

Out of Sight

Human Rights in Psychiatric Hospitals and Social Care Institutions in Croatia

Mental Disability Advocacy Center
and the Association for Social Affirmation of People with Mental Disabilities (SHINE)



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Foreword

I was offered the opportunity to take a part in monitoring visits to institutions for people with disabilities conducted in Croatia by MDAC and SHINE in June 2010. Unfortunately, due to other obligations, I couldn't accept that kind invitation. Having the highest respect for MDAC and SHINE's projects and knowing the outcome of previous inspections already carried out in my country, I've been waiting for accurate information from this study with great expectations. It has been my privilege to be the first to read the results of the report which monitored the implementation of human rights standards in psychiatric and social care institutions in Croatia, and so, it is a pleasure and an honour to write the foreword to this significantly informative, important, and at the same time very touching report.

The shameful history of neglect of persons with mental disabilities is well known: deep stigma and unaddressed discrimination, institutionalisation into deplorable living conditions, and the constant physical and social barriers which prevent their inclusion and full participation in society.

Through its Constitution, the Republic of Croatia has engaged itself to provide special protection and care for people with disabilities and encourage their integration into society. The Croatian legal system has adopted international standards, translated them into law and undertaken a number of reforms and national programs regarding the rights of people with mental disabilities. In August 2007 Croatia became the fourth country in the world to ratify the United Nations Convention on the Rights of Persons with Disabilities (CRPD). However, despite this leadership it has failed to meet its obligations under the international treaty: legislation remains inconsistent, implementation continues to be irregular, and a lack of coordination among the responsible governmental bodies leaves many people with disabilities without much-needed support. These people still face stigmatisation, isolation and discrimination based on their disability, which is often compounded by public misperception and fear. As has been pointed out by the UN Human Rights Council, the European Commission, organisations from civil society, including MDAC and SHINE, and national human rights institutions, Croatia has not done enough to improve the lives of people with intellectual disabilities and mental health disabilities and to bring law, policy and practice into line with international requirements and standards.

The Mental Disability Advocacy Center and its partner organisation in Croatia, SHINE, undertook monitoring visits to investigate the current situation, to identify existing problems and present issues relevant to all stakeholders involved in the protection of people with disabilities - from the Croatian Government, Parliament, Ombudsman's Office and various ministries, to all professionals, including staff who are in daily contact with patients and residents in psychiatric hospitals and social care institutions. This fact-finding mission and analysis of data gathered highlights the gaps that still remain: the lack of progress in national level implementation of the CRPD, undeveloped community-based support programs for people with mental disabilities and as a consequence, virtually no movement to prevent the continuous denial of basic human rights for people with disabilities.

Being a medical doctor, what strikes me the most is the lack of commitment to reform at lower levels of the Government - particularly from the Ministry of Health and Social Welfare - as well as the unlawful

practices of mental health professionals and others involved in care of persons with disabilities and mental illnesses, including their unawareness of legal provisions and ignorance of the human rights implications of their approach and actions.

This report provides both a detailed illustration of the current reality for people with disabilities in institutions in Croatia and makes recommendations for further action and improvement. In this easily accessible but clear analytical research, the authors provide a background on the monitored institutions and present a thorough study of the situation of people with disabilities in psychiatric hospitals and social care institutions with respect to the issues and practice of admission and discharge, guardianship, material conditions, regimes and activities, staff, treatment and measures of restraint. The report and related recommendations helpfully underline the weaknesses and shortcomings of the current legislation and of all stakeholders participating in the protection of the rights of people with disabilities.

The report is also extremely useful as a text to inform wider society which, sadly, often treats people with disabilities as second class citizens; accepting deprivation of their liberty, marginalisation and segregation, leaving them hidden away in institutions where time has stopped, to be forgotten by the community.

Detailed recommendations developed in this report are directed to the Croatian Government as well as all other actors involved in safeguarding and implementing the human rights and fundamental freedoms of people with disabilities. It is my personal and professional opinion that they should be fully considered, carefully followed up, and strongly implemented in everyday practice.

It is imperative that Croatia immediately take steps forward to harmonize national legislation with international regulations, to work on deinstitutionalization as it has promised, and to build a more inclusive society that creates preconditions for rehabilitation, integration and participation of people with disabilities. It is time to shift attitudes and the approach to persons with disabilities from “objects” to individuals with the same entitlements as everyone else; with the right to be treated with dignity, in a safe and human manner, and to be afforded respect in their choices and self-determination.

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This report is based on monitoring of human rights standards in psychiatric hospitals and social care institutions in Croatia. The monitoring visits were conducted in June 2010 by (in alphabetic order): Masa Anisic, Vanja Bakalović, Ngila Bevan, Yana Buhner Tavanier, Gavin Garman, Kristijan Grdjan, Sarah Green, Matt Kinton, Victoria Lee, Mario Malicki and Georgiana Pascu.

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Executive summary

Croatia has a population of nearly 4.5 million people,¹ yet it is estimated that over 10,000 people with disabilities live their lives segregated from society and isolated from public view.² They live “Out of Sight”, in psychiatric and social care institutions often located in remote places. Little is known about what happens inside these institutions. There is no effective human rights monitoring system. As a result, the people who are in such institutions are at significant risk of exploitation and violence and other abuses of their fundamental rights. Moreover, they have little opportunity to complain or to seek redress.

This report presents the findings of monitoring visits made to selected psychiatric hospitals and social care institutions in Croatia carried out by MDAC and SHINE in June 2010. It makes assessments according to the standards of international human rights law, identifies problems in the implementation of these standards and presents specific legislative shortcomings that create limitations or provide an insufficient framework for practice. However, the underlying motivation behind the publication is to shine a light on the daily lives and experiences of people living in these institutions – whether temporarily or as life long residents – and in doing so, to raise awareness of the routine violations of their rights as people who are obliged to live “Out of Sight”. The report endorses but does not seek to repeat the findings of the Human Rights Watch report “One you enter you never leave”, published in October 2010, and as such it was beyond the scope of the MDAC/SHINE monitoring to assess all the human rights concerns related to institutionalisation. This report therefore highlights only the most important findings and identifies the issues of major concern. The cases presented are not intended to be exhaustive, but are used as illustrative examples of the most common experiences we encountered.

Both MDAC and SHINE hope that the findings of this monitoring report and its subsequent recommendations will help the Croatian Government to review its laws, policies and practices in order to fully respect, protect and fulfil the rights of people with disabilities and realise their inclusion into society. Furthermore, and given that Croatia has ratified the Optional Protocol to the UN Convention against Torture, publication of this report aims to promote the importance of rigorous and regular, independent monitoring and inspection of psychiatric hospitals and social care institutions, both by appropriately designated agencies independent of the State and civil society organisations. Human rights violations against people with disabilities, particularly those with intellectual and/or psycho-social disabilities, have long been kept “Out of Sight”. Consequently, policy-makers have afforded people with disabilities little recognition as rightful political constituents and in doing so, have perpetuated the stigma and discrimination already attached to disability and mental illness.

In illuminating the abuses endured by many people with disabilities living in institutions in Croatia, the report intends to reinvigorate the Croatian Government’s motivation to push forward with its public commitments to achieve deinstitutionalisation and take concrete steps towards creating high quality support

1 See 2011 census at http://www.dzs.hr/Hrv_Eng/publication/2011/SI-1441.pdf (last accessed 1 October 2011).

2 See *Once you Enter you Never Leave: Deinstitutionalisation of Persons with Intellectual or Mental Disabilities in Croatia*, Human Rights Watch, September 2010. Available at <http://www.hrw.org/en/reports/2010/09/23/once-you-enter-you-never-leave-0> (last accessed 1 October 2011).

services in the community. There is no justification for people with disabilities to be compelled to live “Out of Sight” in institutions: there is an established right in international law for each person – however “severe” their disability – to live in the community on an equal basis with others.

A summary of the report’s main findings is as follows: **Chapter 1** provides details of the institutions that were monitored and comments briefly on their material conditions. Overcrowding and degrading living conditions in buildings which are ill-equipped to house people on a long-term or permanent basis continues to be a problem in some institutions. Although it is imperative that material conditions be improved in some of the institutions visited in order to create environments which do not constitute inhuman or degrading treatment, such improvements cannot be carried out as a substitute for ensuring that people with disabilities live in the community where and with whom they choose.

Chapter 2 concludes that there is a lack of professional staff employed in psychiatric hospitals and social care institutions and points to a chronic under-investment in mental health and social care services. In particular, there is a shortage of occupational therapists and social workers who are able to work with patients, residents and their families. Furthermore, management teams frequently raised the point that their staff would greatly benefit from more training organised by the Ministry of Health and Social Welfare. Indeed, ad hoc and therefore arbitrary practices will continue unless the Ministry issues guidance on a number of issues, including managing aggressive behaviour and, if they are to be used, how to use restraints in a safe way which respects human rights.

Chapter 3 describes how procedural human rights violations occur during hospital admission and discharge. The report is highly critical of inadequate legal provisions and the lack of understanding and diligence by mental health and legal professionals and the judiciary. As a result, people may be admitted for psychiatric treatment against their will without recourse to legal guarantees. People under guardianship who object to their admission and treatment can nonetheless be forcibly admitted and classed as voluntary patients if their guardian agrees. Basic legal safeguards are not respected in the involuntary admission procedure: many patients are not informed that they are being subject to this procedure until a decision has been handed down, nor are they regularly assigned an attorney or given an opportunity to meet with the judge.

Certain hospitals remain ill-informed of the legal procedures to follow when voluntary patients subsequently withdraw their consent to admission and treatment, leading to cases of unlawful detention. Under the current involuntary admission procedure, people can be legally detained against their will for up to 84 hours before a court examines their case. Further, the reasons for involuntary hospitalisation are not systematically nor adequately documented in patients’ medical files. This means that there is no trace of the grounds on which an individual is detained, making it impossible to gather data, and more importantly, making it very difficult indeed for the detained person to challenge the detention.

Croatia lacks robust legal protection against abuse of rights of patients and residents in psychiatric hospitals and social care institutions respectively. Patients and residents are not informed of their rights as a matter of course – we spoke to many who did not know they had rights or what this meant in practice. Without

this important information, patients and residents cannot defend themselves by invoking their rights, such as the right to make a complaint, or the right to confidentially consult with a lawyer.

Chapter 4 outlines how people facing admission into social care institutions rarely have the opportunity to consent to the decision. Given that most residents are already under guardianship before their admission, contracts for their stay are authorised either by their guardian or a the local government's Centre for Social Care. Once admitted into a social care institution, residents are de facto detained for the rest of their stay without having the possibility to challenge the detention in any way. There are very few possibilities of returning to live in the community. Long term and life-long institutionalisation is reinforced by the system of guardianship and the near-impossibility of revoking guardianship measures and regaining legal capacity. Although social care institution management teams admit that many of their residents require neither guardianship nor institutional care and are capable of community reintegration, very few of these institutions take steps to seek restoration of resident's legal capacity or to find them a place to live in the community. Worse still, one particular social care institution has a policy in which guardianship proceedings are initiated for each new resident, regardless of the person's needs or wishes.

Chapter 5 looks at the daily routine of people living in institutions in more detail. Many residents and patients with whom we spoke complained of the monotony and routine within the institution and staff told us that the sheer boredom could be the worst part of being institutionalised. People in institutions have little privacy and live under the close supervision and control of staff. Staff members restrict people from setting foot outside institution grounds, or in some cases leaving the unit on which they are detained. Consequently, people lose contact with the outside world, a fact which is aggravated by the remoteness of institutions rendering it difficult for family and friends to visit. We also found that patients and residents are discouraged from forming romantic relationships with one another within the institution. Many staff members were adamant that patients and/or residents were not interested in forming intimate relationships; saying that sexual interest or conduct is simply a consequence of their mental disorder which can be managed. As a result of this distorted view, patients and/or residents' right to sexual autonomy is extensively prohibited, and only meagre efforts are made to educate them about relationships and healthy sexual behaviour.

Chapter 6 reveals that mental health treatment was heavily reliant on the administration of medication, with much less emphasis on wider rehabilitative and therapeutic activities aimed at facilitating a prompt return to community living. Treatment plans for patients in psychiatric hospitals and social care institutions were rarely individualised. Despite legal provisions entitling patients to take an active part in the planning and implementation of their therapy, it was found that some patients were not even aware of what their treatment entailed, were frequently not involved in the development of their treatment plan and were unaware of progress made. In the institutional rules of one hospital, the participation of patients in the choice of their therapy is prohibited outright.

Chapter 7 raises concerns about the use and methods of restraint in psychiatric hospitals and social care institutions, an area in which Croatian mental health law is seriously deficient. Contrary to international standards, Croatian legislation does not require restraint to be employed in accordance with

officially-approved procedures and a clearly-defined policy. The law is also silent on how to oversee the administration of chemical restraints. As a result, hospitals and social care institutions have developed their own practices which do not adequately consider the serious human rights concerns associated with the application of restraint measures. Additionally, and in contradiction to Croatian law, the Ministry of Health and Social Welfare has not developed any instructions such as guidelines or training to guarantee that mental health professionals follow the correct procedures which prioritise the health, safety and dignity of the person concerned.

Finally, there is no independent body which is mandated to conduct regular monitoring of psychiatric hospitals and social care institutions with the purpose of examining whether the human rights of patients and residents are respected. This is a most serious failing on the part of the Croatian government. The result of the lack of monitoring is that the rights of people in such institutions can be violated with impunity.

Renewed focus is urgently needed to uphold the rights of people with intellectual and/or psycho-social disabilities living in institutions, and the Croatian government should immediately institute a package of reform which prioritises the deinstitutionalisation of people with disabilities. Moreover, the Convention on the Rights of Persons with Disabilities (CRPD), which Croatia has ratified, obliges States to "closely consult and actively involve"³ people with disabilities in the development and implementation of legislation and policies to implement the Convention. The current deinstitutionalisation plan published by the Croatian government in March 2011 fails to adequately outline how people with disabilities will be given opportunities to participate in this process or provide a satisfactory timeframe for deinstitutionalisation of all people with disabilities including those with long-term intellectual disabilities and mental health problems.

Key recommendations have been drawn up below to assist the Croatian government and related stakeholders in addressing the concerns highlighted in this report:

Summary of recommendations

Overarching areas for reform

There are six key objectives to which government reforms should be directed:

Deinstitutionalisation of people with disabilities and provision of appropriate community-based support services;

Ensuring that the People's Ombudsman has adequate financial and human resources necessary to monitor places of detention - including psychiatric hospitals and social care institutions - as obliged by its designation as the National Preventative Mechanism (NPM under the Optional Protocol to the UN Convention against Torture;

3 See the Convention on the Rights of Persons with Disabilities, hereinafter CRPD, Article A4(3)

Designating or establishing a framework, including one or more independent mechanisms to promote and protect rights and monitor implementation of the Convention on the Rights of Persons with Disabilities (CRPD) as obliged by Article 33(2) of the CRPD.

Reforming the legal capacity system to abolish guardianship or other protective measures that equate to substituted decision-making and implementing models of supported decision-making;

Ensuring that human rights of people with disabilities are respected, protected and fulfilled for people in psychiatric hospitals and social care institutions; and

Ensuring that people with disabilities and their representative organisations are involved in developing law and policy reform that relates to persons with disabilities and that mechanisms are created to ensure their active participation in implementation and monitoring of the CRPD.

Specific recommendations

These recommendations flow directly from the monitoring and also relate to the implementation of the key objectives. They are primarily targeted at the duty-bearers in international human rights law which include the government and related agencies as well as the institutions which are providing services paid for by the state.

Chapter 1: The Monitored institutions

1. **The government** should ensure that the NPM regularly and thoroughly monitors institutions at least once a year and produces publically-available reports;
2. The government should also pass a decree permitting non-governmental organisations to monitor psychiatric hospitals and social care institutions and be afforded the opportunity to comment on the findings of the NPM;
3. **Psychiatric hospital and social care institution** staff should receive training on the purpose and benefits of engaging with independent monitors. External scrutiny should be welcomed as a measure of a democratic society; and
4. **The People's and Disability Ombudspersons** should engage actively in advocacy to ensure that the government equips them with adequate mandate and resources; particularly if the Disability Ombudsperson is designated as the Article 33(2) body tasked with independently monitoring implementation of the CRPD.

Chapter 2: Staff

1. **The government** must ensure that institutions employ a sufficient quantity of trained professional staff, including qualified nurses, as this has a direct impact on human rights as well as on the quality of care, treatment and rehabilitation;

2. **The Ministry for Health and Social Welfare** should develop, disseminate and routinely update minimum competencies for staff working in mental health and social care. These competencies should cover the following areas: preventing and managing aggressive behaviour, prevention of and safe use of restraints, social psychiatry and how to develop and implement individual therapy plans, patient's legal rights and responsibilities, sexual education and relationships; and
3. Following this, training programmes addressing these issues should be coordinated by the Ministry and delivered to staff by experienced professionals. Evaluating staff competency in these areas should be a compulsory element of staff training. Staff should receive systematic and compulsory refresher courses in these issues as part of their continuing professional development.

Chapter 3: Mental health law

1. **The government** should ensure that law or regulation specifies that doctors and nurses have a duty to record in the medical records of patients the decisions and adequate reasons for the conclusions they draw with regard to the legal aspects of a resident/patient's admission, care, treatment and discharge;
2. Remove from legislation the provision allowing for psychiatrists from the detaining hospital to provide an "independent" opinion of a patient;
3. Adopt national patients' rights information, and ensure that these are widely available and handed to each patient – whether detained in law or not. The information should specify a body which patients can contact (address, telephone number) if they think their human rights have been breached;
4. Amend the law permitting verbal consent to hospitalisation to its pre 1999 provisions, i.e. permitting consent to admission in writing only;
5. Amend the law to correct the possibility of a guardian placing a person under their guardianship into a psychiatric hospital, even if the person under guardianship is actively refusing;
6. Create community-based alternatives to hospitals and in doing so take steps to ensure that people without any clinical need do not end up in hospital; and
7. Amend the law to allow psychiatric patients to instigate a judicial review of their detention at any time, not just at six-monthly intervals.
8. **The Ministry of Justice** should ensure that the basic guarantees of a fair hearing are put in place for people with intellectual and/or psycho-social disabilities; and
9. Judges should receive training on the Convention on the Rights of Persons with Disabilities as well as how to ensure the effective participation of people with disabilities in their courtrooms so as to secure their equal access to justice.
10. **The Croatian Bar Association** should provide accredited training to attorneys on mental health review tribunals, and make this qualification a pre-requisite for attorneys to represent people in these hearings; and

11. Instigate disciplinary proceedings against attorneys who fall below the basic standards of lawyering required by international human rights law.
12. **The People's and Disability Ombudsperson's offices** should seek out complaints from legally un-represented or under-represented patients and take these cases to court, seeking damages; and
13. Proactively monitor institutions to clamp down on cases of arbitrary detention and to ameliorate the circumstances that can result in patients being coerced into signing or verbally agreeing to be a "voluntary" patient.
14. **Psychiatric hospitals and social care institutions** must ensure staff know the legal requirements for admission and ensure that these are followed. A culture should be developed whereby staff inform their superiors as well as the Ombudsman when legal requirements are not met
15. Ensure that each patient is told verbally about their rights and what to do if their rights have been violated, and provide this also in a leaflet in a language and format which the patient can understand;
16. Ensure that "voluntary" patients are not placed in locked wards;
17. Ensure that if a "voluntary" patient wishes to leave against medical advice, that the twelve hour time limit (from the time of the withdrawal of consent) a doctor has in order to reach a decision about detaining that person through use of the involuntary detention criteria is not breached; and
18. Stop admitting people where there is no clinical need and take steps to ensure that psychiatry is not used for social control.

Chapter 4: Legal capacity and institutionalisation

The authors of this report strongly recommend that the **Croatian government** do the following as a matter of immediate priority to comply with Article 12 of the CRPD:

1. Amend law to remove plenary guardianship from legislation;
2. Adopt alternatives to guardianship including supported decision-making, advance directives and enduring powers of attorney; and
3. Amend the law to remove the opportunity for guardians to admit someone into a psychiatric hospital or place them in to a social care institution against their will.
4. **Social care institutions and Centres for Social Care** should review each person under guardianship and instigate proceedings to restore the legal capacity of residents who do not want to be under guardianship.

Chapter 5: Institutionalised lives

Article 19 of the CRPD provides that States should establish services to support living and inclusion in the community, and to prevent isolation or segregation from the community. Hence, deinstitutionalisation is not merely about closing institutions, but creating community support services which are truly respectful of autonomy, privacy and dignity. However, for as long as there are people living in institutions, their rights must also be respected, protected and fulfilled.

1. **The government** should prevent the segregation of people with disabilities from the community and its related opportunities for social interaction, employment and amenities by ensuring accessible and affordable transportation. This should include transport from institutions into the community;
2. Ensure that health, welfare, rehabilitation and support services are provided as close as possible to people's own communities, including in rural areas; and
3. Amend the law to enable people whose legal capacity has been restricted to be permitted to vote on an equal basis with others.
4. **Psychiatric hospitals and social care institutions** should ensure adequate access to telephones so that people can have private conversations in order to remain in contact with friends and family, and retain/regain contact with their communities;
5. Ensure access to writing materials, letters, envelopes and stamps, so that people can write letters to friends and family. Ensure that the law allowing an interference with correspondence in psychiatric hospitals⁴ is complied with, and that each instance of interference is documented;
6. Ensure that there is no interference of any kind with correspondence to/from residents of social care institutions;
7. Invest in computers and encourage patients and residents to use email to remain in contact with friends and family and also the internet for the purposes of entertainment, information about their interests and current affairs;
8. Ensure that residents of social care institutions can come and go as they please, and that returning after curfew hours or returning having drunk alcohol are behaviours which are not subject to punishment;
9. Ensure that every person in an institution is given the opportunity and encouraged to participate in political life, through receiving information about political parties and the voting process, and being supported to exercise their right to vote;
10. Ensure that each person in a psychiatric hospital or social care institution is issued with ordinary clothes. Immediately stop the use of uniforms/pyjamas;

4 Law on Mental Health, Article 11, para 4.

11. Encourage residents to personalise their environment (however limited their environment may be) with photographs and other personal items or decorations. Ensure there is space for these items to be stored in a safe and private place;
12. Ensure that individual privacy is respected in every way possible, and that a “home” environment is created for people living in institutions. Staff, for example, should make efforts to help residents to be able to wash, dress and go to bed in privacy. This could be achieved by creatively rearranging spaces, for example by using fabrics or other material to create screens which create privacy;
13. Ensure that essentials for hygienic living, including soap, toilet paper and toothpaste are available freely;
14. Ensure that institutional rules serve a purpose, are reasonable, and have been discussed and agreed with residents;
15. Ensure that people in institutions have the opportunity to develop and express their creative, artistic and intellectual potential. This includes not merely having a recreation room available, but actively encouraging people to spend their time in a meaningful way;
16. To prevent exploitation (for example, carrying out chores or other types of work for free, or for cigarettes or other tokens) people should be paid market rates for work done. Residents should be able to and encouraged to seek employment outside of the institution where possible;
17. Staff should not dictate how patients and/or residents choose to spend their money, but rather provide information about how to manage finances, different options about spending/saving the money, and how to keep it safe; and
18. Ensure that information about relationships and sexuality is provided to everyone in accessible and understandable formats, and that patients and/or residents receive advice and training on relationships, consent, sexual health and family planning from specially-trained staff. Ensure that staff members recognise that patients/residents are entitled to form sexual relationships and retain their fertility on an equal basis with others. Condoms should be freely made available, and patients and/or residents made aware of their rights.

Chapter 6: Restraint and seclusion

1. **The government** should amend the law to ensure that staff try de-escalation techniques to prevent any resort to restraints or seclusion;
2. Amend the law to clarify the circumstances, the manner and duration, in which chemical restraint can (if at all) be used;
3. Amend the law to oblige institutions to allocate a staff member with the specific task of monitoring a restrained individual for the entire period of the patient being restrained/secluded not intermittently. Ensure that video surveillance never replaces a continuous staff presence;

4. Amend the law to oblige institutions to record instances of restraint in the patient's file and in a separate restraint register. Information recorded in these documents should include the steps taken to prevent restraint/seclusion, the reasons why restraint/seclusion was used, for what duration, and how the safety and health of the patient was continuously monitored; and
5. Monitor the use of restraint across all psychiatric hospitals and social care institutions through data collected in institution's restraint register and monitoring visits.
6. **Psychiatric hospitals** should advise patients in writing about the methods of restraint that may be used if they demonstrate specific behaviours and this should be repeated verbally if the situation arises when restraint may be deemed necessary;
7. Ensure that staff engage in a dialogue with patients so as to ensure if at all possible that patients are given an opportunity to consent to the type of restraint method that may be used if necessary. Ensure that mental health services are encouraged to utilise supported decision-making in order to realise this;
8. Adopt written policies on the use of restraint that emanate from Ministry guidelines; and
9. Limit the duration of restraint/seclusion to the minimum possible extent.
10. **The Ministry of Health and Social Affairs** should, according to the Law on Mental Health, develop an ordinance on restraints. The Ministry should proceed to do this as a matter of urgency and disseminate and routinely update guidance for staff working in mental health services on restraint and seclusion;
11. Arrange training for staff in psychiatric hospitals on the use of these policies and the application of restraint; and
12. Ensure that staff members of social care institutions know that the use of restraints such as straight jackets, belts or straps in such settings is unlawful and must not be used in any circumstance. Staff of social care institutions should be trained in how to manage aggressive residents and de-escalated situations which they perceive to be illustrative of a need for restraint through alternative conflict management methods. Regular monitoring of social care institutions should highlight if and why restraints are found on the premises.

Chapter 7: Treatment

1. **Psychiatric hospitals** should ensure that according to the Law on Mental Health, individual treatment plans are adopted and implemented for every patient;
2. Ensure that patients are offered a choice between therapies, or of not taking medication at all; and
3. Ensure that patients receive information about their diagnosis and what it means, the potential benefits, side effects, risks of the proposed medication, and the potential benefits and risks of not taking such medication.

1. Introduction

1.1. International legal standards

There are numerous international and regional human rights instruments containing standards with which Croatia must comply.

