19 January 2015

Forensic commitment - Statement on the current situation and prevention

1. Introduction

One of the goals of the Austrian penal system is resocialisation. For people who - due to a mental, psychosocial or psychiatric impairment or disability - do not understand that the offence they committed was wrong, programmes with a focus on therapy (in the sense of a psychosocial intervention) are laid down. For those who are able to understand that they did something wrong, the law provides for a sentence in combination with therapy. The therapeutic element has to be the main emphasis for those who cannot understand their wrongdoing, whereas for those who can it is just one of the focuses.

In the years following the major reform of the penal system in 1975, dealing with offenders who have mental, psychosocial or psychiatric impairment or disabilities was characterised by a social-therapeutic and flexible approach. The number of those detained was much fewer than 100 persons. In 2014 there were more than 800 persons[1] detained in so-called *Maßnahmenvollzug* (referred to here as forensic commitment). The time in between was particularly influenced by the case of Karl-Otto Haas, who committed a murder while on day release during his release phase. Although Haas was not held in forensic commitment, the conditions there subsequently deteriorated dramatically.[2] The recommendations made by a commission which was installed after the incident – and in particular their partial implementation – will be dealt with later on in this statement. It was not least a report

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[1] For developments see in particular Stangl/Neumann/Leonhardmair, “Wege zur Reduktion der Einweisungen zurechnungsunfähiger Rechtsbrecher in den Maßnahmenvollzug”, Institut für Rechts- & Kriminalsoziologie.

[2] All quotations unless stated otherwise were written down with the agreement of the self-advocates in the prisons of Stein, Karlau, Mittersteig and Göllersdorf, the Asten Center for Forensic Psychiatry and the Forensic Psychiatric Dept. in Mauer-Öhling. Individual names are deliberately withheld.
“At Mittersteig you used to have the feeling that they wanted to help you. They even cared about details which are not so important, but which maybe are after all.” “There were (Mittersteig-) plans which were the same for everybody.” “When you had completed it (the Mittersteig plan) you were released.” “You were asked (at Mittersteig), they explained it and it was understandable.” “The immediate neighbours (of Mittersteig) didn’t know it was a jail.” “In 1993, Karl Otto Haas committed a murder as a normal prisoner, then there was Stockreiter in 1994, and in 1995 there was the hostage-taking in Karlau – since then everything has changed. In the 1990s there were 20 people there due to Section 21; they were the only ones in civilian clothes and also received therapy…” “In 1989, 99 out of 100 wanted to go to Mittersteig because of the support there.” “You were worthy of release just because you wanted to have therapy.” “The Haas case put the penal system back 20 years.”

by the National Audit Office in 2010[3] which has driven the debate about a reform of forensic commitment in recent years. The neglected state of a person accommodated in Stein Prison which became public in May 2014 [4] led to the appointment of a working group by the Minister of Justice Prof. Wolfgang Brandstetter. As can be derived from a reply to a question in Parliament[5], the Monitoring Committee was invited to participate in this working group.[6] In this context, the Committee drew up a statement which is attached hereunder as an annex.

In line with its obligation (Art. 33 para. 3), the Committee spoke to some self-advocates in November and December 2014 in the prisons of Göllersdorf, Mittersteig, Karlau, Stein, the Asten Forensic Mental Health Centre and the forensic mental health department of the Mauer-Öhling Provincial Clinic.[7] This statement provides a forum for the views and experiences of self-advocates, who in reality have no opportunity to participate in the debate on their detainment – a fact which the Committee views as highly problematic due to the clear obligations set down in Art. 4 para. 3. The statement will also illustrate how people with mental, psychosocial and psychiatric impairments are dealt with from the perspective of insufficient inclusion and a – particularly in a social sense – lack of accessibility. Finally, the conformity with international obligations emphasised on several occasions by Minister Prof. Brandstetter – the European Human Rights Convention (EHRC), the minimum rules of the United Nations for the treatment of offenders (SMR)[8] and the anti-torture provisions of the United Nations (CAT)[9] and the Council of Europe (CPT)[10], and of course the Convention on the Rights of Persons with Disabilities[11] – will be considered from the perspective of these people.

The Committee appreciates the commitment of the staff of prisons, therapeutic facilities, follow-up care facilities, forensic mental health departments and other institutions. Despite this commitment, forces are at work within the system of forensic commitment which contribute towards structural violence.[12]

The Committee is aware of the necessity to suitably protect the victims of the violence of persons who are detained in forensic commitment. The protection of victims obviously has to take priority. From the perspective of the Committee, it is possible to do justice to the protection of victims within the framework of resocialisation without playing these issues off against each other. The following statements are intended to strengthen victim protection, also in the interests of prevention.

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[3] Report of the National Audit Office – Forensic commitment for Mentally Abnormal Offenders 2010.
[4] See Falter City Newspaper No. 21/14.
[5] See answer to parliamentary question 2177/AB on 7 October 2014.
[6] For the term “disabilities” and its broad definition see: Statement (Annex).
[7] The Committee wishes to thank the staff in the institutions for their support. The Committee expressly recognises the competence of the Ombudsman’s Office and its commissions within the framework of Art. 16 para. 3 of the Convention. Furthermore, the Committee emphasises that given its existing resources it was unfortunately not possible to interview self-advocates in more detail.
[8] Standard Minimum Rules for the Treatment of Prisoners.
[9] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx.
[10] European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment; http://conventions.coe.int/Treaty/en/Treaties/Html/126.htm.
[11] Cf. FLG III 155/2008.
[12] Regarding structural violence see in particular the statement of the Commission on violence and abuse: http://monitoringausschuss.at/stellungnahmen/gewalt-und-missbrauch-24-02-2011/.

2. Problematic areas

A lack of perspective

“This is undignified. Unbearable,” is one of the many descriptions of forensic commitment. For those who are supposed to receive therapy instead of punishment, but particularly for those whose sentence was served years ago – and in some cases decades ago – the question arises: “How can it be that I am put together with prisoners?” And the remark: “I’m a patient, not a prisoner. Keeping me detained for longer than my sentence is not on.” And: “You’ve got fewer rights here than a prisoner," and: “It says Therapy Centre on the sign outside, but it's a prison.”

