external services. There is an overdue but increasing recognition of the need for a 'whole of government' approach towards managing the root causes of offending behaviour, of which mental illness may be a part. This new commitment is seen in the establishment of an interdepartmental and interagency group for a safer and fairer Ireland, chaired by Dr Ruth Barrington, which seeks to bring together criminal justice, social policy, health and other governmental sectors, agencies and civil society organizations, to find ways for them to work more effectively together. It is hoped that this approach will guide strategy and policy in many areas, including the response to mental illness within the criminal justice system.

48 See further, recommendation 28, Fifth Report of the Implementation Oversight Group to the Minister for Justice and Equality, 2018 (at: www.justice.ie/en/JELR/Pages/Penal_Policy_Review) (last visited: 2 March 2018).

49 Irish Prison Service, *Psychology Strategy 2016-2019* (at: www.irishprisons.ie/wp-content/uploads/documents_pdf/psychology_strategy_2016.pdf) (last visited: 2 March 2018).

50 Frank Porporino, *New Connections: Embedding Psychology Services and Practice in the Irish Prison Service*, 2015 (at: www.irishprisons.ie/wp-content/uploads/documents_pdf/porporino_report.pdf) (last visited: 1 March 2018).

9 Conclusion

It is clear that Ireland has taken steps towards improving the way in which people with mental illnesses are dealt with by the criminal justice system, particularly through the reform of the governing law and the innovations led by forensic mental health services within prisons. Much work remains to be done, particularly at the first point of contact between a person with mental health difficulties and the police services, and, further, the provision of community supports is essential at all phases of the criminal justice process. Too many people who would be more effectively and more justly managed and cared for in healthcare settings continue to come before our courts, and we expect too much of our prison service to pick up the pieces where other services have not.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system

The Japanese situation

Taro Morinaga & Mana Yamamoto[*]

1 Introduction

As may be the case in many jurisdictions throughout the world, how to treat persons with psychiatric disturbances[1] in the criminal justice process has been a controversial issue in Japan, in academic circles as well as in the field of legislation and administration of justice. The question constantly presents fundamental challenges such as whether insane people who have committed serious crimes should be subject to criminal punishment. The debate resurfaces each time the general public comes to know about, for instance, a brutal murderer who is acquitted by reason of insanity or is punished leniently by reason of diminished capacity. In such cases, the established theory under modern penal law – that criminal punishment is not for the mentally ill – seems to be less convincing.

In Japan, the law still maintains the classic 'monistic' criminal justice system. This means that the criminal court is only authorized to impose criminal sanctions based on, and proportionate to, criminal responsibility of the offender with respect to his or her proven criminal acts. Japanese courts are not vested with any power to apply preventive measures on the basis of foreseeable risks of harm to the society in the future. Accordingly, the problem of dealing with mental illness may be larger than in some other jurisdictions.[2]

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1 For the sake of aligning the contents of this report with the Japanese statistics referred to herein, we use the term 'psychiatric disturbance' as set forth in the 'Act on Mental Health and Welfare for the Mentally Disabled', which means schizophrenia, acute poisoning of or dependence on psychotropic substances, mental retardation, psychopathy and other mental disorders (Art. 5). Thus, the scope is wider than those appearing in the definitions of the *DSM-5* and ICD-10 and includes mental disorders such as prison reaction.

2 For example, in Germany, the criminal courts have "dualistic" functions and can treat insane defendants who cannot be criminally punished with preventive detention orders and put them into psychiatric hospitals for treatment against their will. German Penal Code (StGB) Section 63. See also Section 66.

As for coercive medical treatment, Japan has the Act on Mental Health and Welfare for the Mentally Disabled (Law No. 123, 1 May 1950, as amended, hereinafter referred to as the Mental Health Act), but this is an administrative law and is for mentally disabled people in general. It does not call for judicial intervention, and it is not necessarily designed to treat people with psychiatric disturbances to prevent them from coming into conflict with criminal law.

Being well aware of this problem, the Japanese government introduced a new bill dealing with persons with psychiatric disturbances who committed certain types of serious harm such as murder, arson, robbery, rape, forcible sexual misconduct and assault resulting in injury. It was enacted by the National Diet in 2003 as the Act on Medical Care and Treatment for Persons Who Have Caused Serious Cases Under the Condition of Insanity (Law no. 110, 16 July 2003; effective as of 15 July 2005, hereinafter referred to as the 'Medical Care Act'). This law provides for the implementation of a system calling for mandatory court-ordered medical treatment at designated medical facilities upon psychiatric re-examination. The Act applies to those who are accused of having committed the above-mentioned crimes but are acquitted, those who have their sentences suspended or those whose cases are not prosecuted due to insanity or diminished capacity.[3]

Although Japan has procedures to mandate treatment for persons with psychiatric disturbances who come into conflict with the law as briefly described earlier, there are still many mentally disabled people being subjected to criminal procedure and taken to prison because they are not diverted or acquitted automatically because of their disorders. In Japan, as in a number of other countries, the legal concepts of 'insanity' (Art. 39 (1), Penal Code) and 'diminished capacity' (Art. 39 (2), Penal Code) are well established, and they are not medical or scientific concepts. Consequently, it is not the task of psychiatrists but the task of the courts to determine whether a person falls under these categories.[4] Further, psychiatric disturbances may sometimes appear after final sentencing. Therefore, chances are that persons with psychiatric disturbances may be incarcerated lawfully, and it is a reality that a substantial number of prisoners with psychiatric disturbances are serving sentences and many of them are under medical treatment provided by prisons.

Indeed, the statistics show that the number of persons with psychiatric disturbances who were subjected to criminal investigation for penal code offences has doubled over the

3 It may be noteworthy that, even with the enactment of the new law as mentioned above, the Japanese criminal legislation does not seem to have shifted from the "monistic" approach. The bill piously tried to avoid being criticized as introducing a system of preventive measures, which has been a controversial issue for over almost half a century as being repugnant to the culpability principle and the substantive due process of law. Therefore, the law is characterized not as a criminal procedure law, but as a medical law designed to serve the purpose of rehabilitation. This shows how many Japanese academics, lawmakers and practitioners were allergic to preventive measures.

4 For example, Supreme Court of Japan, First Petty Bench Decision, 8th December 2009, Case No.2008(A)1718; available in English on the website www.courts.go.jp – English page.

past 20 years.[5] Persons with psychiatric disturbances represent a significant percentage of the total number of prisoners and probationers. According to the data, the overall increase in the number of prisoners with psychiatric disturbances was caused by the increase in the number of persons with psychiatric disturbances other than mental retardation – neurosis being at the top. Another remarkable figure may be the very sharp increase in the number of females. A similar tendency was observed in the number of persons on parole and probation. Although the background and causes of such tendency need to be further studied carefully and discreetly, such figures are alarming.

Under such circumstances, the government of Japan has intensified the implementation of its comprehensive strategic policy against re-offending and has focused on the issue of treatment of elderly and mentally handicapped people coming into conflict with criminal law. However, such efforts are still underway, and the evaluation thereof may still be premature. Meanwhile, it may be the task of relevant experts and practitioners to look into what has been done so far to discover what may still be lacking. In this sense, the IPPF Colloquium gives the co-authors a good opportunity to revisit the Japanese situation, engage in a comparative discussion with learned experts from many parts of the world and learn from their knowledge and experience.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

2.1 Investigation and prosecution stage

Compared to the relatively benevolent treatment system in the area of correction and probation services, the criminal procedure system of Japan does not have much to offer. The only provision placing special focus on alleged offenders with psychiatric disturbances may be Article 314 of the Criminal Procedure Code which mandates the court to halt the proceedings if the court finds that the defendant is in a state of insanity (which is, again, understood as being a legal decision, not a medical or scientific one). One may suspect that the criminal procedure law of Japan at the time of its enactment did not pay attention to defendants with psychiatric disturbances because it did not envision mentally disturbed

5 The number of persons with psychiatric disturbances taken into prisons was 1,146 in 1996, amounting to 5.1% of the total number of newly accommodated prisoners. In 2015, it was 2,825, representing 13.1%. Among those, the number of females rose from 82 to 495 during the same period. Neurosis rose from 4 to 115. Other mental disorders increased from 44 to 343. Report of the Research Department, No. 56, *Research on Offenses by Elderly and Mentally Disabled and their Treatment*, Research and Training Institute, Ministry of Justice of Japan.

people being subject to criminal procedure. But of course, the reality is to the contrary,[6] and the capacity to understand the process and to stand trial is always at stake. It is the duty and responsibility of police officers, prosecutors, defence counsels and judges to always ascertain such capacity of the defendant in question at every stage in the criminal proceedings and to make sure that the defendant will undergo a fair procedure based on 'notice and hearing'. However, there are no notable codes or rules when it comes to this issue, and everything is left up to practice. One will find no special guarantee for mentally handicapped people in the written criminal procedure law of Japan.

Still, contemporary investigation and prosecution practice, as well as the actual court procedure, pay much attention to this issue. Throughout its history, the Japanese justice administration experienced regrettable cases which led, or came perilously close, to serious miscarriages of justice, and learning from such bitter experiences, investigators, prosecutors and judges as well as defence lawyers seem to cope with this issue with due care, having the notion of due process in mind.

In actual practice, it is the primary responsibility of the prosecutors to deal with this sensitive issue. Prosecutors, although expected to play offence in an adversarial system, are basically accusers – they are at the same time charged with responsibility to oversee the entire criminal process and make sure that both substantive and procedural due process are observed. If they do not diligently and sufficiently perform such duties, cases will end up in dismissals or acquittals, sometimes with harsh comments in court decisions or judgments which will be embarrassing for the individual prosecutor and the prosecution service as a whole.

A prosecutor, whenever he is assigned a case in which there is a possibility that the defendant may be suffering some mental handicap, carefully considers the capacity of the defendant to understand his procedural position and the charges. The prosecutor does this by examining the case file and the evidence, communicating directly with the investigators who handled the case, interviewing the defendant, examining the defendant's medical records and immediately consulting a psychiatrist if he feels it is necessary. Upon such initial considerations, if the prosecutor feels that the defendant is unable to understand the proceedings and the charges, or if he feels that there is a possibility that he might not be able to prove beyond reasonable doubt that the defendant is not insane and has the capacity to stand trial, he will opt to halt the criminal procedure. In accordance with the given circumstances and conditions, the prosecutor will then proceed with the Medical

6 Statistics show that the number of persons with psychiatric disturbances (including suspicion thereof) who were subjected to criminal investigation (i.e. who were officially registered by the police as suspects) on alleged commission of penal code offenses in the year 2015 was 3,950, amounting to 1.7% of the total number of registered suspects of penal code offenses, which was 239,355. The same figure was 1,999 in 1996 (amounting to 0.8% of the total number), which shows that this statistic doubled in two decades. *White Paper on Crime 2016*, Research and Training Institute, Ministry of Justice.

Care Act procedure as already mentioned, or report to the prefectural governor as to the necessity of mandatory hospitalization under the Mental Health Act (this can only be done if there is a present and continuing danger that the defendant will cause serious physical harm to himself or others – the decision is up to the prefectural governor based on the evaluation by a psychiatrist). And, if neither procedure is appropriate, the prosecutor will release and hand over the defendant to his family or relatives or, depending on the circumstances, to a health or welfare institution, for voluntary medical care. In any case, criminal procedure will not be reinstituted.[7]

But most cases in which the prosecutors are able to make immediate decisions to halt further proceedings are usually not so difficult to handle. If it is apparent that the suspect or defendant is insane, the prosecutor will forthwith stop the process. Knowing this, the police also have a tendency not to handle such cases as criminal cases anymore, and they give priority to treatment under the Mental Health Act, i.e. sending the suspect straight to the hospital on the decision of the prefectural governor.

The controversial ones are always those in which the defendants suffer a relatively moderate level of psychiatric disturbance, and they seem to have the ability to understand the proceedings and the charges, but just not as soundly as persons without such disturbances. Here, serious psychiatric disturbances such as schizophrenia in exacerbation seldom come into question. The mental capacity of defendants with mental retardation is frequently challenged at trial. In cases of defendants with modest mental retardation, there is less choice for the prosecutor if the offence committed by that defendant is a serious one and there is enough evidence showing that the defendant acted with diminished capacity at the most and was not insane. In such cases, there is a big risk of infringing defendants' rights and extracting false or unreliable statements, false confessions being the worst. So, a prosecutor in charge of such a case always gets extremely sensitive and acts carefully, and also gives detailed instructions to the police force in order to prevent the investigation from going in the wrong direction.

In order to eliminate this situation, after a series of harsh debates and a period of experiments, the prosecution of Japan decided to formally introduce the audio-visual recording system for the interrogation of suspects and defendants in detention which makes it possible for the prosecutor or his supervisors, as well as judges and defence counsels, to check the legitimacy and appropriateness of an interrogation. The police forces are also following suit, after some research of their own as to the feasibility and usefulness

7 In such cases the prosecutor usually closes the case by making a formal decision of non-prosecution for the reason of 'insanity' if the evidence clearly shows that the defendant is insane or 'insufficient proof' if the prosecution cannot prove beyond reasonable doubt that the defendant is not insane. There may be another decision, especially in minor cases, which is 'suspension of prosecution'. This is often seen in cases where the prosecutor is convinced that the defendant is not insane but deems it proper not to prosecute, taking into account the fact that the mental disorder affected the defendant's conduct.

of video-recorded interrogation especially with respect to mentally handicapped suspects. This system of course reduces the risk of undue, unlawful and insensitive interrogation methods.

Further, as for defendants suspected of having psychiatric disorders, the prosecutors are now encouraged to seek the help of psychiatrists or psychologists when interviewing such suspects. The prosecutors themselves these days undergo trainings aimed at fair and proper handling of suspects and defendants with mental problems, especially the proper way of conducting interviews. In prosecutorial administration, staff members of each prosecution office work towards establishing good relationships with psychiatrists, psychologists and social workers present in their area of jurisdiction and maintain a state of preparedness of being able to respond to any emergency situation relating to suspects and defendants with psychiatric disturbances.

2.2 Adjudication stage

Because the prosecution is very careful not to inappropriately indict defendants with insufficient capacity to stand trial, in actual practice there are only a handful of cases which have been halted because of the defendant's incapacity to stand trial. As briefly mentioned in the introduction, the Criminal Procedure Code of Japan does not provide for dismissal of the case even if the court finds, at some point during the court proceeding, that the defendant is in a state of insanity. The law instructs the court to suspend the process. Here again, the law seems to expect the prosecutors to act, and there are examples of some cases in which the prosecution withdrew the charges and terminated the case. As to whether the court by its own initiative can dismiss the case in such extreme situations without the action by the prosecutor, the state of the law is somewhat unclear. But in a Supreme Court (Third Petty Bench) decision on 28 February 1995,[8] one Justice, in his concurring opinion (which may be regarded as *obiter dictum*), said that: "If competency to stand trial is not subsequently regained, the courts, instead of maintaining a status of suspended trial proceedings until the public prosecutor revokes the prosecution, may be considered able to undertake the eventual termination of proceedings depending on the status, etc., of the defendant".

8 Case No. 1991(A)1048 (at: www.courts.go.jp) (last visited: 14 September 2020). This decision is known as a ruling in which the Supreme Court spoke about the meaning of 'insanity' (a state of *non-compos mentis*) under Art. 314(1) of the Criminal Procedure Code calling for suspension of the proceeding. It said that it means "the lack of competency to stand trial, in other words, the inability to distinguish important interests of the criminal defendant and conduct a reasonable defence accordingly." The case was about a defendant who was deaf and mute and therefore never learned any language, not a psychiatric patient.

So, if a defendant is in a permanent state of insanity at the trial stage with no hope of recovery, it can be predicted that either the prosecution will withdraw the charge or the court may dismiss the case.

3 Detainees with psychiatric disturbances during provisional detention: needs, problems, screening tools

Once criminal procedure is initiated with the start of an investigation, suspects and defendants with psychiatric disturbances are prone to be arrested and detained. This is understandable because they often fulfil the statutory requirements of arrest and detention, i.e. 'probable cause' and 'necessity', the latter explained as necessity to prevent fleeing and destruction of evidence. Investigators and prosecutors often feel the strong need to apply for arrest and detention warrants in cases, especially when suspects with mental disorders show violent attitudes. But on the other hand, they have to be sure that arrest or detention will not deteriorate the health condition of the suspect or defendant, and that the facilities which accommodate the suspect or defendant will be able to cope with the risks of unwanted health damages or other accidents.

Whenever there is the possibility that the targeted suspect may be suffering mental problems, the police force, as well as the prosecution, exerts due care as to the health of the suspect and will do their best efforts to obtain information and evidence with respect to the mental and physical health condition as much as possible to assess the risk of deterioration while being locked up. This is not only to be sure on the side of the police, but to convince the prosecutors who will apply for a detention warrant and the judge who will decide whether to issue such warrant. If the police are unable to gather such information, they will refrain from arrest in the first place. It is common practice that, when the prosecutor applies for a detention warrant he will include in the case dossier to be sent to the judge evidence gathered by the police showing that there is no problem with the suspect's health condition and that the suspect is fit enough to endure detention, such as a medical certificate issued by a physician or psychiatrist, a report from the detention facility supervisor that the cell in which the suspect is to be held is a suitable one and the facility is equipped with adequate resources to cope with contingencies. If such material is not provided by the prosecutor, the judge will deny the application for detention. If the judge decides to detain the suspect, the judge makes sure that the detainee will be held in an appropriate facility which is equipped with sufficient infrastructure and human resources to accommodate suspects with mental problems.[9] It is the power and duty of the judge to

9 Not every detention facility is perfectly equipped with such infrastructure and human resources. Especially, the detention cells at local police stations cannot be expected to be fully equipped. In general, the larger

designate the detention facility, and the place of detention once selected cannot be changed without the permission of the judge.

Nevertheless, pre-trial detention sometimes results in a challenging situation: the so-called 'prison reaction'. Prison reaction is not unique to persons with psychiatric disturbances. It can develop in any human being who enters an environment of deprived liberty. But for persons with psychiatric disturbances who are generally much more vulnerable, the effect of the prison reaction can be serious. Moreover, it is quite difficult to tell whether the symptoms externally observed are caused by prison reaction or by the psychiatric disease which the person has. Therefore, during pre-trial detention, the authorities must be ready to provide adequate medical treatment and, if necessary, provide them with frequent counselling by psychiatrists or psychologists.

In terms of procedural safeguards, if a detained suspect with psychiatric disturbance faces deterioration of his health condition, there are several ways to deal with the situation. The prosecutor may opt for temporary suspension of detention, or simply release the suspect. The court, on its own initiative, or based on the motion of the prosecutor or the defence counsel, can also temporarily suspend the detention or cancel it. These dispositions will usually be followed by voluntary hospitalization, but the possibility of coercive medical treatment by the decision of the prefectural governor as aforementioned is not excluded. If the situation is less serious, the detention facility supervisor can simply take the suspect to a physician or psychiatrist outside the facility for examination and treatment and, if inevitable, have him hospitalized (Art. 62, Act on Penal Detention Facilities and Treatment of Inmates and Detainees, hereinafter referred to as the Penal Facilities Act).[10]

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

As already mentioned in the introductory part, a substantial number of persons with psychiatric disturbances are convicted and serve sentences in prisons. Today, the treatment of prisoners in Japan is legally based on the Penal Facilities Act, which states in Article 30:

detention houses (under the control of the Ministry of Justice), such as the Tokyo Detention House, which has the capacity to accommodate approximately 3,000 detainees, are better equipped, so suspects with mental problems tend to be detained in larger institutions having special facilities and staff for mentally ill people.

10 Law No. 50, 25 May 2005, effective as of 24 May 2006, as amended. This disposition based on the authority of the supervisor of the penal facility is exercised within the framework of incarceration, i.e. the prisoner is not released, and is under the continual watch of prison officers even while in the hospital. The same scheme can be applied to prisoners.

> Treatment of a sentenced person is to be conducted with the aim of stimulating motivation for reformation and rehabilitation and developing the adaptability to life in society by working on his/her sense of consciousness in accordance with his/her personality and circumstances.

In accordance with this instruction, individual treatment is provided to prisoners. Immediately after the intake, the prisoner undergoes a screening test performed by a prison officer in charge of security aimed at assessing the risk of suicide.[11] At the same time, a prison psychologist interviews the prisoner and, based on his expertise in psychiatry, analyses the personal character and problems connected with offending and, if necessary, refers the prisoner to a medical expert for further diagnosis and medical treatment. For prisoners with mental retardation, a specially designed screening tool is used, and if the results show suspicion of mental retardation, the prison psychologist will apply a high-precision intelligence test followed by an assessment by a psychiatrist, making the prisoner eligible for welfare services.

With respect to the medical treatment of prisoners, Article 56 of the same law provides that:

> At penal institutions, efforts are to be made to grasp the physical and mental conditions of the inmates thereof, and hygienic and medical measures adequate in light of the public standards of hygiene and medical care are to be taken in order to maintain the health of the inmates and the hygiene inside the penal institutions.

Specifically regarding persons with psychiatric disturbances, a 1996 circular issued by the Director of the Corrections Bureau, Ministry of Justice, titled *As to the Matter of Inmates with Psychiatric Disturbances*, gives instructions as to early detection of psychiatric disturbance at the time of intake, drawing up of adequate treatment guideline, encouragement of examination by specialized medical experts, efforts to connect with medical care and welfare after release and so on. For the implementation of such instructions, every prison throughout the country has at least one physician, and, if proper treatment within the penal institution is difficult, outside medical institutions cooperate with prisons and examine and treat prisoners. If high-level medical treatment is necessary, there are four medical prisons which are ready to accommodate prisoners with severe mental illness. Under such scheme, prisoners with psychiatric disturbances are treated in

11 This screening test assesses the risk level of the particular prisoner by grades from 0 to 3, taking into account various elements such as the mental condition/symptoms, history of suicide attempts or self-inflicted injuries, loss experiences and so on.

accordance with the nature and severity of their illness. The state is responsible for medical care at penal institutions, thus the cost and expenses thereof are borne by the state.[12]

Every prison implements treatment using psychotherapy. In addition to ordinary counselling, some prisons also conduct occupational therapy such as ceramics, botany and paper artwork, or animal therapy. Any such therapeutic treatment is conducted within a determined period of time, usually about three months, and is repeated if necessary. If the mental condition of the inmate is stabilized, the inmate is transferred to engage in ordinary work in the prison factory, thus enabling him to move closer to a normal social life.

Prisoners with psychiatric disturbances are inherently vulnerable. Their medical condition can rapidly deteriorate. In penal institutions which accommodate a substantial number of inmates with developed schizophrenia, drug dependence or mental retardation, as well as aged inmates or those with some distortion in their personality, incarceration causes the deterioration of inmates' ability to judge situations or to seek help, violent changes in emotion, distraught, persecutory emotion, delusion and triggers serious symptoms such as aggressive and violent behaviour, not eating, urinary incontinence and suicide attempts.

Penal institutions deal with these problems to the best of their ability, including by transfer of prisoners to medical prisons, but if the situation is so serious that the execution of the sentence, i.e. the continuation of imprisonment, will cause extreme damage to the prisoners' health or threatens his life, the execution of sentence can be suspended by a directive of the competent prosecutor, and, if due to such psychiatric disturbance, the prisoner is found in a condition of insanity,[13] it is mandatory for the prosecutor to temporarily suspend the execution of imprisonment and hand over the prisoner to his guardian or to the prefectural governor for hospitalization (Arts 480 and 481, Criminal Procedure Code).

12 The annual cost of accommodation per prisoner with psychiatric disturbance at the medical prison amounts to slightly over 6 million yen (approx. 50,000 Euro). This amount shows that quite benevolent treatment is provided to mentally troubled inmates.

13 The term 'insanity' in this context has a different meaning from those referred to in Art. 39(1) of the Penal Code or Art. 314 of the Criminal Procedure Code. While Art. 39(1) of the Penal Code is about the mental state of the perpetrator at the time of the commission of the offense and Art. 314 of the Criminal Procedure Code is, as already mentioned, about the competency to stand trial, insanity under Art. 480 of the Criminal Procedure Code means the lack of mental capacity of the prisoner to understand that he is being punished, because under prevailing penal law theory in Japan, which puts importance on specific deterrence besides general deterrence and retribution, punishment will be meaningless if the person subject to it does not understand it, feels no disadvantage and no motivation to rehabilitate and refrain from re-offending.

5 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

Although there are different views on this issue stemming from the variety of penal law policies as well as actual practices, it seems that the Japanese corrections authorities try to balance and harmonize these two seemingly contradicting interests. Prisons in Japan work on the fundamental thought that incarceration must be executed diligently as it is ordered by the court, but the physical and mental health must of course not be impaired by that, because deprivation of health is never a part of the punishment. However, it does not mean that whenever there is deterioration of health or a risk thereof, the prisoner must immediately be released or should not be indicted or punished in the first place. It all depends on the seriousness of the health condition of the defendant/prisoner in question, and, if a prison can provide adequate medical care to the prisoner just as he would be treated if he were not incarcerated, then there would be few problems. If no prison is capable to do so, then there are safeguards as already mentioned. The Japanese prisons seem to be, at least so far, fairly successful in balancing these two interests. As for suspects and defendants whose psychiatric disturbances are so serious that it affects criminal responsibility, blameworthiness to be exact, then, as already discussed, there will be non-prosecution, acquittal or non-incarceration sentences in the first place, as the case may require. Theoretically, there don't seem to be any problems.

However, the practice is not that easy. There has been a long-lasting debate also in Japan. Prosecutors have been sometimes suspected of prosecuting defendants who fall under the category of insanity and unreasonably assert that they are not insane, in a state of diminished capacity at the most, because they want the violent defendants to be kept out of the community. Courts have also been suspected of following the prosecutors' lead by almost never making a finding of insanity. Such suspicion seems to have been supported by the fact that the number of persons whose cases were disposed of by non-prosecution by reason of insanity in a year increased after 2005 when the 'Medical Care Act' came into effect.[14] Prosecutors themselves generally find such criticism is not very rational. Psychiatrists also seem to have a different view. There are many psychiatrists who say that the prosecutors tend to find insanity too easily, even as to those suspects who in the eyes of psychiatrists are capable of taking criminal blame, and try to shift to hospitals the burden of caretaking which otherwise should be shouldered by penal institutions. But this criticism from the psychiatrists has not been substantiated.

The problem seems to lie elsewhere. Regarding the practice under the above Act, there are two issues that need to be addressed. One is about the screening of the mental state of

14 Report of the Research Department, No. 56, *Research on Offenses by Elderly and Mentally Disabled and Their Treatment*.

the suspect as a premise for the prosecutor to decide whether to indict or file a motion for compulsory medical treatment under the Act. Before making the decision to prosecute or not, the prosecutor usually asks a psychiatrist to conduct a brief examination of the suspect's mental condition. Such examination is usually done by conducting an interview for two to three hours, and this serves as a quick screening of the mental state. However, it is said that there is considerable unevenness as to the quality of such examinations. It is therefore quite important to improve the examination skills of psychiatrists. Moreover, there are voices in the area of psychiatry arguing that a system of certification that would allow qualified psychiatrists to conduct expert examinations should be established in order to avoid wrong or inaccurate evaluation by inexperienced psychiatrists. Further, there are even discussions that a special scheme should be developed under which suspects with the possibility of psychiatric disturbances are first referred to competent medical institutions which will decide whether the suspect should be placed under criminal prosecution or under medical treatment.

The second issue that is under debate at the moment is the widening of the scope of targeted suspects and defendants under the Medical Care Act. It is a common understanding that this law should apply only to persons who are 'responsive to medical treatment'. This understanding is prevalent more in the legal sector than in the medical sector, because of the path the discussion which led to the current provisions had followed. Since the drafters based their discussions on the 'monistic' theory as described earlier, and at the same time tried as much as possible to avoid the law being understood as opening a gateway to preventive incarceration, they placed the justification of the state's coercive intervention – hospitalization regardless of the will of the person – on the 'possibility to cure by medical treatment', placing the responsibility to apply this standard on the judiciary rather than the administration. Therefore, although in practice the courts have gradually expanded the scope of target persons in conflict with the law by putting less importance on this requirement, there are still individual cases in which the judge refuses to order coercive measures as to the mentally disturbed person thinking that there is little hope for him to recover. The issue of responsiveness comes frequently into question when dealing with people with personality disorders, mental retardation or developmental disorders, who in general are considered as having little responsiveness to medical treatment. However, today there is notable discussion that the responsiveness itself is something that has to be improved by medical treatment, and therefore, people without the possibility to respond to fast-acting treatment or with less hope for recovery in a short period should also be eligible for treatment under this law.

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

As discussed earlier, there are multiple pathways for a person with psychiatric disturbance who comes into conflict with the law. One is to be indicted, found guilty, taken into prison and released upon serving a certain time. Another is to be acquitted or not prosecuted by reason of insanity or to enjoy leniency because of diminished capacity, i.e. the suspension of prosecution or a non-custodial sentence. Or, depending on the circumstances, some may not be subject to criminal process at all – they may be referred to a psychiatric hospital pursuant to the Mental Health Act by a decision of the prefectural governor. In cases where the defendant is released from the criminal procedure despite the commission of designated violent act, the prosecutor proceeds with the hospitalization procedure under the Medical Care Act as already mentioned.

But in any case, the reintegration of such a person into the society is of vital importance. As to persons released from prisons after serving their sentences, who are still affected by mental disease, the Mental Health Act requires the head of the correctional facility to notify the prefectural governor of the release of any such ex-inmate, and the prefectural governor shall have qualified psychiatrists examine his current mental condition. If he is found to be a danger to himself or others because of the mental disease, he will be coercively hospitalized. But here, there is a crucial problem of insufficient resources. There is a substantial number of cases in which the prefectural government is unable to conduct mental examinations because of the large number of cases and the insufficiency of human resources, even in cases where the correctional facility notifies the governor about the risk and stresses the necessity of hospitalization. It is quite common that prisoners with psychiatric disturbances are not eligible for parole because parole officers are not available to conduct the necessary supervision. So instead of being supervised for a period of time after release from prison, they are simply released without supervision after serving full time. Trying to do their best under the given system and circumstances in realizing a smooth transfer to ordinary medical care within society, prison doctors often issue letters of reference for ex-inmates to outside medical institutions.

In 2008, a new system of making arrangements and adjustments with welfare institutions and welfare services was introduced to prisons. Under the system, for physically or mentally handicapped inmates who have no fixed place to live after release and who need support and care, the prison makes necessary arrangements with such institutions and services while they are still serving time. Welfare case workers come to prisons for consultation and advice, and, with the help of relevant institutions such as the probation offices, make necessary arrangements to accommodate such inmates in welfare institutions and enable them to receive proper welfare services immediately after release. However, since this system aims at connecting persons released from prisons to welfare services, there is a

disadvantage that it may be difficult for a person who needs to be hospitalized after release to benefit therefrom. Thus, there may be a need to further establish something like an intermediary institution which temporarily accommodates ex-inmates with psychiatric problems who do not have a place to return to but need medical treatment and welfare services thereafter, and eventually finds and refers them to places where they can finally settle into normal lives.

As for persons who were referred to hospitals by the court under the Medical Care Act, i.e. those who were not imprisoned but were coercively hospitalized or ordered to be treated by designated psychiatric hospitals, the probation offices throughout the country play a significant role with their specialized officers called 'reintegration officers' who have the national qualification of psychiatric social workers. For coercively hospitalized persons, the reintegration officers coordinate the patient's living environment upon release by serving as contact persons between the hospitalized patient and his guardian as well as relevant institutions, attending meetings at designated hospitals with psychiatrists in charge[15] and drawing up treatment programmes. Another important task of these officers is the so-called 'mental health observation' which is applicable to patients placed into community-based treatment, in which the reintegration officer supervises and supports such patients and works hand-in-hand with relevant stakeholders in the community for the purpose of successful rehabilitation and reintegration.

In addition to the above channels, if the level of psychiatric disturbance is not so serious, ordinary probation and parole service does also work. In such cases, probation officers maintain close cooperative relationships with local healthcare and medical institutions and provide benevolent care.

As briefly observed earlier, there are several ways to deal with this quite challenging issue of community reintegration of people with psychiatric disturbances who come into conflict with the criminal law. The authors are of the opinion that it may be worth considering a multidirectional, interactive approach between the existing schemes, making the overall system more flexible and needs based. In turn, this would make it possible to shift from one scheme to the other depending on the status of the patient and necessity. An example of this would be enabling ex-inmates to receive the mental health observation services provided by the reintegration officers under the Medical Care Act under certain conditions.

15 These meetings are called CPA (Care Program Approach) meetings. CPA is understood as being a care management method designed to support patients under both coercive hospitalization and community-based treatment by providing them with planned and coordinated medical care and social welfare aid. Takao Misawa & Naoji Hirabayashi, 'Care Management in the Area of Forensic Psychiatry and Welfare', *Japanese Journal of Forensic Mental Health* 5, p. 320.

7 Conclusion

As one can see, the improvement of the system and practice concerning the treatment of persons with psychiatric disturbances in Japan is still under way. Although there is no criticism saying that the prisons are used as convenient substitutes for psychiatric hospitals, Japan surely has to expedite its efforts, especially the improvement of practices under the recently enacted laws, both in the legal and medical area, given the alarming increase in offences committed by mentally handicapped people. In the area of practice, more communication and interaction between the medical and legal professionals are needed in order to establish systems and good practices which everyone accepts as reasonable and appropriate. In Japan, this issue has recently gained attention, and endeavours are being made for improvement. The Medical Care Act, although it still attracts criticism from many different angles, served as a catalyst for more communication and discussion among stakeholders, especially between doctors and lawyers.

Further, the authors feel the need to revisit and explore the fundamental issues relating to this problem, such as further studying whether the prevailing criminal law theories based on 19th-century liberalism and the classic idea of punishment and intervention proportionate to criminal liability are still robust enough to answer and respond to the questions and challenges posed by anxiety, fear or intolerance on the side of the general public. It leads to the fundamental, yet not sufficiently answered question of what needs to be done to protect society from heinous offences without sacrificing the fundamental values of modern societies and the legal system – human rights, rule of law and due process – which cannot be abandoned.

Prisoners and detainees with mental health disorders in the criminal process and in the prison system in Kazakhstan

Azamat Shambilov[*]

1 Introduction

Mental health disorders are, in general, a problem in modern society. The commitment of a crime by a person with a mental disorder aggravates the situation for this person. The global prison population is currently more than 10 million. Where studies of mental health issues have been conducted with prison populations, the prevalence has been shown to be considerably higher than in the community. This is partly because people with mental health issues tend to be imprisoned at higher rates (because they are more likely to be arrested, to confess and to be refused parole) and partly because the prison environment can cause or exacerbate mental health conditions. Factors such as overcrowding (a problem in at least 115 countries), a lack of privacy, a culture of violence, the use of solitary confinement, abusive use of restraints, lack of meaningful activities, isolation and stress associated with separation from families, as well as inadequate health services, cause or exacerbate mental health issues. The consequences can be severe: suicide rates in prisons are up to 10 times higher than those in the general population, while self-harm rates run at close to 1 in 10 prisoners (in England and Wales in 2015), as opposed to 1 in 250 in the community. These numbers disguise the fact that some prisoners repeatedly self-harm or attempt suicide and that they may also experience less extreme mental health issues.

Despite this widespread problem, many mid- and low-income countries do not provide adequate mental health support to prisoners. There are neither adequate numbers of psychologists and psychiatrists nor prison staff trained and equipped to help retain or improve the mental health of prisoners in their care. Awareness of the holistic nature of measures playing a role in the protection of mental health and dignity – beyond medical interventions – is still low.

The system of psychiatric aid is quite a tabooed topic in modern Kazakhstan. It is related to objective aspects: protection of the rights of sick people and people with disorders,

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safety requirements, confidentiality requirements and usage of medication for treatment. There are also unjustified rules for 'closure' of the information, which has remained a legacy of punitive psychiatry from the times of the totalitarian society or Soviet Union period.

The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care adopted by UN General Assembly Resolution 46/119 of 17 December 1991 formulate basic freedoms and rights of mental patients: for the best available care, for treatment with humanity and respect, for protection from exploitation, discrimination, for protection and representation of interests. The basic principles of the protection of mental patients are as follows: observance of rights, protection of minors, life in the community, standardized diagnostics of illness and provision of care, confidentiality, role of community and culture, consent to treatment.[1]

The World Health Organization (WHO) guide on health protection in prisons identifies the following global problems:

- Mental disorders and suicides are widespread in correctional facilities.
- Prison detention is inherently characterized by several factors that pose a threat to the mental health of convicts.
- Convicts must be provided with the basic healthcare services of the same level and quality as in the community (equivalence principle).
- It is critically important for correctional facilities to collaborate with civil organizations to ensure equality and continuity of treatment.
- Around 6-12% of all convicts are in the need of a transfer to specialized institutions, 30-50% need the support of healthcare services and 40-60% would gain the largest benefit from improvement of mental health. Thus, different levels of support are needed.
- To prevent aggravation of the convicts' mental health in a correctional facility there must be permanent access to medical aid, and convicts in need should also have access to psychiatric aid.
- To reduce the risk of relapse, specialized psychiatric (forensic psychiatric) treatment might be needed.
- The presence of medical employees does not guarantee good mental health conditions. Ensuring good conditions of detention provides additional guarantee against aggravation of mental health and strengthens it. For this, it is important to implement the UN Standard Minimum Rules for the Treatment of Prisoners.

1 The Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, Adopted by UN General Assembly Resolution 46/119 of 17 December 1991.

– The best guarantees are possible when all the employees of correctional facilities have gone through rigorous selection and complete training in methods for reduction of harm for mental health and its strengthening.[2]

As underpinned by international standards and voiced by the WHO and medical bodies, mental health is best dealt with holistically, by considering the living environment and other aspects of life, as well as direct attempts to treat identified conditions. Given this, prison policies and staff attitudes are key to preventing mental health issues and improving the situation of prisoners with mental illness. Positive, non-stigmatizing attitudes by staff can improve the mental health of prisoners and their chances of rehabilitation and reintegration following release. Conversely, negative and stigmatizing attitudes by staff can mean that prisoners feel unable to ask for help when they need it and may lead to human rights abuses (such as ill-treatment by staff who misunderstand the reasons for prisoners' behaviour). As the WHO explains "prison services have had little guidance on mental health, including health promotion and the reduction of the harm that may arise from imprisonment. In addition, prison staff dealing with disturbed or otherwise difficult prisoners may experience workplace-induced stress, with implications for their mental and physical well-being and the good management of prisons". Indeed, prison officers have commented that they have no training on how to identify mental illness and therefore welcome practical guidance.

2 Prisoners with mental disorders during a pre-trial investigation and in court: fair trial

Regulatory documents (Criminal Code of Kazakhstan, Criminal Procedural Code of Kazakhstan and Criminal Executive Code of Kazakhstan) do not introduce the notion of mental disorder. At the same time, the notion of mental disorder is used in the Code of the Republic of Kazakhstan – 'On Health of the Nation and the Healthcare System' – and defines mental disorder (illness) as the disorder of the mental activity of a human caused by the malfunction of the cerebrum.[3] The notion in use does not disclose its content and makes it difficult in many respects to objectively assess a person in conflict with the law. An analysis of procedural components is provided in Table 1.

2 *Health in prisons. A WHO Guide to the Essentials in Prison Health*, WHO Regional Office for Europe, Health in Prisons Project, 2008, p. 152.

3 Code of the Republic of Kazakhstan on Health of the Nation and the Healthcare System with amendments and addenda as of 10 May 2017, (at: http://adilet.zan.kz/rus/docs/K090000193_/k090193.htm) (last visited: 19 September 2020).

Table 1 Analysis of procedural components of the pre-trial stage

Legal framework (law articles)	Content	Comment
Criminal Code Kazakhstan Article 17	**Criminal liability of people with a mental disorder not excluding criminal sanity** 1. A criminally sane person who could not fully be aware of the actual nature and the public danger of his actions (inactivity) or manage them during the commitment of a criminal offence owing to a mental disorder is subject to criminal liability. 2. Mental disorder not excluding criminal sanity is considered by the court in imposition of penalty as a mitigating circumstance and can serve as a reason for imposition of compulsory measures of a medical nature envisaged by this Code.	If a person with a mental disorder is criminally sane, then he is subject to criminal liability, but this can serve as a mitigating circumstance and a reason for compulsory measures of a medical nature.
Criminal Code Kazakhstan Article 75	**Release from punishment resulting from illness** 1. A person with a mental disorder starting after the commitment of a criminal offence depriving him of the ability to be aware of the actual nature and the public danger of his actions (inactivity) or to manage them is released by the court from punishment, and a person serving the sentence is released by the court from its further service. The court can impose compulsory measures of a medical nature envisaged by this Code on such people.	The law guarantees that if a mental disorder has started then the court can release a person from the service of sentence and can impose compulsory measures of a medical nature.
Criminal Procedure Code Kazakhstan Article 271	**Compulsory imposition of the expert evaluation** 1. Imposition and implementation of expert evaluation is compulsory if with regard to the case it is necessary to identify: 4) a mental or physical condition of a suspect, an accused, when there are doubts about their criminal sanity or ability to protect independently their rights and legal interests in a criminal process. **Note**. With regard to a suspect, an accused … **outpatient forensic psychiatric expert evaluation** is imposed and **implemented**. If an expert declares inability to give an opinion without implementation of inpatient forensic psychiatric expert evaluation and placement of a person under the evaluation in inpatient examination, then **inpatient forensic psychiatric expert evaluation** is imposed with regard to the criminal case according to the procedures envisaged by Article 279 of this Code.	Compulsory imposition of the expert evaluation if there are doubts about criminal sanity of a suspect and an accused: outpatient or, if necessary, inpatient expert evaluation.
Criminal Procedure Code Kazakhstan Article 275	**Guarantees the rights and legal interests of the persons under forensic expert evaluation** 1. In implementation of forensic expert evaluation of live people it is prohibited: 1) to deprive or restrain their rights guaranteed by the law (including by means of deception, torture, cruel treatment, violence, threat and other illegal measures) in order to get information from them; 2) to use these people as subjects of clinical studies of medical technologies, pharmacological and medical drugs;	The law guarantees additional rights and legal interests of people under expert evaluation, informs on the methods, provides necessary medical aid, etc.

Legal framework (law articles)	**Content**	**Comment**
	3) to apply methods of examination envisaging surgical intervention. 2. A person under forensic expert evaluation must be informed intelligibly by the body imposing the forensic expert evaluation about the methods of forensic expert studies in use, including alternative ones, possible pain senses and side effects. The specified information is also provided to a legal representative of the person under the forensic expert evaluation, on his request. 3. Medical aid to a person under forensic expert evaluation can be provided only based on the reasons and according to the procedures envisaged by law. 4. A person placed in a medical organization is provided with an opportunity to submit complaints and requests. Complaints and requests submitted in accordance with the procedures envisaged by this Code are sent by the administration of the medical organization to an addressee within 24 hours and are not subject to censorship. 5. Forensic expert evaluation implemented with regard to a person with his consent can be terminated at any stage on the initiative of this person.	
Criminal Procedure Code Kazakhstan Article 279	**Placement in a medical organization to implement expert evaluation** 1. If implementation of forensic expert evaluation with regard to a person presupposes implementation of forensic expert studies in inpatient conditions, then a suspect, a victim and a witness can be placed in a medical organization based on the resolution on imposition of the expert evaluation. If this person has not reached the age of majority or is recognized by the court as incapable, written consent is given by the legal representative. In case of objection or absence of the legal representative, the written consent is given by the custody and guardianship agency. 2. Referral to a medical organization for implementation of the forensic medical or forensic psychiatric expert evaluation of a suspect not in custody, as well as a victim and a witness is made in accordance with the procedures envisaged by the second part of Article 14 of this Code (Article 14. Integrity of the person. Clause 2: Forced placement of a person not in custody in a medical organization for implementation of the forensic psychiatric and (or) forensic medical expert evaluation is allowed only on the decision of the court). 2-1. In the cases envisaged by the second part of this article, within 24 hours the body (person) that has imposed the forensic expert evaluation is obliged to notify someone of majority age from the family, other relatives or close people about the location of a person forced into a medical organization for implementation	The law guarantees rights for a person placed in an inpatient facility for implementation in the expert evaluation. To place a minor in an inpatient facility the consent of his legal representative is needed. Placement in the inpatient facility is limited to 30 days. Extension is possible on the basis of a substantiated request from an expert.

Legal framework (law articles)	**Content**	**Comment**
	of the forensic expert evaluation, and if there are no such people, then the subdivision of internal affairs at the place of residence of this person should be notified. 3. Rules for stay of people under the expert evaluation in a medical organization are defined by the legislation of the Republic of Kazakhstan on healthcare. 4. If a suspect is placed in a medical organization for implementation of inpatient forensic medical or forensic psychiatric expert evaluation, the period within which he must be notified with a resolution on qualification of the suspect's action is suspended from the day the sanction is received until the commission of experts provides the opinion on the mental condition of the suspect. 5. Total timing of stay of a person under forensic medical or forensic psychiatric expert evaluation in a medical organization is **up to 30 days**. If it is impossible to complete forensic expert studies, this timing **can be extended by 30 days on substantiated request from an expert** (commission of experts) in accordance with the requirements of the second part of Article 14 of this Code. 6. If a person is under forensic expert evaluation in a medical organization, his defence attorney, legal representative and representative are eligible to appeal against the resolution on extension of its implementation timing according to the procedures envisaged by this Code.	
Criminal Procedure Code Kazakhstan **Chapter 54**	**Legal proceedings on the cases about the application of the compulsory measures of a medical nature to criminally insane persons**	**Specifics of legal proceedings with regard to criminally insane persons are assigned to a separate chapter**.
	Article 509. Reasons for proceedings on application of the compulsory measures of a medical nature	
	Article 510. Circumstances subject to proof	
	Article 511. Safety measures	
	Article 512. Transfer under the supervision of relatives, custodians and guardians	
	Article 513. Placement in a specialized medical organization	
	Article 514. Severance of a case with regard to a person who has committed an action prohibited by the criminal law in the condition of criminal insanity or becoming sick with a mental disorder after commitment of a criminal offence	
	Article 515. Rights of a person with regard to whom the case is conducted on application of compulsory measures of a medical nature	
	Article 516. Participation of a legal representative	

Legal framework (law articles)	Content	Comment
	Article 517. Participation of a defence attorney	
	Article 518. Completion of preliminary investigation	
	Article 519. Proceedings before a court	
	Article 520. Issues solved by the court when making a decision on a case	
	Article 521. Court resolution	
	Article 522. Appeal and protest against the court resolution	
	Article 523. Termination, change and extension of the application of compulsory measures of a medical nature	
	Article 524. Reopening of a criminal case with regard to a person against whom a compulsory measure of a medical nature is applied	

In Kazakh procedural law there are several procedural roles of a person: a suspect (before accusation), an accused (before submission of a case to court) and a prisoner at the bar (after the submission of a case to court). The law envisages that the presence/absence of a mental disorder and/or incapability (criminal insanity) will be established at the stage before accusation: if doubts arise, an investigator must impose a forensic psychiatric expert evaluation. This does not exclude the opportunity to impose expert evaluation after accusation or at the court stage. Therefore, the law guarantees the consideration of the presence of a mental disorder in investigation and consideration of the case. A person with mental disorders has the same rights as a healthy person (according to articles of chapter 2 of the Criminal Procedure Code of Kazakhstan: respect of honour and dignity, integrity of the person, private life, housing, property, ensuring a right for qualified legal support).

Combination of a mental disorder and criminal insanity allows special proceedings to be conducted on a case, the content of which is reflected in chapter 54 of the Criminal Procedure Code of Kazakhstan (Art. 509-524). Procedural peculiarities envisage transfer under the supervision of relatives, guardians and legal representatives, placement in a specialized medical organization, severance of a case and compulsory participation of a legal representative, a defence attorney. The rights of persons with regard to whom the case is conducted on application of measures of a medical nature are highlighted separately.

A special place is occupied by the issue of minors in conflict with the law with problems of mental health during the investigation period. In the existing practice, imposition of forensic psychiatric expert evaluation is obligatory for children committing serious and extremely serious offences. This, on the one hand, makes it possible to clarify the condition of children and, on the other hand, stigmatizes healthy children. The optimal solution in

this situation can be the use of the opinions of professional specialists such as psychologists or social workers.

3 Detainees with mental disorders during pre-trial detention: needs, problems, instruments of care

In accordance with the requirements of Article 271 of the Criminal Procedure Code of Kazakhstan, on each criminal case forensic psychiatric expert evaluation is obligatorily imposed. Such circumstances, in particular, can be data:

- on the presence of mentally sick relatives in a family of a suspect, an accused;
- on his presence at training in an institution for mentally disabled;
- on injuries sustained in the past;
- on being registered or treated in mental health facilities;
- on release from criminal liability or punishment in the past owing to a mental disorder, etc.

In the resolution on imposition of forensic psychiatric expert evaluation, experts need to solve the following issues, which allow the identification of:

- whether a person had mental disorders in the past;
- the degree and nature of a mental disease during the commitment of an action prohibited by law or during the investigation or court proceedings;
- the sanity of a person during the commitment of an action prohibited by criminal law, the mental condition of a suspect, an accused, after committing a crime during preliminary investigation or court proceedings, or during the service of a criminal sentence based on the court verdict;
- the nature and depth of a mental disorder;
- whether a person represents danger for himself and others taking into account the disease identified;
- whether a person can cause other substantial harm and whether he is in need of a compulsory measure of a medical nature and which in particular;
- whether a person, taking into account the nature and degree of a mental disease, can give explanations, make requests and provide evidence.

The aforementioned requirements allow one to state that during the investigation attention is paid to whether a person has a mental disorder, and consideration needs to be given to his disorder for administering the case and ensuring protection of his rights. After receiving the forensic psychiatric expert evaluation of a person's criminal insanity or his having a

mental disorder after commitment of a crime, an investigator must immediately fulfil the requirements of Articles 509-518 of the Criminal Procedure Code of Kazakhstan:

- severance of a case into separate proceedings is allowed;
- pre-trial restriction is cancelled and, if necessary, safety measure is selected;
- a defence attorney and a legal representative are involved in the case.

The Criminal Procedure Code of Kazakhstan prohibits the application of pre-trial restrictions to persons committing publicly dangerous actions in the condition of criminal insanity or becoming sick with mental disorders after commitment of a crime. The following safety measures envisaged in part 2 of Article 511 of the Criminal Procedure Code can be applied to such persons:

- transfer of a patient under the supervision of relatives, custodians and guardians with notification of the healthcare institutions;
- placement in an organization or a specialized medical organization providing psychiatric care: psychiatric inpatient facility of general type, of the specialized type or of the specialized type with intensive care.

