JUSTICE FOR ALL

Enhancing the Rights of Defendants and Detainees with Intellectual and/or Psychosocial Disabilities:
EU Cross-Border Transfers, Detention and Alternatives

Comparative Report

LUDWIG BOLTZMANN INSTITUTE
Fundamental and Human Rights

JUSTICE
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ABBREVIATIONS

ACC
Austrian Criminal Code

CEDAW
Convention on the Elimination of All Forms of Discrimination against Women

CFR or Charter
Charter of Fundamental Rights of the European Union

CJEU
Court of Justice of the European Union

CoE
Council of Europe

CPT
Committee for the Prevention of Torture

EAW FD
Framework Decision (2002/584/JA) on the European Arrest Warrant

EC
European Commission

ECHR
European Convention on Human Rights

ECtHR
European Court of Human Rights

ESO FD
Framework Decision 2009/829/JHA on Supervision Measures as an Alternative to Provisional Detention or European Supervision Order

EU
European Union

HRC
Human Rights Committee

ODIHR
Office for Democratic Institutions and Human Rights

OHCHR
Office of the High Commissioner for Human Rights

PAS FD
Framework Decision 2008/947/JHA on Supervision of Probation Measures and Alternative Sanctions

Recommendation 2013: Recommendation on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings in 2013

REMS
Residence for the Execution of Security Measures

SPT
Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

TFEU
Treaty on the Functioning of the European Union

TEU
Treaty on European Union

TP FD
Framework Decision 2008/909/JHA on Transfer of Prisoners

UN
United Nations

UNCAT
United Nations Convention Against Torture

UNCRPD Committee
Committee on the Rights of Persons with Disabilities

UNCRPD
United Nations Convention on the Right of Persons with Disabilities

WGAD
Working Group on Arbitrary Detention

WHO
World Health Organization

GLOSSARY

Arrest: Deprivation of liberty of a person by a law enforcement body on the ground of suspicion of committing or having committed a crime. The arrest is then followed by release or a judicial decision on detention.

Alternative measures or alternatives to pre-trial detention: A non-custodial measure of restraint intended to ensure that the person accused of a crime appears before the investigative body or the court for further legal proceedings. As an alternative to provisional measures, 'supervision measures' under Art 4 of the FD 2009/829/JHA are enforceable decisions taken in the course of criminal proceedings by a competent authority of the issuing State in accordance with its national law and procedures.

Alternative sanctions: Non-custodial sanctions that maintain sentenced persons in the community and involve some restrictions on their liberty through the imposition of conditions and/or obligations. Under Art 2(4) of the FD 2008/947/JHA, "'alternative sanction' shall mean a sanction, other than a custodial sentence, a measure involving deprivation of liberty or a financial penalty, imposing an obligation or instruction".

Capacity to be found criminally responsible (or also criminal legal capacity): The capacity to be found criminal responsible refers to the accused's mental state at the time of the offence and his/her ability (or inability, or reduced ability) to appreciate the dangerous nature of a crime or to control his/her behaviour. N.B. In some jurisdictions like the USA, this is referred to as the "insanity defence". Depending on the situation, one can be declared fully incapable to be found criminally responsible (not criminally responsible/liable) or partly incapable to be found criminally responsible (i.e., diminished criminal legal capacity, partly criminally responsible/liable).

Civil involuntary commitment: Institutionalisation/hospitalisation of persons with intellectual and/or psychosocial disabilities without their consent based on their disability (e.g., because they pose a potential risk to harm themselves or others). For the purpose of this project, civil involuntary commitment differs from the mental health regimes mentioned above. While the first originates from a relevant criminal situation and can be considered mechanisms of diversion from the criminal proceedings, involuntary commitment covers situations that are to be classified as purely civil and without any criminal context. Civil involuntary commitment is not covered under this project.

Criminal proceeding: Procedure to implement the substantive criminal laws, decide on criminal charges, acquittal and execute the sentence of imprisonment or any other form of cuastodial measure. According to the CJEU, this also includes proceedings for committal to a psychiatric hospital which, although they do not lead to a 'sentence' in the strict sense, nevertheless result in a measure involving a deprivation of liberty provided that such a measure is justified not only on therapeutic grounds but also on safety grounds.[1]For the purpose of this project, the notion of criminal proceeding encompasses the following stages: pre-trial, trial, and execution/post-trial stage.

Custodial measures applicable to suspected or accused persons declared not fit to stand trial, not criminally responsible or only partly criminally responsible: Deprivation of liberty of persons who were declared not fit to stand trial or incapable or partly capable to be found criminal responsible due to their disability. They are not sentenced to imprisonment (due to lack of criminal responsibility) but are still subjected to deprivation of liberty. The deprivation of liberty is usually justified on grounds of the person's actual or perceived disability combined with other aims, such as to prevent

the commission of further crimes, reduce 'their dangerousness' to themselves and others, and be offered therapy. The custodial measures can take different forms depending on the national legal systems. In certain States, they remain in the purview of the criminal justice system and are referred to as **"security measures"** or "preventive custodial measures". In other States, suspected and accused persons declared not fit to stand trial or not criminally responsible or only partly criminally responsible are diverted from criminal proceedings to **"mental health commitment regimes"**, also referred to as **"compulsory commitment regimes/treatments"**.

Defendant: A person suspected or accused of a crime in a criminal proceeding.

Defendants and detainees with intellectual and/or psychosocial disabilities: The research conducted in the framework of the project showed that the national systems often do not foresee sufficient support for defendants and detainees with intellectual and/or psychosocial disabilities in their criminal proceedings. Relevant provisions foreseen in the 2013 Recommendation have not been implemented into national law. Ordinary proceedings are often not equipped to respond to needs of persons concerned (i.e., appropriate ways of ensuring participation, such as a modified "letter of rights" or inclusion of additional persons to provide support). In some jurisdictions, trials may be held in absentia if the person concerned is presumed "unfit to stand trial", thus effectively excluding them.

Deprivation of liberty: For the purpose of this project, the term "deprivation of liberty" should be understood in line with the definition given by the OPCAT under Art 4: "any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority."

Detainee or person deprived of liberty: A person arrested, in pre-trial detention, imprisoned, subjected to security measures/preventive custodial measures, mental health commitment regimes, preventive detention, or otherwise subjected to any other custodial measures amounting to a deprivation of liberty as defined under Art 4 of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

Execution or post-trial stage: This stage starts after a final and binding conviction judgement and goes until the end of the execution of a sentence.

Fitness to stand trial (or fitness to plead): Fitness to stand trial usually refers to the defendant's mental condition at the time of the criminal proceedings and whether any such condition impacts his/her ability to understand the nature or object of the proceedings, understand the possible consequences of the proceedings or communicate with counsel. This is common, especially in common law traditions. According to the UNCRPD Committee, "declarations of unfitness to plead … and the detention of persons based on those declarations, are contrary to Art 14 of the Convention since it deprives the person of his or her right to due process and safeguards that are applicable to every defendant."[2]

Hearings in absentia: A hearing in the context of criminal proceedings that takes place in the physical absence of the accused. Trial hearings usually require, at the very least, that the legal representative of the accused is present.

Imprisonment: Detention after a final judgement of conviction.

Legal capacity: According to Art 12 UNCRPD, legal capacity refers to the capacity to be a holder of rights under the law as well as the capacity "to engage in transactions and create, modify or end legal relationships". Art 12 of the UNCRPD refers to equal recognition before the law and requires States Parties to "recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life" and to "take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". According to the UNCRPD Committee, legal capacity differs from mental capacity, defined as "the decision-making skills of a person, which naturally vary from one person to another and

may be different for a given person depending on many factors, including environmental and social factors". The UNCRPD Committee has stated that under Art 12 of the Convention, "perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity."

"Ordinary" imprisonment: Detention after a final judgement of conviction in prison as opposed to a specialised forensic/psychiatric facility or specialised prison department.

"Ordinary" proceedings: Criminal proceedings under the criminal procedural code, for criminal offences committed as opposed to proceedings leading to custodial measures.

Pre-trial stage: This stage starts with a criminal investigation against someone who is suspected to have committed a crime and ends with the indictment, the formal charge with a criminal offence under the procedure set out in domestic law. It includes the proceedings before the police, prosecutor and/or investigative judges or judges for the preliminary investigation.

Prisoner: A convicted person, sentenced to imprisonment.

Pre-trial detention: A measure of restraint by which a person accused of committing a crime is kept in custody, ordered by a judicial authority at the pre-trial or trial stage of proceedings to ensure his/her appearance before a court, prevent his/her further criminal activity, and/or prevent unlawful interference with the investigation of the case.

Probation: According to the Council of Europe definitions, "**probation** means the implementation of alternative sanctions and measures, defined by law. It includes a range of activities and interventions, which involve supervision, guidance and assistance aiming at the social inclusion of an offender, as well as at contributing to community safety".[3] **Community sanctions and measures** mean "sanctions and measures which maintain suspects or offenders in the community and involve some restrictions on their liberty through the imposition of conditions and/or obligations. The term designates any sanction imposed by a judicial or administrative authority, and any measure taken before or instead of a decision on a sanction, as well as ways of enforcing a sentence of imprisonment outside a prison establishment."[4]

Under Art 2(5) of the FD 2008/947/JHA "**'probation decision'** shall mean a judgement or a final decision of a competent authority of the issuing State taken on the basis of such judgement: (a) granting a conditional release; or (b) imposing probation measures"; under Art 2(7) of the FD 2008/947/JHA, "**'probation measures'** shall mean obligations and instructions imposed by a competent authority on a natural person, in accordance with the national law of the issuing State, in connection with a suspended sentence, a conditional sentence or a conditional release".

Preventive detention: Deprivation of liberty of persons with intellectual and/or psychosocial disabilities, whose intellectual and/or psychosocial disabilities were identified during trial but have been considered criminally responsible (or in certain jurisdictions, also partly criminally responsible), tried and convicted. Preventive detention is usually applied to reduce 'their dangerousness' for parts of the imprisonment, instead of imprisonment or after imprisonment if the person is still considered 'dangerous'. In some tates, preventive detention may be ordered in addition to a prison sentence and can be upheld indefinitely. Usually, a person can be held in a specialised detention facility, a designated part of a prison or the forensic-psychiatric department of a hospital. Preventive detention differs from preventive custodial measures/security measures in so far as preventive custodial measures/security measures are custodial measures applicable to suspected or accused persons declared not fit to stand trial, not criminally responsible or only partly criminally responsible, while preventive detention is applied to persons who were considered fully capable to be criminally responsible (and in certain states, partly responsible).

Trial stage: This is the stage between the indictment of a person and the final judgement, including the appeals.

EXECUTIVE SUMMARY

This comparative report is the result of a two-year research project co-funded by the European Union's Justice Programme programme and led by the Ludwig Boltzmann Institute of Fundamental and Human Rights in collaboration with partners from Bulgaria, Germany, Italy, Lithuania, and Slovenia. The research examined the implementation of EU Framework Decisions related to judicial cooperation in criminal proceedings, emphasising the rights of defendants and detainees with intellectual and/or psychosocial disabilities. In addition, the research assessed the situation of defendants and detainees with intellectual and/or psychosocial disabilities within the national systems in law and practice and the compliance with international, regional, and national standards, as these factors may impact cross-border cooperation. The project covers procedural safeguards, treatment of persons with intellectual and/or psychosocial disabilities during deprivation of liberty, alternatives to detention and probation measures.

The research explored the legal pathways leading to the deprivation of liberty for individuals with intellectual and/or psychosocial disabilities following their involvement in criminal offences. The examination of (criminal) legal capacity and criminal responsibility, and access to justice for defendants and detainees with intellectual and/or psychosocial disabilities reveals significant challenges within the legal systems of the partner countries. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), particularly Art 12, establishes the principle of 'universal legal capacity,' emphasising equality in legal standing irrespective of disability. However, the research indicates that several European Union (EU) Member States link a denial of criminal legal capacity to disabilities, potentially impacting the exercise of procedural rights, the outcome of criminal proceedings, and the imposition of measures. The lack of criminal legal capacity may result in special proceedings involving security measures, compulsory treatment or preventive detention.

Across the partner countries, the assessment mechanisms for identifying disabilities pose challenges, with inadequate mechanisms to identify indicators and insufficient safeguards for early identification, as well as concerns raised about the quality and impartiality of expert opinions. The scarcity of expert witnesses, influenced by low salaries, further exacerbates these challenges. The prevailing medical approach to assessments focuses primarily on determining criminal legal capacity, lacking consideration for support needs and the ability to withstand trial pressures. Overall, the lack of adequate mechanisms for early disability identification may result in the denial of necessary support for equal access to justice, emphasising the necessity for a more comprehensive and inclusive approach.

Regarding procedural rights, the research shows that despite existing standards to safeguard procedural rights, there is a lack of accommodations for individuals with disabilities during criminal proceedings and the partner countries have not implemented relevant (non-binding) international standards, including from the European Commission. The research reveals variations in the provisions for legal representation for individuals with intellectual and/or psychosocial disabilities, and the effectiveness of defence mechanisms may be compromised in some cases. While some existing specific procedural provisions in national criminal justice systems for persons with intellectual and/or psychosocial disabilities intend to provide accommodations, these proceedings may inadvertently circumvent general procedural safeguards, potentially impacting the defendants' rights. The research underscores the need for comprehensive reforms to align legal practices with the principles of the UNCRPD and ensure equal access to justice for individuals with disabilities.

In the context of this research, deprivation of liberty of persons with intellectual and/or psychosocial disabilities encompasses imprisonment and confinement in psy-

chiatric or forensic institutions. Criminal responsibility assessments dictate whether individuals proceed along the "regular" track and serve sentences of imprisonment in "ordinary" prisons or are subjected to security measures/compulsory treatment or preventive detention in specialised facilities. Criminal responsibility hinges on retrospective assessments of disabilities, contributing to an individual's failure to recognize the the nature (wrongfulness) and consequences of their actions. The presence of a disability, coupled with an assessment of dangerousness, often justifies confinement for treatment and public protection. Despite violating UNCRPD principles against deprivation based on disability, all partner countries permit the deprivation of liberty for individuals with disabilities in the criminal context. Involuntary committal to institutions is widespread, often occurring without a conviction and falling under the purview of the health sector.

The prevalence of intellectual and/or psychosocial disabilities in the general prison population is high across all observed countries, with significant rates of psychiatric conditions and psychotropic medication use. Individuals with intellectual and/or psychosocial disabilities in ordinary prisons often lack adequate support and services, facing isolation and segregation due to security concerns and a lack of resources for other measures.

Regarding forms of security measures and compulsory treatment, all six partner countries have legislation for the commitment to forensic psychiatric institutions or specialised facilities ordered by courts when a defendant is found not criminally responsible by the court. Grave concerns are expressed about the conditions, coercive treatment, and potential unlimited detention within these institutions. The absence of a concrete time frame has been highlighted as problematic by experts, leaving individuals feeling powerless and without agency. The research indicates that in many instances, facilities may not offer necessary treatment, hindering potential improvement and leading to prolonged stays. Transferring individuals to civil law and mental health systems has been criticised for perpetuating indefinite detention. Each country has variations in the types of compulsory medical treatment measures and security measures, including outpatient options, inpatient confinement, and specific conditions for enforcement. Preventive detention/measures, as seen in Austria and Germany, offer another pathway for detention, allowing for indefinite confinement based on the commission of an offence, a disability and dangerousness.

Concerns about the review mechanisms for compulsory treatment have been raised, with lawyers expressing worries about inadequate safeguards for detainees' rights. Some countries conduct automatic reviews every six months, but the effectiveness varies. Legal representation in review proceedings is not universally mandatory, potentially impacting the thoroughness of case reviews. Additionally, the person concerned may not always be heard during the review process, raising questions about fairness and due process. Decisions in review proceedings often heavily rely on expert opinions, and the lack of involvement of external experts in some cases has been flagged as a concern.

The overall research underscores the violation of UNCRPD principles in all partner countries, allowing deprivation of liberty based on perceived dangerousness linked to disability. The complexity and lack of comparability across different regimes and facilities for persons with intellectual and/or psychosocial disabilities highlight the need for systemic changes. The report recommends implementing time limits, ensuring comprehensive reviews, and addressing the blurred lines between medical and security concerns in the deprivation of liberty for this population.

The four EU instruments used in cross-border criminal proceedings are the European Arrest Warrant framework decision, the Transfer of Prisoners framework decision, the European Supervision Order framework decision and the Probation and Alternative Sanctions framework decision. The report revealed a fragmented state of protections concerning persons with psychosocial and/or intellectual disabilities, with general provisions ensuring respect towards fundamental rights but lacking specific safeguards on particular

accommodations for the persons concerned. The EU jurisprudence made fundamental rights violations in the context of cross-border proceedings hard to demonstrate, reinforcing the presumption of fundamental rights compliance as encompassed in the principles of mutual trust and mutual recognition. As a result, while the postponement of a transfer is envisioned in the EU instruments, the total refusal by a State to transfer a defendant or detainee is only acceptable in rare cases of extreme violations of fundamental rights.

At the national level, Member States possess some leeway while transposing EU instruments, which led to a certain fragmentation of rights at the domestic level. Some Member States have recognized more grounds for refusal to transfer, including the non-respect of procedural safeguards. Some have added general provisions to better protect the person concerned during criminal proceedings. Some transposition laws, however, have also altered or removed some protective articles or added constraining obligations. More specifically, Member States have generally failed to add provisions protecting persons with psychosocial and/or intellectual disabilities at the national level. Many partner countries reported how consent, both in relation to the criminal proceedings and to medical treatment, was sometimes not included in the legislation or not sought to properly ensure informed and genuine agreement. Finally, the report showed a general lack of awareness and knowledge in respect of both the framework decisions (except for the EAW FD) and the involvement of persons with psychosocial and/or intellectual disabilities in cross-border proceedings.

INTRODUCTION

OVERVIEW OF THE PROJECT

The findings presented in this comparative report are a product of research that was conducted as part of a two-year project (2023-2024) co-funded by the European Commission (EC), led by the Ludwig Boltzmann Institute of Fundamental and Human Rights (Austria) in cooperation with the Bulgarian Helsinki Committee (Bulgaria), Dortmund University of Applied Sciences and Arts (Germany), Antigone (Italy), Mental Health Perspectives (Lithuania) and Peace Institute (Slovenia).

Within the EU, the need for better coordinated judicial cooperation between the Member States grew significantly during the past two decades. In order to facilitate and simplify judicial cooperation in criminal proceedings, the EC has adopted the following FDs: 2002/584/JHA on the European Arrest Warrant; 2008/909/JHA on the Transfer of Prisoners, 2009/829/JHA on the European Supervision Order, and 2008/947/JHA on Probation and Alternative Sanctions.

The Court of Justice of the European Union (CJEU) clarified in various judgments that the application of mutual recognition instruments must not lead to a violation of fundamental rights[5] and that the respect for fundamental rights is vital to build mutual trust between the Member States and ensure the good functioning of cross-border cooperation.

In 2021, the EU recognised the challenges faced by vulnerable adults who are suspected or accused persons in criminal proceedings, which may hinder their exercise of procedural rights.[6] It called for comprehensive examination of procedural safeguards for vulnerable adults, identification of uniform criteria for determining vulnerability and full and effective access to justice for all European citizens, especially in cross-border situations. Additionally, the EU has ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), symbolising a significant step in setting minimum standards for the rights of persons with disabilities. Furthermore, in 2022, the EC adopted a Recommendation on procedural rights of suspects and accused persons subject to pre-trial detention and on material detention conditions.[7] The Recommendation specifically refers to the UNCRPD and addresses persons with disabilities.

While previous projects have analysed the implementation of EU Framework Decisions into domestic law, little research has been conducted on the situation of defendants and detainees with intellectual and/or psychosocial disabilities and the specific challenges that they may face in cross-border proceedings. The current project thus analyses the implementation of the abovementioned FDs into national law with respect to the rights of defendants and detainees with intellectual and/or psychosocial disabilities. At the same time, the research includes an assessment of the situation of defendants and detainees with intellectual and/or psychosocial disabilities within the national systems, and measures compliance with international, regional and national standards, as national grievances may hinder cross-border cooperation. The project covers procedural safeguards, treatment of persons with intellectual and/or psychosocial disabilities during deprivation of liberty, alternatives to detention and probation measures.

METHODOLOGY

The findings and recommendations contained in this comparative report are based on extensive research on the national level conducted in Austria, Bulgaria, Germany, Italy, Lithuania and Slovenia (partner countries). The research included desk research as well as interviews with national experts representing all relevant stakeholders, including (former) detained persons with intellectual and/or psychosocial disabilities, members of the judiciary, lawyers,

civil society organisations representing defendants and detainees with intellectual and/or psychosocial disabilities in proceedings, probation officers and social workers, medical experts, representatives of national oversight mechanisms and academics. These expert interviews were conducted with nationals from the partner countries as well as from other Member States. Bitte noch einfügen: On the national level, each partner organisation was supported by National Advisory Boards.

In addition to national research, the Ludwig Boltzmann Institute of Fundamental and Human Rights (LBI-GMR) conducted research on relevant international and regional standards, including standards provided inter alia by the EU, UN (including the UNCRPD and United Nations Convention Against Torture (UNCAT)), Council of Europe (including standards set forth by the European Court of Human Rights (ECtHR)) or the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)), which should build the foundation for the protection of defendants and detainees with intellectual and/or psychosocial disabilities.

In addition to the national consultations, the LBI-GMR gathered information from other EU Member States. The LBI-GMR prepared a survey among experts and networks, which collected information from 14 EU Member States. The LBI-GMR further organised a series of four virtual regional workshops to consult with experts from partner countries as well as from other Member States and provide a platform for peer-to-peer exchange. Each virtual workshop targeted a specific stakeholder group: a workshop with lawyers, a workshop with probation officers, a workshop with representatives of oversight mechanisms, as well as a workshop with judges. Furthermore, a one-and-a-half day regional consultation workshop took place in Vienna in June 2023, gathering 56 experts from 13 different EU Member States and representing all relevant fields. This final workshop provided opportunities for interdisciplinary exchange, as well as presented and validated the project findings and recommendations, which are presented in this comparative report.

DEFINITIONS/ TERMINOLOGY

A significant challenge encountered throughout the project was the terminology. The terminology used to describe the situation of persons with intellectual and/or psychosocial disabilities has changed over time and varies from country to country, making it challenging to find a universally satisfactory definition. Considering that this project is based on a human rights approach and has the overall aim of strengthening the protection afforded to these persons, we have chosen to follow an inclusive approach based on the approach adopted by the UNCRPD[8] and in light of previous projects by the LBI-GMR and the members of this consortium.[9]

Following the UNCRPD approach, the project:

- Recognizes that disability is an evolving concept that results from the interaction between persons with impairments on the one hand, and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others on the other hand;

- Departs from a "medical model of disability" that views persons with disabilities as "objects" of medical treatment and in need of charity;

- Takes into consideration the ideas underpinning the "social model of disability", which views persons with disabilities as "subjects" with rights and focuses on the barriers that they face that may hinder their societal participation;

- Applies a "human rights-based approach to disability", which recognizes the intrinsic value of every person for their own end, "rather than focusing on a lack of overall capabilities as measured against a functional baseline".[10]

At the same time, it must be considered that in the European context, other terms are commonly used to indicate the same or similar situations, which adds to the complexity and compounds comparability to some extent.

By way of example, the European Convention of Human Rights (ECHR) uses the phrase "persons of unsound mind" under Article 5(1)(e) ECHR, while the ECtHR in its jurisprudence often uses the term "mentally ill persons". The CPT seems to prefer the use of "patients" or "forensic patients" over the word "prisoners" when talking about persons who were declared not criminally responsible[11] but often refers to "prisoners suffering from a mental illness" to indicate such prisoners who are serving imprisonment in penitentiary facilities.[12] The Council of Europe (CoE) Council for Penological Co-Operation speaks about prisoners with "mental health disorders".[13]

EU law does not regulate this situation. However, it may be helpful to note that the EC Recommendation of 27 November 2013 on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings (2013 Recommendation) uses the term "vulnerable person", which is the umbrella term used to encompass "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."[14]

Other terms commonly used to refer to mental health experiences include "mental illness", "mental disorders", "mental health problems", "mental health issues" and "mental health conditions".[15]

Moreover, as the project analyses the situation of persons with intellectual and/or psychosocial disabilities who are suspected, accused or sentenced for having committed a crime, it refers to **"defendants and detainees with intellectual and/or psychosocial disabilities"**, based on the different legal contexts in which individuals may find themselves in the criminal justice system. However, the term "persons with intellectual and/or psychosocial disabilities" is also used where this distinction is not decisive.

Defendants with intellectual and/or psychosocial disabilities may be **deemed unfit to stand trial (or unfit to plead)**. Fitness to stand trial usually refers to the defendant's mental condition at the time of the criminal proceedings and whether any such condition impacts his/her ability to understand the nature or object of the proceedings, understand the possible consequences of the proceedings, or communicate with counsel. This is particularly prevalent in common law traditions.

Defendants with intellectual and/or psychosocial disabilities may also be found **not criminally responsible** (or lacking criminal legal capacity). The capacity to be found criminally responsible refers to the accused's mental state at the time of the offence and his/her ability (or inability or reduced ability) to appreciate the dangerous nature of a crime or to control his/her behaviour. Depending on the situation, one can be declared fully incapable to be found criminally responsible (not criminally responsible/liable) or partly incapable to be found criminally responsible (i.e., diminished criminal legal capacity, partly criminally responsible/liable).

In other cases, persons with intellectual and/or psychosocial disabilities whose intellectual and/or psychosocial disabilities were identified during trial but have not been considered severe enough to declare the person unfit to stand trial or not criminally responsible (in certain jurisdictions, also partly criminally responsible) will be **subjected to a criminal trial and sentenced.**

OVERVIEW OF THE REPORT

This comparative report summarises research findings and analyses of the situation of defendants and detainees with intellectual and/or psychosocial disabilities within the national systems of Austria, Bulgaria, Germany, Italy, Lithuania and Slovenia.

The report contains key recommendations on the various topics covered by the project to enhance the rights of defendants and detainees with intellectual and/or psychosocial disabilities.

Part 1 has two purposes: to give an overview of the current international standards on the issues concerning safeguards, detention and alternatives to detention for persons with intellectual and/or psychosocial disabilities; and to assess the level of implementation of these standards under the national systems of the six partner countries. To achieve the first objective, Part 1 analyses current standards relevant for EU Member States, including those set by the UN, CoE, and EU, and reflects on how these interrelate and complement each other. As for the second objective, Part 1 provides a comprehensive overview of the status quo in the partner countries. It compares the laws and policies of the six EU Member States and analyses their application, identifying challenges and promising practices. Whenever relevant, examples from other EU Member States gathered during the EU wide project consultations were also added.

Part 2 analyses the four EU cross-border Framework Decisions and their implementation in the six partner countries. It assesses the existing provisions most relevant for defendants and detainees with intellectual and/or psychosocial disabilities in light of fundamental rights standards. Simultaneously, Part 2 will provide an overview of the application of the instruments in practice and identify challenges and promising practices.

The Annex contains case studies on different promising practices in the partner countries.

PART 1

DEFENDANTS AND DETAINEES WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES: INTERNATIONAL STANDARDS AND IMPLEMENTATION WITHIN NATIONAL SYSTEMS

01. OVERVIEW OF RELEVANT STANDARDS

1.1. LEGAL CAPACITY, ACCESS TO JUSTICE, PROCEDURAL SAFEGUARDS

1.1.1. EU STANDARDS

Concerning the European Union's legal framework on access to justice and procedural safeguards, the Treaty on the Functioning of the European Union (TFEU) provides that the Union shall constitute an area of freedom, security and justice with respect for fundamental rights and the different legal systems and traditions of the Member States and shall facilitate access to justice.[16]The Treaty on the European Union (TEU) states that the Union was created based on shared values, including a society where justice and non-discrimination prevail,[17] and also includes a provision on the duty of the Union to offer its citizens an area of freedom, security and justice.[18] The TEU also provides that the Union recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights of the European Union (CFR or Charter),[19] which, in turn, includes the right to an effective remedy and to a fair trial, the right to have access to legal aid and to be advised, defended and represented.[20]

Against this background, it should not be forgotten that, for the first time in history, the EU has ratified a UN treaty, namely the UNCRPD, together with all EU Member States. The UNCRPD, adopted in 2006 and which entered into force in 2008, marked a breakthrough in setting minimum standards for rights of persons with disabilities and was defined as a 'paradigm shift' in approaches to the concept of 'disability' in international human rights law.

The EU is progressing with the implementation of the UNCRPD in several areas and has recently adopted the EU Disability Strategy 2021-2030.[21] Amongst other things, the Strategy recalls the UN International Principles and Guidelines on Access to Justice for Persons with Disabilities and plans for the EU to provide guidance to Member States on access to justice for persons with disabilities in the EU, building on international guidance provided by the UN.

In the context of criminal proceedings, the EU adopted the 2013 Recommendation. It calls upon Member States to strengthen certain procedural rights of vulnerable suspects or accused persons in criminal proceedings and of vulnerable persons who are subject to European Arrest Warrant proceedings. Particular focus is given to the prompt and early identification and recognition of a situation of vulnerability to make sure that the person can effectively participate in the proceedings. Additionally, the following safeguards are mentioned:

- Non-discrimination
- Presumption of vulnerability
- Right to information
- Right of access to a lawyer
- Right to medical assistance
- Recording of questioning
- Privacy

Furthermore, to date, six measures on procedural rights in criminal proceedings have been adopted pursuant to the roadmap, namely:

- Directives 2010/64/EU on the right to interpretation and translation in criminal proceedings
- Directive 2012/13/EU on the right to information in criminal proceedings
- Directive 2013/48/EU on the right of

access to a lawyer in criminal proceedings and European arrest warrant proceedings and on the right to have a third party informed upon deprivation of liberty and to communicate with third persons and with consular authorities while deprived of liberty

- Directives (EU) 2016/343 on the strengthening of certain aspects of the presumption of innocence and of the right to be present at the trial in criminal proceedings

- Directive (EU) 2016/800 on procedural safeguards for children, i.e., persons under the age of 18, who are suspects or accused persons in criminal proceedings

- Directive (EU) 2016/1919 on legal aid for suspects and accused persons in criminal proceedings and for requested persons in European arrest warrant proceedings

While these EU instruments do not refer explicitly to proceedings covering the committal to a security measure/psychiatric hospital, the CJEU established the applicability of certain Directives.

CJEU, Case C-467/18, "Ray-onna prokuratura Lom"[22]
19 September 2019, Request for a Preliminary Ruling.

Relevant topic: Applicability of Directives 2012/13/EU; 2013/48/EU and (EU) 2016/343 to suspects and accused with intellectual and/or psychosocial disability, including in proceedings covering committal to a security measure/psychiatric hospital where the person is declared to be not criminally responsible but is subjected to a detention measure justified on therapeutic and safety grounds.

The Court decided that:

1. Directive 2012/13/EU on the right to information and Directive 2013/48/EU on the right of access to a lawyer apply to judicial proceedings for compulsory psychiatric treatment of not criminally responsible persons.

2. Persons suspected of having committed a crime must be informed as soon as possible of their rights from the moment when they are subject to suspicions which justify, in circumstances other than an emergency, the restriction of their liberty by the competent authorities by means of coercive measures and, at the latest, before they are first officially questioned by the police.

3. Art 47 of the Charter of Fundamental Rights of the European Union, Art 8(2) of Directive 2012/13 and Art 12 of Directive 2013/48 preclude national legislation for compulsory treatment of persons who are not criminally responsible, where that legislation does not enable the court with jurisdiction to verify that the procedural rights covered by those directives were respected in proceedings prior to those before that court, which were not subject to such judicial review.

4. Directive (EU) 2016/343 on the presumption of innocence and the right to be present at the trial in criminal proceedings and Art 51(1) of the Charter of Fundamental Rights do not apply to judicial proceedings for civil involuntary treatment (Art 155 of the Health Act).

5. The principle of the presumption of innocence referred to in Art 3 of Directive 2016/343 requires, in judicial proceedings for compulsory treatment of not criminally responsible persons, that the Public Prosecutor's Office provides proof that the person whose committal is sought is the perpetrator of the crime.

According to the CJEU, the concept of 'criminal proceedings' also covers proceedings for committal to a psychiatric hospital which, although they do not lead to a 'sentence' in the strict sense, nevertheless result in a measure involving a deprivation of liberty provided that such a measure is justified on safety grounds, not merely therapeutic grounds. As a consequence, the CJEU found that the principle of the presumption of innocence referred to in Article 3 of Directive 2016/343 must be interpreted as requiring that the Public Prosecutor's Office provides proof that the person whose committal is sought is the perpetrator of acts deemed to constitute such a danger.[23] The Court admitted that the purpose of such a procedure at issue in the main proceedings is not to determine the guilt of the person concerned, but to decide on his compulsory committal to a psychiatric hospital. However, since the reasons stated for that measure of deprivation of liberty are not just therapeutic grounds, but also safety grounds, it must be accepted that fair trial principles apply also to these proceedings. Therefore, in this case, the Public Prosecutor's Office bears the burden of proof for establishing that the person whose committal is sought is the perpetrator of acts deemed to constitute such a danger.[24]

Referring to Advocate General Campos Sánchez-Bordona's opinion, the Court found that the conclusion of criminal proceedings could also be a precautionary measure consisting of compulsory admission to a psychiatric hospital or similar institution of a person who has been found to lack criminal responsibility as a result of their mental disorder. For the purpose of imposing both a sentence and a coercive medical measure as a consequence of the offence, national law provided that there must be genuine criminal proceedings. This must mean that the rights protected by Directive 2012/13 must be respected during those proceedings; the safeguards laid down in that Directive cannot be excluded in either situation.[25] Although the ruling concerned only certain directives, it can be expected that similar conclusions can be reached for all Directives and the Recommendation.

Finally, in the Conclusions on the Protection of Vulnerable Adults across the European Union, the Council recommended EU Member States to implement Directives 2010/64/EU, 2012/13/EU, 2013/48/EU, (EU) 2016/343 and (EU) 2016/1919, to take into account Recommendation 2013 and ensure that vulnerable adults are promptly identified so as to ensure they can fully exercise their rights. Additionally, it recommended that the European Commission examine the need to strengthen procedural safeguards of suspects or accused persons in criminal proceedings in line with the UNCRPD.[26]

As noted above, being a member of the UNCRPD, the EU is subject to the reporting procedure before the UNCRPD Committee. The UNCRPD Committee recommended that "the European Union take all possible measures to ensure the liberty and security of all persons with all types of disabilities in line with the Convention and the Committee's guidelines on Art 14 (2015)."[27] Moreover, under Art 13, the Committee stated that it was "concerned about discrimination faced by persons with disabilities in accessing justice, owing to the lack of procedural accommodation in European Union member States" and recommended the that European Union "take appropriate action to combat discrimination faced by persons with disabilities in accessing justice by ensuring that full procedural accommodation and funding for training justice personnel on the Convention are provided in its member States."[28]

1.1.2. COUNCIL OF EUROPE STANDARDS

According to the ECtHR, persons who are found not criminally responsible and subjected to detention should be detained in an appropriate accommodation and given adequate care.

According to the ECtHR, the detention of a person on grounds of mental health (of unsound mind) will be "lawful" for the purposes of Art 5 (1) (e) only if effected in a hospital, clinic or other appropriate institution authorised for that purpose.[29] Yet, the Court has accepted that the mere fact that an individual was not placed in an appropriate facility did not automatically render his or her detention unlawful under Art 5 (1) ECHR. A certain delay in admission to a clinic or hospital is acceptable if it is related to a disparity between the available and required capacity of mental institutions. However, a significant delay in admission to such institutions and thus in treatment of the person concerned will obviously affect the prospects of the treatment's success, and may entail a breach of Art 5.[30]

In assessing the appropriateness of the institution in question, the Court has not taken into account so much the facility's primary aim, but rather the specific conditions of the detention and the possibility for the individuals concerned to receive suitable treatment therein.[31] Furthermore, although psychiatric hospitals are, by definition, appropriate institutions for the detention of mentally ill individuals, the Court has stressed the need to accompany any such placement by efficient and consistent therapy measures, in order not to deprive the individuals in question of a prospect of release.[32]

More specifically, the Court takes into consideration:

- the opinions of health professionals and the decisions reached by the domestic authorities in the individual case, as well as more general findings at the national and international level on the unsuitability of prison psychiatric wings for the detention of persons with mental health problems;
- the individualised and specialised approaches that have been adopted for the treatment of the psychological disorders in question; and
- that the authorities are under an obligation to work towards the goal of preparing the persons concerned for their release, for example by providing incentives for further therapy, such as transfer to an institution where they can actually receive the necessary treatment or by granting certain privileges if the situation permits.[33]

Appropriate accommodation is thus a key element in the Court's assessment of a violation of Art 5 ECHR. However, when the conditions attain a particular threshold of gravity, they may also fall into a violation of Art 3 ECHR.[34]

A brief survey of the key standards and recommendations of the CPT with regard to EU Member States revealed the following recommendations concerning procedural safeguards for detainees with intellectual and/or psychosocial disabilities:

- Ensure that all, including those court ordered committals of persons with intellectual and/or psychosocial disabilities, are asked for their consent to medical treatment.
- Ensure that the relevant provisions governing the procedures for placement and discharge for persons deemed not criminally responsible are assisted in law and practice by a lawyer during the review hearing by the court.[35]
- Ensure that forensic patients are heard in person by the relevant judge/court in the context of the renewal of their detention order. In Croatia, for example, while lawyers had been systematically present at all stages of the procedure, judges did not systematically hear the patient in person at the time of the renewal of the detention order.[36]
- Ensure that there are sufficient guarantees for the patients to exercise their right to attend review court hearings.[37]

- Ensure that the patients concerned receive a copy of the court decision (with relevant information on appeal procedures). The patients should be requested to sign a statement acknowledging receipt of it.[38]

- Ensure that ex officio reviews of any involuntary forensic placement decisions are carried out at least once every six months by an independent authority, preferably a court. Such reviews should be based on the opinion from a doctor who is independent of the department holding the patient concerned.[39] The CPT has criticised situations where court approvals consisted in identical wording stating that the legal requirements for extended hospitalisation were met, and recommended that forensic involuntary hospitalisation decisions include individualised detailed reasons explaining the rationale behind the ruling, that patients have an effective right to be heard in person and that hearings are carried out within appropriately short timescales.[40]

- Ensure the possibility for an independent psychiatric opinion (external to the clinic) in the context of review of the placement.[41]

1.1.3. UN STANDARDS

Art 14 (2) UNCRPD provides that "States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law…".

Art 14 (2) complements Art 12 and 13 UNCRPD. Establishing the right to equal recognition before the law, "Art 12 introduces a new paradigm of 'universal legal capacity', that cannot be limited on grounds of disability or mental incapacity."[42] As noted in the literature, "this right has profound implications for a wide range of legal frameworks for states parties to the Convention, including guardianship laws, the insanity defence, civil and criminal trial procedures …" and for many other articles in the Convention, including access to justice (Art 12), detention (Art 14), forced treatment (Art 15, 17, and 25).[43] The General Comment on Art 12 adopted in 2013 by the UNCRPD Committee does not address the question of legal capacity and criminal justice.[44]

An analysis of the more recent concluding observations on Art 14 of the UNCRPD Committee showed that the UNCRPD has consistently recommended that States adopt a number of measures to improve equal access to justice and procedural guarantees in criminal justice proceedings:[45]

- Repealing criminal laws that allow persons with intellectual or psychosocial disabilities to be declared unfit to plead/not criminally responsible, allowing the full application of the rules of due process for a fair trial.[46]

- Ensure that persons with disabilities who have committed a crime are tried under the ordinary criminal procedure with equal access to due process guarantees established for all persons accused of a crime in the criminal justice system, including the presumption of innocence and the rights to defence and to a fair trial;[47]

- Ensure accessibility and procedural accommodation, including provisions to support persons with disabilities in decision-making and to guarantee the right to a defence at all stages of criminal proceedings for persons with disabilities who are under investigation or being prosecuted.[48]

The UNCRPD Committee also pronounced itself on several individual cases about Art 14. None of them concerned an EU Member State. However, some general principles established are relevant nevertheless:

CRPD Committee, CRPD/C/16/D/7/2012, Noble v. Australia

2 September 2016

Relevant topic: unfitness to stand trial due to an intellectual disability; inability to plead or be found guilty; deprivation of liberty based on disability;

Decision: Violation of Arts 5(1) and (2), 12(2) and (3), 13(1), 14(1)(b) and 15 UNCRPD

In the case of **Noble v. Australia**, the UNCRPD Committee found that the decision that author was unfit to stand trial because of his intellectual and mental disability, resulting in a denial of his right to exercise his legal capacity to plead not guilty and to test the evidence against him. Furthermore, no adequate form of support was provided by the State party's authorities to enable him to stand trial and plead not guilty despite his clear intention to do so. He therefore never had the opportunity to have the criminal charges against him determined and his status as an alleged sexual offender potentially cleared. In view thereof, the Committee considers that the situation under review amounts to a violation of the author's rights under Art 12 (2) and (3) and 13 (1) of the Convention.[49] Similar conclusions were reached in two additional cases against Australia decided in 2019, Manuway (Kerry) Doolan and Christopher Leo.[50]

In response to these decisions, the Australian Government issued specific replies, which exemplify the discontent from the part of State Parties with some of the interpretations adopted by the UNCRPD Committee. With regard to procedural accommodations, Australia pointed out that a declaration not to stand trial constituted a legitimate differential treatment with the aim to preserve the fair trial rights of the person concerned, thus constituting a form of reasonable accommodation. The Australian Government further rejected some of the UNCRPD Committee's interpretations, highlighting some points that have also been critically voiced by other States. These include the need for clarity on the UNCRPD Committee's recommendations, inconsistencies between standards established by different human rights bodies and the fact that the Committee's interpretation did not reflect the States Parties views of Art 14.

CRPD Committee, CRP-D/C/22/D/32/2015, Arturo Medina Vela v. Mexico

6 September 2019

Relevant topic: criminal liability and lack thereof based on intellectual and/or psychosocial disability; ability to exercise legal capacity;

Decision: Violation of Arts 5, 9, 12, 13 and 14 in conjunction with Art 4 UNCRPD

The UNCRPD Committee also decided a case against Mexico concerning a person who was declared not criminally responsiblecd.[51] According to the Committee, the State Party had failed to fulfil its obligations under the UNCRPD in different respects and recommended to make all necessary amendments to the criminal laws with regard to the "exempt from liability" concept and the special procedure for persons exempt from criminal liability, with a view to bringing them in line with the principles of the Convention and ensuring respect for due process in cases involving persons with disabilities. This should be done in close consultation with persons with disabilities and the organisations that represent them. Moreover, it should be ensured that persons with intellectual and psychosocial disabilities are provided with appropriate support and reasonable accommodations to enable them to exercise their legal capacity before the courts. The Committee found violations of Art 13 in conjunction with Art 4 of the UNCRPD, pointing out that the person concerned was excluded from the criminal proceedings.