Very many of those detained see no future for themselves. “This is a complete guarantee that nothing's going to happen. “You’re just left hanging.” “This here is 100% hopelessness.” The lack of perspectives is reflected in what they see in others: “You can see that nothing changes with other people too,” and also extends to the system, which nobody thinks is capable of change: “The problem has become too much for them; the fact that they are not solving it is costing people their lifetimes.” “The system is so crooked that a few changes won’t help,” noted a self-advocate, who with regard to the rigidity of forensic commitment commented: “It’s a state within a state.” Or: “This is a separate territory in the justice system.” For most people, the result is "torture of the mind and spirit with years and years of hypocritical reasoning behind it”. Another self-advocate asks: “How can it be that in a democracy a helpless and defenceless minority is at the mercy of a system which is characterised by scientific abuse."

An internal review shows that among the detainees more than eight foreign languages are spoken – the therapy programme, however, is only in German.

The large number of persons who are detained without having a residence permit for Austria is worrying. The danger of them being picked up by the police and deported to their country of origin is great. Alongside a return to the environment which in the large majority of cases is probably indirectly responsible for the offence, suitable support and care is not provided in the majority of these countries.

What is relevant for institutionalisation?

“*De facto*,” said one self-advocate, “everyone is outside the norm, everyone needs to be placed in detention.” In fact many people are institutionalised because of threats which, in a different context, would be seen as an expression of resentment which is common in certain environments and would have no consequences. The number of people committed because of threats towards public officials is noteworthy.[13]

“Bad behaviour” is not psychiatric *per se* either. Conspicuous behaviour as a reaction to traumatic experiences or a drastic change of surroundings or a change of trusted persons should not lead to institutionalisation. The fact is that the number of persons who are committed for these reasons is constantly rising.

[13] See Stangl/Neumann/Leonhardmair, “Wege zur Reduktion der Einweisungen zurechnungsunfähiger Rechtsbrecher in den Maßnahmenvollzug”, IRKS 21.

"Dangerousness"

"Since when has it been possible for the soul to be abnormal?" asked one self-advocate with regard to the terminology of Section 21 of the Criminal Code.[14] In practice it is "dangerousness" which is decisive for detention. "Dangerousness? The reasoning behind it is hypocritical." People who are kept in detention are excluded from privileges with the comment "you're too dangerous", and are detained indefinitely. Many also experience this as an easy solution: "Well it's easier to call me dangerous than to help me." The impression that nothing is done about this 'dangerousness' is difficult to contradict: "They say that I'm dangerous, but they don't do anything for me."

This alleged dangerousness is derived (via 'abnormality') from the statistical likelihood of reoffending. It would be necessary – in combination with other criteria (also ICF[15] based) – to determine the reason for the individual 'disorder' which specifically increases the alleged danger. It is also notable that the tests and scales used for assessment were developed for different cultural contexts and are therefore not suitable for Austria.

The emphasis on supposed dangerousness is problematic in terms of human rights, particularly because the stigma which this label creates leads to many actions – and also omissions – in relation to people in forensic commitment. From the perspective of the Convention, the focus on the supposed danger is incompatible with the ban on discrimination (Art. 2). Detention solely due to a disability does not conform to the Convention either (Art. 14).

"I have a disorder, but I can think." Other aspects, particularly resources[16], must play an equivalent role. One of the decrees[17] on the easing of detention regimes provides for this weighting, but in the assessment for institutionalisation and in everyday life it does not seem to have an impact: "Everything which would have been in my favour for me was not mentioned in court." "One can learn, also by making mistakes, but that view isn't shared here." Or also: "They know all about previous convictions, those are shown immediately. But the things that change are not mentioned." In particular, a person's insight into their illness and its effects – "I can notice myself when the disorder is causing problems" – is frequently not of interest in the case of people who have been detained for a long time.

A disregard for dignity and a lack of legal security

The Committee has already pointed out elsewhere[18] that respect is the aspect which is most obviously lacking in how people with disabilities are dealt with. This also applies to forensic commitment. The credibility of detained persons is regularly called into doubt: "They don't believe the mad and the sick." Or "You're a 21[19] - you're a

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[14] FLG No. 60/1974 in the version FLG I No. 111/2010; para. 2 speaks of "mentally abnormal" and "mental and emotional deviance". See also the Statement of the Committee: The fact that people are 'named' using the figures of criminal law provisions – a 'number 21' – seems to be symptomatic for the way a 'system' sees the people it is detaining.

[15] International Classification of Functioning, Disability and Health (ICF); http://www.who.int/classifications/icf/en/.

[16] See also the explanations in the statement in the Annex p. 2

[17] Decree Zl. BMJ-VD52231/0011-VD2/2008.

[18] See the Statement on Barrier-Free Health Care, http://monitoringausschuss.at/stellungnahmen/gesundheitsversorgung-29-01-2014/.

[19] Section 21 of the Criminal Code is the basis for forensic commitment, see above.

complete idiot." "They think I'm an idiot, that's degrading." And: "Nobody believes me."

The presence of an impairment must not lead to doubts about people's ability to judge situations and their own state of mind, and to have an opinion. It must also not lead to them not being listened to respectfully and to them not receiving an answer as an equal. "The promises that are made are not kept" is a statement which is frequently heard. Those who have been in forensic commitment for decades emphasise that everything was different until 1994: agreements were communicated clearly and adhered to; that was the also case from 2003-2009 in Mittersteig prison. Statements like: "Get used to the fact that you'll die here," show a complete lack of respect and a disregard of the principles of the rule of law, and make it clear that the system fundamentally assumes that there will be no change. "You never know when you'll get out, thus the uncertainty." "They give you hope and then destroy it."[20]

"Most people give up hope for themselves. That's also a form of neglect."

