New Developments in Legal Systems and Their Impact on Forensic Psychiatry

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4.1 Introduction

Forensic psychiatry has well established relations to the legal system, in particular the criminal justice system. The relationship has grown stronger over time and has diversified. It is asserted also that mental health systems in Europe look back on marked progress in the last half century. The relationship between forensic psychiatry and criminal justice has been influenced by theory and research criticizing negative side effects of long-term detention in forensic hospitals and the strong stigma placed on the mentally ill with associating insanity and crime. This in turn had encouraged the development of policies of decarceration, deinstitutionalization, and community-based supervision and treatment [1]. Reform debates on the insanity defense and related law amendments, for example, in Ireland, Scotland, and England/Wales, in fact are still based upon this line of reasoning when attempting to modernize legal language, to bring legal language closer to forensic psychiatry, and, beyond that, to reduce stigmatizing effects which might be associated with the label of "insanity" [2, 3, p. 50].

The interface between forensic psychiatry and the law was formed by the fundamental assumption that criminal punishment may only legitimately be imposed if the criminal act was carried by culpability which in turn requires free will (and free choice between behavioral options). The assumption of free will is based on cognitive capacity to discern right from wrong and the capacity to control one's acts. Mental conditions impairing either cognitive or control capacity affect free will and diminish or exclude culpability but have to be proven through expert (psychiatric) witnesses. Furthermore, the focus on mental illness within the framework of criminal law is also explained by the strong belief that some mental illnesses cause crime

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(in particular violent crime) and that psychiatry may deliver treatment which cures mental illnesses and reduces the risk of relapse in crime. The evolution of modern forensic psychiatry has been linked to several developments among which better understanding of the relationship between mental illness and criminality, the elaboration of legal tests of insanity, new methods of noncustodial treatment of mental disorders, and the changes in attitudes and perceptions of mental illness among the public are described as key achievements [4, p. 87]. However, new developments in forensic psychiatry are rather driven by a different set of issues and controversies. Among these issues conflicts between a welfare-based approach of crime control, punitive responses to crime, and concerns for security stand out [5, pp. 114–116] as does the significant shift away from a medical approach to mentally disordered offenders toward a rights-based approach. Of course, the question of how mental conditions are associated with crime, in particular violent crime, still is pursued in research [6, 7], and the role of forensic psychiatry in making decisions on culpability of offenders continues to trigger debates in forensic and legal arenas as do questions of which mental problems should be considered to impact on culpability, on criminal responsibility, and ultimately on sentencing [8, 9]. But, it is in particular a growing concern for human rights-adjusted mental health legislation in general and the legal status and (basic) rights of mentally impaired individuals which results in an increasingly dense web of legal rules and doctrines directing forensic psychiatric practices and provides for new challenges.

From the 1990s on, a comparative and European look at forensic psychiatry, forensic hospitals, and mental law attracted increasingly interest [10, 11]. To begin with, growing relevance of comparative forensic psychiatry is explained by a common trend in sciences to advance knowledge and innovation and improve practices through looking across borders [12]. Migration and an increasingly culturally and ethnologically heterogeneous nature of European societies then have contributed to raising interest in comparative studies in forensic psychiatry. But, while significant interest in comparative analysis of procedural and substantive criminal law can be noted in Europe, legal disciplines seem to be less interested in comparative forensic psychiatry law, and only few comparative studies address forensic experts in criminal proceedings, substantive criminal law, and related jurisprudence addressing criminal responsibility and mental illness or legal consequences of being judged not responsible of having committed a criminal offense. Almost all of the comparative studies dealing with legal aspects of forensic psychiatry since the 1990s are initiated and carried out by psychiatric/psychological disciplines [10, 13, 14]. The emphasis in these comparative studies is placed on internationally consented definitions and diagnosis of mental illnesses, the impact of forensic expertise on judicial decision-making and on the consequences of findings of insanity on the disposition of criminal offenders.

The interest in comparative legal studies on insanity, crime, and criminal law today is also pushed by widening legal angles through which legitimacy of judicial cooperation is analyzed. While international cooperation in legal matters in the last decades has been mainly driven by concerns for effective containment of terrorism and serious (organized) and cross-border crime, judicial decisions on extradition

today have also to consider how mentally ill offenders will be treated in jurisdictions requesting extradition. In the judgment Aswat v. the United Kingdom (application no. 17299/12) 14 April 2013, the European Court of Human Rights (ECtHR) has held that a schizophrenic detained in the UK should not be extradited to the USA as there would be a violation of Art. 3 European Convention of Human Rights (ECHR, prohibition of inhuman treatment). The Strasbourg Court observed that "… his extradition to a country where he had no ties and where he would face an uncertain future in an as yet undetermined institution, and possibly be subjected to the highly restrictive regime in ADX Florence (a super maximum security prison), would violate Article 3 of the Convention."

More specifically, the creation of a "common space of freedom, security, and justice" in the European Union (initiated through the Tampere program (2009) and regulated in Title V of the Treaty on the Functioning of the European Union), furthermore European policies of harmonization and mutual recognition of decisions in penal matters, and the establishment of European networks of criminal justice-related professions have underlined the importance of systematic collection of comparative legal information and internationalizing forensic psychiatry in the field of education and training as well as in its practices [15]. The interest of legislators in Europe in knowing about comparative mental health legislation and practices before amending the law [16] then has contributed to raising awareness about large variation in legal frameworks dealing with mentally ill offenders and the role of forensic psychiatry in the configuration of pathways to forensic care and treatment [13].

4.2 A Shift of Paradigm: Rights-Based Approaches

Most important in changing the legal frameworks within which forensic psychiatry operates in Europe (and increasingly on a global level) has been a common and today uncontested human rights perspective serving as a fundamental benchmark [17, p. 257]. In Europe, the human rights perspective has been strengthened through the Council of Europe and the European Union and what has been called a paradigm shift in favor of rights-based approaches to individuals with mental problems ([18, 19, p. 11] even notes a patients' rights revolution). The ECHR and jurisprudence of the ECtHR are of relevance when deciding on detention and treatment of mentally ill offenders. As early as 1979, the ECtHR has started to develop jurisprudence on fundamental questions of dealing with persons (and criminal offenders) of "unsound mind." The decision on "Winterwerp v. The Netherlands" is still one of the most cited in the field of law and forensic psychiatry and marks the beginning of the jurisprudence of the ECtHR on restrictions of liberty justified with an "unsound mind" (Art. 5 §1e ECHR). The "Winterwerp v. The Netherlands" judgment held that Art. 5 §1e ECHR does not provide for a comprehensive and binding definition of an "unsound mind." The ECHR leaves room for the legislator when defining unsound mind, mental illness, or insanity as its meaning is considered to be continually evolving (and changing). European legislators therefore are not obliged to provide for an exact definition of what establishes an "unsound mind." Laws on mental

conditions and criminal responsibility shall be able to accommodate advances in scientific knowledge and corresponding changes in the definition of "insanity." However, no arbitrariness is allowed in laws authorizing detention of individuals suffering from mental problems. A statutory basis has to be in place which requests medical expertise as a basis for judicial decisions and which allows for certainty and predictability. From the perspective of Art. 3 ECHR (prohibition of torture and inhuman, degrading punishment/treatment), the ECtHR held also that withholding adequate treatment (which must not be carried by intent on the side of the authorities) will trigger a verdict of inhuman or degrading treatment (ECtHR, M.S. v. The United Kingdom (Application no. 24527/08), 3 August 2012).