Croatia has ratified all major international and regional human rights instruments, including the International Covenant on Civil and Political Rights,⁵ the International Covenant on Economic, Social and Cultural Rights,⁶ the Convention against Torture⁷ and its Optional Protocol,⁸ and the Convention on the Rights of Persons with Disabilities⁹ and its Optional Protocol.¹⁰ At the regional level, Croatia has ratified the European Convention on Human Rights,¹¹ and European Convention for the Prevention of Torture.¹² The Croatian Constitution has deemed that these instruments, as provisions of international agreements, are part of the domestic legal order and take priority over Croatian law where there is a conflict between them.¹³

In addition, there is an array of declarations and principles which have an affect on Croatia and which relate to the guarantee of the rights of persons with intellectual and/or psychosocial disabilities. Examples include the Council of Europe Committee of Minister's Recommendation (1999)⁴ which is about the right to legal capacity, and Recommendation (2004)¹⁰ which sets out many human rights issues relating to people with psycho-social disabilities.

According to these standards, the Croatian Government must protect and fulfil the human rights of everyone in Croatia, in particular those suffering the greatest societal discrimination such as people with disabilities. Moreover, human rights laws also require the Croatian Government to take affirmative measures, including adopting and enforcing appropriate legislation and policies, abolishing inappropriate laws and policies, and taking steps to protect people with disabilities from human rights violations inflicted by third parties. With respect to people with disabilities, the Croatian Government is also obliged to ensure

5 Ratified on 12 October 1992, entered into force on 12 January 1993.

6 Ratified on 12 October 1992, entered into force on 12 January 1993.

7 Ratified on 12 October 1992, entered into force on 12 January 1993.

8 Ratified on 14 September 2005, entered into force on 22 June 2006.

9 Ratified on 15 August 2007, entered into force on 3 May 2008.

10 Ratified on 15 August 2007, entered into force on 3 May 2008.

11 Ratified on 5 November 1997, entered into force on 5 November 1997.

12 Ratified on 11 October 1997, entered into force on 1 February 1998.

13 See Constitution of Republic of Croatia, Article 140 "International agreements concluded and ratified in accordance with the Constitution and made public, and which are in force, shall be part of the internal legal order of the Republic of Croatia and shall be above law in terms of legal effects. Their provisions may be changed or repealed only under conditions and in the way specified in them or in accordance with the general rules of international law." See Constitution of Republic of Croatia, Article 140.

that they have access to a range of in-home, residential, and other community-based services, including the personal assistance necessary to support living and inclusion in the community and to prevent isolation or segregation.¹⁴

Additionally, the Croatian Government has undertaken separate obligations related to EU accession. In March 2007, Croatia presented its Joint Memorandum on Social Inclusion¹⁵ in which it enumerates the challenges which need to be faced in tackling social exclusion and poverty in the prelude to EU accession. In particular, deinstitutionalisation was identified as an important step in ensuring increased accessibility and improved quality of services to persons with disabilities, including those in psychiatric institutions. As stated in the document, “[t]he goal is for [mental health service] users to receive services in their homes and local communities thus creating conditions for integration and rehabilitation within the community itself.”¹⁶ The Memorandum astutely highlights that “legal provisions aimed at deinstitutionalisation of social services are not sufficient; what is needed is a strong support from the state and a different social climate where a new concept of social services and their providers will be realized.”¹⁷

1.2. The requirement to monitor

Despite commitments to the contrary, Croatia still depends heavily on institutionalised care of people with intellectual disabilities and psycho-social disabilities. Little community-based support exists,¹⁸ and the few civil society organisations who work towards ensuring the inclusion of people with intellectual and/or psychosocial disabilities struggle for financial and political sustenance.

Closed institutions such as psychiatric hospitals and social care institutions are of particular concern from the human rights perspective as they are places where there is an increased risk of human rights violations. Once inside these institutions, people with disabilities are put in a situation where they are vulnerable to

14 See the CRPD, Article 19(b).

15 This document was drawn up by the Government of the Republic of Croatia, Ministry of Health and Social Welfare together with the European Commission’s Directorate-General for Employment, Social Affairs and Equal Opportunities. It aims to prepare Croatia for full participation in the open model of coordination in fighting poverty and social exclusion in the EU accession process, see http://ec.europa.eu/employment_social/social_inclusion/jmem_en.htm

16 Joint Memorandum on Social Inclusion of the Republic of Croatia, 5 March 2007, §3.5, p. 20, http://ec.europa.eu/employment_social/social_inclusion/docs/2007/JIM-croatia_en.pdf

17 Joint Memorandum on Social Inclusion of the Republic of Croatia, 5 March 2007, §4.2.4, p. 32, http://ec.europa.eu/employment_social/social_inclusion/docs/2007/JIM-croatia_en.pdf

18 The UNDP has recommended to Croatia to work towards “reducing independence on institutional care in favour of developing community-based services and family care should be a high priority”, UNDP, Unplugged: Faces of Social Exclusion in Croatia, Human Development Report for Croatia, 2006, p. 149; available at http://www.undp.hr/upload/file/130/65078/FILENAME/WEB_engleska_verzija.pdf (last accessed on 1 July 2008). Also, the EU’s Croatia Progress Report 2007 notes that, “community-based services are not sufficiently developed as an alternative to institutionalisation, and financial resources allocated to mental health care are scarce”, European Commission, Croatia 2007 Progress Report, SEC(2007) 1431, from 6 November 2007, p. 12, (hereinafter “Croatia 2007 Progress Report”); available at http://ec.europa.eu/enlargement/pdf/key_documents/2007/nov/croatia_progress_reports_en.pdf (last accessed on 1 July 2008).

exploitation and abuse because they have little contact with the world outside and have limited access to services such as advocacy and legal advice and assistance. These institutions should be open to public scrutiny through independent inspectorate monitoring which can prevent torture and other forms of ill-treatment. The importance of such mechanisms has been recognised in several human rights treaties including the UN Convention on the Rights of Persons with Disabilities (CRPD), the Optional Protocol to the UN Convention against Torture (OPCAT) and the European Convention for the Prevention of Torture. As a State Party to these treaties, Croatia is obliged to establish an independent national mechanism to monitor human rights in all places of detention and this was achieved by the designation of this role to the People's Ombudsman in 2010.¹⁹ However, it remains to be seen whether the People's Ombudsman will have the financial and staffing capability to fulfil its role under OPCAT, and whether the monitoring of psychiatric hospitals and social care institutions will figure prominently in the execution of its mandate.

A further positive development has been the creation of the Office of the Ombudsperson for People with Disabilities²⁰ whose role is to protect, monitor and promote the rights and interest of persons with disabilities. Although this is not described as an obligatory activity set with fixed timeframes, the Ombudsperson for People with Disabilities is allowed to access premises to report on care received by persons with disabilities who work or live in institutions on a temporary or permanent basis.²¹ The Office of the Disability Ombudsperson has visited social care institutions since its inception in 2008. In 2010 it began to visit psychiatric hospitals as well. However, despite the essential watchdog role that the Office of the Disability Ombudsperson can play in this regard, they are not specifically mandated to monitor the human rights of persons with disabilities inside institutions. It is also unclear whether the Office of the Disability Ombudsperson has been designated by the government as the independent body responsible for monitoring implementation of the CRPD as required by Article 33(2). It is essential that the Office of the Disability Ombudsperson works in co-operation with the national preventive mechanism in upholding the rights of persons with disabilities and ensuring that psychiatric hospitals and social care institutions are regular features of human rights monitoring of places of detention. This is of particular importance if the Office of the Disability Ombudsman is designated as the CRPD Article 33(2) monitoring body.

Due to the recent nature of these developments, monitoring of psychiatric hospitals and social care institutions is still rare, and the detrimental consequence of a lack of oversight persist for the people who are placed within them. It is imperative that the Croatian government ensures that the National Preventive Mechanism, the CRPD Article 33(2) body and, if not designated in the aforementioned role the Office of the Disability Ombudsperson, are provided with the resources necessary to sufficiently fulfil their roles.

19 Joint memorandum on social inclusion of the Republic of Croatia, 5 March 2007., §4.2.4, p. 32, http://ec.europa.eu/employment_social/social_inclusion/docs/2007/JIM-croatia_en.pdf

20 Anka Slošnjak was appointed as Ombudsman for persons with disabilities on 30 May 2008. She was appointed by the Croatian Parliament upon the proposal of the Government for a term of eight years.

21 Law on the Ombudsman for persons with disabilities (Official Gazette No 107/07), Article 12(1). The Law also indicate that upon conducting a visit, the Ombudsman must report back to the monitored institution within 30 days, after which the institution should act upon the recommendations of the Ombudsman made therein (Article 12(2)). There is no provision in the law which prescribes this report to be made public.

1.3. Monitoring methodology of this report

The report is based on monitoring visits to four Croatian psychiatric hospitals and four social care institutions conducted between 14 and 25 June 2010 by delegates from the organisations MDAC and SHINE. The multi-disciplinary monitoring team included human rights lawyers, a doctor, a psychiatric nurse, a mental health policy specialist, a special education teacher, human rights activists and former and current users of mental health services. The team was assisted by Croatian-English interpreters. Each monitoring visit lasted one day and most were conducted by at least six members of the team.

The selection of monitored institutions was based primarily on geographical location and on whether the institution had previously been the subject of independent monitoring. Prior to all visits, permission for access to the institution was sought and granted by the Ministry of Health and Social Welfare. Each monitoring visit was structured in a similar fashion. The monitoring team first met with the management of the institution, usually involving participation of the director, social worker(s), psychiatrist(s) and head nurse. This was followed by a visit of the facilities in which team members were able to speak with other staff on duty and patients (in the psychiatric hospitals) or residents (in the social care institutions) from different areas or department of the institution. The medical member of the monitoring team was also usually given permission to review selected medical files and check the records of the institution related to treatment. The rest of the visit was devoted to engaging in discussions with individual patients/residents, unaccompanied by, and out of earshot of, staff where possible.

With very rare exception, all interviews with hospital staff and patients or residents were conducted in Croatian. All individuals who provided information for this report were informed of the purpose of the monitoring and the ways in which their testimony would be recorded and presented. In some instances, interviewees who critiqued existing policies or practices asked not to be cited by name to avoid potential retaliation or retribution. At the end of each visit, team members regrouped for a final discussion session with the institution's management. The present report is based on the discussion and compilation of notes taken during this entire process. Feedback on specific concerns was provided to each institution in October 2010 and in August 2011 MDAC/SHINE sent all of the monitored institutions an earlier draft of the report in the Croatian language. Institutions were given three weeks to comment on the draft and MDAC/SHINE received feedback from five institutions. MDAC and SHINE thank the staff from those institutions for their willingness to engage in this process and we have taken their feedback into account when preparing this final version of this report.

1.4. The social care institutions monitored

A social care institution is an institution established for providing social welfare and accommodation to a person outside of their own family. Typically, residents include adults with physical, psycho-social, intellectual or multiple disabilities, as well as people with alcohol or drug addictions. The Croatian Ministry of Health and Social Welfare is the regulatory authority overseeing the accommodation and services that social care institutions provide.

The **Lobor-grad** institution (Lobor-Grad Home for Mentally Ill Adults, in Croatian; “Dom za psihički bolesne odrasle osobe Lobor-Grad”) is located in Lobor, near Bedekovčina in Krapinsko Zagorska County. Established in 1935 as the Home for Social Care it became the Home for the Care of Elderly and Ill Persons in 1954. It doubled in size following renovations in 1980 and then became the Home for Mentally Ill Adults Lobor-grad in 2002. The institution primarily consists of two main buildings, gardens, and a farm. The first structure dates from the 1970s and is relatively modern containing units with smaller dormitories and separate kitchens. The second contains a 16th century Keglović castle which is registered as a national heritage site, obliging the institution to conform to specific rules restricting the possibilities for renovation or reconstruction. There are also small houses on the grounds which the institution describes as places for some residents to live before they return to the community.

The **Mirkovec** institution (Mirkovec Home for Psychiatrically Ill Adults, in Croatian; “Dom za psihički bolesne odrasle osobe Mirkovec”) is part of the Sestinski Dol Social Care Home located in Sveti Križ, Začrejte municipality in Krapina-Zagorje county and has been operating since the 1970s. Similar to Lobor-grad, the institution has extensive grounds and the main building is a historically-protected castle.

The **Osijek** institution (Osijek Home for Psychiatrically Ill Adults; in Croatian “Dom za psihički bolesne odrasle osobe Osijek”) was originally established as a residence for homeless people but has been operating as a public institution for the care of people with psycho-social disabilities since 2000 (although staff explained that approximately 12% of residents are people who were not transferred elsewhere after this reclassification and do not have intellectual or psycho-social disabilities).

The **Vojnić** institution (Vojnić Center for Work Therapy and Rehabilitation ‘Nada’²², in Croatian, “Centar za radnu terapiju i rehabilitaciju ‘Nada’ – Vojnići”) is a private institution consisting of two facilities; one in the city of Karlovač (not visited by MDAC during this monitoring) and the other situated 22km away in the village of Vojnić. Both facilities were established as and have been operating as private institutions since March 2006. The institution charges a fee for accommodation, which is usually provided by a family member, guardian, or Ministry of Health. Regardless of its private status, Vojnić is subject to the same standards of domestic and international law as all other social care institutions. The facilities are modern and spacious and the majority of residents have dual-diagnoses of both intellectual disability and psycho-social disability.

22 For more info, see the institution’s website, <http://www.centar-nada.hr/index.html> (last accessed on 20 October 2010).

	Official capacity	Number of Residents*	Number under full guardianship	Number under partial guardianship	Number retaining Full legal capacity
Lobor-grad	344	344	84	24	236
Mirkovec	70	90	Unavailable	Unavailable	Unavailable
Osijek	190	132	123	9	0
Vojnic	175	175	164	11	0 (Guardianship is a pre-requisite for admission)

*On the day of the monitoring visit

All of the social care institutions monitored had both male and female residents residing in a mixture of open and closed units. The average age range was between 35 – 65 years old; the youngest resident identified was 27 and the oldest was 90.

1.5. The psychiatric hospitals monitored

Psychiatric hospitals are intended to provide treatment and rehabilitation services for people experiencing a mental health crisis. Sometimes they are part of a general hospital and sometimes, as the case of the ones monitored by MDAC for this report, they are stand-alone institutions. There are seven psychiatric hospitals in Croatia and the majority of general hospitals also have a psychiatric ward.

Jankomir psychiatric hospital (Sveti Ivan Psychiatric Hospital; in Croatian, “Psihijatrijska bolnica „Sveti Ivan“ Jankomir – Zagreb”) is located in the Jankomir district of the capital of Croatia, Zagreb.²³ The facility opened as an institution for people with intellectual disabilities in 1923 and for some time it was a part of Vrapče psychiatric hospital. It has been an independent hospital since 1958. The hospital comprises ten detached buildings including ten wards, and extends across both sides of a street.

23 See the hospital website, <http://www.pbsvi.hr/>.

Popovača psychiatric hospital (Dr. Ivan Barbot Neuropsychiatric Hospital, Popovača;²⁴ in Croatian, “Neuropsihijatrijska bolnica “Dr. Ivan Barbot” Popovača”) is located in the town of Popovača, 65km from Zagreb. The hospital was established in 1933 and consists of ten buildings including a historically protected castle, and occupies extensive grounds. Popovača has 20 wards, three of which are located in the castle and two of which are two kilometers away in a separate annex. The forensic psychiatry unit is the largest in Croatia.

The **Ugljan** psychiatric hospital (in Croatian “Psihijatrijska bolnica Ugljan”)²⁵ is located on the island of Ugljan, which is 11km from the mainland and a thirty minute ferry ride from the coastal town of Zadar. Formerly a prison camp, it now functions as a regional hospital for patients from four counties (Dubrovačko-Neretvanska, Splitsko-Dalmatinska, Šibensko-Kninska and Zadarska). Established in 1955, Ugljan comprises 11 wards in six buildings and significant gardens.

The **Rab** psychiatric hospital (in Croatian, “Psihijatrijska bolnica Rab”) is located in Kapor village on the island of Rab, which is 5km from the mainland and a half an hour ferry ride from the coastal town of Jabalanac.²⁶ Established in 1955 and also a former prison camp; Rab is the regional hospital for Istrian County, but also accepts patients from across Croatia.

	Official capacity	Number of Patients*	Number under guardianship	Minimum length of stay**	Longest length of stay**
Jankomir	551	552	15 partial 75 full	1 day	Information unavailable
Popovača	773	745	280 partial 15 full	1 day	15 years
Ugljan	483	418	7 partial 74 full	15 days	15 years
Rab	480	Information unavailable	Information unavailable	Information unavailable	22 years

*On the day of the monitoring visit

**For non-forensic residents²⁷ as reported by staff

24 <http://www.npbp.hr/v1/>.

25 <http://www.pbu.hr/eng/index.html>.

26 <http://www.bolnicarab.hr/mainen.html>.

27 A forensic patient is a person who has been found unfit to stand trial for a criminal offence or found not guilty by reason of mental illness and ordered to be detained in a mental health facility.

1.6. Material conditions

Dealing first with psychiatric hospitals, material conditions should create a therapeutic environment and should include “sufficient living space per patient as well as adequate lighting, heating and ventilation, [in order to maintain] the establishment in a satisfactory state of repair and [meet] hospital hygiene requirements”.²⁸ Although conditions may depend on resources, provision of the necessities of life must always be guaranteed,²⁹ as “inadequacies in these areas might rapidly lead to situations falling within the scope of the term inhuman and degrading treatment”.³⁰

Conditions differed across and within the psychiatric institutions monitored by MDAC/SHINE. With the exception of **Jankomir**, there were similar features everywhere: living conditions ill-suited to needs, overcrowding, lack of privacy and low levels of basic hygiene. As such, they failed to meet Croatian legal standards³¹ and European standards. Most of the buildings of **Popovača** and **Uglian** were old and dilapidated, and the low standard of material conditions was acknowledged by their directors. Both directors complained that they lacked financing, adding in some cases that they had asked the Ministry of Health for funding to improve conditions and/or open new units to relieve the situation, but that these requests had for the most part been turned down. The poor conditions in **Uglian** had been aggravated by the humidity and proximity to seawater, given that the hospital was on an island. In contrast, there were renovated buildings on the other island hospital of **Rab**. Across all monitored psychiatric hospitals, admissions units and acute units had generally better conditions than chronic units or units for elderly people. Staff at **Rab** did not complain about any lack of money to improve conditions, stating that they received adequate funding because they catered to acute patients and those with addictions.

Jankomir hospital was markedly different than the other hospitals in terms of sanitary conditions. Most notably, the patients in the chronic and geriatric units had clean hair and were clearly regularly washed; further, there were no offensive odours as in some of the hospitals visited. Some of the patients were wearing earrings and other jewellery. Staff said that they change patients’ clothes up to five times a day if they are soiled and monitors concluded that this is credible. Conversely, patients in similar units at **Popovača** and **Uglian** appeared unwashed, had dirty hair, and were wearing clothes which had obviously not recently been cleaned; some units smelled of urine and faeces.

28 See the 8th General Report on the CPT’s activities covering the period 1 January to 31 December 1997, CPT/Inf (98) 12, from 31 August 1998, para 34 (hereinafter “the 8th CPT General Report”), available at <http://www.cpt.coe.int/EN/annual/rep-08.htm> (last accessed 1 October 2010).

29 Ibid, para 33.

30 Ibid, para 32.

31 The standards advised by the Ministry of Health and Social Welfare. See the Book of Regulations on Minimum Conditions Regarding Premises, Staff and Medical and Technical Equipment for Performing Medical Activities (Official Gazette 85/04), issued by Ministry of Health and Social Welfare based on Article 47 para 3 and Article 143 para 3 of the Law on Health Protection (Official Gazette 150/08, 155/09)) upon the prior opinion of the competent chambers and based on Article 11 para 4 and Article 12 para 4 of the Law on the Pharmaceuticals (Official Gazette No. 121/3) upon the request of the Croatian Medical Chamber.

The two units contained in the annex to **Popovača** located a few kilometres away from the main buildings, offered the worst conditions that the monitoring team observed. These were wards 10A and 10B and were described as a “farm” and the “social care wards” by the hospital management, who actively discouraged monitors from visiting them. The building was in relatively good repair but the units were spartan and devoid of any décor. There were two floors: upstairs was for patients who were deemed mobile or “clean” and downstairs was reserved for incontinent patients, which, according to staff, accounted for the smell of faeces. The rooms were large dormitories with around ten beds in each and almost all of the patients were sleeping or lying on their beds; only a handful were dressed. There was limited natural light in the lounge, so patients sat in half darkness during the day. Notwithstanding the short time spent on the unit, monitors concluded from their observations and discussions with staff in charge that they had not received the necessary training and developed the required skills to care for people with mixed/dual diagnosis. Moreover, there was no doctor responsible for this annex.

As for the social care institutions, regulations covering their material conditions regarding space, equipment, and necessary professional and other employees required, can be found in the Official Gazette No. 101/99, 120/02, 74/04, which provides ministerial rules on the material conditions in social care institutions. In practice, the monitoring team found that conditions varied greatly both between and within institutions. The clearest division in terms of quality was between the privately run **Vojnić** institution, which had clearly expended resources on creating a well-equipped, spacious, and modern living environment, and the state-run social care institutions which were overcrowded and less well-resourced.

A second comparison can be drawn between the ‘castle type’ structures in the state run institutions such as **Lobor-grad** and **Mirkovec**, which were classed as national heritage sites, and those that were more modern. The kind of renovation and modification necessary to bring these ‘castles’ up to contemporary standards includes the division of enormous stately rooms with high ceilings and large windows into smaller units, the addition of elevators, and the replacement of old-fashioned electrical and heating fixtures. Such improvements are currently limited or prohibited by law and staff at **Mirkovec** told monitors that this includes the installation of curtain rods; therefore residents cannot control the level of sunlight in the rooms. It was rare to see residents with bedside lamps and they had to turn the central light on at night if they wished to move around. The monitors acknowledge that it is almost impossible for directors of institutions that include listed buildings to provide suitable accommodation and adequate living conditions for residents across all buildings. However, it is of grave concern that in most of the monitored institutions, the units and buildings which exhibit the worst state of repair house the most vulnerable and elderly residents.

Physical accessibility to buildings and activities was poor across the institutions although obviously more pronounced in the ‘castle’ style institutions, which were several stories high and have many winding staircases. This is a troubling observation, given that many residents had physical disabilities and no provisions were being made to facilitate their access to different areas of the institution. The layout excluded them from participating in certain activities located out of their reach, such as recreational activities in the garden. The monitoring team was concerned that some of these patients rarely left their units, if at all. All the institutions visited devoted at least one unit to the care of immobile residents who suffered from somatic conditions. Some of these residents were immobile – dependent on staff to be bathed, be taken outside

for fresh air, and participate in activities – but still in good general health. However, some individuals were elderly and bedridden with very serious conditions and monitors saw no reason not to believe **Osijek** residents' reports that they were not routinely taken out for fresh air, exercise, or any other activity for long periods of time. One resident claimed that the wait for such attention can be as long as a year and when questioned about this, a nurse explained that it was because there were not enough staff.

The bathroom fittings, number of toilets, and hot water supplies, were of an adequate standard across the social care institutions visited. **Vojnić** bathrooms were fitted with special baths for persons with disabilities and some bedrooms at **Osijek** had ensuite bathrooms shared between 2 rooms. However, it was a common observation everywhere except **Vojnić** that there were numerous broken toilet seats, a lack of locks on stall doors, a lack of soap at washbasins, and either a rationing of toilet paper (two rolls per month at **Lobor-grad**) or its absence altogether. Residents told monitors that they were not permitted to wash and shower at will anywhere except **Osijek**, and it was clear that although toilets at **Lobor-grad** were designated to be male and female there was no signage and these divisions were not followed. See chapter 5, 'Institutionalised lives', for further comment on the effects of these conditions on the right to privacy.

1.7. Reception of the monitors

Osijek incorporates guidelines regarding staff-resident relations into their house rules such that staff members are mandated to *"behave towards a resident in a forthcoming way with full respect of his/her personality and provide him/her with any help that can be rendered in accordance with the staff's job description. It is strictly prohibited to insult residents, to ill-treat them physically or mentally, or to subject them to mockery"*.³² Indeed, the culture observed by MDAC and SHINE appeared to reflect that staff did not possess paternal attitudes towards their residents. The same could be said for **Mirkovec** and **Lobor-grad**, where staff were welcoming, open, and willing to speak freely. They did not appear to exhibit fear of, or intimidation from, senior management. They seemed non-authoritarian and open to new ideas and change in order to benefit the lives of the people living under their care. In general, MDAC and SHINE observed warm and friendly attitudes on the part of staff towards residents at these institutions, and no complaints about staff behaviour were raised during any of the interviews.

In comparison, monitors found that **Vojnić** was heavily regimented, and that staff had pre-selected the residents with whom MDAC and SHINE were allowed to speak. Monitors could not freely walk around the institution. It was clear that residents were cautious in what they were saying and at the end of one conversation; a young resident asked monitors if he had said anything wrong. Staff members remained close when monitors approached residents, rendering it difficult for them to have confidential conversations with residents in order to carry out the monitoring effectively.

32 See **Osijek** House Rules, Article 39.

Recommendations

1. **The government** should ensure that the NPM regularly and thoroughly monitors institutions at least once a year and produces publically-available reports;
2. The government should also pass a decree permitting non-governmental organisations to monitor psychiatric hospitals and social care institutions and be afforded the opportunity to comment on the findings of the NPM;
3. **Psychiatric hospital and social care institution** staff should receive training on the purpose and benefits of engaging with independent monitors. External scrutiny should be welcomed as a measure of a democratic society; and
4. **The People's and Disability Ombudspersons** should engage actively in advocacy to ensure that the government equips them with adequate mandate and resources; particularly if the Disability Ombudsperson is designated as the Article 33(2) body tasked with independently monitoring implementation of the CRPD.

2. Staff

This section looks at the numbers and training of staff, issues relating to behaviour and attitude are dealt with in chapter 5, “Institutionalised lives”. Properly trained and professional staff are crucial in order to ensure that human rights standards both in psychiatric hospitals and social care institutions are met.

2.1. The need for training

The UN Convention on the Rights of Persons with Disabilities (CRPD) contains provisions setting out general state obligations, one of which is “[t]o promote the training of professionals and staff working with persons with disabilities in the rights recognized in the present Convention so as to better provide the assistance and services guaranteed by those rights”.³³ With regards to implementing the right to health, the CRPD ensures that States “[r]equire health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care”,³⁴ and that States should “promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services”.³⁵

The European Committee for the Prevention of Torture (CPT) recommends that staff in psychiatric hospitals should be “adequate in terms of numbers, categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), experience and training”, and warns that deficiencies in human resources will often seriously undermine attempts to provide necessary treatment, notwithstanding the good intentions and genuine efforts of the staff in service.³⁶

2.2. Monitoring findings

MDAC and SHINE have two main concerns with regard to professional staff who care for people with intellectual disabilities and work in the mental health system: the shortage of staff, and inadequate training – both of which can directly result in human rights violations.