Many people cannot understand why they are detained for so long: "Many view themselves as victims because they've already served their sentences." Because: "Until the end of your sentence there's hope, and meaning. What happens then (after the end of the sentence) can't be described – it's a hole you can't get out of." Detention for years and decades after the end of a sentence are frequent: given an average sentence duration of 965 days, the average length of detention is just under twice as long: 1,862 days.[21]

Maintaining one's own credibility with regard to relations and partners is particularly problematic: the inexplicable extension of detention is plausible on one or two occasions, but "then they start thinking it's your own fault".

The path to forensic commitment

"The motion for a psychiatric expert report to be drawn up sets the machinery going", and in more than 90% of cases in which a report is made, people will be institutionalised. At the same time, one can say: "You could toss a coin as to whether someone will end up in forensic commitment."

In the proceedings you then hear things like, "this bloke should be locked up". Enquiries showed that nobody had any positive experiences of the assessment process. The proposed time frame of at least six hours was not reached by far among any of those interviewed. "The exploration? One shouldn't exaggerate: it lasted 7 minutes." The times given varied from 5 to 30 minutes. They talked about "everyday things"; some people said they hadn't understood the tests and "just did them", or refused to do them at all. "The rest took 10 minutes."

With regard to the reports, self-advocates said: "The reports are neither state-of-the-art nor do they seem to make sense." "The diagnoses which were used in the 2012 reports are neither valid nor permissible." "The World Health Organisation says that such things don't exist … that doesn't matter."[22]

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[20] Further statements: "You shouldn't get your hopes up too much". "We're running around as if we were on a treadmill, not getting anywhere." "Everything takes forever, nothing gets anywhere." "You'll get work next week," they said to console me, but nothing happened. "I stopped counting the days long ago."

[21] Figures for Section 21 para. 2, see: Stangl et al, "Wege zur Reduktion", IRKS, 32.

[22] The classification of the WHO applied here also works with exclusion criteria which in some cases were apparently not observed.

“The assessor rode roughshod over me – so I just said as little as possible,” is a common statement. And so is this: “Now there’d be a lot of things which I wouldn’t say again, but only think, when I was talking to the assessor.” The level of mistrust towards assessors is high throughout the system, also because the support people are hoping for does not materialise: “My expectations of the report: how they could help me to find solutions.” Or: “It’s sad that my report is just so general.” The result: “The interview with the assessor is meaningless if s/he only sees what the others say.” The description of one individual was especially dramatic: “The assessor comes in, holds out his hand and says: “You’re dangerous!”

Alongside the impression that “the main thing is, there’s something wrong with him", you “can’t get rid of the first report”. Experience shows that passages are copied from the first report. The necessary independence – also with regard to a completely new assessment – is undermined by reports based on existing files. “If you read the one report, you’d think I was a mass murderer; in the next one it says the complete opposite.” Or: “He portrayed me as a Hannibal Lecter, that negative.” But also: “It says there ‘Mr... sees how far he can go. And is that why he’s detained?”

In the proceedings “I didn’t have anything to say,” “I wasn‘t asked” or “they went through the proceedings as if I wasn’t there.” Sometimes there is communication, but: “The judge asks you something, but you can't really say anything.” A self-advocate sums it up: “If you can’t pull the report to pieces… you stand no chance.” It is noteworthy that judges and prosecutors often think that forensic commitment is better than a normal prison sentence. “The public prosecutor thought she was doing me a favour."

Hearing

Over the course of detention in forensic commitment, hearings are held in which judges decide on its extension. “Farce”, “speed hearings”, or also “Hearing? 20 people are dealt with in 45 minutes.” You’re dispatched at a rate of two minutes each. With a lawyer it lasts ten minutes.” The widespread presumption of prior agreements having been made before the hearings increases the feeling of impotence and reluctance to even attend the hearing at all: “Because it's pointless."

A point of considerable criticism is that both with regard to the easing of the detention regime (privileges) and its ending, the practical responsibility is tossed between the court and the management of the institution. “The will of judges to make their own decisions is...limited.” Alongside the dependence of judges on the content of reports and assessments by third persons, particular criticism is also directed towards the fact that only the cover page is read, even if nothing is to be found there about the person’s progress and changes: “Judges only read the cover page – it’s completely different if you continue reading (the report).”

A decree issued by the Federal Ministry of Justice[23] is noteworthy as it formulates representation by a lawyer during hearings as a right within the framework of a hearing for conditional release. It is also remarkable that the different roles and decision-making competences of assessors, judges and prison governors seem to become very blurred in the context of hearings.

[23] Federal Ministry of Justice L64.028/0005-II 3/2007

Everyday life in forensic commitment

“In the first 18 months nothing happens at all,” and: “Everything takes ages.” A person suffering from dementia could only be transferred to a suitable institution after 30 months, and a knee support for a person who was overweight due to medication had to be ordered via the Ministry. Until privileges are approved, “at least a year passes.” Or:"In the report from two years ago it says that the detention order should be lifted.” Overall, one gets the impression that: “The way they deal with people’s time is a catastrophe.” “This is about a person's lifetime. You don’t get the time which they steal from you back again.”

Therapy, the completion of which is indispensable for the prospect of an easing of the regime - also according to the law - is offered once a week for 50 minutes (at most) in some institutions: “There’s therapy once a week, otherwise nothing happens which contributes to your future.” If the relationship with the therapist doesn’t work, the related applications are sometimes rejected out of hand. From the perspective of the detained person this means a hard fight lasting at least one or two years. Those who are in a prison are locked away for up to 23 hours a day. This includes those for whom claustrophobia is part of the diagnosis.

“If you say, 'Can you help me?’ nothing happens, although they know exactly what I need.” The denial of the provision of help and support is described as systematic and also as “the little games they play”. “Those are tests to see the degree to which you can be tormented."

One self-advocate relates how he refused to answer questions about intimate details by pointing out that it was not relevant. The reply was, “You don't have a private sphere.” When he added that he would have to obtain the agreement of his partner, the response was: "You won't get far with that attitude". In the next assessment he was adjudged to be "lacking in compliance".