On a global level it has been the advent of the United Nations "Disability Convention" (ratified today by most European countries) which has brought fundamental changes and challenges for both criminal law and forensic psychiatry [20]. The Disability Convention has been hailed as a major step forward in the protection of human rights of mentally ill criminal offenders [19], but it entails difficult legal questions, yet to be resolved [20, 21].

Fundamental rights bear also on civil and criminal committal proceedings and the enforcement of judicial decisions placing mentally ill offenders in psychiatric hospitals. Particular relevance here have the question of "legal capacity" and the problem under which condition interference with legal capacity (and Art. 8 ECHR protecting privacy) may be justified [22, p. 11]. In general, although somewhat delayed, patients detained in psychiatric hospitals today in Europe are entitled in principle to the same rights which are available to sentenced (and fully criminally responsible) prisoners.

The role and tasks of forensic psychiatry have been shaped then by legal and political developments which give security, public protection, and protection of individual victims top priority [23]. Security is sought through identifying dangerous individuals and adjusting criminal law-based responses to the interest of protecting the public and individual victims (see, e.g., Bill C-14 amending the Mental Regime (Part XX.1) of the Canadian Criminal Code, [23]). Release from secure placements of criminal offenders is made dependent on assessments of future dangers. Predictions of dangerousness are requested today before deciding on detention and release from detention. A focus on security and comprehensive security policies encourage the use of long-term and/or indeterminate deprivation of liberty. Particular concern in this context can be noted for violent crime and sexual crime (in particular pedophiles).

Indeterminate detention in psychiatric hospitals is based on the assumption that a criminal offender suffering from mental problems should be detained as long as the danger of future crimes linked to these mental problems persists [24]. Conventional legal thinking assumes that the interest of protecting the public from serious crime outweighs the interest of the offender in freedom and may serve—independent from the possibility of treatment and cure—as a justification of detaining an offender in a psychiatric hospital [24, 25]. With placing the focus on public protection, however, placement in a secure psychiatric hospital adopts a character of preventive or incapacitating detention. Public protection evidently encourages also

the designation of certain categories of mentally disordered offenders as a particularly "high risk" [23, p. 49]. The latter approach departs from individualizing risk assessment and is therefore also at risk of infringing on the right to be judged on the basis of the facts of an individual case. Furthermore, the security concerns do not only create conflicts with rights-based approaches but turn against policies favoring community-based treatment and reduction of stigma.

Forensic psychiatry thus moved to the field of assessment of dangerousness and general security policies which are rather remote from the core area of psychiatric practices and expertise. This has contributed in forensic psychiatry to a rising tension between punishment and security on the one hand and treatment and reintegration on the other hand [26]. Forensic psychiatry is placed in a social and political environment which tends to widen professional accountability. Accountability of forensic psychiatry today goes beyond compliance with good medical practice applied to patients with mental disorders and includes observance of fundamental rights of patients as well as effective containment of dangers for public security [27, p. 454]. Forensic psychiatry therefore today operates under an increasingly dense web of legally defined conditions which affect in particular also questions of treatment once guided only by medical expertise, standards of good medical practice, and the best interests of the patient.

The shift toward a rights-based approach to mentally ill persons [18] started on the international level decades ago with the "Declaration on the Rights of Mentally Retarded Persons" proclaimed by General Assembly resolution 2856 (XXVI) of 20 December 1971. The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) deal in detail with the rights of persons admitted to mental health care and emphasize standards of involuntary placement and treatment. The International Covenant on Civil and Political Rights provides for a comprehensive set of individual rights which in principle apply also for the mentally ill. The United Nations "Anti-Torture Convention" prohibits inhuman, degrading treatment and punishment as well as torture and establishes besides basic legal standards a system of supervision and monitoring which is focused on places of detention (including psychiatric hospitals). A comprehensive Convention on the Rights of Persons with Disabilities and its Optional Protocol, 13 December 2006 addresses issues of mentally ill persons, in particular questions of legal capacity and detention of the mentally ill.

In Europe, soft and hard law affecting forensic psychiatry and forensic patients principally has been issued through the Council of Europe. Recommendation No R (83)2 on legal protection of persons suffering from mental disorder placed as involuntary patients (1983) was supplemented by Recommendation 1235 (1994) on psychiatry and human rights. Recommendation No (99)4 as of 23 February 1999 establishes basic principles concerning the legal protection of incapable adults. A "White Paper" on the protection of the human rights and dignity of people suffering from mental disorder, especially those placed as involuntary patients in a psychiatric establishment [28], preceded Recommendation (2004) 10 concerning the protection of the human rights and dignity of persons with mental disorders. Recommendation CM/Rec (2009) 3 addresses monitoring the protection of human

rights and dignity of persons with mental disorder. Particular legal relevance for European forensic psychiatry has then the European Convention on Human Rights and the European Convention against Torture. Within the framework of the ECHR, particular relevance for forensic psychiatry comes with the prohibition of torture and inhuman or degrading treatment and punishment (Art. 3), the right to liberty (Art. 5), the right to a fair trial (Art. 6), and the right to private life (Art. 8).

The focus on (human) rights of mentally ill individuals has also brought changes in the institutional framework which is established to monitor compliance with international and European laws and standards in legislation and forensic psychiatric hospitals. Particular emphasis is placed on all kinds of detention facilities because deprivation of liberty is assessed to expose detainees to an elevated risk of maltreatment and abuse.

Important elements in the rights-based approach to forensic patients and detention conditions concern monitoring by independent commissions and effective access to legal review systems [22, p. 10]. Monitoring of (forensic) psychiatric facilities and mental health-related law comes through several avenues. International conventions and the supranational framework of human rights protection:

> Oblige states to report on how conventions are implemented. State reports are then reviewed by a committee which advises as to where and how implementation should be improved.
>
> Provide for individual complaint procedures through which individuals are entitled to bring allegations of violation of fundamental rights before an independent court or an independent committee.
>
> Establish independent commissions mandated with visiting places of detention. Visits result in reports addressing problems of implementation and forwarded to governments.
>
> Require establishment of independent national structures authorized to visit places of detention.
>
> Allow ad hoc investigations carried out by rapporteurs or commissioners appointed by the United Nations or other supranational bodies.