33 CRPD, Article 4(1)(i).

34 CRPD, Article 25(d).

35 CRPD, Article 26(2).

36 See the 8th CPT General Report, paragraph 42.

a) Shortage of professional staff

The monitoring team agreed with the opinion of the management of all the hospitals visited who complained that there is a lack of professional staff providing direct care. Some managers said that the Ministry of Health and Social Welfare (“the Ministry”) viewed low staffing rates as indicative of productivity and efficiency, but they were concerned that under-investment in the workforce implied that the Ministry undervalued the importance of sufficient and quality staffing. In an attempt to resolve this, **Popovača** hospital has in some instances paid for the specialist training of doctors interested in specialising in psychiatry itself; the intention being that they will stay at the hospital on completion of their training. The hospital has also paid for the establishment of a bus route between Zagreb and **Popovača** in order to help retain staff by facilitating their daily commute.

Many of the staff members whom monitors interviewed cited low pay and difficult conditions as reasons why they were unhappy in their jobs. Staff at **Lobor-grad**, and **Vojnić** also raised concerns about burn-out and overwork, and in lieu of counselling services some have formed their own workplace discussion groups to help each other tackle their work related problems. One nurse described the situation by saying that “*the hospital and its patients go from empty to empty*”. Another young female member of staff at the island hospital of **Rab** said she would “*leave in an instant*” if she found a job on the mainland, a view which was backed up by other young professional staff working on **Rab** and the other island hospital of **Ugljan**. This view was also expressed by staff working in the more secluded social care institutions such as **Mirkovec**.

The director of **Mirkovec** explained that there were currently 27 staff at the Zagreb site of the facility and only 23 residents. This is disproportionate compared to the 22 staff working in his facility at **Mirkovec**, which houses 90 residents and, has only one nurse on duty at night-time. However, he asserted that a lack of roads meant that even if the Ministry tried to relocate staff they wouldn’t come. Staff at **Osijek** believed that according to ministerial regulations on staff levels they were understaffed by 27 to 29 positions, yet only the Ministry could authorise new hires, which they were not doing. In contrast, the privately-run **Vojnić** facility seemed to have adequate staffing levels and the financial resources necessary to hire and dismiss staff as required. The management claimed that this helped them attract good staff and keep staff discipline high, a claim which monitors found no reason to disbelieve.

b) Lack of training

Professional staff involved in mental health services should be appropriately trained in how to respect and protect human rights, how to prevent and control violence, and how to avoid the use of restraints and seclusion.³⁷

37 See Council of Europe Committee of Ministers Recommendation R (2004) 10, Article 11, available at <https://wcd.coe.int/wcd/ViewDoc.jsp?id=749565&Site=CM> (last accessed 21 July 2011).

Every psychiatric hospital that MDAC/SHINE visited had either established initiatives to train staff themselves, or to ensure further education through the Croatian Nurses Association and proactive participation in conferences and seminars. Monitors also noted some creative approaches at some social care institutions. Nurses at **Osijek** initiated a monthly lecture series in which a nurse researches a topic and presents it to others in order to supplement the “rarely relevant” training they receive from **Osijek** hospital. Psychologists at **Lobor-grad** have surveyed staff to develop training on anti-stigmatising approaches to care. Staff from **Osijek**, **Mirkovec**, and **Lobor-grad** (along with other institutions which were not part of these visits) reported that they have been meeting every three months since 2007 to discuss the most common challenges that they encounter, and to brainstorm solutions. They keep written records of their meetings and send them to the Ministry to receive feedback and direction on how to deal with their problems. When the monitoring team visited in June 2010, the group reported that they had never received any response from the Ministry.

Despite these proactive efforts to raise standards and facilitate staff development, such activities cannot replace proper training on policies and procedures. The directors of **Mirkovec** and **Osijek** complained that most existing staff were not specifically trained for work with people with intellectual disabilities or psycho-social disabilities: “staff come here straight from university, without any working knowledge”, one said, and added that staff’s “continuous requests to the Ministry for assistance go unanswered”. Indeed many of the staff to whom monitors spoke, including nurses, had received no training whatsoever related to working with people with intellectual or psycho-social disabilities. Furthermore, they were not trained on how to resolve specific issues that would be expected to occur in practice such as dealing with aggressive behaviours, including proper use and protocol for restraints, as well as providing adequate care for permanently bed ridden patients. At the time of the monitoring the Ministry had not issued any guidelines for staff or provided any training on these issues. Many staff told monitors that the Ministry should issue guidelines on how to deal with aggression and the use of restraints as well as social psychiatry and how to develop and implement individual therapy plans. They also highlighted a need for information and training on patient’s legal rights and responsibilities, as well as how to address sexual education and relationships. The effects of the lack of staff guidance and training are elaborated upon throughout this report, specifically in chapters 6 and 7 on “Restraints and seclusion” and on “Treatment”.

2.3. Evaluation

There are a number of knock-on effects which stem from the fact that institutions in Croatia are frequently situated in isolated locations. The criticism is not simply that patients and residents are segregated from the community, although this is a primary concern dealt with in chapter 5 of this report. Isolation also means that the staff who work in the institutions need to live locally, and low wages coupled with a lack of facilities and lifestyle opportunities make the small towns and villages surrounding the institutions unattractive for many professionals. Moreover, institutions are forced to recruit from the small, local community which severely limits the pool of available and quality staff. Clearly, this has a detrimental impact on patients and residents who suffer from a lower standard of care and assistance than should otherwise be provided, not least because the services of professionals such as psychiatrists are difficult to obtain at short notice.

This problem is exacerbated by the lack of training offered by the government meaning that there is wide-variance of medical, nursing and social care, and many practices are ad hoc. Monitors noted a lack of clarity from staff who were confused and unsure about their own responsibilities or the rights of patients and residents.

It was also obvious to MDAC and SHINE that many of the institutions visited were the major source of employment in their respective area. For instance, auxiliary (non-professional) staff outnumbered professionals by roughly four times at **Popovača**³⁸. Staff of that institution argued that as a consequence of staff living locally, plans for de-institutionalisation were strongly resisted, as staff saw the institution providing “*jobs for life*” to local residents. This reasoning appeared to outweigh any potential benefits to staff that may follow from altering their working arrangements (let alone the benefit to patients), and constitutes a significant barrier to the progress of de-institutionalisation and establishing a system of community support services in Croatia.

As this report points out in chapter 5, the obligation to realise the right to independent living and the right of people with disabilities to be included in the community cannot be circumvented by the fact that institution staff will need to receive re-training to meet professional standards and work more flexibly in community-based settings. Moreover, increasing the quantity and quality of mental health services located in the community would better serve persons with disabilities, and provide them with greater opportunities to enjoy their human rights. It would also begin to address the stigmatisation and discrimination that contribute to the institutionalisation of persons with disabilities, as well as their segregation from the wider community. Establishing a range of community-based services would also provide and maintain jobs for other Croatians, and facilitate the development of a more inclusive society.

Recommendations

1. **The government** must ensure that institutions employ a sufficient quantity of trained professional staff, including qualified nurses, as this has a direct impact on human rights as well as on the quality of care, treatment and rehabilitation;
2. **The Ministry for Health and Social Welfare** should develop, disseminate and routinely update minimum competencies for staff working in mental health and social care. These competencies should cover the following areas: preventing and managing aggressive behaviour, prevention of and safe use of restraints, social psychiatry and how to develop and implement individual therapy plans, patient’s legal rights and responsibilities, sexual education and relationships; and
3. Following this, training programmes addressing these issues should be coordinated by the Ministry and delivered to staff by experienced professionals. Evaluating staff competency in these areas should be a compulsory element of staff training. Staff should receive systematic and compulsory refresher courses in these issues as part of their continuing professional development.

38 646 staff in total including 60 doctors.

3. Mental health law

This chapter examines the Croatian mental health law against international standards, and lays out the observations of MDAC and SHINE about how the law operates in practice.

Unlike other areas of medicine, psychiatric treatment can be imposed on a person following a refusal to consent to treatment. In Croatia, like many other countries, people can choose to receive mental health treatment (voluntary patients), or they can be forced to do so (involuntary patients). Croatian law allows psychiatrists to deprive people of their liberty if they meet the legal criteria for detention. While in detention, the law allows for forced psychiatric medication to be administered forcefully (involuntarily).

3.1. European Convention on Human Rights

The most extensive regime of international law relating to the detention of persons in psychiatric facilities to which Croatia is subject is contained in Article 5 of the European Convention on Human Rights and Fundamental Freedoms (ECHR), and the jurisprudence of the European Court of Human Rights. Article 5 articulates a general right to liberty, and then sets out exceptions to this rule. One of these exceptions permits the detention of “persons of unsound mind”, but only when specific conditions are met:

1. The detention must be “lawful”
2. The person detained must be informed promptly, in a language which he or she understands, of the reasons for the detention
3. The person detained must have the right to challenge the detention before a court or similar legal tribunal

Each of these ECHR requirements has been the subject of litigation to, and elaboration by, the European Court of Human Rights (ECtHR):

“Mental disorder”

Following the 1979 case of *Winterwerp v the Netherlands*, a “person of unsound mind” (the out-dated wording of Article 5) has been defined as someone having a “true mental disorder, diagnosed by an objective medical expert”.³⁹ The European Court has not commented on whether this person needs to be a psychiatrist, but the person does need to have appropriate medical qualifications in order to ensure the reliability of the psychiatric diagnosis. It is reasonably justified to assume that these qualifications will include a post-graduate psychiatric qualification. The disorder must also be of a severity that – in the view

³⁹ *Winterwerp v the Netherlands*, Application No. 6301/73, judgment of 24 October 1979, (A/33) (1979-80) 2 EHRR 387, para 39.

of the assessor – it warrants detention, although no further advice has been given about what this means. Ongoing detention is justified only if these requirements continue to be met.⁴⁰ States must therefore engage in periodic reassessments of detained persons, to ensure that the criteria remain met.

Detention must be based on law

The European Convention requires states to have a legislative framework that governs the admission criteria and processes of psychiatric detention. The law must be clear; a person must reasonably be able to predict whether specific behaviours will make them liable to detention.⁴¹ General statements in law about the nature or severity of a diagnosis will not suffice; the law must be clear enough to be foreseeable in its application. It must also be clear enough in its procedural elements that it can be readily determined whether the appropriate processes of detention are being followed.

Place of detention must be appropriate

The question of lawfulness also extends to the place of detention. If detention is imposed for psychiatric reasons, it must occur in a place that offers therapeutic programmes overseen by suitably qualified staff. Certainly, detention should not occur in an environment which is actively non-therapeutic, or is harmful to people's physical, mental, or psychological health.⁴²

Individual must be informed

The person detained must also be told promptly of the reasons for the detention, in a language that he or she understands.⁴³ The information must be sufficient to the extent that it will allow the individual to decide whether, and on what grounds, to challenge the detention.⁴⁴ Logically, this implies that it must include more than simply the relevant legal basis for the detention, but also the factual circumstances, evidence supporting the application of the facts to the law, and reasoning that has given rise to the decision to detain.⁴⁵ Similarly, the requirement that the information be provided in a language understood by the individual should be taken not simply to refer to the need to provide translators where appropriate, but also the need to repeat the information as may be required. It should be ensured that the information is provided when the individual is in an appropriate mental state to understand it, and it should be readily available in writing so that the person can re-read it at leisure.

40 Ibid, para 39.

41 See, eg., *Kawka v Poland*, Application No. 25874/94, judgment of 9 January 2001, para 49, ECHR.

42 *Aerts v Belgium*, Application No. 25357/94, judgment of 30 July 1998, (1998) EHRR 50.

43 Article 5(2) ECHR.

44 *Fox, Campbell and Hartley v the United Kingdom*, Application Nos. 12244/86, 12245/86, 12383/86, judgment of 30 August 1998, A 182 (1990) 13 EHRR 157, para 40.

45 *Gajcsi v Hungary*, Application No. 34503/03, judgment of 6 October 2006, ECHR.

Individual must be able to challenge his or her detention before a court or similar legal tribunal

The person detained must be able to obtain a court hearing at a point in their detention chosen by him or her and hearings must be held promptly following such requests. The person detained has a right to legal representation before and at these hearings,⁴⁶ and the legal representation must be more substantive than the mere appointment of an attorney. The attorney should meet with the person beforehand, discuss their case, gather evidence, and make representations in line with their client's instructions in an adversarial setting. While the judicial body hearing the challenge does not need to be a court, it does need to have quasi-judicial powers: It must have the authority to ensure that its orders and decisions are complied with, including that of calling witnesses and ordering the discharge of the patient.

Scope of Article 5

These provisions apply to all persons subject to detention, or "deprived of liberty", to use the phrase in the introduction to Article 5(1). While this clearly includes all persons subject to the civil or criminal detention powers of mental health legislation, the ECtHR has read the scope of Article 5 more broadly. In its judgment in the case of *HL v the United Kingdom*,⁴⁷ the Court held that a person with autism who lacked the capacity to decide whether or not he would be admitted to a psychiatric hospital was, on the facts of that case, involuntarily deprived of his liberty and therefore, Article 5 applied. Furthermore, the Court held that Article 5 would apply whenever an individual's care was under the "effective and complete control" of the hospital authority.⁴⁸ Given the result in this case, it follows that patients who are de facto detained (but not necessarily detained in law) would fall within the scope of Article 5 of the European Convention. This would apply, for example, to a person who is coerced into signing a paper consenting to their admission in to a psychiatric hospital.

3.2. UN Convention on the Rights of Persons with Disabilities

The ECHR constitutes the most complete body of international law relating to psychiatric detention, but it is not the only relevant international law applicable to Croatia. Most significantly, Croatia has signed and ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD), and the Convention has been incorporated into domestic legislation.⁴⁹ While the ECHR was adopted in 1950, the CRPD was adopted in 2006, so it represents a more contemporary view of the world. As analysed above, the ECHR contains a specific clause suspending the right to liberty for people with disabilities. The CRPD takes a different approach, and is concerned specifically with equality, autonomy, and self-determination of II

46 See for example, *Pereira v Portugal*, Application No. 44872/98, judgment of 26 February 2002, (2003) 36 EHRR 49.

47 Application No. 45508/99, judgment of 5 October 2004 (2005) 40 EHRR 32.

48 Ibid.

49 See Constitution of Republic of Croatia, Article 140.

people with disabilities, including people with mental health disabilities and/or intellectual disabilities.⁵⁰ The ECtHR has said that the ECHR must also be interpreted in the light of present day conditions,⁵¹ and it will be interesting to see how the specific standards of the CRPD are synthesised into European human rights jurisprudence. When relying on the CRPD in the case of *Glor v Switzerland*, the ECtHR “consider[ed] that there is European and universal consensus on the necessity to protect persons suffering from a disability from discriminatory treatment”.⁵²

Article 14 of the CRPD contains rights relating to the liberty of individuals with disabilities, including those with diagnoses of mental illness or intellectual disabilities. Like the ECHR, Article 14 refers to the need to ensure suitable legal protections to any deprivation of liberty, but it goes even further – stating that “the existence of a disability shall in no case justify a deprivation of liberty”. Definitive interpretation of what this means has not yet been enunciated by the UN Committee to the CRPD but based on the negotiation history of the provision, it can be persuasively argued that a (mental) disability can never be a factor at all in the decision to detain individuals.⁵³ This is not the only interpretation, however,⁵⁴ and clarity will only be attained following decisions of the UN CRPD Committee which, at the time of publishing this report (October 2011) has not conclusively developed its jurisprudence on this article.⁵⁵

However, what is clear is that the CRPD is premised on a set of values deeply reflecting the human rights and equality of people with disabilities, rather than management, treatment, and exclusion of them. The CRPD sets out a series of principles which guides interpretation of the convention including: self-determination, “[r]espect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons”,⁵⁶ “[f]ull and effective participation and inclusion in society”,⁵⁷ and “[r]espect for difference and acceptance of persons with disabilities as part of human diversity and humanity”.⁵⁸ The CRPD is clear that “all discrimination on the basis of disability” is prohibited,⁵⁹ and defines disability-based discrimination as “any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others,

50 CRPD, Article 1.

51 *Tyrer v. United Kingdom*, judgment of 25 April 1978, series A no. 26, p. 15, § 31 ; *Airey v. Ireland*, judgment of 9 October 1979, series A no. 32, pp. 14 and following, § 26, et *Vo v. France* [GC], no. 53924/00, § 82, CEDH 2004-VIII.

52 *Glor v. Switzerland*, Application No. 13444/04, judgment 30 April 2009, para. 53.

53 Annual report of the High Commissioner for Human Rights to the General Assembly. A/HRC/10/49, presented 26 January 2009, para 48-9. Available at

54 For a range of possible interpretations, see P Bartlett and V Hamzic, “Reforming Mental Disability Law in Africa”, Nottingham: Human Rights Law Centre, 2010), pp 15-16. Available at <http://www.nottingham.ac.uk/law/hrlc>.

55 Please see the MDAC website for analysis of the CRPD Committee’s Concluding Observations on Tunisia (April 2011) and Spain (October 2011). For full disclosure, MDAC’s Senior Advocacy Officer Gábor Gombos, has been elected to serve on this Committee in his personal capacity from January 2011 for a term of two years.

56 CRPD, Article 3(a)

57 CRPD, Article 3(c)

58 CRPD, Article 3(d)

59 CRPD, Article 5

of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation”.⁶⁰ Any interpretation of Article 14 of the CRPD needs to bear in mind these prohibitions.

3.3. Involuntary detention: law

This section outlines the statutory provisions on how a person gets into, and out of, a psychiatric hospital against their will. A person who is detained in a psychiatric hospital and forced to receive treatment is classed as an involuntary patient. Under Croatian legislation, this can occur if the person “shows symptoms of a severe mental disturbance, and as a result poses a serious and imminent threat to the life, health or security of themselves or others”.⁶¹ Once a hospital receives a medical certificate from a doctor or psychiatrist confirming such a threat, admission can take place. A doctor or psychiatrist not employed by the hospital which the person is being admitted to must prepare the report following a personal examination of the individual.⁶² Alternatively, there is an ‘emergency procedure’ for admission, whereby law enforcement agents can convey the person to a hospital without a medical assessment.⁶³

Upon admission – although there are no specific time limits – the psychiatrist on duty must tell the patient the reason(s) for the involuntary admission, and this reasoning must be recorded in the medical records.⁶⁴ The psychiatrist must also inform the patient of their rights and responsibilities.⁶⁵

Croatian law provides a court review as a check against arbitrary detention and treatment of involuntary patients. From the time of admission, hospitals have 72 hours to decide whether the person should continue to be compulsorily detained, or conversely, be discharged (released).⁶⁶ There is no legal requirement for the hospital to notify a court within these initial 72 hours, or the additional 12 hours permitted for the delivery of a psychiatrist’s opinion.⁶⁷ Thus, the law permits a maximum of 84 hours, or three and a half days (not including the time it may take for a court to decide on the lawfulness of the admission), to commence forced psychiatric treatment without consent if it is determined that there is a severe threat to the patient’s health or life.⁶⁸

60 CRPD, Article 2

61 Law on Mental Health, Article 22 para 1

62 Law on Mental Health, Article 23.

63 Law on Mental Health, Article 24.

64 Law on Mental Health, Article 26 para 1.

65 Law on Mental Health, Article 26 para 2. See also Article 11 para 1 section 1 that mandates the patient to be informed about his or her rights and responsibilities, and advised on the ways of exercising such rights, both at the time of admission and at any subsequent time upon his or her explicit request.

66 Law on Mental Health, Article 3 para 11.

67 Law on Mental Health, Article 27 para 1.

68 Law on Mental Health, Article 9, para’s 1, 3.

In order for the court to decide on the lawfulness of the detention and forced treatment, a judge must visit the involuntarily detained person in the psychiatric institution no later than 72 hours from the court receiving notice of compulsory detention by the hospital – the involuntary patient may now have been detained for a possible maximum of six and a half days (84 plus 72 hours). The patient’s condition must be assessed by a psychiatrist chosen from the register of experts permanently appointed by the court and if the patient’s health allows the judge must interview the patient⁶⁹. The legislation also provides for mandatory legal representation in court hearings which adjudicate upon the lawfulness of the detention. An attorney is assigned to an involuntary patient and the cost of the legal representation is paid by the State if the patient does not have an attorney of their own.⁷⁰

In accordance with the *Winterwerp v. the Netherlands* criteria discussed above, involuntary patients must be discharged from hospital when the reasons for their detention cease.⁷¹ For example, if the patient no longer poses a sufficient risk to meet the statutory criteria that led to their detention, or if the time-limit set by the court for detention expires, the patient must be discharged and is free to leave.⁷² A court must review the detention at least every six months⁷³, and the same procedure must be followed as for an initial detention: collecting medical evidence, informing the patient, assigning an attorney, judge visiting the patient and holding a court hearing, and delivering a judicial decision.

The absence of a provision in Croatian law for involuntary patients to request a court to review the necessity of their detention outside of the six month statutory review is of significant concern. Individuals are entitled to appeal the involuntary hospitalisation order, or its renewal, within three days of the decision and there follows a period of up to eight days wait until their case will be heard.⁷⁴ However, if for any reason they are unable to utilise this timeframe then there are no opportunities to challenge their detention for a further six months; they are not allowed to make independent requests at a time of their choosing.⁷⁵ This legislation is in clear contradiction with international standards that emphasise the importance of the right of patients to actively seek judicial review of their detention.⁷⁶

69 Law on Mental Health, Article 30 para 2.

70 Law on Mental Health, Article 30 para 1.

71 Law on Mental Health, Article 40 para 1. According to the same article, decision on the discharge is issued by the head of the department or by the psychiatrist authorized by the head of the department.

72 For the first decision on involuntary admission, the court can order compulsory hospitalisation for a maximum of 30 days which starts from the day of the psychiatrist’s decision on compulsory detention of the patient, see Law on Mental Health, Article 33 para 3.

73 Law on Mental Health, Article 34, para 3.

74 Law on Mental Health, Article 37 para 3.

75 Law on Mental Health, Article 37 para 3.

76 For example, the ECtHR declared that one of the cornerstones of protection afforded by the ECHR “is that a detainee must have the right to actively to seek judicial review of his detention.” (*Rakevich v. Russia*, application no. 58973/00, judgment of 28 October 2003, para 43. Also the CPT strongly recommends that the involuntary hospitalised patients should independently “be able to request at reasonable intervals that the necessity for placement be considered by a judicial authority”, the 8th CPT General Report, para 56.

3.4. Involuntary detention: practice

This section outlines the areas of concern flowing from the implementation of Croatian mental health law based on MDAC and SHINE’s monitoring of psychiatric hospitals throughout the country. Further research in this area would require consideration of the following: how many people actually get discharged from hospitals by the court, the results of court hearings, attendance and participation of patients at hearings, qualitative review of judge hospital visits, number of attorneys that oppose the proceedings, numbers of state and private attorneys engaged, statistics on lost and won appeals.

a) Inadequate record keeping in medical files

Hospital staff are required to record the reasons for involuntary admission in a patient’s medical records.⁷⁷ Monitors saw such records and reasons which typically stated only conclusions. For example, records contained conclusions such as “the patient is a danger to themselves” without providing (as the law requires) adequate reasoning about how and why this conclusion was reached.⁷⁸ Even accepting the inexact nature of such assessments, the monitoring team did not find any evidence to suggest that any adequate or internationally-recognised risk assessments were systematically carried out prior to admission.

More specifically – but still representative of the files seen across all the hospitals visited – monitors inspected a file of a patient who had had their status switched from voluntary to involuntary after the withdrawal of their consent. The reasons given for this were that he was not aware of his mental state, and that he was suicidal. No information was provided about: how, why, when, or for how long the patient had been demonstrating suicidal thoughts or behaviour, the nature of such thoughts, behaviour or any risk assessment of suicide, or how these circumstances met the legal criteria for involuntary admission. The consequences of failing to comprehensively document procedure are not merely clinical; if the reasons for medical conclusions that result in the detention are not elaborated upon, then there is little information from which the patient or their attorney can base an appeal of that detention.

b) “Independent” experts from the same hospital

The law states that the psychiatrist who assesses a patient’s fitness to be interviewed by the judge ruling on his/her detention must be from the court’s register of experts, and should be independent of the hospital administration. This is an important measure because it acts as a check on the legitimacy of the admissions procedure. Croatian law will tolerate an employee of the detaining hospital undertaking this role only in exceptional circumstances, where time does not permit the involvement of an independent expert.⁷⁹ In practice, the employee is usually a psychiatrist who does not routinely work in the same ward as the patient in question. However, monitors found that this exception is used so frequently as to constitute

77 Law on Mental Health, Article 26.

78 See *Gajcsi v Hungary*, op cit.

79 Law on Mental Health, Article 31 para 2.

general practice, rendering the safeguard cosmetic. The lack of qualified psychiatrists available in Croatia generally, coupled with the often remote locations of hospitals, may mean that it is challenging to find an independent expert (on short notice) to visit a hospital and conduct an assessment within the timeframe set out in law.

c) Inadequate legal representation

The monitoring team identified several shortcomings relating to the availability and adequacy of legal representation. Contrary to the law, some patients were either not assigned attorneys, or were not informed when one had been assigned to them. One patient described how two people came to see him. He said that they could have been the judge and his attorney, but because no one introduced themselves or explained anything to him either before or during the meeting, he could not be sure.

Many patients complained to MDAC and SHINE that they knew an attorney had been appointed to them, but they had had no opportunity to meet them before the court hearing. Other patients reported that they had met their attorney but complained about the brevity of the meeting. By way of justifying this, staff at **Ugljan** commented that “some patients do have cell phones and can call who they want.” When monitors asked whether staff actually help patients to contact attorneys, the deputy director responded that, “no, we [the staff] are the patients’ advocates”.

d) Judges and attorneys fail to identify themselves

Patients also complained that they were not given an opportunity to meet with the judge assessing their case, either in the hospital or a courtroom. Those patients that we spoke to who thought they may have met the judge were often uncertain about his/her identity. They were also unaware of the purpose of the meeting, as this information had not been provided to them. Staff at **Popovača** were candid about the problem, explaining that a court hearing really means a visit by a judge. There was no expectation for there to be any interaction, or any meaningful interaction, between the patient and the judge. This is a serious concern, especially given that the interview with the judge may be the only opportunity for the detained person to access justice and speak out about why they want to leave the hospital.⁸⁰

e) Failure to inform patients of their rights

In all four hospitals visited, the monitoring team met with patients who were unaware that they had rights, and unaware that they were entitled to ask for information about their rights. This meant that they did not know that they were entitled to know: the reasons for their detention, their right to contest and appeal their detention and forced treatment, and their right to be represented by an attorney. Many of the medical files monitors examined did not contain any evidence that staff had told the patient about the reasons for

⁸⁰ Such patients by necessity must wish to leave hospital: if a person wants to be in the hospital they would be a ‘voluntary’ patient.

continued detention, contrary to what Article 5(2) of the European Convention on Human Rights requires. In **Ugljan**, staff asserted that patients knew that they may appeal their detention, but that they were either “*too mentally ill to understand this or did not want to*”.