Throughout the criminal proceedings, the author was consistently denied the chance to participate, testify, challenge evidence, receive notifications and intervene in various stages, with the judge rejecting attempts to do so. The special procedure used did not ensure equal access to justice, even when addressing notification failures, as it still relied on the author's legal representative rather than allowing his active participation. In May 2023, Mexico amended its supported decision-making laws. However, no additional reforms have been implemented. Persons with disabilities continue to face problems in reporting crimes, appointing a lawyer of their choosing, being heard during hearings, standing trial, appealing a decision and asking or offering reparation for a crime.

The UNCRPD Committee would require that where accused persons have difficulty understanding trial processes, they should be provided with comprehensive and meaningful support options that could allow them to understand and participate in the trial process. If this were not sufficient for accused persons to participate in the trial, then it seems that

under the Committee's interpretation of Art 12, an adjudication of the criminal charges should proceed with the defence lawyer operating on what he or she believes is the best interpretation of the individual's will and preference.

In 2020, the UN International Principles and Guidelines on Access to Justice for Persons with Disabilities were adopted.[52] They recommend that States guarantee that persons with disabilities enjoy legal capacity on an equal basis with others, and where necessary, provide the support and accommodations necessary to exercise legal capacity and guarantee access to justice (Principle 1). The guidelines contained in the principles set out a number of specific provisions to this end:

- ensure that individuals with disabilities are universally recognized as having legal capacity and the right to exercise it, with full participation in court proceedings;
- eliminate restrictions based on constructs like "cognitive incapacity" or "mental incapacity";
- amend or repeal laws and policies limiting legal capacity, including those allowing for substituted decision-making, "sound mind" requirements, or doctrines like "unfitness to stand trial" and "incapacity to plead";
- eliminate medical professionals' sole authority in determining capacity;
- remove barriers preventing individuals with disabilities from initiating legal claims;
- establish enforceable rights for individualised procedural accommodations, including support in all legal proceedings;
- provide intermediaries for effective communication between individuals with disabilities and legal entities; and
- grant the right to appeal or seek restoration of legal capacity with access to legal assistance for those previously declared without capacity.

Moreover, according to Principle 5, persons with disabilities are entitled to all substantive and procedural safeguards recognized in international law, whether in criminal, civil or administrative procedures, on an equal basis with others, and States must provide the necessary accommodations to guarantee due process. They include the presumption of innocence and the right to remain silent and are afforded to all persons with disabilities on an equal basis with others. Procedural accommodations to ensure the equal participation of the person with disabilities, when needed, must be available, including suspects and accused persons who require assistance to participate effectively in investigations and judicial proceedings. Accordingly, States ensure equal treatment, protection, and access to justice for suspects and accused persons with disabilities, including the presumption of innocence, accessible information, non-discrimination, procedural accommodations, legal safeguards, choice in defence and healthcare support regardless of legal outcomes.

In September 2022, the Office of the High Commissioner for Human Rights (OHCHR) and the World Health Organization (WHO) issued a Call for inputs on a "Draft guidance on Mental Health, Human Rights, and Legislation". The draft guidelines report that the UNCRPD's impact on criminal responsibility remains under-examined and underlines the need for reform of criminal justice systems. Persons with disabilities require support and accommodation to ensure their equal participation and protection of their rights in legal proceedings. There is a concern that ordering security measures for individuals with mental health conditions who are found not criminally responsible contradicts the principle of no punishment without guilt, potentially resulting in indefinite confinement. Some suggest replacing such measures with general criminal defences and exploring alternative approaches like restorative justice and non-custodial measures to address criminal offences committed by individuals with disabilities and better serve both victims and society.

However, the draft guidelines remain cautious, recognizing the lack of consensus on how to legislate systems of criminal responsibility attribution in a way that fully respects the rights of individuals with mental health conditions and psychosocial disabilities.

1.2. DEPRIVATION OF LIBERTY

1.2.1. EU STANDARDS

The 2013 Recommendation on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings[53] calls upon Member States to strengthen certain procedural rights of vulnerable suspects or accused persons in criminal proceedings and of vulnerable persons who are subject to European arrest warrant proceedings. However, the principles in the detention context established by the Recommendation apply only until the conclusion of the criminal proceedings. In December 2022, the Commission issued a new Recommendation on procedural rights of suspects and accused persons subject to pre-trial detention and on material detention conditions.[54] The Recommendation specifically refers to the UNCRPD and addresses persons with disabilities. Both Recommendations do not contain wording prohibiting deprivation of liberty based on disability. It should also be noted that both Recommendations do not provide for legally enforceable rights or obligations and are of a non-binding nature.

Being a member of the UNCRPD, the EU also is subject to the reporting procedure before the UNCRPD Committee and to its concluding observations and recommendations. So far, the EU has undergone one review cycle. With respect to Art 14, the UNCRPD Committee noted that it was "concerned about the involuntary detention of persons with disabilities in psychiatric hospitals or other institutions on the basis of actual or perceived impairment" and recommended that "the European Union take all possible measures to ensure the liberty and security of all persons with all types of disabilities in line with the Convention and the Committee's guidelines on article 14 (2015)."[55]

1.2.2. COUNCIL OF EUROPE STANDARDS

According to the ECHR, any deprivation of liberty under Art 5 § 1 of the Convention must be "lawful" and "in accordance with a procedure prescribed by law".[56] When it comes to the deprivation of liberty of persons with intellectual and/or psychosocial disabilities, Art 5(1)(e) ECHR comes into play. It states that "the purpose of the detention of(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of ***persons of unsound mind***, alcoholics or drug addicts or vagrants". The terminology used in the ECHR is in clear contradiction to the human rights approach to disability, laid out by the UNCRPD.[57]

The ECtHR has issued extensive jurisprudence on persons with intellectual and/or psychosocial disabilities in the context of criminal proceedings (based mainly on Art 5 ECHR) and criteria in order to strengthen the legal safeguards towards such defendants. In assessing the appropriateness of the medical institution, for instance, the Court has not taken into account so much of the facility's primary aim, but rather the specific conditions of the detention and the possibility for the individuals concerned to receive suitable treatment therein.[58]

The Court has come up with the ***Winterwerp Criteria*** in order to identify the minimum conditions for the lawful detention of an individual on the basis of Article 5(1)(e) ECHR. These include that:

- the persons must reliably be shown to be of "unsound mind", i e., a true mental disorder must be established before a competent authority on the basis of objective and independent medical evidence;
- the mental disorder must be warranting compulsory confinement;
- and the validity of continued confinement must depend upon the persistence of the disorder.

In ***Rooman v. Belgium***[59], the ECtHR developed its position further, stating that any detention of mentally persons with intellectual and/or psychosocial disabilities must have a therapeutic purpose in order to cure or alleviate their mental-health condition, including, where appropriate, bringing about a reduction

in or control over their dangerousness. It also evoked the dual goal of deprivation of liberty, stating it had a "social function of protection" and a "therapeutic function that is related to the individual interest of the person of unsound mind in receiving an appropriate and individualised form of therapy or course of treatment."[60]

To assess the lawfulness and arbitrariness of the detention, the ECtHR also applies a necessity test. This means that, to comply with Art 5(1)(e) ECHR, the detention can be applied only where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest, which might require that the person concerned be detained.[61]

The CPT has issued recommendations regarding the treatment of persons with mental health problems, such as making a clear "institutional and functional separation between mental health facilities (forensic hospitals) and prisons" in light of the different ethos and staffing profiles that characterise prison establishments.[62] Preferably, in the CPT's view, mental health facilities should be under the responsibility of the national health-care system. This is in contradiction of the UNCRPD Committee's position, which recommends not to have separate facilities, but rather to take an approach primarily focused on inclusivity.

Among Council of Europe standards it is relevant to refer to the Committee of Ministers' Recommendation Rec(2004) concerning the protection of the human rights and dignity of persons with mental disorders. The Recommendation considers that the principles established therein are of relevance also in the criminal justice field and that 'imprisonment may be regarded as a form of "involuntary placement"', although the term involuntary placement when used in the Recommendation always means "involuntary placement on grounds of mental disorder".[63] In this context, the Recommendation makes clear that, "under criminal law, courts may impose placement or treatment for mental disorder whether the person consents to the measures or not" (Art 34).

1.2.3. UN STANDARDS

The right to liberty and security, enshrined by the UNCRPD in Art 14, was defined as "one of the most controversial articles in the UNCRPD".[64] According to the UNCRPD Committee Guidelines on Art 14, "article 14(1)(b) prohibits the deprivation of liberty on the basis of actual or perceived impairment ***even if additional factors or criteria are also used to justify the deprivation of liberty***." According to the interpretation of the UNCRPD Committee, the UNCRPD prohibits not only any form of deprivation of liberty based on impairment but also any court ordered mental health commitment regimes and non-consensual mental health treatments.

The UNCRPD Committee has consistently recommended that EU Member States initiate a structural review of the procedures used to sanction persons with disabilities when they commit criminal offences.[65] Amongst others, this review should aim to remove the system of safety measures applicable to persons with disabilities who have been deprived of legal capacity. In other words:

- remove the concept of dangerousness and the related preventive and security measures from its criminal law in cases where a person with a psychosocial disability is accused of a crime and ensure that safety measures do not involve indeterminate deprivations of liberty;[66] and

- repeal the distinction made 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 a crime has been determined.[67]

Two EU Member States (**Ireland** and the **Netherlands**) have entered into declarations concerning Art 14 CPRD. Both countries declared their understanding that the Convention allows for compulsory care or

treatment of persons, including measures to treat mental disorders, when circumstances render treatment of this kind necessary as a last resort and the treatment is subject to legal safeguards.

Many UN treaties include prohibitions on arbitrary detention. However, some UN treaty bodies contain positions that diverge from the standards set out by the UNCRPD.[68] For example, the Human Rights Committee has considered that deprivation of liberty of persons with disabilities could be justifiable and necessary in some cases.[69] Similarly, the UN Committee Against Torture, the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, as well as UN soft law standards, such as the Nelson Mandela Rules, have accepted the possibility of lawful involuntary committal and involuntary treatment, provided there are adequate safeguards and reasonable accommodations.[70] Such safeguards were notably laid down in the trainer's manual drafted by the Office for Democratic Institutions and Human Rights (ODIHR) and Penal Reform International entitled "Introduction to the Nelson Mandela rules, international training programme", which includes recommendations on special accommodations for people in prisons who have intellectual and/or psychosocial disabilities.[71]

Other UN bodies aligned their position to the UNCRPD standards, calling for bans on deprivation of liberty on the basis of impairment and involuntary hospitalisation and forced institutionalisation. These bodies include the OHCHR,[72] the Committee on the Elimination of Discrimination against Women (CEDAW Committee)[73] and the Working Group on Arbitrary Detention (WGAD).[74]

1.3. DEPRIVATION OF LIBERTY: TREATMENT OF PERSONS

1.3.1. EU STANDARDS

The 2022 Recommendation on procedural rights of suspects and accused persons subject to pre-trial detention and on material detention conditions[75] issued by the EC specifically refers to the UNCRPD and contains special measures for persons with disabilities or serious medical conditions, requiring "appropriate care". For persons diagnosed with mental health related medical conditions, it requires "specialised professional care where needed in specialised institutions or dedicated sections of the detention facility under medical supervision" in addition to "continuity of healthcare" for detainees in preparation for release where necessary. Paragraph 76 also states that Member States should take care to provide "appropriate activities for such detainees". There are no additional EU standards specifically regulating the treatment of defendants and detainees with intellectual and/or psychosocial disabilities.

1.3.2. COUNCIL OF EUROPE STANDARDS

According to the ECtHR, in certain cases, the inappropriate conditions of detention for persons with intellectual and or psychosocial disabilities can also amount to a violation of Art 3 ECHR. For detainees who are found not criminally responsible, when assessing a claim under Art 3 ECHR, the Court takes into consideration the cumulative effects of the conditions and the duration of the detention as well as the inadequacy of the medical treatment.[76] As for the medical treatment, the Court requires a comprehensive therapeutic strategy aiming at treating the detainee, showing that there is an individual treatment plan in place for the applicant, and substantiating the administration of therapeutic treatment or the psychiatric care provided.

According to the ECtHR, detaining such individuals in "establishments not suitable for incarceration of the mentally-ill, raises a serious issue under the Convention" or treating them "like other inmates, notwithstanding their particular state of health" may exacerbate the feeling of distress, anguish and fear of the person concerned.[77] For example, in ***W.D. v. Belgium***, the Court held that there had been a violation of Art 3 ECHR because the applicant was detained in a prison environment for more than nine

years without appropriate treatment for his mental condition and with no prospect of reintegrating into society; this had caused him particularly acute hardship and distress of an intensity exceeding the unavoidable level of suffering inherent in detention.[78] In several instances, the Court has also clarified that regular transfers to the prison's hospital cannot be viewed as a solution.[79]

According to the ECtHR, a lack of appropriate medical care for persons in custody is capable of engaging a State's responsibility under Art 3.[80] In addition, it is not enough for such detainees to be examined and a diagnosis made; instead, it is essential that proper treatment for the problem diagnosed should also be provided[81] by qualified staff.[82]

The Court reiterated in ***Rooman v. Belgium***[83] that the mere fact that a detainee has been seen by a doctor and prescribed a certain form of treatment cannot automatically lead to the conclusion that the medical assistance was adequate. The authorities must also ensure that:

- a comprehensive record is kept concerning the detainee's state of health and his or her treatment while in detention;
- a diagnosis and care are prompt and accurate;
- where necessitated by the nature of a medical condition, supervision is regular and systematic and involves a comprehensive therapeutic strategy aimed at adequately treating the detainee's health problems or preventing their aggravation, rather than addressing them on a symptomatic basis;
- the necessary conditions were created for the prescribed treatment to be actually followed through;
- medical treatment provided within prison facilities must be appropriate; that is, at a level comparable to that which the State authorities have committed themselves to provide to the population as a whole. Nevertheless, this does not mean that every detainee must be guaranteed the same level of medical treatment that is available in the best health establishments outside prison facilities; and
- where the treatment cannot be provided in the place of detention, it must be possible to transfer the detainee to a hospital or to a specialised unit.[84]

In ***Rooman v. Belgium***, the applicant complained that his compulsory confinement without psychological and psychiatric treatment in the social protection facility in which he had been placed, and the total lack of any prospects of improvement in his situation on account of this absence of treatment, amounted to inhuman and degrading treatment prohibited by Art 3 of the Convention. In particular, the applicant complained that he was not receiving any treatment in his native language of German, which is also an official language in Belgium. The authorities responsible for the applicant were content with the excuse that there were no German-speaking specialists in the facility to justify the fact that he was not receiving appropriate treatment. The Court considered that these elements are sufficient to demonstrate that the national authorities failed to provide treatment for the applicant's health condition and concluded that there was a violation of Art 3 of the Convention in respect of the period from the beginning of 2004 to August 2017.

The ECtHR jurisprudence does not consider a detainee's segregation as amounting to inhuman treatment in itself. In fact, in order to assess whether a violation of Art 3 takes place with regard to solitary confinement, the ECtHR considers the particular conditions of the case, the stringency of the measure, its duration, the objective pursued and its effects on the person concerned. Moreover, the duration of such confinement is analysed by the ECtHR in conjunction with its justification, the need for the measures taken and their proportionality with regard to other possible restrictions, the guarantees offered to the applicant and the measures taken by the authorities to ensure that the applicant's physical and psychological condition allowed him to remain in isolation.[85] Particular attention is paid by the Court towards those

detainees who have "been shown to have serious mental problems and suicidal tendencies". In these cases, the Court requires special measures to ensure that this condition is compatible with the requirements of humane treatment, irrespective of the gravity of the acts for which he has been convicted or is suspected of having committed.[86]

The ECtHR has noted in several instances that, with regard to forms of coercive and non-consensual measures against patients with psychological or intellectual disabilities in hospitals and all other places of deprivation of liberty, measures should be employed as a matter of last resort, when their application is the only means available to prevent immediate or imminent harm to the patient or others, that sufficient procedural safeguards are provided and that every use of restraint must be properly recorded.[87]

The CPT has issued several standards and recommendations regarding the institutionalisation and treatment of persons with intellectual and/or psychosocial disabilities, including for example:

- ensure institutional and functional separation between mental health facilities (forensic hospitals) and prisons;[88]

- ensure adequate living conditions, including sufficient living space per patient, adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting general hygiene requirements, allowing persons to keep certain personal belongings and providing a lockable space for them;[89]

- ensure medical treatment, which should consist of an assessment of the clinical needs as well as a risk assessment based on structured professional judgement and the identification of treatment targets in consultation with the patient and a multi-disciplinary approach;[90]

- ensure that all categories of psychiatric patients (i.e., voluntary or involuntary, civil or forensic, with legal capacity or legally incapacitated) be placed in a position to give their free and informed consent to treatment. Consent to treatment can only be qualified as free and informed if it is based on full, accurate and comprehensible information about the patient's condition, the treatment being proposed and its possible side-effects, as well as about the possibility to withdraw consent. Any derogation from this fundamental principle should be based in law and only relate to clearly and strictly defined exceptional circumstances. It should also be accompanied by appropriate safeguards;

- ensure access to purposeful activities, including a range of therapeutic options (i.e., group therapy, individual psychotherapy and creative therapies such as art, drama and music, as well as sporting activities) and involvement in clinically appropriate rehabilitative psychosocial activities, recreational activities suited to their needs and unrestricted daily access to the open air;[91]

- ensure the application of safeguards with regard to medical restraints, including: using restraints as a measure of last resort to prevent imminent harm to themselves or others and applying them for the shortest possible time; never using restraints as punishment, for convenience, because of staff shortages or to replace proper care or treatment; ensuring that restraints must be expressly ordered by a doctor after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his/her approval; making sure that every patient who is subjected to mechanical restraint or seclusion is subjected to continuous supervision; and ensuring that a specific central register is established to record all instances of recourse to means of restraint for the management to be able to monitor their use;[92] and

- ensure adequate staffing levels to enable the provision of adequate treatment and care to all residents, as well as psycho-social rehabilitation activities.

1.3.3. UN STANDARDS

Several UNCRPD articles are relevant when it comes to the treatment of persons deprived of liberty with intellectual and/or psychosocial disabilities, including Arts 14, 15, 12, 17 and 25.

Most relevant is Art 15 UNCRPD, which enshrines the prohibition of torture and cruel, inhuman or degrading treatment or punishment. In its concluding observations under Art 15, the UNCRPD Committee's recommendations to EU Member States included, amongst others, the following points:

- collect data on persons with disabilities in detention and conduct research on their situation and needs;[93]
- carry out a review with a view to formally abolish all practices regarded as acts of torture, cruel or inhuman and degrading treatment or punishment;[94]
- abolish the use of non-consensual practices with regard to persons with psychosocial disabilities in medical institutions, such as net beds, physical, mechanical and chemical restraints, forced medication, overmedication, electroconvulsive therapy, intensive treatment of persons with psychosocial disabilities in difficult patients units and other treatment or commitment without their free and informed consent;[95]
- ensure the right of persons with disabilities to make autonomous decisions based on their free and informed consent, including through supported decision making mechanisms, concerning any type of medical treatment and legally recognize involuntary treatment on the basis of disability as a violation of the right of persons with disabilities to be free from cruel, inhuman or degrading treatment.
- repeal, as a matter of urgency, all laws that allow legal guardians to consent to medical experimentation on behalf of persons with disabilities.[96]
- abolish the use of solitary confinement, seclusion and isolation, which may amount to torture or cruel, inhuman or degrading treatment or punishment;[97]
- end the practice of imposing surgical castration and any other kind of forced treatment, as a form of punishment, on persons with disabilities who are deprived of their liberty;[98]
- provide training to medical professionals and personnel on the prevention of torture, cruel, inhuman or degrading treatment or punishment, as provided for under the Convention;[99]
- take immediate steps to address the poor living conditions of persons with intellectual and/or psychosocial disabilities in institutions;[100]
- strengthen independent monitoring and the role of the national mechanism for the prevention of torture and cruel, inhuman or degrading treatment or punishment, also ensuring the involvement of organizations of persons with disabilities in the implementation of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment;[101] and
- set up a complaint procedure accessible to all persons with disabilities in institutions and investigate and sanction perpetrators of practices that may amount to torture or cruel, inhuman or degrading treatment or punishment against persons with disabilities, imposing sanctions proportional to the conduct. This should also ensure that persons exposed to ill-treatment are entitled to and provided with redress and adequate compensation, including rehabilitation.[102]

Furthermore, in concluding observations under Art 14, the UNCRPD Committee has consistently recommended that EU Member States initiate a structural review of the procedures used to sanction persons with disabilities when they commit criminal offences.[103] Some of these recommendations

also explicitly deal with reasonable accommodation.[104] Depending on the national context, the Committee has referred to:

- the need to ensure access to healthcare on an equal footing with others, on the basis of their free and informed consent, and to the same level of health care as that provided in society at large;
- repeal extrajudicial intervention programmes that involuntarily commit individuals to mental health establishments or force them to register with the mental health services;
- ensure their participation in and access to all services and activities, on an equal basis with others, in prisons or other centres of detention; and
- establish an independent formal complaints mechanism accessible to all persons detained in prisons or in forensic institutions.

The UN Special Rapporteurs on Torture have taken different positions. Most pertinent are the positions of Manfred Nowak in his 2008 interim report[105] and Juan Mendez, documented in the report on "Torture in Healthcare Settings: Reflections on the Special Rapporteur on Torture's 2013 Thematic Report".[106] More specifically, the Special Rapporteur noted that:

- Forced and non-consensual administration of psychiatric drugs, and in particular of neuroleptics, for the treatment of mental conditions (or chemical restraints) need to be closely scrutinised and 'may constitute a form of torture or ill treatment. Such outcome will depend on the circumstances of the case and the suffering inflicted'.[107]
- The administration of electro convulsive therapy in its unmodified form (e.g., without anaesthetic and muscle relaxants) can no longer considered to be an acceptable medical practice and may constitute torture or ill-treatment. The administration of electroconvulsive therapy in its modified form is only acceptable with the free and informed consent of the person concerned.
- No therapeutic justification can be used for the use of solitary confinement and prolonged restraints of persons with disabilities in psychiatric institutions, which may amount to torture and ill-treatment. Mendez noted that any type of restraints of persons with disabilities in psychiatric institutions, regardless their duration, may amount to torture and ill-treatment.

Other UN treaty bodies do not seem to go as far as the UNCRPD Committee in their recommendations. The UN Committee Against Torture (CAT Committee) has expressed its concern about the high number of persons with disabilities deprived of their liberty in social, medical and psychiatric institutions without their free and informed consent – including through the use of solitary confinement, restraints and forced medication, which may amount to inhumane and degrading treatment – and about the absence of legal safeguards.[108] The CAT Committee, while accepting the possibility of lawful involuntary committal and involuntary treatment, has recommended ensuring effective supervision and monitoring, appropriate legal safeguards, proper training for medical and non-medical staff, and the use of de-institutionalization strategies and outpatient and community-based services.[109] It has not adopted a consistent position on the provision by the person concerned of their free and informed consent to treatment and institutionalisation Inn the past, it has upheld a person's right to give or withhold their consent[110] and has also allowed for third parties to provide it.[111]

A similar approach is adopted by the Human Rights Committee (HRC), which recommended that States put in place comprehensive procedures for seeking consent for the administration of psychiatric treatment. It recommends that States ensure that non-consensual psychiatric treatment may only be applied, if at all, in exceptional cases as a measure of last resort and when absolutely necessary to protect the health

or the life of the person concerned or to prevent injury to others (provided that the person concerned is unable to give consent) for the shortest possible time and under regular independent review. Procedures should guarantee effective access to judicial review of decisions relating to non-consensual treatment, consistent with Arts 9 and 14 of the Covenant, including by ensuring that relatives and any other legal representatives of patients are sufficiently informed about the procedure for requesting the termination of coercive treatment.[112] On the other hand, the HRC recommended that measures be immediately adopted to abolish the use of enclosed restraint beds in psychiatric and related institutions, establish an independent monitoring and reporting system, and ensure that abuses are effectively investigated, prosecuted and sanctioned and that redress is provided to the victims and their families.[113]

In turn, the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) has focused its efforts on appropriate conditions, monitoring and periodic review, questioning only forced hospitalization or solitary confinement when not based on medical grounds.[114]

1.4. ALTERNATIVES AND PROBATION

1.4.1. EU STANDARDS

At the EU level, in its Recommendation in 2013 on procedural safeguards, the Commission stated that

> *"Member States should take all steps to ensure that deprivation of liberty of vulnerable persons before their conviction is a measure of last resort, proportionate and taking place under conditions suited to the needs of the vulnerable person (…)."*[115]

There are no additional EU standards specifically regulating alternatives to detention and probation of defendants and detainees with intellectual and/or psychosocial disabilities.

1.4.2. COUNCIL OF EUROPE STANDARDS

The ECtHR's jurisprudence tackled the topic of alternatives, notably via the application of Art 5 (1)(e) ECHR, which was found to encompass a fully-fledged necessity and proportionality test. Part of the necessity test includes that other, less severe measures must be considered before detention can be applied.[116] Hence, in its assessment under Art 5(1)(e) ECHR, the ECtHR also considers if the national system envisages alternative means and whether the authorities have considered them. The notion of "alternatives" is broadly used. In certain instances, "alternative" means placing the applicant outside of penal facilities, for example in a civilian mental health facility, including psychiatric hospitals, psychiatric wings in civilian hospitals, mental health community centres and residential (care) homes.[117]

Examining the situation of the detainees with disabilities in Europe, the CoE Parliamentary Assembly denounced "the tendency to imprison offenders rather than impose alternative sentences".[118] In a 2018 resolution it, thus, recommended:

> *"to provide for and further develop the application of adjusted sentences or alternatives to prison sentences, and systematically to consider non-custodial pretrial coercive measures or sentences, or compassionate release, for disabled persons whose circumstances could otherwise justify detention or imprisonment, depending on the nature and severity of their disability and the capacity of the custodial system to provide appropriate care, bearing in mind the principle of reasonable accommodation".*

The Council of Europe Committee of Ministers' Recommendation (2004) contains only incidental provisions on alternatives to detention. According to Art 34(2):

> *"Courts should make sentencing decisions placement or treatment for mental disorder on the basis of valid and reliable standards of medical expertise, taking into consideration the need for persons with mental disorder*

> *to be treated in a place appropriate to their health needs. (…) The provision is without prejudice to the possibility, according to the law, for a court to impose psychiatric assessment and a psychiatric or psychological care programme as an alternative to imprisonment or to the delivery of a final decision".*[119]

Finally, the Council of Europe Committee of Ministers has also adopted a more targeted recommendation on community sanctions and measures[120] and on probation[121]. Both recommendations reinstate a broad non-discrimination principle, including specific references to "physical or mental condition of the person under alternatives and probation" or "disability", thereby implying that persons with an intellectual and/or psychosocial impairment shall be given equal access to alternatives and probation. The recommendations, however, do not provide any additional guidance or procedural accommodation to ensure equal access to alternatives and probation for persons with intellectual and/or psychosocial disabilities.

1.4.3. UN STANDARDS

At the UN level, the UNCRPD and its Committee are silent on alternatives to detention but limit themselves to referring to certain diversion mechanisms. In its Guidelines on Art 14, the UNCRPD Committee outlined first that

> *"…deprivation of liberty in criminal proceedings should apply only as a matter of last resort and when other diversion programmes, including restorative justice, are insufficient to deter future crime"; and second that "diversion programmes must not involve a transfer to mental health commitment regimes or require an individual to participate in mental health services; such services should be provided on the basis of the individual's free and informed consent."*[122]

According to the UNCRPD Committee, not only is any form of deprivation of liberty based on disability prohibited but also any court-ordered mental health commitment regimes and non-consensual mental health treatments are. The UNCRPD Committee recommended to:

> *"eliminate security measures that mandate medical and psychiatric inpatient treatment and promote alternatives that comply with Arts 14 and 19 of the Convention", thereby connecting the right to liberty and security with another important Art of the Convention concerning the 'living independently and being included in the community'.*[123] Art 19 UNCRPD is defined as *"one of the most important rights in the United Nations Convention on the Rights of People with Disabilities (CRPD), since choice, freedom, and inclusion are considered as prerequisites for exercising all other rights."*

Civil society actors maintained that "diversions from the criminal process to coercive mental health treatment are not procedural accommodations but rather violations of the right to access to justice on an equal basis with others." Nonetheless, they conceded that "as a minimum requirement, if such diversion mechanisms are in place and some "special care measures" are applied, they must guarantee the same level of respect for due process as would be available in a normal criminal trial. In other words, persons with disabilities considered to lack "cognitive or mental capacity" must be ensured the same substantive and procedural guarantees as others in the context of criminal proceedings".[124]

The UNCRPD Committee issued several recommendations on the topics of deinstitutionalization. Strictly speaking deinstitutionalization policies concern civil involuntary commitment measures. However, looking at national practices more closely, one realises that often the only reason why persons who have been declared not criminally responsible and subjected to security measures remain in custody is the lack of alternatives in the community. Hence, deinstitutionalization policies may also be relevant for the criminal justice system.[125]

On the specific concept of probation, no recommendations by the UNCRPD could be found.

The 2020 UN International Principles and Guidelines on Access to Justice for Persons with Disabilities recommend to:

> *"establish or support alternative justice mechanisms, such as restorative justice, alternative dispute resolution mechanisms, and cultural and social forms and forums of justice, that are available to persons with disabilities on an equal basis with others, without regard for any construct of capacity to participate".*

In September 2022, the OHCHR and WHO issued a Call for inputs on a "Draft guidance on Mental Health, Human Rights, and Legislation".[126] The draft guidance covers the topic of diversion too, recognising that "many countries have adopted legislation that diverts offenders with mental health conditions and psychosocial disabilities from the traditional criminal system pathway to the mental health system. …The rationale behind this is to reduce incarceration rates, as well as the likelihood of criminal recidivism."

The draft guidance reports "increasing concern among human rights and disability advocates that such diversion programs fail to address the underlying structural inequalities leading to criminalization (i.e., stigma, ableism, racism, poverty, lack of community support, etc.) and often resort to medicalised approaches and coercive practices that are contrary to their human rights. People may stay out of prison but are still subjected to control and coercion, such as community treatment orders. Indeed, in many diversion schemes, if individuals do not comply with the treatment orders imposed, they may return to the criminal justice system."[127]

The draft guidance suggests that diversion programmes are considered an integral part of broader efforts to adopt anti-carceral strategies and legislation should ensure that diversion programmes:

- "are used only when there is sufficient evidence that the individual committed the alleged offence (i.e., there are reasonable grounds, based on the available evidence, to believe the individual committed the alleged offence);
- are provided on a free and voluntary basis, based on adequate information about the nature, content and duration of the programme;
- are oriented towards the provision of person-centred and rights-based community support and restorative justice; and
- do not entail coercive mental healthcare or social control."[128]

Moreover, the draft guidelines also touch upon the issue of deinstitutionalization, giving concrete guidance on how to effectively implement it:[129]

- The creation of new asylums, psychiatric hospitals, neuropsychiatric hospitals or monovalent institutions, social care institutions, public or private, is prohibited.
- The health authority, in coordination with other relevant sectors and service users, shall implement a policy for the deinstitutionalization of persons placed in all kinds of institutions, including the adoption of a plan of action with clear timelines and responsibilities, concrete benchmarks and an adequate budget, a moratorium on new admissions and the development of adequate community support.
- Existing institutions must shift their operations to restore the autonomy and choice of residents and ensure the objectives and principles of person-centred and rights-based, community-based mental health until their definitive replacement.
- Every health or related social facility with long-term inpatient residents shall create a deinstitutionalization committee, with representation of service users.
- Mental health systems shall collect information from mental health and related social care services that have either an inpatient psychiatric unit or emergency department receiving service users with mental health conditions and psychosocial disabilities.

02. IMPLEMENTATION UNDER NATIONAL LAW

2.1 GENERAL CHALLENGES

2.1.1. INCONSISTENCIES BETWEEN STANDARDS

Throughout the project, it has become apparent that not only is there a chasm between fundamental rights standards versus their implementation in practice in the six partner countries, but there are also significant discrepancies between international standards on defendants and detainees with intellectual and/or psychosocial disabilities.

Most notably, the UNCRPD is very clear on the right to access to justice at an equal basis with others, especially Arts 12, 13, and 14, which together establish a new paradigm of 'universal legal capacity' that cannot be limited on grounds of disability or mental incapacity. It is clear from concluding observations on Art 14 of the UNCRPD Committee that it unequivocally rejects "special defences" or "special tracks" in criminal proceedings, such as substituted decision-making regimes and the denial of legal capacity, unfitness to stand trial and exclusion of a person with a disability from judicial processes, and declaration of a person as 'non-liable' or 'of unsound mind'. Instead, according to the UNCRPD Committee, access to justice on an equal basis means that persons with disabilities who have committed a crime should be tried under the ordinary criminal procedure with suitable procedural accommodations (see Section 1.)

This approach is contrasted by standards developed at the CoE and EU levels (see Section 1), both of which do not fundamentally oppose 'special tracks' in criminal proceedings for people with disabilities and do not challenge concepts/assessments such as 'fitness to stand trial', 'criminal responsibility' and 'legal capacity'. These bodies do foresee the possibility of proceedings for people with intellectual and/or psychosocial disabilities outside of the 'ordinary' proceedings but also envision additional procedural safeguards and accommodations.

Similarly there is a discrepancy between the approaches concerning the right of liberty. According to the UNCRPD Committee, 'Article 14(1)(b) prohibits the deprivation of liberty on the basis of actual or perceived impairment ***even if additional factors or criteria are also used to justify the deprivation of liberty'.***" In this context, the UNCRPD Committee recommended the repealing of security measures as well as transfers to mental health commitment regimes requiring an individual to participate in mental health services without their free and informed consent (see Section 1.2.3). The ECtHR, on the other hand, allows for a deprivation of liberty based on disability under certain pre-conditions. In its jurisprudence regarding Art 5 (1)(e) ECHR, the ECtHR has stressed the need to accompany any such placement by efficient and consistent therapy measures in order not to deprive the individuals in question of a prospect of release (see Section 1.2.2).[130]

The findings of the research show that partner countries lean towards following the ECtHR standards rather than the UNCRPD standards. This is due to different reasons, including the fact that the ECtHR mandate and jurisprudence are better known among EU countries. Additionally, there is a lack of clear guidance on how to implement UNCRPD standards. This was also pointed out by various experts in the framework of the consultations conducted throughout the project. Moreover, various reports from the CoE point to the conclusion that "prisons are bad for mental health", they are used as "dumping grounds for people with mental disorders" and that "people with mental

disorders are exposed to stigma and discrimination in prisons".[131] Hence, the assumption in Europe is that specialised mental health facilities under the egis of health ministries focusing on the treatment of persons with disabilities are more suitable places of detention for persons with intellectual and/or psychosocial disabilities.

2.1.2. LACK OF DATA

One general issue throughout the research has been a lack of data. States do not collect specific data on persons with intellectual and/or psychosocial disabilities within the criminal justice system, which makes the assessment of their situation difficult. In federal states, for instance, if data is collected, it is usually done at the state level and not at the federal level. As a result, the situation of defendants and detainees with intellectual and/or psychosocial disabilities, particularly the challenges they face when in contact with the criminal justice system, largely remains opaque. Moreover, justice practitioners working with defendants and detainees with intellectual and/or psychosocial disabilities are often not aware of the applicable legal framework and available options at the national level, especially with regard to non-custodial measures.

While some countries (e.g., **Austria, Bulgaria** and **Slovenia**) collect and publish data on all persons with intellectual and/or psychosocial disabilities who are subjected to security measures/compulsory treatment, in **Germany**, official data is not updated regularly and the last statistics are from 2013/2014, including only some federal states. Other countries like **Italy** do not collect any data, which makes it very difficult to properly assess and analyse the situation of persons concerned, respond to their needs and provide proper support.

2.1.3. DISCRIMINATORY TERMINOLOGY, STIGMA AND DEFINITIONS

National criminal legislations have not yet adopted terminology that seem to be compliant with the UNCRPD nor have they applied the human rights model of disability, opting instead for the medical model. Legislation in the partner countries uses discriminatory terminology. The **Austrian** criminal laws refer to "mental disorders" in the context of security measures, **Italian** legislation talks about "psychic stress" and the **Bulgarian** Criminal Code uses "mental retardation" or long-term or temporary "mental disorder". The **Lithuanian** law conveys "mental deficiencies" with a special procedural legal meaning for such conditions "due to which the suspect or accused person supposedly cannot exercise their rights to defence independently". Many of the terms used contrary to the social model and the human rights approach conveyed in the UNCRPD provide a negative connotation, supporting a stigma that defendants and detainees with intellectual and/or psychosocial disabilities often face, also causing them emotional distress.

Furthermore, national legislations of the partner countries focus on the medical model of disability in the context of criminal proceedings. They do not apply the human rights approach, recognizing the intrinsic value of every person for their own end "rather than focusing on a lack of overall capabilities as measured against a functional baseline".

At the same time, the project revealed that the breadth of terminology, particularly when it comes to "intellectual and/or psychosocial disabilities" and the lack of a unified definition of the term has proven challenging.

2.1.4. RECOMMENDATIONS

- Raise awareness on the various international human rights standards relevant and applicable for defendants and detainees with intellectual and/or psychosocial disabilities, including particularly the UNCRPD.

- Harmonise international and regional standards and increase dialogue between international actors with a view to come to a consensus on the way forward.

- Enhance the collection of systematic and disaggregated data in the criminal justice system on suspects, accused, detained, and sentenced persons with intellectual and/or psychosocial disabilities to ensure a more comprehensive understanding of their involvement in criminal proceedings.

- Consider the establishment of databases on facilities where persons with intellectual and/or psychosocial disabilities can be accommodated to improve visibility towards relevant actors and facilitate information exchanges.

- Amend national legislation to correspond to the (wording of the) UNCRPD in general and abolish discriminatory language/terminology in (criminal) legislation.

2.2. LEGAL CAPACITY, CRIMINAL RESPONSIBILITY AND ACCESS TO JUSTICE

As was already pointed out above, the UNCRPD, especially Art 12 (together with 13 and 14) establishes a new paradigm of 'universal legal capacity' that cannot be limited on grounds of disability or mental incapacity.[132] According to the UNCRPD Committee, persons with disabilities must be able to stand trial on an equal basis (see Section 1.1.3). In order to stand trial, legal capacity is a prerequisite and determinations about criminal legal capacity are very often decisive for the effective participation of defendants and detainees in their proceedings.

The research has shown that in national legislations of EU Member States, intellectual and/or psychosocial disabilities (often "mental health conditions") of defendants have a significant bearing on the criminal proceedings through finding that the disability diminishes their legal capacity. **All partner countries**' legal systems contain a "presumption of criminal legal capacity". An assessment of the criminal legal capacity is only conducted in cases in which there is reasonable doubt. Some experts in Lithuania mentioned that within the past years, there was a trend of heightened thresholds for "criminal irresponsibility"; a lack of criminal legal capacity is becoming more rare, which is mainly due to psychiatrists applying higher standards for the requirement of "irresponsibility".

Some partner countries (**Austria, Germany** and **Italy)** link the criminal legal capacity to a form of "mental disability", "mental disorder" or a "mental health condition". **Slovenia**, on the other hand, simply refers to circumstances that exclude criminal responsibility without explicitly including any reference to a disability.

Under **Lithuanian** law, a person shall be considered legally incapacitated when, at the time of commission of an act forbidden under the Criminal Code, they were unable to appreciate the dangerous nature of the act or to control their behaviour as a result of a mental health condition.[133] Under **German** legislation, a person shall be deemed to act without guilt, who at the time of the commission of the offence, is incapable of appreciating the unlawfulness of their actions … due to their pathological mental disorder, a profound disturbance of consciousness or intellectual disability or any other serious mental disorder".[134] Similarly, the Bulgarian law states that "criminal responsibility is excluded when a person was in a state of mental incompetence at the time of committing the offence; that is, when due to mental retardation, an enduring mental disability or a temporary mental disorder he/she was unable to understand the nature or consequences of his/her actions or was not able to manage his/her actions."[135]

The negation of criminal legal capacity may specifically impact the exercise of certain criminal procedural rights, the outcome of the criminal proceeding, as well as the application of measures of deprivation of liberty or treatment while in detention. In the majority of national systems examined, the confirmation that a lack of criminal responsibility is connected to a disability constitutes a decisive element for the basis of "special proceedings" in the criminal justice context, leading to security measures/compulsory treatment/forensic psychiatric detention/preventive custodial measures (see Section 2.5). Only if the

person concerned has been determined not to have criminal legal capacity and is thus found without criminal responsibility, will these "special proceedings" be applied. Otherwise, the person will be subjected to ordinary criminal proceedings.

Although declaring a defendant not criminally responsible may result in their acquittal (e.g., in Portugal and Czech Republic), the national legislation may nevertheless order a custodial measure (i.e., an alternative measure to criminal penalties with preventive purposes) involving admission to a forensic facility or mandatory community treatment. The criterion of 'dangerousness' is often used to assess the need for imposition of these measures
The determination of criminal responsibility is done based on expert opinions, which assess the situation and condition of the person concerned (see Section 2.3). In practice, people subjected to security measures can spend longer periods of deprivation of liberty than those who were found guilty of the same alleged crimes, sometimes for indefinite periods (see Section 2.5.4).

> As noted by Tina Minkowitz, ***"Acquittal of a criminal offense based on an adjudication of mental incapacity, or declaration that a person cannot be held criminally accountable on account of disability or of mental incapacity, is problematic in light of the recognition that persons with disabilities are equal to others before and under the law."***[136]

In fact, in **Germany**, persons who are subjected to these proceedings and are found not criminally responsible are acquitted of their criminal offence. However, they can be subjected to custodial measures for an indeterminate period of time due to their disability and "dangerousness".[137]In **Austria**, persons who are found not criminally responsible are not formally acquitted. Instead, consequently they may be subjected to custodial measures due to their disability and "dangerousness" for an indefinite period of time.[138]

In **Germany** and **Austria**, there are additionally other forms of deprivation of liberty in place for persons with intellectual and/or psychosocial disabilities who are found criminally responsible. In **Germany**, persons may be subjected to preventive detention as a "continuation of the correctional system" (see Section 2.5.3.2).

Some partner countries (**Germany, Italy**, and **Slovenia**) foresee the possibility of diminished responsibility/partial criminal responsibility, in which case responsibility is not excluded as a whole but considered as a mitigating factor. In both cases, the person may be subjected to a security measure. In this context, a concern was raised by experts from **German**y. By trying to "prove" diminished responsibility to the court, a person may expose themselves to the possibility of ending up in unlimited confinement. In **Austria**, while the law does not explicitly provide for "partial or diminished criminal legal capacity", the law also foresees a diminished ability to understand the wrongdoing as a mitigating factor. In this case however, the person concerned receives an "ordinary prison sentence", and is not subjected to any other form of security measure or compulsory treatment (see Section 2.5.2).[139] In some countries (**Austria, Bulgaria, Lithuania,** and **Slovenia**), a defendant may be found not criminally responsible but the criminal proceedings may be discontinued if the requirements for the imposition of measures are not met. The defendant may have a disability or mental disorder which renders them not criminally responsible in the eyes of the court, but the specific requirements are not met – e.g., they are not considered to pose a danger to society – which would warrant the imposition of compulsory treatment.

