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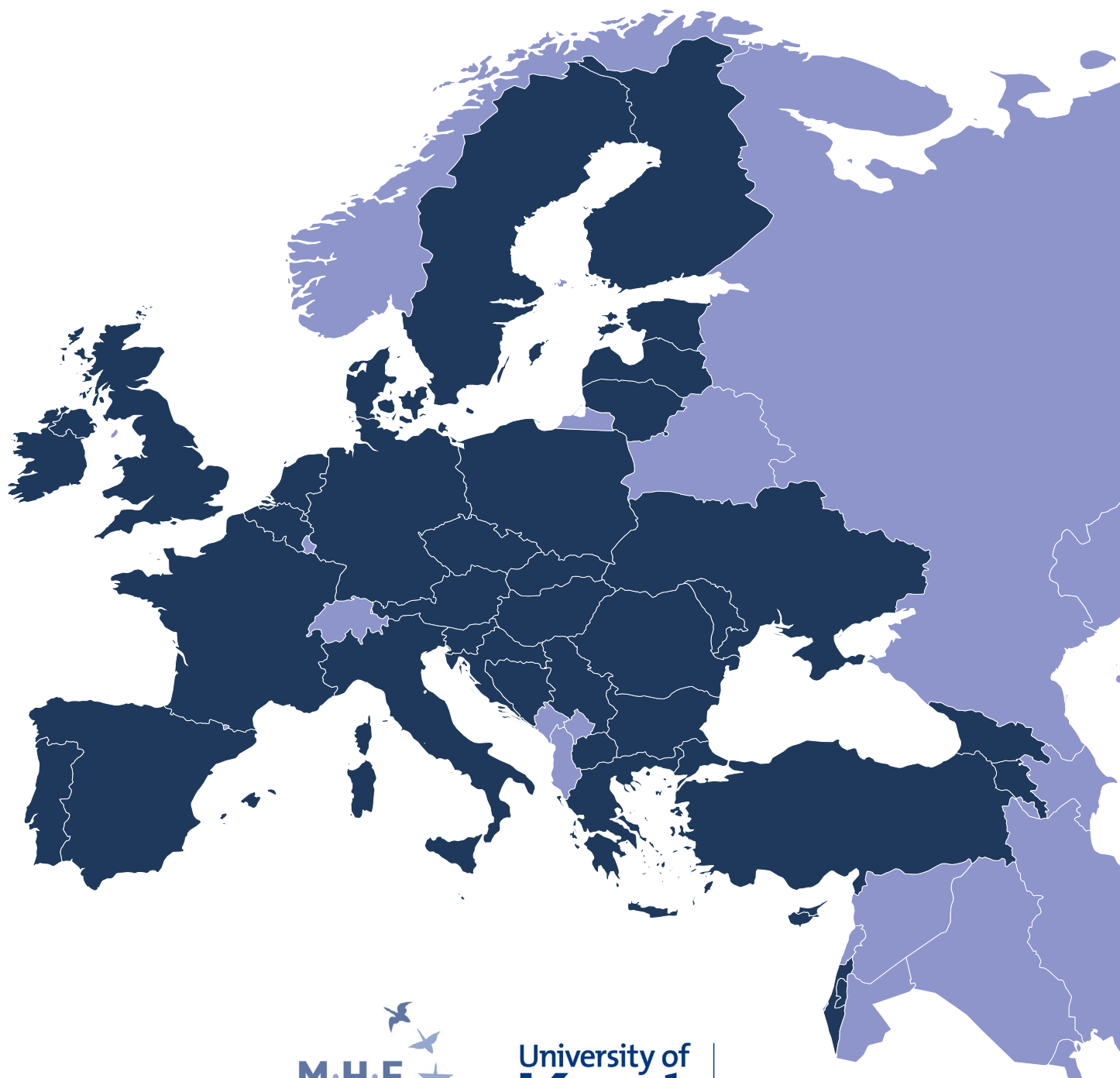
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MAPPING & UNDERSTANDING EXCLUSION IN EUROPE



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ABOUT MENTAL HEALTH EUROPE

Mental Health Europe is a European non-governmental network organisation committed to the promotion of positive mental health, the prevention of mental distress, the improvement of care, advocacy for social inclusion and the protection of the rights of (ex)users of mental health services, persons with psychosocial disabilities, their families and carers.

www.mhe-sme.org

ABOUT THE TIZARD CENTRE

The Tizard Centre at the University of Kent is one of the leading UK academic groups working in intellectual and developmental disability and community-based services.

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MAPPING AND UNDERSTANDING EXCLUSION: INSTITUTIONAL, COERCIVE AND COMMUNITY-BASED SERVICES AND PRACTICES ACROSS EUROPE

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FOREWORD



Prof. Dr Dainius Puras,
United Nations Special Rapporteur on the right
to physical and mental health

When I was asked to write the foreword to the present report – *Mapping and Understanding Exclusion* – I tried to find similar European-level research which not only looked at mental health systems from a health but also a human rights perspective. I quickly realised that this report is unique in its perspective as well as its ambition: to map Institutional, coercive and community-based services and practices in 36 European countries.

My work as the UN Special Rapporteur on the right to physical and mental health has taken me around the world where I have witnessed first-hand the impact of poor quality mental health systems which tend to undermine and violate human rights. My experience as a child psychiatrist and human rights advocate in Lithuania, and greater Central and Eastern Europe, has shown me that despite many efforts and good practices, Europe remains dependent on outdated practices such as institutionalisation and excessive medicalisation. This report is proof positive that much needs to change. It also shows that institutionalisation, long thought of as a Central and Eastern European issue, continues in many Western European countries unabated.

The new focus of the report on coercive measures – such as forced placement and treatment, seclusion and restraint – draws welcome attention to a key issue which has remained in the shadows and gone unaddressed for many years. My view, which was presented in my report on mental health to UN Human Rights Council in 2017, is that the role of psychiatry and other mental health professions, is crucial in the process of change, and that the current status quo, where coercive measures, which should be exceptional but are really widely used, pave the way for massive and systemic violations of human rights of users of mental health services and are detrimental to the health and quality of life of people with mental health problems. Furthermore, the placing of the voices of people with lived experience of these measures front and centre in this report is commendable. The United

Nations Convention on the Rights of Persons with Disabilities requires a paradigm shift in mental health, not least by placing people with mental health problems at the centre of services and by ensuring that they are involved in decisions which affect their lives. Reading the stories of these individuals who report feeling traumatised, isolated and let down by coercive mental health services gives a unique insight into what it is like to be on the receiving end of such measures and will help readers to better understand the experience, the exclusion and stigma that people with lived experience face.

This publication gives reasons to be optimistic and highlights some promising practices (new legislation, pilot programmes, new systems of support etc) aimed at the provision of better mental health services and support. It also speaks to the huge transformative potential for change provided by the EU funding which in recent years, has prioritised investment in the transition from institutional to community-based services. These promising practices should not be considered “alternatives” and should be placed at the centre of mental health systems and coercive services and institutional care should rather be considered unacceptable alternatives that need to be abandoned. Without such bold commitment countries will continue the same pattern of ineffective investment and continue to develop mental health systems of poor quality. This report should be read by every Minister of Health, every mental health professional and academic, every family member and anyone who has any interest in improving mental health services across Europe. It is a wakeup call about the kind of exclusion that results from poor, institutional and coercive mental health practices. The status quo is not good enough; we can and should do better to ensure that mental health services are centred around people, their recovery and that they fully respect their human rights. This report contributes to that future by showing what needs to change.

A NOTE ON TERMINOLOGY

Throughout the report, we use the term 'people with mental health problems' which refers to people who experience or have experienced mental distress, some of whom may have a psychiatric diagnosis, such as depression, schizophrenia, or psychosis. The term 'users/ex-users and survivors of psychiatry' is used to refer to people with lived experience of mental health services or in the context of survivor-led research or survivor organisations. The terms 'patients' or 'residents' appear in relation to statistics or the description of policies or legislation. The relatively new term 'psychosocial disabilities' is an internationally recognised term used in policy work, in particular by the United Nations Committee on the Rights of Persons with Disabilities, to describe the experience of people who have long-term mental impairments which, in interaction with various societal barriers, may hinder the full realisation of their rights. A glossary of key terms used throughout the report can be found below.

GLOSSARY

Coercive measures – refers to involuntary, forced or non-consensual measures carried out in mental health services against people with mental health problems. (See also definitions on involuntary, forced or non-consensual placement and treatment, seclusion and restraint).

Community-based care/services – the spectrum of services that enable individuals to live in the community. It encompasses mainstream services, such as housing, healthcare, education, employment, culture and leisure, which should be accessible to everyone regardless of the nature of their issues or impairment or the required level of support.

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) – the CPT is the anti-torture Committee of the Council of Europe which examines the treatment of people deprived of their liberty with a view to preventing torture and other inhumane or degrading treatment by means of visits and inspections including to mental health facilities.

Community Treatment Orders – also known as CTOs – can be defined as legal orders from a magistrate, clinician or other legally empowered body/person which requires a person with a mental health problem to adhere to treatment in the community. CTOs may also require the person who is the subject of the order to fulfil other conditions i.e. to

live in a certain place or attend at their physicians. If a person with a mental health problem does not follow the conditions of a CTO, they may be asked to return voluntarily to or be forcibly placed in a psychiatric hospital. The legal definition and parameters of CTOs can vary from country to country.

Deinstitutionalisation – the process of developing a range of services in the community regulated by rights-based and outcomes-oriented standards, including prevention, in order to eliminate the need for institutional care.

Guardianship – is a form of substitute decision-making where a person, usually with a disability, is deprived by law of their legal capacity (see definition below) or found to be 'incapacitated' and is appointed a guardian (or trustee or curator etc.) who is empowered to make decisions for or represent the interests of that person. Different types of guardianship regimes exist across Europe including partial guardianship which allows guardians to make decisions in certain areas of life and full or plenary guardianship which empower guardians with total control over the lives of their wards.

Institutions – “any residential care where residents are isolated from the broader community and/or compelled to live together; residents do not have sufficient control over their lives and over decisions which affect them; and the requirements of the organisation itself tend to take precedence over the residents' individualised needs.” (European Expert Group on the Transition from Institutional to Community-based Care: Common European Guidelines, p. 25) Institutions are generally characterised by 'institutional culture' rather than by their size. Types of institutions include long-term

care beds/wards in specialist or general hospitals, institutional residential or social care homes or Social Care Institutions as they are referred to in this document.

Involuntary, forced or non-consensual placement/commitment or treatment – can be defined as any treatment or placement in/commitment to hospital or other institution administered against someone's expressed wishes – expressed verbally or by any other means (body language, advanced directive etc.). Please note that the legal definitions of involuntary placement and treatment vary from country to country.

Legal capacity – is a human right and ensures that people have capacity to be a holder of rights and an actor under the law. At its most simple, legal capacity enables people to make decisions for themselves and for those decisions to be recognised including through the law.

People with mental health problems – people who experience or have experienced mental distress, some of whom may have a psychiatric diagnosis, such as depression, schizophrenia, or psychosis.

People with lived experience – people who experience or have experienced mental distress.

The term is broader and more descriptive than 'mental health problems'. Its underlying assumption is that mental distress is a meaningful human experience, and that it is for the individual to make sense of their own experiences within the context of their personal story. It positions the person as having expertise in their own experience (hence the equivalent term 'expert by experience'). It can be used on its own, or in conjunction with specific experiences, for example 'lived experience of hearing voices' or 'lived experience of coercive measures'.

Users/ex-users – people with lived experience of using mental health services.

Survivor – a rights-based term mostly used by mental health/survivor advocates. The term survivor seeks to show that some psychiatric treatments can be abusive (e.g. forced/involuntary treatment) and may not comply with human rights. It can also refer to a person who has been living/is still living with mental distress.

Supported decision-making – is the practice of supporting people with disabilities and mental health problems to make decision for themselves rather than substituting decisions with those made by a substitute decision-maker (see guardianship above for an example of substitute decision-making regime).

Psychosocial disabilities – an internationally recognised term used in policy work, in particular by the United Nations Committee on the Rights of Persons with Disabilities, to describe the experience of people who have long-term mental impairments which, in interaction with various societal barriers, may hinder the full realisation of their rights.

Recovery – recovery is self-defined, but broadly means living a meaningful and satisfying life, with hope for the future. Recovery is not the eradication of the experiences or 'symptoms' accompanying mental distress, as it would be used in the context of physical health. It can mean living with and managing these experiences, whilst having control over and input into your own life.

Restraint – there are various different types of restraint used in mental health services including:

Physical restraint – the use of manual holding to prevent or restrict the movement of one's body or parts of the body. Mechanical restraint – the use of devices (e.g. handcuffs, straps etc.) to prevent or subdue the movement of one's body or parts of the body.

Chemical or pharmacological restraint – the use of medication to control or subdue behaviour (e.g. rapid tranquilisation).

Seclusion – confinement in a room or secluded area from which a person cannot freely exit.

United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) – legally binding human rights convention signed and ratified by many European States and the European Union.

EXECUTIVE SUMMARY

This report entitled “Mapping and Understanding Exclusion- Institutional, coercive and community based services and practices across Europe” is a new and expanded edition of Mental Health Europe’s 2012 Mapping Exclusion report. The report was put together by the University of Kent and Mental Health Europe (MHE), with the help of MHE members and partner organisations, and with support from the Open Society Mental Health Initiative and the European Union’s Rights Equality and Citizenship Programme. The report aims to capture updated and more comprehensive information on European countries’ mental health laws, the use of involuntary or forced placements and treatments, the practice of seclusion and restraint, as well as emerging issues in the mental health field in Europe. In mapping mental health systems across Europe, the report also sheds light on the situation of human rights for people who use mental health services and people with psychosocial disabilities. This time around there is a special focus on the stories of people who have experienced institutionalisation and coercion in mental health services which we hope will contribute to a more profound understanding of the exclusion these individuals face in society.

The report shows that while the situation described in 2012 has changed somewhat, there is still a substantial number of people with mental health problems living in institutions across Europe and in need of community-based services. Although reforms have taken place, the report shows that there are several barriers such as the poor cooperation between social and health authorities, lack of human rights compliant community-based services, trans-institutionalisation and austerity. Furthermore, in recent years deinstitutionalisation has been painted as a largely Central and Eastern European issue, however institutions exist in many Western countries as well, including France, Belgium, Ireland, the Netherlands, Portugal, and Germany, where tens of thousands of people with mental health problems are still living and where little is being done about this situation. In Central and Eastern Europe, the implementation of EU-funded deinstitutionalisation programmes has been slow, and there are limited data about the actual outcomes of these programmes for people with mental health problems.

The personal testimonies which were graciously provided by people with lived experience of coercive measures and collected for this report show that involuntary placement and treatment can have long-term and devastating effects on people’s lives. Lack of information before and during admission, poor physical conditions, forced medication with severe side effects, the absence of legal aid, physical and emotional harm, social and physical isolation, and stigma all featured in personal testimonies of ex-users and survivors.

In the previous Mapping Exclusion report in 2012, several countries were planning or implementing progressive – and promising – legal capacity reforms. However, by 2017 our report found that only some countries have actually changed their relevant laws and practical implementation of supported decision-making remains wanting almost everywhere. Overall the evidence collected in this report shows that the human rights issues facing people with mental health problems and psychosocial disabilities both within and outside of mental health services should still be of great concern.

RECOMMENDATIONS

Based on the report, we have put together the following recommendations:

1. Those States who have not done so, adopt holistic deinstitutionalisation strategies in partnership with representative organisations of persons with mental health problems and psychosocial disabilities and other relevant stakeholders which are in line with human rights standards, bringing in all relevant ministries and sectors, including health, social care and employment, and are supported by adequate investment to ensure the sustainability of the transition to recovery-oriented, human rights compliant community-based mental health services and supports.

2. In order to reduce coercion in mental health services, European States should:

- Adopt policies which aim to immediately reduce coercion in mental health services and ultimately eliminate such practices altogether in line with human rights standards. Policies and practice should also focus on: providing information to people and their families about their rights and their health; improving the communication between community and hospital teams; utilise “zero visions”, de-escalation procedures and other techniques; establishing outpatient mobile units; and providing human rights training for users and staff with a particular focus on the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) and informed consent

- Support the empowerment of (ex)users of mental health services and persons with psychosocial disabilities and their representative organisations and ensure that they know their rights and can participate in all decisions concerning their lives, in line with Article 4.3 of the UN CRPD;

- Move towards systems of supported, rather than substitute, decision-making in line with Article 12 of the UN CRPD, including through the amendment of capacity and mental health legislation as well as the creation of support services and scaling up of promising practices;

- Properly document and report all incidence of the use of involuntary placement and treatment, restraint and seclusion and reasons for their use and publicly release this data.

3. In line with Article 31 of the UN CRPD, States should document institutional placements and make the statistics

publicly available. Such statistics should be disaggregated to contain data on number of placements, type of institution, duration, reasons for placement as well as demographic characteristics such as age and gender.

4. In line with Article 8 of the UN CRPD, States should invest in population level anti-stigma programmes which are evidence-based. Advocacy campaigns and awareness-raising both at the national and the local levels should always be an integral part of mental health reforms, deinstitutionalisation strategies and implementation.

5. States should introduce personal budget schemes to support deinstitutionalisation and independent and community living. Those States that already have such schemes should ensure that these are available to people with psychosocial disabilities on an equal basis with other persons with disabilities.

6. States need to better monitor deinstitutionalisation programmes and gather data to ensure that people with mental health problems are benefitting from reforms and that the alternatives created through these programmes actually support independent and community living, in line with Article 19 of the UN CRPD.

7. The European Union (EU) should ensure the continuation of vital support for the transition from institutional to community-based services in the Post-2020 Multiannual Financial Framework while also ensuring the strengthening, extension and efficient monitoring of the conditionalities in the regulations governing the use of funds and that funding processes are simplified and reformed to ensure that all funds are used to make the greatest impact possible and in a manner that complies with human rights standards.

8. Efforts at EU level should be complemented by the exchange of information and experiences between countries in the mental health field including follow-up to the Joint Action on Mental Health and Well-being and the EU Compass on mental health and well-being.

9. The EU should provide funding for research on alternatives to coercion, for the scaling up of promising practices on supported decision-making as well as for the empowerment of users of services and persons with psychosocial disabilities.

SETTING THE SCENE

Dan Chisholm,
Programme Manager for Mental Health,
WHO Regional Office for Europe



In 2001, the World Health Organisation (WHO) devoted its World Health Report to the topic of mental health. The title of the report was ‘Mental health: new understanding, new hope’, while the accompanying World Health Day campaign in that year ran with the refrain ‘Stop Exclusion – Dare to Care’. The focal themes chosen back then resonate just as strongly today, no more so than with the publication of this new, updated report on Mapping and Understanding Exclusion across Europe, which reveals just how far we remain from achieving an inclusive, fair and respectful society for everyone to live in.

There are many obstacles holding back meaningful progress towards these socially desired objectives, including outdated laws, misguided policies, limited resources and insufficient use of evidence and information, but lurking behind all of these shortcomings is something arguably more fundamental still: a collective mis-understanding about the intrinsic value of mental health, about the social and other determinants of mental health, and indeed about the rights and entitlements of persons with mental health problems and psychosocial disabilities. These misunderstandings fuel the low priority accorded to mental health promotion and protection, the overly biomedical approach to treatment in many jurisdictions, as well as the stigma and discrimination that so many people with mental health problems face on a daily basis.

Accordingly, the new understandings and insights offered by this new publication on the state of mental health care services across 36 European countries provide a vital source of evidence and information for policy reflection, reformulation and reform. Monitoring of the extent to which countries are implementing their own national mental health policies and plans, and indeed fulfilling their commitments towards internationally agreed goals (e.g. the UN Sustainable Development Goals), conventions (e.g. the UN Convention on the Right of Persons with Disabilities) and action plans (e.g. the WHO European Mental Health Action Plans), is a vital prerequisite for enhancing health system performance and also accountability in the mental health sector. The country-specific profiles contained herein, for example, can be used directly alongside other data sources such as the Mental Health Atlas as inputs into the reporting of progress towards implementation of the European Mental Health Action Plan in and up to the year 2020. The time period for the UN Sustainable Development Goals extends out even further, to 2030, so this new framework should be fully exploited as an opportunity to advocate more strongly for mental health and human rights, not just because mental health and well-being is included as a specified target of the health goal but also because of the mental health links to other goals, most notably those addressing inequalities, inclusion and justice (summarised by the maxim to ‘leave no one behind’).

A particularly welcome addition to this new publication is the use of personal testimonies, which provide a far more direct and explicit account of lived experiences than any amount of country profiling can provide. Accounts of survivorship, but also recovery, are necessary elements of a holistic evaluation of what a mental health care system can do to people. The combination of this micro-level data along with overall country profiles (macro level) and the assessment of individual institutions (meso level) provide the optimal approach to changing policy and practice for the good. At this meso level, the WHO Regional Office for Europe is currently working with 25 Member States on assessing quality standards and human rights protection in selected long-term institutions for persons with intellectual and psychosocial disabilities, with a view to introducing systemic quality improvements via enhanced capacity-building and use of the WHO QualityRights toolkit (which is founded on the main articles of the UN Convention on the Rights of Persons with Disabilities). Together, these related but distinct sources of information unmistakably point to systemic deficiencies in the provision of care and support for persons with intellectual, cognitive and psychosocial disabilities living in long-term institutions across the European region. It is incumbent on governments as well as other national and international partners to turn this evidence of hurt and neglect into targeted opportunities for change and improvement, not just in terms of quality improvement within existing institutions but also in terms of a determined effort to shift the whole locus of care away from them. For this to happen, a change in mindset is needed at all (public, professional and policy) levels of society, to be brought about by evidence-based advocacy, the sharing of testimonies and perspectives, and the building up of awareness, knowledge, capacity and competency. With new understanding comes new hope.

INTRODUCTION

The previous Mapping Exclusion report filled a gap in the knowledge about the state of institutional and community-based mental health services across the European Union (EU) and while some of the information remains relevant, there are some important developments. The new edition – entitled ‘Mapping and Understanding Exclusion- Institutional, coercive and community-based services and practices across Europe’ - aims to capture more information on mental health laws, the use of forced placements and treatments, seclusion and restraint as well as emerging issues in the mental health field in Europe. In mapping mental health systems across Europe, the report also aims to shed light on the situation of human rights for people who experience mental ill-health including those who use mental health services and people with psychosocial disabilities. This time around there is a special focus on the stories of people who have actually experienced institutionalisation and coercion in mental health services and we hope this new additional chapter will contribute to a more profound understanding of the exclusion these individuals may still face in society.

Mental Health Europe collaborated with the Tizard Centre, University of Kent in updating the report. The project was overseen by an Advisory Group consisting of representatives of (ex) users and survivors of psychiatry, human rights experts, members of the disability movement, mental health professionals, and academics at every stage. Information and data for the report was collected between May and October 2017.

This report is presented in four parts. The first part is a review of recent literature – published since the previous Mapping Exclusion report – on deinstitutionalisation and, involuntary placement and treatment, seclusion and restraint. The second chapter explores the lived experiences of involuntary placement and treatment based on personal accounts of (ex)-users and survivors of psychiatry across Europe. The third chapter highlights some current issues and developments in mental health and social services, involuntary placement and treatment, and legal capacity drawing on the information provided by 36 country reports. The fourth and final chapter puts forward some conclusions and policy recommendations for national and European stakeholders. Country reports are presented in Annex 1.

LITERATURE REVIEW

AN EXPLORATION OF THE LITERATURE PUBLISHED SINCE THE FIRST EDITION OF MAPPING EXCLUSION

The aim of this chapter is to update the literature review from the last Mapping Exclusion report, and include literature pertaining to people with lived experience.

There are three specific objectives:

- To scope any developments in deinstitutionalisation and the transition from hospitals and long-stay institutions to a system of community-based supports in the mental health field.
- To identify the extent and reasons for involuntary placement and treatment, as well as the use of seclusion and restraint in mental health care, and to explore the experiences of people who are subject to such procedures reported in the research literature;
- To identify any gaps in research related to these areas.

DEINSTITUTIONALISATION AND THE TRANSITION FROM HOSPITALS AND LONG-STAY INSTITUTIONS TO COMMUNITY-BASED SERVICES

POLICIES

Deinstitutionalisation is generally defined as a shift in the provision of mental health care from hospitals and institutions to services in the community. It is widely accepted and endorsed by governments and international organisations all over the world such as the United Nations (Shen & Snowden 2014). The key issues and priorities facing the implementation of community mental health care differ in low-, medium, and high-income contexts (Thornicroft & Henderson 2016; Caldas Almeida et al. 2015).

For successful deinstitutionalisation, adequate resources must be created and/or shifted to the community. Some particularly helpful strategies have been identified (WHO 2014) including: the provision of mobile clinics and outreach services and of psychiatric beds outside psychiatric hospitals; the discontinuation of new admissions to institutions and the relocation of existing residents to community-based supported accommodation services; the adoption of a mental health policy and strategy; and support for self-help and user groups.

The issue of costs has also received some attention in the literature. Institutional services can appear less costly in middle-income contexts (in particular Central and Eastern Europe) where overall expenditure on mental health care is substantially lower (Petrea 2012; Krupchanka & Winkler 2016). However, any meaningful discussion of expenditure and efficiency must

¹ We searched for studies published in English after 2010 using a range of techniques and sources. Three academic search engines were searched – EBSCOHost (Academic Search Complete, CINAHL Plus, MEDLINE, PsychINFO, PsychArticles); SCOPUS; and PUBmed – using a combination of free text and controlled terms (e.g. MeSH terms) including: mental health/mental* ill*/psychosocial disability; deinstitutionalisation; forced/involuntary placement/admission/treatment; seclusion; restraint. For grey literature we searched the websites of relevant international organisations. MHE member organisations and members of the Advisory Group were contacted to recommend relevant publications. Searches took place in November 2016 and were then repeated in June 2017. Empirical studies were included in the literature review only if they were conducted in Europe and/or countries covered by the current report. Studies related to particular countries are listed under “further references” in the relevant country reports. The list of references can be found in Annex 2, under the Mapping Exclusion section of MHE’s website (www.mhe-sme.org).

also consider quality and outcomes. Low costs tend to be associated with poor quality (although, the reverse is not necessarily true). In effective mental health care systems, the cost of supporting people with substantial needs is likely to be high whether they live in a hospital or in the community (Knapp et al. 2011).

Deinstitutionalisation is also more than simply reducing the number of beds in psychiatric hospitals; however if the process is managed primarily as “dehospitalisation” there can be many adverse effects such as homelessness, re-institutionalisation, and trans-institutionalisation (WHO 2014, pp. 17-18). Deinstitutionalisation has also brought about highly differentiated mental health systems, where restrictive or long-term interventions for individuals with chronic or more severe mental health problems are increasingly shifted to other sectors, such as social care or the criminal justice system, and coercion in the community is on the rise (Novella 2010a, 2010b). At the same time the notion of institutionalisation has also evolved: it should no longer be conceptualised based on the length of stay within physical facilities (Chow & Priebe 2013). Institutions are about control and power, and institutionalisation is “displayed in terms of policy and legal framework, in terms of clinical responsibility and paternalism, or understood as patients’ response to institutional care» (ibid. pp. 10-11). From this viewpoint many community-based services – such as some forms of supported accommodation – can be seen as new forms of institutionalisation.

Finally, while deinstitutionalisation might be a common term used to encompass the transformation in mental health systems, it fails to capture the “unique” historical processes of social change (Henckes 2011). Traditional accounts of deinstitutionalisation tend to focus on causal factors such as anti-psychiatry, new medication, neo-liberalism and new public management as driving forces but to understand deinstitutionalisation in a particular country, it is necessary to recognise the “historically situated” conditions that influence reforms and policy change.

In the context of Eastern and Central European countries – that rely most on institutional care – the tensions between external pressures and local implementation of mental health reforms have been highlighted (Petrea 2012; Phillips 2012; Winkler et al. 2017). Mental health legislation and policies are often ineffective (Krupchanka & Winkler 2016), and external pressures to close psychiatric hospitals can result in the transfer of people with severe mental health conditions to institutions outside the mental health care system (Petrea *ibid.*). Even the effects of joining the European Union were «more legislative and cosmetic than real” in relation to the rights of people with disabilities and deinstitutionalisation (Phillips 2012).

TRENDS

Various studies have explored recent trends in deinstitutionalisation, relying on different sources of data (e.g. OECD 2014; WHO 2014, 2011; Eurostat) and using different indicators (e.g. some focus only on psychiatric hospitals, while others examine long-term mental health facilities etc.):

- Globally, the availability of psychiatric inpatient beds declined (0.41% median decline annually) between 2000 and 2014. In Europe the overall availability of inpatient beds has remained the same, with some notable variations (Hudson 2016). From a longer-term perspective, the number of psychiatric beds declined across Europe (26 countries)² between 1993 and 2013 in Europe (Blüml et al. 2015).
- All post-communist countries³ saw the number of psychiatric beds decline in the period between 1989 and 2009 (this does not necessarily indicate progress, especially if implemented in the context of de-hospitalisation). There was more heterogeneity in forensic provision, which increased in some countries (e.g. East Germany), and stagnated or declined elsewhere (e.g. Czech Republic). The availability of «supported housing» has increased in the majority of countries but there are huge disparities between countries (Mundt et al. 2012).
- In Western Europe⁴ the overall number of psychiatric hospital beds fell, while the rate of forensic beds increased in the majority of countries between 1990 and 2012 (Chow & Priebe 2016).

Progress towards deinstitutionalisation has been investigated using the MENDit tool in 30 European countries (Taylor-Salisbury, Killaspy, & King 2016). With the exception of Italy and Iceland, all countries have inpatient psychiatric units and nearly two thirds provide some form of community-based residential care.

² Countries excluded due to inadequate data: Belgium, Czech Republic, Hungary, Liechtenstein, Luxembourg, Macedonia, Norway, and Turkey.

³ Azerbaijan, Belarus, Croatia, Czech Republic, East Germany, Hungary, Kazakhstan, Latvia, Poland, Romania, Russia and Slovenia.

⁴ United Kingdom, Ireland, Denmark, Austria, Belgium, France, Germany, Switzerland, Netherlands, Spain, and Italy

OUTCOMES

Deinstitutionalisation has far-reaching implications for the lives of people with mental health problems including their quality of life and lived experiences. Various studies examined the outcomes of deinstitutionalisation and evidence suggests that:

- Alternative and community-based services are associated with higher user satisfaction and autonomy (Howard et al. 2010; Lloyd-Evans et al. 2010; Osborn et al. 2010; Zerdila et al. 2013).
- Community-based alternatives are at least as effective as traditional hospital-based services in terms of mental health and quality of life outcomes (Howard et al. 2010; Carta et al. 2013; Thomas & Rickwood 2013).
- At the population level, no adverse effects of deinstitutionalisation have been identified, with some studies reporting important positive effects, such as increased life expectancy and social functioning (Westman, Gissler, & Wahlbeck 2012, Kunitoh 2013; Winkler et al. 2016).
- Increased provision of community-based mental health care is associated with better treatment and outcomes for individuals with long-term mental health problems, regardless of the level of deinstitutionalisation in a particular country (Taylor-Salisbury, Killaspy, & King, 2017).
- Community-based services are also at risk of becoming “institutional” and they could do better in improving the quality of life of people with mental health problems (McInerney et al. 2010; Forrester-Jones et al. 2012).

INVOLUNTARY PLACEMENT AND TREATMENT, AND THE USE OF COERCIVE MEASURES

Involuntary placement and treatment refers to any placement/admission to hospital or treatment administered against someone’s expressed wishes, expressed verbally or by any other means (body language, advanced directive etc.). Involuntary placement can take place in hospitals or in outpatient settings in the community. Compulsory community treatment includes various forms of legal statutes available in some countries – such as Community Treatment Orders – that compel individuals to adhere to treatment, certain conditions and/or supervision in the community.

In recent years – following mental health reforms in many European countries – there has been a shift towards more person-centred and recovery-led approaches. Nevertheless, involuntary placement and treatment remain common, although controversial, features of mental health systems and form part of legislation. The human rights community has increasingly grappled with the use of these coercive measures. The Committee on the Rights of Persons with Disabilities has stated in its jurisprudence that non-consensual commitment and/or non-consensual treatment carried out on the basis of actual or perceived impairment or health condition violates human rights.

Other coercive measures – seclusion and various methods of restraint, including physical, chemical and mechanic restraints – have been found, along with involuntary treatment, to be inconsistent with the prohibition of torture and other cruel, inhumane or degrading treatment or punishment against persons with psychosocial disabilities guaranteed in Article 15 of the UN Convention on the Rights of Persons with Disabilities.

The ethical justification and the clinical practice of involuntary placement and treatment is debated (Katsakou et al. 2012). Compulsory community treatment is especially contested, highlighting the inherent tensions between recovery, person-alisation, and coercion (Molodynski, Rugkåsa & Burns 2010; Banks, Stroud & Doughty 2015). Furthermore, emerging evidence suggests that compulsory community treatment is no more effective than voluntary treatment in the community (Burns et al. 2013; Kisely & Campbell 2014; Rugkåsa et al. 2015). There is a huge lack of robust empirical evidence regarding the effectiveness of coercive measures (Luciano et al. 2014; McLaughlin et al. 2016; Huber et al. 2016).

There are a number of methodological challenges in assessing and comparing the use of involuntary placement and coercive measures, and any findings should be interpreted with caution (Jansen et al. 2011; Bak & Aggernaes 2012).

PREVALENCE AND PATTERNS

According to the EUNOMIA study, there were significant differences in the use of coercive measures, both in terms of types and frequency, among European countries (Fiorillo et al. 2011). In particular, huge differences within and across countries are associated not only with the legal context but also with societal norms and culture, the characteristics of mental health care, as well as organisational factors (Steinert, Noorthoorn, & Mulder 2014; Kalisova et al. 2014). The use of involuntary placement and treatment also varies widely within and across countries (Gandré et al. 2017; McManus, McDonnell & Witty 2015; Bak & Aggernæs 2012).

A large European study (Raboch et al. 2010) involving 10 countries found that overall 38% of involuntarily admitted patients were subjected to some form of coercive measures within four weeks of admission. People who had a diagnosis of schizophrenia were at significantly greater risk of coercion than others. The most common coercive measure was forced medication (56% of all interventions), followed by restraint (36%) and seclusion (8%). Seclusion was associated with longer hospital stays and those subjected to forced medication were more likely to disapprove of their treatment (McLaughlin et al. 2016).

As regards the views of users of services on the appropriateness of involuntary placement, substantial differences among European countries were found (Priebe et al. 2010). A third of those affected thought that their involuntary placement was not justified three months after discharge. There were also substantial differences across countries that were not explained by the characteristics of participants. Women were also more likely to think that their admission was not right.

Research also highlights possible demographic and social variations in involuntary placement and the use of coercive measures although these findings should be interpreted with caution (Beghi et al. 2013). Some studies (Anderson et al. 2014; Iversen et al. 2011; Tarsitani et al. 2013) suggest that there may be ethnic differences in the risk of involuntary placement and use of coercive measures; however others (Kelly et al. 2015; Gajwani et al. 2016) found no such direct relationship, rather that it is mediated by other risk factors.

LIVED EXPERIENCES

There is a growing body of research exploring the lived experiences of individuals who are subjected to various forms of coercive measures.

A review exploring the experiences of involuntary placement (Seed, Fox, & Berry 2016) found that anger is commonly experienced during detention; although some individuals recognise potential benefits of involuntary placement (e.g. a “relief” or “sanctuary”). Staff practices and relationships – therapeutic and personal – are crucial, while disempowering practices and the use of coercive interventions erode trust and the therapeutic bond.

In their review of the lived experience of seclusion, Mellow, Tickle, and Rennoldson (2017) highlighted its negative emotional and sensory impact and concluded that it has the potential to induce harm. Staff play a key role in shaping the experience of seclusion: clear, open, and compassionate interactions and support can potentially mitigate the negative experiences; while uncompassionate care, inadequate support, lack of information and neglect of basic human needs are clearly harmful.

In a review of the lived experience of physical restraint, Strout (2010) identified four key issues: the negative psychological impact, re-traumatisation, perceptions of unethical practices, and the “broken spirit”. Physical restraint is often perceived as a form of control, a punitive measure, and the consequence of breaking ‘rules’. Restraint is also frightening, creating a feeling of helplessness, and violates the integrity of a person. Physical restraint has emotional consequences (e.g. trauma etc.) for those subjected to it as well as those delivering it (Cusack et al. 2016).

In relation to compulsory community treatment, feeling coerced and controlled to comply with Community Treatment Orders was a common experience, as people often felt they had no other choice (Corring, O’Reilly, & Sommerdyck 2017). Nevertheless, some regarded it as preferable to hospitalisation. Issues around medication were central, and many viewed the enforcement of a medication regime as the main purpose of CTOs potentially leading to conflicts with staff.

CONCLUSION

There is a large and growing body of research on deinstitutionalisation and especially on involuntary placement and treatment in Europe. Nevertheless, there are also some evident gaps. Most of the research comes from Western and Northern Europe, and there is relatively little information about Central and Eastern Europe apart from a few large and predominantly comparative studies, which allow little consideration of unique characteristics. As a consequence, there is limited research on the implementation of current deinstitutionalisation and mental health reform programmes. Research on the lived experiences of people with mental health problems is concentrated in only a few, predominantly English-speaking countries, with virtually no information on the lives of people with mental health problems elsewhere.

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UNDERSTANDING EXCLUSION: PERSONAL NARRATIVES OF INVOLUNTARY PLACEMENT AND TREATMENT, SECLUSION AND RESTRAINT

INTRODUCTION

Hospitalisation in the mental health field takes many forms depending on the country's legislation, availability of services or personal circumstances, and the choices of people with mental health problems. However, in many cases, both admission and treatment happen without the informed consent of the person. Moreover, involuntary admission to mental health facilities constitutes a pathway into residential institutions and long-term care (Fundamental Rights Agency, 2012).

In order to understand what happens to people when they are in the care of mental health services involuntarily, we asked people with lived experience about their own stories. We did this for two reasons:

Firstly, personal stories can give emphasis to individual experiences that may pass unnoticed in statistical or legal data. Medicalised understandings of 'what happens' to people in psychiatry are still dominant in much of the literature whilst narratives of those who have lived through those experiences are often regarded as secondary or interpreted only in a medicalised way. Yet, the experiences of people with mental health problems, in all their varieties and complexities, are crucial to understanding what happens in a residential or community setting. Therefore, the point is to bring in a different and experiential perspective of what it means to be placed in a mental health hospital, a clinic, a residential service or, in some cases, to be treated involuntarily in the community.

Secondly, involuntary admission and treatment have long been contested by mental health advocates and the movement of users/ex-users of psychiatry on moral as well as on human rights grounds (Chamberlin, 1978). Books, websites, articles, conferences and personal accounts by ex-users of psychiatry have called for a change in the understanding psychiatric care from the point of view of those who have experienced it (Russo & Sweeney, 2016). Human rights instruments, most powerfully and most recently, the UNCRPD have furthered the issue in the legal field putting emphasis on personal dignity and autonomy, freedom from torture and inhumane treatment, and equality before the law.

Therefore, it is the aim of this chapter to call on the personal accounts, kindly provided by respondents to our call for experiences, to provide readers with personal narratives about the experience of people who have been institutionalised and/or treated or hospitalised without their consent. Powerful, often devastating stories are revealed that tell us not only about what happened to people who submitted their testimonies but also what may happen to many more who might never speak up.

COLLECTING PERSONAL TESTIMONIES

In order to collect testimonies from people who have experienced involuntary placement and/or treatment, we aimed at setting the least possible limitations to participation. Requirements included having a personal experience of involuntary placement/treatment in Europe and submitting one's own story. Calls for participants were sent out by Mental Health Europe and its partner organisations, members, and also through the Tizard Centre social media sites.

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An online interface was set up by using an online survey tool (Qualtrics) where participants were able to submit their experiences in writing. Instead of posing questions that need to be answered separately, a list of topics/indicative questions/prompts (see Annex 4⁵) were used to allow participants freedom in the way, style or extent they wished to present their experiences. Participants could access the interface for submitting their testimonies only after reading information about the research project, its aims and main features, and after electronically signing a consent form. The data collection was designed to give anonymity to all participants, where age, gender and place of living were not mandatory to state when submitting a testimony. The only requirement was to indicate the country where the forced admission took place – with the exception of one personal testimony, all participants fulfilled that requirement. The timespan for which people could report experiences was left open, meaning that stories may cover experiences that happened many years, and in some cases decades ago.

Information about the project and consent forms were provided in 17 languages (Croatian, Czech, Dutch, English, Finnish, French, German, Greek, Hungarian, Italian, Polish, Romanian, Russian, Serbian, Spanish, Slovenian, Swedish, and Turkish) mostly translated by volunteers (please see acknowledgments section). Prospective participants were also offered telephone interviews with members of the research team in four languages (English, French, Hungarian, and Italian). During telephone interviews, information about the project, including the consent form were read out by the researcher and consent was given verbally by participants.

The data collection methods imposed several limitations. Firstly, the call for participants was limited to those individuals who follow MHE and its partner organisations (Disabled People's Organisations (DPOs) and other advocacy organisations) via social media or newsletters. It is possible that most participants have had prior relationship with civil society organisations. Furthermore, most participants who submitted their stories did so online meaning that they must have had access to internet and some level of literacy, thereby excluding those who cannot afford internet, or have no computer skills – this limitation possibly excluded people living in poverty, people with learning difficulties or dyslexia or mental health service users who live in residential institutions where access to internet (or its confidential use) is limited. Recognising this limitation we also allowed for submissions on paper or being interviewed by members of the research team. Finally, being an international study, it was an important aim to present opportunities for people to submit their personal testimonies in any European language; however, due to limited resources we could not include all official and regional languages of Europe.

Using personal narratives of users/ex-users of psychiatry in research imposes its own risks. Although personal stories and individual narratives are increasingly used in social research, such narratives may be taken out of their original context and their meanings can be misinterpreted by researchers. As stated by Russo (2016), interpreting personal narratives can be authoritative and may be as alienating as positivist or medicalised research. Social research with the participation or control of ex-users/survivors of psychiatry, also called survivor-led research (Beresford & Wallcraft, 1997; Russo, 2012), attempts to overcome this dilemma by enabling owners of personal narratives to participate in the interpretation of their own stories.

Due to a range of limitations related to geographic scope, project purpose and resources, as well as the fact that members of the research team did not disclose personal experience of psychiatry, interpretation of testimonials was done without the involvement of those who submitted the testimonies. As such, participation of users/ex-users and survivors of psychiatry

⁵ Annex 4 can be found on MHE's website (www.mhe-sme.org) in the Mapping Exclusion section.

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was limited to submitting their personal narratives and membership in the project Advisory Group and this is recognised as a possible limitation of the research (see acknowledgements for full list of Advisory Group members). Agreeing with the assertion '[the] choice to engage with our narratives rather than interpret them remains to be explored' (Russo, 2016, p. 226), we could not overcome these limitations. It is the intention of this report to present an accessible interpretation of personal experiences that may allow future studies to engage with owners of such stories to avoid 'epistemic violence' or the risk of misinterpretation of personal experiences (Russo, 2016).

Participants had several weeks between May and August 2017 to submit their personal stories. The Tizard Centre, MHE and its national member organisations circulated calls for participants several times during that period. By 31 August 2017, a total of 33 personal testimonies were received, 28 of which were included in the final analysis (see table below). Five submissions were excluded from the analysis: in four cases they were sent in by people who did not experience involuntary admission/treatment or were submitted by family members and in one case the country of origin was unknown. Personal testimonies were shared via different methods: four people were interviewed over the phone and the interviews were transcribed, three people sent their stories/testimonies via email, some of these had already been published; four people sent hand-written responses by post; and 11 submissions were received on-line.

Personal testimonies included in this report were shared in nine languages (English, Finnish, French, German, Greek, Hungarian, Dutch, Serbian and Turkish). Four participants (two from France and two from Hungary) asked to be interviewed in their native languages – in these cases the interviews were recorded in French and Hungarian by researchers. All submitted testimonies and interview transcriptions were translated into English by members of the research team and/or translators. In three cases participants submitted (partially or fully) already published personal stories. One participant submitted both prose and poems about their experiences. Submissions also varied in length and style: the shortest testimonies were only eight lines long, while the longest one was over seven pages.

Table of Personal testimonies per country

Country	Testimonies
Denmark (DE)	1
Finland (FI)	2
France (FR)	3
Georgia (GE)	1
Germany (GER)	2
Greece (GR)	3
Hungary (HU)	2
Ireland (IRE)	1
Netherlands (NL)	4
Norway (NO)	1
Serbia (SR)	3
Spain (ESP)	1
Turkey (TR)	3
United Kingdom (UK)	1
Total	28

For the analysis of testimonies, thematic analysis (Braun & Clarke, 2006) was employed. Thematic analysis is a widely used method to analyse qualitative data, for example texts or personal accounts. Thematic analysis is regularly employed in social research for its ability to find and highlight common, recurring themes across large amounts of text, thereby identifying salient meanings and themes. It is asserted that thematic analysis is an optimal method to analyse these testimonies, because recurring themes may mark shared experiences among participants.

² Countries excluded due to inadequate data: Belgium, Czech Republic, Hungary, Liechtenstein, Luxembourg, Macedonia, Norway, and Turkey.

³ Azerbaijan, Belarus, Croatia, Czech Republic, East Germany, Hungary, Kazakhstan, Latvia, Poland, Romania, Russia and Slovenia.

⁴ United Kingdom, Ireland, Denmark, Austria, Belgium, France, Germany, Switzerland, Netherlands, Spain, and Italy

In the following section, a particular focus will be given to how people experience forced treatment, what meaning they give to what happens to them and how they go on to cope with their experiences. However, it is recognised that this is only one possible common thread that links the reported experiences.

FINDINGS OF THE STUDY – PERSONAL EXPERIENCES FROM ADMISSION TO DISCHARGE

As stated before, one common feature of all personal testimonies is that all participants experienced forced psychiatric treatment and hospital admission at least once in their life. The duration and frequency of involuntary admissions, however, varied among testimonies. The youngest age at the time of admission was 13 and the oldest around 60. The shortest time spent in a closed ward was one night, the longest over 20 years. Many participants only experienced involuntary admission once, others however, several times, up to as many as six times. In this chapter, emerging themes will be presented that featured in the majority of personal testimonies.

It is important to note that personal testimonies cannot and should not be reduced to a template or generalised experience. Not only were the personal experiences unique, but the testimonies submitted to our research varied. Some participants gave more details about one aspect of their forced hospitalisation while others emphasised other details. Therefore, the following presentation of common themes across testimonies should be read neither as a ‘full story’, nor as the only possible way of understanding people’s experiences. Our aim is to give an accessible and structured summary of the 28 testimonies – it is very possible that participants quoted in the following pages would give different emphasis to their own stories.