“We’re the patients who have to be treated and should be the focal point – but instead it’s the computer, the writing of reports and the issue of medication," sums up a self-advocate. Social workers and prison officers describe their corresponding frustration at the growing demands in terms of documentation and detailed written reactions to complaints, and the resulting limitation of their resources for working with the detained persons themselves.

Matching reports on the system-wide management of feedback are problematic. It seems as if this feedback tends to be viewed as criticism, and is instinctively rejected, which can have consequences for the writer. “If you point out any contradictions, they say you’re aggressive, stubborn and are falling back into old ways.” “Criticism leads to the extension of detention.” “Every criticism leads to a measure being taken – I’m already completely motionless.” You’ve got to put on a smile about everything – otherwise you’ll never get out.” Either you cooperate or you’re done for.” And: “You learn to keep quiet.”[24]

[24] Additional feedback: “If you feel unfairly treated it becomes difficult.”
“If you answer back you’re in trouble: you’ve got no chance.” “You have to put up with a lot from them … if you don’t you can vegetate for years on end – if they feel like it they can get you out.” “They harass you.” “Your questions don’t get answered, and that hurts.” “They use stalling tactics.” “Criticism of the system is seen very critically.” “I’ve often thought someone should say that, but I want to be left in peace.” “There would be so much to say, but I don’t say anything anymore.”

Alongside the impression that "When you're in forensic commitment you're fair game," and "When you're in detention you're completely at their mercy," [25] the rigidity of the way out of detention is particularly noticeable: "They've got one route, and that's the one you take," and: "There are no negotiations, it's just decided."

The majority of self-advocates outline a plausible and suitable way of mastering the easing of the detention regime and its challenges. Requests such as external therapy as part of day release - in the context of which the problems of deinstitutionalization can be discussed at the same time - are, in view of the reasons for detention, meaningful. This also applies to the clear formulation of one's own borders in freedom and the need for support, for example via a long-term stay in a residential community, or to the possibility of being released with an electronic tag to care for a family member. "They want to see visible change, but don't say what that's supposed to look like."

"I told them about my problems related to day release – instead of help there were sanctions. "I was supposed to be getting therapy?" said several self-advocates on the difficulties of easing the regime in a suitable way. Alongside the individual consequences – which can also mean the interruption of privileges - there is also the impression of 'collective punishments'. For "security reasons," privileges were cancelled for all of the persons in forensic commitment because something happened to "one of them". Although the idea of forensic commitment is supposed to be therapy and not punishment, day release is regularly carried out with handcuffs.

The severe lack of facilities for follow-up care represents a bottleneck. There are too few facilities, also in terms of quality (suitably specialised), in which it is possible to try out living as part of release. This leads to the following situation: "You haven't got anywhere to live? Then you're staying here." Even people who have their own flat or who can live with their families have to go through a trial period of living in an aftercare facility. "I've got a flat and I have to get out via a trial period in a facility – I'm taking up a place someone else could have." In cases where financing is split between health and social services departments, support and coordination seem to function well. In view of the federal element of aftercare, the Committee wishes to flag the relevant recommendation of the CRPD Committee.[26]

Therapy

The concept of therapy in forensic commitment includes a pharmacological element (medication) and above all talking therapy. In some institutions ergotherapy, occupational therapy and social training are offered.

"It's forced therapy - you do it because otherwise there are consequences." "It's actually blackmail: I have to take it (medication) so that I can get out." Enforced treatment can also lead to descriptions according to which: "It was as if he was remote-controlled; all that was missing was the aerial."

[25] Additional feedback: "They can do what they like." "They do some things just out of nastiness." "You're not human, you just have to function." "Blackmail is a pedagogic method here." "If you can't feel anything, well… that's not right." "It's all harassment." "How much can he put up with – that's what they try to find out here." "Although the case was closed I am treated as if I'd done it." "The arbitrariness that you're subjected to…" "You obviously haven't realised where you are here – you're in forensic commitment," said the officer.

[26] United Nations, Committee on the Rights of Persons with Disabilities, concluding observations on the initial report of Austria, adopted by the Committee at its tenth session (2–13 September 2013) http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fAUT%2fCO%2f1&Lang=en, particularly points 10 and 11.

There are regular descriptions of "shovelfulls of tablets" as well as a questionable attitude to dealing with the severe side-effects of medication, which may also be completely ignored. Overall a tendency can be recognised for the prescribed multi-dimensionality of the bio-psycho-social model to be more like the ‘bio-bio-bio’ model[27]. The implicit message is clear: “If you refuse the medication then this will go on for longer.” One of the detained persons said about his own physical state: “My speech is slightly fogged due to the medication. “

The issue of medication, particularly when forced, but also without sufficient information about side-effects, is fundamentally debatable, especially in light of the Convention.[28]

The larger part of the problems which lead to forensic commitment cannot, however, be solved with medication. “You have to work with the person.”

The talking therapies which are offered are evaluated very differently: those who find a type of therapy and a therapist which/who suits them report definite progress. Where that is not the case they complain about the great difficulties in obtaining alternatives.[29] There do not seem to be any system-wide therapy standards.

Alongside the dominance of drug-based therapy, it is noticeable that those persons for whom therapy has had no effect for a long time are practically given up and declared to have "completed therapy", but are not released. Those who would need alternative forms of therapy receive no offers of such, but remain in detention.

Those who emphasise the positive effects of talking therapy are more or less forced into this insight via group therapy. The option of peer support – which is provided for by the Convention (Art. 26) – was used in the past but apparently not at the moment.

The descriptions of those people who were refused therapy before they committed their offence or received no therapy during previous detention is particularly dramatic. They emphasize that beginning with therapy earlier would have prevented the offence. “I wanted therapy but they didn't take me seriously.” Descriptions of applications for therapy being turned down because they are deemed to be a provocation, are shockingly common.

Background

“I received damages as a victim – in the children's institution we had to kneel on pieces of lego because we'd spoken to each other. That's gone now, as compensation to the man I injured, and that's ok.”