In **Germany**, discontinuation of the proceedings is also possible when "there is no public interest in prosecution" or "if obligations/instructions are fulfilled." Proceedings may also be discontinued without a conviction but on the basis of the imposition of community service, other therapy (e.g., psychotherapy) or reparations. Some countries also provide for the possibility to apply other measures instead of pursuing criminal proceedings (see Section 2.7).

2.3. ASSESSMENT OF DISABILITY

2.3.1. MECHANISMS TO IDENTIFY DISABILITIES

Both in the framework of national as well as regional consultations, experts from the partner countries and other EU Member States (including **Portugal, Czech Republic, Hungary** and **Ireland**) have reported that the identification and recognition of an intellectual and/or psychosocial disability often poses the biggest challenge. Only with this identification, necessary safeguards can be applied and accommodations found.

Whenever disabilities are not identified, persons concerned are declined the opportunity of receiving the necessary support in order to allow them equal access to justice with others. However, the research revealed that the mechanisms to identify common indicators for potential disabilities are not sufficient, preventing authorities from recognizing disabilities in time.

Bulgarian law fails to require adequate mechanisms to relay information on certain signs of potential vulnerabilities of a criminal suspect which may trigger additional support and care or assessment.[140] However, it provides that in the course of criminal proceedings, a medical assessment is mandatory after indictment when there is evidence that the accused person may be incompetent or when the accused person's physical and/or mental condition prevents him/her from comprehending factual information pertaining to the case or from providing a reasonable explanation of facts relating to the case.[141] In some countries, including **Slovenia** and **Austria**, judicial authorities may order a psychiatric assessment in case of suspicions regarding the criminal legal capacity of the person concerned or in case of doubts, of the fitness to stand trial. If these suspicions already occur during the investigation phase, the prosecutor will request an expert opinion; if the indications are perceived later, the expert opinion will be requested during the trial. There are no assessment mechanisms available that may prompt the ordering of the expert opinion. This can lead to a person with a disability being overlooked if there are no "clear" indicators.

In **Italy**, research shows that judges do not always seem inclined to ask for an expert opinion. Usually, expert opinions are only requested if there already is a medical record/ or if the person concerned is already in the health services. Therefore, it is sometimes perceived as "luck" to be subjected to pre-trial detention, as the accused could receive a diagnosis that can be introduced into the criminal proceedings. As a consequence, persons with intellectual and/or psychosocial disabilities very rarely receive adequate support during proceedings.[142]

In **Lithuania**, assessments are only ordered if there is a doubt about a person's ability to appreciate the danger of the crime or a mental health condition is suspected. The precondition for an assessment is that there is sufficient evidence to show that the person has committed an act prohibited by criminal law.[143]

On the other hand, a lawyer from **Germany** argued in the consultation workshop that assessment as it currently exists (i.e., to assess whether the application of special proceedings potentially leading to security measures or compulsory treatment should be held) may in practice have "negative implications" for the person concerned, as these proceedings may lead to the deprivation of liberty for an indefinite period. It was thus argued that lawyers, having the best interest of the person concerned in mind, may decide not to request such an assessment. Similarly, an **Austrian** judge noted that situations of vulnerability should of course be identified early on, but argued that assessments, as they are currently in place (to decide whether or not to apply special proceedings), may be better avoided in the interest of the person concerned as these proceedings may lead to unlimited deprivation of liberty.

2.3.2. AIM AND CONTENT OF EXPERT OPINIONS

In **Bulgaria**, the only goal of the forensic medical assessment is to determine whether or not the accused is criminally responsible and thus whether compulsory treatment is necessary. The necessity and consequent provision of support is not considered in the assessment. There are Guidelines by the Ministry of Healthcare[144] determining the content of a forensic psychiatric assessment, including a recommendation to the court about the nature of the psychiatric hospital, an opinion to what extent the patient's condition requires temporary accommodation. In this case, the expert notifies the head of the psychiatric facility and the need for the compulsory treatment. Experts do not, however, take into account the circle of contacts of the person concerned. The assessment can be a forensic psychiatric assessment, a forensic psychological assessment or a combined forensic psychiatric and psychological assessment. Forensic psychiatric assessment is ordered to determine the condition of a person if a bona fide doubt exists regarding the existence of a mental impairment. The assessment aims to determine whether or not the person was criminally responsible, as well as the fitness to stand trial, the fitness to serve a punishment and the need to apply compulsory treatment measures (and their type). Forensic psychological assessments are performed with the goal to provide information about, among other things, the level of cognitive development of the defendant, their personality and intellectual abilities and how well these match the subject's chronological age, communicative skills and other tasks defined by the authority who ordered the assessment. The forensic psychological assessment is usually performed in combination with a forensic psychiatric evaluation. The goal is not to lead to recommendations for appropriate measures to provide support. There is an official list of expert witnesses; however, other experts may also be requested to assess. Forensic psychiatric assessments of persons who are held in detention take place in health centres with dedicated wards for the treatment of criminal offenders. These assessments may not exceed 30 days, with a possibility to be extended for another 30 days. Outpatient forensic psychiatric assessments can be performed in a medical facility, at the investigative body, in court, in pre-trial detention or at home.

In **Germany** and **Austria**, a psychiatric expert is usually requested to assess the (partial) criminal legal capacity based on an intellectual and/or psychosocial disability, the dangerousness and risk of commission of further acts, as well as the necessity of deprivation of liberty in forensic psychiatry or in preventive detention. The necessity and consequent provision of support for the person concerned in the proceedings is not considered in the assessment. The psychiatric expert is requested to provide an assessment before pre-trial detention and before a measure of correction and incapacitation is ordered/continued/terminated.[145] In **Austria**, if no psychiatric expert is available (within a reasonable time), an expert witness from the field of clinical psychology may be requested.[146]

In **Slovenia**, the expert opinion shall determine the criminal legal capacity as well as the fitness to stand trial. A psychiatric expert is requested to conduct the assessment. If the psychiatric expert identifies an intellectual and/or psychosocial disability, they should include the nature, type, degree and duration of the "mental condition" and evaluate how this condition affected the accountability, how it still affects the behaviour of the person and whether the accused person is as a consequence unfit to stand trial. Clinical psychologists are not included. Assessments of persons who are subject to proceedings for the application of security measures are carried out in forensic psychiatric units of the health care institution.[147]

In **Slovenia**, the judicial authorities have to determine whether the defendant is capable of performing procedural acts, i.e., whether they are fit to stand trial. In order to do so, the judge may request a psychiatric assessment. If there are already indicators during the criminal investigation, the investigating judge may order the assessment. The motion to order a psychiatric examination can also be made by the defence or the prosecution.

In **Italy,** expert witnesses are ordered with the aim of assessing the nature and seriousness of a disability with a view to its relevance to security concerns in the community. The expert opinion appears to be "sentence oriented" and does not focus on the treatment options or the pressure and stress for the person concerned that may be connected with a trial. The experts do not propose possible safeguards during proceedings (e.g. breaks, psychological support, etc.) even in case of obvious difficulties of following the proceedings/trial.[148] The judge or the prosecutor may request an expert opinion. Additionally, the accused or their representative may request an expert opinion. However, the accused is very often not able to afford the expert witness. While this should be covered by legal aid, experts consulted in the framework of the project noted that expert witnesses rarely accept payment in instalments. This is common practice in legal aid procedures (over a period of up to 4 years) and can consequently make it difficult – if not impossible – to find expert witnesses who accept payment via legal aid.

In **Lithuania**, the Law on Forensic Examination provides a clear list of tasks and aims of the forensic psychiatric examination, including the mental state of the accused to determine their ability to understand the essence of their actions at the time of the offence, their dangerousness due to the mental health condition and recommendations on the use of a type of compulsory medical treatment. Forensic psychiatric as well as forensic psychological experts can be requested to conduct an assessment. The person concerned may be held there until the submission of the expert report to the prosecutor or the court. Outpatient examinations are also possible. One of the major challenges is the potentially long waiting time for the forensic psychiatric examination.

In **Lithuania**, the pre-trial judge or the court must order a forensic psychiatric examination. During the investigation, the order will be upon request of the prosecution.

2.3.3. QUALITY OF EXPERT OPINIONS AND ASSESSMENT

One of the main issues raised by many experts in national as well as regional consultations throughout the project was the low quality of expert opinions and the lack of quality reviews of the experts' work and knowledge. In **Bulgaria**, interviewed experts shared their concern on the quality of expert opinions. Judges interviewed in the context of the projects shared that some expert witnesses produce assessments that are not reasoned and carried out in haste, including sometimes wrong data and limited to a half page assessment without any additional information or discussion on medical records of the individual.[149] In **Bulgaria**, there are currently no legislative or other measures in place to assess and guarantee the quality of the expert witnesses' work. While there are formal educational requirements, there is no effective evaluation of their knowledge. In practice, there are no safeguards for their independence (particularly from the appointing authority). In **Lithuania**, forensic psychiatric and forensic psychological experts have to undergo a screening of their professional qualifications every five years. The results of this review are submitted to the Ministry of Justice. Additionally, the Annual Activity Plan of the National Forensic Psychiatric Service foresees four in-service training events each year.[150]

At the same time, in some of the partner countries, concerns have been raised about the impartiality of the experts. In **Germany**, experts interviewed reported that expert opinions are often influenced by the institutions or the courts, who do not want to make any mistakes especially regarding leaves and releases, for fear of public denunciation. Experts tend to receive signals and understand tendencies of what "results" judges may wish for and prepare their opinions accordingly.[151] In **Slovenia** too, judges usually have a good understanding of the "tendencies" of experts. Based on these, judges choose their appointment accordingly.[152]

Experts from **Austria** interviewed in the framework of the project heavily criticised the work of some expert witnesses, including both the examination as well as the written expert opinion. They recounted instances of persons being interviewed only for 10-15 minutes. Instead of having a true case by case assessment and individual analysis, expert opinions appear to be a product of copy-paste. Experts have raised concern that some expert witnesses already have specific tendencies to confirm or deny the capacity to be found criminally responsible and the dangerousness.[153] In Austria, the quality of experts and their work vary greatly. There are some experts that follow the guidance or direction of the judge or the prosecutor regarding the question of criminal responsibility and dangerousness.

Equally, in **Slovenia**, experts reported that interviews between expert witnesses and the accused are sometimes too short to provide a thorough assessment.[154] Additionally, as the opinions are only based on the psychiatric evaluation, insights into the personality of the person concerned are missing. They could be included by opening the assessment to clinical psychologists, for example.

Closely connected to the lack of quality is the scarcity of experts. Two countries (**Bulgaria** and **Austria**) reported a scarcity of expert witnesses. In **Bulgaria**, there currently are only four forensic psychiatrist departments and only eight forensic psychiatrists in the whole country.

Both countries (**Bulgaria** and **Austria**) report that the low salaries are one of the major issues related to the scarcity of experts on the one hand, and the low quality of opinions on the other hand. In **Austria**, due to the scarcity of expert witnesses, the ones that are available usually write many opinions contemporarily, not giving them sufficient time for each individual case. Contrary to this, in **Germany**, experts are paid very well, which makes them more prone to follow the tendencies of the court and their expectations, as they wish to be requested and appointed again in the future.[155] Due to high salaries, there is no shortage of expert witnesses, but only very few can provide an appropriate level of quality. Usually, persons concerned are not the ones to select the expert witness.

2.3.4. CONSENT TO EXAMINATION

In some countries, like **Slovenia**, the law does not require consent to the examination by the person concerned. In **Bulgaria**, the person concerned can only be assessed if they agree to the examination. If the person does not consent, the medical authorities can request from the prosecutor or the court a written order and assistance for the outpatient assessment or temporary accommodation in a psychiatric hospital for an inpatient forensic psychiatric assessment, which results in a circumvention of consent. In **Germany**, if the person concerned does not talk to the expert or consent to the assessment, the expert can assess on the basis of the case file. Additionally, the expert witness can also use the main hearing and include some of the findings there in their expert opinions. The **Austrian** law foresees the mandatory examination by a psychiatrist in proceedings leading to security measures or preventive detention.[156] If the person concerned after having been informed does not provide their consent, the psychiatrist may still observe them during the court hearing and provide an opinion based on the observations or based on the case file.

2.3.5. HIGH VALUE OF EXPERT OPINIONS AND POSSIBILITY OF ADDITIONAL OPINIONS

The abovementioned grievances are of particular concern, as the expert opinions have a very high value and usually courts follow their assessments and recommendations. Whether or not a person is criminally responsible is usually a “legal question” which needs to be decided by the judge/court, but the arguments of experts often outweigh those of other parties, and usually courts follow their assessments and recommendations. The expert opinion is frequently decisive on whether security measures are imposed and it is very difficult for the defendant or

detainee to prove otherwise. In Slovenia, the expert opinion is the basis of the decision of the court about whether or not to impose security measures of compulsory psychiatric treatment in a medical institution. Equally, during review hearings, the person concerned may be given the opportunity to be heard and to explain their participation in therapy, for example, but this is often a matter of formality and lastly, only the expert opinion's statement is taken into account. It is very difficult for the defendant or detainee to combat the opinion. As regards second or alternative opinions, reports show that it is generally difficult to request a second or alternative opinion. Even where second opinions are possible, their value may be different from the first.[157] In **Bulgaria**, neither the defendant nor the court can appeal the forensic findings. Both parties can, however, request a second opinion should they disagree with the first. In this case, it is up to the receiving authority to decide whether or not to order another opinion.[158]

In **Germany**, persons concerned can request the commission of another expert opinion, or simply have another assessment on their own initiative. However, these assessments are usually not granted the same value and are regarded as biased submissions and do not have strong influence on the proceedings. The persons concerned have to cover the costs for these opinions, which poses difficulties in practice as they do not have the resources.[159] Similarly, in **Austria**, the person concerned can request an expert opinion themselves, but this does not have the same value as the court commissioned expert opinion and usually exceeds the financial resources of the person concerned. In **Slovenia**, the person concerned can request another expert if they argue on reasonable grounds that there are doubts regarding the correctness and competence of the expert. The court will then re-examine the first opinion. Only if the doubts cannot be resolved, the judge will request another expert opinion. To encourage the court to appoint a second expert, the person concerned sometimes hires an expert witness to challenge the first expert's opinion. However, this requires financial resources that not all persons concerned can afford.[160]

In **Lithuania**, the person concerned can request further examination if they disagree with the expert's report. However, in practice, the documentation is very complicated and difficult to understand.

2.3.6. CONCLUSIONS AND RECOMMENDATIONS

The existing assessment mechanisms do not correspond with the broad variety of needs that a person with a disability may have. Currently, there is a very strong (purely) medical approach to the assessment of the person concerned and their disability. Usually (forensic) psychiatrists are requested to conduct the assessment. At the same time, the aim of the assessment is purely focused on determining criminal legal capacity and sometimes fitness to stand trial. Considerations regarding the need for support, or the persons' ability to withstand the pressure of trials, are not part of the assessment. Psychologists are rarely included and other stakeholders or persons from the social environment of the person usually are not involved.

Consent to the assessment and examination by an expert witness is usually required, however in some countries it can be circumvented by committal to a psychiatric institution, where consent is no longer necessary. Persons concerned usually do not have the possibility to choose the expert witness and additional or second opinions often do not have the same value as appointed expert witnesses. The scarcity of expert witnesses, influenced by low salaries, further exacerbates these challenges. The prevailing medical approach to assessments focuses primarily on determining criminal legal capacity, lacking consideration for support needs and the ability to withstand trial pressures. Overall, the lack of adequate mechanisms for early disability identification may result in the denial of necessary support for equal access to justice, emphasising the necessity for a more comprehensive and inclusive approach.

Recommendations:

- Develop mechanisms to enable early recognition of intellectual and/or psychosocial disabilities by judges, prosecutors, legal aid, and others by setting up checklists and guidance at all stages of the criminal proceedings, including training opportunities for all actors involved. This includes ensuring that all professionals and actors involved are educated and trained to properly apply the UNCRPD standards.
- Establish a multidisciplinary approach in assessments of intellectual and/or psychosocial disabilities. The assessment should move beyond the medical examination and instead focus on individual needs as opposed to the disability or impairment that could influence the question of criminal responsibility. This will prevent any kind of stigmatisation because the individual assessment will look at social factors, environmenwt, and other factors. Besides psychiatrists and psychologists, this multidisciplinary team should also include, for example, a social worker, who has a paramount role in making a thorough social study about the person and their life situation.
- Provide clear and comprehensive quality standards for the assessment of the disability in order to ensure accuracy, transparency, and uniformity of the assessment. This should include clear guidelines concerning the examination of the person concerned as well as guidance on the written expert opinions. This will enable the judiciary to have a better understanding of the basis of the assessment.
- Develop review mechanisms to assess the quality of the work of expert witnesses and their independence. This could also be accompanied by mandatory educational measures and seminars on new developments and quality standards.
- Ensure free and informed consent by the persons concerned for examinations by expert witnesses.
- Ensure that persons concerned have a say in the selection of expert witnesses.
- Ensure the right for the legal representation to be present during the meeting with the expert.
- Ensure the obligation to record the conversation between the expert and the person concerned.

2.4. PROCEDURAL RIGHTS

2.4.1. ADEQUATE ACCOMMODATIONS IN ORDINARY PROCEEDINGS

Persons with intellectual and/or psychosocial disabilities who are accused or suspected of crimes are in a situation of particular vulnerability. As was already laid out above, there are various standards that should ensure that their procedural rights are safeguarded. However, the research revealed that none of the partner countries have implemented the Recommendation 2013.[161] The practice in the partner countries shows that persons in situations of vulnerability, including persons with intellectual and/or psychosocial disabilities, often do not have any procedural accommodations to support them in the complexities of criminal proceedings. The provision of adequate accommodations and support measures depend on the perception/designation of a defendant as being in a situation of vulnerability; however, even in cases where a disability is detected, the ordinary proceedings usually do not foresee possibilities to provide support, such as mandatory representation, presence of a person of trust or the availability of easy to read documents (e.g., letter of rights) or other forms of support.

Research in **Lithuania** revealed that the national legislation does not include any kind of reference to "vulnerable person". In **Italy** too, it was pointed out that there is a lack of attention towards persons with intellectual and/or psychosocial disabilities and particularly the unavailability of adequate support during the proceedings. Even in cases where difficulties are obvious, no measures are reasonably adapted.[162]

As a means of procedural accommodation, the **Austrian** Criminal Code of Procedure provides vulnerable persons, including persons with a "mental impairment or another comparable condition preventing with the possibility of legal aid.[163] Not only can the person concerned request a legal aid lawyer in case of intellectual and/or psychosocial disabilities, but the judge should, if they identify a vulnerability, also request a legal aid lawyer. Nonetheless, experts have pointed out that ordinary proceedings do not foresee any provisions that would provide persons concerned with additional procedural accommodations.

2.4.2. FITNESS TO STAND TRIAL, RIGHT TO BE HEARD AND TRIAL IN ABSENTIA

Fitness to stand trial usually refers to the defendant's mental condition at the time of the criminal proceedings and whether any such condition impacts their ability to understand the nature or object of the proceedings, understand the possible consequences of the proceedings or communicate with counsel. This may have implications on support mechanisms, legal representation/guardianship and the right to be heard.

While **German** law dictates that defendants must be competent to stand trial, the **German** Code of Criminal Procedure does not foresee a definition of the ability to stand trial.[164] Case law provides some guidance as to the understanding: the person must be able to follow the trial mentally and participate actively. They must also be able to withstand psychophysical stress. There are no regulations in place to support or assist persons with intellectual and/or psychosocial disabilities.[165] Trials can only be held in the presence of the defendants with very few exceptions.[166]

In **Austria**, the court has to assess whether the person is fit to stand trial, i.e., the ability to follow the proceedings, express themselves and exercise their rights effectively.[167] Lack of fitness to stand trial may lead to the nullity of the proceedings. If the court finds the person unable to stand trial, the proceedings will be discontinued. This does not however lead to the formal conclusion of proceedings or an acquittal. Instead, the continuation shall be reassessed on a regular basis. In proceedings leading to security measures, however, the proceedings shall not be discontinued, but instead the court must include the legal representative/guardian. In **Slovenia**, suspension may be ordered (in ordinary proceedings) if the person was not fit to stand trial due to "mental illness" that emerged after the commission of the criminal act, but at the time of the commission, the person had full criminal legal capacity and thus was declared criminally responsible. With the security measures proceedings however, the circumstances that caused the denial of criminal responsibility were present already at the commission of the act, and conditions for security measures were fulfilled.

In **Lithuania**, fitness to stand trial is understood as the ability to exercise individual rights and legitimate interests in the courts of the legal proceedings, such as the exercise of the right to participate in the criminal proceedings, the rights of a defence. In determining fitness to stand trial, a person's mental state is assessed in the past, present and future perspective.[168] Suspects and accused persons have the right to have a legal representative to participate in the proceedings and defend their interests if they have been declared unfit to stand trial.

In **Bulgaria** and **Slovenia**, the presence of the person concerned is not mandatory if their health condition does not allow it. In Slovenia, however, if a person cannot be heard during the proceedings, they are presumed to be objecting to the imposition of security measures. Similarly, in **Austria**, following the latest reform, hearings can no longer be held in the absence of the person concerned. If the person concerned cannot participate, the hearing has to be postponed. The presence of the person concerned cannot be replaced by the presence of their defence attorney or legal guardian. The court can also no longer refrain from questioning the person concerned; they have to be given the possibility to be heard.[169]

2.4.3. ACCESS TO A LAWYER AND RIGHT TO A DEFENCE

The right to access to a lawyer is a fundamental principle in criminal proceedings (see Section 1.1.). In proceedings leading to security measures or custodial measures, additional provisions regarding the defence lawyers must be in place, sometimes granting the defence lawyers with additional rights (which are intended to additionally safeguard the defendants' rights).

In **Lithuania**, once proceedings for compulsory measures are initiated, persons with an

intellectual and/or psychosocial disability are considered not to be able to exercise their rights of defence. In **Austria, Lithuania** and **Slovenia**, the person concerned has to be represented by a defence attorney throughout the entire proceedings leading to security measures. In **Bulgaria**, a public defender is appointed and legal defence is appointed in all cases where persons with an intellectual and/or psychosocial disability are accused. However, representation by a defence attorney is mandatory only in specific cases (equally as for persons without any disability).[170]

In **Austria, Lithuania** and **Bulgaria** the participation of the defence attorney of the person concerned is mandatory during the trial (leading to security measures or compulsory treatment). In **Bulgaria**, however, the defence attorney is appointed only after the person is accused of a criminal offence and the person has been estimated to have an intellectual and/or psychosocial disability which prevents them from legally defending themselves. However, if the person's disability is not estimated or is not estimated as such, which prevents them from legally defending themselves, the person might still not have the right to mandatory legal defence during the trial. In **Germany**, legal guardians can also take on representation in criminal proceedings. In **Austria**, the defence lawyer may take on the responsibilities of the legal guardian, but not vice versa.

In **Austria**, the defence attorney can file motions against the will of the person concerned (if they are found not criminally responsible) if it is in their best interest.[171] In **Lithuania**, persons who are found not criminally responsible cannot question witnesses or refute evidence. Their role becomes passive. They also cannot exercise their right to a defence independently. In **Lithuania**, the court and prosecution is not obliged to accept the waiver of a defence counsel by a person who seems not capable of exercising their own right to a defence based on an intellectual and/or psychosocial disability.[172] Equally, the court is not obliged to inform the person concerned of the referral of the case for compulsory measures. However, the person concerned may still participate in the proceedings, have a defence counsel and appeal against the order for imposition of compulsory measures. In **Slovenia**, representation is mandatory if the person concerned is unable to defend themselves. However, it seems that cases where such grounds for mandatory defence for persons with psychosocial and/or intellectual disabilities are rarely recognised in practice.

2.4.4. SPECIAL PROCEEDINGS FOR COMPULSORY TREATMENT/ SECURITY MEASURES

While some of these national systems appear or pretend to be protective, they can in practice lead to the contrary by denying the enjoyment of procedural rights in respect of legal capacity, access to justice, the effective participation of defendants with intellectual and/or psychosocial disabilities in their own proceedings, presumption of innocence, the principle of no punishment without guilt, the right to testify, the right to refute evidence, the right to attend hearings, the right to complain, procedural accommodations, and access to lawyers.

All partner countries foresee specific procedural provisions in the national criminal justice systems for persons with intellectual and/or psychosocial disabilities. These proceedings may also lead to different forms of deprivation of liberty (see Section 2.5). The person concerned does not have the option to "opt" for regular criminal proceedings; this choice is taken by the investigative body or the courts. In **Austria**, this system provides additional procedural accommodations for persons with intellectual and/or psychosocial disabilities who are in proceedings for compulsory measures.[173] These may include provisions regarding the composition of the court or procedural guarantees of the person concerned (e.g., mandatory representation by a defence lawyer and the presence of the defence lawyer, an expert and the person concerned throughout the hearing).

In other cases, however, the application of compulsory treatment may lead to a circumvention of general procedural safeguards. In **Lithuania**, for example, once a person is

found to be without criminal legal capacity, they cannot take part in any proceedings. That is, the person may not be questioned, may not be shown persons, objects or photographs for identification, and so on. This person may only be subjected to such procedural steps in which their role would be passive. For example, such a person may be shown to a victim to be identified.[174]

In **Bulgaria**, procedural rights are only guaranteed once pre-trial proceedings have been initiated and the person concerned is accused. However, very often, persons with intellectual and/or psychosocial disabilities are not indicted/accused and thus not provided with their procedural rights. Instead of a formal indictment, the prosecution may propose to adopt compulsory medical measures. In this case, the person concerned is not notified of the criminal procedure initiated against them; they are not given access to a lawyer and have no recourse to judicial remedies against the findings of law or fact. While the CJEU found that the concept of 'criminal proceedings' also covers proceedings for committal to a psychiatric hospital which, although do not lead to a 'sentence' in the strict sense, nevertheless result in a measure involving a deprivation of liberty, provided that such a measure is justified not only on therapeutic grounds but also on safety grounds.[175] However, since the judgement of the EU's highest court, according to research and the national experts, no change in law or practice was detected in Bulgaria.

In many cases, states argue that these proceedings are means to support the defendant, who otherwise would not be able to effectively participate, as was argued by the Australian government in the case of ***Noble v. Australia*** (See Section 1.1.3.).

2.4.5. CONCLUSIONS AND RECOMMENDATIONS

The research conducted in the framework of the project showed that the national systems often do not foresee sufficient support for defendants and detainees with intellectual and/or psychosocial disabilities in their criminal proceedings. Relevant provisions foreseen in the 2013 Recommendation have not been implemented into national law. Ordinary proceedings are often not equipped to respond to needs of persons concerned (i.e., appropriate ways of ensuring participation, such as a modified "letter of rights" or inclusion of additional persons to provide support). In some jurisdictions, trials may be held ***in absentia*** if the person concerned is presumed "unfit to stand trial", thus effectively excluding them.

At the same time, the special proceedings foreseen under national law, leading to other forms of deprivation of liberty, The research conducted in the framework of the project showed that the national systems often do not foresee sufficient support for defendants and detainees with intellectual and/or psychosocial disabilities in their criminal proceedings. Relevant provisions foreseen in the 2013 Recommendation have not been implemented into national law. Ordinary proceedings are often not equipped to respond to needs of persons concerned (i.e., appropriate ways of ensuring participation, such as a modified "letter of rights" or inclusion of additional persons to provide support). In some jurisdictions, trials may be held in absentia if the person concerned is presumed "unfit to stand trial", thus effectively excluding them.

- Member States should implement the Recommendation on Procedural Safeguards for Vulnerable Persons Suspected or Accused in Criminal Proceedings.[176]

- Repeal legislation and cease practices that restrict effective participation in the entire proceedings of persons with intellectual and/or psychosocial disabilities in accordance with the UNCRPD.

- Provide procedural accommodations to ensure effective participation in proceedings, e.g., by modifying the "letter of rights" so that the information is presented in a simplified and comprehensible manner.

2.5. DEPRIVATION OF LIBERTY: LAWFULNESS OF DETENTION

2.5.1. DANGEROUSNESS

One aim of the comparative research was to examine which paths can lead to deprivation of liberty of persons with intellectual and/or psychosocial disabilities – in the criminal justice context/following the commission of a criminal offence – in the six partner countries. Deprivation of liberty, in this context, covers imprisonment (in "ordinary" prisons), as well as detention in psychiatric hospitals, forensic psychiatric institutions or special units in public hospitals for the purpose of compulsory treatment. In all six partner countries, an assessment of the defendant's criminal legal capacity (see Section 2.2), alongside a determination of "dangerousness" during criminal proceedings is determinative of which "track" then ensues. Either a defendant will move along the "regular" track, leading towards prison, the ordinary facilities for imprisonment in a country, or they will move along the other track, leading to some other form of security measure consisting of committal to an institution for the purpose of compulsory treatment. This may be in a specialised psychiatric facility, a hospital or an outpatient arrangement, but nevertheless, it is not within a prison where "regular" prisoners are.

In two partner countries (**Austria** and **Bulgaria**) criminal legal capacity is assessed in a dichotomous manner; a defendant is either proclaimed criminally incapacitated or not. In contrast, four of the six partner countries (**Germany**, **Lithuania, Slovenia,** and **Italy**) also allow for a determination of diminished criminal legal capacity. Hereby, the mental state of the defendant at the time of the commission of the offence constitutes a mitigating circumstance. Without criminal legal capacity, the person is determined criminally not responsible, and thus cannot be subjected to "detention".

Whether or not a person is deemed to possess criminal legal capacity depends on their retrospectively assessed mental state at the time of the commission of the criminal offence. In **all partner countries**, a lack, or diminishment, of criminal legal capacity (and consequent denial of criminal responsibility) is dependent on the presence of an impairment (different countries use different terminology, such as mental health issue, mental illness, mental disability, mental health condition, mental disturbance), which caused the person concerned to fail to appreciate the nature and consequences of their act or fail to inhibit/control their wrongful acting. The other crucial element necessary for deprivation of liberty is an assessment of dangerousness, which is either implicitly or explicitly linked to the impairment or disability (see Section 2.2).

In other words, the assessment of dangerousness alongside the presence of a disability permits the confinement of the person concerned in order to provide treatment and improve the person's condition and to "protect the public". A lack of or diminished criminal legal capacity is connected to a mental condition, thereby creating a separate legal system for persons with intellectual and/or psychosocial disabilities. The imposition of some form of security measure – whether compulsory medical treatment in a hospital or committal to a forensic psychiatric institution or preventive measures – is contingent on three elements: the commission of a criminal offence, an assessment of a mental health condition and a determination of the danger to society/fear of the commission of further criminal offences unless the person is confined.

In practice, **all six partner countries** allow deprivation of liberty of persons with intellectual and/or psychosocial disabilities in the criminal context based on perceived dangerousness linked to their disability. This is in violation of the principles enshrined in the UNCRPD, prohibiting deprivation of liberty on the basis of impairment (see Section 1.2.3). Involuntary and non-consensual committal to institutions is a legitimated practice in all countries. Where some form of security measure is imposed, this is often without a conviction and entails a committal to an institution that is frequently under the purview of the health sector.

A common theme throughout the project has been the complexity and opaqueness of the different types of systems and facilities for detaining persons with intellectual and/or psychosocial disabilities who have committed a criminal offence. Depending on assessments of criminal legal capacity, dangerousness and varying other legal, medical and practical considerations, persons concerned come under the purview of different regimes and facilities. There is a reported lack of cooperation and communication between different actors, such as the judiciary, social services and medical personnel in coordinating a suitable response when a person with intellectual and/or psychosocial disabilities commits a criminal offence. Several experts have noted that there needs to be more coordination and knowledge about the options.

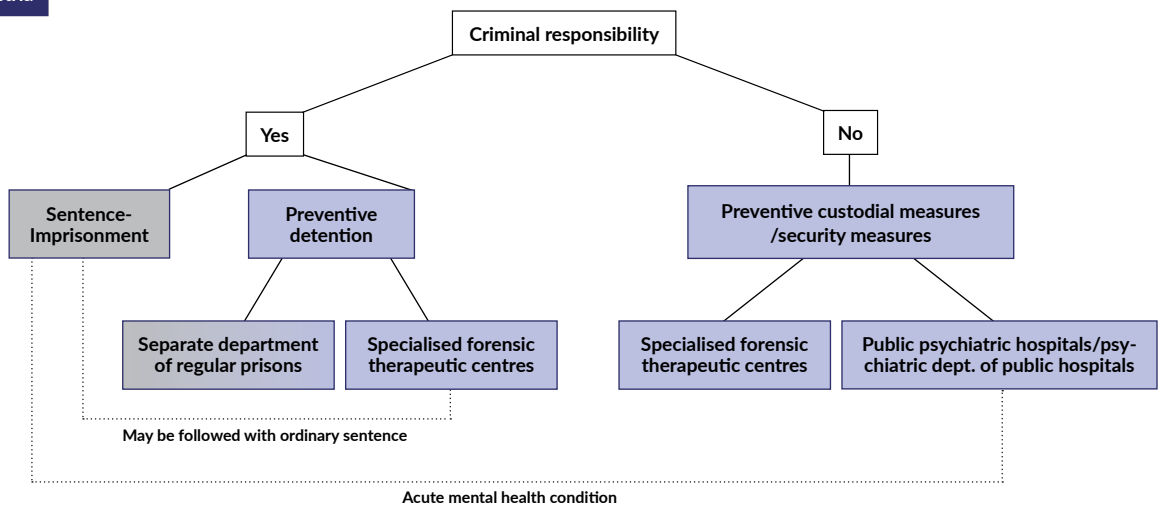
Experts in the consultation workshops have also pointed out an ambiguity in terms of the purpose of the deprivation of liberty. It is often unclear whether it serves primarily the purpose of treatment (and therefore, improvement of the person's condition) or whether the dominant purpose is merely punishment and prevention of future criminal offences, or whether both purposes are equally pertinent. Experts have frequently highlighted blurred lines of demarcation between medical concerns and security concerns. The notion of treatment as a primary goal has been criticised to be problematic when considering that deprivation of liberty is involuntary and that release is often dependent on participation in treatment and evidence of improvement. This is exemplified by **Germany**, where in most states, detainees in forensic psychiatric detention are referred to as patients, which conceals that this measure has a coercive context – the structure of many facilities is similar to that of a prison – and that the persons concerned are often patients against their will.[177] They are also indirectly forced to cooperate or to participate in any treatment they are offered or they otherwise have no realistic chance of release. Due to the fusion of treatment and control and the constantly perceived dangerousness of the person concerned, treatment evolves into "total therapy".[178]

2.5.2. GRAPHIC DEPICTION OF NATIONAL SYSTEMS

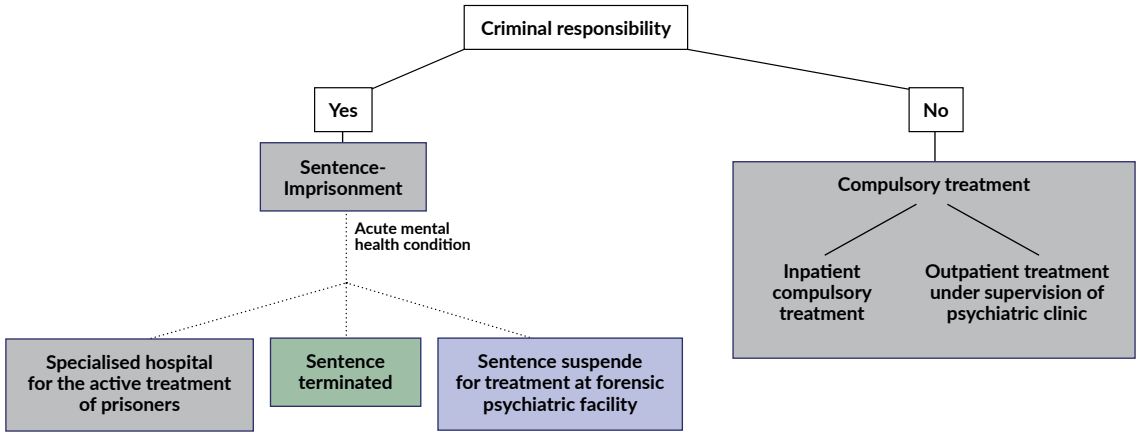
The following infographics depict the pathways by which a person with intellectual and/or psychosocial disabilities who is subject to criminal proceedings may become deprived of their liberty in the six partner countries. These are simplified depictions of criminal justice processes which aim to illustrate the myriad of different measures and institutions that exist within a national system and to facilitate comparisons between the countries. Hereby, 'grey' is used to denote the purview of 'ordinary' imprisonment, whereby 'blue' is used to denote special security measures and (forensic) psychiatric institutions that deprive persons of liberty but are beyond the remit of 'ordinary' imprisonment.

As persons with intellectual and/or psychosocial disabilities may often serve a 'regular' sentence of imprisonment in an 'ordinary' prison (where adequate specialised mental health and other treatment services may not be available), the graphics also depict measures within national systems that come into place when such persons develop an acute mental health condition.

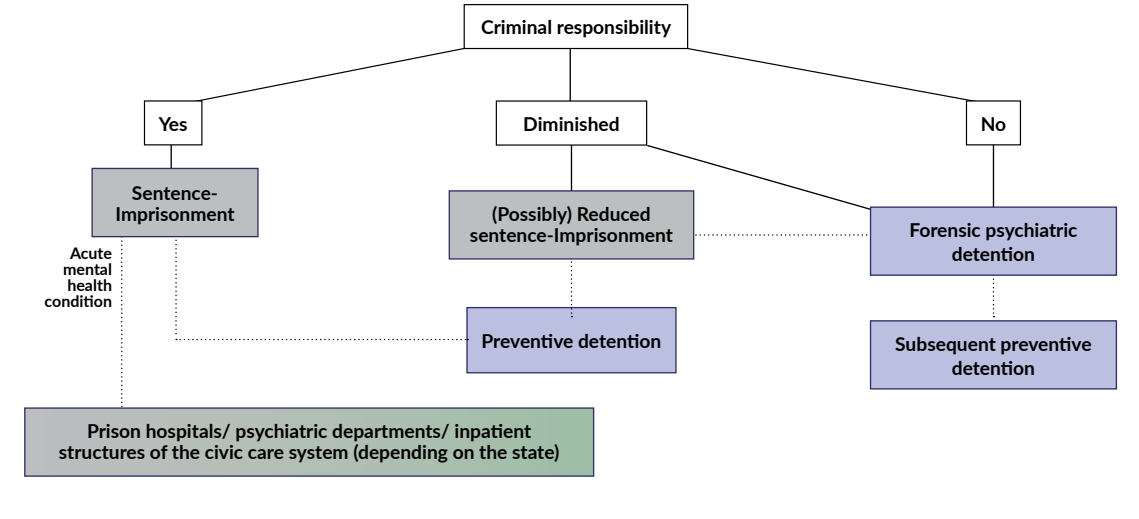
Austria

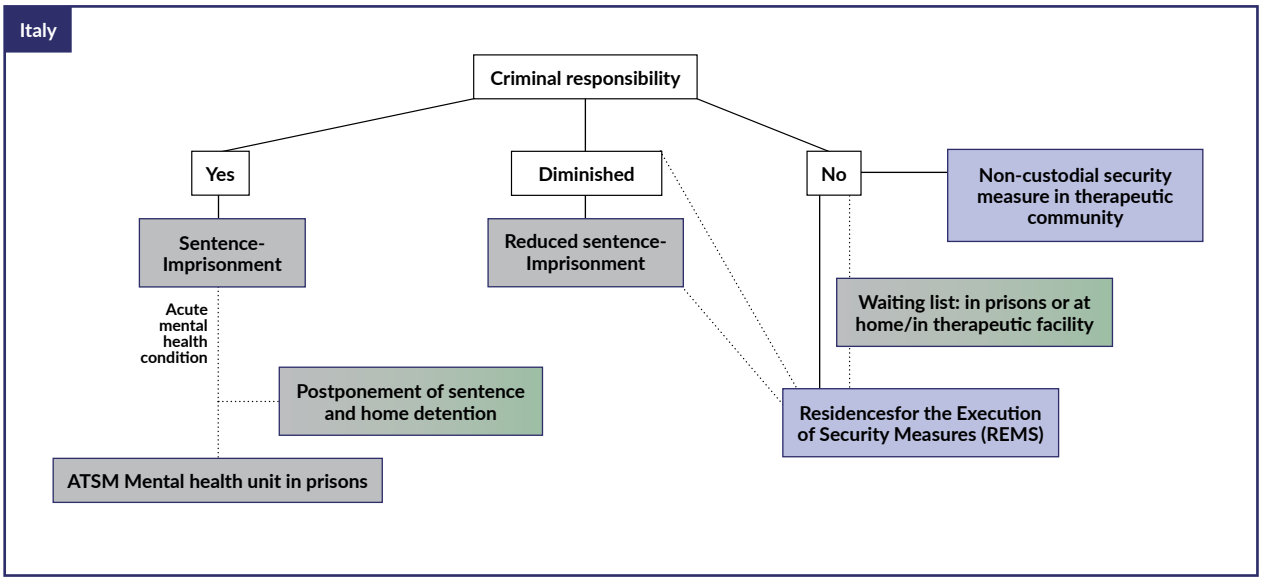


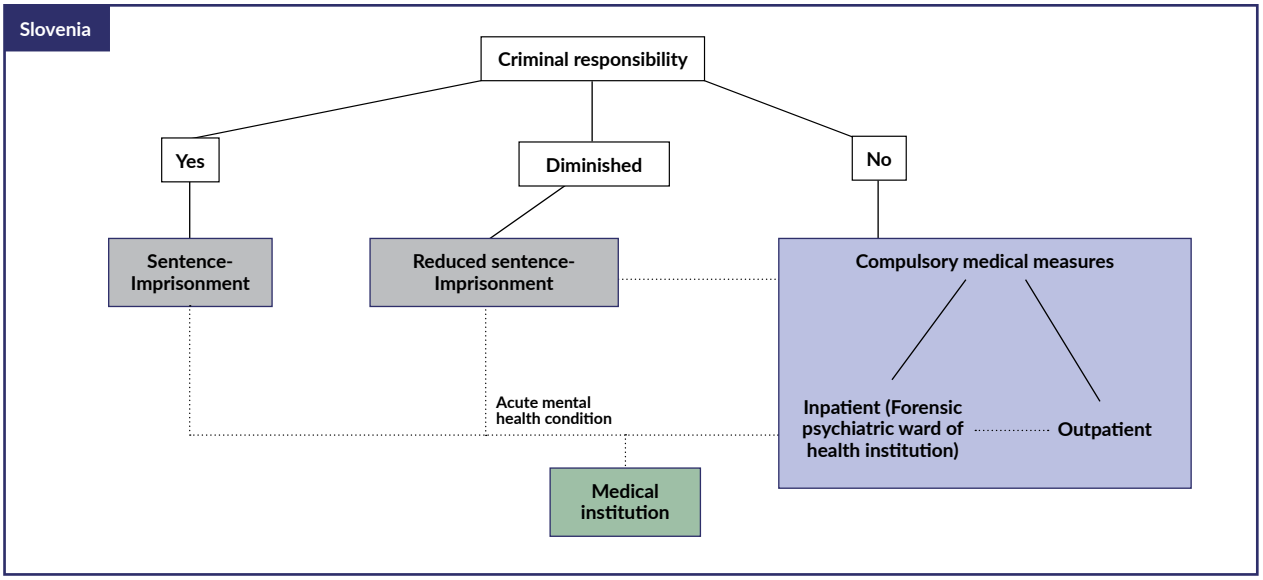
Bulgaria

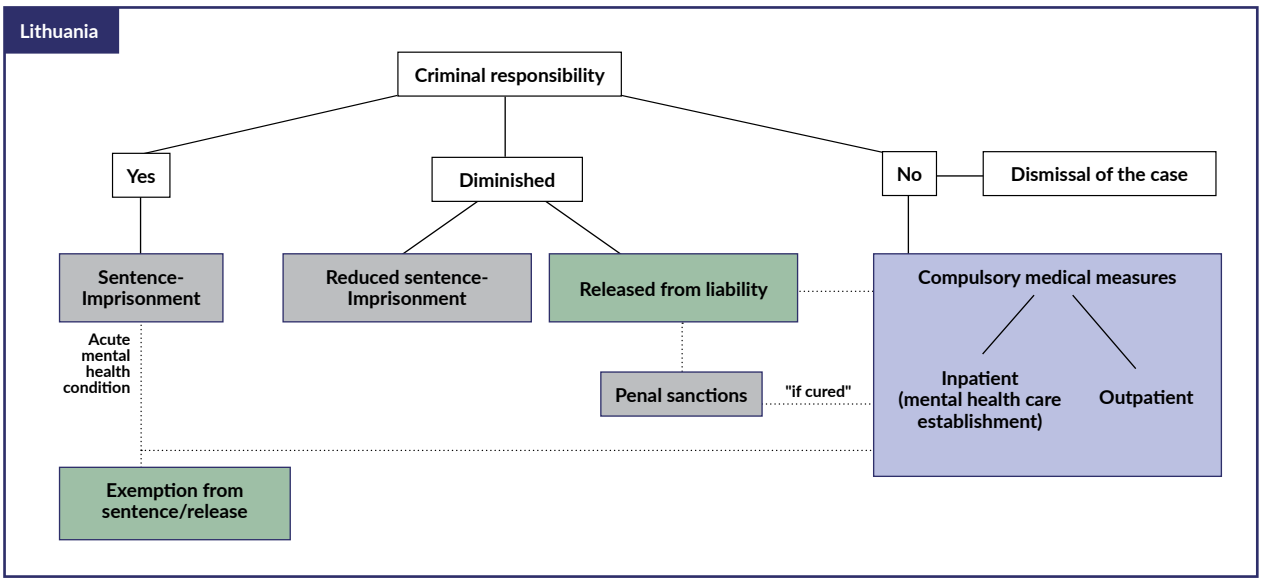


Germany




Italy
Criminal responsibility
Yes
Diminished
No
Non-custodial security measure in therapeutic community
Sentence-Imprisonment
Reduced sentence-Imprisonment
Waiting list: in prisons or at home/in therapeutic facility
Acute mental health condition
Postponement of sentence and home detention
Residencesfor the Execution of Security Measures (REMS)
ATSM Mental health unit in prisons


Slovenia
Criminal responsibility
Yes
Diminished
No
Sentence-Imprisonment
Reduced sentence-Imprisonment
Compulsory medical measures
Acute mental health condition
Inpatient (Forensic psychiatric ward of health institution)
Outpatient
Medical institution


Lithuania
Criminal responsibility
Yes
Diminished
No
Dismissal of the case
Sentence-Imprisonment
Reduced sentence-Imprisonment
Released from liability
Compulsory medical measures
Acute mental health condition
Penal sanctions
"if cured"
Inpatient (mental health care establishment)
Outpatient
Exemption from sentence/release

2.5.2. ORDINARY IMPRISONMENT

Persons with intellectual and/or psychosocial disabilities who have committed a criminal offence often find themselves serving a "regular sentence" in prisons within the general prison population. "Ordinary" imprisonment may happen if the person is deemed to be criminally responsible either because no disability is detected at the pre-trial or trial stage or a disability is detected but is not deemed to have influenced the criminal legal capacity of the person concerned at the time of the commission of the offence so as to result in a negation of criminal responsibility. In the four countries (**Germany, Lithuania, Slovenia,** and **Italy**) where diminished criminal legal capacity is determinable, "ordinary" imprisonment may also ensue, albeit with a possibly reduced sentence. In these four countries, the diminishment of criminal legal capacity begets a reduction in the sentence to be served.