However, to understand the experiences of people who are subjected to forced psychiatry experience, the presentation of main themes in the following pages will broadly follow the course of a hospital stay: admission - life in the hospital (medical treatment, circumstances) - discharge - and life after forced admission. Although this structure is only one possible arrangement of themes, it is hoped to be the most appropriate for a broader, lay audience.

CIRCUMSTANCES OF ADMISSION

The circumstances of hospital admission were detailed in most testimonies. It is not the aim of this research to relate hospital admissions and forced treatment to the actual – often changing – psychiatric diagnoses received by participants and indeed, not all participants noted the actual diagnosis they were given upon admission. Instead, other themes emerged in personal narratives, for example, how decisions about their admission were made and how family members or healthcare professionals participated.

In many cases decisions were made by or with the agreement of the person’s family, which was the case for participants from Denmark, France, Georgia, Hungary and Serbia. The words of one French participant refer to a recurring instance:

So, they said: “There is no choice, we need to compulsorily admit her”. And so it is my dad who signed this hospitalisation upon the request of a third party with the doctors. (FR02)

Some participants explicitly regretted the decision taken by their family members, although one Georgian participant stated:

I cannot blame them, they were afraid and couldn’t think of any other solution. (GE01)

For several participants, it was initially their personal decision to go to hospital although later their consent was not asked for and the treatment became involuntary. For participants from Germany and Hungary, consent was given based on false or incomplete information.

And then I was directed, by two other nurses, to the psychiatric department. I was terrified, yet I wanted to give it a chance. (...) I could think clearly again when they pushed a form under my nose (my dad, who I trust, was there), and I was reading on the form that it was a closed facility, however, I voluntarily chose to be there. To me this was very contradicting, so I specifically asked if it means that I can withdraw from these procedures (of admission) at any time. And it was confirmed. It could be that I repeated it one more time, the question. And then I signed the form. After that I went to the toilet to cry. I felt terrified and it was all so intense. (GER02)

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My baby was born and three days later I found myself in a locked ward. The doctors said that they would quickly sort me out and then I could be with my baby, I just needed to cooperate. And this is why I agreed to it. If I had known that this was just a pretext for them to deprive me of opportunities [the person was placed under guardianship while in hospital] for many years, I would have just come home because they can't force me to do any of this, I wouldn't have agreed to any of this, I could have started taking my medication at home, and that's it. (HU01)

Pressure to sign a consent form is often present in narratives, for example in a personal testimony from Norway:

After only three sessions with the psychologist I was sent to a ward, 'voluntarily', I was strongly recommended to agree. Soon after I came in the door the door was locked behind me and I was put in a sheltered area in the ward with little else furniture than a bed. (NO01)

Other participants recall an 'obedience to the circumstances', for example one testimony from Georgia states:

I was really calm when police came, I just wasn't communicating. Police looked at me and said that they do not see why they should take me to the hospital. Relatives insisted. Finally, I said that I will go and went with the police. It was not my consent to be treated, it was just the obedience to the circumstances, the way how a person may consent to being tortured. I signed the consent form and they locked me with the other patients. (GE01)

It is rare, but present in some testimonies which explicitly mention hope at the time of 'voluntary admission' – a participant from Serbia wrote:

The doctors (duty doctors) and my father insisted, and I had the choice and I agreed. I thought that the decision was correct because I realised that something happened with me and I thought the hospital could help me. (SRB03)

Once admitted and placed in a psychiatric ward, almost all participants mention very intense emotional responses. Feelings about the admission, or institutional placement featured strongly in all testimonies and there was not a single testimony that recalled positive feelings about the admission. The following testimonies from Denmark, Finland, Hungary, Serbia and Turkey reveal overwhelming, negative emotions as a result of forced placement:

My feeling is that I didn't know such horrible things existed in the world. (DEN01)

At the age of 13, I was admitted to a closed adult ward for observation because I was a bit drunk and my parents were traveling. (...) I was told that I should not drink it at that age. I knew it myself, but the punishment seemed unreasonable. It seemed to me that the psychiatrist did it for a moment's whim. The decision felt like a terrible deprivation of liberty. (FIN01)

So I was taken to the hospital. (...) If I look at it from their perspective, it was the right thing to do, but if I see it from my point of view, it was not right at all, because even if I stayed in hospital, all we achieved was that I continued to lie in bed and sleep in the ward and no matter what mood stabilisers I was given, they didn't help me. (HUN02)

I was forcibly hospitalized and wrongly treated because at that time I had no pre-psychosis. It was a real isolation after which I actually started to hear voices. The diagnosis was depersonalising and that was an attack on my identity. (SRB02)

I had never become that bad in my life. I was unable to sleep for days and nights, when I did, I saw nightmares. I wanted to commit suicide because of the doctors, I took them too seriously. (TR01)

Other participants – from Finland, France, the Netherlands, and Turkey – emphasised how the medicalisation of their problems was highly unhelpful, especially when coupled with the feeling of being treated like an object.

The doctor made the decision for me and I was, of course, furious. My opinion was not taken into account and it was rejected, but the opinion of a manic rarely means anything. (FIN02)

My blood pressure was taken several times. I was fed. I was their object. I was cold. I was given a blanket. I resembled a beggar. (FR01)

I was just there to be force-fed really, to be force-fed by a nasogastric tube. Their only worry was to make me regain weight, but what would have been needed was simply more human exchanges, more empathy from the nurses' part, and

more listening, more speaking time, for them to explain to me, for them to render it a little bit more humane really, a little bit gentler. Here, it was the hard method. (FR02)

There was no room for me to deal with my sadness. Every emotion was firmly suppressed and this damaged my feelings. Every emotion was translated as a form of sickness/manic behaviour/hypomania. And no one cared to provide more insight on my psychosis. My opinion with regards to the treatment did not matter. It was just a one-way treatment with me being the uneducated patient and them being the experts. They didn't look further than my 'sickness'. (NE02)

They took me to a four-men ward in the hospital, while my stay was being arranged, my family was next to me but it was still a horrible place, it stank, as soon as you get in people would get at you, the only image left in my head is a horror tunnel. When they first left me, tears filled my eyes, I remember crying and sitting in the same spot for hours and not getting up. (TR03)

Although the above statements show often devastating feelings, more details about other aspects of personal experiences, such as lack of information or social and physical isolation may elucidate why people find involuntary admission overwhelming.

LACK OF INFORMATION AND SOCIAL ISOLATION

There are a number of issues about which information may be helpful when receiving healthcare – diagnosis, possible outcomes, options for treatment, medication and possible side effects, prospective duration of illness and patients' rights are all important bits of information for all of us. Moreover, accessible information is crucial to making decisions about treatment. Despite this, participants spoke about a lack of information in almost every testimony. Strikingly, many people subjected to involuntary psychiatric treatment – as revealed in testimonies from Finland, France, Georgia, and Hungary – lacked information even about the most basic aspects of their healthcare.

Nobody said anything to me. I was there for about 3-4 days, then I was found healthy, even though no one even interviewed me there during my stay. (FIN01)

Of course, these diagnoses were never mentioned in front of me. It was only in 2011 [several years later], when I had access to my file, thanks to charities for the defence of mental health customers' rights. (...) I was taken to the hospital's emergency psychiatrist services without anything being said to me: "We are not allowed to talk in the work environment" they told me. (...) I thus stayed like this until 9pm, the time at which I met a doctor accompanied by a person who I believed to be a nurse, as no one introduced themselves. Nothing was said. (FR01)

They were not asking me what I consider a problem, what bothers me, they didn't honestly describe what they think about my condition, how long I will stay there, why I am taking this particular medication or injections. All my knowledge about that was from the previous practical experience and not from communication with doctors. A miracle sentence "I have communication with another world", is enough to keep them busy and lose interest in you. They wrote a thick history of my illness without actually speaking with me :-). In my medical files there is a sentence that my IQ is lower than the average. They didn't give me any IQ test. (GE01)

I was given mood stabilisers, million different types, but they didn't even care to explain, 'who cares?', and I also got shots for my depression, but again, nothing was said about those either. Nothing was explained. (HUN02)

Besides not receiving information, one of the most important themes featured in almost all personal testimonies was social and physical isolation. Coupled with lack of information and loss of control, social isolation appears to be the most overwhelming aspect of people's experience in a closed ward.

I was banned from all the activities and from visitors on the basis of low-level treatment in the ward. The ban was set because I went to a nearby small shopping centre to break my money (...) Restricting visitors was also cruel because I lost all my friends during that time. (FIN02)

No, that was really at the end, the visiting right, even the right to phone calls and all that. The letters were controlled.

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Me, I tried to conceal my letters in my dirty laundry or in things that were controlled. (FR03)

I was begging for permission to call my mother or father and talk to them about the situation I was in. (GER02)

I didn't have contacts with friends, they didn't visit me. But family came regularly. My wife visited me every day and sometimes my sons as well, although later they stopped almost completely. And it is not allowed to use mobile phones and we didn't get the password to the Wi-Fi. (HUN02)

Contact with others in the same room was discouraged. During the whole period of admission there was little to no support, meetings, or contact with the nurses. (NL02)

Several participants claimed their time on closed wards was difficult because they found little to do which increased the feelings of isolation. Monotony and boredom are featured in testimonies from France, Georgia, Hungary and Ireland.

I am still astounded by what I saw during this hospitalisation: young people completely idle for entire days, spending their time smoking... (FR01)

I slept, and my connection became weaker, the injections made me restless, but I had nothing to do. I tried to sing, dance and even make Pilates exercises. (GE01)

I didn't go to smoke with others or to play table tennis and those things. I did not find a friend, or found very few throughout those years when I was there, someone I could communicate decently with. To be fair I wasn't really in the mood to talk either, so I only listened to others talking, all the stupid things people said. And I read, I read a lot! There were hospital stays when I spent 90% of my time reading, I just took every opportunity to escape from reality. (HUN02)

I was very bored, which only lead to feelings of depression, anger and frustration. Most other patients slept all day, I tried to keep myself busy and not sleep during day with hardly any resources. I was unable to sleep at night because I felt threatened and afraid. (IRE01)

Social interaction with other patients may also be a source of fear. Participants from Finland, an adolescent at the time of admission, and an older participant from France recalled similar, inter-generational conflicts, or even violence on the ward.

I was afraid to be in the midst of medicated adults, I even got a black eye after being in a fight. (FIN01)

I took refuge in my bedroom to set boundaries and to protect myself from the harassment of young people towards the elderly. (FR01)

The above statements demonstrate that involuntary hospital admissions are about much more than just healthcare or 'treatment' – the social context is as important to some as other aspects of a hospital stay.

PHYSICAL ENVIRONMENT

Given that the present study is cross-national, the physical environment in psychiatric hospitals or institutions was expected to vary widely across personal testimonies. Depending on welfare policies, historical or cultural traditions some countries may have modern and well-resourced healthcare facilities, while others may be out-of-date or poorly maintained. In personal testimonies, several participants found it extremely difficult to cope with the physical circumstances in hospitals. Poor hygiene, bad smells, inadequate heating, and poor-quality food were mentioned by several participants from nearly all countries (France, Germany, Hungary, Ireland, the Netherlands, Norway, Serbia, and Spain) regardless the level of resources.

I obviously had no access to toilets, so I had a chamber pot. So I'm not even going to explain to you the stench that there was at certain times. (FR02)

I asked them to let me take a shower, and they showed me to the shower room, where the window was open, the first floor, and it was February. (...) So, I had to take a shower in a cold room with open windows in February, and manage to do it without being seen, and without catching cold. It's ridiculous, how people who need assistance and support, and a safe environment are brought to places, which look like a war situation, where other people need help, and conditions are so bad, that you have to think about your survival. (GE01)

The hospital in our town is a pile of crap, outworn everywhere, shower heads are missing, the walls are yellow of lime scale, very unpleasant I must say, the meals are awful, everyone smokes in the corridors which I found very hard since I am a non-smoker, so I felt very irritated. Irritated and upset. Yes, this made it even more difficult to go back every time when I was involuntary admitted. That's why they had to force me to go back! (HUN02)

Adult nappies hanging on the handle of the seclusion room door was a dark reminder of what can happen to you. (IRE01)

The food was just garbage leading to malnutrition and gastrointestinal complaints. (NL04)

Later I was sent to a long stay hospital outside of the city, in a rural area. Lots of snow. Many old, ghost like buildings. I was scared and I was very upset they had locked me up. (NO01)

Bad hygiene and lack of soap and toilet paper in the toilets. (SRB03)

Later on I realised I was in a psychiatric hospital. It was a sad, gloomy and very ugly environment. (ESP01)

INVOLUNTARY TREATMENT – PHYSICAL RESTRAINT, ELECTROSHOCK AND MEDICATION

There are measures in mental health care that are considered by psychiatry to be treatment, although personal testimonies challenge their appropriateness. Many participants gave us details about physical restraint they were subjected to, and medication was probably the most emphasised aspect of forced hospitalisation. Fear, physical harm and loss of control were the marked reaction that respondents expressed in relation to physical restraint.

Yes attached [to the bed], yes. Today I still bear the bond mark scar on a wrist. I had a bloodied wrist and there you go, they left me like that in my bedroom. The aftercare with the doctor who saw me roughly once a week, was 5 minutes, so there was no psychological follow-up. I was not at all explained the protocol actually. From the end of summer 2006 to the month of March, I remained confined. (FR02)

They tied me twice out of the five times when I was there. They did not tighten it too much. I was told it was in my best interest. When I was thirsty I was given water. When I was not thirsty, I was also given water. (HUN02)

Law and order was maintained by fear, fear of been sedated, restrained and put in seclusion. I witnessed 2 patients being restrained and sedated although it did not happen to me, I found these experiences very traumatic. (IRE01)

I was in an acute ward for a while, a place where they used restriction belts for something as little as that I bit myself in the arm. It was never dangerous what I did to myself, it was just that I was so scared and sad and needed something so very different than being there. I needed someone to care about me and speak with me and understand what I was struggling with inside. Since nobody did, I bit myself in the arm instead, and then I was punished for that by putting me in restriction bed (belts). (NO01)

Electroconvulsive therapy (ECT) or 'electroshock' was mentioned by participants from Greece, Turkey, and the United Kingdom. Similarly to physical restraint, participants spoke about overwhelmingly negative, traumatic experiences.

When I was 19 years old I was hospitalised, and I got electroshocked but my body did not react well so they stopped. I felt lost and I did not think it helped me. (GR05)

...when I didn't 'get better' quick enough, without any choice or mention of the after-effects, they gave me ECT – I don't know how many shocks, or whether, as is common practice, the equipment was obsolete, the staff untrained, the voltage totally arbitrary, because, it seems, when I started to make noises about suing, they conveniently lost my medical records. (UK01)

Medication was probably the most discussed aspect of forced admissions across personal testimonies. Medication, however, is not restricted to hospital settings. For most people, medication represents an experience they live with, often many years,

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or an experience they wish to leave behind. An overwhelming majority of testimonies gave details of how people encountered psychiatric medication during their hospitalisation. Participants from a wide range of countries described shared experiences: lack of information and consent often with no apparent benefits, side effects, perceived overuse, addiction, and secondary effects of medication (i.e. being unable to continue work or education), and concerns over the long-term harm of medication on one's health. What is common in the following excerpts from Danish, Dutch, Finnish, French, Georgian, German, Greek, Hungarian, Irish, Norwegian, Serbian, Spanish, and Turkish testimonies is not only experience but also the characterisation of treatment they received as biomedical which, based on testimonies received, people find questionable, ineffective and even harmful.

Medication is often applied by using physical force and/or offensive language or threats. With the exception of one Serbian participant, all testimonies that mention medication include elements of restrictions or force by staff.

There were too many restrictions. The worst being that I had to take those horrible drugs. (...) Since the drugs take your health away, they have the worst effect possible. (DEN01)

I was devastated. Four nurses entered my bedroom. They offered me to take an antipsychotic Loxapac pill that I refused. Straight away, they seized me even though I was showing no physical resistance, and the female nurse injected me with a neuroleptic solution, under the watch of a male nurse who told me: "You did not want to take the pill, and so you have been given Loxapac by injection". The nursing staff had given me my chemical straightjacket. This action made me think of a rape, especially as I had been subject to a sexual abuse as a child. (FR01)

I said that if they really want me to take medication I want to speak with my doctor first, and I refuse to take anything until I speak with him/her. The nurse answered quite rudely that the doctor won't come until Monday and I have to shut up and obey. There were a few patients in the room together with us, I asked her to at least not do it in the presence of others. She didn't pay attention to my words and just injected me right in front of other patients. (GE01)

I was forced to have my medication first. If not, I wasn't having any breakfast. I was shocked, but still did as I was told. In retrospect, I realize how denigrating this was. (GER02)

The policemen put me in the ambulance car. I was pregnant. I stayed in the ward for 2 weeks when I was pregnant. In the first 4 or 5 days, I was taking the medication as they wanted but after that I cheated. Didn't take them. I pretended to take them but I didn't. I was forced to swallow 5 tablets of Seroxat. Then in the final record they stated they stopped the medication because they felt it was unnecessary. (HUN01)

I still took meds 'voluntarily'. I felt pressured to do so, and I thought, if I am ever going to get out of here, I better do as they say. But the mental health staff did not believe that I took my meds, because when they took blood tests, they said the levels of the meds in my body were low. So they decided to give me depot injections coercively instead. (NO01)

I was forced to take medication and threatened with injections if I did not comply for my full stay. Medication caused me a lot of side effects, incontinence, anaphylactic reaction, suppressed emotions etc. (...) Most patients face this torture because of medication refusal not because they are violent. (IRE01)

Initially I was given a sedative, later antipsychotics and antidepressants. At first (violently) without asking me, so the next time I started cooperating. (SRB01)

He prescribed some pills, I bought them, put them in the palm of my hand and said to myself that it couldn't be possible that these pills would alleviate the pain in my soul. I couldn't see any connection between them and myself. (ESP01)

The security put me on the floor and gave me the injection, after staying on the floor for some time, I got up and fell asleep in the corner of the cigarette and television room, on the sofa. When I woke up in the morning, the patients found that I was cold, so they brought me breakfast, and I didn't even have strength to raise my arm but I ate the breakfast, three olives, bread, jam and an egg, I remember my first day very well..., after that my medical and electroshock therapy was continued. (TR03)

Other participants emphasised that medication may have been forcibly taken but, in their view, the medication has still been largely ineffective.

From 40 years of age, when the disease showed her teeth, until now I'm 57 I have not found a medication that responds to me (my symptoms – drug side effects, platelet drop, etc.). (GR01)

To be fair, they tried all sorts of medications in my case, so I got this type and that type, but between 2008 and 2012 I felt so depressed nonetheless, and it didn't matter if I stayed in hospital or not! So to me they were not useful at all. I could not influence my manic periods with medication either. For a long time I also got injections 'depression injections', these were applied every month but those had no effect whatsoever, nothing at all. (HUN02)

Besides 'lithium' I was also receiving anti-depression medication and 'preventive' anti-psychotic medication. According to the psychiatrist there were positive effects, even though I wasn't experiencing that (not much was changing). (NL02)

Another group of testimonies recall the difficulties people have when coping with side effects of medication, or the long-term harm they have experienced they relate to the medication applied as part of forced treatment. Both side effects of medication and long-term harm caused by pharmacotherapy raises the question mentioned earlier – lack of information and lack of consent (especially informed consent) make it impossible for people to 'own' the medical therapy they are forced to receive. In testimonies, the impact of medication is overwhelmingly negative on people's health, with sometimes far-reaching effects.

During hospitalisation, I was given enormous quantities of medicine at high concentrations. The resulting side effects of paralysis and weight gain caused me a lot of negative attitudes towards hospitalisation. (...) I would have hoped (liked) that I would not be chemically paralysed with such strong medication. I was so heavily medicated that I could not lift my feet off the ground or keep the cutlery in my hands. I have been out of work since the involuntary treatment I just described, I'm afraid that the strong medication has had a lasting impact on my cognitive abilities. (FIN02)

They gave me forced medication and I had to stop my university study because of side effects. I stayed in another mental hospital for one year and after my release I had nothing anymore. (NL03)

[I] was forced to take various medications such as antipsychotics, anti-depression, mood stabilizers, benzodiazepine and other medication to reduce the side effects. Besides, a wrong diagnosis and the physical symptoms were not taken seriously: atypical face aches, ocular manifestations or Raynaud disease, migraine, irritable bowel syndrome, asthma, effort strain, hay fever, auto-immune reactions, various serious eczema symptoms etc. (NL04)

I was put on some other antipsychotics, and yet a new nightmare started. Gradually the meds made me a complete shadow of myself. I could hardly do anything, I couldn't feel, and I could hardly think nor speak. I got very depressed, so depressed that I for the first time in my life got suicidal. (...) I tried to make them listen, I told them I needed to stop getting meds – they were not interested in listening to me. They told me I was better. I was clearly the very opposite. (NO01)

The drugs ruined me even more, they put me into a terrible, devastating state, then I got addicted to drugs. I knew the side effects of those drugs very well. (...) The drugs were too strong for me, I began to stop using them by myself. (...) doctors spent more time representing drugs than patients, their doorstep were full of drug commercial agents. (TR01)

SEEKING JUSTICE

In all the countries included in this study, a variety of civil rights, health regulations and various human rights instruments are in place to guarantee the rights of everyone. Not everyone is equally aware of their rights granted by law, but some testimonies, including from France, Germany, Norway, Turkey and Georgia, voiced views about effects on their rights.

I telephoned the President of the Circle of reflection and proposition of actions for psychiatry (Président du Cercle de réflexion et de proposition d'actions sur la psychiatrie) who explained my rights and who reassured me because he was respecting me as a subject with rights. (FR01)

After a while, I was informed of my rights, I was simply explained that it was like this and that, and all I had to do was shut my mouth really, that I did not have the choice, that I was in danger. (...) You also ask about how it went post-hospitalisation, and it's true that for a long time I could not talk about it. And this is why I went through the step of asking

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for access to the medical files so late, because it was so complicated to return to this past in full force, really. So I went through this step late and today I hope that... I would like to obtain a conviction, even if symbolic. For me, it will be important to heal me completely. (FR02)

Even me when once I asked for my contract in paper format, I did not have the right. I asked for the patient's charter to file a complaint, they laughed in my face. Well, it still wasn't very cool, really. I had no power to defend myself, anyways. (FR03)

Had contacts with users and survivors from abroad, and even completed a course about the UN CRPD and its meaning. So, it can be said that I had quite a knowledge about my rights when I was admitted to the hospital for the third time, in 2011. (...) According to the legislation of my country I was kept there and drugged illegally, because I was a "voluntary patient", that is I signed the consent form and was free to change my opinion at any time. And they had to call the court. (GE01)

I could not go through a legal complaint process because I was too scared. I have never got any justice for what I went through. (NO01)

My lawyers also directed me in the same direction, they took the easy way out, anyone could interpret any situation as they like, it is all about perception, the odds are either stacked in my favour or not and they possess unfathomable authority in doing so, I can only watch, there is nothing else I can do. Just because I have the right to petition it doesn't mean I will have a positive outcome. (TR01)

Some respondents spoke of legal challenges being difficult to launch, for example because people are influenced or pressed not to do so, or because legal procedures may be lengthy, emotionally draining and expensive.

When I had to be hospitalized in psychiatry in the XXX. Straße because of a depressive episode, I was pressed by this doctor to withdraw the complaint. (GER01)

I am finding it both financially and emotionally difficult to complete my judicial process because just like the health sector, the legal system also has contradictions within itself, I come across many bureaucratic obstacles. (TR01)

Others talked about how they learnt to take on the administrative and legal challenges following their negative experiences.

I do not believe in lawyers at all. I deal with everything myself, even if it takes longer, I don't care. Now I have access to the Internet so I go on-line, check which authority is responsible, I am not faint-hearted. This is how I achieved that they agreed to do a review. I threatened them with a complaint to their supervisory body, I don't care about the consequences because they are simply ignoring their own decisions. They have all the rights when they want to make my life harder, but they have no responsibilities when they should be helping me. (HU01)

DISCHARGE AND RETURN TO THE COMMUNITY – STIGMA, EMPLOYMENT, AND COMMUNITY TREATMENT ORDERS

Discharge from hospitals are not detailed in all personal accounts. In those personal accounts that mention leaving the hospital, the decisions were, once again, often not made by the person themselves and discharge may seem as unexplained as the admission was to some respondents. Excerpts from France, Hungary and the United Kingdom represent such experiences.

I met the psychiatrist on Monday late morning: she authorised me to leave for medical reasons. I had entered for medical reasons and I was leaving for medical reasons (which I discovered on the exit pass. Nothing had ever been said on whichever diagnosis of chronic psychosis). I therefore ask myself the following question: does the justice system have a role or is it only the psychiatrist who takes the decision? (FR01)

So, whenever I was in the ward to 'have my medication adjusted', then they usually just let me go after two or three weeks, and never discharged me by saying that I got better and I was ready to go home. (HUN02)

I was despatched back with no after-care to the family home where problems had arisen. (UK01)

After leaving hospital, many participants find readjustment in society extremely difficult. Various mentions of stigma and lack of employment opportunities appear in testimonies from Finland, Hungary, Norway, Serbia, Spain and the United Kingdom.

But I had to face another huge problem: discrimination. I was fired from my job as a journalist when they knew I had bipolar disorder. Years later, the same story, I was fired from the university where I was a teacher. Not because of the symptoms, but because of the word, the label, the diagnosis. (ESP01)

Long inpatient admissions have separated me from my social environment and I have been discriminated against and labelled (stigmatised?) for example by a health centre or friends. Forced treatment has been the last rivet. (FIN02)

Coming back to work unfortunately was a bit difficult. The manager was asking me denigrating questions and my workplace, strangely, was making me think of what had happened to me. (GER02)

I went back to teach but they don't know about my illness because I didn't tell them. Even here in the village only I told people I had to. Not even to the teacher in the kindergarten. I wrote the book under a pseudonym exactly for this. My child knows. Not the diagnosis but the fact that Mom is on medication. (HUN01)

I gradually managed to get back to work for a while, but then I got an exhaustion syndrome that lasted a couple of years. I think it may have been at least partly a late psychosomatic reaction. Today I am not working. (NO01)

The prospects for the job seemed to me to be non-existent, the probability of finding a job was zero. (...) I was stigmatized and auto stigmatized. When I was out of psychiatry, I was socially isolated, abandoned, and alone. (SRB02)

At the first opportunity I moved to a town where almost no-one knew me, to avoid the embarrassment of social situations, and I still have cold sweats in large groups when I might be called upon to introduce people I'd known for years, but can't remember their names – every day I need to muster the courage to venture forth so as not to be trapped in lonely isolation. (UK01)

For some participants, psychiatric treatment continues long after hospitalisation. Mental health care, however, can be enforced involuntarily in the community as well, as is demonstrated in testimonies from Finland, Norway and the Netherlands.

In the post-treatment period I was blackmailed with involuntary treatment. (FIN02)

I continued to receive treatment for a long time after being discharged (8 years). This was for my 'bipolar disorder'. The treatment consisted of administering medication. Even though I requested it, the therapy to learn how to deal with my fear of bonding with others was rejected. According to them this was high-risk for me. I am questioning the diagnosis. To me, I have accepted it for too long. Everyone around me accepted my treatment plan and they were afraid of me 'having a relapse', which didn't give me a chance to challenge the diagnosis. (NLO2)

Then they let me out on the terms that I would live with some relatives and take my meds. I was still not forced to take meds officially, this was medicating through indirect coercion and I felt so controlled and scared after being in the hospital that I did not dare not to take them. (...) After some months, they put me in a rehabilitation institution. I continued to get depot injections coercively, now through CTO [community treatment orders], by the same doctor that I had had contact with earlier. Now, basically what happened when I came to her was that she put a needle in me – her former care and interest in me had clearly vanished. (NO01)

TRAUMA CAUSED BY INVOLUNTARY CARE

It was the aim of this research to collect information about what happens to people in involuntary care, and how they experienced it. Both in the internet-based prompts and in oral interviews it was suggested in a neutral way that participants attempted to tell us about their overall feelings about institutionalisation and forced hospitalisation and treatment.

Based on testimonies, the overall feelings of people were overwhelmingly traumatic. Not everyone condemned all aspects of the treatment, with some agreeing with the involuntary treatment, however, the majority of testimonies expressed negative opinions. Fear, humiliation, shame, loss of trust in healthcare, stigmatisation and self-stigmatisation were mentioned across personal accounts – participants told us about long-lasting damage that restraint and compulsory admission causes.

I was really afraid I would have to go there again. I was also depressed about it. But ultimately I felt really anxious. (FIN01)

I believe that I was in need of involuntary treatment, because I would have caused a great deal of destruction to my life as a “free” man. However, I am a little sad about how my circle (of friends) disappeared and how I was overwhelmed with a shocking condition. However, I live in the belief that no chemical restraint will ever be done to me, because nowadays, my family knows how to treat me. (FIN02)

Inevitably, I was slightly angry at the doctors and I did not accept all the after-care, which led to the illness hanging around for longer years. And I left there, really traumatised. (...) And I was really hurting from this hospitalisation. So it was a long reconstruction. I often had nightmares in relation to this, I truly had images which came back to my mind and I struggled to get over it. Today, [...] I actually have recourse to the hospital for inhumane and degrading care. (FR02)

It is now very hard for me to return to the hospital given the past trauma. I have confidence issues, automatic issues, traumas and I am not over it, so it's still left scars in everyday cases, I think. (FR03)

In terms of its effect on my life, it continued, largely because I advocate for the rights of people with mental diagnoses, so, this wasn't something ruining. The overall feeling about all these facts and situation is negative, I think that people in the 21st century deserve much more, and that psychiatry stopped somewhere in the Middle Ages. (GE01)

After my second stay in psychiatry, my psychological condition worsened. (...) For decades I have been living in fear of compulsive treatment. (GER01)

Even though it was just for 2 nights, this was the most intense experience ever in my life. I thought I would have been in there for months, forced to give up my identity. Two years after this whole incident I still felt unsafe. I was so determined to gain back my integrity. I was dealing with fear, nightmares and a lot of insomnia. (GER02)

If someone told me now that I have to stay in the X hospital again, I would still tell him that he'd better call the police then because I am not going to the psychiatry on my own will. Period. (HUN02)

I have terrible flash backs, dreams, nightmares of my time in the hospital. (...) My overall feeling of my experience is that I have suffered one of the worse traumatic experiences of my life. I would never volunteer to go to hospital because of my experience, I was not treated as a human being should be. I am now severely damaged by a service that was supposed to help me. (IRE01)

I am medication free for 5 years now. I even found a good (psycho-analytical) therapist. I believe the stigma, the exaggerated diagnosis, the exaggerated medication, the horror-stories, believing in being sick, the lack of confidence caused by the dominant treatment, and the stubbornness to listen to my opinion of my sickness, have cause a bigger problem for me than the psychosis itself. But, it is a fact that it [involuntary admission] has affected me for a long time, and has traumatised me for sure. (NL02)

I left the hospital the same day that they gave me this message, and I have not been in any contact with forced psychiatry since. I have neither been suicidal since. The ‘treatment’ I got in psychiatry has still had a massive negative impact on my later life. I was traumatized by forced psychiatry – for three years I did not even dare to contact a ‘normal doctor’ for somatic issues. If I heard sirens I was so scared psychiatry was about to come and lock me up again. (NO01)

The first hospitalisation additionally damaged my safety and self-respect. I was stigmatized and auto stigmatized. (...) This experience seems like a depressive, repressive and arrogant expression of force by the “family” and psychiatric system. It does not help me, I felt even worse after that. (SRB02)

Instead of helping me, the exact opposite happened, they caused permanent damage to me financially and emotionally both noticeably and discretely and it is impossible to repair this. (TR01)

Like many ECT survivors, I suffer from fear of doctors and hospitals, and a few years ago I had uveitis, but kept putting off seeing my doctor. (UK01)

ALTERNATIVES, RECOVERY, AND ACTIVISM

As stated before, in the present chapter the focus is on the experience of people who have been in involuntary mental health care. The set of themes which emerged during data analysis shows the resilience and critical thinking of some of the respondents who have gone through involuntary psychiatry. After leaving psychiatry, several participants expressed their views on alternatives and in several cases such alternatives were viewed to be effective and helpful.

The participation in a mental health forum organised by the French network for the hearing of voices (REV) was an important improvement for me, just like the trainings which also allow me to meet people who make the choice of respecting each and everybody’s humanity. (FR01)

I think there needs to be an option of safe place where persons in need (because of the crisis or some unusual experience), will be able to go and stay, without medication. Or with medication, but only according to their wishes. I would very much have preferred this option. And, it is important to enable the patient to say what he/she need in advance. (GE01)

Now, I feel that the experience of forced hospitalisation and overdosing with drugs was unnecessary and it could have been avoided. If only I had had the opportunity to choose and pay a psychotherapist or if I had more support and attention from the family, or if I was a member of a psychiatric association and went to art therapy. (SRB02)

I tried 20 different forms of alternative therapy – using barter for those I couldn’t afford, and even found a sympathetic doctor who actually listened. (UK01)

Many testimonies were submitted by people, who have become advocates or activists since their hospitalisation. Human rights, a sense of justice and peer-support are recurring themes in these personal accounts. Several participants claim that becoming an activist or seeking justice actually helped them overcome negative feelings forced hospitalisations caused. Testimonies from countries like France, Georgia, Germany, Hungary, Norway, Spain and the UK detailed the efforts of respondents around advocacy and speaking out about their experiences in involuntary mental health care.

And this is why I went through the step of asking for access to the medical files so late, because it was so complicated to return to this past in full force, really. So I went through this step late and today I hope that... I would like to obtain a conviction, even if symbolic. For me, it will be important to heal me completely. (FR02)

The experience changed the course of my life, instead of being a biologist (I have MD in Biology), I became involved in NGO work. Because when I looked at this awful situation in hospitals I understood that theoretical knowledge gained by science means nearly nothing if you don’t have the proper implementation. (GE01)

This self-struggle has changed me till this day. I have learned to be less obsessed with goals like making a career, the desire for material things, and even distance myself from relationships. (...) The way how I face situations now, my ability to deal with things in a different way, values I cherish, my body which I have learned to defend, and my spirit of activism which is always a part of me, everywhere I go. (GER02)

I wrote about this when I published the book about my experiences. (HUN01)

I am angry with psychiatry for the human rights violations it could freely expose me to, and I find it very upsetting that

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I can tell my story and it is met with so much silence and unwillingness to listen and validate that these are grave human rights violations. I want a legal ban on psychiatry's 'free-state' human rights violations. (NO01)

Since then, I've been doing my best to help people in situations like me, and I can say, that it has helped me as well. (...)

From my point of view, one of the best ways to do this is to have a strong user movement(...). We have laws, but if there are no pressure groups, it is difficult for these laws to be respected. (ESP01)

My anti-ECT stance helped me regain some of the campaigning zeal of my youth, and I've broadened out, been involved in anti-war and anti-fracking protests... (UK01)

CONCLUSIONS

The data collected provided a range of insights into how people have experienced forced psychiatric treatment across different countries. What remains most striking though is not only the variety but also the consistency of testimonies in their main features – people from various linguistic or social backgrounds, in various welfare and cultural contexts, from different parts of Europe feel similarly traumatised by forced mental health care. Based on personal testimonies, the human rights of users of psychiatry are systematically ignored across Europe.

The findings of this report also correspond with other recent observations about coercion and restraint in mental health (Rose, Perry, Rae, & Good, 2017). As both Rose et al. (2017) and Tania Strout (2010) observed, perceptions of involuntary treatment or restraint are overwhelmingly traumatic and can be grouped in four categories: negative psychological impact, re-traumatisation, perceptions of unethical practices, and broken spirit. There can be several reasons why present psychiatric practices should be reconsidered and changed, but the voices of those who experienced involuntary treatment should be integral part of any debate.

Finally, it is important to note that some of the respondents reacted to traumatic experiences by becoming active in the emerging advocacy movement of users/ex-users of psychiatry. It is the assertion of this report that such pathway from trauma to activism may be present and that the growing movement of advocates and Mad Studies scholars (for example 'survivor researchers' – see Russo and Sweeney, 2016) may be able to both help people overcoming their traumatic experiences and changing the discourse or the political power relations presently allowing for running psychiatric practises that may harm many people.

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INSTITUTIONAL, COERCIVE, AND COMMUNITY-BASED SERVICES AND PRACTICES – TRENDS AND ANALYSIS

BACKGROUND

The first edition of the *Mapping Exclusion* report (2012) provided a comprehensive overview about the state of institutional and community-based services for people with mental health problems in 32 countries across Europe and Israel. It highlighted that psychiatric hospitals are still widespread and many people are hospitalised long-term. Social care institutions were found in nearly half of the countries, which provided limited or no community-based residential alternatives for people with long-term mental health problems. Institutionalisation takes different forms in different countries. For example, in Central and Eastern Europe institutionalisation occurs in social care settings more so than in long-term hospitals. Nevertheless, the number of people with mental health problems in social care institutions is often not known, because it is not reported in official statistics. At the same time, a variety of community-based residential service models already exist across Europe, in some places alongside institutional arrangements. Still, availability and access to community-based residential care was found to be an issue in many countries. At the same time compulsory treatment in the community was emerging as a new form of coercion in some countries.

The report also found that the majority of countries still practiced full deprivation of legal capacity and had plenary guardianship regimes, although a number of states were introducing more progressive legal capacity legislation. New models of supported decision making were also being developed across Europe. It is not known how many people with mental health problems are deprived of their legal capacity; however links between guardianship and long-term institutionalisation were highlighted in many countries.

The adoption of United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) in 2006 has also had implications for mental health systems as the Committee on the Rights of Persons with Disabilities has stated in its jurisprudence that institutionalisation and non-consensual commitment and/or non-consensual treatment (referred to in this report as involuntary placement and treatment), seclusion and restraint carried out on the basis of actual or perceived impairment or health condition – such as mental health problems or psychosocial disabilities – violates human rights. The UN CRPD requires a paradigm shift in mental health services away from coercive, overly medicalised and isolating services towards systems which are community-based, supportive and empower people with psychosocial disabilities to live independently.

Since the publication of the previous report there have been some important developments. The updated report aims to capture these, alongside more comprehensive information on mental health laws and the use of involuntary placement and treatments, seclusion and restraint across Europe. This chapter aims to provide a snapshot of mental health services and related practices highlighting some key developments and emerging issues since the publication of the previous report. It is intended that this analysis will also reflect and map the exclusion that many people with mental health problems and psychosocial disabilities face and the situation of human rights in mental health services across Europe.

METHODS

For the country reports, information was collated from existing sources, such as national statistics, reports, and other publications primarily by members of Mental Health Europe between April and October 2017. In countries with no MHE members, or where members could not respond to our request for data, other experts from the mental health or related fields were contacted for information. The full list of individuals and organisations who contributed to the country reports can be found in the acknowledgements section of this report.

Information was collated using a template designed by the research team with input from the Advisory Group (see Annex 3).⁶ Returned templates were reviewed and, where relevant, cross-checked using other data sources (e.g. WHO Mental Health Atlas, EUROSTAT etc.) by two of the authors (Ágnes Turnpenny and Gábor Petri). Draft country reports were then sent back to MHE members/contributors for final comments and approval.

The country reports (Annex 1) are presented in five main sections. The first section gives a general overview of psychiatric inpatient, rehabilitation, and social care facilities with particular attention to long-term hospitalisation/institutionalisation. The second and third sections present information about the availability of community-based mental health supports and residential arrangements. The fourth section addresses involuntary admission and treatment, including the availability of compulsory community-based treatment. The fifth section focuses on legal capacity and guardianship legislation, while the final sections highlight other issues that are emerging or significant in particular countries, such as deinstitutionalisation processes, ongoing reforms, and further references identified in the literature review.

The level of detail and the scope of information presented in the country reports varies substantially, reflecting the diversity of mental health systems, the situation of human rights for people with mental health problems and psychosocial disabilities and the challenges across Europe on the one hand, and the availability of information and official data at the national level on the other.

The analysis presented in this section is narrative and thematic rather than quantitative. The data does not allow the direct comparison of countries; however it highlights where major differences exist across countries. Although considerable efforts have been made to ensure the consistency of reporting and verify the accuracy of information, some errors may remain.

FINDINGS

In total 37 templates were returned from 36 countries: England and Scotland returned separate templates. One country – Luxembourg – that appeared in the previous report could not be included this time. There are five new countries: Armenia, Georgia, Macedonia, Turkey, and Ukraine. The countries represent very diverse political and administrative systems, as well as socio-economic conditions.

PSYCHIATRIC HOSPITALS, WARDS, AND INSTITUTIONS

Five countries – Austria, Germany, Hungary, Italy, and Sweden – reported no psychiatric hospitals, elsewhere psychiatric hospitals still co-exist alongside psychiatric units in general hospitals. It must be noted, however, that the distinction between psychiatric hospitals and units in general hospitals can sometimes be difficult to make. Some previous psychiatric hospitals have become units that belong to the general hospital, but the building is still the same and the segregation persists in the sense that the unit is still not necessarily physically situated in the general hospital.

In most countries the majority of beds are found in general hospitals. There are countries – e.g. Armenia, Bosnia and Herzegovina, the Czech Republic, Malta, and Romania – where the majority of inpatient beds are provided in psychiatric facilities, which are often large hospitals. In the Czech Republic there are three psychiatric hospitals with over 1,000 beds each and an additional eight hospitals with over 600 beds on average.

Although information about the proportion of long-stay patients is limited, long-term hospitalisation – in most cases defined as a hospital stay of 12 months or longer – appears especially prevalent in some countries, regardless of the level of community-based resources or the presence of psychiatric hospitals. For example, one in five people in psychiatric units in

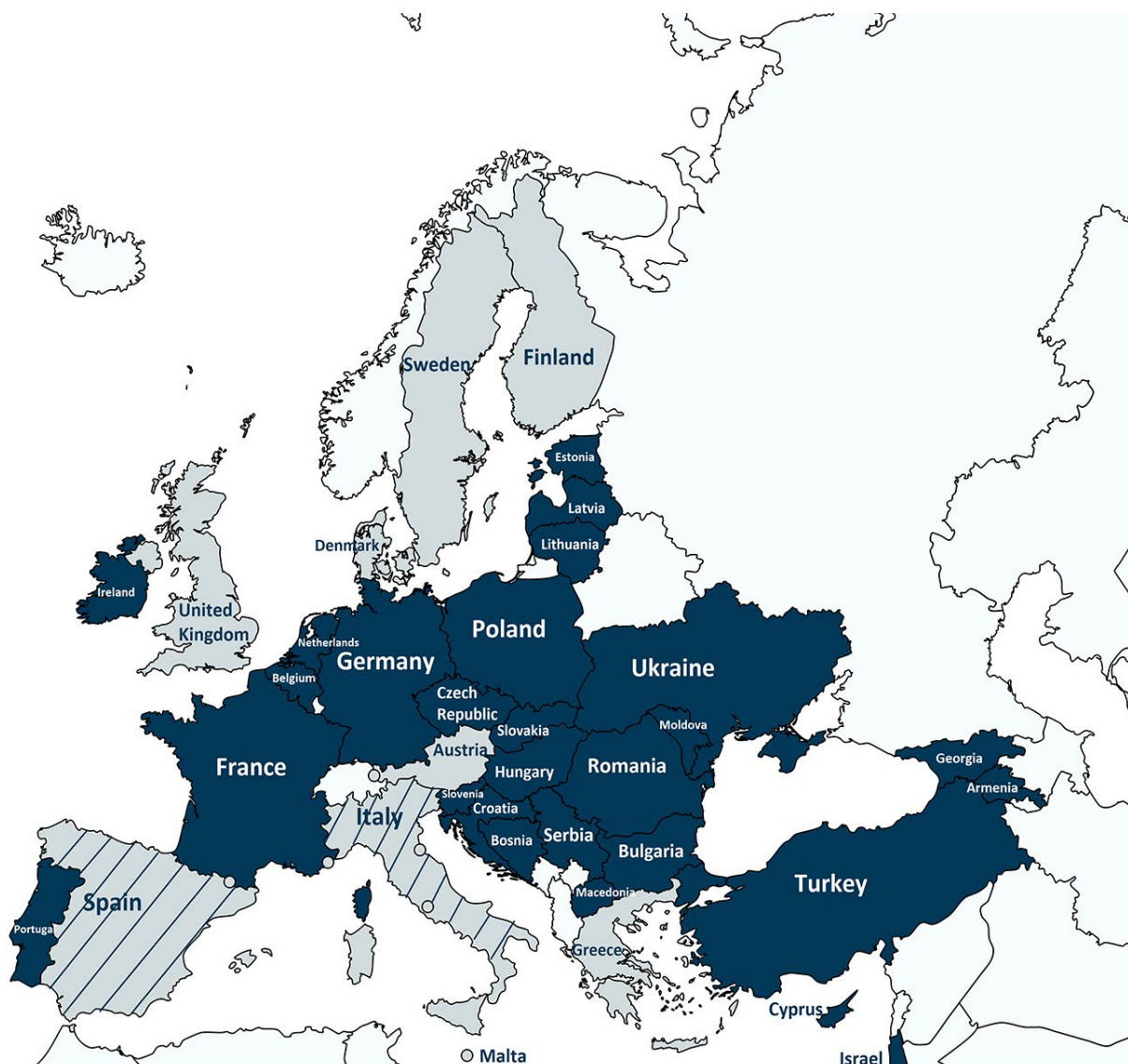
⁶ Annex 3 can be found on MHE's website (www.mhe-sme.org) in the Mapping Exclusion section.

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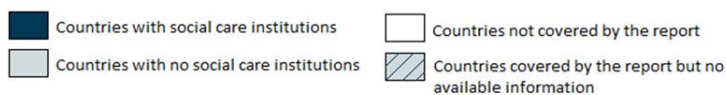
Hungary are hospitalised for 12 months or longer. Similarly, in France, even though there are no designated long-stay beds, five per cent of people admitted in hospitals for psychiatric care stay for more than one year; this is equivalent to around 15,000 inpatients per year, occupying one in four beds. In Belgium a considerable proportion of beds in psychiatric facilities, including general and specialist hospitals, are long-term. In Romania and Israel about a third of inpatient beds are occupied by long-stay patients. In Armenia a large proportion of patients are hospitalised long-term, the average length of stay in psychiatric hospitals is just under 12 months.

Social care institutions for people with psychosocial disabilities are still prevalent across Europe: they are the main form of residential support for people with long-term mental health conditions in the countries of the former Eastern bloc. For example, in Romania approximately one in 12 people with a long-term mental health problem are institutionalised.

Institutions are also found in Western Europe, primarily Belgium, France, Netherlands, and Germany, where they exist alongside community-based residential arrangements.