If during the preliminary investigation, before mental illness has been established, a pre-trial restriction was applied to a person who has committed an action prohibited by the criminal law in the condition of criminal insanity and was not cancelled on the completion of the investigation, then the restriction must be immediately cancelled on the basis of the resolution of a prosecutor or the resolution of the court when the case has been accepted by them for their proceedings. If a safety measure is selected, the person must be transferred to a medical organization providing psychiatric care or transferred under supervision.

There is a specialized organization in Kazakhstan, the Republican Psychiatric Hospital of Specialized Type with Intensive Care (RPHSTIC) in Aktas Village of Almaty Oblast. The closed nature of the institution and inconsistency in the statements of the personnel and management on the need to observe ethics do not allow a complete analysis of the institution to be made. The mass media periodically publish contradictory information on the stay of the patients in this hospital[4] in interviews with the personnel about 'high-profile patients'.[5]

Actual transfer of a patient under supervision or his placement in a specialized medical organization owing to the application of safety measures must be procedurally recorded in the form of a protocol. Enforcement of the procedural decision of the bodies conducting a criminal process on delivery of a person in a specialized medical organization for execution of expert evaluations or into a court session or to the place of forced treatment is imposed

4 At: www.np.kz.

5 At: www.nur.kz/335164-vrach-rasskazal-o-zhizni-lyudoeda-dzhumagalieva-v-psihiatricheskoj-klinike.html.

on the bodies of internal affairs in coordination with a medical organization, into which a criminally insane person is placed.

4 Convicts with mental disorders in prison: needs, problems, instruments of care

After legal proceedings the court issues one of the following resolutions:
- termination of a case based on the reasons shown in part 1, Article 35 of the Criminal Procedure Code if there are identified circumstances excluding proceedings on the case;
- release of a person from criminal liability and application of one of the compulsory measures of a medical nature;
- termination of a case without application of a compulsory measure of a medical nature;
- submission of a case to the prosecutor for organization of the investigation according to the standard procedures.

The type of compulsory measure of a medical nature selected by the court takes into account:
- the public danger of the committed action;
- the degree and depth of a mental disorder;
- the presence and degree of this person's danger for the wider public or for himself or the possibility of him causing other substantial harm;
- the needs of the person in treatment.

The chief reason for determining the type of compulsory measure of a medical nature is the degree of danger of a mentally sick person to himself and to others and the possibility of him committing even more substantial harm. The resolution must contain the evidence that a person suffers from a mental disorder. It must also be stated whether the person at the moment of the commitment of an action was in a condition of criminal insanity or a mental disorder that started after the crime was committed.

Enforcement of the court resolution applying a compulsory measure of a medical nature on the basis of the reasons envisaged by the clauses is imposed on the healthcare bodies, which have psychiatric inpatient facilities under their jurisdiction and on the bodies of internal affairs. The healthcare bodies on which the application of compulsory measures of a medical nature and provision of psychiatric care is imposed, are obliged to examine a patient every six months. On the basis of the applied methods of treatment and medical care these healthcare bodies are to submit a substantiated opinion to the court on change, extension and termination of the compulsory measure of a medical nature in accordance

with Article 96 of the Criminal Code of Kazakhstan.[6] Stay of a person in a psychiatric inpatient facility without regular extension by court of a compulsory measure of a medical nature is illegal.

Statement (opinion) of the commission of psychiatrist-doctors on the need to terminate, change or extend a compulsory measure of a medical nature must be considered solely by the judge of the court that has issued the resolution on the application of a compulsory measure. It is known, however, that there are many people with mental disorders in prisons. Studies in different countries, employing various techniques and assessments, have found that 30 to 80% of the convicts have mental health problems. According to different estimates, approximately half of the convicts in prisons (colonies) had a medical history of intentional self-injury, mental disorder or drug abuse. Mental disorders, especially those frequently accompanied by criminal behaviour include personality disorders, alcohol and drug addiction and mental deficiency. In addition to these categories, there is a large group of repeat criminals characterized by social isolation, often with no permanent place of residence and work. Many of them have low intellect, and some suffer from chronic schizophrenia. Criminality in this group is simply one of the manifestations of total incapability to adapt to life in society.

The report on monitoring by the public monitoring commission for 2017 contains a description of the existing institutions and their operational procedures.[7] The extract from the report is given without changes. Convicts serving their sentence in correctional facilities with mental illnesses identified during this period, upon the opinion of the medical commission of the facility, are transferred for treatment to the Republican Psychiatric Hospital (RPH) of a general type located in the territory of correctional facility LA-155/14 in Zarechny Village, Almaty Oblast. The activity of this hospital is based on the Order of the RK Minister of Health No. 15 of 6 January 2011. It should be noted that this hospital is designed for the treatment of mental patients (men only) and that there are 50 beds in the wards of the inpatient facility. At the time of monitoring (2017) there were 28 convicts from different correctional facilities of Kazakhstan. Care and treatment of the patients is conducted within 20-30 days. There are cases of repeated treatment of the convicts in the RPH. Living conditions for the detention of mental health patient convicts do not fully comply with the requirements. There are no sanitary installations in the wards and no potable water. Patients are conveyed by the controllers from their wards on the second floor to the ground floor, which has a shared toilet with two lavatory bowls and one sink with cold water. This inevitably creates difficulties for mental patients who lack control

6 On judicial practice related to application of compulsory measures of a medical nature. Regulatory resolution of the Supreme Court of the Republic of Kazakhstan of 9 July 1999 No. 8 with amendments as of 15 May 2017.

7 The report on monitoring by the public monitoring commission of Almaty City and Almaty Oblast of the institutions in the Department of the Penal System, MIA RK for Almaty Oblast in 2017.

over their biological functions. Furthermore, doctors of the hospital do not provide patients with diapers, and neither is the procurement of diapers envisaged in the RPH.

In addition, the Criminal Executive Code (Prison Code) does not envisage any beneficial procedures to ensure the engagement of mental patients with families and relatives, and, in our opinion, this is negatively reflected in the condition of patients and their recovery. By law, such engagement is provided to these patients in the RPH according to the norms for the provision of engagement at the main place of the service of their sentence. Similarly, it is necessary to consider the issue of additional care packages received by the patients and telephone calls to relatives. Moreover, this right of the convicts is envisaged by the Prison Code. However, there is no payphone in the RPH for telephone calls with relatives and hence no possibility to communicate with them. Also, people who have become mentally unhealthy after the verdict of the court during the service of their sentence do not have legal representatives and guardians to protect their rights, a provision that is very necessary, in our opinion, as because of their mental status they are unable to adequately evaluate the surrounding environment and occurring events. The Prison Code does not envisage free visits of mental patients by legal representatives and guardians. Besides, contrary to what obtains during the pre-trial proceedings and in the court, where these people are provided with lawyer's services, in a correctional facility no legal support is available from lawyers. Moreover, legal support from a lawyer is needed when a convict becomes mentally ill and cannot be fully aware of the legal consequences related to illness. People under compulsory measures of a medical nature are also in need of legal support.

The right of the patients to receive information is also breached in the RPH. As monitoring has shown, in the RPH there are no boards in places accessible by patients displaying information on their rights and responsibilities, the daily schedule of the hospital, as well as the rights of doctors, including in the case of applying physical containment. Such information is needed as patients staying in these institutions are sane and capable of adequately receiving information, having only temporary problems with mental health.

At the same time, according to the provisions of the law and the aforementioned order, mentally sick convicted women and minors are not treated in the RPH but in medical units in institutions where they are serving their sentence. However, quality treatment of mental diseases is not conducted, for example, in the women's colony LA-155/4, although women are intensely subject to mental disorders resulting from conviction. During the last two years in this institution there were two cases of convicted women with mental illness, and treatment was conducted in the same institution. Adequate and planned treatment of such patients, convicts, is not conducted in the institution because there are no specialists (a vacancy for a psychiatrist has been unfilled for several years), and neither are diagnostics and medical drugs available for the treatment of such diseases as the institution does not have a licence to deal with psychotropic medication. As monitoring has shown, convicted women with mental diseases are treated with available medication

and not according to the diagnosis of the disease and are placed in the isolation cell in the medical unit. Their behaviour is under general observation. For example, in this institution convict V.K. was held in the isolation cell of the medical unit during her mental illness for 2-3 months, until she got better. However, V.K. is still in this institution and has been under observation for more than 2.5 years as her condition is not stable and from time to time she is transferred to the medical isolation cell during recrudescence. Treatment and prophylactics of this mental patient are also complicated by the fact that she is a citizen of another country and her examination in a civil hospital is not possible. Unfortunately, institutions of civil healthcare do not accept convicted women, citing the lack of special cells-wards for detention of the convicts.

The results of the last study conducted by the Office for National Statistics in the UK show that nine out of 10 convicts have objective symptoms of one or several mental disorders.[8] Neurotic disorder is diagnosed for 59% of convicted men and 76% of convicted women. More than 25% of women in pre-trial detention reported a suicidal attempt during a preceding year, and 2% of men and women under investigation reported an attempt of suicide one week before an interview in prison. Fifty-eight percent of men and 36% of women in custody under investigation had in the past consumed alcoholic drinks with dangerous consequences. Sixty-six percent of women under investigation abused psychoactive substances during the year preceding their admission to prison. Comorbidity was the norm: seven out of 10 convicts had more than one mental disorder, and people with functional psychoses often had three or four other disorders, including abuse of alcohol or other psychoactive agents. On the basis of limited scientifically justified data it is assumed that elderly convicts suffer from mental disorders very often: 55% have active psychopathologic symptoms.[9]

Researchers[10] and practitioners argue for the need to fulfil several tasks in order to enhance the quality of psychiatric aid provided to criminals and people at risk of committing a crime. First, it is paramount to ensure that patients with serious mental diseases do not get into the system of criminal proceedings. This can be ensured by providing effective long-term care or by replacing criminal liability with alternative types of correctional influence. Second, it is important to return these people to the system of mental health protection as soon as possible if they have already entered into the system of criminal proceedings and at the same time meet the criteria for their transfer in accordance with the provision of the law on protection of mental health. Also, these people should be

8 Nicola Singleton, Howard Meltzer & Rebecca Gatward, *Psychiatric Morbidity among Prisoners in England and Wales*, London: HMSO, 1998.

9 Pamela J. Taylor & Janet M. Parrott, 'Elderly offenders. A study of age-related factors among custodially remanded prisoners', 152 *British Journal of Psychiatry* 3 (1988), pp. 340-346.

10 John Reed, 'Delivering psychiatric care to prisoners: problems and solutions', 8 *Advances in Psychiatric Treatment* 2 (2002), pp. 117-125.

consulted about their treatment in prison (colony) if they do not meet the criteria for transfer.

If there are people with mental disorders in prisons, it is hard to organize transfer to more suitable conditions of care for several reasons. First, there are difficulties in identifying a disease. During their admission to prison many convicts do not reveal their existing serious mental disorders. According to various estimates, around 40% of the convicts show symptoms of disorders only when in a colony. Second, even when mental illness is identified in a colony, medical support is of very low quality. Some doctors lack proper professional training in order to carry out the work they face, and sometimes medical support does not comply with the required ethical standards. Kazakhstan has no standards for medical care in prisons, and there are no psychiatrists. A psychiatrist is invited for consultation only in very rare, critical cases.

Several problems, listed here, need to be solved:

- Organization of quick examination and, if necessary, getting the consultancy of a specialist and treatment in the conditions of a colony or immediate transfer to a specialized institution.
- Ambiguity of resolutions, orders, instructions and SOPs (and often their absence) creates problems in response, resulting in delays. Even when a responsible body is known, a suitable consultant is sometimes hard to find.
- Convicts often have to wait weeks and even months for their first visit to a psychiatrist who must examine them. It is necessary to ensure the availability of psychiatric aid within the same time in which the aid is provided to a person in freedom.
- No interdepartmental coordination (Ministry of Internal Affairs – Ministry of Health): correctional institutions are afraid of repeated crimes, and medical institutions refuse to accept convicts because there is no specialized guard force in hospitals.
- Psychological services of correctional institutions need to apply special methods of clinical diagnostics to conduct screening.
- It is necessary to organize the provision of social and psychological aid to patients who remain in correctional institutions owing to their indications.

5 Treatment of convicts with mental disorders: responsibility for causing harm to health or perverting the course of justice?

The issue of treating convicts with mental disorders is contradictory in nature. On the one hand, patients often do not get necessary care because of the aforementioned reasons, to which we can add the difficulty of taking special medication under the conditions prevailing in a correctional facility (requirements for storage of medication, permission for storage

of medication, risk of misuse). Furthermore, special psychotherapeutic, social-psychological aid for patients is not envisaged by standard procedures.

In 2009, Alexander Lobadenko, a psychiatrist from Pavlodar oblast (North Kazakhstan) revealed incorrect opinions of the forensic psychiatric expert commission (FPEC).[11] Orders of the Ministry of Health regulating the establishment of FPEC in 1997-1998 had not been registered in the Ministry of Justice as of 2009. The following is the reply of the Kazakhstan vice-minister of justice, D. Kostavletov, to Mr. Lobadenko on 5 June 2009:

> The Ministry has considered your statement regarding Order of the Kazakhstan Minister of Health from 18 August 1997 No. 407 "On Measures for Further Improvement of Forensic Psychiatric Expert Evaluation in the Country", Order of the Chairman of the Health Committee of Kazakhstan Ministry of Education, Culture and Health of 23 February 1998 No. 93 "On Improvement of the Procedures of Compulsory and Other Measures of a Medical Nature with regard to Socially Dangerous Patients", Order of the Chairman of the Committee of 13 May 1998 No. 269 "On Measures for Further Improvement of Organization of Psychiatric Aid". These orders must be cancelled by the body that has issued them as unregistered regulations not having legal force.

In 2010 this void was filled by a document called 'On Approval of the Instruction for Conducting Forensic Psychiatric Expert Evaluation' on orders of the minister of health of the Republic of Kazakhstan as of 12 March 2010 No. 164 registered in the Ministry of Justice of the Republic of Kazakhstan as of 29 March 2010 No. 6143.[12] On the other hand, there are examples of usage of psychiatry for punitive purposes and illegitimacy of the FPEC opinions. There are cases where psychiatrists, on receiving deliberately misleading reports from neighbours, relatives, colleagues and other parties, can forcefully admit citizens to psychiatric institutions without objective reasons. A review of the mass media, reports and studies is presented in Table 2.

11 At: http://pavon.kz.

12 At: http://adilet.zan.kz/rus/docs/V100006143_.

Table 2 Legal breaches with regard to rights of people based on psychiatric features

Category of breach	Description of facts
False diagnosis	For 10 years the leader of the organized criminal group S. Smirnov was misdiagnosed. Investigator Vladimir Grigoryev proved that for 10 years they had made false diagnoses relating to a dangerous criminal, leader of the organized criminal group, S. Smirnov, which allowed him to escape criminal liability. Specialists and experts identified that all clinical diagnoses made relating to the leader of the organized criminal group S. Smirnov from 1998 to September 2009 did not comply with the requirements of part 1, Article 10 of RK Law of 16 April 1997 No. 96-1 'On Psychiatric Aid and Guarantees of the Citizens' Rights When It Is Provided' valid until 18 September 2009 as these diagnoses were not confirmed by the objective data (objective anamnestic data, objective clinical data, medical documents, results of laboratory, instrumental studies, opinions of the specialists).[13]
	Leader of the organized criminal group Zaur Magomedov received a false psychiatric diagnosis. In December 2009 a native of Kyrgyzstan, Zaur Magomedov, born in 1986, committed assault on a resident of Almaty and took USD 100,000 from him, but in June 2010 the forensic psychiatric expert evaluation recognized him as criminally insane. Zaur Magomedov was sent to the psychiatric hospital of Talgar for forced treatment. After the arrest of Magomedov on 31 January 2011, in this hospital, the police sent him to his homeland, Kyrgyzstan. On 11 February 2014, after his extradition to Kyrgyzstan, Zaur Magomedov, along with a partner in crime, killed a militiaman in the town of Karakol. In Kyrgyzstan the investigators did not raise the issue of repeated forensic psychiatric expert evaluation for Magomedov, and he was placed in the psychiatric hospital of Kyzylzhar in the Dzhalal-Abad region. A criminal case was initiated against the officials of the psychiatric hospital of Kyzylzhar as Magomedov was freely moving around the territory of Kyrgyzstan, and his actions were illegal.
Illegal placement in a psychiatric inpatient facility based on a fabricated diagnosis	Nurlan Alimbekov is a philosopher from South Kazakhstan Oblast; in 2008 he was placed in RPHSTIC in Aktas Village based on a fabricated psychiatric diagnosis. He was accused on the basis of an article, of inciting ethnic hostility and expressing ideas against close integration of Kazakhstan and Russia.[14]
	Azimkhan Abashev, Perizat Aidarbekova and Galymzhan Azimkhanov are entrepreneurs from Taraz. From 27 December 2011 to 7 February 2012, they were kept illegally in two psychiatric hospitals, father and mother in Shymkent and son in Almaty. Judge Sandugash Azimkhanova, their daughter, placed them there because of the family restaurant 'Emir'. Psychiatric diagnosis of all three victims was cancelled, and Sandugash Azimkhanova was sentenced to 5 years in a colony according to Article 127, 'Illegal placement into a psychiatric inpatient facility'.
	Viktor Yershov, a resident of Yesil village, Osakarovka Raion, Karaganda Oblast, illegally spent seven months at RPHSTIC in Aktas Village in 2009. He submitted an application that he was beaten up by a local farmer, who together with a policeman, later placed him illegally in the psychiatric institution. On 10 December 2009 the decision of Osakarovka Court was cancelled by the regional court.

13 "Psychiatry System" Reference-book (at: https://delo1310.wordpress.com/).

14 At: https://rus.azattyq.org/a.

Category of breach	Description of facts
	Sergei Smirnov is a leader of the organized criminal group from Almaty. From 1998 to 2009 he was receiving false psychiatric diagnoses and escaped criminal liability. In 2012 investigator Vladimir Grigoryev proved the false nature of Smirnov's psychiatric diagnoses.
	Aslant Ilyasov, son of NSC General Ilyasov, was accused of fraud with oil. To avoid criminal liability, he received a false psychiatric diagnosis and was sent to RPHSTIC in Aktas Village, where he was identified as having 'depersonalization syndrome', and the FPEC found that he had symptoms of the 'moderate depression period'. Aslant Ilyasov disappeared from RPHSTIC and reappeared later with different passport details, driving an expensive foreign car and presenting himself as a successful businessman.
	Abzal Shakarov, a policeman from Pavlodar, wrote a letter to Nurotan Party in 2008 about how policemen slip drugs. The policemen brought him to the regional psychoneurological outpatient facility with a resolution on conducting forensic psychiatric expert evaluation. Pavlodar doctors diagnosed him with 'schizophrenia, paranoia'. In March 2009, in Almaty, the public consultative expert council (PCEC) of 10 professors passed an opinion on Shakarov's mental condition– 'No mental disorders'. The head of the fourth Psychoneurological Outpatient Facility for men in Pavlodar, Alexander Lobadenko, sent a request to the Ministry of Justice to confirm that all examinations made with regard to Shakarov – both FPEC in Pavlodar and PCEC in Almaty – were illegal. This was because the orders of the Ministry of Health regulating the establishment of these joint bodies in 1997-1998 are not registered in the Ministry of Justice.
	Yermek Taichibekov is a blogger from Zhambyl Oblast. In 2015 he was accused of inciting ethnic hostility according to Article 174-1. The commission in Taraz found that he had thought disorders: "Symptoms of paranoiac syndrome with ideas of reformism and nobility, there are distortions in thinking in the form of circumstantiality, propensity for 'ponderism', and there are also disorders in emotions in the form of dimness, monotony, limitation of the range of interests, the nosological features of which cannot be defined in outpatient conditions". FPEC in RNPH of Almaty annulled the opinion of psychiatrists from Taraz and recognized Yermek Taichibekov as healthy.

A special problem is the system according to which children's treatment is organized. Aid to children under 16 is provided in children's units of psychoneurological hospitals and to those over 16 in shared units. A child's stay in special institutions (special schools) complicates the provision of support to children as the structure of the institution does not envisage psychiatric aid.

6 Reintegration of convicts with mental disorders in society: needs, problems, solutions

The report of the monitoring group[15] notes that "the laws of Kazakhstan envisage only application of compulsory measures of a medical nature or forced outpatient treatment at a psychiatrist for the people who have committed crimes. At the same time, rights of mentally sick convicts are not envisaged separately by the penal law, their rights are similar to the rights of all convicts, which witnesses that the law does not recognize mentally sick convicts as sick. Upon expiry of the term of sentence, the norms of the penal legislation do not envisage any measures for socialization of such people, all the burden for socialization of patients is on close relatives". However, the degree of protection of people released from prisons with mental health problems corresponds to the degree of protection of other Kazakh citizens who get necessary psychiatric aid.

At the same time, there is a lack of awareness of the services that former prisoners can receive both as outpatient and as inpatient aid. These problems are related to the general system of reintegration of former convicts and a solution was found in a few pilot projects in Kazakhstan. Thus, the Penal Reform International office in Central Asia, with the support of the Ministry of Foreign Affairs of the Kingdom of Norway, implemented a unique project in Kazakhstan: *Rehabilitation of ex-prisoners and protection of their rights by joint efforts of civil society and state*.

As part of the project, models were proposed for strengthening rehabilitation services provided by the state in collaboration with civil society. The dynamics of the development of the probation services show that after three years the number of people who received social and legal support increased. In the first 10 months of 2016, social and legal support was provided to 30,235 registered people, including treatment (10,766), psychological support (11,806), education (231), employment (4,270), restoration of documents (297) and other support (8,663).

The Decree of the President of the Republic of Kazakhstan from 8 December 2016 No. 387 'On approval of the Comprehensive Strategy for social rehabilitation of citizens released from prison and registered with probation services in the Republic of Kazakhstan for 2017-2019'[16] formalizes several programme solutions on social rehabilitation. It is beyond the scope of this article to discuss the results of the implementation, but the following important components of this programme should be noted:

15 The report on monitoring by the public monitoring commission of Almaty City and Almaty Oblast of the institutions in the Department of the Penal System, MIA RK for Almaty Oblast in 2017.

16 At: http://adilet.zan.kz.

- improvement of organizational basics of resocialization and regulatory framework;
- creation of the conditions to improve the process for resocialization of the citizens released from prisons and registered with probation services;
- improvement of the mechanism for social adaptation of convicts through the establishment of the social support system; and
- development of human resources and scientific bases for the resocialization process.

The foregoing components also help to solve problems of resocialization of people with mental health problems: organizational and interdepartmental interactions to organize help and social support allowing tracking of the dynamics of disorders and providing timely consultancy support.

7 Conclusions

In Kazakhstan many necessary reforms have been implemented, legislative and legal regulation is conducted and several documents are elaborated to protect the rights of people in conflict with the law and having mental disorders. Guidance addressing healthcare professionals working in prison is available to a greater degree, based on general psychological and psychiatric expertise. However, prison staff are also required to address the mental health issues of prisoners, and in many counties they are not equipped or trained to do so. Too often the issue is understood as entirely 'medical' and a matter concerning healthcare professionals (including psychologists and psychiatrists) alone, when, in fact, many other factors in day-to-day prison life have a considerable impact on mental health. Among them are social and family contact during imprisonment, handling of conflicts through mediation rather than disciplinary procedures, reasonable adjustments to prison management for detainees with mental disabilities, provision of information to prisoners with mental and learning disabilities, provision of safety from violence in prison, refraining from isolation and enabling meaningful activity. The following are examples of positive developments in Kazakhstan:

1) Criminal, Criminal Procedural and Criminal Executive Codes (Prison Code) contain norms necessary to ensure the protection of the rights of people in conflict with the law and having mental health problems.
2) Important norms are procedural norms that formalize the need to impose and conduct expert evaluation allowing the presence of a mental disorder to be established.
3) Impermissibility of applying detention measures during investigation for people with mental disorders is an important norm. The usage of safety measures for such people provides protection for patients themselves and the people around them.

4) Elaborated instructions, provisions, orders and programmes aimed at improving the system.
5) Development and introduction of a comprehensive strategy for social rehabilitation of citizens released from confinement and registered with probation services in the Republic of Kazakhstan for 2017-2019.

The negative features include the following:
1) Weak interdepartmental coordination between the Ministry of Internal Affairs, healthcare and social protection agencies, which complicates processes for diagnostics of disorders, imposition and conduct of treatment and reintegration of a patient.
2) High level of confidentiality characterizing specialized institutions' treatment of people with mental disorders who are in conflict with the law.
3) Lack of standards for screening, diagnostics, treatment and resocialization of people in conflict with the law and having mental disorders in correctional institutions and on probation, as well as in specialized institutions.
4) Practice of illegal placement of people in specialized psychiatric institutions based on fabricated diagnoses, as well as practices of false diagnoses.
5) Lack of specialists in correctional institutions (psychiatrists and clinical psychologists), lack of conditions for detention and treatment of criminally sane convicts with mental disorders.
6) Lack of a system of support for people with mental disorders conforming to conditions prescribed by the law enforcement system.
7) Without adequate guidance and sensitization to the identification of mental health issues and adequate measures to address them, prison staff may cause or exacerbate mental health issues. Even where psychological and psychiatric care is available, the role of prison staff cannot be overstated. Their actions and attitudes can promote and improve or hinder and infringe the mental health of prisoners.

The revised UN Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules) provide an opportunity to raise these issues that should not be missed. A range of provisions on the treatment of prisoners and on prison conditions have been updated to meet modern standards, many of which are relevant to holistic measures protecting and improving the mental health of prisoners.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system in the Netherlands

Michiel van der Wolf & Paul Mevis[*]

1 Introduction

On the topic of how the Dutch criminal justice system deals with mentally disordered offenders, historically and politically the 'track' attracting most attention is a safety-measure for non- or diminished responsibility mentally disordered offenders considered dangerous. The Netherlands is well known for its TBS-order, a safety-measure of 'entrustment' (TerBeschikkingStelling) for offenders to be executed in high-security forensic mental health facilities. Why it has been 'much envied'[1] abroad can be explained by the fact that it succeeds in treating and reducing re-offending rates within a diverse group of offenders including personality disordered and sex offenders alongside offenders with psychotic disorders.[2] This treatment is paid for by the Ministry of Justice and Security, and carried out in designated forensic psychiatric centres (FPCs). Even though since 2008, there is a broader approach to 'forensic care' – meaning that the Ministry of Justice and Security is paying also for care within the (forensic) mental health system, as it is for treatment with the penitentiary system, on the basis of a wider range of legal frameworks – the TBS-measure still attracts most attention in academia, and certainly in media and parliament.

As traditionally most forensic assessment and treatment is focused on this 'track', the two aspects that are at stake in this contribution are often somewhat overlooked, both in practice and in academia. Probably because of all these forensic psychiatric investments into the TBS, treatment within prison is scarce and more and more dealt with through transfer or diversion into the (forensic) mental health system. And the possible significance

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1 In the words of Conor Duggan, 'To move or not to move – that is the question! Some reflections on the transfer of DSPD patients in the face of uncertainty', 13 *Psychology, Crime & Law* 1 (2007), pp. 113-121, p. 114.

2 See K. Drieschner, J. Hill & G. Weijters, *Recidive na tbs, ISD en overige forensische zorg*, Den Haag: WODC-Cahier, 2018-22.

of having a mental disorder within the criminal process often seems subordinate to making sure the defendant is quickly sentenced and disposed into a fitting forensic mental health setting, like the FPCs on grounds of a TBS-order. The latter is partly explained by the fact that in the Dutch inquisitorial justice system the 'fairness' of the procedure is not only governed by equality of arms but also by the assumption that the court will take the interests of all parties involved (including society) properly into account.

However, there are recent developments which should ensure that these aspects are given more attention. As most transitions within (forensic) mental health law,[3] these developments are only partly explained by scientific, legal, societal or political paradigm shifts, partly by financial arguments and partly as a consequence of a high-impact single case. Even though, from the perspective of security, treatment of detainees is now also administratively part of the realm of 'forensic care' – the 'Forensic Care Act (FCA)' was adopted in stages within the last couple of years – especially the case of Michael P., who killed a young woman on leave even before his official parole, has switched attention more to security and treatment of mentally disordered offenders who have not been sentenced to a TBS-order but a 'mere' prison sentence.[4] The increased focus on mentally disordered defendants, however, is mainly due to 'European' influences, coming both from the direction of the European Court of Human Rights as a body of the European Council and the European Commission as a body of the European Union. All these mentioned developments will be addressed in the relevant paragraphs below.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

2.1 Suspension of prosecution due to unfitness[5]

The most far-reaching, and thus most debated, provision for mentally disordered defendants related to the right to a fair procedure is the possibility of suspending prosecution in the case of unfitness. It is of issue in both the pre-trial inquiry and the trial phase, because it is directed at the phase at hand. Someone could for example be unfit to be inquired during

3 See Paul S. Appelbaum, *Almost a Revolution. Mental Health Law and the Limits of Change*, New York: Oxford University Press, 1994.

4 See M.J.F. van der Wolf & P.A.M. Mevis, 'Beschouwingen over weigeren en beveiligen n.a.v. de zaak Michael P. Rechtspraakrubriek', *DD* 2018/27, pp. 321-366.

5 Parts of this section are based on M.J.F. van der Wolf, H.J.C. van Marle, P.A.M. Mevis & R. Roesch, 'Understanding and evaluating contrasting unfitness to stand trial practices. A comparison between Canada and The Netherlands', 9 *International Journal of Forensic Mental Health* 3 (2010), pp. 245-258.

the pre-trial investigations, or unfit to stand trial, or both.[6] In the Dutch Code of Criminal Procedure (Art. 16 CCP), unfitness is listed as one of the possible reasons for suspending prosecution:

> If a defendant suffers from such a mental disorder, psychogeriatric condition or mental disability that he is not capable of understanding the intention of the criminal proceedings against him, the prosecution will be adjourned. As soon as the defendant has recovered, the suspension of the prosecution will be lifted.[7]

The current criterion stems from 1986 and was a codification of a ruling by the Supreme Court of the Netherlands in the renowned case of Pieter Menten. While nominated for arrest at the end of the Second World War for war crimes committed in German-occupied territories in Central Europe, he was not prosecuted until the late 1970s after some media attention and consequential upheaval in both society and parliament. Since expert witnesses had called him a 'physical and mental wreck' due to his age, the District Court of Rotterdam had suspended the prosecution due to his inability to participate in the defence. But the Supreme Court (1980) ruled the then-criterion of mere 'insanity' (which had existed since 1838) had to be interpreted as mentioned in the current provision cited above, and that in this sense Menten could not be called insane.[8] While the circumstances may give rise to the assumption of a 'political' decision, it is actually in line with previous case law and legislative history. The formulated capacity criterion is probably to be viewed as the explanation of senselessness (or irrationality), which was the criterion for insanity used in the legislative process leading up to 1838.[9] The mere incapacity to defend oneself is in spite of confusion among judges, legislators and legal scholars not a sufficient rationale for suspension. This is supported by the fact that since 1928 there is an additional provision for adult mentally disordered defendants, as there is for minors, who are unable to defend themselves (which will be further elaborated on in Section 2.2).

Another Dutch debate on the scope of the unfitness doctrine is whether the application of Art. 16 CCP rules out the later application of safety-measures on grounds of diminished or non-responsibility. This is connected to the question of the timing of the presence (or

6 Unfitness to have a sanction executed post-conviction but before the start of the execution is regulated by Art. 6:2:3 CCP.

7 Translation by P. Bal & F.A.M.M. Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces*, Den Haag: BJU, 2004, p. 83, except for our necessary addition of 'the intention of'.

8 Supreme Court of the Netherlands, 5 February 1980, *NJ* 1980, 104.

9 See M.D.C. Moncada Castillo, M.J.F. van der Wolf, H.J.C. van Marle & P.A.M. Mevis, 'Psychisch gestoorde verdachten. Artikel 6 EVRM vraagt om herijking van de Nederlandse antwoorden op procesonbekwaamheid', *Strafblad* 2010, pp. 320-337.

onset) of the disorder. Originally, since the Dutch Code of Criminal Procedure of 1838, the unfitness doctrine had been reserved for cases in which the disorder had its onset after committing the offence. This probably had something to do with the responsibility doctrine up until 1886, Art. 64 of the French Code Pénal, which stated that there was 'no crime' ('il n'y a crime ni delit') when it was committed by a 'lunatic'. No crime meant no prosecution (and only a possible civil disposition into a mental hospital), while for offenders for whom the disorder had revealed itself after the offence, some procedural consideration was needed since they were prosecuted. However, in 1886 the non-responsibility (or legal insanity) doctrine became an excuse, which meant that even accused who were mentally disordered at the time of the crime were prosecuted and could be directed to a mental hospital by the criminal court. Moreover, since 1886 the non-responsibility doctrine demands a (causal) relation between disorder and offence, which meant that there was a certain group of disordered offenders (no relation) that was ineligible for neither the responsibility criterion nor the unfitness criterion, which made it harder to get into an appropriate facility. It was not until 1928 that procedural consideration was enacted for offenders who were either not responsible or had diminished responsibility for the act, through the guarantees of Art. 509a CCP (see Section 2.2), but still the prosecution of these individuals could not be suspended on the grounds of unfitness. The Dutch rationale has probably long been that being in a suitable therapeutic environment without the uncertainty of a pending criminal process was more important than some procedural values. This goal could be reached through non-prosecution and subsequent civil commitment of mentally disordered offenders or, if they were prosecuted, through a verdict of non- or diminished responsibility which would get them into a psychiatric hospital or TBS-clinic (or another suitable environment), even if this took a criminal trial which they did not understand but in which their interests were more or less taken care of by the inquisitorial judge. This is supported by the fact that the criterion for lifting intent (more or less corresponding with that of Art. 16 CCP) is so strict as not to prevent disordered offenders from getting into TBS-clinics, which is not possible after acquittal.[10] Since the TBS has more and more been reserved for severe violent offenders, this shortcut gets closed for less severe mentally disordered offenders, leaving them with the penitentiary system.

So, the Dutch unfitness doctrine has always been determined by the responsibility doctrine and the consequential appropriate facility, rather than by procedural values like fairness. However, when Article 16 CCP was changed after the Menten case and the criterion was formalized, the ever-present segment 'after the committing of the act' was left out. Even though the legislature deliberately eliminated the segment, there has long been confusion among scholars. Some still advocated that the disorder has to have had its onset

10 Geert Knigge, *Strafuitsluitingsgronden en de structuur van het strafbare feit. Preadvies voor de vergelijkende studie van het recht van België en Nederland*, Den Haag: Boom, 1993.

after the offence,[11] while others find the unfitness doctrine applicable to offenders who were already disordered at the time of the crime.[12] The confusion is understandable from a historical point of view, but from a point of view of procedural values this inequality seems outdated. Whereas also in the Anglo-American legal realm historically other rationales for the unfitness doctrine have been recognized – such as ensuring the accuracy of the criminal proceedings, maintaining the dignity of the judicial process and maximizing the efficacy of punishment[13] – in modern times it is recognized that only the fundamental right to a fair trial is firm enough grounds for such a consequence. And since fundamental rights are for all, the unfitness practice should be similarly applicable to offenders who were already disordered at the time of the offence, for example, those with chronic disorders already present at the time of the offence and/or disorders from which one will never recover. Therefore, one can say that only since this legislative change in 1986, the Dutch unfitness doctrine is pursuing the equal right to a fair trial.

Even though since then the law also mentions that after 'recovery' the prosecution may be continued, the strict Dutch substantive criterion has rendered the doctrine not only a rarity but also mainly applicable for very serious conditions, often not recoverable disorders. In practice, it takes conditions of severe neurocognitive impairment, for example, after acquired brain injury or neurodegenerative disorders.[14] Therefore, sometimes suspension is accompanied by a more definite termination of the prosecution. Where in adversarial justice systems, psychosis is a common disorder among the unfit, in the Netherlands just a couple of cases can historically be traced in which a defendant with a psychotic disorder met the criteria, for example, when decompensation led to a temporary vegetative existence. In these cases recovery was possible and the prosecution continued, with time spent deprived of liberty deducted from the eventual sentence.[15] Lengthy civil commitment without an establishment of guilt, the bone of contention in jurisdictions where unfitness is 'big business'[16] is therefore not yet an issue in the Netherlands, even though in theory this would be possible as pre-trial detention or in meeting the criteria for civil commitment.

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11 P. Bal & F.A.M.M. Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces*, Den Haag: BJU, 2004.

12 See CH. Haffmans, *De berechting van de psychisch gestoorde delinquent, handleiding voor juristen bij vraagstukken op het raakvlak van strafrecht en psychiatrie*, Arnhem: Gouda Quint, 1989.

13 Law Reform Commission of Canada, *Study paper: Fitness to Stand Trial*, 1973; Law Reform Commission of Canada, *A Report to Parliament on Mental Disorder in the Criminal Process*, 1976.

14 See E.M. Gremmen, *De kwetsbare psychisch gestoorde verdachte in het strafproces. Regelgeving, praktijk en Europese standaarden*, Oisterwijk: Wolf Legal Publishers, 2018, for an overview of case law.

15 P. Bal & F.A.M.M. Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces*, Den Haag: BJU, 2004; E.M. Gremmen, *De kwetsbare psychisch gestoorde verdachte in het strafproces. Regelgeving, praktijk en Europese standaarden*, Oisterwijk: Wolf Legal Publishers, 2018.

16 For example, Szasz's Psychiatric Justice has been translated into Dutch: T.S. Szasz, *Het recht om terecht te staan. Rechtsbedeling door psychiaters*, Bilthoven: Ambo, 1971.

Exactly in this aspect, fairness is competing with fairness, as speedy adjudication is also part of the right to a fair trial and in the interest of the individual. As the Dutch criterion for unfitness, 'understanding the intention of the proceedings' is not really elaborated on in case law and thus leaves room for interpretation; this is also where a consideration of all the relevant interests comes in. Especially since suspension delays or even averts restoration for victims, relatives and society, it is not the popular option, especially in cases of severe offending. This is, next to old age, one of the explanations why the issue often arises in the late prosecution of war crimes of the Second World War.[17] As mentioned earlier, the fact that the easiest way to a high-security forensic mental hospital is through imposing the TBS-order at the end of a trial also persuades courts to proceed with the trial to ensure someone gets to the best possible place for treatment, in both his interest and that of others. This is, for example, being used in cases of persons already in closed facilities who commit (multiple) violent offences towards staff or other patients, when other ways than criminal prosecution to get someone to a higher level of security have failed.[18] So, next to the fact that the Dutch criterion for unfitness is a high standard, the fact that it leaves room for interpretation and thus for other considerations is one of the reasons that it is not often used in practice. Of course in an inquisitorial justice system, like the Dutch system, there is less emphasis on the active participation of defendants, as not the parties but the court is the driving force of the process of fact-finding.[19] In fact, it is already quite remarkable that there even is an unfitness provision in the Dutch CCP, as not all inquisitorial jurisdictions do, but as we explained in the beginning of this section this had to do with a peculiar and pragmatic origin. But given the provision and given that in 'modern times' fairness is the overriding human rights' rationale behind it, we will ask and answer the question whether more emphasis should be placed on using the doctrine in the future. But first, in the next section, we will see what (other) safeguards exist for lesser incapacities in the Dutch CCP and whether their existence is part of the explanation of the limited use of the unfitness doctrine.

2.2 Additional safeguards (related to counsel) to ensure a fair procedure

Specifically, for the phase of the trial, an additional safeguard exists in the Dutch CCP for mentally disordered defendants, as already mentioned in Article 509a which reads:

17 P. Bal & F.A.M.M. Koenraadt, *Het psychisch onvermogen terecht te staan. Waarborg of belemmering van het recht op een eerlijk proces*, Den Haag: BJU, 2004.

18 See District court of Amsterdam, 13 October 2016, ECLI:NL:RBAMS:2016:7497.

19 See J. Gunn & P.A.M. Mevis, 'Adversarial Versus Inquisitorial Systems of Trial and Investigation in Criminal Procedure', in K. Goethals (ed), *Forensic Psychiatry and Psychology in Europe. A Cross-Border Study Guide*, Basel: Springer International Publishing, 2018, pp. 3-17.

> [T]he court will, if it is suspected that the defendant suffers from a mental disorder, psychogeriatric condition or mental disability, and that as a consequence he lacks the capacity to attend his interests, state such in its decision.[20]

For this decision no forensic assessment is needed, but the court can order such an assessment to verify their suspicion (Art. 509b CCP). In the following articles, some means of compensation for this incapacity are provided. Related to ensuring a safe trial the most important are the appointment of counsel (Art. 509c CCP) and the transfer of all the rights of the defendant to the counsel (Art. 509d under 3 CCP). This means that, for example, if the defendant wants to appeal the decision of the court (or not), the counsel may overrule that wish.

In the Dutch inquisitorial approach trial *in absentia* is far less problematic than in adversarial systems. And in general, when only counsel is present but there is an explicit warrant from the defendant that counsel may act on his behalf, officially it is not even a trial *in absentia*. The situation of Article 509d under 3 CCP is more or less comparable, even though the warrant is not given by the defendant but by the court. Of course, this is due to the context that not only the defence counsel but also the court is expected to serve the interests of the accused. That is shown, for example, in case law that suggests that the accused is a full participant in the process, since the presence of counsel is no reason not to be excused for the incorrect use of procedures on account of a mental disorder.[21] With the status of full participant in the process comes that defendants can also waive counsel and defend themselves, even though this rarely happens in practice. However, in a high-profile case, when the defendant waived counsel, the Supreme Court assessed that the Court of Appeal should have verified better whether this had been done 'unambiguously' referring to Article 509a CCP and the suspicion of a mental disorder.[22]

How do these safeguards relate to the unfitness doctrine of Article 16 CCP and the suspension of prosecution? Evidently, not being able to attend to your own interests is also a form of unfitness, be it milder than not being able to understand the intention of the proceedings at all, but it is one that may be remedied within the context of the inquisitorial trial. Some understanding of their complementariness may also be drawn from the timing of the enactment of these provisions. Suspension existed ever since 1838, when defendants were still denied a right to counsel. And Article 509a was enacted in 1928 when the TBS-order was introduced, because it was to be expected that more offenders with mental disorders would be prosecuted (and directed to an appropriate facility after

20 Own translation.
21 Supreme Court of the Netherlands, 12 June 2001, *NJ* 2001, 696.
22 Supreme Court of the Netherlands, 17 November 2009, *NJ* 2010, 143.

trial). Here another feature of the Dutch system reveals itself, the long-standing discretionary competence of the magistrate public prosecutor to not prosecute a defendant, for example, on medical grounds and/or when civil commitment is chosen as a means of diversion. But sometimes, when the prosecutor does bring such a case to a criminal court, it may be declared inadmissible. Sometimes the unfitness criterion has been used to that end in addition to the notion that there was no real chance of recovery.[23] Case law and research show that other relevant circumstances for preferring inadmissibility of prosecution over suspension of trial may be the 'mental age' of the defendant (as being under the real age for criminal responsibility, which is 12), the fact that the defendant already lived (and offended) in a closed facility and the minor severity of the offence.[24] Non-prosecution, either through a decision by the public prosecutor or by decisions of inadmissibility or suspension by a judge, actually remains the exception. And the Netherlands is no exception to the rule that many people who enter the criminal justice system have a mental disorder. Therefore, it is quite remarkable that also the safeguards of Article 509a are not often used in legal practice.[25] In that sense it is not a big part of the explanation why Article 16 CCP is rarely used; actually, similar explanations seem to underlie the underuse of these options, which together form the unfitness doctrine: safeguards generally present within the inquisitorial system are considered to be enough, and the downside at hand – suspension or counsel taking over the defendant – does not seem to be a popular alternative for looking after the interests of the defendant by the court itself.

Of course, as Article 509a CCP and further is only applicable in the phase of the trial, the question as to what safeguards are in place for mentally disordered defendants during the earlier stages of the criminal process, like the police interrogation, still stands. From empirical evidence it is clear that mentally disordered defendants are more susceptible to suggestive questioning, and therefore have a higher risk for false confessions.[26]

More or less along the broader discussion about the proper codification of the fit to stand trial problem in current and upcoming Dutch CCP-legislation, one specific element of the duty to take care of mentally disturbed accused did find its way to a concrete change of the Dutch CCP. Derived from the Salduz judgment of the ECHR[27] and as implementation of the EU-Directive of 22 October 2013,[28] the right of access to a lawyer in criminal proceedings especially during police interrogation was redrafted is 2017. An accused in

23 Court of Appeal The Hague, 27 November 2008, *NbSr* 2009, 52.

24 E.M. Gremmen, *De kwetsbare psychisch gestoorde verdachte in het strafproces. Regelgeving, praktijk en Europese standaarden*, Oisterwijk: Wolf Legal Publishers, 2018.

25 *Ibid*.

26 C. de Ruiter, M. Peters & T. Smeets, 'Psychisch kwetsbare verdachten tijdens het politieverhoor: nut en noodzaak van forensische psychologische expertise', *GZ-Psychologie* 2010-1.

27 ECtHR, Judgment of 28 November 2008, *Salduz v. Turkey*, Appl. 36391/02.

28 Directive 2013/48/EU.

general can waive their right to counsel, but in case of a 'vulnerable' accused, this possibility is excluded by Article 28b CCP. The idea of the legislator is that in these cases, counsel should be appointed at least to inform these accused properly about their rights and the consequences of a waiver. The CCP does not contain a further definition of vulnerable, but here the definition from an EU-Recommendation will apply.[29] The aim of the Recommendation is to encourage Member States to strengthen the procedural rights of "all suspects or accused persons who are not able to understand and to effectively participate in criminal proceedings due to age, their mental or physical condition or disabilities". Member States should foresee a presumption of vulnerability in particular for persons with serious psychological, intellectual, physical or sensory impairments, or mental illness or cognitive disorders, hindering them to understand and effectively participate in the proceedings (Recommendation 7) and they should be promptly identified and recognized as such (Recommendation 4).

Since 2017 this is already realized in Dutch law, although limited to a specific point about the right to legal assistance during interrogation. It illustrates that a broader debate about, as we saw above, partly 'old-fashioned' and partly traditional and typically Dutch characteristics based, law on criminal procedure is necessary and ongoing. Let us therefore illuminate some other recent and future developments, also in the somewhat broader perspective of the actual operation of re-codification of the Dutch CCP.

2.3 Recent and future developments[30]

Even though the unfitness doctrine and its related safeguards are hardly used, there are several reasons to believe that the subject will attract more attention in the future. First of all, because the responsibilities of the defence counsel, aimed at quality and fairness, are increasing to strengthen the 'adversarial element' in our criminal process, it requires more from the capacities of defendants.[31] Here, as mentioned in the introduction, 'European' influences come into play. In 2013 already the European Commission issued a "Recommendation on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings".[32] Among the vulnerable persons were children and mentally disordered, as they are often treated similarly in criminal law (e.g. diminished

29 Recommendation of 27 November 2013, (2013/C 378/02).

30 Parts of this section are based on M.J.F. van der Wolf, 'Berecht kwetsbare verdachten a.u.b. alleen volwaardig', *Tijdschrift Modernisering Wetboek van Strafvordering* 2018-2, pp. 174-177.

31 P.H.P.H.M.C. van Kempen, 'Aandacht voor de slechts beperkt capabele verdachte in voor- en hoofdonderzoek – aanbevelingen voor de wetgever', *DD* 2016/22.

32 Recommendation of 27 November 2013, (2013/C 378/02).

responsibility).[33] As consensus could be reached only on children, for that group the recommendations became binding and are integrated in law on the national level,[34] but no consensus could be reached on the mentally disordered, as even European cultures differ too much in their legal traditions regarding this group.[35] Nevertheless, recommendations may still impact the national legislator. Unarguably binding, however, are the decisions of the European Court of Human Rights, and they seem to point in a similar direction. A safeguard which is directly inferred from the right to a fair trial is the right to effective participation:

> [E]ffective participation in this context presupposes that the accused has a broad understanding of the nature of the trial process and of what is at stake for him or her, including the significance of any penalty which may be imposed. It means that he or she, if necessary with the assistance of, for example, an interpreter, lawyer, social worker or friend, should be able to understand the general thrust of what is said in court. The defendant should be able to follow what is said by the prosecution witnesses and, if represented, to explain to his own lawyers his version of events, point out any statements with which he disagrees and make them aware of any facts which should be put forward in his defence (see, for example, Stanford, cited above, § 30).[36]

Even though it may be argued that these rulings have mainly been made against jurisdictions with adversarial justice systems (and in cases of children), and that the court does not judge the system, it may also be argued that the Dutch criteria for unfitness of mentally disordered offenders as well as the possible safeguards fall short of the demands of the ECHR.[37] At least, some Dutch academics, legislators and judiciaries seem to think so. In her dissertation from 2018, Gremmen argued that the fluctuating and contextual character of unfitness, independent of its causes, and the corresponding options for compensation,

33 Directive of 11 May 2016 on Procedural Safeguards for Children who Are Suspects or Accused Persons in Criminal Proceedings, (EU) 2016/800.

34 See COM(2013)820, p. 9-1; and M.J.F. van der Wolf, 'Waarborgen Voor Kwetsbare, Psychisch Gestoorde Verdachten: Europa Vraagt Om Versterking Van De Rechtspositie', in P.A.M. Verrest & S. Struijk (eds), *De Invloed van de Europese Unie op het Strafrecht*, Den Haag: Boom Juridische uitgevers, 2016, pp. 73-84.

35 See also M.J.F. van der Wolf & H.J.C. van Marle, 'Legal Approaches to Criminal Responsibility of Mentally Disordered Offenders in Europe', in K. Goethals (ed), *Forensic Psychiatry and Psychology in Europe. A Cross-Border Study Guide*, Basel: Springer International Publishing, 2018, pp. 31-44.

36 ECtHR, Judgment of 15 June 2004, *SC v. United Kingdom*, Appl. 60958/00, para. 29.

37 Peter Verbeke, Gert Vermeulen, Tom Vander Beken, & Michaël Meysman, 'Protecting the fair trial rights of mentally disordered defendants in criminal proceedings: exploring the need for further EU action', 41 *International Journal of Law and Psychiatry* (2015), pp. 67-75.

based on the criteria of the ECHR, should be placed together in one article in the CCP.[38] Her conclusion is acknowledged in the draft of new provisions on this matter in the operation called 'Modernizing the CCP'. The latest version of the draft published in July 2020 contains in Article 6.1.44 para. 1:

> [I]f the public prosecutor or the judge[39] suspects during the trial that the defendant has a disability or illness, as a result of which he is unable to understand the proceedings against him and to participate in this, he shall take the measures he deems necessary to enable the defendant to do so or to sufficiently compensate for this. The first sentence applies irrespective of the moment of origin or onset of the disability or the illness.