In all partner countries, if full criminal responsibility is found, a defendant – no matter if they have a disability or not – will receive a sentence and may serve imprisonment. Principally, this is aligned with the UNCRPD standards, provided there are certain procedural accommodations offered to persons with disabilities.

However, in reality, persons with intellectual and/or psychosocial disabilities who are confined in ordinary prisons rarely receive adequate support and services (see Section 2.6.8). Most countries do not provide for special wards for persons with specific needs, such as persons with intellectual and/or psychosocial disabilities. In **Bulgaria**, the head of the prison may establish separate wards for certain categories of detainees, namely "persons with a high degree of public danger, suffering from alcoholism or drug addiction, persons with mental disorders or vulnerable persons with a view to their safety, as well as the safety of other prisoners and prison employees as well."[179]

Intellectual and/or psychosocial disabilities are often not detected in the penal system and prisons often do not provide adequate treatment services and accommodations. Instead, such detainees may be isolated and segregated in an effort to manage security concerns (see Section 2.6.4). Generally, the research has shown that in all countries observed there is a large number of persons with intellectual and/or psychosocial disabilities within the general prison population. Estimations of the rates of serious psychiatric conditions in prison vary within and between countries (due to the difficulties in collecting precise data, see Section 2.1.2), but figures are undoubtedly high. Similarly high are the rates of prescription of psychotropic medications (see Section 2.6.8), indicating high levels of psychiatric conditions among the prison populations. For example, in **Germany**, it is estimated that approximately 40 to 70% of all detainees live with a mental health condition.[180]In **Italy**, estimates from the period between September 2021 and September 2022, show that around 40% of detainees regularly take psychotropic drugs.[181] Notwithstanding the observation that pharmacological treatment may be overprescribed when the necessity is questionable (see Section 2.6.8), this indicates that within the general prison population, there are alarmingly high levels of detainees with mental health conditions serious enough to warrant treatment and experts throughout the project have stated that mental health treatment services in prison are far from adequate.

In some countries (**Germany, Slovenia** and **Italy**), it is also possible for a court to impose a form of security measure to be served subsequently, after a person has finished serving (possibly) a reduced sentence of imprisonment in an ordinary prison. In **Slovenia**, when imposing a reduced sentence, the court will, by the same judgement, also impose a security measure of compulsory psychiatric treatment and confinement in a medical institution if it establishes that the conditions for such a measure under the Criminal Code are fulfilled.[182]

In contrast, within the **Austrian** system, the converse is possible, and persons who are declared criminally responsible may receive a (regular) sentence in addition to their (potentially unlimited) preventive detention. In this case, the preventive measures should be applied first, and the prison sentence after. The time they spend in preventive detention counts towards the sentence. If they are released from the preventive detention before the end of their sentence (if they have received one), they are transferred into the "ordinary" prison.[183] In practice, however, preventive detention very often exceeds the prison sentence. One of the reasons for this extended stay is that during the preventive detention, the person concerned often does not receive the therapy needed in order to demonstrate an improvement in their condition and qualify for release, or therapies start very late (see Section 2.6.8.1).[184]

All six partner countries provide for a specific measure to respond to a detainee in prison who is experiencing an acute mental health condition, either because a pre-existing condition worsens or because they develop a severe mental health condition while imprisoned. In three countries (**Italy, Bulgaria** and sometimes in **Germany**), there is the option of providing psychiatric care for detainees with acute mental health issues in a specialised unit within an ordinary prison, as well as the option of either postponing the sentence for care in the community or transferring detainees to psychiatric facilities in the community for treatment. Special mental health units in prisons, such as the ATSMs (***Articolazioni per la tutela della salute mentale***) in **Italy**, have been criticised for their lack of a precise legal framework and little therapeutic efficacy due to a lack of treatment options and insufficient personnel.[185] Another issue with such specialised units is that they only exist in selected prison facilities. For example, in **Bulgaria**, only in Sofia and Lovech are there are specialised hospitals for active treatment of prisoners at the prisons.[186]

In some countries (**Austria**, some states in **Germany**) it is possible to transfer detainees with acute mental health conditions to psychiatric departments of public hospitals or use the inpatient structures of the civic care system. However, in practice, arranging such transfers is not without difficulties due to a lack of capacity of prison hospitals, the lack of willingness of public hospitals or need for further security staff for the transfer/placement in a public hospital.

Moreover, in five of the partner countries (**Slovenia, Lithuania, Bulgaria, Austria**, and **Germany**) detainees who exhibit acute mental health conditions may also be (temporarily) transferred from prisons to psychiatric institutions or places where compulsory treatment measures are usually executed and where persons who are determined to not be criminally responsible are placed. In other words, it is still possible for detainees with disabilities who are serving a sentence of imprisonment in an ordinary prison (because they have been determined to have full or diminished criminal responsibility) to (temporarily) come under a regime belonging to the "second track" and under the purview of a security measure. Thereby, the distinction between persons who are deemed dangerous based on intellectual and/or psychosocial disability, and therefore without criminal legal capacity, and persons who are deemed to have criminal legal capacity but develop an acute "condition", becomes blurred.

Such referrals to other institutions for (compulsory) treatment are often short and, according to experts, the quality of treatment and care provided is often low, as the facilities may lack the necessary resources. Afterwards, the person is then transferred back to the prison, and it can happen, as reported in **Austria** and **Slovenia**, that the same prisoners can be transferred back and forth between the prison and the forensic psychiatry unit several times.[187]

2.5.3. FORMS OF SECURITY MEASURES AND COMPULSORY TREATMENT

2.5.3.1. FORENSIC PSYCHIATRIC INSTITUTIONS

All six partner countries have legislation providing for the committal to a closed institution based on the absence of criminal legal capacity, for compulsory treatment as some form of security measure. Throughout the research and across all countries, grave concerns have emerged regarding the conditions of detention, coercive treatment and possibilities of unlimited detention within forensic psychiatric institutions (see Section 2.6.1).

In **Lithuania, Slovenia, Bulgaria** and **Italy**, when a defendant is determined to be not criminally responsible, compulsory treatment/compulsory medical measures are ordered by a court which can be implemented either as an inpatient confinement or in an outpatient manner in the community. It is important to mention, if treatment is ordered in an outpatient fashion, it is still compulsory.

In **Lithuania**, different options of compulsory medical treatment measures may be ordered by the court:[188] (i) out-patient observation under the conditions of primary mental healthcare; (ii) in-patient observation under the conditions of a general observation at a specialised mental healthcare establishments; (iii) in-patient observation under the conditions of an enhanced observation at specialised mental healthcare establishments; and (iv) in-patient observation under the conditions of a strict observation at specialised mental healthcare establishments.

In **Slovenia**, the security measure of compulsory psychiatric treatment and care in a healthcare institution may be enforced in the forensic psychiatric wards of the healthcare institutions that meet special professional and security conditions prescribed by the law.[189] Currently there is only one such facility in Slovenia, the Forensic Psychiatry Unit of the University Clinical Centre Maribor. All persons subjected to the security measure of compulsory psychiatric treatment and confinement and those detained during the proceedings for the application of the security measures are placed in this facility.[190]

In **Bulgaria**, compulsory treatment (inpatient and outpatient) may be ordered for persons who were found to lack criminal legal capacity due to an intellectual and/or psychosocial disability at the time of the commission of the offence, defendants who have developed mental incapacity before the judgement was delivered and detainees who developed mental incapacity while serving their sentence. This order of compulsory treatment may take the form of (i) outpatient treatment under the supervision of a psychiatric clinic and in the care of relatives; (ii) inpatient treatment in a general psychiatric facility; or (iii) inpatient treatment in a specialised psychiatric hospital or in a specialised ward in a general psychiatric facility.[191] The court-ordered compulsory treatment may be discontinued or amended when this is required by changes in the patient's condition or if it is necessitated by the course of his/her treatment.

In **Italy**, defendants who are found to be either not criminally responsible or to have diminished criminal legal capacity, may receive a court-ordered committal to a Residence for the Execution of Security Measures (***Residenze per l'Esecuzione delle Misure di Sicurezza*** (REMS)). As of 2021, there were 36 REMS facilities across the country, with considerable waiting lists.

In **Germany**, compulsory treatment can be ordered as "forensic psychiatric detention", which describes the execution of custodial measures of correction and incapacitation.[192] Forensic psychiatric detention purports to protect the general public from serious unlawful acts, as the committal is coupled to an assessment of the person's dangerousness, as well as to provide treatment. The detention aims to treat the person concerned until inpatient detention no longer proves necessary, which may be indefinite.

In **Austria**, persons with an intellectual and/or psychosocial disability who have com-

mitted a criminal offence as a consequence of their disability and who, due to their disability, are presumed to commit other offences in the future, may be subjected to security measures. The persons who are found to lack criminal legal capacity and are therefore declared criminally not responsible are subjected to security measures either in a "forensic therapeutic centre" or in psychiatric hospitals or psychiatric wards of public hospitals. Currently, there are three specialised centres in Austria. There, persons are usually accommodated in residential units where they should receive broad therapeutic care and support aimed at achieving mental stability, understanding of the disease and cooperation in treatment.[193] The preventive measure in a public hospital underlies some of the provisions applicable to the deprivation of liberty under criminal law, and partly, the provisions applicable to the involuntary placement under civil law.[194]

2.5.3.2. PREVENTIVE DETENTION/MEASURES

Another pathway to detention, even indefinite detention, exists for defendants and detainees with intellectual and/or psychosocial disabilities in **Austria** and **Germany**. In contrast to the other countries surveyed, both systems provide for the possibility of imposing preventive detention/measures as a form of special security measure on defendants who are found criminally responsible by the court. Preventive detention/measures, necessitates the same elements as other forms of deprivation of liberty discussed above – that is, the commission of an offence, an impairment and dangerousness – and in addition, is expressly grounded in a purported attempt to protect the public by preventing further crimes in the future. Both **Austria** and **Germany** have a system of preventive detention/measures, albeit with significant differences.

In **Germany**, preventive detention constitutes a continuation of punishment. It can be ordered subsequent to a sentence of imprisonment, either a "regular" sentence where the person has been found to be criminally responsible, or a reduced sentence, where the person has been found to have diminished criminal legal capacity. One of the core requirements of preventive detention in **Germany**[195] is the separation requirement: persons accommodated in preventive detention must be accommodated separately from the prison system in special buildings or wards. Life in preventive detention must be adapted to the general living conditions in freedom. This adaptation, however, is limited due to security concerns. However, the separation requirement may also lead to segregation and a reduced offer for those accommodated in preventive detention.[196] Furthermore, there is often little differentiation between the prison system and preventive detention in terms of security and order.[197]

There is also the possibility for retrospectively extended or imposed preventive detention, after the end of a served prison term. Although, nowadays, this is only possible in exceptional circumstances.[198] The imposition of retrospective preventive detention has come before the ECtHR, which ruled that it does not violate Art 7 ECHR because of a need for therapeutic treatment of a "person of unsound mind" (Art 5(1)(e)). The ECtHR considered the conditions in **Germany**'s preventive detention as adequate treatment in this sense to consider it as different from punishment. The ECtHR cut preventive detention off from its origins[199] and even found that a violation of Art 7 ECHR could somehow be "cured" by placing the detainee in a therapeutic environment.[200] In contradiction to Art 14 UNCRPD, individuals in (retroactive) preventive detention are detained explicitly because of their disability ("unsound mind"). Furthermore, with the prospect of detention in psychiatric hospitals, the **German** system already provides for the possibility of detention of persons with psychosocial and/or intellectual disabilities in a therapeutic environment.

In **Austria**, persons with intellectual and/or psychosocial disabilities who are found criminally responsible, may also be deprived of liberty and are subjected to preventive measures. They can be confined in specialised forensic therapeutic centres or in

special departments of prisons. Currently, there is only one specialised forensic therapeutic centre and three special departments in prisons.[201] A recently passed reform law foresees the extension of forensic-therapeutic institutions instead of detaining persons in special departments of "ordinary" detention facilities.[202]

2.5.3.3. PRE-TRIAL DETENTION

The research in the six partner countries has shown that, with regard to pre-trial detention, persons with intellectual and/or psychosocial disabilities subject to criminal proceedings may either (a) spend the proceedings phase at liberty, (b) serve pre-trial detention in an ordinary prison or (c) serve some form of provisional security measure. Experts have mentioned that where alternatives to pre-trial detention exist, such as home arrest, electronic monitoring or bail, these options are rarely applied to defendants with intellectual and/or psychosocial disabilities.

A temporary committal to a form of security measure may be imposed with relative ease, provided there are grounds to assume that the defendant may not be criminally responsible or that they may pose a danger to society. Another purpose of committal at this stage may be to conduct (forensic) psychiatric assessment and observation for the purpose of drawing up psychiatric expert opinions on the mental capacity of the defendant. For example, in **Bulgaria**, persons with intellectual and/or psychosocial disabilities serving pre-trial detention are detained in "ordinary" prisons, without any special regimes. However, a court may commit a person to a psychiatric hospital for assessment for a duration of up to 30 days; this type of measure is considered a form of pre-trial detention by law. The time period for the assessment may be extended once by no longer than 30 days following the same procedure as above if the court-appointed period proves insufficient.[203]

In **Germany**, temporary detention in a psychiatric hospital may be ordered, which is considered neither a measure nor pre-trial detention.[204] It can be ordered if there are pressing reasons for the assumption that the offence was committed in a state of diminished or lack of criminal legal capacity and public safety requires detention in a psychiatric hospital or addiction treatment facility. However, detention in a psychiatric hospital prior to judgement or a detention order also means that even the suspicion of a disability, together with the suspicion of being dangerous, is sufficient to place the individual in a system of measures of correction and incapacitation.[205]

In **Austria**, persons with intellectual and/or psychosocial disabilities who are considered to possess criminal legal capacity are usually detained in (ordinary) pre-trial detention facilities. Persons who are considered to lack criminal legal capacity, who are subjected to pre-trial measures should be placed in forensic-therapeutic centres.[206] Where appropriate – and provided that the person concerned receives appropriate treatment and care – they may be placed in a psychiatric public hospital or in the psychiatric department of a public hospital.[207]

In **Italy,** provisional security measures may be imposed on persons subject to criminal proceedings which are served in the REMS.[208]

2.5.4. DURATION AND LIMITS

In four out of the six partner countries (**Germany, Austria, Bulgaria**, and **Lithuania**), unlimited and indefinite deprivation of liberty of persons with intellectual and/or psychosocial disabilities is possible, meaning the imposed measures do not contain a time limit and may last for as long as the grounds for their imposition prevail. In other words, the detention may continue, unless the detainee's mental condition improves (i.e., they are considered "cured") or the detainee is no longer considered to be a danger to society (see Section 2.6.8.1). Experts in the consultation workshops have noted that the lack of a concrete time limit for the confinement in an institution leaves persons feeling powerless, without agency and that their (life) time, hopes and wishes are worthless.

However, a significant issue here is that facilities may often simply not offer the treatment/therapy that would be necessary

for potentially alleviating the detainee's condition, precluding any possibility of improvement and leading to overlong stays. A lack of demonstrated "improvement of the situation" and "reduction of danger" may also prevent a detainee from accessing conditional release, where it exists. Experts in **Austria** have furthermore raised concern with regards to persons concerned whose situation cannot "improve" as is foreseen by law as a necessary requirement for release, due to their mental condition. In these cases, there is little to no perspective of being released.[209]

Another reason for long durations of detention is that in order to be granted (conditional) release, there has to be a plan in place for post-release care. Experts have raised concerns that a lack of social support systems or a lack of adequate housing options in the community can negatively impact release prospects, preventing equal access to justice for all (see Section 2.7.3).

The research has shown that in many countries, it is difficult to be discharged/released from a security measure and sometimes one compulsory measure is simply substituted by another, which may be an outpatient arrangement or within the civil law system, as long as it is a court-ordered compulsory treatment. Even if there is a time limit prescribed in law for compulsory treatment within the criminal context, there are still avenues through which a person may be detained indefinitely under the purview of different measures (e.g., a health regime). For example, in **Slovenia**, compulsory treatment in the criminal context can only be imposed for a maximum of five years. However, the duration is not determined in the judgement. Instead, every six months, the court must re-examine whether further treatment and confinement in a mental health institution are still necessary.[210] After the five-year period ends, if it is deemed necessary for the purpose of continuing treatment or further custody of the person concerned, further measures and treatment under civil law may be imposed.[211] Once the person is transferred under such a civil law regime, they can be either treated and supervised within the community (at liberty) or, if they are considered unable to do so, they are placed in a social care institution. In such a case, there is no time limit as the security measure and the deprivation of liberty can be periodically extended indefinitely.[212] Experts recommend that such a transferral into the civil law and the mental health system should be avoided and instead, community based support should be strengthened.

In **Italy**, there exists a maximum duration of compulsory treatment (in the REMS) that cannot exceed the maximum sentence for the type of crime for which the person is accused or convicted (see case-study in Annex 4). Following a stay in the REMS, few persons are discharged into the community without additional measures; a survey from 2020 showed that of 172 patients that had been discharged from the REMS, 56% saw their measure transformed into probation, 30% were allowed a form of leave that may be granted in preparation for the end of the security measure, 5% had their measures revoked, 3% were imprisoned in a prison and 3% were ordered another measure.[213] Nonetheless, the REMS system in Italy has been perceived as a good practice by many other EU Member States due to the introduction of a maximum duration of deprivation of liberty, as well as their small scale approach to deprivation of liberty and prevention of overcrowding by limiting capacities (although there are also downsides to these limitations. or For more information, see case-study Annex 4).

Experts in the consultation workshops have recommended that a time limit should be implemented in every national system, especially because the absence of a time limit entails a lack of legal certainty and a lack of perspective and hope for the person concerned. Some experts have recommended that the length a person is detained in an institution, be it a hospital or a psychiatric facility, should not exceed the maximum sentence that is possible for the committed offence. This would arguably be fairer than stating an arbitrary time period for all offences and detainees across the board, to demonstrate a link between the offence and the detention. On the other hand, some experts have expressed that compulsory

treatment is a different type of deprivation of liberty than a prison sentence, which should mainly pursue therapeutic purposes, and therefore there must not be a link to the offence; compulsory treatment should not be conceived of as punishment.

2.5.5. REVIEWS

Regular reviews of the necessity of continued compulsory treatment are crucial safeguards for detainees with intellectual and/or psychosocial disabilities. Lawyers have raised concerns that the review mechanisms in place are often insufficiently safeguarding the rights of the persons deprived of liberty and frequently it may appear as if the hearing was a mere formality and decisions were already taken before.

In some countries (**Lithuania, Bulgaria** and **Slovenia**), automatic reviews as to whether the security measure is to be continued occur every six months. In **Austria**, as regards the continuation of preventive measures, the competent court for the execution of the measure has to decide on the necessity of the continuance on an annual basis.[214] As part of the review, the court has to determine whether the preventive measure is still necessary, thus, whether the degree of dangerousness is still existing.

Similarly, in **Germany**, the continuation of preventive detention, as well as detention in a psychiatric hospital, must be reviewed by the courts at least annually. After ten years of preventive detention, the respective period is nine months. The review of the detention in an addiction treatment facility is due every six months. The institution must send regular reports to the Chamber of the Execution of Sentences.[215] However, in practice, these regular reviews are often a "mere formality" and do not show any change, and thus, the detention continues.

In **Slovenia** and **Austria**, persons concerned or the forensic psychiatry unit can also request additional reviews. However, in **Lithuania**, persons concerned are not able to request a review in addition to the automatic review hearings every six months, where they are usually not present, but they may appeal decisions to continue the measures.[216]

Legal representation is not mandatory in all countries. While it is, for instance, mandatory in **Slovenia**, in **Austria,** persons who are subjected to custodial measures or preventive detention do not have obligatory representation in review proceedings, and their right to be assisted by a lawyer is very often not existent in practice, which lowers the chances of having the case properly reviewed and consequently, the chances of being (conditionally) released.[217] This is not the case for persons deprived of their liberty under civil involuntary treatment, who have access to a patient attorney who can advise them on legal matters and in their review proceedings.

In **Germany**, if consecutive preventive detention is ordered in the judgement (which only starts after the end of the sentence in prison), the court will assess the necessity of preventive detention during the prison sentence. For this assessment, the court must request a defence lawyer, if the person concerned does not have one.

Another issue is that in review proceedings, the person concerned may not be heard. In **Bulgaria**, neither the person concerned nor their lawyer are heard when the court rules *ex officio* on the continuation, replacement or termination of compulsory treatment in a court hearing, after mandatory consideration of the opinion of the relevant psychiatric facility and the conclusion of an expert psychiatrist.[218] In **Slovenia**, an interviewed lawyer mentioned that some of the judges treat these hearings as a matter of formality and that the person's statement is not really taken into account, and the only information that matters is the expert opinion. The court will acquire the report from the institution where the measure is being implemented, and the report will be sent to the detainee for them to read and comment on it. However, if the court concludes that a hearing is not necessary and the parties to the proceedings do not request one, the court will just issue a written decision regarding the extension of the measure.[219]

In **Lithuania**, the judge has the right to require attendance at the review hearings (occurring every six months), provided that, according to the opinion of the medical board, the nature of the health condition does not preclude the attendance.[220] In **Germany**, persons concerned usually participate in the review hearings. However, the research showed that their statements are usually used (twisted) to confirm the continuation of the custodial measure. Their statements may be interpreted as lack of taking responsibility for their actions.[221]

The research has revealed that very often, decisions in review proceedings are based almost exclusively on the expert opinions. For example, in **Austria**, with regard to security measures and preventive detention, the court has to consult a medical expert once every two years as part of the hearing regarding the conditional release.[222] However, in some cases, review decisions are based on the expert opinions from the criminal proceedings, which can date back years.[223] Very often only statements of internal experts (medical doctors at the hospital/forensic centre) are taken into account. The CPT, in its recent report, raised concerns about this practice, as involving external experts independent from the institution where the person is deprived of their liberty offers an important safeguard, particularly for persons who have already been detained for a long time. In some cases, years go by without "new" expert opinions being requested and taken into account.[224] In **Germany,** external expert witnesses are always requested regarding the continuation of preventive detention, whereas for the continuation of compulsory measures, this is not the case. Instead, internal experts are requested to provide their opinion on the situation and condition of the person concerned.

Also, in **Bulgaria**, the duration of stays in psychiatric hospitals for compulsory treatment are sometimes prolonged, for a lack of alternatives. If a person does not have a home, ties to social services or a social net in the community, getting released is very difficult. At the same time, reportedly, persons might be discharged too soon, before any improvement of their condition in the sense that their danger to society has diminished. A representative from **Bulgaria** has noted that security measures might last for a very long time, not because of the persisting danger the person concerned supposedly poses to society, but rather because of a lack of alternatives for care in the community.[225]

2.5.6. CONCLUSIONS AND RECOMMENDATIONS

The research examined the variety of paths that can lead to deprivation of liberty of persons with intellectual and/or psychosocial disabilities in the six partner countries. **All partner countries** allow deprivation of liberty of persons with intellectual and/or psychosocial disabilities in the criminal context based on perceived dangerousness linked to their disability. This is in violation of the principles enshrined in the UNCRPD, prohibiting deprivation of liberty on the basis of disability.

Depending on assessments of criminal legal capacity, dangerousness, and varying other legal, medical and practical considerations, persons concerned come under the purview of different regimes and facilities, which are embedded in complex systems and difficult to compare across countries: imprisonment (in 'ordinary' prisons), as well as detention in psychiatric hospitals, forensic psychiatric institutions, or special units in public hospitals for the purpose of compulsory treatment. The research found that involuntary/non-consensual committal to institutions is a legitimated practice in all countries. Deprivation of liberty of persons with intellectual and/or psychosocial disabilities often blurs the lines between medical concerns and security concerns. The research indeed showed that security concerns very often prevail and that the needs for support and care of the individual are not taken into account sufficiently.

In most partner countries, unlimited and indefinite deprivation of liberty of persons with intellectual and/or psychosocial disabilities is possible under some form of security measure. It is difficult to be discharged/released from a security measure and sometimes one compulsory measure is simply substituted by another.

General recommendations for deprivation of liberty of persons with intellectual and/or psychosocial disabilities

- Ensure that the basis for the deprivation of liberty is a measure of last resort, including in the context of pre-trial detention, and allowed only in compliance with international human rights standards in accordance with States' obligations.

- For all proceedings concerning persons with intellectual and/or psychosocial disabilities, establish a multidisciplinary approach in case management by social workers/service providers, psychiatrists/psychologists, relatives/close persons and judges with a view on providing the individual with the support needed and prepare for release into the community.

Recommendations on duration and review of deprivation of liberty of persons with intellectual and/or psychosocial disabilities

- Abolish the possibility of unlimited detention for persons with intellectual and/or psychosocial disabilities in accordance with the UNCRPD.

- Provide sufficient and effective remedies during the execution of the deprivation of liberty, including appeals and regular automatic reviews which include reviews specifically dedicated to the specific needs of the person concerned.

- Ensure adequate and suitable legal representation for persons with intellectual and/or psychosocial disabilities during execution of custodial measures (i.e., review proceedings, ad hoc complaints, etc.).

2.6. DEPRIVATION OF LIBERTY: TREATMENT

2.6.1. (MATERIAL) DETENTION CONDITIONS

The research revealed multiple concerns related to the conditions of detention for persons with intellectual and/or psychosocial disabilities during deprivation of liberty, including regarding treatment and material detention conditions that are not compliant with international standards. Grievances regarding standards of conditions of detention have been raised in all places of deprivation of liberty, including prisons, psychiatric hospitals and forensic centres. Of concern are, for example, infrastructure and unsanitary environments, as reported in **Italy** and **Bulgaria**, and mistreatment and verbal and physical abuse of detainees with intellectual and/or psychosocial disabilities by staff, as well as by other detainees (e.g., in prisons in **Lithuania** or psychiatric hospitals in **Bulgaria**).

Notwithstanding, conditions of detention in the partner countries vary significantly depending on whether the person was found criminally responsible and which kind of detention a person is subjected to: ordinary prison sentence, preventive detention, security measures, compulsory psychiatric treatment, etc.

There was a general consensus among experts and participants involved in the project that prison is not an adequate place for persons with mental health issues, and, in fact, the environment and regime of a prison often worsens existing mental health issues or causes the development of mental health challenges. The CPT is clearly in favour of a separation of institutions (i.e., prisons with prisoners to be separated from persons with intellectual and/or psychosocial disabilities who are in need of therapy and therapeutic measures). Contrary to this, the UNCRPD Committee follows the opinion that there should not be a separation, but instead, each individual should receive the care and support they need in the community with others in order to reduce and limit stigmatisation and isolation (see Section 1.2.).

2.6.2. (LACK OF) FACILITIES/ OPTIONS & OVERCROWDING

When it comes to the deprivation of liberty of persons with intellectual and/or psychosocial disabilities, a principal observation of the project has been the lack of suitable options for treatment facilities (in-patient, as well as out-patient) and insufficient capacities of these facilities. Although separate psychiatric facilities should not exist for persons with disabilities, according to the UNCRPD (see Section 1.2.3), experts have noted that faced with unsuitable environments in prison, such facilities may be preferable in some cases.

A lack of inpatient treatment facilities for persons with intellectual and/or psychosocial disabilities who have committed an offence – though their detention is contested within legal and international instruments – means that persons concerned are often confined in prisons without adequate support, treatment, and care. Indeed, there are some indications that a lack of capacity in psychiatric facilities may lead to an increased likelihood that people will be sent to prison (see discussions on "Penrose's law", which proposes the thesis that the size of the prison population is inversely related to the number of beds in psychiatric hospitals).[226]

In the absence of adequate accessible services in the community, experts have highlighted a need to adjust the capacity of (forensic) psychiatric institutions. In **Germany**, the majority of the forensic psychiatric hospitals are highly overcrowded with many persons concerned having to share a room with at least one other person, to the detriment of their privacy. Similarly, in **Austria**, many psychiatric hospitals or forensic departments of public hospitals are overpopulated, some even by up to 100%.[227] The **Austrian** NPM mentioned the negative influence of overcrowding on living conditions in forensic departments of public hospitals. Due to this overcrowding, patients share their rooms with up to six others.[228]

Similarly, insufficient capacity in mental health centres for inpatient treatment was noted in **Bulgaria** and in **Slovenia**, where only one such facility exists in the whole country: the forensic psychiatric unit of the University Clinical Centre Maribor.

In **Italy**, the REMS consistently exhibit very long waiting lists. According to Antigone's estimation, in 30% of cases, patients are detained in prisons as they are awaiting admission to a REMS facility. This can present a severe challenge as prisons may not offer a suitable environment or treatment for the person concerned, as has also been the subject in the ECtHR ruling in ***Sy v. Italy.***[229]

Interestingly, it was also noted that in **Italy**, as the system for detaining persons who are deemed not criminally responsible in psychiatric institutions has improved considerably (via the establishment of the REMS, see case study in Annex 4) and material conditions have become better, treatment and support for persons with mental health needs in "ordinary" prisons have deteriorated. On the other hand, representatives from **Bulgaria** have noted in the consultation workshops that prisons could be considered a better place for people with disabilities, compared to psychiatric institutions, because the material detention conditions in prison are better and prisoners are able to file complaints to a judge.

2.6.3. RESTRAINT AND DISCIPLINARY MEASURES

Persons who are deprived of their liberty may be subjected to measures of restraint. It has been noted by experts that persons with psychosocial and/ or intellectual disabilities are more often affected by security orders and disciplinary procedures. These may include inter alia solitary confinement in a special security cell, search of belongings, or the use of measures of (mechanical) restraint, such as cuffs or restraining jackets.

In **Austria**, the NPM has raised concern with regard to restraining practices; due to the lack of space and resources and single rooms in public hospitals, persons are being subjected to mechanical restraints (in the presence of other patients), suggesting a possible Art 3 ECHR (prohibition of torture) violation. The

NPM further witnessed that fixation straps were not removed after their requirement but instead stayed there to restrain the person during sleep. It also found that the documentation of restraint measures (including the use of fixation straps, isolation, etc.) was not complete or only vaguely referred to the danger for the person or others.[230] The CPT recently recommended keeping a register of measures such as fixation or isolation, as especially with regard to the prevention of inhuman treatment, meticulous documentation is of utmost importance.[231]

In **Bulgaria**, the CPT has highlighted that mechanical restraint continues illegally in social care institutions and in psychiatric hospitals, which does not conform with international guidelines and is often recorded fraudulently or not at all.[232]

In 2018, the **German** Federal Constitutional Court assumed that mechanical restraints as a special security measure to avert danger to self or others resulting from an underlying medical condition are permissible in principle under strict conditions. The court further found that it has to be closely linked to the psychiatric treatment of the underlying medical condition taking place in detention.[233]According to the guidelines of the court, physical restraint is an interference with the fundamental right to freedom of the person concerned. In order to ensure the protection of the person affected by a restraint involving deprivation of liberty, a reservation of a judicial order and a daily judicial on-call service is required. In response to this decision, the Court's regulations were applied to the prison system and it was therefore assumed that mechanical restraint was actually permissible in this context. However, this cannot be deduced at all, as the regulations refer to a medical context. CPT has been recommending for years that the measure of restraint be abolished, but above all that it not be used in a non-medical context.

In **Germany**, there is a comprehensive catalogue of disciplinary measures in prisons that can be imposed in a highly formalised procedure. In addition, there are similar measures that can be ordered as security measures but do not require a formalised procedure. These measures are used on the basis of self-harm or perceived danger to others and are regularly imposed on detainees who are perceived as disruptive, often including detainees with psychosocial and/or intellectual disabilities. This also applies to various forms of isolation, which can lead to severe deterioration in the person's condition if support is not provided.[234]

2.6.4. ISOLATION

One recurrent theme that has come up throughout the research both on national levels in the partner countries, as well as the regional consultations with regard to detention conditions, is isolation. In reality, according to experts, many persons with intellectual and/or psychosocial disabilities are confined in prisons or forensic psychiatric institutions without meaningful contact with other detained persons or the outside world. Isolation may be imposed for the protection of the person concerned, as a punishment or disciplinary measure or due to a lack of personnel and resources (see Section 2.6.6). For example, detainees who exhibit aggressive behaviour (to themselves or others) might be met with isolation measures, often in combination with fixation measures and medication, as reported in **Bulgaria**, **Lithuania** and **Germany**.

It was also reported that in **Austria**, persons subject to the security measures or preventive detention frequently experience loneliness and desperation, which had been exacerbated due to COVID-19 prevention and control measures implemented in the facilities. Based on a visit in 2021, the CPT has noted that in one forensic unit at a prison, patients were locked in their cells for extensive periods of time, with the "night lock-up" starting at noon on some days.[235] These conditions are often worse for persons in pre-trial detention where detainees may be locked in their cells for 23 hours per day, as has been reported in **Austria**, and even fewer services are available.

Similarly, in **Germany**, detainees in forensic psychiatric detention who are in isolation are

frequently prohibited from having contact with relatives on the outside, as well as with other detainees.[236] In the framework of the consultation workshops, it was reported from experts that in the **Czech Republic**, patients are not able to leave their cells and are not allowed to leave the premises or get fresh air while in forensic treatment.

2.6.5. PURPOSEFUL ACTIVITIES, PRIVACY AND PRIVILEGES

Isolation and loneliness might also be felt more viscerally in the absence of purposeful activities. Purposeful activities, such as work or recreation, can have a positive impact on detainees. In **Slovenia**, the NPM has recommended enhancing opportunities for work and meaningful activities for convicted prisoners.[237]

Surveillance in private rooms is another security measure which has raised concern, infringing on the detainees' privacy. In **Germany**, detainees in forensic psychiatric detention may be detained in rooms with camera surveillance without the possibility to blur the sanitary area for privacy.[238] Video surveillance in private rooms has also been observed in **Croatia** (purportedly for security reasons) and in some prisons in **Italy** in units for persons with mental disabilities, where, in addition, lights are on for 24 hours a day. Concern was voiced that the reasons for such surveillance are not primarily security-based but because it might ease demands on staff.

Detainees in psychiatric institutions may find themselves in similarly "total" institutions as prisons and are often prohibited from leaving the facility for special occasions, such as for family bereavement, as was reported in **Italy** and raised by an expert from **Romania** in a consultation workshop. Often, the assessment of dangerousness, which is a grounds for detention in a psychiatric institution, precludes any possibilities for temporary leave. However, conversely, successful leaves can serve to demonstrate that dangerousness is not exhibited anymore and the person concerned may qualify for a conditional release (see Section 2.7.3).

In **Germany**, compared to the prison system, forensic psychiatric detention offers more possibility for leaves and such measures that are part of the reintegration process toward the end of one's detention. Within the framework of leaves and similar measures, inpatient confinement is lifted, converted into ambulatory controls and finally removed.[239] Using a stage model, it is intended to be able to react to changes in individual behaviour. The stages can be categorised as follows: (i) reduction of inpatient controls with accompanying staff; (ii) reduction of institutional controls through the increase in informal control structures; and (iii) removal of formal controls with independent leaves without supervision. This system exists because detention in a psychiatric hospital is indefinite. Nevertheless, these leave measures do not exist in preventive detention and they can also lead to detention being prolonged, due to potentially long outpatient care.[240]

In **Slovenia**, the Forensic Psychiatry Unit in Maribor currently has a semi-open ward, where patients are included in the available (limited) rehabilitation activities (see the case study in Annex 6). The patients in this ward have supervised exits to the city and weekend exits.[241] In **Italy**, there is the option of granting leave from prisons during the day and going to work, returning to prison at night, but this option is not available to persons serving a form of security measure.

In **Austria**, the interruption of the security measure/preventive detention is often used (i.e., living in an extra mural facility for a trial period to assess the situation and condition of the persons).[242] The interruption may only be allowed if it is expected that the person will not commit further offences during the interruption and after 90 days, the extra-mural facility has to determine whether the interruption was successful, additional time is needed and conditional release is recommended. Research shows that this privilege has been used increasingly over the past years and has become an essential requirement for conditional release in many cases.[243]

2.6.6. LACK OF SPECIALISED STAFF

A prominent finding across all six partner countries and beyond has also been a lack of specialised staff – medical staff, psychologists, psychiatrists – in prisons as well as psychiatric institutions.

For example, in one detention facility in **Austria**, medical care was not available after 3:30 pm or on weekends. In another detention facility, three psychiatrists were available for a total of 22 hours per week for an estimated 800 detainees, more than 100 of which were in preventive detention.[244] Furthermore, experts in **Austria** have reported that prisons (and also special prison departments for persons with intellectual and/or psychosocial disabilities) do not have sufficient staff from the general health field and still primarily depend on prison staff (carrying weapons).[245] This was also confirmed by the latest CPT report in 2023.

The **Bulgarian** Ombudsman Institution, in its 2020 Annual report, noted that psychiatric hospitals exhibited insufficient numbers of doctors, nurses and paramedics, creating conditions for untimely and low-quality treatment of patients, as well as risk in terms of monitoring and care for patients with aggression and auto-aggression.[246]

In prisons, prison officers are usually not trained to interact with persons with intellectual and/or psychosocial disabilities and are not able to provide specialised care, also due to constraints in staff time and resources. In general, a shortage of people working in the forensic field and in social work and related fields has been reported in **Slovenia** and other countries. It was reported during the consultation workshops that in **Croatia**, to alleviate the lack of support for persons with disabilities in prisons, there are sometimes paid assistants, who are fellow detainees and assist them in their daily life.

In **Slovenia**, due to a shortage of psychiatrists in prisons, detainees often have to wait a long time to access psychiatric support, and it has been observed that in the evening and on weekends, the medicinal therapy, including psychiatric, is not distributed by medical staff, but prison guards.[247] On the other hand, some interviewed psychiatric experts reported positive experiences regarding availability and the quality of psychiatric care in prisons. They also mentioned that the assessment and referral mechanisms in place have led to significant decreases in suicide rates in **Slovenian** prisons in the last ten years.[248]

2.6.7. MONITORING, SAFEGUARDS AND HAVING A VOICE

Experts have highlighted that NPMs and monitoring bodies perform crucial tasks in monitoring places of deprivation of liberty, including where persons with intellectual and/or psychosocial disabilities are held. However, one challenge for NPMs that has been raised was the many inconsistencies in international standards, and a lack of guidance specifically for monitoring the deprivation of liberty of persons with intellectual and/or psychosocial disabilities.

Furthermore, NPM visits can be limited in time and scope, and their purpose is not to give a voice to individual experiences. Experts have raised the need to give detainees the opportunity to have their voice heard and share their experiences of detention and grievances beyond filing formal complaints. NGOs were suggested as potentially suitable to fill that role and to develop "living libraries" of persons with intellectual and/or psychosocial disabilities who experienced detention. External research can also describe situations and analyse perspectives of persons concerned, but access to institutions can be highly restricted.