The stigmatisation of patients with psycho-social disabilities may be one reason why hospitals are routinely failing to inform patients of their rights. The relevant supporting legislation does not help to alleviate such attitudes. For instance, Croatian law states that rights information need not be given to the patient directly, but can instead be given to a third party such as a guardian or relative.⁸¹ This provision may easily lead to patients being denied opportunities to receive information about their legal position and exercise rights on their own behalf, instruct others to do so, or seek support in doing so. The law assumes that such third parties would accurately convey this information in a responsible and timely manner; the law also implies that there is no expectation that a patient needs to be directly involved in the process of exercising their rights – it is something which can or should be done for them if a third party deems it necessary. This may go some way in explaining one of MDAC and SHINE’s most serious concerns stemming from the monitoring of psychiatric hospitals (and also social care institutions): staff’s uncertainty about patient’s rights. Staff in all four monitored hospitals were vocal in their desire to receive government guidance on human rights.

3.5. Voluntary admission: law

The previous sections dealt with coercion in psychiatry, and the status of people who are detained against their will on an ‘involuntary’ basis. However, people can of course choose to seek and receive mental health services on a voluntarily basis. Given the fact that community mental health services in Croatia are under-developed and mental health services continue to rely on large residential institutional settings, one would expect to see many voluntary patients in such settings.

Croatian law defines the decision to voluntarily consent to treatment as “freely given permission” which is “based on an adequate knowledge of the purpose, nature, consequences, advantages and risks of this medical treatment and alternative possibilities of therapy”.⁸² Croatian legislation does not require consent to be provided in written form at any stage of the hospital admission procedure; it is sufficient that a doctor makes an entry in the patient’s medical records, stating that the patient has given verbal consent.⁸³ This is a concerning development because permitting voluntary admission on verbal consent alone clearly increases the risk of coercion, abuse, or the misunderstanding or misinterpretation of potential patients’ wishes.

Prior to its amendment in 1999,⁸⁴ Croatian mental health law contained rigorous safeguards to ensure that a person had both the capacity and intention to give consent to hospitalisation:

81 Law on Mental Health, Article 11 para 1 and 3.

82 Law on Mental Health, Article 3 para 12.

83 Law on Mental Health, Article 21.

84 Law on Mental Health (Official gazette 111/97, 27/98, 128/99, 79/02).

1. The potential patient had to provide written consent to admission in the presence of the head of the admissions department or a psychiatrist specifically authorised by the head of the department, as well as in the presence of the psychiatrist on duty.
2. These professionals were obliged to assess the person's competence to freely give their consent and to make a note of this in the person's medical records.⁸⁵
3. If written consent could not be obtained or the person was not able to give written consent, the hospital was under a duty to inform the court.
4. The court was then required to follow the same legal procedure as that required for an 'involuntary' patient.

These amendments to the Law on Mental Health were introduced as a direct result of pressure from psychiatrists and judges who felt overburdened by having to follow the former, more stringent procedure.⁸⁶ The removal of the procedural protections was made without any regard to patients' rights and has already been the subject of international criticism, with which MDAC and SHINE concur.⁸⁷

3.6. Voluntary admission: practice

a) Coercion into giving 'voluntary' consent

It appears that the new law has not changed practice completely, with all four psychiatric hospitals visited continuing to ask voluntary patients to sign a consent form to admission. Psychiatrists at **Ugljan** and **Rab** say that they maintain the practice of completing evaluation forms assessing the patient's competence to give consent.⁸⁸ Despite exercising these safeguards, monitors found reason to believe that coercion into giving 'voluntary' consent to admission is a widespread problem in Croatian psychiatric hospitals.

From discussions with medical staff, it became apparent that little effort is taken to inform patients about their rights when they are consenting to admission or continued hospitalisation. Also, there was little effort to actively reduce the quantity, and qualitative nature, of compulsion taking place. Moreover, 'voluntary' patients in several hospitals repeatedly told us that they were forced, or felt undue pressure, into signing paperwork on admission. One patient in **Jankomir** reported that medical staff in the ambulance on the way to the psychiatric hospital told her that she had to sign the consent form or they would "*involve the*

85 Law on Mental Health, Article 21 para 1.

86 See Jukić, Goreta, Kozumplik, Herceg & Majdančić, "Implementation of First Croatian Law on Protection of Persons with Mental Disorders", *Collegium Antropologicum* 29 (2005) 2, at 547; See also Turković, Dika, Goreta & Ćurđević, *Zakon o zaštiti osoba s duševnim smetnjama Komentar s priložima*, Zagreb, 2001.

87 See, for example, CPT 2003 Report, para 152, available at <http://www.cpt.coe.int/documents/hrv/2007-15-inf-eng.htm>

88 In Ugljan hospital 'voluntary' patients are required to sign a consent form reading, 'After I was informed of my rights and obligations in relation to hospital psychiatric treatment and other medical treatment (according to the Law on the Protection of Persons with Mental Disorders), I give my free consent for these treatments in Ugljan Psychiatric Hospital'.

police". Another woman in **Popovača** said that she signed papers because she was confused and felt pressure from relatives to do what they wanted. Patients in both **Rab** and **Ugljan** told monitors that they signed consent papers only because they "didn't want any trouble" and that if they protested they would be "forced to go anyway".

Concern was heightened by staff at **Ugljan**, who commented that a large proportion of patients who were initially resistant to being taken to hospitals subsequently "calm down" and accept admission and monitors had reason to believe that a substantial number of patients were incorrectly identified as 'voluntary', and should therefore not properly be considered as such. In **Popovača**, staff told the monitoring team that involuntary patients were admitted only "sometimes", and management at both **Ugljan** and **Jankomir** said that only two to three percent of patients were classed as 'involuntary'. The **Jankomir** director elaborated that the figure had been about 19% before the change of law which increased the time from 12 to 72 hours after admission before involuntary proceedings must have been initiated. This tends to support the contention made by **Ugljan** doctors that patients can be "convinced" to accept admission within these 72 hours and subsequently be classed as 'voluntary'.

Notwithstanding the abuse of power inherent in coercing an individual into psychiatric treatment, there are practical consequences to this regime. The monitoring team gained an impression from patients that they did not understand the nature of their 'voluntary' status. Many patients seemed to interpret it as a voluntary "contract" to sign away or transfer decision-making about their treatment to the hospital, which was then no longer obliged to disclose full information about the treatment administered. For some patients, being a 'voluntary' patient simply meant to them that they had agreed to obey the House Rules. This casts considerable doubt upon the validity of patient's consent to their continued stay or treatment in hospital, and suggests that they are, in reality, deprived of their liberty and should therefore be classed as 'involuntary' patients.

Moreover, efforts to secure consent before the 72 hour time limit means that 'voluntary' patients are denied access to the rights protections extended to 'involuntary' patients – such as judicial review of detention – both during the initial 72 hours and throughout their stay. This gains added significance if, as described above, patients are under the impression that they have given up their rights by signing a consent form. Given that almost all patients in the hospitals visited are classed as 'voluntary', MDAC and SHINE are concerned to see such a low use of formal powers of involuntary admission. The low statistics hide a considerable number of people who are de facto detained, yet whose detention is not recognised as such in contradiction to international law.⁸⁹

In part, the monitoring team's conclusion that coercion was taking place was influenced by the observation that staff preferred to deal with patients who were classed as 'voluntary'. Persuading or putting pressure on a person to give consent, assuming such consent, or even pretending it has occurred, is quicker, simpler, and more administratively convenient than initiating the process to classify a patient as involuntary.⁹⁰

89 HL v the United Kingdom, Application no.45508/99, judgment of 4 October 2004.

90 See for example Jukić, Goreta, Kozumplik, Herceg & Majdančić, "Implementation of First Croatian Law on Protection of Persons with Mental Disorders", *Collegium Antropologicum* 29 (2005) 2, at 547.

This approach creates a culture of disrespect for patients' human rights, and fosters environments where subsequent rights violations can more easily take place.

For many people in psychiatric hospitals who are also under guardianship (see chapter 4), the notion of 'voluntary' status is an absurdity. A person under guardianship can be sent on a 'voluntary' basis to a psychiatric hospital by their guardian, regardless of their ability to make that decision themselves. Moreover, the guardian can override any explicit refusal or objection by that person. The verbal consent of the guardian – who in some cases may also be a member of hospital staff – is all that is required to detain that person. Clinical need is neither a prerequisite for admission nor a basis from which the hospitalisation can be challenged (and even if it was, people under guardianship are denied the right to act in legal matters and therefore do not have recourse to a court).

The monitors found several people in this situation in the hospitals visited. For example, in **Ugljan**, 81 patients were under guardianship (74 under total guardianship), meaning that they are indeterminately detained in the hospital on the decision of their guardian only. This situation was dealt with in the ECtHR judgment of *Shtukaturov v. Russia* in 2008,⁹¹ in which the Court found it unlawful under the European Convention on Human Rights for a guardian to give proxy consent to psychiatric detention. If people under guardianship were classed as 'involuntary' patients and they did not want to be in the hospital, at least they could benefit from the modest safeguards of a court review of their admission and the verification of their condition by a medical expert.

b) De facto detention of 'voluntary' patients

The common sense, as well as legal meaning of 'voluntary', both implies and requires that patients be able to move reasonably freely throughout a hospital during their stay, and can leave the hospital whenever they like. Anomalies in the discharge procedures observed in the hospitals visited further supports the contention that a substantial number of patients classed as 'voluntary' are in fact being detained and forced to receive psychiatric treatment.

In all of the hospitals monitored, the monitoring team found 'voluntary' patients (including some also under guardianship) who had been placed in locked units where their freedom of movement was restricted. At **Jankomir**, 'voluntary' patients are held in locked units as a matter of course for the first seven days after their admission, and 'voluntary' patients were observed in closed units at both **Rab** (chronic ward 5) and **Ugljan** (acute male wards 9 and 11).

When questioned, staff did not view as problematic the contradiction of keeping 'voluntary' patients behind locked doors. The most common justifications given by staff were that such measures were taken in the patients' best interests, or for the convenience of staff. Other reasons included preventing self harm. When questioned by MDAC, a staff member at **Ugljan** said that this was "the way it had to be".

91 *Shtukaturov v. Russia*, Application no. 44009/05, judgment of 27 March 2008.

'Voluntary' patients are prevented from leaving the hospital when they want. In Croatian law, if a 'voluntary' patient decides to discharge himself and a psychiatrist thinks that the patient meets the statutory criteria for compulsory detention, the hospital may detain that person for 12 hours from the withdrawal of consent.⁹² However, monitors were told by the hospital director, a psychiatrist and a social worker in **Jankomir** that *"if a voluntary patient wants to leave against the advice of the doctor, s/he is forcefully kept, and staff wait 72 hours in accordance with the law, to inform the court."* A similar account was heard at **Rab**.

This practice is unlawful. The misapplication of the law by mental health professionals may arise from the assumption that there should be a period of time to allow a psychiatrist to make a mental health assessment, and that this time is of the same duration (72 hours) as when a patient is initially admitted.⁹³ However, the above example serves to illustrate the extent to which many professionals are unaware of the legal provisions that regulate their work. Mental health professionals are working in ad hoc environments where they do not appreciate the legal basis for, and human rights implications of, their actions.

To illustrate further, in some of the institutions monitored, although discharge of 'voluntary' patients must be approved by a psychiatrist, it is only granted in cases where the patient is not in a psychotic state and where they have somewhere to go. Some patients contradicted these quasi-legal criteria, asserting that even when these conditions are met, psychiatrists would not necessarily allow patients to leave.

One young adult 'voluntary' patient in the **Ugljan** unit for social psychiatry and rehabilitation told monitors that when he informed his doctor that his mother would be coming to collect him, the doctor replied, *"it's not your mother who decides when you go home, but me."* A neuro-psychiatrist, also at **Ugljan**, told the monitoring team that only she decides on allowing 'voluntary' patients to leave, adding as a caveat that in some cases she may consult other doctors and nurses to get their opinions. A psychiatrist on **Rab** went so far as to state that if a 'voluntary' patient wants to go home, *"we will discharge him but at the same time we will make contact with the family to advise them that he should be readmitted, even against the patient's will."*

Alarming, the monitoring team was told that if a 'voluntary' patient at **Ugljan** withdraws consent, a psychiatrist will evaluate the person's mental state to see if the refusal is *"genuine"* – the implication being that refusals can be deemed incompetent and therefore ignored.

In effect, hospitals are operating without recourse to either Croatian law or international human rights law. As a result, people are being detained unlawfully as 'voluntary' patients, or being re-classed as 'involuntary' patients in order to continue their detention. Therefore, despite the existing legal safeguards, it is clear that once a patient is admitted to a hospital, it becomes increasingly difficult for them to leave.

92 Law on Mental Health, Article 28 para 1 and 2.

93 Law on Mental Health, Article 25 para 1.

c) Lack of community support services

The stigma attached to mental illness, coupled with the discrimination faced by people with this label, means that it is not uncommon for involuntary hospitalisations to be motivated by reasons other than those mandated by law. In every hospital visited, staff told MDAC and SHINE about families who were not able or willing to care for a relative with psycho-social disabilities, and therefore asked their local doctor to admit them to or prolong their stay at a psychiatric hospital. As a consequence of listing to many similar reports, the monitors concluded that the medical system often gives in to these requests.

One employee at **Ugljan** said he had seen the same patients return to the hospital *“fifty to seventy times when there was no clinical need.”* Some staff also claimed that the police are complicit in using psychiatric hospitals as a substitute for social support programmes – routinely transporting people with psycho-social disabilities from a family setting to a psychiatric hospital when community support services would have prevented a hospitalisation. Doctors at **Jankomir** provided an example where a parent called the police to take away their son because he was behaving in *“a psychotic manner”*. Reportedly, police found the young man in a park with friends and despite the fact that he was not displaying any unusual behaviour; they detained him and took him to **Jankomir**. He was admitted as an involuntarily patient.

As has been analysed in the 2010 Human Rights Watch report⁹⁴, Croatia lacks a system of community support services, and MDAC and SHINE do not consider it necessary to repeat their arguments and analysis here. The lack of services contributes to the phenomena of individuals remaining in hospital for extraordinarily prolonged periods of time. When a hospital is unable to discharge a patient into the care of relatives or a social care institution (for which there are long waiting lists), it is common for the patient to remain in the psychiatric hospital even though they no longer require clinical care. The monitoring team interviewed a man with intellectual disabilities and a mental health condition who complained that he had been living at **Rab** hospital for over twenty years. One doctor at **Ugljan** told monitors that, *“there were probably 50-60 people [out of 418 patients] who needed institutional care due to the level of their disorder, and a greater number remain in the hospital simply because they have nowhere else to go”*. Also both at **Ugljan** and **Popovača** the monitoring team was told that there were citizens of other ex-Yugoslav countries in their care, who had nowhere to return after the War, and therefore will most likely remain in the system for the rest of their lives. Even at their best, psychiatric hospitals are settings in which rights are systematically suspended. Persons displaying symptoms of mental illness should not be arbitrarily removed from society and condemned to accept a hospital as their home simply because there are no apparent alternatives. It is therefore essential that community based alternatives to hospitalisation are developed and embedded in Croatian health and social care systems. Only through this process will services respond effectively, will hospitals operate within their mandate, and will the exercise of provisions governing detention for psychiatric reasons meet the expectations of international human rights law.

94 *“Once you Enter you Never Leave: Deinstitutionalisation of Persons with Intellectual or Mental Disabilities in Croatia”*, Human Rights Watch, September 2010. Available at <http://www.hrw.org/en/reports/2010/09/23/once-you-enter-you-never-leave-0> (last accessed 22 July 2011).

Recommendations

1. **The government** should ensure that law or regulation specifies that doctors and nurses have a duty to record in the medical records of patients the decisions and adequate reasons for the conclusions they draw with regard to the legal aspects of a resident/patient's admission, care, treatment and discharge;
2. Remove from legislation the provision allowing for psychiatrists from the detaining hospital to provide an "independent" opinion of a patient;
3. Adopt national patients' rights information, and ensure that these are widely available and handed to each patient – whether detained in law or not. The information should specify a body which patients can contact (address, telephone number) if they think their human rights have been breached;
4. Amend the law permitting verbal consent to hospitalisation to its pre 1999 provisions, i.e. permitting consent to admission in writing only;
5. Amend the law to correct the possibility of a guardian placing a person under their guardianship into a psychiatric hospital, even if the person under guardianship is actively refusing;
6. Create community-based alternatives to hospitals and in doing so take steps to ensure that people without any clinical need do not end up in hospital; and
7. Amend the law to allow psychiatric patients to instigate a judicial review of their detention at any time, not just at six-monthly intervals.
8. **The Ministry of Justice** should ensure that the basic guarantees of a fair hearing are put in place for people with intellectual and/or psychosocial disabilities; and
9. Judges should receive training on the Convention on the Rights of Persons with Disabilities as well as how to ensure the effective participation of people with disabilities in their courtrooms so as to secure their equal access to justice.
10. **The Croatian Bar Association** should provide accredited training to attorneys on mental health review tribunals, and make this qualification a pre-requisite for attorneys to represent people in these hearings; and
11. Instigate disciplinary proceedings against attorneys who fall below the basic standards of lawyering required by international human rights law.
12. **The People's and Disability Ombudsperson's offices** should seek out complaints from legally un-represented or under-represented patients and take these cases to court, seeking damages; and
13. Proactively monitor institutions to clamp down on cases of arbitrary detention and to ameliorate the circumstances that can result in patients being coerced into signing or verbally agreeing to be a "voluntary" patient.

14. **Psychiatric hospitals and social care institutions** must ensure staff know the legal requirements for admission and ensure that these are followed. A culture should be developed whereby staff inform their superiors as well as the Ombudsman when legal requirements are not met
15. Ensure that each patient is told verbally about their rights and what to do if their rights have been violated, and provide this also in a leaflet in a language and format which the patient can understand;
16. Ensure that “voluntary” patients are not placed in locked wards;
17. Ensure that if a “voluntary” patient wishes to leave against medical advice, that the twelve hour time limit (from the time of the withdrawal of consent) a doctor has in order to reach a decision about detaining that person through use of the involuntary detention criteria is not breached; and
18. Stop admitting people where there is no clinical need and take steps to ensure that psychiatry is not used for social control.

4. Legal capacity and institutionalisation

This chapter sets out how Croatia's system of legal capacity conspires to deprive people of their liberty, segregate them from society, and remove their rights. According to the Disability Ombudspersons Office there are over sixteen thousand people with disabilities who are deprived of their legal capacity in Croatia. However, there remains a lack of statistics available on how many residents of social care institutions are under guardianship. Monitors found that in some of the social care institutions visited for the purposes of this report, nearly all residents were under some form of guardianship.⁹⁵

4.1. Guardianship law

a) The current system

Guardianship is a system whereby a person deemed to be 'incompetent' or 'incapable' of making decisions about their lives is appointed a substitute decision maker – a guardian – to act on their behalf. In Croatia, it is a local government department called the Centre for Social Care (CSC) that makes this determination following the written recommendation of a psychiatrist.⁹⁶ Once granted, guardianship is usually a life-long status, although provisions do exist for a temporary arrangement lasting two to three years. Croatian law provides the option for a person to choose who becomes their guardian⁹⁷; in practice, however, proceedings are usually initiated by a family member, institution director or the CSC itself. A review of an individual's guardianship status should be initiated by the CSC every three years, and must include a doctor's opinion on the health status of the person relevant to the reasons for the deprivation of their legal capacity.⁹⁸

Given that as many of the residents of adult institutions for people with intellectual and/or psycho-social disabilities are deprived of legal capacity, the guardianship system has a profound impact on the institutionalisation of people with disabilities. The system is intended to protect the interests of the person under guardianship, and the guardian is obliged to respect the wishes of the person and consult them when making the decisions that influence their lives. However, the removal of legal capacity automatically deprives individuals of fundamental human rights, including but not limited to: the right to work, to marry, to bring-up children, to control one's own money and property, and to make independent decisions about where and with whom they want to live. People under guardianship are also prohibited from voting⁹⁹, exacerbating the political invisibility of people with disabilities. As the director of **Vojnić** succinctly said, "a guardian's rights are greater than their obligations".

95 Please see the table in chapter 1 for numbers of residents under guardianship in the social care institutions visited.

96 Statistics available at <http://www.posi.hr/>. Last accessed 30 September 2011.

97 The Family Act, Official Gazette No. 116/03, 17/04, 136/04, 107/07, and 57/11 Art 174 (5).

98 The Family Act, Official Gazette No. 116/03, 17/04, 136/04, 107/07, and 57/11 Art 165.

99 The Act on the Election of Members of the Croatian Parliament – revised text, Official Gazette No. 69/03 Art 4

According to an ECHR case, guardianship is available in Croatia on the basis that the adult “is not able to care for his or her own needs, rights and interests, or who presents a risk for the rights and interests of others”.¹⁰⁰ The Croatian guardianship system conflicts with Article 12 of the UN Convention on the Rights of Persons with Disabilities (CRPD) because it fails to acknowledge that persons with disabilities “have a right to recognition everywhere as persons before the law” (i.e. the capacity to be holders of rights) as well as the right to exercise these rights. The CRPD is premised upon the idea of participation and inclusion, and even the Preamble sets out that “persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them”.¹⁰¹ Article 12 is a cross cutting provision of the CRPD and is the precursor to the enjoyment of all other rights set forth in the Convention. The Article makes clear that persons with disabilities “enjoy legal capacity on an equal basis with others in all aspects of life” (i.e. the capacity to exercise rights and duties by way of their own conduct as holders of rights).¹⁰²

Further, the Convention requires that people who may need support in exercising their rights should have access to such supports.¹⁰³ Croatian legislation fails in this respect, as the law does not currently contain alternatives to guardianship. For as long as this remains the case, there is no opportunity for persons with disabilities to enjoy their rights on an equal basis with others, including the right to live independently and be included in the community – the key concern of this report.¹⁰⁴ Specific studies are available on the shortcomings of guardianship systems in general and its relationship to the institutionalisation of persons with disabilities.¹⁰⁵ The implementation of guardianship in Croatia has also been criticised previously.¹⁰⁶ However, the need to reform the guardianship system has specifically been identified by both the EU and the Croatian government as a priority issue in anticipation of Croatian accession to the EU.¹⁰⁷ The monitoring findings, as outlined in this chapter, serve to highlight the detrimental impact of the guardianship system in Croatian social care institutions on the human rights of people subject to it.¹⁰⁸

100 Section 159 of the Family Act (Obiteljski zakon, Official Gazette nos. 116/2003, 17/2004, 136/2004 and 107/2007), cited in European Court of Human Rights judgment of *Krušković v. Croatia*, judgment 21 June 2011, Application No. 46185/08, para. 13.

101 CRPD, Preamble para (o).

102 OHCHR (26 January 2009). Thematic Study on ‘Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities, paragraph 7. Available at <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> (last accessed 28 August 2011).

103 CRPD, Article 12(3).

104 CRPD, Article 19.

105 See for example, reports by the Mental Disability Advocacy Centre on guardianship and human rights in Bulgaria, the Czech Republic, Hungary, Kyrgyzstan, Russia and Serbia available at www.mdac.info

106 See for example “Once you Enter you Never Leave: Deinstitutionalisation of Persons with Intellectual or Mental Disabilities in Croatia”, Human Rights Watch, September 2010. Available at <http://www.hrw.org/en/reports/2010/09/23/once-you-enter-you-never-leave-0> (last accessed 22 July 2011).

107 See the Joint Memorandum on Social Inclusion of the Republic of Croatia, 5 March 2007, §4.2.4.2 (in the Memorandum, guardianship is referred to as “custodianship”); available at http://ec.europa.eu/employment_social/social_inclusion/docs/2007/JIM-croatia_en.pdf (last accessed 22 July 2011).

108 Article 165 of the Family Act.

b) Guardianship feeds institutionalisation

As outlined above, admission into social care institutions is governed by the Law on Social Care,¹⁰⁹ and decisions about placement is taken by a local government department called the Centre for Social Care (CSC)¹¹⁰ following the request from the individual who would like to go into an institution, or from a guardian.¹¹¹ If the application is approved, the CSC makes inquiries with individual institutions regarding the availability of a bed (for which monitors were told there is a long waiting list). Alternatively, residents may be admitted to a social care institution following treatment in a psychiatric hospital. Unlike the process for admission into a psychiatric hospital, the decision of the CSC to place a person in a social care institution is an administrative, not legal, procedure. Social care institutions are outside the purview of mental health laws and consequently, residents cannot access the safeguards provided for by those laws. For example, there is no mechanism whereby an individual can request a review of the placement decision, and if they want to leave, there is no court to who they can turn.

Therefore, residents of social care institutions fall into two groups: those who seek accommodation in them based on their own free will (e.g. people who have no relatives or insufficient resources to take care of themselves), and those who have been deprived of their legal capacity and reside in social care institution upon the decision and request of their guardian. It is this latter category of residents which were predominantly encountered during MDAC's 2010 monitoring visits.

c) Autonomy and supports

MDAC's main critique of the Croatian guardianship system is that, similar to systems elsewhere, it is based on a false premise. The false premise is that people can be divided into two groups: those who are capable and those who are incapable. This is clearly a fiction, as decision-making is both time and transaction specific. Everyone needs assistance at some time in their lives: we may be voluntarily or involuntarily intoxicated, knocked over by a car and unconscious, we may be in a mental health crisis. Support is also dependent on the transaction to be made: for example, a person may feel that they have enough understanding and information to make an autonomous choice about having a filling put in a tooth, but not about cardiac surgery. A person may feel entirely comfortable in making decisions about how to spend their monthly salary but not know how to invest a fortune won through the lottery.