United Nations conventions relevant for forensic psychiatry (International Covenant on Civil and Political Rights, UN Convention against Torture, UN Disability Convention) contain a procedure through which State parties on a regular basis or on request report on how the respective convention is implemented. State reports are due at certain intervals or at the request of those committees established to examine reports and monitor implementation of State Parties obligations. In the case of the International Covenant on Civil and Political Rights, the Human Rights Committee has the mandate to review state reports and make suggestions and recommendations to the State parties. The UN Convention against Torture provides for a Committee against Torture, and the United Nations Disability Convention establishes the Committee on the Rights of Persons with Disabilities.

The ECHR does not establish a State reporting system. But instead, the ECtHR has jurisdiction over cases brought through an individual complaint procedure and alleging violations of fundamental rights enshrined in the ECHR after domestic judicial appeals are exhausted. The judgments of the ECtHR have to be implemented by national governments. The Court, furthermore, can order that damage is paid by the government to those applicants whose rights have been found violated.

Then, the ECtHR has developed a procedure which places those European states at particular scrutiny from which a multitude of similar cases originate indicating a systemic problem. The so-called pilot-judgment procedure was invoked in the judgment ECtHR W. D. v. Belgium (application no. 73548/13, 6 September 2016). It was held that Belgian practice of detaining offenders with mental disorders in prison psychiatric wings where they do not receive adequate care and treatment exhibits a systemic problem. The problem results in a constantly increasing number of cases where Belgium routinely is found in violation of Art. 3 ECHR (prohibiting inhuman treatment through withholding adequate care for mentally disordered offenders) and in violation of Art. 5 §1 ECHR (infringement on the right to liberty as detention does only comply with Art. 5 §1 ECHR if the link between the purpose of detention and the actual conditions of detention is broken). Belgium was given a period of 2 years to solve the systemic problem, and proceedings in all similar cases (approximately 40) were adjourned.

An individual complaint procedure is also provided through the Optional Protocol to the International Covenant on Civil and Political Rights, by the UN Convention against Torture and the Disability Convention. These committees may receive complaints brought by individuals alleging violations of rights guaranteed by the conventions. Individual complaints are examined by the committees. The findings and assessments of the committee result in communication and consultation with the state which was found in breach of individual basic rights. This procedure, however, other than proceedings before the ECtHR, does not result in a judgment binding the state that has violated individual rights. Furthermore, the committees may examine particular situations through launching inquiries.

The European Committee for the Prevention of Torture (CPT) was established to monitor effective implementation of the European Convention against Torture (which prohibits torture as well as inhuman and degrading punishment or treatment). Monitoring is carried out in the form of regular visits of all those places in member states where persons are detained. This includes besides prisons also forensic hospitals. Reports on findings of such visits are forwarded to the government which should respond to the findings and proposals as to how to adjust conditions of detention and related practices to the standards of the Anti-Torture Convention. A similar monitoring system has been adopted through the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment. A Subcommittee on Prevention of Torture has the task to visit places where persons may be deprived of their liberty in State parties in order to prevent conditions of detention which may result in risks of cruel, inhuman, or degrading punishment or treatment. Recommendations of the Subcommittee on Prevention will be discussed in a dialogue with state authorities on possible implementation measures.

The United Nations Convention against Torture and the Disability Convention oblige State parties in Optional Protocols to introduce national (and independent) bodies which have the right to visit places of detention (and psychiatric facilities) in order to examine whether conditions comply with the standards. The United Nations Convention against Torture seeks to establish a system of regular visits undertaken

by an independent body which will monitor also conditions of detention (and resulting risks of maltreatment and torture) in forensic psychiatric hospitals. The Disability Convention requires State parties to put in place a structure mandated with implementing and monitoring the convention (Art. 33). Art. 16 §3 of the Disability Convention obliges State parties to introduce effective monitoring of all facilities and programs designed to serve persons with disabilities by independent authorities. Effective monitoring must extend also to forensic hospitals. In Europe, the CPT monitors the implementation of the obligation to have independent monitoring mechanisms in place (see, e.g., CPT 2013, §127 for forensic psychiatric hospitals in Portugal).

Finally, the United Nations and the Council of Europe through Human Rights Commissioners provide for a general possibility to monitor places of detention and to launch investigations into particular areas in order to monitor implementation of human rights. In Europe, the European Commissioner of Human Rights has made mental health law, psychiatric treatment, and forensic hospitals a particular issue in reports as of 2008 and 2012 [22, 29, 30].

The particular focus of human rights instruments on places of detention and a legally endorsed and generalized suspicion that individuals deprived of liberty are at a particular risk of infringements of basic rights have moved also forensic psychiatry into the spotlight of monitoring and supervision. And, nongovernmental organizations, among them also organizations critical of forensic psychiatry, increasingly influence not only the making of international human rights instruments but also jurisprudence resulting from individual complaint procedures and monitoring of forensic hospitals.

4.3 A Changing Sociopolitical Climate and Changing Practices

Looking at practices of forensic psychiatry, internationally still significant variation can be observed. Comparative data, specifically describing forensic psychiatry are not available on the international nor on the European level, but general data on mental health systems show that Europe counts some 7.4 psychiatrists per 100,000 of the population while in Africa the rate amounts to 0.07 psychiatrists per 100,000 [31, p. 53]. This enormous gap points to a quite different relevance of forensic psychiatry in criminal justice systems of various world regions (most probably also to differences in the relevance of mental disorders for criminal justice practices) and raises furthermore the question of how modern communication technology can contribute to alleviate the problem of access to forensic psychiatric and psychological services [32]. However, significant differences in the rates of psychiatrists per 100,000 of the population can be also observed in Europe (and OECD countries, see [33, p. 25].

Comparative data on civil and criminal commitments to forensic hospitals in Europe do not exist. This is considered a general problem which creates obstacles for assessing “quality and effectiveness of the various legal frameworks and

forensic care provisions" throughout the European Union member states [34, p. 446]. In some European countries, a significant increase in the number of inmates held in forensic hospitals was observed during the last decades (see, e.g., [35] for Germany; [36] for Austria). The increase is explained by a rise of admissions to forensic hospitals and by an increase in the average duration of detention in psychiatric hospitals ([35, p. 35]; see also [37]). Swedish research has shown that duration of confinement in forensic psychiatric hospitals is particularly marked for violent offenders [38, p. 641]. In Germany, (non-violent) sexual offenders experience the longest periods of detention in a psychiatric hospital [35, p. 38]. The increase in the number of admissions and the increase in the average length of confinement may be assumed to reflect security concerns and lower (legal) thresholds of committing criminal offenders to psychiatric hospitals and increasing reluctance to release offenders from forensic detention [25]; it might be also a result of strict and effective containment of long prison sentences (and life imprisonment) in countries where individual guilt has been given priority over deterrence and incapacitation in sentencing. This in turn might have made resort to detention in psychiatric hospitals more attractive [39].