Experts (including from **Austria**, **Bulgaria** and **Lithuania**) have noted that persons with intellectual and/or psychosocial disabilities – whether they are held in prison, but particularly if they are in a compulsory treatment regime – are often not aware of the possibility to file a complaint. If they are, individuals are often either not able to access support to file a complaint or they are discouraged from filing a complaint, as this might be perceived as non-compliance and draw negative repercussions (such as the administration of additional medication, as experts from **Slovenia** have noted).

2.6.8. TREATMENT

2.6.8.1. ADEQUACY OF TREATMENT

The research has revealed that adequate and evidence-based psychosocial and/or psychiatric treatment, based on free and informed consent, is rarely offered to detainees with intellectual and/or psychosocial disabilities, whether they are detained in an ordinary prison, special prison units or (forensic) psychiatric institutions. For detainees in pre-trial detention, such treatment is often non-existent.

Generally, when it comes to prisons, all partner countries follow some form of admission procedure that includes the medical assessment of any health needs, including a psychological assessment of mental health needs. However, most prisons do not offer sufficient psychiatric or psychotherapeutic services and there is a lack of qualified staff (see Section 2.6.6). A lack of continuous care and treatment options while serving a prison sentence can lead to a deterioration of health conditions and the isolation of the persons concerned. Individuals with intellectual and/or psychosocial disabilities may struggle to adapt to the prison environment and participate in programs. Research in **Germany** has shown that if a transfer to a psychiatric department, within or outside the correctional system, is not possible, detainees with intellectual and/or psychosocial disabilities who demonstrate specific needs may be moved to observation and/or highly secured cells, thus isolating them from other detainees. Particularly, individuals whose disability has not been diagnosed may be perceived as "troublemakers" and are more likely to face security and disciplinary measures, often being isolated. Due to a lack of alternatives, individuals with psychotic disorders, self-harm tendencies and suicidal thoughts may be housed in these conditions for months. However, their health condition usually does not improve with this type of isolated placement. The correctional system is often unable to provide the necessary medical and psychological treatment, close supervision and hygiene standards. Consequently, the persons concerned end up living in deplorable conditions, contributing significantly to the deterioration of their health. Furthermore, due to their health status, further measures such as privileges and releases are often discontinued.[249]

Although (forensic) psychiatric institutions embody the express purpose of providing treatment, the research has shown that the availability and quality of psychiatric treatment is lacking in many countries. In **Germany**, on average, only 30% of the detainees in preventive detention are in therapy, although the proportion of persons affected with mental health conditions requiring treatment is significantly higher at 79.3%.[250]

In **Austria**, multiple experts from different fields (including representatives of NPMs, lawyers, medical doctors and probation officers) have pointed out that persons who are subjected to preventive detention very often do not receive the necessary treatment and support they need. There have been multiple accounts of persons not receiving the treatment (particularly therapeutic treatment) they need for multiple months.[251]

A lack of adequate treatment is not simply problematic because it can lead to deterioration of a person's mental and physical wellbeing, but also because it can have repercussions on the length of detention. Successful treatment – and improvement of a person's condition – are often linked to conditional release prospects. In **Austria**, persons who are subjected to preventive detention are often detained in ordinary prisons (or specialised departments within ordinary prisons) that simply do not offer the treatment/therapy that is necessary, impacting the possibilities for conditional release – which is often dependent on a demonstration of active participation in therapeutic services and improvement of one's condition – and leading to overlong stays in preventive detention.[252]

A lack of adequate treatment is especially prevalent for persons in pre-trial detention, where services are generally even scarcer and there are generally no special regimes in place to ensure the provision of treatment and special medical care for persons with intellectual and/or psychosocial disabilities in ordinary

pre-trial detention facilities. In **Austria**, other facilities are available, but persons with intellectual and/or psychosocial disabilities usually do not receive the necessary treatment when serving pre-trial detention, whether they are deemed to possess criminal legal capacity and detained in (ordinary) pre-trial detention facilities or considered to be without criminal legal capacity and committed to a public hospital where they receive treatment primarily in the form of medication.[253]

Another finding throughout the research concerns the overuse of medication and pharmaceutical treatment in prisons as well as in psychiatric institutions. Calming and psychotropic medication may be dispensed at disproportionate levels in the absence of other treatment options (eg psychotherapy). For example, the CPT has stated during its 2020 visit to **Bulgaria** that treatment was predominantly pharmacotherapeutic.[254]

In **Italy**, the ***Sestante*** case has brought to the forefront routine administration of "abnormal and exaggerated doses" of psychotropic drugs in mental health units in prison.[255] This case concerns a young man named Sestante who exhibited severe psychiatric symptoms and was detained in the Turin prison in the ATSM section ***(Articolazioni per la tutela della salute mentale; special mental health units in prisons)***. In this special section for persons with intellectual and/or psychosocial disabilities, the detention conditions have been reported to be very poor, with crumbling and dirty environments and a total lack of meaningful human contact, total absence of activities, and frequent administration of psychotropic drugs. For example, the medical file of the man in question contained "abnormal and exaggerated doses" of psychotropic drugs, as one study found. There was no communication with the person with regard to his condition and the therapy administered. The light had been kept on at all times during the young man's ten months in that section. In the middle of winter, the young man found himself with a broken window, which meant he had to stay close to the radiator and in his dazed condition due to high doses of drugs, he acquired a burn on his back. The 'Sestante' Section (ATSM) of the Turin prison was later closed following an official complaint to the public prosecutor's office filed by Antigone.[256]

A significant problem that has been raised throughout the research is a lack of continuity of care. When detainees are transferred from one facility to another or moved from inpatient to outpatient treatment, or released, in most countries there are no adequate mechanisms in place to ensure that essential and confidential medical information, as well as other relevant information about the person concerned, is shared with service providers. For example in **Bulgaria**, there are databases recording psychiatric patients' information, but other medical institutions or facilities that these patients might be transferred to, would not have access to the database.[257]

2.6.8.2. CONSENT IN TREATMENT

Together with the availability and accessibility of appropriate treatment also comes the issue of non-consensual treatment, as was raised by the experts consulted in this project. This is of particular relevance, as the refusal of accepting medication is often interpreted as "non-compliance" and can consequently lead to a prolongation of detention. International standards, including the UNCRPD, require free and informed consent, including through supported decision making mechanisms, prior to any medical treatment, and the UNCRPD views involuntary treatment on the basis of disability as a violation of the right of persons with disabilities to be free from cruel, inhuman or degrading treatment.[258]

Experts have noted that it can be very difficult to ensure informed consent to treatment with regard to detainees with intellectual and/or psychosocial disabilities and not enough attention is paid to ensure that treatment is not coercive. A person might sign something without fully understanding the ramifications and the right to withdraw consent at any point and refuse treatment. In fact, involuntary treatment has been observed throughout all the partner countries. Especially in psychiatric facilities, consent for treatment is frequently not sought, and compulsory treatment is applied. This has been reported by experts from **Lithuania** and **Slovenia**.

During its 2020 visit to **Germany**, the CPT criticised the fact that the forcible administration of rapid-acting tranquillisers, also known as chemical restraint, was only documented as "emergency medication" and not as a restraint measure in patients' medical records.[259] In 2021, the Federal Constitutional Court imposed constraints on the coercive treatment of detainees in a psychiatric hospital. In Germany, the Federal Constitutional Court stated that the facility may not ignore the rejection of coercive medical treatment if this rejection was made in a state of mental capacity with a patient decree.[260] However, this is limited to coercive treatment designed to protect the person concerned. The state's obligation to protect the fundamental rights of other persons who come into contact with the person concerned and be at risk of harm remains unchanged. The patient's autonomous decision can only extend as far as their own rights are affected.

In **Austria**, if persons subjected to security measures or preventive detention refuse to participate in a medical examination/treatment which is absolutely necessary under the circumstances, they may be subjected to these measures by force, provided this does not involve a risk to life and is otherwise reasonable for them.[261] Unless there is imminent danger, the approval of the Ministry of Justice must be obtained before any compulsory examination or treatment is ordered. In practice, experts have raised concern that consent is not always obtained, and persons concerned are not properly informed of their medication. Approvals from the Ministry are sometimes simply obtained by phone, without further documentation. Experts have also raised concerns regarding the consequences of refusing to take medication, where persons are perceived as non-cooperative, which may negatively influence their annual review and chances of receiving privileges.[262]

Similarly, in **Germany**, treatment in forensic psychiatric detention, as in other hospitals, is based on a contract with the patient. Due to the special situation in forensic psychiatric detention, some measures go beyond this contract, such as compulsory medication, accommodation in certain residential groups or similar. Nevertheless, it should not be overlooked that this measure has a coercive context and often goes against the will of the persons concerned.[263] The persons concerned are also indirectly forced to cooperate, to participate in any treatment they are offered, and even talk about themselves and their offences the way they are expected to by the institution. Otherwise, they have no realistic chance of release. This was also expressed as a problem in **Austria**, where lack of consent or refusal to take medication without further information can be seen as opposition and reluctance to cooperate and accept responsibility.[264] Due to the fusion of treatment and control and the constantly perceived dangerousness of the person concerned, treatment evolves into "total therapy".[265] All activities in the hospital are characterised by the therapeutic mission. However, a concept of treatment that encompasses all measures makes it impossible to separate specific measures of security and order and the provision of a dignified quality of life. In other words, the boundaries between therapy, care and discipline become blurred.[266]

In **Italy**, compulsory medical treatment is only possible in specialised health facilities and not in prison. Theoretically, and generally in practice, if compulsory treatment of a detainee is considered necessary, the person has to be transferred to one of these facilities.

2.6.9. CONCLUSIONS AND RECOMMENDATIONS

The research revealed multiple concerns related to the treatment of persons with intellectual and/or psychosocial disabilities in all places of deprivation of liberty, including prisons, (forensic) psychiatric hospitals, preventive detention and other institutions for compulsory treatment.

Although separate psychiatric facilities should not exist for persons with disabilities, according to the UNCRPD (see Section 1.2.3), experts have noted that faced with unsuitable environments in prison, such facilities may be preferable in some cases. Considering the rather poor conditions and treatment options in prisons and psychiatric facilities

as they are now, determinations on which option is the least damaging to detainees are difficult to render, and decisions might best be made on an individual and case-by-case basis, depending on the needs of the person concerned and the available options in a particular country or region.

In many places of detention in the six partner countries, material detention conditions and overcrowding of facilities, as well as a lack of specialised staff (medical staff, psychologists, psychiatrists) negatively impact the availability and quality of treatment. In addition, the research has found practices with regard to isolation, restraint measures, overuse of medication and non-consensual treatment are not compliant with international standards.

The following recommendations apply to all facilities where persons with intellectual and/or psychosocials disabilities are deprived of liberty, including prisons, (forensic) psychiatric hospitals and other institutions for compulsory treatment.

Conditions of detention for persons with intellectual and/or psychosocial disabilities

- Ensure that conditions of detention are adapted to the specific needs of persons with intellectual and/or psychosocial disabilities and, generally, are in line with international human rights standards, in particular with the UNCRPD.
- Take measures to decongest overcrowded facilities, where possible, through the application of non-custodial measures and outpatient treatment, which are tailored to the specific needs of persons with intellectual and/or psychosocial disabilities.
- Ensure that adequate support and accommodations (physical, informational, attitudinal, medical, and other) are available and accessible in all facilities where persons with intellectual and/or psychosocial disabilities are detained.
- Facilitate cooperation with CSOs and other extramural services to ensure that detainees with intellectual and/or psychosocial disabilities have access to social and legal support, treatment and care.
- Abolish the use of solitary confinement, seclusion, isolation, which may amount to torture or cruel, inhuman or degrading treatment or punishment. Isolation should never be used as a punishment and must be limited to the shortest period possible.
- Limit the application of restraint measures, in line with international human rights standards, and, when unavoidable, ensure adequate documentation of any use of restraining measures.
- Ensure the availability and accessibility of suitable purposeful activities for detainees with intellectual and/or psychosocial disabilities with a view to facilitating social reintegration.
- Ensure the availability of privileges and relaxations of the regime to provide opportunities in order to prepare persons for their release with a view to facilitating social reintegration.
- Ensure adequate numbers of specialised staff (medical staff, psychologists, psychiatrists) in all facilities that detain persons with intellectual and/or psychosocial disabilities, as well as mandatory training for prison staff and other institutional staff interacting with persons with intellectual and/or psychosocial disabilities deprived of liberty.
- Ensure cooperation with international and national monitoring bodies to facilitate oversight and work towards a harmonisation of standards for persons with intellectual and/or psychosocial disabilities.
- Provide detainees with intellectual and/or psychosocial disabilities with the opportunity to share their experiences (e.g., by developing a “living library”, where they can report and write about personal experiences during their deprivation of liberty, if they are able to).

Treatment of defendants and detainees with intellectual and/or psychosocial disabilities

- Provide sufficient staffing, resources and capacity of inpatient and outpatient medical and mental health care services in order to ensure compliance with international human rights standards for defendants and detainees with intellectual and/or psychosocial disabilities.

- Guarantee comprehensive medical assessment upon admission to a custodial facility and ensure that medically relevant information is shared between healthcare providers in the community and in custodial settings on a need-to-know basis to facilitate continuity of care.

- Ensure early and adequate treatment, where needed, including in pre-trial detention. Upon admission, where needed, develop a therapy plan jointly with the person concerned and ensure that treatment is available, accessible and can be commenced as soon as possible.

- Ensure that detainees with intellectual and/or psychosocial disabilities are continuously informed of their treatment, medication, condition, etc. in a comprehensible manner and ensure that their understanding is genuine and informed.

- Maintain adequate updated and accessible records on any non-consensual treatment to ensure effective remedies and access to justice for the person concerned. Ensure that these cases are also discussed with the person concerned in hindsight to ensure full understanding and transparency.

- Define clear legal requirements to offer therapeutic measures to the person concerned, especially of a kind that is not only related to recidivism prevention but also (other) psychosocial needs of the person.

- Amend legislation, where appropriate, to bring prison healthcare under the auspices of ministries of health instead of ministries of justice to ensure treatment and conditions of detention are adapted to the specific therapeutic needs of persons with intellectual and/or psychosocial disabilities.

- Ensure that all health and medical professionals (including psychiatric professionals) obtain the free and informed consent of persons with intellectual and/or psychosocial disabilities, if needed, through supported decision making mechanisms prior to any treatment; ensure there is a possibility to withdraw consent.

2.7. ALTERNATIVES AND PROBATION

2.7.1. PREVENTION AND DIVERSION

International standards prescribe that deprivation of liberty should be a measure of last resort (see Section 1.2). Generally, there has been a broad consensus throughout the project, where experts from all types of professional backgrounds were consulted, that a shift towards prevention is necessary.

Experts in the consultation workshops have called for strengthening measures that prevent a person with intellectual and/or psychosocial disabilities from going through criminal proceedings, such as community-based services and social support structures. Such measures should be low-threshold, comprehensive and high-coverage services, and should serve persons with intellectual and/or psychosocial disabilities in the community before and regardless of any criminal offence committed. For example, according to the Bulgarian Ombudsman, in **Bulgaria**, psychiatric hospitals have patients (e.g. homeless persons) who live there permanently due to a lack of sufficient residential social services for people with intellectual and/or psychosocial disabilities.[267]

When persons with intellectual and/or psychosocial disabilities are the subject of criminal proceedings, the judiciary should consider options that would either dismiss the charges completely or not bring any charges to begin with, in favour of diversion measures. For example, in **Germany**, the prosecutor has the discretion to pursue diversion without further reaction, meaning the prosecution

can be discontinued if the person's guilt is considered minimal and there is no public interest in prosecution.[268]

An expert from the field of psychiatry also reported that in **Ireland**, judges have the discretion to refrain from conviction and discontinue the proceedings and instead, the defendant donates a designated amount of money to a so-called "Poor Box", representing a donation to a charity chosen by the judge.[269] Similarly, in **Germany**, in case of a less serious criminal offence, the public prosecution office, with consent of the person concerned and the court, may dispense with the public charges and issue measures if the degree of guilt does not present an obstacle and the measures can eliminate the public interest in criminal prosecution.[270]

In general, in several countries, there are options for judges/prosecutors to discontinue a criminal case concerning a person with intellectual and/or psychosocial disabilities if they deem that the offence is not grave enough or the person's disability does not reach a threshold of severity. However, these decisions do not necessarily constitute diversion. Diversion is an alternative procedure in a criminal case where the prosecution is interrupted through a deal between the defendant and the prosecutor where the prosecutor either dismisses the charges completely or does not bring any charges to begin with.[271]

Experts from different countries stated that prisons constitute a "revolving door" for many persons and diversion is a key issue when it comes to persons with intellectual and/or psychosocial disabilities in the criminal justice context. These persons have fallen through the "safety net" of their social circle, families, general healthcare and community-based treatment and support providers. The concept of "revolving door" often includes persons concerned being subjected to treatment for short periods (including very often only medication, rather than other forms of treatment) and being released with no additional support or guidance. Often, the situation is aggravated by other factors, such as homelessness, lack of social ties and other means of support. This lack of resources and support within society (and general healthcare system) in many cases leads to persons with intellectual and/or psychosocial disabilities ending up in the criminal justice system for minor offences – the criminal justice system being the only system that "cannot refuse" a person due to lack of resources.

Instead of pursuing criminal proceedings, "you have to get people around a table and find a tailor-made solution" (as one participant at the regional consultation workshop argued). This should be a multidisciplinary approach and, crucially, involve the person concerned and reflect their views. One suggestion that has been mentioned is the implementation of small-scale, residential, tailored options in the community.

In **Austria**, where pre-trial custodial measures may be applicable at the pre-trial stage, the law dictates a subsidiarity of deprivation of liberty vis-à-vis non-custodial measures/ extramural care and treatment. Pre-trial custodial measures must not be ordered (or continued) if the aims can also be achieved by having the affected person treated and cared for without being subjected to a preventive custodial measure.[272] In this case, the court has the possibility to refrain from the pre-trial custodial measure. Before doing so, the court may involve the head of the probation services and request them to organise a social net conference (see case study in Annex 1).

2.7.2. ALTERNATIVES TO DEPRIVATION OF LIBERTY

Generally, the national research showed a lack of regulations and legislation on the topic of alternatives to deprivation of liberty for persons with intellectual and/or psychosocial disabilities. This leads to inconsistencies in courts' decisions, and although it may leave courts with the possibility to impose tailored sentences, it can also lead to unchecked arbitrariness and fragmented standards. The research revealed that when legislations on non-custodial measures are available, they rarely provide for the specific situation of sentencing a person with intellectual and/or psychosocial disabilities, which leads to un-

suited decisions from judges concerning how and where the accused needs to undergo criminal punishment, or if such punishment is lawful at all. Especially as it regards pre-trial detention, there are few alternatives for people with intellectual and/or psychosocial disabilities.

Experts from **all partner countries** have lamented that there exists too little awareness among judges, prosecutors, lawyers and social workers with regard to available options for non-custodial measures – where they are available. This issue is also linked to the lack of training of judges, prosecutors, police officers, lawyers and probation officers when dealing with a person with intellectual and/or psychosocial disabilities, as well as a lack of resources. Some experts participating in the workshops have recommended that databases with civil society organisations and facilities that can provide various services could be useful. One option could be to implement a centralised system containing data on available residential care facilities (extra-mural and after-care), therapeutic services, lists of psychologists/psychiatrists, probation services, etc. This would help all actors involved in supporting the individuals to find their way back and prepare an individual package, and it would help courts in ordering alternative measures, as they would have a better overview of the available resources.

Non-custodial measures can constitute an important part in the reintegration process. However, while non-custodial measures and sanctions exist in **all partner countries**, these options are either not sufficient or diverse enough, or not available and tailored to persons with intellectual and/or psychosocial disabilities. They also might not constitute viable options for persons with specific needs. Probation is also not automatically proposed, and even if it is chosen by the court as a sentence, it is rarely adapted to the specific needs of the person with a mental disability. For example, in **Italy**, there exists an alternative to the criminal trial called "messa alla prova" or probation, which is widely used. Individuals accused of offences that carry a maximum sentence of six years can apply for it. The program entails a detailed plan and a set of activities, including community work, and its successful completion results in the extinguishment of the offence. However, there are no special provisions for defendants with intellectual and/or psychosocial disabilities. Probation officers from various countries have shared that they seldom work with persons with intellectual and/or psychosocial disabilities and in such cases, there are no tailored programmes available. A challenge for probation officers is that the available programmes often do not take into account persons with disabilities and/or substance use disorders. The research shows that this category of probationers will show lower success rates in terms of rehabilitation, which is directly linked to the unsuitability of said measures.

Moreover, the alternatives made available for detainees with intellectual and/or psychosocial disabilities are often actually measures depriving them of liberty, including for instance, home detention, closed wards or general inpatient treatment. There is a general lack of “true” alternatives which genuinely focus on the importance of rehabilitation and reinsertion into society (e.g. therapeutic community). Alternatives also require infrastructures, facilities, and professionals which are often missing. It was reported that many defendants needed to wait for months, even years, to be provided an alternative to detention in a specialised facility. Occasionally, some detainees remain in prison just because of the lack of available structures.

Furthermore, such non-custodial measures may only be applicable as an alternative to serving a prison sentence, and not as an alternative to a form of custodial measure or preventive detention. For example, electronic monitoring with home detention is theoretically an option in some countries as an alternative to imprisonment (mostly towards the end of one’s sentence) but not as an alternative to a security measure for detainees who have been determined to be not criminally responsible. In **Austria**, there are several non-custodial measures that are self-standing sanctions: diversion,[273] monetary penalties and the electronic monitoring anklet. However, these non-custodial

measures are usually not available to the preventive measures system (including security measures and preventive detention).[274]

On the other hand, there are various non-custodial measures that may be ordered by the court, in combination with a conditional suspension of the measures. These include, among others, the order to live at a certain residence with a specific family or in a specific home/facility; to undergo another form of outpatient care or to receive care in a daily structure; additionally, the court may order specific treatment measures (including psychotherapeutic or medical treatment), which requires the consent of the person concerned.[275] The **Austrian** law provides, however, that the court must examine whether it can refrain from the execution of a security measure or preventive detention because the dangerousness can be countered with other measures.[276] As a rule, probation services should also be ordered unless they are exceptionally dispensable.[277]

Similarly, in **Germany**, when ordering compulsory treatment in a forensic psychiatric institution, the court may suspend the deprivation of liberty and order probation measures if the aim of the forensic psychiatric treatment can be achieved without deprivation of liberty.[278] In this case, an intensive form of offender supervision of conduct will be in place (***Führungsaufsicht***).

Probation might not necessarily function as an alternative to deprivation of liberty (replacing confinement in an institution), inasmuch as it can actually prolong the period that a person spends under the net of criminal justice sanctions. For example, in **Italy**, persons may be sentenced to the REMS for no longer than the maximum sentence for the offence committed. However, once discharged from the REMS, in 56% of cases the measure is transformed into probation.[279] It has been noted by experts, however, that in some cases, the aftercare provided through probation services might be a beneficial form of continuity of care, in the absence of which persons may struggle to adapt to community living.

Several countries provide for non-custodial measures – either linked to discontinuing the criminal proceedings or as a part of conditional release or probation – that consist of the obligation to participate in a form of therapy (e.g., psychotherapy) or undergoing outpatient treatment at a healthcare institution in the community or open wards (e.g., in **Czech Republic** and **Germany**). For example, in **Italy**, data suggests that about 80% of probation prescriptions require residence in a therapeutic or rehabilitative community.[280] It is important to mention that while outpatient compulsory treatment is generally preferable to inpatient compulsory treatment, it constitutes a security measure nevertheless. It should also be noted that in countries where outpatient care is available, there is often inadequate geographical coverage, with services being available primarily in urban areas. The punitive nature of outpatient compulsory treatment is especially of concern in **Italy**, where there exists no maximum duration for probation, meaning a person who is ordered into probation in a therapeutic community (as an alternative to being sentenced to prison or the REMS) could, in theory, be under probation indefinitely.[281]

With regard to non-custodial measures that could be imposed on persons with intellectual and/or psychosocial disabilities who have been convicted of a criminal offence, options that are already in place in some countries for certain groups might prove suitable. While innovative solutions are needed, adapting some practices that are already in place could be a pragmatic option in some cases.

For example, in **Austria**, social net conferences, originally introduced as an alternative to custody for juveniles, can now also be applied for adults. The social net conference is a specific program that brings together members of the social environment of the person concerned (in the context of criminal proceedings) as well as other relevant actors (e.g., representatives of extramural facilities) with the aim of developing a binding future plan for the person concerned in order to avoid deprivation of liberty (by way of conditionally suspending the custodial measure or conditional release). (See case study in Annex 1)

2.7.3. RELEASE

The research has revealed that, in all partner countries, persons with intellectual and/or psychosocial disabilities are frequently not assisted or offered services after their sentences reach an end. Furthermore, in prisons, programmes aimed at facilitating reintegration after release that may be available to some detainees who are nearing the end of their sentences, are often unsuited to the needs of persons with intellectual and/or psychosocial disabilities, or entirely unavailable to them. It was reported that such persons have a higher chance of not being taken care of by their families, of ending up unemployed or even homeless. Experts have reported that it is very difficult for persons with intellectual and/or psychosocial disabilities to leave prisons or other institutions where security measures are carried out. The reason is that in order to be granted (conditional) release, there must be a plan in place as to where the person can go afterwards. A lack of social support system or a lack of adequate housing options in the community can negatively impact release prospects. Generally, the research has not revealed many promising practices with regard to post-release services for persons with intellectual and/or psychosocial disabilities.

Halfway Houses, such as in Lithuania, have been cited as potentially promising (see case study in Annex 5). Half-way houses in Lithuania aim to ensure the continuity of the social rehabilitation of detainees, facilitate their employment activities (i.e., work, education, studies), as well as the intensive preparation for their release on parole. Although Halfway Houses are not exclusively for persons with intellectual and/or psychosocial disabilities (around 3% of all detainees serve their sentence in a half-way house), they are considered to be beneficial for them for several reasons: half-way houses have small communities of detainees and the number of staff is higher than in other detention facilities; and half-way houses provide a wide range of social and community activities and the opportunity to strengthen relationships with relatives and loved ones, as detainees are able to go home on leave for up to two days a week.

However, such placements are temporary solutions, with the goal of leading to independent living in the community and may not be suitable for some persons with intellectual and/or psychosocial disabilities who are not able to live independently. Similarly, in **Germany**, there exist some forensic residential groups used as aftercare facilities with follow-up socio-therapeutic rehabilitation measures for detainees in forensic hospitals. They provide a living space for persons concerned and support them in developing independence. The move-in can already begin during the ongoing detention in the clinic as a form of trial housing. The duration of the stay usually depends on factors such as supervision of the person's conduct, supervision orders and the person's stage of development.[282]

It has been mentioned – in **Austria, Bulgaria, Italy, Slovenia**, as well as other countries – that one of the major challenges is an ongoing reluctance to (conditionally) release persons from security measures. One of the main reasons is the (fear of) "public denunciation and critique" in cases of recidivism of persons with intellectual and/or psychosocial disabilities who are released.[283] In **Italy**, persons are rarely released from the REMS directly into the community; most released persons come under other supervision measures instead, often for a long time (see the case study in Annex 4). This challenge also pertains to the aforementioned forensic residential groups in **Germany**. Cooperation between the hospital and these facilities is often complicated because there are doubts concerning the detainees and the control measures in place after their release. Socio-therapeutic institutions, residential homes, residential groups, as well as outpatient doctors, psychotherapists and social workers often refuse to accept (former) detainees because of their offences. However, if persons concerned do not find follow-up accommodation or have their own flat, their detention can be prolonged or they have to rely on homeless shelters.[284]

Another issue that has been noted is that in **Austria**, detainees serving a "regular" prison sentence are habitually granted conditional release after serving two-thirds of their sentence.[285]

This option is not available to detainees in the preventive measures system, who might be detained indefinitely. Experts have recommended that conditional release should be a possibility for people serving preventive detention or preventive custodial measures, as a 'built-in' feature of the system.

Another difficulty relates to the issue that the possibility of release might be tied to an "improvement" or "recovery" of the person's condition and – related to that – their (continued) dangerousness. Naturally, with some disabilities, such as intellectual disabilities, no "cure" can be expected, even after serving compulsory treatment in a psychiatric facility. In **Austria**, as in other countries, whether a non-custodial measure is deemed suitable often depends on the assessed level of 'dangerousness' that a person presents. This is despite an absence of evidence that dangerousness can be assessed accurately and that such assessments can predict further offending. In **Austria**, there are indications that recidivism rates of persons who were in preventive detention are rather low.[286]

2.7.4 CONCLUSIONS AND RECOMMENDATIONS

The research has revealed several issues and shortcomings regarding alternatives and probation vis-à-vis defendants and detainees with intellectual and/or psychosocial disabilities and a stagnating and unsuited legal framework. In most countries, once a person with intellectual and/or psychosocial disabilities has been convicted of a criminal offence, deprivation of liberty is the default. As a consequence of unsuitable legislation and rules, persons with psychosocial and/ intellectual disabilities are often given lengthy prison sentences instead of being granted an alternative measure. Experts have argued that non-custodial measures, which are often considered 'alternatives', should become a real option rather than a divergence from the default.

In terms of post-release support, the research has found that there is a lack of tailored services for persons with intellectual and/or psychosocial disabilities to help with their reintegration after release. When services are available for detainees in prisons, they may not be suited to persons with intellectual and/or psychosocial disabilities, and for persons being discharged after being subjected to a security measure or compulsory treatment measure, no such services may be available. Also, a lack of social support system or a lack of adequate housing options in the community can negatively impact release prospects.

Recommendations on alternatives to deprivation of liberty of persons with intellectual and/or psychosocial disabilities

- Strengthen prevention efforts in the community and the general healthcare systems through enhanced social support structures and low threshold (mental) health services for persons with intellectual and/or psychosocial disabilities to prevent them from "ending up" in the criminal justice systems.

- Strengthen the use of diversion measures for persons with intellectual and/or psychosocial disability who come into contact with the criminal justice system.

- Establish mechanisms to strengthen cooperation between courts and social services to identify the social conditions of a defendant, such as family conditions, social net, employment, etc. For all cases concerning persons with intellectual and/or psychosocial disabilities, establish a multidisciplinary approach in case management for social workers/service providers, psychiatrists/psychologists, relatives/close persons and judges.

- Create centralised systems collecting information on existing facilities and services for treatment, care and implementation of non-custodial services for persons with intellectual and/or psychosocial disabilities in a country or state, while also respecting the right to privacy and medical confidentiality. This could serve to provide a better overview and raise awareness on available resources, including outpatient treatment options to support courts in ordering alternative measures.

- Increase the number and available forms of outpatient treatment (including the opportunity for the person concerned to be free during the day for community activities and to visit the facility only to have dinner, sleep, take medication, etc.) to allow for a smooth transition into community living.

- Develop new forms of services, specifically aimed to support the community living of persons with intellectual and/or psychosocial disabilities.

- Consider therapeutic community approaches and open forensic psychiatry units for the implementation of security measures of compulsory psychiatric treatment and confinement in a medical institution.

Recommendations on release and rehabilitation of persons with intellectual and/or psychosocial disabilities

- Ensure the availability and accessibility of adequate evidence-based and tailored rehabilitation services for detainees with intellectual and/or psychosocial disabilities; services should involve a multidisciplinary approach.

- Strengthen conditional release mechanisms to facilitate the rehabilitation and the reintegration of persons with intellectual and/or psychosocial disabilities into the community.

- Strengthen post-release and post-discharge options and ensure availability of necessary aftercare services (including half-way houses, as well as services provided by social service providers, probation services, CSOs, etc.), providing support for the person with intellectual and/or psychosocial disabilities upon release. Ensure the involvement of the social net of the person concerned.

- Ensure continuity of care through the sharing of treatment and other records with service providers in the community, on an as-needed basis and with the consent of the person concerned.

PART 2

DEFENDANTS AND DETAINEES WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES IN EU CROSS-BORDER PROCEEDINGS

03. OVERVIEW ON EU CROSS-BORDER PROCEEDINGS AND FUNDAMENTAL RIGHTS

In the European Union, one of the most basic principles applicable among the Member States is that of mutual trust as enshrined in the Treaty of the European Union (TEU) Art 4 (2) and (3).[287] This principle was interpreted by the Court of Justice of the European Union (CJEU) as requiring, ***"save in exceptional circumstances, to consider all the other Member States to be complying with EU law and particularly with the fundamental rights recognised by EU law."***[288] The TEU also provides for the recognition of the Charter of Fundamental Rights of the European Union (CFR or "Charter") as having the same legal status as the Treaties.[289] Thus, both the principle of mutual trust and the need for fundamental rights respect apply in the context of the EU's legislative instruments, including the Framework Decisions.

Concerning the topic of cross-border proceedings, four Framework Decisions are of relevance in the context of this project: the European Arrest Warrant (2002/584/JHA),[290] the Transfer of Prisoners (2008/909/JHA),[291] the European Supervision Order (2009/829/JHA)[292] and the Probation Measures and Alternative Sanctions (2008/947/JHA).[293] Art 1 of the European Arrest Warrant (EAW FD), of the Transfer of Prisoners (TP FD), of Probation Measures and Alternative Sanctions (PAS FD) and Art 5 of the European Supervision Order (ESO FD) consist of a common provision expressly providing for the obligation for the instruments to ***"respect fundamental rights and fundamental legal principles as enshrined in Art 6 of the Treaty on European Union."***[294] This obligation is strengthened by Recitals, including one common Recital, which stresses the necessity to respect fundamental rights, to follow the principle of mutual trust and also take into consideration the specific cases of persons with intellectual and/or psychosocial disabilities.[295]

The EU fundamental rights framework, in the context of cross-border proceedings, relies on several international provisions. First, as mentioned above, it includes Art 6 of the TEU, which states that ***"the Union recognises the rights, freedoms and principles set out in the Charter of Fundamental Rights of the European Union (…) which shall have the same legal value as the Treaties. (…) The rights, freedoms and principles in the Charter shall be interpreted in accordance with the general provisions in Title VII of the Charter (…). Fundamental rights, as guaranteed by the European Convention for the Protection of Human Rights and Fundamental Freedoms and as they result from the constitutional traditions common to the Member States, shall constitute general principles of the Union's law."***[296]

Second, and as indicated in Art 6 TEU, the fundamental rights framework of the EU includes the CFR. Under Art 52, the Charter indicates that ***"in so far as this Charter contains rights which correspond to rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms, the meaning and scope of those rights shall be the same as those laid down by the said Convention. This provision shall not prevent Union law providing more extensive protection. (…)".***[297] ***Art 53 of the Charter states that "nothing in this Charter shall be interpreted as restricting or adversely affecting human rights and fundamental freedoms as recognised, in their respective fields of application, by Union law and international law and by international agreements to which the Union or all the Member States are party (…)".***[298]

Finally, and following the wording of Art 53, the EU is a party to the UNCRPD, together with all the Member States, which means that the treaty is part of the fundamental rights framework. The CJEU has adjudicated on a case involving an individual with a mental disability, confirming the application of the

UNCRPD in EU jurisdictions by following the Convention's definition of "disability", stating it was ***"a condition caused by an illness medically diagnosed as curable or incurable where that illness entails a limitation which results in particular from physical, mental or psychological impairments which in interaction with various barriers may hinder the full and effective participation of the person concerned in professional life on an equal basis with other workers, and the limitation is a long-term one."*** [299] The obligation to respect the rights of persons with disabilities is further strengthened by Art 21 of the Charter, which focuses on non-discrimination. It states that ***"any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited."***[300] Following the UNCRPD provisions, the term "disability" is defined as ***"long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder (the) full and effective participation (of persons) in society on an equal basis with others."***[301]

Art 53 of the Charter also provides for the minimal level of protection provided vis-à-vis EU law, stating notably that the Charter cannot be interpreted as ***"restricting or adversely affecting human rights and fundamental freedoms as recognized (…) by the European Convention for the Protection of Human Rights and Fundamental Freedoms."***[302] The jurisprudence of the ECtHR represents the lowest threshold for protection and has been relied on by the CJEU in cases involving cross-border proceedings.

The EU fundamental rights framework thus relies on different international instruments, which were interpreted in the context of several CJEU judgements. The most relevant caselaw developed in the context of cross-border proceedings in relation to fundamental rights was ***Aranyosi and Căldăraru***[303] (and later ***ML***[304] and ***Dorobantu,***[305] among others). They all involve the use of the EAW FD, as no cases could be identified that relied on the TP, ESO and PAS FDs and fundamental rights. In ***Aranyosi and Căldăraru***, the Court stated that, if there is a real risk that a specific fundamental right of the requested person will be violated by surrendering him or her to the issuing State, the national court of the executing State should refuse to do so.[306] When doing so, the Court expressly stressed that such decision constituted an exceptional derogation to the principle of mutual trust between Member States.[307] In the judgement, the Court created a two-step approach to guide national jurisdictions. At the outset, it must be established that there are systemic and generalised deficiencies in the state of the issuing authority (step 1); and that there are good grounds to believe that the specific person that is subject to the European Arrest Warrant will indeed suffer a breach of the a fundamental right (step 2). The CJEU later indicated that, in order to apply the two-step approach, the first step needs to be confirmed before the instance can demonstrate the second.[308] If both steps are completed, the executing authority may refuse to surrender the individual under Art 1(3) EAW.

Art 8 EAW FD lays out the information to be transmitted by the issuing state to the executing state in the context of the EAW.[309] However, such a list does not include specific guarantees for the transfer of arrested individuals who suffer from intellectual and/or psychosocial disabilities. Based on the principle of mutual trust, states should rely on the presumption of good treatment. However, the EAW FD provides for the ad hoc possibility of the executing state to request additional information to the issuing state if the former finds it insufficient to allow the surrender.[310]

In the cases of ***Aranyosi and Căldăraru***, ***Dorobantu*** and ***E.D.L.,***[311] the fundamental right not to be subjected to inhuman or degrading treatment, as found in Art 4 of the Charter, had been violated. The cases relied also on the European Convention on Human Rights provisions, under Art 3 (prohibition of torture) and Art 15 (derogation in time of emergency), as well as on ECtHR jurisprudence. Read in combination with Art 23(4) of the EAW Framework Decision, which stipulates that ***"the surrender may exceptionally be temporarily postponed for serious humanitarian reasons, for example if there are substantial grounds for believing that it would manifestly endanger the***

requested person's life or health,"[312] these cases demonstrate the central role of the right not to be subjected to inhuman and degrading treatment in EAW proceedings. Indeed, out of the two fundamental rights which have been relied on by the Court to accept the refusal for the executing state to surrender an arrested individual, Art 4 is the most used.

In the cases of ***LM***[313] and ***Lluís Puig Gordi,***[314] the fundamental right of having access to a tribunal established by law, as found in Art 47 of the Charter, had been recognised by the Court as having been violated, adding the right to a fair trial to the right not to be subjected to torture. The cases also relied on Art 6 (right to fair trial) of the ECHR and on associated ECtHR jurisprudence. The ***Lluís Puig Gordi*** case added the necessity for the first step of the test from ***Aranyosi and Căldăraru*** to be fulfilled before finding whether the second step was met.[315] The right to a fair trial and, more accurately, the right to be tried by a tribunal established by law, is thus the second fundamental right that the Court relied on to accept an executing state's refusal to surrender an arrested individual after the right to not be subjected to inhuman and degrading treatment. As of today, and despite subsequent cases and preliminary references having been brought in front of the Court (which could have allowed for more fundamental rights to be accepted in the context of Art 23(4) EAW FD), only Art 4 and Art 47 of the Charter were used.

Most recently, the CJEU issued a preliminary ruling[316] (E.D.L.) related to the fundamental right not to be subjected to inhuman or degrading treatment, as well as the right to health in the context of EAW proceedings. However, the right to health as evoked by the Court, was not that from the Charter (Art 35) and thus constituting a fundamental right, but instead was found in Art 23(4) of the EAW FD.[317] The Court also did not consider the right to integrity (Art 3 of the Charter) as having been violated despite its inclusion in the preliminary referral addressed to Luxembourg.[318] This ruling shows the Court's conservative approach to Art 1(3) and Art 23(4) of the EAW FD, presenting the refusal to surrender an arrested individual as a necessarily rare exception to the principle of mutual trust between Member States.[319] An in depth analysis of the E.D.L. ruling will be presented in Section 3.1.1.

3.1 EUROPEAN ARREST WARRANT

3.1.1 EAW AND FUNDAMENTAL RIGHTS

The EAW FD or FD 2002/584/JHA is a simplified cross-border judicial surrender procedure with the aim of replacing previous lengthy extradition tools. Adopted in the aftermath of the 2001 9/11 attacks amid concerns that existing extradition laws were too cumbersome to effectively tackle serious cross-border crimes, the European Arrest Warrant (EAW) is regarded as the flagship EU judicial cooperation measure.

However, the EAW may have severe implications for persons concerned. For example, the EAW involves the arrest and surrender of a person for the purpose of standing trial or to serve a sentence in a country other than where the person is located. This typically involves detention in the country of arrest, as well as where the person is surrendered to. Because of the long distance in a cross-border setting, people face separation from their families, potential job loss, and may be sent to a country where they have no social ties, support system or do not even speak the language.[320]

The EAW FD contains a number of references to fundamental rights in its text. These include Recital (10): ***"The mechanism of the European arrest warrant is based on a high level of confidence between Member States. Its implementation may be suspended only in the event of a serious and persistent breach by one of the Member States of the principles set out in Article 6(1) of the Treaty on European Union, determined by the Council pursuant to Article 7(1) of the said Treaty with the consequences set out in Article 7(2) thereof."***

Recital 12 is a provision common to all four framework decisions ("common recital"): "This Framework Decision respects fundamental rights and observes the principles recognised

by Article 6 of the Treaty on European Union and reflected in the Charter of Fundamental Rights of the European Union, in particular Chapter VI thereof. Nothing in this Framework Decision may be interpreted as prohibiting refusal to surrender a person for whom a European arrest warrant has been issued when there are reasons to believe, on the basis of objective elements, that the said arrest warrant has been issued for the purpose of prosecuting or punishing a person on the grounds of his or her sex, race, religion, ethnic origin, nationality, language, political opinions or sexual orientation, or that that person's position may be prejudiced for any of these reasons."

Art 1(3) also is a provision common to all four framework decisions ("common article"), stating that: "This Framework Decision shall not have the effect of modifying the obligation to respect fundamental rights and fundamental legal principles as enshrined in Article 6 of the Treaty on European Union."

In 2021, fundamental rights issues led to 86 refusals reported by ten of the 25 replying Member States. 64 of these refusals were registered in Germany alone. By way of comparison, ten Member States reported 108 refusals in 2020, 73 of those being registered in Germany alone, as was found by the European Commission for the year 2021.[321]

Refusal to execute an EAW based on general fundamental rights grounds in 2021 (Article 1.3 EAW FD)[322]

Austria	Bulgaria	Germany	Italy	Lithuania	Slovenia
0	2	64	4	X	0

3.1.2 EAW AND PERSONS WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES

The EAW FD is the only one of the four framework decisions that does not contain any provisions concerning persons with intellectual and/or psychosocial disabilities. However, the 2013 Recommendation calls upon Member States to strengthen certain procedural rights of suspects in situations of vulnerability or accused persons in criminal proceedings and of persons in situations of vulnerability who are subject to European Arrest Warrant proceedings.[323] It provides that:

> *"The executing Member State should ensure that a vulnerable person who is subject to European arrest warrant proceedings has the specific procedural rights referred to in this Recommendation upon arrest."*[324]

Concerning persons with intellectual and/or psychosocial disabilities vis-à-vis the principles established by the UNCRPD and its Committee, more entry points could be considered at the EU level. For example, the Charter enshrines fair trials rights, especially the presumption of innocence and the rights of defence under Art 48.