In September 2009 Thomas Hammarberg, the Council of Europe Commissioner for Human Rights, commented on this issue, saying that a person's disabilities and the resulting problems about representing oneself to authorities "is no justification for a policy to routinely incapacitate people with mental disabilities and put them under legal guardianship where they have no say in important decisions affecting their

109 Law on Social Care (Official gazette 73/97, 27/01, 59/01, 82/01, 103/03, 44/06 and 79/07).

110 Law on Social Care, Article 75(1).

111 Law on Social Care, Article 76.

lives”.¹¹²

To move away from incapacitation and towards autonomy and independence, it is necessary for law to ensure, as the CRPD requires, that people with disabilities get the supports they may need in order to make any decision that may confront them. A system which only consists of total guardianship and nothing else can never achieve this objective.

Supported decision-making includes a range of ways to help an individual make decisions, and to ensure that third parties – like doctors, lawyers, bankers, service providers, or community workers – respect those decisions. It enables all people to maintain their full legal capacity. Article 12 of the CRPD recognises that all persons, regardless of disability, have a right to express themselves and make their own decisions, known as *autonomous decision-making*. It also recognises that people have the right to supports in order to exercise their legal capacity,¹¹³ known as *supported decision-making*. Therefore, people who need support to make decisions should get such support without their legal capacity being removed.

Supported decision-making enables people to make decisions with the help of the people who they are closest to and whom they trust: family, friends, and colleagues. In general, this is the way that people make decisions: they rely on the knowledge and expertise of the people around them because it is impossible to have all the skills and information necessary to make every kind of potential decision in life. For example, in buying a car, a person may consult a number of people for various reasons: a salesman about availability, a mechanic about the engineering, friends about their preferred make and model, partner and family about the size and colour, and bank manager about whether they can afford it.

Sometimes a person may not follow any of this advice, or may take advice from unreliable or unqualified people, and this may result in making a mistake. However, it is their prerogative to do so. The dignity of risk is part of what it means to be a human being; making a mistake is an inherent risk of decision-making and is not a foundation on which a person should be denied the capacity to exercise their rights. The law should not overly-protect a person with disabilities from making mistakes, when it does not protect people without disabilities from making mistakes. Supported decision-making simply brings this natural way of making decisions into law. As the Commissioner for Human Rights of the Council of Europe has said, independence and autonomy are “not about being able to do everything on your own, but about having control of your life and the possibility to make decisions and have them respected by others”.¹¹⁴

Principles to guide law reform to introduce supported decision-making include:

1. **Legal capacity remaining intact** - Supported decision-making is different from depriving or limiting a person of legal capacity. A supported person retains full legal capacity, and technically can make all decisions independently.

112 Thomas Hammarberg, “Viewpoint: A neglected human rights crisis: persons with intellectual disabilities are still stigmatised and excluded”, 14 September 2009.

113 CRPD, Article 12(3).

114 Thomas Hammarberg, “Viewpoint: A neglected human rights crisis: persons with intellectual disabilities are still stigmatised and excluded”, 14 September 2009, para. 5.1.

2. **Free agreement** - Supported decision-making must be based on the free agreement of the supported person and the supporter(s).
3. **Relationship of trust** - Supported decision-making must build on relationships of trust between the supported person and the supporter(s).
4. **Voluntariness** - Supported decision-making must be based on a voluntary relationship between the supported person and the supporter(s).
5. **Unpaid support** - Support should be independent of service delivery; it usually comes from friends, family, non-governmental organisations, or community groups.
6. **The supported person makes the decision** - The support person assists the supported person in an interdependent way but does not take over the decision-making. The role of the supporter(s) is to facilitate and assist the supported person to understand choices, to make a decision, and to communicate the decision to others.
7. **Safeguards** – Like guardianship systems, exploitation and abuse can take place in supported decision-making systems too. For example, the support person could withhold relevant information or make the decision for the supported person. Regulations must contain effective safeguards to prevent and remedy exploitation, violence, and abuse. Adult protection systems need to be introduced.

In January 2009, the Parliamentary Assembly of the Council of Europe (PACE) invited member states to “guarantee that people with disabilities retain and exercise legal capacity on an equal basis with other members of society”,¹¹⁵ by ensuring that their “right to make decisions is not limited or substituted by others, that measures concerning them are individually tailored to their needs and that they may be supported in their decision making by a support person”.¹¹⁶

The PACE further recommended that member states comply with the CRPD and ensure that, “people placed under guardianship are not deprived of their fundamental rights (not least the rights to own property, to work, to a family life, to marry, to vote, to form and join associations, to bring legal proceedings and to draw up a will), and, where they need external assistance so as to exercise those rights, that they are afforded appropriate support, without their wishes or intentions being superseded”,¹¹⁷ and that there should be safeguards such as periodic review that fully involve the person concerned and which provide adequate legal representation.¹¹⁸

115 Resolution 1642 (2009) of the Parliamentary Assembly of the Council of Europe, 26 January 2009, “Access to rights for people with disabilities and their full and active participation in society”, para 7. Available at <http://assembly.coe.int/Main.asp?link=/Documents/AdoptedText/ta09/ERES1642.htm> (last accessed 22 July 2011).

116 Ibid, para 7.1.

117 Ibid, para. 7.2.

118 Ibid, para. 7.3.

4.2. Legal capacity – practice

This section outlines some of the ways in which the practice of guardianship impacts on the human rights of people with disabilities in Croatia, with reference to people in institutions and their right to live independently in the community.

a) Guardianship causes arbitrary detention

Guardianship is sometimes used by families to dispose of unwanted family members. Many of the residents monitors spoke to in institutions were unable to have their guardianship status revoked because their guardian – usually a family member – had refused. Consequently, these people have no other choice but to remain in the institution, as law provides no other mechanism for people to access justice systems directly.

The monitoring team spoke to a woman at **Mirkovec** who had been living in the institution for twenty years, and prior to that had spent ten years in **Lobor-grad**. She told the monitors that she had repeatedly expressed her desire to return to the house she owns and live with her family. Her son/guardian currently lives in her house with his wife and two sons, and has told his mother there is no room for her there. The woman considered her guardianship status unnecessary but also that her opinion was irrelevant because as she informed us, “the county [government] wanted it.” The monitor’s enquiries revealed that the only medication she appeared to be taking was for her blood pressure. The monitoring team also met a man who had been living in, and trying to leave, **Lobor-grad** for eighteen months. The institution’s social workers were aware that he wanted his legal capacity restored and all agreed that there was no need for him to be there. However, his mother/guardian would not agree to this because she feared he would return to their home town where the community perceived him as a troublemaker.

When legal capacity is removed and people are institutionalised, violence, exploitation, and abuse become more likely. In 2008, the then UN Special Rapporteur on Torture, Manfred Nowak, published a report focusing on people with disabilities.¹¹⁹ In this report, Nowak directly links legal capacity with the possibility of being subjected to torture, explaining that:

“Torture, as the most serious violation of the human right to personal integrity and dignity, presupposes a situation of powerlessness, whereby the victim is under the total control of another person. Persons with disabilities often find themselves in such situations, for instance when they are deprived of their liberty in prisons or other places, or when they are under the control of their caregivers or legal guardians. In a given context, the particular disability of an individual may render him or her more likely to be in a dependant situation and make him or her an easier target of abuse. However, it is often circumstances external to the individual that render them “powerless”, such as when one’s exercise of decision-making and legal capacity is taken away by discriminatory laws or practices and given to others.”¹²⁰

119 Manfred Nowak, “Interim Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment”, A/63/175, 28 July 2008. Available at <http://unispal.un.org/UNISPAL.NSF/0/707AC2611E22CE6B852574BB004F4C95> (last accessed 21 July 2011).

120 Ibid, para 50.

Nowak goes on to make the point that deprivation of legal capacity is one form of State acquiescence concerning violence against people with disabilities.¹²¹

b) Guardianship causes life-long institutionalisation

The monitoring team spoke to several residents in **Lobor-grad** who had been there for more than twenty years, and staff at all the social care institutions visited told us that they expected recently-arrived residents under guardianship to remain in the institution for the rest of their lives. The director of **Vojnić** called it a “*permanent stay*” and management at **Mirkovec** confirmed that beds only become available “*when someone dies*”. The typical length of stay for residents of **Osijek** is between ten to fifteen years, the longest so far being 43 years. Staff explained that the underlying intention of the social care system is for people to remain at the institution indefinitely. As a consequence, staff said that efforts to return people to community settings, restore a resident’s legal capacity, or develop individual’s skills for life outside an institution, were often in vain.

c) Guardianship does not prevent abuse

As a system, guardianship is intended to protect people from harm. But MDAC and SHINE’s findings suggest that the system lacks the safeguards necessary to achieving that goal. The “*lack of interest*” of guardians, as reported by institutional staff, was given as a reason why some people remained in institutions involuntarily. The monitoring team was told that several residents under guardianship have no contact with their guardians at all. The remote location of social care institutions was considered to be a common reason why guardians failed to meet their obligatory biannual visits¹²². Some institutions identified the indifference of guardians as a serious concern, especially when it came to consent to medical treatment. This is because persons under guardianship are not entitled in law to make any healthcare decisions – including treatment for somatic or mental health conditions – irrespective of their actual wishes.

d) Local government as a barrier to reform?

This section outlines the views of staff at the social care institutions visited who shared their opinions on why the guardianship system is failing residents in their facilities.¹²³ Management and staff at **Mirkovec**, **Lobor-grad**, and **Osijek** indicated to the monitors that inaction on the part of the CSC had led to a growing awareness of the staff’s own role in facilitating residents’ return to the community. The directors of these institutions told MDAC and SHINE that they believed guardianship was inappropriately applied in many cases because residents’ competencies and conditions did not warrant such a measure. It was encouraging to hear that some institutions had developed internal procedures to assist residents in having

121 Ibid, para 69.

122 The Family Act, Official Gazette No. 116/03, 17/04, 136/04, 107/07, and 57/11 Art 202 (1).

123 This report is based solely on observations and interviews with staff, residents and patients at the monitored institutions. Further research in this area would include seeking the opinions of Centers for Social Care.

their guardianship status revoked, should they show an interest in doing so. Staff at **Osijek** told monitors that they are proactive in informing residents that they can apply to have their guardianship status revoked, and assisted them by contacting the relevant CSC on their behalf. The most vocal advocates for this position were staff from **Lobor-grad**, who told monitors that they were “committed” to initiating the removal of guardianship if there was no need for it. However, it must be noted that neither institution provided the monitors with evidence to substantiate these claims. However, the **Lobor-grad** facility has initiated a programme of sheltered housing on their grounds, intended to offer a transition between institutional and community living and MDAC and SHINE commend the intention behind this initiative.

Staff at all the social care institutions expressed concern that the Centres for Social Care (CSCs) were struggling to cope with a workload which was too heavy, resulting in inadequate follow-up to a resident’s individual circumstances. Institution staff were clearly frustrated, and criticised the defensive attitude of the CSC. The most common complaints were that:

1. Institution visits from CSC staff are narrow in purpose and they “never considered any of the proposals or complaints” raised by staff;
2. CSCs are not responsive to residents’ requests, including wanting to revoke their guardianship status;
3. CSC “refusal” to verify improvements in resident’s medical conditions (when legal capacity is revoked on the basis of medical evidence, verification of a positive change in condition is a precursor to the reinstatement of legal capacity);
4. CSCs underutilise the legal provision to regularly review the guardianship status of persons under guardianship;
5. Prior to the three-yearly review, CSCs only rarely initiate procedures to revoke the guardianship status of residents who obviously do not require it;
6. CSCs are unwilling to cooperate with institutions either in terms of their duty to supervise guardians, or in relation to how they themselves function as guardians;
7. Where the CSC is the guardian, their social workers do the “bare minimum” in attending to the needs of the people under guardianship for whom they are responsible;
8. CSCs pay less attention to those persons under guardianship of the CSC who live in institutions compared with those who lived in the community. The reason for this is thought to be an assumption that the institution’s staff fulfil a quasi-guardian role;
9. CSCs prefer residents to be accommodated in institutions on a permanent basis and do not act on proposals for residents to be reintegrated into the community;
10. The CSCs’ refusal to recognise the right to live in the community is a barrier to initiating programmes that advocate for community living;
11. CSC staff are unapproachable and intimidating. Some institution staff told the monitors that they were afraid to criticise the CSC for fear of negative consequences for the institution.

e) Conflicts of interest

The monitoring team was aware from previous monitoring in Croatia during 2007, that it was a prevalent practice for institution staff to act as guardians of residents within the institutions where they worked. When the function of guardian is divested on directors or social workers of the institution where the resident lives, competing interests arise and it cannot be guaranteed that the resident's rights and interests will be protected above all other concerns and conflicts. On a positive note, it was observed that this practice appears to be in decline in some institutions. In particular, the directors of **Mirkovec** and **Lobor-grad** expressed disapproval of this procedure and both stated that they had opposed recommendations for their own appointment, or that of their staff, as guardians to residents in their institutions. Contrary to findings made in 2007, there were no longer any staff acting as guardians for residents in these particular institutions.

However, the monitors were gravely concerned about policy and practice at **Vojnic** institution, which initiates guardianship procedures for all new residents; revocation of legal capacity is a pre-requisite to continued residence at the institution. Staff members explained that *"decisions concerning residents are easier to take if we do not have to consult and seek consent from the residents themselves or their family"*, and that such measures were *"taken to better protect the resident"*. It is clear that guardianship is used for staff convenience, because then residents do not need to be asked about decisions affecting their lives. This clearly demonstrates the way in which guardianship is used to remove rights, rather than promote, protect, and fulfil them.

Recommendations

The authors of this report strongly recommend that the **Croatian government** do the following as a matter of immediate priority to comply with Article 12 of the CRPD:

1. Amend law to remove plenary guardianship from legislation;
2. Adopt alternatives to guardianship including supported decision-making, advance directives and enduring powers of attorney; and
3. Amend the law to remove the opportunity for guardians to admit someone into a psychiatric hospital or place them in to a social care institution against their will.
4. **Social care institutions and Centres for Social Care** should review each person under guardianship and instigate proceedings to restore the legal capacity of residents who do not want to be under guardianship.

5. Institutionalised lives

An institution is any place where persons “are isolated, segregated and/or congregated in which people do not have, or are not allowed to exercise control over their lives and day to day decisions”.¹²⁴ For many people with disabilities who live in psychiatric or social care institutions, the lifestyle that they experience is characterised by what sociologist Erving Goffman has called “total institutions”.¹²⁵ This notion covers buildings that are physically and socially segregated from the rest of society. The lives of people inside institutions are conducted almost entirely within the institution walls, and under the authority and control of the institution staff. People in such situations are dependent on the institution for all their basic needs and are not allowed to make autonomous choices about their daily life or future plans. Institutionalised living often means that residents are not at liberty to decide when they wake up or go to sleep, what or when they eat and drink, which room they live in or how to furnish it, who they live with and for how long, who they spend time with – when, where and how –, where they work, and how they spend their free time.

Furthermore, people in institutions are forced to go through the motions of a daily routine that is not only strictly imposed and repetitive, but also identical to the routine of all the other people living in the institution. The components of the routine are performed in groups and there is no individual treatment or choice available within the routine. Institutionalised living often means that residents are forced to sleep as a group, eat as a group, wash as a group, spend their day as a group and – to the extent that employment is possible in an institution – work as a group. Privacy is lost, and when undressing is a public act and intimate relationships are monitored by staff and observed by other residents, degradation and humiliation become an inevitable fact of life.

Removal of personhood is further characterised by the wearing of uniforms and the denial, or lack, of personal possessions. In short, life in institutions deprives people of the means to express their respective personalities or perceptions of social status. With choices stripped away in deference to the rules and efficient functioning of the institution, the power gap between staff and residents widens, and discipline increases. There is no room for individual autonomy within the system of the “total institution”, and behaviour diverging from the norm is punished.

For people experiencing short or long-term placement as a patient in a psychiatric hospital, or for those who are compelled to live in social care institutions as residents, the staff are often the only people from wider society with whom patients/residents have regular contact. The attitude and morale of staff, as well as their conduct, is therefore integral to both the physical and mental wellbeing of patients/residents. The working culture within an institution has a direct impact on the extent to which persons in institutions

124 Definition of an institution commonly used by disabled people’s organizations including Inclusion Europe and the Canadian Association for Community Living, <http://www.cacl.ca/english/index.asp>

125 Goffman, E., (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, Garden City, N.Y.: Doubleday, Anchor.

suffer violations of their rights. However, the very nature of a “total institution” implies that even the most well-meaning of employees is able to exercise a considerable amount of control and coercive influence over patients/residents.

Standards developed by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) require healthcare providers to review rules and practices capable of generating a climate of tension between staff and patients.¹²⁶ With respect to the attitude of doctors and nursing staff, the CPT encourages a genuine interest in establishing a therapeutic relationship with patients, and warns against neglect of “patients who might be considered as burdensome or lacking rehabilitative potential”.¹²⁷ Despite the varied nature of patient-staff relations across and within the psychiatric hospitals monitored, monitors observed that staff generally, in their behaviour towards patients, did not always give priority to a therapeutic focus, and they appeared to exercise considerable control over patients – especially those from closed units, where one patient told the monitoring team that they had been made to “feel powerless”.

Moreover, although institutional styles of living do not reflect a way of life that would be pursued or even deemed acceptable by larger society as a whole, it is usually justified by an overarching plan or rationalisation (prison for example). Thus in social care institutions, the rationale for long-term segregation is “care” and “rehabilitation”, even though few people make it back into the community. In (non-forensic) psychiatric institutions the rationale is “therapy”, even if it is imposed, or “cure”, even though psychiatric medications affect only symptoms. In the case of the institutionalisation of persons with disabilities, the justification is often premised on prejudice, misconception, protectionism, and stigma, resulting in the violation of a myriad of rights – including the right to live independently and be included in the community, the right to participate in public and political life (for example the right to vote), the right to participation in cultural life, recreation, leisure and sport, the right to freedom of expression and opinion, and access to information, respect for privacy, the home and the family, the right to health and the right to work.¹²⁸

By their very nature, institutional living arrangements reduce privacy, choice, and autonomy; they increase isolation and segregation, and they foster relationships of confinement, dependency, discipline, and powerlessness. This chapter provides examples of how this happens in psychiatric and social care institutions in Croatia, and highlights the inherent discrimination and dehumanization that results from removing people from the community, thereby compelling them to live in institutions and expecting them to regard it as their “home”.

126 See the 8th CPT General Report, para 31.

127 Ibid, para 41.

128 CRPD Articles 19, 29, 30, 21, 22, 23, 25 and 27 respectively.

5.1. Segregated

From a therapeutic and protective viewpoint, maintaining contact with others is essential. Therefore, visits, correspondence, and telephone access should be both available and accessible for patients.¹²⁹ The Law on Mental Health also grants patients the rights to: socialise with other persons in the institution, have visitors,¹³⁰ send and receive mail (at their own expense), and make phone calls without supervision or restriction.¹³¹

a) Geographic segregation

The remote geographical location of institutions is a significant barrier for patients/residents to maintain relationships with their family and friends. For example, **Popovača** and **Mirkovec** are both a one and a half hour drive into the countryside from Zagreb. It is almost impossible to reach **Popovača** using public transport, and it is a long walk from the nearest train station to **Mirkovec**. Located on islands off the Dalmatian coast, **Ugljan** and **Rab** are physically removed from the mainland society and access for visitors, which requires taking a ferry, is difficult and expensive. The monitoring team was told on numerous occasions, both by staff and patients that people in these hospitals were sent there “to be forgotten”.

Geographic distances have an impact on contact between patients/residents and their visitors. Of the 483 patients at **Ugljan** hospital, only ten per month receive family visitors, according to nurses. Transport availability and costs were also put forward as reasons why guardians fail to meet their visiting obligations. Moreover, there is no overnight accommodation available at the **Rab** hospital, and visiting times are only two hours per day, by prior appointment. Staff confirmed that unannounced visitors are turned away, a situation which significantly curtails the likelihood of people visiting. **Mirkovec** and **Lobor-grad** both hold annual “family days” and staff report that this initiative has helped to maintain relationships, and more residents now occasionally return home for short stays. For the majority of residents, an annual family day is the only time, if at all, that they receive a visitor.

Croatian legislation stipulates that admission of a person to a psychiatric hospital outside the region of their ordinary place of residence should be an exception.¹³² However, it appears that scant regard is taken of this provision. The monitoring team met people who had been admitted to hospitals and social care institutions located hundreds of kilometres from their home towns or most recent places of residence. This compounds the difficulties of maintaining social relationships, and staff across the social care institutions,

129 See, for example, the 8th CPT General Report, para 54.

130 See Law on Mental Health, Article 11 para 1 section 9.

131 See Law on Mental Health, Article 11 para 1 section 10.

132 C.f. Law on Mental Health, Article 12 para 1 mandates that the person shall be placed in psychiatric hospital in a place of his/her residence; if s/he doesn't have a residence, then a place of his/her habitual residence; if s/he doesn't have a habitual residence then in a place where s/he is found; and if there is no psychiatric hospital in this place, then in the psychiatric hospital which is nearest to the place of his/her residence/habitual residence/where patient was found. Also, under Article 12 para 2 of the Law on Mental Health, written consent of the person or person's guardian is required in order to place a person in a hospital which doesn't fulfil the above mentioned conditions.

particularly **Lobor-grad**, echoed the view of hospital staff in expressing that the lack of contact between residents and their family and friends greatly contributed to their beliefs that they had – or would soon be – forgotten about.

b) Censorship of communication

A person's segregation from society does not just stem from the physical isolation inherent to being in an institution. It is also a product of obstacles to broader communication with people who are not institutionalised. With visitors being rare for so many institutionalised people, communication with the outside world must be maintained through letters and phone calls (the monitors did not find any evidence of email use due to patients/residents not having access to the internet).

All patients and residents at the institutions monitored were permitted to use public-payphones (although at **Vojnić** there were only two to cater for 175 residents), and keep mobile phones (although this was only feasible for those who were working or had somebody to pay the bill). From conversations with patients, residents, and staff, monitors concluded that the financial cost of using the telephone meant that this was not actually an effective way of maintaining regular contact with the outside world.

MDAC and SHINE received several complaints of interference with incoming and outgoing mail at **Vojnić**, **Rab**, and **Popovača**. The **Vojnić** director's response was that the staff controlled parcels in order to inspect the contents for "alcohol, perishable food, or objects of potential danger". Staff at **Popovača** stated that they regularly check the incoming mail of patients under court restrictions in order to check for "abusive mail". One patient at **Rab** reported seeing staff members reading a letter written by a patient and heard the staff discuss whether to send it on to the addressee. Whether this was an isolated incident or a broader practice, it breaches the inviolability of the right to freedom and privacy of correspondence and communications guaranteed by Croatian, and international, laws.¹³³

Whereas maintaining existing relationships is hard, establishing new social contacts outside of the institutions is near impossible. These man-made communication barriers constitute significant hurdles for people in institutions, making it very difficult for the government to claim that it is ensuring that people with disabilities enjoy "[f]ull and effective participation and inclusion in society", a core Principle in the UN Convention on the Rights of Persons with Disabilities.¹³⁴

¹³³ According to the Law on Mental Health, Article 11, para 4, the right to send and receive mail, parcels and have visitors can only be limited if there is a reasonable doubt that the person tends to acquire weapons or drugs, organise escape, commit a criminal act, or when a person's health condition requires so. Monitors did not find that there were policies in place in institutions nor training for staff, about how to operationalise this law. Thus, the censorship was carried out in an arbitrary fashion.

¹³⁴ CRPD, Article 3.

c) Restrictions on freedom of movement

Unlike the situation for “involuntary” patients¹³⁵ in psychiatric hospitals, residents of social care institutions should be free to leave and return to the institutions as they please because they are not detained in law. The rules and regulations outlining this are usually in the house rules, such as curfew at 9pm (in **Osijek**) or 10pm (in **Mirkovec**) with special permission required for overnight stays, and authorisation from the Centre for Social Care for absences of longer than one night. The general practice across the social care institutions visited was that permission to leave the premises was required from a social worker, but there were no serious repercussions or punishments if they left or stayed out without permission.

At **Mirkovec** and **Lobor-grad**, staff reported that residents rarely fail to return. MDAC was told that “they usually either come back, or go home, and then neighbours or people from the village call us to fetch them back”. Alternatively, staff search for the person on their own or notify the police. There are serious consequences for residents who fail to return on time. Residents returning drunk to **Mirkovec** are forced to wear only their pyjamas for the next day. Alternatively, staff may prevent them from leaving at a later date. Psychologists at **Lobor-grad** explained that the only solution to deter residents from going absent without leave was to extend their work therapy hours – that is, they make patients work for 12 days instead of 10 in order to get their full pocket money. Of most concern, one resident at **Vojnić** reported that a person leaving without permission is restrained with belts, as punishment upon their return. The monitors concluded that patients rarely left this particular institution to visit the community.

At **Osijek**, **Mirkovec**, and **Lobor-grad**, patients confirmed that residents frequently left the institution to visit the shops, church, library and so on, in the surrounding villages. However, the extent to which residents participated in community life was difficult to evaluate, as neither residents nor staff were forthcoming with concrete examples of regular activities or events.

d) Denial of political participation

For people living institutionalised lives, their segregation is political, as well as physical and social. Those under guardianship face particular difficulties. Adults who have been fully deprived of legal capacity are prohibited from voting.¹³⁶ A judge can specifically remove voting rights when partially restricting an adult of legal capacity.¹³⁷ Some staff at **Lobor-grad** expressed the opinion that residents who retain the right to vote were “probably not aware of this right,” especially those registered outside of the region. They were still disenfranchised “by virtue of where they were living”. Staff in **Mirkovec** concurred, saying that even for those who can vote, “they can’t make it to the polling booths so in effect no-one votes even if they want to”. Only at **Osijek** were residents able to vote within the institution, and this was after the management

135 See chapter 3 for analysis of problems concerning categorisation of patients as ‘voluntary’ and ‘involuntary’.

136 Article 2 of the Electoral Register Act.

137 Article 159(3) of the Family Act. Article 29 of the Convention on the Rights of Persons with Disabilities obliges Croatia to guarantee that persons with disabilities have the right to vote on an equal basis with others and by virtue of Article 45 of the Croatian Constitution all citizens over the age of 18 are entitled to vote.

took the initiative to notify the relevant authorities. In none of the institutions monitored did the monitors see any information relating to elections, political parties (other than in the occasional newspaper), or any materials about political participation in general or how to vote.