“My first longer stay in a psychiatric ward? I was 18 then.”

“I tried to commit suicide five times.”

“I had myself admitted to (to the psychiatric ward) to get some hot food.”

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[27] Terminology used by the former President of the US Psychiatric Association Stephen Scharfstein.

[28] For more details see also: Fundamental Rights Agency, Involuntary Placement and Treatment of Persons with Mental Health Problems, 2012.

[29] Additional feedback: “The therapist told me for two months that he didn’t like working here – and that was my therapy.” “The prison governor said: “He’s giving therapy to my therapist, not the other way around.”

"I'm also a victim of Dr. W."[30]

"I told them about my thoughts of murder, and they committed me straight away."

Without wishing to play down the offences, there seems to be a clear tendency to apply forensic commitment to persons who were themselves victims of violence, who have a history of psychiatric treatment, who have overtaxed state institutions (particularly youth welfare), and in whose cases it was "only a matter of time" until this measure would be used as a "viable option" or "remedy".

Frequently, 'awkward' behaviour turns into a feeling of being overwhelmed, and then to threats. There is evidence of a tendency for people to be committed to an institution for threats against public officials.[31]

Forensic commitment as an acceptable alternative to other forms of institutionalization is an alarming indicator for the fact that the latter are overburdened. The penal system as a means of therapy for experiences of violence is evidently highly problematic.

However, the obvious violence which is created in sum from a person's prior history and from detention is alarming: these are people who can no longer take doctors seriously, who specify suicide as their prime alternative, and for whom a hunger strike is the next step towards it.[32]

Forensic commitment has long since become a part of this system of structural violence. "You really can't cope with the psychological problems resulting from indefinite detention." Coming to terms with them must be based on Art. 16 para. 4 CRPD.

"The room is just locked – there's no door handle so we can't get out. The thing with the handle does me in, I dream about it... about the handle."

A sense of security: dignity of risk

The general public's need for a sense of security is at the forefront of all discussions about the reform of forensic commitment. The fear of negative headlines is so great that it is practically equivalent to a ban on thinking. The fact that the reoffending rate for persons released from commitment is very low, and glaringly lower than for persons released from normal prison sentences, is ignored. This is a clear indicator for the excessive rigidity of the current system.

But: "Safety-first thinking is so dominant that – just to be on the safe side – nothing is done," because: "People expect an unrealistically high sense of security."

The – alleged – need for bogeymen in the form of monsters weighs heavier than the entitlement to resocialisation and the acceptance of basic social risks. The 'no risks' mentality[33] which is thus apparently maintained runs directly counter to resocialisation: the more people are portrayed as being inhuman, the more difficult

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[30] As is well known, the case against Dr. W. because of sexual abuse of several minors was not pursued due to the limitation period.

[31] Stangl et al, 21.

[32] Additional feedback: "I slashed my wrists, it was my only chance." "Hunger strike is the only possibility I can see to be heard." "If I'm still here in five years time? I'll be dead." "I've told all of this 50 times already; I don't experience anything." "I said I was alright although I felt terrible."

[33] "Aus dem Auge, aus dem Sinn" (Out of Sight, Out of Mind) – Criminal law experts criticise the treatment of mentally-ill prisoners http://www.jku.at/PR/content/e13544/e13537/e190045/e193064/e218870/PA_Strafvollzug_ok_ger.pdf.

resocialisation becomes, but - importantly - so does the prevention of acts of violence:[34].

The principle of the dignity of risk.
“To say someone is a beast is more sensational – as if it didn’t hurt you when you harm someone else.” The cases in the newspapers? They don't exist here. Broken families, people who have no-one they can talk to,” is what you encounter in forensic commitment. From a handful of offences which are particularly objectionable, a category of persons is constructed which justifies locking people away for an indefinite period. But also those whose offences are particularly reprehensible have a right to change and - in some case perhaps on certain conditions - to be reintegrated into society.

3. Recommendations

The overdue reform of forensic commitment needs to reorganise three main areas:

- Specific and prompt support for those who, due to the existing regulations, have become victims of structural violence, and a suitable transition scenario for quick release
- A reform of the criteria for commitment with standards for assessment
- Comprehensive measures by the ministries responsible for health, social affairs and youth to prevent the tendency towards escalation in institutions as well as preventing experiences of violence and a history of psychiatric treatment.

1. Legal subjectivity

a. Persons with psychiatric problems are people with legal subjectivity and should be encountered as such. An amendment of the term "mentally and emotionally abnormal offenders" is required, as is the calling into question of the image which is held of detained persons (Art. 1 CRPD).

b. The potential discrimination by the stigma of having a psychiatric problem – intensified by the offence – should be counteracted by suitable training measures and campaigns to raise awareness (Articles 4 & 8 CRPD). The dignity of risk in particular needs to be established as an individual and general social principle.

c. The definition of the criteria for commitment has to focus on the person’s resources in each phase of a potential detention. The person’s disability per se should not be decisive for commitment (Art. 14 CRPD) [35]; the criteria for reports must be adapted correspondingly.

2. Therapy, not punishment, and: resocialisation as the core task and main focus

Therapy should begin at the earliest possible time and be offered locally (Articles 19, 25(c) and 26 para. 1(b) CRPD). Alongside health care (Art. 25), the therapy programme also has to include rehabilitation (Art. 26) and education, particularly the acquisition of “practical abilities and social competence” (Art. 24 para. 3 CRPD)

[34] Terminology used by the former President of the US Psychiatric Association Stephen Scharfstein.
[35] See also the very clear interpretation of the specialist committee: http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E .

3. Non-discrimination (Art. 5 in conjunction with PP(p) CRPD)

a. raising awareness for the effects of stigma
b. multiple discrimination due to age, particularly among young people, young adults and older people, whose institutionalisation should be principally rejected
c. an end to the detention of people without a residence permit, and the provision of a permit to such people whose act of violence was most probably caused by the reason for their flight.

