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The Ability of Human Rights to Limit the State's Power to Punish in Europe: Connecting Prison and Mental Health Policies through the Concept of "Transpolicies"

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While scholars have pointed out the factors determining the impediments to and efficacy of international human rights rules, poor attention has been paid to human rights violations relating to transfers between prison and psychiatric detention. There is a lack of intersection of policy spheres in this regard that should be remedied. Our contribution aims to challenge traditional sociolegal boundaries by integrating the intersection of policy and subdisciplines that cover penal justice (prison and police stations), psychiatric institutions, and human rights.

Raising the question of human rights' ability to limit the state's power to punish in Europe compels us to explore different forms of "transinstitutionalization," especially between prisons and psychiatric institutions and between prisons and immigration detention centers that present as "total institutions" (hosting populations perceived to be "deviant"), and share many similarities, including the risk of human rights violations. We forge the concept of "transpolicies" to take into account the mutual influence and the domino effects of such detention policies that are acknowledged, and both promoted and fought, by the European human rights institutions. In the empirical part, we focus on the increasing interactions between prison and mental health policies, taking Belgium as an example as it is known to raise specific human rights challenges.

INTRODUCTION

The phenomenon of institutional and judicial control over various institutions and sectors is often described as an influential and spreading sociolegal trend that is contributing to the development and reform of modern societies. This is particularly the case for places of detention such as prisons, police stations, immigration centers, and psychiatric hospitals,[1] as international bodies and courts have tried to influence detention policies at least since the 1960s. UN and European judicial and inspectorate

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1. This article intends to go beyond torture and relates to inhumane treatment and its prevention through the policies the article sets out.

bodies that share the general principles and aims of what is commonly referred to as "global justice" have gained increasing prominence in the fields of detention and penal policy and practice over time—and particularly in recent years. All of those bodies work in their diverse capacities to ensure that human rights legislation is observed and monitored within the borders of each nation-state.

While penal, prison, health care, and immigration policies have always been an exclusive competence of and a monopoly exerted by nation-states, these policies have been progressively controlled, monitored, and influenced by UN and European institutions such as the Council of Europe (CoE) and the European Union. Emphasizing that "detention" covers all places where persons are deprived of their liberty by public authorities, the UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) both supervise and visit all places of detention, including not only prisons but also health care facilities (Cliquennois and Snacken 2018). These monitoring and supervision functions have been developed through the lens of human rights (van Zyl Smit and Snacken 2009; Daems and Robert 2017). In this regard, upholding the rule of law, ensuring accountability for decisions made by penal and administrative bodies, and protecting fundamental rights are crucial aspects of democracy (van Zyl Smit and Snacken 2009; Aizpurua and Rogan 2022; O'Connell and Rogan 2023).

These foundational principles of public law are significant in the detention environment, where the potential for abuse has been well documented (Rhodes 2004; Simon 2007, 2014; Haney 2008; Lynch 2009; van Zyl Smit and Snacken 2009; Rubin 2017; Western, Simes, and Bradner 2022), where the legitimacy of authority can be fragile, and where detainees are considered to belong to marginalized, vulnerable, and poor groups (Wacquant 2009; Lara-Millán 2021) with limited awareness of their rights. Custodial institutions are a very specific context in which constitutional and human rights are interpreted, and the meaning and effects of public law and legal consciousness in these institutions require particular attention and scrutiny (van der Valk, Aizpurua, and Rogan 2022). In this regard, international human rights frameworks underline the importance of accountability in custodial settings, including inspection, monitoring, and complaint mechanisms for protecting human rights and the rule of law (Evans, Bicknell, and Morgan 2018; O'Connell and Rogan 2023). While scholars have pointed out the factors determining the impediments to and efficacy of international human rights rules and norms (Blau and Moncada 2007), poor attention has been paid to the comparison of human rights violations in prison and in psychiatric detention. In this regard, there is a lack of intersection of policy spheres covering criminal and penal justice, mental illness, and human rights that should be remedied.

Our article aims to challenge such traditional sociolegal boundaries by integrating the intersection of policy and subdisciplines that cover criminal and penal justice, health care policy, psychiatric institutions, and human rights. It combines the study of these sociolegal fields and places of deprivation of liberty (prisons and psychiatric hospitals) with a view to analyzing the nature of relations between human rights and the state's power to punish through its implementation in different detention settings with potentially different human rights protections. This article intends therefore to engage

with existing scholarship on penal, prison, and health care policies; punishment; and human rights protection.

The state's power to punish is implemented not only through penal and prison policies, but also—and increasingly—through health care, psychiatric, and immigration policies. We show that such "total institutions," in which persons perceived for different reasons as "deviant" are deprived of their liberty, present many similarities, including the risk of ill treatment and other human rights violations. We also observe enhanced forms of "transinstitutionalization" between those institutions, especially between prisons and psychiatric institutions, with some detainees moving between the two on a more or less regular basis. Similar movement can be witnessed between prisons and immigration detention centers, as shown, for example, in the studies on "bordered penality" (Aas and Bosworth 2013; Franko 2019; Bosworth and Vannier 2020). We wonder whether such transinstitutionalization leads to different degrees of human rights protection. We forge the concept of "transpolicies" precisely to take into account the legal strategic policies applied by the European human rights institutions to the processes of transinstitutionalization used by national authorities. We find that these European policies, through the judicial decisions of the European Court of Human Rights (ECtHR) and the monitoring of detention policies by the CPT, two organs of the Council of Europe, simultaneously *foster* and aim to set *limits* on these processes of transinstitutionalization. In addition, national monitoring bodies have been created (in some European countries quite recently) or strengthened (following the ratification of the optional protocol to the UN Convention on torture and inhumane treatment) and designed to control police custody, prisons, immigration detention centers, and psychiatric hospitals. Raising the question of the ability of human rights to limit the state's power to punish in Europe therefore compels us to explore the intersections between those institutions and policies.

In the empirical part, we focus on the intertwining between prisons and psychiatric hospitals. Our article relies on a sociolegal analysis of the EU and CoE's recommendations of various kinds, including the reports and recommendations made by the CPT and by national monitoring authorities. We also focus on the judgments of the European courts—the ECtHR and the Court of Justice of the European Union (CJEU)—and their impact on detention policies regarding prisons and psychiatric institutions, notably through an examination of the action plans submitted (in the context of pilot and quasi-judgments[2]) by states to the CoE Committee of Ministers in response to condemnations and findings of the ECtHR against them (for an example of the way in which such sources can be used, see Cliquennois and Champetier 2016). As Belgium is known to raise significant human rights challenges relating to the lack of adequate psychiatric care in its prisons, has recently increased its efforts to transfer mentally ill offenders to forensic and private psychiatric institutions, and is planning new sanctions involving closed psychiatric facilities (see below in the third section), this country represents a good case study to analyze the complex interactions between prison and mental health policies.

2. Pilot judgments can be identified through the group of identical and repetitive cases they gather and that derive from systemic problems and the same root cause (the dysfunction under national law) of human rights violations.