In the last sentence the mentioned discussion about the unfitness doctrine is recognizable and settled (once again). The discussion about the discretionary competence or admissibility of the prosecution is also addressed, in relation to the different interests at stake. No prosecution should follow if "taking measures will not lead to the defendant being sufficiently able to understand and participate in the trial against him within a reasonable time and taking measures cannot sufficiently compensate for this" unless the officer "is of the opinion that in view of the public interest or the interests of victims, the court should adjudicate the case".[40] And of course there are other safeguards in place for parties of interest to complain about a decision of non-prosecution. If the case is already on trial, the court would be able to suspend the proceedings if measures are not immediately effective, but may be in time, while it should declare inadmissibility of the prosecution if no recovery to fitness is to be expected.[41] This last addition is related to the fact that in the intended new CCP, suspension is no longer a final decision. However, this stance on inadmissibility is not in line with the most recent position of the Supreme Court on the matter, which aims at courts not supervening too easily in the discretionary competence of the prosecution, on the grounds of a different balancing of interests.[42] In a recent very high-profile case of a 'sectarian' father who kept six of his nine children unregistered, and captive for years, in a farm in a rural area (Ruinerwold), a lower court did declare the prosecution inadmissible, as the father had suffered brain trauma in recent years. Interestingly, the court did not use the criterion for unfitness in the Dutch legislation, but

38 E.M. Gremmen, *De kwetsbare psychisch gestoorde verdachte in het strafproces. Regelgeving, praktijk en Europese standaarden*, Oisterwijk: Wolf Legal Publishers, 2018, pp. 318-320.

39 Investigative judge or trial court.

40 See Art. 6.1.46 under 3 Draft of July 2020.

41 Art. 6.1.46 under 2 and 3 respectively.

42 Supreme Court of the Netherlands, 31 October 2017, *SR* 2017, 446. The Court of Appeal should not have supervened in this case of a psychotic TBS-patient who threatened his parole officer.

mainly that of 'effective participation' from the ECHR and the draft legislation.[43] A documentary about the children, however, suggested that the father was fit enough to stand trial, and may have exaggerated certain symptoms to escape prosecution; restoration for the children is now sought through a civil lawsuit.[44]

The draft legislation for a new Dutch CCP is still far from becoming adopted, as it may be altered before being submitted to parliament, and may undergo changes in the process there, but it is clear that things are moving in a certain direction, similarly in academia, administration and legal practice. The suggested provisions acknowledge the diversity of unfitness, both in terms of causes and effects, nature and degree. They provide a tailored approach with more room for choosing less restrictive means (than suspension or representation by counsel). The draft legislation only omits to explicit what measures of compensation may qualify. Especially, since the Dutch solution in Article 509d may infringe on the right of non-discrimination, as a defendant's legal counsel in criminal prosecution should never fully assume the defendant's position to ensure a fair trial despite the defendant's disorder.[45] Suggestions for such measures can be found (among others) by Van Kempen[46] and Gremmen. From the right to information about procedural rights "in a format accessible to them" (para. 8 of the EU-Recommendation), Gremmen derives the right to have someone present during proceedings in addition to counsel, who is most able to communicate with the defendant, such as a family member, care professional or confidant, as a kind of translator. This person understands the person best and can safeguard whether the defendant understands what is going on.

In this respect it is of some importance that the EU-Recommendation introduces a "presumption of vulnerability" (para. 7), which raises the issues of screening, the training of actors within the proceedings, forensic assessment and possibilities to challenge its outcomes and consequent decisions. Even without such a presumption, raising awareness about these issues may already have quite an impact. We are already under the impression that awareness has been raised due to all the mentioned developments, which is visible in the frequency of cases in which it is discussed. In addition, we see developments that may increase the number of vulnerable defendants, as more emphasis is placed on prosecution of offences committed in closed facilities,[47] and the criminal court was recently handed

43 District court of North-Netherlands, 4 March 2021, ECLI:NL:RBNNE:2021:671.

44 Documentary 'The Children of Ruinerwold' by Jessica Villerius.

45 See also Art. 5 of the 2006 UN Convention on the Right of Persons with Disabilities.

46 See also P.H.P.H.M.C. van Kempen, 'The Right to Fair Preliminary Investigation and Trial for Vulnerable Defendants: The Case of the Netherlands', in Ronnie Mackay & Warren Brookbanks (eds), *Fitness to Plead: International and Comparative Perspectives*, Oxford: Oxford University Press, 2018, pp. 231-253, and P.H.P.H.M.C. van Kempen, 'Aandacht voor de slechts beperkt capabele verdachte in voor- en hoofdonderzoek – aanbevelingen voor de wetgever', *DD* 2016/22.

47 See J.M. Harte, M.E. van Leeuwen & R. Theuws, 'Agressie en geweld tegen hulpverleners in de psychiatrie; aard, omvang en strafrechtelijke reactie', *Tijdschrift voor Psychiatrie* 2013-5, pp. 325-335.

the competency to warrant civil commitment, when its criteria apply, in any stage of the proceedings, if it is "in the interest of criminal law enforcement",[48] which may mean that instead of using its discretionary competence for diversion, the prosecution will more often let the court decide on the matter. This option for diversion is explained elaborately in the next sections.

3 Detainees with psychiatric disturbances in provisional detention, in prison and in community reintegration: needs, problems, screening tools

3.1 Introduction: the Dutch penitentiary system related to forensic care[49]

In this third section, the care for and treatment of detainees with psychiatric disturbances in provisional detention, in prison and in their community reintegration are addressed together, because they are in large part governed by the same legislation. Detainees in provisional detention and in prison are governed by the same internal legal position, as laid down in the so-called Penitentiary Principles Act (PPA). This means that, especially when it comes to special needs (almost) all provisions and services are also available during pre-trial detention. The PPA formally distinguishes penitentiary institutions in prisons and houses of containment, with the former being reserved for people serving a prison sentence and the latter for almost all possible legal frameworks for deprivation of liberty, including pre-trial detention and short prison sentences. Police cells do not fall under the PPA, but can be used for detainees in the execution of a sentence in case of non-available capacity in penitentiary institutions. In that case, the period in detention in police cells is for a maximum of ten days.[50] Another formal designation under the PPA is institutions for repetitive offenders, which are reserved for people who are convicted to a specific order (ISD). Similar to the TBS-order, this is considered a safety-measure, which is dogmatically different from a penalty (like a prison sentence) as it is not intended as retributive.[51] Section 3.7 explains how detainees in all these facilities are being screened for mental health problems.

48 Art. 2.3 FCA.

49 Parts of this section are based on J. Legemaate, M.C. Ploem, J. uit Beijerse, P.A.M. Mevis, M.J.F. van der Wolf, C.P.M. Akerboom, M. Schol, H. Winter & N. Woestenburg, *Thematische wetsevaluatie gedwongen zorg*, Den Haag: ZonMW, 2014.

50 Art. 15a PPA, and there are regulations for the quality of police cells.

51 See M.J.F. van der Wolf & M. Herzog-Evans, 'Mandatory Measures: "Safety Measures". Supervision and Detention of Dangerous Offenders in France and the Netherlands: A Comparative and Human Rights' Perspective', in M. Herzog-Evans (ed), *Offender Release and Supervision: The Role of Courts and the Use of Discretion*, Oisterwijk: Wolf Legal Publishers, 2014, pp. 193-234.

Whenever a detainee is receiving mental healthcare, this care falls under the FCA, mentioned earlier. Other than the PPA, the FCA is not an act on the internal legal position of detainees; it is merely an 'organizational' act, labelling which care is being paid for by the Ministry of Justice and Security. Forensic care may be administered in three 'systems', 'pillars' or 'pathways' with specific legislative frameworks for the internal legal position: (1) the penitentiary system, governed by the PPA, (2) the TBS-system, governed by the TBS-care Principles Act (TPA) and (3) the (forensic) mental health system, governed by civil (mental) health laws, different for voluntary care, coerced care for persons with mental disorders, coerced care for persons with psychogeriatric conditions or mental disabilities. Detainees may be treated within all three systems, for example, through transfer (all relevant provisions will be discussed in the following sections). Forensic care now covers almost 30 legal frameworks within the criminal law sphere, which can be divided roughly in care related to the TBS-status, care as a condition in a conditional legal framework and care for detainees. Especially the last two categories cover multiple phases within the criminal process: the prosecution (including provisional detention), the trial (sentences imposed which involve care) and the execution of sentences. As a consequence several actors may decide on forensic care, like the prosecutor, the court and the Minister, as competencies are divided over the course of the criminal process. Community reintegration is generally within a conditional legal framework, like conditional release, in which the ex-detainee needs to adhere to certain conditions in order to not be placed (back) into detention. Since conditional frameworks generally require consent, in terms of the legal position they are viewed as people receiving voluntary care, and are largely covered by the same health legislation as when we would go to our own general practitioner. Detainees transferred from prison to the (forensic) mental health system were similarly viewed as consenting with the transfer. When they consent to placement in a (forensic) mental health accommodation, since the enactment of new mental health legislation in 2020, some restrictions may be placed on these forensic patients related to receiving visits, liberties or means of communication.[52]

In all three systems, special facilities exist for treatment. Within the penitentiary system, the most notable institutions for forensic care are the so-called penitentiary psychiatric centres (PPCs), of which there are four in place throughout the country. The TBS-system consists of about seven FPCs. Within the forensic mental health system, the facilities with the highest security – albeit one level less secure than FPCs – are forensic psychiatric clinics (FPKs), five in total. There are also a number of forensic psychiatric departments in psychiatric hospitals (FPAs). Within the realm of addiction care, there are separate clinics and departments in place with similar levels of security. Furthermore, any mental health facility that meets the criteria may have a contract with the Ministry of Justice and Security

52 Art. 9:9 Wvggz and Art. 51a Wzd.

for delivering forensic care, including outpatient clinics. Finally, many homes for assisted living may be paid for on the basis of forensic care.

3.2 Developments in forensic care: why it became a Justice responsibility and related challenges[53]

As the TBS has long been the preferred framework for the treatment of offenders, and maybe has also served as an argument not to invest too much in the treatment of other detainees, two main developments especially in the 1990s led to a different policy approach in Dutch forensic care. The costs of the TBS-system had long been shared unequally, with 80% coming from the budget of the Ministry of Health and 20% from the Ministry of Justice. This division was based on the distinction between costs of treatment and costs of security. However, throughout the 1990s the TBS-population started rising, under the influence of harsher penal policies and the increase of multi-problematic patients due to the influence of drug abuse. And as the costs rose similarly, cost-effectiveness became an important issue. One of the ideas in the early 2000s for dealing with this issue was integrating the TBS-system into the general mental health system, in order to increase the outflow of patients to less secure facilities.[54] Increasing the options for TBS-outflow had already led to a more diversified forensic mental health field, with the development of FPKs and FPAs. At the same time, and due to the same developments in society as mentioned for the rise of the TBS-population, the number of people with psychiatric disturbances in other areas of the criminal justice system, such as prison or conditional sentences, increased as well. In 2008 the TBS-population reached a peak of 2,100, but it was also the year in which a new financial system was introduced for forensic care, completely opposite from the earlier suggestion. In fact, it would be the Ministry of Justice (and Security, after a telling name change) that would from then on pay for all forensic care, including that within general mental health facilities. Unofficially, the argument probably was that 'he who pays the piper calls the tune', both regarding the flow towards less secure facilities, which would no longer be obstructed by financial barriers, and the demand for security and control regarding this target group. Especially this latter aspect had its roots in a few high-profile re-offences, which had led to a Parliamentary Inquiry

53 Parts of this section are based on M.J.F. van der Wolf, ' "Going Dutch" – taking care of forensic mental health care', *Prison Insider*, 2021; M.J.F. van der Wolf, J. Reef & A.C. Wams, *Wie zijn geschiedenis niet kent… Een overzichtelijke tijdlijn van de stelselwijzigingen in de forensische zorg sinds 1988*, Instituut voor Strafrecht en Criminologie, Universiteit Leiden (2020); and M.J.F. van der Wolf, A.W.T. Klappe & P.A.M. Mevis, 'Over stromen, waterscheidingen en koudwatervrees: de overgang van strafrecht naar GGZ sinds de Wet forensische zorg', *Strafblad* 2020-5, pp. 257-264.

54 Commissie Kosto, *Veilig en wel: Een beleidsvisie op de tbs*, Den Haag: Ministerie van Justitie, 2001.

and the introduction of more safety regulations within the execution of the TBS-order,[55] causing the mean duration of inpatients to increase in over ten years. This made the TBS-order less popular among defendants who refused to undergo forensic assessment often on the advice of their lawyers, and among judges who had to impose the order, resulting in a drop of the population to around 1,300 in 2018. This meant a further shift of the disturbed population towards prison. The introduction of the PPCs was also a recommendation of the Parliamentary Inquiry Commission.

Officially the goals of this policy change (again) were the tailored placement of patients in terms of the required level of security and intensity of treatment ('the right patient on the right bed'), creating enough capacity for forensic care (mainly through the 'buying' of beds within the general mental health system), safeguarding the quality of care aimed at the protection of society and a good connection between forensic and general mental healthcare.[56] Of course, these goals presuppose that treatment of offenders is effective in protecting society – as a recent re-offending study shows.[57] What this study also shows is that any form of sober detention in a criminal justice pathway increases re-offending. This may be related to the decrease of mental functioning in detention – and the consequential increase of psychiatric disturbances – which is also underscored by recent Dutch research.[58] But the beneficial effects of forensic care and its related popularity among legal decision-makers come at a cost.

The mentioned financial model that was introduced in 2008 has been codified in 2019 in the FCA. Meanwhile, the yearly budget for forensic care has increased from around 500 million to more than 800 million euros. Even though the TBS-population was dropping in these years, the populations in less secure facilities (and outpatients) have been rising ever since. The shift of the population from high to lower secure facilities is one of several explanations for this phenomenon. It can also be explained that as an effect of the different and much broader system of registration, many existing patients now suddenly show up in the numbers. Another effect is probably the mentioned success of forensic care in reducing re-offending and policy changes to direct more offenders to this type of care. A growth in the actual target group could also be an option, possibly due to a decline in secure beds within regular psychiatry and societal barriers in reaching proper care in time. And finally, there could be a contagious labelling effect, in which much more forensic patients now bare the double stigma of dangerous and disordered, as the policy change

55 Commissie Visser, *Tbs, vandaag over gisteren en morgen*, Den Haag: SDU, 2006.

56 *Kamerstukken II* 2009/10, 32 398, nr. 3, p. 3.

57 K. Drieschner, J. Hill & G. Weijters, *Recidive na tbs, ISD en overige forensische zorg*, Den Haag: WODC-Cahier, 2018-22; and for a commentary C.L. van der Vis, S. Struijk & M.J.F. van der Wolf, 'Recidivecijfers na forensische zorg: een juridische "proof of the pudding", *Ars Aequi* 2020, pp. 321-330.

58 For example, J. Meijers, *Do not restrain the prisoner's brain: Executive functions, self-regulation and the impoverished prison environment* (dissertation), Amsterdam: VU, 2018.

has made them more recognizable. This could explain the reluctance of societal facilities to take these patients in. It seems that the Ministry of Justice and Security has to buy its way deeper and deeper into society and general mental healthcare, to enable these patients to flow back into the community. This explains why recently especially many new contracts have been made with assisted living facilities. The barrier between forensic care and general care seems to have shifted instead of breached, as was the aim of this policy. It used to be that the barrier was between the TBS-system and the (forensic) mental health system, now it is between the forensic mental health system and general or community care. This is also visible in the problems that exist with another provision in the FCA, which is somewhat alien to the Act as it is on non-forensic care, and will be discussed in the next section.

Meanwhile, the shift from high-security TBS-care towards less secure forensic care in other frameworks met its lower limit. Eventually, the consequent mismatch of patient and bed led to the high-profile re-offence mentioned in the introduction. Michael P. was in a reintegration programme at the end of his prison sentence (see Section 3.7), placed in an FPA with leave liberties, when he raped and killed a student who went on a bike ride. The case became even more high profile because the girl was missing for a few days, with a lot of media attention for the search parties. The prison sentence Michael P. served was for the violent rape of two young girls, among other offences, because of which he was deemed very dangerous by the district court. But in two instances the judges did not apply a TBS-order, also because he did not cooperate with the forensic evaluation and no disorder – a requisite for TBS-imposition – could be established.[59] After many investigations into the incident, first of all there were legislative changes aimed at reducing the possibility of avoiding TBS for people who refuse evaluation. Secondly, it led to more leeway to share file information between prison and mental health facilities. And finally, policies were put in place to only transfer prisoners to the (forensic) mental health system after proper risk assessment and offence analysis.[60]

Not necessarily because of these changes, but probably more because of the raised awareness of risks, the TBS-population is rising again due to what is called a 'Michael P. effect'. In addition, effective efforts to reduce the mean duration of TBS-treatment, also through more cooperation between all parties involved (Ministry, clinics, solicitors), may make judges less reluctant to impose TBS in comparison to the past.[61] As the numbers in

59 See for an analysis of the case M.J.F. van der Wolf & P.A.M Mevis, 'Beschouwingen over weigeren en beveiligen n.a.v. de zaak Michael P. Rechtspraakrubriek', *DD* 2018/27, pp. 321-366.

60 Onderzoeksraad voor veiligheid, *Forensische zorg en veiligheid. Lessen uit de casus Michael P.*, Den Haag: Onderzoeksraad voor veiligheid, 2019; and for the new policy: *Kamerstukken II* 2018/19, 33 628, nr. 44, p. 8.

61 Both revolve conferences of all relevant parties in Lunteren, as well as individual case 'care conference' with all parties involved for cases of very long treatment or impasses. Because even though the mean duration of the TBS-treatment has been diminished to about 8 years, the group of people who are still in TBS after

the other frameworks for forensic care are not diminishing as a result, the budget is severely under pressure. There have been legal procedures from facilities against the Ministry of Justice and Security which is slowly turning off the financial tap, even though several reports indicate that as a result of this the safety within facilities is decreasing, also because of a shortage of staff.[62] And now the opinion has been voiced again in academia to shift a part of the budget back to the Ministry of Health, as there are more threats to these much needed investments if it remains on the Justice budget where it is more prone to cuts, as it fights with other priorities and a societal scepticism.[63] Investments into offenders are just less easy to sell to the public than investments in patients. Academics pointing towards risk assessment seem to fuel this development as it drives the focus away from mental disorder, which also from a human rights perspective ensures the right to treatment, in the direction of more sober detention and means of control in the community.[64] The scientifically sound argument that in the long run any investment in forensic care will be cost-effective because of its risk-reducing effects is not always spent on politicians who think in four-year circles.

In sum, the cost of forensic care is not only financial, as the budget shift may have made these necessary investments less sustainable. The policy change has also broadened the stigma, as it used to be that only TBS-incidents were headlines, while after Michael P. also patients who do not return from an unaccompanied leave out of an FPA make the news.[65] And finally, as mentioned, the barrier between forensic care and general or community care has not been breached but shifted, as financial barriers still exist (see also Section 3.3). Barriers due to differences in the legal position also remain, as some necessary restrictions of rights and liberties for the transfer of forensic patients to general care are still not allowed within general mental health legislation.[66]

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15 years is quite large. See P. Oosterom, B. Bezemer & J.A.W. Knoester, 'Zorgconferenties in de tbs – ervaringen opgedaan in het project "15-plus" ', *Strafblad* 2019, pp. 32-36.

62 Andersson Elffers Felix, *Forensische zorgen; Onderzoek naar de kwaliteit en veiligheid in de forensische zorg*, 14 mei 2018 (at: www.aef.nl/storage/images/Onderzoek_naar_kwaliteit_en_veiligheid_in_de_forensische_zorg__Forensische_zorgen.pdf).

63 P.L.M. Steinmann, *Stelselwijziging forensische zorg: Verklarend onderzoek naar een centralisatie van sturing in de zorg* (dissertation), Twente: Universiteit Twente, 2019.

64 See J. Bijlsma, T. Kooijmans, F. de Jong & G. Meynen, 'Legal insanity and risk: An international perspective on the justification of indeterminate preventive commitment', 66 *International Journal of Law and Psychiatry* (2019).

65 '"Gevaarlijke" patiënt ontsnapt uit forensische kliniek Den Dolder waar Michael P. verbleef', *De Volkskrant*, 5 June 2019.

66 That is why more harmonization of these laws was suggested in J. Legemaate *et al.*, *Thematische wetsevaluatie gedwongen zorg*, Den Haag: ZonMW, 2014.

3.3 Diversion to the mental health system: non-forensic care[67]

As mentioned in Section 2, the long-standing option for the prosecution to use its discretionary competence to divert someone from the criminal justice system to general mental healthcare through civil commitment is no longer the only option for diversion since the introduction of Article 2.3 FCA. It was earlier explained why in the Netherlands treatment is mostly administered under direction of the Ministry of Justice and Security, but even as this treatment may be done in the mental health system, it does not fit the international definition of diversion.[68]

The new option for diversion in Article 2.3 FCA was enacted in 2020, a year later than the rest of the FCA in order to align it with new (civil) mental health legislation. So, since the beginning of 2020, it hands the criminal court the opportunity to warrant coerced care, when the criteria from the civil mental health laws are met, in any stage of the criminal process – prosecution, trial/sentencing and execution of sentences. The article replaced the existing option, limited to the trial phase, to impose civil commitment for offenders regarded as not criminally responsible due to a mental disorder (NCRMD).

Several consequences arise from this legislative change. First of all, it increases the possible scope of application. Not only because of the fact that it is no longer limited to the trial phase but also because NCRMD is no longer required, the option confluence with other sentences or frameworks is created, as well as the combination with an acquittal. In practice, the combination with conditional prison sentences is most prevalent. In such a case, the new option in the mental health legislation to only warrant coerced medication, instead of commitment to a hospital, may also be of use. However, there are a few reasons why, especially for the former group of NCRMD, the new option is less favourable than before. First of all, the maximum duration of the warrant is six months, instead of the former one-year period. Secondly, other than the former option, Article 2.3 FCA is in policy not considered to be forensic care. This means that – especially since forensic care directives are also increasing – it is really hard to find secure enough beds within general mental health. Even though legally it is possible to be placed on a forensic bed, in practice it seems to be really hard. Thirdly, another difference with the old situation is the formal requirement of expert advice. A forensic evaluation used to be enough, but now a medical declaration and treatment plan from the receiving facility are necessary. If this facility does

67 Parts of this section are based on P.A.M. Mevis, A.W.T. Klappe & M.J.F. van der Wolf, 'Het afgeven van een zorgmachtiging door de strafrechter: overzicht en eerste indrukken van de praktijk betreffende art. 2:3 Wfz sedert 1 januari 2020. Rechtspraakrubriek', *DD* 2020/43 and M.J.F. van der Wolf, A.W.T. Klappe & P.A.M. Mevis, 'Over stromen, waterscheidingen en koudwatervrees: de overgang van strafrecht naar GGZ sinds de Wet forensische zorg', *Strafblad* 2020-5.

68 See H.J.C. van Marle, M.M. Prinsen & M.J.F. van der Wolf, 'Pathways in Forensic Care: The Dutch Legislation of Diversion', in K.T.I. Oei & M.S. Groenhuijsen (eds), *Progression in Forensic Psychiatry: About Boundaries*, Deventer: Kluwer, 2012, pp. 105-120.

not want to have the patient, in not delivering these advices, they can avoid receiving the patient. As the prosecution is in charge of acquiring these documents and demanding the warrant, this has led to major discussions between the prosecution and criminal courts about the possibility of a warrant by the court *ex officio*, without the required documents being available. The Supreme Court of the Netherlands ruled that this should be possible for the court on the basis of the forensic evaluation for the criminal trial.[69] However, with this victory the battle is not won, because the only thing the court can decide is warrant care, and not order or impose it. If the facility does not want to execute the warrant, the warrant will expire. And general mental health facilities do not want these forensic patients, because they do not have the same security as forensic facilities, fear the consequences of disruptive behaviour for the wards and have a different aim of treatment[70] – not reduction of re-offending, but merely the psychiatric condition – while it is an exclusion criterion in civil mental health law if treatment cannot be effective.

One of the possible consequences may be that as a resort, to ensure more security, TBS-orders will increasingly be used for this group, providing more security than needed. In the consequential debate, the plea has been made that the old safety-measure for the NCRMD should be re-enacted.[71] We have suggested to just start labelling Article 2.3 FCA warrants as forensic care, especially since the Minister of Justice and Security is already more involved in this provision than a strict definition of diversion may allow – a release from civil commitment before the term of the warrant ends can only be done by the hospital in deliberation with the Minister.

3.4 (Forensic) Care for detainees in provisional detention

As a consequence of the situation described above, there are two ways of receiving care for defendants in provisional detention with psychiatric disturbances: through diversion and through forensic care. The options for diversion are described in the last section. Article 2.3 FCA may be applied whenever there are proceedings before a judge, for example, when the provisional detention has to be prolonged, as the constitution renders the competence to deprive an individual of their liberty to a judge. But as mentioned earlier, it is also possible for the prosecution at any time during the criminal process to request an Article 2.3 FCA warrant, after which a hearing will take place. This option may lead to less use of the prosecution's own discretionary competence to end prosecution to ensure

69 Supreme Court of the Netherlands, 9 April 2021, ECLI:NL:HR:2021:534.

70 A. Visscher *et al*, 'Behandel "boeven" buiten de reguliere psychiatrie', *De Volkskrant*, 12 July 2020.

71 L.E. van Oploo, M.M. Prinsen & Th.J.G. Bakkum, 'De invoering van artikel 2.3 Wet forensische zorg – Consequenties voor de strafrechtspraktijk', *NJB* 2020/2166, afl. 32, pp. 2385-2386.

civil commitment through a civil court. The difference is that Article 2.3 FCA may be used without ending the prosecution, as it may be continued after the treatment.

The first option for forensic care is, however remarkably, also related to the discretionary competence of the prosecution. It may end the prosecution conditionally, under the condition that the defendant undergoes treatment.[72] As long as the defendant adheres to the conditions within the given time frame, the prosecution will not proceed. A second option for forensic care in the phase of prosecution is through the possibility that the prosecution can 'sentence' a defendant of minor crimes by way of a penal order without intervention of a judge. The sentence in a penal order – which cannot be a prison sentence – may also be conditional, with the directive of treatment.[73] If the defendant does not consent to this penal order and the sentence applied therein, they can appeal to have the court decide their case. As these two options for forensic care are generally only used for minor offences, while provisional detention is less feasible in those cases – even though the Netherlands is known, and convicted by the ECHR, for its very wide and casual use of provisional detention[74] – they are in theory only applicable to defendants in provisional detention. A practically more relevant option for forensic care for this group is as a condition in the conditional suspension of provisional detention.[75]

In addition, some options for forensic care (for both provisional detainees and prisoners) exist in the PPA. They all involve transfer, apart from the option that psychiatric treatment is being brought into the ward from outside.[76] Of course on regular wards, other consensual treatment efforts are possible as basic mental healthcare (derived from the principle of equivalence of care compared to society), such as the distribution of medication or access to general psychological or medical staff, which has to be present in the penitentiary institution. If treatment of a higher intensity is needed, for example, if someone is unfit for detention on a regular ward – which no longer is the official criterion, but in practice is still of influence – a (provisional) detainee may be transferred to a PPC. PPCs are the only penitentiary facilities in which coerced medication is possible outside acutely risky situations, if the detainee meets the criteria. The most lenient criterion for coerced medication is if not administering it will lead to an unreasonably lengthy period of restriction of liberty, which is surrounded with legal safeguards as in the Netherlands we have only recently moved away from a very strict position on coerced medication and were known as the world champions of using isolation cells, even in cases of psychiatric

72 Art. 167/ 242 CCP.
73 Art. 257a CCP.
74 See College voor de Rechten van de Mens, *Tekst en uitleg. Onderzoek naar de motivering van voorlopige hechtenis*, Den Haag, 2017.
75 Art. 80 CCP.
76 Art. 42 PPA.

decompensation.[77] Academic criticism on the PPCs is that they generally only do crisis interventions, to stabilize individuals and place them back on regular wards, instead of aiming at reducing re-offending as may be expected of forensic care.[78] As they are part of the penitentiary system this is considered an internal transfer. Finally, two provisions exist for external transfer to the (forensic) mental health system. The first is in case it is necessary due to a mental disorder.[79] The second option is derived from the duty to provide the necessary care, which is placed on the institution. If such basic mental healthcare may not be delivered within its walls, transfer is in order.[80] On all transfers, the Minister eventually decides.

3.5 (Forensic) Care for detainees in prison

Even when serving a prison sentence, the option of Article 2.3 FCA exists in theory, even though in this stage, deep into the criminal justice system, diversion is not really a feasible argument. More relevant are the mentioned internal and external transfer options that also apply to detainees in provisional detention as explained in Section 3.4.

However, there is one other option for convicted prisoners that does not apply to provisional detainees, and that is the placement in an FPC. The provision allows for placement in a TBS-institution if detainees 'are eligible' for it.[81] It is unclear what would make them eligible, and even when there were empty beds in FPCs due to a shrinking TBS-population, this provision was not used, even though the forensic treatment (aimed at risk reduction) would have been superior to that in PPCs. For a special group of prisoners, the provision mentions that their eligibility for this transfer should regularly be screened. These are the prisoners that, due to their diminished responsibility, are sentenced by the court to a combination of prison and the TBS-order, in that order of execution. This CCP-provision for this group is also hardly used by the Ministry, even though these are prisoners with a mental disorder established by a court, and many have argued that in prison the condition becomes worse after which any treatment will be more difficult: "it is like feeding the gastric patient pea soup before treatment".[82] There has long been a provision, between 1997 and 2010, which promoted the transfer of these patients to the

77 Term used by Commissie Visser, *Tbs, vandaag over gisteren en morgen*, Den Haag: Sdu, 2006. See also J. Legemaate *et al.*, *Thematische wetsevaluatie gedwongen zorg*, Den Haag: ZonMW, 2014.

78 See J. Legemaate *et al.*, *Thematische wetsevaluatie gedwongen zorg*, Den Haag: ZonMW, 2014.

79 Art. 15 under 5 PPA.

80 Art. 43 PPA.

81 Art. 6:2:8 CCP.

82 See Hjalmar van Marle & Michiel van der Wolf, 'Boter Aan De Galg En Erwtensoep Aan De Maagpatiënt', in Joke Harte, Thieu Verhagen & Mariette Zomer (eds), *Most Probably the Best Professor of Forensic Psychiatry. Liber amicorum prof.dr. Dick Raes*, Nijmegen: Wolf Legal Publishers, 2009, pp. 133-142.

TBS-institution after serving a third of the prison sentence, even though in that time this could hardly be achieved due to the capacity shortage in the TBS-system at that time. Now, the moment of conditional release is the general transfer time. That used to be after serving two-thirds of the prison sentence; however, very recently, to better communicate the retributive aspect of the sentence to victims and society, this moment is pushed back for long sentences to two years before fully serving the sentence.[83] It is expected that judges will counter this development by imposing lower sentences.[84] Judges could also make more use of their competence to advice on when to transfer these prisoners to the TBS-institution.[85]

As the TBS itself is not executed within the penitentiary system, and the whole chapter circles around it, we will not go into too much detail on the indeterminate order for dangerous mentally disordered offenders here.[86] But for understanding the remainder of the information, it is relevant to know that it is a safety-measure for mentally disordered offenders that are assessed as dangerous, in practice also because of an established influence of the disorder in the offence and consequent diminished or non-responsibility. A multidisciplinary forensic evaluation is required for imposition, but also after every four years of execution as a counter-expertise on the advice of the clinic. The order is of indeterminate duration but has to be reviewed by the court at the latest every two years. However, the duration is determined to four years in cases where a no violent or hands-on sexual offence was committed, while the conditional TBS-order is maximized at nine years. Within the execution an extensive system of leave exists, which is used as a treatment instrument in an individual case and ideally gradually becomes less restrictive. Every new phase in the leave system has to be warranted by the Minister. As mentioned, it is its own system or pathway, with its own act for the internal legal position. Under the TPA, coerced medication is possible on comparable grounds as in PPCs.

Another safety-measure, however, the one for repetitive offenders, is indeed executed within the penitentiary system, and these individuals are detainees in terms of the PPA. The placement in these so-called ISDs differs from the TBS-order as it is not meant for severe offences, but for the repetition of minor offences often based on (drug) addiction, and it cannot be combined with a prison sentence. It is maximized at two years, which is

83 *Staatsblad* 2020, 224, in force since 1 July 2021. This, in theory and practice, heavily criticized change of a vital element in Dutch prison approach is 'nevertheless' officially called 'Law on punishment and protection'.

84 J. uit Beijerse *et al.*, *De praktijk van de voorwaardelijke invrijheidstelling in relatie tot speciale preventie en re-integratie*, Den Haag: Boom Juridisch, 2018.

85 See T.J. Lindhout, M.J.F. van der Wolf & H.J.C. van Marle, 'De Fokkensregeling is dood; leve de Fokkensregeling!', *Sancties* 2011, pp. 347-357.

86 For more background, see M.J.F. van der Wolf & M. Herzog-Evans, 'Mandatory Measures: "Safety Measures". Supervision and Detention of Dangerous Offenders in France and the Netherlands: A Comparative and Human Rights' Perspective', in M. Herzog-Evans (ed), *Offender Release and Supervision: The Role of Courts and the Use of Discretion*, Oisterwijk: Wolf Legal Publishers, 2014.

in many cases disproportionate in relation to the minor offences (even when repetitive), but as a safety-measure it is not bound by such proportionality, the time being used to try and break the pattern of offending through treatment. Therefore, (the execution of) this safety-measure is considered forensic care.[87] The sentencing court may, in applying this measure, order an intermediate review of this sanction. By using this non-obligatory option, the sentencing court opens the possibility that the execution of the order may be terminated in the course of the two years of execution if treatment progress is absent, to avoid two years 'bare' detention in an ISD institution.[88]

3.6 (Forensic) Care for detainees reintegrating into the community

Even if all the criminal justice frameworks are to expire, Article 2.3 FCA civil commitment may be used to keep someone off the streets. Of course this is only when the individual meets the criteria from civil mental health law, which may be problematic if the framework is only used to avoid re-offending (see Section 3.3). It is of course more frequently used in case of termination of the TBS-order, than after a prison sentence, even though especially individuals that are still in a PPC at the end of their sentence are sometimes directed to the mental health system as well. As from a criminal justice point of view general mental health facilities are considered to be part of 'the community', coerced placement in such facilities on the basis of Article 2.3 FCA in this context falls under the scope of this section. However, of course, legal frameworks aimed at reintegration into the community are generally no longer characterized as consisting of deprivation of liberty but as restriction of liberty.

Such frameworks of supervision often consist of conditions under which someone is allowed (back) in the community, and which are being supervised by the probation services. Of course all conditional frameworks require consent to the conditions, even though the conditions could even mean inpatient treatment in a forensic mental health facility. When these conditions do not merely consist of monitoring, controlling restrictions, but also of treatment, this will also be considered forensic care. The most obvious frameworks are those of conditional release from prison[89] – while such a scheme also exists for the TBS-order.[90] But even the (partly) conditional prison sentence can be used in this way, the difference being that the probation period is specifically set by the imposing court, instead

87 Art. 38p CC (Criminal Code).

88 Art. 38n under 3 CC; Sanne Struijk, 'Punishing Repeat Offenders in the Netherlands: Balancing between Incapacitation and Treatment', 33 *Behavioral Sciences & the Law* 1 (2015), pp. 148-166.

89 Art. 6:2:10 CCP.

90 Art. 38g CC. For the reintegration of TBS-patients of course the last stages of the system of leave (described in 3.5) are relevant as well as an instrument called Forensic Psychiatric Supervision, in which the clinic and probation share responsibilities.

of the remaining period of the sentence, and in general the time spent in prison is much shorter.[91] A specific option for prisoners prior to conditional release is a so-called penitentiary programme, in which for purposes of reintegration some liberties are already granted, and which may consist of treatment or transfer to a forensic mental health facility. In fact, this was the framework in which Michael P. was working towards his conditional release on an FPA, warranted by the Ministry. Another, very rare, possibility is a conditional pardon, granted by the Crown.[92]

Only one framework of restriction of liberty after a prison sentence does not require consent. It is a rather new safety-measure of supervision for violent and sexual offenders considered dangerous introduced in 2018 and called the Measure of Influencing Behaviour or Restricting Liberty.[93] It is to be executed after a prison sentence or after the TBS-order, most logically after the two mentioned modalities of maximized duration (see Section 3.5). It has to be imposed by the trial court, while at the end of the prior sentence (or measure), a court has to decide whether its execution is still necessary and appropriate. As it may be of indeterminate duration, it is under a lot of scrutiny from academics.[94] Especially if it is not used for influencing behaviour through treatment but only for control, it will be hard to prove any changes in the level of risk with lengthy supervision as a result.[95]

When all legal frameworks have expired, it is very hard to have any reintegration efforts or supervision paid for. However, after forensic care in some regions Forensic FACT (Flexible Assertive Community Treatment) teams may reach out to ex-prisoners. Another initiative in forensic mental health is that treatment staff will continue the therapeutic relationship after the legal framework has ended. It has shown to be effective in reducing re-offending.[96] However, as this is care that is paid for by the facility itself, or even completely voluntary, the question is how sustainable such aftercare can be.[97]

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91 Art. 14a CC. The TBS-order and ISD-order may also be imposed conditionally as frameworks of care, but cannot be partially imposed.

92 Art. 13 Gratiewet in conjunction with Art. 6:7:1 CCP. However, this framework may become more relevant as it is part of the provisions granting individuals sentenced to life imprisonment an evaluation after 27 years, which were put in place in order to adhere to ECHR case law requirements on providing 'perspective'. See W. van Hattum & S. Meijer, 'An Administrative Procedure for Life Prisoners: Law and Practice of Royal Pardon in the Netherlands van Hattum', in D. Van Zyl Smit & C. Appleton (eds), *Life Imprisonment and Human Rights*, Oxford: Hart Publishing Ltd, 2016, pp. 141-165.

93 Art. 38z CC.

94 See S. Struijk & P.A.M. Mevis, 'Legal Constraints on the Indeterminate Control of "Dangerous" Sex Offenders in the Community: The Dutch Perspective', 2 *Erasmus Law Review* (2016), pp. 95-108.

95 M.J.F. van der Wolf, 'Legal control on social control of sex offenders in the community: a European comparative and human rights perspective', 2 *Erasmus Law Review* (2016), pp. 39-54.

96 P. Schaftenaar, *Contact gezocht. Relationeel werken en het alledaagse als werkzame principes in de klinische forensische zorg* (dissertation), Amsterdam: SWU, 2018.

97 See M.J.F. van der Wolf, 'De beperkingen van de strafrechtelijke plaatsing in de GGZ (artikel 37 Sr)', *Sancties* 2017, pp. 74-80.

3.7 Screening

In all the relevant stages in the criminal process that are the subject of this chapter, the National Institute for Forensic Psychiatry and Psychology (NIFP) fulfils an important role in the screening of individuals who may be in need of care.

First of all, whenever someone is arrested, police may notify the NIFP in obvious urgent cases of need for mental healthcare, as they do not structurally screen for this. Another option that the police have, based on a covenant between the police and general mental health, is to immediately transfer (divert) someone to forensic mental healthcare, generally in case of minor offences, as some sort of discretionary competence derived from that of the prosecution.[98] Since 2020 civil mental health legislation also allows for temporary placement in a police cell, if it is not yet clear whether any disruptive behaviour may be due to a mental disorder.[99] If a defendant is placed in provisional detention, the probation services are notified and they visit the detainee. This visit plays an important role in signalling whether someone in provisional detention may be in urgent need of mental healthcare, as they structurally screen for this. When probation signals the NIFP, based on this information, for example, the NIFP may choose to send either a psychiatrist or a psychologist for a first screening, generally (but not in every district) even before the first appearance before an investigative judge. The psychiatrist or psychologist screens for two purposes, the need for care being one of them, and the need for forensic assessment in service of (preparation of) the trial being the other. In the latter situation, deliberations with the prosecution will lead to a decision whether or not (further) assessment is necessary, and in what kind of form (monodisciplinary, multidisciplinary or even with observation). This is based on questions related to responsibility, risk and need for treatment.[100] Pre-trial detention can – on court order – be executed in an institution for observation of the accused. The highly esteemed Pieter Baan Center (part of the NIFP) is taking care of almost all these clinical assessments of adult offenders.

As the NIFP is also in charge of providing psychiatrists to work in penitentiary institutions, screening in pre-trial detention may lead to a discussion in the multidisciplinary team meeting within the institution, which decides on treatment matters. The team, consisting of the psychologist, psychiatrist, medical doctor, nurses and social workers, may advice the director to apply for transferring the detainee to a PPC, for example. In fact, this screening mechanism is similar for prisoners, even though they are not screened as structurally as detainees coming into provisional detention. It has often been advised

98 Convenant Politie – GGZ 2012.

99 Art. 7:3 under 6 Wvggz.

100 See, for example, W.F. Kordelaar & G.R.C. Veurink, 'De Indicatiestelling Voor Gedragsdeskundige Expertises', in H.J.C. van Marle, P.A.M. Mevis & M.J.F. van der Wolf (eds), *Gedragskundige Rapportage in Het Strafrecht*, Deventer: Kluwer, 2008, pp. 125-154.

to screen prisoners more structurally. Even though every inmate is investigated medically, they are usually not tested psychologically. Ideally every inmate should be tested psychologically and for addiction issues when entering the programme. The means to do this are not available at this point.[101] Recently a risk-screening tool has been tested by the NIFP for structural use with satisfying results for ensuring a tailored approach to risk reduction during detention. Addiction and some mental dysfunctions are among the risk factors of the screening tool.[102]

Finally, the NIFP also plays a leading role in the indication process of where forensic care should be administered. They have an overview of all contracted facilities with their combinations of levels of security and treatment intensity, to be able to place the right patient on the right bed. In general, this process follows the decision on forensic care by the prosecution, a judge or the Minister, but it could also precede such a decision. Especially in the latter case, the process acts as a screening tool for the need for forensic care.[103]

4 Conclusion

The first part of this chapter was on safeguards in the criminal process to ensure the right to a fair trial of defendants with psychiatric disturbances, and the second part of this chapter dealt with the possibilities of – and screening for the need for – (forensic) care in the penitentiary system. Even though on both issues, a lot of developments may be observed, we can conclude that the realm of care is a much bigger business in the Netherlands than the realm of procedural safeguards. As explained in Section 2, especially the inquisitorial justice system accounts for the latter as well as our TBS-system which pulls some defendants through the criminal process as a magnet, while a tradition of forensic care – again very much related to the TBS-system – accounts for the former. However, developments in academia, legislation and legal practice suggest that more attention is being given to procedural safeguards for this group of vulnerable defendants. When it comes to care, the broadening of forensic care from the TBS-order to the penitentiary and forensic mental health system has provided more detainees to profit from forensic care, even though some effects – also related to the responsibility of the Ministry of Justice and Security – jeopardize the sustainability of investments in forensic care (as discussed in Section 3.2). The entire field of forensic care in the Netherlands is diverse, which should allow for the intended tailored approach, but this goal is being complicated by a similar complexity in the

101 See already Raad voor de Strafrechtstoepassing en Jeugdbescherming, *De zorg aan gedetineerden met een ernstige psychische stoornis of verslaving*, 2 April 2007.

102 M. de Vries Robbé, M. van den End & M. Kempes, *Onderzoeksrapport Pilot 'Risicoscreening in detentie'*, Den Haag: DJI, 2021.

103 See FCA.

governing legal situation. In penitentiary institutions especially, much may still be gained in terms of screening for treatment needs and administering treatment aimed at risk reduction, as somehow such efforts are sometimes seen as contradictory to retribution. In communicating to society however, there is no better story to tell than forensic care in keeping people safe.

Defendants and detainees with psychiatric disturbances in the criminal process in New Zealand

Yvette Tinsley & Warren Young[*]

1 Introduction

New Zealand has a high prevalence of prisoners with mental health and addiction problems, and the Department of Corrections manages more people with mental illness than any other department, institution or agency in the country.[1] The Ministry of Health has estimated that prisoners are three times more likely to require access to specialist mental health services than people in the general population.[2] New Zealand has ratified the International Covenant on Civil and Political Rights, which sits alongside the Convention on the Rights of Persons with Disabilities and the UN Principles for the Protection of Persons with Mental Illness. These international instruments, when combined with the New Zealand Bill of Rights Act 1990 (NZBoRA), should offer protection for defendants and detainees with mental disorder or intellectual disability. In this chapter, we examine whether the protections work in practice to maintain fair and safe processes for people with mental disorders at each stage of the criminal system. We argue that the challenges posed by differing philosophies of treatment and punishment combined with New Zealand's high rate of imprisonment make successful reform of the treatment of prisoners unlikely. In turn, this compromises the ability of prisoners with mental health needs to be successfully reintegrated at the end of their sentence.

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1 Department of Corrections, *Change Lives Shape Futures: Investing in better mental health for offenders* (2017) pdf presentation.

2 Office of the Auditor-General, Report 2008, *Mental Health Services for Prisoners: Performance Audit Report*, Wellington, 2008.

2 Detainees with psychiatric disturbances in provisional detention

Persons with psychiatric disturbances may be taken into custody by a Police officer in three circumstances:

- a person who is experiencing a mental health crisis but has not necessarily offended may be detained to prevent them from harming themselves or to enable them to be assessed by a medical practitioner;
- a person who is reasonably suspected of having committed an arrestable offence may be arrested in order to determine whether they should be charged or dealt with in some other way;
- a person who is intoxicated in a public place or while trespassing on private property may be taken into custody for the purposes of transporting them to their place of residence or a temporary shelter or for detaining them in a detention facility for detoxification.

We will deal with each of these situations separately.

2.1 Non-offenders experiencing a mental health crisis

The Police receive a large number of emergency calls for assistance from persons experiencing a mental health crisis, or from their family members or friends. Such calls fall into two categories: those who are threatening or attempting suicide; and those who are otherwise demonstrating a high level of mental impairment to the extent that they are a risk to themselves or others. Since 2012 such calls have been increasing at a rate of approximately 8% per annum. In 2016 there were 46,359 calls (about 5.5% of the total volume of emergency calls) and the Police attended 32,890 of these.

In these circumstances three separate powers of detention may be available to the attending Police officers. First, the Police (and indeed any other person) may use such force as may be reasonably necessary to prevent the commission of suicide.[3] This may include detention at the scene for such time as is necessary to avert the risk. However, this statutory power does not allow detention beyond that necessary to avert an imminent risk of suicide, and does not permit ongoing detention to address mental health needs. Secondly, a Police officer who is assisting a 'duly authorized officer' (a designated mental health nurse) may enter premises and take into custody a person who may be suffering a mental disorder, where that is required to enable a medical practitioner to examine the person,

3 Crimes Act 1961, section 41.

and may transport the person to a place of assessment for that purpose.[4] Thirdly, a Police officer may take into custody a person who is found in a public place and acting in a manner that gives rise to a reasonable belief that he or she may be mentally disordered.[5] The officer may then take that person to a Police station, hospital or some other appropriate place in order for a medical practitioner to examine the person as soon as practicable.

When a person in the second or third category is detained, they must be assessed by a medical practitioner within six hours. If an assessment is not undertaken within that period, they must be released. In practice, the detainee is assessed first by a duly authorized officer; a medical practitioner attends only if some further assessment or ongoing detention is required. At the end of the maximum period of detention, the person must be released (perhaps with voluntary follow-up appointments with mental health services), unless the medical practitioner determines that there are reasonable grounds for believing that the person may be mentally disordered and that a further period of detention for assessment, observation and treatment may be required. In the past, there have been a significant number of detentions beyond the statutory limit of six hours, partly because of poor training of custodial staff and partly because of the unavailability of mental health staff to undertake assessments. Better training in the last three years should have reduced the incidence of these unlawful detentions.[6]

There are no mandatory screening tools that must be used in assessments. Rather, the medical practitioner must determine whether the test for mental disorder is met. That test is that the person has an abnormal state of mind (whether of a continuous or an intermittent nature), characterized by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it poses a serious danger to the health or safety of that person or of others, or seriously diminishes the capacity of the person to take care of himself or herself.

The original intent of the Mental Health (Compulsory Assessment and Treatment) Act 1992 was that those experiencing a mental health crisis would be subject to a joint response by mental health services and Police, and that they would be taken to a health facility for assessment. However, that has never materialized and in practice most such detainees have ended up detained in Police cells. Sometimes this has been because they have been affected by alcohol or drugs, or otherwise volatile and aggressive, and could not be safely managed elsewhere. However, much more often it has been because mental health services have been spread thinly and places of assessment other than Police facilities have been lacking. The consequences of this for those detained in Police cells have been severe.

4 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 41.

5 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 109.

6 See Independent Police Conduct Authority, Report 2015, *Report on Review of Police Custodial Management*, 2015 (at: www.ipca.govt.nz).

They have been searched and processed in the same way as other prisoners; they have often been subject to an inadequate risk assessment; they have been managed by officers who have lacked the training and skills to deal with those who are in mental distress and have employed poor containment and control strategies; and they have been placed in an environment that is inherently harmful to those in mental distress, thus exacerbating that distress.[7]

In recognition of these problems, the New Zealand Police have worked very closely with the mental health services of District Health Boards over the last three years to reduce the number of people in this category who end up in Police cells. As a result, there has been a 71% reduction between 2014 and 2017 – from 4,995 in 2014 to 1,453 in 2017. This has been achieved by adopting strategies to encourage a coordinated response to calls for assistance by Police and mental health services wherever this is practicable; organizing assessments in health facilities such as hospital accident and emergency departments (which were previously ill equipped to receive such people); and only transporting people to a Police cell as a last resort.

At the time of writing, the Government is also considering the development of a trial 'co-responder' model, which would see a team comprising Police, mental health and ambulance being co-located in two districts, so that they could respond together to calls for assistance according to the identified need. The intended outcome would be that people experiencing a mental health crisis (without associated offending) would only be taken to Police cells where they presented a risk to others that could not be safely managed elsewhere.

Where people experiencing a mental health crisis do end up in Police custody, systematic and robust risk assessment is required to ensure that they receive appropriate care. As with other prisoners, detainees are assessed for risk according to the information that is known about them and their observed behaviour. They are then assigned to one of three categories: 'not in need of specific care' (which requires that they be checked at least once every two hours); 'in need of care and frequent monitoring' (which requires they be checked at least five times an hour at irregular intervals); and 'in need of care and constant monitoring' (which requires that they be kept under continuous observation at all times).[8] If they require medical attention, a medical practitioner must be called as soon as possible, and there is a roster of Police doctors for that purpose. A change in their risk status also requires the approval of a medical practitioner or duly authorized officer.