Countries with social care institutions



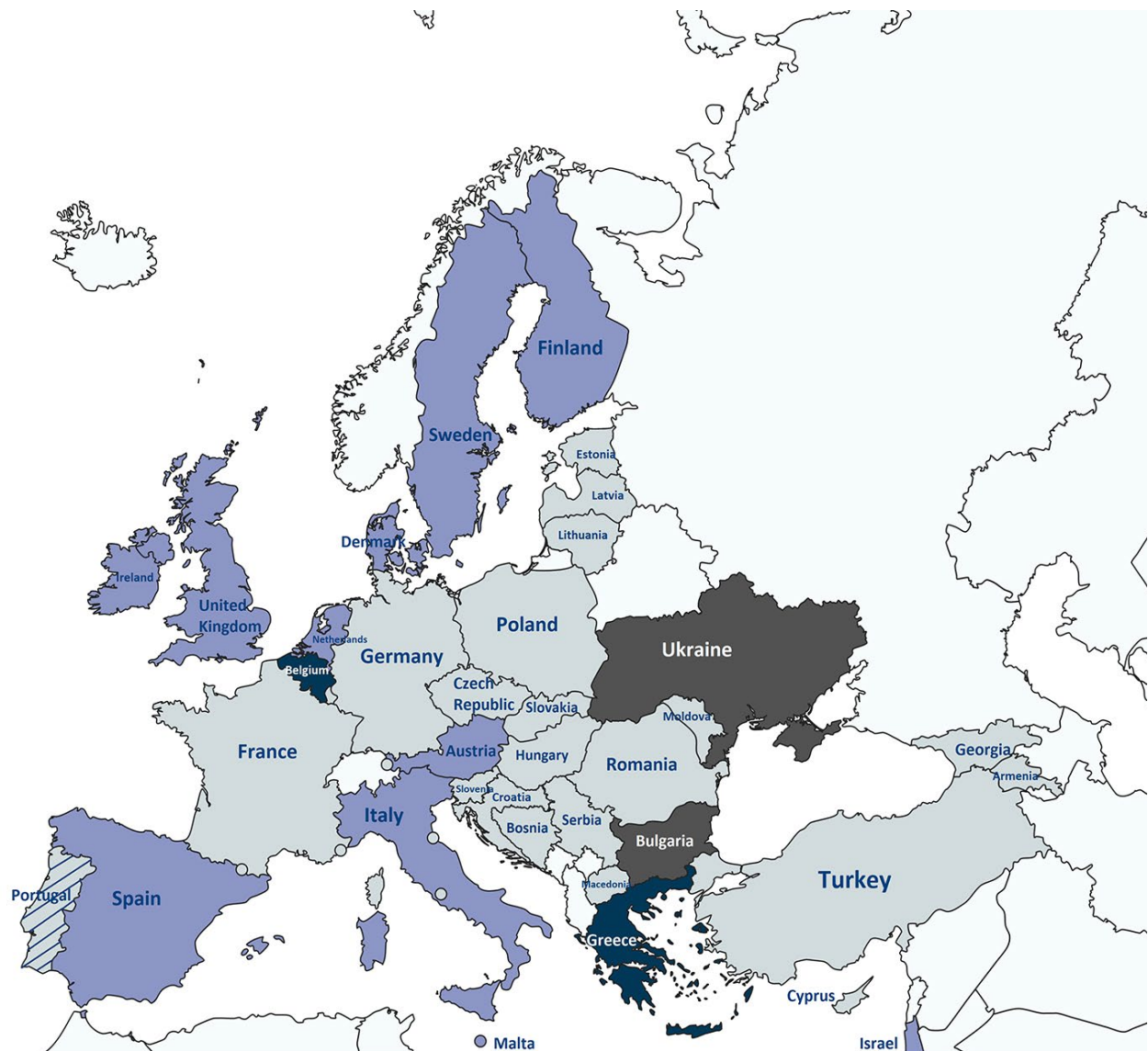
DISCLAIMER

Although all efforts have been made to ensure the data is accurately reflected in the following maps, this has not always been possible due to limitations in the design software. For example, due to software limitations, the whole of Israel is not visible in the present map. Please note that information collected from Ukraine does not include data on territories which are not under the control of the Ukrainian government. Information on the United Kingdom only reflects data available in England and Scotland.

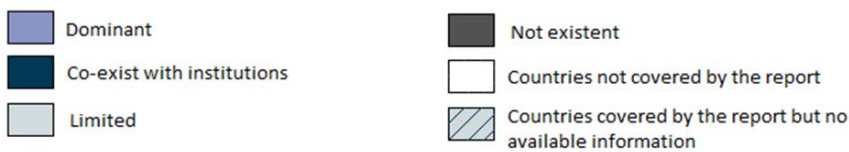
In some countries – such as Armenia, Georgia, Moldova, and Serbia – institutions accommodate mixed groups of adults in vulnerable situations, including people with psychosocial disabilities, intellectual disabilities and elderly people. There are some instances where children with disabilities are mixed with adult populations. In Moldova it is estimated that a third of people in institutions have a psychosocial disability. Elsewhere – in Germany, Hungary, and France – there are institutions specifically for people with psychosocial disabilities.

COMMUNITY-BASED SERVICES

Community-based residential services are dominant in many Western and Northern European countries, and in Italy. Their availability is limited in countries with high rates of institutionalisation, and they seem to be absent in Bulgaria and Ukraine. Furthermore, community-based residential services in Central and Eastern Europe are often provided without an adequate regulatory framework, including sustainable financing, by non-governmental/voluntary organisations. Limited funding might also mean that they are relatively large (e.g. group home type settings) and available only for people with less severe mental health problems. It should be noted that countries define community-based care and services differently; what might be labelled 'supported living' in one country may be quite different to what is labelled 'supported living' in another country. There was also some indication that some residential services, which are defined as community living, are large in size and appear to exhibit institutional features (e.g. 'high support' community residences in Ireland, 'supported living' settings in Hungary).



Countries with community-based residential care



Although outpatient and community-based mental health care is available in every country, a key distinction seems to be whether these are mostly provided in clinical settings – e.g. mental health centres, outpatient clinics – or available in primary and mobile settings supported by multidisciplinary teams. Limited capacity of services and access to adequate support can be an issue in both types of settings. A common theme highlighted by various country reports is that mental health centres and outpatient settings often do not provide effective psychosocial rehabilitation or psychotherapy to prevent hospitalisation and support recovery; instead they rely heavily on pharmacological treatment. On the other hand, the lack of specialist knowledge and long waiting times can make mental health care in primary settings problematic for some users.

There is a noticeable absence of non-hospital intensive services for people in acute crises, such as Soteria houses and places of sanctuary, that exist in relatively few countries (e.g. the United Kingdom, France and in Spain some user organisations are trying to create these).

SUPPORT NETWORKS

Peer support networks, user/survivor-led organisations, and “hearing voices networks” operate in nearly all countries; yet in many countries they experience enormous difficulties and an uncertain future in the absence of long-term/public funding. In Eastern Europe user-led organisations are often established and funded by foreign donors and when funding runs out, they can face closure, as it is demonstrated by the example of Romania. User involvement in policy and decision making is limited or non-existent, with little interest and commitment from governments in the region.

Another issue highlighted by some of the country reports – for example Turkey – is that some of the grassroots/user organisations that claim to provide peer support are actually dominated by family members and professionals.

Elsewhere there are some promising developments. In France there are 352 clubhouse-type “Mutual Help Groups” (Groupes d’entraide mutuels – GEM) approved and financed under a Government programme. In Spain the growth of user organisations has been a relatively recent development. Across the country there are user organisations with an increasing influence in mental health care and on the lives of people with mental health problems.

INVOLUNTARY PLACEMENT AND TREATMENT

The regulation of involuntary placement and treatment varies greatly across Europe. Presenting a significant risk of serious harm to oneself or others is a common criterion for involuntary placement with a few notable exceptions such as Spain, where the need for therapeutic treatment of the person, combined with a mental health problem are sufficient criteria for involuntary placement.

It should be noted that, the Committee on the Rights of Persons with Disabilities has stated in their Guidelines on Article 14 of the UN CRPD on the right to liberty and security of persons with disabilities that such criteria are discriminatory and violate human rights because they are based exclusively on the “perceived impairment or health condition”, and only on presumption of dangerousness.

The majority of countries do not distinguish between different types of involuntary placement; but in some countries there are different types of involuntary placement and these are associated with specific procedural requirements and safeguards. For example in Scotland the Mental Health (Care and Treatment) (Scotland) Act 2003 authorises three compulsory powers: 1) Emergency detention for up to 72 hours in a hospital; 2) short-term detention for up to 28 days in a hospital; 3) Compulsory Treatment Order for periods of six or 12 months in a hospital or the community. In France there are four forms of involuntary placement: 1) at the written request of a third party (usually a family member) requiring two medical certificates (at least one from a doctor outside of the institution where the person will be hospitalised); 2) at the “urgent” written request of a third party (usually a family member) and one medical certificate; 3) in case of “imminent peril” requiring the request of the Director of the hospital and only one medical certificate from a doctor outside of the institution where the person will be hospitalised; 4) at the order of the Police Prefect when “a person’s disorders require care” and “public safety is in danger or a serious violation of public law and order has been committed”. In this case, one medical certificate from a doctor from outside of the institution where the person will be hospitalised is required.

In most countries involuntary placement is understood as an authorisation for involuntary treatment. There are few exceptions to this; for example in Scotland detention under a longer term Compulsory Treatment Order does not automatically imply that forced treatment can be given, this requires specific authorisation by the Mental Health Tribunal; however, it is almost invariably the case that an order authorising detention will also authorise compulsory treatment. In the Netherlands the planned new Act on Compulsory Mental Health Care (Wet verplichte geestelijke gezondheidszorg; WVGGZ) is expected to result in major changes in the legal framework of involuntary placement and forced treatment. In the proposed system the judge will not only decide whether involuntary treatment is necessary, but also decides which form of restraint is allowed. Individuals will also have the right to draw up their own plan of action to discontinue compulsory treatment.

All countries reported procedural requirements and safeguards set out in legislation for those undergoing involuntary placement and treatment. These mainly consist of an independent review or authorisation by a court or tribunal. For example, in France the Law (No. 2011-803 entitled “Law on the rights and protection of persons receiving psychiatric care and the conditions applicable to their care” amended via Law No. 2013-869) now requires a hearing before the “Judge of Liberties

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and Detentions” who must render a decision confirming or reversing the decision to hospitalise and treat a person without consent within 12 days of their date of hospitalisation. Those admitted involuntarily are provided with legal counsel who may be made available through legal aid and may also petition this Judge to lift their detention. Since September 2014, most hearings take place on site at the psychiatric hospital.

Similar provisions are also in place elsewhere; however a number of countries highlight serious concerns over their implementation, such as inadequate provision of information on rights, representation in front of courts, and legal aid. Anecdotal evidence from various countries – including Bulgaria, Lithuania, Czech Republic, Romania, Hungary, Moldova – backed up by the reports of the European Committee on the Prevention of Torture suggest that doctors and hospitals are often keen to avoid the “bureaucracy” associated with involuntary placement and coerce individuals into agreeing to “voluntary” placement and treatment before the deadline to apply for court authorisation.

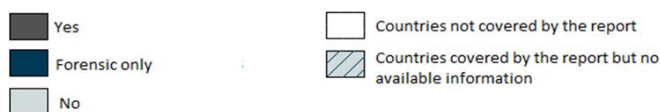
Another concern raised in various country reports is that the procedural and legal safeguards associated with involuntary placement do not apply to social care settings where many people are admitted against their expressed wishes with no due process, access to legal aid, or periodic reviews.

Consequently, any data on prevalence or trends in involuntary placement should be approached with extreme caution and interpreted in the local context. A number of countries where relatively reliable data on involuntary placement exist, reported an increase including England, Scotland, Ireland, Belgium, and France. Elsewhere, such as Austria and Sweden the rate of involuntary placement has been relatively stable since the early 2010s. Two countries – Finland and Germany – reported a decrease following legislative changes and targeted programmes to reduce the use of coercion in psychiatry.

Compulsory treatment in the community (community treatment order, CTO) as a form of involuntary treatment exists in a number of countries across Europe, although in some jurisdictions it is only applicable to forensic patients. Community treatment orders compel treatment within the community. This type of involuntary treatment is viewed as a way to keep people in the community and out of hospital while also requiring them to adhere to treatment as well as, in some places, other conditions (alcohol or drug tests, having to live in a certain place etc.). Where data exist, they suggest that this is a rapidly expanding form of involuntary treatment. In France community treatment orders represented 40% of all people currently subject to a form of compulsory treatment in 2015, while in Scotland approximately 40% of existent compulsory treatment orders were community based in 2015/16. In Malta around a third of people receiving compulsory treatment were in the community.



Countries with Community Treatment Orders (CTOs)



SECLUSION AND RESTRAINT

Information on the use of seclusion and restraint is limited. Seclusion and restraint include:

- Physical restraint – the use of manual holding to prevent or restrict the movement of one’s body or parts of the body.
- Mechanical restraint – the use of devices (e.g. handcuffs, straps etc.) to prevent or subdue the movement of one’s body or parts of body.
- Chemical or pharmacological restraint – the use of medication to control or subdue behaviour (e.g. rapid tranquilisation).
- Seclusion – confinement in a room or secluded area from which a person cannot freely leave.

Even though most countries have regulations and protocols and their use must be recorded, the data is often not aggregated or reported publicly. In France this is changing: in March 2017, an “Instruction (DGOS DGS / 2017-109) on the policy to

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reduce the use of seclusion and restraint” created a register based on regular reporting and for the first time, data should be made available on the use of restraint in 2017/2018. Many countries – such as Romania, Poland, Hungary, the Czech Republic, Moldova, Latvia, Lithuania, and Ukraine – report concerns around the recording and monitoring of seclusion and restraint.

Some countries reported positive developments, for example in Israel a national initiative to reduce forced treatment resulted in a 60% decline in their use. In Spain there is a general decreasing trend in the use of coercive treatment, as user movements are more present. User and Family Associations are fighting to reduce coercion in psychiatry; the “zero restraint” campaign in several regions, the adoption of legislation and discussions in this direction in regional parliaments are promising developments.

LEGAL CAPACITY AND GUARDIANSHIP

Although a number of countries have made progress in this area since the publication of the previous Mapping Exclusion report, full guardianship and substitute decision making still exist in the majority of countries (see map below). This is despite the fact that the UN CRPD prohibits guardianship and substitute decision-making which denies people their right to make choices, not just in terms of their health, and can effectively bar them from, for example, voting, standing for elections, entering employment, marrying, raising a family, managing their finances and entering in contracts.

A handful of countries adopted new legislation since 2012 that either no longer allow full/plenary guardianship, or introduce supported decision-making or legal safeguards. These countries include Austria, Hungary, Ireland, Croatia, Czech Republic, and Latvia. In Georgia, the constitutional court declared full legal incapacitation unconstitutional. It should be highlighted that legislative changes are not always followed by actual change in guardianship practices: for example, in the Czech Republic revision of full guardianship applications is slow and progress is hindered by both limited resources in the judiciary and attitudinal factors.

As a result of these reforms guardianship and substitute decision-making systems have become more complex and in some cases allow different approaches to co-exist (for example guardianship with supported decision-making for some individuals in Hungary). Also, some of the newer substitute decision-making regimes have been adopted to circumvent the need to remove or limit legal capacity to satisfy the UN CRPD without providing effective assistance / legal provisions for supported decision-making. Finally, “supported decision-making” covers a variety of practices, with little information and data on their effectiveness and outcomes as yet. For example, advanced directives, which are usually considered a form of supported decision-making, allow people with mental health problems to make directives in advance in case of a crisis situation where they can outline their will and preferences in terms of treatment (e.g. what medications they do not wish to take, preferences about hospitalisation). However, definitions of advance directives and the cases in which they are applied vary from country to country and in the case of Croatia, advanced directives actually represent a form of substitute decision-making.

Some countries have high rates of guardianship – for example in Austria, Finland, and Hungary over 0.5% of the total population was reported to be under guardianship – whereas in other countries the reported number is much lower. In Israel for example, there were five to 11 cases of full legal incapacitation annually between 2011 and 2014 (total population of Israel was 8,547,100 in 2016).

The number of individuals with mental health problems among those under guardianship is not reported in any of the countries.

PERSONAL TESTIMONY FROM HUNGARY

I stopped taking my medication and I found out I was pregnant a few months later. I refused to take medication until my child was born. By then I accumulated some debts, I was evicted from my rented flat, lost my job, and also had a few problems with the police. My baby was born in July and three days later I found myself in a locked ward. I was told that the doctors would quickly sort me out and then I could be with my baby. This is why I agreed to hospitalisation and treatment because they said I would be out in a month or two and I could look after my baby. In reality I was not allowed to see my baby for months and while I was in hospital the psychiatrist decided to start the proceedings for plenary guardianship. Although by then I was doing well, I was taking my medication and was cooperating with them; the psychiatrist thought I could not be trusted to manage my own affairs financially because of my debts. There was no court hearing or anything, I just got a letter that informed me that my father was appointed as my guardian and I had to keep receipts for all financial transactions, even for a toilet roll or a pack of cigarettes.

When I got out of the hospital I found out that my child was placed in foster care and I was only allowed to visit once a week for two hours. Then they moved my child to a different foster family, that was hours away and I was allowed to visit once a month. I was also told that if I missed two visits in a row my baby would be placed for adoption. So I did everything they said, they coerced me into taking my medication and pay off my debts, which I did after I got my disability pension.

I managed to convince my parents to become kinship carers for my child after about a year, so at least we got to live under the

same roof. In the meantime, the date for the court hearing for my guardianship finally came through, more than two years after the procedure was started. My father was not allowed to be present and my appointed lawyer did not say a word. The guardianship authority said that I needed to be under guardianship because of the “financial catastrophe” I caused, and I could not be trusted to manage my own affairs and assets, especially my property. So ultimately all this was about the money.

We decided to appeal against the decision. Six months later I was assessed by a forensic psychiatrist who found that I had full mental capacity and did not recommend guardianship. So, in the end, after three years my guardianship was annulled and I got my legal capacity back.

With this decision I went to the child protection agency and told them that I want my child back. They did not agree to this but said that the case would be reviewed every year. However, there was no review in the following two years. I don't know why. Then my mother fell seriously ill and I got really worried. If something happened to her, my child could be placed back in out-of-family foster care. So I kicked up a big fuss and threatened the authorities with taking them to court. In the end – apart from the health visitor – they all supported my case and after more than five years I legally became the parent of my child. But guardianship robbed years from my and my child's life. There is so much stigma and ignorance towards parents with schizophrenia.



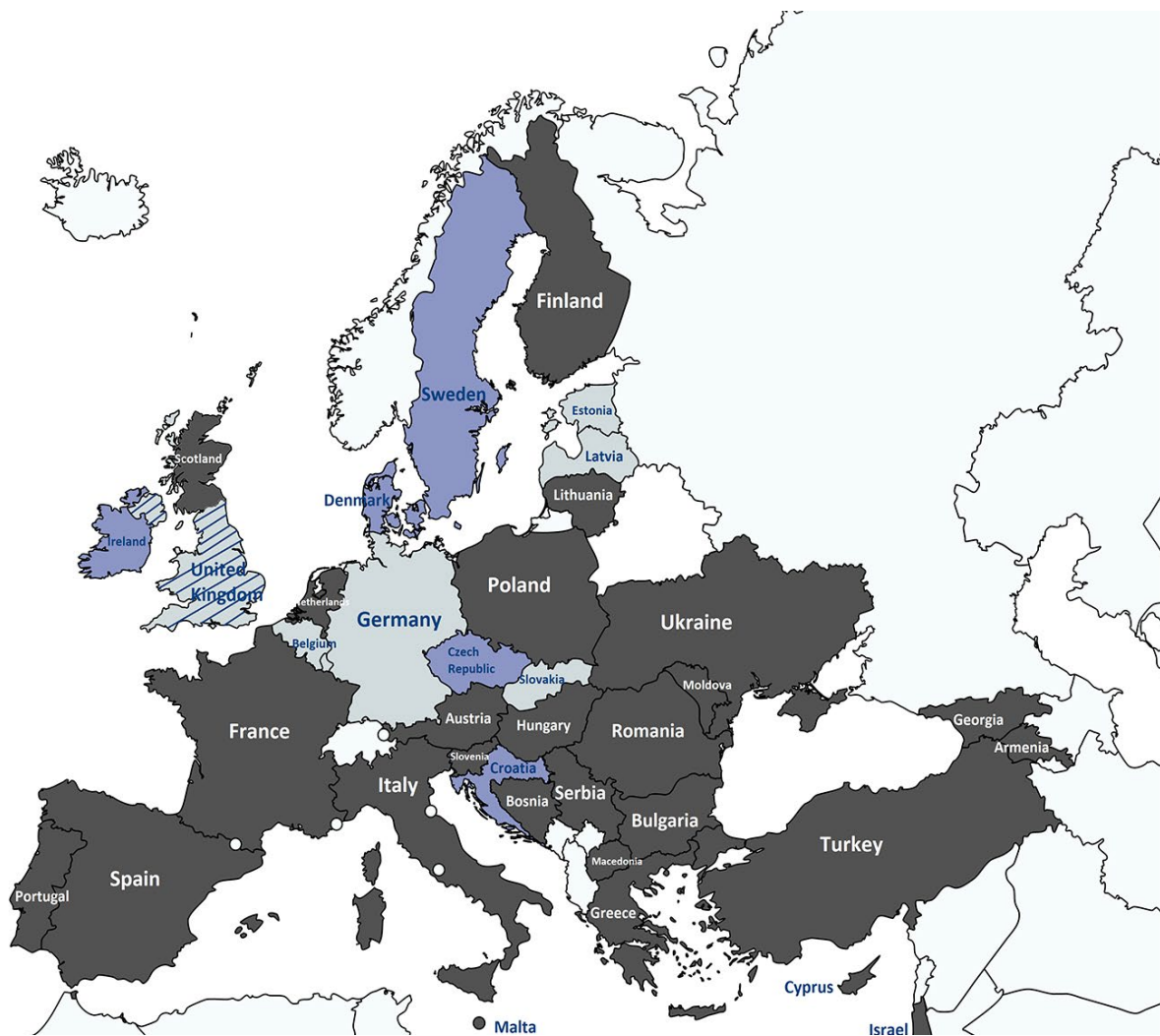
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Some negative developments were highlighted: in France the maximum duration of guardianship ordered by a judge was extended from 5 years to 10 years in 2015 (Article 441 of the Civil Code). Due to a lack of time and resources, guardianship measures are often renewed without hearing from the person concerned.

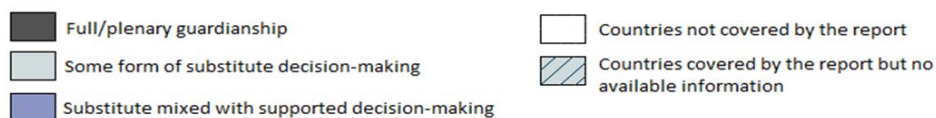
Although the information provided is very limited in this regard, it was reported that institutionalisation is often associated with deprivation of legal capacity (e.g. in Bosnia and Herzegovina, the Czech Republic etc.). A large share of people with psychosocial disabilities who live in institutions have restricted legal capacity; in Hungary for example 80% of people in mental health institutions are under some form of guardianship.

Further concerns raised in relation to guardianship and institutionalisation include conflicts of interest and the appointment of professionals responsible for the health or social care of individuals as guardians. This practice was reported in France, Romania, Lithuania, and Ukraine.

Most countries reported that legal capacity can be restored, however this is an exception and far from straightforward in most cases. For example, in Moldova legal capacity was restored in only two cases to date.



Countries with guardianship, substitute and supported decision-making



*The above map classifies countries according to the most restrictive form of guardianship/substitute decision-making available in the country.

MENTAL HEALTH REFORMS AND DEINSTITUTIONALISATION

Deinstitutionalisation remains on the policy agenda in many countries. Mental health reforms are implemented with varying effectiveness and impact. For example, in Germany the aim of the “Bundesteilhabegesetz” (Federal Participation Law, 2017), was to ensure that support and services are centred around the needs of the people with mental health problems, by strengthening ambulant, multi-professional and community-based psychiatric services. In Ireland the Vision for Change policy document set out a plan to reform Irish mental health services, for example by developing stronger community-based services, reducing the number of residential places, more service user involvement and supporting the ‘recovery model’ across policies and services. In the Netherlands plans for the transformation and the reorganization of psycho-neurological institutions were developed and are currently being implemented. Finland is in the process of closing down psychiatric hospitals and shifting beds into general hospitals. In France the January 2016 Law on the modernisation of the health care system has differentiated mental health policy (medical and social players), psychiatry (institution-structure based) and community care. An important Decree issued in August 2017 obligates regions to draft their first territorial mental health plan within 36 months. Turkey is focusing on capacity building in primary care.

Countries in Eastern Europe, on the other hand, tend to be focusing on deinstitutionalisation in social care and many are shifting large residential institutions to smaller scale community-based settings. These policies are promoted and funded by the European Union; however the adequacy of these programmes is often criticised – primarily the types of services created – and some country reports – Lithuania, Slovak Republic, Former Yugoslav Republic of Macedonia – highlight that services for people with mental health problems are marginalised within these.

EMERGING ISSUES AND PROMISING PRACTICES

Three further issues were highlighted by country reports that affect countries to varying degrees. Firstly, the impact of austerity on services and increasing income inequalities feature in reports from Ireland, Spain, France, Portugal, Scotland, and Greece. Elsewhere (e.g. Turkey and Eastern Europe) limited resources, including the lack of professionals, continue to be an issue. Secondly, migration and the refugee “crisis” are increasingly important challenges in a number of countries, such as Turkey and Malta. Finally, France and Belgium highlighted the issue of cross-border institutionalisation of French nationals with psychosocial disabilities in Belgium. Although this is not new, there has been great concern about this since the mid-1990s, and agreements have been signed between the social security authorities of both countries, France continues to lack appropriate structures with persons concerned and families seeing this situation as forced exile.

There were also reports of promising developments and practices. For example in Latvia, following the adoption of new legal capacity legislation in 2013, currently there are several initiatives and pilot projects to foster the development of supported decision making, including a larger scale pilot project initiated by the Government with funding from the European Social Fund. In Lithuania a promising recent development has been the increased control by the Parliament in the field of mental health (including human rights in closed institutions). This was done by establishing the Commission for Suicide and Violence Prevention in the Parliament of the Republic of Lithuania in 2016.

In Spain, the adoption of legislation to reduce coercion in the community of Navarra and related discussions in other regional parliaments (e.g. Valencia), are promising developments. A manifesto produced by associations of users, carers and professionals (Manifiesto de Cartagena) against coercive practices in 2016, has since been endorsed by various regional autonomic parliaments. In France several promising and human-rights-compliant practices have been highlighted: a Respite House (Lieu de Repit) launched in January 2017 on an experimental basis by the «Just» group for social justice; the first Recovery College-style «training centre in recovery” (COFOR; Centre de Formation au Rétablissement); a training programme for peer health mediators launched by the WHO Collaborating Centre in Lille with partners across the country and the financial support of the Ministry of Health and the Caisse Nationale de Solidarité pour l’Autonomie. In Scotland the work of the Mental Welfare Commission as the ‘watchdog’ for human rights has been commended, while in the Netherlands the proposed Act on Compulsory Mental Health Care is expected to bring about major changes in the legal framework of involuntary placement and forced treatment. (More information on these can be found in the corresponding country reports.)

POLICY CONCLUSIONS AND RECOMMENDATIONS

The revision of Mapping Exclusion shows that progress has been made in some areas since the last report, however it also highlights that the transition from institutional to community-based services has been uneven and has stalled in some countries. In Central and Eastern Europe, the implementation of EU-funded deinstitutionalisation programmes has been slow, and the data is limited about the actual outcomes of these programmes with fewer tangible outcomes for people with mental health problems who often find themselves at the ‘back of the queue’ when it comes to moving out of social care institutions in comparison to other target groups ie people with more visible disabilities and children. This is because deinstitutionalisation programmes usually focus on persons with disabilities and in some countries the legal category of disability excludes people with mental health problems / psychosocial disabilities. Furthermore, the cooperation between social and health authorities and services is reported to be poor in many countries which hinders both planning and implementation of reforms in the mental health field. In several countries austerity has also had a negative impact on services and the lives of people with mental health problems. Deinstitutionalisation programmes are currently running in several Eastern European countries by using European Structural Funds, however, data is limited about the actual outcomes of these programmes. Furthermore, in recent years deinstitutionalisation has been seen as a largely Central and Eastern European issue, however institutions exist in many Western countries as well, including France, Belgium, Ireland, the Netherlands, Portugal, and Germany, where tens of thousands, of people with mental health problems are still living and where little is being done about them.

Personal testimonies collected for this report show that involuntary hospital admission and involuntary treatment can have long-term and devastating effects on people’s lives. Lack of information before and during admission, poor physical conditions, forced medication with severe side effects, the absence of legal aid, physical and emotional harm, social and physical isolation, and stigma all feature high in personal testimonies of ex-users of psychiatry.

In the previous Mapping Exclusion report in 2012, several countries were planning or implementing progressive – and promising – legal capacity reforms. However, by 2017 our report found that only some countries have actually changed their relevant laws and practical implementation of supported decision-making remains wanting almost everywhere.

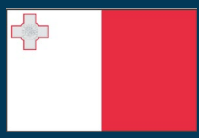
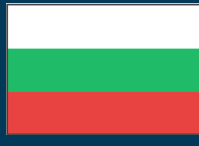
Some positive findings include that user organisations seem to be getting more organised and stronger in some countries and this offers hope for future changes in policy and practice. There were also some promising practices highlighted in the country reports citing new legislation, pilot programmes etc. aimed at the provision of better mental health services and support.

Overall the evidence collected also shows that the human rights issues facing people with mental health problems and psychosocial disabilities both within and outside of mental health services should still be of great concern.

RECOMMENDATIONS

Based on the report, we have put together the following recommendations:

1. Those States who have not done so, adopt holistic deinstitutionalisation strategies in partnership with representative organisations of persons with mental health problems and psychosocial disabilities and other relevant stakeholders which are in line with human rights standards, bringing in all relevant ministries and sectors, including health, social care and employment, and are supported by adequate investment to ensure the sustainability of the transition to recovery-oriented, human rights compliant community-based mental health services and supports.
2. In order to reduce coercion in mental health services, European States should:
 - Adopt policies which aim to immediately reduce coercion in mental health services and ultimately eliminate such practices altogether in line with human rights standards. Policies and practice should also focus on: providing information to people and their families about their rights and their health; improving the communication between community and hospital teams; utilise “zero visions”, de-escalation procedures and other techniques; establishing outpatient mobile units; and providing human rights training for users and staff with a particular focus on the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) and informed consent
 - Support the empowerment of (ex)users of mental health services and persons with psychosocial disabilities and their representative organisations and ensure that they know their rights and can participate in all decisions concerning their lives, in line with Article 4.3 of the UN CRPD;
 - Move towards systems of supported, rather than substitute, decision-making in line with Article 12 of the UN CRPD, including through the amendment of capacity and mental health legislation as well as the creation of support services and scaling up of promising practices;
 - Properly document and report all incidence of the use of involuntary placement and treatment, restraint and seclusion and reasons for their use and publicly release this data.
3. In line with Article 31 of the UN CRPD, States should document institutional placements and make the statistics publicly available. Such statistics should be disaggregated to contain data on number of placements, type of institution, duration, reasons for placement as well as demographic characteristics such as age and gender.
4. In line with Article 8 of the UN CRPD, States should invest in population level anti-stigma programmes which are evidence-based. Advocacy campaigns and awareness-raising both at the national and the local levels should always be an integral part of mental health reforms, deinstitutionalisation strategies and implementation.
5. States should introduce personal budget schemes to support deinstitutionalisation and independent and community living. Those States that already have such schemes should ensure that these are available to people with psychosocial disabilities on an equal basis with other persons with disabilities.
6. States need to better monitor deinstitutionalisation programmes and gather data to ensure that people with mental health problems are benefitting from reforms and that the alternatives created through these programmes actually support independent and community living, in line with Article 19 of the UN CRPD.
7. The European Union (EU) should ensure the continuation of vital support for the transition from institutional to community-based services in the Post-2020 Multiannual Financial Framework while also ensuring the strengthening, extension and efficient monitoring of the conditionalities in the regulations governing the use of funds and that funding processes are simplified and reformed to ensure that all funds are used to make the greatest impact possible and in a manner that complies with human rights standards.
8. Efforts at EU level should be complemented by the exchange of information and experiences between countries in the mental health field including follow-up to the Joint Action on Mental Health and Well-being and the EU Compass on mental health and well-being.
9. The EU should provide funding for research on alternatives to coercion, for the scaling up of promising practices on supported decision-making as well as for the empowerment of users of services and persons with psychosocial disabilities.



ANNEX 1: COUNTRY REPORTS



ARMENIA

COUNTRY INFORMATION

- **Population:** 2,924,000 (United Nations, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Armenian mental health care relies mostly on long-term psychiatric beds in hospitals where the average length of stay is almost a year. There are outpatient facilities available in the community but residential support for people with mental health problems is nearly absent in the country. Many residents in institutions are under restrictive guardianship regimes. Although since 2013, the Armenian government committed to the reform of the mental health system, implementation seems to be hindered by lack of appropriate funding.

DETAILED INFORMATION

Institutions and psychiatric hospitals

There are no long-term beds in psychiatric hospitals in Armenia, although residential rehabilitation services exist. Some social care institutions might fulfil some aspects of “institutional culture” but not systematically. In 2013 approximately 46,000 persons (=75,500 stays) were treated in psychiatric departments in general or specialist hospitals. The average length of stay was 20 days.

	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution
Long-term beds in general hospitals (2015)	2	50	610	28 days	1 public, 1 private
Long-term beds in specialist hospitals (2015)	9	1,330	7,363	56 days	public
Social care institutions (2017)	2	n.a.	570	permanent	public

Source of data: National Institute for Health, Ministry of Health; Ministry of Social Affairs, 2015.

Community-based residential support

In Armenia, community-based residential support is almost non-existent, with only 1 facility that provides support for people with mental health problems.



Type of community-based service	Total number of units	Total number of beds/places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community-based residential arrangement: group home	1	16	10	permanent	n.a.	24-hour care for people with mental health problems
Supported living facilities	0					
Respite homes	0					
Soteria houses	0					

Source of data: National Institute for Health, Ministry of Health; Ministry of Social Affairs, 2015.

Other community-based support

Mental health support in the community is usually provided through outpatient care at mental health centres. Only one day centre was found which gives support to a small number of people and there was no information about peer support or user/survivor organisations in Armenia.

Type of community-based service	Total number of units	Total number of patients/users	Sectoral distribution	Main client groups
Mental health centres (outpatient)	n.a.	22,489	public	People with mental health problems
Mobile units	0.			
Day services	1	30	?	People with mental health problems
Peer support/peer support networks	0			
User/Survivor organizations	0			
Club Houses (including cultural support networks)	0			

Source of data: National Institute for Health provided the information on Mental health centres (outpatient) for 2015; Ministry of Social Affairs provided the rest of the information for 2017

Involuntary placement and involuntary treatment

In Armenia, involuntary treatment is regulated by the Law on Psychiatric Care. According to Article 22(1) of the Law, the presence of mental illness, an assumed threat to oneself or others and lack of adequate treatment are required upon involuntary admission. Involuntary treatment is regulated by the Civil Procedure Code. If the person refuses to consent to treatment, a court procedure must be launched within 72 hours. The Court is then obliged to investigate the case and reach a decision within 5 days upon receiving the suit. Therefore, the total period of time until a court decision is made can be as many as eight days. Although court decisions may be appealed, such appeals are extremely rare: between January 2010 and June 2016, only 2 out of 248 forced treatment applications were appealed against at the Court of Appeals.⁷

⁷ Source of data: Judiciary of Armenia, www.court.am



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In recent years, there has not been significant growth in the court rulings on involuntary treatment: 41 applications in each year within 2011-2013, 43 applications (2014), 42 applications (2015) and 36 applications in 2016.

Community Treatment Orders are carried out in Armenia, based on the Article 9 of the Law on Psychiatric Care.

Legal capacity and guardianship

Guardianship is regulated in Article 31 of the Armenian Civil Code. Legal capacity can be fully restricted, when a person is judged to be unable to understand the effect of his/her actions or to control them as a result of his / her “mental disorder”. A guardian is assigned over such a person. Legal transactions following this shall be done by the guardian. People under guardianship are denied of many rights, for example the right to vote, the right to employment, most private and family rights and to enjoy safeguards to one’s liberty and security.

The total number of people under guardianship is not available. In 2015, 140 persons were declared legally incapable or partially capable, and in the first half of 2016 100 persons were declared as such.

Many residents in long-term institutions in Armenia are under guardianship, for example over 400 out of the 450 beneficiaries of Vardenis Psychoneurologic Boarding House have been restricted of their legal capacity.

Other information

In 2013 the Government of Armenia adopted a Concept Paper on Providing Alternative Social Care and Support Services to Persons with Mental Health Problems and an accompanying Action Plan for 2013-2017. In 2014, the Government also approved the 2014-2019 Strategy of Preserving and Improving Mental Health in the Republic of Armenia, and its Action Plan. These documents aim at reducing long-term residential care and developing more community-based support for people with mental health problems. Reports about the implementation suggest that although efforts have been made, for example new national policies are being developed and a small number of residents moved out from one residential institution, there is a lack of adequate government funding which prevents meaningful systemic reforms.⁸

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

⁸ <http://hcav.am/wp-content/uploads/2017/02/The-development-of-mental-health-strategy-in-Armenia.pdf>



AUSTRIA

COUNTRY INFORMATION

- **Population:** 8,773,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Austria started closing its long term psychiatric institutions in the 1970s. By today, no long-term beds exist in psychiatric care. Instead a number of support services are available in the community through rehabilitation centres and acute hospitals. User/survivor organisations are active in many parts of the country. The number of people under guardianship is high, however new legislation will enter into force in 2018 which allows for forms of supported decision-making. The number of involuntary admissions has risen sharply over the last 15 years.

DETAILED INFORMATION

Institutions and psychiatric hospitals

There are no long-term beds in psychiatric hospitals in Austria, although residential rehabilitation services exist. Some social care institutions might fulfil some aspects of “institutional culture” but not systematically. In 2013 approximately 46,000 persons (=75,500 stays) were treated in psychiatric departments in general or specialist hospitals. The average length of stay was 20 days.

	Total number of units	Total number of beds	Sectoral distribution
Acute beds in general hospitals	23	1,665	Public
Acute beds in specialist hospitals	8	2,285	Public

Community-based residential support

In Austria, both various supported living arrangements and group homes are available. There are very few sanctuaries for people in crisis, and they are not publicly funded. Psychiatric rehabilitation centres are available in many regions, as well as some mobile units for those having acute psychosocial crisis in the community.

Type of community-based service	Total number of units	Total number of beds/places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community-based residential arrangement: group home + supported living	386	5,178	n.a.	n.a.	n.a.	people with mental health problems (incl. adolescents and children)
Places of sanctuary for persons in crisis	2	~10	n.a.	n.a.	Non-profit	people with mental health problems
Respite homes	0					
Soteria houses	0					
Other: Psychiatric Rehabilitation Centres	14	1,193	n.a.	6-8 weeks	Mixed – financed by pension insurance	people with mental health problems
Other: mobile units for persons in psychosocial crisis	13	-	n.a.	-	mixed	persons in acute psychosocial crisis

Other community-based mental health support

Much of mental health care in Austria are provided in the community, through mental health centres and day services, which are both publically funded. There are over 100 user / survivor networks, including Hearing Voices networks. Some club houses and peer support networks are also available in across Austria.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups
Mental health centres outpatient)	242	4,4378 (without Vienna and Upper Austria)	mixed	publically funded	people with mental health problems
Mobile units or community mental health teams	n.a.	3,260 (without Vienna and Salzburg)	mixed	publically funded	people with mental health problems
Day services	227	6,533 (without Burgenland)	public	publically funded	people with mental health problems
Peer support/peer support networks	7	n.a.	n.a.	n.a.	people with mental health problems
User/Survivor organizations (including Hearing Voices networks)	102 (without Upper Austria, Salzburg and Styria)	n.a.	n.a.	n.a.	people with mental health problems
Club Houses (including cultural support networks)	87 (without Burgenland and Carinthia)	n.a.	n.a.	n.a.	people with mental health problems

Source of data: Kern, D.; Sagerschnig, S.; Valady, S. (2014). Planung Psychiatrie 2014 – Evaluierung der außerstationären psychiatrischen Versorgung. Wien: GÖG

Involuntary placement and involuntary treatment

In Austria involuntary placement is regulated by the Unterbringungsgesetz (Involuntary Placement Act)⁹ (UbG) which regulates compulsory hospitalisation to a psychiatric hospital or unit. It is applied whenever people have mental health problems, they endanger themselves or others seriously and gravely due to their conditions, and when adequate treatment

⁹ Unterbringungsgesetz: <https://www.ris.bka.gv.at/GeltendeFassung.wxe?Abfrage=Bundesnormen&Gesetzesnummer=10002936>



cannot be ensured by means other than by inpatient stay in a psychiatric department.

The UbG distinguishes between involuntary placement upon request of the patient (Unterbringung auf Verlangen) vs. without request of the patient (Unterbringung ohne Verlangen). It outlines court responsibilities and procedures (hearing must be within a maximum of 4 days following admission, trial within a maximum of 14 days following the hearing). The Law defines legal representation of the patient (Patientenanwaltschaft, Patient Advocacy and Representation), as well as legal remedies.

In 2015, there were 24,308¹⁰ involuntary hospital admissions in Austria, and there were 270 forced placements at admission per 1,000 hospital admissions¹¹ (including only hospitals that execute forced admissions).

The total number of involuntary placements has increased in absolute numbers (2000: 14,694; 2015: 24,308) as well as in rates (in the year 2000: 183 per 100,000 inhabitants, in the year 2015: 282 per 100,000 inhabitants), although rates have been more or less stable since 2010. Around 80% of all involuntarily hospitalised persons were hospitalised once, about 13% twice, 4% three times (in 2015). Short involuntary placements in hospital have also increased (placements being terminated before the hearing i.e. the trial).¹²

Involuntary treatment is regulated in Article 35 of the UbG. The patient's consent can be overruled, if obtaining the consent would threaten the patient's life or would result in severe harm to her/his health.¹³ In 2015 about 33 per cent of all involuntary placements involved at least one restraint of freedom of movement (UbG § 33), showing a slight (absolute and relative) decline compared to the years 2013 and 2014. Regional differences are considerable (24-52%).

Community Treatment Order is not an established legal category in Austria.

Legal capacity and guardianship

Guardianship exists in Austria, based on the Sachwalterschaftsänderungsgesetz Act (2006).¹⁴ According to the Federal Ministry of Justice, in 2016 there were 58,548 people living under some form of guardianship regime. In March 2017, the Austrian Parliament passed a new, more progressive bill. The 2. Erwachsenenschutzgesetz will come into force by July 1st 2018 and will replace the previous law. The new Act focusses on higher level of autonomy and self-determination and it will support forms of supported decision-making.¹⁵

Other information

Deinstitutionalisation started in Austria at the end of the 1970s. Today, officially there are no publically funded residential psychiatric institutions in Austria.

It is reported that several debates among professional bodies and civil society organisations have focussed on trending issues in mental health such as media and its impact, migration, social exclusion and terrorism.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

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Pro Mente Austria | Website: www.promenteaustria.at | Email: office@promenteaustria.at

¹⁰ The Federal Computing Centre (BRZ); statistical analysis: GÖG/ÖBIG; all age groups included

¹¹ Annual hospital UbG survey; data collection and analysis: GÖG/ÖBIG; all age groups included

¹² Ladurner, J., Sagerschnig, S., Nowotny, M (2015): Analyse der Unterbringungen nach UbG in Österreich. Report commissioned by the Federal Ministry of Health. Vienna.

¹³ Ladurner, J., Sagerschnig, S., Nowotny, M (2015): Analyse der Unterbringungen nach UbG in Österreich. Report commissioned by the Federal Ministry of Health. Vienna.

¹⁴ https://www.ris.bka.gv.at/Dokumente/RegV/REGV_COO_2026_100_2_264486/REGV_COO_2026_100_2_264486.pdf https://www.ris.bka.gv.at/Dokumente/RegV/REGV_COO_2026_100_2_1332496/REGV_COO_2026_100_2_1332496.pdf

BELGIUM

COUNTRY INFORMATION

- **Population:** 11,366,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Belgium has a very high number of both long-term and acute psychiatric beds. Average length of stay exceeds one month even in acute specialist units. Although a national deinstitutionalisation strategy has existed since 2011, and community-based services – including over 4,000 supported living places – are available, the mental health system relies heavily on long term residential facilities. Progress in the current Belgian deinstitutionalisation strategy has been hindered by a number of factors. Available data shows that the number of involuntary admissions is also rising.

DETAILED INFORMATION

Institutions and psychiatric hospitals

Belgium has a very high number of long-term hospital beds in psychiatric facilities, including general and specialist hospitals. The average length of stay is over three months. Care homes are also widespread with an average stay of over five months.

Type of institution	Total number of units (1)	Total number of beds (1)	Total number of patients/users (per year) (3)	Length of stay (2)	Sectoral distribution (public, private, non-profit)
Long-term beds in general hospitals	2	139	1,951	Average stay: 95 days	Mixed
Long-term beds in specialist hospitals	44	5,200	27,500	Average stay: 95 days	Mixed
Care/nursing homes	40	2,943	6,895	Average stay: 167 days	Mixed

Sources of data: (1) <https://www.health.belgium.be/nl/gezondheid/organisatie-van-de-gezondheidszorg/delen-van-gezondheidsgegevens/gezondheidszorginstellingen> (2017); (2) http://www.mloz.be/files/etude_sejours_psy_nl_0.pdf (2014); (3) https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/diensten_1.pdf (2012); (4) Indicateurs de Santé mentale EN WALLONIE, Magazine Wallonie Santé N°6 | 2016 (2016)

The number of acute beds is also high in Belgium. The average length of stay in specialist psychiatric hospitals on ‘acute’ beds is more than a month.

Type of institution	Total units	Total beds	Total number of patients/users (per year)	Length of stay	Sectoral distribution
Acute beds in general hospitals	35	2,967	45,510	Average stay: 18 days	Mixed
Acute beds in specialist hospitals	55	4,755	47,375	Average stay: 37 days	Mixed

Sources of data: https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/GI2015_Kerncijfers-CGG-EPD.pdf; Indicateurs de Santé mentale en Wallonie, Wallonie Santé N°6, 2016.