4. Legal protection

a. Access to legal support must be ensured during detention. Legal representation should also be obligatory for hearings (Art. 13 CRPD in conjunction with the jurisprudence of the ECtHR on Art. 5 par. 4 ECHR.
b. A representation of the interests of persons held in forensic commitment which is analogous to that laid down by the law on the accommodation and treatment of persons with psychiatric disorders in psychiatric care should be established (Art. 12 para. 3 CRPD).
c. On issues of consent, Art. 12 in conjunction with Art. 25 of the CRPD is decisive; legal protection in this field must satisfy the requirements of Art. 12 para. 4 CRPD.

5. Suitable therapy

a. The concept of rehabilitation used in the Convention is broader than the current programme (Art. 26 and Art. 24, particularly para. 3 CRPD).
b. Particularly for victims of violence, but also for those who have come under pressure from the structural violence of the system, the provision of therapy should be ensured (Art. 16 para. 4 CRPD).
c. Therapy should be offered immediately – if necessary also during pre-trial detention.
d. Forced treatment is not compatible with the Convention; a discussion on its practical realisation is currently being held internationally, and forensic psychiatry should contribute towards this.[36]

6. Reasonable accommodation: assistance and support

a. The concept of assistance and support in the Convention makes alternative approaches in the resocialisation process necessary. This includes the facilitation of therapy as a part of privileges; see also the concept of reasonable accommodation (Art. 2 and in addition Art. 16 para. 4 CRPD).

7. Qualitative examinations:

a. The increasing number of commitments of persons who cannot be dealt with by support facilities, whose behaviour becomes conspicuous after a change of support person, and who have a history of psychiatric care, has to be examined from the perspective of quality.

[36] See also the reference in footnote 19 of the Statement in the Annex p. 6

b. The obstacles which the system creates regarding privileges, thus also producing the possibility of the reduction of privileges as a sanction, also need to be questioned from the perspective of quality.

8. Preventive measures

A history of psychiatric care, escalations in care facilities, increasing levels of violence etc. can be intercepted earlier and in different ways. This requires, among other things, the interaction of the fields of:

- Health care
- Parental advice
- Youth welfare
- Social therapy programmes
- The field of education

9. Improved role for social work

Providing assistance to those about to be released and the prevention of spirals of violence are two out of many fields in which good social work can contribute specialist skills and support. An occupational profile and the greater recognition which comes with it are overdue.

10. Participation: the obligation to involve self-advocates

The Committee wishes to emphasise the obligation to involve self-advocates in all processes (Art. 4 para. 3 CRPD) and urges the participation of self-advocates in the next reform discussions.

11. Accompaniment of the reform process: examination

The implementation of the recommendations of the so-called Haas Commission of 1994 would have avoided many negative developments.[37] The Committee therefore strongly urges that the implementation of all reform proposals be monitored and evaluated.

For the Committee

The Chairperson

4. Annex – Statement

[37] See footnote 2, p. 1 on the Haas Commission.

Independent Monitoring Committee
for the Implementation of the UN Convention on the
Rights of People with Disabilities

MonitoringAusschuss.at

11 December 2014

Statement for the working group on forensic commitment at the Ministry of Justice[1]

Proviso:

Due to the timelines and the expertise of the working group, the Monitoring Committee will give its views in a strongly modified way in the form of a statement. Note that a detailed statement in accordance with the standards of the Committee is planned for January 2015.[2]

1. Basis:

General principles

From the point of view of the Committee, in addition to the general principles of the Convention (Art. 3 CRPD), the following general principles are of key importance for the discussion:

- Resocialisation as one of the goals of the Austrian penal system
- Therapy as a key task, especially of health care
- Proportionality as a principle of constitutional law
- Non-discrimination
- The dignity of risk as a dimension of resocialisation

Area of application of the Convention

The non-definition of Article 1 of the CRPD explicitly covers persons with mental, psychosocial and psychiatric impairments or disabilities. As emphasised elsewhere, the interaction with various barriers – including attitude-related ones – [Preamble (e) of the CRPD] is decisive for the description of persons with disabilities.

Legal subjectivity

The legal subjectivity of persons with disabilities is limited in various aspects – paternalistic attitudes lead to them not being able to decide for themselves in many cases, even though this is provided for by the law. Making decisions over people's heads, and not even asking them, is one of the many facets of this paradigm.

The fact that people are referred to using the numbers of criminal law provisions – e.g. a 'number 21' – seems to be symptomatic for the way a 'system' sees the people

[1] The Committee wishes to express its gratitude to numerous experts for their helpful information. In particular Dr. Julia Kozma, LL.M., member of the CPT (European Committee for the Prevention of Torture of the Council of Europe), the staff of the WHO Mental Health Department and Prof. Arthur Kleinman, Harvard.

[2] All of the Committee's statements can be viewed online at www.monitoringausschuss.at.

it is detaining. It says a lot that – aside from sections of the criminal code – there is obviously no commonly used term for people in forensic commitment. This also belies a tendency to keep people helpless or to relegate them into a category of 'others' which makes it considerably more difficult to bridge the gap to 'normal' people.[3]

In view of the severe inroads into the lives of people who are kept in forensic commitment, maintaining legal subjectivity has particular significance.

One dimension of legal subjectivity is the right to choose – this is limited almost exclusively for people in detention.[4]

The focus on deficits and discrimination

Disabilities are the subject of considerable prejudices and stereotypes in Austria. This is particularly true in the case of mental, psychosocial and psychiatric impairments. In the context of forensic psychiatry this is exacerbated by the aspect of presumed 'dangerousness' – towards oneself and others – which creates a stigma and fear that intensify marginalisation.