7 For a more detailed analysis of these problems, see Independent Police Conduct Authority, Report 2015, *Report on Review of Police Custodial Management*, 2015 (at: www.ipca.govt.nz).

8 New Zealand Police, *People in Police Detention*.

2.2 Mentally impaired offenders

The above procedures apply when a person who is experiencing a mental health crisis is not arrested for an offence. But many of those who are psychiatrically disturbed and experiencing a crisis do offend. Even if they are not directly threatening or causing harm to any person, or destroying any property, they may be acting in a volatile and disoriented way that disturbs the public peace and causes people to fear for their safety. As a result, they may be liable to arrest for the offence of disorderly behaviour. In this event, notwithstanding their mental impairment they may be charged and processed through the criminal justice system. The procedures and programmes described in subsequent sections of this chapter then apply.

However, they are not automatically charged with an offence. There is still an opportunity after arrest for them to be diverted out of the criminal justice system. Unlike a number of other jurisdictions, there is no mental health court for this purpose that enables a mental health intervention overseen by the judiciary. Rather, diversion out of the criminal justice system is likely to occur prior to the laying of charges in three ways. First, the Police may simply warn and release them, perhaps into the care of family members who have put appropriate care arrangements in place. Secondly, the Police may call a duly authorized officer or medical practitioner to arrange for an assessment and then release them (with or without a warning) on the basis that there is appropriate follow-up by mental health services to address their mental health needs. Thirdly, as an alternative to a charge, the Police officer may apply to the Director of Area Mental Health Services for the person to be detained under the Mental Health (Compulsory Assessment and Treatment) Act 1992 for assessment, observation and treatment. If that application is granted, they then become the responsibility of the mental health system rather than the criminal justice system.

2.3 Detention for detoxification

A person who is mentally impaired may be under the influence of alcohol and drugs, which may be the trigger for his or her impairment or be exacerbating a pre-existing mental health condition. A Police officer who finds such a person intoxicated in a public place, or intoxicated while trespassing on private property, may detain that person if he or she reasonably believes that the person is incapable of protecting themselves from physical harm, or likely to cause physical harm to another person or significant damage to property. Any person so detained must be taken to their place of residence or to a temporary shelter unless this is not reasonably practicable. However, virtually no temporary shelters exist, and it is frequently not reasonably practicable to take the person home, given their level of intoxication and uncertainty about whether an appropriate caregiver will be present at

their residence. As a result, severely intoxicated people are frequently taken into Police custody and placed in Police cells for the purposes of detoxification. They must be released as soon as they are assessed no longer to be intoxicated, and they cannot be detained for longer than 12 hours unless a medical practitioner recommends a further period of detention not exceeding 12 hours. The powers of detention available to the Police under the Mental Health (Compulsory Assessment and Treatment) Act 1992 cannot be used cumulatively upon the detoxification power. That is, the Police are not permitted to hold a person for the purposes of detoxification, and then after 12 hours detain them for another six hours for the purposes of a mental health assessment.

3 Defendants with psychiatric disturbances and intellectual disabilities during pre-trial inquiry and at trial

In this section, we outline the procedural safeguards and trial processes designed to protect and respond to the special needs of suspects, arrestees and defendants with psychiatric disturbance and/or intellectual disability. When such persons are arrested in relation to a criminal offence, they are afforded the same rights to legal advice, fair questioning and procedural trial rights as all other arrestees and defendants. In addition, the New Zealand courts have emphasized the need for special care where persons questioned have a disability or other impairment. Once the case comes to trial, there are provisions relating to fitness to stand trial and the defence of insanity, and some additional sentencing options (which we discuss in the next section).

3.1 Rights and protections when questioned

If a person with psychiatric disturbance is arrested on suspicion of an offence, then like all suspects in New Zealand they have the right to legal advice, protection from unfair or oppressive questioning and a right to silence. These protections can be found in sections 23-25 of the NZBoRA, in tandem with a Practice Note issued by the Chief Justice and a set of guidelines termed 'the Judges' Rules'. Statements or confessions which contravene the protections may be inadmissible in court (see, for example, section 30 of the Evidence Act 2006). Although there are no particular statutory and regulatory protections for persons with a psychiatric disturbance or intellectual disability when questioned about possible criminal offending, the New Zealand courts have made it clear that questioning such persons should involve special care. Rights must be communicated in a way that is comprehensible for the individual accused, and this is a subjective test that is assessed from

the suspect's point of view.[9] In the case of *R v. Samuelu*,[10] the accused, who suffered from schizophrenia and also had an intellectual impairment, was repeatedly informed of his right to instruct a lawyer. However, the way in which this was communicated to him was held to have been inadequate, especially because the police officers interviewing him were aware of his mental illness. The judge was clear that:

> [T]he rights secured and guaranteed by the Bill of Rights Act have a 'special value' to those who are mentally impaired. The Courts will not simply turn a blind eye to treating people who are mentally unwell as if they are well.[11]

The decision in *Samuelu* suggested that the Police should have taken more steps to ensure that the defendant was interviewed fairly, and to increase the likelihood that his statement would be reliable. The current Police Manual of Best Practice[12] outlines the type of steps the court required in *Samuelu*. It contains guidance for interviewing officers regarding suspects who should be given 'special consideration', including those who have a mental illness or intellectual disability, or are intoxicated. The Manual requires officers to consider fairness to the suspect, including the likelihood that they may give unreliable statements or be susceptible to oppression at interview. While acknowledging that the approach should be tailored to the individual needs of each suspect, it emphasizes the need to ensure fairness and transparency by:

- Video-recording of interviews;
- Undertaking background checks, and speaking to family and health professionals to find out whether full and fair communication is possible;
- Considering whether the interview should be delayed (for example, where the suspect is intoxicated);
- Using simple language and checking understanding when informing suspects of their right to legal advice and right to remain silent;
- Arranging a support person where appropriate (for example, when interviewing officers think that suspects do not understand their rights). Support persons can include the suspect's friends or family members, or professionals such as mental health workers;
- Arranging for the suspect to speak to a lawyer;
- Using free recall interviewing to minimize the risk of influencing the suspect's responses.

9 *R v. Morris* 31/7/01, Potter J, HC Auckland T012578, para. 23.
10 (2005) 21 CRNZ 902, CRI-2003-004-38062.
11 *Ibid*., para. 101.
12 New Zealand Police, *Investigative Interviewing suspect guide*, from Police Manual of Best Practice.

Should the suspect be charged, found fit to plead and brought to trial, then before the judge decides whether to admit a statement made by the defendant, he or she must take into account (where relevant to the case):[13]

(a) any pertinent physical, mental or psychological condition of the defendant when the statement was made (whether apparent or not);
(b) any pertinent characteristics of the defendant including any mental, intellectual or physical disability to which the defendant is subject (whether apparent or not);
(c) the nature of any questions put to the defendant and the manner and circumstances in which they were put.

The effect of this requirement is to build scrutiny of Police interviewing techniques into the decision as to whether statements are excluded or admitted.

3.2 Fitness to stand trial

Where there are doubts as to the capacity of the defendant to understand proceedings or instruct counsel, they may be found unfit to stand trial. The finding of unfitness is closely linked to the right to a fair trial, as set out in section 25(a) of NZBoRA, and to the right of the defendant to be present and advance a defence (section 25(e) of NZBoRA).[14] The issue of fitness to stand trial may be raised by either party.[15] The governing statute is the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIPA). For the purposes of the Act, 'mental impairment' includes both mental disorder and intellectual disability.[16] It may also include other conditions that restrict cognitive understanding, such as brain damage and neurological conditions.[17] The focus in a fitness to stand trial hearing is on the state of mind of the defendant at the time of the proceedings, rather than their state of mind at the time of the alleged offending. Section 4 of CPMIPA provides that:

> **unfit to stand trial**, in relation to a defendant, –
> (a) means a defendant who is unable, due to mental impairment, to conduct a defence or to instruct counsel to do so; and

13 Evidence Act 2006, s 28 (exclusion of unreliable statements). Section 29 (exclusion of statements influenced by oppression) contains an identical requirement.

14 For a discussion of the connection of the fitness inquiry to the rights guaranteed in the 1990 Act, see Court of Appeal Wellington, judgement of 2 November 2005, *R v. Cumming* [2006] 2 NZLR 597.

15 *R v. T* [1993] DCR 600; see also Robert Chambers, 'Trial Rights for the Mentally Impaired', 24 *New Zealand Universities Law Review* 3 (2011). Similarly, either party may appeal a decision as to fitness to stand trial.

16 High Court, Palmerston North, judgement of 8 December 2005, *S v. Police*, CRI 2005 454 047. See *Barton v. R* [2012] DCR 193 for a summary of New Zealand decisions on conditions amounting to 'mental impairment'.

17 *R v. H* [2014] NZHC 1423.

(b) includes a defendant who, due to mental impairment, is unable –
(i) to plead:
(ii) to adequately understand the nature or purpose or possible consequences of the proceedings:
(iii) to communicate adequately with counsel for the purposes of conducting a defence.

Before a court can make a finding that a defendant is not fit to stand trial, there are three main steps to satisfy. First, section 9 of CPMIPA requires that the judge be satisfied the evidence is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence charged. The standard of proof required is 'on the balance of probabilities', and if this standard is not reached then the defendant is discharged.[18] In inquiring into the defendant's involvement in the offence prior to any assessment of their disability or fitness to stand trial, New Zealand differs from the common law approach. For example, in England and Wales the 'evidential sufficience' inquiry follows a finding of unfitness. The current New Zealand process is designed to facilitate the early discharge of a defendant, sparing them from an unfitness inquiry where there is insufficient evidence to establish that they caused the *actus reus* of the offence. However, there has been growing disquiet over the operation of section 9 inquiries in practice, because they require the defendant to go through a form of trial in order to determine whether they are fit to actually stand trial.[19] Because of the difficulties with the operation of section 9, the Government has proposed an amendment to CPMIPA so that the evidential sufficiency hearing takes place after the finding of unfitness to stand trial.[20] Secondly, if the judge is satisfied that the defendant did cause the act or omission, the next step is to establish that the defendant has a mental impairment, which requires the evidence of two health assessors (such as psychiatrists, psychologists or specialist assessors for the intellectually disabled).[21] Finally, where the evidence indicates mental impairment on the balance of probabilities, the court will hear evidence from each party as to whether the defendant is fit to stand trial.[22]

18 The prosecution may appeal this decision (as well as decisions as to mental impairment and fitness to stand trial: section 19 of CPMIPA). If the defendant is found to have caused the act or omission, they may appeal the decision by virtue of section 16(1)(a) of CPMIPA.

19 *R v. Te Moni* [2009] NZCA 560.

20 Courts Matters Bill clauses 107-113. At the time of writing, the Bill was at the Select Committee stage (at: www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_74734/courts-matters-bill).

21 Section 14 of CPMIPA. See also *R v. McKay* [2009] NZCA 378 at [49-50].

22 In *McKay v. R* [2009] NZCA 378, six steps were suggested as part of the fitness inquiry itself: obtaining health assessor reports; make the reports available to counsel; give each side an opportunity to present evidence as to impairment and fitness; allow each side the opportunity to make submissions; make a finding on the balance of probabilities as to mental impairment and fitness to stand trial; and either proceed to trial or other disposition.

The decision as to unfitness therefore requires consideration of the extent of the impairment, the nature of the charge, the nature of the probable evidence and any available means to assist the defendant in understanding the proceedings and conduct a defence.[23] The ability to understand and communicate must be 'adequate' and does not have to reach a standard whereby sophisticated understanding is achieved, because even most defendants who are fit to stand trial would require counsel to assist in understanding the legal ramifications of what is said or done.[24] The court may find a defendant unfit to stand trial at any time after the commencement of proceedings up to the point where all of the evidence is concluded. Where the matter arises during the trial, the judge may take into account any evidence already heard in the trial when determining whether the defendant caused the act or omission that forms the basis of the offence charged.

If a finding of unfitness is made, there are two further steps for the court to fulfil. First, the court must order inquiries to be made to determine the most appropriate way to deal with the person. These should be completed within 30 days, during which time the person may be bailed or remanded in a hospital or secure facility. The report of these inquiries (including reports from health assessors) and all the circumstances of the case are considered in the second step of determining the most appropriate disposition option.

Before the 2003 Act, almost all defendants found unfit to stand trial were detained as 'special patients' in secure hospital units. However, section 24 of CPMIPA now requires that the court must be satisfied that the making of an order to detain the defendant as a special patient (if mentally disordered) or special care recipient (if intellectually disabled) "is necessary in the interests of the public or any person or class of person who may be affected by the court's decision". This focuses on the interests of the public, although it does not preclude consideration of the interests of the defendant, as the Court of Appeal has outlined:[25]

> First, there is the need to be protected from further offending by the offender. The longer term public interest, and one that the offender obviously shares, is to ensure that the offender is managed and treated in a manner best calculated to achieve the ultimate goals of rehabilitation and reintegration into the community.

The maximum period for which a defendant may be detained as an unfit special patient or special care recipient is ten years for offences punishable by life imprisonment, or half

23 *Jones v. R* [2015] NZCA 601.
24 See *JA v. R* [2014] NZCA 590.
25 *M v. R* [2012] NZCA 142 at [7].

the maximum term of imprisonment for any other offence.[26] These defendants are detained in a secure facility, and the charges against them remain so that if they become fit to stand trial within the period of the special patient order, they may be brought before the court again. If the defendant remains unfit to stand trial, they will be transferred to ordinary patient or care recipient status at the end of the maximum period. However, if the medical staff deem that it is safe to transfer them to ordinary patient or care recipient status within the detention period even though they remain unfit to stand trial, the consent of the Minister of Health and Attorney General is required. The provision for executive input into the decision has rightly been subject to criticism, including by the New Zealand Law Commission, which had particular concern about the potential for politicization of release decisions because "there are certain times (such as election years) and certain factors (for example, particularly nasty high profile cases) that will tend to make Ministers more risk averse".[27] Despite agreeing that there was an issue with ministerial decision-making in fitness to stand trial and insanity change of status decisions, the Government has yet to change the law. This leaves special patients and care recipients at risk of added stress and politicized decision-making, potentially remaining in secure detention for longer than is necessary for the protection of the public.

If the court does not deem a special patient or special care recipient order to be necessary, section 25 of CPMIPA provides several other disposition options:

> (1) If, after considering the matters specified in section 24(1)(a) and (b)[28]concerning a defendant found unfit to stand trial or acquitted on account of his or her insanity, the court is not satisfied that an order under section 24(2) is necessary, the court must deal with the defendant –
>
> (a) by ordering that the defendant be treated as a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992;[29] or
>
> (b) by ordering that the defendant be cared for as a care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003;[30] or
>
> (c) if the person is liable to be detained under a sentence of imprisonment, by deciding not to make an order; or
>
> (d) by ordering the immediate release of the defendant.

26 Section 30(1) CPMIPA 2003.

27 New Zealand Law Commission, report 2010, *Mental Impairment Decision-Making and the Insanity Defence* R120, at [10.3] p. 71.

28 http://www.legislation.govt.nz/act/public/2003/0115/latest/link.aspx?id=DLM223889#DLM223889.

29 http://www.legislation.govt.nz/act/public/2003/0115/latest/link.aspx?id=DLM262175.

30 http://www.legislation.govt.nz/act/public/2003/0115/latest/link.aspx?id=DLM224577.

When a court makes an order under section 25, the charges may be stayed and no further proceedings brought. An order under section 25(1)(a) is to be regarded as a compulsory treatment order for the purposes of the Mental Health (Compulsory Assessment and Treatment) Act 1992, and the court must specify whether it is to take effect as community or inpatient treatment. Similarly, an order under section 25(1)(b) must direct whether the defendant must be detained in a secure care facility. Where the defendant is subject to a sentence of imprisonment, section 25(1)(c) provides that sentence may continue to run and no additional order made. Finally, immediate release may be considered where the alleged offence is not in the most serious category and there is deemed to be low risk of the behaviour recurring. What is missing from the order under section 25(1)(d) is the possibility of attaching conditions to the release, and as such it is likely that it is not used as often as it could be. Without the possibility of oversight, judges may be understandably reluctant to order immediate release. While the addition of a few words at the end of section 25(1)(d) could address the concern,[31] such a reform has not been included in the Government Bill amending CPMIPA.

3.3 Insanity defence

For those defendants who were mentally disordered at the time of the alleged offence, the defence of insanity is available in New Zealand by virtue of section 23 of the Crimes Act 1961. As in a number of other common law jurisdictions, the defence is based on the M'Naughten Rules, and the current provisions have not been substantially changed since codification:

> (1) Every one shall be presumed to be sane at the time of doing or omitting any act until the contrary is proved.
> (2) No person shall be convicted of an offence by reason of an act done or omitted by him or her when labouring under natural imbecility or disease of the mind to such an extent as to render him or her incapable –
> (a) of understanding the nature and quality of the act or omission; or
> (b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.
> (3) Insanity before or after the time when he or she did or omitted the act, and insane delusions, though only partial, may be evidence that the offender was, at the time when he or she did or omitted the act, in such a

31 *R v. K* [2017] NZHC 518, at [17].

condition of mind as to render him or her irresponsible for the act or omission.

(4) The fact that by virtue of this section any person has not been or is not liable to be convicted of an offence shall not affect the question whether any other person who is alleged to be a party to that offence is guilty of that offence.

As can be seen from reading the statutory section, the defence is a very limited one that does not use current medical terminology. The presumption of sanity in section 23(1) places the burden of proof on the defendant, on the balance of probabilities. The defence requires that there is a 'natural imbecility' or 'disease of the mind', which must result in the defendant either not understanding the nature and quality of the act or not knowing that the act was morally wrong. If acquitted on account of insanity, then the disposition options in section 24 and section 25 of CPMIPA are available, as for unfitness to plead (see the discussion above). Unlike those found unfit to plead, defendants acquitted by reason of insanity are subject to indefinite detention if they are ordered to be detained under section 24.

4 Responsibility for mentally impaired offenders

Historically, the primary responsibility for dealing with convicted offenders with acute mental health needs has moved back and forth between the health sector and the corrections system. At some points in New Zealand's history, psychiatric institutions were 'dumping grounds' for the detention of offenders who had been found criminally liable but whose mental health needs made them too difficult to manage in prison. Injustices and abuses of human rights resulted.[32] At other times, the health sector has been a reluctant player in the provision of mental health services to prisoners, resulting in the detention of mentally unwell prisoners in inappropriate custodial environments and leaving a pool of unmet mental health need.[33] The present system, at least in theory, attempts to navigate between these two extremes. There is a conflict inherent in the aims of corrections, which prioritizes punishment, and health, which prioritizes treatment. Yet the corrections and health systems are expected to play complementary roles, with coordination and a degree of integration of their respective services.

32 See, for example, Committee of Inquiry into Procedures at Oakley Hospital and Related Matters, Report 1983.

33 A. Simpson, P. Brinded, T. Laidlaw, N. Fairley & F. Malcolm, *National Study of Psychiatric Morbidity in New Zealand Prisons*, Department of Corrections, 1999.

The key elements of this hybrid system for offenders convicted of a criminal offence are as follows:

- The sentencing court may impose a community-based sentence (e.g. a sentence of supervision with appropriate conditions), and in doing so may treat mental impairment as a mitigating factor where this is not outweighed by any risk to the safety of the public.
- Instead of imposing any sentence, the court may order that the offender be committed as a patient under the Mental Health (Compulsory Assessment and Treatment) Act 1992 or, in the case of an intellectually disabled person, be cared for as a care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.[34] In this case, the person is treated as an ordinary committed patient or care recipient and is no longer subject to criminal jurisdiction. An offender's rehabilitative needs are not sufficient to impose an order of this sort; it will only be appropriate if the offending is serious enough to warrant it.[35]
- The court may sentence an offender to a term of imprisonment, but at the same time order that he or she be detained in a secure psychiatric facility as a special patient or in a secure facility for the intellectually disabled as a special care recipient.[36] The prison sentence continues to run while the offender is in the psychiatric or care facility, but if the person becomes well enough to be discharged during the term of the prison sentence, he or she will be transferred back to prison to serve the remainder of the sentence.
- Where a person is sentenced to imprisonment, but is subsequently diagnosed with a mental illness that requires treatment in a psychiatric facility, he or she may be transferred to the psychiatric facility for that purpose.[37] The prison sentence continues to run while the person is detained in the psychiatric facility. Again, if the person becomes well enough to be discharged from the facility before the prison sentence expires, he or she must be returned to prison to serve the remainder of the sentence.

It is apparent that this hybrid system allows for a substantial proportion of mentally ill offenders to be diverted from the prison system to the health sector.

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34 Criminal Procedure (Mentally Impaired Persons) Act 2003, section 34(1)(b).

35 Court of Appeal Wellington, judgement of 2 August 2011, *R v. Goodlet* [2011] NZCA 357, [2011] 3 NZLR 783.

36 Criminal Procedure (Mentally Impaired Persons) Act 2003, section 34(1)(a).

37 Mental Health (Compulsory Assessment and Treatment) Act 1992, section 45.

4.1 The prevalence of mental disorder amongst prisoners

The reality is rather different. The most reliable information on the prevalence of mental disorder comes from a 2016 survey[38] of 1,200 male and female prisoners, who were aged 18 years and over, proficient in English and in custody for less than three months.[39] They were assessed by means of the World Health Organization Composite International Diagnostic Interview version 3.0[40] and the Personality Diagnostic Questionnaire 4+ (PDQ-4).[41] The survey revealed very high rates of mental disorder. When substance use disorders were included, 91% were diagnosed as having a mental disorder at some stage during their lifetime and 62% within the last 12 months. But even when the diagnosis was restricted to anxiety or mood disorders, the lifetime prevalence rate was 62%, and the prevalence rate within the last 12 months was 47%. These rates were up to three times higher than the reported rates for the general population – for example, a prevalence rate for any mental disorder within the last 12 months of 62% compared to 21%. Females had significantly higher prevalence rates than males.

These rates do not imply that the offending that led to the imposition of a prison sentence was caused by the prisoners' mental disorder. Nor does it necessarily suggest that they should not have been sentenced to imprisonment. That is because the data does not distinguish between those with pre-existing mental health conditions and those whose impairment has arisen as a result of their imprisonment. It is undoubtedly the case that a substantial proportion of prisoners lead dysfunctional lives, and it would not be surprising to find pre-existing levels of anxiety, mood and substance use disorders that are substantially higher than those of the general population. Equally, prisons are injurious environments, especially for those who are already mentally fragile or vulnerable. As a result, they may trigger a disorder in a person who is predisposed to it, or exacerbate a pre-existing condition.

Two key points can be drawn from this observation. The first is that prison is inevitably injurious to mental health, and those with a mental impairment should not be there unless there is no other appropriate option to respond to their offending. The second is that if those who do end up in prison have a mental disorder (either because it already existed or because the prison environment triggers it), the State has a duty to provide appropriate treatment and mental healthcare.

38 Devon Indig, Craig Gear & Kay Wilhelm, *Co-morbid Substance Use Disorders and Mental Health Disorders among New Zealand Prisoners*, Department of Corrections, Wellington, 2016.

39 Prisoners who were regarded as unable to safely participate as a result of their mental health or their behaviour were excluded.

40 See further http://hcp.med.harvard.edu/wmhcidi/index.php.

41 See further www.pdq4.com/index.html.

4.2 *Assessment and treatment of mental impairment*

The duty to provide appropriate treatment and care is in fact spelt out in legislation. Section 75 of the Corrections Act 2004 provides that a prisoner is entitled to receive reasonably necessary medical treatment of a standard equivalent to the standard of healthcare available to the public. This general obligation is set out in more detail in the Corrections Regulations 2005. Regulations 71-73 require that every prison must have a health centre; that it must promptly meet health needs; that, as far as practicable, it must maintain the physical and mental health of prisoners to a satisfactory standard; and that access to adequate medical treatment must be available for that purpose. There are a variety of empowering provisions to enable health centre managers to give effect to these obligations.

There has been persistent criticism of the Department of Corrections for failing to invest sufficient resources to meet mental health needs.[42] In response to this criticism, over the last five years the Department has put considerable effort into improving its performance. This culminated in the launch in August 2016 of a new Strategic Plan for addressing the mental health needs of prisoners.[43] The Strategic Plan is comprehensive in its scope and purports to provide a wide array of assessment tools, treatment options and specialist units to address prisoners' needs.

5 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

As a first step, all new receptions into prison receive a basic health triage assessment, usually undertaken by a registered nurse, which is called a Reception Health Triage Assessment. Corrections custodial staff also undertake a risk assessment to identify the level of risk of self-harm, including suicide. These assessments are designed to ensure that immediate needs are addressed in a timely manner. All new prisoners, and all returning prisoners if they have not been in prison within the last 24 months, then receive an initial Health and Substance Use Assessment, generally within seven days of arrival but usually much earlier. This initial health assessment includes a mental health screening tool that was introduced in 2012. This may be supplemented, either then or at a later date, by a variety of more in-depth assessments where the need for them is indicated by the initial assessment or

42 See, for example, Office of the Auditor-General, Mental Health Services for Prisoners, *Report 2008, Performance Audit Report*.

43 This plan is published in Department of Corrections, *Change Lives Shape Futures – Investing in Better Mental Health for Offenders*, Wellington, 2017 (at: www.corrections.govt.nz/resources/strategic_reports/investing_in_better_mental_health_for_offenders.html).

prior pre-sentence reports. These include a specific alcohol, smoking and substance abuse screening test; a psychopathy checklist screening test; a test for those with emotional, behavioural or interpersonal difficulties; and a test to identify those at risk of short-term violence. These supplementary tests are administered by Corrections Health Services staff, case managers or psychologists. Following these assessments, the case manager is required to develop an individualized case management plan, which may provide a number of potential avenues for the delivery of treatment for mental health needs.

First, as noted above, a prisoner who is assessed as suffering from a mental disorder that warrants committal under the Mental Health (Compulsory Assessment and Treatment) Act 1992 may be transferred to a psychiatric institution under section 45 of that Act. They are detained in secure hospital forensic units and are transferred back to prison to serve the remainder of their sentence if they become well enough to be discharged during the term of the sentence.

Secondly, those with moderate to severe mental health needs may be referred to the Regional Forensic Psychiatric Service for assessment and treatment, generally by means of visits to the prison by psychiatric nurses and psychiatrists. Forensic liaison nurses from the Regional Forensic Psychiatric Service also attend prisons on a regular basis for consultations to assess any needs that may arise, and to generate referrals to psychiatrists for further consultation where appropriate.

Thirdly, for those prisoners with mild to moderate mental health needs, ongoing treatment is the responsibility of the Department of Corrections and may be provided by its own health services or by contracted external mental health services providers. Services include medication, one-to-one or group therapy and health education. In three pilot sites, the prison has been supplementing the services of the Regional Forensic Psychiatric Service by contracting experienced primary mental health clinicians from the private sector to support health and custodial staff in the provision of treatment. This was extended under a pilot programme which began in early 2017. Under this programme, teams of contracted mental health workers are working with prisoners across 15 prisons to stabilize and address their mental health needs. They are made up of professionals including psychiatrists, nurses with postgraduate qualifications in mental health, psychologists and occupational therapists.

Fourthly, there are some specialist units that have been established to cater for prisoners who are at risk or have complex needs and cannot function in the mainstream prison environment. For example, Rimutaka Prison has a high dependency unit set up in 2012 for prisoners with mental health conditions such as dementia, physical disabilities or neurological disorders.

Fifthly, New Zealand's major maximum security facility at Auckland Prison is being rebuilt so that it can more effectively manage prisoners with serious mental health and/or complex behavioural issues. The new prison will include a unit specifically to manage those with severe mental health needs and will be supported not only by specialist

corrections staff but also by regional psychiatric service staff. Individuals will be assessed, a management plan developed and their healthcare complemented by contracted external providers, onsite in the prison. As well as better training and more support for staff, the stated aim of such redevelopments is to:

> […] assess and intervene early to treat people before their behaviour escalates (or deteriorates), which will not only reduce the demand for our more acute services within prison, but also that of in-patient beds in secure facilities … we want to improve the individual's mental health and wellbeing so they can take their next steps towards their rehabilitation.[44]

It is too early to tell how successful these changes within prisons prove to be in promoting the health and well-being of prisoners with mental health problems.

Sixthly, in 2016 the Department of Corrections launched a new strategy for dealing with issues of substance abuse and dependency.[45] Building on this strategic vision, it offers a suite of programmes in prisons for those assessed as having an alcohol or drug problem. These include brief support programmes for all with an identified need; 20 hours of treatment for prisoners serving short sentences with all levels of need, who do not have time for more intensive treatment; 8-week intensive treatment programmes for prisoners with a moderate alcohol or drug treatment need; and 3-6 months' treatment programmes in specialist units for prisoners with a moderate to high treatment need. An approach is also being piloted in one prison to implement a programme called SBIRT (screening, brief intervention and referral to treatment), in order to establish the prevalence of methamphetamine use amongst prisoners and refer them for treatment.

Finally, as part of routine case management in the mainstream prison environment, corrections psychologists and other external contracted staff provide individual and group treatment targeting a variety of mental health issues that may be contributing to the person's offending.

All of these initiatives demonstrate that the Department of Corrections is committed to fulfilling their statutory obligations and addressing their mental health needs. However, the reality is gloomier than this suggests. A major impediment to the successful implementation of the various strategies adopted over the last decade is New Zealand's comparatively high and rapidly rising population. According to the World Prison Brief,[46] New Zealand's prison population in September 2018 reached 10,435 or 214 per 100,000

44 Department of Corrections, *Change Lives Shape Futures: Investing in better mental health for offenders* (2017), pdf presentation.

45 Department of Corrections, *Breaking the Cycle: Our Drug and Alcohol Strategy through to 2020*, 2016.

46 At: https://www.prisonstudies.org/sites/default/files/resources/downloads/wppl_12.pdf.

of the population. That has risen from a muster of 7,887 (185 per 100,000) in 2008 and 8,597 (194 per 100,000) in 2013. The muster has been rising faster than projections, with the result that the number of people being incarcerated is rapidly outstripping capacity. There is consequently substantial pressure on prison facilities, including the provision of services.

This substantially constrains the ability of corrections to provide targeted and individualized intervention for all those with a mental health need. After the initial health assessment, there is no systematic ongoing health needs assessment. Corrections itself acknowledges that, unless they obviously manifest themselves in other ways, health conditions (including mental conditions) that emerge while a prisoner is in prison are primarily identified by prisoners' self-reporting.[47] If problems and needs are, therefore, not identified at initial assessment, they are likely to go unrecognized and unaddressed. Notwithstanding the existence of case managers who are supposed to be responsible for the case management of each prisoner, many do not have the skills or training, and are not in a good position, to know the needs of their customers well. There is no overall collection of statistical data on mental health needs, and no overall information on the extent to which a particular health need is prevalent in each prison. As a result, the level of funding required to meet the needs that exist is determined somewhat arbitrarily. The situation is still worse for Māori offenders with mental health problems. Māori, who are the largest ethnic group accessing all forms of rehabilitation,[48] have a holistic approach to health, both physical and psychological. The different approach required is something that the corrections system has struggled with, notwithstanding increased employment of Māori staff and greater community consultation.

These barriers to successful intervention and treatment are exacerbated by the pressure on external mental health resources. Regional psychiatric services are stretched in dealing with the growing demand from the general population, to such an extent that at the time of writing the Government had announced the establishment of a ministerial inquiry to examine the growing crisis in the sector.[49] The demands of the general population may be given higher priority, partly because prisoners may be perceived to be in a physically safe

47 Office of the Ombudsman, Report 2017, *An unannounced inspection of Christchurch Men's Prison*, December 2017 (at: www.ombudsman.parliament.nz/system/paperclip/document_files/ document_files/2453/original/online_report_on_unnanounced_inspection_of_christchurch_men_s_prison_december_2017.pdf?1515977898).

48 Department of Corrections, *Briefing to the Incoming Minister 2017*, p. 19.

49 At: www.newsroom.co.nz/2018/01/23/77434/mental-health-inquiry-a-blueprint-for-the-future. The initial draft of this chapter detailed the calls for a Royal Commission to be held, including in the People's Mental Health Review Report (at: www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=11841136). However, a Royal Commission was rejected by the new Government in favour of a ministerial inquiry, a controversial decision. The inquiry will include a review of addiction services.

and secure environment in prison.[50] Even if they are not, the overall pressure on external mental health services, and particularly acute services, limits access to these services.

In addition, prisoners often have high and complex needs that are difficult to treat in a prison environment. These include prisoners with so-called personality disorders who pose ongoing management problems. As a result, many prisons have developed at-risk units (now called Intervention Support Units) for the safe management of prisoners with complex needs and an increased risk of self-harm. Most stay for only a short period until they are stable enough to be moved back to the mainstream prison environment, but a small proportion stay for a longer period. While some treatment is available, these units are primarily a management tool, and have been the subject of a number of criticisms by independent inspectors for having limited therapeutic interventions and operating on the basis of formulaic management plans that are identical regardless of security classification or level of required observation;[51] for being anti-therapeutic and not fit for purpose; and having limited communal space and cage-like exercise yards.[52] As a result, a national review of the operation of these units was commenced in July 2017.

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

The mental illness prevalence figures discussed in section IV(i) suggest that both pre-existing conditions and the effects of prison on mental health create challenges for successful reintegration of offenders when they leave prison. The New Zealand Department of Corrections provides reintegration services to assist prisoners to become prosocial members of society: those with mental health needs require special assistance with the sudden change in environment, reconnection with their community and difficulties with employment or housing. The community response to serious and high-needs offenders returning to their towns has often been a barrier to successful reintegration, and in acknowledgement of this, new roles have been created to improve public understanding about how offenders are managed in the community. The new officers focus on relationship building with schools and community groups, improving notification when someone who has offended against children is released into the community. The hope is that a more supportive community will improve the chances of successful reintegration and

50 Kate Frame-Reid & Joshua Thurston, 'State of Mind: Mental Health Services in New Zealand', 4 *Practice: New Zealand Corrections Journal* 2 (2016).

51 Office of the Ombudsman, Report 2017, *An Unannounced Inspection of Hawke's Bay Regional Prison*, July 2017, pp. 18 and 36.

52 Office of the Ombudsman, Report 2017, *An Unannounced Inspection of Christchurch Men's Prison*, December 2017, p. 16.

rehabilitation: it is too early to gauge how successful this has been, as the community engagement officers were only inducted a year ago.

For all prisoners, there has been a growing recognition of the need to provide services such as employment support, accommodation assistance and help with maintaining connections or reconnecting with the offender's family, whanau and wider community. Employment support services were introduced in 2014 to offer further active case management, job placement and in-work support for those recently released or on a community sentence. There are also specialized services for short-term and long-term prisoners.[53] Despite this growing recognition and increase in reintegration services, there is still relatively little resource employed in reintegration as compared to the costs involved in the incapacitation of high numbers of prisoners.

6.1 Recent reintegration initiatives specifically for offenders with mental health and addiction needs

The pilot programme for treatment within prisons by community mental health professionals (see Section V) is part of a wider $14 million two-year mental health pilot programme that started in 2017. As well as treatment in prison, four Community Corrections sites have contracted mental health teams to work with offenders with mental health needs; the teams will support ex-prisoners who have mental health needs with their transition back into the wider community; and teams will also provide advice and training to corrections staff. The pilot programme has three additional strands:

- There is a recognition that women prisoners have increased rates of mental disorder and addiction linked to historical trauma. Over half of women prisoners have a lifetime diagnosis of post-traumatic stress. The pilot programme builds on an initiative that started in 2016 to offer additional social work and counsellor support in New Zealand's three women's prisons. The focus is on building skills for prison life and to help with successful reintegration.
- The programme acknowledges the difficulties prisoners with mental health disorders have in finding suitable accommodation post-release. Corrections has included a strand within the programme to provide 'supported living'. This includes contracts with supported living providers in two cities (Auckland and Hamilton) for both men and women in the community that link to community treatment providers. For a small number of men with exceptionally high needs, there is temporary supported accommodation in self-care units on prison land on their release from prison.

53 Juanita Ryan & Robert Jones, 'Innovations in Reducing Re-offending', 4 *Practice: New Zealand Corrections Journal* 2 (2016).

– The programme provides wrap-around support for families of some offenders with mental health disorders, both while in prison and post-release. The programme is targeted in particular at families who are considered vulnerable: in need of assistance to enable them to support the offender when they are released from prison.

Although the previous Government appeared to be confident that there would be continued funding after the two-year pilot programme, it is by no means certain that the funds will be available.[54] Whether there is community capacity to deal with the need for the additional services the pilot requires is also questionable. The programme will not be successful if it stretches existing services without working with the health sector and private providers to increase staff and resource: something that can only be achieved if health professionals have some confidence that it will continue to be funded.

The pilot has been introduced in addition to some other recent reintegration initiatives, which range from intensive guided release for long-term prisoners, to culturally responsive programmes for Māori that aim to form supportive community networks in preparation for release. Some of these initiatives are not suitable for those with complex or high needs, who may lack the minimum security clearance required to be considered for some reintegration opportunities, such as placement in external self-care units. There has also been an increase in provision for prisoners with addictions. For example, in tandem with the alcohol and other drug programmes in prison, since July 2016, a total of 15 aftercare workers have been contracted to continue programmes for 6-12 months post-release. This support sits alongside other outpatient programmes that are primarily for offenders serving community sentences who have high alcohol and drug treatment needs.

6.2 The call for 'therapeutic' mental health courts

In recent years there has been a call to establish specialist mental health courts in New Zealand, as a type of therapeutic or problem-solving court. New Zealand has an Alcohol and Other Drug Treatment Court pilot[55] and two specialist homeless and special

54 New Zealand Government, *The Estimates of Appropriations 2015/16: Vote Corrections*, at 5. For a ten-year update on reintegration see Annaliese Johnston, *Beyond the Prison Gate: Reoffending and Reintegration in Aotearoa New Zealand* (2016), Salvation Army Social Policy and Parliamentary Unit.

55 For discussion and evaluation of the pilot, see Katey Thom & Stella Black, *Ngā whenu raranga/Weaving strands: #1. The therapeutic framework of Te Whare Whakapiki Wairua/The Alcohol and Other Drug Treatment Court*, Auckland, New Zealand: University of Auckland, 2017; Katey Thom & Stella Black, *Ngā whenu raranga/Weaving strands: #2. The processes of Te Whare Whakapiki Wairua/The Alcohol and Other Drug Treatment Court*, Auckland, NZ: University of Auckland, 2017; Katey Thom & Stella Black, *Ngā Whenu Raranga/Weaving strands: #3. The roles of Te Whare Whakapiki Wairua/The Alcohol and Other Drug Treatment Court team*, Auckland, NZ: University of Auckland, 2017; and Katey Thom & Stella Black,

circumstances courts. These courts deal with offenders who have complex needs including mental health needs. The aim of a mental health treatment court would be to divert offenders from prison, rather than to reintegrate them after prison, but a key part of the treatment would be similar to reintegration aims: to forge community networks, assist with employment and housing, and address the high rates of mental illness amongst offenders. There has been no robust discussion in New Zealand about the types of case and offender that may be served by a mental health court: for example, whether it is restricted to less serious offending; whether all mental health conditions would qualify (and if not, which ones); and the consequences of poor compliance with treatment. There is some consensus that such a court would be best suited to less serious recidivist offenders who are currently in a 'revolving door' between health and criminal justice; that treatment for such offenders would be preferable to incarceration; and that the current system is not working for many mentally disordered offenders. However, there is little consensus that a specialist court would in fact address the problems, and it would certainly not address the difficulties posed by prison for those with more serious mental disorders.

7 Conclusion

Ultimately, the high rate of imprisonment in New Zealand constrains policies to treat and reintegrate suspects, defendants and prisoners who have mental health and addiction problems. The operation of the system, and particularly prison, is largely anti-therapeutic. The competing philosophies of punishment and treatment, and the differing aims of criminal justice and mental health, preclude smooth integration of health and justice services for those who have high and complex mental health needs. The $14 million pilot programme attempts to address treatment and reintegration both within and outside prison, but it is a small part of the wider process, has uncertain funding and is putting pressure on already stretched community mental health services. The impact of prison itself on the mental health of prisoners exacerbates pre-existing mental disorder and substance abuse. Therefore, if the rate of imprisonment continues to climb, the success of any new initiatives will be severely compromised. It follows that an important part of any reform to better support defendants and detainees with mental health problems is to address the rising prison population and the policies that are driving it.

Ngā Whenu Raranga/Weaving strands: #4. The Challenges Faced by Te Whare Whakapiki Wairua/The Alcohol and Other Drug Treatment Court, Auckland, NZ: University of Auckland, 2017.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system of Poland

Małgorzata Wąsek-Wiaderek & Paulina Duda[*]

1 Introduction

The Polish system of criminal justice provides for two main procedural paths for conducting criminal proceedings against a person with mental disturbances. With reference to insane defendants, that is, defendants who cannot be held criminally responsible, the proceedings will be discontinued. They cannot be punished, although they may be subjected to preventive measures if they pose a threat to others. The second path concerns defendants with mental disturbances whose ability to recognize the meaning of their acts is diminished but not excluded. They may be found guilty and punished but the court has the discretion to mitigate the severity of the sentence imposed. They may also be subjected to preventive measures, for example, placement in a psychiatric institution, which is imposed additionally to the penalty of imprisonment. Such defendants are assigned with ordinary criminal trial but, like defendants belonging to the first group, have a right to a mandatory defence. Additionally, the second path concerns defendants who committed serious crimes in connection with a disorder of sexual preferences. They may be found guilty and punished. However, preventive measures, including a psychiatric detention, can be imposed on them besides the penalty of imprisonment.

Special needs of detainees with mental disturbances is addressed by the Polish Code of Criminal Procedure of 1997 (consolidated text published in Journal of Laws of 2017, item 1904, with amendments, thereafter referred to as 'the CCP') and the Executive Penal Code of 1997 (consolidated text published in Journal of Laws of 2018, item 652, thereafter referred to as 'the EPC').

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The purpose of this essay is to give a general overview of the legal framework that applies to defendants with psychiatric disturbances in Poland. We will also outline the most important flaws in practice which have developed in the process of application of this legal framework.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

2.1 Pre-trial stage of the proceedings

In accordance with the CCP, the pre-trial stage of the criminal proceedings may take the form of investigation (*śledztwo*) or inquiry (*dochodzenie*). In principle, the investigation is conducted with reference to felonies and more serious misdemeanours.[1] In order to obtain the status of a suspect (*podejrzany*) in the course of investigation, a person must be acquainted with a formal decision to bring charges against him/her and be heard as a suspect. In the course of inquiry, charges may be presented to a suspected person also orally, during an interrogation. Thus, in order to obtain the procedural status of a suspect, a suspected person (*osoba podejrzana*) must be heard by a procedural organ after being served with the charges. Before the first interrogation the 'letter of rights and duties' shall be handed over to the suspect. In accordance with the standard form of the interrogation of a suspect, before its commencement, a public prosecutor or a police officer shall inquire whether suspect's mental or physical health is in order. Any reference to mental problems made by a suspect or noticed by a procedural organ *ex officio* shall be written down in the minutes of the interrogation and taken into account by appropriate authorities since reasonable doubts as to the mental state of a suspect must result in adequate procedural steps. In particular, in accordance with the Directives issued by the Police Commander in Chief, before conducting the interrogation of a suspect, a police officer shall acquaint himself/herself with all information concerning the case and the person who will be interrogated. Furthermore, a police officer shall establish whether an interrogation shall be conducted in the presence of an expert in psychology, psychiatry or another medical

1 See more information on the Polish criminal justice system: P. Kruszyński, 'The investigative stage of criminal process in Poland', in: Ed Cape, Jacqueline Hodgson, Ties Prakken & Taru Spronken (eds), *Suspects in Europe. Procedural Rights at the Investigative Stage of the Criminal Process in the European Union*, Cambridge: Intersentia Publishers, 2007, pp. 181-206; Dorris de Vocht, 'Report on Poland', in: Ed Cape, Zaza Namoradze, Roger Smith & Taru Spronken (eds), *Effective Criminal Defence in Europe*, Cambridge: Intersentia Publishers, 2010, pp. 425-488.

expert.[2] As transpires from § 38 of the Directives, if a suspect's behaviour during an interrogation causes doubts on his/her sanity and a continued interrogation could breach the suspect's rights, a police officer shall suspend the interrogation and transfer the case-file to a public prosecutor with a motion for appointment of two psychiatric experts in order to examine the suspect's sanity. Despite the above-mentioned rules, early identification of a suspect as a vulnerable person does not work properly in practice.[3]

Pursuant to Article 79 § 1 (3) of the CCP, a defendant must be represented by the defence counsel if there are good reasons to doubt his sanity *tempore criminis*, that is if there is justified doubt as to his ability to understand the meaning of his deed or to control his behaviour, at the time of committing the offence. Furthermore, the participation of a defence counsel in the proceedings is obligatory if there is justified doubt whether the conditions of a defendant's mental health allow him to participate in the proceedings or to conduct his defence in an independent and reasonable manner (Art. 79 § 1 (4) of the CCP). Thus, doubts as to the sanity of a suspect *tempore criminis* or doubts as to his/her mental state *tempore procedendi* shall result in immediate appointment of an *ex officio* defence counsel if a suspect is not represented by a defence counsel of his own choosing. In the Polish criminal procedure, an *ex officio* defence counsel may be appointed only by a court, the president of the competent court or the court referendary. Agencies conducting an investigation or an inquiry are not entitled to such appointment. As emerges from § 11(4) of the Regulation of the Minister of Justice of 27 May 2015,[4] in cases of mandatory defence, the investigating agency shall submit the motion for an appointment of an *ex officio* defence counsel to the competent court without delay. Article 81a § 2 of the CCP stipulates that such motion shall be examined immediately.

According to the case law of the Polish Supreme Court, doubts as to a defendant's mental state may be justified, inter alia, by a mental illness, brain trauma, another illness that can lead to psychological changes,[5] the fact that a suspect's insanity or limited sanity was established in other criminal proceedings,[6] a psychopathy, mental retardation or

2 See § 17 of the Directives no. 3 of the Police Commander in Chief concerning selected investigating activities conducted by the Police, issued on 30 August 2017 (Official Journal of the Police Commander in Chief of 2017, item 59).

3 See cases examined by the Polish Commissioner for Human Rights: Jolanta Nowakowska, *Wczesna identyfikacja osób wymagających szczególnego traktowania, będących uczestnikami postępowania karnego*, in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jednostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, pp. 149-172.

4 *Journal of Laws* of 2017, item 53.

5 Supreme Court, judgment of 12 April 1972, IV KR 26/72, Bulletin of the Supreme Court 1972, no. 9, item 173. , SN I KR 47/79, OSNPG 1979, no. 173.

6 Supreme Court, judgment of 15 September 2010 r., IV KK 425/09, LEX no. 603806.

damage to the central nervous system,[7] previous epilepsy episodes,[8] deviation from the norm in the accused's behaviour,[9] sexual dysfunctions, long-term or compulsive alcohol abuse, abuse of psychotropic substances, a lack of rational justification for committing the offence or inadequate motivation.[10]

In case of doubts as to the suspect's mental health arising at the pre-trial stage of the proceedings, the public prosecutor shall appoint at least two psychiatric experts to deliver a psychiatric opinion (Art. 202 of the CCP). It should contain information on the mental state of the suspect at the moment of committing the offence, as well as on his mental state at the time of and his ability to participate in the proceedings, and, if necessary, also the information on whether there is a need to apply preventive measures, including psychiatric detention (Art. 202 § 5 of the CCP). Upon the request of psychiatric experts, a suspect may be placed in psychiatric hospital for observation for a period no longer than 4 weeks. In exceptional circumstances, his placement might be extended. The entire period of observation in each case shall not exceed 8 weeks. It is in the court's discretion to decide on the need for observation and specify its location and duration. It is worth stressing that compulsory observation in a medical institution may be ordered only if the collected evidence indicates a high probability that the suspect has committed an offence (Art. 203 of the CCP).

Article 79 § 3 of the CCP provides that in case of mandatory defence the participation of a defence counsel is obligatory at the trial and during the sessions of the court (*posiedzenia*) which require the participation of the accused. Although the wording of this provision suggests that mandatory defence applies only to the judicial (trial) stage of the proceedings, it is obvious that a suspect with mental disabilities must be assisted by the defence counsel once the justified doubts as to his/her mental state arise for the whole duration of the case. However, pursuant to Article 79 § 4 of the CCP, if the court finds that the opinion of expert psychiatrists is substantiated and the suspect's sanity *tempore criminis* and *tempore procedendi* was not excluded or significantly reduced, it may decide that the participation of the defence counsel in the proceedings is no longer obligatory. In such circumstances, the president of the court discharges the defence counsel from his duties, unless there are other reasons for the suspect to have a defence counsel appointed *ex officio*. Confirmation of mental disabilities of a suspect by psychiatric experts results in mandatory defence for the entire course of the proceedings (until final adjudication of the case).

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7 Supreme Court, judgment of 5 March 1980, V KRN 34/80, OSNPG 1981, no. 1, Item 13.

8 Supreme Court, judgment of 15 September 2005, II KK 2/05, LEX no. 157541.

9 Supreme Court, judgment of 20 June 1986, III KR 154/86, OSNPG 1987, no. 4, Item 50.

10 See Ryszard A. Stefański, *Obrona obligatoryjna w polskim procesie karnym*, Warsaw: Wolters Kluwer, 2012, pp. 140-146.

As was mentioned earlier, a suspect shall be granted obligatory defence from the moment when the investigating agency begins to doubt his or her sanity. Although such assessment shall take place as soon as possible, it is up to the public prosecutor to decide on the appointment of psychiatrists for the examination of a suspect's mental health. As a rule, such appointment takes place after the first interrogation of a suspected person as a suspect. Thus, a suspect who is vulnerable due to his or her mental disability is usually interrogated for the first time without the assistance of a defence counsel. As already stated, a suspect is informed in writing of the right to silence and the right to be represented by a defence counsel of his or her own choosing or appointed *ex officio*. However, he or she may not be able to understand the meaning of such information due to mental disability.[11] Unfortunately, the Polish law on criminal procedure does not provide for a postponement of a suspect's interrogation until appointment of an *ex officio* defence counsel, even in the case of obligatory defence. In accordance with Article 301 of the CCP, the first interrogation should be conducted with the participation of the appointed defence counsel at the request of a suspect. This means that a suspect must appoint a counsel of his own choice before the first interrogation in order to take advantage of his right to be assisted by the defence lawyer during the first interrogation. If he or she is not able to pay for legal assistance, he may request appointment of an *ex officio* defence counsel. However, the investigating organ is not obliged to postpone investigating activities, including the first interrogation, until the examination of the suspect's request for *ex officio* defence counsel. In the majority of cases, even if the investigating organ is informed by a suspect of his or her mental problems during the first interrogation, which should result in appointment of an *ex officio* defence counsel under the mandatory defence scheme, the first interrogation is not postponed until such appointment. Moreover, the suspect's statements given during the first interrogation without assistance of a defence counsel may be used in the course of the trial (Art. 389 § 1 of the CCP).[12]

2.2 Trial stage of the proceedings

The rules described earlier, which concern mandatory defence for a suspect with mental disabilities as well as the obligation to appoint psychiatric experts in order to establish

11 See ECtHR, Judgment of 31 March 2009, *Płonka v. Poland*, Appl. 20310/02, para. 36-42. The ECtHR found that the applicant, a person suffering from an alcohol problem for many years, was not able to understand consequences of a decision to waive her right to defense and her right to silence.

