International Disability Alliance (IDA)

Disabled Peoples' International, Down Syndrome International, Inclusion International,
International Federation of Hard of Hearing People,
Rehabilitation International, World Blind Union,
World Federation of the Deaf, World Federation of the DeafBlind,
World Network of Users and Survivors of Psychiatry,
Arab Organization of Disabled People, European Disability Forum,
Red Latinoamericana de Organizaciones no Gubernamentales de Personas con Discapacidad y sus familias (RIADIS)

Suggestions for disability-relevant recommendations to be included in the Concluding Observations Human Rights Committee 100th Session (11 - 29 October 2010)

The International Disability Alliance (IDA) has prepared the following suggestions for the concluding observations, based on references to persons with disabilities to be found in the Human Rights Session 100th Session state report on Belgium.

BELGIUM

(ratified the Convention on the Rights of Persons with Disabilities on 2 July 2009)

State report

References to persons with disabilities in the state report:

Concluding observation 18

The Committee is concerned that, despite the recommendations it made in 1998, the State party has not ended ***its practice of keeping mentally-ill people in prisons and psychiatric annexes to prisons*** *for months before transferring them to social protection establishments. It reminds the State party that this practice is inconsistent with articles 7 and 9 of the Covenant.*
The State party should end this practice as quickly as possible. It should also ensure that providing ***mental patients*** *with care and protection and managing social protection establishments both form part of the Ministry of Health's responsibilities.*

In order to clarify the concepts at issue here, it will be useful to distinguish between "mental illness" and "detention". The former is a medical condition, while the latter has legal connotations. **A person who is mentally ill will not necessarily be detained, but may be confined**.

The issue of the detention of **mentally ill persons** is one that is being addressed both by the competent Federal authorities and by those of the federated entities (Communities) with a view to ensuring that social assistance is available for these persons in order them to become reintegrated into society.

We shall begin by describing the measures that have been taken by Federal institutions on the one hand and by Community institutions on the other.

1. At the Federal level, a variety of measures have been taken with a view to ensuring that every detainee receives any attention that his specific situation may require. These

measures are currently being implemented.

• Following the Interministerial Conference on Public Health held in May 2004, the various Ministers with responsibility for health care proposed that pilot projects should be used to test a number of health care models for specific groups. The longer-term goal would be to establish **mental health care delivery "circuits" (**or "routes") ("zorgcircuits") and networks. To that end, the measures outlined in the paragraphs below have been initiated:

> • Depending on the type of care required by a detainee, he will be steered to a particular institution, in the context of a "**mental health care delivery circuit**", which for the detainee will in a sense be a "detention route".
> • **Psychiatric care institutions** will be of three kinds: high security (Antwerp and Ghent, Tournai and Mons), medium security (Bierbeek, Zelzate, Rekem, Titeca and Tournai), and low security.
> • The Sentence Enforcement Courts (instead of social protection committees, as at present), working in close coordination with all the relevant agencies, will assume responsibility for the admission, progression and discharge of detainees in the care delivery circuit.
> • Independent coordinators will provide liaison between the authorities that order committals (at present social protection committees, but in the future, Sentence Enforcement Courts) and **psychiatric care institutions**. Their task will be simultaneously structural (based on their practical knowledge of **mental health care institutions** and those of the justice system) and individual, inasmuch as they will make recommendations to the committing authority concerning the institution best suited to a particular detainee's needs.

These measures will be implemented pursuant to **the Act of 21 April 2007 *on the detention of persons with mental disorders* (*M.B.*, 13 July 2007), which has not yet entered into force.** However, pilot projects are already being implemented by SPF Public Health and SPF Justice.