We have conducted nonparticipant observations of detention conditions and transfers between these different kinds of facilities for three months (one month in 2011, one month in 2016, and one month in 2019) in three Belgian remand prisons (those of Brussels, Mons, and Namur) and two establishments for "the protection of society" housing mentally ill patients (Tournai and Paifve). Observational data were gradually gathered on meetings attended by prison and medical staff, on their decision making in the field of assignment, transfers, dispensing of medicines, disciplinary sanctions, and suicide prevention, and on their interactions with mentally ill patients. These observational data were written down in an observational book (that was made and used by one of the authors) and were interpreted and compared (between institutions) on the ground and through inductive theory. In addition, we performed a document analysis of legal human rights protections in Belgian prisons, Forensic Psychiatric Centres, and a private psychiatric hospital housing mentally ill offenders transferred from prison.

This sociolegal perspective remains unexplored by both European sociologists and lawyers. On the one hand, sociologists generally tend to underestimate the impacts of human rights on the detention policies adopted by regional organizations such as the Council of Europe and the European Union. On the other hand, lawyers tend to focus narrowly on specific rulings of the ECtHR and the CJEU, or on courts' techniques and methods of interpretation, without analyzing the relations between different detention policies or compliance and noncompliance with court rulings by national governments and administrations.

We present, in the first section, the theoretical aspects of our research and the concepts of "transinstitionalization" and "transpolicy." In the second section, we underline the practical and human rights challenges in prisons and psychiatric institutions. We analyze, in the third section, the impacts of human rights standards on mentally ill offenders in Belgium. In the fourth and last section, we scrutinize the impact of transinstitutionalization on the protection of human rights in Belgian prisons, Forensic Psychiatric Centres, and a psychiatric institution.

THEORETICAL ASPECTS: THE INCREASED INTERTWINING OF STATE POWER, "TRANSINSTITUTIONALIZATION," AND "TRANSPOLICY"

"Penality" has been described as "the network of laws, processes, discourses, representations and institutions which make up the penal realm" (Garland 1990, 17) and as contributing to the expansion of the carceral state (Phelps 2016). Psychiatric institutions have long been part of this penal realm, as offenders presenting mental disorders can in many countries be held either in prisons or in (forensic) psychiatric institutions (Traub et al. 2020), and individual transfers between those institutions have been and still are very common. Moreover, "transinstitutionalization" between prisons and mental health care has also been described at the macro level, as the opening up of psychiatric institutions in the 1960–70s in many Western countries led to increased incarceration into prisons of medium- and high-risk patients (Harcourt 2011; Raoult and Harcourt 2017). However, less academic attention has been paid to

psychiatric and social care institutions that are outside the penal realm but are also partly in charge of offenders presenting psychiatric problems.

In addition, and while some significant moves existing between prisons and psychiatric institutions have been noticed and studied by the sociolegal literature (Grabosky 1980; Steadman et al. 1984; Liska et al. 1999; O'Sullivan and O'Donnell 2007; Harcourt 2008, 2011; Cartuyvels and Cliquennois 2015; Raoult and Harcourt 2017), this literature does not capture a recent and very influential process of "transpolicy" between prisons, psychiatric institutions, and immigration detention centers, since this literature tends to focus on the developments of the penal and carceral state (Young and Petersilia 2016; Goodman, Page, and Phelps 2017; Simes 2021). We forge the concept of "transpolicy," which is similar to the concept of intersectionality in human rights, to refer to a policy that is fully aware of and even relies on the mutual influence and blurring between different domains such as prison, psychiatric, and immigration policies. On the one hand, transpolicy sometimes consists in applying a policy specific to a field and in transferring and translating this into another domain (internal or even external to the penal field). This process is applied, for instance, by the ECtHR and the CPT by developing human rights standards that are (partly) common to all forms of deprivation of liberty. On the other hand, "transpolicy" also refers to awareness of a domino effect between the penal, psychiatric, and immigration realms and then consists in fighting such transinstitutionalization by limiting the institutional overlaps and mixing of prisoners, mentally ill offenders, and migrants and isolating each domain (for example prisoners) from others (for example psychiatric patients).

We first analyze to what extent this process of "transpolicy" is applied in the field of European human rights standards as developed by the ECtHR and the CPT.

PRACTICAL DEVELOPMENTS: HUMAN RIGHTS CHALLENGES AND EUROPEAN STANDARDS IN PRISONS AND PSYCHIATRIC INSTITUTIONS

Prisons and psychiatric institutions resort to similar forms of deprivation of liberty, resulting in detainees' loss of autonomy, high dependency on staff, risk of psychological distress for the former, and risk of abuse of power by the latter. Both types of institutions can be described as types of total institutions intended mainly for the protection of society over the interests of the individual inhabitant—although psychiatric institutions theoretically aim to serve both (Goffman 1961). There is some discussion in the penological literature on whether modern Western prisons and psychiatric institutions can still be described as "total institutions" in view of the increased opening of these institutions to outside society, the gradual introduction of fundamental rights in prisons (Lemire 1991; Farrington 1992; Chantraine 2000) and the evolution of the use of psychiatric institutions to be less punitive (O'Sullivan and O'Donnell 2007). However, the two main central characteristics of total institutions according to Goffman—their comprehensive, all-encompassing control over the time and different life domains of their inhabitants, and the fact that the needs of a large group of inhabitants are addressed by a bureaucratic organization—remain unabated. The concept of the "total

institution" as an ideal type hence continues to be useful (Davies 1989; Schliehe 2016; Casier 2021).

The need to open up such institutions to scrutiny by society and monitoring by independent bodies is recognized by the creation of international bodies such as the Council of Europe's CPT in 1989 and the United Nations' Subcommittee for the Prevention of Torture (SPT) in 2002. In Europe, the preventive work of the CPT is meant to complement the ex post facto juridical assessment by the European Court of Human Rights (ECtHR) of violations of Article 3 of the European Convention for the Protection of Fundamental Rights and Freedoms (ECHR), which prohibits all forms of torture and inhuman or degrading treatment or punishment. The CPT Standards (which are derived from its visits to places of detention) and ECtHR's case law illustrate both the similarities between and some specific characteristics of both types of institutions analyzed here.

The Transpolicy Approach Applied by the ECtHR and the CPT: Fostering Transinstitutionalization through Diversification of Types of Confinement

The connections between prison and psychiatric policies have been acknowledged by the ECtHR in at least two ways: in its recent case law concerning prison overcrowding; and in its transpolicy approach to counteract the blending between prisoners and mentally ill offenders.

Historically, the ECtHR has received several thousand complaints related to prison overcrowding. Following the CPT's views, in 2001 the ECtHR reversed its yearlong jurisprudence concerning overcrowding, recognizing that although not deliberately imposed, it can in itself result in inhuman or degrading treatment.[3] It has since decided in a majority of cases to pronounce pilot judgments (for a definition, see note 2), obliging nation-states through a specific proceeding (in which action plans have to be submitted to the Committee of Ministers of the Council of Europe, which is charged with monitoring the execution of pilot judgments) to pass new laws and to apply new administrative practices meant to solve the underlying and systemic issues of prison overcrowding.[4] In its pilot judgments, the ECtHR has not only denounced prison overcrowding as a violation of the right to dignity and of the prohibition on inhuman and degrading treatment (Article 3 ECHR), but has adopted a global and holistic approach (excluding a case-by-case approach) to identify the causes of such violation. In this regard, the ECtHR has recommended that some states build psychiatric hospitals and even immigration facilities as ways to tackle prison overcrowding.[5] These establishments are intended to receive populations that cannot be appropriately accommodated and cared for within a typical prison setting. An even stronger finding was that keeping mentally ill offenders in prisons without adequate mental health care, as occurs in Belgium, results both in a form of illegitimate deprivation of liberty under Article 5 ECHR (which enshrines the right to liberty and prohibits illegitimate

3. Dougoz v. Greece, App. No. 40907/98 (March 6, 2001).

4. Council of Europe, Resolution (2004)3 of the Committee of Ministers on Judgments Revealing an Underlying Systemic Problem.