While the question of what determines sentencing practices and whether sentencing is biased and discriminating against immigrants and ethnic minorities has received significant attention since the 1980s, research on biased admissions to forensic psychiatric hospitals is scarce. Evidence from the UK points to marked differences in admissions for different ethnicities [40]. In Denmark, an ethnic minority background has been found associated with higher rates of involuntary admissions to psychiatric hospitals and involuntary treatment. In particular for men, an ethnic minority background correlates with involuntary admission to psychiatric care [41, p. 9]. Furthermore, it is assumed that a significant share of prisoners detained in regular prisons suffers from psychiatric problems and does not receive adequate treatment [42–45]. Mental health problems among criminal offenders include personality disorders and alcohol and illicit drugs problems. The magnitude of mental health problems in prisons is associated with high suicide rates [46]. The pilot-judgment procedure initiated through the judgment ECtHR W. D. v. Belgium (application no. 73548/13, 6 September 2016) against Belgium underlines the significance of this problem.

The sociopolitical climate within which forensic psychiatry operates has changed significantly in the last decades as have changed penal systems and policies guiding the development of criminal law and punishment. While there is still concern for marginalization and stigmatization of criminal offenders diagnosed with mental disorders (see, e.g., the proposal of the Law Reform Commission (for England/Wales) 2013, 46 to replace insanity by a lack of ability to conform to the law due to a "recognised medical condition") and new treatment optimism has been found to emerge slowly after decades of treatment and rehabilitation pessimism [47], the victim of crime and potential victims of crime have moved irrevocably into the penal policy arena and with them new legislation which seeks to empower victims of crime and to protect effectively victims of crime also in criminal proceedings against mentally disordered offenders [48]. However, the issue of victims' rights in (criminal or

mental health) proceedings against offenders with mental disorders has not yet been explored in detail (for a North American perspective, see [48, 49]).

Criminal justice systems once focused on the criminal offender (and rehabilitation) now seek to accommodate the needs and interests of victims and in particular to serve interests of potential victims. New concern for crime victims seems to fuel on the one hand calls for tougher sentences and the appetite for criminal punishment and on the other hand interest in more security through incapacitating dangerous criminal offenders. Both, the appetite for punishment and the interest in incapacitation seek solutions in long periods of secure confinement. Placement in psychiatric hospitals as a consequence of complete absence of or diminished criminal responsibility of criminal offenders certainly may be considered to have incapacitating effects. Penal commitments to forensic psychiatry regularly still come in the form of indefinite deprivation of liberty which will be terminated only if dangerousness has been reduced effectively and reduction is confirmed by psychiatric expertise (see, e.g., [24]). However, in Norway the Breivik case has shown that incapacitation through indefinite commitment to a psychiatric hospital (which is based on a finding of lack of criminal responsibility) will not necessarily meet public expectations and find public approval [50]. Public attitudes on mental illness and legal dispositions of the mentally ill offender evidently are still influenced by the belief that acquittal based on insanity will result in lenient treatment and possibly quick release of insane offenders [48] and that a too wide conception of insanity will negatively impact on criminal law-based crime prevention and deterrence [9]. The case of John Hinckley in the USA underlines the significant influence high-profile cases involving forensic psychiatry may have on legal frameworks as do cases preceding recent reform of the insanity defense statute in Canada [23]. But, despite calls for complete abolition of the insanity defense (or a finding of lack of culpability due to mental disorder, see [24, p. 77]), abolition policy evidently did not find wide support (see, e.g., the New Zealand [51, p. 30]). Sweden so far remains the only country where in principle all mentally ill offenders are held criminally responsible and treatment needs are accommodated in the sentencing decision as well as in the enforcement process ([52]; see also [53] for ongoing debates on reforming the “insanity defense” in Sweden).

No uniform development can be noted for criminal justice policies with respect to mentally disordered offenders in Europe. While rights-based approaches seek to strengthen the position of the mentally ill in criminal proceedings, concerns for victims and public security tend to move criminal law and punishment toward emphasizing accountability and just desert.

4.4 Criminal Responsibility and Mental Disorders: Challenges

The United Nations Disability Convention, however, when recognizing legal capacity (Art. 12 §2) also of persons suffering from mental problems has been interpreted as requesting abolition of “a defense based on the negation of criminal

responsibility because of the existence of a mental or intellectual disability" [54, p. 47]. Instead, it is argued, "disability-neutral doctrines on the subjective element of the crime should be applied, which take into consideration the situation of the individual defendant" [54, p. 47]. In fact, the ongoing debates on the consequences Art. 14 of the Disability Convention will have on how insanity (or mental problems) will be dealt with in criminal justice systems reveal that the convention had deserved a more in-depth discussion of its possible legal consequences for mentally disordered criminal offenders and the rules governing the disposition of mentally disordered offenders. It demonstrates also growing influence of nongovernmental organizations critical of both detention in general and forensic psychiatry. If the Disability Convention urges for a radical departure from conventional approaches and requests a complete prohibition of deprivation of liberty based on the existence of any disability, including mental disorders or intellectual deficits, then a fundamental question of alternative practices and suited criminal law-based legal regulations of mental disorder turns up [21]. Contrasting Art. 14 1 (b) of the Disability Convention stating plainly that "the existence of a disability shall in no case justify a deprivation of liberty" with Art. 5 §1e ECHR allowing for deprivation of liberty of persons of "unsound mind" results then in an open dissent. The ECHR and the United Nations Disability Convention are headed evidently in different directions. The Disability Convention would be also a significant move away from the basic standards established through the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991). These include in Principle 16 fundamental standards to be complied with when authorizing involuntary admission to a mental health facility and with that acknowledge that detention based on the finding of mental disorders may be legitimate.

While unanimous conviction prevails that the ECHR recognizes differential treatment of persons of "unsound mind" to be legitimate, a strict interpretation of the Disability Convention as outlined above seeks to minimize and ultimately outlaw what is assessed to be discriminatory practices [55, p. 25]. A conflict emerges also when looking at Art. 12 of the Disability Convention and the concept of legal capacity. The ECtHR continues to recognize a mental disorder as justifying limitation of legal capacity, but the Commissioner for Human Rights has found that "the European human rights system has not yet fully incorporated the paradigm shift envisioned in the CRPD towards granting persons with disabilities a primary right to support in their decision-making" [30, p. 16].

The interpretation of Art. 14 adopted by the Committee on the Rights of Persons with Disabilities ([56], No. 7) refers to discussions of the scope of Art. 14 during the drafting which resulted in rejecting a limitation of prohibition of detention based on a finding of disability alone. Also detention based on a combination of insanity and dangerousness is considered to be discriminatory and in violation of Art. 14. Although jurisprudence of the European Court of Human Rights applies strict standards as to the conditions under which a person of "unsound mind" may be detained, Art. 5 e clearly states that an "unsound mind" is a legitimate ground for deprivation of liberty. And, judgments of the ECtHR, while recognizing the existence of the Disability Convention, reiterate that detention of a mentally disordered person "may

be necessary not only where the person needs therapy, medication or other clinical treatment to cure or alleviate his condition, but also where the person needs control and supervision to prevent him, for example, causing harm to himself or other persons" (ECtHR, Case of Stanev v. Bulgaria**,** Application no. 36760/06), Judgment, 17 January 2012, no. 146). Even where no treatment is envisaged (or possible), the ECtHR considers detention in compliance with Art. 5 ECHR if "the seriousness of the person's condition in the interests of ensuring his or her own protection or that of others" (ECtHR, Case of Stanev v. Bulgaria**,** Application no. 36760/06), Judgment, 17 January 2012, no. 157).