Community-based residential support

In Belgium, community-based residential support is available through supported living settings, which provided over 4,000 places for users of mental health services in 2017. There are no group homes for mental health service users in Belgium.

Type of community-based service	Total units	Total beds/places	Total number of users (per year)	Length of stay	Sectoral distribution
Supported living	88	4,247	+/- 4,500	Average stay: 162 days	Private

Sources of data: https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/GI2015_Kerncijfers-CGG-EPD.pdf; Indicateurs de Santé mentale en Wallonie, Wallonie Santé N°6, 2016.

Other community-based mental health support

In Belgium, community-based mental health care is provided in outpatient centres which are available across the country and publically funded. Mobile units are also available. Day-centres, also supporting people after hospitalisation, are used by over 23,000 people. There are several peer support networks and organisations of users/survivors of psychiatry; however these are usually dependent on charity funding.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution (public, private, non-profit)	Are they publically funded?	Brief description of main client groups
Mental health centres (outpatient)	101 (with 194 sites)	Approx. 78,000	mixed	Public funds	Outpatients, ambulatory care
Mobile units/community mental health teams	23 networks (41 teams) covering Belgium	n/a	private	Public funds	Outpatients, out-reaching,
Day services	50	Approx. 23,400	Mixed	Public funds	Outpatients, former care in psychiatric wards
Peer support/peer support networks	Approx. 50	n/a	Private	Charity	
User/Survivor organisations	Approx. 15	n/a	Non-profit	Public funds + charity	

Sources of data: https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/GI2015_Kerncijfers-CGG-EPD.pdf; Indicateurs de Santé mentale en Wallonie, Wallonie Santé N°6, 2016.

Involuntary placement and involuntary treatment

In Belgium, involuntary admission is executed based on three criteria: 1) there is a mental health illness, 2) other 'suitable treatment' is unavailable or is refused, and 3) the person is seriously endangering their own or someone else's life/safety or integrity. Under ordinary procedure the request is made which is followed by circumstantial medical report to the magistrate (justice of the peace) and the decision on admission follows within 10 days.¹⁶

In case of urgency, an emergency procedure is launched via an attorney of law and admission is immediate with an observation period of max. 40 days, which may be prolonged.

In every case, the patient is assisted by a lawyer and by his legal representative. The total time of involuntary placement is max. 2 years. This measure does not imply that the patient has to stay in the (psychiatric) hospital for this period, and people can continue to receive involuntary outpatient care, as approved by a psychiatrist and a court.

¹⁶ https://med.kuleuven.be/nl/permanente-vorming/pentalfa/bestanden/2014-2015/03_05/vandenbergh.pdf

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Originally, the option for emergency procedure was intended as an exception, nevertheless around 85% of forced placements follow this emergency procedure.¹⁷

Data available from Flanders show there was a steady rise in the number of involuntary admissions: from 4,576 (2010) to 5,092 admissions (2014), which correspond to 10.12% (2010) and 11.09% (2014) of specialist hospital admissions.¹⁸ Although official data is unavailable but civil society sources claim there may be similar trends in Brussels and Wallonia.

Community Treatment Order is not an established legal category in Belgium.

Legal capacity and guardianship

In 2013, new legislation entered into force that replaced previous regulations on the limitation of legal capacity. Under the new legal framework, 'Peace Judges' (Juge de Paix) rule on whether a person is able to manage herself/himself or to manage his/her property. The judge may define actions where the person needs assistance or where they will be represented by others. Assistance may be given by people close to the person or by a multidisciplinary team.

Supported decision-making is being exercised when a counsellor is appointed to assist the person. The protected person can also appoint a trustee who acts as an intermediary between them and the administrator.

Other information

In 2011, Belgium adopted a deinstitutionalisation strategy known as Article 107.¹⁹ The programme proposed the creation of networks of care in order to develop community-based options to replace institutional care. However, data was not available about the progress of Article 107.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>)

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Hand in Hand | Website: www.ipso-gent.be | Email: ipso@ipso-gent.be

Huis Perrekes | Website: www.perrekes.be | Email: perrekes@skynet.be

Psychiatrisch Centrum Gent-Sleidinge (PCGS) | Website: www.pcgs.be | Email: info@pcgs.be

¹⁷ https://med.kuleuven.be/nl/permanente-vorming/pentalfa/bestanden/2014-2015/03_05/vandenbergh.pdf.

https://www.health.belgium.be/sites/default/files/uploads/fields/fpshealth_theme_file/hgr_advies_9193_dwanginterventie.pdf

¹⁸ https://www.departementvwg.be/sites/default/files/media/documenten/Rapport%20gedwongen%20opname%202014V2_0.pdf

¹⁹ More information available in French: <http://www.psy107.be/index.php/fr/>



BOSNIA AND HERZEGOVINA

COUNTRY INFORMATION

- **Population:** 3,509,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Mental health care in Bosnia and Herzegovina relies heavily on residential institutions and long-term hospitals. Community-based services are mostly available through publicly funded outpatient services. Residential support in the community (i.e. supported living arrangements) and day centres are established and run by civil society, in the absence of public funding. Although the country has a current deinstitutionalisation strategy, it is reported that actual reform programmes may only be launched in the local or regional levels with the cooperation of municipalities and civil society.

Decisions about the deprivation of legal capacity and involuntary admission to hospitals are often made together. Statistics on many aspects of mental health care are either not collected or not disclosed by the state.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Bosnia, three specialist hospitals and 13 psychiatric units in general hospitals with acute beds are available for people with mental health problems.²⁰ Data is unavailable about the number of beds and the average length of stay in these facilities. There are also three long-term residential care homes in the country (total number of residents unknown). In long-term specialist hospitals (see table below) the average length of stay is estimated to be around 10 years. In many facilities residents are both people with mental health problems and people with intellectual disabilities.

	Total number of units	Total number of beds	Total number of patients	Sectoral distribution	Client group
Long-term beds in specialist hospitals	8	3,000	3,000	Public	Mixed (adults, adolescents and children)

Community-based residential support

In Bosnia, currently there are only supported-living type of residential support is available. All available community-based residential facilities were developed and are run by civil society organisations.

Type of community-based service	Total number of units	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community-based residential facilities: supported living	20	70	2 years	Non-profit	People with mental health problems (incl. adolescents and children)

²⁰http://www.who.int/mental_health/evidence/atlas/profiles-2014/bih.pdf



Other community-based mental health support

In Bosnia, outpatient care is available across the country, although there are no official statistics available about the exact number of facilities. Mental health centres is publicly funded, but other types of support (e.g. mobile units or club houses) are either unavailable or not funded by the state. Non-profit organisations, however, provide a significant part of community-care services by running both day-centres and reaching at least 400 people annually through organisations of users/survivors of psychiatry.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups
Mental health centres (out-patient)	Approx. 70	Approx. 3,500	public	Publicly funded	people with mental health problems
Mobile units or community mental health teams	0				
Day services	Approx. 20	Approx. 2,000	Non-profit	n.a.	people with mental health problems
Peer support/peer support networks	0				
User/Survivor organizations	4	Approx. 400	Non-profit	n.a.	people with mental health problems
Club Houses	0				

Source of data: Estimations for 2016 by civil society experts, submitted by SUMERO

Involuntary placement and involuntary treatment

Involuntary admissions are regular in Bosnia. Under the Law on Extrajudicial Procedure (The Official Gazette of BH, No. 2/98, 39/04.) it is possible to admit and keep people with mental health problems under medical treatment even without their consent. Criteria for placement and discharge are decided upon by the court within 24 hours, based on the opinion of a court certified psychiatrist. These medical experts cannot be employed by the institution in which the person in question is forcefully accommodated. Admission can be made without the consent of the person in case it is assumed that the patient's (or someone else's) health or safety is at risk. Data about the number of involuntary admissions are unavailable.

However, court decisions are sometimes missing, as it was shown in the case of Hadžimejlić and others against Bosnia and Herzegovina, before the European Court for Human Rights. In the judgment the court established that Bosnia violated article 5 of the European Convention on Human Rights, in that for several years the applicant was institutionalized without a court decision.

Community Treatment Order is not an established legal category in Bosnia.

Legal capacity and guardianship

Persons with mental health problems in Bosnia can be deprived of legal capacity, i.e. the right to inheritance, the right to marry etc. Procedures are set out in the Family Law and Non-contentious Proceedings Act. Centres for social work and local courts initiate the procedures. After deprivation of legal capacity there is little or no monitoring and complaint procedures are difficult to launch. Furthermore, the process of restoration of legal capacity is practically non-existent. It is reported that in most cases forced placement in closed-type institutions happens along with the deprivation of legal capacity, often leading to the deprivation of property and forced treatment. In making decisions about legal capacity the court and judges usually rely exclusively on medical documentation. Supported decision-making is not part of Bosnian law.

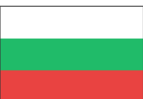
Official statistics are unavailable but it is estimated that at least 5,000 people are under some form of guardianship in Bosnia.



Other information

Bosnia has a deinstitutionalisation strategy «Strategy of deinstitutionalization and transformation of social protection facilities in the Federation of B&H (2014-2020)». The strategy aims to develop and strengthen services such as home care, personal assistance services, and other services to support community living. Progressive reforms on the national level in Bosnia are reported to be facing resistance and lack of coordination mostly because of the diversity and political instability of the country.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.



BULGARIA

COUNTRY INFORMATION

- **Population:** 7,101,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

The Bulgarian mental health system offers both acute hospital beds and outpatient care for those living in the community. However, residential support (for example supported living facilities or small group homes or respite centres) are virtually non-existent in Bulgaria. Although the country has almost 4,000 long-term beds in adult social care institutions, there is no deinstitutionalisation strategy for mental health. Despite proposals for new regulations, Bulgaria still has both full and partial guardianship regimes.

DETAILED INFORMATION

Institutions and psychiatric hospitals

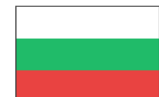
In Bulgaria, there are altogether 3,997 beds in 54 different residential institutions. Many of these institutions provide services for both people with mental health problems and people with intellectual or developmental disorders. Out of 54 care homes 33 are located in rural areas or in small villages far from the community. The number of average length of stay and number of patients are collected on the local/municipal level.

	Total number of units	Total number of beds	Total number of patients	Sectoral distribution	Client group
Caring/nursing homes	13	1,036	n.a.	Public	Adults with 'mental disorders'
Caring/nursing homes	14	825	n.a.	Public	Adults with 'mental retardation'
Caring/nursing homes	27	2,118	n.a.	Public	Adults with dementia

Source of data: National Centre of Public Health and Analyses, Sofia

Acute hospital beds are available across Bulgaria, both in general hospitals and in specialist psychiatric hospitals. In 2016 there were over 30,000 admissions to acute psychiatric inpatient facilities. Data was not available about the average length of stay in these facilities.

	Total number of units	Total number of beds	Total number of patients (2016)	Sectoral distribution
Acute beds in mental health hospital units	12	2,383	9,554	Public
Acute psychiatric beds in general hospitals	22	991	20,626	
Forensic inpatient unit (outside psychiatric hospitals)	2	60	379	Public



Source of data: National Centre of Public Health and Analyses, Sofia

Community-based residential support

In Bulgaria, there are no known residential services (for example supported living arrangements, group homes, respite homes or Soteria houses) supporting people with mental health problems living in the community.

Other community-based mental health support

It is reported that in Bulgaria, user access to new services depends on the health status, the available building stock, and the ability to protect projects. With few exceptions 'resident services' are micro-institutions that do not provide "social inclusion".

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding	Main client groups
Hospital-based mental health outpatient care	3	3,720 (2017)	mixed	publically funded	
Community (non-hospital based) mental health outpatient care	12	150,535 (2017)	mixed	publicly funded	
Day services or 'treatment facility'	426	345,226 (2017)	public	publicly funded	people with mental health problems
Peer support/peer support networks	n.a.	n.a.	n.a.	n.a.	
User/Survivor organizations	n.a.	n.a.	n.a.	n.a.	
Club Houses	n.a.	n.a.	n.a.	n.a.	

Source of data: National Centre of Public Health and Analyses, Sofia

Involuntary placement and involuntary treatment

Section 2 of Chapter 5 of the Bulgarian Health Act (2004) regulates involuntary treatment in mental health. Requests can be made by either the head of a psychiatric care facility (normally a psychiatrist) or a public prosecutor. Decisions about placement and treatment without the patient's consent can be made by a court. The participation of a psychiatrist, legal practitioner and public prosecutor is mandatory.²¹ There were 379 involuntary placements in 2016.²²

Community Treatment Orders (CTOs) can be executed in Bulgaria under the Health Act. Data about the number of CTOs is not available.

Legal capacity and guardianship

Guardianship is regulated by the Bulgarian Family Code (2009) and the Code of Civil Procedure (2008). Both full and partial guardianship exist. In 2012 there were 7,040 people under guardianship: 6,249 under full guardianship and 791 under partial guardianship; 3,679 people under guardianship live in long-term residential care.²³ Despite proposals for changes in the regulation of legal capacity the actual codification has been postponed.

Other information

Currently Bulgaria has no deinstitutionalisation strategy in mental health. Recently, a National Mental Health Program 2018-2024, which sets out partial measures for deinstitutionalization, was submitted to the Ministry of Health for approval.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

²¹ <http://solicitorbulgaria.com/index.php/bulgarian-health-act-part-2>

²² Source of data: Regional Health Inspectorate

²³ https://www.rcpsych.ac.uk/pdf/PUBNS_IPv13n4_92.pdf



CROATIA

COUNTRY INFORMATION

- **Population:** 4,154,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Long-term hospitals and social care institutions are still widespread in Croatia. However, residential support in the community such as supported living or group homes are available in some parts of the country and provide only 213 places. Other types of community support only exist sporadically.

The new Croatian guardianship regulations, which entered into force in 2015, abolished full guardianship and provides various rights for people under substitute decision-making policies. Croatia also has a national deinstitutionalisation strategy, but it covers mental health only marginally.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Croatia, long-term stay is provided both in hospitals and social care institutions, often found in rural areas. Residential institutions also provide “organized housing” (a form of group home or supported accommodation) which are included in the below figures, because housing units are still connected to the institutional settings and do not meet the definition of “community based residential services”.

	Total number of units	Total number of beds	Total number of patients	Sectoral distribution	Average length of stay	Client group
Long-term bed in specialist hospitals (2015)	8	2,829	16,742 (discharged patients in 2015)	Public	52.6 days	Adults with mental health problems
Social care homes (2015)	28	3,823	3,715	Public and private	Often life-long	Adults with psychosocial disabilities

Sources of data: Annual Statistical Report on Social Care Homes and their Users; Ministry of Demography, Family, Youth and Social Policy, 2016; Croatian Health Statistics Yearbook 2015

Acute hospital units are available in many parts of Croatia and they provide over 1,100 beds. The average length of stay is between 10-12 days. Long-term hospital stay cannot exceed 60 days.

	Total number of units	Total number of beds	Total number of patients (2016)	Average length of stay	Sectoral distribution
Acute beds in general hospitals	n.a.	362	11,378	10.4 days	Public
Acute beds in specialist hospitals	n.a.	768	21,095	12.9 days	Public

Source: Croatian Health Statistics Yearbook 2015



Community-based residential support

In Croatia, community-based residential services for people with mental health problems are rare. In 2015 a total of 213 service users²⁴ received some form of residential support (either 24-hour or short term support) and such services were run and financed both by the state and non-profit organisations. Croatian legislation does not define forms of support for community living; however, existing community services do provide support such as personal assistance.

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Other community-based mental health support

Data was scarce about community-based mental health outpatient care. It is reported that there are at least four organisations established or run by users/survivors of psychiatry.

Type of community-based service	Total number of units	Total number of visits	Sectoral distribution	Source of funding?	Main client groups (adults/children)
Mental health outpatient and day treatment facility ²⁵	177	13,165 (2013)	mixed	publically funded	Adults with mental health problems
User/Survivor organizations	4	n.a.	n.a.	n.a.	Adults with mental health problems

Involuntary placement and involuntary treatment

The Act on Protecting Persons with Mental Health Problems (Official Gazette no. 76/14, in force, as of January 1, 2015) regulates involuntary admissions and treatment under Sections 3(1)(11) and (12). Involuntary placement may be ordered by the criminal court in cases of “forensic patients”, following consequent application of abovementioned provisions – in these cases further actions are regulated by both the Criminal Procedure Act and the abovementioned Mental Health Act: in the first six months decisions are taken by criminal courts, after that (e.g. about the prolongation of the order) by civil courts.

Placement without consent is also possible to ensure that the procedural rights of people under guardianship are respected. Under this provision, in case a person under guardianship opposes the decision of the guardian to be placed into a psychiatric hospital, the person is guaranteed the same judicial process as if it would be applied to people with full legal capacity in the procedure – thus the provisions for appeal for judicial decisions are applicable too.

Community Treatment Orders (CTO) exist in Croatia for “forensic patients” only. The court may order the treatment when the presumed existence of ‘danger’ is not of such a degree that warrants the institutional placement. People under CTO are required to take medical treatment. The community treatment order may last for up to five years.²⁶

Legal capacity and guardianship

The Croatian Family Act (Official Gazette no. 103/15, in force from 1 November 2015) abolished full guardianship, however partial guardianship remains in place. Substitute decision making is also still possible in the form of an advance directive for certain legal matters. The Act on Protecting Persons with Mental Health Problems Sections 68–73 regulate these advance directives for people with mental health problems which is more a power of attorney function which allows people under the Act to empower someone else to make decisions in case of their ‘incapacity’. Decisions regarding placement and treatment in psychiatric hospitals can then be made on behalf of the person who is incapacitated, except for decisions relating to bio-medical research and electroconvulsive therapy which are not allowed on the basis of substituted decisions.

²⁴ Source of data: Annual Statistical Report on Social Care Homes and their Users, 2015; Croatian Ministry of Demography, Family, Youth and Social Policy.

²⁵ http://www.who.int/mental_health/evidence/atlas/profiles-2014/hrv.pdf

²⁶ The Act on Protecting Persons with Mental Health Problems (Official Gazette no. 76/14; in force, as of January 1, 2015; Sections 50 – 59



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In the procedure of deprivation of legal capacity, if a guardian ad litem is not appointed in an advanced directive, a lawyer from the Centre for Special Guardianship will be present. In the procedure for forced placement into psychiatric hospital the person will get an attorney assigned by the court.

Those deprived of their legal capacity can still exercise some rights such as recognition of paternity, consent to recognise paternity, consent to marry, consent to dissolve marriage, consent to enter into civil partnerships with persons of different or same sex and consent to dissolve these unions, consent to adoption (except when consent is substituted by the court), decision on termination of pregnancy, decision to participate in biomedical research (Section 258 of the Family Act).

In 2015, the total number of people under guardianship was 18,014 of which 15,059 (83.6%) were fully deprived of legal capacity and 2,955 (16.4%) were under partial guardianship.²⁷ It is possible to gain legal capacity back, however cases are rare. The total number of people to whom legal capacity was restored in 2015 is 53.

Croatian law does not have provisions for supported decision-making.

Other information

Croatia does have a national deinstitutionalisation plan in place (Strategy on Deinstitutionalization and Transformation of Social Care Homes and Other Legal Persons doing Social Welfare in the Republic of Croatia 2011 – 2016). However, the Strategy only marginally covers people with mental health problems and with a delay in implementation until 2018. For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

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Susret – Association for Psychological Support | Website: www.udruga-susret.hr | Email: info@udruga-susret.hr



CYPRUS

COUNTRY INFORMATION

- **Population:** : 854,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Cyprus, people with mental health problems are often placed into homes for the elderly or social care institutions for people with intellectual disabilities. Community-based residential support is only available for people with intellectual disabilities.

DETAILED INFORMATION²⁸

Institutions and psychiatric hospitals

There is no specific policy or legal framework for placing adults with mental health problems in certain types of institutions. If there is no family support, people live in social care institutions for the elderly or for disabled people, or they live in the community with the support of social carers. The evaluation for social care need and the estimation of costs are the responsibility of the Ministry of Labour, Welfare and Social Insurance, based on the legislation for the Minimum Guaranteed Income.

Currently there are 115 registered social care homes for the elderly and disabled persons (private or non-profit). Of the 115, there are 5 institutions where all residents (total number 143) are people with mental health problems. Data is not available about the total number of people with mental health problems living in homes for elderly or disabled people. Institutional (residential) care is strictly provided to people when their individual needs cannot be met on a 24-hour basis by their family or other supportive services (home care, day care). Social Welfare Services place people in need of residential care in governmental, community or privately owned residential homes (homes for the elderly and the disabled).

	Total number of units	Total number of beds	Total number of patients	Sectoral distribution	Average length of stay	Client group
Social care homes	6	n.a.	143	Private and non-profit	n.a.	People with mental health problems

Sources of data: Social Welfare Services, Ministry of Labour, Welfare and Social Insurance.

Data is not available on acute hospital beds in Cyprus.

Community-based residential support

Community-based residential support services are available only for adults with intellectual disabilities in Cyprus. Relevant programmes are being established by non-governmental organisations which are inspected and partly financed by the Social Welfare Services and the Ministry of Labour, Welfare and Social Insurance. The Ministry of Health (Mental Health Services) is in the process of promoting a relevant legal framework for such services.

Other community-based mental health support

Currently 1,104 people with mental health problems are recipients of some form of public assistance benefit such as direct

²⁸ Data collection was carried out with the help of the Cypriot Social Welfare Services, the Commissioner for Administration and Human Rights (Ombudsman), and the Office of the Law Commissioner.

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payments or personal budgets. However, public assistance allowances are being replaced by the Guaranteed Minimum Income (GMI), as part of the overall reform of the Social Welfare System. Of the 1,104 people, 261 individuals also receive care services (home care services, institutional care, etc.).

Involuntary placement and involuntary treatment

Involuntary placement and treatment are regulated separately in Cyprus. According to the Psychiatric Care Law, the procedure for involuntary placement starts with an application, submitted to the Court by the patient's personal representative or by the police or a social worker. The application should be supported by a psychiatric opinion on the need for hospitalisation. The temporary hospitalisation decree is valid for up to 28 days and the court sets a date by which it shall consider whether a continuous treatment is necessary or not. On that date, if the court considers that the patient should be hospitalised, it will issue a permanent hospitalisation decree for an initial period of up to 2 months that may be renewed under specific provisions of the Law.

By Law the court should also hear the views of the patient before the decision is made, unless she / he is not seen to be in a position to testify. In such a case, the court hears the views of the patient's representative or the views of the social worker, who may be accompanied by a lawyer and a psychiatrist. The Court may renew the Continuous Treatment Decree at the request of the patient's representative or nurse or social worker, for a period of up to 12 months. The application shall be accompanied by a medical opinion of the treating psychiatrist, after consultation with the inter-professional team of the centre, where possible. In case of disagreement, this fact refers to the psychiatrist's opinion. The patient or his / her personal representative may request a medical opinion from an independent psychiatrist of their choice.

Recently, Social Welfare Services have recommended the amendment of the Psychiatric Care Law, in order to restrict social workers' involvement during the above procedure, considering that they do not possess the necessary qualifications or expertise regarding mental health issues.

In Cyprus, 98% of admissions in psychiatric hospitals are voluntary.²⁹

Legal capacity and guardianship

In Cyprus, legal capacity can be restricted based on The Administration of the Property of Disabled Persons Law, 1996 [L.32(I)/1996], The Psychiatric Treatment Laws, 1997 to 2007, and The Parents and Children Relations Laws, 1990 to 2008. There is only full guardianship in Cyprus, and the removal of capacity is based on a medical opinion and a court hearing. There is currently no alternative to the full deprivation of legal capacity (no partial or ad hoc guardianship).

Supported decision-making is not yet an established provision in Cypriot law. However, following the recommendations of the UN CRPD Committee, a working group was set up to examine the possibilities of progressive legal capacity legislation. The work of the working group is hindered by disagreements about the provisions to be entailed in a new legislative framework – for example, Mental Health Services decided to not participate in the working group.

Other information

The Psychiatric Care Law of 1997 and its later amendments gave momentum for psychiatric reform, deinstitutionalization and establishment of Community Psychiatry. The appointment by the government of the Cyprus Mental Health Commission (Epitropi Eoptias Ke Prostasias Dikeomaton Psychika) contributes to the implementation of the principles of the Law, especially regarding the rights of patients and the minimum standards during their hospitalisation.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Kinsi Proaspisis Dikeomaton Psychik Asthenon (KY.PRO.DI.PS.A) - Advocacy Group for the Mentally Ill |
Website: www.ekpedevsiveltiosimosi.wordpress.com | Email: agftmi@cytanet.com.cy

²⁹ http://www.who.int/mental_health/evidence/atlas/profiles-2014/cyp.pdf



CZECH REPUBLIC

COUNTRY INFORMATION

- **Population:** 10,578,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In the Czech Republic, large residential psychiatric hospitals and social care homes are still common. The government recently launched a national psychiatric reform programme that aims to establish more community-based services and reduce the number of institutional places. However, community-based support is often scarce, and only a small number of people can access supported living arrangements or other forms of support. Recent changes in guardianship reforms mean less restriction in legal capacity for people with mental health problems.

DETAILED INFORMATION

Institutions and psychiatric hospitals

There are many long term psychiatric hospitals and social care institutions in the Czech Republic. There are three psychiatric hospitals with over 1,000 beds each and an additional eight hospitals with an average of over 600 beds. The number of beds in psychiatric hospitals has remained stable over recent years. Hospital buildings are often old, dating back to Austro-Hungarian times, having six to twelve patients per room, and up to 40 to 70 patients per ward.

A recent study on long-term psychiatric care found 3,601 patients with schizophrenia who have previously been hospitalized between 1998 and 2012. Of these 260 were hospitalised for over 20 years and all of them were hospitalised for over one year. Nearly 20% (n = 707) died during hospitalisation. Discharges of 19.36% (n = 697) were only administrative in their nature. Out of 2,197 truly discharged patients, 14.9% (n = 327) were re-hospitalized within 2 weeks after the discharge.³⁰

Social care homes have 40 to 200 beds, and they provide services for people with dementia, people with intellectual disability, addiction, and for people with psychosocial disabilities. No data are available on the exact number of people with psychosocial disabilities in these services – the figure below is an estimation.

Type of institution	Total number of units	Total number of beds	Total number of patients/users (per year)	Length of stay	Sectoral distribution (public, private, non-profit)	Client group
Long-term beds in general hospitals	0	0	0			

³⁰ Source: Winkler, Petr, Long-term hospitalisations for schizophrenia in the Czech Republic 1998–2012, Schizophrenia Research 175 (2016) 180–185.

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Long-term beds in specialist hospitals (2015)	18	8,583	38,865	76.3 days	Mainly public (under Ministry of Health)	Adults and children
Social care institutions (2017)	231	2,500 – 3,000	n.a.	n.a.	Mainly public (Ministry of Social Affairs, municipal level, regional governments) and NGOs	
Forensic inpatient units	5	177	n.a.	n.a.	Public (Ministry of Justice)	Sexual offenders, addictology etc.

Source of data: Institute of Health Information and Statistics of the Czech Republic, Register of Social Services; Ministry of Health; National Institute of Mental Health; Statistical Yearbook of Prison Service of the Czech Republic.

Acute beds are available across the country in specialist, psychiatric hospitals. In 2013, the Czech government launched a Psychiatric Reform Programme to develop community services and to increase the number of beds in psychiatric wards in general hospitals. Using European Structural Funds, eight hospitals received funding. The total number of units in general hospitals did not change and the number of beds slightly increased in 2015, mostly because current health insurance policies still finance large wards in hospitals while appropriate financial support for smaller units is lacking. No investments were made in community services.

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Acute beds in general hospitals	30	1,308	19,955	17.2 days	Public, private	Adults
Acute beds in specialist hospitals	0	0	0			

Source of data: Institute of Health Information and Statistics of the Czech Republic

Community-based residential support

In the Czech Republic, residential support outside large traditional institutions is provided mostly through group homes, often for up to 10 residents, many of them run and funded by NGOs. Supported living is also available in some regions, providing accommodation and support both for people with mental health problems and people with intellectual disabilities. Other types of residential support such as respite homes or Soteria houses are not available.

Type of community-based service	Total number of units	Total number of beds/ places	Total number of users	Length of stay	Sectoral distribution	Client group
Community-based arrangement: group homes	36	431	n.a.	n.a.	Non-profit; public	Mainly for people with psychosocial disabilities (381 beds).
Community-based arrangement: Supported living	26	182	n.a.	n.a.	Non-profit; public	Mixed client groups, incl. people with intellectual disabilities. 2/3 estimated people with psychosocial disabilities
Places of sanctuary for persons in crisis	204	n.a.	n.a.	n.a.	Non-profit; local communities and Regional Governments; public	Specialised facilities for homeless people, for victims of domestic violence, people in crisis. Only 1 facility with 4 beds for people with mental health problems.

Source of data: Register of Social Services



Other community-based mental health support

Outpatient services are mostly delivered by private practitioners (psychiatrists) who work outside of interdisciplinary teams (consisting for example of social workers, psychologists etc.), focusing mostly on purely medical treatment. The average time of visits is estimated by the Association of Outpatient Psychiatrists to be around 12 minutes per patient. Under the currently running Psychiatric Reform Programme, the Czech Government aim to establish up to 100 new community mental health centres, built on mostly interdisciplinary mobile teams, with a psychiatrist, psychologist, social workers, nurses, expert by experience and vocational consultants. These community mental health teams / centres are new types of services, therefore currently only very few are being piloted.

Direct payments are available in the Czech Republic but data is not available on recipients with psychosocial disabilities. A survey conducted by Fokus Association suggests that only a fraction of people with mental health problems receive such direct payments. Personal assistance is available only to people with physical disabilities.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Are they publically funded?	Main client groups
Mental health centres (outpatient)	1,137	n.a.	Mostly private; some public as part of hospitals	Both public and private.	Mixed group
Mobile units/community mental health teams	6 (30)	Approx. 1,000 (6,000)	Both public and NGOs	Ministry of Labour and Social Affairs and health insurance	Adults (mostly people with severe mental illness)
Day services	228	Approx. 1,330 (estimated number of users with mental health problems)	Non-profit, local communities and regional government-led services	Ministry of Labour and Social Affairs	People with learning disabilities, people with addiction, and elderly people.
Peer support/peer support networks	1	30	Non-profit	no	People with psychosocial disabilities
User/Survivor organizations	8	Approx. 250	Non-profit	No permanent funding. Grants may be available from public or private bodies.	People with psychosocial disabilities
Club Houses	0*				
Hearing voices networks	1	20 – 30	Non-profit	No funding.	People with psychosocial disabilities.
Cultural support networks (theatre, sports clubs etc.)	They are part of other services and organizations.	n.a.	n.a.	Funding is irregular, may be public or private.	People with psychosocial disabilities

Sources of data: Institute of Health Information and Statistics of the Czech Republic, Register of Social Services, 2015

Involuntary placement and involuntary treatment³¹

In the Czech Republic, involuntary admissions are regulated by the Act on Health Services No. 372/2011 Coll. (Section 38, Paragraph 1, letter B). Under this regulation, a person may be hospitalized without consent when all following conditions are

³¹ Source of data: Liga lidských práv and Centrum podpory transformace: Involuntary hospitalisation of psychiatric patients in the Czech Republic, 2015, p. 21-27.



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present: the person is immediately and seriously threatening himself or herself; the person shows the signs of mental illness or is under the influence of an addictive substance; the threat from the person cannot be eliminated otherwise. The law sets out other obligations, e.g. about the facility and the right to be represented by the court.

Any involuntary placement must be reviewed by an independent court. This is specified in Sections 104-110 of the Civil Code and Sections 66-83 of the Act on Special Proceedings of the Court. The healthcare facility must advise the court about any involuntary hospitalisation within 24 hours and the court must decide within 7 days whether the hospitalisation is lawful. If it is judged to be unlawful, the hospital must immediately release the patient.

However, involuntary placement can also be started without submitting the proposal to the court. The procedure begins by the healthcare facility notifying the court about hospitalizing the person without consent. The notification should include a statement of all the important facts that led to the hospitalisation, including the reasons for fulfilling the legal conditions.³²

Official data provided by the Ministry of Health about the number of patients released from the officially declared involuntary placements is 366 people in 2016. There is no data available about the number of the involuntary placements actually started which could potentially be much higher.

Legal capacity and guardianship

In the Czech Republic, guardianship legislation has gone through significant changes recently. In 2010 there were 5,741 persons with restricted legal capacity and 26,520 persons under full guardianship. The new Civil Code, which entered into force in 2014, abolished full guardianship and introduced supported decision-making. However, courts struggle to change the former decision from deprived to restricted legal capacity. It is reported by NGOs that the attitudes of most attorneys have not changed, courts have limited resources and people with intellectual disabilities or psychosocial disabilities are restricted of their legal capacity instead of providing them measures that allow supported decision-making. For example, when people are admitted to residential institutions, about 60% have restricted legal capacity (survey of Prague City Town Hall, 2016, unpublished).

Although some NGOs are trying to provide supported decision-making under the new Civil Code and to establish guardianship boards, but such programmes remain sporadic.

Other information

In 2014, the CPT recommended that the Czech Republic should allocate sufficient money for the implementation of the national plan for the transformation of psychiatric, health, social and other services and ensure deinstitutionalisation process. The Committee also recommended the abolition of cage beds or net beds, and change the law to prohibit the use of net and cage beds, and to ensure the effective monitoring of conditions in psychiatric hospitals.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Fokus | Website: www.fokus-cr.cz | Email: info@fokus-cr.cz

³² The usual practise (reported by patients) is that the process starts as an involuntary placement but later healthcare personnel try to convince the patient to get his/her consent with the placement to avoid the necessary reporting procedures. Patients often succumb to pressure and give their consent even if they do not agree with it. Therefore, NGOs such as Fokus do not consider the official data available on involuntary placements as representative and credible.



DENMARK

COUNTRY INFORMATION

- **Population:** 5,748,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

There are no long-term psychiatric institutions in Denmark. Long-term psychiatric beds provide an average 16 days of stay in general or specialist hospitals while acute beds are found only in emergency units. Involuntary admissions and forced treatment are both present in practice in Denmark.

DETAILED INFORMATION

Institutions and psychiatric hospitals³³

In Denmark hospital services are provided by the five administrative regions. In all of the regions psychiatric care is organized separately. While in some regions psychiatric facilities are specialist hospitals, in other regions psychiatric wards are part of general hospitals. In 2017, there were psychiatric wards in 30 different locations in Denmark. Some wards provide general care, while others are specialised for example in psychoses, forensic psychiatry etc.

Type of institution	Total number of units	Total number of beds	Total number of patients/ users (per year)	Length of stay	Sectoral distribution (public, private, non-profit)
Long-term beds in general and specialist hospitals	30	2,739	118,697	Average stay: 16 days	n.a.

Websites of regional authorities (search conducted on 12 April 2017)

In Denmark, acute psychiatric treatment is provided by emergency rooms at psychiatry hospitals or general hospitals. However, no data were available about the average length of stay.

Community-based residential support

Residential support for those living in the community is provided through short term stays in 'temporary housing' facilities. Group homes for people with mental health problems also exist.

Type of community-based service	Total number of units	Total number of beds/ places	Total number of users (per year)	Length of stay	Sectoral distribution
Temporary housing	813 (incl. units for other groups)	-	2,035 (April 2012)	Can be years	Municipality
Long term housing	367	-	2,406 (April 2012)	No limit	Municipality

Sources of data: <http://www.bedrepsykiatri.dk/media/62927/2013-sfi-sociale-tilbud.pdf>

³³ Sources of data: Benchmarking af psykiatrien 2015 (Benchmarking of psychiatry 2015): http://www.regioner.dk/media/4053/benchmark-af-psykiatri_m-forside-251116.pdf and Monitorering af tvang i psykiatrien, 2016 (Monitoring of forced placement/treatment in psychiatry, 2016) <https://www.sst.dk/da/udgivelser/2016/monitorering-af-tvang-i-psykiatrien-juli-2015-juni-2016> and websites of regional authorities (search conducted on 12 April 2017)

**Other community-based mental health support**

In Denmark community care is available for those living in the community; outpatient centres, mobile units and in-home care are all established types of services. Data was not always available about the range of services available, mostly because statistics are published on municipal level and through service provider organisations. Peer support networks for people with different types of mental health problems are run in many communities. Some are initiated and run by the municipalities; others are initiatives by private or user-controlled organizations. There is also a large number of national and local user-led organisations for people with mental health problems and their relatives – data about these are not available.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Are they publicly funded?	Brief description of main client groups
Mental health centres (outpatient)	n.a.	114,000 (Incl. both psychiatric emergency departments and outpatient treatment services)	Health services on regional level	Yes	People with mental health problems
Mobile units/community mental health teams	All five regions in Denmark	n.a.	Health services on regional level	Yes	People with mental health problems
In-home care	Available in all 98 municipalities	42,000	Municipality	Yes	People with mental health problems
Peer support/peer support networks	Available in many communities	n.a.	All sectors	Partly	Various
User/Survivor organizations	Many	n.a.	Non-profit, private	Some	Various

Sources of data: http://www.kl.dk/ImageVaultFiles/id_82738/cf_202/F-lles_om_fremtidens_socialpolitik.PDF

Involuntary placement and involuntary treatment

In Denmark, involuntary placement and involuntary treatment are regulated in the 1989 Law on the use of force in psychiatry (Om anvendelse af tvang i psykiatrien). The law was amended in 2015. Forced placement and treatment can only be used if the patient is in psychosis and is either assumed to propose a danger to themselves or others or if the prospect of treatment or significant and decisive improvement of the condition would be significantly impaired without hospitalisation. Decisions can be appealed and tried before court.

There were 4,699 involuntary admissions into psychiatric facilities during 2016.

Legal capacity and guardianship

There are three different forms of guardianship in Denmark, and guardianship is restricted to specific areas 'necessary' for every individual. Under Section 5 of the Law on Guardianship, guardianship can be established if a person is mentally ill or, due to illness, is unable to look after their own interests. Depending on the type of guardianship, the restriction of legal capacity can be requested by the family, the local council, a police constable, or even by the person concerned.

Supported decision-making is an established legal provision but data is not available about how many people use it. Civil society sources claim in forced admissions supported decision-making provisions are seldom in place.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Sind - Danish Association for Mental Health | Website: www.sind.dk | Email: landsforeningen@sind.dk
 Død I Psykiatrien | Website: <http://www.doedipsykiatrien.dk/index.php/en/> | Email: doedipsykiatrien@gmail.com



ESTONIA

COUNTRY INFORMATION

- **Population:** 1,315,635 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Estonia, people with mental health problems often receive special care services. It is also possible to receive 24-hour care services or community-based services. Although the country is implementing deinstitutionalisation programmes, the availability of community-based residential supports is limited. People with mental health problems can be placed under guardianship.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Estonia there are four types of special care services for adults with mental health problems or psychosocial disabilities. These are: 24-hour service, 24-hour service for persons with multiple disabilities, 24-hour service for persons with unstable recovery from a mental health problem, and 24-hour service by court order. Some of these providers also provide non-institutional services.

Services are financed by the state budget. In 2015 the average length of stay was about 11 months per year in the first three types of services, and seven months per year in court-ordered services.

General care homes are institutions that provide 24-hour care services for persons who are temporarily or permanently unable to manage in their own home environment because of their health status, disability, or living environment. The majority of residents (nearly 90%) are older adults.

Type of institution/hospital	Number of hospitals / institutions	Number of beds / places	Number of patients/users (per year)	Length of stay (average)	Sector	Client groups served
Long-term psychiatric beds in general hospitals*	8	518	6,236	20.8 days	Public (state, local government)	87.3% adults, (defined as 15 years and older)
Long-term beds in mental health hospitals*	2	108	3,180	10.0 days	Private sector	100% adults (defined as 15 years and older)
Acute beds in general hospitals*	2	101	2,257	28.6 days	Public sector (state)	99% adults
Acute beds in mental health hospitals*	1	3	100	5.6 days	Private sector	100% adults

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Special care institutions**	46	2,732	2,699 (at the end of 2016); Total number of users during 2016: 3,028	7-11 months	Public (local government, state), private sector	
General care homes**	152	8,126	7,597 (at the end of 2016), out of which 1,564 persons with a mental disability (of these 799 with dementia).	7.8 months per year	Public (local government, state), private sector	87% aged 65 or over

Source: *Indicators are calculated from data routinely submitted in health care statistics reports. National Institute For Health Development (Health statistics and health research database <http://pxweb.tai.ee/>). Data for the year 2015. **Ministry of Social Affairs administrative data, welfare statistics database (H-veeb: <https://hveeb.sm.ee/>). Data for the year 2016, unless otherwise noted.

Community-based residential support

Community-based residential services and domiciliary care are provided by public (local government, state) as well as independent and private sector organisations in Estonia. The most common residential arrangements are community and supported living. There is no temporary accommodation available for those in crisis (e.g. Soteria, places of sanctuary etc.).

Type of community-based service	Number of units	Number of places	Number of users	Length of stay	Client groups
Special care service: living in a community	20	258	237 (at the end of 2016) Total number of users during 2016: 271	10 months (2015)	Adults with mental health problems or psychosocial disabilities.
Special care service: supported living	81	1,148	893 (at the end of 2016) Total number of users during 2016: 1,089	10 months (2015)	Adults with mental health problems or psychosocial disabilities.
Special care service: assistance in everyday life	97	-	2,408 (at the end of 2016) Total number of users during 2016: 2,793	-	Adults with mental health problems or psychosocial disabilities. Usually provided in the person's home or day care centres.
Special care service: supported working	71	-	758 (at the end of 2016) Total number of users during 2016: 987	-	Adults with mental health problems or psychosocial disabilities.

Source: Ministry of Social Affairs administrative data, welfare statistics database (H-veeb: <https://hveeb.sm.ee/>). Data for the year 2016, unless otherwise noted.

Involuntary placement and involuntary treatment



Involuntary emergency psychiatric care is regulated by the 1997 Mental Health Act (amended in 2016) in Estonia.³⁴

Chapter 3 sets out the rule of involuntary emergency psychiatric care. Involuntary admission is taken as authorisation for involuntary treatment. The criteria for involuntary psychiatric treatment are (§11 (1)):

1. The person has a severe mental disorder which restricts his or her ability to understand or control his or her behaviour;
2. Without inpatient treatment, the person endangers the life, health or safety of himself or herself or others due to a mental disorder;
3. Other psychiatric care is not sufficient.

The Law provides procedural safeguards:

- Involuntary psychiatric treatment shall be applied only on the basis of a court ruling. Involuntary psychiatric treatment may also be applied without a court ruling if it is inevitable for the protection of the person or the public and if a court ruling cannot be received as quickly as necessary. In this case it must be documented.

- Involuntary treatment must start within 48 hours from admission and court approval is necessary if it continues beyond 48 hours. There are also provisions for review.

The use of restraint must be documented and supervised, and patients must be appropriately informed (§14).

Psychiatric coercive treatment and supervision is available for forensic cases in Estonia. “The objective of psychiatric coercive treatment is the treatment of mental disorders, decreasing the risk resulting from mental disorders and restoring the person’s coping skills for independent coping in the society” (§17 (1)). It is regulated by the Mental Health Act and the Penal Code.³⁵ It can be administered in inpatient and outpatient settings by licensed providers.

According to data from the Estonian Ministry of Social Affairs (2016) there were 3,005 cases of involuntary emergency psychiatric care, including 2,260 cases of continuation of treatment by court permission. There were 48 cases of coercive psychiatric treatment (in hospital) in the same year.

Legal capacity and guardianship

Legal capacity and guardianship are regulated by the 2009 Family Law Act in Estonia (Chapter 13).³⁶ According to §203, if an adult person is “permanently unable to understand or direct his or her actions due to mental illness, mental disability or other mental disorder, a court shall appoint a guardian to him or her on the basis of an application of the person, his or her parent, spouse or adult child or rural municipality or city government or on its own initiative. A guardian shall be appointed only for the performance of the functions for which guardianship is required. Guardianship is not required if the interests of an adult can be protected by granting authorisation and through family members or other assistants. Upon establishment of guardianship, a court shall assess the person’s capability to understand the legal consequences of contraction of marriage, acknowledgement of paternity and other transactions concerning family law.”

According to the population register data, there were 4,910 persons aged 18 years or over, who had a valid guardianship court judgment for at least one day in 2016.

Guardianship can be terminated and full legal capacity restored (§206).

During the year 2016 there were 2,334 people with “mental disabilities” who had limited legal capacity in special care institutions and 292 such persons in general care institutions. There is no information on the proportion of those who had a psychosocial disability.

The Estonian Chamber of Disabled People in cooperation with the Foundation Õigusteenuste Büroo (Legal Services Office)

34 Available in English: <https://www.riigiteataja.ee/en/eli/501022016017/consolide>

35 Available in English: <https://www.riigiteataja.ee/en/eli/524072017009/consolide>

36 Available in English: <https://www.riigiteataja.ee/en/eli/519062017013/consolide>

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started offering legal services for persons with disabilities as of 2017.

Other information

Estonia is implementing deinstitutionalisation programmes in social care co-financed by the European Union. Community based services are prioritised to residential ones. The Special Care Development Plan for 2014-2020 froze the number of the 24/7 care places. There was also a decision to give preference to community based solutions and supported living arrangements for people with mental health problems. The Welfare plan for 2016-2023 also supports this and one of the key indicators measures community based services against residential institutions (2014 1.2, 2015 1.4, aim 3.0). The relocation of people from large dormitories is underway as part of the reorganisation of 24/7 care into smaller units and (non-residential) community-based measures. There is a plan to introduce a new approach to funding and organising special care services in 2020.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Estonian Mental Health Association | Email: evty@evty.ee



FINLAND

COUNTRY INFORMATION

- **Population:** 5,503,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Mental health care in Finland is provided both in hospitals and in the community. Community-services such as mobile teams, day centres, peer groups and other forms of community support are available across the country. Compulsory treatment and use of coercion has been steadily decreasing in Finland, which was achieved through systematic development in several areas. Guardianship and community treatment orders are both established legal possibilities that effect people with mental health problems.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Finland, psychiatric hospital care is provided both in units that are part of general hospitals and in separate specialist hospitals. The trend over several years has been to close down separate psychiatric hospitals and to move psychiatric units into general hospitals. Most of the wards are acute psychiatric wards. Long-term wards are not reported separately in official statistics. Statistics suggest that about one in ten patients receives treatment for longer than 90 days.

There are also forensic psychiatric hospitals where patients are often treated for more than one year.

	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution	Client group
Psychiatric hospitals and psychiatric units in general hospitals	n.a.	n.a.	23,431 patients whose treatment ended in 2015 + 3,012 patients in treatment on Dec. 31st 2015	31.1 days	Public	All age groups

Source of data: sotkanet.fi; statistical information system on health and welfare in Finland (original data source: national hospital and outpatient register HILMO); THL's report Psychiatric specialist medical care 2015 (<http://www.julkari.fi/handle/10024/134729>)

Community-based residential support

In Finland psychiatric rehabilitation homes are available both with 24-hour and part-time assistance.