It should be emphasised that 'dangerousness' is often based on threats which, depending on the situation, can be viewed either as a statement of resentment common in a certain environment, the basis for enforced psychiatric care, or forensic commitment. The tendency for there to be an escalation when public officials are involved has been proven elsewhere.[5]

Describing persons with disabilities solely through their supposed deficits does not do justice to the diversity of human beings and makes it difficult to see these people's resources. According to the Convention, it is necessary to turn away from 'defectology' and similar expressions of this perspective. The ICF developed by the World Health Organization illustrates a different way of seeing people.[6] A potential analysis or similar approaches has proven to have an important role to play in the assessment of persons with psychosocial impairments who have been convicted of criminal offences.[7]

In the context of forensic commitment, discrimination against persons with psychosocial impairments is also exacerbated by other multipliers. Neither the aspect of old age (young people and older people in forensic commitment) nor of origin or ethnicity, particularly language, appear to be taken into consideration. The stigmatisation as a 'prisoner' intensifies all these factors significantly.

[3] There seems to be a consensus on the need for linguistic reform of the term "mentally abnormal offenders". Self-advocates propose: "Persons with mental illnesses who have committed offences against the law due to their illness."
[4] Exceptions to the basic rule in constitutional law are, for example, Section 69 para. 4 of the Lower Austrian Provincial Parliament's Election Regulations, Section 54 para. 3 Election regulations of the Burgenland Provincial Parliament with regard to sanatoriums and nursing homes.
[5] See Stangl/Neumann/Leonhardmair, "Wege zur Reduktion der Einweisungen zurechnungsunfähiger Rechtsbrecher in den Maßnahmenvollzug", IRKS 21.
[6] See also e.g.: Mini ICF-APP by Professor Linden.
[7] On the presumed minimum effort/expense instead of many: Stangl et al., "Von Krank-Bösen und Bös-Kranken, Der österreichische Maßnahmenvollzug als Beispiel sektoraler Detentionsakzeptanz", 22.

The detention of persons with mental illnesses who have no residence permit is highly concerning. The Committee has already referred to the relevance of the trauma of refugees and called for alternative procedures.[8]

The Committee wishes to point out the comprehensive anti- discrimination clause in the Convention (Art. 5 CRPD) as well as the ban on “multiple and aggravated” forms of discrimination [Preamble (p) in conjunction with Art. 6 CRPD].[9] In addition, the obligation to eliminate discriminatory practices (Art. 4 para. 1(a) CRPD) and the effects of structural discrimination (Art. 4 para. 1(d) & (e) CRPD) are of key importance.

2. Article 25: health care

The support of persons with psychosocial impairments is primarily a question of health care, which is a human right.[10]

There are a considerable number of persons whose psychosocial impairment was already known and whose forensic commitment was ‘only a matter of time’. Reform plans must lead to measures which have their effect immediately before this question arises on a specific individual basis (see also the specification of prevention in Art. 25(b) CRPD.[11] A growing phenomenon is also the detention of persons whose behaviour changes dramatically after the loss of primary care giver, and which leads – after transgressions – to commitment in spite of their questionable suitability for imprisonment.

Therapies need to begin at the earliest possible moment. Persons who are detained for an over-average period in pre-trial detention must have access to therapy.

Assignment to forensic commitment or not appears very random in some fields – this is a fact which is particularly related to the competence of judges and the issue of psychiatric expert reports. Above and beyond this, however, the question of ensuring adequate health care in the penal system in general, including a suitable therapy programme, has to be posed.

With regard to the therapy programme, it should be underlined that this should not only be understood in the meaning of Art. 25 (health care), but probably also in the sense of rehabilitation (Art. 26) and education (Art. 24), and particularly the acquisition of “practical abilities and social competence” (para. 3). It is also worth noting that rehabilitation measures can be “reasonable accommodation” in the meaning of Art. 2. Therapies following experiences of violence (Art. 16 para. 4) in particular can also fall into this category.[12]

In relation to the federal competences in Austria, the Committee wishes to emphasise the validity of the Convention “for all parts of a Federal State” (Art. 4 para. 5 CRPD).

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[8] Statement on the amendment of the Citizenship Act, http://monitoringausschuss.at/begutachtungen/begutachtungen-2013/.

[9] Worthy of emphasis here is, among other things, the lack of differentiation between a value-free sexual orientation and frowned-upon sexual abuse, which is particularly lacking in the media.

[10] Art. 25 UDHR, Art. 12 ESC rights (FLG 590/1978), Art. 25 CRPD.

[11] On the high rate of persons with a previous history see: Stangl et al., Detentionsakzeptanz, 18.

[12] On the guarantee obligation for appropriate steps as a part of non-discrimination see, Art. 5 para. 3 CRPD.

3. Articles 19 & 25: Community Based Services

At the latest when a sentence has been served, the care of persons with psychosocial impairments should take place close to their own communities: Articles 19, 25(c) and 26 para. 1(b) CRPD.[13] Therapy settings like those which are offered in the Asten Forensic Centre need to be provided in local communities as a part of social services. Here the Committee expressly refers to the guidelines of the World Health Organization on comprehensive community based services (CBR Guidelines).[14]

Safety must be created primarily via respect, being treated as an equal, trust and proximity. It is mistaken to believe that the population can be convinced that 'locking up' individuals can increase the safety of the general public. Alongside the doubts on whether a perception of safety can be promoted by rigorous separation, the fundamental principle of resocialisation is thus diminished in a threatening way.

Here the Committee sees a case for the application of the principle of 'dignity of risk'. People whose decisions are regularly made for them, and for whom others always 'know better', have very few or no opportunities to make mistakes and to learn from them. The basic insight that mistakes and risk are a part of life has to be understood in a more comprehensive way in the context of psychosocial disorders: there is no such thing as a risk-free society – it is part of the dignity of a society that risks are allowed and thus – in this context - resocialisation is made possible at all; see in particular Art. 16 para. 4 CRPD.

It is worrying in terms of human rights, the rule of law and democracy that the consequences of locking people up for indefinite periods seem to be accepted as 'collateral damage'.[15] The fact is that the effects of the 'no risks' policy and mentality promoted by certain media cannot be guaranteed.[16] In addition, it needs to be made clear that the risk of resocialisation is not disastrous *per se*: the proportionality principle must also have its place in the blame culture.