12 See critical analysis of a suspect's right to defense during the first interrogation: Sławomir Steinborn & Małgorzata Wąsek-Wiaderek, 'Moment uzyskania statusu biernej strony postępowania karnego z perspektywy konstytucyjnej i międzynarodowej', in: Maria Rogacka-Rzewnicka, Hanna Gajewska-Kraczkowska & Beata T. Bieńkowska (eds), *Wokół gwarancji współczesnego procesu karnego. Księga Jubileuszowa Profesora Piotra Kruszyńskiego*, Warsaw: Wolters Kluwer, 2015, pp. 429-455.

his/her mental state apply accordingly to the judicial stage of the proceedings. The content of the opinion of psychiatric experts is decisive for the further course of the case since the defendant cannot be criminally responsible if he was insane *tempore criminis*. In accordance with Article 31 of the Criminal Code of 1997 (consolidated text: Journal of Laws of 2017, item 2204, with amendments, thereafter referred to as 'the CC'), whoever was incapable of recognizing significance of the prohibited act or controlling his conduct because of a mental disease, mental deficiency or other mental disturbance, shall not commit an offence (the state of insanity of the defendant). If at the time of the commission of an offence the ability to recognize the significance of the act or to control one's conduct was diminished to a significant extent, the court may apply an extraordinary mitigation of the penalty. However, these rules shall not be applied when the perpetrator has brought himself to a state of insobriety or intoxication, causing the exclusion or reduction of accountability which he has or could have foreseen.

The state of insanity, as defined in Article 31 § 1 of the CC, may be established already at the pre-trial stage of the proceedings on the basis of an opinion of psychiatric experts. Thus, if there is no need to put a suspect in psychiatric detention for preventive purposes or to apply other preventive measures, the criminal proceedings shall be discontinued by the decision of the public prosecutor based on Article 17 § 1 (2) of the CCP. However, if there are grounds to apply preventive measures, the public prosecutor shall refer the case to the court with the motion to discontinue the proceedings (Art. 324 of the CCP) since only a court is competent to apply preventive measures to an insane defendant.

The most severe preventive measure is a psychiatric detention in a closed psychiatric institution. It may be applied only if it is highly probable that, due to his or her mental state, a defendant may commit again criminal acts of serious social danger (Art. 93g § 1 of the CC). As mentioned earlier, the risk of posing a threat to others should be assessed by a panel of at least two psychiatric experts. A psychiatric detention may be imposed on the following defendants, if they pose a threat to the society:

1) Insane persons.
2) Persons with diminished sanity, if they are sentenced to the penalty of imprisonment, the penalty of 25 years of imprisonment or the penalty of life imprisonment. Placement in the psychiatric institution may take place only if there is a high risk that a defendant will commit a criminal act of a significant social danger in connection with his/her mental illness or mental disturbances.
3) Persons who committed a serious criminal offence in connection with a disorder of their sexual preferences, if they are sentenced to the penalty of imprisonment, the penalty of 25 years of imprisonment or the penalty of life imprisonment (Art. 93g of the CC). Placement in the psychiatric institution may take place only if there is a high risk that a defendant will commit a criminal act against life, health or sexual freedom in connection with disturbances in his/her sexual preferences.

In general, other preventive measures (like therapy, addiction therapy or electronic control of a defendant's stay) may be applied after serving a prison sentence by a defendant or after releasing a defendant from psychiatric detention (Art. 93d of the CCP).

A special, reduced criminal procedure may be followed only with reference to insane persons. As a rule, a public prosecutor's motion for discontinuation of criminal proceedings due to the insanity of the accused and for the application of preventive measures (Art. 324 of the CCP) shall be examined by the court at the trial. However, if the evidence collected at the pre-trial stage of the proceedings confirms the perpetration of the offence by the accused and his insanity at the moment of committing the offence does not give rise to any doubts, the motion may be examined at a session of the court without opening of the main trial. Participation of the public prosecutor and the defence counsel in the court's session is obligatory.[13] Also the defendant shall participate in the court's session, unless, following a psychiatric opinion, his participation would be inadvisable (Art. 354 of the CCP). Pursuant to the law, an examination of the case brought against the insane defendant at the court's session shall be an exception to the general rule of submitting such case to a full trial. However, in practice, the majority of motions for discontinuation of the criminal proceedings due to insanity of the accused is examined at court's sessions. This is confirmed by research conducted in 13 district courts in Poland referring to data collected from 2006 until 2011. During this period of time, public prosecutors submitted 180 motions for discontinuation of the proceedings and application of psychiatric detention. Only 38 motions (21.1%) were examined at the full trial while 78.9% of cases were examined at courts' sessions.[14] In accordance with Article 354a of the CCP, before taking the decision concerning the application of a preventive measure of psychiatric detention, the court should hear the psychologist and psychiatric experts.

Defendants belonging to the second and third group (i.e. persons with diminished sanity and persons who committed a serious criminal offence in connection with a disorder of their sexual preferences) are judged at an ordinary criminal trial. However, before applying preventive measures, the court must hear the psychologist and, in some cases, also psychiatrists, who issued an opinion on the defendant's state of health. With reference to defendants who have committed a criminal offence due to a disorder of their sexual preferences, the court shall additionally hear an expert on sexology (Art. 354a of the CCP). Whenever psychiatric experts confirm defendant's insanity or diminished sanity, he or she must be represented by the mandatory defence counsel during the judicial proceedings. The opinion of psychiatrists may also indicate that even though the suspect had full ability to recognize the meaning of the prohibited act and to control his conduct *tempore criminis*,

13 Supreme Court, judgment of 5 October 2005, II KK 139/05, LEX no. 157553.

14 Małgorzata Pyrcak-Górowska, *Detencja psychiatryczna orzekana jako środek zabezpieczający w świetle badań aktowych*, Kraków: Krakowski Instytut Prawa Karnego, 2017, pp. 233, 291.

he is unable to participate in the criminal proceedings due to his mental condition. As already mentioned, this is a separate and independent ground for mandatory defence of the accused. Moreover, if the defendant cannot participate in the proceedings due to his mental illness or because of any other serious disorder, the criminal proceedings shall be suspended for as long as such an impediment exists. During the period of suspension, adequate measures shall be applied in order to protect evidence against loss or distortion (Art. 22 of the CCP).

3 Detainees with psychiatric disturbances in provisional detention: needs, problems, screening tools

A suspect arrested by the police shall be instructed to a medical screening if the information at the disposal of the police or the circumstances of an arrest indicate that the suspect suffers from psychiatric disturbances.[15] Such medical examination shall be carried out by the general practitioner; there is no requirement to bring an arrested person to a psychiatrist. This is rightly criticized by the Polish Commissioner for Human Rights who argued that with reference to suspects revealing psychiatric disturbances the opinion on whether he should be placed in police arrest should be issued by a psychiatrist.[16]

In accordance with Article 259 of the CCP, in the absence of exceptional reasons indicating otherwise, detention on remand should not be ordered if the deprivation of liberty of the accused might give rise to a serious danger to his life or health. As transpires from the case law, the court may refuse the application of detention on remand relying on defendant's state of health only if he or she would not be provided with adequate medical care at the detention centre.[17] Thus, Article 259 of the CCP shall be applied with regard to Article 260 of the CCP which states as follows:

15 § 1 (3) d of the Ordinance of the Minister of Interior Affairs of 13 September 2012 concerning medical examination of arrested persons; *Journal of Laws of 2012*, item 1102.

16 Jolanta Nowakowska, 'Wczesna identyfikacja osób wymagających szczególnego traktowania, będących uczestnikami postępowania karnego', in: Ewa Da- widziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jednost- kach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, p. 158.

17 Supreme Court, judgment of 12 April 2011, II KK 254/10, OSNwSK 2011, item 724; Kraków Court judgment of Appeal of 12 November 2009, II AKz 475/09, Krakowskie Zeszyty Sądowe 2019, no. 1 item, 25. See also Krzysztof Dąbkiewicz, *Tymczasowe aresztowanie*, Warsaw: LexisNexis, 2012, p. 131.

> [I]f the health of the defendant so requires, detention on remand may be served solely in an appropriate medial institution, including psychiatric institution.[18]

The Regulation of the Minister of Justice of 16 June 2015[19] issued on the basis of Article 260 § 2 of the CCP currently lists 86 medical institutions, all of them located in the framework of the penitentiary facilities. Among them, there are only 6 penitentiary facilities providing 24-hour psychiatric care for inmates, with total capacity of 72 inmates.[20] Thus, the Regulation allows for placement of detainees with mental disabilities in psychiatric institutions outside the penitentiary system if they offer appropriate security conditions (§ 2 (2) of the Regulation) but does not list such institutions.

Article 260 of the CCP corresponds with the content of Article 213 of the EPC stating that in cases mentioned in the CCP, detention on remand shall be executed outside a detention centre, in a medical institution indicated by the agency at the disposal of which the accused person remains. This agency shall also define the conditions of the defendant's detention in such an institution. Thus, there are no legal obstacles in placing a detainee with mental disorder in a psychiatric hospital outside the prison system. However, Article 213 § 2 of the EPC states that the costs of the stay of a detainee in such an institution should be borne by an agency at the disposal of which a detainee remains. For this reason, procedural agencies prefer placing a detainee in psychiatric facilities within the prison system which is much cheaper than psychiatric care outside penitentiary facilities. Furthermore, as indicated earlier, the Regulation issued on the basis of Article 260 § 2 of the CCP does not list psychiatric institutions functioning within the general scheme of public medical care. This was criticized by the Polish Commissioner for Human Rights in his general intervention addressed to the Ministry of Justice. In the opinion of the Minister of Justice, despite the lack of a list of psychiatric institutions, there are no legal obstacles to placing detainees in hospitals outside the prison system. He explained that the list is not necessary since it would only restrict the court's discretion to indicate the appropriate medical institution. In 2016, the total number of detainees hospitalized in such institutions was 87.[21]

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18 Adam Kwieciński, 'Wybrane problemy związane ze stosowaniem i wykonywaniem tymczasowego aresztowania woec osób z zaburzeniami psychicznymi', in: Leszek Bogunia (ed), *Nowa Kodyfikacja Prawa Karnego, Vol. XXVI*, Wrocław: Wrocław University Publishing House, 2010, pp. 157-158.

19 *Journal of Laws of 2016*, item 1733, with amendments.

20 See information provided in the letter of the Polish Commissioner of Human Rights to the Minister of Justice concerning change of regulations concerning persons with psychiatric problems in detention centres; document issued on 29 July 2016, at: www.rpo.gov.pl (last visited: 15 June 2018).

21 See Ewelina Brzostymowska, 'Osoby pozbawione wolności z niepełnosprawnością psychiczną', in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jed- nostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, pp. 195-196.

In accordance with the law in force until 30 June 2015, admitting a detainee with acute psychosis to the detention centre was prohibited. The new Ordinance of the Minister of Justice of 23 June 2015 with binding force as from 1 July 2015[22] allows for admitting such persons to a detention centre. However, they shall be immediately provided with adequate medical assistance. New rules have caused many practical difficulties; in particular, they resulted in moving detainees from one detention facility to another. From 1 July 2015 until 31 May 2016, in order to provide detainees with appropriate psychiatric care, immediately after admission, that is on the day of admission to a detention centre, 25 detainees had to be transported to another detention facility, 46 detainees had to be temporarily placed in another detention facility and 27 detainees had to be placed in a psychiatric institution outside the prison system.[23]

As previously discussed, an insane defendant cannot be held criminally responsible but he might be a subject of preventive measures, including psychiatric detention. Execution of this preventive measure may take place in special psychiatric institutions that offer appropriate psychiatric care and security conditions. In every case, such an institution is indicated by the court upon obtaining an opinion of the Psychiatric Commission, acting in accordance with Article 201 of the EPC. However, pursuant to Article 264 of the CCP, if a preventive measure of psychiatric detention has been imposed with a final decision, a defendant may be kept in an ordinary detention centre until the enforcement of the preventive measure. It usually takes some time to find a closed psychiatric institution appropriate for execution of this measure. A practice of keeping insane defendants in a regular detention centre pending their transfer to a hospital had been found incompatible with Article 5 § 1 of the ECHR in a few cases against Poland. The ECtHR underlined that "it would be unrealistic and too rigid an approach to expect the authorities to ensure that a place is immediately available in a selected psychiatric hospital. However, a reasonable balance must be struck between the competing interests involved. […] in striking this balance particular weight should be given to the applicant's right to liberty".[24]

In *Mocarska v. Poland*, the ECtHR found that a delay of 8 months in admission of a person to a psychiatric hospital cannot be accepted. Similar conclusion was reached with reference to a period of 2 months and 25 days in *Pankiewicz* case[25] and almost 5 months

22 The Ordinance of the Minister of Justice on administrative activities concerning detention on remand and execution of imprisonment and their documentation, thereafter referred to as "the Ordinance"; *Journal of Laws 2015*, item 927, with amendments.

23 Ewelina Brzostymowska, 'Osoby pozbawione wolności z niepełnosprawnością psychiczną', in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jednostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, p. 192.

24 ECtHR, Judgment of 6 November 2007, *Mocarska v. Poland*, Appl. 26917/05, para. 47.

25 ECtHR, Judgment of 12 February 2008, *Pankiewicz v. Poland*, Appl. 34151/04, para. 45.

in *Kumenda* case.[26] Until 1 July 2015 the CCP had not specified a time limit for keeping an insane person in a regular detention centre awaiting enforcement of preventive measures for psychiatric detention. In order to execute the judgments of the ECtHR in the earlier-mentioned cases, Article 264 § 3 of the CCP has been designed to provide that a detention on remand pending enforcement of such a preventive measure may be applied no longer than 3 months with the possibility of extension, in a particularly justified case, for another month. However, such detention on remand must be served in the conditions allowing for an adequate rehabilitation or resocialization, as well as medical and therapeutic treatment.[27]

As emanates from data collected by the Polish Commissioner for Human Rights, on 5 January 2017 only five insane defendants were waiting for placement in a closed psychiatric hospital in order to enforce preventive measure. The average period of application of detention on remand pending enforcement of psychiatric detention amounted to 1to 2 months.[28] So, currently this temporary measure is not overused.

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

In Poland, there are four types of correctional facilities (prisons and detention centres): (1) juvenile correctional facilities; (2) correctional facilities for first-time convicts; (3) correctional facilities for recidivists (repeat offenders) and (4) correctional facilities for persons serving a military detention sentence (Art. 69 of the EPC). Pursuant to Article 70 of the EPC, prisons are organized as: (1) closed prisons; (2) semi-open prisons; or (3) open prisons. These listed types of prisons differ, in particular, in terms of security level, isolation of convicts and movements inside and outside the facility. Following Article 81 of the EPC, a sentence of imprisonment is served under the following regimes: (1) programmed treatment; (2) therapeutic regime; or (3) ordinary regime.

In accordance with the law, every prisoner is first admitted to a detention centre and placed in a transitional cell pending a decision of the Penitentiary Commission to transfer him/her to an appropriate type of prison (Art. 70 of the ECP). In every case, the court that issued a judgment shall submit to a detention centre all information relevant for the

26 ECtHR, Judgment of 8 June 2010, *Kumenda v. Poland*, Appl. 2369/09, para. 30-33.

27 Amendment to the CCP introduced by the Law of 27 September 2013 with binding force as from 1 July 2015; *Journal of Laws 2013*, item 1247.

28 Ewelina Brzostymowska, 'Osoby pozbawione wolności z niepełnosprawnością psychiczną', in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jednostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, p. 202.

identification and classification of an inmate, including medical and psychological opinions gathered in the course of criminal proceedings (Art. 11 § 2 of the EPC).[29] All convicts and detainees who enter a detention centre are asked about their state of health (Art. 79a of the ECP) and promptly examined by a doctor (Art. 79b of the ECP, Art. 101 of the EPC; § 9 (3) of the Ordinance on Detention;[30] § 9 (1) of the Ordinance on Imprisonment[31]). Such medical examination shall take place within 3 days from the admission to a detention facility. There is no requirement that such initial examination shall be carried out by a psychiatrist.[32] If the initial examination does not give an answer to all questions concerning a detainee's health, a prison's general practitioner might refer him/her to a specialist. At this stage it may be necessary to obtain a professional psychiatric opinion, which may affect further treatment of a detainee – placement in a suitable medical institution or, as will be explained later, even suspension or adjournment of the execution of proceedings.[33] It is also worth pointing out that, according to §§ 12 and 13 of the Ordinance of the Minister of Justice of 14 June 2012, inmates suffering from mental illness may be referred by a psychiatrist or the general practitioner of a prison to a psychiatric ward of a prison in order to widen diagnosis by carrying out appropriate examinations. However, it is important to emphasize that psychiatric wards in prisons are places for short-term stays, so it is not possible to treat chronic psychosis there, because isolation of a patient does not help him improve.[34] To summarize, the time spent in a transitional cell is important for persons with mental disabilities. It gives them the opportunity to adapt to the conditions of deprivation of liberty and allows for carrying out further psychiatric examination of an inmate, if it appears necessary, before making a decision regarding prisoner's classification.

As acknowledged earlier, § 34 of the new Ordinance of the Minister of Justice of 23 June 2015[35] does not exclude admission to a detention facility of a prisoner suffering from acute psychosis and requiring immediate hospitalization. Such a person shall be immediately provided with appropriate medical care and a place in the psychiatric ward of a prison

29 See Piotr Pałaszewski, 'Przyjęcie tymczasowo aresztowanych do aresztu śledczego', in: Leszek Bogunia (ed), *Nowa Kodyfikacja Prawa Karnego. Tom XXV*, Wrocław: Wrocław University Publishing House, 2009, pp. 225-227.

30 The Ordinance of the Minister of Justice of 22 December 2016 concerning order and organization of execution of detention on remand, *Journal of Laws of 2016*, item 2290.

31 The Ordinance of the Minister of Justice of 21 December 2016 concerning order and organization of execution of a penalty of imprisonment; *Journal of Laws of 2016*, item 2231.

32 See § 4 (1) of the Ordinance of the Minister of Justice of 14 June 2012 concerning medical assistance provided to persons deprived of liberty (consolidated text: *Journal of Laws 2017*, item 2131).

33 Adam Kwieciński, 'Wybrane problemy związane ze stosowaniem i wykonywaniem tymczasowego aresztowania woec osób z zaburzeniami psychicznymi', in: Leszek Bogunia (ed), *Nowa Kodyfikacja Prawa Karnego, Vol. XXVI*, Wrocław: Wrocław University Publishing House, 2010, p. 159.

34 Dorota Rogala, Aleksandra Banach, Dorota Jachimowicz- Gaweł, Żaneta Skinder & Małgorzata Leźnicka, 'Health care system for persons detained in prisons in Poland', 40 *Hygeia Public Health* 4 (2013), p. 443.

35 The Ordinance of the Minister of Justice on administrative activities concerning detention on remand and execution of imprisonment and their documentation; *Journal of Laws 2015*, item 927, with amendments.

hospital (§ 35 of the Ordinance). Because not all detention facilities have psychiatric wards, prisoners requiring immediate hospitalization must be promptly relocated to another detention centre which may have a negative impact on their mental health and could generate significant costs.[36]

Article 82 of the EPC provides that, in order to create adequate conditions of individual treatment and ensuring safety in prison, convicts are divided into classes following, inter alia, their physical and mental health, including level of dependence on alcohol, intoxicating or psychotropic substances, degree of demoralization and social threat and the type of offence committed.[37] For the purpose of such classification, prisoners revealing psychiatric disturbances are subjected to an obligatory psychological examination conducted by a psychologist who issues a 'psychological-penitentiary' statement.[38] Moreover, pursuant to Article 83 of the EPC, inmates undergo psychiatric examination if it appears to be necessary. However, their consent must be sought before such an examination. If an inmate refuses to consent, the penitentiary judge may order psychiatric and psychological examination even against his/her will.

As a rule, such examination is carried out in diagnostic centres in detention wards. These are professional institutions consisting of experienced specialists in various areas (psychiatry and psychology), providing a complex diagnosis of the mental health of a detainee. In principle, the term of the observation/examination shall not exceed 2 weeks, but may be prolonged for a defined period after a penitentiary judge has been notified.[39] The results of the examination are presented in a psychiatric opinion (in case of a psychiatric examination) or in a psychological-penitentiary statement. In addition to the diagnosis on mental health and its assessment, the opinion shall indicate recommendations for further psychiatric care. On the other hand, in accordance with § 4 of the Ordinance of 14 March 2000, the psychological–penitentiary statement should also explain the process and degree of demoralization and vulnerability of a prisoner. The information obtained in this way forms the basis for the placement of a person in an adequate penitentiary facility and the application of an appropriate regime of imprisonment.

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36 See General petition of the Commissioner for Human Rights to the Minister of Justice of 29 July 2016, IX.517.2.2015.JN, (at: www.rpo.gov.pl/pl/content/wystapienie-do-ms-ws-zmiany-rozporzadzenia-dot-ochrony-osob-pozbawionych-wolnosci-z-niepelnosprawnoscia-intelektualna) (last visited: 20 May 2018).

37 For details, see J. Pomiankiewicz, *The Polish penitentiary system*, (at: www.internationalpenalandpenitentiaryfoundation.org/Site/documents/Stavern/25_Stavern_Report%20Poland.pdf) (last visited 20 May 2018).

38 See § 11 of the Ordinance of the Minister of Justice of 14 August 2003 concerning penitentiary activities in prisons and detention centres (consolidated text: *Journal of Laws 2013*, item 1067).

39 See § 2 (4) and (5) of the Ordinance of the Minister of Justice of 14 March 2000 on the organization and conditions of carrying out psychological and psychiatric examinations in diagnostic centres (*Journal of Laws of 2000*, no. 29, item 369.

It is noted in the literature that observations made in such establishments are not reliable in terms of determining the possibility of adapting to the conditions prevailing in custody. It is underlined that the conditions in the centres are a bit artificial, and the narrow specialization of employed medical staff may pose a risk of schematic attitude in an individual case. Staying at a diagnostic centre is not a condition for being subjected to psychiatric or psychological examination. It will be indispensable if there is the need for psychiatric observation.[40] Still, those psychiatric and psychological opinions are used by the Penitentiary Commission in the process of classification of convicts.

Article 96 of the EPC outlines that prisoners suffering from non-psychotic mental disturbances shall serve the sentence of imprisonment under the therapeutic regime which offers special rehabilitation as well as psychological and medical care. Thus, the therapy of an inmate shall have priority over other aims of imprisonment. To conduct a therapeutic treatment, a director of a prison may allow for execution of imprisonment in accordance with special rules, conditioned by a type of mental disability of an inmate and deviating from general rules of order applied in prison.[41] On 31 March 2018, the total number of prisoners serving their sentence under the therapeutic regime due to non-psychotic mental disturbances or intellectual impairment was 3155 (i.e. 4.63% of all convicts) while on 31 March 2017 this was 3229 (i.e. 4.72% of all convicts).[42]

The Executive Penal Code lists three procedural measures which may be applied on prisoners suffering from severe mental disturbances. First, in accordance with Article 15 § 2 of the EPC, if there is a long-lasting obstacle to serving a penalty of imprisonment due to psychiatric disorder or any other severe illness, the execution of a penalty shall be suspended until removal of this obstacle. This measure may be applied only exceptionally. Although there is no definition of 'long-lasting' illness, some authors indicate that it should last at least 6 months or even for 1 year.[43] Furthermore, under Article 150 of the EPC, a court shall adjourn the execution of a penalty of imprisonment with reference to a prisoner suffering from a severe psychiatric disturbance, if it endangers his life or causes severe danger to his health. In case of exacerbation of mental illness during execution of a penalty, a penitentiary court shall decide to break the serving of the sentence (Art. 153 in conjunction

40 Adam Kwieciński, 'Prawne podstawy badań psychologicznych i psychiatrycznych skazanych w toku wykonywania kary pozbawienia wolności', in: Leszek Bogunia (ed), *Nowa Kodyfikacja Prawa Karnego. Tom XXIII*, Wrocław: Wrocław University Publishing House, 2008, p. 140.

41 § 27 (2) of the Ordinance of the Minister of Justice of 21 December 2016 concerning order and organization of execution of prison sentence, Journal of Laws of 2016, item 2231. See also Adam Kwieciński, 'Skazani z niepsychotycznymi zaburzeniami psychicznymi', in: Adam Kwieciński (ed), *Postępowanie z wybranymi grupami skazanych w polskim systemie penitencjarnym. Aspekty prawne*, Warsaw: Wolters Kluwer, 2013, p. 162.

42 See statistical information provided by the Central Headquarters of Prison Services (at: https://sw.gov.pl/strona/Statystyka-kwartalna) (last visited 21 June 2018).

43 Kazimierz Postulski, 'Stan zdrowia skazanego w aspekcie zdolności do odbywania kary pozbawienia wolności', *Prokuratura i Prawo* 7-8 (2015), pp. 172-173.

with Art. 150 § 1 of the EPC) for the time necessary to improve a prisoner's mental health. Since this measure constitutes derogation from the principle of continuity of execution of a custodial sentence, it must be interpreted strictly.[44] Priority should be given to providing a prisoner with adequate medical treatment in a prison hospital and only if such treatment is impossible a penitentiary court shall apply Article 153 of the EPC.[45] It is necessary to obtain the opinion of two experts in psychiatry to reach a decision that the current state of mental health of an inmate precludes further execution of the sentence of imprisonment.[46] In 2015 and 2016 penitentiary courts approved altogether 189 motions for a break in execution of a penalty of imprisonment. In 44 cases, a break was granted upon the motion of a head of a penitentiary facility, filed due to the mental illness of an inmate.[47]

The prisoner's right to medical care is guaranteed by Article 115 of the EPC. According to this provision, a prisoner is provided free health services, medicines and sanitary articles. It does not matter whether a prisoner is an insured person within the meaning of Article 2 (1) of the Act of 27 August 2004 on healthcare benefits financed from public funds.[48] If appropriate care cannot be provided by a specialist in a given unit, a prisoner can be placed in another penitentiary facility. Within this scheme, all inmates suffering from mental problems shall be offered treatment in prison. If a psychiatric illness persists, a prisoner shall be placed in a psychiatric hospital inside or, exceptionally, outside a prison. A decision concerning hospitalization of a prisoner in the psychiatric ward of a prison or in an institution outside prison shall be taken by a psychiatrist or general practitioner.[49]

Thus, the legal framework for psychiatric care for prisoners seems to be correct and appropriate. However, the Polish penitentiary system faces practical problems. First, the number of psychiatrists working within the penitentiary system is too low to offer adequate psychiatric treatment to all inmates.[50] Secondly, the number of psychiatric wards of prisons

44 Court of Appeal in Cracow, judgment of 14 January 2016, II AKzw 1136/15.

45 Kazimierz Postulski, 'Stan zdrowia skazanego w aspekcie zdolności do odbywania kary pozbawienia wolności', *Prokuratura i Prawo* 7-8 (2015), pp. 166-167.

46 Court of Appeal in Cracow, judgment of 8 April 2016, II AKzw 298/16, Krakowskie Zeszyty Sądowe 2016, item 44.

47 Ewelina Brzostymowska, 'Osoby pozbawione wolności z niepełnosprawnością psychiczną', in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jed- nostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, p. 203.

48 Kazimierz Postulski, 'Stan zdrowia skazanego w aspekcie zdolności do odbywania kary pozbawienia wolności', *Prokuratura i Prawo* 7-8 (2015), p. 156.

49 See § 13 of the Ordinance of 14 June 2012 concerning medical care of persons deprived of liberty (consolidated text: *Journal of Laws of 2017*, item 2131); See also Roy Walmsley, *Further developments in the prison systems of Central and Eastern Europe: achievements, problems and objectives*, Publication Series No. 41, Helsinki: HEUNI, 2003, p. 402.

50 See Petition of the Commissioner for Human Rights to the Minister of Justice of 29 July 2016, IX.517.2.2015.JN.

providing 24-hour psychiatric treatment is not enough. As stated in the first chapter of this paper, in Poland there are only six penitentiary facilities with psychiatric wards capable of providing psychiatric care to 72 inmates. Thus, in some penitentiary facilities inmates must wait for admittance to the psychiatric ward of a prison for up to 2 months.[51] These wards usually offer only short-term hospitalization. For example, in 2015 these facilities hospitalized 1258 inmates altogether.[52] With reference to inmates suffering from severe psychosis, a penitentiary court shall apply obligatory suspension of execution of a sentence or an obligatory break in its execution (Art. 153 § 1 of the EPC in conjunction with Art. 150 § 1 of the EPC). Despite these regulations, such prisoners are still placed in the penitentiary system. For example, on 5 January 2017, 11 inmates diagnosed as suffering from severe psychosis or schizophrenia were placed in prison facilities. They unsuccessfully applied for a break in the execution of prison sentence.[53] The law quality of psychiatric care provided in Polish prisons and detention centres was condemned in a few judgments of the ECtHR.[54] Examples of improper practice of keeping persons suffering from acute psychosis in inadequate prison conditions are also provided by the Helsinki Foundation for Human Rights.[55]

5 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

Pursuant to Article 2 para. 3 of the Prison Service Act[56] one of the duties of the members of the Prison Service (*Służba Więzienna*) is to ensure that persons in provisional detention and convicts obtain proper healthcare. Hence, the responsibility for the detainees' health falls on prison facilities. On the other hand, inmates placed in psychiatric wards of prisons are subjected to general methods of psychiatric care, including measures of coercion indicated in the Mental Health Act. This has significant consequences for inmates, as, in

51 Ewelina Brzostymowska, 'Osoby pozbawione wolności z niepełnosprawnością psychiczną', in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jed- nostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, p. 191.

52 *Ibid*., p. 209.

53 *Ibid*., p. 208.

54 ECtHR, Judgment of 20 January 2009, *Sławomir Musiał v. Poland*, Appl. 28300/06, para. 97; ECtHR, judgment of 3 February 2009, *Kaprykowski v. Poland*, Appl. 23052/05, para. 72-77; ECtHR, judgment of 24 July 2012, *Wenerski v. Poland (no. 2)*, Appl. 38719/09, para. 48-59.

55 See cases presented at: www.hfhr.pl/en/psychiatric-condition-and-deprivation-of-liberty-hfhr-intervenes-in-case-of-schizophrenia-patient-detained-on-remand/ (last visited: 30 June 2018). See also Report on the Human Rights of persons deprived of liberty, p. 18; Report available at: www.hfhr.pl/wp-content/uploads/2017/05/Report-CPT-FIN.pdf (last visited: 21 July 2018).

56 The Prison Service Act of 9 April 2010, consolidated text: *Journal of Laws 2017*, item 631.

practice, they are primarily perceived as prisoners and secondarily as patients, even in a relationship with a physician.[57] This is well evidenced by a case described by T. Bulenda. During an inspection in a hospital ward of a prison an inmate told him that once he introduced himself to the officers of a prison service as a patient of the hospital, they immediately corrected him by pointing out that he was is not in fact a patient, but a detainee.[58]

Moreover, the EPC sets forth a few solutions which tend to force members of the Prison Services to treat a detainee suffering from psychiatric problems primarily as a prisoner and not as a patient. For instance, the Code provides for the presence of the officers of the Prison Service during a medical examination of persons suffering from non-psychotic psychiatric disturbances (Art. 115 § 7a of the EPC). An officer may leave the room only on the examined person's clear request. In everyday practice, it happens that a detainee is forced to speak about his or her most intimate issues in the presence of someone who is not bound by the doctor-patient privilege.[59]

Yet another problem is the use of means of coercion stipulated in the Mental Health Act towards inmates suffering from psychiatric problems and admitted to the psychiatric wards of prisons. Such measures are sometimes abused. Article 18 (1) of the Mental Health Act[60] includes a closed list of situations justifying the use of coercive measures. They are justified if a person commits an action threatening life or health of another person, other persons or of public security, abruptly destroys or damages property in the close surroundings or gravely violates functioning of a healthcare facility. However, consultations conducted by the representatives of the Polish Commissioner for Human Rights proved that means of coercion were sometimes implemented despite the lack of sufficient prerequisites or were disproportionate to inmates' actions.[61] Another problem connected to this issue is the lack of supervision over the person towards whom the measure of immobilization was applied. Under the Ordinance of the Minister of Health of 28th June 2012,[62] a person towards whom means of coercion were applied shall remain in a single room with no items which may be used to injure the person's body. Such room shall be

57 Maria Niełaczna, 'Problemy systemu penitencjarnego – ocena Stowarzyszenia Interwencji prawnej', in: Ewa Kościelska- Koszur (ed), *Więzienna służba zdrowia- obecny stan dyskusji i kierunki reform*, HFHR Publications, 2013, p. 5.

58 Teodor Bulenda, 'Wątpliwości prawne dotyczące prawa więźniów do opieki medycznej. Kontekst reformowania więziennej służby zdrowia', in: Ewa Kościelska- Koszur (ed), *Więzienna służba zdrowia- obecny stan dyskusji i kierunki reform*, HFHR Publications, 2013, p. 19.

59 Przemysław Kazimirski, 'Służba zdrowia dla osób pozbawionych wolności – z perspektywy Krajowego Mechanizmu Prewencji', in: Ewa Kościelska- Koszur (ed), *Więzienna służba zdrowia- obecny stan dyskusji i kierunki reform*, HFHR Publications, 2013, p. 5.

60 Consolidated text: Journal of Laws of 2017, item 882, with amendments.

61 Ewa Dawidziuk, 'Stosowanie w zakładach karnych i aresztach śledczych przymusu bezpośredniego przewidzianego w ustawie psychiatrycznej', 89 *Przegląd Więziennictwa Polskiego* 4 (2015), pp.100-101.

62 *Journal of Laws of 2012*, item 740.

constantly monitored and a patient shall be inspected every 15 minutes even while asleep. The time of immobilization is specified as well. However, in practice, the supervision over a person kept on the forensic psychiatric ward of the correction unit is limited to checking recordings from cameras installed in the patient's room. Moreover, in some exceptional cases patients remained immobilized even for 70 or 169 hours, while the time limits set forth in the Ordinance mentioned above is 4 hours with the possibility of extension (§ 4 (1)).[63]

All convicts have the right to medical care free of charge (Art. 115 § 1 of the EPC). Nevertheless, under Section 115 § 1a of the EPC a detainee has no right to choose the physician or a nurse of the basic medical care. Thus, if a detainee would like to obtain a medical assistance in another medical facility (outside prison) than offered by prison administration, a director of the prison may exceptionally agree after obtaining an opinion of a doctor providing medical care in a penitentiary facility. This consent may be granted only if prison medical facilities are able to provide a given medical treatment but an inmate would like to have it carried out by a medical staff chosen by him/her.[64] Hence, as a rule, medical care shall be provided to all inmates within the framework of penitentiary system. Only exceptionally, if penitentiary facilities are not able to provide adequate specialized treatment to a detainee, he/she shall be treated in a medical facility outside the prison or detention centre. The comprehensive analyses of the situation of inmates with psychiatric disturbances in prisons, conducted recently by the Polish Commissioner for Human Rights confirm that psychiatric care offered in penitentiary facilities is not satisfactory although it has improved during the last few years.

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

It has already been emphasized that inmates who suffer from non-psychotic conditions and mental disabilities should serve their sentences in the therapeutic system (Art. 96 of the EPC). Such a system enables a detainee to obtain health services and to gain the experience necessary to live independently outside the facility. Moreover, inmates following therapeutic regime are trained in terms of co-existing with the rest of the society. Specific conditions and organization of actions aiming at social rehabilitation of convicts serving their sentences under the therapeutic system are defined in the Ordinance of the Minister of Justice of 14 August 2003 concerning penitentiary activities in prisons and detention

63 Ewa Dawidziuk, 'Stosowanie w zakładach karnych i aresztach śledczych przymusu bezpośredniego przewidzianego w ustawie psychiatrycznej', 89 *Przegląd Więziennictwa Polskiego* 4 (2015), pp. 103-107.

64 See Kazimierz Postulski, *Kodeks karny wykonawczy. Komentarz*, Warsaw: Wolters Kluwer, 2017, p. 621. See also decision of the Court of Appeal in Cracow of 17 April 2013 r., II AKzw 665/13, Lex no. 1311932.

centres. A convict serving his/her sentence under the therapeutic regime shall be signed up for a proper therapeutic ward for persons suffering from non-psychotic psychiatric problems (Art. 15 of the Ordinance). This facility is expected to provide prisoners with personalized correctional programmes as well as programmes motivated by the nature of the facility. Selected convicts may still serve their sentences under the therapeutic regime but in a regular prison facility (outside a therapeutic ward). This is allowed with reference to detainees who obtained a psychological and correctional opinion stating that the correctional treatment may take place outside a professional, therapeutic facility.[65] In such a case, professionally trained staff shall be responsible for the execution of personalized correctional programmes.

According to the literature, it is frequently very difficult to organize a therapeutic treatment outside a therapeutic ward due to the lack of proper conditions. Hence, effectiveness of any treatment conducted outside a professional facility appears to be rather unsatisfactory.[66] Within the therapeutic ward, the schedule of activities is carefully planned, which eliminates the effect of the so-called prison frustration. These activities include: classes improving cognitive and social functioning dedicated to those who suffer from psychiatric problems, training sessions in interpersonal skills, relaxation classes, psychological training sessions and workshops, educational classes, occupational therapy, as well as cultural classes. Each of the activities is conducted in small groups, which enhances the comfort and intimate atmosphere.[67] Unfortunately, the disproportion between the number of therapeutic facilities and the number of detainees remains high. According to the data collected in 2016, out of 156 penitentiary facilities in Poland, only 53 had their own therapeutic wards while the number of detainees serving sentences in these facilities constantly increased (e.g. in 2001 there were 2,169 convicts, while in 2013 there were 3,758).[68]

The individual therapeutic programme applied to a convict shall be dynamic and undergo constant updates depending on specific needs of a person suffering from psychiatric disturbances. Constant monitoring of the progress made by a detainee is necessary to draft a prognosis, which will be taken into consideration during the proceedings concerning conditional release. Individual correctional and therapeutic programmes are indeed the most successful tools of rehabilitation of a detainee.[69]

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65 Kazimierz Postulski, *Kodeks karny wykonawczy. Komentarz*, Warsaw: Wolters Kluwer, 2017, p. 566.

66 *Ibid*.

67 Piotr Braun, 'Osoba niepełnosprawna w izolacji penitencjarnej', 7 *Niepełnosprawność- zagadnienia problemy rozwiązania* 2 (2013), pp. 135-138.

68 Piotr Kozłowski, 'Zróżnicowanie społeczności więźniów, a proces ich resocjalizacji', in: Mieczysław Ciosek & Beata Pastwa- Wojciechowska (eds), *Psychologia Penitencjarna*, Warsaw: PWN, 2016, pp. 202-203.

69 Aldona Nawój-Śleszyński, 'Systemy wykonywania kary pozbawienia wolności i ich potencjał reedukacyjny', 92 *Przegląd Więziennictwa Polskiego* 3 (2016), p. 8.

Reintegration of convicts suffering from psychiatric disturbances after their release constitutes a separate issue. Coming back to their previous environment may be challenging and the risk of committing prohibited acts again is significant. In accordance with Article 169b § 3 of the EPC, convicts with psychiatric disturbances related to the committed crime, shall be classified as belonging to group 'C'. This means that they 'pose increased risk' of committing a criminal act again. Thus, if probative measures (like, for instance conditional release) are applied to those convicts, they are subjected to a close supervision of a professional guardian. Article 169b § 10 of the EPC stipulates a list of actions which shall be applied by a guardian to a convict classified as belonging to group 'C'. The list includes closely cooperating with the police to monitor if the released follows the law; conducting regular community interviews; summoning the released to appear at the office of the guardians' team of the prison service in person and remaining in contact with facilities providing therapy, treatment or other actions fostering rehabilitation.

The EPC lists the following organs as competent to assist prisoners in their re-adaptation process: officers of the Prison Service, staff of incarceration facilities and a court's probation officer. While the aid provided to released convicts by the Prison Service is limited to material support (inter alia, financial benefits, funded tickets, help in obtaining proper documents),[70] the support of a court's probation officer appears to be the most beneficial form of assistance to the convict suffering from psychiatric problems. Pursuant to Article 164 of the EPC, the 6 months prior to the end of the sentence or planned conditional release are crucial to properly prepare a convict for a life after release.[71] A Penitentiary Committee establishes this period when necessary and with a convict's consent. Within this time inmates may contact a court's probation officer. The main task of such a person is to create conditions enabling social re-adaptation of an inmate. A probation officer shall speak with a convict and analyse his/her files. Collecting these data shall enable the court's probation officer to develop the best possible post-release programme (§ 41 (1) (2) of the Ordinance of 13 June 2016).[72] It should address all problems of that person, which may impede the process of rehabilitation, as well as methods of coping with these issues, including the imposition of specific duties.[73] Such duties shall be understood as, for instance, therapy or continuation of psychiatric treatment after release. Implementation of the post-release programme involves the cooperation between a court's probation officer

70 Monika Marczak, 'Przygotowanie do readaptacji społecznej osób osadzonych w jednostkach penitencjarnych', in: Małgorzata Kuć (ed), Lublin: Towarzystwo Naukowe KUL, 2008, p. 264.

71 For details, see Grażyna Barbara Szczygieł, 'Preparation of convicts to be released from prison under Article 164 EPC', 11 *Ius Novum* 2 (2017), pp. 157-164.

72 The Ordinance on the activities of guardians in the process of execution of criminal penalties (*Journal of Laws of 2016*, item 969); Wiesław Liszke, 'Przygotowanie skazanego do życia po zwolnieniu z zakładu karnego przez kuratora sądowego', *Probacja* 3-4 (2009), p. 117.

73 Aleksandra Iwanowska, *Przygotowanie skazanych do życia na wolności w trybie art. 164 k.k.w.*, Warsaw 2013, Publication of The Office of Polish Commissioner for Human Rights, p. 75.

and administrative bodies of a national and local government. Pursuant to Article 41 of the EPC, these bodies are responsible for providing convicts and their families with necessary material and medical help, as well as support in finding employment and accommodation. Unfortunately, such division of responsibilities results in low effectiveness of these actions.[74]

From 2014, inmates who suffer mental disturbances and still pose a threat to others at the end of serving their sentence may not be released but instead placed in special psychiatric establishments. On 22 January 2014, the Act specifying the procedures for dealing with persons with mental disorders who pose a threat to the lives, health or sexual freedom of other persons entered into force.[75] The Act applies to persons who fulfil the following three conditions: (1) they are serving a penalty of imprisonment or a penalty of 25 years of imprisonment under therapeutic regime; (2) in the course of execution of such a penalty they suffered from psychiatric disorders or disorders of their personality or disorders with reference to sexual preferences and (3) these psychiatric disorders were of such nature and intensity that there is at least high probability of committing a criminal act with the use of violence or a threat of violence directed against life, health or sexual freedom and subject to penalty of the maximum statutory sentence of at least 10 years of imprisonment. If the psychiatric and psychological opinion issued with reference to a person fulfilling the first condition (i.e. a person who is serving a penalty of imprisonment or a penalty of 25 years of imprisonment) is pointing to the fact that he/she fulfils the second and the third condition mentioned here, the head of a prison shall file a motion for the institution of court proceedings to establish that a convict shall be classified as 'posing a threat' (Art. 9 of the Act). Such a motion is examined by a competent Regional Court which shall apply the Code of Civil Procedure. In order to establish whether an inmate is 'posing a threat', the court shall appoint two psychiatric experts and an expert in psychology (with reference to persons disclosing personality disorder) and a psychologist and sexologist (with reference to persons disclosing sexual preference disorders) (Art. 11 of the Act). An *ex officio* legal counsel shall be appointed for a convict who does not have a legal counsel of his own choosing (Art. 12 of the Act).

In accordance with Article 13 of the Act, upon the motion of the psychiatrists, the convict may be placed under psychiatric observations for a maximum period of 4 weeks. The above-mentioned procedure may result in: (1) imposing preventive monitoring on the person posing a threat; (2) decision on the placement of such a person in the National Centre for Prevention (thereafter referred to as 'the NCP'), or (3) decision that a person does not pose a threat to the public.

74 Kazimierz Postulski, *Kodeks karny wykonawczy. Komentarz*, Warsaw: Wolters Kluwer, 2017, p. 264.

75 Adopted on 23 November 2013; *Journal of Laws of 2014*, item 24, with amendments.

The preventive monitoring shall be applied if the nature and intensity of psychiatric disorder is pointing to a high risk of committing a crime with the use of violence or a threat of violence directed against life, health or sexual freedom, which is subject to the maximum penalty of imprisonment of at least 10 years. The placement in the NCP shall be ordered if there is a very high risk of committing the earlier-mentioned types of crimes (Art. 14 (2) and (3) of the Act). Duration of application of both measures is not determined in advance.

In accordance with Article 22 of the Act, the preventive monitoring is executed by the head of the competent regional office of the police. The person subjected to this measure is obliged to inform the police about the change of his/her place of residence, his/her name, his/her employment and, upon the request of the police – the dates and places of planned departures. The person subjected to the preventive monitoring may be ordered to undertake appropriate therapy in a medical institution indicated by the court (Art. 16 of the Act).

In accordance with Article 25 of the Act, a person placed in the NCP shall be subjected to therapeutic treatment aimed at improving his/her health and behaviour to allow the functioning of such person in the society. The head of the NCP shall prepare an individual therapeutic programme for every person posing a threat to others. The person placed in the NCP may apply at any time for release from the Centre (Art. 32 (1) of the Act). If the Court refuses to grant the release, its decision may be appealed under certain conditions. The NCP is classified as a medical institution providing therapy for persons posing a threat to others.[76]

In the judgment of 23 November 2016, the Polish Constitutional Court ruled that the measures provided in the Act are of a non-punitive nature.[77] Thus, the provision of the Act which states that it may apply to persons convicted for crimes committed before its entry into force is not inconsistent with the Polish Constitution. In the opinion of the Court this measure is merely indirectly linked with the past of the person posing a threat. The purpose of the isolation is to subject the person to a therapy in a special facility or to preventive monitoring. On no account may such isolation constitute another sentence for an offence committed in the past,' said the Constitutional Court.[78] The Act caused numerous controversies in the medical and psychiatric communities. Its application in practice is

76 See *Report on the Human Rights of Persons Deprived of Liberty*, Helsinki Foundation of Human Rights, May 2017, pp. 22-24 (at: www.hfhr.pl/wp-content/uploads/2017/05/Report-CPT-FIN.pdf) (last visited: 20 July 2018).

77 Case no. K 6/14, OTK-A 2016, item 98.

78 See the press release of the Constitutional Court available at: http://trybunal.gov.pl/en/news/press-releases/after-the-hearing/art/9472-ustawa-o-postepowaniu-wobec-osob-z-zaburzeniami-psychicznymist-warzajacych-zagrozenie-zycia-zd/ (last visited: 3 July 2018).

also criticized by non-governmental organizations.[79] As transpires from daily press, a lawyer of the Helsinki Foundation on Human Rights submitted a complaint to the ECtHR concerning the application of the Act.

7 Conclusion

Polish law seems to shape an adequate legal framework for proper medical and penitentiary treatment of convicts with mental disturbances. The controversies arise mainly with reference to the Act on procedures for dealing with persons with mental disorders who pose a threat to the lives, health or sexual freedom of other persons.

Unfortunately, the recent research and interventions of the Commissioner for Human Rights indicated shortcomings in providing inmates with adequate psychiatric care. As underlined in the third part of this paper, there are not enough psychiatrists in penitentiary facilities. Also, the number of psychiatric wards of prisons is not satisfactory. Prisoners complain that psychiatric treatment provided in penitentiary facilities is of low quality, based mainly on prescription of medicines.

The penitentiary system must also cope with inmates whose mental illness is revealed in the course of serving a prison sentence. On 5 January 2017, there were 69 such inmates placed in all penitentiary facilities in Poland. Although acute and severe psychosis is a ground for ordering an obligatory break in the imprisonment in order to undergo psychiatric treatment, such persons remain within the prison system.[80] This is mainly due to the lack of psychiatric hospitals outside which would fulfil security requirements and could provide inmates, who were granted a break in imprisonment, with adequate psychiatric treatment. Special, closed psychiatric institutions intended for execution of preventive measures with reference to insane defendants are fully occupied and for this reason cannot provide psychiatric treatment to convicts.[81]

On the other hand, during the last few years the penitentiary system has solved the problem of prison overcrowding. In addition, the Program of Promotion of Psychiatric Health and Prevention of Psychiatric Disturbances in Penitentiary Facilities (2011-2015) was adopted in 2011 within the framework of the National Program of Protection of

79 See M. Szwed, *Rights of persons deprived of liberty. Fundamental legal and practical issues. HFHR perspective*, Warsaw, July 2018, pp. 29-20; (at: www.hfhr.pl/prawa-osob-pozbawionych-wolnosci-podstawowe-problemy-prawne-i-praktyczne-raport-hfpc/) (last visited: 20 July 2018).

80 Ewelina Brzostymowska, 'Osoby pozbawione wolności z niepełnosprawnością psychiczną', in: Ewa Dawidziuk & Marcin Mazur (eds), *Osoby z niepełnosprawnością intelektualną lub psychiczną osadzone w jed- nostkach penitencjarnych. Z uwzględnieniem wyników badan przeprowadzonych przez pracowników Biura Rzecznika Praw Obywatelskich*, Warsaw 2017, Published by the Office of the Commissioner for Human Rights, pp. 202-205.

81 *Ibid*., p. 206.