The ECHR is a child of the 1950s and an era when an "unsound mind" did not raise concerns when it came to justifying deprivation of liberty (nor did it raise concerns as "vagrancy" is also still a ground listed in Art. 5 §1 and justifying detention). Mental disorders were assessed to raise the risk of violent crime or self-harm [57, 58]. And, an additional judicial finding of dangerousness in terms of risks of future crime based on psychiatric expertise and a precise statutory framework allowing for fair proceedings was considered to present sufficient protection of human rights.

But, lack of or diminished culpability due to an unsound mind not only justifies deprivation of liberty in a psychiatric hospital and possibly involuntary treatment. Lack of culpability carries also protection of criminal offenders of unsound mind from harsh punishment (and protection of criminal children either completely exempt from criminal responsibility or considered to have diminished culpability), an issue also raised under international law addressing the question of eligibility for the death penalty. International law requests that persons of unsound mind should not be sentenced to death nor be executed (see the United Nations Safeguards guaranteeing the rights of those facing the death penalty, 25 May 1984). And, evidently, most European State parties did not see problems arising from Art. 14 for national criminal codes regulating the connection between insanity, criminal procedure, and punishment when signing and ratifying the Disability Convention. So far, only the reservations of The Netherlands and Norway—introduced when ratifying the Disability Convention—declare that these State parties understand the convention to allow "for compulsory care or treatment of persons, including measures to treat mental illnesses, when circumstances render treatment of this kind necessary as a last resort, and the treatment is subject to legal safeguards." For England/Wales Peay [55, p. 25] stated that the Government has been in "something of a state of denial" (about non-compliance with the Disability Convention). Norway confirmed its position in the State Report 2015 ([59], No. 112) underlining that Art. 14 must be read as prohibiting deprivation of liberty based solely on a judgment of unsound mind and that corroboration of this interpretation is found in the legislation and practice of State parties to the Disability Convention. This interpretation is supported by the Human Rights Committee's General comment no. 35 on Article 9 (liberty and security of person) of the International Covenant on Civil and Political Rights [60, p. 19].

The Committee on the Rights of Persons with Disabilities, however, continues to urge State parties to bring standards and tests regarding "unfitness to stand trial" or "unfitness to plea" as well as legal rules determining deprivation of liberty of

persons with unsound mind in line with Art. 12 and Art. 14 of the Disability Convention (see, e.g., [56, 61]; see also [29]). Support in favor of such reforms is voiced by nongovernmental organizations neither affiliated with law nor with forensic psychiatry and taking sides with those considered victims of (forensic) psychiatry. NGOs have gained significant influence in the drafting of international standards (and conventions) and in the interpretation of human rights law.

The position of the Committee on the Rights of Persons with Disabilities obviously is based upon two premises.

> A finding of lack of culpability (or denying criminal responsibility) based on an "unsound mind" carries risks of stigma and exclusion which must be contained effectively.
>
> Nondiscrimination requests criminal offenders diagnosed with an "unsound mind" must be treated as are treated those offenders found fully responsible and only be deprived of liberty when adjudicated guilty of a criminal offence.

Partisans of the position that the Disability Convention should be interpreted as allowing for different procedures, treatment, and dispositions of persons (and offenders) of unsound mind invoke the culpability principle which insists on full cognitive capacity and capacity to control one's acts as necessary conditions of criminal culpability and criminal punishment and as conditions to participate actively in fair trial proceedings. A criminal trial concerns a charge of criminal wrongs and responsibility for such wrongs. Legitimacy of criminal proceedings therefore depends on defendants able to understand these charges and to respond adequately [62, p. 446]. A criminal trial involving persons who do not comprehend their situation and therefore are not in a position to defend themselves effectively and, moreover, punishment inflicted on an offender whose cognitive or control capacity during the criminal act was seriously impaired would result in verdicts of "unusual" or "inhumane" treatment and punishment, an infringement on human dignity, and violations of the fair trial principle [20]. Interpretation of Art. 12 §2 and 14 thus is decisive for the legal framework which regulates in criminal procedural law how offenders of "unsound mind" are processed and in substantive criminal law which legal consequences may result from a disability attributed to mental illnesses.

Most criminal justice systems today provide for alternative procedures if a criminal suspect (or criminal defendant) is found to be insane and lacking culpability [10]. Alternative procedures may be applied if the defendant is assessed to be unfit to stand trial (or to plead) before trial procedures started. In this case either diversion to mental health proceedings or alternative criminal proceedings (if a criminal code provides for a second track of measures of rehabilitation and security) are initiated. The difference is important though as the ECtHR will assess justification of deprivation of liberty in proceedings where a criminal court motivates a committal to a psychiatric hospital by a criminal offense committed in a state of unsound mind (and continuing dangerousness) on the basis of Art. 5 §1a (lawful detention of a person after conviction by a competent court, see ECtHR Case of Klinkenbuss v. Germany, Judgment 25 February 2016). If an offender is diverted to the mental health system, then Art. 5 §1e, detention of persons with an unsound mind, will be

applicable. Here, proceedings may result in commitment to psychiatric hospitals if dangerousness is established. In case a criminal trial has started, either proceedings are terminated (and alternative procedures begin) or the defendant is acquitted and referred to the mental health system or (in systems with a second track of measures of rehabilitation and security) committed to a psychiatric hospital by the criminal court. A finding of not guilty because of an "unsound mind" and dangerousness followed by a committal to a psychiatric hospital will then open a range of questions related to involuntary placement in forensic psychiatry. Here, involuntary treatment raises issues with respect to Art. 12 and 14 of the Disability Convention.

In general, current reforms of unfitness to stand trial and to plead seem to acknowledge that diversion from the regular criminal process should be a "last resort" to be applied only if the capacity to participate effectively in trial proceedings is lacking and impairment of that capacity cannot be compensated [63, p. 3].