Type of community-based service	Total number of units	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Psychiatric rehabilitation homes (24-hour assistance)	n.a.	n.a.	4,344 (clients on 31 Dec 2015)	n.a.	public, private, non-profit
Psychiatric rehabilitation homes (part-time assistance)	n.a.	n.a.	3,456 (clients on 31 Dec 2015)	n.a.	public, private, non-profit



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Other community-based mental health support

In Finland, a range of different services are provided for people with mental health problems who live in the community. Organisations and groups of users/survivors of psychiatry are also available.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups
Mental health centres (outpatient; specialised services)	n.a.	165,667 patients and 2,004,881 visits	Public	Yes	n.a.
Mental health treatment in primary care	n.a.	Mental health visits (physicians) in primary health care per 1,000 inhabitants: 11.5; Mental health visits (other than physicians) in primary health care per 1,000 inhabitants: 114	public	Yes	n.a.
Visits in private physician services (psychiatry)	n.a.	155,997	Private	private	n.a.
Mobile units, part of specialized psychiatric outpatient treatment	Mobile units are relatively common, exact number is not available.		public	public	n.a.
Day services	Day services are relatively common, exact number is not available.		public, non-profit, private	public, non-profit, private	n.a.
Peer support/peer support networks	Peer support groups are common, exact number not available.		NGOs, public services	public, non-profit	n.a.
User/Survivor organizations	170 local, regional and national mental health associations	n.a.	NGOs		n.a.
Club Houses	25	n.a.	n.a.	n.a.	n.a.
Hearing voices networks	Several groups	n.a.	n.a.	n.a.	n.a.
Cultural support networks (theatre, sports clubs etc.)	Several groups	n.a.	n.a.	n.a.	n.a.

Source of data: sotkanet.fi; statistical information system on health and welfare in Finland (original data source national hospital and outpatient register HILMO. THL's report Psychiatric specialist medical care 2015 (<http://www.julkari.fi/handle/10024/134729>))

Involuntary placement and involuntary treatment

In Finland, the Mental Health Act (1116/1990; amended 1720/2009, 1338/2010) regulates involuntary treatment. Involuntary treatment is possible in psychiatric hospitals or psychiatric wards in general hospitals, not elsewhere. Involuntary placement does not exist separately. A person can be ordered to have treatment in a psychiatric hospital (or a psychiatric unit in a general hospital) against his or her will only if a) the person is diagnosed as mentally ill; b) the person needs treatment for mental illness, which, if not treated, would become considerably worse or would severely endanger the person's health or safety or the health or safety of others; and 3) all other mental health services are inapplicable or inadequate. These conditions are applicable for general psychiatric patients and for forensic psychiatric patients as well. A minor can also be ordered to have treatment in a psychiatric hospital against his or her will if the minor needs treatment for a serious mental disorder



which, if not treated, would become considerably worse or severely endanger the minor's health or safety or the health or safety of others, and if all other mental health services are inapplicable.

Three different medical practitioners have to give their medical opinions before a person can be admitted for involuntary treatment. The first opinion is given by a medical practitioner who makes an initial examination of a person's mental condition. If the doctor suspects that a mental health condition fulfilling the conditions set out in the Mental Health Act is present, the person can be sent for observation in a psychiatric hospital for four days. If all three conditions according to the Mental Health Act are fulfilled during the observation time, a forced placement of the person (=involuntary treatment) may be recommended. The involuntary treatment can be continued for a maximum of three months, and then for an additional six months. Every time a decision to continue the involuntary treatment is made, a new suggestion and a decision to continue the forced treatment in hospital are required as described above. The patient has to be offered the possibility to see an independent physician, who is required to give a statement of the actual condition. Every decision to continue involuntary treatment has to be sent to the administrative court which reinforces or rejects the decision.

There were 7955 involuntary treatment admissions, out of 36,813 (total number of admissions) in 2015. The number of involuntary admissions has been decreasing in recent years from 9,176 involuntary admissions in 2006; 8,570 in 2010; 8,207 in 2014, and 7,955 in 2015.

The use of coercion (such as isolation, using restraints, compulsory injections etc.) has decreased as well, for all age groups, except for those aged 18-24 years.

Community treatment orders (CTOs) are only applicable to forensic patients in Finland. Upon medical opinion, people are considered to be able to continue their psychiatric treatment as outpatients, but remaining in involuntary psychiatric care. Patients can be readmitted to the hospital at any time if reports from the outpatient unit and the actual mental condition of the patient indicate the need for involuntary hospital treatment. A decision to terminate a CTO may be made, but patients are expected to cooperate in order to ensure that they continue the psychiatric care voluntarily. There were 47 patients under CTO in 2016.

Legal capacity and guardianship³⁷

In Finland, guardianship is regulated in the Guardianship Services Act (442/1999).³⁸ A guardian or donee is appointed when someone's mental capacity is perceived to have changed to a degree that the person is unable to manage his/her financial affairs or personal assets or other personal issues. Courts can choose one of three degrees of guardianship: to identify certain legal acts or other issues where the person can only act with an appointed guardian; to partially restrict the person's legal capacity, relevant to areas of life; or to declare the person's legal incompetence. Guardians are appointed by courts or local register offices, and guardian can be a member of the person's family, a friend or, for example in the case of conflict of interest a public guardian. Guardians are appointed for a fixed period of time.

According to data held by Local Register offices, the total number of people under some form of guardianship in 2016 was 32,631.

Other information

Deinstitutionalisation was part of the National Plan for Mental Health and Substance Abuse Work (years 2009-2015), but currently there is no national strategy for deinstitutionalising existing long-term beds.

According to civil society reports, there is increasing user involvement and peer work in treatment planning and provision. The use of expertise by experience in the field of mental health is increasing in Finland. Networks of professionals work together to decrease coercion in psychiatric treatment.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

³⁷ Source of data and more information: <http://www.alzheimer-europe.org/Policy-in-Practice2/Country-comparisons/2016-Decision-making-and-legal-capacity-in-dementia/Finland>

³⁸ Available in English: <http://www.finlex.fi/en/laki/kaannokset/1999/en19990442.pdf>



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Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

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FORMER YUGOSLAV REPUBLIC OF MACEDONIA

COUNTRY INFORMATION

- **Population:** 2,073,702 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Information on Macedonia's mental health and social care systems is extremely limited. The country relies heavily on long-stay psychiatric hospitals and institutions; community-based care is underdeveloped. Although a deinstitutionalization strategy is currently being implemented, this primarily concerns the social care sector, especially children and adults with intellectual disabilities.

DETAILED INFORMATION

Institutions and psychiatric hospitals

There is limited information on the number of psychiatric hospitals and long-stay institutions in the FYRM. It is estimated that around one third of patients were hospitalised long-term (1 year or over) in psychiatric hospitals (WHO MHA country profile 2011).

	Number of units	Total number of beds	Sectoral distribution
Psychiatric units in general hospital	12	n.a.	Public
Psychiatric hospitals	4	n.a.	Public

Source: WHO Mental Health Atlas Country Profile, 2014³⁹

Community-based residential support

There is limited information on community-based residential services in the FYRM.

Type of community-based service	Total number of units	Total number of places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community residential facilities	4	25	n.a.	n.a.	n.a.	n.a.

Source: WHO Mental Health Atlas Country Profile, 2011⁴⁰

³⁹ Available here: http://www.who.int/mental_health/evidence/atlas/profiles-2014/mkd.pdf?ua=1

⁴⁰ Available here: http://www.who.int/mental_health/evidence/atlas/profiles/mkd_mh_profile.pdf?ua=1

**Other community-based mental health support**

Mental health services are provided in outpatient and day treatment facilities.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding	Main client groups
Mental health outpatient facility	19	n.a.	n.a.	n.a.	n.a.
Mental health day treatment facility	3	n.a.	n.a.	n.a.	n.a.

Source: WHO Mental Health Atlas Country Profile, 2014⁴¹

Involuntary placement and forced treatment

No information is available on involuntary placement and forced treatment in the FYRM.

Seclusion and restraint

No information on the use of seclusion and restraint in the FYRM.

Legal capacity and guardianship

Existing legislation allows for substituted decision making – plenary guardianship – for persons with disabilities.

Other information

The Government of the Republic of Macedonia started deinstitutionalisation in 2000. The main focus is on the one hand on decreasing the number of people who live in residential institutions, and improving living conditions on the other. The Macedonian Government signed a Memorandum of Cooperation with the UNICEF Office and the World Health Organization to stop new admissions to social care institutions (CRPD/C/MKD/1, October 2014).⁴²

There is a National Strategy on Equal Rights for Persons with Disabilities in the Republic of Macedonia (Revised) 2010-2018 and a National Strategy on Deinstitutionalization in the Social Protection System in the Republic of Macedonia (2008 - 2018).⁴³ There is no information on the implementation of these strategies, especially in relation to people with mental health problems.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

41 Available here: http://www.who.int/mental_health/evidence/atlas/profiles-2014/mkd.pdf?ua=1

42 http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fMKD%2f1&Lang=en

43 Available: https://www.mindbank.info/collection/country/fyrom/disability_strategies_and_plans



FRANCE

COUNTRY INFORMATION

- **Population:** 67,024,459 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Since 2015, France no longer has a national mental health plan, as policy on mental health and psychiatry is to be managed and mainstreamed at an inter-ministerial level, together with action at the level of regional “health territories” with more direct responsibility and plans. In 2016, the existence and role of the “Local Mental Health Councils” was strengthened, however, the representation of mental health users/survivors in both these local councils and national bodies is still limited. There are large regional disparities both in terms of resources and provision of mental health and social care in France. Since the law reform in 2011/2013 introducing for the first time judicial supervision of the forced hospitalisation and treatment system, general concerns include the high rate of long-term hospitalisation, increasing use of involuntary admission and forced treatments, compulsory treatment in the community and guardianship practices. The cross-border treatment and institutionalisation of French nationals with mental health problems in Belgium is also problematic.

DETAILED INFORMATION

Psychiatric hospitals

In France psychiatric inpatient care for adults is provided in general and specialist psychiatric hospitals. These are not designed to offer “long-term beds”. However, approximately 5% of people admitted in French hospitals for psychiatric care stay for more than one year, equal to around 15,000 inpatients per year, occupying one in four beds.

Type of institution	Units	Beds	Patients / year	Length of stay	Sector
Acute beds in general hospitals	182	11,750	97,147	Average annual length of hospitalisation (continuous or not): 38 days, average length of stay: 21 days, 2% admitted for more than 1 year	public
Acute beds in specialist hospitals (public)	90	22,382	141,701	Average annual length of hospitalisation (continuous or not): 52 days, average length of stay: 30 days, 6% admitted for more than 1 year	public

Acute beds in specialist hospitals (not for profit)	63	6,944	39,012	Average annual length of hospitalisation (continuous or not): 56 days, average length of stay: 31 days, 5% admitted for more than 1 year	Not for profit
Acute beds in specialist hospitals (private for profit)	150	13,138	65,476	Average annual length of hospitalisation (continuous or not): 70 days, average length of stay: 38 days, 0.7% admitted for more than 1 year	Private for profit

Source: SAE 2015 (Statistique annuelle des établissements de santé), Rim-P 2015, exploitation Irdes, Enquête Es 2014: Ida Falinower (DREES), 2016, « L'offre d'accueil des personnes handicapées dans les établissements et services médico-sociaux entre 2010 et 2014 », Études et Résultats, n°975, Drees, September 2016 (data refer to 2014 and 2015).

Social care institutions

Type of institution	Units	Places / beds	Users / patients (per year)	Length of stay	Groups served
Social care Institutions (partially broken down below in italics according to the type)	4,480	146,610			For adults with all types of disabilities, between 13% to 32% of residents with mental health problems
After-care Centres (Foyers de postcure)	47	1,448	3,236	Short and medium term	100% for former patients leaving psychiatric hospitals
Therapeutic / social home stay in family (Accueil familial thérapeutique and accueil familial social)	164	3,805	3,187	Short and medium term	For adults with all types of disabilities
Residences for adults with disabilities (Foyers d'hébergement pour adultes Handicapés)	n.a.*	39,081	37,200	Long-term	19% have a "mental deficiency"
Residences providing lodging, occupational therapy and medical care (Foyer d'accueil polyvalent) and Residences for disabled persons unable to work but physically and mentally autonomous to a certain extent (Foyers occupationnels ou de vie)	n.a.*	53,900	Data unavailable	Long-term	19% have a "mental deficiency"



Residences for adults with disabilities requiring medical surveillance and constant care, treatment and physical therapy (Maisons d'accueil spécialisées -MAS)	n.a.*	27,628	27,200	Short and medium term	13% have a "mental deficiency"
Residences for persons with severe or more than one disability unable to work (Foyer d'accueil médicalisé -FAM)	n.a.*	26,583	25,800	Long-term	24% have a "mental deficiency"
Forensic psychiatric units (UMD - Unités pour Malades Difficiles)	10	620	No reliable figures available	Medium to long-term	100% for persons judged not criminally liable for a criminal act committed
Specially-designed psychiatric units (UHSA - Unités hospitalières spécialement aménagées)	8 (with a 9th unit to open by end of 2017 in Marseille)	440	No reliable figures available	Short-term	Reserved exclusively for prisoners who need psychiatric care and are transferred here.

Source: SAE 2015 (Statistique annuelle des établissements de santé), Rim-P 2015, exploitation Irdes, Enquête Es 2014: Ida Falinower (DREES), 2016, « L'offre d'accueil des personnes handicapées dans les établissements et services médico-sociaux entre 2010 et 2014 », Études et Résultats, n°975, Drees, September 2016 (data refer to 2014 and 2015).

* This information not published by DREES since 2012.

Community-based mental health services and supports

Type of community-based service	Units	Patients / users (per year)	Sector	Funding	Groups served
Mental health centres (outpatient)	2,171	1.3 million	89% public and 11% non-profit	General budget allocated to public psychiatry	
Mobile units/ community mental health teams	152 "Psychiatry and Precarity" mobile units.		Public	General budget allocated to public psychiatry	
Day services	18,188 places in day-hospitals + 271 therapeutic workshop units (ateliers thérapeutiques) + 1,234 therapeutic activity centres (CATTP)	84,657 users of day hospitals, 6,890 users of therapeutic workshop, 70,136 users of therapeutic activity centres	75% public, 18% not for profit, 7% private for day hospitals, 90% public for CATTP, 10% not for profit	General budget allocated to public psychiatry	
SAVS home social support SAMSAH home medical-social support for adults with disabilities	Data unavailable	50,103	Public	Public	28% have «mental deficiencies»

Peer support/peer support networks	Approx. 30 peer mediators working in 2017		Mainly public psychiatric hospitals and outpatient centres, also with home support units	Public	
User/Survivor organizations	Approx. 12		Non-profit	Public and private	All are “hybrid” user/survivor organisations with a mix of users, family members and professionals. Over half are devoted to specific pathologies.
Clubhouses	1 Clubhouse in Paris based on “Clubhouse international” format. 352 Clubhouse-type “Mutual Help Groups (Groupes d’entraide mutuels - “GEM”)		Non-profit	Public and private	Clubhouse created and managed by family and professionals. GEMs approved and financed under Government programme.
Hearing voices networks	1 Hearing Voices Network - Réseau français des entendeurs de voix (REV) with several regional chapters (Morlaix, Digne, Grenoble)		Not for profit	Public and private	
Cultural support networks (theatre, sports clubs etc.)	n.a.				

Source: SAE (Statistique annuelle des établissements de santé), exploitation Irdes DREES, Panorama des Etablissements de santé, 2017, pp.88-91, CNSA for GEM (data refers to 2015)

Community-based residential support for adults with mental health problems

There are no “places of sanctuary” – as this term is commonly understood by service users – for persons in crisis in France. There are “crisis centres” operated by professionals, the number of which has been cut and many of which are located within a psychiatric service. No data is available for some other community-based residential arrangements, such as “appartements associatifs”, “familles gouvernantes” or “maisons relais” which exist to a small extent.



Type of community-based service	Units	Places / beds	Users / patients (per year)	Length of stay	Sector
Community-based residential arrangement: group home (Appartements thérapeutiques)	88	1,397	1,510	Several months to several years. Often 6 months, renewable.	Public and not for profit
Crisis centres (Centre d'accueil et de crise)	Data unavailable	452	3,179	Designed for short-term stay	Public
Respite / Soteria houses (Lieu de répit PADUPP)	1 to open in Marseille end of 2017 on experimental basis	6	N/A	Designed for short-term stay	Not for profit funded by public sources
Home hospitalisation (hospitalisation à domicile)	Data unavailable	653	1,697	Data unavailable	Public

Source: SAE (Statistique annuelle des établissements de santé), 2015

Personal budgets

There is no system of personal budgets for people with mental health problems in France.

Involuntary placement and forced treatment

On 5 July 2011, the French Parliament passed Law No. 2011-803 entitled “Law on the rights and protection of persons receiving psychiatric care and the conditions applicable to their care” reforming the previous Law dating from 1990. The constitutionality of this Law was challenged by a non-profit organization defending the rights of persons hospitalized without their consent (CRPA), leading to an amendment via Law No. 2013-869 dated 27 September 2013 providing better guarantees for the respect of patients’ rights.

There are four forms of involuntary placement:

- at the written request of a third party (usually a family member) requiring two medical certificates (at least one from a doctor outside of the institution where the person will be hospitalized);
- at the “urgent” written request of a third party (usually a family member) and one medical certificate;
- in case of “imminent peril” requiring the request of the Director of the hospital and only one medical certificate from a doctor outside of the institution where the person will be hospitalized;
- at the order of the Police Prefect when “a person’s disorders require care” and “public safety is in danger or a serious violation of public law and order has been committed”. In this case, one medical certificate from a doctor outside of the institution where the person will be hospitalized is required.

The criteria for involuntary placement are: the person is incapable of giving his/her consent and his/her mental state requires immediate care and constant medical surveillance in a hospital or regular medical surveillance outside of the hospital. An additional criterion applies to these last two forms: a serious risk of harm to the person him/herself.

A 72-hour observation period has been established before deciding if the person will be hospitalized or treated on an outpatient basis without their consent.

For the first time in history, this Law now requires a hearing before the “Judge of Liberties and Detentions” who must render a decision confirming or reversing the decision to hospitalize and treat a person without consent within 12 days of their date of hospitalisation. Involuntary patients are provided with legal counsel who may be made available through legal aid and



patients may also petition this Judge to lift their detention. Since 1 September 2014, most hearings take place on site at the psychiatric hospital.

The number of forced placements was 80,000 in 2015 (Rim-P), representing an increase of 13% compared to 2012. In 2015 24% of inpatients were interned involuntarily (Coldefy & Fernandes 2017).⁴⁴

Involuntary hospitalisation in case of “imminent peril” more than doubled between 2012 –when it was introduced – and 2015: from 8,500 people to 19,500 people. Involuntary placement at the order of a police prefect increased by eight per cent in the same period (ibid).

In France involuntary hospitalisation is taken as authorisation for forced treatments.

Since the 2011 reform, persons may be subject to a community treatment order (CTO) outside of full-time hospitalisation which may take different forms: treatment dispensed by authorized facilities, home treatment, home hospitalisation, and part-time or short-term intermittent hospital stays. The CTO is issued by the hospital psychiatrist (based on location of residence) and can only be modified by that psychiatrist (transposed to articles 3222-1 and L3211-2-1 of the Public Health Code). The CTO specifies the type of care, place and schedule for treatment. The person’s opinion must be sought prior to and for any change of the CTO. Person’s subject to a CTO may not be “coerced” or “physically forced” to receive treatment and if they refuse treatment at any point, must be hospitalized or re-hospitalized in compliance with one of the involuntary placement procedures described above. The CTO is not subsequently subject to judicial review and the duration a person is subject to forced treatment on an outpatient basis depends upon the decision of the medical and/or police authorities. Although difficult in practice, the person subject to the order may petition the court to lift the CTO.

In 2015, 37,000 persons were subject to CTOs (including or not hospitalisation) new and ongoing (Rim-P), this is equivalent to 28 per 1,000 people treated in the community. In 2015, CTOs represented 40% of all people currently subject to a form of compulsory treatment (those in hospital and those subject to CTO) (Coldefy & Fernandes 2017). Note that when both the public and private sectors are counted, over two million persons in France receive psychiatric outpatient care, with an annual hospitalisation rate of 400,000.⁴⁵ Moreover, according to the CNAMTS, 6.2 million additional people consume psychotropic medication.⁴⁶

Since the initial law reform of 2011, the number of persons subject to compulsory treatment (forced hospitalisation or CTOs) has increased by 15%. Some of the reasons for this include: the introduction for the first time of CTOs in France often used as a follow-up to forced hospitalisation; facilitation of forced hospitalisation through the “imminent peril” method, which has more than doubled (+ 128%) in four years; and the increased focus on ensuring public “security” since that time.

On 15 February 2017, Members of Parliament Mr Denys Robiliard and Mr Denis Jacquat, filed their evaluation report on the new law reform citing their concerns about the increased number of involuntary hospitalisations, exaggerated use of emergency procedures, geographical disparities, lack of certain statistics and lack of information on rights provided to persons subject to forced hospitalisation.⁴⁷

There is particular controversy surrounding the historic “exception to ordinary rules of law” in Paris (existing nowhere else in France), which is the “Infirmierie Psychiatrique de la Préfecture de Police de Paris” (IPPP) created in 1872 operating under the authority of the “Direction de la Protection du Public de la Préfecture de Police” and not the health authorities. Persons arrested for “behavioural disorders likely to disturb the peace” are interned here and seen by psychiatrists working under the authority of the police.

In 2011, the French Controller of places of deprivation of liberty (“Contrôleur des lieux de privation de liberté”) Jean-Marie Delarue, demanded that the IPPP be closed. He stated that “the IPPP has no autonomy and is a department of one of the

44 Coldefy, M., & Fernandes, S. (2017). Compulsory Psychiatric Treatment: An Assessment of the Situation Four Years After the Implementation of the Act of 5 July 2011. *Questions d’Économie de la Santé*. n°222 - February 2017. IRDES. Available: <http://www.irdes.fr/english/issues-in-health-economics/222-compulsory-psychiatric-treatment.pdf>

45 Reference: Drees, Panorama des établissements de santé : <http://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/publications/panoramas-de-la-drees/article/les-etablisements-de-sante-edition-2017>

46 Reference: Rapports Charges et produits pour les années 2013 à 2017 : <https://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/rapports-et-periodiques/rapports-charges-produits-de-l-assurance-maladie/rapports-charges-et-produits-pour-2013-a-2017/rapport-charges-et-produits-pour-l-annee-2017.php>



Paris Police Prefecture Divisions... Although the medical doctors who work there may not be under the direct authority of the Paris Police Prefecture, they are paid by the Prefecture and their material working conditions and career management are dependent upon it. This institution therefore has nothing to do with a hospital.” He added that the IPPP “fosters doubts about the distance between public policy concerns and medical concerns... why should a police institution be responsible for the assessment of a medical situation?” Mr Delarue recommended that these resources be transferred to hospitals.

The current Contrôleur des lieux de privation de liberté, Mme Adeline Hazan has issued several scathing reports, including her last Annual Report 2016, the Report on “Isolation and restraint in mental health institutions” (14 April 2016), and the Urgent Recommendations by the Controleur after very serious human rights violations were observed in the Centre psychothérapeutique de l’Ain (Bourg-en-Bresse) issued on 8 February 2016.⁴⁸

The majority of psychiatric institutions have been developing additional secure or «intensive care» units known as USIP (Unités de soins intensifs psychiatriques), UMAP (Unités pour malades agités et perturbateurs) and USI (Unités de soins intensifs). In the last few years, special forensic units have successively been built as well for prisoners, known as UHSA (Unités hospitalières spécialement aménagées), under the authority of the prison authorities.

In his report “Respecting the human rights of persons with psychosocial and intellectual disabilities: an obligation not yet fully understood” issued 24 August 2017, Nils Muiznieks, European Council Commissioner for Human Rights pointed to “questionable practices during my country visits, such as the large numbers of compulsory hospital placements in France”.⁴⁹

During her country visit to France in October 2017, UN Special Rapporteur on the Rights of Persons with Disabilities, Catalina Devandas-Aguilar, stated “There is no such thing as a good institution. France must completely overhaul the methods used to provide housing and support to move in the direction of a truly inclusive society. Other countries have done so, and France can too.” She added that France “must move away from paternalistic and segregating practices”.

Seclusion and restraint

The Law on modernization of the health care system promulgated on 26 January 2016⁵⁰ as a follow-up to the 2009 “HPST” (Hôpital, Patients, Santé et Territoires) Law entrusting more responsibility to the regional health authorities met with much criticism and strikes by health care professionals.

Article 72 of this Law now provides a framework to govern the use of restraint and seclusion in psychiatry which are supposed to be measures “of last resort”, to be used only to prevent “immediate or imminent harm”. This Law also made it mandatory for all psychiatric facilities where patients are hospitalized without their consent to keep a register recording each case of seclusion and restraint, with the name of the prescribing psychiatrist, date, time, duration and the names of health professionals supervising these measures. The Register may be in digital format and must be made available on demand to inspection authorities.

In February 2017, the High Authority of Health (HAS) issued “Recommendations of good practice of seclusion and restraint in general psychiatry” providing for a prescription, time limits (12 hours for seclusion, six hours for restraint), and conditions of renewal. Finally, on 29 March 2017, an “Instruction (DGOS DGS / 2017-109) on the policy to reduce the use of seclusion and restraint” laid down the terms of implementation of the register which has been slow to be implemented and how these data and indicators are to be used and provided to the Ministry of Health every six months for better monitoring purposes.

However, with the use of new terminology such as “Quiet” or “Time-out” rooms (Chambre d’apaisement, Chambre de réflexion), there is controversy about the extent of full reporting to be provided in this new register.

Patients’ lawyers and the judge have access to this Register. In spite of a better (and legal) framework for these types of

47 Reference: <http://www.assemblee-nationale.fr/14/rap-info/i4486.asp>

48 Documents available at the Controleur’s website: <http://www.cglpl.fr/>

49 Reference: <http://www.coe.int/fr/web/commissioner/-/respecting-the-human-rights-of-persons-with-psychosocial-and-intellectual-disabilities-an-obligation-not-yet-fully-understood>

50 Available here: <https://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000035315389&dateTexte=&categorieLien=id>

measures, no immediate legal recourse is available to patients who are subject to seclusion or restraint.

There are no figures to measure the use of restraint, however the recent Reports from 2016 of the Contrôleur des lieux de privation de liberté mentioned above state that the use of seclusion and restraint has been “increasing over the last 20 years”. The Contrôleur reported that these practices had become “banal” due to a lack of staff and an insufficient number of psychiatrists, and that “the manner in which physical restraint is being implemented is often humiliating, indignant and sometimes even dangerous”.

Data should be made available, for the first time, on the use of restraint in 2017/2018.

As regards seclusion: four per cent of all inpatients in 2003, 8% in 2015 (28,000), with the average amount of time in seclusion being 15 days per patient (approximately the same in 2003 and 2015 based on data available (Coldefy, 2016)).⁵¹

The introduction for the first time in history in 2011 of judicial supervision of the forced hospitalisation and treatment system which was previously exclusively under the control of the health and police authorities, has led to many changes and difficulties in implementation. The number of coercive measures lifted by the courts has been on the rise each year thus concerning more people (6,373 persons released by the courts in 2015 compared to 5,699 in 2014, i.e. 11% more), with still approximately eight per cent of all cases leading to the measures being lifted by the courts due to the overall increase in the number of forced hospitalisation and treatment orders.

The fact that in 2016, official guidance on restraint and seclusion in mental health services was finally issued by the health authorities, together with the creation of hospital registers and an observatory of these practices has at least made professionals more aware of human rights violations committed but these practices per se are still not challenged.

Guardianship

France still has a guardianship system that allows for substituted decision-making.

The legal framework for adult guardianship in France is set out in the 5 March 2007 Law reforming the legal protection of adults and the Ordinance dated 15 October 2015 on the simplification and amendment of family law. There are three levels of legal guardianship for ‘protected adults’ ordered by the judge:

- (1) judicial safeguard (Sauvegarde de justice), where persons retain full capacity and are assisted by a caretaker, but their decisions may be annulled by the court if they are found to be against the person’s “best interests”;
- (2) ‘curatorship’ (curatelle – partial guardianship)
- (3) ‘tutorship’ (tutelle – full guardianship).

Article 425 of the Civil Code does not provide a precise definition of ‘capacity,’ nor does it recognize degrees of incapacity, but rather focuses on the consequences of incapacity and holds that “any person unable to provide for his/her own interests because of an alteration, medically attested, of his/her mental or body faculties likely to prevent him/her from expressing his/her consent can benefit from one of the legal protection measures.”

Guardianship can apply to property and assets as well as to personal matters (medical decisions, place of residence). At the time the guardianship measure is ordered by the judge, the person may be stripped also of the right to vote (Article L.5 of the Electoral Code) under the tutelle system and to hold public office under both the tutelle and curatelle systems (Article L.200 of the Electoral Code). Persons under guardianship are not allowed to donate their blood (Article L.1221-5 of Public Health code) and can only appoint a person of trust for support in medical matters with the approval of the judge or family guardian and these persons have the power to dismiss any previous person of trust already appointed (Article L.1111-6 of the Public Health Code). Persons under guardianship cannot be a member of a jury in criminal court (Article 256 of the Criminal Procedure Code) and cannot get married or enter into a civil partnership without the authorization of their guardian or the judge (Articles 460 and 461 of the Civil Code). Under all three guardianship systems, persons are not allowed to get divorced (Article 249-3 and 4 of the Civil Code) or this right is restricted (Article 249-4 of the Civil Code).

⁵¹ Coldefy, M. (2016). Les données administratives de l’isolement, Santé mentale, septembre 2016, 210, pp. 46-50



Moreover, in 2015, the maximum duration of guardianship ordered by a judge was extended from five years to 10 years (Article 441 of the Civil Code). Due to a lack of time and resources, guardianship measures are often renewed without even hearing the person concerned which is supposed to remain an exception.

It is possible to re-gain legal capacity through a petition to the guardianship court. However, the reform of the justice system for the 21st Century (Law No. 2016-1547 dated 18 November 2016) will transfer jurisdiction in guardianship matters and social security cases to a special division of the Tribunal de Grande Instance whose judges are unfamiliar with this subject (Decree of application currently pending).

An additional problem which has been raised is the fact that persons responsible for the medical and social care and living accommodations of persons under guardianship may be appointed to act as their guardians in spite of the fact the Council of State ruled in 2014 that this creates conflicts of interest and cases have proven that it has.

A report issued on 4 October 2016 by the Cour des Comptes (Audit Court) investigating the status of court-ordered guardianship ten years after the 2007 reform was extremely critical about how guardianship is being managed, pointing out how the system is extremely variable depending on geographic location, and that there are serious risk to the rights and security of people due to a lack of control systems although significant assets (several dozen billion Euros is often cited) are being managed by guardians.⁵²

Certain safeguards do include the provision under Article L.1111-4 of the Public Health Code that the consent of a person under guardianship must systematically be sought if they are able to express their will and participate in decisions. Medical information from doctors about a person under guardianship must be given to their guardian (Article L.1111-2 of the Public Health Code), although the person under guardianship must also receive this information in a manner “suited to his/her discernment” and participate in decisions.

There is also an advance planning measure: it is possible to sign an enduring power of attorney (Mandat de protection future) to decide in advance what measures should be taken in the event of future loss of legal capacity. This system is still based on an assessment of the person’s mental capacity and allows for the deprivation of legal capacity. The person has no control over when the power of attorney comes into force or ends. However, this type of “Advance Directive” is not widely used.

A tool for supported decision-making was included in the 2007 Law, but is much less implemented. The personalized social assistance measures system (MASP - Mesure d’accompagnement social personnalisé) is a voluntary agreement with social services to support the person to deal with his/her resources and be more included in the community with no impact on the person’s legal capacity. This system is not being implemented due to a lack of resources, the contractual and complex nature of the agreement, insufficient communication by the public authorities about this option, and a lack of motivation by the county social authorities due to cost concerns.

More recently, Ordinance No. 2015-1288 dated 15 October 2015 created a new system of family authority (habilitation familiale) to protect a family member’s best interests which must be based on a medical certificate and the decision of the judge. The objective was to include the entire family as the person’s guardian free of charge. There is subsequently no judicial review of this system.

Guardianship in France is still a widespread solution, and used much more than in other European countries. Indeed, according to “official” statistics from the Ministry of Justice, 700,000 people in France were under one of these forms of guardianship as of December 2015, which is identical to the figure given officially in 2006. However, this figure which was provided by the Ministry of Justice in 2006 is considered “erroneous” according to the French Cour des Comptes which stressed that after correction, the number of persons under guardianship has increased at a much quicker pace since the 2007 reform (+5% on the average per year since 2009).

⁵² Reference: <https://www.ccomptes.fr/fr/publications/la-protection-juridique-des-majeurs-une-reforme-ambitieuse-une-mise-en-oeuvre>

Other information

Cross-border treatment and institutionalisation

Since the mid-1990s, there has been great concern about the institutionalisation in Belgium of French persons with psychosocial disabilities (particularly psychotic or autistic children) and the conditions of their care. Agreements have been signed between the social security authorities of both countries and France continues to lack appropriate structures with persons concerned and families seeing this situation as forced exile.

In 2014, The UN CRPD Committee condemned this practice in its Concluding Observations on the initial report on Belgium (CRPD/C/BEL/CO/, par. 32.).⁵³

In 2016, the European Disability Forum also pointed out that this unacceptable practice was continuing in its Parallel Report on EU implementation of the UN CRPD (page 37).⁵⁴

Deinstitutionalisation

In April 2016, the Haut Conseil de la Santé Publique published an evaluation report of the Mental Health Plan 2011-2015⁵⁵ stating that progress had been made to “recognize the role of persons with mental disorders and their families”, that there had been an increase of studies and recommendations and that regional medical and social authorities and practitioners were now playing a greater role as planned, even if there are major disparities between regions in terms of care practices and resources. Since the Haut Conseil recommended that “Policy on mental health and psychiatry” be managed in the long-term and mainstreamed at an inter-ministerial level rather than successive plans, there has not been another “Mental Health Plan” on the national level, but many territorial-level mental health plans are on their way.

In October 2016, Michel Laforcade subsequently issued a “Report on Mental Health”⁵⁶ commissioned by the Ministry of Health in 2014 to provide proposals on a “seamless pathway” for mental health and social services and recommended a regulatory road map to better implement the Law on modernization of the health care system in the field of mental health care.

At the same time, the Minister of Health announced the creation of a 75-member National Mental Health Council chaired by the sociologist Alain Ehrenberg to focus on four priorities: well-being of children and youth, suicide prevention, care and follow-up of persons in poverty, and tools to facilitate regional mental health care development. Several Committees within the Council have been created, including a Committee on Psychiatry with five sub-committees on involuntary treatment, outpatient care; psychiatric hospitalisation (particularly long-term hospitalisation); prevention, accessibility and continuity of care, and finally, child/adolescent psychiatry and prevention. It should be noted that the vast majority of the members of the Council and its committees are professionals and service providers, with only one national user organisation (FNAPSY) being a member of the Council and only one of the sub-committees (psychiatric hospitalisation), with the same being true for the national family organisation (UNAFAM) in one sub-committee on outpatient care. Very little representation of any other organisations of users and survivors of psychiatry is ensured, particularly as regards the issue of restraint and seclusion.

The January 2016 Law on the modernization of the health care system has differentiated mental health policy (medical and social players), psychiatry (institution-structure based) and community care. An important Decree issued 25 August 2017 lays down the priorities for regions, including the obligation to draft their first territorial mental health plan within 36 months. The main objectives are better and quicker access to mental and physical health care and social support, better follow-up, early prevention, coordinated crisis and emergency care (including at home), focus on categories representing special risks (children, teenagers, elderly, families, persons with disabilities, with addictions, suffering from trauma, and prisoners), along with the training of many different players involved. Access to housing, education, employment and social life with inclusion in the mainstream environment is to be developed, with the objective being “recovery” beyond clinical remission and the “empowerment” of persons with psychosocial disabilities and the fight against stigmatization (via psychoeducation, support for carers, peer support and GEM clubhouses).

⁵³ http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FBEL%2FCO%2F1

⁵⁴ http://www.edf-fepth.org/sites/default/files/2015_03_04_edf_alternative_report_final_accessible.pdf

⁵⁵ Available here: <http://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=555>

⁵⁶ Available here: http://solidarites-sante.gouv.fr/IMG/pdf/dgos_rapport_laforcade_mission_sante_mentale_011016.pdf



The existence and role of the “Local Mental Health Councils” (slowly established since the early 2000s, with approximately 125 active today) was legalized and strengthened in both the 2016 Law and Decree. Composition of these Councils varies widely depending on locality, and may include elected officials, mental health and social service professionals, police and court services, the national family organisation, but often with little input from mental health service user organisations aside clubhouses. The WHO Collaborating Centre in Lille supports the establishment of these Local Mental Health Councils.⁵⁷

Promising and more human-rights compliant practices

- **Respite House (Lieu de Repit)**: Launched in January 2017 on an experimental basis by the “Just” group for social justice of the Marss association (Mouvement et action pour le rétablissement sanitaire et social) composed of doctors, social workers, legal specialists, researchers and users of psychiatry in a five-story building owned by the public hospital in the centre of Marseille as a place with the stated objective to help avoid forced hospitalisation. To provide this alternative, financing of 1 million Euros has been obtained for one year **to provide ten respite beds (equal to the price of three hospital beds)** to receive people in a mental health crisis situation and should open by the end of 2017. Staff available 24/7 will include eight peer mediators, a psychologist, a social worker, two nurses and a cook. Other workshops dedicated to empowerment and well-being of service users are also planned.

- **COFOR (Centre de Formation au Rétablissement)**: Also in Marseilles, this project to create the first Recovery College-style “training centre in recovery” by the Association Solidarité Réhabilitation (members: Regional institute for social work, Public Hospital network of Marseilles, Aix-Marseilles University) on the premises of the Marseilles school for social workers was launched at the end of 2016, financed by the Ministry of Social Affairs and Health. The majority of staff and trainers are peer workers. Opening in September 2017, students will be paid to attend classes in eight subject-matters, including recovery tools such as “WRAP” and “IMR”, “users’ rights” and advocacy, medication training, self-help, sports, meditation and health education, with a media library, documentation centre, self-help groups and free workshops.

- Collectif Contrast: In 2015, this group of interdisciplinary researchers in social sciences (Centre Max Weber, Cermes 3, CEM, Cersa, Sphere, Arènes) launched a two-year research project called “Capdroits” on care and support relationships in contexts where the capacity of persons to give their consent is weakened or undermined and how care and support can be provided in compliance with the UN CRPD, particularly Article 12. This project has brought together a wide range of players, including a number of user organisations through a dozen local working forums in five French regions to foster the participation of persons with disabilities in debates on issues which first and foremost concern them directly, to promote the acceptance of their contributions by relevant academic researchers and public authorities and to shed new and experience-based light on how these persons may exercise their rights.⁵⁸

- WHO Collaborating Centre Lille: Since 2012, the WHO CC together with partners (Regional health authorities of Nord/Pas-de-Calais, Ile-de-France and Provence Alpes Côte d’Azur, University of Paris 8) and with the financial support of the Ministry of Health and the CNSA (Caisse Nationale de Solidarité pour l’Autonomie) have launched a one-year theoretical and practical training programme for peer health mediators followed by one-year supervised training at various mental health care facilities with students being paid under contract during the two-year study and internship. Twenty-nine peer mediators have graduated from the programme and 14 are currently working in this capacity. A new Bachelor’s degree will be offered as of January 2018 by the WHO CC and the University of Paris 13 for 30 more peer mediators. Approximately 15 other peer workers are under short-term contracts, working for temporary employment agencies or self-employed in co-operation with home care mobile units (SAMSAH) or similar structures. In addition, the WHO “Quality Rights” programme has now been translated into French, followed by a pilot project in French-speaking Belgium. Quality Rights should be rolled out in several psychiatric facilities in France in 2018.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe’s website (<http://www.mhe-sme.org/>).

⁵⁷ <http://www.ccomssantementalelillefrance.org/sites/ccoms.org/files/Etat%20des%20lieux%20des%20CLSM-05-2015.pdf>

⁵⁸ See: <http://contrastcollectif.wordpress.com>



102 Country reports

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

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GEORGIA

COUNTRY INFORMATION

- **Population:** 3,713,000 (National Census, 2014)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Mental health care in Georgia relies heavily on long-term beds in psychiatric hospitals. Support in the community is scarce, and there are very few outpatient facilities or mobile teams available for people with mental health problems. Residential support in the community is only provided in four group homes where people with mental health problems live together with people with intellectual disabilities. Following a judgment by the Georgian Constitutional Court in 2014, a reform of the legal capacity legislation has been launched.

DETAILED INFORMATION

Institutions and psychiatric hospitals

Psychiatric inpatient care is mostly provided in large specialist (psychiatric) hospitals in Georgia, where 60% of people stay for more than six months. Alternatively, there is a small number of beds in general hospitals as well. In regional psychiatric hospitals' long-stay wards people stay for many years.

	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution	Client group
Long-term beds in specialist hospitals (2017)	6	1,400	n.a.	Up to 6 months	Public	Adults
Caring/nursing departments (2017)	1	100	100	Often many years	Public	Adults

Source of data: Ministry of Health; <http://www.ncdc.ge/>

Acute hospital beds are available in 6 specialist and general hospitals in Georgia. Data was not available about the number of patients.

	Total number of units	Total number of beds	Average length of stay	Total number of patients (2016)	Sectoral distribution
Acute psychiatric beds in general hospitals (2017)	2	45 (10 beds for children and 35 for adults)	15 days	n.a.	Hospitals are private but psychiatric beds are publically funded
Acute beds in specialist hospitals (2017)	6	155	15 days	n.a.	Public

Source of data: Ministry of Health

Community-based residential support

In Georgia, community-based residential arrangements are scarce. Currently, there are no supported living facilities, respite homes or crisis centres/sanctuaries available in the country. There are four group homes for a total number of 24 residents; however these services provide residential care for both people with intellectual disabilities and for people with mental health problems.



Other community-based mental health support

In Georgia, community-based mental health support may be provided through outpatient centres, day services and/or mobile community teams; however, these are only available in a few parts of the country and reach a relatively small number of people.⁵⁹

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups (adults/children)
Mental health centres (outpatient)	3	90	Mainly public	Public	People with mental health problems
Mobile units/community teams	6	200	Public and non-profit	State, municipal, donors	People with mental health problems
Day services	4	n.a.	Public	State, municipal	People with mental health problems
Peer support/peer support networks	n.a.	n.a.	n.a.	n.a.	n.a.
User/Survivor organizations	1	n.a.	n.a.	n.a.	n.a.
Club Houses	0	0			
Hearing Voices networks	0	0			

Source of data: <https://matsne.gov.ge/ka/document/view/3530020> State health care program, 2016

Involuntary placement and involuntary treatment

In Georgia, involuntary inpatient psychiatric care is regulated in Article 18 of the Psychiatric Care Act. (N 3451, Parliament of Georgia, LHG, 30, 27/07/2006). Involuntary admission shall be carried out when a patient, due to his/her mental disorder is seen to be lacking decision-making capacity and providing care without hospitalisation is not possible. Criteria for involuntary treatment include: a) delay in care may impose danger to the life/health of the patient or others; b) the person, by his/her actions, may inflict serious harm to him/herself or others.

If a medical commission finds that these criteria are fulfilled, and involuntary hospitalisation is needed, a Court may issue an appropriate order on hospitalisation. The patient may receive involuntary treatment within 48 hours upon hospitalisation. The patient, their legal representative or – in case of absence of the latter – a relative should be informed immediately about the decision. Community Treatment Orders are not an established legal category in Georgia.

Legal capacity and guardianship⁶⁰

In 2014 a precedential decision was made by the Georgian Constitutional Court in the case of 'Irakli Qemoklidze and Davit Kharadze, Citizens of Georgia v the Parliament of Georgia' and in its judgment the Court upheld that the Georgian guardianship regulations did not comply with the development and equality enshrined in the Constitution of Georgia.⁶⁰ A Court allowed the Georgian state a six-month period to launch and implement reforms. Early reports on the implementation, however, indicate that although legislative changes were made by the Georgian Parliament, but progress is hindered by the short timeframe; blanket decisions on support are unsatisfactory and plenary guardianship is still systemic.

The number of people living under guardianship was 3,500 in 2015.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports

⁵⁹ Source of data: <http://ssa.gov.ge/files/2017/Sajaro/1/3/02/28.02.2017.pdf> and <http://www.ombudsman.ge/uploads/other/4/4563.pdf>

⁶⁰ Source of data: Georgian Public Defender (2016): Legal capacity – Legislative reform without implementation.

⁶¹ In the law, prior to this judgement, people with psychosocial disabilities were deprived of their legal capacity. A person without legal capacity was unable to make transactions since such as signing a contract or making an agreement. Decisions about the deprivation of legal capacity may have been made for an indefinite period of time



GERMANY

COUNTRY INFORMATION

- Population: 82,800,000 (Eurostat, 2017)
- CRPD signatory: YES, CRPD ratification: YES

GENERAL SUMMARY

Mental health care in Germany is provided in the community through acute hospital beds, community centres, and multidisciplinary teams. Although community psychiatry is available across the country, clinics and private psychiatric practitioners are still dominant forms of outpatient support. Recent government reforms are aiming at developing more available community support but funding is dropping which risks meaningful improvements.

There is a large number of people who still live in social care institutions or nursing homes in Germany. Although German law has abolished full guardianship, about 0.5 million people with mental health problems are still under partial substitute decision-making.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Germany, there are no long-term psychiatric beds in general hospitals. Long-term inpatient mental health care is only provided in forensic psychiatry. However, social care institutions still exist, many of them for up to over 100 residents. Care/nursing homes are also widespread across Germany.

	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution	Client group
Long-term beds in general hospitals	0	0	0			
Long-term beds in specialist hospitals (1)	77	n.a.	12,166	n.a.	public	Forensic psychiatry
Social care Institutions (2)	11,215	831,918 ⁶²	n.a.	n.a.	public	
Care/nursing homes (2)	12,381	48,682	n.a.	n.a.	public	
Other: "geschlossene Heime" (asylums) ⁶³ (2)	89	n.a.	n.a.	n.a.	public	

Source of data: (1) Destatis 2015 / (2) GMK 2012

Acute beds are provided across Germany and can be found both in psychiatric hospitals and in general hospitals. Psychiatric beds are also available for children and adolescents in many regions.