5.2. Denial of privacy, dignity, and identity

The majority of patients at **Ugljan** and **Rab** were wearing thin, cotton, pyjama-style hospital uniforms day and night. When asked about this, staff said that patients were free to wear their own clothes but usually decided not to. Many did not have their own clothes. Staff went on to explain that practicality and convenience were also primary considerations for the clothes they wore, as well as there being “no room for patients to store their own clothes and belongings.” The wearing of hospital-issued clothes was also considered to be a security measure; if patients left the grounds, they were easily identifiable by locals and could be returned immediately. Monitors were told by one woman at **Ugljan** that she was forced to wear the uniform because staff believed she would run away, despite the fact that she was a “voluntary” patient (see chapter 3.), and had also repeatedly stated that she remained there because she did not want to return home to her abusive father.

Many of the residents at **Popovača** also wore uniforms. Staff again cited practicality and the fact that some residents did not have their own clothes, or were too far away from families for relatives to bring clothes, as the primary reasons for uniforms. As in **Ugljan** and **Rab**, these uniforms were general issue, meaning that each set was not “individually owned” but handed out, taken back for laundering at predetermined intervals or as necessary and then replaced – a different set each time. Monitors were left with the impression that residents with limited means opted to wear the uniform in order to “save” their own clothes from wear and tear. Monitors heard from one woman that she did not like the staff to wash her clothes because sometimes when she gave them her underwear to wash, what was returned to her was not her own. International standards emphasise individualisation of clothing in psychiatric hospitals as an important part of the therapeutic process.¹³⁸ Requiring patients to wear pyjamas or uniforms in hospitals during the day – rather than providing regular clothes in different sizes – diminishes personal identity and self-esteem, and further de-humanises patients in an already dehumanising environment.

a) Personal belongings

Most of the residents at the social care institutions visited did not have control over their finances, or were of limited financial means. Therefore, they were unable to buy additional or replacement clothes or items. As such, residents are heavily dependent on the institutions to provide them with appropriate clothing, and staff said that they rely on charities to supply the clothes.

138 See the 8th CPT General Report, para 34.

Personal belongings can enhance a person's sense of security and autonomy,¹³⁹ and across all of the institutions, a lockable cupboard was the only private space available. Having said that, the monitors met many individuals, particularly at **Ugljan, Rab,** and **Jankomir,** who either had no locker or lockable bedside cabinet, or had a locker which was broken. Therefore, they had to store any possessions under their bed. The monitoring team noted that there were very few personal photographs, or other personal decorations/items, displayed in any of the institutions visited. Bedroom walls were generally bare and devoid of clocks or pictures. Other than cigarettes and a few toiletries on bedside tables, patients/residents appeared to have very few possessions.

The impersonal atmosphere seems to be partly created by rules. The director of **Vojnić** explained that apart from small trinkets at their bedside, residents are not allowed to decorate their rooms as they please, the only exception being *"the inside of their wardrobes which must remain closed"*. As a result, all the rooms looked identical and barely lived in, thus contributing to an ambiance of a hospital ward. Considering that the institution is designed to provide long-term, and frequently life-long, accommodation to many of its residents, the sterile and anonymous spaces were quite the opposite of an environment conducive to a homely atmosphere. By contrast, the bedrooms and communal areas at **Jankomir** contained pot-plants, pictures, and paintings, including some created by patients. This contributed to the warmer overall atmosphere of this hospital in comparison to the others.

Bedroom overcrowding was a problem in the majority of institutions visited. This is a particular concern considering the length of time people spend in these institutions. There is very little, if any, privacy from other patients, or residents and staff. A typical room consists of rows of beds with enough room between them to walk around, although the number of beds in a room varied greatly (between four and fourteen)¹⁴⁰ depending on the institution and the unit. Residents are woken up every morning in a room full of people – some of whom they may not even know. They have to dress and undress in front of others. They must socialise, relax, conduct their personal and intimate relationships, and sleep in view of everyone else who happens to be in the room at the time.

In the hospitals of **Ugljan, Rab,** and **Jankomir,** doors to some of the bedrooms contained windows that were not covered by blinds or curtains. Patients were exposed to constant observation by staff, other patients, and visitors. MDAC and SHINE were concerned that staff (particularly in **Vojnić**) had little regard for the privacy of residents, and they frequently entered bedrooms without knocking. This included opening doors of consultation rooms where residents were being examined by medical staff.

b) Degrading practices in the showers and toilets

MDAC heard multiple accounts from residents and patients of how they were humiliated while showering. Many bathrooms contain multiple showerheads, but no partitioning between each one. Patients at **Rab**

139 See the 8th CPT General Report, para 34.

140 There were rooms with 4 beds only in Loborgrad, Mirkovec had rooms with up to 14 beds and Popovaca and Ugljan both had dormitory style rooms with 10 beds.

said that they had to ask staff for permission to have a shower. **Popovača** residents claimed they are permitted to shower only once per week.

Staff at **Ugljan** told the monitors that residents may bathe whenever they wish, although both showers and bathrooms were locked at the time of the visit. However, “supervised” bathing is compulsory twice a week, and such a practice is illustrative of the invasive control that some institutions have over residents. Those who need assistance are washed by two staff members, and it was unclear what the procedures are if a person refuses to bathe. For those who do not need assistance two auxiliary nurses are present during the washing: one holding towels and one observing. Staff reported that those who supervise showers are always female. This claim was disputed by some male residents. Female staff also supervise bathing at **Lobor-grad**. When questioned about the routine at **Ugljan**, staff expressed pride that the patients were safe, explained that staff had to watch them in order “to make sure that they didn’t swallow any soap or shampoo”, and staff also needed to ensure that toiletries were returned afterwards. Overall, the monitors concluded that there was a culture of watching over people in the shower.

The monitoring team observed a similar lack of privacy in the toilet areas. Monitors witnessed a female resident using a toilet while the door was open, and the woman was in full view from the main corridor. When staff were asked why there were no separate male and female toilets, they responded that “it wasn’t needed”.

Across all the institutions monitored, it was common that residents did not have their own soap. Neither soap nor toilet paper was freely provided in the bathrooms/toilets. Staff controlled these items, and the monitors heard frequent reports of shortages and rationing. In some cases, individuals were required to provide their own toilet paper, toiletries, and towels. However, some patients did not possess such provisions and were unable to have relatives bring them in, which raises concerns about basic hygiene, as well as equity issues.

c) Rigid rules

In some institutions, staff appeared to be overprotective of residents by overlooking their autonomy and preferences, as well as underestimating their abilities with respect to the performance of simple tasks. For example, when monitors were conducting interviews at **Vojnić** during the end of afternoon rest time (4pm), when residents are required to vacate their rooms and collect their afternoon snack. Staff were observed to rush from room to room, open bedroom doors abruptly without warning, and shout loudly at residents that they must leave their rooms and go downstairs. Also, the staff repeatedly interrupted the interviews that the monitoring team was trying to conduct at the time. Ultimately, staff took the interviewees by the arm and escorted them downstairs for the distribution of the snack.

In general, **Vojnić** stood out as the institution with the most rigid regime of a strict daily routine. This routine not only set meal times, but also included afternoon rest times when residents were obliged to return to their rooms. The overall ambiance was sterile because of a rule-bound, hospital-type atmosphere, and there was seemingly little opportunity for residents to make any choices about their daily activities and conduct.

5.3. Monotony and denial of opportunity

The life-style experienced by patients/residents across the institutions visited was uniform and routine, with few opportunities for leisure, employment, or education, and little choice about anything. Many of the people monitors spoke to complained of the monotonous regimes under which they lived. Meals always arrived at the same time. There were few activities available to pass the time. Boredom was endemic, resulting from every day being the same as the one before.

Repetitive rhythms do not support recovery, or the development of a person's capabilities. Although routine can offer the benefit of a structured lifestyle, it can be detrimental if it lacks variation tailored to an individual's interests and talents. The monitors found that some staff were aware of the monotony. One nurse noted to monitors that the uniformity and routine was *"the worst part about living in the institution"*.

a) Leisure

When rooms for leisure activities existed, they were locked, or appeared to be used rarely (if at all). In a modern compound across the road from the main campus of **Jankomir**, there was an art studio, theatre, computer room, and rooms for group and occupational therapy. During the monitoring, the rooms at **Jankomir** were locked and not being used, and it was not clear how frequently patients could gain access to them. Monitors did speak to a number of patients who were sitting outside. They had no complaints about their freedom to move around the hospital and gave examples of borrowing books from the library, as well as using the tennis court.

Rab boasts a large workshop for arts and crafts, a music room, a gym, and computers claiming to be staffed by a number of occupational therapists and educators. Monitors did not actually see any patients using the facilities and it was unclear whether these services were available to all patients, including those in closed units. The extent to which the large investment in equipment for therapeutic purposes was necessarily meeting the needs of rehabilitation was also unclear, and therefore requires more detailed research.

b) Access to fresh air

The only outdoor space attached to the forensic unit of **Ugljan** hospital was a small and empty yard devoid of seats or shelter from the weather. Patients had only restricted access to it. There was a small day room inside the unit that was too small for all the patients to be in at the same time. Patients wandered back and forth along the short corridor of the dimly-lit unit, crowding around the locked window and the door leading to the yard.

The forensic unit in **Rab** did not have an outside area designated for use by patients. Certain forensic patients were allowed outside for specified periods, but a large number of patients were restricted from going outside at all. Here, patients crowded in the hallway because dormitories were locked during most of the day, preventing patients from accessing their bedrooms. Staff stated that this was to ensure that

patients kept active during the day, yet during the visits on warm summer days in 2010, most patients were gathered in the front of their buildings smoking for the duration of MDAC's visit. There was no meaningful activity, and nothing which would keep the patients active. **Popovača** hospital had extensive gardens and there was plenty of space surrounding each unit but it appeared that patients were not permitted to be outside and they were huddled in groups in corridors, similar to the patients at **Rab** and **Ugljan**.

c) Daily activities

The monitors saw radios and televisions being used by residents in some of the bedrooms and common spaces of **Lobor-grad** and **Mirkovec**, and some residents were knitting or playing cards. These institutions also have birthday parties for residents and regular movie nights (one was being shown at **Lobor-grad** during the visit). Rooms dedicated to arts, crafts, and painting, were observed in all the social care institutions, although monitors did not see any of them being used. The monitoring team was told that there were also occasional excursions to attend cultural or sporting events, when there were enough resources. The view of the director of **Vojnić** was that providing computers and Internet was pointless because of the residents' intellectual disabilities, but monitors noted that there was a computer provided for residents' use at Mirkovec. In general, common spaces were relatively small, although outdoor spaces were utilised at **Mirkovec**, **Lobor-grad**, and **Osijek**. Smoking, sleeping, and drinking coffee, appeared to be the primary daytime activities of the majority of residents.

While speaking to the social workers at **Osijek**, monitors observed at least four to five residents knocking at the office door for cigarettes. It was explained that the social worker distributes cigarettes that are bought by the residents' relatives in order to ensure that residents do not smoke their packs all at once, but rather, that the packs are rationed throughout the week. It seemed that this method was used in response to the health concern of smoking. It was clear that cigarettes were also given to patients as quasi payment for work carried out. When questioned about this practice, staff responded by quoting experts who hold the view that *"this is a part of therapy for persons with mental disabilities as it calms them down"*.

d) Education, skills and employment

With respect to education, none of the hospitals employ an inclusive or special education teacher. However, **Vojnić** did have a special education worker and work therapist. More specifically, there were no programmes tailored to the needs of patients with intellectual disabilities. At **Ugljan**, the absence of a special education teacher was rationalised on the basis that those patients with intellectual disabilities also have diagnoses of mental illness, and because they were being treated in relation to the latter, the hospital found no need to offer them special education tailored to their intellectual disabilities. This approach appears to directly contravene Croatian law.

All the social care institutions visited offered some degree of therapeutic activities, including: activities called "occupational therapy" or "work therapy", arts and crafts, music, and sports. In **Osijek**, the social worker and occupational therapist appeared to be making efforts to ensure that activities were sufficiently

available for residents, so that they could occupy their time and attempt to maximise their potential. Staff explained that although therapy used to consist exclusively of arts and crafts, they were now focusing on building skills for self-sufficiency. Thus, they offered an extensive programme of group therapy. Including: home education (cooking or serving for example), art, music, religion, recreational groups, development of mental acuity (writing or solving problems for example), and seminars on healthcare issues (for example, diabetes).

Lobor-grad also ran weekly “therapeutic communities” sessions that were led by the residents (they set the agenda and take the minutes). These sessions are aimed at providing individuals with the opportunity to speak to staff about their concerns. According to the staff, the topics centre on issues related to everyday life, such as the amount of pocket money residents need, quality of food, and complaints against other residents. Ultimately, they use the forum to try to solve the identified problems together. However, the limits of such approaches were proffered by a psychologist in **Lobor-grad** who commented that *“it would be difficult to help people by counselling when they live in bad conditions, for instance when they have no bedside lamp”*. This reflects a general view that there is a hierarchy of needs – that if one does not have basic notions of safety and comfort in place, it is difficult to focus on therapy. This notion supports the thesis of this report, which is that basic notions of human rights should be put in place first.

Conversely, in **Vojnić**, monitors concluded that rehabilitation was limited to the skills necessary for functioning within the institution. Here, the training included basic skills such as personal hygiene and making beds. Staff, such as occupational therapists and others facilitating therapy sessions with residents in **Vojnić**, confirmed this, noting that “rehabilitation workshops” did not teach paying bills, budgeting, vocational training, cooking, shopping or learning the value of and how to use money - skills essential for rehabilitation and rejoining the community. In this respect, institutional settings do not “enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life”,¹⁴¹ which is the obligation of habitation and rehabilitation set out in the CRPD.

Croatian law provides people in psychiatric hospitals with the opportunity to receive remuneration for the work undertaken in work-therapy projects that bring profits to the institution.¹⁴² This law does not seem to be followed. Patients in **Rab** and **Jankomir** claimed that the hospital used them for labour, under the guise of “work therapy”, but they received no payment. A female patient at **Jankomir** commented that she had to *“clean the hallways and the toilets – they [the staff] say it is ‘work therapy’”*, and a female patient at **Rab** observed that she saw, *“little therapeutic value in cleaning toilets”*. Other patients told monitors that this so-called work therapy is a non-optional chore, which includes tasks such as delivering meals

from the central kitchen to the units, and bringing sheets from the laundry and distributing them to patients. There are large lavender fields on the hospital grounds at **Rab** where patient’s plant, tend to, and harvest the flowers as “work therapy” and in return receive cigarettes.

141 CRPD Article 26(1).

142 See the Law on Mental Health Article 11 para 1 and 5.

Opportunities for employment were very limited in all the social care institutions visited, but it was commonplace to hear that residents carried out chores that contributed to the running of the facilities. In exchange for the resident's labour, the institution gave them goods, such as sweets, snacks, coffee, and cigarettes. These, staff explained, were given to help individuals "win" places on excursions or, as one director explained, simply to "combat the monotony of life." At the **Osijek** and **Lobor-grad** institutions, the chores were formally classed as "occupational therapy". One female resident at **Mirkovec** summed up the combination of chores and monotony when she told the monitors that she had spent the morning "cleaning bathrooms and hallways", and therefore, "I am [now] free to drink coffee and do nothing".

Tasks carried out in social care institutions typically include helping with the laundry, clearing and wiping tables, assisting in the kitchen with food preparation (although this is forbidden at **Vojnić** for "security reasons"), general cleaning and up-keep of the bedrooms and common areas, collecting rubbish and cutting grass, sweeping pathways and, at **Lobor-grad**, helping on the farm. (In **Mirkovec** MDAC monitors saw several people working in the garden, using strimmers and weeding, noting that the grounds were very well kept. The residents seemed to enjoy both using the gardens and doing the gardening work).

Until 2009, residents in **Mirkovec** were paid 100 Kuna (approximately 14 EUR), in addition to their pocket money, for chores performed in the institution. This practice has ceased, apparently as a result of the economic downturn – a reason that the residents seemed to accept without complaint. At **Osijek**, however, social workers distribute cigarettes as a form of payment and as a rough guide, a patient/worker would "earn" two and a half cartons of cigarettes per week for "full-time work", although the nature of the work and the definition of full-time remained undefined.

Lobor-grad operated a "Commission" made up of staff and one resident. The commission determines how much money individual resident-workers should be paid at the end of each month, up to a maximum of 300 Kuna, approximately 42 EUR. There is no fixed hourly rate or transparent system to gauge the remuneration. Decisions seemed to be made arbitrarily based on a record of working hours and the "level of effort expended", as one staff member of the commission told monitors. Residents told the monitoring team that they thought this system was unfair and many told MDAC that resident-workers were not given just rewards for their work. Monitors interviewed a female resident-worker who had just returned from working and was visibly exhausted. She told the monitoring team that she had worked hard for hours, but was not satisfied with what she receives in return.

Croatian law specifies that permanent and temporary residents of social care institutions can be given 20% of their basic monthly state social security payment, which in 2010 amounted to 100 Kuna (20% of 500 Kuna, amounting to approximately 14 EUR), "to spend on their personal needs".¹⁴³ The remaining 80% of the social security payment goes to the social care institution. The same law which grants people the 20% goes on to say that the entitlement can be withdrawn from a person whose psycho-physical condition means that they "do not have personal needs which can be satisfied with such support".¹⁴⁴

143 Law on Social Care, Article 63(a)(1).

144 Law on Social Care, Article 63(a)(1).

In practice, the finances of residents are controlled and overseen by guardians or staff of the social care institution who distribute the 100 Kuna allowance to residents, many of whom view this as “pocket money”. As an indication of how much this would buy, at the time of the visits, a packet of chewing gum cost around 5 Kuna and cigarettes cost 20 Kuna. Alternatively, if staff felt that a resident could not take care of their pocket money, it was either distributed on an as-needed basis, or kept as credit at the cafeteria (where deductions were made to cover the cost of snacks, coffee, and cigarettes). In **Osijek**, staff explained that if there is more than 100 Kuna remaining from a resident’s pension after the expenses of the institution are deducted, then the remainder is placed in the resident’s “account”, which can be spent with the approval of their guardian. If less than 100 Kuna remains, then the resident receives the money in cash, without prior consultation with their guardian. In **Vojnić**, the institution provides some additional “pocket money” from its own funds for cigarettes and coffee. From speaking to residents monitors found that there were some residents across all the institutions who received small amounts of money from relatives.

From speaking to residents, it was also apparent that many were not aware of how much “pocket money” they were entitled to, or (in cases where it was being held as credit on their behalf) how much was left in their account. Dissatisfaction was also expressed at staff refusing to give residents the amount they requested when they wanted it for something staff thought was unsuitable. A resident in **Vojnić** complained that he received money but that it was “not enough to buy a bus ticket”, which is why he wanted the money. During the visit to **Lobor-grad**, residents approached monitors much more frequently than at other institutions, and asked for money or cigarettes. While speaking to the director at **Vojnić**, she responded to a patient gesturing outside by opening the window and handing him some small coins. The monitoring team concluded from these observations that some residents felt that they have needs which are not being met by the institution.

The **Osijek** institution has a rule that allows for residents to work if they are “physically and psychologically fit” and if they have the permission by a social worker,¹⁴⁵ although at the time of the visit, no residents were employed either by the institution or by external entities.

Residents of institutions that are located near populated areas, such as **Mirkovec**, sometimes gained employment in the nearby village as casual workers. In the opinion of the institution directors, residents receive a “completely inadequate compensation for their work”. Directors said that they were unable to control such exploitation because those residents were free to come and go as they pleased. The directors also noted that it was problematic if residents spend their (albeit little) income on alcohol. In **Lobor-grad**, monitors were told that the institution holds any money earned by residents, who can make “withdrawals” without the consent of a guardian. Although in some cases, the guardian may have had to give prior authority for them to work.

In summary, there are significant problems with employment, both of patients in psychiatric institutions, and residents in social care institutions. Both categories of people are exploited by the current system, by the arbitrary nature of the payments, by the provision of products instead of money, and by the fact that they do not earn the minimum wage. This raises questions about Croatia’s commitment to complying

145 Osijek Institution’s “House Rules”, section 53.

with European Union law,¹⁴⁶ which sets out an anti-discrimination framework concerning employment and vocational training. Furthermore, the right to non-discrimination in employment is set out in the UN Convention on the Rights of Persons with Disabilities,¹⁴⁷ as well as the right to be free from exploitation.¹⁴⁸

5.4. The taboo of sex

While institutions have the responsibility of providing therapeutic environments and protecting patients and residents from abuse and exploitation,¹⁴⁹ they also have an equal responsibility not to deny people the opportunity to experience relationships with others inside and outside of the institution – to express their sexuality and to exercise their reproductive rights.¹⁵⁰ The issue of sexuality should not be taken lightly. There must be a balance between protecting people from unwanted advances and incidents, and allowing people to form relationships on an equal basis with others. Human relationships can evolve over the duration of time, which is especially important for people forced to be in a psychiatric hospital or a social care institution for a long period of time.¹⁵¹

Although many staff members were noticeably uncomfortable and unwilling to discuss the topic of sexuality, monitors found a spectrum of attitudes and approaches to this issue – ranging from distaste at the notion that patients/residents should exercise these rights, discouragement of sexual relations, tacit tolerance of relationships (and subsequent abuse), and the development of some positive practices. Overall, a poor level of reproductive rights services, such as information and education on family planning, was observed across the institutions – especially with respect to women with disabilities – and none of the hospitals visited had any written policies on relationships between patients. Furthermore, none provided patients with written information about relationships or intimacy.¹⁵² Despite this, the monitors met many patients and residents who said that people formed relationships, and had sexual partners within the institution.

In general, staff at **Lobor-grad** and **Mirkovec** showed a positive attitude towards personal relationships and the sexuality of residents, and residents confirmed that it was possible in these institutions for couples to live together and share a room. The sexual wishes of residents appeared to be recognised by staff at **Lobor-grad**, and access to gynaecological and contraception services were made available as

146 Specifically, The Employment Framework Directive, Council Directive 2000/78/EC of 27 November 2000 establishing a general framework for equal treatment in employment and occupation.

147 CRPD, Article 27.

148 CRPD, Article 16.

149 See CRPD, Article 16.

150 See CRPD, Article 23. See also the UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, Resolution 48/96 of the UN General Assembly, from 20 December 1993, Rule 9 (hereinafter “Equalisation of Opportunities Rules”).

151 See Buckley, Hogan, Svendsen, and Gintoli, G., “Dilemmas of Managing Sexual Activity Among Psychiatric Patients”, in Buckley (ed.), *Sexuality and Serious Mental Illness*, Amsterdam: Harwood Academic Publishers, 1999 (hereinafter “Sexuality and Serious Mental Illness”), p. 61.

152 See especially CRPD, Articles 6 and 25(a).

part of individualised approaches to treatment and therapy. Here, the social worker and psychologist said they were aware of the couples in the institution and the developments in their relationships, adding that it was *“necessary to stay attentive as it has a large impact on the well-being of other residents”*. They provided an example of a couple who had been together for some time, and staff had discussed the possibility of trying to place the couple together with two other residents in a house in the community. Ultimately, however, the staff decided that the couple’s on-off relationship and turbulent fights would mean that placing them in a small environment would be *“unhealthy”* for them, as well as the other residents. Staff said that there could be no overriding policy on relationships applicable to all residents in all situations, but rather, it was better to individually tailor measures to each resident and couple.

The monitoring team were concerned that many patients in the psychiatric hospitals monitored were endangered by the *“neglect and psychiatrisation”* syndrome – a term used to describe the response of professionals to sexuality among persons with mental illness. In this case, patients’ sexual lives are considered disturbed, and therefore are assumed to be a treatable consequence of their mental health diagnosis.¹⁵³ In all the psychiatric hospitals MDAC visited, whether it was explicitly stated or not, sexual relations were not permitted. When MDAC raised this issue with staff at **Ugljan** hospital, a psychiatrist responded that *“sexual conduct is uniquely motivated by patients’ psychotic status”*, and that is why such conduct is prohibited.

In the hospitals and at **Vojnić**, staff generally disregarded or ignored the sexuality of patients/residents, and were adamant in their statements that patients/residents did not have any sexual needs or desires. One staff member claimed, for example, that residents were *“happy just to hold hands,”* before noting that residents sometimes masturbate. Nurses in **Ugljan** said that *“the patient’s illness prevents them from having any sexual desires. As such there is no risk of pregnancy”*, but also explained that two patients voluntarily had an intrauterine device/coil fitted, and some women take the contraceptive pill. These facts, as told by staff, made it clear to the monitors that staff members know that sexual intercourse is taking place in the hospital.

The director of **Vojnić** initially stated that there were no sexual relations between male and female residents because *“they did not have such needs.”* When quizzed further, the director conceded that staff would *“allow sexual relations if women agreed to protect themselves.”* However, residents reported contrary information, with one man alleging that he had been forbidden from engaging in sexual activity after being caught by staff, and a female resident told a similar story, adding that she and her boyfriend are forced to go outside grounds to be intimate.

Even in places where sexual intercourse was not expressly forbidden, it was common to hear from residents that couples engaged in sexual activity wherever they could find a space to be alone. These places included outdoor spaces within the territory of the institution (**Mirkovec**), and in bathrooms or a room that is empty during the day (**Osijek**). The risk of ignoring what is obviously going on is that staff have pushed this activity beyond their sphere of knowledge and influence, thus leaving **vulnerable** women and men at

153 See for example, *Sexuality and Serious Mental Illness*, p. 9. See also Vandereycken., *“Shrinking sexuality: The half-known sex life of psychiatric patients”*, *Therapeutic Communities*, Volume 14 (1993), at 143.

risk of exploitation, abuse, sexually transmitted diseases, and unwanted pregnancies.

Staff did not report any cases of sexual harassment or abuse, and monitors heard no allegations of such incidents from residents. The lack of complaints procedures and information on sexuality or sexual and reproductive rights may contribute to a lack of reporting, but if so it was unclear to what extent. Nevertheless, it is clear that ignoring the issue altogether resulted in a greater likelihood that residents were unaware of appropriate conduct. They often did not know how to form friendships and relationships, and were unaware of their human right both to express their sexuality, which includes the right to say no. When the monitoring team asked staff how they would prevent and detect sexual abuse, staff across the social care institutions responded by saying that they could identify abuse through two ways: first, by observing changes in a resident's mood and behaviour, and second, by residents informing them of the abuse. MDAC and SHINE remain concerned that these ad hoc answers cause victims of abuse to go un-noticed and their needs un-addressed. Moreover, such a haphazard approach allows abuses to continue with impunity.