5. Claes v. Belgium, App. No. 43418/09, §98 (January 10, 2013).

detention) and in inhuman or degrading treatment under Article 3.[6] Such a policy then aims at transferring such population from prisons to immigration detention centers and psychiatric hospitals that are supposed to be more appropriate.

The ECtHR has also recommended developing alternatives to short prison sentences[7] and limiting the use of pretrial (before serving their sentences) and preventive (after serving their sentences) detention for offenders.[8] Such offenders include foreigners and mentally ill offenders in addition to "ordinary" offenders sent to prisons.

The CPT has also applied such a "transpolicies" approach by fighting the mixing of prisoners and mentally ill offenders in its national visit reports and annual General Reports (GR), summarized in the CPT Standards (CPT 2010a). According to these standards, mentally ill prisoners should be kept and cared for in a hospital facility that is adequately equipped and has appropriately trained staff. That facility could be a civil mental hospital or a specially equipped psychiatric facility within the prison system. The CPT acknowledges the argument that, from an ethical standpoint, it is more appropriate for mentally ill prisoners to be hospitalized outside the prison system, in institutions for which the public health service is responsible. On the other hand, the CPT also recognizes the argument that the provision of psychiatric facilities within the prison system enables care to be administered in optimum conditions of security, and that more robust medical and social services are possible within that system. Whatever course is taken, the standards state that mentally ill prisoners should be kept separate from other prisoners (CPT 2010a, §§43–44).

Common Standards for Prisons and Psychiatric Institutions

Both the ECtHR and the CPT apply common standards for prisons and psychiatric institutions. These standards are dynamic and follow new developments in policies and practices in the forty-seven[9] member states of the Council of Europe. The case law of the ECtHR has increasingly been influenced by the CPT Standards and CPT findings (General Reports by the CPT concerning prisons are the 2nd CPT 1992, 3rd CPT 1993a, 11th CPT 2001, 21st CPT 2011a, 25th CPT 2016a, and 26th CPT 2017a; for psychiatric institutions they are the 8th CPT 1998a and 16th CPT 2006a).

Common standards for the CPT concern the fact that ill treatment in institutions can take many forms and is not necessarily deliberate or willfully imposed by staff but can result from organizational failings or inadequate resources. It is related to the overall

6. W.D. v. Belgium, App. No. 73548/13 (September 6, 2016); Bamouhammad v. Belgium, App No. 47687/13, §§115–23 (November 17, 2015); Action Plan Submitted by Belgium to the Committee of Ministers of the Council of Europe (DH-DD(2016)474) Concerning the Judgment of L.B. v. Belgium, App. No. 22831/08 (October 2, 2012); Claes v. Belgium, App. No. 43418/09, §98 (January 10, 2013); Dufoort v. Belgium, App. No. 43653/09 (January 10, 2013); Swennen v. Belgium, App. No. 53448/10 (January 10, 2013); Committee of Ministers, Human Rights Meeting (1259e Meeting), 7–9 June 2016, Strasbourg.

7. Torreggiani and Others v. Italy, App. No. 43517/09 (January 8, 2013); Stella and Others v. Italy, App. Nos. 49168/09, 549908/09, and 55156/09 (September 16, 2014).

8. M. v. Germany, App. No. 19359/04 (December 17, 2009).

9. Reduced to forty-six as of March 16, 2022, following Resolution CM/Res (2022)2 on the Cessation of the Membership of the Russian Federation to the Council of Europe.

quality of life in an establishment: a satisfactory program of activities; constructive relations between prisoners and staff; material conditions that respect human dignity (no overcrowding; access to sanitation); daily access to outdoor exercise; and regular contacts with the outside world.

More detailed standards initially developed by the CPT in order to protect specific groups of prisoners at risk are also applicable to other institutions: standards to protect inmates considered "dangerous" to others or more vulnerable to violence by others; those put in isolation for reasons of discipline, security, or for their own protection; and persons held in dormitory systems. The attitude of staff is of paramount importance in all institutions: they should be "properly recruited and trained," be present in "adequate numbers," and possess "interpersonal communication skills," all factors allowing them to achieve "dynamic security." Effective complaint and inspection mechanisms must assure sufficient scrutiny of the treatment of the inhabitants of closed institutions.

The CPT consistently emphasizes that medical services carry a special responsibility in all closed institutions with regard to the provision of adequate physical and mental health care; prevention, assessment, and reporting of instances of torture and physical ill treatment; suicide prevention; assessment of prisoners who are unfit for detention for medical reasons; and the confidentiality of medical information and treatments. General principles regarding health care services therefore relate to: access to a doctor; equivalence of care; patients' consent and confidentiality; preventive health care; professional independence; and professional competence.

As for the ECtHR, it has applied the same standards concerning unacceptable material conditions and inappropriate medical treatment under Article 3 ECHR (inhuman and degrading treatment) in prisons (see above) and in police custody;[10] the psychiatric wing of a prison hospital;[11] transit zones, border guard stations, and immigration detention centers;[12] and a social care home for persons with mental disorders.[13]

Other aspects relating to inhuman and degrading treatment under Article 3 concern the use of physical restraint on patients, whether in prison or in psychiatric hospitals, which must always be a measure of last resort, legal, necessary, and proportional.[14] And allegations of ill treatment in a psychiatric hospital, similar to such allegations in prisons or other institutions, entail a responsibility on the part of the authorities to conduct a thorough and effective investigation into the applicant's allegation.[15]

In order to be legitimate under Article 5 ECHR (right to liberty and security), the European Court of Human Rights has stressed that, irrespective of the facility in which

10. Pilot judgment Rezmiveş and Others v. Romania, App. Nos. 61467/12, 39516/13, 48231/13, and 68191/13 (April 25, 2017); Rupa v. Romania, App. No. 58478/00 (December 16, 2008); M.S. v. the United Kingdom, App. No. 24527/08 (May 3, 2012).

11. Martzaklis and Others v. Greece, App. No. 20378/13 (July 9, 2015).

12. Riad and Idiab v. Belgium, App. Nos. 29787/03 and 29810/03 (January 24, 2008); R.R. and Others v. Hungary, App. No. 36037/17 (March 2, 2021); S.D. v. Greece, App. No. 53541/07 (June 11, 2009); A.A. v. Greece, App. No. 12186/08 (July 22, 2010), and many other cases. For a full overview, see European Court of Human Rights, Factsheet – Migrants in detention, March 2023.

13. Stanev v. Bulgaria, App. No. 36760/06 (January 17, 2012).

14. M.S. v. Croatia, App. No. 75450/12 (February 19, 2015); Aggerholm v. Denmark, App. No. 45439/18 (September 15, 2020).