Psychiatric Health. Unfortunately, due to the lack of funds the Prison Service had to achieve the goals of the programme without additional budgetary support. The programme resulted in modernization of the psychiatric ward of the Kraków Detention Center.[82]

82 *Ibid.*, p. 209.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system in Portugal

Anabela Miranda Rodrigues & Sónia Fidalgo[*]

1 Introduction

In Portugal, the perpetrator of a crime will be punished with a penalty or with a security measure – penalties and security measures are the legal consequences of the crime. The penalty is based on guilt; the security measure applies when the defendant is criminally dangerous. According to Article 40º, no. 1, of the Portuguese Penal Code (hereafter, PC), the application of penalties and security measures aim at the protection of juridical assets (general positive prevention) and at the defendant's reintegration in society (special positive prevention).[1] By establishing, in a general and abstract way, the facts that are considered crimes and the penalties that correspond to them, the criminal law requires a complementary regulation to be carried out in practice – this is the subject of criminal procedural law. There is a 'mutual relationship of functional complementarity' between criminal law and criminal procedural law.[2] The purpose of criminal proceedings is threefold: the realization of justice and the discovery of the material truth, the protection of citizens' fundamental rights against the state and the restoration of community legal peace affected by the crime. However, it is not possible to fully realize these three purposes. It is necessary to 'establish the practical agreement of the conflicting purposes', always within the limit of the person's dignity.[3]

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1 About the purposes of punishment, see Anabela Miranda Rodrigues, *A determinação da medida da pena privativa da liberdade*, Coimbra: Coimbra Editora, 1995, p. 152, and the same author, 'O sistema punitivo português', *Sub Judice* 11 (1996), p. 27.

2 Figueiredo Dias, *Direito Processual Penal*, Lições coligidas por Maria João Antunes, Secção de Textos da Faculdade de Direito da Universidade de Coimbra, 1988/1989, § 4 and § 5.

3 See Figueiredo Dias, 'O Novo Código de Processo Penal', *Textos Jurídicos – I, Ministério da Justiça*, 1987, p. 13; Figueiredo Dias, *Direito Processual Penal*, Lições coligidas por Maria João Antunes, Secção de Textos

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

In Portugal, the defendant is the person for whom there are well-founded suspicions of having committed a crime under investigation (Arts 57º, 58º and 272º, no. 1, of the Portuguese Code of Criminal Procedure – hereafter, CCP). Since the Portuguese criminal procedure has an accusatory structure,[4] the defendant has the status of an active participant (*sujeito*) of the process. He has autonomous rights of conformation of the process.[5]

According to the Article 32º, no. 1, of the Constitution of the Portuguese Republic (hereafter, CRP), the criminal procedure shall ensure all the safeguards of the defendant, including the right to appeal. Article 60º of the CCP – establishing the defendant's procedural status – states that from the moment when a person acquires the status of defendant, he is ensured the exercise of procedural rights and duties, without prejudice to the enforcement of coercive and patrimonial guarantee measures or to the implementation of evidence formalities, as provided for by law. The defendant has, in particular, the right to attend all procedural acts that directly affect him; the right to be heard by the court or by the examining judge (*juiz de instrução*) whenever they render a decision that personally affects him; the right to refuse answering any questions addressed by an authority on charges against him; the right to choose a lawyer or ask the court to appoint a defence counsel for him; the right to be assisted by a defence counsel in all procedural acts where he takes part and, when detained, to contact such counsel in privacy; the right to take part in the inquiry and examination, propose evidence and require any necessary measures and the right to plead his defence before the close of the trial hearing (Arts 61º, no. 1, *(a), (b), (d), (e), (f) (g)*, 341º, no. 1, and 361º of the CCP). Therefore, the defendant's procedural status has three fundamental dimensions: the safeguards of the defence; the principle of presumption of innocence until the sentence in which the defendant was convicted has transited *in rem judicatam* and the principle of respect for the defendant's will.[6]

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da Faculdade de Direito da Universidade de Coimbra, 1988/1989, § 29 and Maria João Antunes, *Direito Processual Penal*, Coimbra: Almedina, 2018, p. 14.

4 The Portuguese criminal procedure has an accusatory structure composed of an investigation principle. See Figueiredo Dias, *Direito Processual Penal*, Lições coligidas por Maria João Antunes, Secção de Textos da Faculdade de Direito da Universidade de Coimbra, 1988/1989, § 51 and Maria João Antunes, *Direito Processual Penal* … , p. 21.

5 See Figueiredo Dias, 'La protection des droits de l´homme dans la procedure penale portugaise', *Boletim do Ministério da Justiça* (1979), p. 173 and Figueiredo Dias, 'Sobre os sujeitos processuais no novo Código de Processo Penal', in: *O Novo Código de Processo Penal. Jornadas de Direito Processual Penal*, Coimbra: Almedina, 1988, p. 7.

6 About the defendant's procedural status, see Anabela Miranda Rodrigues, 'A defesa do arguido: uma garantia constitucional em perigo no "admirável mundo novo"', *Revista Portuguesa de Ciência Criminal* 12 (2002), p. 549 and Maria João Antunes, *Direito Processual Penal* … , p. 36.

In Portuguese law, we find the reference to people who suffer from psychiatric disturbances by using the term 'mental illness' (*anomalia psíquica*).[7] When a person suffers from a mental illness, there are two different problems to be considered. On the one hand, there is the problem of the exclusion of his criminal responsibility (*inimputabilidade*). Article 20º of the PC establishes that a person shall not be criminally responsible if, due to a mental illness, he is incapable, at the time of committing the act, to appreciate its unlawfulness or to conform his conduct in accordance with that appreciation. This is a problem of criminal substantive law.[8] But, on the other hand, there is also the procedural problem of the defendant's fitness to stand trial. It may occur that a defendant, who shall not be criminally responsible due to a mental illness, also reveals unfitness to stand trial. However, the person who suffered from a mental illness at the time of committing the act, and who was considered not criminally responsible, may have procedural capacity. And, conversely, the mental illness may have arisen only after the time of committing the act – or, in any case, it may not have determined the defendant's criminal responsibility – and may determine the defendant's unfitness to be tried.[9]

When the defendant is not criminally responsible due to a mental illness and the proceedings end with the application of an internment security measure,[10] the CCP does not provide for the mental illness to determine the procedural incapability of the defendant, nor does it establish that criminal proceedings are suspended because of that incapability. The proceedings remain unchanged despite the fact that the defendant is not criminally responsible due to a mental illness. This is a consequence of the Article 1º*, (a)* of the CCP, which states that for the purposes of this Code, 'crime' means the set of conditions on which the application of a criminal penalty or security measure depends. The CCP does not provide for special procedures for defendants who are not criminally responsible due to a mental illness. Therefore, the question of the defendant's excluded criminal responsibility will be decided after the trial hearing. Only at the time of the deliberation

7 See, for instance, Art. 30º, no. 2, of the CPR, Arts 20º, 91º, 104º and of the PC, and Art. 202º, no. 2, of the CCP.

8 About the problem of the exclusion of criminal responsibility due to a mental illness, see Figueiredo Dias, *Direito Penal. Parte Geral*, Coimbra: Coimbra Editora, 2007, p. 560.

9 About the distinction between these two problems, see Pedro Soares de Albergaria, 'Anomalia psíquica e capacidade do arguido para estar em juízo', *Julgar* 1 (2007), p. 175; Damião da Cunha, 'Inimputabilidade e incapacidade processual em razão de anomalia psíquica. Algumas razões à luz das soluções do CCP', in: *Homenagem de Viseu a Jorge de Figueiredo Dias*, Coimbra: Coimbra Editora, 2011, p. 89; Maria João Antunes, 'Capacidade processual penal do arguido', in: *Trastornos mentales y justicia penal. Garantías del sujeto passivo com transtorno mental en el processo penal*, Navarra: Aranzadi, 2017, p. 522-523.

10 Art. 91º of the PC states that whoever perpetrates a typically illicit act and is considered not criminally responsible due to a mental illness, is sent by the court to internment in an establishment for cure, treatment or security in terms of Art. 20º, whenever there is a ground for fear that he may perpetrate other acts of the same kind, on account of mental illness and the gravity of the act.

does the court decide if there is any cause of exclusion of guilt and if it will be possible to apply a security measure (Arts 368º and 369º of the CCP).

The absence of special procedures in Portugal for defendants who are not criminally responsible due to a mental illness is due to two main reasons. On the one hand, the declaration of the defendant's excluded criminal responsibility presupposes the establishment of a *nexus* between the concrete fact and his mental illness (Art. 20º, no. 1, of the PC). Therefore, the issue of the defendant's excluded criminal responsibility is decided in the proceedings in which the act is investigated, like any other guilt-related issue. On the other hand, the application of the internment security measure presupposes that the defendant commits a typical act (Art. 91º of the PC), so that the act must be investigated in criminal proceedings.[11] In addition, in this way, the defendant who suffers from a mental illness is entitled to all the guarantees of criminal procedure provided by the CPR and by the law.[12]

However, it may happen that the defendant suffers from a mental illness at the time of committing the act, but the mental illness has no connection with the act itself, or the mental illness may occur only after the time of committing the act. In these cases, the defendant is considered criminally responsible, but the procedural problem of his fitness to be tried may arise. The current CCP (1987) does not refer explicitly to the consequences of the procedural incapability of the defendant due to mental illness. Criminal proceedings continue regardless of whether the defendant has a mental illness that prevents him from exercising his right of defence or excludes his capability to assume the status of an active participant of the process.

The previous CCP (1929) expressly provided for the suspension of proceedings when the mental illness was subsequent to the commission of the act. The criminal proceedings were suspended until the defendant regained full use of his mental capability (Art. 130º of the CCP 1929).[13] The doctrine understood that the lack of procedural capability of the

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11 See Maria João Antunes, *O internamento de imputáveis em estabelecimentos destinados a inimputáveis (os Arts. 103º, 104º e 105º do Código Penal de 1982)*, Coimbra: Coimbra Editora, 1993, p. 13, footnote 1; Maria João Antunes, *Direito Processual Penal …* , p. 8 and p. 204; Maria João Antunes, 'Capacidade processual … ', p. 526; Damião da Cunha, 'Inimputabilidade e incapacidade … ', p. 93.

12 See Maria João Antunes, *Medida de segurança de internamento e facto de inimputável em razão de anomalia psíquica*, Coimbra: Coimbra Editora, 2002, p. 104 and 164; Maria João Antunes, 'Capacidade processual … ', p. 526; Damião da Cunha, 'Inimputabilidade e incapacidade … ', p. 94. In the previous CCP (from 1929), the issue of the defendant's excluded criminal responsibility was decided in a procedural incident – the incident of mental alienation (Art. 125) – without establishing any relation between the mental illness and the act. See Figueiredo Dias, 'Para uma reforma global do processo penal português. Da sua necessidade e de algumas orientações fundamentais', in: *Para uma nova justiça penal*, Coimbra: Almedina, 1983, p. 216; Damião da Cunha, 'Inimputabilidade e incapacidade … ', p. 93; Maria João Antunes, 'Capacidade processual … ', p. 527.

13 See Pedro Soares de Albergaria, 'Anomalia psíquica e capacidade do arguido para estar em juízo', *Julgar* 1 (2007), p. 178; Germano Marques da Silva, *Direito Processual Penal Português*, Lisboa: Universidade Católica, 2017, p. 312; Maria João Antunes, 'Capacidade processual … ', p. 524.

defendant should lead to the suspension of the criminal proceedings because the mental illness prevented him from participating with autonomy in the proceedings and also prevented him from understanding the meaning of the penalty imposed by the court.[14]

In the current CCP, the defendant's mental illness is not a cause for suspension of the proceedings, even if it reduces or excludes the defendant's fitness to stand trial.[15] In the task of harmonizing the different purposes of the criminal proceedings, the Portuguese CCP prevails in the purpose of discovering the material truth, the realization of justice and the restoring of community legal peace affected by the crime, as well as serving the purpose of general positive prevention that the prison sentence must achieve. The fulfilment of all these purposes depends to a large extent on the period of time within which the punishment takes place.[16]

The circumstance that in the current CCP the defendant's mental illness is not a cause for suspension of the proceedings does not mean that the mental illness has no relevance in criminal proceedings.[17]

Actually, the Portuguese legislator is concerned with the protection of the defendant's right of defence, when he suffers from a mental illness. According to Article 32º, no. 3, of the CPR, a defendant has the right to choose counsel and to be assisted by him in relation to every procedural act. The law shall specify those cases and phases of procedure in which the assistance of a lawyer is mandatory. One case of compulsory assistance specified by the CCP is when the issue of the defendant's excluded or diminished criminal liability was raised (Art. 64º, no. 1, *(d)*, of the CCP). When the defendant suffered from a mental illness at the time of committing the act, but the mental illness had no connection with the act itself, or only occurred after the act was committed – cases in which the issue of the defendant's excluded or diminished criminal liability had not been raised – a defence counsel for the defendant may be appointed, at the court's or defendant's request, where the specific circumstances of the case show the need or the convenience for the defendant to be assisted (Art. 64º, no. 2, of the CCP). Where the defendant is not present at the trial hearing due to serious illness and the hearing is to take place in the defendant's absence,

14 See Castanheira Neves, *Sumários de Processo Criminal*, Coimbra, 1968, p. 165; Maria João Antunes, *O internamento de imputáveis em estabelecimentos destinados a inimputáveis (os Arts. 103º, 104º e 105º do Código Penal de 1982)*, Coimbra: Coimbra Editora, 1993, p. 63.

15 Some Portuguese doctrine criticizes this solution of the current CCP, arguing that the process should be suspended in the case of procedural incapability of the defendant due to psychiatric disturbances. In this sense, Pedro Soares de Albergaria, 'Anomalia psíquica … ', p. 178; Damião da Cunha, 'Inimputabilidade e incapacidade … ', p. 109; Germano Marques da Silva, *Direito Processual Penal …* , pp. 312-313.

16 In this sense, Maria João Antunes, 'Capacidade processual … ', p. 524; Maria João Antunes, *O internamento de imputáveis …* , p. 65; Maria João Antunes, *Direito Processual Penal …* , p. 41.

17 See Maria João Antunes, *Direito Processual Penal …* , pp. 41-42.

there will also be compulsory assistance by a defence counsel (Art. 64º, no. 1, *(g)*, and Art. 334º, no. 4, of the CCP).[18]

A mental illness may also have relevance in criminal proceedings in case of expert proof. The CCP expressly provides for the possibility of carrying out a psychiatric expertise (Art. 159º, no. 6 and no.7). This psychiatric expertise may be performed, for instance, so that the judge can decide on the defendant´s excluded or diminished criminal responsibility. Nevertheless, the CCP does not associate the result of the psychiatric expertise with the possible lack of procedural capacity of the defendant.[19]

A mental illness still has relevance in criminal proceedings in case of proof by confession. The defendant may confess to the facts at the trial hearing. According to Article 344º of the CCP, where the crime is punishable by imprisonment up to 5 years, if the defendant confesses to the facts, these facts are considered to be proven. If no further evidence is produced, the judge can still establish the concrete penalty. Nevertheless, where the judge has doubts about the free nature of the confession, in particular because he has doubts related to the defendant's mental integrity or to the veracity of the confessed facts, the effects referred to earlier will no longer take place, that is, the facts are not considered to be proven. This is a way to protect the defendant against a false self-incrimination. In the context of the proof by confession, the Portuguese legislature admits, thus, that the mental illness of the defendant may influence his procedural capacity.[20]

3 Detainees with psychiatric disturbances in provisional detention: needs, problems, screening tools

According to the Portuguese law, we may distinguish between police custody (*detenção*) and custody on remand (*prisão preventiva*). Custody consists of the deprivation of liberty by the police, for the purposes referred to in Article 254º of the CCP: (a) within a maximum period of 48 hours, the detainee shall be tried in summary form or be brought before the competent court for the first judicial interrogation or for the application or enforcement of a coercive measure; (b) to ensure the immediate presence or, if possible, as soon as possible, but not for more than 24 hours, of the detained person before the judicial authority

18 See Maria João Antunes, 'Capacidade processual … ', p. 525.

19 See Maria João Antunes, 'Capacidade processual … ', p. 527. About the expert proof, see Maria João Antunes & Sónia Fidalgo, 'Noções de direito e processo penal que relevam para a prática pericial', in: *Manual de psiquiatria forense*, Lisboa: Pactor, 2017, p. 57; Fernando Vieira, Ana Sofia Cabral and Maria João Latas, 'A (in)imputabilidade e a perícia psiquiátrica prevista no artigo 159º do CPP', in: *Manual de psiquiatria forense*, Lisboa: Pactor, 2017, p. 145.

20 See Maria João Antunes, 'Capacidade processual … ', p. 528.

in a procedural act.[21] The Portuguese CCP does not provide for special rules concerning persons with psychiatric disturbances in police custody.

Custody on remand is a coercive measure and the coercive measures are always applied by a judge, even during the inquiry stage (Arts 194º and 268º of the CCP).[22] The judge may remand the defendant into custody where he deems all the other coercive measures inadequate or insufficient in the particular case (Art. 202º of the CCP). According to Art. 28º, no. 4, of the CPR, custody on remand is exceptional in nature and shall not be ordered or maintained whenever it is possible to grant bail or apply another more favourable measure provided for by law.

The Portuguese CCP provides for a special rule when the defendant to be remanded into custody suffers from a mental illness. Article 202º, no. 2, of the CCP states that should the defendant to be remanded into custody suffer from a mental illness, the judge, after hearing the defence counsel and, whenever possible, a relative of the defendant, may, while the mental illness persists, in lieu of remanding the defendant into custody, decide that he will be remanded to a psychiatric hospital or to another suitable similar institution, while adopting the necessary precautionary steps so as to prevent the defendant from escaping and re-offending. This decision to remand the defendant to a psychiatric hospital or to another suitable similar institution aims not to prejudice the psychiatric treatment of the defendant.[23]

The rules laid down in the Portuguese Mental Health Law (Law 36/1998, of 24 July 2008) also express this concern with the treatment of a person who suffers from a mental illness. The Law 36/1998 establishes the general principles of mental health policy and regulates the compulsory hospitalization of people with mental illness (Art. 1º). This compulsory detention may only be determined in cases where it is deemed to be the only way of guaranteeing that the detained patient is submitted to treatment (Art. 8º).[24] This compulsory hospitalization of people with mental illness is not a criminal sanction. The compulsory hospitalization takes place according to a mixed model of medical and judicial decisions, when the person suffering from a severe mental illness creates a situation of

21 See also Art. 27º, no. 3, *(a)*, *(b)*, *(f)*, of the CPR. About police custody, see Maria João Antunes, *Direito Processual Penal* … , p. 136.

22 In Portugal, the inquiry is directed by the Public Prosecutor, but where the act may affect the rights, freedoms and guarantees of the defendant, the intervention of a judge (*juiz de instrução*) is required (see Art. 263º, 268º and 269º of the CCP). About the inquiry stage, see Anabela Miranda Rodrigues, 'O inquérito no novo Código de Processo Penal', in: *O Novo Código de Processo Penal. Jornadas de Direito Processual Penal*, Coimbra: Almedina, 1988, p. 61. About the application of coercive measures in criminal proceedings, see Nuno Brandão, 'Medidas de coacção: o procedimento de aplicação na revisão do Código de Processo Penal', *Revista do Centro de Estudos Judiciários* 9 (2008), p.71; Sónia Fidalgo, 'Medidas de coacção: aplicação e impugnação (Breves notas sobre a *revisão da revisão*)', *Revista do Ministério Público* 31 (2010), p. 247.

23 See Maria João Antunes, 'Capacidade processual … ', p. 527.

24 Emphasizing this aspect of the Portuguese legislation, see *WHO Resource Book on Mental Health, Human Rights and Legislation*, Publications of the World Health Organization, 2005, p. 30 and 47.

danger for legal goods and refuses to submit to the necessary medical treatment, or when the absence of treatment will deteriorate the state of health of a patient with severe mental illness who does not have the necessary judgment to assess the meaning and scope of consent (Art. 7º, *(a)*, and Art. 12º of the Law 36/1998). The Law 36/1998 expressly provides for the possibility of the defendant's compulsory hospitalization under the terms of this law during the pending of criminal proceedings – the existence of criminal proceedings does not preclude the application of compulsory hospitalization when the defendant suffers from a mental illness (Art. 28º of the Law 36/1998).[25]

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

Article 91º of the PC states that whoever perpetrates a typically illicit act and is considered not criminally responsible due to a mental illness, is sent by the court to internment in an establishment for cure, treatment or security, whenever there is a ground for fear that he may perpetrate other acts of the same kind, on account of mental illness and the gravity of the act. This security measure is a real criminal sanction.[26]

Nevertheless, it may happen that, despite the mental illness at the time of committing the act, the defendant is able to appreciate its unlawfulness and to conform his conduct in accordance with that appreciation (Art. 20º, no. 1, of the PC). When there is no ground for excluding the defendant's criminal responsibility and he is sent to prison, but he shows that, due to mental illness he was suffering at the time of the crime, the regime of this common establishment may be harmful to him, or that he might seriously upset that regime, the court may order his internment in an establishment allotted to persons whose criminal responsibility was excluded due to mental illness, for the time corresponding to the duration of the punishment (Art. 104º of the PC). In these cases, the defendant is criminally responsible, but regarding the mental illness, the judge determines the internment in an institution allotted to defendants who are not criminally responsible.

25 About the compulsory hospitalization according to the Portuguese Mental Health Law, see Pedro Soares de Albergaria, *A Lei da Saúde Mental. Lei n.º 36/98, de 24 de Julho – anotada*, Coimbra: Almedina, 2003, *passim*; Vieira de Andrade, 'O internamento compulsivo de portadores de anomalia psíquica na perspectiva dos direitos fundamentais', in: *A Lei de Saúde Mental e o Internamento Compulsivo*, Coimbra: Coimbra Editora, 2000, p. 71; Maria João Antunes, 'Internamento compulsivo de portador de anomalia psíquica', *Estudos em Homenagem ao Conselheiro Presidente Rui Moura Ramos*, vol. 2, Coimbra: Almedina, 2016, p. 423; Ana Sofia Cabral, Sofia Brissos and Francisco Santos Costa, 'A Lei de Saúde Mental e o internamento compulsivo', in: *Manual de psiquiatria forense*, Lisboa: Pactor, 2017, p. 319.

26 Regarding the conditions, purposes and duration of the internment security measures, see Figueiredo Dias, *Direito Penal Português. As consequências jurídicas do crime*, Lisboa: Editorial Notícias, 1993, p. 454; Maria João Antunes, *Penas e medidas de segurança*, Coimbra: Almedina, 2017, p. 116.

When the mental illness is subsequent to the crime, the court may order the internment of the defendant in an establishment allotted to persons who were considered not criminally responsible, for the time corresponding to the duration of the punishment, if due to the mental illness from which the defendant suffers, he is criminally dangerous, the regime of the common establishments may be harmful to him, or he might seriously upset that regime (Art. 105º of the PC).[27] Where the mental illness subsequent to the crime does not make the defendant criminally dangerous in terms that, if the defendant were considered not criminally responsible it would determine his effective internment, the fulfilment of the prison penalty for which he had been condemned is suspended (Art. 106º of the PC). In these cases where the mental illness is subsequent to the crime, the rules established in Articles 105º and 106º of the PC emphasize the effect that the mental illness may have on the defendant's capacity to understand the prison sentence, that is his 'susceptibility to feel the penalty and to be influenced by it'.[28]

The Code of Enforcement of Penalties and Custodial Measures (hereafter, CEP) states that the enforcement of the deprivation of liberty applied to a defendant who was considered not criminally responsible or to a defendant who was considered criminally responsible but was interned, by judicial decision, in an establishment allotted to not criminally responsible persons, is directed to the rehabilitation of the internee and his reintegration into the family and social environment, preventing the practice of other criminal acts and serving the defence of society and the victim in particular (Art. 126º, no. 1, of the CEP). Such measures shall preferably be carried out in a non-prison mental health unit and, where justified, in prisons or specially designated units (Art. 126º, no. 2, of the CEP). The internees are subject to permanent medical supervision (Art. 253º of the Prisons General Regulation).

According to the statistics of the Portuguese General Directorate of Reintegration and Prison Services,[29] on 31 December 2017, in Portugal, there were a total of 13,440 prisoners. Of these, 275 were considered not criminally responsible due to a mental illness and they are complying with an internment security measure. Of these, 138 are interned in psychiatric units inside prisons and 137 are interned in non-prison units and psychiatric hospitals.[30]

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27 See Maria João Antunes, 'Capacidade processual … ', pp. 529-530.

28 See Maria João Antunes, 'Capacidade processual … ', p. 530.

29 The General Directorate of Reintegration and Prison Services is an organization of the Portuguese Ministry of Justice. Its mission is to define and implement the state policies on criminal prevention, providing support and technical advice to the court, to the social reintegration services for youth and adults namely through the supervision of court sentences, probation, parole, alternative measures to imprisonment and also delivering prison services (Art. 1º of the Decree-law 215/2012, of 28 September 2012). (at: http://ecopris.europris.org) (last visited: 20 April 2018).

30 See statistics of the Portuguese General Directorate of Reintegration and Prison Services, year 2017, (at: www.dgsp.mj.pt/) (last visited: 20 April 2018).

We are not sure that the Portuguese judges, public prosecutors and lawyers are truly aware of the different situations we have talked about.[31] It is important that the following distinctions become clear:

a) The defendant is considered not criminally responsible due to a mental illness because he is incapable, at the time of committing the act, to appreciate its unlawfulness or to conform his conduct in accordance with that appreciation (Arts 20º and 91º of the PC);
b) Despite the mental illness at the time of committing the act, the defendant is considered criminally responsible. However, he shows that, due to mental illness he was suffering at the time of the crime, the regime of the common establishments may not be adequate (Art. 104º of the PC);
c) The defendant suffers from a mental illness after committing the act – the mental illness is subsequent to the crime – and the regime of the common establishments may not be adequate (Arts 105º and 106º of the PC).

5 Treatment of prisoners with psychiatric disturbances: health or justice responsibility?

The internment of persons whose criminal responsibility was excluded due to mental illness, under Article 91º, no. 1, of the PC, is a criminal reaction. The same happens in situations where a person, who was considered criminally responsible, is subject to internment in an establishment allotted to persons who were considered not criminally responsible, under Articles 104º and 105º of the PC.

The administrative and financial components of the implementation of these custodial measures must be ensured by the Ministry of Justice. Within the Ministry of Justice, the enforcement of these custodial measures is a responsibility of the General Directorate of Reintegration and Prison Services. The fact that the custodial measure order is served in a non-prison mental health facility, under Article 126º, no. 2, of the CEP, does not change the criminal nature of the custodial measure, nor the consequent responsibility of the General Directorate of Reintegration and Prison Services for its enforcement. The complexity of the issues involved in the distribution of responsibilities for administrative and financial tasks related to the enforcement of custodial measures in a mental health

31 In a case judged by the Portuguese Supreme Court of Justice (on 24 May 2017), the defendant was sentenced to prison and during the enforcement of the prison sentence the agent became mentally ill. The Portuguese Supreme Court considered that in this situation the defendant should be considered not criminally responsible due to a mental illness during the enforcement of imprisonment, and his 'penalty would become a security measure' (Process no. 697/10.3TXEVR-C.S1, unpublished). About this decision, see Maria João Antunes, 'Prisão ilegal em estabelecimento de inimputáveis. Providência de *habeas corpus*', *Revista de Legislação e de Jurisprudência* (2018), in course of publication.

unit should be subject to regulation in a specific law (Art. 126º, no. 5, of the CEP). Nevertheless, such a law has not yet been published.[32]

6 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

The CEP establishes that the purpose of the enforcement of penalties and custodial measures is the reintegration of the defendant in society, the protection of legal assets and the defence of society (Art. 2, no. 1). The state has the duty to promote the socialization of the prisoner.[33] And before socialization, the execution of the sentence must be *non-desocializing*. The first goal of the prison must be to avoid the desocialization of the prisoner.[34] This idea is reflected in the Portuguese law, which states that the execution, "as far as possible, avoids the harmful consequences of deprivation of liberty and approaches itself of the beneficial conditions of community life" (Art. 3, no. 5, of the CEP).

Alongside the concern to avoid the desocialization of the prisoner, socialization also includes another aspect: the enjoyment of fundamental rights.[35] The prisoner, by his condition, continues to be a citizen subject to a special status that does not exclude the benefit of fundamental rights. The idea of socialization is, thus, directly related to the *legal status of the prisoner*.[36] The relationship between the prisoner and the administration is no longer a special relationship of power (outside the world of law), but a legal relationship in which both the prisoner and the administration have rights and obligations. The CPR establishes, since 1989, that convicted persons who are the object of a sentence or security measure that deprives them of their freedom retain their fundamental rights, save for the

32 Regarding this unclear situation in Portugal, see *Parecer do Conselho Consultivo da Procuradoria Geral da República*, of 2nd of March 2017, Parecer: P000342016 (at: www.ministeriopublico.pt) (last visited: 20 April 2018).

33 On the debate on socialization, see Anabela Miranda Rodrigues, 'Polémica actual sobre o pensamento da reinserção social', Separata de *Cidadão delinquente: reinserção social*, 1980, *passim*; Anabela Miranda Rodrigues, *A determinação da medida da pena …* , p. 317 and 558; Anabela Miranda Rodrigues, 'L'exécution de la peine privative de liberté. Problèmes de politique criminelle', in: *L'exécution des sanctions privatives de liberté et les impératifs de la sécurité – Actes du colloque de la FIPP*, Budapest, Hongrie, 16-19 févr. 2006, Nijmegen: Wolf Legal Publishers, 2006, p. 52; Anabela Miranda Rodrigues, 'Aspectos jurídicos da reclusão', in: *Educar o outro – Humana Global*, 2007, p. 115; Anabela Miranda Rodrigues, 'Superpopulação carcerária. Controlo da execução e alternativas', *Revista Electrônica de Direito Penal AIDP-GB*, ano 1 (2013), p. 13. On the 'new' right to socialization in the emerging new state model, see Anabela Miranda Rodrigues, 'Execução penal socializadora e o novo capitalismo – uma relação (im)possível?', *Revista Brasileira de Ciências Criminais* 23 (2015), p. 17 and 30.

34 Anabela Miranda Rodrigues, *Novo olhar sobre a questão penitenciária*, Coimbra: Coimbra Editora, 2002, p. 45.

35 Anabela Miranda Rodrigues, *Novo olhar …* , p. 51; Anabela Miranda Rodrigues, 'Execução penal socializadora … ', p. 31.

36 Anabela Miranda Rodrigues, *Novo olhar …* , p. 65.

limitations that are inherent to the purpose of their convictions and to the specific requirements imposed by the execution of the respective sentences (Art. 30º, no. 5). We also find this idea in Art. 6º of the CEP, which establishes the legal status of the detainee: "the detainee retains the ownership of the fundamental rights, with the exception of the limitations arising from the meaning of the wording of the sentence or the decision to apply a custodial measure, and also of the restrictions imposed, in accordance with and within the limits of this code, for reasons of order and security of the penitentiary establishment".

The articulation of the regime provided for in the Constitution and in the law has three consequences: the prisoner keeps all his fundamental rights during the execution of the sentence (Art. 6º of the CEP); all the limitations of these rights must be provided by law (Arts 18º and 165º, no. 1, *(b)*, of the CPR); the law may only limit these rights when this limitation is inherent to the meaning of the wording of the sentence or imposed for reasons of order and security by the prison establishment (Art. 6º of the CEP).[37]

Thus, the detainee holds a set of rights provided for in Article 7º of the CEP.[38] This article establishes, in particular, the prisoner has the right to the protection of his health and may access the national health service in conditions identical to those of other citizens (Art. 7º, no. 1, *(i)*, and Art. 32º of the CEP; Art. 55º of the Prisons General Regulation).[39]

In particular, concerning the internment of persons whose criminal responsibility was excluded due to mental illness, and the internment of persons who were considered criminally responsible in an establishment allotted to persons who were considered not criminally responsible, the law establishes that it is mandatory to make a therapeutic and a rehabilitation plan, structured according to needs, individual skills and risk assessment (Art. 128, no. 1, of the CEP and Art. 254º of the Prisons General Regulation). The therapeutic and rehabilitation plan of the defendant shall respect his individuality and dignity, promote his involvement and that of his family, include occupational activities and individual or group therapies, favour his integration into rehabilitation programmes and, whenever the personal and procedural situation allows, in community structures and create the necessary conditions for the continuity of post-release treatment (Art. 128º, no. 2, of the CEP). In drawing up the plan, it should be sought to obtain the participation and adherence of the internee, unless his state of health renders this participation unnecessary or unfeasible (Art. 128º, no. 4, of the CEP). The plan is periodically evaluated and updated, depending on the treatment needs of the internee and the internee's conditions of family and social insertion (Art. 128º, no. 5, of the CEP).

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37 See Anabela Miranda Rodrigues, *Novo olhar …* , p. 197.

38 See Anabela Miranda Rodrigues & Sónia Fidalgo, 'Le système pénitentiaire portugais', in: *Les systèmes pénitentiaires dans le monde*, Paris: Dalloz, 2017, p. 300.

39 About access to the National Health Service, see *Parecer do Conselho Consultivo da Procuradoria Geral da República …* , § II. 3. 4.

Nevertheless, in this context, the law in action seems to be different from the law in books. There is lack of professionals (physicians and nurses) in the psychiatric units and many defendants stay in prison much longer than necessary, because there are no community structures where they can be integrated. The state has real difficulties with providing suitable places where defendants may stay when they are no longer criminally dangerous, but they still need guidance and support. Therefore, in many cases there are no real conditions for the continuity of post-release treatment and the community reintegration of prisoners with psychiatric disturbances is quite difficult.[40]

7 Conclusion

In the current CCP, the criminal proceedings remain unchanged despite the fact that the defendant suffers from a mental illness. The CCP does not provide for special procedures for defendants who are not criminally responsible due to a mental illness and the defendant's mental illness is not a cause for suspension of the proceedings. Nevertheless, the CCP has some special rules to be applied when the defendant suffers from a mental illness. Concerning the situation of defendants with psychiatric disturbances in prison, it is necessary to distinguish between the cases in which the provisions of Articles 20º and 91º of the PC apply, and the other cases in which the regime provided for the Articles 104º, 105º and 106º of the PC shall be applied. Despite the law in books, the community reintegration of prisoners with psychiatric disturbances in Portugal is quite difficult.

Considering the procedural problem of the defendant's fitness to stand trial, in the Portuguese CCP other priorities prevail: the purpose of discovering the material truth and the realization of justice, the restoring of community legal peace affected by the crime, and the purpose of general positive prevention that the prison sentence must achieve. The fulfilment of all these purposes depends to a large extent on the period of time of the punishment.

Considering the criminal substantive law problem of the exclusion of criminal responsibility of a person who suffers from a mental illness, maybe it is time to rethink the Portuguese model. One may ask whether the defendants who are considered not criminal and are responsible due to a mental illness should continue to be subject to criminal prosecution and to the application of security measures, or whether they should instead be referred to the general regime of compulsory treatment and hospitalization,

40 About the social reinsertion of the prisoners, see Conceição Gomes, Madalena Duarte and Jorge Almeida, 'Crimes, penas e reinserção social: um olhar sobre o caso português', in: *Actas dos ateliers do V Congresso Português de Sociologia – Sociedades Contemporâneas: Reflexividade e Acção, Atelier: Direito, Crimes e Dependências*, 2003, p. 27.

provided for in the Mental Health Law.[41] Thus, the state intervention would depend on the need for treatment of the defendant and not on the circumstance that the defendant is criminally dangerous. In this new (medical care) model, the treatment of defendants with mental illness would become a responsibility of the health system and not of the criminal justice system.

41 Raising this question, Maria João Antunes, 'O passado, o presente e o futuro do internamento de inimputável em razão de anomalia psíquica', *Revista Portuguesa de Ciência Criminal* 13 (2003), p. 360; Maria João Antunes, 'O internamento compulsivo de portador de anomalia psíquica em Portugal. Breve referência à Lei Brasileira de Reforma Psiquiátrica de 2001', *Revista da Escola Superior da Magistratura do Estado de Alagoas* 6 (2017), p. 88; Damião da Cunha, 'Inimputabilidade e incapacidade … ', p. 102.

Defendants and detainees with psychiatric disorders in the Spanish criminal justice system

Ana Cerezo[*]

1 Introduction

The Spanish criminal justice system provides a restrictive measure of confinement in a psychiatric penitentiary hospital, applicable to individuals declared not criminally responsible due to an alleged anomaly or psychiatric alteration established in Article 20.1 of the Spanish criminal code (Art. 96.2.1) (hereinafter CrimC). The requirements for the application of a restrictive measure of confinement in a psychiatric penitentiary hospital, established in Articles 95.1 and 101 of the Spanish criminal code, are threefold, namely, (a) that the offender has committed a crime, (b) that from the fact and personal circumstances of the offender can be deduced a prognosis of future behaviour that reveals the probability of committing new offences and (c) the assessment of the complete or incomplete exoneration (Arts. 20.1 and 21.1 CrimC respectively), or even of an alleged anomaly or psychiatric alteration analogical attenuation (Art. 21.7 CrimC) – possibility allowed by the Supreme Court through a consolidated jurisprudence.

The complete exoneration of criminal responsibility of Article 20.1 CrimC will be assessed in those cases in which the inability to understand the wrongfulness of the act or to act in accordance with that understanding is complete. Namely, when the offender's cognitive and volitional capacities are totally diminished and, as the main consequence, he or she will be declared unimpeachable, not criminally responsible. In this case, a restrictive measure of confinement in a psychiatric penitentiary hospital will be applied.

The incomplete exemption of criminal responsibility of Article 21.1 in relation to Article 20.1 CrimC will be applied in those cases in which the offender´s incapacity is due to an alleged anomaly or psychiatric alteration, although not total, that is the offender does not totally misunderstand the act committed but understands to a notably decreased level. The offender will be declared semi-attributable and, through Article 68 CrimC, will entail

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the reduction of the sentence in one or two degrees, as well as the application of a restrictive measure of confinement in a psychiatric penitentiary hospital.

In cases in which the incidence of mental disorder in cognitive and volitional capacities is slight, the offender is responsible for the acts committed and the provisions of Article 21.7 CrimC will be applied, in relation to Articles 20.1 and 21.2, which will lead to a qualified or simple attenuation of the sentence (Art. 66 CrimC).

In the latter two cases, attention must be paid to the provisions of Article 99 CrimC, that is the application of the vicarious system and, therefore, of the debt of time to serve the restrictive measure of the sentence and the authority of the judge or court to suspend the compliance of the prison sentence or to apply any of the non-custodial measures, in case the effects achieved by the restrictive measure were to be jeopardized.

Of all the fundamental principles in the application of the restrictive measures that follow an acquittal by reason of insufficient mental capability, the interest in regard to the internment in the psychiatric penitentiary hospital should be because of the principle of proportionality. This principle abandons criteria related to dangerousness to focus on the offence committed. This principle, enunciated in Article 6.2 CrimC, argues that restrictive measures cannot be more burdensome or more time-consuming than the sentence abstractly applicable to the crime committed, nor exceed the limit of what is necessary to avert the criminal dangerousness of the offender. Specifically, in the restrictive measure of confinement in a psychiatric penitentiary hospital, Article 101 CrimC determines that the internment cannot exceed the time that the custodial sentence would have lasted if the offender had been declared responsible, and to that effect, the judge or court will set a maximum time limit in the sentencing. The maximum time limit has to be understood as the maximum of the abstract sentence established by the article that defines the crime.[1] Therefore, and as is usual among restrictive measures, the regulation of the proportionality of the measure of internment in a psychiatric penitentiary hospital is nothing more than a brief reiteration of the general regulation of the proportionality of restrictive measures, totally expendable as it does not add anything new.[2]

1 Pablo Gómez-Escolar Mazuela, 'Algunas cuestiones sobre la medida de seguridad de internamiento psiquiátrico', in: Montserrat Navarro García & José Luís Segovia Bernabé (eds), *El juez de vigilancia penitenciaria y las medidas de seguridad*, in *Estudios de Derecho Judicial*, nº 127 (2007).

2 Asier Urruela Mora, *Las medidas de seguridad y reinserción social en la actualidad*, Granada: Comares, 2009.

2 Detainees with psychiatric disorders during custody and pre-trial detention

In practice, police interventions are often with detainees suffering from psychiatric disorders. In these situations, the police's treatment of the subject usually differs from the standard treatment of any other person without this type of disorder. The treatment applied to detainees with psychiatric disorders differs according to the severity of the mental illness. In those situations, in which detainees are suspected of having a mental disability, police usually require the assistance of mental health emergency services. While waiting for them to arrive at the crime scene the police will try to neutralize the detainee's actions, thus preventing them from self-harming or causing harm to bystanders. When the emergency services arrive, the transfer of the detainee to a health centre is imminent. The police must be collaborative, guarding the ambulance, if necessary (in these cases they are forbidden to carry any type of firearm.) In medical centres, a doctor will certify whether the patient's internment in the corresponding service is necessary (or not) or whether he/she will remain in police custody if needed.

In those cases where mental problems are detected once the defendant has been arrested and is in custody, the way of proceeding is different. As established in Article 40 of the General Prisons Organic Law (hereinafter LOGP), as soon as possible, it is mandatory to carry out an examination of the detainee in custody and pre-trial detention to determine whether or not physical or mental disorders exist, taking appropriate measures if so. In practice, however, doctors are never present in the municipal stations. The medical check is carried out by ambulatory doctors working in the nearest health centres, normally located at distances not exceeding 1,000 m and in any case less than 5 minutes by car.

For all these reasons, it is essential to establish a suicide prevention programme in custody and pre-trial. Moreover, considering that the characteristics used to determine a suicide risk profile are the type of crime (murders, homicides or rapes), non-recidivists and people with psychiatric disorders. In addition to this, the presence of different preventive procedures aimed at preventing the detainee's sense of loneliness, psychological reinforcement, frequent rounds of the custody cell, and in certain, more serious cases, mechanical immobilization by placing handcuffs at fixed points on the bed is also important. Finally, it is essential to train police officers to diffuse mental health situations in lieu of arrest.

3 Prisoners with psychiatric disorders in prison

3.1 Psychiatric penitentiary hospitals

Article 7.c LOGP provides for the existence of special penitentiary establishments for prisoners with health problems. Article 11 LOGP defines them as those in which the welfare character prevails, distinguishing three types of centres: hospital centres, psychiatric centres and social rehabilitation centres. With respect to prisoners with psychiatric disorders, Article 183 of the Prison Rules that defines the Organic Law in-depth (hereinafter RP), approved by Royal Decree 190/1996 of 9th February, distinguishes between psychiatric penitentiary hospitals and psychiatric penitentiary units. Psychiatric penitentiary hospitals, as is clear from Article 10 RP, are independent and separate centres with their own organization, under the penitentiary administration. Psychiatric prison units, which have not yet been put into operation, will be integrated into regular prisons.

In relation to the prisoners who enter psychiatric prisons or psychiatric units in regular prisons, Article 184 RP classifies them into three groups: (a) detainees or prisoners with psychiatric illnesses, whom the judicial authority decides to submit for observation only, and only for the time required to issue a timely report; (b) detainees who have been declared not responsible completely or partially for criminal activities because of their mental disorders (Article 20.1 and 21.1 CrimC), when a restrictive measure of internment in a psychiatric prison had been applied to them, and (c) prisoners who, according to Article 60 CrimC, have had a restrictive measure of internment in a psychiatric prison imposed on them because of a later mental illness, diagnosed once they were in prison.

Regarding the location criteria of these specific prisons, the first paragraph of Article 191 RP establishes the determining criteria for deciding the location and design of psychiatric facilities. Factors such as therapeutic criteria, the need to encourage recreation and the use of free time by prisoners, as well as the provision of sufficient space for the adequate development of therapeutic and rehabilitative activities are all taken into account. The second section of Article 191 RP proposes the territorial distribution of the penitentiary psychiatric facilities in a way that favours the rehabilitation of the prisoners, rooted in their family environment.

The regimental features to be fulfilled by inmates in the psychiatric penitentiary hospitals are contained in Articles 186 to 190 RP. In accordance with Article 186 RP, upon admission, the inmate will be attended to by a doctor, who, after an evaluation of the reports of the centre of origin and the result of his own medical checkup, will decide which is the most suitable destination and the most appropriate treatment for the inmate, until they can be assessed by a psychiatrist.

For its part, Article 187 RP, in view of the peculiarity of the internment of the inmates who demand greater control over their situation and evolution, sets a short review period for the Multidisciplinary Team that is in charge of the supervision of the inmate. This team must send a report to the public prosecutor on the status and evolution of each of the inmates every six months.

Article 188 RP establishes the obligation that the separation of the different departments of each psychiatric prison should be made in accordance with the needs of each inmate. This limits the restrictions on the personal freedom of the patient to those strictly necessary according to the health status of the patient or the success of the treatment. This limit also determines the exceptionality of the use of coercive means – only admitted by indication of the medical staff and during the minimum time necessary prior to the pharmacological effect, respecting at all times the dignity of the person and notifying the corresponding judicial authority. Finally, this limit overrides the provisions of the disciplinary system in psychiatric penitentiary hospitals.

Article 189 RP requires the creation, in writing, of a general programme of rehabilitation activities, as well as individual rehabilitation programmes, in order to increase the possibilities of deinstitutionalization of the prisoners and facilitate their return to their social and family environments, as well as their reintegration in the community health resources.

Finally, Article 190 RP regulates relationships with the outside world, determining that they will be served within the framework of an individual rehabilitation programme. The programme must indicate the number of submissions and permits to temporarily leave the prison, the persons with whom the patients can communicate and the conditions in which they are held.[3]

Regarding the length of the restrictive measure, in addition to full compliance with it, Article 97 CrimC offers a range of possibilities for the judge or sentencing court: (a) to decree the cessation of any restrictive measure imposed as soon as the criminal dangerousness of the individual disappears; (b) to substitute the restrictive measure for another that it deems more appropriate or (c) to suspend the execution of the measure in view of the result obtained with its application.

Another aspect to be dealt with regarding the restrictive measure of confinement in a psychiatric prison is that of the breach of sentence, regulated in Article 100.1 CrimC. In these cases, the judge or court will order the re-entry of the inmate in the same institution from which he/she has escaped or in another one. In the event that the broken measure is not deprivation of liberty, the judge or court may substitute it for confinement (Art. 101.2

3 Luis Fernández Arévalo, 'Hospitales Psiquiátricos Penitenciarios y actividad penitenciaria', *Revista de Estudios Penitenciarios* (Homenaje al profesor Francisco Bueno Arús, Secretaría General de Instituciones Penitenciarias, Ministerio del Interior) (2006), pp. 249-264.

CrimC). In both cases, the third paragraph of the same provision obligates the judge to take the judgment into account and clearly indicates that refusal to submit to medical treatment, even if he/she has consented at the beginning, does not constitute a breach of the measure in itself.

In Spain there are only two psychiatric penitentiary hospitals: one in Alicante and the second in Seville. The psychiatric prison of Focalent in Alicante opened in 1984 and deals with penitentiary psychiatric care of the whole national territory, with the exception of Extremadura, Canary Islands, Andalusia, Ceuta and Melilla and Catalonia, as well as of the whole female prison population of all of Spain that is affected by psychiatric disorders on whom a confinement of restrictive measure has been imposed. Focalent penitentiary hospital has a capacity of 371 beds.[4] The psychiatric penitentiary hospital in Seville, which was inaugurated in June 1990, is responsible for the male prison population of Andalusia, Extremadura and the Canary Islands, as well as Ceuta and Melilla. It has a capacity of 158 beds.

We must highlight in this section the organizational and structural differences of psychiatric penitentiary hospitals with respect to regular prisons. On the one hand, Article 265.4 RP establishes that in psychiatric prisons there will be only three collegiate boards: the Board of Directors, the Economic-administrative Board and the Multidisciplinary Teams. On the other hand, the first paragraph of Article 265 RP organizes regular prisons around five collegiate bodies, the same as those in psychiatric prisons plus the Disciplinary Commission and the Board of Treatment in charge of the Technical Teams.

The modification in the structural organization chart of the psychiatric prisons, unlike regular prisons, is favoured by the absence of the classification system in degrees, which is the reason why the legislator did not feel it necessary to keep either the Treatment Board or the Disciplinary Commission, the latter due to the express prohibition of the disciplinary regime in these psychiatric prisons (Article 188.4 RP). In order to alleviate foreseeable problems due to the absence of the standard treatment board in regular prisons, the penitentiary administration published the circular 7/1996, of June 12th, through which, in its tenth paragraph, it assigned the functions of the Treatment Board to the Board of Directors. It is not a simple question, due to the great differences that separate these boards, in functions, composition and in their natures – purely treatment in the first place and regulatory in the second place.[5]

4 Secretaría General de Instituciones Penitenciarias, *Hospitales Psiquiátricos dependientes de la Administración Penitenciaria: Propuesta de acción*, Madrid: Ministerio del Interior, 2011.

5 Luis Fernando Barrios Flores, 'Origen, evolución y crisis de la institución psiquiátrico penitenciaria', 27 *Revista de la Asociación Española de Neuropsiquiatría* 100 (2007), pp. 473-500.

All of this presupposes the commitment to a bureaucratic penitentiary model instead of the treatment model of regular prisons, showing that decisions on issues related to prison treatment in psychiatric penitentiary hospitals are taken by a board comprising the Director of the psychiatric prison, the Deputy Director of Regimes, the Deputy Director of Treatment, the Director of Medical services, the Deputy Director of Staff, the Administrator and the Deputy Director of open prisons. Something similar occurs with the difference between the technical teams in regular prisons and the multidisciplinary mental health teams in psychiatric prisons. Article 185.2 RP states that in order to ensure an adequate level of care, psychiatric prisons must have at least one Multidisciplinary Mental Health Team, comprising the necessary professionals to provide the specialized assistance that the patients need, as well as for the execution of the reintegration programmes.

3.2 The high level of mental disorders among the Spanish prison population

The high level of mental disorders among the prison population is significant.[6] Specifically, in Spain (Catalonia aside), in 2014, there were a total number of 529 inmates complying with a restrictive measure of psychiatric internment.[7] If that number is subtracted from the 397 people hospitalized in the psychiatric penitentiary hospitals in Seville and Alicante, we have a total number of 132 inmates, who are complying with a restrictive measure in regular prisons. Several reports have highlighted that both the number and the acuity level of inmates with mental disorders are rising – even as the prison population is falling. Although prevalence estimates vary widely, the high level of mental disorders among the adult prison population is one of the biggest current challenges facing the Spanish correctional system.

Almost two decades ago, the Andalusian Ombudsman sent a report to the lower house of the Spanish Cortes Generales which, under the heading 'The situation of the mentally ill inmates in Andalusian prisons', showed the situation of these inmates through a thorough and detailed analysis and drew attention to the legal abandonment and the profound lack of protection of these people. The study focused on inmates with severe psychiatric disorders, excluding the occasionally mentally ill. In 1998, the number of chronically mentally ill prisoners in Andalusia reached 370, implying that 2% of inmates who entered

6 Juan Felipe Higuera Guimera, 'Penados con deficiencias psíquicas en establecimientos 'no psiquiátricos' penitenciarios', in: Francisco Bueno Arus, José Luís Guzmán Dalbora & Alfonso Serrano Maíllo (eds), *Derecho penal y Criminología como fundamento de la política criminal. Estudios en homenaje al profesor Alfonso Serrano Gómez*, Madrid: Dykinson, 2006, pp. 815-836.