The monitoring team noted the absence of women in the outside areas of **Ugljan**, which was a curious observation because there were several female units at the institution. From interviews with female patients living in those units, it emerged that women were not prohibited from accessing other parts of the hospital grounds but rather, "chose" not to walk outside because staff had raised fears amongst them about the dangerousness of male patients. One female patient said that she was afraid of leaving the perimeter of her unit because she did not want to be raped by a male patient. If this case was illustrative of a climate of fear then this may be increasing female patients' perceptions of detention, making them easier for staff to control. It may also be created by stigma that some staff and patients may have against people labelled with psycho-social disabilities – such a stigma being based on erroneous stereotypes that people with psycho-social disabilities are more dangerous than others simply on account of such disabilities.

Staff in all the social care institutions visited were keen to point out that there had been no abortions in recent years, implying that there was little or no sexual activity (or at least no evidence of such activity). Nonetheless, staff explained to monitors that if a woman deprived of legal capacity becomes pregnant, the Centre for Social Care (a local government office), together with the guardian of the pregnant woman, decides whether the foetus should be aborted. Ultimately, it is up to these two entities to decide whether the woman herself will be involved in this decision. If the pregnant woman has legal capacity, she retains the decision, but the monitoring team was told that it is unlikely that she will keep the child because the baby will be placed with the woman's family or given up for adoption. It was unclear whether these women retain the right to see their children.

In the institutions where sexual relations were permitted or tolerated, it was reported that sexually active women needed approval from their guardian to use oral or internal methods of contraception. In this respect, staff complained that guardians, in particular parents, have problems in accepting that people with disabilities had sexual needs. Therefore, guardians often did not approve the taking of contraception. Contraception was made available exclusively for women; they were prescribed contraceptive pills (the monitoring team heard of four women in **Vojnić**, one in **Osijek**) or intrauterine devices (monitors heard

of two women in **Vojnić** and one in **Osijek**). Staff explained that they kept track of residents who they thought could be sexually active (but did not explain what this category means), and discussed contraception with them in individual consultations. However, it appeared that it was not taken into account that the forms of contraception made available do not prevent the transmission of sexually-transmitted diseases. None of the institutions distributed condoms or made them available on request. In **Mirkovec**, staff assured the monitors that male residents could buy condoms in town. No mention was made of female patients being empowered to demand condom use.

5.5. The right to live in the community

Thus far, this chapter has described aspects of the lives of people living in psychiatric hospitals and social care institutions in Croatia. The violations to their rights, incursions on their dignity, and removal of their autonomy and personhood, have been documented throughout this report and in the recent Human Rights Watch report.¹⁵⁴ The common theme is that persons with disabilities are at heightened risk of these human rights violations because of living in an institution – a life which they did not chose, but rather, was imposed upon them by spouses, family, guardians, doctors, psychiatrists, judges, social workers, local government, and so forth.

Ultimately, successive governments in Croatia have tacitly endorsed this policy of social segregation by allowing such institutions to continue to exist. The Croatian government is responsible for protecting, respecting, and fulfilling the human rights of people within its territory. The failure to reverse policies that support continued institutionalisation is mirrored by the failure to develop community support services that would enable people with disabilities who are currently in institutions – as well as future patients/residents – to live in the community on an equal basis with others.

By ratifying the Convention of the Rights of Persons with Disabilities (CRPD), the government has made a commitment to putting an end to institutions of the type visited by MDAC and SHINE, and set out in this report. Article 19 of the CRPD recognises that living in the community is an inalienable and universal human right. There is no requirement for a person with a disability to prove their eligibility, ability, or entitlement to live in the community.¹⁵⁵ Persons with disabilities who live in institutions are segregated from the community and treated unequally in violation of this right. Reforming institutions so that they are smaller, in materially better condition, or located closer to large towns and cities, does not remedy the situation or fulfil the right to live in the community on an equal basis with others.

The right of an individual to choose their place of residence engages the right to liberty and the right to

154 “Once you Enter you Never Leave: Deinstitutionalisation of Persons with Intellectual or Mental Disabilities in Croatia”, Human Rights Watch, September 2010. Available at <http://www.hrw.org/en/reports/2010/09/23/once-you-enter-you-never-leave-0> (last accessed 22 July 2011).

155 Tirza Leibowitz, ‘Living in the Community – Disentangling the Core Right’, paper presented at the Colloquium on Disability Law and Policy, Centre for Disability Law and Policy, National University of Ireland, Galway, April 2010, p.6 available at <http://www.nuigalway.ie/cdlp/colloquium.html>

freedom of movement – both of which are core civil and political rights immediately applicable on ratification of the CRPD. Croatia continues to interfere with these rights and oblige persons with disabilities to live in a particular living arrangement. In doing so, Croatia is in contravention of international law.¹⁵⁶

In order to remedy this situation, it is imperative that Croatia abolishes laws and policies that allow for the institutionalisation of persons with disabilities – whether this happens automatically, or through some process which justifies institutionalising someone when it is deemed “absolutely necessary”, “a measure of last resort”, or in the “best interests” of the person. All of these are all irrelevant justifications. Furthermore, state assistance should not be qualified on the condition that a person can fulfil everyday tasks without outside support, or that people with certain disabilities or certain degrees of support needs must live in institutions, or that these individuals are only entitled to state support if they live within an institution.¹⁵⁷ Institutions should not accept new admissions, and should ultimately cease to exist altogether.

Independent or community living refers to people with disabilities being able to live and participate in their communities with the same choices, control, and freedom as other people. Any practical support or assistance that they may need in order to participate in everyday life – such as living in their own homes with their families, going to school or work, and taking part in community activities – should be provided based on a person’s aspirations and self determination.¹⁵⁸

Providing meaningful opportunities to facilitate a person’s right to live independently, and to their fullest potential, in the community requires developing specific and sustainable community services and supports, as well as ensuring equal access to general facilities and making reasonable accommodations when necessary.¹⁵⁹

Steps that a State may take in order to achieve this end may include phasing out institutions and directing funds towards providing services, such as mental health services in the community – developing these services in line with the social mode of disability. Moreover, States could amend legislation and develop policies that create viable options for living in the community on an equal basis with others; this should include non-discriminatory housing process. States’ parties could also establish programmes to facilitate the transition from institutions to in-home settings, providing training on topics such as independent living skills and supported employment.¹⁶⁰ Actions that promote full inclusion and participation in the community should be devised and monitored through close consultation with persons with disabilities, and their

156 Camilla Parker & Luke Clements; *The UN Convention on the Rights of Persons with Disabilities: A New Right to Community Living?*, E.H.R.L.R. 2008, 4, pp.508-523.

157 The Open Society Mental Health Initiative, see <http://www.osmhi.org/?page=98>

158 European Coalition for Community Living (ECCL), ‘Creating successful campaigns for community living: An advocacy manual for disability organizations and service providers’, November 2008.

159 According to Article 2 of the CRPD reasonable accommodation “means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms”. Read alongside Article 5(3) of the Convention it follows that a failure to provide reasonable accommodation constitutes discrimination.

160 The Open Society Mental health Initiative, see <http://www.osmhi.org/?page=98>

representative organizations¹⁶¹.

The provision of measures such as these is essential in order to meet the economic and social rights dimension of Article 19 of the CRPD. There is no limitation upon the right to live in the community. The obligation is to ensure full realisation, not merely realisation to the extent a State deems possible. Individual States may be at different stages of the implementation process but must not unduly delay the realisation of this right, particularly because it affects the enjoyment of so many other rights provided for under the Convention.

States are obliged to take measures utilizing the maximum of their available resources, with a view towards achieving progressive, but ultimately full, realisation of the right to live in the community.¹⁶² The way in which a State allocates resources, provides incentives, administers services, creates targets, and accounts for decisions made in this regard, should reflect measurable progress in materialising this right to live in the community within a specific and agreed time frame.¹⁶³

Recommendations

Article 19 of the CRPD provides that States should establish services to support living and inclusion in the community, and to prevent isolation or segregation from the community. Hence, deinstitutionalisation is not merely about closing institutions, but creating community support services which are truly respectful of autonomy, privacy and dignity. However, for as long as there are people living in institutions, their rights must also be respected, protected and fulfilled.

1. **The government** should prevent the segregation of people with disabilities from the community and its related opportunities for social interaction, employment and amenities by ensuring accessible and affordable transportation. This should include transport from institutions into the community;
2. Ensure that health, welfare, rehabilitation and support services are provided as close as possible to people's own communities, including in rural areas; and
3. Amend the law to enable people whose legal capacity has been restricted to be permitted to vote on an equal basis with others.
4. **Psychiatric hospitals and social care institutions** should ensure adequate access to telephones so that people can have private conversations in order to remain in contact with friends and family, and retain/regain contact with their communities;

161 Articles 4(3) and 33 of the CRPD on participation, monitoring and implementation.

162 Article 4(2) CRPD.

163 Gerard Quinn & Michael Ashley Stein, 'Challenges in Realizing the Right to Live in the Community: Creating successful campaigns for community living', Focus on Article 19 of the UN Convention on the Rights of Persons with Disabilities, European Coalition for Community Living (ECCL), 2009, p.29.

5. Ensure access to writing materials, letters, envelopes and stamps, so that people can write letters to friends and family. Ensure that the law allowing an interference with correspondence in psychiatric hospitals¹⁶⁴ is complied with, and that each instance of interference is documented;
6. Ensure that there is no interference of any kind with correspondence to/from residents of social care institutions;
7. Invest in computers and encourage patients and residents to use email to remain in contact with friends and family and also the internet for the purposes of entertainment, information about their interests and current affairs;
8. Ensure that residents of social care institutions can come and go as they please, and that returning after curfew hours or returning having drunk alcohol are behaviours which are not subject to punishment;
9. Ensure that every person in an institution is given the opportunity and encouraged to participate in political life, through receiving information about political parties and the voting process, and being supported to exercise their right to vote;
10. Ensure that each person in a psychiatric hospital or social care institution is issued with ordinary clothes. Immediately stop the use of uniforms/pyjamas;
11. Encourage residents to personalise their environment (however limited their environment may be) with photographs and other personal items or decorations. Ensure there is space for these items to be stored in a safe and private place;
12. Ensure that individual privacy is respected in every way possible, and that a “home” environment is created for people living in institutions. Staff, for example, should make efforts to help residents to be able to wash, dress and go to bed in privacy. This could be achieved by creatively rearranging spaces, for example by using fabrics or other material to create screens which create privacy;
13. Ensure that essentials for hygienic living, including soap, toilet paper and toothpaste are available freely;
14. Ensure that institutional rules serve a purpose, are reasonable, and have been discussed and agreed with residents;
15. Ensure that people in institutions have the opportunity to develop and express their creative, artistic and intellectual potential. This includes not merely having a recreation room available, but actively encouraging people to spend their time in a meaningful way;
16. To prevent exploitation (for example, carrying out chores or other types of work for free, or for cigarettes or other tokens) people should be paid market rates for work done. Residents should be able to and encouraged to seek employment outside of the institution where possible;
17. Staff should not dictate how patients and/or residents choose to spend their money, but rather provide information about how to manage finances, different options about spending/saving the money, and how to keep it safe; and

164 Law on Mental Health, Article 11, para.4

18. Ensure that information about relationships and sexuality is provided to everyone in accessible and understandable formats, and that patients and/or residents receive advice and training on relationships, consent, sexual health and family planning from specially-trained staff. Ensure that staff members recognise that patients/residents are entitled to form sexual relationships and retain their fertility on an equal basis with others. Condoms should be freely made available, and patients and/or residents made aware of their rights.

The next two chapters highlight two specific sets of issues of particular concern to people in psychiatric and social care institutions: mental health treatment, and chemical and physical restraints and seclusion.

6. Restraints and seclusion

This chapter looks at the law and practice in Croatia of using physical and chemical restraints, as well as seclusion in psychiatric hospitals and social care institutions. Although these practices should be subject to appropriate professional medical guidelines, they must also come under the purview of human rights. The UN Convention on the Rights of Persons with Disabilities (CRPD) states that every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.¹⁶⁵ As the UN Special Rapporteur on Torture has noted, “*there can be no therapeutic justification for the prolonged use of restraints, which may amount to torture or ill-treatment*”.¹⁶⁶ He has made similar observations with regard to “*prolonged solitary confinement and seclusion*”.¹⁶⁷

Since restraints and seclusion may compromise a person’s integrity and right to be free from torture, inhuman and degrading treatment, or punishment, psychiatric institutions should minimise their use through the recognition and prevention of disturbed or violent behaviour. This should be accomplished through using enhanced observation and de-escalation techniques. The European Committee for the Prevention of Torture (CPT) recommends that initial attempts to deal with agitated or violent behaviour should be, as far as possible, non-physical (verbal persuasion); and where physical restraint is absolutely necessary, it should in principle be limited to manual control.¹⁶⁸ International standards require the use of restraint solely in exceptional circumstances, where it is strictly necessary based on the conduct of the person concerned and when no other means are available to prevent immediate or imminent harm to the patient or others.¹⁶⁹ Where physical intervention is unavoidable in response to behaviour that poses a significant risk to a resident or to others, its use should be supported by a strong legal framework and written policies that meet the requirements of international standards.

In order to facilitate the management of restraint and oversee the prevalence of its use, all instances of its use should be recorded, both in a specific register established for these purposes and in the patient’s file. Entries should include: the times at which the measure of restraint began and ended, the circumstances that called for it and the reasons the staff resorted to that measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.¹⁷⁰

Methods of restraint should be employed in accordance with officially approved procedures¹⁷¹ and clearly-defined policy.¹⁷² Comprehensive guidance and training of staff in both non-physical and manual control

165 CRPD Article 17: protecting the integrity of the person.

166 Nowak report, op cit, para. 55.

167 Ibid, para 56.

168 See the 16th CPT General Report, para 39, hereinafter “16th CPT general Report”, available at <http://www.cpt.coe.int/en/annual/rep-16.htm>.

169 Recommendation No. R (2004) 10, para. 27

170 See the 16th CPT General Report, para. 52.

171 See, for example, Recommendation No. R (2004) 10, para. 27.

172 See the 8th CPT General Report, para 47.

techniques are strongly recommended.¹⁷³ Restraints should never be used as punishment, although in practice there is a fine line between controlling a situation and punishing someone's behaviour. Where robust legal, policy, training and monitoring frameworks are lacking, the risk that institution staff will resort to restraint as a routine method of problem solving increases.

6.1. Types of restraint and seclusion

Although the use of a particular method depends on the individual circumstances, international standards require that the method of restraint used "should be the most proportionate (among those available) to the situation encountered".¹⁷⁴

a) Physical restraint

The types of physical restraint used in Croatia include straps (usually leather or canvas) that are fastened with buckles or magnetic locks that cannot be undone without a key, thereby attaching patients to beds. These are usually applied to the wrist, ankle, or across the chest. Restriction of limbs is achieved by using shoulder restraints, waist belts, or thigh, hand, and foot restraints. In Croatia, straightjackets are used; these are a material shaped like a back-to-front jacket with over-long sleeves that are designed to be tied to the back of the jacket so that the arms are kept close to the chest and reach around towards the back, thereby restricting the movement of arms.

b) Seclusion

Seclusion is a process of separating a person from others, most commonly by placing them in a special room in which they cannot interact with other patients and/or harm them/or themselves. It is used in Croatian psychiatric hospitals.

c) Chemical restraint

Chemical restraint is the use of medication in order to modify or control behaviour. Examples of medications used include sedatives, anti-psychotics, hypnotics, and tranquilisers.

173 See the 8th CPT General Report, para 47.

174 See the 16th CPT General Report, para 39

6.2. Legal Framework

Croatian legislation incorporates some of the requirements of international law and standards stipulated above. However, the law fails to provide adequate protection to patients, residents, and staff across all institutions. In particular, the Law on Mental Health is applicable only within psychiatric hospitals, so the instances of restraint and seclusion in social care institutions have no legal basis and are thus subject to meagre legal safeguards. However, the monitoring team was told by staff in social care institutions that they sometimes find themselves in situations where they are required to use restraints to prevent harm to residents. The practice of restraint in social care institutions is dealt with in section 6.5 of this chapter.

The Law on Mental Health only regulates certain aspects of the use of physical force and seclusion,¹⁷⁵ and is silent on chemical restraint.¹⁷⁶ According to the law, it is a psychiatrist who must decide on the use of physical force or seclusion, and the psychiatrist must also supervise its application.¹⁷⁷ In cases of exceptional urgency, a non-psychiatrist doctor, a medical nurse, or technician can also make the decision. This is permitted only when it is not possible to wait for this decision to be made by a psychiatrist, who must be immediately informed of the application of this measure and who will decide on its further use.¹⁷⁸ The law also requires that professional medical staff constantly monitor the physical and psychological condition of the restrained person.¹⁷⁹ The law does not oblige staff to try verbal de-escalation techniques prior to any attempt at physical restraint, although it recommends that “if the circumstances allow it, the person shall in advance be warned about the use of physical force”.¹⁸⁰ Moreover, the law does not establish any obligation for psychiatric hospitals to hold a separate register specific to the use of restraint – ‘incidents’ are to be recorded into patient’s medical files only.¹⁸¹ Hospitals need not, under the law, have written policies.

The provisions on restraint in the Law on Mental Health are weak and inadequate. The law instructs health care workers to refer to the ordinances of the Ministry of Health and Social Welfare for further guidance on the use of restraint,¹⁸² but at the time this report went to press, no such ordinances had been adopted. The Ministry does not provide training for staff on how to prevent restraints and seclusion, or on how to use such methods safely and in adherence to human rights law.

175 Seclusion is regulated in the same way as the use of physical force. However, the differences are that the reasons, manner and the extent of the use of physical force should be recorded in a person’s medical records (Law on Mental Health, Article 58 para 2) and the person shall be forewarned before the use of force if possible (Article 58 para 1). Those provisions do not apply to seclusion.

176 See Law on Mental Health, Chapter VIII – Articles 54 – 58.

177 See Law on Mental Health, Article 56 para 1.

178 See Law on Mental Health, Article 56 para 2.

179 See Law on Mental Health, Article 57.

180 See Law on Mental Health, Article 58 para 1.

181 See Law on Mental Health, Article 58 para 2.

182 See Law on Mental Health, Article 55.

6.3. Restraint in Practice

Notwithstanding the legislative shortcomings, the monitors concluded that the application of existing rules concerning the use of restraint in practice was often problematic. The management teams of some psychiatric hospitals have created protocols and policies regarding the use of restraint, resulting in practices that vary between hospitals and between wards/departments within the same hospital. There was little or no staff training about restraint practice, and some policies did not advise staff what to do in emergencies. Staff were unsure about what the exact legal regulations are, and monitors were of the opinion that they were trying to avoid speaking about the use of restraint.

a) Authorisation of restraint

In **Ugljan** hospital, each new staff member is provided with the hospital's regulations. This document stipulates that patients may be restrained with a strap for a temporary therapeutic purpose only, and never as a measure of repression or punishment. The restraint must be initiated and terminated only by a doctor, who must designate a member of staff to constantly monitor the patient whilst the restraint is in place.¹⁸³

In contrast, **Jankomir** hospital issues staff with guidelines that require them to attempt de-escalation through verbal persuasion; *"facing violent patient's starts with conversation...after which psycho-pharmaceuticals can be used and physical force if necessary"*.¹⁸⁴ The guidelines limit the use of restraint to the protection of people, and disallow it for the protection of property; in this sense, it provides stricter guidelines than the national law. The guidelines also state that prior to physical restraint being used, the patient *"must be told what will be done to him/her and what the procedure is like"*, and that *"in principle, the patient is asked for his/her consent"* and *"asked to cooperate"*.¹⁸⁵ Such guidance is a positive start to ensuring safe and respectful restraint practice.

Given the low number of doctors in all the hospitals, it appeared likely that restraints are often initiated without a doctor's involvement – let alone a psychiatrist, as mandated by the law.¹⁸⁶ In **Jankomir**, only one or two nurses are on night shift per unit. One night shift doctor is on call to cover the entire hospital. Pre-restraint assessment of individual patients in these circumstances is likely to be impossible. Management at **Popovača** told monitors that restraints could only be authorised by doctors. However, one staff member lower down the management chain told the monitoring team that auxiliary staff and nurses restrain people *"every day"*, and that doctors are rarely involved. In the **Popovača** annex (2km from the main facility), there was no doctor on site at all so approvals of restraint, if such approvals were sought at

183 See Ugljan Hospital House Rules, 5 May 1995, Article 66.

184 Psihijatrijska bolnica "Sveti Ivan", Zagreb: Smjernice za postupanje s bolesnikom nasilnog ponašanja (Guidelines for the treatment of patient with violent behaviour), May 2004. The Guidelines open with the instruction that *"facing violent patients starts with CONVERSATION"*. It is noted that verbal persuasion is the preferred technique of the CPT, see the 16th CPT General Report, para 39.

185 Jankomir, Guidelines for the treatment of patient with violent behaviour, May 2004

186 See Law on Mental Health, Article 56 para 1.

all, are arranged over the telephone. The monitoring team was informed of several cases where incidents of restraint were not reported to relatives or the guardian of the person subjected to the measures, as required by Croatian law.¹⁸⁷

b) Duration of restraint

Physical restraints appear to be used in Croatian hospitals for longer than necessary. In **Ugljan**, patients remain in restraint belts for, on average, *“one day or less, but in exceptional circumstances for two to three days”*, according to a staff member. This staff member added that the restraints were undone every two hours. Monitors were told that on the acute female ward at **Jankomir**, the patients are strapped to a bed only for a couple of hours, but one patient on that ward told monitors that in the previous week she had been in restraints for 15 hours, even though she had become calm after a couple of hours.

c) Restraint wrongly used as “treatment”

Monitors saw first-hand that the use of restraints has knock-on effects for the health, safety, and dignity of people subject to those restraints. When monitors visited Ugljan and **Jankomir**, they heard reports of patients being restrained with straps to their beds and placed in diapers rather than being allowed to use toilet facilities.

When the monitoring team visited the **Popovača** annex that houses the chronic male and female wards, two people were restrained to their beds. One man was tied by the ankle with a magnetically-fastened strap. Staff explained that this was a measure to stop him falling out of bed. However, the monitoring team observed that if the man fell out of bed he would nevertheless hit his head on the floor and monitors concluded that the man had been restrained in order to prevent him from getting out of bed. In another bed lay a 27 year-old man who was tied to his bed by one of his hands and one of his feet. He was awake and appeared to have intellectual disabilities, but also appeared to be fairly sedated. The staff member in charge explained that the man *“attacks staff and other patients”*, allegedly through eye-gouging, and that no staff member was strong enough to contain him. The nurse pulled back the man’s bedclothes (without asking or informing him) to show monitors his body. The man’s limbs showed some muscle atrophy from immobility, and the nurse said that he was still too strong for staff; and that the restraints barely held him which meant that he inflicted injuries on himself while fighting them. The nurse said that the man had been tied to a bed or wheelchair for most of every day for three or four years. The man’s medical records confirmed that he was routinely tied to the bed for periods ranging from one hour to twelve hours, without a break. Taken as a whole these circumstance may amount to a breach of Article 3 of the European Convention of Human Rights (torture and inhuman or degrading treatment or punishment).

187 See Law on Mental Health, Article 58 para 3.

d) Monitoring of restraint

It is encouraging that some hospitals keep specific registers on the use of restraint – a requirement of international standards but, unfortunately, not of Croatian law. At **Jankomir**, a comprehensive form that calls for the recording of vital signs is used, including temperature, blood pressure, pulse, intake of food and beverage, and elimination of body fluids. In practice, however, some registers were frequently incomplete. Staff members at **Jankomir** are also required to enter a note in the hospital list on their monitoring of the patient under restraint every 15 to 30 minutes.¹⁸⁸ The protocol at **Popovača**, which has been in place since 2006, requires staff to complete two forms for each restraint incident. However, these are placed only in the patient's file and a separate register is not used.

In **Ugljan**, staff must record the use of restraints in the diary of each unit, and a form must be filled out for each restrained patient. This form must identify the authorising doctor, the reason for the restraint, the staff involved, and any relevant medical information. The form must be signed by the nurse and the head of the unit. However, few of the selected forms shown to monitors were completed correctly. They frequently bore no signatures, leaving open the question of who had authorised the measure and who had monitored the patient throughout the restraint period.

The monitoring team spoke with a man in **Ugljan's** acute unit whose medical records confirmed that he had been restrained over ten times between February and June 2010, each restraint period lasting from five hours to two days. Each restraint episode had been recorded, the reports including comments on his behaviour – that he bathed, ate, used the toilet, and was calm or aggressive. He had challenging behaviour and had assaulted other patients. Whilst in isolation, he was filmed on closed circuit television (CCTV). Staff said that restrained patients are not observed constantly, but are under observation for 30-minute intervals. This is an unsafe practice that breaches CPT standards,¹⁸⁹ as the CCTV camera cannot substitute for constant observation because staff do not constantly watch the screen in the nursing office.

The monitoring team was acutely disappointed at the absence of any separate register specific to the use of restraint at **Rab**. MDAC heard markedly divergent accounts about restraint practice from patients than from staff. MDAC was told by staff at the hospital that restraint use was rare, but patients reported that restraints – particularly straightjackets – were frequently used. One doctor said that magnetic locked straps are used to tie patients to beds, while another doctor said they were not used. According to one patient, three or four patients were put in straightjackets on one unit in the three days prior to the visit. Monitors had no means of testing the differing accounts of the frequency of restraint use, and – just as importantly – neither did the hospital management. Thus, diligent record keeping of restraint data is a necessity in order to prevent abuses; it is also an expectation of international human rights law that these records be available for monitoring and audit, at ward, hospital, and national level.¹⁹⁰

188 Jankomir, Guidelines for the treatment of patient with violent behaviour, May 2004.

189 See, "Means of restraint in psychiatric establishments for adults" 16th General Report on the CPT's activities covering the period 1 August 2005 to 31 July 2006, CPT/Inf (2006) 35, , from 16 October 2006 (hereinafter "the 16th CPT General Report"), para. 50. This is contained in the "CPT Standards" (CPT/Inf/E (2002) 1 - Rev. 2010).

190 See, for example, CRPD Article 31.

6.4. Seclusion

Seclusion (or 'isolation') was used in all hospitals with the exception of **Jankomir** (according to staff there). **Jankomir** had intensive care areas in both the male and female acute units. These are rooms of four beds in a row, accessed from the closed unit corridor but viewed through a blind-shielded window from the nurses' station, which is situated between the open and closed unit. Patients may be strapped to beds in this room, according to staff, only for an hour or so. CCTV surveillance of patients in crisis was extensive and in some instances seemed to replace personal contact and consultation between staff and patients.¹⁹¹ In **Ugljan**, CCTV surveillance was used to monitor patients in seclusion rooms in almost all units.¹⁹² Staff are required to make a contemporaneous record of the seclusion period, including the person's vital signs, so there are at least some procedural guidelines in operation in the hospital. However, the monitors were told by staff that patients may be taken out of isolation for showers and walks, implying that the use of isolation may sometimes extend beyond just an hour or two.