• To accommodate high-risk detainees, two new centres ("Forensisch Psychiatrisch Centrum") with a total capacity of 390 patients are to be established in Ghent and Antwerp. These centres should be operational by 2012 at the latest. A coordination forum has been set up to enable SPF Justice and SPF Public Health to discuss the medical care of detainees in the first place and, in the second place, security measures and the respective roles of SPF Justice and SPF Public Health at the future "Forensisch Psychiatrisch Centrum" (FPC) in Ghent. These prospective centres are to be integrated into the above-mentioned mental health care delivery circuits for detainees.

• Specific supplementary measures have also been taken for **medium-risk detainees with mental disorders, with placement in specialized psychiatric hospitals**.

• Renovation work designed to expand the capacity of the Paifve social protection establishment, adding accommodation for approximately 80 additional patients, began on 17 March 2008.

• However, experience has shown that in practice it is no easy matter to transfer detainees into social protection establishments, as their capacity is still inadequate. Accordingly, some of them are accommodated in **psychiatric annexes to prisons**. In an effort to upgrade the conditions in which these persons are detained, multidisciplinary teams have been operating there since June 2007. Each team comprises a psychiatrist, a psychologist, a social worker, an occupational therapist, a psychiatric nurse, a physiotherapist and an education specialist, and is supported by prison officers who have had specific training. In addition, it will soon be possible to accommodate larger numbers of

inmates in psychiatric annexes, as in 2006 a decision was taken to reopen the Lantin psychiatric annex.

2. Under the special Act on institutional reform of 9 August 1980, social assistance to detainees with a view to their reintegration into society falls within the jurisdiction of the Communities (article 5, para. 1, II, 7). Accordingly, the Communities are taking preventive and follow-up measures designed for **persons with mental illnesses**.

<u>Recommendations from IDA</u> :

- To adopt effective measures to eliminate involuntary internment linked in legislation to an apparent or diagnosed mental illness, whether in prisons or in psychiatric facilities, and to repeal legislation which authorizes such internment, so as to comply with its obligations under the CRPD (ratified by Belgium) which reaffirm the obligations already foreseen in the ICCPR, and recommendations of the Special Rapporteur on Torture ("The Special Rapporteur recalls that article 14 of CRPD prohibits unlawful or arbitrary deprivation of liberty and the existence of a disability as a justification for deprivation of liberty." Report of the Special Rapporteur on Torture, 28 July 2008, A/63/175, para 64).

- To ensure that persons with disabilities, including persons with psychosocial disabilities, detained for reasons of law enforcement and punishment for crimes are treated in compliance with the objectives and principles of the CRPD, including provision of reasonable accommodation (Article 14(2) CRPD), and are entitled to all the guarantees of international human rights law, including the ICCPR, on an equal basis with other detainees.

- To ensure that participation by detainees with psychosocial disabilities* in mental health services or programs is entirely voluntary, that a wide range of supports, including peer support, is offered to them in general population, and that reasonable accommodation and trauma-informed approaches* guide policy in relation to these detainees.

*Note on terminology:

- **Psychosocial disabilities**: instead of using the terms "mental impairment" or "mental health problem", the term "psychosocial disabilties" is preferred because it moves away from the medical model and refers to the interaction between psychological and social/cultural components of disability. The word psychosocial refers to the interaction between psychological and social/cultural components of our disability. The psychological component refers to ways of thinking and processing our experiences and our perception of the world around us. The social/cultural component refers to societal and cultural limits for behavior that interact with those psychological differences/madness as well as the stigma that the society attaches to labeling us as disabled.

- **Trauma-informed approaches**: A trauma-informed approach is based on the recognition that many behaviors and responses (often seen as symptoms) expressed by people with psychosocial disabilities are directly related to traumatic experiences that often cause mental health, substance abuse, and physical concerns. For many people with psychosocial disabilities, systems of care perpetuate traumatic experiences through invasive, coercive, or forced treatment that causes or exacerbates feelings of threat, a lack of safety, violation, shame, and powerlessness. Unlike traditional mental health services, trauma-informed care recognizes trauma as a central issue. Incorporating trauma-informed values and services is key to improving program efficacy and supporting the healing process.