15. Filip v. Romania, App. No. 41124/02 (December 14, 2006).

persons presenting mental disorders are placed, they are entitled to a suitable medical environment accompanied by real therapeutic measures, with a view to preparing them for their eventual release.[16] The Court has also stated that the assessment of whether a facility is "appropriate" must include an examination of the specific conditions of detention prevailing in it, and particularly of the treatment provided to individuals suffering from psychological disorders.[17] Safeguards were also developed by the Court concerning the legality, necessity, and proportionality of deprivation of liberty through psychiatric commitment (for an overview, see Niveau, Jantzi, and Godet 2021; ECtHR 2022).

As far as mental health care is concerned, in all the cases involving detainees' suicides heard to date, the ECtHR has examined whether the relevant national governments have taken all necessary measures to prevent such suicides, in the context of the attribution of liability.[18] The main principles on which such examinations are based were established in 2000 in the *Tanribilir* judgment on police custody,[19] in 2001 in the *Keenan* judgment on prisons,[20] and in 2019 in the *Fernandes de Oliveira* judgment on psychiatric hospitals.[21] In these judgments, the ECtHR set two main common criteria for establishing the state's duties in the field of suicide prevention. Nation-states are required to adopt a regulatory framework and to take preventive operational measures. The analysis of ECtHR case law shows that the ECtHR's judicial philosophy of suicide prevention in all forms of detention has two essential common features: a risk-based approach and a focus on material impediments to suicide that reflects a presuicide approach and entails a punitive aspect (Cliquennois, Snacken, and van Zyl Smit 2022).

This presuicide and risk-based approach was also endorsed by the CPT in 1993 (CPT 1993a) and was further developed in its CPT Standards, which were subsequently cited by the ECtHR in *Isenc v. France*[22] (CPT 1993b). The CPT Standards explain how detainee suicides should be prevented in terms that are similar to those of the ECtHR, as regards both suicide risk factors and measures to manage them: identification of at-risk individuals through medical supervision at admission; training of prison staff in recognizing signs of suicidal risks; special observation of persons at risk of suicide; and restriction of access to objects that could allow them to commit suicide (CPT 1993b, §59). The same risk-based, presuicide, and coercive approach is applied by the CPT Standards to psychiatric hospitals: risk screening, suicide risk management, and training of staff (CPT 2017b).

Such common standards tend to reinforce the transinstitutionalization process and the transfer of populations from one institution to another as they are partly monitored and guided by the same human rights standards. On the one hand, transinstitutionalization could be considered to no longer be a problem since the standards are the same not only in theory but—supposedly—also in reality. In this regard, the Belgian case study constitutes a solid test to check whether human rights standards are really shared

16. Rooman v. Belgium, App. No. 18052/11 (January 31, 2019).
17. Ibid.
18. L.C.B. v. United Kingdom, App. No. 23413/94 (June 9, 1998).
19. Tanribilir v. Turkey, App. No. 21422/93 (November 16, 2000).
20. Keenan v. United Kingdom, App. No. 27229/95 (April 3, 2001).
21. Fernandes de Oliveira v. Portugal, App. No. 78103/14 (March 31, 2019).
22. Isenc v. France, App. No. 58828/13 (February 4, 2016).

by prisons and psychiatric hospitals. On the other hand, such reinforced transinstitutionalization constitutes a serious issue because other institutions such as psychiatric hospitals are no longer counted as "penal institutions" and thus their detainees are excluded from the "penal populations," while the deprivation of liberty and the risks they create have many similarities to those in prisons. This is why the study of detention of mentally ill offenders in nonpenal institutions is necessary to enlarge the scope and the analysis of potential human rights violations in detention.

THE IMPACTS OF EUROPEAN HUMAN RIGHTS STANDARDS ON THE SITUATION OF MENTALLY ILL OFFENDERS IN BELGIUM

Belgian prison and mental health care policies are analyzed in the light of the European human rights case law and standards set up, respectively, by the ECtHR, the CPT, and the Council of Europe's Commissioner for Human Rights. The reports made by the Belgian monitoring bodies of prisons have not been included as source materials because—in the absence of ratification by Belgium of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment—they have not (yet) been recognized as the National Preventive Mechanism[23] that would have allowed the harmonization of the controls exercised over prisons and psychiatric institutions. They are hence not part of the transpolicy framework discussed here. Similarly, the Belgian civil case law has been excluded since such domestic remedies have been considered by the ECtHR to be ineffective and inefficient (in due time) and to fail to offer sufficient guarantees of protection to prisoners and mentally ill patients.[24] In practice, vulnerable persons deprived of liberty—and of competent lawyers—really struggle to get access to justice (Cliquennois and Nederlandt 2022).

Gross Human Rights Violations in Belgian Prisons: Lack of Adequate Psychiatric Care

In Belgium, as in other countries, offenders who commit a crime that is directly related to a severe psychological or psychiatric disorder are not held criminally liable for their actions. If this disorder persists at the time of the trial, they can be subjected to a "protection of society measure" called "internment." Under the Act of 1 July 1964 Regarding the Protection of Society,[25] the length of the interment measure became indeterminate, based on the idea that it could not be predicted how long the "curing process" of the offender would take. A Commission for the Protection of Society (CPS), comprising a judge (chair), a defense lawyer, and a psychiatrist, would decide whether to send mentally ill offenders for outpatient treatment in society, to a civil psychiatric

23. The Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment obliged the ratified states to create a National Preventive Mechanism that is in charge of visiting all places of detention and issuing public reports on them.

24. Isenc v. France, App. No. 58828/13 (February 4, 2016); Vasilescu v. Belgium, App. No. 64682/12, §75 (November 25, 2014); Bamouhammad v. Belgium, App. No. 47687/13, §§165–66 (November 17, 2015).

25. Act of 1 July 1964 Regarding the Protection of Society against Abnormal and Recidivist Offenders, *Moniteur Belge* 7 July 1964.

hospital, or to a prison, where "psychiatric units" or "Sections or Establishments for the Protection of Society" were supposed to offer adequate treatment. The CPS also decided on the provisional or final release of such offenders, based on an evaluation of their progress and whether their treatment had been successful. However, as internees did not receive adequate psychiatric care in prison and were only subjected to medication, they were at risk of spending their whole lives in prison (Snacken et al. 2016; Cartuyvels and de Spiegeleir 2022).

Both the CPT and the ECtHR have considered the situation of mentally ill prisoners in the psychiatric units and in the Social Protection Sections or Establishments in Belgian prisons to constitute a systemic and severe breach of both Article 3 and Article 5 ECHR. In 2013, 1,100 offenders subjected to a measure of internment were held in prison, waiting—often for several years—to be transferred to a more adequate facility. Their numbers largely exceeded the capacity of the "psychiatric units" in remand prisons, supposed to deal with remand and sentenced prisoners presenting mental problems, and the "Sections or Establishments for the Protection of Society," meant to deal exclusively with mentally ill offenders held in prison under a measure of internment. As a result, many interned prisoners were being held at their assigned location without adequate care. Moreover, even the "specialized" facilities failed to offer sufficient and adequate mental health care (Vandevelde et al. 2011; Mormont 2014). For many years, the CPT, along with the Council of Europe's Commissioner for Human Rights, noted problems with the transfer of mentally ill prisoners to disciplinary blocks (CPT 1994, pp. 62–66); the complete lack of medical and psychiatric consultation on prisoners' admissions and discharges;[26] and the continued shortage of prison health care staff.[27] In light of these breaches, the CPT called for a complete revision of this prison system (CPT 2016b, p. 43) and the UN Human Rights Committee even asked the Belgian government to close its prisons' psychiatric units as they were being used for the long-term housing of the mentally ill.[28]

In a number of rulings, the ECtHR also condemned this system and reinforced the pressure on the Belgian government to radically reform it. The failure of the Belgian prison authorities to provide sufficient on-site medical care or to offer an alternative to prison for the mentally ill was found to result in an illegitimate form of deprivation of liberty (Article 5(1) ECHR).[29] Moreover, detaining such persons for several months

26. Ibid.

27. Council of Europe's Commissioner for Human Rights—Visit to Belgium, 15–19 December 2008 (ref. CommDH (2009)), p. 14.

28. United Nations Human Rights Committee. Consideration of the Report Submitted by Belgium under the International Covenant on Civil and Political Rights (Draft Concluding Observations, November 2010).