With respect to German criminal law, Pollähne [21] has suggested to bring insanity rules in line with the prohibition of discrimination through wording used in the provision which regulates the consequences of a "mistake of law." The result would be a general exclusion of culpability for all offenders who when committing a criminal offense lacked comprehension of the wrongfulness of the act. While such an approach in fact reflects a general and not discriminating ground for establishing lack of culpability, it does not account for those conditions which do not impair cognition but affect the capacity to control the act. Moreover, significant differences between various grounds now hidden under the umbrella of "lack of comprehension" still would call for different responses. The reason to excuse an act committed under the condition of a "mistake of law" normally is found in the complexity of legal regulations (in particular those applicable in the economy, commerce, or taxation), sometimes also in significant cultural differences in assessing the wrongfulness of certain acts [64]. However, this type of excuse will not result in a need of further measures as such a defense may work only once. Lack of comprehension as a consequence of a mistake of law regularly is eliminated through the criminal trial itself. While some psychological or psychiatric conditions may have also only temporary effects on comprehension and criminal culpability, others will continue to impair cognitive and control capacity. Along more or less the same line of arguments and from the viewpoint of common law, compliance with the Disability Convention (or interpretation of Art. 12, 14 by the Committee) is sought through "subjectifying" criminal defenses and replacing insanity defenses by general defenses which justify or excuse if the offender believed in circumstances that, if true, would have amounted to justification or excuse of the offense [20]. Also here, impairment of control capacity would not be included, and also here, the problem will be just moved below the surface of "subjectifying." Of course, the most important question following the statement that an offender believed in circumstances which would justify an act of homicide will be why the offender believed so. And, it will certainly make a difference whether the offender believed that a gun was pointed toward him or her or whether the offender believed that another person is part of a large-scale conspiracy ultimately aimed at destroying the world.

Thus, the debate on how the Disability Convention should be interpreted reflects at the same time a basic conflict about how broad the insanity defense or exculpation based on insanity should be and a conflict about legitimate grounds for broadening or restricting insanity defenses. Calls for restrictions (or complete abolition) of insanity defenses are not justified with a possibly damaging loss of deterrence but with protecting human rights (and human dignity) of disabled persons. Withholding criminal responsibility (and blame) because of insanity is equated with denying that a person can be addressed as a "reasonable" person, as a fellow participant (or fellow citizen), and an equal in legal practices [62, p. 449, 65]. And, behind that reasoning two suspicions hide. A first suspicion is well entrenched and asserts that a special defense of insanity furthers stigma and exclusion and, moreover, "perpetuates the extremely damaging myth that people with mental disability are especially dangerous or especially lacking in self-control" [20] and ultimately exposes individuals with mental disabilities to discriminatory and inhumane practices (in particular in the form of involuntary medical treatment) and the risk of long-term and disproportionate confinement in psychiatric hospitals. A second suspicion concerns that the emergence of new clinical pictures might be triggered not by a legitimate attempt to exempt the inculpable from criminal punishment but by the interest to incapacitate offenders considered to be particularly dangerous through opening a pathway into closed psychiatric institutions.

It cannot be expected that law and practice of State parties to the Disability Convention will in the foreseeable future change toward complete abolition of insanity defenses, diversion of those assessed unfit to stand trial and plead to alternative proceedings, and involuntary commitment to forensic hospitals [66]. In fact, if commitment to psychiatric hospitals (either justified with a criminal offense committed while mentally disordered and dangerousness caused by that mental disorder) would not be acceptable because of discriminating against the disabled, then of course, the perceived need of public protection (or protection of individuals from self-harm) would not desist to call for consideration. But, what could be alternative legal grounds which would be on the one hand "de-linked from disability" and on the other hand "neutrally defined so as to apply to all persons on an equal basis" [66, p. 175]? A neutral definition will certainly be wider than current criminal justice and mental health systems provide for in Europe and therefore carry the risk of widening powers of detention. The ECHR today allows detention only when imposed by a criminal court in response to a criminal offense (Art. 5 §1a) or when falling under other enumerated grounds listed in Art. 5 ECHR (among them an "unsound mind") and thus restricts the state's power of detention. The only option of a neutrally defined ground which would not discriminate against disabled persons will be "dangerousness." It can be assumed that introduction of dangerousness would find massive political support in face of ongoing debates on how to respond effectively to terrorism, violent crime in general, and sexual offenses and how to prevent such crimes of persons not assessed to be of unsound mind nor close to preparing or committing such offenses (acts which would carry a sentence of imprisonment). The German Federal Constitutional Court when dealing with the question of (retroactive) preventive detention in Germany which was judged to be in violation of the

ECHR by the ECtHR has found that a mental disorder which does not exclude or diminish criminal responsibility and therefore falls well below the threshold of insanity defenses established by criminal law may invoke nevertheless the ground of "unsound mind" to justify detention in a treatment facility (Federal Constitutional Court, 2 BvR 1516/11, 15 September 2011). The ECtHR has held that the finding of a mental disorder (sexual deviance), the necessity of treatment, and a high risk of serious crime comply with detention based on Art. 5 §1e (unsound mind). The ECtHR said also that detention justified properly with requirements coming with detaining a person of unsound mind will not amount to "punishment", but remain treatment (ECtHR Bergmann v. Germany, Judgment, 7 January 2016). Sexual predator laws in the USA exhibit a parallel line of reasoning [67]. Neither the line between criminal responsibility and exclusion of criminal responsibility nor the line between a psychologically completely healthy person and one mentally disordered and dangerous but criminally responsible can be drawn through applying psychiatric methods. These lines will ultimately be drawn by law and politics [53, p. 48]. But there is still the question of how far forensic psychiatry should be removed from determining these lines.

De-linking mental disorders, culpability, and dangerousness completely would reduce the potential of discrimination to the disadvantage of mentally disordered offenders at the expense of risks of widening the powers to detain dangerous persons in general significantly. It would also entail a shift in the role of forensic psychiatry which moves away from providing expertise on the links between mental disorder, culpability, and dangerousness toward expertise on links between mental disorders, the necessity (and possibility) of treatment, and dangerousness. The emphasis of psychiatric expertise, however, would be then on prediction of dangerousness.

But, the Disability Convention has brought new momentum to a process of reassessing some crucial issues associated with linking an unsound mind and criminal law. Reassessment refers to the recognition that persons with disabilities should not be seen merely as recipients of charity or medical attention but as holders of rights who have "inherent human dignity worthy of protection equal to that of other human beings" [18] and are capable to make valid decisions. Placing emphasis on proportionality and addressing the problems allegedly associated with findings of unfitness to stand trial and involuntary commitment to psychiatric hospitals result in scrutinizing particularly diagnosis of medical conditions establishing insanity, link between various mental disorders and (violent) crime, and predictions of dangerousness.

4.5 Adjudication, Detention in Forensic Psychiatric Hospitals, Dangerousness, and Proportionality

From the viewpoint of mental disorders, adjudication of criminal offenders carries several risks. An offender might be found guilty, although a mental disorder has impaired cognitive or control capacity and is subject to a more severe penalty than

would have been imposed if a mental disorder would have been correctly diagnosed. Punishment then may also result in serving time in prison facilities where adequate treatment cannot be provided. Adjudication may result in a finding of not guilty due to insanity and in indeterminate confinement in a psychiatric hospital because the offender is assessed to exhibit a high risk of re-offending. Here, also the problem of correct diagnosis arises as arise the problems of assessing dangerousness. Seen from the outcome of criminal proceedings, both classifications as culpable and insane may work to the advantage and the disadvantage of criminal defendants.