4. Articles 4 & 8: training and raising awareness

In the field of psychosocial impairments there is an enormous need for further education and training for all professions: there is a lack of specialist doctors and recognised and specifically trained social workers, too few personnel for care in the community, and too few suitably trained assessors. Due to a lack of resources there are hardly any multi-disciplinary assessments, and there are judges who are dependent on assessors due to limited knowledge – the list could go on and on…

The Committee stresses the obligations according to Art. 4 para 1(i) and in particular Art. 13 para. 2 (prison officers) and Art. 26 para. 2 CRPD.

The role of the media in the portrayal of persons with psychosocial disorders needs to be critically observed. Alongside the obligation to eliminate discriminatory practices (Art. 4 para. 1(b) CRPD) and Art. 4 para. 1(e), the Committee refers to the more than comprehensive provision on raising awareness in Art. 8, which prescribes among

[13] This implicitly means an adequate extension of suitable aftercare facilities.
[14] WHO: CBR Guidelines - http://who.int/disabilities/cbr/guidelines/en/.
[15] Stangl et al., Detentionsakzeptanz, 18.
[16] On the 'no risks' mentality see: http://www.jku.at/PR/content/e13544/e13537/e190045/e193064/e218870/PA_Strafvollzug_ok_ger.pdf.

other things that persons with disabilities should be portrayed in a way which corresponds with the goals of the Convention (Art. 8 Abs. 2(c) CRPD).

5. Article 13 – access to justice

Access to justice (Art. 13 CRPD) needs to be understood in a holistic way.[17] Reports must fulfil the requirements of the Convention, particularly with regard to the consultation of persons with disabilities. Assessors shall apply methods of alternative communication (Art. 2 CRPD). Reports must be independent, also in the sense that they are detached from earlier findings and preliminary reports – different phases must be evaluated by different assessors. Assessment should also be increasingly approximated towards the standards of the recovery approach[18], according to which persons with disabilities are consulted as equals and are the focus of considerations. Family members and other reference persons have to be involved in the assessment phase.

Hearings must comply with the requirements of the rule of law. The appearance or reality of collusion must be strictly avoided. The detained person should be informed in good time about a hearing and the related legal possibilities in a way which is understandable for them. Obligatory legal representation (legal aid) would appear to be indispensable in view of the accounts made by those affected. The hearing should be of adequate length in relation to the issue. Assessments by third persons should be questioned if possible, and detained persons should be asked about their perspective in a suitable way. The ban on victimisation should be taken into account accordingly.

It should be noted that the critical questioning of therapy proposals and other measures by detained persons must be responded to in a suitable way. Retaliation measures as a reaction to critical questions can never be justified.

6. Articles 25 & 14 ff. - enforced treatment and the liberty and security of the person

The international discussion of a ban on enforced treatment on the basis of the Convention is ongoing.[19] The Committee stresses that the goal must be the complete prevention of enforced treatment in accordance with the Convention. There is obviously a dramatic need for additional resources in order to make alternative treatments and approaches in dealing with persons with psychosocial impairments possible.

The Committee particularly emphasises the fundamental principle of independence (Art. 3(a) CRPD) as well as the corresponding provision on legal capacity (Art. 12 CRPD). In addition, Article 25(d) is authoritative on issues of consent. Legal

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[17] See most recently: Beate Rudolf: „Recht haben – Recht bekommen. Das Menschenrecht auf Zugang zum Recht", Deutsches Institut für Menschenrechte, October 2014.

[18] See, for example: Deegan P. E. (1988) Recovery: the lived experience of rehabilitation. Psychosocial Rehabilitation Journal, 11, 11-19.

[19] See the report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez A/HRC/22/53; CRPD Committee, General Comment No. 1 – Article 12: Equal Recognition before the Law, CRPD /C/GC/1, and the related discussion: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/DGCArticles12And9.aspx; and most recently the Statement on Article 14 of the Convention, September 2014, http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15183&LangID=E.

protection should, in any case, be adapted to the requirements of the law on the accommodation and treatment of persons with psychiatric disorders in psychiatric care and strengthened in the light of Art. 12 para. 4 CRPD.

The specification of the requirement "that the presence of a disability shall under no circumstances justify the deprivation of a person's liberty" requires an in-depth discussion in which experts from different fields must participate in accordance with Art. 4 para. 3 CRPD. A recommendation for action by the CRPD Committee to the Republic of Austria has already been issued.[20]

The entire range of possibilities, particularly the least severe means, should be examined in detail on the basis of the principle of proportionality. The Committee stresses that there are a multitude of possibilities for the support of persons with disabilities which in the current phase of great upheaval are subject to powerful surges of development at a global level. These possibilities reflect the broad range of needs of people who are currently in forensic commitment and thus, in the view of the Committee, cover them.

7. Article 4 para 3 and the realisation of recommendations

The Committee underlines the necessity of the involvement of self-advocates and those affected.[21] Alongside the immediate obligation to conduct the discussion on the reform of forensic commitment with the persons detained in it[22], the Committee also stresses the fundamental necessity of self-advocacy in the field that is not within the penal system.[23]

The Committee notes with regret that the recommendations of the so-called Haas Commission[24] were not comprehensively realised, and urgently calls for a transparent arrangement for the sustainable implementation of recommendations.

For the Committee

The Chairperson

[20] Concluding observations on the initial report of Austria, recommendations for action 29 http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fAUT%2fCO%2f1&Lang=enhttp://monitoringausschuss.at/stellungnahmen/handlungsempfehlungen-des-un-fachausschusses-umsetzungsstand-09-09-2014/.

[21] See Statement on participation http://monitoringausschuss.at/stellungnahmen/partizipation-19-04-2010/ and the public session on participation http://monitoringausschuss.at/sitzungen/wien-30-10-2014-politische-partizipation/.

[22] The Committee does its utmost given the means at its disposal to partly fulfil this requirement. A statement including the feedback from persons held in forensic commitment is scheduled for January 2015.

[23] In light of the Convention, the Committee recognises a necessity to discuss self-advocacy in forensic commitment.

[24] It is worthy of note that Karl-Otto Haas was held as a normal prisoner.