29. Aerts v. Belgium, App. No. 25357/94 (July 30, 1998); L.B. v. Belgium, App. No. 22831/08 (October 2, 2012); Claes v. Belgium, App. No. 43418/09, §98 (January 10, 2013); De Donder and De Clippel v. Belgium, App. No. 8595/06 (December 6, 2011); Dufoort v. Belgium, App. No. 43653/09 (January 10, 2013); Swennen v. Belgium, App. No. 53448/10 (January 10, 2013); Saadouni v. Belgium, App. No. 50658/09 (January 9, 2014); Gelaude v. Belgium, App. No. 43733/09 (January 9, 2014); Lankester v. Belgium, App. No. 22283/10 (January 9, 2014); Van Meroye v. Belgium, App. No. 330/09 (January 9, 2014); Plaisier v. Belgium, App. No. 28785/11 (January 9, 2014); Oukili v. Belgium, App. No. 43663/09 (January 9, 2014); Moreels v. Belgium, App. No. 43717/09 (January 9, 2014); Caryn v. Belgium, App. No. 43687/09 (January 9, 2014); Smits v. Belgium, App. No. 49484/11 (February 3, 2015); Vandervelde and Soussi v. Belgium, App. No. 49861/12 (February 3, 2015).

without adequate care constituted degrading treatment in breach of Article 3 ECHR.[30] The ECtHR also raised the more general question of the supervision of mentally ill offenders in need of treatment[31] and denounced the inadequacy of prison psychiatric units and Social Protection facilities for mentally ill patients, the shortages of medical and psychiatric staff in prisons (which also relate to remand and sentenced prisoners: Snacken and Beyens (1994)), the lack of health care in prisons, prison overcrowding, and the shortage of prison psychiatric facilities.[32]

In its 2016 pilot judgment of *W.D. v. Belgium*, the ECtHR found that the breaches of Articles 3 and 5(1) ECHR were caused by a structural deficiency that is unique to the Belgian psychiatric detention system and required the Belgian state to decrease within two years the number of mentally ill offenders detained in prison psychiatric or Social Protection facilities without appropriate treatment.[33] These critiques were reiterated by the CPT in 2017 (CPT 2018a, §114) and by the Court in 2019 and 2021.[34] On December 1, 2019, 537 mentally ill offenders with internee status were still being detained in prisons in inappropriate conditions.[35]

Reaction by the Belgian Authorities: Prison and Health Care Policies

In reaction to the "transpolicy" approach to mentally ill offenders applied by the ECtHR in its judgments, the Belgian authorities passed new legislation on internment, created new psychiatric institutions and multidisciplinary health care teams, and made transfer from prisons to psychiatric institutions easier.

New Legislation

In response to the condemnations by the ECtHR and the pressure exerted by the CPT, the Belgian government launched a reform of prison mental health services. Its Plan for Internment aims, as far as possible, to gradually remove mentally ill offenders from prisons to secure outpatient care facilities where they can be offered treatment and prepared for social reintegration after their release.[36] As part of this process, the 1964 Offenders and Recidivists Act was replaced by the Internment Act of 5 May 2014, which came into effect on October 1, 2016. The new Act explicitly states that the internment measure is a safety measure aiming simultaneously at protecting society and at providing care and treatment to facilitate the offender's social reintegration (Article 2). The care is provided by a health care trajectory adjusted to the individual needs of the offender and respecting his human dignity. Internment can no longer be

30. Claes v. Belgium, App. No. 43418/09, §98 (January 10, 2013).
31. Saadouni v. Belgium, App. No. 50658/09, §§6, 56 (January 9, 2014).
32. Claes v. Belgium, App. No. 43418/09, §98 (January 10, 2013).
33. W.D. v. Belgium, App. No. 73548/13, §§164–65, 170 (September 6, 2016).
34. Rooman v. Belgium, App. No. 18052/11 (January 31, 2019); Venken et al. v. Belgium, App. No. 46130/14 (April 6, 2021).
35. Communication from the Government (19 March 2020) to the Committee of Ministers, in Follow-up to the Group of Judgments L.B. v. Belgium and W.D. v. Belgium.
36. Ibid.

imposed for just any type of offense, and is now only permitted in case of misdemeanors or felonies that harm or threaten the physical or mental integrity of third persons (Article 9). The Act also limits the conditions under which a prisoner can be interned in a prison (Articles 3, 19, 59–61) and strengthens the judicial review of such decisions (Articles 60–65).[37] The internment must be implemented in an institution or Section for Protection of Society organized by the Ministry of Justice; in a Forensic Psychiatric Centre; or in an organized private institution recognized by the government—community, province, or local—that is able to provide the required care (Article 3). Temporary placement in a psychiatric wing of a prison is only possible in case of provisional arrest or suspension of a provisional release. The Act moved decisions on allocation and (provisional) release of mentally ill prisoners from the Commissions for the Protection of Society to newly created Chambers for the Protection of Society within the Court for the Implementation of Sentences, which are thus becoming full-fledged judicial bodies consisting of a professional judge as chair, a clinical psychology assessor, and an assessor in charge of social reintegration. Provisional release is based on their evaluation of whether the person demonstrates a sufficient stabilization of the mental disorder in relation to the risk of reoffending[38] (Heimans, Vander Beken, and Schipaanboord 2014, 2015; Vander Beken, Heimans, and Schipaanboord 2016; Cartuyvels 2017; Devynck and Scheirs 2017).

However, the Internment Act of 5 May 2014 has already been amended on several occasions, most notably by the new law of 28 November 2021 on "making justice more humane, faster and firmer."[39] By June 2022, the number of mentally ill prisoners in Belgium had increased again to 764, of which only 457 were held in Social Protections Sections or Establishments.[40] Allegedly in order to protect prison directors from being held liable for illegitimate detention and pending the building of three new Psychiatric Forensic Centres by 2027, temporarily keeping internees under remand in the psychiatric annexes of prisons is again lawful under national legislation. Investment in psychiatric care in the prisons' Social Protection facilities is reinforced through cooperation between the Ministers of Justice and of Public Health, but it is unclear to what extent this will remedy the structural problems highlighted by the ECtHR.[41]

More future transfers to Forensic Psychiatric Centres or Units for the Protection of Society are to be expected if the new Draft Penal Code, submitted by the Minister of Justice in November 2022, becomes effective. The Draft Code introduces a new sanction of compulsory treatment in closed Forensic Psychiatric Centres for offenders with underlying mental disorders but who are held criminally accountable and hence are not interned. Moreover, the Draft Code also proposes a new form of preventive detention in a closed facility such as a Forensic Psychiatric Centre or a Section or

37. Internment Act of 5 May 2014 (no. 2014009316), *Moniteur Belge* 9 July 2014.

38. And occasionally in relation to medical reasons, when the health status of the patient is incompatible with further detention (Internment Act of 5 May 2014).