It was clear to the monitoring team that seclusion was not being used as a measure of last resort in **Rab**. Staff reported that all newly-admitted patients in the forensic unit were automatically placed in isolation to conduct observation of their behaviour. Hence, these patients were not placed in isolation on account of any risk that they posed to themselves or others, but rather, as a precautionary, disciplinary, and controlling measure. Monitors spoke to an elderly woman with diabetes who had been confined to her room in order to prevent her from eating; at the time of the visit she was not displaying any psychotic symptoms, and she was not agitated. On the chronic wards at **Rab**, patients in seclusion had no access to normal toilet facilities, but were required to use a bottle. Whilst in this unit, monitors observed an isolation room adjacent to the unit's entrance door. One male and one female patient were inside the room and the door was locked with two deadbolts. Staff said that the two patients had chosen to go there because the room was cooler; however, it appeared to monitors that staff viewed these two patients as troublesome and thus took the opportunity to lock the room whenever the patients were in it.

6.5. Policy and practice in social care institutions

MDAC found that directors and staff at social care institutions used restraints and seclusion without any regulation or training. There are no guidelines on how to deal with challenging or aggressive behaviour. There are no standardized protocols or recording procedures, and there is no training or education on the prevention and use of restraint.

The official view from management appears to be that interventions such as seclusion, having no basis in law, do not occur. Whilst the monitors noted some progressive attitudes and practices in a number of social care institutions, it was clear that some forms of seclusion and other restraint were used. The official denial of such practices increases the risk of unprofessional, abusive practice. It also means that neglect

191 See the 16th CPT General Report, para. 50.

192 Yet, there is no video surveillance in the acute unit, where it could be a great aid in closely monitoring patients in crisis.

and abuse are likely to be carried out with impunity, as there is no recording of any incidents, and no recourse for people who want to complain about how they are treated. The monitoring team noted that, on occasion, staff seemed uncertain of their legal powers and reluctant to talk openly about their practice. In some cases, monitors felt that staff members were not being entirely transparent in their answers about questions concerning the use of restraint, although in part this may be a reflection of staff's lack of experience with having external monitors ask sometimes uncomfortable questions.

a) Physical restraint

Overall, it appeared that means of physical restraint in social care institutions were used less frequently than in psychiatric hospitals. However, it was unclear whether this is a reflection of policy, or due to the likelihood that psychiatric hospitals contain more people in a mental health crisis than social care institutions.

The directors of **Mirkovec**, **Osijek**, and **Lobor-grad** institutions claimed that no physical restraint had been used in their institutions for many years. Monitors did not find any physical or verbal evidence to the contrary while visiting **Mirkovec**, although the team did see evidence of a patient being restrained with a strap at **Lobor-grad**. Staff at these institutions stated that violence was very rare and usually only a problem when residents had been drinking alcohol. They explained that if a person became agitated or posed a danger to themselves or others, then the police or an ambulance would be immediately called and the person transferred to a psychiatric hospital by staff or emergency services. The monitoring team was told that alternatively, male nurses and orderlies would – about once a month – intervene in fights and de-escalate the situation. There were no reports of injury to either staff or residents, and residents with whom MDAC spoke confirmed this. At **Ugljan**, monitors heard from residents that straps were used, and noted the physical presence of straps in a pile of laundry. When questioned about this, staff repeated that straps were not used and that their presence in the laundry was incidental.

Physical restraint methods are used in **Vojnić**, and the head nurse showed monitors restraint belts and straightjackets. The restraint belts were made out of wide leather straps with a buckle that is fixed to beds. Staff told the monitors that these had not been used in the last year. The straightjacket was new out of its packaging, and staff explained that the one they actually used was in the wash. Restraint or seclusion was reported to never last longer than two hours, during which time residents were checked every fifteen minutes. There was a restraint protocol, and curiously, a consent form that should be signed by the resident. There was no specific restraint register, and staff had no training on the management of aggressive behaviour. When asked about this, one of the institution's managers stated that using restraints "*is not complicated*". The head nurse first said that restraint is a measure of last resort, but then followed that up by saying that sometimes restraint is used as a preventive measure and that one resident 'voluntarily' wore a straight-jacket at times. This was disputed by residents, one of whom told monitors that if a resident leaves the institution without permission, they are punished upon their return – "*they get the [restraint] belts*".

In general, staff in social care institutions stated that they relied on transferring residents who exhibit difficult behaviour back to a psychiatric hospital. Staff at all the social care institutions stated that a doctor's permission was required before any kind of third party intervention was made (e.g. police or doctor), or a

restraint technique was used on a resident. This system of transfers clearly cannot provide a solution during the time that it takes for an ambulance or other transport to arrive. Furthermore, it is questionable whether such transfers are always in residents' best interests or whether they might, in some circumstances, escalate a situation that would otherwise be manageable with less disruption to residents' care. At no institution was the monitoring team shown any specific protocols outlining policies on appropriate courses of action, and it was reported at **Mirkovec** and **Osijek** that decisions were made on "a case by case basis".

The situation in **Vojnić** appeared to be different from that of the other social care institutions visited; monitors concluded that, in many ways, this institution operated as a quasi-psychiatric hospital. The management was proud that in eight years they had not sent any resident to a psychiatric hospital for treatment, and had even taken some "unmanageable" residents from other social care institutions. This institution did appear to provide some specific training on restraint to staff, and was proud of the skills staff exhibit in managing residents labelled as 'difficult'. The monitoring team was told about one person who was transferred from **Rab** two years ago; previously, it was normal for the resident to be tied to his bed. Upon arrival, the **Vojnić** staff replaced straps with towels and then used isolation for short periods of time, rather than physical restraint and staff reported that now, after some time, no restraints are used. Staff also reported negative experiences for residents at other institutions previous to their transfer to **Vojnić**. In particular, they described the case of a young man with an intellectual disability who was transferred there from the Stančić social care institution six months prior to MDAC's monitoring visit. Upon arrival, staff said that he was in an agitated mood and they placed him in the isolation room for an hour. When staff tried to calm him down, he asked repeatedly for his hands to be tied because he was accustomed to this measure. Staff said that they refused to tie his hands and instead, made efforts to work with him to control his agitation. As a result, the condition of the resident improved and measures of restraint were no longer necessary. The monitoring team was also informed about a blind resident with intellectual disabilities and psychosis who refused to bathe – he had been forcibly bathed in a previous institution and was now violently and aggressively opposed to a bath. **Vojnić** staff had approached the matter differently by including him in the process of bathing and trying to understand his fear, and had thereby reintroduced bathing without physical restraint, but rather, by more empathic measures.

b) Seclusion

MDAC was clearly told by staff that no seclusion or isolation room existed at **Lobor-grad**, **Mirkovec**, or **Osijek** social care institutions. Therefore, there were no policies regulating this practice. The monitors found no evidence to suggest otherwise in the case of the first two facilities, but there was some evidence of seclusion at **Osijek**. At this institution, monitors discovered a seclusion room at a dead-end turn at the end of a corridor leading to the laundry room, a route not used as a throughway. The room was heavily padded on the outside and the door was locked and had a prison-style observation hatch. Inside, the room contained a bed, a folded blanket, a pillow, and a table. The room looked like it had recently been in use – there was a plastic cup and partially full water bottle on the table by the bed, and a cigarette packet on the floor. When monitors asked staff about the room they insisted that the room was only ever used as an overflow reception room, and that residents may initially sleep there whilst other arrangements were made. However, a resident told the monitoring team that she had been secluded in the said room

about six weeks earlier, as a response to returning to the institution drunk. She stated that she had been kept in isolation for two days, reportedly having to use a bucket for a toilet because she was not permitted to use the general facilities. Two other residents also informed monitors that from their recollections, the seclusion room was used an average of once a month.

In **Vojnić**, there was a room designated for seclusion: it had padding on the doors, walls, and floor. Also, there was a mattress on the ground and the room had a window through which staff could observe the person inside. The room led into a locked corridor for staff use only. The institution had procedures that required approval by a psychiatrist before or shortly after seclusion started, and staff were informed that this is “so that it cannot be used as a punishment.” Moreover, there was a seclusion book that recorded length of stay, the identity of the person who approved the intervention, and the reason for seclusion. Although nursing staff told monitors that the room was rarely used and had not been used for six months prior to the visit, the institution’s director said that she found isolation more acceptable than “tying people up” and that seclusion was used “for an hour or two for auto-aggression or aggressive behaviour”.

6.6. Chemical Restraint

The use of chemical restraint is a cause for concern considering the dangers involved in administering medication for non-therapeutic purposes. Chemical restraint must therefore be dispensed with the greatest of safeguards, and should never be used for the convenience of staff, or as a means of coercion, discipline, or punishment.¹⁹³ Side effects of chemical restraints may have a particular effect depending on the patient’s individual health status. Therefore, it is especially important to consider when medication is used in combination with mechanical restraints or seclusion.¹⁹⁴

MDAC and SHINE did not receive any allegations of chemical restraint being used as punishment from any residents of social care institutions. Having said that, there is a thin line between the use and abuse of psychiatric medication. Chapter 3 of this report outlined the procedure whereby a person in a psychiatric hospital can receive involuntary psychiatric treatment before the court has an opportunity to assess the necessity; whether this is considered to be chemical restraint is open to opinion. Chapter 7 of this report explains how some of the people in the psychiatric hospitals that were visited displayed signs of being over-medicated as a form of institutional control – this too may be classed as chemical restraint.

193 See Explanatory Memorandum to Recommendation R(2004)10, para 145.

194 See the 16th CPT General Report, para 41.

6.7. Evaluation

MDAC and SHINE are concerned that there are no national rules, procedures, or training on restraint and seclusion. At all institutions, monitors were told that the use of restraint and seclusion is exceptional; however, there is evidence that the exception becomes the rule, especially in environments where staff are not trained regarding the alternatives to these practices. There was a general lack of understanding that restraint and seclusion are measures of last resort, and should therefore not be thought of as being part of the package of care and treatment. The monitoring team was concerned about this practice in the hospitals where newly admitted patients are put, as a matter of course, into seclusion. This is a practice that has nothing to do with care and treatment, but rather, is a means of the patient to the regime of the hospital – a way to make clear where the power lies and what will happen if the rules are not complied with. As such, this is seclusion without a therapeutic purpose – a practice that could well amount to torture, inhuman, and degrading treatment or punishment. Thus, it is clearly a violation of international human rights law binding on Croatia.

In social care institutions staff denied the practice, even though it appeared that restraints and seclusion do occur. While it is understandable for staff to be wary of talking to external human rights monitors about a practice that they know is wholly unregulated, the monitoring team was nonetheless alarmed by such staff conduct. An environment where abusive practices appear to be hidden only serves to heighten suspicions about what goes on when human rights monitors are not present.

In summary, the ad hoc application of restraints and seclusion puts patients and residents at risk. It also puts management and staff at risk – from unsafe practices, from criminal prosecution, and from civil law suits. The management of restraint in both psychiatric and social care institutions needs to be strictly regulated at the institutional and governmental level in order to bring the practice in line with international human rights law.

Recommendations

1. **The government** should amend the law to ensure that staff try de-escalation techniques to prevent any resort to restraints or seclusion;
2. Amend the law to clarify the circumstances, the manner and duration, in which chemical restraint can (if at all) be used;
3. Amend the law to oblige institutions to allocate a staff member with the specific task of monitoring a restrained individual for the entire period of the patient being restrained/secluded not intermittently. Ensure that video surveillance never replaces a continuous staff presence;

4. Amend the law to oblige institutions to record instances of restraint in the patient's file and in a separate restraint register. Information recorded in these documents should include the steps taken to prevent restraint/seclusion, the reasons why restraint/seclusion was used, for what duration, and how the safety and health of the patient was continuously monitored; and
5. Monitor the use of restraint across all psychiatric hospitals and social care institutions through data collected in institution's restraint register and monitoring visits.
6. **Psychiatric hospitals** should advise patients in writing about the methods of restraint that may be used if they demonstrate specific behaviours and this should be repeated verbally if the situation arises when restraint may be deemed necessary;
7. Ensure that staff engage in a dialogue with patients so as to ensure if at all possible that patients are given an opportunity to consent to the type of restraint method that may be used if necessary. Ensure that mental health services are encouraged to utilise supported decision-making in order to realise this;
8. Adopt written policies on the use of restraint that emanate from Ministry guidelines; and
9. Limit the duration of restraint/seclusion to the minimum possible extent.
10. **The Ministry of Health and Social Affairs** should, according to the Law on Mental Health, develop an ordinance on restraints. The Ministry should proceed to do this as a matter of urgency and disseminate and routinely update guidance for staff working in mental health services on restraint and seclusion;
11. Arrange training for staff in psychiatric hospitals on the use of these policies and the application of restraint; and
12. Ensure that staff of social care institutions know that the use of restraints such as straight jackets, belts or straps in such settings is unlawful and must not be used in any circumstance. Staff of social care institutions should be trained in how to manage aggressive residents and de-escalated situations which they perceive to be illustrative of a need for restraint through alternative conflict management methods. Regular monitoring of social care institutions should highlight if and why restraints are found on the premises.

7. Treatment

The right to health is embedded in international law, which is binding on Croatia,¹⁹⁵ and it is widely accepted that mental health constitutes a core component of the right to health. It has been authoritatively stated that “the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment”.¹⁹⁶ Thus, the right to health is connected with many other issues documented in this report, including housing, a right that is directly connected with the right to live in the community. Furthermore, the Convention on the Rights of Persons with Disabilities (CRPD) contains a right to rehabilitation, which should “enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life”.¹⁹⁷

7.1. Treatment plans

International standards mandate that treatment for patients in psychiatric hospitals should be directed towards protecting the dignity, rights, and freedoms of the patient.¹⁹⁸ Hence, treatment and care should be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised when necessary, and provided by qualified professionals.¹⁹⁹ The CPT stresses the necessity for such individual plans to be written in a manner accessible both to the patient and to the clinical staff involved in the patient’s treatment.²⁰⁰ Croatian legislation adds to these requirements by prescribing that every person with a “mental disorder” that is admitted to a psychiatric institution has the right to take an active part in the planning and implementation of his or her therapy, recovery, and re-socialisation.²⁰¹ MDAC and SHINE’s monitoring found that these provisions are not adequately and systematically put into practice; procedures between institutions, as well as between units of the same institution, often differ.

In **Jankomir**, monitors were told that treatment plans are designed during weekly multi-disciplinary team meetings with a psychiatrist, a social worker, a unit doctor, and a head nurse; these treatment plans were

195 See in particular Article 25 of the CRPD, and Article 12 of the International Covenant on Civil and Political Rights in which States parties recognise “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

196 See Committee on Economic, Social and Cultural Rights, “General Comment No. 14: The Right to the Highest Attainable Standard of Health”, 2000, para. 4.

197 CRPD, Article 26.

198 Committee of Ministers of the Council of Europe (2004) Recommendation to member states concerning the protection of the human rights and dignity of persons with mental disorder, Recommendation No. R(2004)10, 22 September 2004, Article 12.

199 Ibid, Article 12 and the 8th CPT General Report, para. 37.

200 See CPT 2003 Report, para. 133.

201 Law on Mental Health, Article 11 para 1 and 3.

then subsequently developed during sessions with the patients themselves. Monitors commended the staff of **Jankomir** for this practice. However, in **Rabj Popovača**, and Ugljan, several patients complained that they were never given an opportunity to participate in creation of their respective treatment plan, whilst others were unsure of what their treatment consisted of, or were unaware that they had a treatment plan at all. When asked about their individual treatment, one patient in **Rab** commented, *“I am stuck here with all these people, I didn’t know I should have a personal treatment.”* In **Popovača**, it was unclear whether a multi-disciplinary approach is taken at all; the medical documentation in many cases was comprised of only psycho-pathological information. Of greatest concern was **Ugljan** hospital, where the institutional rules actually prohibit patients from actively participating in their treatment: *“The patient cannot decide nor participate in the choice of therapy that is given to him/her, but s/he has the right to get an answer about medication given, if s/he is capable of understanding or accepting the explanation”*.²⁰² When questioned about this, **Ugljan** staff told monitors that patients did have individual care plans. However, when monitors asked to view some of these, only drug charts were presented. International law requires more than a drug chart: it requires an individualised plan which sets out activities and steps towards rehabilitation which, as noted above, is defined in the CRPD as an obligation on States to “enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life”.²⁰³

There are no specific international or Croatian legal provisions that address the healthcare of residents within social care institutions, yet persons living in these institutions should be able to access healthcare on an equal basis as those who live in the community. Ideally, residents should have treatment plans tailored to their specific needs. These plans should address problematic health or behavioural issues and establish a time-bound course of steps to provide treatment, therapy, rehabilitation, and appropriate medical treatment. This individual approach to treatment and participation in one’s own health and welfare should contribute to the maintenance or development of a patient/resident’s decision-making capabilities, and ultimately facilitate their rehabilitation and reintegration into the community.

However, the monitoring team found neither individually tailored treatment plans, nor formal or regular assessment of residents’ capabilities, in any of the monitored social care institutions. The following obstacles were listed by the staff as the most common barriers to individual treatment: a lack of financial resources, staff shortages, a large number of residents with a mixed spectrum of diagnoses (as well as the differing health needs of residents), and the absence of guidance and training from the Ministry of Health and Social Welfare. One social care institution director stated that individualised treatment was *“simply not feasible.”*

Despite these problems, monitors observed promising attempts to provide individual plans at both **Mirkovec** and **Lobor-grad**, and therefore commend the directors of these institutions for their commitment to prioritising residents’ health care and rehabilitation amid challenging circumstances. A psychologist at **Lobor-grad** showed monitors a comprehensive template named “Individual plan for therapy”, which was being designed for all new residents coming to the institution. This template is supposed to be jointly

202 Ugljan Hospital House Rules, Article 28.

203 CRPD, Article 26.

filled out by a resident doctor, a nurse, and a social worker; it consisted of sections that address problems, goals and interventions (along with psychological and physiological functioning of the resident), and the team's conclusion and action plan. The monitoring team was told that the process of completing the assessment was intended as a requirement for all residents. MDAC and SHINE strongly recommends that other institutions follow **Lobor-grad's** lead in developing individualised treatment programmes as a matter of priority.

7.2. Types of treatment

In general, psychiatric treatment can include both pharmacotherapy (administration of medication) and a wide range of rehabilitative and therapeutic activities, including "talking-therapies". Pharmacotherapy should not only entail prescribing medication but also monitoring its effects, and determining the necessity of its continued use. In this respect, the CPT has highlighted the importance of regular reviews of both a patient's state of health and any prescribed medication, as a means of enabling "informed decisions to be taken as regards a possible de-hospitalisation or transfer to a less restrictive environment".²⁰⁴ International standards also call for the provision of a broad range of therapies including: occupational and group therapy, individual psychotherapy, art, drama, music and sports, access to recreation rooms and outdoor exercise, as well as educational and employment opportunities to enhance independence and functioning.²⁰⁵ These standards are elaborated further by Croatian legislation, which stipulates the right to participate in education and work-training according to general or specialised curricula.²⁰⁶ This legal provision appears to be only partly implemented.

In practice, treatment across all hospitals consisted principally of pharmacotherapy (medication). The availability of, and the importance given to, psycho-social and other forms of therapy was far lesser in comparison. **Jankomir** was a notable exception, where monitors were impressed by the initiatives the director had taken to both provide training in psychotherapy for several staff members, and to encourage the staff to consider a psycho-dynamic approach.

None of the social care institutions employed a psychiatrist full time, although all have psychiatrists available on a contractual basis. These psychiatrists visit the institutions at intervals, between two and four times per month. The social care institutions refer residents to psychiatrists on an as-needed basis. In order to evaluate the practices of pharmacotherapy in the institutions, a medically-qualified member of the monitoring team checked a selection of medical records. Across the institutions, it appeared that the psychiatric status of residents was routinely followed up and that residents were receiving medication based on the prescriptions by psychiatrists. The majority of medical files seen by the medically-trained monitoring team member included notes reviewing prescriptions, and short comments on psychiatric status.

204 The 8th CPT General Report, para 40.

205 See the 8th CPT General Report, para 37; see also Equalisation of Opportunities Rules, Rule 3.

206 Law on Mental Health, Article 11 para 1 and 4.

General medical treatment was available to residents of all social care institutions – monitored, either directly by the staff, or by contracted medical doctors from local hospitals or medical providers. The monitoring team found that general practitioners (family doctors), psychiatrists, gynaecologists, and dentists, were available for visits at least once per week in order to address residents' needs. Moreover, institutions also arranged hospital visits for their residents on an as needed basis. Monitors witnessed this exact process at **Mirkovec**, and the residents of other institutions expressed no complaints about their access to general health care.

7.3 Medication

Across all psychiatric hospitals, the use of second generation anti-psychotic medications has been integrated into treatment regimes, and it was positive to see regular on-site testing for those patients who were taking medication which required such testing. In general, the patients who were interviewed said that they were informed of their diagnosis, and many appeared to have at least some understanding of their medication regime. However, there were notable instances where this was not the case. For example, one patient in **Ugljan** who was detained under mental health legislation told monitors: *"I don't know my diagnosis. I take five milligrams of Apaurin [Diazepam] and fifty milligrams of Laponex [Clozapine] in the morning and afternoon, and Apaurin and one hundred milligrams of Laponex in the evening to sleep"*. The same patient said he had never been told why the psychiatrist prescribed this treatment, what the prognosis was, or what the likely side effects would be.

Moreover, the monitoring team observed patients with symptoms of overmedication (tremor, sleeping in the day, and stupefaction), which limited the ability of monitors to question patients about their treatment. Patients displaying these symptoms, or a combination of them, was common in some units of **Popovača**, **Ugljan** and **Rab** hospitals. The principle effect of overmedication is sedation, and it was difficult for monitors to determine whether this practice illustrated an institutional culture, or rather, the intentional result of efforts to cope with the effects of inadequately-trained and low levels of staff. Either way, patients who remain asleep or bedridden due to overmedication have little opportunity to engage in the complementary psychotherapeutic and occupational activities the law entitles them to, or to play an active role in the decision-making and management of their treatment. It also reduces their ability to assess the reasons for their admission to the hospital or to consider whether they would like to leave, and if necessary, to take the legal action to do so. Some psychiatrists working on the institutions visited shared monitors concerns, with one saying that he had been systematically reducing the doses of patients' medication since the start of his tenure as psychiatrist to the institution's residents.

Patients in the psychiatric hospitals of **Ugljan** and **Rab** made additional complaints regarding significant delays in meeting with their psychiatrists to discuss the alleviation of unpleasant side effects of medication. These included: twitching, nausea, restlessness, headache, palpitations, and general malaise. Staff told monitors that the reason for such delays was a lack of available psychiatrists.

With the exception of **Vojnić**, monitors observed that residents of social care institutions knew the names of the medication they were taking, and were aware of their diagnosis. However, they were not always informed or aware about how the medication prescribed may help their condition, or how they could take an active role in their therapy. Some patients also expressed frustration over their lack of involvement in the process of developing their psychiatric treatment. For example, a resident at **Lobor-grad** said that *“almost everyone in the home is labelled a schizophrenic.”* He knew the medication he was taking but was not happy about it; when asked why he did not consult his psychiatrist to request a change, he replied that he *“would not be taken seriously”*. Similar concerns were expressed at **Vojnić**, where the majority of residents interviewed were totally unfamiliar with one or all aspects pertaining to their diagnosis, medication, and/or the potential benefits and risks of their treatment.

The monitors found that residents did not self-medicate in any of the social care institutions visited, and that nurses distribute and oversee medication. In **Lobor-grad**, the nurse was seen going to the units to distribute medication. However, residents in other institutions were required to go to the clinical room to receive their medication. In this room,, they were supervised to ensure that it was taken. In **Osijek**, residents’ mouths were checked to make sure that they had swallowed their tablets. Nurses stressed, however, that if a resident refused to take their medication despite nurses’ best efforts to convince them, they would ultimately not be forced. However, it was found that 93% of residents in **Osijek** are under guardianship, so these residents have no authority in law to refuse their treatment if the guardian has given consent. This raises potentially serious human rights concerns.

7.4. Evaluation

Article 25 of the CRPD obliges States to “raise awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private healthcare” as a prerequisite to ensuring “that care is provided on the basis of free and informed consent”. It is clear that much psychiatric care and treatment in Croatia fails to meet this basic standard. The monitors observations, in conjunction with the nature of the complaints about medication and treatment in both the psychiatric and social care institutions, leads to the following conclusion: there are violations of the right to health in these institutions, and depending on the individual circumstances, potentially a violation of the right to be free from torture and inhuman or degrading treatment or punishment. The monitoring team was disappointed to observe an overall attitude of staff that patients/residents lacked the capacity to understand “what’s best for them”, and therefore do not need to be involved in, or informed of, treatment decisions made on their behalf. This leads to a purely functional administration of medication that fails to take into account the human rights of the individual involved, and leaves them no choice to but to put their trust in institution staff. Such regimes contribute to the exercise of power over patients/residents by the institutions themselves, further individual’s disempowerment and likelihood of lifelong institutionalisation, and increase the possibility for convenient measures of control – such as over medication – to become the norm. A right to health cannot be realised if treatment is based on the premise that the individual is not expected to get better and return to the community.

Recommendations

1. **Psychiatric hospitals** should ensure that according to the Law on Mental Health, individual treatment plans are adopted and implemented for every patient;
2. Ensure that patients are offered a choice between therapies, or of not taking medication at all; and
3. Ensure that patients receive information about their diagnosis and what it means, the potential benefits, side effects, risks of the proposed medication, and the potential benefits and risks of not taking such medication.

More information about the **Mental Disability Advocacy Center** can be found at www.mdac.info

Our vision is a world of equality – where emotional, mental and learning differences are valued equally; where the inherent autonomy and dignity of each person is fully respected; and where human rights are realised for all persons without discrimination of any form.

Our mission is to advance the rights of children and adults with intellectual disabilities or psycho-social disabilities. We achieve this through three organisational objectives:

1. Creating a body of progressive jurisprudence
2. Instigating law reform
3. Empowering people with disabilities and promoting participatory politics

We operate within four intersecting programmes:

1. Strategic litigation
2. Advocacy
3. Research and monitoring
4. Capacity-building

Please see our website for related publications including:

1. The ITHACA toolkit for monitoring human rights and general health care in mental health and social care institutions.
2. Building the architecture for change: Guidelines on Article 33 of the UN Convention on the Rights of Persons with Disabilities.

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