⁶² No aggregated data for residents with mental health problems.

⁶³ Closed homes, where people are placed under deprivation of liberty. People with mental health problems can be placed in such 'asylums' by the German federal authorities under «Psychisch-Kranken-Gesetze» ('Mental-Ill-Laws') if they endanger themselves or others.



	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution	Client group
Acute psychiatric beds in hospitals (both specialist and general hospitals)	409	55,450	835,298	22.7 days/user on average	Public	adults
Acute psychotherapy/ psychosomatics beds in hospitals (both general and specialist hospitals)	237	10,439	83,012	42.2 days/user on average	Public	adults
Acute children/youth psychiatry beds in hospitals (both general and specialist hospitals)	144	6,148	57,653	36.2 days/user on average	Public	Children and adolescents

Source of data: Destatis 2015

Community-based residential support

In Germany, community-based residential support to people with mental health problems is provided mostly through supported living arrangements. At least one 'runaway' house also exists in Berlin, and the Soteria model is run in some parts of the country, although data was unavailable about these.

Type of community-based service	Total number of units	Total number of beds	Total number of users (per year)	Length of stay	Sectoral distribution
Community-based residential arrangement: group homes	n.a.	n.a.	n.a.	n.a.	n.a.
Community-based residential arrangement: Supported living	n.a.	27,483 (2005)	81,094 (2010)	n.a.	n.a.
Respite homes	n.a.				
Runaway houses (Weglaufhaus)	At least one	13			

Source of data: GMK 2012; www.weglaufhaus.de

Other community-based mental health support

There are no comprehensive data collected concerning community-based services in Germany. The figures below are based on information by the national umbrella organisation Association of Community Psychiatry (Dachverband Gemeindepsychiatrie).

In Germany, personal budget is part of the "Teilhabeleistungen" (participation service) which people with disabilities are entitled to according to the German social code. It is not often requested by people with mental health problems due to low awareness and formal problems in receiving it. Personal assistance is an important part of the current health and social care reforms that come with the "Bundesteilhabegesetz" (federal participation law), which has been partly in effect since 2017. Its practical implementation remains to be developed on federal and state levels.



Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups
Mental health centres (out-patient) - "Psychiatrische Institutsambulanzen" (ambulant multidisciplinary services based in clinics) (1)	450	9.6 million	Public	SGB V (Social Code V for Health Care)	People with mental health problems
Mobile units/community mental health teams / Integrated Care (1)	80 community based, 16 clinic based		Public	SGB V	
Day services	n.a.				
Peer support/peer support networks	n.a.				
User/Survivor organizations (2)	13 (one federal and 12 state associations)			Private with partly public support	
Other: Psychotherapists (children, youth, adults) (3)	28,631		4.8 million		
Other: Specialist doctors for psychiatry, psychotherapy, psychosomatics (3)	6,737		7.2 million		

Source of data: (1) GMK 2012 / (2) Dachverband Gemeindepsychiatrie 2017 / (3) KBV 2016

Involuntary placement and involuntary treatment

In Germany, the existence of a significant risk of serious harm to oneself or others and a confirmed mental health problem are the two main conditions justifying involuntary placement. The need for a therapeutic purpose is not explicitly stipulated. The Civil Code also specifically refers to a danger that the person may commit suicide or do serious damage to his/her health, without specifying the nature or immediacy of the danger. Private law placements are intended to serve the health interests of the individual and are regulated by federal civil law. Public law placements, on the other hand, aim primarily to avert danger both to oneself and to others. Each of the 16 German federal states has its own laws.

Decisions by the German Federal Supreme Court and the German Constitutional Court challenged existing law on coercive treatment in 2012, which brought about new legal provisions in 2013, putting in place stricter criteria. Some small scale studies suggest the new rules may lead to smaller number of applications of involuntary treatment.⁶⁴

In Germany, in 2013 there were 139,608 judicial approval procedures for forced placements – no numbers on voluntary placements were available. Rough estimates indicate a rate of two to eight per cent of forced treatments in German psychiatry per year, which correspond to 24,395 to 97,580 persons.

Community Treatment Orders are not an established legal category in Germany.



Legal capacity and guardianship

In Germany, the concept of guardianship was abolished in the 1992 “Betreuungsgesetz“, and new regulations were introduced in the “Bürgerliche Gesetzbuch” (German Civil Code). There is no full guardianship, although the law still allows for partial substitute decision-making.

If a person is seen as unable to manage his personal matters, for example due to mental health problems, a court can appoint a “rechtlicher Betreuer” (legal supporter). Legal supporters usually oversee financial management and medical treatment. Legal supporters can be a professional or a relative. The legal supporter is bound to uphold the interests of the client. Such legal provision was given to 1.3 million people in Germany in 2014. Although there was a small drop in this number between 2012 and 2014, the current figures are still substantially higher than in 1995 when only 625,000 received such legal provision.⁶⁵

It is estimated that at least 500,000 people with mental health problems are under partial substitute decision-making policies.

Other information

Deinstitutionalisation has been an important policy in Germany since the 1970s, when the reduction and abolition of long-term psychiatric clinics started.

Until today, the German system of state welfare and its different services (health insurance, pension insurance, rehabilitation and participation, social welfare, care insurance, child and youth welfare) are divided into the “Sozialgesetzbücher” (social codes) and different funding agencies. This often leads to ineffective and uncoordinated practice of services, especially for people with mental health problems who often have needs for multiple of these services. Bureaucratic barriers often add problems of accessibility.

The aim of the newly signed Bundesteilhabegesetz (Federal Participation Law, 2017), was to ensure that support and services are centred around the needs of people with mental health problems, making access to services easier and better coordinated. Yet, critics are pointing out that the Bundesteilhabegesetz may lead to cuts in funding, which might bring about problems with the quality of the desired services. Much of the funding in mental health is still centred on clinical treatment and the number of beds in clinics is still increasing (+13% between 2003 and 2013).

Current legal frameworks provide chances to further expand ways of treatment which are preferred by community-based psychiatry, like home treatment and integrated care.

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

Dachverband Gemeindepsychiatrie | Website: www.dvgrp.org | Email: dachverband@psychiatrie.de
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Bundespsychotherapeutenkammer (BptK) | Website: www.bptk.de | Email: info@bptk.de
Zentegra | Website: www.zentegra.de | Email: www.zentegra.de/kontakt/
Pfalzlinikum | Website: www.pfalzlinikum.de | Email: info@pfalzlinikum.de

64 Zinkler, M. (2016). Germany without Coercive Treatment in Psychiatry—A 15 Month Real World Experience. *Laws*, 5(1), 15.

65 https://bdb-ev.de/57_Daten_und_Fakten.php



GREECE

COUNTRY INFORMATION

- **Population:** 10,757,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Greece, the ongoing psychiatric reform has resulted in important changes: traditional psychiatric hospitals were replaced in many regions by acute wards in general hospitals and there were many developments in community mental health care as well. However, community-based services are underdeveloped in many regions of the country.

The number of involuntary admissions is extremely high compared to international trends. The number of people under guardianship has also been rising slightly and the vast majority of court decisions order plenary guardianship. The rising demand for mental health care is accompanied by a drop in financial expenditure in healthcare and scarce human resources due to austerity measures implemented by successive governments.

DETAILED INFORMATION

Institutions and psychiatric hospitals

As a result of the Greek psychiatric reforms, five out of nine previous psychiatric hospitals (asylums) have closed and now all administrative regions (with the exception of central Greece) provide psychiatric beds in general hospitals only. The closing of the remaining psychiatric hospitals and the reallocation of services to general hospitals and community services is still ongoing. Officially, there are no long-term beds in general hospitals, however in some cases patients stay in acute beds for longer periods due to lack of alternatives.

Type of institution	Total number of units	Total number of beds	Total number of patients/ users (per year)	Length of stay	Sectoral distribution	Client group
Long-term beds in general hospitals	0*	n.a.				
Long-term beds in specialist hospitals	3	n.a.	144** (until June 2015)		public	Young adults (18-22), adults, older people, people with mental health problems, people with developmental disorders, people with substance disorder
Care/nursing homes	0					
Psychiatric units	36				private	

Source of data: Final Evaluation report of the implementation of the Psychiatric Reforms for the period 2011-2015; Ministry of Health.

Acute beds are the preferred type of inpatient care in Greece. However, after the closure of some long-term psychiatric hospitals, the development of acute wards in general hospitals was only partly successful because of insufficient infrastructure, delays in the development of an integrated primary health system and delays in the integration of acute wards in general hospitals. Currently, psychiatric hospitals still represent 60% of hospitalisations of acute mental health problems.



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Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Acute beds in general hospitals (2013)	38	n.a.	n.a.	26 days/average duration	public	People with mental health problems
Acute beds in specialist hospitals (2013)	3	n.a.	n.a.	32-33 days / average duration	public	People with mental health problems

Source of data: Final Evaluation report of the implementation of the Psychiatric Reforms for the period 2011-2015; Ministry of Health.

Community-based residential support

In Greece, residential support for people with mental health problems living in the community is provided through group homes and supported living arrangements (e.g. residential houses, protected apartments). Around half of these services are run by non-profit organisations. The network of supported living arrangements such as protected apartments and residential houses has improved in recent years, however there are significant differences between administrative regions – in some regions such services are growing, in others no improvements are seen. No comprehensive legislation is in place to support independent living in the community.

Type of community-based service	Total number of units	Total number of beds/places	Total number of users	Length of stay	Sectoral distribution	Client group
Community-based residential arrangement: group home	226	1,535 (at non-profit-organizations)	1,535 (at non-profit-organizations)	n.a.	Public 119 Non-profit 107	
Community-based residential arrangement: Supported living	261	328 (at non-profit-organizations)	328 (at non-profit-organizations)	n.a.	Public 179 Non-profit 82	

Source of data: Greek Federation of Mental Health Organizations "ARGO"; Final Evaluation report of the implementation of the Psychiatric Reforms for the period 2011-2015.

Other community-based mental health support

In Greece, the primary mental health care system (e.g. mental health centres, mobile units/community mental health teams, and day services) is not sufficient to meet all needs. There was no considerable development in recent years. The geographic distribution of the network is uneven, for example West Macedonia and Southern Aegean Regions still do not have mental health centres and almost half of all day centres operate in the Attica region. On the other hand, several associations founded by users/ex-users of psychiatry (or families) have been established across Greece. Their involvement in services somehow increased, but remains often insubstantial.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Are they publically funded?	Main client groups
Mental health centres (outpatient)	40	See below*	Public 39 Non-profit 1	Ministry of Health	Mixed, e.g. adults with mental health disorders, behavioural problems, severe psychosocial problems, cancer, autism, Alzheimer, addiction, psychogeriatric problems etc.
Mobile units/community mental health teams	28	26,000 (for non-profit-organizations)*	Public 15 Non-profit 13	Ministry of Health	Adults with mental health problems, behavioural problems, severe psychosocial problems



Day services	79	6,800 (for non-profit-organizations)*	Public 11 Non-profit 68	Ministry of Health	Adults with mental health disorders, behavioural disorders, severe psychosocial problems, cancer patients
Centres for the response on Alzheimer disease	14		Public 2 Non-profit 12	Ministry of Health	Individuals with Alzheimer, psychogeriatric problems, psycho-organic syndromes
Peer support/peer support networks	0				
User/Survivor organizations	several				people with psychosocial problems
Club Houses	0				
Hearing voices networks	At least one				people with psychosocial problems
Cultural support networks (theatre, sports clubs etc.)	several		Part of projects or other services		
Social Cooperatives	22		Private		people with psychosocial problems in the phase of vocational rehabilitation
Rehabilitation and Vocational Reintegration Units	10			Ministry of Health	individuals with psychosocial problems in the phase of vocational rehabilitation
Day Hospitals	14		Public 12 Non-profit 2	Ministry of Health	Adults with mental health disorders, behavioural disorders, severe psychosocial problems

*The primary health care system (mental health centres, mobile units/community mental health teams, day services) has offered its services for 2015 to 605.264 persons (including children and adolescents).

Sources of data: Greek Federation of Mental Health Organizations "ARGO"; Ministry of Health

Involuntary placement and involuntary treatment

Greek legislation (Law 2071/1992 "Modernization and Organization of the Health System", 1992) establishes three criteria for involuntary hospitalisation: (a) the existence of a mental health problem; (b) lack of ability to make decisions regarding one's best interest; (c) without hospitalisation the person's health would deteriorate or no treatment would be available. The hospitalisation of a person is ordered when it is presumed to be necessary to reduce the risk of violence either against himself/herself or against a third party.

All decisions are based on medical opinions. It is mandatory to inform people about their rights during the procedure. Involuntary placement can only exceed six months in cases where this is recommended by three different psychiatrists (two of them appointed by the public prosecutor). The decision about the placement must be reviewed after three months. A recent report by the Greek Ombudsman⁶⁶ found that 97% of forced hospitalisations are carried out by the police which was in many cases unjustifiable. The report stated that the use of handcuffs and armed personnel is contrary to the needs of the people subjected to the procedure.⁶⁷

In 2013, there were 3,233 involuntary hospitalisations in Attica Region, and around 75% of involuntary admissions were carried out in specialist, psychiatric hospitals. The rate of forced placements among all hospitalisations is four times higher in Greece than the European average.⁶⁸ Community Treatment Orders are not an established legal category in Greece.

66 Greek Ombudsman's Ex officio Investigation into the Involuntary Hospitalisation of Mental Patients (May 2007)

67 http://psy-dikaionata.gr/wp-content/uploads/2016/05/egxeiridio_teliko_en.pdf

68 Final Evaluation report of the implementation of the Psychiatric Reforms for the period 2011-2015.



112 Country reports

Greece has no official statistics regarding restraints and seclusion. Reports by the Greek Ombudsman suggest that measures taken during involuntary hospitalisation are inadequate and violate the rights of patients⁶⁹.

Legal capacity and guardianship

The Greek Civil Code defines three different types of restricted legal capacity: full guardianship deprives people from entering into any legal act; partial guardianship removes rights to enter into certain (individually specified) legal acts; full supportive guardianship is a form of co-decision, which does not remove rights to enter into legal acts, but the guardian must give his/her consent to decisions made by the person. A combination of the above categories may also be possible.

Data from several administrative regions suggest there is a slight rise in guardianship applications in Greece and the vast majority of court decisions order full privative guardianship.⁷⁰

Supported decision-making is not provided by Greek law.

Other information

A recent pilot project established new advocacy services that are able to respond to needs in the community.⁷¹ The initiative received very positive response from communities and it is hoped that further efforts in human rights awareness may contribute to better rights protection of people living in the community.

Please see the acknowledgments section of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

Mental Health Institute for Children and Adults (M.H.I.C.A.) | Website: www.inpsy.gr | Email: info@inpsy.gr

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EPIONI | Website: www.epioniblog.wordpress.com | Email: www.epioniblog.wordpress.com/contact/

⁶⁹ Greek Ombudsman, (as the National Torture Preventive Mechanism) special report to the CPT, 2015

⁷⁰ «Study on Article 12 (Equality before the Law), Article 13 (Access to Justice) and other provisions of the International Convention on the Rights of Persons with Disabilities». The project was implemented by the Centre for European Constitutional Law - Themistoklis & Dimitris Tsatsos Foundation from November 2011 to June 2012 on behalf of the National Confederation of People with Disabilities.

⁷¹ <https://psy-dikaiomata.gr/en/what-we-do-2/>



HUNGARY

COUNTRY INFORMATION

- **Population:** 9,797,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Hungary, there is a high number of beds both in long-term hospitals and in residential institutions for people with mental health problems. Physical conditions in many hospitals and institutions are poor. Outpatient services (mental health centres) and day centres are available across the country, but community-based support is still scarce.

The country has recently launched an ambitious deinstitutionalisation strategy co-funded by European Union Structural Funds, which aims to move out up to 10,000 residents from social care institutions into new, smaller scale residential services by 2023 (the proportion of people with mental health problems is not known). Early monitoring reports suggest the implementation of this programme may result in the creation of some services for up to 25 residents per facility. On the other hand, supported living arrangements are being established across Hungary and supported decision-making is also increasingly used by courts as an alternative to guardianship.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Hungary, long-term beds are still widely available both hospitals and social care institutions. Long-term beds in general hospitals had almost 20,000 users in 2016, while there were nearly 10,000 people with psychosocial disabilities in long-stay social care homes. There are two types of social care institutions: “institutions of care and nursing” and so-called rehabilitation institutions, which should help develop independent living skills and prepare people to return to the community – although anecdotal evidence suggests this is rarely the case.

Many hospitals and social care institutions are reported to have very outdated infrastructure, and wards are often overcrowded.

Residents usually stay in social care institutions for longer periods of time, several years or decades. The average length of stay in long-term psychiatric hospital wards are: under one year – 80%; between one to five years 17%; over five years – 4%.⁷²

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Long-term beds in general hospitals (2016)	62	5,456	19,237	62 days	public	People with mental health problems, people with dementia

⁷² http://www.who.int/mental_health/evidence/atlas/profiles-2014/hun.pdf

Long-term beds in specialist hospitals (2016)	4	338	4,558	61 days	public (1 unit/15 beds in private)	People with mental health problems, people with dementia
Temporary home for people with psychosocial disabilities (2016)	7	101	228	5 months	Government – 5 Other (NGOs) – 2	People with mental health problems
Institution of care and nursing for people with psychosocial disabilities (2016)	78	8,430	9,326	107 months	Central Government – 58 Municipality – 1 Non-profit – 3 Church – 6 Other (NGOs) – 10	People with various mental health problems, dementia etc.
Rehabilitation institution for people with psychosocial disabilities (2016)	7	128	174	27 months	Central Government – 6 Other (NGOs) – 1	People with mental health problems

Source of data: National Healthcare Database (Működési engedély nyilvántartó rendszer); The Social Register and Database of claimants (KENYSZI); Operating licences (Működési engedély), 2016.

Acute beds are available across Hungary, mostly in psychiatric wards within general hospitals.

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Acute beds in general hospitals	44	2,902	41,573	17 day	public	Adults with mental health problems
Acute beds in specialist hospitals	1	152	n.a.	n.a.	public	Adults with mental health problems

Source of data: National Healthcare Database (Működési engedély nyilvántartó rendszer), 2016

Community-based residential support

In Hungary, residential support for people with mental health problems in the community is scarce. Following recent legislative changes, services which are referred to as “supported living” are being established, and currently they provide accommodation and support to nearly 400 users. It must be noted that these are similar to group homes and can accommodate up to 12 people in a single setting. Many of these services are being developed by NGOs or churches. Sheltered housing services for people with mental health problems are non-existent in Hungary.

Type of community-based service	Total number of units	Total number of beds/places	Total number of users	Average length of stay	Sectoral distribution	Client group
Group homes of rehabilitation for psychiatric patients	15	230	212	73 months	Central government – 14 Other (NGO) – 1	People with mental health problems



Supported living for psychiatric patients	28	455	389	8 months	Central government – 11 Non-profit – 5 Church – 4 Other (civil – 8	People with mental health problems
Places of sanctuary for persons in crisis	(1)				Temporarily closed due to funding difficulties	People with mental health problems
Respite homes	0					
Soteria houses	0					

Source of data: The Social Register and Database of claimants (KENYSZI); Operating licence (Működési engedély), 2016

Other community-based mental health support

Support in the community is provided largely through psychiatric outpatient centres, which are available across Hungary. Rehabilitation services are largely non-existent. There are some community support services, although their availability is limited. These aim to support people with mental health problems to live independently in the community. Day centres should be provided by local authorities with more than 10,000 inhabitants, but their availability is limited. They provide meals, social and recreational activities, and support in managing one's own affairs. However, other alternatives are nearly non-existent with only one reported mobile team, only five club houses and very few cultural networks. Another key issue is the lack of multidisciplinary working and coordination between health and social care services. Organisations of users/survivors of psychiatry are present in Hungary, including one hearing voices network.

Type of community-based service	Total number of units	Total number of users (per year)	Sectoral distribution	Are they publically funded?	Main client groups
Mental health centres (outpatient)	120	1,350,000	public	Public (health)	People with mental health problems
Mobile units/community mental health teams	1	n.a.	NGO	Private and public	People with mental health problems
Community support for people with mental health problems	n.a.	3,900	Mostly non-profit	Public (social care)	People with mental health problems
Day services	98	4,420	Central government – 1 Municipality – 36 Non-profit – 14 Church – 26 Other (civic) – 21	Public (social care)	People with mental health problems
Peer support/peer support networks	0				
User/Survivor organizations	4	Approx. 100 members altogether	NGO	Own	Users/ex-users or psychiatry
Club Houses	5	--	public	Municipalities and NGOs	Various. Some are held together with clubs for elderly people.
Hearing voices networks	1	50	NGO	Own	

Cultural support networks (theatre, sports clubs etc.)	less than 5	Approx. few hundred	NGO	Private donors, grants	-
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Sources of data: Mental Health Interest Forum (Pszichiátriai Érdekvédelmi Fórum); The Social Register and Database of claimants (KENYSZI); Operating licence (Működési engedély)

Involuntary placement and involuntary treatment

In Hungary, involuntary psychiatric treatment (and consequent admission into psychiatric institutions) is carried out when it may protect the patient or others from harm to life, health and personal integrity. The law regulates that people admitted to psychiatric hospitals must receive information about their rights both orally and in written form⁷³, but it is reported by civil society that this rule is seldom followed in practice.

In 2016, a total of 1,791 cases of restraint were reported by residential institutions providing services to people with mental health problems.⁷⁴ This number excludes restraint carried out in acute hospitals.

Legal capacity and guardianship

The Hungarian Civil Code (Act V of 2013) regulates the limitation of legal capacity. Two types of restrictions of legal capacity are possible: full and partial guardianship. The court decision on legal capacity must be reviewed every five or 10 years, depending on the category of guardianship.

A recent survey carried out by Mental Health Interest Forum (PÉF) suggests that only 19% of those people with mental health problems who live in social care institutions have full legal capacity, while 43% live under partial and 39% under full guardianship.

Recent legislation (Act CLV of 2013 on Supported Decision Making) established the legal category of supported decision-making. According to civil society reports, supported decision-making is gaining ground in practice and results in some cases in the restoration or keeping of legal capacity. However, according to the Ministry of Justice, in 2015 there were still 56,942 people under guardianship in Hungary, which is slightly less than in previous years.

Other information

Hungary adopted a national deinstitutionalisation strategy (DI Strategy) in 2012 aiming at the reduction of institutional beds and the development of community services. The DI Strategy aims to move out up to 10,000 residents to the community by 2023. This number includes both people with intellectual disabilities and people with psychosocial disabilities currently living in social care institutions; the proportion of people with psychosocial disabilities is unknown but is likely to be a minority of those currently in institutions. Two psychiatric institutions were included in the first phase of the implementation (out of six institutions) between 2007 and 2013. Newly established community services may still be for up to 25 residents per facility.⁷⁵

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Pszichiátriai Érdekvédelmi Fórum – Mental Health Interest Forum | Website: www.pef.hu | Email: pef@hu.inter.net

⁷³ http://www.ijsz.hu/UserFiles/tajekoztato_pszich_betegek_jog_borito_0328_v4.pdf

⁷⁴ Source of data: Integrated Legal Protection Service (Integrált Jogvédelmi Szolgálat), 2016.

⁷⁵ Kozma, A., Petri, G., Balogh, A., & Birtha, M. (2016). The role of EU funding in deinstitutionalisation (DI) in Hungary and the experiences of the DI programme so far. Budapest: Hungarian Civil Liberties Union.



IRELAND

COUNTRY INFORMATION

- **Population:** 4,774,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: NO

GENERAL SUMMARY

In Ireland residential care is provided in psychiatric hospitals or care units. Long-stay 'community residences' for up to 25 people per unit accommodate approximately 1,500 residents, and people may live in these settings for several years. Acute beds are also available where the average length of stay is nearly one month.

Although the country set out ambitious mental health reform plans in 2006, but austerity measures and lack of clear policy guidance has resulted in very little progress. Staff shortages and lack of funding imposes boundaries even for existing services.

DETAILED INFORMATION

Institutions and psychiatric hospitals

Units included under psychiatric hospitals/continuing care units are all psychiatric hospitals with the exceptions of four facilities. There may be some acute beds included in some of the hospitals/units captured below and thus not all of the data for hospitals/units above are a reflection of long-term beds/use. There are also over 100 'community residences' that were mostly established during Ireland's deinstitutionalisation programmes in the 1980s – these homes are for 10 to 25 residents, and inspectorial visits revealed poor physical conditions and financial abuse of residents. Residents often stay in these homes for several years.

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Psychiatric hospitals/continuing care units (2016)	27	n.a.	2,905 admissions ⁷⁶	177.5 days (median 12 days)	Public	Adults with mental health problems – under 18s are sometimes admitted.
Private hospitals (2016)	6	Unsure	4,253 admissions ⁷⁷	The average mean length of stay for all discharges from private hospitals during 2016 was 48.9 days (median 31 days).	Private	Adult units

⁷⁶ On 31st December 2016 there were 999 residents in psychiatric hospitals/continuing care units.

⁷⁷ On 31st December 2016 there were 484 patients resident in private hospitals.

⁷⁸ Estimations based on inspectorial visits and data from the Health Service Executive. Source of data: DOTCOM and <https://www.irishtimes.com/news/social-affairs/isolated-and-institutionalised-the-reality-of-life-for-many-mentally-ill-patients-in-community-care-1.1842799>

'Community residences' / 24 hour supervised settings ⁷⁸ (2014)	Approx. 115	Approx. 1,500	n.a.	Up to several years	Public	People with mental health problems
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Source of data: National Psychiatric Inpatient Reporting System (NPIRS)

Acute beds are available in psychiatric units within general hospitals – such wards can be found across Ireland. In 2016, there were 68 cases when children under 18 were admitted to adult psychiatric units.

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Acute beds in general hospitals (2016)	21	1,017 places as at 31/12/2016	10,132 admissions ⁷⁹	27.1 days (median 11 days)	Public	Adults although under 18s are sometimes admitted.

Source of data: National Psychiatric Inpatient Reporting System (NPIRS); Mental Health Commission.

Community-based residential support

In Ireland, community-based residential support is provided through supported living arrangements, group homes, and supervised hostels.

Type of community-based service	Total number of units	Total number of beds/ places	Average length of stay	Sectoral distribution	Client group
Community-based residential services; supported living (2011)	800	n.a.	n.a.	n.a.	Adults with mental health problems

Source of data: Mental Health Commission: Register of Approved Centres (as at 7th October 2011)

Other community-based mental health support

In Ireland, 90% of mental health difficulties are dealt with in the primary healthcare system, for example by general practitioners, although the lack of specialist knowledge and long waiting times are making this level of healthcare often unsatisfactory for users.⁸⁰ Specialist support in the community relies heavily on community mental health teams which are multidisciplinary teams of health and social professionals.

Type of community-based service	Total number of units	Total number of users (per year)	Sectoral distribution	Are they publicly funded?	Main client groups
Mental health centres (outpatient)	n.a.	n.a.	n.a.	n.a.	n.a.
Community mental health teams	119	n.a.	public	yes	Adults with mental health problems

Sources of data: <https://www.mentalhealthreform.ie/wp-content/uploads/2015/06/A-Vision-for-Change-web-final-2.pdf>

⁷⁹ On 31st December 2016 there were 795 people resident in acute units in general hospitals.

⁸⁰ <https://www.mentalhealthreform.ie/wp-content/uploads/2015/06/A-Vision-for-Change-web-final-2.pdf>

⁸¹ Mental Health Commission, Annual Report, 2016



Involuntary placement and involuntary treatment

In Irish law, two criteria are listed in the assessment requirements for forced treatment, alongside having a mental illness: the risk of harm and the need for treatment health problem. The law requires more than two medical opinions. The decision is made by a Mental Health Tribunal and a panel composed of a psychiatrist, a barrister/solicitor, and a layperson who cannot be a doctor or a nurse.

In Ireland the number of involuntary admissions has risen from 46.5 per 100,000 inhabitants (2013) to 52.6 per 100,000 inhabitants (2016).⁸¹

Legal capacity and guardianship⁸²

In 2015 a new law on legal capacity entered into force, the Assisted Decision-Making (Capacity) Act 2015. The new legislation states that everyone over 18 is presumed to have legal capacity unless shown to the contrary. Capacity under this law is based on a functional evaluation where the assessment is about whether the person is able to understand the nature and consequences of the decision to be made in the context of the choices available at the time.

People can appoint someone as a decision-making assistant. The decision-making assistant advises and supports the person regarding issues such as the person's personal welfare, assets and properties, and other issues set out in a decision-making agreement. There is also a possibility for co-decision-making agreements. If the court finds that the person is unable to make decisions, a decision-making representative may be appointed. However, the new law does not alter previous legislation that regulate capacity or consent for issues such as civil partnership or divorce, adoption, guardianship, sexual relations, or making a will.

Some policies under the new law only commenced in late 2016 and 2017 therefore reports on the implementation are not yet available.

Other information

The Vision for Change policy document set out a plan to reform Irish mental health services, for example by developing stronger community-based services, reducing the number of residential places, more service user involvement and supporting the 'recovery model' across policies and services.⁸³ Recent reports about the implementation of this plan showed that, although some progress was made (for example more interdisciplinary mobile teams work in the country), overall the aims of the reform plans are yet to be realised. Underfunding and the lack of a clear implementation plan both hinder meaningful reforms. Furthermore, since the economic crisis and following austerity policies, staff in mental health services has dropped from 10,476 (2008) to 8,967 (2014) whole time equivalents, putting even existing services at risk.

Ireland also has a National Disability Inclusion Strategy 2017-2021 which consists of objectives such as the move-away from residential institutions and the strengthening of community-based services for people with mental health problems.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

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⁸² Source of information: DOTCOM: the Disability Online Tool of the Commission. <http://www.disability-europe.net/>

⁸³ <http://health.gov.ie/blog/publications/the-report-of-the-expert-group-on-mental-health-policy-a-vision-for-change/>



ISRAEL

COUNTRY INFORMATION

- **Population:** 8,547,100 (World Bank, 2016)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In 1995 the government of Israel adopted universal health coverage for all citizens, with the exclusion of mental health services and addiction treatment. In July 2015 following extensive revision of the National Health Assurance Act and a reform of mental health services, all inpatient and outpatient services fall under the remit of the sole aegis of the four health insurance organisations (Kupot Holim), with regulatory oversight from the Ministry of Health.

Community based rehabilitation programmes are funded by the government, on the basis of the Rehabilitation of Mentally Ill Persons in the Community Law, 2000. This law has enabled the Department of Mental Health and its Division of Rehabilitation Services to develop and provide a wide range of programmes and services to those eligible by law (18 years old and with a recognized mental health disability) in the areas of housing, vocational and employment, supported education from matriculation through peer support in higher education, family counselling centres, individual care management.

Israel introduced new guardianship legislation in 2016, with stronger safeguards and less restrictive options.

As well as recognizing the need to reduce stigma and increase inclusion, there is an awareness of the diverse cultural needs of the population, therefore all the above-mentioned services, both mental health and rehabilitation are developed to meet the needs of the different religious and social groups in Israeli society.

DETAILED INFORMATION

Psychiatric hospitals and institutions

There various types of traditional and alternative inpatient settings for people with mental health problems in Israel:

- Ecological Model\Pivot - In development, scheduled to open December 2017. Housing for people with mental health problems and severe cognitive impairments.
- Rehabilitating Community In development, scheduled for 2018. Housing for people with severe, long-term mental health problems, specifically persons with a history of violent behaviour and/or mild cognitive impairment, who need intensive support to maintain activities of daily living.
- Hostels provide 24-hour staff support availability, in a congregate care setting.
- Hostels for Mentally ill adults with medical and physical needs – second degree to the use of newer psychotropic medications as well as the effects long term smoking, poor nutrition and a neglect of basic health needs, there has been increase in obesity, hyper tension and other metabolic diseases. In addition early aging and decrease of functioning linked to the severity of the mental health condition, results in a need to develop residential programmes that focus on maintaining individuals in the community and preventing further physical deterioration, while still addressing recovery



and rehabilitation issues.

- Hostels for Persons with mental health and substance addiction or abuse: this is in development for 2018.

There is no information about the average length of stay in various types of hospital settings. However, approximately a third of inpatients in psychiatric hospitals were long-stay (1 year or over), and half of these stayed five years or more (Israel country profile, WHO 2014).⁸⁴

There are also a wide range of initiatives including “peer specialists” – professionally trained persons with lived experience who work with staff as mediators and patient advocates in inpatient settings as well as residential programmes.

Type of service	Number of services	Typical size	Total number of places
Psychiatric hospitals (including forensic units)	11	Average number of beds 300	2,906
Inpatient psychiatric wards in general hospitals	17 hospitals 21 wards	Average ward size 35	661
Ecological Model \Pivot	2	68	138
Residential Care Facilities	10	40	600
Hostels	85	30	2,550
Hostels for people with complex mental and physical health needs	12	30	360
Hostels for persons with Comorbid mental health and addiction or substance abuse	2	30	60
Residential programme for survivors of Sexual Abuse	2	20	40
Residential programme for persons with Eating Disorders	3	14	42

Source: Department of Mental Health Services, Ministry of Health Israel

Community-based residential and social supports

There are various community based residential or other social supports available for people with long-term mental health problems in Israel.

- Hostels – Supportive community model – 24-hour staff support and availability; clients live in the community, in independent apartments and houses within a one kilometre radius of staff offices.
- Supportive Housing Services – Services delivered in the home of the clients, the majority live with families, some in group homes. Staffed by social workers and counsellors, staff is not available 24 hours a days. Clients are more functionally independent and access services in the community. The staff with the client build a treatment /rehabilitation plan that touches on ADL and IADL skills including employment a

⁸⁴ Available: http://www.who.int/mental_health/evidence/atlas/profiles-2014/isr.pdf?ua=1

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- In Home Care: in home service with focus on activities of daily living skills (e.g. self-care etc.).
- Peer Counselling- focuses on developing and improving social skills including the use of community centres, participating in sport teams and other outdoor activities.

Type of service	Number of services	Typical size	Total number of places/service users
Hostels –Supportive community model	50	60	3,000
Supportive Housing	Number of service providers 79	-	11,000 persons receive services
In Home Care provider	3 service providers	-	1,200
Peer social support	3 service providers	-	1,700

Source: Department of Mental Health Services, Ministry of Health Israel

Personal budgets

Two pilot projects are underway with the intention of reaching over 400 users. Israel hopes with the success of the pilot projects to adopt and expand personal budget scheme to those whose needs are not met by more traditional treatment and rehabilitation programmes.

Other community-based mental health services

Community based rehabilitation programmes are funded by the government, on the basis of the Rehabilitation of Mentally Ill Persons in the Community Law, 2000. The Department of Mental Health and its Division of Rehabilitation Services provide a wide range of programmes and services in the areas of housing, vocational and employment, supported education from matriculation through peer support in institutions for higher academic studies, family counselling centres, individual care management.

While more than 90 percent of population live in urban areas, there is also a sizeable group who live in rural and outlying areas with little public transportation. Mental health services these areas are partially provided via tele-psychiatry, mobile clinics or rotating services.

Involuntary Placement and Involuntary Treatment

In Israel the authority of forced hospitalisation and or involuntary treatment is vested in the district psychiatrist or the court.

The district psychiatrist can issue an order for forced hospitalisation if all the criteria are met simultaneously:

- The person is in a psychotic state
- As a result of this there is an immediate risk of harm to oneself or other people.
- The individual refuses to be examined / admitted on a voluntary basis.

The district psychiatrist can order the compulsory hospitalisation of a person for a period of 7 days. The district psychiatrist is entitled to extend this by an additional seven days on the basis of a request from the director of the department in which the person is hospitalized. The authority to extend the hospitalisation order is in the hands of a district psychiatric committee.

Hospitalisation – voluntary or involuntary – of people with mental health problems should be a last resort.

For more information see Israel's Initial State Party report to the Committee on the Rights of Persons with Disabilities (Israel 2017, paragraphs 139-163).

Seclusion and restraint

In 2015 the Department of Mental Health Services announced a national initiative to reduce the use of mechanical and physical restraints in inpatient settings. Hospital staff received training, and the overall effect since 2016 has been a 60% documented reduction in the use of restraint and seclusion.



Guardianship

Although complete removal of legal capacity is possible in Israel, this is not common practice. In the years between 2011 and 2014 there were five to 11 cases annually (Israel 2017).⁸⁵

On March 29, 2016, the Knesset approved the amendment of the Legal Capacity and Guardianship Law (Amendment No. 18), 5766 - 2016.

At the centre of the change is the creation of a legal mechanism to grant ongoing power of attorney and introduce a system of advance directives regarding one's property and medical treatment.

The amendment also establishes principles and methods of action for custodians and stresses that the role of the Custodian is to hear the opinion of the person and to assist him in fulfilling his wishes, to provide him with information on his affairs and to participate in making decisions concerning him, to the extent possible.

The amendment also expands the supervisory system and the powers of the supervisors in the Administrator-General and establishes principles and rules for the appointment of guardians. In accordance with these principles, the court considering the appointment of a guardian shall examine all possible alternatives, including supported decision-making.

For more information see Israel's Initial State Party report to the Committee on the Rights of Persons with Disabilities (Israel 2017, paragraphs 87-106)

Other issues

Deinstitutionalization

Israel continues to develop community-based housing programmes. Since the 2015 mental health reform, long-stay patients have been targeted by the more intensive programmes.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

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⁸⁵ Israel's Initial State Party report to the Committee on the Rights of Persons with Disabilities 2017, para. 89.

Available: <https://www.mindbank.info/item/6620>



ITALY

COUNTRY INFORMATION

- **Population:** 60,589,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

The Italian mental health care system went through profound changes from the 1970s onwards, during which time almost all long-term beds/units and segregated facilities were closed down. Therefore, Italian mental health care in Italy is almost exclusively provided in the community, through acute hospital beds and community mental health centres. Italy also has many cultural networks, user/survivor organisations and peer support groups that may provide opportunities for people in the community.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Italy, public psychiatric hospitals do not exist anymore, instead all psychiatric units are part of general hospitals. Administrative regions of Italy manage their own healthcare systems which makes data collection difficult.

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Psychiatric hospitals/continuing care units (2016)	0					
Private hospitals (2016)	n.a.					
Other long-term institutions (social care institutions, private care homes)	n.a.	29,733	n.a.	756 days	Private and public	Mixed

Source of data: Rapporto sulla Salute mentale, 2015

Acute beds are available in specialist units within general hospitals. Psychiatric units in general hospitals are called Services for Assessment and Treatment (SPDC).

Type of institution	Total number of units	Total number of beds	Total number of users (per year)	Average length of stay	Sectoral distribution	Client group
Acute beds in general hospitals: Services for Assessment and Treatment (SPDC) within the general hospital (2015)	357	5,330		12.6 days	Public 329 Private 28	

Source of data: Rapporto sulla Salute mentale, 2015



Community-based residential support

In Italy, the most popular form of residential support for people with mental health problems in the community is group homes.

Type of community-based service	Total number of units	Total number of beds/ places	Total number of users	Average length of stay	Sectoral distribution	Client group
Community-based residential arrangement: group homes	2,271					

Source of data: Rapporto sulla Salute mentale, 2015

Other community-based mental health support

In Italy, community mental health centres (including mobile teams working within centres) can be accessed in all regions across the country. Each of the 20 Italian regions are responsible for developing their health services, including mental health services, therefore services and regional coverage vary. Several organisations run by users/survivors of psychiatry and peer support groups are also available.

Type of community-based service	Total number of units	Total number of users (per year)	Sectoral distribution	Are they publically funded?	Main client groups
Mental health centres (outpatient, 2015)	1,246	777,035 ⁸⁶	Mostly public	Public	
Mobile teams	Mobile teams are usually incorporated in community mental health centres. Total number unknown.				
Peer support/peer support networks	Several				
User/Survivor organizations	Several				
Hearing voices networks	Approx. 30 groups				
Cultural support networks (theatre, sports clubs etc.)	Several groups and national network				-

Sources of data: Rapporto sulla Salute mentale, 2015; AISME.

Involuntary placement and involuntary treatment

Italian law allows for involuntary treatment, which is justified when a mental health problem is present, along with the 'need' for therapeutic intervention. The law does not list the criteria of presenting a danger to oneself or others as a condition.

Forced treatment can be carried out only in hospitals belonging to the public sector, most commonly in acute units in general hospitals (SPDC – Psychiatric Service for Assessment and Treatment). No more than 15 persons can be placed in SPDCs. Most of people (about 90%) are admitted voluntarily. There were 8,777 forced placements in Italy in 2015, which is a slight drop from previous years.

Community Treatment Orders are not an established provision in Italian healthcare.

Legal capacity and guardianship

In Italy, no statutory definition is given to 'capacity', but reference is made to doctrinal explanations: (a) legal capacity is the capacity, belonging to any person, to have individual rights and obligations (b) capacity to act is the capacity to enter into legally binding agreements and more generally to perform any act which may entail rights and obligations.

⁸⁶ Total number of patients, reported by the Mental health Departments, 2015.



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The Probate Judge appoints adult guardians following a request from family members, social services or the Public Attorney. All three forms of guardianship (full guardianship, limited guardianship and caretaking with residual capacity) can include decision-making in both personal welfare and financial affairs matters. The Civil Code states that a person who ‘suffers from a permanent mental impairment’ that prevents them from looking after their own interests may be placed under full guardianship; a person whose ‘mental impairment’ is not so severe as to require full guardianship can be placed under limited guardianship.

In 2004 the “Amministratore di Sostegno” or Support Administrator law entered into force. The law intends to ‘support people with no autonomy or with partial autonomy, avoiding limiting the capacity of action of the person, as much as possible’. The concept of support is different from the paternalistic concept of substitute decision making concept of the old law. However, the old legislation is still in place, and is often used in juridical procedures.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

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Tages Onlus | Website: www.tagescharity.org | Email: info@tagesonlus.org

LATVIA

COUNTRY INFORMATION

- **Population:** 1,950,116 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Although Latvia's mental health and social care systems are still heavily institutional, and reports on the violation on human rights are especially concerning, important and promising steps have been taken in legal capacity laws' reform and supported decision-making. While the social care sector has a deinstitutionalisation strategy, this is lacking in the mental health care sector.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Latvia "current policies encourage the institutionalization of mental health patients by only providing financial coverage of inpatient care".⁸⁷

Long-term care for people with mental health problems is also provided in psychiatric hospitals and social care institutions. Currently there are six psychiatric hospitals and five state-run social care institutions in Latvia. There were a total of 27 branches across the five social care institutions with a combined capacity of 4,306 places (416 places for children and 3,890 places for adults).

There were also 979 state-funded social care beds in four psychiatric and six municipal hospitals, private long-term care institutions or NGO-run institutions.

There is no information on the number of long-stay patients in psychiatric hospitals or the total number of people with mental health problems in social care homes.

	Total number of units	Total number of beds	Sectoral distribution
Psychiatric hospitals ⁸⁸	6	2,066	Public
Social care institutions ⁸⁹	27	4,306	Public
Social care bed	n.a.	979	Public, private, non-profit

Community-based residential support

Community-based residential support systems are underdeveloped in Latvia. In 2017 there were 13 group homes / apartments for persons with mental disabilities and five "half-way houses" built on the grounds of social care institutions.

In 2014 there were 242 persons with intellectual and / or psychosocial disabilities receiving community-based group home services.⁹⁰

There are no personal budgets/assistance schemes in Latvia.

87 Latvia Healthcare Facilities Master Plan 2016-2025, p. 95, Available: <http://www.vmnvd.gov.lv/uploads/files/58b57889c736b.pdf>

88 Latvia Healthcare Facilities Master Plan 2016-2025, p. 99, Available: <http://www.vmnvd.gov.lv/uploads/files/58b57889c736b.pdf>

89 Available: http://www.lm.gov.lv/upload/socialie_pakalpojumi/vsac_filiales_v_sk_01012017.pdf

90 Ministry of Welfare, Action Plan for the implementation of deinstitutionalisation for the period 2015 – 2020 [Rīcības plāns deinstitutionalizācijas īstenošanai 2015. – 2020. gadam], Available: http://www.lm.gov.lv/upload/aktualitates/4/riciplans_groz_22032016.pdf, p.12

Type of community-based service	Total number of units	Total number of beds/places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community-based residential arrangement: group home ⁹¹	13	205	205	indefinite	Public, non-profit	Their size varies. Max. size of group homes should be 16 according to the law, but there are group homes with 24 to 27 places.
Community based residential arrangement: half-way house ⁹²	5	121	121	indefinite	Public	Half-way houses are built on the grounds of social care institutions.

Other community-based mental health support

Community-based mental health support is limited in Latvia, there are no mobile units or community mental health teams, club houses, peer support networks, or organisations of ex-users and survivors of mental health services.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups
Mental health centres (outpatient)	4 ⁹³				
Day services	n.a.	954 in 2016 ⁹⁴			Persons with intellectual disabilities and / or persons with psychosocial disabilities

Involuntary placement and involuntary treatment

In Latvian legislation, in addition to having a mental health problem, two criteria need to be fulfilled for an involuntary placement: there needs to be a risk of harm and a need for treatment. The prerequisites of exhausting all less restrictive measures are not explicitly mentioned in the law. The law does not refer to the person's opinion in the course of an involuntary measure either, and only professionals are involved in the decision-making. Section 1(6) of the Latvian Medical Treatment Law (Ārstniecības likums) mentions that a "doctors' council" is convened, which is defined as "a meeting of not fewer than three doctors, in order to determine a diagnosis and the further steps of medical treatment." A person may receive free legal assistance if he/she does not have a legal representative. Reviews of placement measures take place every six months.

Various reports have noted violations of human rights in psychiatric hospitals and social care homes, including a high number of deaths in institutions and the lack of investigation, excessive use of psychotropic medication, restrictions on the freedom of movement, violence including sexual assault.⁹⁵

⁹¹ Data obtained by RC ZELDA from the Ministry of Welfare

⁹² Data obtained by RC ZELDA from the Ministry of Welfare

⁹³ Two are located in capital - Riga, one in Daugavpils and one in Cesis.

⁹⁴ According to data of the Ministry of Welfare 954 persons with intellectual and/or psychosocial disabilities received services of day care centres in 2016.

Data available in Latvian at: <http://www.lm.gov.lv/text/3684>

⁹⁵ RC ZELDA, Thematic report submitted to UN CRPD Committee on 27 February 2017, available: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=INT%2FCRPD%2FICO%2FLVA%2F26871&Lang=en



In its Concluding Observation on Latvia, issued on 31 August, the UN CRPD Committee⁹⁶ recommended Latvia to:

- repeal all relevant legislation in order to prevent the institutionalization of persons with intellectual and/or psychosocial disabilities and increase the availability of community based mental health services;
- repeal provisions which allow for the involuntary commitment of persons with disabilities in mental health institutions, and ensure the accessibility of its review by a court of law to persons with disabilities;
- ensure the free movement of persons residing in institutions; and
- ensure access for persons with intellectual and/or psychosocial disabilities who are deprived of their liberty to their personal medical files and to required medication (p. 6).