7 Ministerio del Interior, *Anuario Estadístico 2014* (at: www.interior.gob.es/documents/642317/1204854/Anuario-Estadistico-2014.pdf/4c7f4a33-0b68-49ec-9abd-df470992f43b) (last visited: 12 October 2020).

prison had a chronic mental illness and about 4% were at that time chronically ill in Andalusian prisons.

Regarding the sample, the Andalusian Ombudsman indicated that the majority were young, chronic patients, finding some significant cases in people older than 60. On the other hand, the socio-demographic factors of the sample revolved around four considerations: they were people with (a) very low cultural level, almost illiterate; (b) very low economic level; (c) minimal professional skills and (d) a lack of specific family support.[8] In short, the sample showed a group of fully marginalized individuals or, at the very least, in danger of social exclusion, whose mental illness added to the stigma of being prisoners. Added to this situation is the absence, at that time, of any kind of mechanism for post-penitentiary social reintegration.

The Andalusian Ombudsman highlighted the lack of prison staff specialized in psychiatry with respect to medical treatment in prison and concerning social care. He indicated that the sole social care provided to these people was mainly based on family contacts. However, their family relationships were often damaged or broken due to the mental illness. Similarly, the report indicated the absence of classification in semi-open regimes and the non-granting of release permits.

The Andalusian Ombudsman concluded his report with eight recommendations: (1) the adoption of social and sanitary preventive measures in order to attend to the chronic mentally ill without family support; (2) the adoption of concrete and effective measures for the provision of social and sanitary means necessary for the care of the chronically mentally ill who do not have family support; (3) the establishment of specific coordination programmes to enable the mentally ill who remain in prison to receive adequate psychiatric care; (4) the promotion of the necessary care resources to guarantee the functional reintegration of the chronic mentally ill; (5) the creation of a public tutelary institution, responsible for the exercise of guardianship or guardianship of legally incapacitated adults; (6) the development of concrete social and health measures to accommodate chronically mentally ill inmates deprived of family support released from prisons; (7) the need to develop social and labour reintegration measures for the chronically mentally ill offenders, as far as possible and (8) the establishment of specific treatment programmes for the rehabilitation and social reintegration of the mentally ill inmates in prisons.

In 2007, the Sub-Directorate General of Prison Health echoed this problem and published a study called 'Study on mental health in prisons'. This is a descriptive study using data collected from the medical reports of a sample of 970 inmates from 64 Spanish

8 Defensor del Pueblo andaluz, *La situación de los enfermos mentales internados en Centros Penitenciarios andaluces*, BOPA nº 193, de 3-3-1998, Debate en Diario de Sesiones de la Comisión de Asuntos Sociales nº 220 serie A, Sesión celebrada el 9-12-1998, V Legislatura (at: www.defensordelpuebloandaluz.es) (last visited: 12 October 2020).

prisons.[9] The study concludes that one in four inmates suffers from psychiatric disorders, and if drug addiction is included, the rate increases to one in two. The study also notes that among inmates there is a 2 to 4 times greater chance of suffering from a psychotic disorder and a greater chance of depression than the general population, a probability that rises to ten times higher when it concerns an antisocial personality disorder.

In 2011, a report on the 'Prevention of Mental Disorders in Spanish Prisons' (PRECA Study) was published. It is a descriptive, epidemiological study that seeks to obtain reliable data on mental disorders in the prison population, using a sample of 707 inmates from five prisons situated in Catalonia, Madrid and Aragon.[10] The study concludes that the prevalence of psychiatric disorders among Spanish inmates is higher than in the general population. Thus, in a sample of the general Spanish population, it was estimated that the prevalence of mental disorder among men was 15.7% in 2006, while in the prison population it was about three times higher (42%). Similarly, it points out the relevance of drug addiction in the development of mental illness, noting that 76% of inmates had a history of substance use disorder – mainly alcohol and cocaine – and *also*, most prisoners with affective disturbances, anxiety or psychotic disorders *also* have a history of drug abuse. In fact, if drug addiction is excluded, a significant decrease in the rates of mental illness of prisoners is seen. In connection with this, the report also indicates that eight out of ten prisoners have suffered a lifetime of mental disturbance – including drug abuse – and that four out of ten were suffering from a mental disorder in the year that the study was carried out.

4 Treatment of prisoners with psychiatric disorders

Two tools in particular have been used by the penitentiary administration to try to solve or, at least, to improve the situation of mentally ill inmates who were declared in court to be criminally responsible for a crime. In part, these improvements reflect the recommendations that the Andalusian Ombudsman proposed in his report in 1998. However, for some of the aforementioned improvements to be implemented has taken a long time. These tools are the 'Program for Comprehensive Care for Mentally Ill Offenders in Prisons (PAIEM)' and the 'Social Mediation for Mental Illness Program'; for open prisons.

9 Secretaría General de Instituciones Penitenciarias, *Estudio sobre salud mental en el medio penitenciario*, Área de Salud Pública, Subdirección General de Coordinación de Sanidad Penitenciaria, Madrid: Ministerio del Interior, 2007 (at: www.msssi.gob.es).

10 Grupo Preca: *Informe sobre Prevalencia de Trastornos Mentales en Centros Penitenciarios Españoles*: Barcelona, 2011 (at: www.derechopenitenciario.com/comun/fichero.asp?id=2505) (last visited: 12 October 2020).

The PAIEM aims to respond to the health needs of the prison population. Its current version dates from 2013,[11] but the previous version of 2009,[12] established the basis of the protocol that was introduced after the implementation of the programme. PAIEM establishes three intervention objectives: (a) to detect, diagnose and treat all inmates suffering from some kind of psychiatric disorder; (b) to improve the quality of life of these people, increasing their personal autonomy and their adaptation to their environment and (c) to optimize their social reincorporation and the appropriate referral to a community health resource.

In order to achieve these objectives, an Individualized Rehabilitation Program (RIP) by the Multidisciplinary Mental Health Team in prisons is elaborated. This team comprises health staff, psychologists, educators, social workers – and whenever possible, NGOs or associations – the jurists in prison, the teachers, the sports trainers and a prison officer from the inmate's module. The prison officer also has the function of knowing the severity of the mental pathology of the inmates included in the PAIEM and is responsible for intervening from the moment the inmate is detected until his release from prison. The patient is assigned an auxiliary mental health support inmate and a tutor. The first helps the patient in all those tasks that the Multidisciplinary Team determines will help him in the process of adaptation to the programme. The second is the cornerstone of the PAIEM. In effect, the tutor is in charge of establishing a direct, close and stable relationship with the inmate, to increase his self-esteem and his safety. The tutor becomes the person of reference of the inmate, attending to him/her and making a closer follow-up of his/her illness. The tutor is one of the members of the Multidisciplinary Team, each one of whom should tutor one or more inmates. Finally, the PAIEM protocol envisages the elaboration of a Social Reintegration Plan whose objectives are to ensure the progressive transfer of inmates to mental health centres in the community.[13]

The Social Mediation for Mental Illness Program, whose latest version dates from 2014,[14] is intended as a complement to PAIEM, focusing on ensuring the continuity of care for the mentally ill offender who is awarded third grade or parole. In this way, it aims to consolidate a Multidisciplinary Team called 'the Bridge Unit', which works in open prisons. The main objective of the Bridge Unit is to coordinate the different administrations

11 Secretaría General de Instituciones Penitenciarias, *Protocolo de aplicación del programa marco de atención integral a enfermos mentales en centros penitenciarios*, 2009 (at: www.institucionpenitenciaria.es).

12 Secretaría General de Instituciones Penitenciarias, *Protocolo de aplicación del programa marco de atención integral a enfermos mentales en centros penitenciarios*, 2009 (at: www.institucionpenitenciaria.es).

13 J. Sanz, P. Gómez-Pintado, A. Ruiz, F. Pozuelo & J.M. Arroyo, 'Programa de Atención Integral al Enfermo Mental en las prisiones españolas (PAIEM). Valoración tras cuatro años funcionando', 16 *Revista Española de Sanidad Penitenciaria* 3 (2014), pp. 91-102.

14 Secretaría General de Instituciones Penitenciarias, *Protocolo de aplicación del Programa Puente de Mediación Social en enfermedad mental para Centros de Inserción social*, Madrid: Ministerio del Interior, 2014 (at: www.institucionpenitenciaria.es).

involved so that the inmate has all the resources necessary to continue recovery beyond prison available to him/her. In all phases of the programme, similarities and differences regarding the PAIEM programme are contemplated. In general, the main differences are a more common use of NGOs or volunteers outside of prison to achieve the social reincorporation of the inmate to the programme. The similarities are found in the inclusion criteria, the assignment of a tutor and the possibility of voluntary abandonment of the programme. The Bridge Unit members are a psychologist, a jurist, an educator or coordinator of the open prison and the professionals of the third sector – being able to include, in addition, a director of programmes, a teacher, a sports trainer, a prison officer and any other type of professional.

On the other hand, as a manifestation of the provisions of Article 190 RP, it is necessary to emphasize the 'Therapeutic Release Permits Program', promoted by the psychiatric prisons. Since June 17th 1985, a programme of psychological intervention in social skills training has been carried out, through the granting of therapeutic release permits from prison on a regular and scheduled basis, through the fulfilment of two key objectives: within the social scope, the development of the inmates in alternative social situations, their adaptation to diverse environments and the generalization of social habits and, within the institutional scope, the improvement of the inmates' expectations towards the institution.[15] This programme contemplates five different modalities of release permits: therapeutic release permits with hospital staff, therapeutic release permits with family, therapeutic release permits with volunteers, therapeutic release permits without accompaniment and release permits. Of all of them, the latter is of particular interest because they can last for longer than a month, depending on the individual circumstances of the patient. These release permits are spent in the home or in the shelter offered by the prison chaplaincy.

5 Community reintegration of prisoners with psychiatric disorders

While the issue of social reintegration is normally very complicated, it is even more so when it comes to psychiatric disorders. The stigma of a prison term is extremely detrimental to reintegration. The absence of care networks available after release from prison makes it difficult to reintegrate the psychologically ill, which, in many cases, leads to the continued re-entry of these patients in prison. In order for the patient to be reintegrated into society, it is essential that there is a positive relationship with a standardized family and social

15 Angeles López, 'El enfermo mental en prisión: perspectiva psiquiátrica', in: Silvia Ventura Mas & Fernando Santos Urbaneja (eds), *La respuesta judicial ante la enfermedad mental*, *Estudios de Derecho Judicial*, nº 92, Madrid: Consejo General del Poder Judicial, 2006.

environment, which accepts the patient and looks after his/her interests, facilitating his/her reintegration. Unfortunately, most mental patients in prison lack this standardized environment, either due to economic difficulties, which prevent the family from adequately caring for the patient, or because of the alteration that the patient can cause in the family unit. In addition, there are often cases in which crimes committed by the patient have occurred within the family or in the neighbourhood. In these cases, it is even possible for a court to establish the impossibility of returning to the place where the crime was committed, because of a restraining order. In those cases, in which the patient lacks a family support network who welcomes him/her, it is necessary for an institution to meet this need. This is where the greatest difficulties arise because there are no alternatives in the community. This results in patients having to remain in prison longer without parole, or longer as judicial internees, since the length of the internment restrictive measure, although it cannot exceed the limit established by law, can be affected according to the evolution of the psychiatric pathology and the resources available for life outside prison.

6 Conclusions

In this section, some criminal policy proposals are discussed in relation to several modifications on the basis of the restrictive measure of confinement in a psychiatric prison and the disappearance of psychiatric penitentiary hospitals.

6.1 Changes to the restrictive measure of confinement in a psychiatric prison according to the basis for the measure

Restrictive measures can be defined as criminal sanctions involving the deprivation or restriction of fundamental rights, which are applied by the courts according to the criminal dangerousness of the individual in order to achieve the sanction's end goal of prevention. Through the application of a restrictive measure of confinement in a psychiatric prison, the primary aspect of the assistance or therapeutic component is qualified to effectively and coherently achieve the re-socialization of the mentally ill person. This supposes eliminating along with the mental illness the supposed criminal dangerousness of the individual – so that he/she manages to regain sufficient personal autonomy to develop as a person in society. The basis of these measures is founded in the criminal dangerousness of the individual, defined as the state of social maladjustment of an individual. These are externalized by demonstrated behaviours contrary to orderly coexistence, typified as criminal offences, from which the relevant probability that the individual will continue to carry out harmful actions against society is derived.

In this sense, it is possible to appreciate two particular characteristics of criminal dangerousness: the fact that it is a prognostic judgment, that is to say, a calculation of probabilities; and that prognostic judgment is based on a previous criminal offence that will always tip the balance of the judgment, especially if we are talking about severe offences. To summarize, this prognosis of dangerousness has a certain static character,[16] which together with the psychiatric pathology enhances the stigma or prejudice against mentally ill offenders in society. Therefore, in addition to tipping the balance in probabilistic terms, it leads to difficulties in the social reintegration of the offender.

Without ignoring the above, it must be said that there is a fundamental rationale for restrictive measures – especially those of confinement in a psychiatric prison – which is rarely mentioned: the constitutional principle of equality envisaged in Article 14 of the Spanish Constitution. In its negative dimension, this principle requires different treatment of situations that are not the same, or, applied to the case, differential treatment by the legislative and judicial statements towards criminal responsible offenders or the unimpeachable. The latter, because of their pathology, are in a situation of incomprehension or amelioration from the criminal law, which justifies a legal response, lacking criminal reproach and focusing on the recovery, to the greatest extent possible, of the person affected by mental illness.

The end consequence of the aforementioned rationale is specifically in the change in emphasis of the restrictive measure of confinement in a psychiatric prison from a criminal dangerousness point of view to one of therapeutic necessity. Consequently, the most appropriate way to solve the existing problem in relation to mental illness would be to implement the therapeutic basis necessitating the restrictive measure of confinement in a psychiatric prison, which would be materialized in principally three ways:

1) The establishment of a length of internment, estimated on the basis of the therapeutic needs of the patient, setting the time of deprivation of liberty as the period strictly necessary for the stabilization of the mentally ill. This would favour, once agreed, the treatment on the outside, through therapeutic release permits, progressively increasing in duration, until reaching a period of semi-liberty and, finally, the definitive release. For this purpose, the provisions contemplated in both the PAIEM and the Bridge Programme can be used. Thus, once the total duration of the internment has been served, the patient is transferred to community-based mental health resources which monitor the patient.
2) The compliance with Article 191 RP with the creation of the Psychiatric Units to foster the social and family contacts of inmates, bringing the place of confinement closer to their homes, instead of sending them to the psychiatric penitentiary hospitals

16 Rodríguez Sáez & Leyva Grasa, 'El fundamento ético-jurídico de la medida de internamiento psiquiátrico', 7762 *Diario La Ley* (2011).

in Seville or Alicante. Regarding the non-creation of these prison psychiatric units, the judges of penitentiary surveillance, in point 18 of the conclusions and agreements of its XII Meeting, urged the penitentiary administration to create them. This request seeks to satisfy the demand for specialized psychiatric care in the different territorial areas, in accordance with the imperative contained in Article 3.4 LOGP.[17]

3) The possibility of developing an involuntary outpatient treatment to substitute short-term confinements in psychiatric prisons. This type of measure is more appropriate because it promotes the social development of the patient and contributes to the recovery from his/her illness.

Through the combined actions of these three aforementioned proposals, the quality of life of the mentally ill offenders declared unimpeachable or semi-attributable would be greatly improved. At the same time, the letter of the law would be better respected in regular prisons, once this group of inmates were transferred to the psychiatric units and would no longer be dealt with in the regular prison system.

6.2 Disappearance of psychiatric penitentiary hospitals

The growth in the number of mentally ill inmates is mainly attributed to the gap between the need for treatment and the availability of mental health services in the community, especially for those who require in-patient care. The deinstitutionalization of the mentally ill has resulted in the closure of large psychiatric hospitals or 'asylums' beginning in the 1980s, leaving many providers ill-equipped to service the large number of patients in community-based settings.

Over the last three decades, correctional facilities have become the *de facto* service providers for individuals with mental health disorders who come into contact with the law. Spain has established psychiatric penitentiary centres or hospital prison wards to offer specialized care to inmates with severe psychiatric disorders until they can be transferred to an outside forensic institution.

There are academics and professionals in matters of mental illness who are currently advocating the complete disappearance of hospital prisons. This option ultimately proposes the total attainment of psychiatric rehabilitation in the community, leaving aside the punitive character of the psychiatric penitentiary hospitals. This calls for the transfer of responsibility to the community to meet the needs of and rehabilitation of mentally ill offenders.

17 According to Art. 3.4 LOGP, 'The penitentiary administration shall ensure the life, integrity and health of inmates'.

In this sense, the argument for the disappearance of psychiatric penitentiary hospitals is based on the fact that prison is not the best place to care for these types of inmates for several reasons: (1) the overcrowding of these centres without an increase in human and forensic resources; (2) the lack of varied occupational periods; (3) prison subculture; (4) the deterioration or complete absence of the social ties of the patient, due to the remoteness of the only two psychiatric prisons in Spain; (5) a similar system in hospital prisons as regular prisons; (6) the lack of coordination with judges so as to improve, suspend or replace the measure when there is an improvement in the patients; (7) the absence of training for prison officers; (8) the lack of adequate treatment since the criminal offence, in many cases, often dates to well before being committed to psychiatric prison; (9) the confinement of restrictive measures in psychiatric prisons is increasingly of very short duration, which in practice supposes the impossibility of curing the mental illness; (10) the information on the inmates in psychiatric prisons is scarce, partial and limited; (11) in psychiatric prisons the prisoners are denied autonomy and personal responsibility; (12) the chronicity of many psychiatric pathologies means that, when serving long-term sentences the offender deteriorates; (13) in the vast majority of cases where the inmates are released, having reached the maximum time allowed for the measure, the medical treatment has not taken effect, and so criminal dangerousness is still present; (14) internment cannot be validly extended without taking into account the nature and extent of the mental illness; (15) many of the offenders are incapacitated, so their abilities are depleted, but they are still expected to understand and comply with prison regulations and routine; (16) insufficient number of psychiatric doctors and mental care staff; and (17) the board of directors in hospital prisons are highly bureaucratic, which leads them to prioritize regulations over care.[18]

18 Talia González Collantes & María Sánchez Vilanova, 'Psicopatía y medidas de seguridad', 34 *Estudios penales y criminológicos* (2014), pp. 127-171.

Defendants and detainees with psychiatric disturbances in the criminal process and in the prison system in the United States of America

Emilio C. Viano[*]

1 Introduction

Jails and prisons in the United States have *de facto* become the largest mental health institutions in the country. One could say that modern America has returned to practices first used in the colonial times. A 2014 report[1] by the Treatment Advocacy Center, a Virginia based non-profit group that promotes access to mental health care, in collaboration with the National Sheriffs Association, traces America's history of the problem. In summary, as early as the 1700s, "voices of protest in the colonies, claiming that confining mentally ill persons to prisons and jails was inhumane", led to the opening of the nation's first psychiatric ward at the Pennsylvania Hospital in Philadelphia in 1752 and the nation's first psychiatric hospital in Williamsburg, VA in 1773. In the 1800s movements exposing pervasive and appalling treatment and conditions in the nation's state prisons and county jails strengthened widespread acceptance that individuals with mental illness belonged in hospitals. By 1880, 75 public psychiatric hospitals existed in our young nation. An 1880 census concluded that less than 1% of individuals contained in prisons and jails were 'insane'.

Ironically, in the 1960s and 1970s, a well-intentioned policy shift both in the United States and in many other countries in Europe and elsewhere called 'deinstitutionalization', was rapidly adopted and implemented. It consisted of the authorities' decision to dramatically diminish the various states' psychiatric hospital population freeing patients to return to the community where they would, supposedly, receive the needed treatment in a more humane and realistic setting. This policy was based on the realization and

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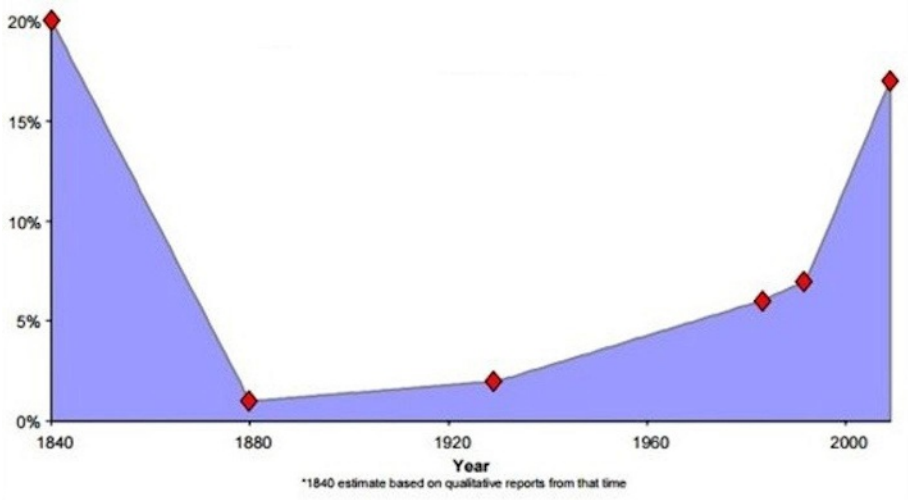
1 Report of the Treatment Advocacy Center and National Sheriffs Association, *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey*, 8 April 2014.

acceptance that it was inhumane to keep individuals locked up in hospitals, frequently under unacceptable, even abusive conditions, and that patients would be better served and enjoy a better quality of life living in the community, receiving their services through special programmes. There is no question that the policy was well-intended and based on research showing that many individuals with behavioural health challenges function better and even thrive while receiving treatment in community settings and with the support of family and friends. However, this approach, at times implemented rather quickly for budgetary reasons also, was missing important elements for its success, especially knowledge and experience on how to establish community-based treatment programmes taking into account that their evolution might be challenging and needing a major investment of funds for an extended period of time; that community acceptance was a crucial element and that it might not be easy to obtain; and that steady financing was paramount so that the needs of the mentally ill now living in the community could be met adequately and in a reliable manner. Unfortunately, one must say that this noble experiment eventually failed for many reasons, especially lack of experience and good planning, community rejection, and lack of sufficient and reliable funding. Thus, towards the end of the 20th century there was a return to the colonial times use of jails and prison to warehouse the mentally challenged who were also often caught up in the world of addiction and drug abuse leading to their arrest and prosecution. According to the Treatment Advocacy Center's 2014 report, in 2012, there were estimated to be 356,268 inmates with severe mental illness in prisons and jails.[2] That translates to 20% of inmates in jails and 15% of inmates in state prisons. The graph shown in Figure 1 illustrates this full circle historical cycle.[3]

2 *Ibid.*

3 Report of the Treatment Advocacy Center, *More Mentally Ill Persons are in Prisons and Jails than Hospitals: A Survey of the States*, 2010.

Figure 1 Percentage of jail and prison inmates with serious mental illness



The financing of mental health programmes by the government, federal and states, is quite limited. In part because of the stigma still attached to mental illness and addiction that does not facilitate an open discourse on the problem and therefore the needed support. Mental health is not a priority and therefore the public funds provided are insufficient and often unreliable. Private insurance provides limited 'lifetime coverage' (alcoholism and drug addiction treatment is normally limited to a 30-day programme) and the reimbursement provided to the mental health professionals and institutions is so limited that participation in insurance plans is discouraged because co-payments can be high and unaffordable. The result is that access to care is in reality quite restricted. All of this is complicated by the reality that many persons with mental challenges are also involved in substance abuse, legal or illegal. The National Center on Addiction and Substance Abuse at Columbia University found that in the United States only about 1 in 10 people with addiction involving alcohol or drugs other than nicotine receives any form of treatment.[4] Another study by the same National Center found that "of the 2.3 million inmates crowding (the) nation's prisons and jails, 1.5 million meet the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) medical criteria for substance abuse or addiction. Another 458,000 inmates, while not meeting the strict DSM-IV criteria, had histories of substance abuse; were under the influence of alcohol or other drugs at the time of their crime;

4 Report of the National Center on Addiction and Substance Abuse, *Addiction Medicine: Closing the Gap between Science and Practice*, New York: Columbia University, 2012.

committed their offense to get money to buy drugs; were incarcerated for an alcohol or drug law violation; or share some combination of these characteristics".[5]

Thus, in the United States, the challenge of mentally ill inmates in jails and prisons is the result of several policies coming together to cause this critical situation: draconian penalties for drug abuse, including 'soft' drugs; high numbers of inmates generated by mandatory sentencing laws, especially those punishing drug use; therefore overcrowding in jails and prisons making it very difficult to provide the individualized attention and diagnosis needed to then properly address the problem; very limited funds allocated for the provision of mental health services (at times only 1% of the overall correctional budget); building of prisons in remote and isolated areas to generate local employment and income in economically depressed regions making it hard to find a pool of mental health specialists to work in the institutions; lack of training and skills on the part of correctional personnel faced with mentally ill inmates that they do not know how to handle except, often, with excessive force, isolation, and even serious mistreatment (e.g. use of straight jackets or strapping inmates to restraining chairs for prolonged periods of time) and over-medication to tranquilize them; the insufficient public and private health insurance plans and the current uncertainty about the existing law to provide universal health care and more, all come together to maintain and even worsen the dire situation of mental health services in jails and prisons for the foreseeable future. The draconian budget cuts proposed by the last President for the 2018 budget favouring dramatically increased military spending and gutting basically all services for the poor, the addict, the homeless, those encountering financial and health crises and more, do not indicate that a reversal of policies and practices will occur any time soon. Most basic of all is that correctional institutions, now crowded with mentally challenged inmates, are not psychiatric or psychological entities for the cure of mental illness.

It appears that presently the situation of defendants and detainees with psychiatric disturbances in the criminal process is also influenced by various trends: prejudice and denial about mental illness and addiction; the widespread opioid and other drugs, legal or illegal, addiction in the country; a punitive attitude of large segments of the population toward the deviant, the addict, the homeless and the poor; the overall narrative and values of the country that underline individualism and personal material success more than communal and mutual help, support and compassion. On the other hand, courageous and innovative programmes, often funded by enlightened and socially responsible foundations and donors, are keeping the flame of hope alive; support the growth of the pool of positive experiences; and continue pointing us in the right direction.

5 Report of the National Center on Addiction and Substance Abuse, *Behind Bars II: Substance Abuse and America's Prison Population*, New York: Columbia University, 2010, Results Summary Section.

2 Defendants with psychiatric disturbances during pre-trial inquiry and at trial: fair procedure

2.1 Pre-trial

General Application – Special Guarantees During Pre-trial Inquiry

The Fifth Amendment of the U.S. Constitution[6] guarantees protection of the rights of the citizens from possible misuses by the government during legal proceedings. The Fifth Amendment states that no person "shall be compelled in any criminal case to be a witness against himself". A request to testify can lead to an erroneous self-incrimination of the accused. When an individual is arrested, he is taken into custody and subject to interrogation.[7] Unfortunately, the Fifth Amendment has not always been able to protect the rights of an individual and the privilege against self-incrimination has been often jeopardized. Thus, it was essential to create procedural safeguards that could ensure a fair pre-trial inquiry in a custodial setting. It was the landmark decision of the United States Supreme Court in *Miranda v. Arizona*[8] which established that some fundamental warnings must be given, in clear and unambiguous terms, to the accused before questioning him in a custodial interrogation. The case established that the individual has the right to the presence of an attorney, the right to information that he can understand, the right to remain silent during police interviews and that he must be provided with the warning that any of his statements can be used against him.[9] It is only after the warnings are read to the individual, that the accused can 'knowingly and intelligently'[10] waive these rights and agree to be interrogated.

Nevertheless, in *Miranda*, the U.S. Supreme Court left it to Congress and the States to formulate other effective safeguards concerning the rights of the individual in a pre-trial inquiry. The only requirement was that those methods of protection must be as effective as the warnings in Miranda.[11] Two examples of safeguards enacted after the Supreme Court decision in Miranda are as follows: 18 U.S.C. § 3501 and Rule 5(d) of the USCS Federal Rules of Criminal Procedure. Two years after the decision in Miranda, the Congress enacted 18 U.S.C. § 3501, in which sections (a) and (b) were focused on *Miranda*'s rights. In particular, §3501(a) provides that "in any criminal prosecution brought by the United

6 USCS Constitution Amend. 5.

7 American Bar Association, *How Courts Work, Steps in a Trial* (at: www.americanbar.org/groups/public_education/resources/law_related_education_network/how_courts_work/arrestprocedure.html) (last visited: 25 April 2017).

8 *Miranda v. Arizona*, 384 U.S. 436 (1966).

9 *Miranda v. Arizona*, 384 U.S. 444 (1966).

10 *Ibid.*

11 *Miranda v. Arizona*, 384 U.S. 490 (1966).

States", a confession "shall be admissible in evidence if it is voluntarily given". The statute requires that the trial judge must assess the voluntariness of the statement based on the totality of the circumstances.[12] However, § 3501(b) also states that the 'presence or absence' of any particular factor "need not be conclusive on the issue of voluntariness of the confession".[13] The statute was later considered as a failed attempt to overrule the U.S. Supreme Court's decision in *Miranda*.[14] Rule 5(d) of the USCS Federal Rules of Criminal Procedure[15] sets a clear procedure aimed to protect the rights of the defendant who is charged with a felony. Moreover, the rights under the rule are similar to the ones granted under *Miranda*. It is important to note that if a defendant waives his *Miranda* rights, he cannot later seek any of the protections that are granted under Rule 5.

2.1.1 Miranda rights – failed protection?

The *Miranda*'s rights can be only validly waived in the circumstance in which the accused has understood both the nature of his rights and the consequences that derive from waiving them. In the case in which the individual has not 'knowingly and intelligently' waived his rights, then the evidence obtained during the interrogation cannot be used against him in a court of law.[16] In addition, every statement made by the individual must be voluntary. Even if, to some extent, the nature of a custodial interrogation is *de facto* coercive, the individual must spontaneously decide whether he should make a statement or not, without any form of physical or psychological pressure or intimidation.[17]

The *Miranda*'s warnings must be granted each time an individual is subject to custody. In the case of *United States v. Mendenhall*,[18] the Supreme Court decided that an individual is considered 'in custody' if a reasonable person, in the same position of the accused, would believe that he is not free to leave the interrogation.[19] The adequacy of the individual's competency to waive his *Miranda* rights could be litigated before the judge. For example, in *People v. Knapp*,[20] the Supreme Court of New York established that the trial court "erred in refusing to suppress [the defendant's] confession on two grounds, i.e., that he did not knowingly, voluntarily, and intelligently waive his Miranda rights because he lacked the

12 Title 18 - Crimes and Criminal Procedure, Section 3501(b), p. 686 (at: www.gpo.gov/fdsys/pkg/USCODE-2009-title18/pdf/USCODE-2009-title18-partII-chap223.pdf).

13 *Ibid.*

14 Department of Justice, Office of Legal Policy, *Truth in Criminal Justice' Series Office of Legal Policy: The Law of Pretrial Interrogation*, 22 U. Mich. J.L. Reform 437, 442 (1989), *Dickerson v. United States* 530 US 428, 431 (2000).

15 *Miranda v. Arizona, supra* note 8, at 479.

16 Federal Rules of Criminal Procedure, Rule 5(d) (at: www.justia.com/criminal/docs/frcrimp/rule5.html) (last visited: 13 April 2017).

17 *Miranda v. Arizona, supra* note 8, at 462.

18 *United States v. Mendenhall*, 446 U.S. 544 (1980).

19 *Ibid.*

20 *People v. Knapp*, 124 A.D.3d 36 (2014).

capacity to do so, and because his intellectual limitations, combined with coercive police tactics, rendered his statements involuntary".[21]

A form of protection is afforded to juveniles. Indeed, minors are more inclined to feel coerced by the presence of police officers. Furthermore, they are more susceptible to answer the questions when, instead, a reasonable adult in the same situation would consider that he is free to leave the interrogation. As such, in *J.D.B. v. North Carolina*,[22] the Supreme Court established that a child's age must be taken into account especially when it "was known to the officer at the time of the interview",[23] or when it "would have been objectively apparent to a reasonable officer".[24] In such circumstances, the interrogation must be perceived 'in custody' and the *Miranda* rights must be granted to the minor.[25] However, the Supreme Court decision did not explicitly state that every time that a juvenile is interrogated this situation creates an 'in custody' situation. Instead, it seems clear that the Court will evaluate police interviews of minors more cautiously.

In addition, *Miranda* fails to require evidence of what the suspect understood at the time of the interrogation. For most defendants who suffer from psychiatric disturbances, the courts usually consider the mental disability as only one of the factors that must be considered in the totality of the circumstances. Numerous concerns are expressed regarding a judgment *a posteriori* about the competence of the individual to waive his *Miranda* rights. Indeed, an evaluation of suspect's IQ, mental health and previous experience with the criminal justice system, cannot truly replace the information regarding the accused's knowledge and understanding at the time of the waiver. For instance, in *People v. Richardson*,[26] the Appellate Court decided that "despite his cognitive impairment, at the time of evaluation, the problem was not so severe as to compromise his ability to understand the nature and purpose of the proceedings pending against him".[27]

Research shows that the *Miranda* warnings do not necessarily protect the most vulnerable.[28] In fact, it has been proven that adults with mental disabilities and juveniles do not often understand the meaning of the *Miranda* warnings and lack the capacity to understand the nature of their rights.[29] Hundreds of individuals have been incarcerated for crimes that they did not commit.[30] The introduction of the DNA evidence has, and

21 *People v. Knapp*, 124 A.D.3d 38 (2014).
22 *J.D.B. v. North Carolina*, 564 U.S. 261 (2011).
23 *J.D.B. v. North Carolina*, 564 U.S. 274 (2011).
24 *Ibid.*
25 *J.D.B. v. North Carolina*, 564 U.S. 281 (2011).
26 *People v. Richardson*, 1-11-3075 (2015).
27 *Ibid.*, at 19.
28 Andrew Guthrie Ferguson, 'The Dialogue Approach to Miranda Warnings and Waiver', 49 *American Criminal Law Review* 1437 (2012), p. 20.
29 *Ibid.*, p. 21.
30 Innocence Project, *False Confessions or Admissions* (at: www.innocenceproject.org) (last visited: 21 April 2017).

continues to, support cases of wrongful convictions.[31] They are mostly individuals with psychiatric disturbances or juveniles who, due to pressure, their age or mental impairment, feel compelled to confess to a crime that they never committed.[32]

Despite growing evidence showing a connection between mental illness and wrong convictions, the situation does not seem encouraging. Since 2005, an increasing number of court decisions affirm that juveniles have the mental capacity to waive their *Miranda* rights. In evaluating whether the minor 'knowingly and intelligently' waived his *Miranda* rights, the courts take into account the following factors: whether there was coercion by the police and whether the minor had past experience(s) dealing with the law enforcement. In addition, in *Fare v. Michael C*,[33] the Court also established the principle of 'totality of the circumstances'. This means that the Court, in evaluating the competency of the minor, must take into account the "juvenile's age, experience, education, background, and intelligence, … capacity to understand the warnings given him, …, and the consequences of waiving those rights".[34] The lack of adequate protection concerning mentally ill people and minors, has led to the opinion that new procedural mechanisms must be created in order to promote a non-waivable right to legal counsel prior to a juvenile's interrogation.[35] It has also been suggested that the authorization of parents or guardians for juveniles to waive their *Miranda* rights must be considered insufficient without the presence of an attorney.[36]

In connection with people who suffer from psychiatric disturbances, it has been reported that there is an overrepresentation of people who suffer from mental illnesses detained and incarcerated in the United States.[37] Currently, there are ten times more people who suffer from mental illness present in jails and prisons than in psychiatric hospitals.[38] It is also interesting to note that almost one in three women incarcerated in the United States is mentally ill.[39] Where the psychiatric disturbance is not present, however, incarcerated women often share a history of trauma in their lives. The criminal justice setting and the

31 Richard A. Leo, 'False Confessions: Causes, Consequences, and Implications', 37 *The Journal of the American Academy of Psychiatry and the Law* 3 (2009) (at: http://jaapl.org/content/37/3/332).

32 *Corley v. United States*, 556 U.S. 303, 321 (2009).

33 *Fare v. Michael C.*, 442 U.S. 707 (1979).

34 *Fare v. Michael C.*, 442 U.S. 725 (1979).

35 Natalie Short, 'Mitigating "The Coercive Effect of the Schoolhouse Setting": Adolescents' *Miranda* Rights and Law Enforcement Interrogations at Schools', 19 *New Criminal Law Review* 93 (2016), p. 8.

36 *Ibid.*

37 Aaron Levin, *Initiative Aims to Reduce Number of People With Mental Illness in U.S. Jails*, American Psychiatric Association, 28 May 2015 (at: http://psychnews.psychiatryonline.org).

38 *Ibid.*

39 Mark Moran, *Mental Illness Highly Prevalent Among Incarcerated Women*, American Psychiatric Association, 7 March 2014 (at: http://psychnews.psychiatryonline.org).

use of physical restraint can exasperate past phenomenon of trauma and provide the perfect setting for the beginning of a mental illness.[40]

2.2 Trial

The criminal justice system has an increasing number of detainees who suffer from mental conditions. As a consequence, mental health law involves more criminal justice matters and has progressed from being largely civil to both civil and criminal.[41] For instance, people who suffer from mental illnesses have a higher likelihood of being unfairly targeted with death penalty charges.[42] As such, it also appears that the death penalty is disproportionately charged when a defendant suffers from a mental disability.[43]

2.2.1 Competency – Is the defendant able to stand trial?

First, it is essential to ensure due process in all parts of the legal proceedings. The defendants who suffer from psychiatric disturbance must be fully aware of the nature of the proceedings and the consequences of the decision. The U.S. Supreme Court's decision in *Dusky v. United States*[44] established that the "test must be whether he has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding - and whether he has a rational as well as factual understanding of the proceedings against him".[45] The 'competency standard' was also applied by the U.S. Supreme Court in *Godinez v. Moran*[46] in connection with the defendant's competency to plead guilty or waive the right to counsel.

2.2.2 Guarantees and aid to demonstrate incompetency to stand trial

Defense counsel, prosecution and judges have the duty to investigate if incompetency of the defendant is suspected. In this case, if a mental examination is required, it will be conducted in a maximum-security hospital, and it will assess whether the individual is incompetent to stand trial. In the case in which the attorney does not investigate signals of the client's mental problems and consequently provides an inadequate representation to the defendant, the court has a duty to require a mental examination. In *Coleman v. State*,[47] the Supreme Court stated that "[o]nce a mental health evaluation has occurred,

40 *Ibid.*
41 John Parry, *4-20 Treatise on Health Care Law Section 20.7*, p. 1 (at: https://advance.lexis.com).
42 Aaron Levin, *Some Prosecutors Said to Unfairly Target Those With Mental Illness*, American Psychiatric Association, 1 December 2014 (at: http://psychnews.psychiatryonline.org) (last visited: 4 May 2017).
43 *Ibid.*
44 *Dusky v. United States*, 362 U.S. 402 (1960).
45 *Ibid.*
46 *Godinez v. Moran*, 509 U.S. 389 (1993).
47 *Coleman v. State*, 127 So. 3d 161 (2013).

the trial court must hold a separate competency hearing before the trial begins. If a criminal defendant's mental competence is questioned during trial, and a motion for mental examination is granted, the trial must be suspended until a mental examination is completed and a separate hearing on mental competency is conducted. A failure to follow this procedure is not cured by a retrospective competency hearing".[48] If the Court fails to hold a competence hearing, the judgment must be reversed.[49]

2.2.3 If the accused is considered to be mentally incompetent to stand trial – what next?

An essential element of fair trial and due process is the presumption of innocence in favour of the accused. As such, a mentally ill defendant who is found to be incompetent to stand trial, and is not yet convicted, must be presumed innocent. However, mentally incompetent defendants are regularly confined in maximum-security units of mental hospitals until they are competent to stand trial.[50]

2.2.4 Special procedures

A mental disorder is defined by the DSM-5 as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities […]".[51] Special approaches for mentally ill people include: 'incompetency to stand trial', 'not guilty by reason of insanity', 'guilty but mentally ill' and 'diminished capacity'.[52]

A similar procedure is designed for the defendant who is found 'incompetent to stand trial' and a defendant 'not guilty by reason of insanity'. For both defences, the disposition is not supposed to be punitive. However, the individual will be confined. The reasons behind the confinement are for the protection of society at large and for providing the individual with medical treatment (if he was found 'incompetent to stand trial' then he will be confined until his mental health is restored). In addition, if the individual is 'not guilty by reason of insanity', he would be acquitted because he lacks the *mens rea*, and consequently, lacks criminal responsibility. For this reason, the individual cannot be punished. However, due to the *actus reus* he will be confined in order to receive treatment.

48 *Coleman v. State*, 127 So. 3d 168 (2013).

49 *Sanders v. State*, 9 So. 3d 1132, 1133 (2009).

50 Grant H. Morris, Ansar M. Haroun & David Naimark, 'Competency to Stand Trial on Trial', 4 *Houston Journal of Health Law & Policy* 193 (2004), p. 2 para. 194.

51 Eric R. Maisel, *The New Definition of a Mental Disorder* at: www.psychologytoday.com/blog/rethinking-psychology/201307/the-new-definition-mental-disorder (last visited: 7 May 2017).

52 John Parry, *supra* note 41, at p. 1.

A test to assess insanity was developed by the British House of Lords in the case of *M'Naghten*[53]: "[A]t the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong".[54] The *M'Naghten* test was adopted as such in a number of states in the United States. It was later modified in *Smith v. United States*[55] with the 'irresistible impulse test': "The modern doctrine is that the degree of insanity which will relieve the accused of the consequences of a criminal act must be such as to create in his mind an uncontrollable impulse to commit the offense charged. This impulse must be such as to override the reason and judgment and obliterate the sense of right and wrong to the extent that the accused is deprived of the power to choose between right and wrong".[56] An alternative to the 'irresistible impulse test' is the *Durham*[57] role which states that "[a]n accused is not criminally responsible if his unlawful act was the product of mental disease or mental defect".[58] Thus, different standards have been used in different states of the Union.

It is of note that in 1984, the Insanity Defense Reform Act[59] was the first federal act created to regulate the insanity defence. The Act did not abolish the insanity defence, but restricted the application of *M'Naghten* and created more limits to apply the insanity defence. Significant provisions include the fact that it "placed the burden of proof on the defendant to establish the defense by clear and convincing evidence, limited the scope of expert testimony on ultimate legal issues, eliminated the defence of diminished capacity […]".[60] Prior to the enactment of the law, the federal standard for 'insanity' was that the government had to prove a defendant's sanity beyond a reasonable doubt (assuming the insanity defence was raised). Following the Act's enactment, the defendant has the burden of proving insanity by 'clear and convincing evidence'.[61] Expert witnesses for either side are prohibited from testifying directly as to whether the defendant was legally sane or not.[62] They can only testify as to his mental health and capacities, with the question of sanity itself to be decided by the finder of fact (the jury or the judge) at trial.

53 M'Naghten's Case 10 C & F 200 (1843) at: http://swarb.co.uk.
54 *Ibid.* at: http://swarb.co.uk/daniel-mnaghtens-case-hl-1843/.
55 *Smith v. United States*, 36 F.2d 548 (D.C. Cir. 1929).
56 *Smith v. United States*, 36 F.2d 549 (D.C. Cir. 1929).
57 *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954).
58 *Durham v. United States*, 214 F.2d 874-875 (D.C. Cir. 1954).
59 Insanity Defense Reform Act of 1984. Criminal Resource Manual 634 (at: www.justice.gov/usao/eousa/foia_reading_room/usam/title9/crm00634.htm).
60 United States Department of Justice, *634. Insanity Defense Reform Act of 1989* (at: www.justice.gov/usam/criminal-resource-manual-634-insanity-defense-reform-act-1984) (last visited: 5 May 2017).
61 *United States v. Freeman*, 804 F. 2d 1574 (11th Cir. 1986).
62 *Ibid.*

Mounting criticism of the insanity defence as a way for suspects to evade conviction led some states to introduce a new category: 'guilty but mentally ill'.[63] Mental health services are required to rehabilitate the individual once he has served his sentence. However, defendants found guilty but mentally ill tend to receive the same sentencing as guilty defendants without mental illness. It has been suggested that treatment is mostly insufficient and that the real scope of this special procedure is to imprison the individual for an undetermined time rather than providing him with psychiatric assistance and care.[64] In some cases, the death penalty has been applied to defendants who are guilty but mentally ill.[65] Being profoundly mentally ill is not enough to avoid the death penalty, even though over the past decade, U.S. courts have barred the death penalty for the intellectually disabled and for juveniles. The Supreme Court found that they have less culpability due to their lower mental functioning and immaturity. To avoid the death penalty one has to be deemed 'legally insane'.[66] The 'insane' is narrowly defined as "those who are unaware of the punishment they are about to suffer and why they are to suffer it" – a definition that excludes most people with severe mental illness.[67] The supreme courts of Illinois and Indiana have ruled expressly that the death penalty may be imposed on a guilty but mentally ill defendant. The Georgia General Assembly has taken action[68] that could be read to evidence a decision that guilty but mentally ill defendants may be sentenced to death.[69]

The American Bar Association[70] and other organizations oppose executing mentally ill convicts because individuals with serious mental illness can be threatened and coerced into false confessions, have difficulty understanding their rights, and have less access, because of their mental illness, to safeguards designed to protect fundamental rights, including the right to effective assistance of legal counsel.[71] Eight states with the death

63 The GBMI was first adopted in Michigan in 1975. It stemmed from the 1974 case of *People vs. McQuillan*, 392 Mich. 511 (1974), 221 N.W.2d 569, No. 11 April Term 1974, Docket No. 54, 613, Supreme Court of Michigan, Decided 6 September 1974 (at: http://historyforensicpsych.umwblogs.org).

64 John Parry, *supra* note 41, p. 1 and 2.

65 Mark Bookman, '13 Men Condemned to Die Despite Severe Mental Illness', *Mother Jones* (2013) (at: www.motherjones.com/politics/2013/01/death-penalty-cases-mental-illness-clemency).

66 Anne S. Emanuel, 'Guilty But Mentally Ill Verdicts and the Death Penalty: An Eighth Amendment Analysis', 68 *North Carolina Law Review* 37 (1989) (at: http://scholarship.law.unc.edu).

67 Shaila Dewan, 'Does the U.S. Execute People with Mental Illness? It's Complicated', *The New York Times* (2017) (at: www.nytimes.com/interactive/2017/us/mental-illness-death-penalty.html).

68 See Act of 7 April 7, 1988, No. 1313, 1988 Ga. Laws 1003, 1004, 1010 (codified at GA. CODE ANN. §§ 17-7-131(b)(1)(E), -1310) (Supp. 1988)).

69 See *Thompson v. Oklahoma*, 108 S. Ct. 2687, 2707 (1988) (O'Connor, J., concurring), pointing out that Congress did not indicate whether it considered the eligibility of 15-year-olds for the death penalty when it passed the Comprehensive Crime Control Act of 1984, which lowers to 15 the age at which a defendant may be tried as an adult.

70 Severe Mental Illness and the Death Penalty. American Bar Association Death Penalty Due Process Review Project, American Bar Association, December 2016 (at: www.americanbar.org).

71 Death Penalty Information Centre, *Mental illness and the death penalty* (at: https://deathpenaltyinfo.org/mental-illness-and-death-penalty).

penalty are considering a ban on capital punishment for people with mental illnesses or brain injuries, although only one statute has passed. In 2012, Connecticut exempted a capital defendant from execution if his "mental capacity was significantly impaired or [his] ability to conform [his] conduct to the requirements of law was significantly impaired but not so impaired in either case as to constitute a defence to prosecution".[72] This applies only to future offences.

The criminal justice system's failure to guarantee due process for people with mental illnesses makes discriminatory application of the death penalty more likely. Overall, the administration of the death penalty is increasingly fraught with enormous expense, too-frequent errors and unequal application.

As a final special procedure and a mitigating factor, there is the 'diminished capacity' category. It is the judge that has the discretion to consider it a mitigating or an aggravating factor.[73] The basis of the mitigating factor in such an instance is that the defendant's culpability is considered diminished.[74] Conversely, the basis of the aggravating factor in this instance is considered as an element that increases the possibility to commit crimes in the future.[75]

Generally, the courts do not accept the voluntary use of intoxicants as a defence. However, courts are more willing to allow this defence where the intoxication was unintentional and caused by medication.[76]

3 Detainees with psychiatric disturbances during provisional detention: needs, problems, screening tools

3.1 Problems in dealing with detainees who suffer from psychiatric disturbances and are held in provisional detention

The way in which the United States' criminal justice system deals with mental health is problematic. The criminal justice system is more often considered an alternative to the civil commitment to provide access to treatment, community services and medication for the individuals that suffer from psychiatric disturbances. The treatments provided by the criminal justice system are insufficient and the lack of specific training of the staff, the

72 General Statute § 53a-46a (h)(3) (2009).
73 Carissa Byrne Hessick & Douglas A. Berman, 'Towards a Theory of Mitigation', 96 *B.U.L. Rev.* 161 (2016), p. 175.
74 *Ibid.*
75 *Ibid.*
76 John Parry, *supra* note 41, p. 119.

inadequate facilities and unawareness regarding mental illness do not improve the general condition of detainees who suffer from psychiatric disturbances.

The reason why a growing number of mentally ill people currently find themselves in the criminal justice system instead of in psychiatric institutions started after World War II, when the mental health care system in the United States was reformed significantly. On 3 July 1946, the National Mental Act was enacted with the aim of amending the Public Health Service Act and finding "more effective method[s] of prevention, diagnosis, and treatments" of mental disorders[77] alongside other objectives. In addition, the Act authorized the institution of a major research and intervention centre known as the 'National Institute for Mental Health'. Also funds for the construction of community mental health centres were provided.[78] The reforms enacted by the Act were aimed at improving the mental health of Americans by investing in research, experiments and the training of personnel.[79] However, with the end of World War II, many veterans were returning to the United States in precarious mental conditions. There is evidence[80] that shows that between 1947 and 1950, more than 2,000 mentally ill veterans where lobotomized[81] in the United States.[82] The use of lobotomies performed on mentally ill people then decreased due to public concern regarding the efficacy of treatments in institutions which were considered overcrowded and archaic, and to the entrance into to the U.S. market of the first antipsychotic drugs in the mid-1950s.[83]

However, it was in the 1960s that the process known as 'deinstitutionalization'[84] began. On 31 October 1963, President John F. Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act,[85] known as 'Community Mental Health Act'.[86] The Act provided grants to states for the construction of public and non-profit

77 79th Cong., 2D Sess, *National Mental Health Act*, July 3, 1946, p. 421.