39. Law of 28 November 2021, *Moniteur Belge* 30 November 2021.

40. Service Public Fédéral Justice, Tables rondes Surpopulation carcérale – Internement – Données chiffrées. Accessed June 16, 2023. https://justice.belgium.be/sites/default/files/PPT%20Table%20ronde%20internement%2021%20octobre%202022.pdf.

41. Ministry of Justice. 116 extra zorgverleners voor geïnterneerden in gevangenissen. April 27, 2022. https://www.teamjustitie.be/2022/04/27/116-extra-zorgverleners-voor-geinterneerden-in-gevangenissen/.

Establishment for Protection of Society for sentenced prisoners who appear to still constitute a risk to society at the end of their sentence.[42]

Building New Institutions

Attempts at fostering the transfer of mentally ill from prisons to more adequate psychiatric care started in 2001, when several pilot projects led to the creation of ninety medium-security/medium-risk forensic beds in three private psychiatric hospitals (Devynck and Scheirs 2017). The number of such forensic beds has since increased to 280, but only twenty of these were targeted at high-security/high-risk patients.[43] As a result, the mentally ill offenders who presented a combined profile of a high risk of recidivism and a high need for surveillance remained in prisons.

In order to comply with the ECHR's requirements, Belgian authorities therefore built two new secure psychiatric hospitals in Ghent (2014) and Antwerp (2015), conforming to the new health care trajectory, which now house 450 high-risk mentally ill offenders.[44] These new hospitals should provide better conditions for mentally ill offenders than the old prison psychiatric units did (van den Ameele et al. 2015; Snacken, Devynck, and Uzieblo 2022). In the long run, the 2026 Masterplan by the Belgian authorities foresees for 2026:

- The construction of two new Forensic Psychiatric Centres (Wavre, Paifve) with a capacity of five hundred places;
- the reorganization of a regional psychiatric center (Les Marronniers, Tournai): the current 370 places will be divided into 250 places for forensic psychiatry and 120 for "long stay" interned patients; and
- the opening of a high-security psychiatric center with 120 additional places for "long stays" (Aalst).[45]

The Ministries of Public Health and of Justice set up a joint working party and a "care and detention" think tank led by the Federal Public Health Service (see Memorandum 25 July 2014: "Towards full health care for internees and detainees in Belgium")[46] to map statistical and qualitative data on mentally ill prisoners and to identify their care and treatment needs. This led the Belgian prison authorities to develop partnerships

42. After review by the Council of State, an amended version of the first Book of the Draft Penal Code, including both new sanctions, has been approved by the Federal Council of Ministers on May 12, 2023. FOD Chancellerie of the Prime Minister – Algemene directie Externe Communicatie. May 12, 2023, https://news.belgium.be/nl/hervorming-van-het-eerste-boek-van-het-strafwetboek-tweede-lezing.

43. Federal Ministry of Public Health. Vers une Belgique in bonne santé. Accessed June 15, 2023. https://www.belgiqueenbonnesante.be/fr/donnees-phares-dans-les-soins-de-sante/soins-en-sante-mentale/soins-de-psychiatrie-legale/internement.

44. Action plan – Communication from Belgium Concerning the Case of L.B. against Belgium (Application No. 22831/08), 1280 meeting (7–9 March 2017) (DH), DH-DD(2017)186, Committee of Ministers of the Council of Europe, Strasbourg, 20 February 2017, p. 7.

45. Action Plan (30/06/2021), Communication from Belgium to the Committee of Ministers Concerning the Group of Cases L.B. v. Belgium and W.D. v. Belgium, 1411th Meeting (September 2021) (DH), DH-DD(2021)679, Committee of Ministers of the Council of Europe, Strasbourg, 6 July 2021, p. 21.

46. Action Plan (30/06/2021), Communication from Belgium to the Committee of Ministers Concerning the Group of Cases L.B. v. Belgium and W.D. v. Belgium, 1411th Meeting (September 2021) (DH), DH-DD(2021)679, Committee of Ministers of the Council of Europe, Strasbourg, 6 July 2021, p. 21.

with external institutions that could accommodate them securely outside prisons. Furthermore, discussions have begun between Belgian prisons and the two new secure psychiatric hospitals mentioned above to define possible courses of action to provide better support to mentally ill prisoners and to adapt the care they receive to their individual requirements and then, as far as possible, to make better decisions about their reclassification and reintegration.[47]

However, these reforms still do not meet the human rights standards and the "transpolicy" approach set up by the ECtHR and relayed by the Belgian civil courts,[48] which requires a fundamental reform of the prison psychiatric system.[49] An updated action plan was hence submitted in June 2021 underlining new reforms undertaken, including some efforts in health care services in prison, the reinforcement of psychiatric staff, the improved training of prison officers (including for sensitivity to psychiatric illness), the creation of a new Protection of Society Section in the prisons in Ghent and Namur, and the diversification of psychiatric centers focused on medium and lower risk and on specific categories (mental disabilities, autism, Korsakov syndrome, addictions, sexual offenses), and targeting a significant turnover.[50]

This twofold strategy on the part of the Belgian state hence leads not only to an increase in the number of its secure psychiatric institutions but also to the improvement of mental health care in prison.[51] This has resulted, on the one hand, in the reduction of the number of interned mentally ill offenders in Belgian prisons by half since 2013, but on the other hand in still leaving such offenders in prisons under the argument that improving their health care services now allows prisons to legitimately house internees.[52]

The Creation of "Multidisciplinary Care Teams" (2007)

According to the CPT, multidisciplinary "care teams" should be implemented in Belgian prisons in addition to the existing "psychosocial teams," as the latter is limited to an expert function of diagnosis and prognosis for the implementation of sentence modalities and provisional release. The lack of sufficient medical staff in the prisons and in the psychiatric and Protection of Society Sections of the prisons, and the lack of independence of these health care services from the prison authorities in terms of functioning and medical confidentiality, have been regularly denounced by the CPT since at least 1993 (CPT 1994, pp. 56–67; CPT 1998b, pp. 54–61; CPT 2006b, pp. 15, 40, 43–45; CPT 2010b, pp. 52–55; CPT 2012, pp. 15–18, 25–26; CPT 2016b, pp. 35–38). The CPT refers to the UN Standard Minimum Rules for the Treatment of Prisoners and the European Prison Rules ("EPR") of 2006 and updated in 2020, which

47. Ibid., p. 5.
48. For instance, Court of Appeal Antwerp, 28 October 2019 and 18 January 2021.
49. W.D. v. Belgium, App. No. 73548/13, §§112, 169 (September 6, 2016).
50. Action Plan (30/06/2021), Communication from Belgium to the Committee of Ministers Concerning the Group of Cases L.B. v. Belgium and W.D. v. Belgium, 1411th Meeting (September 2021) (DH), DH-DD (2021)679, Committee of Ministers of the Council of Europe, Strasbourg, 6 July 2021, pp. 20–24.
51. Ibid., pp. 28, 35.
52. Ibid., pp. 34–35.