In this sense, it may be particularly interesting to note that the CJEU has interpreted the Directive (EU) 2016/343 as applying to proceedings covering committal to a security measure/psychiatric hospital, where the person is declared to be not criminally responsible but is subjected to a detention measure justified on therapeutic and safety grounds (See Section 2.4.).[325]

One could thus question if the transfer of a defendant with intellectual and/or psychosocial disabilities to countries that do not interpret the presumption of innocence in such a way could in principle be in violation of Art 48 EU Charter (presumption of innocence and the rights of defence) and could thus amount to a ground for refusal under Art 1(3) EAW FD.

In conclusion, the EAW FD is the most used of all four FD and does offer protection to individuals involved in these proceedings vis-à-vis

fundamental rights violations for both its recitals and the common provision on Art 6 TEU. However, it is the only framework decision which includes no provisions relevant to the situation of persons with psychosocial and/or intellectual disabilities. As seen, the 2013 Recommendation acts as a complementary document to protect individuals in situations of vulnerability, but remains a non-binding text.

The EAW FD is also the only one of the four FDs which was adjudicated on by the CJEU in a case involving a person with intellectual and/or psychosocial disabilities, namely, the E.D.L preliminary ruling.

Nature of decision - Preliminary Ruling requested by Italy

Date - 18 April 2023
Jurisdiction - CJEU

Question to the CJEU - "Must Article 1(3) of Framework Decision 2002/584, examined in the light of Articles 3, 4 and 35 of the Charter, be interpreted as meaning that, where it considers that the surrender of a person suffering from a serious chronic and potentially irreversible disease may expose that person to the risk of suffering serious harm to his or her health, the executing judicial authority must request that the issuing judicial authority provide information allowing the existence of such a risk to be ruled out, and must refuse to surrender the person in question if it does not obtain assurances to that effect within a reasonable period of time?"

Among the several decisions issued by the CJEU on the EAW FD in respect of fundamental rights violations, the E.D.L. case represents a landmark (along with the Aranyosi and Caldararu case). The requesting national jurisdiction (Italy) asked the CJEU in a preliminary ruling whether the Arrest Warrant Framework Decision Art 1(3) could be interpreted in light of the Charter Art 3 (right to integrity of the person), Art 4 (prohibition of torture and inhuman or degrading treatment or punishment) and Art 35 (right to health care). The result would lead to the possibility for the executing state to refuse the extradition of an arrested person in the case where the individual suffers from a serious illness. The Court, in its preliminary ruling, first re-affirmed the principle of mutual trust, stating that Member States must presume that health checks and health services will be provided in any EU country in the case the arrested individual needs it.[326]

The Court then added a caveat to this principle by evoking Art 23(4) of the European Arrest Warrant Framework Decision, which states that, if the arrested person were to be endangered by the extradition process, the state could choose to temporarily suspend it. For this decision to be valid, the executing state needs to check whether there are substantial grounds to believe that, based on objective elements such as medical certificates or expert reports, the execution of the arrest warrant might put at risk the health of the arrested person. Such risk must be evident. This request follows Art 15(2) of the EAW FD which states that ***"if the executing judicial authority finds the information communicated by the issuing Member State to be insufficient to allow it to decide on surrender, it shall request that the necessary supplementary information (...) be furnished as a matter of urgency."***[327] The Court then recalled that such assessment must be interpreted in the light of Art 4 of the Charter.[328]

The ruling subsequently stated that there could be a possibility whereby the mere transportation of an arrested individual from a Member State to another could constitute a potential violation of Art 4 of the Charter. For this to happen, the executing judicial authority must have found that:

> ***"(...) in the light of the objective material before it, substantial and established grounds for believing that the surrender of the requested person, who is seriously ill, would expose him or her to a real risk of a significant reduction in his or her life expectancy or of a rapid, significant and irreversible deterioration in his or her state of health."***[329]

The Court stated that, in this case, the executing state needed to request from the issuing state all necessary information in order to make sure that the conditions surrounding the execution of the European Arrest Warrant would be carried out such as to avoid any violation of Art 4 of the Charter and Art 23(4) of the EAW FD.[330] If the issuing state can provide such guarantees, the executing state must therefore execute the arrest warrant.[331]

However, there may be situations whereby the executing authority would conclude that there are serious and established grounds to believe that, if the arrested individual is surrendered to the issuing state, the person would be at risk (as pointed out at paragraph 41). The executing state can come to this conclusion relying on the information provided by the issuing state and also on any other relevant information. Two conditions have been laid down in the preliminary ruling: the necessity to find there are substantial grounds to believe the arrested individual could see their health put at risk following paragraphs 41 and 42 on the one hand, and the obligation for this risk not to be short-term on the other hand.[332]

The Court subsequently stated that, based on the circumstances, it did not find it necessary to rely on Art 3 (right to integrity) and Art 35 (right to health care) of the Charter.[333] The ruling did not provide any further explanation on the dismissal of other Charter provisions and followed its established jurisprudence by solely using Art 4 of the Charter. Finally, it must be pointed out that, despite the reliance on Art 4 of the EU Charter on the prohibition of torture and inhuman or degrading treatment or punishment, the Court did not apply the two-step test established in Aranyosi and Căldăraru. Therefore, when rendering a decision on health-related issues based on Art 23(4) EAW FD, the CJEU will check whether the health of the concerned individual will be at risk (risk of imminent death or risk of suffering a serious, rapid and irreversible decline in their state of health or a significant reduction in life expectancy) and observe that this risk is not short-term. However, the Court will not check whether there are systemic or generalised deficiencies affecting an objectively identifiable group of persons to which the requested person belongs on the one hand, and whether there is a specific and precise analysis of the individual situation of the requested person vis-à-vis potential violations on the other hand.[334] In this sense, the CJEU's approach when confronted with health endangerment of the concerned individual who needs to go through a cross-border transfer is closer to its jurisprudence related to asylum and migration than to its EAW jurisprudence. Indeed, the CJEU already decided that

> *"even where there are no substantial grounds for believing that there are systemic flaws in the Member State responsible for examining the application for asylum, the transfer of an asylum seeker within the framework of the Dublin III Regulation can take place only in conditions which exclude the possibility that that transfer might result in a real and proven risk of the person concerned suffering inhuman or degrading treatment"*.[335]

The E.D.L. ruling proves that the threshold to rebut the mutual trust presumption is very high at the level of the CJEU. This tendency is also illustrated in general by the two-step approach created by ***Aranyosi and Căldăraru***, which requires that the individual proves first that there are systemic and generalised deficiencies in the state of the issuing authority and that there are good grounds to believe that the specific person that is subject to the EAW will indeed suffer a breach of their fundamental rights. It was argued during the consultation workshop that the second step should suffice in order to refuse the execution, as fundamental rights violations could take place in a specific detention centre and only there in a given statef. This high threshold, as found in E.D.L. and ***Aranyosi and Căldăraru***, shows how the CJEU considers the principle of mutual trust and the presumption of the respect of fundamental rights by Member States as a priority.[336]

3.2 TRANSFER OF PRISONERS

3.2.1 TP AND FUNDAMENTAL RIGHTS

The transfer of prisoners covers custodial sentences or measures involving deprivation of liberty and allows for the transfer of a sentenced person from one Member State to another Member State for the execution of a custodial sentence or measure involving deprivation of liberty. The rationale behind the Framework Decision is to facilitate social rehabilitation by enabling sentenced persons to serve their sentences in the environment where they have the strongest social connections and support.

When it comes to fundamental rights, the TP FD includes the common recital as well as the common article (see Section 3.1.1). The TP FD also contains:

> Recital (14): *"This Framework Decision shall not have the effect of modifying the obligation to respect fundamental rights and fundamental legal principles as enshrined in Article 6 of the Treaty on European Union."*

3.2.2 TP AND PERSONS WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES

The TP FD does contain certain provisions relevant for detainees with intellectual and/or psychosocial disabilities, including the following:

> Art 1(b): "*(…)'sentence' shall mean any custodial sentence or any measure involving deprivation of liberty imposed for a limited or unlimited period of time on account of a criminal offence on the basis of criminal proceedings."*

> Art 9: *"1. The competent authority of the executing State may refuse to recognise the judgment and enforce the sentence, if: (…) (k) the sentence imposed includes a measure of psychiatric or health care or another measure involving deprivation of liberty, which, notwithstanding Article 8(3), cannot be executed by the executing State in accordance with its legal or health care system. (…) 3. In the cases referred to in paragraph 1(a), (b), (c), (i), (k) and (l), before deciding not to recognise the judgment and enforce the sentence, the competent authority of the executing State shall consult the competent authority of the issuing State, by any appropriate means, and shall, where appropriate, ask it to supply any necessary additional information without delay."*

However, the TP FD does not provide for specific procedural accommodations for persons with intellectual and/or psychosocial disabilities. For example, most EU Directives and Recommendations are not applicable at the post-trial stage.

The TP FD thus includes fundamental rights guarantees both in its Recital and in the common provision on Art 6 TEU, just like the EAW FD. Contrary to the latter, however, it does include relevant parts applicable to persons with psychosocial and/or intellectual disabilities in cross-border proceedings, notably providing a ground for refusal in cases whereby psychiatric medical treatments given as a sentence by the issuing state are not lawful in the executing state. Nonetheless, there is still a lack of provisions directly referring to persons with intellectual and/or psychosocial disabilities.

3.3 EUROPEAN SUPERVISION ORDER

3.3.1 ESO AND FUNDAMENTAL RIGHTS

The ESO allows a judicial authority in a Member State where a person is suspected of having committed an offence to ask the state where the person resides to monitor compliance with pre-trial supervision measures. These measures consist of specific prohibitions or obligations in anticipation of the trial being held. This allows a suspected person to remain in their state of residence under supervision measures until the trial takes place in the issuing Member State instead of facing surrender under an EAW and pre-trial detention in the issuing Member State. It aims to promote, inter alia, social rehabilitation and non-custodial measures for non-residents (Art 1).

Together with the PAS FD, it was adopted to mitigate the risks created by the EAW and diversify alternatives available. Both instruments were welcomed at the time of adoption as offering a solution to the problem of overreliance on the EAW, as well as the fundamental rights consequences linked to this overreliance.

When it comes to fundamental rights, the ESO FD includes the common recital as well as the common article (see Section 3.1.1). Although lower, considering that the PAS FD applies only to non-custodial measures, fundamental rights risks may arise and should be assessed. This could be, for example, in the case where the person concerned is subjected to a measure of medical/therapeutic treatment that is not compatible with international standards (eg., certain non-consensual practices).

3.3.2 ESO AND PERSONS WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES

The ESO does contain certain provisions relevant for defendants with intellectual and/or psychosocial disabilities. While in principle, all supervision measures indicated under Art 8(1) could be applied also to defendants with intellectual and/or psychosocial disabilities, a certain measure is explicitly targeting this group.

Article 8(2) contains a separate list of measures setting out that the supervision measures can apply, only if the State has been notified. Among such measures, subsection (d) includes "an obligation to undergo therapeutic treatment or treatment for addiction."

The following countries have agreed to supervise the obligation to undergo therapeutic treatment or treatment for addiction: **Slovenia, Belgium, Denmark, Spain, France, Austria, Germany, Portugal, Croatia and Romania.**[337]

In certain cases, the notifications issued by Member States to inform the EC on their transposition laws when implementing directives and framework decisions[338] seem to also set up a number of conditions. For example, **Austria** notified that it is prepared to monitor the obligation to undergo treatment for addiction or other medical treatment, but only if the person consents to the measure[339] Similarly, the notifications of Portugal refer to ***"Treatment, with prior consent, for an addiction which contributed to the commission of the offence, in an appropriate institution."***[340]

Other countries do not seem to have notified at all or have notified that they will not monitor the obligation to undergo therapeutic treatment or treatment for addiction. These include: **Bulgaria, Italy, Lithuania, Cyprus, Czech Republic, Estonia, Greece, Hungary, Ireland, Latvia, Luxembourg, Netherlands, Poland, Slovakia and Sweden.**[341]

However, the ESO FD does not provide specific procedural accommodation for persons with intellectual and/or psychosocial disabilities. For example, most EU Directives and Recommendations are not applicable in the post-trial stage. This may be problematic, for example, in respect of the provisions on consent.

The ESO FD therefore includes fundamental rights guarantees both in its recital and in the common provision on Art 6 TEU. It also includes relevant parts applicable to persons with intellectual and/or psychosocial disabilities in cross-border proceedings vis-à-vis the obligation to undergo medical treatment as a supervision measure. This measure is, however, limited as it necessitates the agreement of the executing state in order to be applied. Just like in the context of the EAW and the TP FD, the ESO FD does not contain any provision specifically targeting persons with intellectual and/or psychosocial disabilities.

3.4 ASUPERVISION OF PROBATION MEASURES AND ALTERNATIVE SANCTIONS

3.4.1 PAS AND FUNDAMENTAL RIGHTS

The PAS FD allows for the transfer of a sentenced person to a different Member State to serve a non-custodial sentence imposed by the original issuing state. It allows convicted persons who want to move to their home country to serve their non-custodial sentence there without the risk of violating the terms of their sentence by moving to another Member State (and subsequent arrest and surrender under the EAW because of such violation). It aims to ensure the due course of justice and promote non-custodial measures for non-residents (Art 2). It enables sentenced detainees to serve within an environment in which they have the strongest social and cultural bonds, relations and support, and gives them the best chances of rehabilitation.[342]

Together with the ESO, it was adopted to mitigate the risks created by the EAW and strengthen alternatives. When it comes to fundamental rights, the PAS FD includes the common recital as well as the common article (see Section 3.1.1). The PAS FD also includes:

> Recital 16: *"A Member State may refuse to recognise a judgment and, where applicable, a probation decision, if the judgment concerned was issued against a person who has not been found guilty, such as in the case of a mentally ill person, and the judgment or, where applicable, the probation decision provides for medical/therapeutic treatment which the executing State cannot supervise in respect of such persons under its national law."*

Even though the PAS FD applies to non-custodial measures and therefore the risks for fundamental rights violations are lower, fundamental rights risks should still be assessed, just like for the ESO FD. This could, for example, be the case when the person concerned is subjected to a measure of medical/therapeutic treatment that is not compatible with international standards (e.g., certain non-consensual practices).

3.4.2 PAS AND PERSONS WITH PSYCHOSOCIAL AND INTELLECTUAL DISABILITIES

The PAS FD does contain certain provisions relevant for defendants with intellectual and/or psychosocial disabilities. While in principle, all supervision measures indicated under Art 4 could be applied also to defendants with intellectual and/or psychosocial disabilities, certain measures are explicitly targeting this group. Art 4 includes: "an obligation to undergo therapeutic treatment or treatment for addiction." Contrary to the ESO FD, these measures are all applicable and no additional notification procedure is necessary.

The following additional provisions are to be noted, as they could also be relevant for persons with intellectual and/psychosocial disability:

> Art 11: *"The Competent authority of the executing State may refuse to recognize the judgment or, where applicable the probation decision if: … i) the judgment or, where applicable the probation decision provides for medical/therapeutic treatment which, notwithstanding Article 9, the executing State is unable to supervise in view of its legal or health-care system."*

However, the PAS FD does not provide special procedural accommodations for persons with intellectual and/or psychosocial disabilities. For example, most EU Directives and Recommendations are not applicable in the post-trial stage. This may also be problematic for the provisions on consent.

The PAS FD thus contains provisions on fundamental rights both in its recitals and in its common provision on Art 6, just like the three other afore-mentioned FDs. It also contains certain provisions which could apply to individuals in situations of vulnerability, as well as specific parts directly targeting persons with intellectual and/or psychosocial disabilities.

04. NATIONAL TRANSPOSITION OF THE FRAMEWORK DECISIONS

States are required to transpose EU law into their own national legal systems. However, they are not obliged to follow the exact same wording and can add rules. The requirement is that the national transposition meets the aims of the framework decision/directive, but it is up to each individual Member State to develop its own laws to determine how to apply these rules.[343] While some countries take this leeway as an opportunity to add safeguards and protections for the concerned individuals, others decide to take a more restrictive approach.

The four tables provide an accessible and comprehensive summary of transposition laws and relevant provisions, as well as a legislative overview of which articles are missing. It must also be stressed that, in the case where a State has a corresponding national article, the provision can sometimes be incomplete or include caveats or alternative wording.

Table with national transposition laws for EAW

EAW	Criminal responsibility	In absentia hearing	Postponement or refusal of surrender for human rights violations	Right to a lawyer a legal instruction and translations	Fundamental rights	Consent
Austria[344]	Art.9(1)	Art.11(1)	Art.25(1)	Art.16a(1) and § 30a(1) (2) (3)	Art.19(1) (4)	Art.2a0(2)
Germany[345]	Art.83(1)	Art.83(1) (2) (3)	Art.83c(4)	Art.83j(1) (2) (3) (4)	Art 73	Art.80(3) and 83b(2)
Italy[346]	Art.18	Art 18-ter. (1) (2) (3)	Art 23. (2) (3) (4) and Art 24.(1)	Art 9. (5 bis) and Art 10.(1) and Art 12.(1)	Art.1(3 ter) and Art 2.(1)	Art 14.(1) (2) (4) (5)
Bulgaria[347]	Art.6(1)	Art 40(2)	Art.54(3)	Art.43(4) (5) (7) and art.44(3)		Art.45
Slovenia[348]		Art.10(10) and Art.13	Art.35(3)	Art.17, Art.19, Art.16 and Art.20	Art.3	Art.21, Art.22 and Art.23
Lithuania[349]	Art.8(2)	Art.9(5)	Art.9(3)(1)	Art.8(1)(6) and art.51(1) (8)[350]	Art.9(3) (1) and art.71(2)[351]	Art.71(3)[352]

Table with national transposition laws for TP

TP	Right to appeal	In absentia hearing	Postponement or refusal of surrender for human rights violations	Right to a lawyer and legal instruction and translations	Consent	Social reintegration	Medical treatment	Criminal responsibility
Austria[353]	Art.42b(7a)		Art.40(12) (refusal)	Art.41(8)	Art.42			Art.40(5)
Germany[354]	Art.84b(4) and Art.84g(2) and Art.84h(3) and Art.85d	Art.84b(3)			Art.84a(3) (4) and Art.84l(4) and Art.85(2)			Art.83(1) (2)
Italy[355]	Art.15(3)	Art.13(1)(i)	Art.7(2) (postponement)	Art.15(3)	Art.1 and Art.5(4) and Art.6(5) and Art.10(1) (4) and Art.12(5)	Art.5(2)	Art.13(1) (m)	Art.13(1) (g)
Bulgaria[356]	Art.12(10) (11)	Art.15(1) (9) an d Art.12(6)		Art.12(3) (4) (5)	Art.22	Art.9(3) and Art.10(3)	Art.15(11)	Art.15(1) (7)
Slovenia[357]			Art.132(1) (8) (refusal)		Art.120(2) and Art.123(2) (3)	Art.133(3)	Art.132(1) (9)	Art.132(1) (6)
Lithuania[358]	Art.7(6)	Art.7(3) and Art8(9)	Art.8(1) (1)(refusal)	Art.8(9) (b)	Art.3(2)(2)	Art.3 and Art.5(2) and Art.6(3)	Art.8(11)	Art.8(1) (4)

Table with national transposition laws for ESO

ESO	Right to appeal	In absentia hearing	Postponement or refusal of surrender for human rights violations	Right to a lawyer and legal instruction and translations	Consent	Social reintegration	Medical treatment	Criminal responsibility
Austria[359]			Art.101(1) (9)		Art.100(1) (10)	Art.101(2)	Art.100(1) (8)	
Germany[360]	Art.90u(2) and Art.90v(1)				Art.90p(1) (2) and Art.90y(1)			
Italy[361]	Art.12(5)		Art.10(2)		Art.6(2)			Art.13(1)(g) (age limit)
Bulgaria[362]	Art.8	Art.7(2)		Art.7(3)	Art.6(3) and Art.16			
Slovenia[363]	Art.107(2) and Art.109(4)		Art.107(2)		Art.102(2) and Art.103		Art.102(2)	
Lithuania[364]	Art.41(8)				Art.40(4) (2) and art.43(2)			Art.40(4)(7)*

*("immunity from criminal liability in accordance with the norms of international law or the laws of the Republic of Lithuania")

Table with national transposition laws for PAS

PAS	Right to appeal	In absentia hearing	Postponement or refusal of surrender for human rights violations	Right to a lawyer and legal instruction and translations	Consent	Social reintegration	Medical treatment	Criminal responsibility
Austria[365]	Art.82(9) (c) (aa) (bb)	Art.82(9)(a) (b) (c)	Art.84(3)		Art.82(12) and Art.84(5)		Art.82(10)	
Germany[366]	Art.90c(4) (2) and Art.90h(2) and Art.90i(3)	Art.90c(3) (1) (b)		Art.90c(2)	Art.90c(4) (1)		Art.90b(6) (m)	
Italy[367]	Art.13(1) (h) (3)	Art.13(1) (h) (1) (2)	Art.1	Art.12(3)			Art.4(1) (m) and Art.13(1) (i)	Art.13(1)(g) (age limit)
Bulgaria[368]	Art.15(10) (c) and Art.17	Art.15(10) (a) (b) and Art.16(2)		Art.15(10) (b)	Art.15(10) (c)		Art.15(11)	Art.15(1) (9) (age limit)
Slovenia[369]	Art.170(4)				Art.178(2)	Art.178(1) and Art.179(2)	Art.163(j)	
Lithuania[370]	Art.26(6)	Art.27(1)(10) (a) (b)	Art.27(1) (1)	Art.26(3)			Art.25(3) (11) and Art.27(1) (12)	Art.27(1)(4) (age limit)

4.1 TRANSPOSITION INVOLVING SAFEGUARDS

4.1.1 GROUNDS FOR REFUSAL

4.1.1.1 FUNDAMENTAL RIGHTS VIOLATIONS

Regarding the EAW FD, **Austria** reported that the transposition contains additional provisions on grounds for refusal to surrender based on fundamental rights violation. The domestic legislation provides a two-fold limitation: Firstly, the court must have objective indicators for the violation. Secondly, the concerned person must lack remedies before the ECtHR or the CJEU.[371] As the latter requirement can generally only be determined in cooperation with the issuing authority, further information may be requested by the executing authority. This is based on the consideration that fundamental rights violations are best determined and dealt with in the course of the proceedings in the issuing state.[372] **Austria** also de facto appoints an expert to make an assessment of the individual on their fitness to be transferred before any transit in general, despite the fact that such safeguard is not expressly provided for in the national legislation, allowing for a possible suspension or postponement of the transfer.[373] **Germany** evoked a domestic case concerning the obligation to investigate potential fundamental rights violations for a person in a situation of vulnerability even without an already existing expert statement describing a possible danger.[374] This jurisprudence goes beyond what the **Italian** court asked the CJEU in the E.D.L. case,[375] which only dealt with the possible danger found on the basis of an expert statement. The German jurisprudence rather focused on the general obligation to investigate potential violations in the executing country.

Vis-à-vis the TP FD, and regarding the particular aspect of the grounds for the refusal to execute a request for transferring a prisoner, partner countries have identified additional bases in national transposition acts. Similar to the EAW FD,[376] the TP FD already foresees the possibility to refuse a transfer in case the decision was decided in order to punish someone for their *"sex, race, religion, ethnic origin, nationality, language, political opinion or sexual orientation"*.[377] To this discriminatory component, **Slovenia** notably added that a sentence which could be considered to have been rendered in violation of fundamental rights or freedoms could also be a ground for refusal.[378] **Italy** also pointed out in their national report that fair trial violations, as a category of fundamental rights, could be the basis for a refusal to execute the sentence.[379] Still on the TP FD, **Slovenia** pointed out the possibility for courts to reject the recognition and execution of the imposed sentence when it includes psychiatric treatment, healthcare or another measure involving deprivation of liberty which cannot be executed in the country.[380] **Bulgaria** also reported that a court is not required to recognize and execute a judicial act when the imposed punishment includes coercive medical measures (compulsory treatment) or measures involving deprivation of liberty.[381]

Concerning the ESO FD, **Austria** reported that, as an executing authority, the national transposition foresees a ground for refusal relating to a violation of the principles laid down in Art 6 TEU, or if there are objective indicators that the ESO was issued for the purpose of persecuting or punishing this person based on discriminatory grounds.[382] While grounds for refusal related to fundamental rights are optional under the ESO FD, they are binding under national law.

4.1.1.2 SOCIAL REHABILITATION

The necessity to keep the best interest of the individual involved in the proceedings was also reported as a potential ground for refusal to execute proceedings in the context of framework decisions.

Regarding the TP FD, **Slovenia** added a ground related to the best interest of the defendant, reporting that a national court could submit to a competent authority of the issuing state an opinion of refusal stating the reasons why the transfer to **Slovenia** would not facilitate the integration of the person concerned into the

social environment.[383] The need to focus on rehabilitation and not only on the sentence was also highlighted during the consultation workshop by German representatives.

The TP, ESO and PAS FDs have, as a goal, to ensure the concerned individual can ultimately be rehabilitated and reintegrated into the community. However, the comparative tables presented above show that for the TP FD, only **Italy**,[384] **Bulgaria**, **Slovenia** and **Lithuania** included a provision on social reintegration in their national law. For the ESO FD, only **Austria** included such a provision. Finally, on the PAS FD, which is dedicated to alternatives to detention and probation and thus should take social reintegration as a core principle, only **Slovenia** included in their transposition laws any provisions on rehabilitation.

4.1.2 ADDITIONAL SAFEGUARDS

4.1.2.1 LEGAL ASSISTANCE

Among the different additional safeguards, research has revealed that some states strengthened the right to legal assistance in the context of cross-border proceedings.

In respect of the EAW FD, **Slovenia** reported the obligation for the defendant to have a defence counsel appointed during the entire surrender proceedings, or from the first hearing on the surrender until the execution of the surrender.[385] The protection even extends to a right to choose a lawyer from the issuing Member State. The investigating judge then provides the requested person with information received from the competent authority of the issuing state to facilitate the choice of a lawyer, including information on eligibility for free legal aid.[386] In **Austria**, the right to have access to legal aid is guaranteed and defendants who are in a vulnerable position have the right to free representation in (all) interrogations.[387] In case of language difficulties, interpreters are available.[388] **Italy**, for its part, ensures that third persons, including family members or consular authorities, can be notified of the EAW as part of the legal aid.[389]

4.1.2.2 REFUSAL OF THE TRANSFER

Finally, a particular additional safeguard observed was the case of refusing the execution of a FD that would lead to a fundamental rights violation in itself.

Concerning the TP FD, **Slovenia** mentioned a complaint received by the national Ombudsperson about a **Slovenian** national who was prosecuted in Poland.[390] It had been established that the sentenced individual had an intellectual and/or psychosocial disability and the question of the person's mental capacity was also considered. Their parents received information about the execution of the security measure of compulsory psychiatric treatment, notably involving the use of electric shocks. The Ombudsperson, informed by the parents of the individual, contacted the Ministry of Foreign Affairs and also the Polish Ombudsman. The person was transferred to **Slovenia** and the security measure was implemented at the Forensic Psychiatry Unit. The person avoided violent medical interventions but was still detained in a psychiatric unit.

4.2. CHALLENGES WITH REGARD TO TRANSPOSITION

4.2.1 RESTRICTIVE TRANSPOSITION OF FRAMEWORK DECISIONS

4.2.1.1 ABSENCE AND ALTERATION OF SOME PROTECTIVE PROVISIONS

Among the shortcomings observed in national transpositions of the four FDs, the first shortcoming is created by the restrictive transpositions of EU law into domestic legislation, notably in the case where provisions have been altered or removed altogether. The research also revealed shortcomings which affect, in particular, persons with intellectual and/or psychosocial disabilities who are the subjects of cross-border proceedings.

Concerning the ESO FD, national reports highlighted a tendency to leave aside the FDs' provisions that might concern persons with intellectual and/or psychosocial

disabilities, like Art 8(1) (d) and (e) ESO FD.[391] **Bulgaria** reported that the national legislation indeed left aside the possibility to supervise therapeutic treatment or treatment for addiction measures and that health conditions were not taken into account when criminal legal capacity was being assessed.[392] **Germany** also did not transpose the exact words of the ESO FD, notably leaving aside the commitment to undergo therapy. The report, however, stated the country later acknowledged that therapeutic treatment and treatment for addiction could be monitored, provided that the person concerned consents in a notification to the European Council in 2016, a non-binding document.[393] **Slovenia**, for its part, reported that the national legislation transposing the ESO FD did not contain any provisions regarding the applicability or the manner of application of the ESO FD to persons with intellectual and/or psychosocial disabilities or in general to persons in a situation of vulnerability.[394]

Regarding the PAS FD, some states have reported incomplete transpositions with direct consequences for persons with intellectual and/or psychosocial disabilities. **Slovenia**, for its part, did not transpose Recital 5 of the PAS FD which protects individuals from discrimination in the context of the PAS proceedings. Although this provision does not expressly include disability as a ground for non-application, it could still have been interpreted in a broader way to encompass any form of discrimination by national courts. **Slovenia** also did not fully transpose Recital 16 dealing with the possibility of not recognising a judgement that is rendered against an individual who was found not criminally responsible; the Recital gives the example of a "mentally ill person" or where the probation involves medical treatment which would run contrary to the legislation of the executing state.[395] **Slovenia**'s legislation, however, while evoking the possibility to refuse the sentence when it includes medical treatment that would go against national law, does not make a reference to the wording: "judgment concerned was issued against a person who has not been found guilty, such as in the case of a mentally ill person".[396]

4.2.1.2 ADDITIONAL OBLIGATIONS

Shortcomings in national transpositions can emanate from altered or missing provisions and from a different wording. In other cases, issues can also come from added provisions that conflict with fundamental rights application.

Concerning the TP FD, **Austria** created the obligation of equivalency of the measure concerning the TP proceedings. This "adapted" measure should correspond to the original measure and must not be more severe than the latter. If the sentence is higher than the maximum sentence under **Austrian** law, the court has to reduce the sentence to the maximum sentence, but not more.[397] If the measures cannot be adopted, the court may refuse to execute. To be in line with the TP FD, a broad interpretation is required, thus also including proceedings concerning persons with intellectual and/or psychosocial disabilities who, because of their disability, are subjected to other proceedings.[398] Some challenges arose in practice due to the specific rules applicable for persons with intellectual and/or psychosocial disabilities who are found criminally responsible but still subjected to security measures (see Section 2.5). As not all countries provide for this type of measure, the execution of a sentence in another country may be hindered and thus the transfer refused. Expert interviews have, however, revealed that there have been transfers in the past despite this rule. Therefore, persons with intellectual and/or psychosocial disabilities can be at a disadvantage because of the fragmented legislation at the national level in the EU. This is to add to the general problem of the lack of specific provisions about defendants with intellectual and/or psychosocial disabilities in the TP FD, just like for the EAW FD.

4.2.2 ADDITIONAL SAFEGUARDS AT THE NATIONAL LEVEL

4.2.2.1 REFUSAL OF THE PROCEEDINGS

As seen above, transposition gives States the possibility to adapt the EU provisions and, notably, to make it more efficient at the

domestic level but also to add protective provisions. However, the research showed that some countries did not take the opportunity of the transposition to create better protections despite the existence of certain CJEU jurisprudence already highlighting the issue of forcing persons with intellectual and/or psychosocial disabilities to go through cross-border proceedings.

Concerning the EAW FD, a major point of contention within the EAW proceedings is that of postponement and the absence of any possibility to refuse the surrender. The need for such a possibility was highlighted in the E.D.L. case at the CJEU.[399] **Slovenia**[400] and **Bulgaria**,[401] for their parts, have not identified any transposed provision adding this option, but only that health reasons could be invoked to push the date of the transfer as found in Art 23 EAW FD. **Slovenia** stressed that, although postponements have been observed, this would not affect the decision on the transfer in any case.[402] **Lithuania** added that the application for postponement could only be made by the prosecutor and not by the defence.[403] Finally, as can be seen in the comparative tables on transposition laws (see Section 4), **Bulgaria**'s domestic legislation does not even contain a provision on fundamental rights.

The comparative tables revealed that the TP FD, contrary to the EAW FD, was not transposed with a focus on fundamental rights despite the fact that both FDs involve a transit. Only **Austria**,[404] **Slovenia**[405] and **Lithuania**[406] included a provision at their domestic level on possible refusal to execute the FD because of fundamental rights violations. **Italy**, for its part, only recognises the possibility to postpone and not to refuse the execution of the FD in cases of fundamental rights violations.

4.2.2.2 NO ADDITIONAL PROCEDURAL SAFEGUARDS

Among the additional provisions that could have been found in the national transpositions of the four FDs, the research shows an absence of procedural safeguards.

Concerning the EAW FD, **Lithuania** pointed out that the mandatory presence of a legal representative is foreseen in cases where **Lithuania** is the executing State but not the issuing State.[407] **Slovenia** also reported that, during the EAW proceedings, the defendant did not have the right to a person of trust to be present, or that there are no guidelines on the obligation to record hearings involving persons with intellectual and/or psychosocial disabilities.[408] Although the recording of interviews is quite common, the decision to do so remains with the investigating judge.

4.2.2.3 NO ADDITIONAL PROVISIONS TO PROTECT PEOPLE WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES

It was found that States did not add protective provisions at the domestic level applying to persons with intellectual and/or psychosocial disabilities in cross-border proceedings.

Regarding the EAW FD, there is a general absence of protective provisions in domestic legislations and a missed opportunity concerning transposition laws. This was notably pointed out by **Bulgaria**[409] and **Slovenia**.[410] **Lithuania** evoked a situation whereby a defendant in a vulnerable state sees their needs assessed and from such assessment safeguards can be applied. However, this decision depends entirely on the actors involved as there is also a lack of specialised guidelines.[411] **Slovenia** also stressed how judges and prosecutors would only rely on the information found in the EAW notice by the executing authority, which means that if a person with intellectual and/or psychosocial disabilities has not been assessed before arriving on **Slovenia**n territory, they will not be upon arrival.[412] Defendants in a vulnerable situation will therefore end up following the same proceedings as the rest of the defendants and only go through psychiatric examination once admitted to a detention facility. Such difficulties were highlighted during the consultation workshop with prosecutors, where an Italian judge evoked the unsuitable nature of the EAW as a legal basis when it involved a person with an intellectual and/or psychosocial disability, going as far as stating that there should be a presumption of a fundamental rights breach in this case.

Regarding the TP FD, **Austria** stressed the issue of the lengthiness of the proceedings, stating that if a transfer is postponed or refused, it is primarily due to lack of timely response by the issuing authority. Many experts have pointed out that cross-border proceedings are lengthy and bureaucratic. The authorities prefer to have the execution of a custodial measure in **Austria** rather than having to physically move an individual across borders. This consideration sometimes seems to take priority over the needs of the most vulnerable detainees.[413]

In respect of the PAS FD, partner countries like **Austria**[414] and **Slovenia**[415] have reported that no additional safeguards were included in national laws concerning persons with intellectual and/or psychosocial disabilities. During the consultation workshop, an Italian expert added that safeguards were all the more necessary in the context of probation, as it could require that the individual moves to another country and has their sentence translated. It was observed that such adaptation was much more difficult than a TP proceedings for instance, where the individual only has to be sent to another state. The participant evoked examples from **Italy** where interpretation and translation during the proceedings were of poor quality and also added there was a need for cultural adaptation on the part of officials and interpreters.

On both the ESO and the PAS FDs, as indicated by the comparative tables on national transposition laws, **none of the six partner countries** have added provisions on criminal responsibility related to disability (with Lithuania having a more open provision referring to the norms of international law or the laws of the Republic of Lithuania, see Section 4). Although lack of criminal liability is included as a ground for the refusal to execute all four FDs in the case where the individual was a minor, no transposition laws mentioned mental disability explicitly. On the PAS FD, only **Bulgaria**, **Italy** and **Lithuania** have a provision on criminal responsibility, but only in relation to the age limit and not on disability.

4.3 SAFEGUARDS IN RELATION TO PERSONS WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES IN TRANSPOSITION LAWS

4.3.1 CONSENT IN THE CONTEXT OF TRANSFERS

4.3.1.1 INCLUSION OF CONSENT IN THE LEGISLATION

Consent is a component which can be found in all four FDs, emanating from the individual concerned, the executing State or the issuing State, a component which can play a role before the trial or after. The consent to transfer from a State to another by the individual is the one on which this study primarily focuses, as it raises several issues concerning fundamental rights applications. Consent related to individuals' transfer can be found in the EAW FD,[416] ESO FD,[417] TP FD.[418] However, such consent-related provisions are not identical and do not uniformly grant the individual the possibility to refuse a transfer with full knowledge and understanding of the situation.

Regarding the EAW FD, it is clear that consent is amongst the safeguards that need specific attention regarding persons with intellectual and/or psychosocial disabilities. Among the four FDs, it is the only one that allows for the individual to fully refuse a transfer. Article 11 states that *"when a requested person is arrested, the executing competent judicial authority shall, in accordance with its national law, inform that person of the European arrest warrant and of its contents, and also of the possibility of consenting to surrender to the issuing judicial authority"* and *Art 13 states that "each Member State shall adopt the measures necessary to ensure that consent and, where appropriate, renunciation, as referred to in paragraph 1, are established in such a way as to show that the person concerned has expressed them voluntarily and in full awareness of the consequences. To that end, the requested person shall have the right to legal counsel."*

The partner countries have, however, reported an eclectic state of affairs at the domestic level on the matter. States like **Lithuania**[419] and **Slovenia**[420] do not offer better safeguards on the necessity to ensure a person with intellectual and/or psychosocial disabilities has given their informed consent on the proceedings. The report from **Lithuania** stated that judges could intervene when they believe the defendant is not understanding their situation, which remains an arbitrary decision not emanating from a binding legislation. It was notably pointed out that a large proportion of detainees, when they are interviewed and are given explanations on the EAW FD, still do not understand their situation fully with or without a disability. An expert interviewed in the context of the project stated that individuals most of the time "do not understand the seriousness of the consequences of their signatures or consent given to certain procedures."[421] **Lithuania** also evoked the Letter of Rights given to defendants to explain their rights and their possibility to refuse the transfer, stating it was not accessible, even for people who are not in a situation of vulnerability.[422] This issue was also stressed by **Slovenia**, where the legislation stipulates that defendants need information on the EAW procedure but does not mention any obligation to provide individuals in a vulnerable position accessible forms and documents.[423] **Lithuania** also reported that a distinction is made on consent but not on the vulnerability of the defendant. The distinction is made between consent given in the context of general criminal proceedings and consent given in the context of an EAW. Although the latter is usually faster and easier to give, it is then followed by a hearing during which judges check whether the defendant understands what they are agreeing to and to verify that the consent is genuine.[424] On the other side of the spectrum, **Italy** showed that the requested person could consent to their surrender both at the validation hearing and at the hearing for the coercive measures.[425]

4.3.1.2 WHEN CONSENT IS NOT INCLUDED IN THE LEGISLATION

In the case where consent by the individual for a transfer is not provided for at the national level de jure, the research conducted by partner countries showed that the need to ensure that persons with intellectual and/or psychosocial disabilities could provide genuine and informed consent was felt by relevant actors. The research thus shows how consent was sought ***de facto***.

Concerning the TP FD, following Art 6, consent to transfer is not a requirement in several situations, including when the judgement is forwarded to the Member State of the defendant's nationality; to the Member State to which the sentenced person will be deported once they are released from the enforcement of the sentence on the basis of an expulsion or deportation order included in the judgement or in a judicial or administrative decision or any other measure consequential to the judgement; and to the Member State to which the sentenced person has fled or otherwise returned in view of the criminal proceedings pending against them in the issuing State or following the conviction in that issuing state.[426] In the case where the defendant has an intellectual and/or psychosocial disability, however, consent is of particular importance. If consent is not an actual requirement, other safeguards need to be put in place to adapt the proceedings to a vulnerable group. **Italy** has pointed out that, if defendants have good legal representation, their voices would be better heard and consent would be more seriously taken into account despite the lack of an obligation to obtain it before a transfer.[427] Finally, **Lithuania** has reported that, even though the TP procedure does not provide for exceptions or special application requirements for persons with intellectual and/or psychosocial disabilities, judges verify the genuineness of the consent of the convicted person by holding court hearings.[428]

However, **Bulgaria** presented a case where the consent of the defendant was not taken into consideration despite their vulnerability, notably because of the absence of any domestic legislation requiring consent be given.[429] It involved an individual who was not present at the court hearing and did not express an opinion then. From the declaration of the person attached to the notification from **Austria** (the State transferring

the detainee), it can be established that he did not consent to the sending of the court decision and the notification to Bulgaria, stating as reasons the poor conditions in the prisons in Bulgaria and that he would receive no visits once there. The Bulgarian court nonetheless decided that the man should be placed under compulsory treatment in a regular psychiatric hospital near his place of residence in Bulgaria.

4.3.2 CONSENT FOR TREATMENT

Transfers from one state to another constitute an important part in FDs proceedings, as it could easily lead to fundamental rights and procedural rights violations of persons with intellectual and/or psychosocial disabilities compared to other measures. However, some of these other measures also represent a challenge for persons with intellectual and/or psychosocial disabilities when it comes to safeguards, namely, the obligation to undergo medical treatment. As shown by the comparative tables on national transposition laws, not all domestic legislation contains provisions on medical treatment. Regarding the ESO FD, only **Austria**[430] and **Slovenia**[431] have included an article on treatment. Regarding the TP FD, **Austria**[432] and **Germany**[433] have no provisions on treatment.

Concerning the ESO FD, some Member States have changed the content on consent regarding the supervision measure imposing therapeutic treatment while transposing the EU text. Medical treatment is presented in the FD as an optional supervision measure as opposed to a mandatory one.[434] **Austria** stated that national law transposed such an optional supervision measure into a compulsory measure, provided that the person concerned consented to said measure, which strikes a balance.[435] In **Lithuania**, although the obligation contained in the transposed legislation to undergo therapeutic treatment or treatment for addiction is included in the list of non-custodial penalties, there is no such obligation in the list of supervision measures.[436] **Slovenia** stated that national courts could execute supervision measures by applying ***mutatis mutandis*** the provisions of the Criminal Code regarding measures of custodial supervision or security measures.[437]These include an obligation to undergo therapeutic treatment or treatment of addiction, which is enforced by custodial supervision with the ordering of treatment in an appropriate medical institution, and if the person consents, also to treatment of addiction to alcohol or drugs. This means that the individual is not required to give their consent in the case of orders involving medical treatment. **Slovenia** also mentioned that, when an order to undergo treatment is issued, there is not even a list of national institutions that implement such measures in the country, although the obligation to prepare such a list was prescribed over a decade ago.[438]

4.3.3 CONSENT FOR IN ABSENTIA HEARINGS

Another part of the proceedings included in the framework decisions and which must be highlighted in respect of the specific situation of vulnerable persons is hearings. They can be considered as the continuation of a consent requirement as hearings exist to inform the person involved about their situation and ensure they understand the proceedings as well as ask if they have questions. However, it was observed that most hearings could be held in absentia in the context of the four FDs. While there can be instances where **in absentia** hearings are possible and adapted, one must see that such acceptance cannot so easily be applied in a case involving a person with intellectual and/or psychosocial disabilities.