Legal capacity and guardianship

The reform of legal capacity laws started in 2010 following the judgement of the Constitutional Court of Latvia on a case prepared by RC ZELDA on behalf of an individual with intellectual disability.⁹⁷

The new legislation on legal capacity entered into force on 1 January 2013. This abolished plenary guardianship and introduced partial legal capacity restrictions that only allow for the restriction of material rights. Thus the court can no longer restrict an individual's personal non-material rights and right to represent herself / himself before authorities and in court. Also such rights as right to vote, right to marry, parental rights, right to make decisions related to medical treatment etc. cannot be restricted under any conditions. However the law did not include supported decision making mechanisms.

The UN CRPD Committee (CRPD/C/LVA/CO/1, 29 August 2017) recommended Latvia to "repeal the legal provisions in the Civil Law concerning substituted decision-making and restore the full legal capacity of all persons with disabilities through a supported decision-making regime that respects the autonomy, will and preferences of the person" (p. 5).

Currently there are several initiatives and pilot projects to foster the development of supported decision making in Latvia (RC ZELDA, 2016).⁹⁸

The Government is also supporting a larger-scale pilot project of supported decision making in the period between 2017 and 2020 with funding from the European Social Fund, implemented by RC ZELDA.⁹⁹

Other information

Latvia has no plans to replace psychiatric hospitals with community-based mental health care.¹⁰⁰ However, the social welfare sector has plans for deinstitutionalisation for the period 2015-2020. According to the Deinstitutionalisation Action Plan, by 2020 the Latvian Government intends to close down three long-term state-funded social care institutions and move 700 adults with intellectual and/or psychosocial disabilities who are currently institutionalized to community-based settings. Additional funding will be provided for developing community-based social care services for 1,400 adults with intellectual and/or psychosocial disabilities who already live in the community.¹⁰¹

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

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96 CRPD/C/LVA/CO/1, 29 August 2017, available: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2FC%2FLVA%2FCO%2F1&Lang=en
 97 27 December 2010 Judgment of the Constitutional Court no.2010-38-01, para. 10. Available: http://www.satv.tiesa.gov.lv/wp-content/uploads/2010/04/2010-38-01_Spriedums_ENG.pdf

98 RC ZELDA (2016), Handbook: FIRST STEPS IN IMPLEMENTATION OF SUPPORTED DECISION MAKING IN LATVIA. Riga, Latvia, Available: http://zelda.org.lv/wp-content/uploads/ZELDAS_bro%C5%A1%C5%ABra_EN_WEB.pdf

99 More information: <http://zelda.org.lv/en/news/rc-zelda-commences-work-on-the-development-and-implementation-of-the-support-person-service-2619>

100 Latvia Healthcare Facilities Master Plan 2016-2025, p. 95, available: <http://www.vmnvd.gov.lv/uploads/files/58b57889c736b.pdf>

101 Ministry of Welfare, Action Plan for the implementation of deinstitutionalisation for the period 2015 – 2020 [Rīcības plāns deinstitutionalizācijas īstenošanai 2015. – 2020. gadam]. Available: http://www.lm.gov.lv/upload/aktualitates/4/ricplans_groz_22032016.pdf

LITHUANIA

COUNTRY INFORMATION

- **Population:** 2,847,904 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Mental health policy and services in Lithuania still rely heavily on psychotropic medication, hospitalisation, and institution-ization. Community-based mental health care remains a low priority. Although deinstitutionalisation in social care is currently underway, there are concerns about the lack of community-based services. Promising practices are often fragmented and project-funded without long-term sustainability.

DETAILED INFORMATION

Institutions and psychiatric hospitals

According to information from the Ministry of Health, the average stay in long-term psychiatric beds ranges from 53 to 435 days depending on the hospital. In acute beds in general hospitals this figure is 14 to 26 days, while in specialist hospitals it is 13 to 34 days. There is no information on the number of long-stay patients (usually defined as longer than 1 month in Lithuania) in acute hospitals.

Social care institutions in Lithuania are defined as settings with more than 30 places with at least two thirds of residents having mental health problems or psychosocial disabilities (Ministry of Social Security and Labour). There are 27 such institutions in Lithuania (see table below), however, this figure might be an underestimate of the extent of institutionalization because in total there are 43 residential settings – including other types of residential support – with a total of 6,259 beds for persons with mental health problems or psychosocial disabilities; some of these are institutional in their nature.¹⁰²

	Total number of units (e.g. hospitals, institutions)	Total number of beds	Sectoral distribution
Acute beds in general hospitals	17	n.a.	Public
Acute beds in specialist hospitals	4	n.a.	Public
Long-term beds in general hospitals	13	1,421	Public
Long-term beds in specialist hospitals	3	1,154	Public
Social care Institutions	27	5,473	Public
Care/nursing homes	60	n.a.	Public

Source: Ministry of Health (data gathered by Lithuanian Institute for Hygiene), 2016

Community-based residential support

In Lithuania community-based accommodation services for people with mental health problems are extremely limited and primarily consist of group home placements, also called ‘independent living homes’, that are available for a fraction of those using residential care; their exact number is not known. Short-term respite services are provided in long-stay institutional settings. It must be noted, that these facilities, even though classed as ‘community-based services’ in Lithuania, are often a smaller version of segregated institutional settings with a similar institutional culture.

¹⁰² *Psichikos sveikatos perspektyvos “Gyvenimas savarankiškai ir įtrauktis į bendruomenę. JT Neįgaliųjų teisių konvencijos 19 straipsnio įgyvendinimo Lietuvos socialinės globos sistemoje stebėsenos ataskaita”, 2015*



Type of community-based service	Total number of units	Total number of places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community-based residential arrangement: group home	7	117	101	n.a.	All sectors, including public, private, NGO	Mixed group. People with intellectual and/or psychosocial disabilities. Three out of seven group homes accepts people with intellectual disabilities only.
Community-based residential arrangement: Supported living	21	510	449	n.a.	Public and NGO	Older persons and persons with intellectual and/or psychosocial disabilities.
Places of sanctuary for persons in crisis	34	833	8,936	1-3 months	Public and NGO	At risk adults, not mental health specific. There are 29 crisis centres and 5 temporary shelters.
Respite homes	13	58	n.a.	n.a.	Public and NGO	They are usually newly established within social care institutions. Adults with psychosocial or mental disabilities.

Source: Ministry of Social Security and Labour of Lithuania (data gathered by Lithuanian Department of Statistics), 2015

There are no personal budgets foreseen, personal assistance schemes are not legally regulated and established on a national level. Some of personal assistance (information, consultation, and support) is provided in a very fragmented way, poorly accessible, and provided by non-governmental organisations on a project basis.

Other community-based mental health support

There are no mobile units or community mental health teams in Lithuania, mental health care in the community is provided in outpatient mental health centres. Although legislation provides for the establishment of mobile units and community mental health teams as part of psychiatric facilities, the managers of the psychiatric facilities refused to implement these alternative services because no adequate funds had been allocated for this purpose.

Regarding mental health centres at primary health care, it is suggested that they do not serve as community mental health services because they neither stop institutionalization nor prevent hospitalisation, and they do not provide psychosocial rehabilitation. The availability of psychotherapy is extremely limited, and they do not provide effective support for children and adults in need. They mainly provide treatment with psychotropic medications. Additionally, as described above, no mobile outreach teams operate from these mental health centres, they are static services.

There are different types of day centres for people with mental health problems in Lithuania. Some are part of the mental health centres and are attended by their clients. The services provided are time-limited and include psychological and psychiatric consultations, art therapy, etc. The number in the table below refers to this type of day service.

Other types of day centres provide long-term day care for people with any type of disabilities. The Ministry of Social Security and Labour have provided information about 226 day care centres, but it is not known how many are for people with psychosocial disability. Among the above mentioned day care centres, the NGO Lithuanian Care Community for Persons with Psychosocial Disabilities (Lietuvos sutrikusios Psichikos žmonių pagalbos globos bendrija) manages 39 units across Lithuania with 2,410 registered service users who have psychosocial disabilities.

Although there are some peer support networks, user/survivor organisations, cultural support networks in Lithuania, their exact number is not known. Some of these operate on the local, community level, while others belong to national umbrella organisations.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding?	Main client groups
Mental health centres (outpatient)	114	No data	Public (107) and private (7)	National Health Insurance Fund	Persons with mild mental health problems; persons with severe and moderate mental health problems after release from psychiatric hospitals.
Day services (part of mental health centres)	40	7,005	public	National Health Insurance Fund	

Source: Ministry of Health (data gathered by Lithuanian Institute for Hygiene), 2016

Involuntary placement and involuntary treatment

The current Mental Health Care Act in Lithuania has not been comprehensively reviewed since its adoption in 1995. It does not separate forced placement and forced treatment. The criteria for involuntary placement and forced treatment according to this law are: being diagnosed with a serious mental health disorder and posing a real danger to self, others, and/or to property.

In 2008 the Mental Health Care Act was amended in order to include a provision on obligatory legal representation in cases of involuntary hospitalisation of persons with mental health problems. Involuntary hospitalisation and involuntary treatment shall be initiated for no more than three working days without the permission of the court. If the permission is not given by the court, involuntary hospitalisation should be terminated. If permission is given, involuntary hospitalisation can be extended.

However, there are concerns about the due process, safeguards and remedies foreseen for ensuring free and informed consent when a person is making a decision about his/her hospitalisation. Similarly there are concerns about the adequate provision of a complaints process to allow the individual to challenge the lawfulness of the involuntary hospitalisation (deprivation of liberty) and redress such limitation of a person's liberty by his/her immediate release and compensation are inadequate.

In 2014 a task force was set up by the Ministry of Health to review the Mental Health Care Act. The draft law is still pending before the Parliament. The proposed new law still includes provisions on involuntary hospitalisation and treatment of persons with disabilities, and there is no separate procedure for hospitalisation and treatment.

At the same time there are also attempts to broaden the criteria for involuntary placement and forced treatment to include those "suspected to have mental health and behavioural problems due to abuse of psychoactive substances".

According to a survey by the Ministry of Health in 2016, there were 1,011 cases of involuntary hospitalisation in Lithuania. However, the accuracy of this figure should be treated with caution as anecdotal evidence suggests that hospitals/doctors try to avoid the "bureaucracy", particularly the involvement of the court and often "persuade" – coerce – the individual to sign papers on a "voluntary" basis.

Compulsory outpatient supervision and treatment in primary health care level is defined in the Criminal Code for people who are recognized by court as incompetent or partially competent as well as for people who perceived significant mental problems after the sentence and are not capable to understand and control their actions. Neither number of community treatment orders, nor the rate is available.

Seclusion and restraint

There is no general regulation of the use of seclusion and restraint in Lithuania, and facilities adopt their own policies. There are serious concerns about the recording of seclusion and restraint. Most facilities do not have appropriate rules, regulations and/or records of these.

Legal capacity and guardianship

Existing legislation allows for substituted decision making for persons with disabilities. The Civil Code stipulates that an individual may be deemed as incapacitated by court ruling in specific areas of life, and shall be placed under guardianship. This can



also mean the full incapacitation of an individual. People who are deprived of their legal capacity are prevented from voting and their right to marry is restricted too.

Under existing legislation it is possible to re-instate legal capacity and this can also be initiated by the individual under guardianship him/herself.

New legal capacity legislation was adopted in 2016, which contains provisions on advance directives and agreement for support provision; its uptake to date remains low.

In terms of the number of people under guardianship, a register¹⁰³ was established in 2011, although the information is not publically available. According to the data provided by the Ministry of Justice there were around 7,000 persons deprived of legal capacity and around 50 people with partial legal capacity at the end of 2015. It is estimated that up to one in five people with intellectual or psychosocial disabilities may be deprived of legal capacity (Population Census Data).

According to the data provided by the Ministry of Social Security and Labour of the Republic of Lithuania, there were 1,403 persons under guardianship residing in social care institutions and having an institutional guardian on January 1, 2016.

Other information

Deinstitutionalisation has been very slow in Lithuania. The country adopted a National Mental Health Strategy in 2007. One of the objectives of this is “Deinstitutionalisation and modern services that meet the needs of the clients”. However, no measures have been undertaken to address this challenge and development of community-based mental health care remains a low priority for the Ministry of Health and for the government in general.

The Ministry of Social Security and Labour is responsible for planning the use of structural funds to implement deinstitutionalisation in social care and child protection set out in the Transition Plan from Institutional Care to Community Based Services for Disabled, Children without Appropriate Parental Care and Disabled Adults 2014-2020 in Lithuania. Nevertheless, there are some concerns that too little attention and financing is directed towards the specific target group of children and adults with disabilities and the creation of actual community services for them and their families. There is a lack of independent monitoring of the implementation of deinstitutionalisation.

Additionally, there is no plan for the deinstitutionalisation of mental health care services, i.e. large and segregated psychiatric hospitals that are under the auspices of the Ministry of Health, rather than that of the Ministry of Social Security and Labour.

There are a number of promising initiatives by different stakeholders (especially by NGOs, and also by some municipalities) that are in line with the public health and human rights based approaches. However, these initiatives are often side-lined by the official state mental health policies and services, and usually they have to survive mainly from project-based funding, which does not provide long-term sustainability.

A promising recent development was that the parliamentary control has been increased in the field of mental health (including human rights in closed institutions). This was done by establishing the Commission for Suicide and Violence Prevention in the Parliament of the Republic of Lithuania in 2016.

Please see the acknowledgments section of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Mental Health Perspective | Website: www.perspektyvos.org | Email: vilnius@perspektyvos.org

¹⁰³ http://info.registrucentras.lt/faq/neveiksniu_asmenu

MALTA

COUNTRY INFORMATION

- Population: 440,433 (Eurostat, 2017)
- CRPD signatory: YES, CRPD ratification: YES

GENERAL SUMMARY

Although mental health services in Malta are still primarily hospital based, community-based services are also being encouraged and have been successfully established across the country. The Mental Health Act from 2012 provides stronger safeguards for involuntary placement and compulsory community treatment.

DETAILED INFORMATION

Institutions and psychiatric hospitals

The Mental Health Services in Malta are mainly hospital based, in the Mount Carmel Hospital, the psychiatric hospital in Malta. The hospital has both long-stay and short-stay beds. There is also a Short Stay Psychiatric Unit (SSPU) at Mater Dei Hospital, the General Hospital, which caters for a wide range of male and female patients with acute psychiatric problems. Admission to this unit is on a voluntary basis. Admission to the psychiatric hospital may be on a voluntary or involuntary basis. There is a Short-stay Ward at the Gozo General Hospital (Gozo is the sister Island to Malta). This SSW-GGH caters for individuals with acute mental ill health. It provides 12 beds (Ref. Annual Report, 2015, Mental Health Services).

In 2016 there were 276 long-stay patients (staying over a year) and 560 males and 363 females accessed short term in-patient services. The average length of stay was four weeks in the SSPU and up to eight weeks in the psychiatric hospital.

The patients are followed through outpatient services or community-based services through the main Outreach Department, once they are discharged or sent on leave. Substance abusers are often encouraged to follow a rehabilitation programme.

	Total number of units (e.g. hospitals, institutions)	Total number of beds	Sectoral distribution
Psychiatric hospital	1	564	Public
Short stay psychiatric unit in General hospital(MDH)	1+1 in Gozo	120	Public

Source: Medical records, 2016; Annual Report 2015, Mental Health Services

Community-based residential support

There are various types of community-based residential arrangements in Malta for people with long-term mental health problems.

Type of community-based service	Total number of units	Total number of places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
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Community residential facilities: hostels	5x/x	57	57	Long term residential hostels	Part public	The hostels cater for persons with severe and persistent mental illness who cannot live independently in the community. Four of the hostels are for males and one for females, whereas the group home is for females.
Community residential facilities: flats	3xxx--x	8	8	Long term	Part public	The service is for people with mental health problems who can live independently in the community.
Community-based rehabilitation house	1	20	20	Maximum 1 year	Part public	Villa Chelsea is run by Richmind Foundation.

Source: Annual Report 2015, Mental Health Services

Other community-based mental health support

Some of the community-based mental health services are operated from the Mount Carmel Hospital, such as the outpatient service, community outreach team, and a roaming mental health team. The Outreach Department provides follow-up services for people leaving the hospital. A multi-disciplinary department for youths and adolescents caters for young clients with psychiatric and psychological problems.

There is also an outpatient department within the General Hospital. Mental health clinics and day centres have been set up in different areas over the Maltese Islands to cater for the needs of clients living in the community and provide follow-up services.

There are also other community-based support network, such as a hearing voices network and befriending services.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding	Main client groups
Mental health outpatient facility	1	11,008 reviews in 2016	public	Public	n.a.
Mental Health Outpatient for youths and adolescents	1	3,038	public		
Community mental health clinic	5	6,172 reviews in 2016	Public	Public	n.a.
Roaming mental health team	1	743 reviews in 2016	Public	Public	n.a.
Day centre	5	287 clients registered	Public	Public	n.a.

Source: Medical records, 2016;



Involuntary placement and involuntary treatment

The Mental Health Act (1981) was replaced by a new Mental Health Act in 2012. The new Mental Health Act is more user-focused and promotes treatment in the least restrictive manner and for the shortest possible duration. The role of the Commissioner for Mental Health was established by the Act, and is responsible for:

- Approving, monitoring, and reviewing involuntary care;
- Investigating alleged cases of human rights abuse and taking appropriate action;
- Ensure closure of care episodes (e.g. discharge from involuntary care).

In 2015 the Commissioner received 111 applications for Involuntary Admission for Treatment Order, out of which 108 were approved. The number of applications for community treatment order was 45, out of which 43 were approved. On 31 December 2015 there were around 50 people admitted involuntarily in inpatient settings and 25 individuals receiving compulsory care in the community. Over 70% of involuntary hospital stays lasted 10 days or less.

One in four involuntary placement were young people aged under 30 and a similar proportion were people aged 60 years or over.

Reference: Annual Report 2015, Office of the Mental Health Commissioner, Malta¹⁰⁴

Legal capacity and guardianship

The 2012 Mental Health Act acknowledges the fact that mental capacity can vary from a transient phase lasting a few days or months up to situations which merit mental incapacitation or interdiction by a Court of Law. Certification of lack of mental capacity for people with mental health problems can only be done by specialists in psychiatry. The Mental Health Act also provides for the revocation of a certificate of lack of mental capacity. This revocation is supported or otherwise by an independent specialist appointed by the Commissioner for Mental Health. Every decree of incapacitation or interdiction given by a court of law on grounds of lack of mental capacity must be notified to the Commissioner who may request the re-assessment of the incapacitated or interdicted person by three independent specialists and shall inform the court accordingly if there are changes in circumstances.

Information on the Guardianship Board: Guardianship Legislation was enacted in Malta by Act No XXIV of 2012. The Office of the Guardianship Board was inaugurated in 2014. Applications for Guardianship are filed at the Guardianship Registry located in Santa Venerary. Supported decision-making is still being discussed.

Other information

There are no plans to close the long-stay psychiatric beds in Malta, but patients from these wards are actively being rehabilitated in the community.

In 2015, nearly 11% of acute admissions were refugees or asylum seekers, and a further 12% were non-Maltese nationals (EU residents/visitors etc.).

“The worrying feature for refuge or asylum seekers with mental disorders is the virtually inexistent [sic] social networking to support safe return to the community, apart from the cultural significance of mental disorder in Middle Eastern, North African, East African and West African communities.” (Annual Report 2015, p. 22).

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Friends of Mount Carmel Hospital Society | Website: <https://www.facebook.com/Friends-of-Mount-Carmel-Hospital-Society-1644847559108682/> | Email: josborg5@gmail.com

¹⁰⁴ <https://deputyprimeminister.gov.mt/en/CommMentalHealth/Documents/Annual%20Report%202015%20Final.pdf>



NETHERLANDS

COUNTRY INFORMATION

- Population: 17,081,507 (Eurostat, 2017)
- CRPD signatory: YES, CRPD ratification: YES

GENERAL SUMMARY

The provision of mental health care and support in The Netherlands is mixed - primarily community-based but with some institutional provision. The provision of services is already moving towards the stated aim to reduce institutional provision by about a third by 2020. However, the necessary development of community-based resources seems to be lagging behind. A major reform of involuntary placement and forced treatment is currently on-going.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In 2014, there were 8,250 service providers in the Netherlands (Source: NZa Marktscan, 2017). Estimates of the total number of beds in 2014 (Source: Trimbos instituut, 2016):

- Short term care (specialized mental health care): 10,000;
- Long term mental health care: 7,000;
- Sheltered housing: 17,000.

The majority of these service providers consist of private practices. GGZ Nederland (the Dutch Association of Mental Health and Addiction Care) is the umbrella organisation for specialist mental health and addiction care providers, their membership accounts for approximately 85% of the total market share.

Personal budgets

Mental health care in the Netherlands is paid for by private health insurance for short term care (Zorgverzekeringswet), public insurance for long term care (WLZ AWBZ); by dedicated municipal funds for support, rehabilitation and for sheltered housing (WMO); and by the Department of Justice for forensic care (WFZ). Mental health care for children (until age 18) is funded by dedicated municipal funds for youth care (Jeugdwet).

At present personal budgets are only available in the WLZ, the Zorgverzekeringswet, Jeugdwet and WMO AWBZ on official medical grounds. In mental health care, personal budgets are mainly used by parents to take care of their children with (severe) mental health problems or intellectual disabilities, in order to prevent institutionalization.

This legislation is now under review because this arrangement is exceeding its national budget

Deinstitutionalisation

In June 2012, the Dutch government, health insurers, mental health organisations, mental health professionals, and mental health client organisations agreed to transform one third of the institutional mental healthcare places into community-based mental health care within the next eight years. That means a decrease of institutionalised places by approximately 8,000-10,000 between 2012 and 2020. This operation is still underway. Although there is a marked reduction in institutional places, the required build-up of outpatient, community-based services does not seem to be meeting demand.¹⁰⁵

¹⁰⁵ Reference: Trimbos-institute, Landelijke Monitor Ambulantisering en Hervorming Langdurige GGZ 2016, p.

Involuntary placement and forced treatment

The existence of a significant risk of serious harm to oneself or others caused by a psychiatric disorder assessed by a medical expert are the main conditions justifying involuntary placement as a last resort. The need for a therapeutic purpose is not explicitly stipulated. One expert opinion issued by a medical expert concerning the assessment of an individual's psychiatric condition is presented to the court. The court then decides on the necessity of a compulsory admission.

The Dutch Psychiatric Hospitals (Compulsory Admissions) Act (in Dutch the BOPZ) regulates the circumstances involved in involuntary hospitalisation and treatment in psychiatric institutions. The BOPZ states that all of the following conditions must be met before involuntary placement can take place:

- There has to be a significant risk of serious harm to oneself (including severe self-neglect or social breakdown), to others or to society as a whole;
- Which is caused by a psychiatric disorder;
- As assessed by a psychiatrist;
- That there must no alternative other than detention to avert the danger;
- And that the patient is refusing voluntary hospitalisation.

If all of these conditions are met, a judge can decide to have the patient committed. Detainment can be enforced through two procedures: an Acute Involuntary Admission (Inbewaarstelling – IBS) or a Court Order (Rechterlijke Machtiging – RM).

An Acute Involuntary Admission (AIA) is used in case of imminent danger. Anyone can request an AIA, but a psychiatrist has to examine the individual for the aforementioned conditions. If the psychiatrist concludes that an AIA is necessary, a medical report is submitted to the mayor, who then decides whether or not an AIA is issued. Within 24 hours of issuing an AIA, an individual is put into detainment. When an individual is detained, the public prosecutor decides (within one workday of detainment) whether or not further detainment is necessary. If this is deemed necessary, the public officer passes the matter on to the court. The court then passes judgment on the continuation of the compulsory admission within another three workdays (Nuijen, 2010).

A Court Order (CO) is used when a client meets the aforementioned conditions, but when there is no emergency. It can be issued through several channels:

- People “nearest and dearest” to a person judge the person to be a danger to himself or to others because of a mental disorder. They want the person to be admitted, but the client is reluctant, so they can request a CO.
- If third parties wish to request a CO for an individual, they must make a request to the public prosecutor. The public prosecutor has to take any further initiative.
- A person with a mental disorder can request a CO for himself.
- A CO can be issued when a client is already admitted in a psychiatric institution (e.g. if the client has been admitted through an AIA) (Forti et al. 2012).¹⁰⁶

Every person can ask a judge (in cases of involuntary placement) or a complaint committee (in cases of involuntary treatment) to end the placement or treatment. Apart from the person in question, other patients or people can file a complaint on behalf of the patient. The decision of both the judge and the complaint committee may be appealed by the person with mental health problems to a higher court (FRA 2012).¹⁰⁷

In the Netherlands, every psychiatric hospital has to have an independent patients' advocate to support patients. All patients have the right to keep contact with the advocate, including those subjected to seclusion or restraint. The patients' advocate is an employee of a national organisation of patients' advocates – an independent organisation – and his /her services are free of charge.

In recent years the Netherlands seem to show an increase in Court Orders and Acute Involuntary Admissions. And in an increase of provisional and conditional court orders, to prevent involuntary placement. It is thought reasons for this devel-

¹⁰⁶ Forti, A. et al. (2014), “Mental Health Analysis Profiles (MhAPs): Netherlands”, OECD Health Working Papers, No. 73, OECD Publishing. <http://dx.doi.org/10.1787/5jz158z60dzn-en>
¹⁰⁷ Available: http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf



opment can be found in a combination of an increase of deinstitutionalisation in combination with an unmet need for the required build-up of outpatient, community-based services and early prevention in neighbourhoods. This legislation is under review at the moment. The Dutch government is planning to replace the Psychiatric Hospitals (Compulsory Admissions) Act with two new laws:

- The Care and Coercion Act (Wet zorg en dwang) will deal with institutions for persons with intellectual disabilities and persons with dementia.
- The Act on Compulsory Mental Health Care (Wet verplichte geestelijke gezondheidszorg; WVGGZ) deals with persons with mental ill health.

If both of these Bills are adopted by the Parliament, this will result in major changes in the Dutch legal framework regarding involuntary placement and involuntary treatment. Where current laws focus on institutionalization, the WVGGZ focuses on treatment in both institutionalized and ambulatory settings. Among others the new laws will mean a stronger position for the rights of patients and relatives, for instance patients will have a legal right to a family confidential. They can offer a listening ear and give advice. The judge will not only decide whether involuntary treatment is necessary, but also decides which form of restraint is allowed. Patients will have the right to draw up an own plan of action to turn off compulsory treatment. And the WVGGZ creates the option to give patients treatment partly voluntary if possible and partly involuntary. The new laws have been adopted by the House of Representatives and are at the moment subject of debate at the Senate. It is expected that once adopted, the new laws will enter into force in 2020.

Legal capacity and guardianship

The Civil Code of 1992 (Burgerlijk Wetboek) sets up a gradual system based on substitute decision making. In general every individual is considered to be capable of making his/her own decisions until declared not capable of doing so by an expert. The law contains three general procedures with regard to persons who, as a result of their mental health problems or disability, have been declared not capable to manage their own affairs:

- executor (bewindvoering) covers issues concerning the property and financial matters of the person;
- mentorship (mentorschap) aims at protecting the interests of the person regarding care and treatment; and
- wardship (curatele), in which legal capacity in almost all matters are transferred to the guardian.

All these types of guardianship require a court order, based on an objective and independent opinion. Of these three possibilities, wardship (curatele) limits most the possibilities of the person involved to make their own decisions. For that reason, it is common practice to apply for executorship or mentorship, while wardship is seen as a legal measure of last resort.

There are no minimum or maximum time limits for these measures. At the same time, the law does not provide with a definition of competency or capacity (FRA 2009).¹⁰⁸ The individual who is placed under guardianship may appeal to the District Court against the decision.

Each year, Dutch courts deal with approximately 27,000 requests in total for the three guardianship categories. However, since there is no official registry, it is known what proportion of those placed under guardianship has mental health issues (Blankman 2016).¹⁰⁹ Mental health problems probably constitute only a fraction of the aforementioned number.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

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RINO Noord-Holland | Website: www.rino.nl | Email: info@rino.nl

¹⁰⁸ Available: <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-NL.pdf>

¹⁰⁹ Available: http://www.international-guardianship.com/pdf/GBC/GBC_Netherlands.pdf

POLAND

COUNTRY INFORMATION

- **Population:** 37,972,964 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Poland mental health is primarily provided in psychiatric hospitals and long-term residential care is institutionalised. The availability of community-based services is limited. The proportion of patients hospitalised for one year or longer fell between 2011 and 2014. There are legal safeguards around involuntary placement and forced treatment, however they might not always be adhered to in social care institutions. The legal incapacitation system is directly against the provisions stated in Article 12 of the UN CRPD.

DETAILED INFORMATION

Institutions and psychiatric hospitals

Most of Poland's inpatient capacity is in psychiatric hospitals: there are more than twice as many beds in psychiatric hospitals than in general hospitals (35.0 as opposed to 14.2 beds per 100,000 population; WHO MHA 2014)¹¹⁰. In 2011 the number of beds in psychiatric hospitals was 15,014 (WHO MHA 2011)¹¹¹. Approximately 15% of inpatients in psychiatric hospitals were staying longer than one year in 2014 (WHO MHA 2014), down from 29% in 2011 (WHO MHA 2011). The average length of stay was 28 days in psychiatric units (the highest of all types of units in Poland, including rehabilitation units), 30 days in psychiatric hospitals¹¹² (GUS, 2015¹¹³).

	Total units	Total beds	Total number of users	Sectoral distribution
Psychiatric hospitals	48	17,800	200,800	Public
Psychiatric units in general hospitals	142	6,800 ¹¹⁴	86,400 ¹¹⁵	Public
Psychiatric medical care facilities and psychiatric care facilities	59	5,700	7,600	Public

Source: Central Statistical Office of Poland, Health and Healthcare in 2015

¹¹⁰ Available: http://www.who.int/mental_health/evidence/atlas/profiles-2014/pol.pdf?ua=1

¹¹¹ Available: http://www.who.int/mental_health/evidence/atlas/profiles/pol_mh_profile.pdf?ua=1

¹¹² Dependent on region: from an average of 18 days (in Opolskie voivodeship) to an average of 49 days (in Podkarpackie voivodeship).

¹¹³ Central Statistical Office of Poland, Health and Healthcare in 2015; <http://stat.gov.pl/obszary-tematyczne/zdrowie/zdrowie-i-ochrona-zdrowia-w-2015-roku,1,6.html>

¹¹⁴ data including detoxication units

¹¹⁵ data including detoxication units



Community-based residential support

There is very limited up-to-date information on the availability of community-based residential support for people with mental health problems in Poland. The main type of community residential support is supported houses but in 2015 only 434 persons with mental health problems used them.¹¹⁶ The main types of non-residential support are social assistance centres and community self-help homes (CRPD/C/POL/1 2015).¹¹⁷ The previous Mapping Exclusion report (2011) identified 198 social assistance centres with a total of 20,634 places and 690 self-help community homes with 22791 users, not all of whom have mental health problems. The availability of small-scale community-based accommodation is very limited in Poland.

Other community-based mental health support

Community-based mental health support primarily consists of outpatient and day treatment facilities in Poland (WHO MHA 2014). Information on other community-based support is limited.

Involuntary placement and forced treatment

The Act on Mental Health Protection sets out the rules of involuntary placement in Poland. Individuals who lack mental or legal capacity can be admitted to hospital upon the written consent of the person's statutory representative, or in certain cases – direct threat to self or to other people – without this. Involuntary placement must be approved by the guardianship court. Hospital must inform the guardianship court about any involuntary placement and initiate the legal proceedings within 72 hours. There are similar legal safeguards in the context of involuntary placement in social care institutions; however a report by the CPT found that these are often breached (CPT/Inf (2011) 20)).¹¹⁸

According to national statistics there were 45,137 involuntary hospital admissions in 2015, 14% of all admissions. The rate of forced treatment was 2.24% in the same year (a total of 7,191 cases).

Seclusion and restraint

As a general rule the use of seclusion and restraint must be ordered and supervised by a doctor, and registered on a “restraint form” in psychiatric hospitals and social care homes (ibid).

Legal capacity and guardianship

In 2017 Poland has no legal forms of supporting persons with disabilities that are consistent with Article 12 of the UN CRPD and the model of supported decision making.¹¹⁹

Instead, there are two different types of incapacitation: plenary (total) and partial. Under plenary incapacitation, a guardian is appointed and acts on behalf of the ward in all matters. Under partial incapacitation, a supervisor is appointed whose agreement is essential for the validity of legal acts made by the ward. People aged 13 or over can be placed under plenary incapacitation; and those who are aged 18 or over can be placed under plenary or partial incapacitation. People are placed under plenary incapacitation (and so lose all legal capacity) if, for example due to intellectual disability, they cannot “control their behaviour”. Such vague wording could lead to the abuse of this provision. Analyses of practice do indicate a number of abuses when ruling incapacity by courts.¹²⁰ If the circumstances do not warrant plenary incapacitation, but a person needs assistance, he or she can be placed under partial incapacitation and the legal capacity of the person is partially restricted.

“Incapacitation is granted indefinitely in Poland, and the supervision of its application is limited to reporting by the legal guardians and carers of incapacitated persons.”¹²¹

¹¹⁶ Data from report MPiPS-03 for year 2015, <http://www.mpips.gov.pl/pomoc-spoleczna/raporty-i-statystyki/statystyki-pomocy-spolecznej/statystyka-za-rok-2014-a/>

¹¹⁷ Available: https://www.mindbank.info/collection/country/poland/crpd_country_reports

¹¹⁸ <https://rm.coe.int/168069791c>

¹¹⁹ Alternative Report on the Implementation of the UN Convention on the Rights of Persons with Disabilities, p. 37; available at: <http://konwencja.org/english/>

¹²⁰ Open Society Institute, Rights of People with Intellectual Disabilities. Access to Education and Employment – Poland, 2005; M. Tomaszewska: Charakter prawny decyzji o ubezwłasnowolnieniu w sądowym stosowaniu prawa, Toruń 2008, s. 203 – 236; I. Kleniewska: Postępowanie w sprawach o ubezwłasnowolnienie w praktyce sądowej, (w:) Prawo w działaniu 2006, nr 1, Warszawa, s. 119 – 134

¹²¹ Alternative Report..., p. 26

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In 2015 there were a total of 86,900 persons deprived of full legal capacity in Poland (with 74,500 under plenary and 12,400 under partial guardianship). In 2015 an exceptionally high number of applications for incapacitation (n = 13,600) were registered by the courts and the majority (nearly nine thousand) were approved.¹²²

Other information

There is no general deinstitutionalisation strategy nor a working group tasked with drafting such a strategy or plan according to the European Experts Group's (EEG) European Guidelines on Deinstitutionalization. Poland is not monitoring on a systematic basis the development of community based services or the deinstitutionalization process in general, including the European funds used for the social inclusion programmes. Poland gathers only limited data on usage of residential care institutions and community-based services by persons with mental health issues.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see [the acknowledgments section](#) of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

Coalition for Mental Health | Email: topos@topos.org.pl

Foundation Polish Institute of Open Dialogue (Fundacja Polski Instytut Otwartego Dialogu) | Website: www.otwartydialog.pl
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¹²² Press information on situation as of 2015, but coherent with data from previous years; available at: <http://www.dziennikpolski24.pl/artykul/9353281,87-tys-ubezwlasnowolnionych-lawinowo-przybywa-wnioskow-o-pozbawienie-praw-babc-i-dziadkow.id.t.html>



PORTUGAL

COUNTRY INFORMATION

- **Population:** 10,309,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Portugal, mental health care is available both in specialist and general hospitals and through community-based services across the country. The Portuguese National Mental Health Plan (2007-2016) successfully restructured mental health care from hospitals to outpatient services; however, austerity measures have impacted on both the population and the implementation of the programme. Portugal has a very old guardianship policy in place that severely restricts the rights of those subjected to restrictions of their legal capacity.

DETAILED INFORMATION

Institutions, psychiatric hospitals and residential care

In Portugal hospital care is provided across the country, both in specialist and general hospitals. There are also care homes available for over 600 residents.

	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution
Beds in general hospitals	3	Approx. 810	1,336	n.a.	n.a.
Beds in specialist hospitals	30	Approx. 740	n.a.	n.a.	n.a.
Other residential care facilities	28	Approx. 630	n.a.	n.a.	n.a.

Source of data: WHO Mental Health Atlas, 2014

Community-based mental health support

There are several types of services that are available to people with mental health problems in Portugal: local adult mental health services (41 units), local psychiatric services for children and adolescents (9 units), and community mental health units (20).

Involuntary placement and involuntary treatment

For involuntary mental health hospital admission there are two criteria in addition to having a mental health problem - the risk of harm and the need for treatment. Regular reviews of placement measures take place every three months.

Legal capacity and guardianship ¹²³

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In Portugal, under the Civil Code (Article 138 to 156) both partial and full guardianship exist – the **regulation dates** back to the first Civil Code that entered into force in 1966. There are no professional guardians in Portugal. The person's views are not automatically heard by the court during the restriction of legal capacity – a court hearing is only mandatory if someone contests the case.

People with limited legal capacity – including people with mental health problems – may lose their right to vote, to marry or to take parental responsibilities, to sign legally recognised contracts and to manage their own assets or properties. Some of these restrictions are directly linked to psychiatric conditions, for example, it is not possible to enter marriage for those who have a 'psychic anomaly' (Art 1601 of the Civil Code).

Other information

The National Mental Health Plan 2007-2016 (extended until 2020) set out priorities including the development of community-based care and the reduction of specialist hospital beds. Under this programme, mental health services in general hospitals have been established and progress has been made in establishing new services in the community and training professionals. However, funding systems still encourage institutional forms of care and financial support available for community services in mental health is still problematic. Austerity measures have also impacted on both general and specialist services.¹²⁴

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

ARIA - Associação de Reabilitação e Integração Ajuda | Website: www.aria.com.pt | Email: aria.sede@gmail.com

¹²³ Sources: Parallel report to the CRPD Committee by Disability and Human Rights Observatory, 2015; Alzheimer Europe, Portugal, 2017 (<http://www.alzheimer-europe.org>)

¹²⁴ Augusto, G.F. (2014). Mental health in Portugal in times of austerity. *The Lancet. Psychiatry*, 1(2), 109.



REPUBLIC OF MOLDOVA

COUNTRY INFORMATION

- **Population:** 3,553,056 (Eurostat, 2016)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Although mental health services in Moldova are still primarily hospital-based and residential services are provided in institutions, the country has made progress towards deinstitutionalisation and the development of community-based mental health care. Moldova still practices the deprivation of legal capacity and there are concerns around the implementation of legal procedures regulating involuntary placement.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Moldova there are three psychiatric hospitals and four “psycho-neurological internats” that provide primarily social but also some medical services for those in need of long-term care. The number of inpatients in the psychiatric hospitals is around 2,000 (WHO MHA 2014); there is no information on the proportion of long-stay patients. Psychiatric hospitals can accommodate civil and forensic patients on the same ward (CoE 2016, p. 56).¹²⁵

The four “internats” accommodate a mixed group of vulnerable adults, including people with intellectual disabilities and older adults. Approximately a third of residents have psychosocial disabilities.

Residents typically stay for an indefinite period, most often for decades. A substantial share of the population served by these institutions is elderly, many of whom have grown old in the institution.¹²⁶

	Total number of units (e.g. hospitals, institutions)	Total number of beds	Sectoral distribution
Psychiatric hospitals*	3	n.a.	Public (health)
Psychiatric units in general hospitals*	25	n.a.	Public (health)
Psycho-neurological institutions for adults**	4	1,665	Public (social care)

* WHO Mental Health Atlas 2014, Republic of Moldova country profile¹²⁷

** The plans for the transformation of the residential institutions subordinated to the Ministry of Labour, Social Protection and Family, 2016

¹²⁵ <https://rm.coe.int/16806975da>

¹²⁶ Reference: Plans for the transformation of the residential institutions. Ministry of Labour, Social Protection, and Family, 2016.

¹²⁷ Available: http://www.who.int/mental_health/evidence/atlas/profiles-2014/mda.pdf?ua=1



Community-based residential support

In recent years a number of community-based accommodation services were established in Moldova to support those in need of residential care. In 2016 there were nine supported living services in four localities, and 11 community homes in nine localities. The legal framework for providing supported living services was approved in 2010 (Regulations No. 711 of 09.08.2010). The first supported living services for people with mental health problems were set up in the town of Balti in 2011. The legal framework for the provision of community homes was established in 2015 (Decision No 885 of 28.12.2015). Most of the beneficiaries of these services are people with intellectual disabilities; the number of service users with long-term mental health problems is not known.

Type of community-based service	Total number of units	Total number of places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Supported living	9	-	34	indefinite	NGO	Primarily for individuals who have mild support needs, 2-6 places per supported living unit, typical home in the community.
Community home	11	73	73	definite	NGO, public	Primarily for individuals with high support needs, placement decided by multidisciplinary team. Children and adults.
Respite care	5	n.a.	216	Up to 30 days	NGO, public	Primarily for individuals with high support needs, children and adults.

Source: The plans for the transformation of the residential institutions subordinated to the Ministry of Labour, Social Protection and Family, 2016

Other community-based mental health support

Moldova has made some progress in shifting the balance of care from psychiatric hospitals to community-based services. A National Mental Health Programme 2017-2021 was approved by the Government of the Republic of Moldova.¹²⁸ This document sets the policy framework aimed at establishing a system of community mental health services throughout the country and at reducing the number of unnecessary hospitalisations in the psychiatric hospitals. The goal of the Programme is to promote the community mental health by developing integrated mental health services and increasing the functionality of the psychiatric care delivery system, bringing them closer to the community and respecting the patients' rights.

The country also has a "Strategy for the Development of Community-Based Mental Health Services (2012-2021)" accompanied by an action plan.

The regulation of community mental health centres was approved in 2014. Mental health centres are part of the Integrated Mental Health Service and are subdivisions of primary care settings. Centres were established in all territorial-administrative units with a population of up to 100-150 thousand inhabitants.

The centres are responsible for providing services to all persons with mental health problems of the catchment area. They provide:

- Outpatient mental health counselling services;
- Day centre services;
- Mobile home assistance and crisis services.

¹²⁸ <http://www.particip.gov.md/proiectview.php?l=ro&idd=3724>



The services provided by day centres are divided into three basic programmes:

- A programme for medical and psychosocial rehabilitation through supervision and professional counselling: support treatment provided by the day carer, vocational rehabilitation services, leisure, counselling and psychotherapy for patients and their families;
- A programme to prevent the institutionalization, focussed on the deinstitutionalisation and social inclusion: housekeeping, artistic and social activities;
- A programme to maintain and improve the health condition: complex nutrition, maintenance of the personal hygiene, promotion of a healthy lifestyle, prevention of the somatic and psychiatric diseases.

There is no information about the availability of peer support networks, (ex) user/survivor organisations, and Hearing Voices network in Moldova.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution	Source of funding
Community mental health centres (outpatient)	43	n.a.	42-public 1-private	Public (Mandatory Health Insurance)
Mobile units/community mental health teams	4	2,400	public	Public (Mandatory Health Insurance)
Day services (as part of community mental health centres)	20	Approx. 800	public	Public (Mandatory Health Insurance)

Source: National Mental Health Programme 2017-2021

Involuntary placement and involuntary treatment

In the Republic of Moldova forced treatment is regulated by the Mental Health Act no. 1402 adopted on 16.12.1997 and the Civil Procedure Code.

According to Art. 309 of the Civil Procedure Code, the request for the approval of the involuntary hospitalisation and the forced treatment must be submitted by the medical institution to the local court. The court shall examine the request within three days. The participation in the hearings of the person whose admission is requested and of the representative of the medical institution is mandatory. The decision granting the approval serves as a basis for the forced hospitalisation and the forced treatment of the person for the period prescribed by the law. The law does not allow the internment for an unlimited period.

However, evidence from CPT (CPT/Inf (2016)¹²⁹; CPT/Inf (2012) 3)¹³⁰ suggests that this placement procedure is often breached in practice and most patients are formally admitted voluntarily, even if they are not allowed to leave the hospital.

Furthermore the legal safeguards around involuntary placement do not apply to residents in social care institutions. In its recommendations the CPT

[C]onsiders that the procedure for involuntary placement and stay of residents in social care institutions must be accompanied by appropriate safeguards. In particular, placement must be made in the light of objective medical expertise, including of a psychiatric nature. Further, all residents who are involuntarily placed in this type of establishment, whether or not they have a legal guardian, must enjoy an effective right to bring proceedings to have the lawfulness of their placement decided speedily and reviewed regularly by a court and, in this context, must be given the opportunity to be heard in person by the judge and to be represented by a lawyer.” (ibid, p. 74)

129 <https://rm.coe.int/16806975da>

130 <https://rm.coe.int/16806975d7>



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Seclusion and restraint

The use of seclusion and restraint is not routinely recorded, even in individual medical/care records (ibid).

There are also concerns about violence, abuse, and inhuman and degrading treatment in institutions and psychiatric hospitals. Effective mechanisms for reporting crimes and other are not in place. Moldova's national mental health legislation establishes that complaints concerning the violation of the rights of the persons hospitalized in psychiatric institutions are examined by the Ombudsperson. These complaints are directly submitted to the administration of the institution or hospital, which forwards them to the Office of the Ombudsman. This complaint mechanism is formal, lacking transparency and independence. It discourages people with mental health problems from reporting an infringement out of fear of potential retaliation.¹³¹

Legal capacity and guardianship

Existing legislation allows for substituted decision making – plenary guardianship – for persons with disabilities in Moldova.

Guardianship is authorized under Article 24 of the Civil Code of the Republic of Moldova, according to which a court can order the guardianship, when a person “cannot understand or control his/her actions, because of a psychological disorder (mental illness or mental impairment).

The guardian, as the legal representative of a person declared as “incapacitated”, executes all legal acts in the name and on behalf of the person concerned.

The practice of depriving the persons with disabilities of their legal capacity and of placing them under full guardianship¹³² is still widely used in the Republic of Moldova, with up to 4,000 persons being under guardianship. According to information provided by the Ministry of Justice, 665 persons were deprived of their legal capacity by virtue of a court order between 2012 and 2014.¹³³

A person deprived of his/her legal capacity has little chance and no legal avenues to regain it. According to the procedural law, only the guardians, the family members, the psychiatric institutions, the guardianship authorities or the prosecutors have the right to file a petition on behalf of the individual, requesting to restore his/her legal capacity.¹³⁴ To date legal capacity was restored in only two cases: the first one in 2015, and the second in 2017.