follow the Council of Europe's Recommendation 98(7) on health care in prison.[53] Recommendation 98(7) requires member states to establish prison medical services that are independent from the prison authorities and that work in close collaboration with external medical and hospital facilities operating under the authority of the national Ministry of Health.[54]

This principle was translated into the 2005 Belgian Prisons Act, which grants prisoners the right to receive quality health care that meets the common standards set up by the Belgian health system in close collaboration with external health providers (Article 88). It also requires the prison authorities to transfer prisoners whose state of health requires a medical examination that cannot be carried out in prison to an external hospital (Article 93). In addition, the Belgian Ministry of Justice issued Circular 1800 on June 7, 2007, to implement its obligation under the EPR to set up prison psychiatric services closely connected to the external psychiatric services provided to the general population as part of the general national mental health network. Circular 1800 also delineates the division of tasks and responsibilities between the various types of prison health care workers and sets up an Ethics Committee to ensure the independence of newly recruited qualified prison health care workers (such as psychiatrists, coordinating psychologists, occupational therapists, etc.) from prison officers and managers. Nevertheless, the CPT has stressed that this reform was largely insufficient and that prison health care should be placed under the authority of the national Ministry of Health (CPT 2016b, p. 35). In addition, there is sometimes an overlap between these two types of teams ("care" and "expert" functions) resulting in a lack of trust among prisoners (Colette-Basecqz and Nederlandt 2018; Snacken 2021).

Moreover, the CPT has denounced the shortage of psychiatrists and of health care teams not only in prisons but also in psychiatric hospitals (CPT 2018a, §128). This shortage that also concerns prison officers (CPT 2022) results in a lack of adequate psychiatric care, activities, and social life (CPT 2022), inappropriate medication (administered by prison officers), and delays in transfer to general and psychiatric hospitals.[55] The Belgian response to the CPT emphasized "the shortage of psychiatrists, also in general society" due to a general shortage of health care professionals and to competition with the private sector (CPT 2018b, pp. 28–29).

Transfer from Prisons to Psychiatric Institutions: Lost in Translation?

Both the ECtHR and the CPT have denounced the delays in transfers from prison to psychiatric institutions. Difficulties arise as some psychiatric institutions refuse to house mentally ill prisoners (with specific profiles) based on their own selection of "manageable" patients (see CPT visit to Jean Titeca civil hospital in 2001, CPT 2002, pp. 49–57; CPT visit to Fond'Roy Psychiatric Clinic in 2009, CPT 2010b, pp. 77–83;

53. Recommendation 98(7) of the Committee of Ministers Concerning the Ethical and Organisational Aspects of Health Care in Prison.

54. Rule 40.1 of the European Prison Rules, Recommendation Rec(2006)2-rev of the Committee of Ministers to Member States on the European Prison Rules Revised and Amended by the Committee of Ministers on 1 July 2020 at the 1380th Meeting of the Ministers' Deputies.

55. Ibid., §§147–63.

CPT 2011b, pp. 59–68; CPT visit to Center for Forensic Psychiatry (CPL) Ghent in 2017, CPT 2018a, pp. 52–59; Response from the Belgian Government to the CPT visit to Belgium in 2017, CPT 2018b, pp. 37–45).[56] Moreover, the new forensic psychiatric institutions still do not offer enough beds to house the more than seven hundred mentally ill offenders still remaining in prisons.[57] Conversely, certain mentally ill offenders prefer to stay in prison rather than moving to private psychiatric institutions due to earlier negative experiences (Devynck 2021; Snacken, Devynck, and Uzieblo 2022).

One fundamental issue is thus to document whether this "transinstitutionalization" results in fewer human rights violations. After its visit to the Forensic Psychiatric Centre of Ghent in 2017, the CPT "welcomed the reform of the psychiatric internment system, geared in the long term to better care for patients in specialized establishments" (CPT 2018a), but also underlined that "the psychiatric facilities in prison establishments suffered from the same old systemic problems" (CPT 2018a). Consequently, the CPT again recommended ensuring better care for psychiatric patients subject to an internment measure.

More fundamentally, our nonparticipant observations show that the use of common standards tends to blur the distinction between carceral and psychiatric institutions and does not guarantee their effective implementation as such. In prisons housing mentally ill individuals who should be transferred to psychiatric hospitals, the tasks of the prison and psychiatric staff are blurred, as prison officers are often dispensing medication in psychiatric wings and the psychiatric staff is regularly watched and filmed by prison officers in a carceral mode. Our observations, which are in line with the statements made by the CPT about the inappropriateness of prison psychiatric facilities for mentally ill prisoners and in particular of medication being administered by prison officers (CPT 2018a, §§147–63), demonstrate that suicidal inmates and prisoners suffering mental distress caused by their conditions of detention are also assigned to the psychiatric units, along with mentally ill patients. Conversely, we have observed that some offenders serving a determinate sentence are assigned by the Chambers for the Protection of Society to psychiatric hospitals for an indefinite period of time when they are considered to have become mentally ill during their sentence and their detention to be inappropriate by prison authorities (Internment Act 5 May 2014, Article 77).

THE IMPACT OF TRANSINSTITUTIONALIZATION ON THE PROTECTION OF HUMAN RIGHTS—COMPARING PRISONS, FORENSIC PSYCHIATRIC CENTRES, AND A PSYCHIATRIC INSTITUTION IN BELGIUM

The easier transfer of mentally ill offenders from prisons to psychiatric hospitals and the process of transinstitutionalization raise human rights challenges in *two*

56. Moreels v. Belgium, App. No. 43717/09, §§70–71 (January 9, 2014); Gelaude v. Belgium, App. No. 43733/09, §§65–66 (January 9, 2014); Oukili v. Belgium, App. No. 43663/09, §§67–68 (January 9, 2014); Claes v. Belgium, App. No. 43418/09, §§133–34 (January 10, 2013); Saadouni v. Belgium, App. No. 50658/09, §§76–77 (January 9, 2014).

57. In 2001 there were 90 forensic beds in forensic psychiatry, while in 2014 and 2017, 264 and 182 places, respectively, were created in the Forensic Psychiatry Centre of Ghent and in the Forensic Psychiatry Centre of Antwerp.

domains, linked to their position of dependency within particular power relations with staff: (1) as detainee and (2) as patient.

As Detainee

A small-scale comparison of the *legal protection* in Belgian prisons, the Forensic Psychiatric Centres (FPCs), and one private psychiatric institution (Driesen 2021) shows that the dependent position as detainee is *best recognized* by the Prison Act of 2005, which is broadly applicable to mentally ill offenders held in prisons (Article 167). Guarantees are in principle offered in the areas of: humane living conditions; sentence planning; dynamic security; disciplinary procedures; strip searches; normalization of the prison regime; preparation of reintegration; and independent monitoring by the local Supervision Committees and the Central Council for Supervision of Prisons as well as judicial decisions made by the Complaints Committees—even though the latter have only been effective since October 2020.[58]

However, *reality* in prisons is much more dire, and our observations—some of them corroborated by official and judicial sources—tend to show that overcrowding in most remand prisons results in inhumane conditions;[59] that sentence planning is still a pilot project; that the limits imposed on strip searches are circumvented;[60] that activities, vocational training, and prison labor are not sufficiently available (CPT 2018a); that lack of intellectual skills tends to hinder access to justice for mentally ill persons;[61] that transfer from prison wings to psychiatric wings is weakly judicially reviewed by the Complaints Committees;[62] and that preparation of reintegration is hampered by the lack of adequate mental health care (CPT 2018a). Mentally ill offenders can be punished for disciplinary offenses in prison despite their mental illness and put in disciplinary cells that are also used to observe mentally ill offenders and calm them down (CPT 2018a, §§164–73). By contrast, disciplinary offenses committed by mentally ill persons who are detained in Forensic Psychiatric Centres and put in disciplinary confinement (distinct from medical confinement that is also used in Psychiatric Forensic Centres) can be judicially reviewed with regard to their lucidity and liability.[63] Moreover, daily life in prison is further regulated by the internal House Rules, which may vary between prisons, but must remain within the framework of the Prison Act of 2005.