The indeterminate nature of a criminal commitment to a psychiatric hospital has drawn criticism in particular from the viewpoint of proportionality. In fact, a sentence of detention in a psychiatric hospital may result in a period of confinement far longer than a prison sentence imposed on a culpable defendant for a similar crime (see, e.g., ECtHR Case of Klinkenbuss v. Germany, Judgment 25 February 2016, where the complainant had spent 28 years in forensic psychiatric hospitals for criminal offenses committed as a juvenile which could have resulted if found completely culpable in a maximum prison sentence of 10 years). And, even less serious crimes therefore carry a risk of lengthy detention for offenders for whom lack of criminal responsibility or diminished criminal responsibility has been found. In some European criminal code books, proportionality has been recognized as limiting imposition and duration of confinement in a psychiatric hospital (also the Supreme Court of Canada has adopted the "least onerous and least restrictive test to the type of detention imposed as well as on conditions of continued detention, [23]). In the German criminal code, §62 stresses that detention in a psychiatric hospital may not be ordered if—in face of seriousness of adjudicated criminal offenses and those predicted—detention would be disproportionate. Italian criminal law introduces proportionality criteria from another angle and provides in Art. 222 of the penal code that the minimum duration of detention in a psychiatric hospital is 10 years for crimes for which the law provides a life sentence and 5 years for crimes that provides sentences of less than life. In Switzerland, the maximum period of detention in a psychiatric hospital has been set at 5 years (§59 Swiss Criminal Code). Detention can be renewed for another 5 years in case of persisting dangerousness. The Dutch criminal code restricts an order of treatment in a psychiatric hospital for offenders not held responsible to 1 year (sec. 37). An "entrustment order" (terbeschikkingstelling, sec. 37a) may be imposed if the offender suffers from a mental disease or defect must not have necessarily impaired culpability. Duration of entrustment orders is graded on the basis of crime seriousness and dangerousness and may amount to indeterminate confinement in case of serious violent crime.

In Germany, indeterminate committal to a psychiatric hospital received widespread public and professional attention in the wake of the "Mollath case" [25, 68]. Mollath—accused of assaulting his wife and acts of vandalism—was assessed insane and acquitted. The criminal court, however, imposed a measure of rehabilitation and security in the form of indeterminate detention in a psychiatric hospital where he remained for 7 years for criminal offenses which would have attracted a suspended prison sentence at most if he would have been found guilty. Debates on proportionality and effective safeguards against abuse of forensic psychiatry

ensued and resulted in an amendment of the criminal code in 2016. While the Association of German Defense Councils had suggested to place an absolute limit of 8 years on commitment to forensic psychiatric care and to restrict forensic psychiatric detention to serious crimes of violence [69], the amendment which ultimately went into force in 2016 now provides in §67d (6) German Criminal Code that confinement to a psychiatric hospital may not exceed 6 years unless it is established that the mental condition carries a high risk of relapse in serious crimes of violence. Implementation of proportionality is moreover sought by intensifying judicial review of persisting dangerousness on the basis of (external and independent) psychiatric expertise.

In general, a trend toward restricting indefinite detention in a forensic psychiatric hospital to a risk of serious crimes of violence (and acts endangering health and life of others) seems to gain support. Nevertheless, strict and effective implementation of the proportionality principle will be possible only by imposing mandatory limits on the total period of detention [70, p. 232, 71, p. 6].

Another avenue toward proper consideration of proportionality is opened through the development of alternatives to secure placement (or closed psychiatric institutions) in the form of community-based forensic psychiatry and implementation of the "last resort" principle and ultimately also through adopting multi-agency approaches which seek to provide coordinated and intensive support in after-release settings and in the community [72]. Resorting to community-based forensic psychiatry as a less intrusive way of dealing with mentally disordered offenders is backed up by evidence that community-based systems are not more costly than closed psychiatric care and, if well managed, tend to provide better-quality services [22, p. 9]. In Italy, legislation went into force in 2014 which (after deinstitutionalization policies implemented in the 1970s) is considered a second revolution in forensic psychiatry [34]. The aim of the new legislation is to dismantle and ultimately abolish large forensic psychiatric facilities and to transfer responsibility for forensic psychiatric care (and for insane and dangerous criminal offenders) to the national mental health system. Current forensic psychiatric hospitals shall be replaced by small-scale residential facilities (not more than 20 inmates) or community-based psychiatric care. The implementation of the new law shall result in a process of discharging patients of forensic psychiatric hospitals to small residential facilities and into community care and restrict new admissions to "exceptional cases" [34, p. 445]. Although the process of closing conventional forensic psychiatric hospitals was in some aspects delayed, it was concluded "that the transfer of forensic hospital patients to community psychiatric services has been a positive experience overall" [73, p. 37].

The question of whether decisions on criminal culpability were wrong and have resulted in consequences to the disadvantage of criminal defendants is not only triggered by the risk of indeterminate confinement as a consequence of wrongfully assuming a defendant was mentally ill but also by a wrong finding of criminal culpability because of the risk of harsher criminal punishment than deserved. A finding of guilt does not automatically result in indeterminate confinement to a psychiatric hospital but (if dangerousness is not established) in mitigation of punishment or

complete acquittal. A wrongful conviction may also result from false confessions resulting from interrogation practices which expose suspects with mental problems and intellectual deficits to particular risks. Moreover, an offender suffering from mental disorders has to be admitted to adequate care and treatment. According to the ECtHR's jurisprudence, withholding appropriate care and treatment may raise issues of inhuman and degrading punishment/treatment (Art. 3 ECHR). Art. 2 ECHR and the right of life may be invoked in case mental problems result in suicide (see ECtHR, Renolde v. France (application no. 5608/05), 16 October 2008). Health screening of offenders when admitted to pretrial detention or prison as a first safety measure therefore must be introduced in prison laws.

Prediction of dangerousness has become a prominent topic affiliated with security [74, 75]. An assessment of dangerousness is necessary and requested by criminal law before imposing preventative detention or committing an offender to a psychiatric hospital. Also decisions on dangerousness may be wrong. However, a finding of dangerousness implies that two types of mistakes can occur. Dangerousness may be wrongly assumed, and an offender is admitted to a forensic psychiatric hospital although this offender would not relapse into crime. On the other hand, an offender may be judged to be not dangerous, will not be detained, and after release commits a serious crime. The first type of mistake (or error), of course, will not be easily detected. The second type of errors results regularly in significant public attention, in pressure on the legislator, and possibly also in criminal charges and/or civil law suits against those deemed to be responsible of wrongly assessing dangerousness [27, 76, p. 455]. Of course, errors coming with statements on probabilities may not be equated with mistakes, and all methods of prediction will result in errors. But, expectations of the public and the judicial system tend to request minimization (or complete exclusion) of errors and move forensic psychiatry toward an "unfairly defensive" role through neglecting, first, the probabilistic nature of assessments of dangerousness and, second, the closeness of dangerousness associated with mental disorder and dangerousness associated with "free will" [73]. Some higher courts in Europe, in fact, have held that prediction of dangerousness may not be based on actuarial instruments alone but must be based on clinical assessments of individual conditions. The German Federal Court of Justice has found that an assessment of dangerousness following the application of Static 99 was insufficient (German Federal Court of Justice), decision as of 30. 3. 2010, 3 StR 69/10). The Swiss Federal Court has set aside judgments of trial courts which assessed dangerousness on the actuarial instrument FOTRES alone (Swiss Federal Court 6B_772/2007, as of 9. 4. 2008; 6B_424/2015 as of 4. 12. 2015).