78 *Ibid.*, p. 425.

79 *Ibid.*, p. 421.

80 Michael M. Phillips, 'The Lobotomy Files: Forgotten Soldiers', *The Wall Street Journal* (at: http://projects.wsj.com/lobotomyfiles/) (last visited: 11 May 2017).

81 In the 1940 and the1950s, lobotomy was widely used to 'cure'" mental illness. Even the oldest sister of President John F. Kennedy, Rosemary, was lobotomized to cure what today would be considered a learning disability. From a vibrant and attractive young woman she was reduced to a feeble and dependent person for the rest of her life by a decision of her father, it is said, to protect the image and social status of the Kennedy family.

82 *Ibid.*

83 Matt Ford, 'America's Largest Mental Hospital is a Jail', *The Atlantic*, 8 June 2015 (at: www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/) (last visited: 12 May 2017).

84 Open Society Foundation, *What is Deinstitutionalization?*, April 2015 (at: www.opensocietyfoundations.org/explainers/what-deinstitutionalization) (last visited: 16 May 2017).

85 Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, 77 Stat. 282, 31 October 1963.

86 Matt Ford, *supra* note 83.

facilities for mentally ill people[87] with the aim of reducing the number of patients confined in mental institutions and directing the mental treatments towards community care.[88] Despite federal legislation and policies encouraging the deinstitutionalization process, the public mental health system in the United States was failing, as it is today.[89] No adequate services and treatments are available for mentally ill people and many are victims of suicide, substance abuse, homelessness and incarceration.[90] Indeed, it has been estimated that more than two million people who suffer from mental illness are incarcerated each year.[91] Although the criminal justice system considers that everyone must be considered innocent until proven guilty,[92] in reality, many individuals are currently in U.S. jails without going to trial or being convicted.[93] In fact, jails differ from state and federal prisons, due to the fact that they are mostly run at the local county or city level. Millions of individuals are detained annually in county jails[94] (not all at the same time). Los Angeles County (with approximately 19,185 detainees in 2014), Rikers Island New York, Cook County in Illinois, Harris County in Texas, and Philadelphia are the five largest jails in the United States.[95] It has been reported that in Los Angeles County, between 2009 and 2016, there was an increase of 60% of detainees who suffered from psychiatric disturbances.[96] The current number of mentally ill people present in jails has been estimated to account for more than 25% of the detainee population in Los Angeles.[97]

It is of note that jails and prisons do not only have problems dealing with detainees and prisoners who suffer from psychiatric disturbances at the time of the detention. Many detainees and prisoners that apparently do not suffer from any psychiatric disturbance may also develop psychiatric disturbances as a consequence of the predominant conditions

87 Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, *supra* note 85, p. 286.

88 Laura E. Hortas, 'Asylum Protection for the Mentally Disabled: How the Evolution of Rights for the Mentally Ill in the United States Created a "Social Group"', 20 *Connecticut Journal of International Law* 155 (2004), p. 161.

89 Young Minds Advocacy, *The Community Mental Health Act of 1963 – Still Pursuing the Promise of Reform Fifty Years Later*, 31 October 2013 (at: www.ymadvocacy.org) (last visited: 8 May 2017).

90 *Ibid.*

91 National Alliance on Mental Illness, *Jailing People With Mental Illness*, 2015 (at: www.nami.org) (last visited: 12 May 2017).

92 *Coffin v. United States*, 156 U.S. 432, 404-405 (1895).

93 National Alliance on Mental Illness, *supra* note 91.

94 Human Rights Watch – World Report 2016, *United States, Events of 2015*, 2015 (at: www.hrw.org) (last visited: 16 May 2017).

95 Breeanna Hare & Lisa Rose, 'Pop. 17,049: Welcome to America's largest Jail', CNN, 26 September 2016 (at: www.cnn.com/2016/09/22/us/lisa-ling-this-is-life-la-county-jail-by-the-numbers/) (last visited: 12 May 2017).

96 *Ibid.*

97 *Ibid.*

of the incarceration.[98] According to Human Rights Watch "[j]ail and prison staff throughout the US use unnecessary, excessive, and even malicious force against prisoners with mental disabilities. Although no national data exists, research … indicates that the problem is widespread and may be increasing in the country's more than 5,100 jails and prisons".[99]

In addition, there is a widespread belief in society that the treatment of mental illness provides an unfair avenue to deliberately avoid punishment.[100] In *Addington v. Texas*,[101] the Supreme Court affirmed that "[t]he state has a legitimate interest under its parens patriae powers in providing care to its citizens who are unable because of emotional disorders to care for themselves; the state also has authority under its police power to protect the community from the dangerous tendencies of some who are mentally ill".[102] Both the *parens patriae* power and the authority to protect the community are often executed by judges and police officers.

Indeed, with the process of deinstitutionalization and the increasing number of detainees, the police have become a fundamental part of the criminal system and have an impact on the future of mentally ill people.[103] Police offices – while dealing with minor offences – often need to consider and decide whether the individual should enter the mental health system or the criminal justice system.[104] Moreover, many encounters of the police with mentally ill people result in the citizen being killed by police. As a result, it has been suggested that there is a need to train police officers to recognize mental disturbances and know how to access mental health resources accordingly.[105]

3.2 Mentally ill detainees and their special needs

Access to justice, access to treatment, the environment in jail, and safety and security are some of the most important needs of a mentally ill detainee.[106] In the event of detention, a detainee needs access to qualified legal counsel and access to free legal aid.[107] Mentally

98 World Health Organization and International Committee of the Red Cross, *Mental Health and Prisons* (at: www.who.int/mental_health/policy/mh_in_prison.pdf) (last visited: 9 May 2017).

99 Human Rights Watch, *World Report 2016: United States*, 2015, p. 4 (at: www.hrw.org/world-report/2016/country-chapters/united-states) (last visited: 16 May 2017).

100 Richard Lamb & Linda E. Weinberger, 'Persons With Severe Mental Illness in Jails and Prisons: A Review', 49 *Psychiatric Services* 4 (1998).

101 *Addington v. Texas*, 441 U.S. 418 (1979).

102 *Addington v. Texas*, 441 U.S. 426 (1979).

103 H. Richard Lamb, Linda E. Weinberger & Walter J. DeCuir Jr, 'The Police and Mental Health', 53 *Psychiatric Services* 10 (2002), p. 1266-1271. (at: Doi: 10.1176/appi.ps.53.10.1266).

104 *Ibid.*

105 *Ibid.*

106 United Nations Office on Drugs and Crime, *Handbook on Prisoners with Special Needs*, 2009, p. 12 (at: www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf).

107 *Ibid.*

ill people are considerably vulnerable due to the fact that they are usually unaware of their rights.[108] In addition, individuals who suffer from psychiatric disturbances must be provided with access to treatments and to psychiatric care. Due to the high percentage of mentally ill people in jails, guards also need to be trained to recognize when certain behaviour can lead to mental illness. This can help insure that a detainee has access to treatment.[109] For example, the correctional officers of Cook County Jail in Illinois now receive 60 hours of training on advanced mental-illness treatment[110] and the jail uses the support of different rent subsidies and health specialists to coordinate treatment support and housing.[111] This led to an 89% reduction in arrest of people with mental illnesses and an 86% reduction in jail time.[112] However, the general situation of individuals who suffer from psychiatric conditions in jails in the United States is critical and their mental illnesses are not adequately treated with the consequence that their general mental condition becomes even worse.[113]

Mentally ill people, due to their condition, are particularly vulnerable to abuse, sexual assaults, and violence by other detainees[114] and staff who may use excessive force and solitary confinement as punitive measures.[115] It is only recently that some states took the lead in improving jail conditions for individuals who suffer from medical conditions. For instance, in Colorado, a very recent $9.5 million proposal aims to invest in the number and quality of treatment centres, mental health centres as well as ensuring a better transportation system to these facilities from rural Colorado.[116] In addition, a bill is currently being discussed to prohibit mentally ill people who did not commit any crime from being detained in jails because they represent a possible danger for themselves or their community.[117] In King County in Washington, recently successful diversion programmes and the inclusion of supportive housing and community-based treatments led to a 45% reduction in the number of mentally ill people in jails and prisons. Mental health courts have been also created in the following states in the United States to help prevent mentally ill individuals from being confined in jails and being treated adequately:[118] Nevada, Ohio

108 *Ibid.*

109 Lori A. Marschke, 'Providing Deliberate Indifference: Next to Impossible for Mentally Ill Inmates', 39 *Valparaiso University Law Review* 487 (2004), p. 491.

110 Matt Ford, *supra* note 83.

111 Michael Ollove, *New Efforts to Keep Mentally Ill Out of Jail*, 19 May 2015 (at: www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/19/new-efforts-to-keep-the-mentally-ill-out-of-jail).

112 *Ibid.*

113 National Alliance on Mental Illness, *supra* note 91.

114 United Nations Office on Drugs and Crime, *supra* note 106.

115 Human Rights Watch, *Callous and Cruel, Use of Force Against Inmates with Mental Disabilities in US jails and prisons*, 12 May 2015 (at: www.hrw.org) (last visited: 10 May 2017).

116 Jennifer Brown, *Colorado Would Outlaw Using Jails for Mental Health Holds, Increase Services Under $9.5 Million Proposal*, 6 March 2017 (at: www.denverpost.com/2017/03/06/colorado-proposal-outlaw-jail-mental-health-hold/) (last visited: 11 May 2017).

117 *Ibid.*

118 Michael Ollove, *supra* note 111.

and New York.[119] However, more work needs to be done to ensure that people who suffer from psychiatric disturbances are not detained in jails and receive treatment. Instead, they are often overmedicated to avoid disciplinary problems inside the facility and generally no effective psychiatric rehabilitation programmes are provided.[120]

3.3 Screening tools to detect whether the person suffers from psychiatric disturbances

The general rule for detecting mental illness in U.S. jails is a three-stage process. First, the mental health of the detainee is evaluated with the use of mental health screening to identify individuals who may need a mental health assessment for a severe mental health disorder or they may need to be monitored.[121] Second, if the results of the first assessment show that mental health issues have been detected then, within 24 hours, another assessment will be conducted by trained mental health personnel.[122] Third, if the detainee suffers from acute mental disturbances, a full scale psychiatric evaluation will be performed.[123]

There are six mental health screening tools (out of 22) that have been replicated by other studies:[124] The Brief Jail Mental Health Screen (BJMHS),[125] Correctional Mental Health Screen for Women (CMHS-W),[126] Correctional Mental Health Screen for Men (CMHS-M),[127] the England Mental Health Screen (EMHS),[128] the Jail Screening Assessment Tool (JSAT),[129] and the Referral Decision Scale (RDS).[130] The first three, in accordance with the National Institute of Justice, seem to work better in correctional facilities.[131] However, screening procedures are considered highly variable, and there is a need to

119 *Ibid.*

120 Human Rights Watch, *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons*, 12 May 2015 (at: www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and).

121 U.S. Department of Justice, *Mental Health Screens for Corrections*, p. 3 (at: www.ncjrs.gov/pdffiles1/nij/216152.pdf) (last visited: 9 May 2017).

122 *Ibid.*

123 *Ibid.*

124 Virginia Department of Behavioral Health and Developmental Services, *Mental Health Screening in Local and Regional Jails*, 26 October 2016, p. 3 (at: http://dls.virginia.gov/groups/mhs/screen%20jails.pdf) (last visited: 17 May 2017). And Martin *et al.*, 'Mental Health Screening Tools in Correctional Institutions: A Systematic Review', *BMC Psychiatry* 2013, p. 1 (at: Doi: 10.1186/1471-244X-13-275).

125 Virginia Department of Behavioral Health and Developmental Services, at 2, 7-8.

126 *Ibid.*, at 5-7.

127 *Ibid.*, at 5-7.

128 Martin *et al.*, *supra* note 125.

129 *Ibid.*

130 *Ibid.*

131 U.S. Department of Justice, *supra* note 122 at 2.

develop better and more reliable procedures.[132] In fact, approximately 63% of detainees who, through independent screening tests were found to suffer from acute mental symptoms, were instead not recognized as such during the screening routine performed by the jail staff.[133]

3.4 Special measures that must be taken for a detainee who suffers from psychiatric disturbances

In 2013, the U.S. Congress enacted the Helping Families in Mental Health Crisis Act.[134] The Bill grants payments to the states to improve the condition and the services of community behavioural health clinics and provide specialized mental health training for correctional officers in jails and prisons.[135] In 2015, the Comprehensive Justice and Mental Health Act[136] was introduced to strengthen the mental health system and improve public safety.[137] While the bill per se was not enacted, provisions of this bill were incorporated into another bill which was approved.[138]

In fact, Congress found that each year, approximately 2,000,000 individuals with serious mental illnesses are incarcerated in jail (not all at the same time) and that "an even greater number of individuals who are detained in jails each year have mental health problems that do not rise to the level of a serious mental illness but may still require a resource-intensive response".[139]

As such, under this bill, resources would be granted "[t]o provide support for academy curricula, law enforcement officer orientation programs, continuing education training, and other programs that teach law enforcement personnel how to identify and respond to incidents involving persons with mental health disorders or co-occurring mental health and substance abuse disorders,[140] … procedures to identify and appropriately respond to incidents in which the unique needs of individuals who have a mental illness are involved, to Federal first responders and tactical units".[141]

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132 U.S. Department of Justice, *supra* note 122 at 7-8.
133 U.S. Department of Justice, *supra* note 122 at 2.
134 Helping Families in Mental Health Crisis Act of 2013, 113 H.R. 3717 (2013).
135 *Ibid.*, at 401.
136 Comprehensive Justice and Mental Health Act of 2015, 114 S. 993 (2015).
137 *Ibid.*, at p. 1.
138 This bill was incorporated into: H.R. 34: 21st Century Cures Act. Enacted – Signed by the President on 13 December, 2016 (see: www.govtrack.us/congress/bills/114/hr34/summary).
139 *Ibid.*, at section 3.
140 *Ibid.*, at section 8.
141 *Ibid.*, at section 10.

However, the states must find the best measures that need to be taken to address mental health issues in their jails. For instance, the Texas Health & Safety Code[142] has a section which provides rules for disease management practices and jail diversion measures: "A local mental health authority shall ensure the provision of assessment services, crisis services, and intensive and comprehensive services … [It must also ensure] that individuals are engaged with treatment services".[143] Furthermore, the Code also provides that monitoring systems must be in place. It is important to note that 18 USCS § 3142[144] allows the detention of a defendant pending trial under certain circumstances and upon the issuance of an order of detention from a judicial officer.[145] However, some procedural safeguards must be met in order to ensure that the detention is truly needed. 18 USCS § 3142 (1) states that the detention order needs to "include written findings of fact and a written statement of the reasons for the detention". The individual may then appeal the detention order pursuant to 18 U.S.C. § 3145.[146] In addition, the Eighth Amendment of the U.S. Constitution – while stating that "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted" also ensures protection and access to mental health services to mentally ill people.

4 Prisoners with psychiatric disturbances in prison: needs, problems, screening tools

4.1 Problems related to dealing with prisoners who suffer from psychiatric disturbances

In 2016, Mental Health America reported that one out of five adults in the United States, and in general over 40 million Americans, suffer from mental health issues.[147] Over 56% of them do not have access to sufficient treatment or cannot afford any type of mental care.[148] For instance, in Vermont, a state in the United States that is considered an example for good access to treatment, 43% of adults who suffer from psychiatric disturbances do not receive adequate treatment.[149] In addition, when it comes to prisons, not enough mental health professionals are available in the prison systems due to the fact that prison staff are

142 Tex. Health & Safety Code § 533.0354.
143 *Ibid.*
144 United States Code Service, Sec. 3142 Release or detention of a defendant pending trial, PL 115-30.
145 *Ibid.*
146 United States Code Service, Sec. 3142 Review and Appeal of a Release or Detention Order, PL 115-30.
147 Mental Health America, *The State of Mental Health in America* 2017 (at: www.mentalhealthamerica.net) (last visited: 23 May 2017).
148 *Ibid.*
149 *Ibid.*

often underpaid and most prisons are located in isolated or remote locations.[150] Such a shortage of mental health professionals reflects unfavourably on the provision of mental health services in prisons.[151] Very often, the few mental health professionals available are overloaded with a large number of patients.[152] Clearly, this factor adversely affects the quality of diagnosis and treatment plans for the prisoners who suffer from mental health issues.[153] Due to the low number of mental health professionals, prisoners are often not treated by the appropriate mental expert, such as a psychiatrist, and are instead treated by general prison staff, nurses or physicians.[154] Mississippi, Arkansas, Texas, Georgia and Florida are considered the states with the lowest access to mental treatment and the highest number of prisoners who suffer from psychiatric disturbances.[155] In the United States, over 57,000 people who suffer from psychiatric disturbances are in prison and jail.[156] The American Psychological Association reported that "while the United States has only 5 percent of the world's population, it has nearly 25 percent of its prisoners – about 2.2 million people".[157] More specifically, 1,330,000 individuals are imprisoned in state prisons and 197,000 in federal prisons.[158] The individuals behind bars in the United States are mostly poor inmates, and about half of them suffer from mental health conditions.[159] In addition, mental disorders and disturbances vary significantly in the way in which they manifest, their severity, and the symptoms they cause.[160] This is problematic because only the most serious mentally ill prisoners are acknowledged as individuals that have a mental impairment.[161] For instance, many prisoners who suffer from antisocial personality disorders or major depression[162] are more likely not to be diagnosed as mentally ill and therefore not be considered for a specific treatment. Mental health services in prisons usually give priority to inmates who suffer from acute mental illnesses.[163] The lack of sufficient treatment and mental care offered in the prison system has a negative impact not only on mentally

150 Human Rights Watch, *Report USA 2003 – Sec. IX Inadequate Mental Health Treatment in Prisons*, 2003 (at: www.hrw.org) (last visited: 25 May 2017).
151 *Ibid.*
152 *Ibid.*
153 *Ibid.*
154 *Ibid.*
155 Mental Health America, *supra* note 148.
156 *Ibid.*
157 American Psychological Association, *Incarceration Nation*, October 2014 (at: www.apa.org/monitor/2014/10/incarceration.aspx) (last visited: 18 May 2017).
158 Modern Challenges in Jails and Prisons, *Mass Incarceration: The Whole Pie 2017*, 14 September 2017 (at: https://statepen.wildapricot.org) (last visited: 26 May 2017).
159 *Ibid.*
160 U.S. Department of Justice – National Institute of Corrections, *Mental Health Services* (2004), p. 2 (at: https://s3.amazonaws.com/static.nicic.gov/Library/018604.pdf) (last visited: 25 May 2017).
161 *Ibid.*
162 *Ibid.*
163 *Ibid.*, p. 5.

ill prisoners but also on their families and on the nation as a whole.[164] The American Psychological Association reported that "1 out of every 100 American adults is incarcerated, a per capita rate 5 to 10 times higher than that in Western Europe or other democracies. … [and] while the United States has 707 incarcerated people per 100,000 citizens, for example, China has 124 to 172 per 100,000 people and Iran 284 per 100,000".[165]

4.2 Mentally ill prisoners and their special needs

As stated above, access to treatment is surely one of the most important needs while considering the condition of mentally ill prisoners. This means that they need access to mental health treatment, qualified mental health staff and periodic assessments regarding their mental health.[166] This process allows the formulation of a treatment plan, being placed in special housing (for example if the prisoner has suicidal tendencies),[167] and better ensures long-term results. Access to justice, the prison environment, security and preparation for release are other special needs that must be considered while dealing with inmates who suffer from psychiatric disturbances. For instance, often prisoners are placed in overcrowded cells or in isolation. These types of environments can significantly aggravate their mental conditions. Inmates with suicidal tendencies must be particularly supervised.[168] Even though suicide rates in prisons are lower than in jails,[169] suicide is still considered one of the leading causes of death in prisons.[170] For instance, a famous American footballer Aaron Hernandez, was found dead by hanging from a bedsheet in his prison cell.[171] In addition, a special need that is often not considered enough in the prison system is preparing the inmates for release. Prisoners who suffer from mental conditions need assistance in being reintegrated into society and support after being released.[172] However, the cooperation between the criminal justice system and civil health services is practically absent.[173] In addition, prisoners who suffer from psychiatric disturbances need continuity of mental

164 American Psychological Association, *supra* note 158.
165 *Ibid.*
166 Thomas L. Hafemeister & Jeff George, 'The Ninth Circle of Hell', 90 *Denver Law Review* 1 (2012), p. 8.
167 *Ibid.*
168 U.S. Department of Justice – National Institute of Corrections, *National Study of Jail Suicide* (2010), p. 45.
169 Lindsay M. Hayes, 'Prison Suicide: An Overview and Guide to Prevention', 75 *The Prison Journal* 4 (1995), pp. 431-456 in U.S. Department of Justice – National Institute of Corrections, *National Study of Jail Suicide* (2010), p. 2.
170 C. Mumola, *Suicide and Homicide in State Prisons and Local Jails*, Special Report, U.S. Department of Justice (2005) in U.S. Department of Justice – National Institute of Corrections, *National Study of Jail Suicide* (2010), p. 2.
171 Eric Levenson & Evan Simko-Bednarski, 'New Details on Aaron Hernandez's Apparent Suicide in Prison', *CNN* (5 May 2017).
172 United Nations Office on Drugs and Crime, *supra* note 106.
173 *Ibid.*

care once they leave prison. Furthermore, the poor background of the majority of prisoners leads many of them to become homeless and is definitely not conducive to ensuring that they receive adequate mental treatment.[174]

4.3 Screening tools to detect whether the person suffers from psychiatric disturbances

According to the National Commission on Correctional Health Care mental screenings should be performed on inmates as soon as possible.[175] The examination includes a screening to assess whether the inmates suffer from mental illnesses.[176] The screening process is brief and starts with an interview of approximately 20 minutes.[177] It is important to note that the assessment tools that are used in jail are also used in most prisons.[178] The first screening is important because, as stated for the screening tools in jail, it assesses which inmates need further mental evaluation. However, in practice, mental issues are generally difficult to identify and the screening systems usually overlook some mental disturbances.[179] In addition, non-treated mental illnesses lead to a decline in the mental health of the individual and can result in severe psychological damage.[180]

4.3.1 Different tools for juveniles

While dealing with juveniles, there are special screening tools (e.g. the Massachusetts Youth Screening Instrument 'MAYSI-2',[181] the Global Appraisal of Individual Needs 'GAIN-SS',[182] and the Trauma Symptom Checklist for Children 'TSCC'[183]) and assessment tools (e.g. the

174 *Ibid.*

175 National Commission on Correctional Health Care, *Receiving Screening*, 2011 (at: www.ncchc.org/spotlight-on-the-standards-25-1) (last visited: 30 May 2017).

176 United Nations Office on Drugs and Crime, *supra* note 106 at p. 28.

177 James R. P. Ogloff *et al.*, 'Mental Health Services in Jails and Prisons: Legal, Clinical, and Policy Issues', 18 *Law and Psychology Review* 109 (1994), p. 123.

178 *Ibid.*

179 E. Lea Johnston, 'Conditions of Confinement at Sentencing: The Case of Seriously Disordered Offenders', 63 *Catholic University Law Review* 625 (2014), p. 629.

180 *Ibid.*

181 The Council of State Governments Justice Center, *Screening and Assessment*, The Judges' Guide to Mental Health Jargon, p. 18 (at: www.prainc.com/wp-content/uploads/2015/08/JMHJ-preview_v2.pdf). See also: National Council of Juvenile and Family Court Judges, *Massachusetts Youth Screening Instrument* (at: www.ncjfcj.org/massachusetts-youth-screening-instrument-maysimaysi-2) (last visited: 1 June 2017).

182 The Council of State Governments Justice Center, *supra* note 182 at 18. See also Michael L. Dennis *et al.*, *Gain-SS*, October 2008, p. 7 (at: https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/gainssmanual.pdf) (last visited: 1 June 2017).

183 The Council of State Governments Justice Center, *supra* note 182 at 20. *See* also Jennifer Meltzer Wolpaw *et al*, 'Trauma Symptom Checklist for Children', in: Thomas Grisso *et al.* (eds), *Mental Health Screening and Assessment in Juvenile Justice*, New York: The Guildford Press, 2005, p. 152.

Child Behavior Checklist 'CBCL'.[184] the Child and Adolescent Functional Assessment Scale 'CAFAS',[185] and the Million Adolescent Clinical Inventory 'MACI'[186]) used to evaluate whether the youth suffers from a mental issue. Screening is a brief procedure, not diagnostic and can be performed by a non-mental health staff.[187] Additionally, the screening test evaluates whether the youth needs an assessment.[188] The assessment procedure offers a more complete and personal evaluation and it is performed by qualified mental health professionals.[189] There are at least five different settings in which a screening test can be performed on a youth: Detention Intake, Juvenile Assessment Center (JAC), Court Clinical Services, Intake Probation Departments and Assessment Centers.[190]

4.4 Special measures that must be taken for a detainee who suffers from psychiatric disturbances

First, sufficient screening, assessments and mental care should be available at all times.[191] Prisons in the United States at present offer some sort of assistance to mentally ill people.[192] However, it is not at all sufficient; many mentally ill prisoners remain untreated and their mental conditions become significantly worse.[193] Second, it is important for a mentally ill individual, especially in an environment such as prison, to form trusting relationships with mental health professionals.[194] However, the criminal justice system does not invest enough to ensure an adequate relationship between the mentally ill and health professionals, thus making it difficult to ensure that the prisoner would be able to continue the treatment that

184 The Council of State Governments Justice Center, *supra* note 182 at 21. *See* also Jeniffer A. Rosenblatt, Abram Rosenblatt & Edward E. Biggs, 'Criminal Behaviour and Emotional Disorder: Comparing Youth Served by the Mental Health and Juvenile Justice Systems', 27 *The Journal of Behavioural Health Services & Research* 2 (2000) (at: https://link.springer.com/article/10.1007/BF02287315).

185 The Council of State Governments Justice Center, *supra* note 182 at 21. See also The University of Toledo, *The Child and Adolescent Functional Assessment Scale (CAFAS): A Reliability and Validity Evaluation*, 2011, p. iii (at: http://utdr.utoledo.edu/cgi/viewcontent.cgi?article=1555&context=theses-dissertations) (last visited: 1 June 2017).

186 The Council of State Governments Justice Center, *supra* note 182 at 22. See also US National Library of Medicine – National Institutes of Health, A review of the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A) and the Millon Adolescent Clinical Inventory (MACI) With An Emphasis on Juvenile Justice Samples, 2009 (at: www.ncbi.nlm.nih.gov/pubmed/19762519) (last visited: 1 June 2017).

187 The Council of State Governments Justice Center, *supra* note 182 at 15.

188 *Ibid.*

189 *Ibid.*

190 *Ibid. supra* note 182 at 15-17.

191 Terry A. Kupers, 'Mental Health and the Law: A Community Mental Health Model in Corrections', 26 *Stanford Law & Policy Review* 119 (2015), p. 129.

192 Jamie Fellner, *Prisons No Place for the Mentally Ill*, Human Rights Watch, 12 February 2004 (at: www.hrw.org) (last visited: 25 May 2017).

193 *Ibid.*

194 Terry A. Kupers, *supra* note 192 at 129.

he or she had been receiving prior to entering into prison.[195] Last, adequate measures must be taken to provide a safe and secure environment at all times for vulnerable prisoners, such as mentally ill inmates, who are more exposed to abuses and punitive measures from other prisoners and prison staff.

4.5 The prison system and mental treatment of prisoners

Society and the criminal justice system have special obligations that must be fulfilled when dealing with individuals who suffer from psychiatric disturbances.[196] For instance, this includes the duty to provide medical and mental health services and to afford protection from abuses.[197] In this connection, adequate training and attitudes should be required in dealing with prisoners with mental illnesses.[198] However, most of the time, officers and staff are trained to resort to the use of force.[199] Supervision and vigilance inside correctional facilities is used to ensure that orders are followed, but they are not necessarily meant to protect the prisoners' well-being.[200] Some disciplinary situations in prisons actually worsen an inmate's mental health. For example, placing a mentally ill individual in prolonged solitary confinement, along with using other punitive measures can cause additional harm to his/her mental health.[201] Prison overcrowding is also a negative element. In 2011, the Supreme Court of the United States established, in *Brown v. Plata*,[202] that the Eastern and Northern Districts of California had to reduce the number of prisoners inside its facilities since the overcrowding environment violated the Eighth Amendment. The court reasoned that inmates in California with serious mental conditions were not receiving minimal and adequate treatment. Some prisoners were confined and at times even physically restrained in very harsh and isolated conditions for up to 12 months before being considered for mental health care.[203] In 2006, the prisons in California had a suicide rate of 80% higher than the average rate in United States' prisons. Furthermore, 72.1% of these suicides were deemed by the court to have been avoidable.[204] The prisons in California were so

195 *Ibid.*, at 130.
196 Mental Health America, *Position Statement 56: Mental Health Treatment in Correctional Facilities*. (at: www.mentalhealthamerica.net) (last visited: 23 May 2017).
197 *Ibid.*
198 *Ibid.*
199 Jamie Fellner, 'Prisons, Mental Illness and Excessive Force', *The New York Times* (25 August 2015). (at: www.nytimes.com/2015/08/25/opinion/prisons-mental-illness-and-excessive-force.html) (last visited: 24 May 2017).
200 *Ibid.*
201 Thomas L. Hafemeister & Jeff George, *supra* note 167 at 53.
202 *Brown v. Plata*, 563 U.S. 493 (2011).
203 *Ibid.*, at 504.
204 *Ibid.*, at 504.

overcrowded that clinical and custodial staff were outnumbered, mental health services were insufficient, and the environment was violent, chaotic and excessively harsh.[205] Placing inmates in such unsafe and unsanitary environment could also cause hidden mental disturbances to become worse.[206] It has been suggested that, alongside providing mental treatment and care for inmates who suffer from psychiatric disturbances, prison staff should also be sensitive to trauma histories and psychosocial variables.[207]

In addition, prison staff must be trained on how to deal with cross-cultural issues and understand the needs of minority groups.[208] Indeed, minority groups are overrepresented in the U.S. criminal justice system. "African Americans are incarcerated in state prisons at a rate that is 5.1 times the imprisonment of whites. In five states (Iowa, Minnesota, New Jersey, Vermont, and Wisconsin), the disparity is more than 10 to 1. … Latinos are imprisoned at a rate that is 1.4 times the rate of whites. Hispanic/white ethnic disparities are particularly high in states such as Massachusetts …, Connecticut …, Pennsylvania …, and New York."[209]

In addition, since 1980, prisons started to be built in non-urban and rural areas[210] where the staff was predominantly white and prisoners were mostly minorities and from disadvantage areas.[211] This generated cultural clashes, perpetuated racial tensions and conflict inside the facilities, and had a negative impact on the conditions inside the prison. Distance from urban areas also represents a huge obstacle for prisoners' families who live there to arrange visits to the facility, considering that most of them come from poor backgrounds and cannot afford frequent visits.[212] In addition, another impediment to prison visits is the fact that very few prisons have visitation programmes that are aimed at encouraging visits and that visitation is never guaranteed, even if scheduled, due to varying security conditions in the institutions and also to bureaucratic practices and even the whim of the staff.

205 *Ibid*., at 517.

206 *Ibid*., at 520.

207 Mark Moran, *Mental Illness Highly Prevalent Among Incarcerated Women*, American Psychiatric Association, 7 March 2014.

208 United Nations Office on Drugs and Crime, *supra* note 106 at 69.

209 The Sentencing Project, *The Color of Justice: Racial and Ethnic Disparity in State Prisons* (2016) (at: www.sentencingproject.org/wp-content/uploads/2016/06/The-Color-of-Justice-Racial-and-Ethnic-Disparity-in-State-Prisons.pdf) (last visited: 24 May 2017).

210 Tracy Huling, *Building a Prison Economy in Rural America* (2002), p. 1 (at: www.prisonpolicy.org/scans/huling_chapter.pdf) (last visited: 25 May 2017).

211 *Ibid*., p. 6.

212 Texas Jail Project, *Jails Can Reduce Recidivism by Increasing Visitation – The Effect of Prison Visitation on Offender Recidivism*, 2011 (at: http://texasjailproject.org) (last visited: 26 May 2017).

4.5.1 Preparation for release and support after release

Once a mentally ill individual leaves prison it is uncommon that arrangements will be made to ensure that he or she will receive mental treatment. Furthermore, a lack of health insurance or other economic barriers decrease the likelihood of them having access to mental treatment after release.[213] It has been demonstrated that once mentally ill individuals are released from the criminal justice system, their priorities are to secure food, money and clothes.[214] In a survey of 115 former inmates, only 12% of them stated that mental treatment was one of their priorities.[215] As such, mechanisms must be found to ensure that mentally ill individuals can have access to a post-release mental treatment plan.[216] In addition, to ensure long-term results and avoid recidivism, studies have shown that some special needs must be considered. For instance, while dealing with female prisoners, it must be considered that many of them are mothers.[217] To ensure long-term-results, their relationships with their children, partners and family must be considered.[218] Similarly, while dealing with minorities, their families and communities should be considered in the transition plan for their release due to the importance that family ties represent for certain communities and cultures. However, such ties are hard to maintain when visiting for example is difficult and expensive.

4.5.2 Imprisonment as a cause of mental health issues

More work needs to be done in order to prevent imprisonment from worsening an inmate's mental health problems. As discussed, overcrowded prisons, isolation, the excessive use of force, absent or little contact with family members and friends can cause and aggravate mental disturbances. It has been shown that abuses on LGBTI prisoners have the effect of exacerbating depression, anxiety, and cause psychological disturbances.[219] As such, the criminal justice system must invest more resources in order to ensure that vulnerable prisoners do not leave correctional facilities in an even worse mental state than when they entered the facility.

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213 National Institute of Corrections, *Mentally Ill Persons in Corrections* (at: https://nicic.gov/mentalillness) (last visited: 24 May 2017).

214 Science Daily, *Released Inmates Need Programs to Meet Basic, Mental Health Needs, Study Shows*, 6 January 2014 (at: www.sciencedaily.com/releases/2014/01/140106103737.htm) (last visited: 25 May 2017).

215 Ibid.

216 Terry A. Kupers, *supra* note 192 at 130.

217 Mark Moran, *Mental Illness Highly Prevalent Among Incarcerated Women*, American Psychiatric Association, 7 March 2014.

218 *Ibid.*

219 Shana Tabak & Rachel Levitan, 'LGBTI Migrants in Immigration Detention: A Global Perspective', 37 *Harvard Journal of Law & Gender* 1 (2014), pp. 2-3.

5 Community reintegration of prisoners with psychiatric disturbances: needs, problems, solutions

5.1 *In what way and to what extent the United States is challenged by such a phenomenon*

On October 31, 1963, President John F. Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act,[220] also known as the 'Community Mental Health Act'.[221] The Act accelerated the so-called 'deinstitutionalization' meant to replace treatment in psychiatric hospitals with community-based treatment.[222] In 1965, Medicare and Medicaid were created.[223] These services where formed to provide health insurance to vulnerable groups in society such as the elderly and poor.[224] However, these services had significant limits on the range of coverage that related to mental disturbances. For instance, individuals who suffered from psychiatric disturbances needed to sustain higher costs for ambulatory mental health treatment and had a limit of days that they could spend in psychiatric hospitals.[225] This process significantly changed the way in which mental health services were provided in the United States and the importance that was assigned to mental health care. Few of the community-based treatment centres were actually put into operation and even those soon had to drastically reduce their activities or even close because of lack of funding in the long run. At the same time the increase in criminal activity especially in large cities during the 1970s and afterwards, along with other social and political movements that upset the established order like the civil rights movement, the anti-Vietnam war protest, and the hippies' and students' protests spurred the development of the 'law and order' and 'get tough on crime' policies and the War on Drugs. Being tough on crime for many years towards the end of the twentieth century in the United States became a litmus test for electability to political office. Later, the 'broken window' and 'quality of life' approaches to law enforcement also justified stamping out any behaviour that did not conform to prevailing norms, however defined. The end result, in part and for example, is that correctional facilities in New York, Los Angeles and Chicago currently act as the three biggest psychiatric facilities in the country. The number of

220 Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, *supra* note 85.

221 Matt Ford, *supra* note 83.

222 H. Richard Lamb & Leona L. Bachrach, 'Some Perspectives on Deinstitutionalization', 52 *Psychiatric Services* 8 (2001), pp. 1039-1045 (at: http://ps.psychiatryonline.org).

223 Richard G. Frank, 'The Creation of Medicare and Medicaid: The Emergence of Insurance and Markets for Mental Health Services', 51 *Psychiatric Services* 4 (2000), p. 465 (at: http://ps.psychiatryonline.org).

224 *Ibid.*

225 *Ibid.*

hospitalized persons with serious mental illness (SMI) decreased from 550,000 in the 1950s to 70,000 in 2012; concurrently, the prison population grew from 178,000 in the 1950s to 2.3 million today. The percentage of individuals with SMI in prisons increased from 7% in 1880 to 21% in 2005.[226] According to the Bureau of Justice Statistics, in state, federal and local jails, more female inmates suffer from mental health disturbances than male inmates.[227] In addition, "[n]early a quarter of both State prisoners and jail inmates who had a mental health problem, compared to a fifth of those without, … served 3 or more prior incarcerations".[228]

The National Bureau of Economic Research recently assessed that there is a connection between mental disturbances and use of drugs which often lead to arrest and conviction.[229] More specifically, the National Bureau estimates that there is an increased use of alcohol, cocaine and cigarettes among mentally ill individuals.[230] Furthermore, mental illnesses are also associated with high recidivism rates because of re-arrest[231] and with incarceration as a consequence.[232]

Clearly, prisons and jails are overwhelmed with the presence of mentally ill inmates and something should be done in order to provide mental treatment and care for the inmates and even better, divert mentally ill people away from jail or prison.[233] Different initiatives around the United States try to introduce positive change in this direction. For instance, the Stepping Up Initiative – which has the support of important partners in the fields of law enforcement, policy and research[234] – is a national initiative which aims to decrease the number of inmates who suffer from psychiatric disturbances.[235] Recognizing the critical role local and state officials play to introduce change, the National Association of Counties (NACo), The Council of State Governments (CSG) Justice Center and the American Psychiatric Association Foundation (APAF) are collaborating on this national initiative. Reducing the Number of People with Mental Illnesses in Jail: Six Questions

226 Center for Prisoners Health and Human Rights, *Incarceration and Mental Health* (at: www.prisonerhealth.org/educational-resources/factsheets-2/incarceration-and-mental-health) (last visited: 27 May 2017).

227 Doris J. James & Lauren E. Glaze, *Mental Health Problems of Prison and Jail Inmates*, Bureau of Justice Statistics, 6 September 2006 (at: www.bjs.gov/index.cfm?ty=pbdetail&iid=789) (last visited: 30 May 2017).

228 *Ibid.*

229 The National Bureau of Economic Research, *Mental Illness and Substance Abuse*, 31 May 2017 (at: www.nber.org) (last visited: 31 May 2017).

230 *Ibid.*

231 The Center for Prisoner Health and Human Rights, *supra* note 227.

232 *Ibid.*

233 The Hill, Transcript of President Donald Trump's Speech to the Major Cities Chiefs Police Association, 8 February 2017 (at: http://thehill.com) (last visited: 27 May 2017).

234 Stepping Up Initiative, *Partners* (at: https://stepuptogether.org) (last visited: 29 May 2017).

235 Stepping Up Initiative, *Stepping Up: A National Initiative to Reduce the Number of People with Mental Illnesses in Jails* (at: https://stepuptogether.org) (last visited: 29 May 2017).

County Leaders Need to Ask[236] serves as a blueprint for counties to assess their existing efforts to reduce the number of people with mental illnesses and co-occurring substance use disorders in jail by considering specific questions and progress-tracking measures.

5.2 *Treatment of prisoners – health or justice responsibility?*

Punitive measures against those convicted of crimes can have different purposes. For instance, punishment may be used as deterrence, retribution, for rehabilitation purposes and for incapacitation.[237] First, deterrence is a criminal penalty that is executed to prevent similar or other crimes from being committed.[238] Second, retribution is used to punish perpetrators for their act or omission.[239] Third, incapacitation is used to prevent individuals from committing other wrongdoing.[240] Last, with rehabilitation, the criminal justice system prepares the individual to reintegrate back into the society upon being released.[241] An important argument to support this approach is that retribution, incapacitation and deterrence (of that specific perpetrator, not of society as a whole) are applied to individuals who suffer from mental illness, and they are not effective.[242]

A cost-benefit argument can also be brought up to debate that the mentally ill do not belong in prison. By placing an individual who suffers from mental disturbance in prison, it costs at least three times more than incarcerating a person who does not need mental care.[243] On the average, incarcerating an individual who suffers from mental disturbance costs at least $31,000 per year. As such, it would be far less expensive for tax-payers, and far more effective for the individual, to invest in treatment provided by community mental health services which can cost approximately $10,000 per year.[244]

Another issue in dealing with mental disorder behaviour is that the law enforcement often finds itself in the position of acting as a mental health professional.[245] Police officers

236 Risë Hanenberg, Tony Fabelo, Fred Osher & Michael Thompson, *Reducing the Number of People with Mental Illnesses in Jail*, January 2017 (at: https://stepuptogether.org).

237 *Ewing v. California*, 538 U.S. 11, 35 (2003).

238 *State v. Santiago*, 122 A. 3d 1, 56 (2015).

239 *Ibid.*

240 *Ibid.*

241 Criminal Law Information, *Rehabilitation in Criminal Law* (at: http://gunsandbutter.blogspot.com/2012/02/rehabilitation-in-criminal-law.html) (last visited: 30 May 2017).

242 Georgia Lee Sims, 'The Criminalization of Mental Illness: How Theoretical Failures Create Real Problems in the Criminal Justice System', 62 *Vanderbilt Law Review* 1053 (2009), p. 1063.

243 Mary Giliberti, *Treatment, Not Jail: It's Time to Step Up*, National Alliance on Mental Illness, 5 May 2015 (at: www.nami.org) (last visited 31 May 2017).

244 *Ibid.*

245 Newt Gingrich & Van Jones, 'Mental Illness Is No Crime', CNN (at: www.cnn.com/2015/05/27/opinions/gingrich-jones-mental-health/) (last visited: 30 May 2017).

do not have sufficient training to deal with people who suffer from mental disorders[246] leading to delayed treatment and even worse to the use of lethal force. More communities are currently trying to invest in police training and diversion programmes. Some states are now investing in developing so-called specialized police responses (SPRs) to deal with individuals who suffer from mental conditions.[247] Inside the SPR units, there are the Crisis Intervention Teams (CIT) constituted by police, mental health professionals and mobile crisis teams.[248] This new approach in dealing with mental health is progressive and has resulted in a degree of success in this area. In fact, when individuals who suffer from mental disturbances are referred to a mental health treatment, instead of being incarcerated, they are less prone to recidivism.[249] However, the success of this approach is strictly related to the resources and budget that is allocated to it.[250]

Diversion programmes are initiatives that redirect an individual, who suffers from mental disturbances and is involved in the criminal justice system, away from the penal system to special mental treatments services.[251] The Patient Protection and Affordable Care Act (known as 'Affordable Care Act' or 'Obamacare')[252] was an important step in providing higher and more affordable access to medical and mental treatments for poor and disadvantaged people. However, on May 2017, the Unites States House of Representatives passed measures to repeal and replace the Affordable Care Act.[253] Additionally, the Federal budget proposed by President Trump for 2018 and beyond envisions drastic cuts into Medicaid that pays for some health insurance for the poor. Thus, even though it is clear that mentally ill people do not belong in prison, it appears that jails and prisons will continue to be the primary mental health institutions in the country for the foreseeable future.

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246 H. Richard Lamb, Linda E. Weinberger & Walter J. DeCuir Jr., 'The Police and Mental Health', 53 *Psychiatric Services* 10 (2002) (at: http://ps.psychiatryonline.org).

247 Police Mental Health Collaboration, *Specialized Police Responses to People with Mental Illnesses* (at: https://pmhctoolkit.bja.gov) (last visited: 31 May 2017).

248 *Ibid.*

249 *Ibid.*

250 *Ibid.*

251 Frank Sirotich, 'The Criminal Justice Outcomes of Jail Diversion Programs for Persons with Mental Illness: A Review of the Evidence', 37 *Journal of the American Academy Psychiatry Law* 4 (2009), p. 461 (at: http://jaapl.org/content/jaapl/37/4/461.full.pdf) (last visited: 26 May 2017).

252 The Patient Protection and Affordable Care Act, Public Law 111-148, 23 March 2010 (at: www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf) (last visited: 30 May 2017).

253 Thomas Kaplan and Robert Pear, 'House Passes Measure to Repeal and Replace the Affordable Care Act', *The New York Times*, 4 May 2017 (at: www.nytimes.com/2017/05/04/us/politics/health-care-bill-vote.html) (last visited: 30 May 2017).

5.3 International protection – Aspiration values

In general, many treaties have aspirational values which focus their attention on rights, liberties, and on the physical, mental and social well-being of the individual. For instance, the American Declaration of the Rights and Duties of Man (1948), the American Convention on Human Rights (1969), the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (1988), the Inter-American Convention on the Elimination of all Forms of Discrimination against Persons with Disabilities (1999) and the UN Convention on the Rights of Persons with Disabilities (CRPD) which states at Article 1(2) "[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".[254]

However, the treaties listed above have not been ratified by the United States, except the American Declaration, even though the Unites States is a member of the Organization of American States (OAS).[255] The United States also needs to ratify other important treaties such as the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[256] Thus, recourse to international norms to protect the rights and ensure the appropriate treatment of the mentally ill in the United States is basically non-existent or at best, quite limited.

254 United Nations, Convention on the Rights of Persons with Disabilities and Optional Protocol (at: www.un.org/disabilities/documents/convention/convoptprot-e.pdf).

255 OAS, *Charter of the Organization of American States*, 30 April 1948 (at: www.oas.org/en/sla/dil/inter_american_treaties_a-41_charter_oas_signatories.asp#UnitedStates) (last visited: 30 May 2017).

256 The United Nations Human Rights Office of the High Commissioner, *Reporting status for United States of America* (at: http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/Countries.aspx?CountryCode=USA&Lang=EN) (last visited: 30 May 2017).

The International Penal and Penitentiary Foundation

The Series

The International Penal and Penitentiary Foundation (IPPF) has a long history and can trace its roots back to 1872. Its aim is to promote studies in the field of the prevention of crime and the treatment of offenders, especially by scientific research, publications, teaching and international colloquiums.

The IPPF's members are from around the world, are recognized experts in penal and penitentiary matters, and are either high judges, high officials of the prison system, or university professors.

Recent publications of the IPPF regard, e.g., "Prison policy and prisoners' rights", "Minorities and cultural diversity in prison", "Pre-trial detention", "Prevention of reoffending: the value of rehabilitation and the management of high-risk offenders", "Women in Prison: The Bangkok Rules and Beyond", and "Overuse in the Criminal Justice System: On Criminalization, Prosecution and Imprisonment".

History and purpose

International efforts to harmonize criminal justice policy date back to the nineteenth century, when representatives of various European nations met periodically to exchange information and to consider common standards in the treatment of offenders. In 1872, cooperation took a step forward when an International Prison Commission (IPC) was set up to collect national prison statistics and make recommendations for prison reform in Europe. When the League of Nations was formed in 1919, it saw as part of its mandate the promotion of the rule of law in the international community. The IPC became affiliated with the League and continued to hold conferences, meeting in 1925, 1930 and 1935. In the latter year, the IPC became the International Penal and Penitentiary Commission (IPPC). When the new United Nations was created in 1945, it incorporated crime prevention and standards of criminal justice into its policy-setting role. In December 1950, the IPPC was dissolved, to be replaced by the International Penal and Penitentiary Foundation. The IPPF is a foundation governed by the Swiss Civil Code and created on the 5th of July 1951. The Foundation shall have as its aim to promote studies in the field of the prevention of crime and the treatment of offenders, especially by scientific research, publications and teaching. The IPPF strives to foster the rule of law and internationally recognized human rights standards.

See for further information at: www.ru.nl/ippf

La Fondation internationale pénale et pénitentiaire

Les activités de la FIPP

La Fondation internationale pénale et pénitentiaire (FIPP) est une institution dont les origines remontent à 1872. Elle vise à promouvoir les études dans le domaine de la prévention de la criminalité et le traitement des délinquants, plus particulièrement en menant des recherches scientifiques, en éditant des publications, des cours et par l'organisation de colloques internationaux.

La FIPP compte des membres dans le monde entier, tous experts reconnus dans les matières pénale et pénitentiaire: hauts magistrats, hauts fonctionnaires du système pénitentiaire ou professeurs d'université.

La FIPP a entre autres récemment publié « Politiques pénitentiaires et droits des détenus », « Minorités et diversité culturelle en prison », « Détention avant jugement », « Prévention de la récidive; valeur de la réhabilitation et gestion des délinquants à haut risque », « Femmes en Prison; Les règles de Bangkok et au delà » et «Le recours excessif au système de justice pénale; Aux sanctions et poursuites pénales et à la détention ».

Histoire et objectif

Les efforts internationaux entrepris pour harmoniser la politique pénale et pénitentiaire remontent au 19e siècle, quand des représentants de plusieurs États européens ont commencé à se réunir périodiquement pour échanger de l'information et élaborer des standards communs dans le domaine du traitement des délinquants. En 1872, la coopération s'intensifia avec l'instauration de la Commission Pénitentiaire Internationale (CPI), chargée de réunir des statistiques nationales sur la prison et de formuler des recommandations pour la réforme des institutions carcérales en Europe. Instituée en 1919, la Société des Nations s'est vue confier le mandat de promouvoir des règles de droit en la matière auprès de la communauté internationale. La CPI devint affiliée à la Société des Nations et continua d'organiser des conférences et rencontres, en 1925, 1930 et 1935, avant de devenir la Commission Internationale Pénale et Pénitentiaire (CIPP). Quand en 1945, à la suite de la Société des Nations, fut créée l'Organisation des Nations Unies, cette dernière maintint parmi ses objectifs principaux la promotion de la prévention du crime et de standards en matière de justice criminelle. En décembre 1950, la CIPP fut dissoute et remplacée par la Fondation internationale pénale et pénitentiaire. Instituée le 5 juillet 1951, la FIPP est une fondation, au sens des articles 80ss du Code civil suisse. La Fondation a pour but d'encourager les études dans le domaine de la prévention du crime et du traitement des délinquants, notamment par la recherche scientifique, les publications et l'enseignement.

La FIPP s'efforce de promouvoir l'état de droit et les normes internationales des droits de l'homme.

Voir pour plus d'informations : www.ru.nl/ippf