Such overarching legislation on the position as detainee *is absent* for the other institutions. The FPCs and the private psychiatric institutions must answer to the same criteria of medical care and organization as other hospitals, laid down in the Royal

58. The case law of the local Complaints Committees and the Central Council for Supervision of Prisons, which are concerned with disciplinary sanctions and security measures decided by the prison administration, is available online at https://jurisprudence.ccsp.belgium.be/Decisions-et-appels.

59. Bamouhammad v. Belgium, App. No. 47687/13 (November 17, 2015).

60. Complaints Committee, Decision No. KC04/22-0034 (April 11, 2022).

61. Complaints Committee, Decision No. CP26/22-0004 (April 7, 2022), p. 4.

62. Complaints Committee, Decision No. CA/21-0036 (March 19, 2021), pp. 3–4.

63. Complaints Committee, Decision No. CA/21-0112 (August 23, 2021); Decision No. CA/22-0028 (March 25, 2022); and Decision No. CP26/22-0004 (April 7, 2022); Council of State, Decision No. 247.098 (February 20, 2020).

Decree 23 October 1964 (and updated by the Royal Decree 19 December 2014), but these decrees are silent on issues of the internal daily regime. As a result, all aspects of daily life are regulated by the internal House Rules, which offer very little legal protection.

As far as the FPCs are concerned, an independent audit[64] has shown, for example, that contacts with the outside world are insufficiently regulated and guaranteed; that no regulation exists on the application of strip searches or on the freedom of religion or belief; and that the system of complaints to be lodged with the ombudsman lacks credibility with the patients. Moreover, these internal House Rules are not made public, and access to the Rules is restricted and difficult. This situation is comparable to the much-criticized situation in Belgian prisons before the enactment of the Prison Act of 2005.

The internal House Rules of the selected private psychiatric institution, which has a long history of also housing mentally ill offenders, are made public on the website of the institution. The center emphasizes that it is not a prison but a medium-security institution. Regulations are quite detailed and vary between the different units. Violence toward staff or fellow patients is not tolerated, but no particular sanction is mentioned. Unsupervised visits are restricted to some units and depend on the assessment by the medical team. Degrees of freedom (e.g., weekend leave) can be regained through cooperation with the treatment program. The process of complaints is very complex and differs from the one for prisons and for the Psychiatric Forensic Centres as complaints can be lodged with the responsible medical or nursing team, the internal complaint officer, or with an independent external ombudsperson. With regard to the FPCs in Ghent and Antwerp, both the Flemish ombudsman and the federal ombudsman are competent to deal with the complaints brought by detainees.[65] Moving from one type of institution to a different one has then a real impact on monitoring and the ability to take cases to the judiciary, as specific rules apply for each kind of institution. Daily life may also vary based on individual agreements between the patient and the multidisciplinary staff—the Rules emphasize though that the agreements are binding on both patient and staff, and may not overrule basic rights.

As Patient

The Act on the Rights of Patients of 22 August 2002 is applicable to all patients, independent of whether medical care is offered on an outpatient basis or in an institution, but also allows for some legal derogations. It guarantees the right to high-quality medical care, in accordance with the patient's human dignity and autonomy; to a free choice of medical practitioner; to information and informed consent; to access to the medical file; to the protection of private life; and to lodge a complaint with an ombudsperson. These rights as a patient seem *better protected* in the FPCs and the private institution than in prison.

64. DEPARTEMENT WELZIJN, VOLKSGEZONDHEID EN GEZIN, *Auditverslag 2019*, Brussels, https://docs.vlaamsparlement.be/pfile?id=1622942, 57.

65. See le Médiateur fédéral. Plaintes. https://www.federaalombudsman.be/fr/plaintes.

However, the most recent CPT report on the FPC in Ghent and our own observations reveal that while most constraints consist of negotiated limits on moves, overmedication and forced medication do occur, along with the overuse (on behalf of psychologists and psychiatrists but performed by prison officers) of both isolated (up to twenty days) and confined (up to forty-four days) rooms that are constantly filmed (via CCTV) in order to observe, calm, constrain, and even punish restless and violent patients—not unlike what occurs in prisons. Such assignments are exclusively justified by the authorities on psychiatric grounds—without any reference to punishment (CPT 2018a, §§129–37)—and thus cannot be judicially reviewed, despite potentially threatening both the right to dignity and the right to private life.

The FPCs also derogate from the right to free choice of a medical practitioner, but visits by one's personal doctor are allowed at the patient's own expense. The House Rules of the private institution explicitly refer to all the rights granted by the 2002 Act on the Rights of Patients. All other aspects of medical treatment depend on individual agreements and are consequently subjected to a certain level of differentiation and discretion. Psychiatric and medical care in both the FPCs and the private institution are based on an individual diagnosis and a treatment plan that is of better quality than that in prison, and aim at gradual reintegration into society.

CONCLUSION

Studying the intersection of policies applied to different places of detention—prisons, Forensic Psychiatric Centres, and psychiatric hospitals—and integrating the sociolegal subdisciplines that cover criminal justice, health care, and human rights illustrate the complex nature of relations between human rights and detention.

We have shown enhanced forms of "transinstitutionalization" and "transpolicies" between prisons and psychiatric institutions. Such "total institutions," which host persons who are perceived for different reasons as "deviant," present many similarities, including the risk of ill treatment and other human rights violations, and are monitored through the same European human rights standards. However, the use of these common standards also clashes with efforts made by the European human rights institutions to thwart the mixing of prisoners and psychiatric patients. Transpolicies then result in establishing common standards and in resisting the process of transinstitutionalization that is enhanced by the creation and use of common standards. In addition, the ECtHR case law has pushed the Belgian state not only to build new psychiatric hospitals (with the risk of psychiatric expansion) but also to improve health care and psychiatry in prisons—which are thus more suitable to still house mentally ill offenders. These paradoxes could explain why prison and psychiatric populations remain intertwined to a certain extent.

The example of the transinstitutionalization of mentally ill offenders from Belgian prisons to Forensic Psychiatric Centres and private psychiatric institutions also illustrates that, while rights to care as a patient may be better protected outside prison, the risks of dependence on staff in a total institution may be more recognized—at least formally—in prison than in these other institutions. Transfer of such patients from prison to psychiatric hospitals, with the concomitant risk of being "lost in translation,"

should hence not automatically be taken to guarantee better human rights protection. More comparative research between such institutions remains necessary and more reflection on the lack and effects of litigation in terms of transinstitutionalization is needed. In particular, there is clearly room for more investigation into such paradoxes led by transpolicies that evolve over time and reveal the contradictions of such policies' efforts.

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