Regarding the EAW FD, the relevant provision is Art 14 on hearings and consent to surrender, which states that ***"where the arrested person does not consent to his or her surrender as referred to in Article 13, he or she shall be entitled to be heard by the executing judicial authority, in accordance with the law of the executing Member State."*** The specific aspect on in absentia hearings focused on by partner countries was, however, the trial hearing and not on the hearing dedicated to ensure consent is given before a surrender. This provision is Art 5 and states that:

> *"The execution of the European arrest warrant by the executing judicial authority may, by the law of the executing Member State, be subject to the following conditions: where the European arrest warrant has been issued for the purposes of executing a sentence or a detention order imposed by a decision rendered in absentia and if the person concerned has not been summoned in person or otherwise informed of the date and place of the hearing which led to the decision rendered in absentia, surrender may be subject to the condition that the issuing judicial authority gives an assurance deemed adequate to guarantee the person who is the subject of the European arrest warrant that he or she will have an opportunity to apply for a retrial of the case in the issuing Member State and to be present at the judgment."*

Research conducted by partners on this topic showed that no additional safeguards were added de jure or de facto to ensure in absentia hearings were restricted or used as the last resort. The defendants do not have to be part of the hearing taking place before the surrender. **Italy** reported that, if the individual had knowledge of the trial or that they voluntarily evaded it, the courts could still proceed with the EAW and surrender the person, which follows the EAW FD's spirit.[439] In absentia hearings are also possible in **Slovenia** in the context of the fulfilment of an EAW.[440] No information was found on the adequate assurance to guarantee the person will have an opportunity to apply for a retrial of the case, as found in the FD. **Germany**, on the other hand, appears to have adopted a more protective interpretation of the possibility to refuse to execute. In 2021, 26 Member States (13 of which did not record any cases) reported a total of 159 refusals to execute an EAW based on decisions rendered in absentia and **Germany** alone reported 105 cases.[441]

Member States which have refused to execute an EAW in the context of criminal proceedings involving irregular in absentia trial hearings in 2021

Member States which have refused to execute an EAW in the context of criminal proceedings involving irregular in absentia trial hearings in 2021

Austria	Bulgaria	Germany	Italy	Lithuania	Slovenia
4	3	0	105	X	0

Regarding the ESO FD, the text does not provide for a consent requirement in the case of a hearing. Just like for the TP FD, the failure of the individual to appear if regularly summoned is not an obstacle to the consideration of the case, as stated in the Bulgarian research, even though it is a general rule.[442] Germany also reported that, at the national level, when the supervision measure includes a transfer to another Member State as an optional provision, the individual could voice their agreement or disagreement. However, the courts will be the ultimate decision-maker in these cases, and are not bound by the individual's choice.[443] In general, consent was not an important part of the ESO FD and the concerned individual is rarely asked their opinion. The ESO also does not provide for specific safeguards for persons with intellectual and/or psychosocial disabilities and national legislations have not added protection in their transpositions of the framework decision.

The specific PAS FD also does not provide for a specific safeguard for persons with intellectual and/or psychosocial disabilities regarding in absentia hearings. The text provides at Art 9 (1)(e)[444] that in absentia hearings are a ground for non-recognition except when the concerned individual was informed by a competent authority of the time and place of the proceedings and did not attend it. This was also transposed at the national level, as was pointed out by Bulgaria, which stated that the failure of the person to appear when regularly summoned is not an obstacle to the consideration of the case.[445] **Italy** also transposed this article, allowing in absentia hearings if the individual has been officially informed but did not attend anyway and did not add any particular safeguards regarding vulnerable persons.[446]

4.3.4 RECOMMENDATIONS

Ensure the informed consent of the concerned individual:

- Establish formal procedures to ensure the free and informed consent of suspected or sentenced persons at the national level, in particular in the context of consent for medical treatment in cross-border proceedings and in the context of ***in absentia*** hearings. The concerned individual must understand the proceedings they are currently in as well as the consequences of their given consent.

- Ensure interpretation and translation in EU languages when necessary, in particular during hearings and when seeking medical treatment, to ensure the person concerned understands the proceedings.

- Ensure that persons with intellectual and/or psychosocial disabilities in criminal proceedings are involved in the process from the beginning to the end and that decisions are not taken without them.

Ensure a safe transfer:

- Ensure prompt assessment of the suitability of a person to be subjected to transfer, taking into account particular needs and circumstances, notably the looking to the country where they have the strongest social ties or medical accommodation during the transfer.

- Ensure accommodations of support (e.g., company of a person of trust or with medical assistance) throughout the transfer to avoid possible deteriorations of the situation of the person concerned.

- Ensure continuity of care in case of transfer (including by providing necessary documentation of services/therapy received). Information transmitted needs to be translated or directly written in the language of the executing state.

Adapt EU standards and jurisprudence to the concerned individuals' needs:

- Implement the 2013 Recommendation by all Member States and create specific guidelines in order to better adapt such cross-border proceedings to persons with intellectual and/or psychosocial disabilities, with a focus on consent.

- Ensure that focus in cross-border cases is on the assessment of the individual's state and risks of fundamental rights violations rather than the enforcement of the principle of mutual trust and mutual recognition among Member States. Organise strategic litigation to change the CJEU jurisprudence and remove the first step of the two step approach as established in the Aranyosi and Căldăraru decision (systemic or generalised deficiencies or deficiencies affecting an objectively identifiable group of persons to which the requested person belongs).

05. APPLICATION OF THE FRAMEWORK DECISIONS IN MEMBER STATES

5.1 GENERAL CHALLENGES

The general tendency observed in both the national research and the workshop transcripts is that EU framework decisions were difficult to understand, difficult to apply and mostly time-consuming. **Austria** indicated that it was a long (and often costly) process for the legal representatives of persons concerned in the context of cross-border proceedings due, inter alia, to language barriers and the difficulties met in communicating with their client and the relevant authority.[447] **Bulgaria** also evoked the issues of language barriers, notably in the context of the use of the PAS FD, reporting the unavailability of interpreters and translators for many languages, even European ones. This issue particularly applies in the context of smaller cities. In bigger towns, it was stated that there is no specialisation for interpreters anymore, neither for those who participate in proceedings where minors are involved nor in criminal matters where disabled persons are involved, which means they are not aware of the specific terminology.[448] **Slovenia** mentioned the overly bureaucratic nature of the proceedings and the superficial nature of the checklists involved. They highlighted that information was aplenty but not always relevant, notably on the contextual part of the proceedings.[449]

As was discussed during the regional consultation workshop, the fact that the defendant concerned is a person with intellectual and/or psychosocial disabilities adds another layer of obstacle in the cross-border proceedings. It was said that such individuals will usually be perceived as dangerous, which will be used as an informal ground for refusal to rely on any FD involving the transfer to their jurisdiction or their supervision within their State for instance.

5.2 LACK OF DATA

The lack of data is the only issue which has been identified by all six partner countries as well as participants of the workshops concerning all four framework decisions.

Concerning the EAW FD, **Bulgaria** reported the absence of statistics at the national level on EAW in general.[450] **Austria**, a federal state, wrote on the difference between the Ministry of Justice being the issuing authority and collecting data, and the regional courts as executing authorities which, on their side, do not systematically collect data.[451] It was also reported how the data itself was not thorough. An Italian participant pointed out during the consultation workshop that either there is a lack of data altogether or databases exist but are unknown to the relevant actors.

Regarding the TP FD, data is either not systematically gathered, like in **Bulgaria**[452] or **Lithuania**,[453] or collected in a very limited manner, like in **Austria**.[454] There, while the Ministry of Justice collects data as issuing authority, the courts do not systematically collect data. Where data is available by the Ministry of Justice, it is also limited.

For the ESO FD, partner countries including **Bulgaria**[455] and **Lithuania**[456] have reported a lack of data collection regarding its use. The latter added that data could exist but was not made public and accessible.

Finally, concerning the PAS FD, just like the EAW, TP and ESO FDs, its application at the national level is also poorly documented because of an absence of data collection on these cases. **Lithuania** stated that, if there were any statistics on the use of the PAS, it was not accessible to the general public.[457]

Bulgaria wrote that the reason why there was no data on PAS was because there was no case to begin with, including no case involving persons with intellectual and/or psychosocial disabilities.[458] **Slovenia** also indicated it could not find any case involving persons with intellectual and/or psychosocial disabilities.[459]

The second issue found in respect of data concerns the absence of disaggregated data, which corresponds to the separation of compiled information into smaller units in order to elucidate underlying trends and patterns. A Portuguese participant evoked the difficulty to navigate cases without a functioning database offering research tools or filtering for research. Such possibility is paramount in order to better monitor the way in which persons with intellectual and/or psychosocial disabilities are involved in such proceedings.

Regarding the EAW FD, and in the case where databases are available at all, there is usually no disaggregated data, as was pointed out by **Lithuania**.[460] This makes research on persons with intellectual and/or psychosocial disabilities particularly difficult to find, as contrary to the three other framework decisions, EAW cases are more numerous. This would virtually mean that interested parties would have to go through hundreds of cases in order to find the ones involving such individuals.

Concerning the TP FD, in states where data was gathered and available, the absence of disaggregation was also observed. Otherwise, there was merely a lack of cases involving persons with intellectual and/or psychosocial disabilities where transfer of prisoners was refused on fundamental rights grounds, as was pointed out by **Slovenia.** [461]

Concerning the ESO FD, it was also found that when data was available, there was no disaggregated data on persons with intellectual and/or psychosocial disabilities. This shortcoming was pointed out by **Bulgaria**,[462] **Slovenia**[463] and **Austria**.[464] The latter stated it was due to a lack of a unified process of the courts on the application of these measures.

Finally, it can be that disaggregated data is available, and reveals no violation of fundamental rights regarding persons with intellectual and/or psychosocial disabilities. **Lithuania** stated that several rulings have mentioned the possibility to postpone an EAW transfer in case of such violations, but this was never applied.[465]

5.3 LACK OF AWARENESS

5.3.1 LACK OF AWARENESS OF THE FRAMEWORK DECISIONS

Another obstacle found in the context of this research was the general lack of knowledge on the four FDs and their application.

Concerning the EAW FD, it was reported during the regional consultation workshop that there is a general lack of knowledge about the FDs other than the EAW FD. However, each proceeding differs from another: for instance, whether to use it at the pre-trial or post-trial stage, or which authority is involved. Also, it must be noted that not all FD proceedings include international transfers as a main tool. The EAW and TP FDs mainly focus on such transits whereas the ESO FD includes a transfer only when the individual has breached their obligation to report to the competent authorities, and the PAS FD does not contain any provision about a transfer whatsoever. It was added during the regional consultation workshop that the lack of awareness and knowledge about the ESO and TP FDs on the matter of transfers led to an overuse of the EAW FD, even when it was not the most adapted cross-border procedure. **Germany** reported, on this specific issue, a case where the EAW FD was used to transfer an individual, which was subsequently turned into a TP FD because it was viewed as more suitable for the person concerned.[466]

Concerning the ESO FD, **Austria** reported that it was applied in a very limited manner. Researchers also explained such perception by identifying a general lack of knowledge and/or awareness of the ESO FD's existence and purpose.[467] In **Slovenia**, the research could not identify

any ESO application and found there were none on orders related to persons with intellectual and/or psychosocial disabilities because there were no cases on ESO to begin with.[468] It was also expressly stated during the regional consultation workshop that the non-application of the ESO FDs directly came from the lack of knowledge surrounding it. This general lack of knowledge leads to cross-border proceedings almost entirely relying on the EAW FD instead of any of the three others, as was additionally pointed out in the **Lithuanian** research. They presented this situation as a particularly problematic issue, as the ESO FD should be applied as the alternative, ensuring people do not spend time in detention unnecessarily.[469]

Regarding the PAS FD, it was found that, among the three FDs, the PAS FD was reported as being the least known and the least relied on. A participant at the regional consultation workshop stated that, before even knowing about the FDs, actors needed to have better knowledge about probation and alternatives to detention at the national level in general. They added that some states barely provided for any forms of alternatives at all to begin with. The research also showed that, because of said lack of awareness, certain practices were observed at the national level.

Concerning the EAW FD, it was pointed out during the regional consultation workshop that courts had a tendency to primarily rely on the EAW to transfer a defendant, although other FD proceedings could be more suitable, especially in cases involving persons with intellectual and/or psychosocial disabilities. For instance, the issuing of an EAW could be replaced by the issuing of an ESO in order to ensure that the individual concerned remains in the country where they have the strongest ties, including family or carers, which would be a better choice for persons with intellectual and/or psychosocial disabilities. It was suggested that the basis of such a choice between FDs would be the assessment of the individual concerned, including medical and therapeutic assessment. Once such a basis is available, only then can judges choose which proceeding is most suitable. A **Portuguese** participant at the regional consultation workshop added that some states used the EAW as a tool to deport foreign people and save money.

Regarding the PAS FD, it was reported that the lack of knowledge can be identified as one of the reasons why it is rarely used, a tendency observed in several states. Some competent authorities do not apply the PAS FD thoroughly like in **Slovenia**, where a case was identified involving a Slovenian national who wished the probation measure to be implemented in Sweden where he had lived and the latter rejecting the possibility of transfer without any justification.[470]

5.3.2 LACK OF AWARENESS OF THE DIFFERENT NATIONAL LEGAL SYSTEMS

Another problem that was reported were the difficulties accessing and/or understanding other states' legal systems in the context of cross-border proceedings. Indeed, even though the FDs are EU competences, criminal law is a matter of the State.[471] Following this logic, each Member State has a different system which leads to a fragmentation of the proceedings, sometimes even leading to blatant incompatibility. **Austria** mentioned the different regulations on the specific issue of criminal legal capacity concerning persons with intellectual and/or psychosocial disabilities between **Austria** and **Bulgaria**. The report notably used the example of a case whereby Austria requested the transfer of an accused person with a disability, but Bulgarian courts found that he was not responsible for his crime and thus refused the transfer. In the end, the Sofia Appellate Court annulled the decision of the Regional Court, allowing the extradition of the Bulgarian citizen to Austria. Yet, this example shows the obstacles that can be found in the way of cross-border proceedings.[472] Findings from **Austria**, as well as participants from the regional consultation workshop, also highlighted the issue of continuity of the criminal proceedings once the cross-border part is over and touched specifically on the issue of treatment.

This problem concerns both cases related to transfer of persons as well as probation measures. Once the person is transferred, it is hard to ensure the person receives the same pharmaceutical or psychological treatment they would be given in a state due to differences in systems.[473] This also includes the handling at the border, where states and individuals have no guarantees that support and safeguards are going to be continued throughout the transfer.[474] Some actors pointed out that, in practice, it is often difficult to make sure that the detention facility in the executing Member State receives all the necessary information regarding the person concerned, including, for example, their therapy plan/ past achievements, etc. It is based on the individual dedication of the staff involved to contact facilities in other countries to ensure continuity of care. They only get informed of the transfer briefly before the transfer date, which leaves little to no time to adequately prepare and contact the corresponding facility. **Lithuania** also evoked the absence of a mandatory right to a lawyer in their code of criminal procedure for cases involving cross-border proceedings when they are the requesting state.[475]

Concerning the EAW FD, at the national level, courts dealing with cross-border cases need to research other states' systems and standards in order to gather all the necessary information for the execution of an EAW. This notably includes finding information on a legal system, criminal procedure and human rights standards, ***de jure and de facto***. This necessitates access to case-law, to legislation and to contact points, including the competent authorities and the practice in the country regarding international transfers. The lack of accessible data-bases makes this step difficult and leads to inconsistencies in the application of the EU FDs at the national level. Domestic tribunals need to assess what the minimum standards for medical treatment are, and as was pointed out by a **Bulgarian** national during the regional consultation workshop, such standards vary greatly from state to state.

5.3.3 RECOMMENDATIONS

- Collect data at the national level, enhance the collection of systematic and disaggregated data in the criminal justice system on suspects, accused, detained, and sentenced persons with intellectual and/ or psychosocial disabilities in cross-border proceedings by integrating this information in national databases (if available) or by setting up new databases.

- Collect data and create a database for cross-border purposes, taking into consideration the UNCRPD, GDPR and other human rights standards available at the European level and national level. The database should include disaggregated data on both national legal systems and EU law, as well as information on the state of prisons (such as CPT reports from visits or NGO reports) in accordance with CJEU jurisprudence.

- Increase awareness and knowledge, both by the national government and the European Commission, of the TP FD, ESO FD and PAS FD to avoid overuse of the EAW FD and ensure the FD used is most suited to the specific situation of the concerned individual.

- Increase knowledge, both by the national government and the European Commission, of the ESO FD and PAS FD to reduce deprivation of liberty as a criminal punishment, particularly unfit for people with intellectual and/or psychosocial disabilities.

- Increase awareness of competent authorities and other relevant actors, both by the national government and the European Commission, of the ESO FD, TP FD and PAS FD (for example, by providing more training, workshops and meetings).

- Strengthen the application of the ESO FD and PAS FD in order to reduce deprivation of liberty and ensure judicial cooperation is in line with international human rights, as for defendants and detainees with intellectual and/or psychosocial disabilities, deprivation of liberty and transfer may be particularly harmful.

- Improve access to information on national criminal justice systems of other EU Member States to strengthen cooperation and facilitate exchange between actors (e.g., by developing a database). This will enable competent authorities to identify and overcome possible differences between national jurisdictions.

- Include FDs and their purpose in the ***curriculum*** of judicial training.

- Consider the development of a database to include information on different areas (in EU languages): national legislation, cross-border cases, cases involving persons with intellectual and/or psychosocial disabilities, transfers postponed, transfers refused, contacts of relevant national authorities and actors and references to grounds for refusal. Any sort of database would need to respect the privacy of individuals with disabilities in order to avoid labelling. There is thus a need to select what kind of information would be available in a database and to make sure only selected people have access to it. Any development should take into consideration the UNCRPD, other human rights standards and GDPR standards (protecting personal data), available at the European level and national level.

- Member States (especially federal states) should consider the establishment of national centralised authorities or setting up a department within the prosecutor's office with the mandate to apply all cross-border framework decisions.

- Mainstream the collaboration between prosecutors' offices and NPMs when confronted with cases where fundamental rights violations are a risk.

- At the regional level, the European Judicial Network (EJN) or Eurojust could take a bigger coordinating and advisory role to ensure better communication and cooperation between Member States and solve the issue of mistrust.

5.4 CHALLENGES REGARDING COMMUNICATION AND COOPERATION

5.4.1 COMMUNICATION

The application of the FDs can be hindered by issues in the communication between Member States. **Germany** pointed out that involved actors and institutions sometimes had to come up with solutions not provided for in the FDs or even at the national level of norms. **Germany** reported that hospitals and practitioners in prisons' healthcare sometimes use informal ways to establish contact with organisations in neighbouring countries in order to ensure further treatment after the person concerned leaves Germany.[476] Even in the case that these alternative routes are taken to ensure the application of the PAS FD, other obstacles hinder treatment, such as missing financial support or long waiting lists.[477]

A **Lithuanian** participant in the regional consultation workshop also evoked this absence of communication between relevant actors in ensuring the good application of the PAS FD's content. They reported that in cases when the judge is appointed to supervise a person undergoing probation in a foreign country, supervision happens through long distance communication, relationships with relatives, or, if a visitor comes to the country of origin, meetings in person. The individual also usually needs to write the reports to courts. However, the participant stated that such supervision measures on probation did not qualify as proper supervision but that supervision remained preferred over transfers because the bureaucracy associated with the supervision of probation was less stringent despite the loss of qualitative efficiency. They also evoked how there is no possibility to truly control the risk people undergoing probation pose to local communities. In **Germany**, hospitals and practitioners in prison healthcare sometimes rely on informal ways to establish contact with organisations in other states in order to ensure the good administration of medical treatment once the person concerned leaves Germany due to the absence of official means of communication.[478]

5.4.2 COOPERATION

Another obstacle observed was that, when the option of an FD was there or even when such reliance was mandatory, the national courts or relevant actors were sometimes reluctant to use them. **Austria** evoked first a lack of knowledge of other States' judicial systems, but more importantly, a general tendency not to trust other Member States' legal systems.[479] This idea was notably brought forward by the **Netherlands** during the regional consultation workshop, where it was said there was a general belief that once you let a person go, the involved countries do not trust each other to bring the person back to the court (in time) for the hearing. In **Germany**, the same mindset was observed, added to a general defiance towards the level of sanctions applied by the other EU Member States. **Germany** indicated a certain fear that the person will no longer be punished to the extent provided for in the sentence after the transfer.[480]

This distrust extends to the point where some states choose not to respond at all to other States requesting the opening of cross-border proceedings. **Lithuanian** and **Portuguese** representatives, during the regional consultation workshop, notably evoked issues with cooperation with certain states. In **Lithuania**, there is a general understanding that communication with specific countries on this matter is poor and that nothing can be done about it. Even more serious was the issue of Member States which refused to rely on the framework decisions in general, even when all conditions were met, as was raised by a **Lithuanian** and a **Romanian** participant at the consultation workshop.

The principles of mutual trust and mutual recognition which entail a presumption of fundamental rights' application in Member States are notably at stake in the cases where countries have created their own presumptions towards other countries. Indeed, while the EU Court prioritises trust and strictly applies the presumption that States will respect fundamental rights by relying on a very high threshold for its rebuttal, domestic courts have been found to generally use a different approach.

At the EU level, the TEU provides for the possibility to rebut the presumption of fundamental rights' application in the case where all the conditions found under Art 7 TEU are fulfilled. It states that:

> *"On a reasoned proposal by one third of the Member States, by the European Parliament or by the European Commission, the Council, acting by a majority of four fifths of its members after obtaining the consent of the European Parliament, may determine that there is a clear risk of a serious breach by a Member State of the values referred to in Article 2.*[481]*"*

Such values are:

> *"respect for human dignity, freedom, democracy, equality, the rule of law and respect for human rights, including the rights of persons belonging to minorities. These values are common to the Member States in a society in which pluralism, non-discrimination, tolerance, justice, solidarity and equality between women and men prevail."*[482]

However, we observe at the national level the rebuttal of such presumption with rules set at the domestic level, which change depending on the country and which do not always have to be based in law. In **Austria**, for instance, it was reported that the Ministry of Justice issued decrees on how to handle cross-border cases with the specific Member States where the risk of fundamental rights violations appears high. These may concern the conditions in detention as well as fair trial guarantees.[483] Such inversion of the presumption exists also with the CPT, as was reported by **Lithuania**. Their report stated that some Lithuanian prisons were presumed to systematically infringe on the respect of fundamental rights.[484] **Germany** evoked a domestic case in which a preliminary ruling was requested from the CJEU on the obligation to investigate potential fundamental rights violations for a person in a situation of vulnerability even without an

already existing expert statement describing a possible danger.[485] This jurisprudence goes beyond what the Italian court asked the CJEU in the E.D.L. case,[486] which only dealt with the possible danger found on the basis of an expert statement. The German jurisprudence rather focused on the general obligation to investigate potential violations in the executing country. In this sense, **Austria**, **Germany** and **Lithuania** were observed to have turned the fundamental rights' respect presumption into a fundamental rights' violation presumption in certain cases. As previously mentioned, **Germany**'s courts will sometimes intervene in the proceedings but not to ensure the interests of the defendant are protected. Rather, judges will focus on the application of the punishment in other states. German judges have a tendency to fear that the defendant will no longer be punished to the extent provided for in the sentence after a transfer.[487] This tendency runs contrary to the mutual trust and mutual recognition principles.

In **Slovenia** however, the tendency lies more towards the respect of the presumption, as potential fundamental rights violations are not sought by the judges but left to the defence to bring up, which leads to an uneven scrutiny towards fundamental rights on the territory.[488]

Domestic courts will thus have a tendency to disregard the presumption of fundamental rights' respect either by creating a presumption of fundamental rights' violations or by not trusting that other States will enforce the prescribed sentence they selected. These two identified reasons not to transfer both run contrary to the principles of mutual trust and mutual recognition.

5.4.3 RECOMMENDATIONS

- At the regional level: strengthen cooperation and communication on all levels, including not only in respect of competent authorities in both the issuing and executing countries but also lawyers, probation officers, psychiatrists and other medical personnel, NPMs, etc.

- At the regional level: institutionalise/formalise channels of communication and cooperation between all actors, including the judiciary, attorneys, forensic-psychiatrists, extra-mural facilities as well as after care facilities and probation agencies (e.g., by providing an EU-wide platform and forum for exchange).

- At the regional level: consider setting up networking events that could ensure that actors from different Member States are able to share their experiences and learn from one another about their jurisdictions, good practices, and common challenges.

- At the regional level: the EJN or Eurojust could take a bigger coordinating and advisory role to ensure better communication and cooperation between Member States and address the issue of mistrust.

- At the national level: ensure a common approach on application of standards in all cases by way of regular exchange between competent authorities, especially in federal states.

- At the regional level: Mainstream the collaboration between Prosecutors' offices and NHRIs when confronted with cases where fundamental rights violations are a risk.

06. CONCLUSIONS

The analysis delved into the legal pathways leading to the deprivation of liberty for individuals with intellectual and/or psychosocial disabilities, revealing substantial challenges in assessing criminal legal capacity and criminal responsibility. Access to justice for defendants and detainees with these disabilities presented notable issues, diverging from principles established in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), particularly the principle of 'universal legal capacity.' Several EU Member States link a denial of criminal legal capacity to disabilities, potentially impacting procedural rights, criminal proceedings outcomes, and the imposition of measures, including security measures, compulsory treatment, or preventive detention.

Across partner countries, mechanisms for identifying disabilities pose challenges, characterised by insufficient indicators, inadequate safeguards for early identification, and concerns about the quality and impartiality of expert opinions. The scarcity of expert witnesses compound these challenges. The medical approach to assessments primarily focuses on determining criminal legal capacity, neglecting support needs and the ability to withstand trial pressures. The lack of adequate mechanisms for early disability identification may result in the denial of necessary support for equal access to justice, necessitating a more comprehensive and inclusive approach.

Examining procedural rights, the research unveiled a lack of accommodations for individuals with disabilities during criminal proceedings, with partner countries failing to implement relevant international standards, including those from the European Commission. Provisions outlined in the 2013 Recommendation on procedural safeguards for vulnerable persons suspected or accused in criminal proceedings were not implemented into national law. Ordinary proceedings are often ill-equipped to respond to the needs of persons concerned, potentially excluding them from trials, and trials may be held in absentia if the person is presumed "unfit to stand trial." The research advocates for comprehensive reforms aligning legal practices with the principles of the UNCRPD to ensure equal access to justice for individuals with disabilities.

The research explored various paths leading to the deprivation of liberty of persons with intellectual and/or psychosocial disabilities in the six partner countries. All partner countries permit deprivation of liberty based on perceived dangerousness linked to disability, violating UNCRPD principles prohibiting such deprivation. Individuals come under different regimes and facilities based on assessments of criminal legal capacity, dangerousness, and other legal, medical, and practical considerations, contributing to a complex and incomparable system. The research indicated that involuntary/non-consensual committal to institutions is legitimised in all countries, often blurring the lines between medical and security concerns.

In most partner countries, unlimited and indefinite deprivation of liberty is possible under some form of security measure, creating a problematic absence of a concrete time frame for detention. Facilities may not offer necessary treatment, leading to prolonged stays, and individuals may be transferred between measures without clear guidelines. Variations in compulsory medical treatment measures and security measures were observed, including outpatient options, inpatient confinement, and specific conditions for enforcement.

The research uncovered multiple concerns related to the treatment of persons with intellectual and/or psychosocial disabilities in places of deprivation of liberty, including prisons, psychiatric hospitals, preventive detention, and other institutions for compulsory treatment. Material detention

conditions, overcrowding, lack of specialised staff, and non-compliance with international standards in terms of isolation, restraint measures, overuse of medication, and non-consensual treatment were highlighted. In prisons, the prevalence of intellectual and/or psychosocial disabilities was found to be high, with inadequate support and services leading to isolation and segregation.

Several issues and shortcomings regarding alternatives and probation for defendants and detainees with intellectual and/or psychosocial disabilities were identified, highlighting a stagnating and unsuited legal framework. Persons with these disabilities often receive lengthy prison sentences due to unsuitable legislation, and non-custodial measures, considered 'alternatives,' should become real options rather than deviations from the default. Post-release support tailored for persons with these disabilities is lacking, impacting reintegration prospects due to inadequate services and housing options.

The examination of the four key EU instruments employed in cross-border criminal proceedings—namely, the European Arrest Warrant Framework Decision, the Transfer of Prisoners Framework Decision, the European Supervision Order Framework Decision, and the Probation and Alternative Sanctions Framework Decision— revealed a fragmented state in the protection of individuals with psychosocial and/or intellectual disabilities. While general provisions ensure fundamental rights respect, specific safeguards addressing unique needs are lacking. The EU jurisprudence complicates demonstrating fundamental rights violations, reinforcing a presumption of compliance. At the national level, Member States exhibit variability, leading to a fragmented domestic rights landscape. Partner countries reported inadequacies in addressing consent in legislation, a lack of awareness regarding framework decisions, and a need for coordinated efforts at both EU and national levels to fortify the protection of vulnerable individuals in cross-border criminal proceedings.

ANNEX - CASE STUDIES ON PROMISING PRACTICES

ANNEX 1: AUSTRIA - SOCIAL NET CONFERENCE

I. DESCRIPTION AND OVERVIEW

The Social Net Conference (SNC) offers a defendant who has committed a criminal offence the opportunity to develop a plan for the future together with their social network (in the context of criminal proceedings), which includes solutions to problems for the time after detention/being subject to preventive measures and is intended to prevent further criminal offences. It is aimed at avoiding detention/being subject to preventive measures or shortening it.

SOCIAL NET AND COORDINATION

A SNC is coordinated by an employee of the association "Neustart" (the central probation service in Austria), involving the social environment of the person concerned in overcoming their crisis and dealing with their conflicts. Coordinators are specially trained persons and are only responsible for preparing the SNC, moderating it and drawing up the future plan. Their role is clearly distinct from that of probation officers. The aim is to help the person concerned to lead a life that enables them to refrain from committing punishable acts in the future. Who is part of this social network must be assessed on a case-by-case basis and includes family members, friends and other reference persons. The person concerned is responsible for selecting these persons. If the person concerned does not have a social network, a SNC cannot be carried out. In addition to the social network, probation officers and, if necessary, other helpers, therapists, employees of care facilities, etc. also take part. However, their role is to be distinguished from that of the social network.

PLAN CREATION, TOPICS AND TEMPLATE

The **relevant topics** of the SNC include the residential stay (whether in the family home, assisted living, in an extra-mural facility or in one's own flat), a personal future and security plan for the execution loosening, and a plan for life in freedom for the time after release. The latter, among other things, deals with the future professional career, which includes suggestions regarding the compliance with orders/instructions and the handling of crises, an "emergency plan" (who takes over what in case of a crisis), the daily structure as well as the meaningful planning of leisure time and the maintenance of social contacts.[489] This future plan is then to be submitted to the court and provides an improved basis for decision-making on conditional suspension of the measure or conditional release. The aim of the SNC is to promote the application of non-custodial measures and thus to shorten the duration of deprivation of liberty.[490]

The implementation of the future plan is accompanied, monitored and reported back to the court as part of the probation service. Furthermore, follow-up conferences can be organised to ensure that the person concerned receives the necessary support and to identify possible challenges, etc.

At present, it is possible to convene a SNC in two cases with regard to persons with intellectual and/or psychosocial disabilities who are subject to preventive measures:

Refraining from pre-trial preventive measure: A person with an intellectual and/or psychosocial disability who is urgently suspected of a criminal offence, is to be temporarily placed in a forensic therapeutic centre, if there are sufficient grounds to assume that the requirements for being subjected to preventive measures in accordance with Art 21 (1) or (2) of the Austrian Criminal Code and one or more grounds for detention within the meaning of Art 172 (2) and (6) of the Code of Criminal Procedure (grounds for imposing pre-trial detention) are met.[491] However, the court may refrain from the pre-trial preventive measure if its purpose can also be achieved by treating and caring for the person concerned without such placement.[492] Before deciding to temporary refrain from execution of the pre-trial preventive measure, the court may (since the introduction of the new reform law)[493] instruct the head of a probation service to conduct a social net conference,[494] and to present a plan for the application of alternative measures.[495]

Temporary refraining from execution of preventive measure: If the requirements of Art 21 (1) or (2) StGB are met, the person concerned shall be placed in a forensic therapeutic centre. However, the court must examine ex officio whether it is possible to provisionally refrain from execution of preventive measure by setting conditions and ordering probation assistance. If the person concerned has already been provisionally accommodated, the court must instruct the management of the forensic therapeutic centre to review the requirements for provisional refraining. A social network conference can be organised for this purpose.

II. DEVELOPMENT

The steadily increasing number of people with intellectual and/or psychosocial disabilities being subjected to preventive measures is a fundamental problem in the Austrian criminal justice system. This upward trend has been observed since the end of the 1980s and continued to intensify in the first decade of the new millennium. The reasons for this increase appear to be diverse. The main causes are not only to be found in the increasing numbers of admissions, but also in the slow releases, which consequently also prolongs the duration of deprivation of liberty.[496] Therefore, there is an urgent need for the application of non-custodial measures. This has also been advocated by the Council of the European Union which recommends that Member States should increasingly allow alternatives to custodial measures. This would better prepare offenders for reintegration into society and contribute to the prevention of recidivism.[497]

This is exactly where the SNCs come in. The SNC is a new methodological approach of social work that goes back to the model of the "Family Group Conference" first developed in New Zealand for juvenile offenders. The model is based on the assumption that juveniles who are in a crisis phase of their lives (which manifests itself in the commitment of crimes) are themselves capable of decision-making and problem-solving. The SNC aims to involve the young person's social environment (parents, other family members, friends, neighbours, teachers, etc.) in overcoming their crisis and dealing with their conflicts, and to support them in not committing (more) offences in the future.

In Austria, the SNC was first introduced and launched to reduce pre-trial detention for juveniles. Based on a successful pilot project for juveniles, this system was transposed into national law and entered into force in 2016.[498]

After this successful introduction of the SNC´s for juvenile offenders, the Ministry of Justice commissioned the central probation service in Austria "Neustart" to test the model of a SNC in the preventive measure system, among others for detainees with intellectual and/or psychosocial disabilities, in Vienna, Lower Austria, Styria, Upper Austria and Salzburg as of 1 April 2015. Within the framework of the pilot project "Sozialnetzkonferenzen bei Maßnahmenuntergebrachten" ("SNCs for persons subjected to preventive measure systems") throughout a period of 16 months, 60 SNCs were assigned and 40 SNCs were carried out. The addressees were all prisons and psychiatric clinics in the aforementioned federal states. The court followed the plan of the SNC in its discretionary decision in 24 of the 36 cases and positively decided with regard to conditional suspension ("bedingte Nachsicht"), conditional release ("bedingte Entlassung") or reduction ("Strafmilderung") of the sentence by a SNC. Only in two of the positively decided cases did the clients breach conditions or drop out.[499] A total of 36 of the 40 SNCs carried out were completed positively and participants found the project to be very positive and promising. The project was completed on 31 July 2016.[500]

Following the new reform, which entered into force on 1 March 2023, the SNC´s have received a legal basis for cases involving persons with intellectual and/or psychosocial disabilities.[501]

III. DEVELOPMENT

The advantages of social net conferences are manifold. SNC's provide **persons concerned** with the opportunity **to actively participate in the process,** as well as involve family and other relevant social contacts.[502] The person concerned is present throughout the entire

conference. Developing the future plan alongside the social net and the probation officer can have a very positive psychological effect on the person concerned, giving them perspective and the feeling of ownership of this plan.

Further advantages include:

- comprehensive, interactive information flow on all sides (professionals, family members, the person concerned);
- well and comprehensively planned leisure activities; and
- more clarity regarding tasks, roles and responsibilities, as well as more understanding and acceptance for necessary plans.

In addition, SNCs are not only an advantage for the person concerned, but also for the relatives and caretakers, who may otherwise feel overwhelmed and left alone with problems and burdens they have experienced with their relatives' situation/disability. Against this background, they experience the SNCs as a forum in which they have been comprehensively informed for the first time about the requirements, tasks, aspects and problems to be considered.[503] Last but not least, the prison facilities, whose capacities are often overstretched, also benefit. In order to alleviate strain on the prison facilities and forensic therapeutic centres, alternative measures to deprivation of liberty are urgently needed.

IV. REMAINING CHALLENGES

While there are many advantages to the implementation of SNCs, some challenges remain. Firstly, the implementation in practice depends crucially on whether there will be enough outpatient alternative support measures and resources to the forensic-therapeutic centres. This also requires secure funding.[504]

Secondly, studies have shown that the success rate often depends on whether the person concerned is embedded in a suitable social network. However, unfortunately, many defendants and detainees with intellectual and/or psychosocial disabilities do not have a strong social environment which may preclude them from this opportunity.[505]

Furthermore, considering the interests and needs of victims of violent acts requires sensitivity, especially if the acts have occurred in a social proximity and if there is a possibility of future contact between the victim and the perpetrator. In such cases, it is advisable to diligently examine and plan the involvement of the victim's side in advance.[506]

In addition, SNCs are under considerable time pressure. The SNC has little time to talk to all relevant actors (family, psychologists, doctors, the concerned person himself) from their commencement until the time of the decision about a possible alternative measure. However, they require sufficient time for good quality planning about the future of the person concerned, which is crucial for a positive decision of the court regarding any alternative measures.[507]

Finally, since Art 431 (2) 2 ACCP is merely a discretionary provision, it remains to be seen to what extent judges will make use of the right of ordering a SNC. So far SNCs are only foreseen in case of the refraining from the execution of preventive measures, but not conditional release (as the reform law does not cover the conditional release yet).

ANNEX 2: BULGARIA - MULTIDISCIPLINARY APPROACH IN CASE MANAGEMENT

The promising practice identified in Bulgaria during the desk research and interviews was that of a multidisciplinary approach in case management by social workers/service providers, psychiatrists/psychologists (as expert witnesses), the person with a disability and his/her relatives/close persons and judges applied by two judges in two courts during court proceedings for involuntary/compulsory treatment. It was set up within a project and showed good results but is an exception in practice. The positive sides of this approach are that the judges receive valuable and reliable information about the person's actual situation, needs and potential and may decide the case in a way that respects the rights of the person with disabilities (with a focus on Art 6 (fair trial) ECHR and Art 12 and Art 13 of the UNCRPD). The approach also helps the person to be ensured with support during the proceedings and afterwards.

Description of the project:

Name: ***Ex iure ad iusstatium*** (from law to justice); principles of fair trial for persons with disabilities, http://equalrights.gip-sofia.org.

During the period 2020-2022, the Bulgarian Centre for Non-Profit Law (human rights NGO), the Global Initiatives in Psychiatry - Sofia (service providing NGO, lead partner) and the Union of Judges in Bulgaria (partner) had implemented a project "Ex iure ad iusstatium (from law to justice); principles for a fair trial for people with disabilities", supported by the Active Citizens Fund - Bulgaria (www.activecitizensfund.bg) within the Financial Mechanism of the European Economic Area 2014-2021.

The project aimed to unite the efforts of practising judges, lawyers and NGOs (service providers and human rights NGOs) in **elaboration and testing of an innovative algorithm for applying procedures guaranteeing the respect of the rights of persons with disabilities in accordance with the most modern international human rights acts (mainly ECHR and UNCRPD) in court proceedings.** The model mainly affected proceedings for placement of persons with psycho-social and intellectual disabilities in specialised institutions under the Social Assistance Act, for compulsory treatment under the Health Act and for involuntary treatment under the Criminal Procedure Code.

The **main anticipated outcome** was the creation of tools to turn the court into a social centre integrating knowledge and support for the person in a vulnerable situation. During the project implementation new and specialised training materials, guaranteeing that the rights of people with psycho-social and intellectual disabilities are respected in court procedures at every stage, were developed and discussed. A guidebook and two analyses are being elaborated currently and will be uploaded on the website of the project (in Bulgarian) http://equalrights.gip-sofia.org.

The elaborated model for multidisciplinary approach in case management in the above mentioned cases was tested in 40 court cases by the judges, expert witnesses and social service providers.

The main **target groups** are judges, prosecutors, service providing NGOs, and persons with psycho-social and/or intellectual disabilities.

The **identified problems that led to this project** were: the poor out-patient healthcare services; the poverty and the lack of access to support and meaningful activities for persons with psycho-social and/or intellectual disabilities; and the lack of coordination between police, court, psychiatric facilities and social services. All these problems lead to long unnecessary stays of patients who do not need active treatment in psychiatric hospitals or to lack of any care while treatment is needed. In the meantime, these persons with disabilities do not receive any support during the court proceedings either.

The pilot project identified as a promising practice brings social service providers, judges, medical experts and the person with disability work together in assessment of the situation of the concerned persons and in provision of support before, during and after the court proceedings. This is not explicitly provided for in legislation as an obligation but is an available option since 2020 when the Social Services Act was enforced. However, such appropriate social services are not provided in all court regions yet and the judges are not aware of them wherever they are available.

According to the interviewed judges and service providers (implementing the project) **support services for persons concerned should be referred by the court.** The view that the judge can and should refer to social services and/or services providing support, tracking out-patient treatment, and ensuring that no one is arbitrarily deprived of liberty (because of lack of housing) should be vigorously applied in practice. Currently, in judicial circles in Bulgaria, this unpopular understanding is interpreted as over-empowerment and is considered to usurp the role of the social worker. However, the judges must be aware of the CRPD principles and rights of the persons with disability and must collect evidence about the readiness and ability of the social workers and all other experts to apply these principles and standards on the practical level. In case the judge or the prosecutor find there is no proper service in place or/and social workers and/or other experts are not prepared to properly apply the CRPD, the legal framework should allow them to recommend to the relevant authorities building such services or ensure capacity building of the social workers/ other experts.

Social service providers and the Social Assistance Departments (which work with people with disabilities) should be involved in compulsory and involuntary treatment proceedings and probation proceedings, because they are competent under the Social Assistance Act and the People with Disabilities Act. This is not a working model yet because **the law does not explicitly require the court to refer to them**. All alternatives (to detention and compulsory treatment) options should be available to the court for people who are in such a complicated social status to be explored.