Some European countries have established Criminal Case Review Commissions which are mandated to examine convictions of persons when doubts arise as to the wrongfulness of a finding of guilt (see [77, p. 215] for England, Scotland, and Norway). In other countries, reopening of criminal proceedings (to the advantage of a convicted criminal offender) applies on grounds of new evidence which may result in an acquittal (or mitigation of punishment). A study on reopening criminal proceedings in Switzerland has found that new evidence on mental problems of convicted offenders played a significant role for granting a retrial in serious criminal

cases. New psychiatric expertise was decisive in three out of four convictions for homicide [78, p. 1161]. However, a major problem seems also to be wrong confessions from mentally disordered suspects [79, p. 148].

4.6 Involuntary Treatment and Coercion in Forensic Psychiatry

Wide acceptance of the rights-based approach to the treatment of defendants with mental problems has also resulted in refueling well-entrenched debates on involuntary treatment in psychiatric settings. Reasoning based on Art. 12 §2 of the Disability Convention asserts that also in the context of involuntary treatment jurisprudence and standards established by the ECtHR (and state legislation and practices) is "incompatible with … Art. 12 §2 and should no longer be regarded as valid" [80, p. 415]. Involuntary treatment has been scrutinized in jurisprudence of constitutional courts and the ECtHR. But, the ECtHR in principle holds that involuntary treatment may be legitimately applied if it was persuasively shown to be necessary (Gennadiy Naumenko v. Ukraine (application no. 42023/98, 10. 2. 2004) and if a statutory basis allows for predictability of forced treatment and fair proceedings (ECtHR, X v. Finland (Application no. 34806/04), 19 November 2012).

The German Federal Constitutional Court in a landmark decision as of 23 March 2011 (2 BvR 882/09) has declared involuntary treatment to infringe on the right of physical integrity as well as the right to self-determination. According to the reasoning of the Court, impaired capacity of discernment might even intensify and deepen an infringement if a mentally impaired person experiences involuntary treatment as particularly threatening. The focus is placed on the impact involuntary psychiatric treatment has on the body of a patient in the form of physical side effects of medicaments but also on the impact certain medicaments have on mental processes in the brain. In particular the latter is considered to have the capacity to affect the core of personality (privacy). However, the Federal Constitutional Court argued that in principle and under very narrowly defined conditions involuntary treatment may be justified. The Court asserts also that the Disability Convention does not prohibit involuntary treatment. On the contrary, Art. 12 §4 of the Disability Convention is interpreted as implicitly recognizing legitimacy of involuntary treatment because it requests implementation of proportionality and strict rules which protect against conflicts of interest and abuse. According to the 2011 judgment, substantive and procedural law must be in place which recognizes the relevance of the (natural) will and is guided solely by an interest of the detained person him-/herself to restore the foundations of self-determination (and the capacity to work toward release to the community). Involuntary medication of a detainee cannot be justified by a danger for others (detention prevents such danger effectively). A basic condition of involuntary treatment concerns convincing evidence that lack of capacity of comprehending the necessity of specific treatment is caused by the mental problem which shall be treated. From this starting point, the Court outlined requirements for legislation authorizing involuntary treatment in (forensic) psychiatric hospitals. First, a

law on involuntary treatment has to follow a standard test of proportionality. Treatment must be suited to restore the capacity of self-determination and present the least intrusive measure. Proportionality in this sense requests a serious attempt to achieve consent based on full information (on treatment, aims, and possible effects) and on trust (see in this respect United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991, principle 11 §9 requesting full information also in cases where legal capacity is impaired). Then, proportionality must be established through weighing the predictable benefit of treatment against the burden placed on the involuntarily treated person which should result in a clear preponderance of benefits. Second, implementation of the proportionality principle demands also for procedural safeguards. In order to allow for effective judicial review, detailed information that a measure of involuntary treatment is to be applied has to be provided sufficiently early. Another element in the procedural aspects of proportionality concerns full records of the process of initiating and carrying out involuntary treatment (see also ECtHR, Dvořáček v. Czech Republic (application no. 12927/13), 6. 11. 2014, where it was held that a specific form setting out consent and informing of the benefits and side effects of treatment would have reinforced legal certainty for all concerned, but the failure to use such a form was insufficient for a breach of Art. 3 ECHR).

Finally, the particular risks coming with coercion under conditions of detention call for an independent examination prior to carrying out involuntary treatment. The German Federal Constitutional Court in this respect invoked principle 11 §6b and §13 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care 1991 which emphasize the need for an independent (external) review of decisions related to involuntary treatment. Independent reviews could be done by a custodian, by an ombudsman, or by a judicial authority. In fact, the conditions outlined include also a model of "supported decision-making" as required by Article 12 of the UN Disability Convention. The ECtHR has expressed the view that it shares the opinion of the German Federal Constitutional Court elaborated in the 2011 decision. Involuntary hospitalization may be used only as a last resort and in absence of a less invasive alternative, if it carries true health benefits without imposing a disproportionate burden on the person concerned (ECtHR, Pleso v. Hunagry (Application no. 41242/08), 2 October 2012, no. 66).

Conclusions

Current challenges for forensic psychiatry follow from legal developments which emphasize rights-based approaches to those assessed to suffer from mental disorders. In particular the Disability Convention has provoked a new debate on whether and to what extent mental disorders and intellectual deficits may justify an assessment of lack of or diminished culpability and involuntary admission to psychiatric hospitals and treatment. Strong concern for fundamental rights of detainees in forensic hospitals has resulted in increasingly strong monitoring by independent organizations. Forensic hospitals thus are exposed—as are prisons or police holding cells—to the suspicion that places of detention are particularly

prone to risks of maltreatment and abuse. Paramount interest in security and protection of the public and crime victims has moved forensic psychiatry toward assessment of dangerousness and assessment of (causal) links between mental disorders and dangerousness but also toward assessments of alternative methods (community treatment) as elements in tests of proportionality. Forensic psychiatry increasingly has to deal with questions which fall outside the core area of professional expertise and to answer for practices (and results) which are primarily the outcome of legal and policy decision-making.

Take-Home Messages

- Forensic psychiatrists and psychologists should be aware of new developments in legal systems across Europe, since it affects their daily practice.
- Current legal developments emphasize rights-based approaches to those assessed to suffer from psychiatric disorders.
- Forensic psychiatric hospitals are exposed to the suspicion that they are particularly prone to risk of maltreatment and abuse.
- Forensic psychiatry and psychology increasingly have to deal with questions which fall outside the core area of professional expertise.

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