Some of the interviewed judges already use the opportunity to ask Social Assistance Departments for an assessment of the person's situation and share that Social Assistance Departments provide poor quality reports and no assistance. Usually the assessment provided by the Social Assistance Department is useless because it only contains information about the person's age, address, pension amount, social security and tax status and nothing about the actual challenges in his/her life situation. However, **some social service providers (NGOs) collect and process essential information about the person and gradually start to work on case management successfully with the courts** (but still on a pilot project basis). Within the periodic court review of the compulsory treatment (every six months, under Art 432 of the Criminal Procedure Code), the court may direct information and counselling to the social services under the new (2020) Social Services Act, as long as such services have been created. The provider of such a service can make an actual and adequate assessment of the person's needs. There are already some such assessments under the mentioned pilot project, elaborated by the Global Initiative in Psychiatry (NGO). Judges need a connection to a person's support network in order to order release from in-patient compulsory/involuntary treatment. However, finding or building such a network takes months or years in the majority of the cases. The judicial authorities actively must seek for innovative practices based on UNCRPD applications and when done so, to take proactive actions to inform the judges and prosecutors for them. In this regard **judges recommend a database with service providers to be set up to enable them to refer accused, defendants and convicted persons with disabilities** to them and ask feedback from them about the person's condition for the purpose of regular court review of the treatment.

ANNEX 3: GERMANY – REFORM OF THE ACT ON CRIMINAL LAW-RELATED COMMITTAL TO A PSYCHIATRIC HOSPITAL OR AN INSTITUTION FOR WITHDRAWAL TREATMENT IN NORTH RHINE-WESTPHALIA (STRUG NRW)

The StrUG came into force on 31.12.2021. It standardises detention according to sec 63, 64 Criminal Code (StGB) in the Land of North Rhine-Westphalia (NRW).[508] Until the reform, the legal text was largely unchanged since 1999, apart from isolated amendments.

The revision of the legal text was due to multiple reasons:

- In its decision of 4 May 2011, the Federal Constitutional Court (FCC) demands, amongst other things, the compliance with the principle of proportionality, a therapy- and freedom-oriented enforcement of the detention

- Empirical knowledge of the treatment of persons with psychosocial disabilities has evolved

- The average period of detention is 10.2 years in North Rhine-Westphalia, which is longer than the national average. 33% of those placed under sec 63 Criminal Code had been detained for more than 10 years as of December 31, 2017.[509]

Treatment, except for compulsory medical measures, is only permissible based on the right to self-determination. For this reason, persons concerned are no longer referred to as patients but as detainees (untergebrachte Person) in the legal text, who may or may not undergo treatment on a self-determined basis.

According to sec 3, the detainees' dignity and personal integrity must be respected and protected. Life in forensic psychiatric detention is to be adapted to the general living conditions outside, provided that security concerns do not prevent this. Detainees shall be given space and opportunity to maintain and develop their individuality. In addition, detainees have a right to appropriate accommodation, food, treatment and care (sec 3 para 2). However, the principle of individual accommodation is missing entirely. Currently, facilities of forensic psychiatric detention are overcrowded. Often, overcrowding leads to multiple occupancy of rooms. The lack of privacy can trigger conflicts and disrupt therapeutic treatment.[510] However, at least double rooms are common even without overcrowding: Often psychiatric hospitals for forensic psychiatric detention are orientated towards regular hospitals (including general psychiatry) where rooms with at least two beds are the standard. Of course, it should be noted that the duration of detention is generally much shorter in general hospitals.

In addition to complying with the principle of proportionality, the FCC demands that forensic psychiatric detention be oriented toward therapy and liberty. This includes the requirement for individualization of treatment, which must offer a realistic prospect of release.[511] In order to achieve the objective of rehabilitation, detainees have a legal right to the removal of restrictions on their liberty.[512]

The degree of deprivation of liberty is based on the predicted danger (sec 4 para 1) and expressed in levels (sec 4 para2), meaning that measures to deprive a person's liberty must be defined and justified. The degree of deprivation of liberty is indicated in degrees: from 0 (little: the detainee is entitled to live outside the facility in an external facility or their own home) to 4 (intensive: the primary place of residence of the detainee is the facility. They are not entitled to leave it). This new direction is important: the focus no longer lies on measures that need to be assessed (and granted), but interventions are to be defined and justified from the point of view of ensuring the protection of the general public.

With its decisions in March 2011 and July 2018, the FCC strengthened the right of self-determination of detainees. The UN Convention on the Rights of Persons with

Disabilities has also strengthened the right to self-determination of persons in forensic psychiatric detention.[513]In sec 8, the person's right to self-determination is highlighted by involving them in the planning of treatment. The treatment and rehabilitation plan should be an offer towards the detainee and must consider alternative possibilities of inpatient stay (sec 8 para 2). When issuing the treatment plan, the principle of regionalisation must be considered. This provides the possibility of treatment and accommodation close to the residence (sec 55).

The StrUG is oriented towards social rehabilitation and assigns a more significant role to the Forensic Outpatient Unit in treating the persons concerned (sec 16). These units will support detainees from the very beginning of their detention and are intended to ensure the treatment, care and supervision of detainees staying outside the inpatient area in preparation for release. Moreover, they will provide the treatment of persons concerned after the release.

Night confinement is a regular practice in many facilities and is, among other things, a result of staff shortages and staff cuts.[514] Night confinement can have negative consequences for the therapeutic process. It is therefore a good sign that night confinement is considered a special security measure (sec 32 para 1 No. 4). Therefore, a reasoned case-by-case decision is needed. When night confinement is ordered, the legal guardian, the legal representative and, at the request of the detainee, another trusted person must be informed immediately (sec 32 para 4). Nevertheless, night confinement is a regular practice in some facilities and is, among other things, a result of staff shortages and staff cuts.[515]

According to Sec 33 para 2, restraint (Fixierung) may only be ordered as a measure of last resort if it is indispensable to avert a current significant danger to the person or a significant danger to the legal interests of others, and if, based on the person's behaviour or condition, other less severe measures to avert the danger do not appear to be sufficient. Following a judgement of the FCC, restraining a person for more than 30 minutes is a deprivation of liberty that needs a judicial decision, the monitoring of a medical doctor as well as personal observation.[516] Regarding the use of physical restraint, sec 33 para 6 states that uninterrupted, direct, personal one-on-one supervision has to be provided. The legislature thus followed the case-law of the FCC and the recommendation of the National Agency for the Prevention of Torture.[517] According to sec 33, restraint is defined as a measure that deprives the person of their freedom of movement. The National Agency criticises that sec 33 lacks a definition of a 3-point-restraint: the lack of a clear definition can lead to the use of such restraint, even though it might not represent the milder means (in an individual case) and which is seemingly not covered by the procedural safeguards.[518]

According to sec 50, the house rules should contain detailed information on the personal rights and obligations of the detainees in easy-to-understand language. However, this has not yet been implemented by all facilities. Translations in other languages are also lacking.[519]

In conclusion, the success of the reform and the changes it will bring to the detainees will depend heavily on employees' attitudes toward those detained and on the quality of therapy services provided on-site.[520] Innovative legal terms and regulations may enhance changes of attitude and practice, but they should however not be equated with them. Furthermore, it is worth emphasising that the protection of the general public is still at the forefront of the law while rehabilitation and the empowerment of the person's self-determination are only mentioned after that.

ANNEX 4: ITALY - THE REMS SYSTEMS

THE CREATION OF THE REMS SYSTEM

As previously mentioned, the REMS system, despite representing a step forward in the treatment of people with intellectual or psychosocial disabilities, presents many criticalities that should be addressed by policy makers, but the foundation of its creation goes back to twenty years ago.

In Judgement No 253 of 2003, the Constitutional Court defined as "constitutionally illegitimate Art 222 CP (Admission to a Judicial Psychiatric Hospital), in so far as it does not allow the judge, in the cases provided for therein, to adopt, instead of the admission to a psychiatric hospital, a different security measure, provided for by law, suitable to ensure adequate care for the mentally ill person and to cope with his social dangerousness". The Court specified "that the automatism of a segregating and 'total' measure, such as admission to a judicial psychiatric hospital, imposed by the law, even when it appears in practice to be unsuitable, breaches the constitutionally necessary balance and violates essential requirements for the protection of the rights of the person, in this case the right to health referred to in Article 32 of the Constitution".[521]

Since then, it took five years and the prison healthcare reform of 2008: in the DPCM of 1 April 2008, annex C, the abolition of the OPGs (***Ospedali Psichiatrici Giudiziari*** - Judicial Psychiatric Hospitals) was scheduled; experts began at that time to highlight the problem of the presence of 6 OPGs in Italy, a country where the choice of deinstitutionalisation of the mentally ill non-offenders had been made since 1978 (Law No. 180 of 1978, the so-called Basaglia Law). This annex produced certain effects that nevertheless remained confined to experts. The main effect it produced, which came from the prison health reform, is that of a migration of competences over OPGs from the Ministry of Justice to the Ministry of Health (therefore to the Regions and to the local health authorities).

In 2010, the Parliamentary Commission of Inquiry on OPGs was established, chaired by Senator Ignazio Marino, which represented a turning point in this matter because it made the country see the degradation in which inmates in OPGs were forced to live. From that moment, it was possible to start thinking about the construction of a new legislation that would lead to the abolition and closure of those facilities and the guarantee of the start of a path of care and protection for these persons centred on community mental health services. The new legislation was introduced with law no. 9 of 2012, which, however, failed in its purpose of reform.

Law No. 9 of 2012 was thus supplemented by Law No. 81 of 2014, which not only postponed the date of the final abolition of the OPGs, but also went on to better specify the future functioning of an undeniably complex area of the penal and health system. In addition, the law went on to establish an active Coordination Body for the two-year period 2014-2016. It had indeed been noted that not all the Regions were moving at the same pace to set up ad hoc health facilities (REMS) suitable to accommodate a part of the OPG inmates and future inmates. Even at the level of the territorial institutions, there was in those years much resistance in accepting the creation of these facilities on the territory due to an important lack of institutional dialogue. This newly established coordination mechanism was called upon to respond to all these practical difficulties, a task that it failed to accomplish to the extent that an ad hoc Commissioner had to be appointed for the two-year period 2016-2017.

Law no. 81 of 2014 has established some fundamental principles on the subject: first of all, it has recognised the priority of healthcare assistance, also by assigning the internal management of the REMS exclusively to healthcare authorities. In addition, the focus must be on the therapeutic project, which must be individualised; REMS must be organised in compliance with the principle of territoriality of admissions on a regional basis with respect to the residence of the person to be admitted; REMS represent measures that should be used as a last resort, a char-

acter that is also reaffirmed by the system of waiting lists. These prevent overcrowding and also prevent the misuse or overuse of a measure that should maintain a residual character.

This is the first time that a ***'numerus clausus'*** is introduced in the Italian penal system. A principle as banal as it is revolutionary, the number of guests in REMS can never exceed the maximum capacity and therefore REMS cannot be 'overcrowded'. This has resulted in a 'waiting list' of people waiting to be admitted to REMS. The most critical cases are those who are waiting in prison, as in the case of Giacomo Sy, who chose to file an appeal to the ECtHR, highlighted above.

In 2017, all OPGs were closed; the inmates who had been confined there until then followed different paths: some entered the REMS, others returned to freedom after years, not without some difficulties due also to the long removal from the free society and the difficulties of the territorial social services.

The OPGs were replaced by a set of health and social services offered in the community. The right to health, which by the Constitution must be ensured regardless of a person's legal status to all individuals, was thus placed on a formal level in a position of precedence over the right to security - albeit balanced with this. The person recognised as not being fit to be found criminally responsible, accused or found to have committed a crime, was no longer to be simply interned but was to be granted the right to be cared for and treated. The system of care designed for this purpose was to be centred on the community and on a plurality of interventions of which the REMS were to represent the ***extrema ratio***.

In 2017, the Superior Council of the Magistracy expressed itself on the issue as follows: 'The reform, therefore, has placed at the centre of the new system the Departments of Mental Health, which have become the owners of the therapeutic and rehabilitative programmes for the purpose of implementing, as a rule, treatment in territorial and residential contexts. The REMS are, therefore, only one element of the complex system of treatment and rehabilitation of psychiatric offenders'.

While the idea might be that all difficulties have been overcome since then, this has not been the case. The economic crisis led to a major reduction in the resources allocated to health and mental health in particular. All the scaffolding that had represented the abolition of the OPGs, instead of being strengthened, was to some extent neglected since then.

At the end of 2021, the two Ministries involved in the matter, the Ministry of Health and the Ministry of Justice, decided to reconstitute a Coordination Body chaired by Professor Nerina Dirindin. The objective prescribed for the body was to understand, in the Regions with the most critical issues, what measures to take, especially in light of the Constitutional Court's preliminary order no. 131 of 2021 in which the Court formulated questions submitted to all the different institutions involved in the management of intellectual or psychosocial disabilities within the criminal justice system: the Ministry of Justice, the Ministry of Health and the Conference of the Regions and Autonomous Provinces. These three institutions delivered to the Constitutional Court 'a single comprehensive report, prepared jointly', which has already been presented above.

Quotes of the report were published in the subsequent Court's judgement No. 22 of 27 January 2022 and contain valuable information that will be reported here, also because it is often the only source of information and numerical data on the subject.

As of 31 July 2021, there were 36 active REMS in the country. At that date, the REMS housed 596 people against an official capacity of 652 places; it must be noted that a waiting list system is active in the REMS and that therefore the negative difference in admissions was linked to the needs of that particular moment, which coincided with the pandemic. The report highlighted a discrepancy in the information on the so-called waiting Lists for placement in REMS to the

different institutions: the Ministry of Justice had 750 people on the waiting list, while the Conference of the Regions and Autonomous Provinces had 568 on the same date, and a further 103 people who could not be placed in REMS because they were in prison or because they could not be found. While this might appear a mere numerical difference, in reality, it is a more general indicator of a communication difficulty (that becomes a management one) between the institutional actors involved. The average time spent on the waiting list is indicated in the Report as 304 days; however, further clarification is needed. The REMS system, belonging exclusively to the National Health Service, is organised on a regional and provincial basis (for the autonomous provinces); it follows - as also stated in the Report - that the 304 days of waiting represent a national average, since there are very deep differences from Region to Region. In some regions the phenomenon of waiting lists seems to be marginal, while five regions (Sicily, Apulia, Campania, Calabria and Latium) seem to have the longest waiting times and also the largest numbers (172 people waiting in Sicily alone). It is worth noting the existence of the requirement of territoriality with regard to placement in REMS, which means that it is unlikely that a person will be placed in a REMS in a Region other than their Region of residence (as of 31 July 2021, only 19 out of 596 persons were in this condition). As of 31 July 2021, there were 61 persons in prison on the waiting list for a place in an REMS, none of whom according to the DAP were placed in hospital psychiatric services (ex Art 286 CPP). In the Report, as cited in the Court's judgement, there is also a significant decrease in the number of prisoners waiting for a place in the REMS from 98 on 28 October 2020 to 35 on 25 October 2021. Between 20 June and 25 September 2021, according to the DAP 15 probation orders were issued in favour of people on the waiting list for placement in REMS and previously detained in prison.

In the Report, the Ministries identified some of the difficulties encountered by the system up to that time; the Ministry of Justice summarised the limitations of the system in the lack of places in the REMS and the difficulty of communication between the actors involved. For the Ministry of Health, the limitations were to be found in the culture of the operators (health workers, judiciary and prison workers).

Following the reception of this report, the Constitutional Court, in Judgment No. 22 of 2022, while recognising the constitutionality of Law No. 81 of 2014 and therefore judging positively the path of abolition of the OPG, nevertheless indicated some friction points with the constitutional principles. It indicated in particular the need to promptly execute the judicial measures andto address the problem of the waiting list, thus referring detailed analyses and solutions to the various institutional actors and not excluding, indeed hoping for a new legislative intervention.

Indeed, the Court calls for a comprehensive and urgent reform of the system, which would ensure that the admission to REMS 'has an adequate legal basis', ensuring at the same time 'the development and proper functioning, throughout the national territory, of a sufficient number of REMS to meet the real needs, in the framework of an overall and equally urgent development of facilities on the territory able to ensure alternative interventions adequate to the needs of treatment and to those, equally essential, of protection of the community'.

A critical passage of the Court's motivations concerns the nature of the custodial security measure that currently combines deprivation of liberty and coercion of treatment. An interpretation that raises many perplexities because for the offender with an intellectual or psychosocial disability the Laws No. 180 of 1978 and No. 219 of 2017 do not apply, but even more so because on the psychiatric medical level there can be no treatment without consent, participation, responsibility and the prospect of freedom. If such an interpretation of the security measure were to persist, it would open a question mark over the meaning of the Health care management of REMS.

Great limitations concern the whole system of measures aimed at those persons with intellectual or psychosocial disabilities who are recognised as people who cannot be charged. In their case, the abolition of forensic psychiatric hospitals should have also caused a paradigm shift from one centred on the prevalence of the public interest in security (which entailed a 'neutralisation' of the person) to the prevalence of the right to health care (balanced by the collective right to security) of the person declared unfit to stand trial because of an intellectual or psychosocial disability. For this reason, in the idea of the 2014 legislator, the introduction of the REMS should have represented an ***extrema ratio*** in a framework of management of cases of social dangerousness that should have been managed on the territory and by the territory in particular by the mental health services. However, the greatest limitation lies precisely here. There are few residential facilities (e.g., community facilities) able to cope with these requests and little if any territorial coordination between health authorities, courts and community facilities. There is also resistance in the culture of all the institutional actors involved in this issue, who end up resorting more easily to the known routes, preferring detention or in any case measures of deprivation of liberty.

The REMS also have certain limitations, two of them being the fact that the waiting lists are often filled by people awaiting in prison (the ECtHR recently expressed its opinion in the ***Sy vs. Italy*** case). Secondly, even though the law that led to the abolition of the OPGs also abolished the so-called 'white life sentences', imposing a maximum limit on the duration of the measure of confinement in the REMS, making it coincide with the duration of the maximum sentence for the crime committed, in reality, leaving the REMS is often not so simple and straightforward.

Also, the creation of the REMS system has created an important effect on the management of people with intellectual or psychosocial disability in prisons within the ATSMs. Indeed, Law No 81 of 2014 made it impossible to 'unload' people who develop an intellectual or psycho-social disability onto REMS. Until then, the prison institution had in fact the possibility of having an institution, OPGs, on which to 'unload' all problematic and difficult cases. The prison would have continued to send people to the REMS and overcrowd them, as it did with the OPGs before, using the label of intellectual or psychosocial disability as an 'excuse' to delegate the management of that individual to others. The only way to break this mechanism, was to distinguish the sanctioning response, precluding, by law, the possibility of resorting to admission to REMS.

Despite the many limitations and criticalities of the REMS system, it is undeniable that it represents a great improvement from the previous OPG system both in terms of conditions of detention (which were previously called 'unworthy of a civilised country' by the President of the Republic) as well as of mental health service, which is now oriented on the care needs of the person. From these points of view, the REMS system can be considered a success even though many improvements still need to be done.

ANNEX 5: LITHUANIA - HALFWAY HOUSES IN LITHUANIA

Recommendation Rec(2006)2-rev of the Committee of Ministers to member States on the European Prison Rules stresses that prisoners shall be allocated, as far as possible, to prisons close to their homes or places of social rehabilitation.[522]

The first Halfway House in Lithuania was opened in 2016, in Alytus, after the Ministry of Justice of the Republic of Lithuania started the implementation of the project supported by the Kingdom of Norway "Reducing the number of convicts held in closed-type penitentiary institutions by establishing 4 new open-type penitentiary institutions". Subsequently, Halfway Houses were opened in Marijampolė, Vilnius and Pravieniškės.

A Halfway House is a special structural unit of a penitentiary or remand home, the main

task of which is to ensure the continuity of the social rehabilitation of convicts, combining it with their employment activities (work, education, studies), as well as the intensive preparation of their release on parole from a detention institution. It should be noted that Halfway Houses for convicts are not separate institutions of the penal enforcement system and do not have an independent legal status.[523]

According to the Lithuanian Prison Service, Halfway Houses are for those convicts who are trying to reintegrate back into society, make amends and who do not pose a danger to the community.

STATISTICS

Since 2016, around 400 prisoners have been transferred to Halfway Houses in Lithuania. Data on persons with intellectual and/or psychosocial disabilities in Halfway Houses is not collected, which is the same as in other fields of the criminal justice system in the country, so it is difficult to say how many people of the target group live in Halfway Houses. However, they are the main focus of the evaluation of the functioning and effectiveness of Halfway Houses in this Case Study. According to representatives of the Lithuanian Prison Service,[524] one of the indicators of the effectiveness of Halfway Houses is the re-offending and return of convicts to a semi-closed or closed regime. After spending time in a Halfway House, people are less likely to re-offend and end up back in prison. In addition, between 2016 and 2021 (five years), 43 prisoners were sent back to detention facilities, which accounted for about 11% of the total number of prisoners in Halfway Houses during the period.[525]

In 2022, 140 convicts were accommodated in all Halfway Houses, with a relatively even distribution between the individual Halfway Houses:

- Alytus Halfway House (max. 20, on average 15);
- Marijampolė Halfway House (max. 20, on average 18);
- Vilniaus Halfway House (max. 60, on average 45);
- Panevėžys Halfway House (max. 20, on average eight);
- Pravieniškės Halfway House (max. 20, on average 19).[526]

The practice of Halfway Houses shows that on average about 110-120 prisoners serve their prison sentences in Halfway Houses, which is about 85% of the occupancy rate in Halfway Houses. This is not a large number of inmates. On average, about 4,400 prisoners are serving prison sentences in penitentiaries and remand prisons. Thus, only 3% of the convicts serve their prison sentences in Halfway Houses.

According to the Lithuanian Prison Services Strategic Guidelines for 2022-2030, it is planned to establish 20 Halfway Houses (with a maximum capacity of 20 persons each), evenly distributed throughout Lithuania.[527] The guidelines stipulate that the work of the Halfway House is coordinated by the prison in the geographically nearest location.

In 2021, the Director of the Prisons' Department under the Ministry of Justice of the Republic of Lithuania issued an order on the approval of a plan of measures for the development of Halfway Houses in 2022-2024.[528] According to the plan, Halfway Houses will be opened in Šiauliai city, Kaunas district and Klaipėda region in the next two years.

CRITERIA FOR CONVICTED PERSONS

Not all categories of prisoners can be transferred to Halfway Houses. The requirements for transfers are both formal and personal change. For example, persons at high risk of re-offending are not transferred to Halfway Houses.

The existing legal framework provides that there are two categories of prisoners who can be transferred to a Halfway House: 1) prisoners who are eligible for parole and apply for transfer themselves (Art 69(2) of the Code for the Execution of Criminal Penalties of the Republic of Lithuania); 2) pris-

oners who cannot be released on parole and whose application for transfer to a Halfway House is submitted by the administration of the institution (Article 69(3) of the Code for the Execution of Criminal Penalties of the Republic of Lithuania).

According to Prof. R. Uscila, the requirements for the transfer of a convicted person to a Halfway House are relatively high:

1) the convicted person must be an active participant in the resocialisation process (carrying out the measures set out in the individual social rehabilitation plan in the penitentiary home, working or engaging in other meaningful activities) and must be classified in the "light" group;

2) the risk of re-offending is low or has clearly decreased during the sentence;

3) the convicted person is eligible for parole from the penitentiary institution and there is no more than one year left before the application of this institute;

4) the convicted person must have served at least a quarter of the sentence, and the convicted person whose partially suspended sentence has been revoked, as well as whose conditional release from the penitentiary institution has been revoked, and who has been sentenced by the court to serve the remaining part of the custodial sentence imposed by the sentence, – have served at least six months of the custodial sentence from the beginning of the execution of the court's decision on the suspension of the execution of the sentence or on the revocation of the conditional release and the referral to a correctional institution;

5) the convicted person must not have any previous penalties for infringements of the law committed while serving the sentence;

6) the convicted person has not previously been transferred from an open colony or Halfway House to a penitentiary because of violations of the law.

In addition, prisoners must work or study, refrain from committing offences, follow a prescribed route when travelling to work, an educational institution, a shop or any other place, keep to a daily routine, and take part in resocialisation measures. Prisoners are also encouraged to take care of the Halfway House and its grounds as their home, with an emphasis on the development of appropriate social and work skills. The status of the prisoner as a dependent, where the prison used to take care of everything "from scratch", is being abandoned in favour of autonomy and responsibility.

The algorithm for transferring a prisoner to a Halfway House is described below:

1. The convicted person or institution applies for transfer to a Halfway House;

2. The director of the prison decides whether the prisoner meets the formal grounds;

3. The prison accepts the assignment to the Resocialisation Unit to prepare the documentary material required for the transfer;

4. Material to be submitted to the Lithuanian Prison Service's Halfway House Commission;

5. The Commission shall examine the case in question and make a proposal to the Lithuanian Prison Service or the head of a subordinate institution;

6. The Director of the Lithuanian Prison Service or a subordinate institution shall take a decision on the transfer of a convicted person to a Halfway House.[529]

BENEFITS OF HALFWAY HOUSES INCLUDING FOR PEOPLE WITH INTELLECTUAL AND/OR PSYCHOSOCIAL DISABILITIES

First of all, Halfway Houses have a small community of inmates. The number of staff working with them is relatively the highest compared to other detention facilities. There are four core staff and one supervisor working with 20 convicted persons.

As representatives of the Lithuanian Prison Service (who have had direct experience of working in Halfway Houses) stated during an interview, each person receives a great deal of individual attention in order to get to the bottom of their problems and challenges. If necessary, individuals are referred for help for addictions or health problems.[530]

Although there is no official data on the number of persons with intellectual and/or psychosocial disabilities in the penal system, according to a representative of the Lithuanian Prison Service, in the past year, up to ten persons were identified by the staff as having a disability (both intellectual and/or psychosocial and physical).

Although staff members are not specifically trained to recognise or respond to the individual needs of persons with disabilities, during the interviews, professionals indicated that there are staff members with similar experience, and that the competences of the staff member are also taken into account when transferring a person to a Halfway House.

However, the aim is to identify individual needs as early as possible. As a result, from 2021, social workers and their assistants have been working in the penitentiary system, whose functions include getting to know the person and identifying potential problem areas, arranging for the treatment of addictive diseases or other health problems, etc.[531] However, if the need for help arises while a person is in a Halfway House, it is organised.

Professionals who have worked directly with inmates at the Halfway House report positive changes in their behaviour. There is solidarity with the new arrivals and a certain takeover of the duties of social workers in terms of helping, explaining or escorting them to work, education or health facilities.

Moreover, according to the Lithuanian Prison Service, Halfway Houses do not have the subcultures that prevail in prisons. There is also contact with social workers, which is maintained after release.

It is also worth mentioning that Halfway Houses involve inmates in a wide range of social and community activities. While there is usually some initial opposition from local communities to the establishment of such a facility, this eventually subsides. Communities notice that there is more protection, inmates contribute to the cleaning of the community environment, and willingly join in activities and classes.

It should be noted that people living in Halfway Houses have the opportunity to strengthen their relationships with their relatives, improve their emotional health. People currently living in Halfway Houses have the possibility to go home for up to two days each week, as well as to take a holiday at home (up to 20 days, as defined in the Labour Code).

In conclusion, although Halfway Houses are not exclusively for persons with intellectual and/or psychosocial disabilities, it is considered that it can be beneficial for them in several ways:

1. Individualised care and support: Halfway Houses can provide individualised support for detainees with disabilities based on their individual needs. This can include access to specialised healthcare professionals, counselling services, and educational resources;

2. Peer support: Halfway Houses provide opportunities for detainees (including those with intellectual and/or psychosocial disabilities) to connect with persons who are facing similar challenges. This peer support can help individuals build social connections and develop coping strategies;

3. Transitional support: Halfway Houses provide transitional support to detainees with disabilities who are being released from prison or other institutional settings. This support can include access to medical and mental health services, housing assistance, employment training, and other resources that can help the individual successfully reintegrate into life in the community.

4. Reduced recidivism: Halfway Houses have been shown to reduce recidivism rates among detainees. By providing transitional support, peer support, individualised care, and other resources, Halfway Houses can help individuals successfully reintegrate into the community and reduce the likelihood of reoffending.

ANNEX 6: SLOVENIA - OPEN FORENSIC WARD

"The essential is invisible to the eye! And the essential is love. Now, how do you love someone who killed someone? It is necessary to understand this man and the circumstances and from birth onwards... and to understand his illness." (Dr. Žagar 2023)

To determine whether a person can be held criminally responsible, the judge may order a psychiatric examination. If it is found that the defendant was at the time of the offence incapable to be found criminally responsible, proceedings for the application of security measures will be carried out. This may result in imposing the security measure of compulsory psychiatric treatment and confinement in a medical institution. Since 2012, there is only one such facility in Slovenia where such measures can be carried out – (a closed) Forensic Psychiatry Unit of the University Clinical Centre Maribor. **However, in the past there was an open forensic psychiatry ward in Slovenia – and it seems that such a ward was a unique practice in Europe.**

Although the practice does not exist anymore, the experiences and its elements seem to be a promising practice, which is why we chose the Department of Forensic and Social Psychiatry of the University Psychiatric Hospital in Ljubljana, Slovenia (hereinafter: DFSP) for the Slovenian national case study. The Department was (for a certain period) an open institution organised as a therapeutic community (TC) and which had a psychotherapeutic and rehabilitative orientation. The DFSP offered "treatment for psychotic offenders, prisoners, and people with socially accentuated psychiatric disorders" (Kobal and Žagar 1994). However, there was a selection of forensic patients that were to be treated within the DFSP and those who were assessed as too much of a risk, were still referred to a closed ward of a psychiatric hospital.[532] Nevertheless, the experience showed that rehabilitation of many of the forensic patients can be achieved with alternative approaches such as TC.

The DFSP was founded on 15 August 1967 by the University Psychiatric Hospital founded DFSP and the first head the Department was first Dr. Kobal who was later replaced by Dr. Žagar.[533] Both were psychiatrists who beforehand had experience as prison psychiatrists. They were also among the main protagonists of this development, and we could say that if it wasn't for them, an open forensic psychiatry warn would never have existed. But to be precise, the initiator was Kondža Joco, senior medical technician. Dr. Žagar (2023) explained in an interview:

> *"He took the initiative and said to professor Kobal... This was a closed department in the beginning and there were many patients, probably 30 of them or more. And some could go home, some couldn't go home, because they still had the measure issued by the court) and were new and aggressive and so on... and they weren't allowed to go out. Then he said to professor Kobal "Well, they know who can go out and who can't go out anyway, what if we try to leave the door open?". And when they opened the ward, nothing happened. Everything went well according to a program that had been planned before."* However, as written by Kondža and Kobal (2014): *"The department became open. But not mindlessly and without control. Safety inside and outside the ward was the basic rule. After the bars were removed, we started to open the doors gradually."*

According to Kobal and Žagar there was a general tendency to organise other departments as TCs at that time, which helped the DFSP to become a true therapeutic, rehabilitative and environment-oriented TC (for a certain period).[534]

In 1994, there was room for 15[535] patients[536] and the department was not hospital-like and had open doors and non-barred windows. DFSP also provided out-patient services – at that time 20 patients were in family care.[537] Not all admitted patients at the DFSP were criminal offenders – the group was mixed, comprised of major offenders (offences such as murder, manslaughter or other grave violent acts), minor offenders (offences involving property for example) and patients with no criminal background (no conviction). Also, their diagnoses varied from schizophrenic psychoses, other psychoses to (severe or minor) personality disorders, sometimes in combination with alcohol or drug addiction.[538]

The DFSP staff consisted of one psychiatrist, one social worker, one senior medical technician and three nurses.[539] Every patient was received by the head of DFSP and the team. First, the Therapeutic Pact was to be signed, which proscribed inappropriate behaviour, excessive drinking, drug-taking and absconding. In case patients breached the Therapeutic Pact, all circumstances were investigated and specific treatment plans could be made. It was only rarely necessary "to proceed to discharge, transfer into one of the closed hospital units, further intensive hospital treatment or return to the prison".[540] Each patient had an individual rehabilitation plan. The goal was to rehabilitate the patient and return him to his home environment as soon as possible.[541]

Dr. Kobal started TCs and Dr. Žagar continued them – and added even more TCs: music therapy, art therapy, recreational therapy. Multidirectional communications were established between the offenders and the medical staff, among the medical staff and among offenders themselves. In various groups they met daily or several times a week. There was an analytic psychotherapy group,[542] some patients were part of music therapy or psychodrama, occupational and recreational therapy groups, and there was one group led by the social worker and one led by medical staff. Together, staff and patients discussed and agreed on how the ward should function. The staff also met with relatives or patients' other relevant persons to discuss "the circumstances that should be taken into account in their future contact with the offender".[543] During their regular weekly meetings "they also determined who goes home and who doesn't. And whoever doesn't go doesn't go, he stayed there. He didn't need a cop to guard him" (Žagar 2023).

Most patients got to use shorter or longer breaks over the weekends (except if assessed that contacts would not be beneficial for either patients or their relatives or both), they could go for walks in pairs or small groups and some were also allowed to go out for walks alone. The team even organised shorter and longer trips – to the cinema, museums, events, including other cities. Sometimes they rented a bus or even drove the patients in their own cars.[544] Obviously, the effort was made to help patients "establish the contact with the outside world". After the patients concluded their stay in DFSP they could receive out-patient treatment and continue to be monitored. In case the deterioration of the patient's condition was detected rehospitalization could be required.[545]

In 1992–1993 the average stay of the patients in DFSP was 62 days (at that time an average stay in Slovenian psychiatry was 55 days) while the longest stay could last up to a year (Žagar 2023). In the period of 1984 – 1994, there were no suicides, despite the fact that DFSP often cared for extremely suicidal persons transferred there from prisons[546] (Kobal and Žagar 1994, 269–271). Looking back, Dr. Žagar (2023) still considers the DFSP to be successful. The rules were rarely broken and violence among the patients or against the staff was hardly ever detected. The DFSP's success is attributed to the atmosphere of the TC, but also to the fact that lower-risk patients were selected, the small number and homogeneity of the Slovenian society, the socio-cultural tendencies of the population to self-aggressiveness rather than to violence and the adequate provision of psychiatric and social services.[547]

Looking back now, Žagar (20023) says the

key was “an agreement and trust” between the staff and the patients. He took the risk (of potential incidents) when allowing patients to go outside and/or to go home over weekends or holidays. “But if I estimated that someone was really dangerous, I sent him to a closed ward – for a certain period of time.” Žagar (2023) also said: “There should be a forensic open part and a forensic closed part and I don't really like what's there (in Maribor) now, because it's mostly a closed part, and they don't have the courage for an open part, like I had. Well, you don't have to praise me, but you have to be self-confident and work with some risk. I worked with risk and I was aware of it.”

On the reasons for moving (actually closing) the department in 1998, Dr. Žagar (2023) said: "I have to say that since the department was opened, since it was formed, colleagues started saying ‘this doesn't belong here, these are criminals, they need to go somewhere else, as far away as possible. There are teenagers here, what if someone attacks a teenage girl’ and I don't know what else. But there was never anything." Until 1998, the DFSP was part of a Mental Health Centre, but as explained by Kondža and Kobal (2014), “the ward was a stranger in the dynamic Center for Mental Health. The organisers, therapists and staff were aware of this and constantly looked for opportunities for its independence from other units of the hospital, so that it would not physically and emotionally disturb those who were doing different work. They overtook us and in 1998 the department was abolished, and the remaining patients were placed in the secured ("intensive") department of the psychiatric clinic in Polje in Ljubljana." The “open door” policy was no longer there.

When asking Dr. Žagar about the potential for re-establishing such an open forensic and social psychiatry ward, he said: “The main question is who would work there. Who would want to work there and for what money?” As he further explained: “You know, a working team is very important. We were considered to be the most harmonious team. We got along well and respected each other, and we also respected the patients, because if there was any disrespect, I couldn't stand it. Even if you killed someone in a certain situation in your life, that did not stop you from being a person who deserves respect. … If there is no harmony, then fighting and incidents occur. …But back then this wasn't the case. Why wasn't it? Probably also because of our relationship. Attitude is important. Punishment... in 500 years, not even in 500 years... they will be appalled by the punitive policy we (now) have.”

The forensic unit as such (be it closed or semi-clo sed or open) is a specific place and the following quote best describes it: "It is difficult to draw a line between freedom and non-freedom in the department. Here, two completely different institutions meet: medical and judicial, which have quite different points of view and different approaches to solving the same issues. The court enforces the principle that people living in a social community must follow valid social norms, which also applies to mental patients - and psychiatry enforces the principle that a patient is just a patient, regardless of possible legal measures against him. With mutual tolerance, we can carry out all the therapeutic activities that are necessary in the ward (therapeutic communities, occupational therapy, recreational activities, contacts of the patients with their relatives, free exits, etc.), although we have to agree to the closed-door system and the fact that the approval and consent of the court is required for the permanent discharge of the patient. The partial restriction of freedom therefore applies not only to patients, but also to the therapeutic team. This is a reality that must be considered" (Kondža 1976, 59).

As pointed out, the collection “Challenges in forensic psychiatry” was published in 2014, which completely ignored the long-term practice, experience and successes of the DFSP, "which worked for over 30 years at high humane, social and professional level".[548] To conclude, Dr. Žagar said: “In our society, everything in retrospect, even what was positive, is forgotten, and we start all over again.”

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520 Deutscher Anwaltverein, Stellungnahme des Deutsches Anwaltsvereins durch den Ausschuss Strafrecht zu dem Entwurf eines Gesetzes zur Durchführung strafrechtsbezogener Unterbringungen in einem psychiatrischen Krankenhaus und einer Entziehungsanstalt in Nordrhein-Westfalen (2020), page 4.

521 For more information, see: https://www.altalex.com/documents/news/2003/07/23/ricovero-in-ospedale-psichiatrico-giudiziario-illegittimita-dell-art-222-cod-pen

522 Recommendation Rec(2006)2-rev of the Committee of Ministers to member States on the European Prison Rules.

523 Uscila R.,The practice of halfway houses for convicts in Lithuania (Nuteistųjų pusiaukelės namų taikymo praktika Lietuvoje) (2022), https://repository.mruni.eu/bitstream/handle/007/18563/XVIII%20Vilnius%202022_compressed-88-92.pdf?sequence=1&isAllowed=y

524 The information is based on an interview with representatives of the Lithuanian Prison Service conducted on 14 March 2023.

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526 For more information, see: https://www.altalex.co For more information, see: http://www.kaldep.lt/lt/kalejimu-departamentas/administracine_informacija/ataskaitos/metu.html

527 Order No V-28 of the Prison Department under the Ministry of Justice of the Republic of Lithuania "On the Approval of the Strategic Operational Guidelines of the Prison Department under the Ministry of Justice of the Republic of Lithuania for 2022-2030, (2022) (Kalėjimų departamento prie Lietuvos Respublikos teisingumo ministerijos direktoriaus įsakymas „Dėl pusiaukelės namų plėtros 2022-2024 m. priemonių plano patvirtinimo), http://www.kaldep.lt/lt/kalejimu-departamentas/teisine-informacija/teises-aktai/kiti-teises-aktai.html.

528 Order No V-28 of the Prison Department under the Ministry of Justice of the Republic of Lithuania "On the Approval of the Strategic Operational Guidelines of the Prison

Department under the Ministry of Justice of the Republic of Lithuania for 2022-2030, (2022) (Kalėjimų departamento prie Lietuvos Respublikos teisingumo ministerijos direktoriaus įsakymas „Dėl pusiaukelės namų plėtros 2022-2024 m. priemonių plano patvirtinimo), http://www.kaldep.lt/lt/kalejimu-departamentas/teisine-informacija/teises-aktai/kiti-teises-aktai.html.

529 Uscila R.,The practice of halfway houses for convicts in Lithuania (Nuteistųjų pusiaukelės namų taikymo praktika Lietuvoje) (2022), https://repository.mruni.eu/bitstream/handle/007/18563/XVIII%20Vilnius%202022_compressed-88-92.pdf?sequence=1&isAllowed=y

530 The information is based on an interview with representatives of the Lithuanian Prison Service conducted on 14 March 2023.

531 Order No. A1-939/1R-324 of the Minister of Social Security and Labour of the Republic of Lithuania and the Minister of Justice of the Republic of Lithuania On Approval of the Description of the Procedure for the Social Integration of Persons Released from the Places of Serving the Penalty of Imprisonment (2020) (Dėl iš laisvės atėmimo bausmės atlikimo vietų paleidžiamų asmenų socialinės integracijos tvarkos aprašo patvirtinimo), https://e-seimas.lrs.lt/portal/legalAct/lt/TAD/f0de4554095911ebbedbd456d2fb030d/asr

532 The Law on Execution of Penal Sanctions in force at that time led to the establishment of a commission (two judges and two psychiatrists) which decided on the most appropriate institution for each offender (Kobal and Žagar 1994, 266–267).

533 Not much information is available, therefore we do not have names of all the heads.

534 According to Kobal and Žagar (1994, 266) there was an opposition to these ideas and plans, and they point out three groups that had to be persuaded not to prevent the developments: psychiatrists (and other staff) of the University Psychiatric Hospital, staff of the DFSP "who had to change their basic attitudes and many deeply-ingrained habits", and the authorities (medical as well as legal).

535 In his article Svoboda in nesvoboda na oddelku za forenzično in socialno psihiatrijo from 1976 Kondža wrote that this unit had room for 51 patients at the beginning. Later on, the number of patients was reduced to around 15 (Kondža and Kobal 2014).

536 Patients admitted to DFSP were all male, due to the fact that female forensic patients were only few and it was not possible to create a mixed ward; female forensic patients were admitted to the neighbouring mixed ward or other wards of the hospital or were in an out-patient care (Kobal and Žagar 1994, 267).

537 In case of family care – especially for individuals with the most severe disabilities– the DFSP staff provided support in the sense of medical and social aid (Kobal and Žagar 1994, 269). According to dr. Žagar (2023) their medical technical staff visited these patients once a month and gave them therapy (medicine) prescribed by the psychiatrist. They were supervising that patient's life, how he is doing, how the family accepts him, whether there are any conflicts etc. These patients were not involved in any group therapy after they left the hospital. According to Kondža and Kobal (2014) this program of family care was established in 1969.

538 Kobal and Žagar (1994), at 266.

539 In an interview Dr. Žagar (2023) said they also had 1/3 psychologist, 1/3 music therapist, 1/3 occupational therapist, 1/5 or maybe even 1/8 of a recreational therapist.

540 Kobal and Žagar (1994), at 268-269.

541 Kondža and Kobal (2014).

542 "At the time, I was also doing education in group analytic psychotherapy and we also practised this for them, 3 times a week. We sat down together and sat for an hour and a half. It is important that the therapist encourages the positive that is in the person. It is in everyone, even in these patients. And that we respected them. You know, this respect, as I looked around abroad... what we were supposed to observe abroad, we were better than them. They could come here to learn from us. Abroad, the emphasis was on guarding, protection. But this stank to us, security, because we are not policemen. We are doctors." (Žagar 2023).

543 Kobal and Žagar (1994), at 268-269.

544 Kondža and Kobal (2014).

545 Kobal and Žagar (1994), at 268-269.

546 However, there were two tragic events: in one case, »a paranoid patient on the visit at home injured his wife« and then, thinking that he had killed her, he committed suicide; in another case, a patient killed his ex-wife while he went for a walk in the town alone (Kobal and Žagar 1994, 269). However, that obviously happened some time before 1985, as Dr. Žagar in his interview (on 11.4.2023) reassured that during more than ten years when he was working there no such incidents occurred.

547 Kobal and Žagar (1994), at 269-271.

548 Kondža and Kobal (2014).

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