However, people with mental health problems can receive state-guaranteed legal aid and some lawyers are specialized in providing legal aid to people with mental health problems.¹³⁵

The first ever person who had her legal capacity restored in 2015 was represented by a lawyer from the state-guaranteed legal aid system, Ciobănaș Alexandru.¹³⁶

Other information

Currently, the Republic of Moldova does not have any strategy (a concrete policy document) for deinstitutionalization approved by the Government, especially for the people with mental health problems. At the same time, a number of actions have been undertaken in Moldova to promote the deinstitutionalization process, including services for people with mental health problems.

131 For more detail, see the United Nations Human Rights Office of the High Commissioner, Mental Disability Advocacy Centre et. al. (2015). The Human Rights of People with Mental or Intellectual Impairments in the Republic of Moldova. An Assessment of Key Aspects of the Domestic Law and Policy Framework in Light of the UN Convention on the Rights of Persons with Disabilities, pp. 64-76, available at http://www.mdac.org/sites/mdac.info/files/moldova_report_2015_english.pdf.

132 Legal Assistance Centre for Persons with Disabilities. (2013) The Right to Legal Capacity of Persons with Disabilities. A Comparative Study of the Legislation of the Republic of Moldova and International Standards in the Field available on <http://soros.md/files/publications/documents/Anexa%201-%20Studiu%20comparativ.%20Drept%20la%20capacitate%20juridica.pdf>

133 Response on the request for public information, by Ministry of Justice from 25 May 2015, Available at: <https://drive.google.com/file/d/0ByGIZdbDrRjrM0RzQIIMTOhMQkE/view>

134 Civil Procedural Code No. 1107 of June 6, 2002, Art. 170 para. (1) Letter c)

135 Decision No 35 of 27 December 2016 on updating the list of specialized lawyers providing legal aid to people with Mental Disabilities, available at http://www.cnajgs.md/uploads/asset/file/ro/1080/File0004_2_PDF

136 <http://www.cnajgs.md/ro/news/primul-caz-de-redobandire-a-capacitatii-de-exercitiu-in-practica-judiciara-a-republicii-moldova>.



In 2015-2016, a complex evaluation of the psycho-neurological institutions under the Ministry of Labour, Social Protection and Family was carried out. Following this process, plans for the transformation and the reorganization institutions were developed. The implementation of these plans is currently underway. At the same time, the number of new admissions to institutions is monitored and controlled closely, and redirected to alternative, community-based services where possible. However, due to the slow progress in creating alternative community-based accommodation, some people are stuck in psychiatric hospitals for longer than necessary (CPT/Inf (2016)).

In 2017 the Government of the Republic of Moldova intends to develop a national programme for the deinstitutionalization of the persons from the residential institutions under the Ministry of Labour, Social Protection and Family.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

ROMANIA

COUNTRY INFORMATION

- **Population:** 19,638,309 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

Note on terminology: The Romanian legislation refers to “people with mental disability”, which in addition to people with long-term mental health problems and psychosocial disabilities, also includes people with intellectual and developmental disabilities (such as autism). In legislation the term “people with psychic/psychiatric disability” is used. The “Act on Mental Health and Protection of People with Mental Disorders” (no. 487/2002) defines psychiatric disability as the “inability [...] to cope with life in society, the situation arising directly from the presence of the psychiatric disorder” (Art. 5/i). Therefore, this country profile will use the term “mental and psychiatric disabilities” to reflect the original terminology, rather than the term “mental health problems” and “psychosocial disability” used elsewhere in the report.

GENERAL SUMMARY

Romania still has a predominantly institutional mental health and social care system, although deinstitutionalisation has been on the agenda for many years and it is now underway. The key issues facing mental health and social care services in Romania are:

- A lack of qualified personnel such as psychiatrists, nurses, psychologists, social workers;
- Poor infrastructure and physical conditions;
- Lack training of staff working with people with mental health problems;¹³⁷
- Attitudes of professionals and staff towards people with mental health problems;
- Human rights abuses, disempowerment of people with mental health problems;
- Inadequate and / or lack of implementation of existing legislation, including UN CRPD implementation. Law No. 8/2016 regarding the establishment of the mechanisms provided by CRPD established the Monitoring Council.¹³⁸

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Romania a large proportion of people with a psychiatric disability live in different types of social care institutions or psychiatric hospitals (that are under the coordination of the Ministry of Health).

Psychiatric departments in general hospitals or university hospitals are the main type of inpatient psychiatric care in Romania, typically for people with less severe problems. Psychiatric hospitals provide chronic care for people with long-term and / or severe mental health problems.¹³⁹

¹³⁷ Ombudsman, Report on the visit at Neuropsychiatric Recovery and Rehabilitation Centre Maciucă, Valcea County, 31.01.2017, Available: http://www.avp.ro/rapoarte_mnp/2017/raport_mnp_1_2017.pdf

¹³⁸ Legea 8/2016 privind infiintarea mecanismelor prevazute de Conventia privind Drepturile Persoanelor cu Dizabilitati. Available: http://www.dreptonline.ro/legislatie/le-gea_8_2016_mecanisme_conventia_drepturile_persoanelor_cu_dizabilitati.php

¹³⁹ Report on the result of the REFINEMENT project. Available: http://cordis.europa.eu/result/rcn/149791_en.html



According to Eurostat¹⁴⁰, the number of psychiatric beds in Romania was of 16,503 in 2014. This represents a slight decline compared to the number of beds compared to the late 2010s (WHO, 2011).¹⁴¹ The majority of these beds are located in psychiatric hospitals rather than in psychiatric departments of general hospitals. The size of psychiatric hospitals ranges from 50 beds to 1,250 beds. Approximately 50% of these beds are located in large hospitals. The size of the psychiatric departments in general hospitals is much smaller (min = 21, max = 300). Around two thirds of the beds are for acute patients and the rest for people with long-term mental health problems (Sfetcu, 2017).¹⁴²

The data on social care institutions relate to the end of 2016 and include all adults with mental or psychiatric disabilities. Most social care institutions accommodate mixed groups of vulnerable people including older people, adults with intellectual and psychiatric disabilities, sometimes even people with other types of disability. It is estimated that at least 8% of people with mental and psychiatric disabilities are institutionalised.

Although there is no information on the length of stay, anecdotal evidence suggests that a large proportion of people spend their whole life in these settings. The Report of Public Policy Institute Bucharest on the UN CRPD implementation for 2014 shows that the main reason for leaving the residential social care system (2014, for all types of disability) remains death (76%), and this proportion is increasing year on year (as the population of institutions ages).¹⁴³ The second most common reason was family integration/re-integration but this represented only 16% of the total.

Type of institution	Number of units	Number of places/beds (users)	Source of funding
Psychiatric hospital ¹⁴⁴	39	8,107	Public
Psychiatric units in general hospitals	n.a.	7,709	
Social care Institutions ¹⁴⁵ , out of which:			
- Crisis Centre	2	(34)	Public
- Care and Assistance Centre	115	(4,159)	Public
- Integration Centre through Occupational Therapy	17	(1,007)	1 public-private unit
- Pilot Centre for the Recovery and Rehabilitation of People with Disabilities	3	(162)	
- Training Centre for an Independent Life	2	(20)	Public
- Neuropsychiatric Recovery and Rehabilitation Centre	67	(5,135)	1 public-private unit
- Centre for the Recovery and Rehabilitation of People with Disabilities	64	(2,565)	2 public-private units
- Respite Centre	3	(10)	Public
- Protected Housing	115	(775)	16 public-private units

Source:

WHO Mental Health Atlas 2011, Romania country profile

Public institutions of social care for adults with disabilities, coordinated by Ministry of Labour and Social Justice through the National Authority for Persons with Disabilities, on 31 December 2016, Source: Ministerul Muncii si Justitiei Sociale, Autoritatea Nationala pentru Persoanele cu Dizabilitati, Statistici trimestriale, Statistica trim IV 2016, ANPD NR PERS HAND TRIM 2016, <http://anpd.gov.ro/web/transparenta/statistici/trimestriale/>, Statistic data Bulletin, <http://anpd.gov.ro/web/wp-content/uploads/2015/04/ANPD-Buletin-statistic-IV-2016.pdf>

140 http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Hospital_beds_by_type_of_care,_2014.png

141 Available: http://www.who.int/mental_health/evidence/atlas/profiles/rou_mh_profile.pdf?ua=1

142 Sfetcu, R., Country profile ROMANIA in Scheffler, R.M., Chereches, R., (Editors) Mental Health Systems in Central European Countries: Moving Forward on Improving Service Delivery, Access, and Financing (Forthcoming 2017)

143 Public Policy Institute Bucharest, Report on monitoring the UN CRPD implementation, Edition V – art.9, 13, 19, 21, 24, 25, 27, 29, and 30, Available: <http://www.ipp.ro/wp-content/uploads/2016/02/Conventia-onu-5.pdf>

144 Available: http://www.who.int/mental_health/evidence/atlas/profiles/rou_mh_profile.pdf?ua=1

145 Public institutions of social care for adults with disabilities, coordinated by Ministry of Labour and Social Justice through the National Authority for Persons with Disabilities, on 31 December 2016, Source: Ministerul Muncii si Justitiei Sociale, Autoritatea Nationala pentru Persoanele cu Dizabilitati, Statistici trimestriale, Statistica trim IV 2016, ANPD NR PERS HAND TRIM 2016, Available: <http://anpd.gov.ro/web/transparenta/statistici/trimestriale/>, Statistic data Bulletin, <http://anpd.gov.ro/web/wp-content/uploads/2015/04/ANPD-Buletin-statistic-IV-2016.pdf>

Community-based residential support

Community-based services such as protected housing and respite centres are coordinated by Ministry of Labour and Social Justice and are mentioned above. The protected housing, “maximum protected”, “moderately protected”, and “minimally protected”, with 10 to around 30 people living in each house, are actually small institutions, especially the first two types.

The Statistical data Bulletin¹⁴⁶ gives information about public residential and non-residential social care institutions for adults with disabilities (Chart 10., p. 5) and lists the residential and non-residential social care institutions for adult people with disabilities under the coordination of Ministry of Labour and Social Justice (p. 17). However, there is limited information about supported housing provided by independent/non-governmental organisations.

Other community-based mental health support

Although the community-based care for people with mental and psychiatric disabilities was on the agenda for years, community-based mental health services are limited in Romania.

Mental Health Centres (MHCs)¹⁴⁷ were established to provide community care but they are still relatively underdeveloped. MHCs should provide a wide range of services, including home visits and preventive actions. However, due to insufficient financing they often have to operate on a minimal level.¹⁴⁸ It is estimated that only 10% of these centres carry out activities related to the concept of community care. Some centres have psychologists and nurses, but very few have social workers and specialists in occupational therapy. Most mental health centres only offer outpatient consultations and do not have an interdisciplinary team.¹⁴⁹

Most community-based support initiatives are run by non-governmental organisations, including individuals with a lived experience of mental health problems, carers, and professionals. There is no official data on the number of these initiatives; however there is a Hearing Voices network in Romania, user/survivor organisations (Aripi Association), club houses and cultural associations (e.g. Estuar Foundation). They are typically funded by projects and donations that provide little long-term sustainability.

Type of community-based service	Total number of units	Total number of patients/users (per year)	Sectoral distribution (public, private, non-profit)
Mental health centres (out-patient)	52	n.a.	Public
Day services	n.a.	n.a.	n.a.

Involuntary placement and forced treatment

Although from a legislative point of view there is comprehensive legislation and legal safeguards regarding the rights of persons with mental and psychiatric disabilities in terms of involuntary placement and forced treatment, this is not always applied/implemented in its entirety. There are serious rights violations reported by survivors, by Romanian and / or international human rights defenders and / or non-governmental organizations which deal with the protection of human rights (see for example reports by the CPT).¹⁵⁰ The Report by Nils Muižnieks, Commissioner for Human Rights of Europe, following his visit to Romania from 31 March to 4 April 2014, lists several court cases lost by Romania. See also *Atudorei v. Romania*.¹⁵¹

The Act on Mental Health and Protection of People with Mental Disorders (Legea Sanatatii Mintale si Protectiei Persoanelor

¹⁴⁶ http://www.mmuncii.ro/j33/images/buletin_statistic/dizabilitati_an2016.pdf

¹⁴⁷ The Order of the Minister of Health no. 375/2006 on organization and functioning of Mental Health Centres, <http://lege5.ro/Gratuit/ha2tcnrx/ordinul-nr-375-2006-pri-vind-infintarea-organizarea-si-functionarea-centrelor-de-sanatate-mintala&d=2017-05-15>

¹⁴⁸ Sfetcu, R., Country profile ROMANIA in Scheffler, R.M., Chereches, R., (Editors) *Mental Health Systems in Central European Countries: Moving Forward on Improving Service Delivery, Access, and Financing* (Forthcoming 2017)

¹⁴⁹ “Decide for myself” – Research on the quality of life of people with psychosocial disabilities, [http://www.decidentrumine.ro/uploads/Decid%20pentru%20mine_raport%20cercetare\(1\).pdf](http://www.decidentrumine.ro/uploads/Decid%20pentru%20mine_raport%20cercetare(1).pdf)

¹⁵⁰ <http://www.coe.int/en/web/cpt/romania>

¹⁵¹ <http://www.globalhealthrights.org/health-topics/hospitals/atudorei-v-romania/>



cu Tulburari Mintale, 487/2002) provides the procedural requirements for forced placement and provision for appeal.¹⁵²

The law defines the non-voluntary admission (forced placement) as “hospitalisation against the will or without patient’s consent” (Art. 5/p) and devotes Section 2 of Chapter V to Non-voluntary admission with 16 articles in total:

- The non-voluntary procedure applies only after all attempts of voluntary hospitalisation have been exhausted. (Art. 53)
- A person may be hospitalized through the involuntary placement procedure only if one psychiatrist decides that the individual has mental ill-health and because of this a) there is imminent danger of harm to him/herself or to others; b) non-intervention could cause a serious deterioration of his/her condition or prevent him/her from receiving suitable treatment. (Art.54)
- Non-voluntary admission is performed only in psychiatric hospitals with suitable conditions for specialized care under specific conditions. (Art.55)
- The request for involuntary placement of a person is made by: a) the family doctor or the psychiatrist; b) the family of the individual; c) representatives of the local public administration; d) the armed forces or prosecutors; or e) the civil court. These people need to provide the reasons for involuntary hospitalisation and sign the admission papers (Art 56).
- The psychiatrist assessing the mental health status of the individual and the justification of involuntary placement, must inform the individual and their legal representative about their rights and forward the documentation to the non-voluntary admission commission within 24 hours (Art 60).
- The commission should decide about involuntary placement within 48 hours from the application and inform the individual and their legal representative. They have the right to appeal; if possible the individual should be heard by the commission. Legal aid is also available.
- Involuntary admission must be recorded on the individual’s medical files.
- Non-voluntary admission is not a reason for limitation of legal capacity.

Seclusion and restraint

There are separate rules for the use of physical, mechanical, and chemical restraint, as well as seclusion. In general, the law stipulates that these should be used as a last resort and only if the least restrictive techniques were inadequate or insufficient to prevent any impact or injury. It should be used under supervision and for a limited time only. It should be recorded and the individual’s legal representative informed.

Despite the legal provisions, the incidents of restraint and seclusion are not always recorded (according to reports of the Ombudsman Institution), and the medical information related to restraint and monitoring the restraint process or the information is minimal. There is very little publicly available information on the prevalence and use of seclusion and restraint in Romania.

Legal capacity and guardianship

Existing legislation allows for substituted decision making – plenary guardianship – for persons with disabilities in Romania.

Guardianship is governed by the Family Code and other legal provisions including the Act on the Protection and Promotion of the Rights of Persons with Disabilities no. 448/2006,¹⁵³ Art. 25.¹⁵⁴ In a letter addressed to Prime Minister of Romania Sorin Grindeanu on March 2017, the Commissioner for Human Rights of the Council of Europe Nils Muižnieks raised the issues of inadequate legal representation of people with disabilities (no guardian being appointed or conflict of interests arising between the guardian and concerned person) and the absence of an appropriate legal framework providing an independent legal representation of people with disabilities.¹⁵⁵

¹⁵² http://www.dreptonline.ro/legislatie/legea_sanatatii_mintale.php

¹⁵³ http://www.dreptonline.ro/legislatie/legea_sanatatii_mintale.php

¹⁵⁴ http://www.dreptonline.ro/legislatie/lege_protectia_persoane_handicap_448_2006_rep_2008.php

Tutela – protecție sau obstacol în calea integrării persoanelor cu dizabilități intelectuale?/ Guardianship - a protection or obstacle to the integration of people with intellectual disabilities? Available: <http://www.crj.ro/wp-content/uploads/docs/Tutela%20protecție%20sau%20obstacol%20EE%20calea%20integrării%20persoanelor%20cu%20dizabilități%20integrale.pdf>

¹⁵⁵ <https://rm.coe.int/letter-from-nils-muiznieks-council-of-europe-commissioner-for-human-ri/1680711350>

Other information

The National Strategy for People with Disabilities, “A barrier-free society for people with disabilities”, 2016-2020 was launched in September 2016.¹⁵⁶

The National Authority for Disabled People initiated the Programme of National Interest - “The Establishment of social services such as day centres, respite centres / crisis centres, and protected housing with the purpose of deinstitutionalisation of people with disabilities living in old-age institutions and the prevention of institutionalization of persons with disabilities from the community”, approved by the Government Decision no. 798/2016.¹⁵⁷ The goal of the Programme of National Interest is to develop social services that will lead to the full participation of people with disabilities in society. Investments mainly address the replacement of social care institutions of more than 120 places with smaller scale services. As result:

- 300 adults with disabilities will move out of institutions,
- 75 new protected houses,
- 76 new day centres,
- 8 new respite/crisis centres will be established.

The programme is not aimed at people with mental health problems specifically.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe’s website (<http://www.mhe-sme.org/>).

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

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Romanian League for Mental Health | Website: www.lrsm.ro | Email: lrsmoffice@gmail.com

¹⁵⁶ National Strategy for People with Disabilities, Available: <http://anpd.gov.ro/web/wp-content/uploads/2016/09/MO-nr-737Bis-din-22-septembrie-2016.pdf>

¹⁵⁷ Programme of National Interest. Available: <http://anpd.gov.ro/web/despre-noi/programe-si-strategii/programe-de-interes-national/>



SERBIA

COUNTRY INFORMATION

- **Population:** 7,040,000 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Serbia, support for people living with mental health problems in the community is available through mental health outpatient services within general, primary medical care centres. Other forms of support such as personal assistance schemes or supported living arrangements are mostly unavailable for people with mental health problems. Although the Serbian government has committed to deinstitutionalisation several times since 2007 and European Union funding was available after 2011, the sustainability of pilot programs launched and services established is uncertain because of lack of funding.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In Serbia, inpatient psychiatric care is often given in long-term psychiatric hospital units. Data were not available on the number of psychiatric beds in general hospitals or acute beds in psychiatric units. Social care institutions or nursing homes are also widespread in Serbia, with over fifteen thousand residents, including children and older people.

	Total number of units	Total number of beds	Total number of patients	Average length of stay	Sectoral distribution	Client group
Long-term beds in general hospitals	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Long-term beds in specialist hospitals	5	3,000	n.a.	n.a.	Public	Adults with mental health problems
Social care institutions/nursing homes	n.a.	n.a.	15,530	Many years ¹⁵⁸	Public and private	Children, adults and elderly

Source of data: Institute of Social Policy, Ministry of Health, 2016

Community-based residential support

In Serbia, residential support for people with mental health problems is difficult to access because services are scarce and even the existing examples are only being piloted. Data collection about such services is being hindered by the lack of a public register for relevant public services. New types of services such as supported living arrangements are run mostly by non-profit organisations.

¹⁵⁸ According to MDRI-Serbia, 71% of users in the institution have spent more than 6 years, half has spent more than 10 years, almost a quarter has spent 20 years in the institution.



Type of community-based service	Total number of units	Total number of beds/places	Total number of users (per year)	Length of stay	Sectoral distribution	Brief description
Community-based residential arrangement: group homes	0					
Supported living facilities	few	n.a.	n.a.	n.a.	Public and non-profit	Supported living facilities are being piloted
Respite homes	n.a.	n.a.	n.a.	n.a.	Non-profit	Mostly for people with intellectual disabilities or multiple disabilities
Soteria houses	0					

Other community-based mental health support

Mental health support in the community in Serbia is mostly reliant on outpatient services that can be found across the country. Day services are also available in some regions, but they provide services mostly for people with intellectual disabilities. Recent efforts to support organisations of users/ex-users/survivors of psychiatry have resulted in the establishment or further development of 12 organisations representing groups of people with mental health problems.¹⁵⁹

Type of community-based service	Total number of units	Total number of patients/users	Sectoral distribution	Main client groups
Mental health centres (outpatient)	73	n.a.	public	People with mental health problems
Mobile units or community mental health teams	n.a. ¹⁶⁰			
Day treatment facilities	14	n.a.		Mostly for young people with intellectual disabilities.
Peer support/peer support networks	1	n.a.		
User/Survivor organizations	12	Over 100		
Club Houses (including cultural support networks)	n.a.			

Source of data: WHO Mental Health Atlas, 2014; Mental Disability Rights Serbia.

Involuntary placement and involuntary treatment

In Serbia, the conditions and procedure are defined by the Law on the Protection of Persons with Mental Disabilities, Article 21 (Reasons for detaining without consent and accommodation without the consent of person with mental disorders). A person with mental health problems can be placed in a psychiatric institution without their consent if a doctor or psychiatrist estimates that, due to mental health conditions, the person seriously and directly endangers their own life / safety, or the life and safety of another person. According to the law, the involuntary placement shall only happen if it is impossible to provide adequate healthcare through less restrictive ways.

Community Treatment Orders also exist in Serbia.

In specialist psychiatric hospitals, three percent of all admissions are involuntary.¹⁶¹

¹⁵⁹ This network exists and functions under the name “NaUm” since 2015, and is funded by the EU and implemented by Caritas. Its members are providing community-based services free of charge. Some of these services are in form of group therapies, self-help groups, psychological consultations, various educational workshops, recreational activities etc. Their work aims to promote prevention, anti-discrimination, awareness raising, social inclusion and general improvement of lives of persons with mental health issues through improvement of state policies and laws in the field of social affairs, health protection, education and employment. Website: <https://mrezanaum.org>

¹⁶⁰ Some pilot mobile units have been established under EU-funded projects but they face uncertain future once EU-funding ceases.

¹⁶¹ http://www.who.int/mental_health/evidence/atlas/profiles-2014/srb.pdf



Legal capacity and guardianship

Serbian provisions about legal capacity and guardianship can be found in the Constitution of the Republic of Serbia (“Official Gazette of RS”, no. 98/2006) and Family Law (“Official Gazette of RS”, no. 18/2005, 72/2011) and in the Non-Contentious Proceedings Act (“Official Gazette of SRS”, no. 25/82 and 48/88 and “Official Gazette of RS”, no. 46/95) while the procedure for appointing guardians is regulated by the Law on Administrative Procedure (“Official Gazette of SRJ”, no. 33/97 and 31/2001 and “Official Gazette of RS”, no. 30/2010).

People can be deprived of their legal capacity if they are, ‘as a result of illness or difficulties in psychological or physical development, incapable of normal reasoning and therefore unable to care independently for his or her own rights and interests’ (Article 64, paragraph 1 and Article 146 para. 1 and 2 of the Family Law). Legal capacity of people under full guardianship is equivalent to the legal capacity of a younger minor (child below the age of 14).

Partial guardianship may be in place if a person, as a result of illness or difficulties in psychological or physical development, threatens their own rights and interests or the rights and interests of others (Article 147, paragraph 1-3 of the Family Law). Partial legal capacity is equivalent to that of an older minor (child between the age of 14 and 18). Court decision on partial deprivation of legal capacity can determine the legal actions that the person who is partially deprived of legal capacity can or cannot independently undertake.

Recent changes (May 2014) of the Law on Non-Contentious Proceedings brought some changes in the procedure for deprivation and reinstatement of legal capacity, especially in the mandatory periodic review of the court’s decision of deprivation of legal capacity.

In 2016, there were 13,030 people under guardianship (93% under full and seven per cent under partial guardianship¹⁶²).

Other information

The Serbia Government adopted the Strategy and Action Plan for Mental Health Protection Development in 2007. The Strategy and its Action Plan set out to establish services in the community for people with mental health problems and to decrease the number of beds in big psychiatric hospitals. It was reported that although the Strategy was adopted, no appropriate by-laws were developed and funding was also lacking for the implementation.¹⁶³

However, relevant funding for deinstitutionalisation was received through European Union neighbourhood policies in 2011 which was followed by subsequent projects managed by authorities and implemented by social care institutions. For example, the EU-funded ‘Open Arms’ project distributed more than EUR 2.3 million on 19 projects financed through grants (50,000 to 200,000€). As a result, more than 150 people with ‘mental disabilities’ moved out from residential institutions, more than 200 were prepared to leave the institution, and more than 900 people in the community benefited from services launched outside institutions. However this initiative was contained to institutions which were part of the program and there was no positive spill-over effects to other residential institutions in Serbia.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe’s website (<http://www.mhe-sme.org/>).

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

KRUGOVI | Website: www.krugovi.org | Email: www.krugovi.org/kontakt/

¹⁶² Source of data: The Report on the Work of Centres for social work for 2016, the Republic Institute for Social Protection.

¹⁶³ <http://www.zavodsz.gov.rs/english/PDF/save/ECV%20experts%20%20report.pdf>



SLOVAK REPUBLIC

COUNTRY INFORMATION

- **Population:** 5,435,343 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In the Slovak Republic, psychiatric hospitals and social care institutions are still common. Community-based supports are scarce, and only a small number of people can access supported living arrangements or other forms of community-based residential support. Recent changes in guardianship reforms mean less restriction in legal capacity for people with mental health problems. Generally, the availability of information and data on mental health in the Slovak Republic is limited.

DETAILED INFORMATION

Institutions and psychiatric hospitals

Inpatient care for people with mental health problems is provided in psychiatric hospitals and psychiatric units in general hospitals. There is no information on the proportion of patients who are hospitalised long-term. In 2015 the average length of stay was 26 days (Health Statistics 2015, National Centre for Health information).

Social care institutions are the main form of residential support for people with disabilities, including those with long-term mental health conditions. According to some sources the number of adults with disabilities in institutions can be as high as 30 thousand (Policy Department on Citizens' Rights and Constitutional Affairs 2016).¹⁶⁴ The number/proportion of people with mental health problems living in social care institutions is not known.

	Total number of units (e.g. hospitals, institutions)	Total number of places/beds	Sectoral distribution
Psychiatric units in general hospitals	n.a.	2,062	public
Psychiatric hospitals	9	1,674	public
Social care institutions	267	13,469	public

Source: WHO Mental Health Atlas, Slovak Republic country profile 2011¹⁶⁵

Community-based residential support

There is no official database of community-based accommodation services for people with mental health problems or psychosocial disabilities in the Slovak Republic. Most of the services are provided in general social care homes and the availability

¹⁶⁴ Available: [http://www.europarl.europa.eu/RegData/etudes/IDAN/2016/571371/IPOL_IDA\(2016\)571371_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/IDAN/2016/571371/IPOL_IDA(2016)571371_EN.pdf)

¹⁶⁵ Available: http://www.who.int/mental_health/evidence/atlas/profiles/svk_mh_profile.pdf?ua=1



of supported accommodation services in the community is extremely limited. The country is currently implementing deinstitutionalisation in social care (see below).

Although personal assistance services are available in the Slovak Republic, this is very scarcely used by people with long-term mental health problems or psychosocial disabilities.

Other community-based mental health support

In the Slovak Republic the main form of non-hospital mental health care are outpatient mental health centres. There are no mobile or community mental health teams. Day services provide for mixed groups and a range of ages (including older people without disabilities). The number of people with mental health problems using day centres is not known.

There are some support networks for people with mental health problems; however information about these is limited.

Type of community-based service	Total number of units	Total number of patients/users (per year)
Mental health centres outpatient)	351	29,267 visits per 100 thousand inhabitants
Mobile units or community mental health teams	-	-
Day services	522	n.a.
Peer support/peer support networks	Up to 20	

Source: Health Statistics 2015, National Centre for Health information

Involuntary placement

Two criteria, the risk of harm and the need for treatment are listed alongside having a mental health problem for involuntary placement. Act no. 576/2004 Col. on Health Care stipulates in §6, Art. 9 that informed consent “is not necessary for outpatient or inpatient care in case of a person that due to her/his mental health condition or symptoms of a mental health condition is a threat to her/himself or their surroundings, or his/her health status might deteriorate significantly [in the absence of care]”. Any physician can prepare the evaluation for the involuntary placement and the law does not explicitly require the physician or have any specific expertise in psychiatry. The law does not refer to the person’s opinion in the course of an involuntary measure.¹⁶⁶

Involuntary placement is taken as an authorisation for forced treatment.

Information about the number/proportion of involuntary placements and forced treatment is not publically available.

Seclusion and restraint

The use of seclusion and restraint is recorded at facility level, no general statistics are available.

Guardianship

Although the guardianship system in the Slovak Republic still supports substitute decision-making, Act no. 161/2015 Col. (Civil extra-dispute law) no longer allows full legal incapacitation.

Other information - deinstitutionalisation

¹⁶⁶ http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf



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Deinstitutionalisation is an official policy of the Slovak government. In mental health, a National Program on Mental Health was adopted in 2002, which has not been implemented. There is also strategic document entitled Reform of psychiatric care in the Slovak Republic from 1991, with a detailed plan for deinstitutionalisation; however this has not been implemented either.

The country is currently implementing deinstitutionalisation in social care supported by funding from the EU structural funds. In the period between 2016 and 2020 approximately 230 million euros are allocated to support deinstitutionalisation and investment in community-based services. This policy has come under criticism due to its slow progress (Policy Department on Citizens' Rights and Constitutional Affairs 2016). Institutions for people with mental health problems have been largely left out of these initiatives.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

Open the Doors, Open your Hearts (ODOS) | Website: <http://www.odos-sk.com/> | Email: odosba@stonline.sk

Slovak League for Mental Health | Website: www.dusevnezdravie.sk | Email: dusevnezdravie@dusevnezdravie.sk



SLOVENIA

COUNTRY INFORMATION

- **Population** 2,065,895 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Slovenia has a mixed system of mental health and social care, where community-based services exist alongside institutional care. The country allows plenary guardianship. There are legal and procedural safeguards around the use of involuntary placement and forced treatment; however there is limited information about their implementation. Slovenia is implementing deinstitutionalisation policies in social care using the structural funds of the European Union.

DETAILED INFORMATION

Institutions and psychiatric hospitals

The majority of psychiatric inpatient services are located in psychiatric hospitals in Slovenia. The average length of stay is estimated at around six weeks and there is no information on the proportion of long-stay patients in hospitals.

Slovenia provides long-term residential care for people with mental health problems in social care institutions, where people with mental health problems often live together with other groups such as older people and people with intellectual disabilities. The number of people with mental health problems in social care institutions is not known.

At the beginning of 2015, there were 20,224 beds in 98 residential homes, out of which five were dedicated to adults with disabilities, the rest were primarily for older people and included some private homes as well.

	Total units	Total beds	Sectoral distribution
Psychiatric hospitals*	5	1,185	Public
Psychiatric units in general hospitals**	5	600-800	Public
Special care institutions for adults***	5	1,552	public

Source:

*NIJZ (national institute for public health), Ministry of Health databases, 2016/17

**estimate based on 2009 data, no accurate data available

***Skupnost socialnih zavodov (Association of Social Institutions of Slovenia)

Community-based mental health services and residential support

There is a network of psychiatric clinics, accessible to people with mental health problems in Slovenia. People either can refer themselves directly to these clinics, or they are referred by family doctors (for most conditions family doctors act as gatekeepers but in the area of mental health self-referral to secondary care is possible). According to the Mental Health Atlas country profile there are 111 outpatient and 22 day treatment facilities in Slovenia (WHO 2014).¹⁶⁷ Many of the mental

¹⁶⁷ Available: http://www.who.int/mental_health/evidence/atlas/profiles-2014/svn.pdf?ua=1



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health outpatient clinics are small outpatient clinics staffed by a single psychiatrist supported by a nurse. Outpatient facilities are run privately but the majority of them are funded publically, by the Health Insurance fund. These clinics are independent of hospitals but can refer patients if necessary.

Other services in the community are provided by hospitals, the social care sector and voluntary agencies, all with a slightly varying focus.

A range of community centres is provided by several sectors. Hospitals run day hospitals in their buildings for people with severe mental health problems. Some hospitals also organise basic community services, for example have visiting nurses, although this is mostly to administer depot medication.

There are also generic community nurses employed by primary care centres that provide basic home care for patients with various long-term conditions, and family doctors can also do home visits; however these are not specifically aimed at people with mental health problems.

Social services provide social care coordinators in social work centres for people with complex needs, according to the mental health law. There are 31 such coordinators in Slovenia.

The voluntary sector (NGOs) provides day centres and sheltered housing for people with long-term mental health problems. For example ŠENT runs 2 day centres for 50-70 people with mental health problems and five / six apartments in the capital Ljubljana. NGOs also offer group homes and social workplaces.

There is no information on the availability of personal budgets for people with mental health problems in Slovenia.

Involuntary placement and involuntary treatment

Forced placement is covered by several articles in the Mental Health Act (Zakon o duševnem zdravju (Uradni list RS, št. 77/08 in 46/15 – odl. US)). This sets out the procedures and provides legal safeguards for the application of involuntary placement and forced treatment.

Involuntary placement of an individual without their consent should be a last resort and it is only allowed when the following conditions are met:

- there is a serious risk of harm to own life or the lives of others, if an individual is endangering their health or the health of others, or if an individual is causing significant material damage,
- and the behaviour outlined above is caused by mental ill-health, which impairs an individual's capacity for sound judgement and the capacity to control their behaviour.

Admission to forced treatment takes place:

- by court order, issued based on a recommendation for admittance to forced treatment;
- in emergencies, before a court order is issued, if all the required conditions are met.

Forced treatment is regulated by both the Mental Health Act and the Patient Rights Act (Zakon o duševnem zdravju (Uradni list RS, št. 77/08 in 46/15 – odl. US)).

As a general rule, forced treatment should be a last resort and authorised by the patient's legal representative with their best interests in mind. The legal representative's decision can be challenged by the psychiatrist. In the absence of a legal representative, emergency consent to forced treatment can be given by the patient's family. However, the law stipulates that "the legal representative and other persons referred to in the fourth paragraph of this Article cannot refuse urgent medical assistance to a patient with mental health problems".

Community treatment orders (CTOs) exist in Slovenia. The Mental Health Act uses the term "supervised treatment" for CTO. Supervised treatment is permissible if all of the following conditions are met:



- If the individual has a severe and chronic mental health conditions,
- If they were previously subjected to involuntary hospitalisation in connection with their mental health condition (see above criteria),
- If the individual can be adequately treated in their home environment.

Seclusion and restraint

The use of seclusion and restraint must be supervised and recorded. There is no publically available information on their use, however the CPT has raised concerns regarding the use of restraint during their periodic visit in 2012 (CPT, 2012).¹⁶⁸

Legal capacity and guardianship

The Act on Administrative Procedure (APC) sets out the rules concerning legal capacity, guardianship, and supported decision-making. In 2012 there were 6,433 people under guardianship. It is possible to regain legal capacity; however there is little information about this.

Other information

Slovenia has a deinstitutionalisation policy in social care and is in the process of replacing residential institutions with smaller scale housing and community-based services. The programme is partly financed by the EU's structural funds.

Please see [the acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

SENT, Slovenian Association for Mental Health | Website: www.sent.si | Email: info@sent.si

¹⁶⁸ <https://rm.coe.int/1680697db3>



SPAIN

COUNTRY INFORMATION

- **Population:** 46,528,966 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

In Spain each region (17 autonomous communities) has control over their own resources and has devolved competences in the health and social sectors. Thus, each region has developed a different community and hospital network, with different names, run by different public or private organisations, controlled sometimes by the health sector, sometimes by the social care sector, sometimes by a mixture of both. The Minister for Health from the National Government has the duty to collect general data and coordinate strategies, but due to the economic crisis, lack of resources, lack of political interest, and conflicts between regions and the National Government, there have been no comprehensive national data collected nor a renewed mental health strategy. Every region collect their own data; however not all of these are published, so it is difficult to get a general overview of trends. The AEN Observatory used to monitor inequalities and resources for community development, but this has also stopped due to the lack of resources.

In general there has been a trend towards developing policies to reinforce community services, promoting more supported and independent living, supported employment, and more human rights oriented services. But due to economic crisis, in most regions there has been a decline or stagnation of available resources. There have been no legal developments in involuntary placement, forced treatment, and guardianship, however the growing influence of user/survivor groups have the potential to bring about change in the future.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In the majority of regions acute care is provided in Psychiatric Units in General Hospitals. In many regions these units are named mental health hospital units (not psychiatric), trying to keep a continuity of care and model with de community mental health units that form the basis of the community care model in Spain. There are no long-term psychiatric beds in general hospitals.

Although recent data are not available, the average length of stay in acute beds varies between 14 to 21 days. There is no data on the proportion of long-stay patients, but it is uncommon because those who need long-term care tend to be moved to long-term places in a different type of setting. In the Spanish model of care, inpatients do not remain long in general hospitals.

The availability of psychiatric beds in general hospitals have decline slightly over the recent years, in line with the general decline in the number of inpatient beds.

There are some psychiatric hospitals in a few regions; some of these are public but most of them are private or run by religious societies, with the public sector purchasing beds. The availability of beds varies considerably between regions.

There is no general data about the availability of nursing or care homes, because there is great variability across regions (in terms of sector, size, type of services etc.). The general model in most regions is the development of a continuum of support with the view on independent living.



There are data showing an increase of residential beds in nursing homes in some regions in the private sector, with different forms of public financial support.

Community-based residential support

There are no sanctuaries, respite homes or Soteria houses. Some user organisations are trying to create these (e.g. in Sevilla there is the beginning of a club house with the function of a sanctuary and respite).

Staffed houses, group homes, hostels, and supported living are run by different organisations and controlled by different ministries depending on the region. These community based services (especially supported living) have seen the greatest increase over the last few years. Most of networks provide a graduated level of support

There are no personal budgets schemes in Spain. The General Law Promoting Autonomy is rarely applied to mental health needs, sometimes because a budget is given to the carer rather than to the person in need directly.

Other community-based mental health support

There have been no changes in the model of community based mental health care in Spain since the previous Mapping Exclusion report. Some regions have intensive community support teams or assertive community treatments teams that provide domiciliary or community services. There are also day hospitals, and psychosocial and vocational rehabilitation centres in most regions.

A relatively recent development has been the growth of user organizations. Andalucía, Madrid, Catalonia, Navarra, Galicia, and other regions have user organisations with an increasing influence in mental health care and the lives of people with mental health problems. Mutual support / peer support groups (Grupos de apoyo mutuo) is the model developed most extensively. Some of them are becoming hearing voices groups but this is still in its early stages. The World Congress of Hearing Voices Network in Madrid in 2015 gave an important impetus to these groups.

There is huge variation in the development of cultural support networks. They exist in big urban areas (especially Barcelona) and some other regions where mental health policies support these networks.

Involuntary placement and forced treatment

There has been no change in the regulation of involuntary placement and forced treatment since the previous Mapping Exclusion report. In Spain, the need for therapeutic treatment of the person, combined with a mental health problem, could justify involuntary placement. Legislation does not list the criteria of presenting a danger to oneself or others as a condition for involuntary placement. According to Article 763 (1) of the Spanish Civil Procedure Act, 155 (Ley 1/2000, de 7 de Enero, de Enjuiciamiento Civil) the main criterion to be fulfilled in order to subject a person to involuntary treatment is the mental health problem of the person concerned. Article 763 builds upon a clinical criterion. This means that any clinical circumstance that strongly requires the provision of treatment under hospital conditions would be sufficient to order an involuntary placement.

Compulsory community treatment does not exist in Spain.

Seclusion and restraint

Every Region or Health Area has a protocol for the use of restraint but not for seclusion. The use of restraint is recorded, but the data is not available publically. The use of seclusion and restraint varies greatly even within the same region. For example some data from Andalucía in 2009 showed that the number of restraint incidents – adjusted by the number of beds – ranged from 3.25 to 33.08 between acute units. This led to a strategy to reduce the use of restraint and record every incident, which is clearly changing practices but new data are not available.

Overall, there is a general decreasing trend in the use of coercive treatment, as user movements are more present and there is an influence of CRPD and good practice. However, some user associations highlight that the economic crisis with budget cuts has halted this trend in some regions. User and Family Associations are fighting to reduce coercion in psychiatry (the “0 restraint” campaign in several regions, the adoption of legislation in Navarra to reduce coercion and discussions in this

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directions in other regional parliaments like Valencia are promising developments) and there seems to be openness from the mental health system. Users', carers' and professional associations produced a manifesto (Manifiesto de Cartagena) against coercive practices in 2016, which has since been endorsed by regional autonomic parliaments.¹⁶⁹

Legal capacity and guardianship

There are no changes since the previous Mapping Exclusion report. Spain has a guardianship system based on the deprivation of legal capacity. The CRPD Committee has called on the Spanish Government to align legal capacity legislation with the CRPD; however the Spanish Government rejected this.

Although every citizen has a right to legal aid in the Spanish system, it is not commonly used in relation to involuntary placement, although it is available during the process of incapacitation.

Personal ombudsman and supported decision-making schemes are not available in Spain, although some regions are running some pilots. Advance directives and accorded crisis plans have been introduced in some regions (for example in Extremadura Region by the Fundación para la promoción y apoyo a las personas con discapacidad de Extremadura Futuex).

Other information

Spain currently does not have an updated mental health strategy for the national health system, although most regions have their own mental health plans that support social inclusion, development of supported and independent living, supports for employment, sometimes human rights.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the acknowledgments section at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATIONS

Asociacion Espanola de Neuropsiquiatria (AEN) | Website: www.aen.es | Email: aen@aen.es

Confederacion Salud Mental Espana | Website: www.consaludmental.org | Email: confederacion@consaludmental.org

Fundacion Intras | Website: www.intras.es | Email: projd@intras.es

Fundacion Mundo Bipolar | Website: www.ibpf.org/resource/fundacion-mundo-bipolar | Email: www.ibpf.org/contact

Asociacion Nacional de Enfermeria en Salud Mental | Website: www.aeesme.org | Email: aeesme.aeesme@gmail.com

Andalusian School of Public Health (EASP) | Website: www.easp.es | Email: comunicacion.easp@juntadeandalucia.es



SWEDEN

COUNTRY INFORMATION

- **Population:** 9,995,153 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Sweden adopted a mental health reform in 1995 and closed most of the long-stay hospitals and institutions for people with mental health problems by the end of the 1990s. What remains now is a limited number of hospital beds in psychiatric wards – both open wards and confined wards for involuntary placement and forensic psychiatric care. Full legal incapacitation no longer exists in Sweden, although the country has two types of guardianship for adults that provide different levels of restrictions.

DETAILED INFORMATION

Institutions and psychiatric hospitals

Sweden no longer has mental health institutions or long-stay psychiatric hospitals. Inpatient care is provided in psychiatric units in general hospitals (1,436 units¹⁷⁰). Eighty-two per cent of patients stay less than one year, 16% between one and five years and 2% for more than five years. There are places for forensic psychiatric care (1,600 persons approximately every year treated¹⁷¹) and specialist places for the psychiatric treatment of children (257 children treated involuntarily in 2016)¹⁷². Residential support – mainly group homes – are provided by municipalities for children and adults with mental health problems. However, there is no aggregated data at the national level.

Personal budgets

There is no system of personal budgets for people with mental health problems in Sweden.

Involuntary placement

In Sweden new rules on forced treatment, including forced treatment in the community, were introduced in September 2008.¹⁷³ The involuntary treatment order must be based on a treatment certificate issued by a physician other than the one deciding to admit the patient. The judgment as to whether the treatment certificate will be issued is the first step in the assessment by two physicians regarding the need for compulsory care. The decision regarding admission is taken by the chief physician/psychiatrist at the facility where the individual will be treated. Furthermore, the administrative court reviews all compulsory admissions, and always has an independent specialist in psychiatry, who assesses the patient. Two criteria – the risk of harm and the need for treatment – are listed alongside having a mental health problem.

Approximately 12,000 persons are treated involuntarily every year.¹⁷⁴ The number of involuntary commitments was recorded for the first time in 2010: that year 22% of the 52,000 patients were treated under involuntary commitment (Lindelius, 2012).

¹⁷⁰ http://www.who.int/mental_health/evidence/atlas/profiles-2014/swe.pdf?ua=1

¹⁷¹ <http://www.socialstyrelsen.se/publikationer2015/2015-12-19>

¹⁷² <http://www.socialstyrelsen.se/statistik/statistikdatabas/psykiatrisktvangsvard>

¹⁷³ [http://www.socialstyrelsen.se/regelverk/tvangsvard/oppentvangsvard\(nyavardformen\)](http://www.socialstyrelsen.se/regelverk/tvangsvard/oppentvangsvard(nyavardformen))

¹⁷⁴ <http://www.socialstyrelsen.se/statistik/statistikefteramne/psykiatrisktvangsvard>



Guardianship

As of January 1, 1989, one can no longer declare an adult as incapable, as the concept was abolished in Swedish law. However, there are two types of guardianship for adults.

If someone, due to illness, mental health problems, a weak state of health or similar circumstances, needs help to manage his/her affairs a mentor or god man (good man) can be appointed by the court. This cannot be done without the consent of the individual unless the person's condition is a "hindrance to consent". Having a mentor does not deprive the individual of their legal capacity, unless they are considered "unable" to give consent (to be determined on a case by case basis).

A trustee or förvaltare can be appointed when an individual is perceived as not being able to care for him/herself or his/her property due to the same reasons that a curator is appointed. The listed reasons are illness, mental health problems, weak state of health, or similar circumstances. The appointment of a trustee does not require the consent of the person perceived to be in need of assistance in managing his/her affairs

The trustee has exclusive power to represent the person in all matters that are covered by the appointment and the person concerned cannot, without permission from the trustee, enter into legally binding acts albeit she/he as a principle rule maintains the right to dispose of salary in case she/he are employed. Having a trustee does not affect the person's right to vote or to marry.

There are approximately 58,000 persons in Sweden having a "god man", and 10,500 persons having a trustee appointed.

A promising system exists in Sweden in relation to supported decision-making, called the 'Personal Ombudsman' (PO). POs have no medical responsibility, nor do they make any decisions in the capacity of an authority; they work only to represent the individuals they assist. The scheme is profitable in socioeconomic terms as individuals with PO support require less care and their psychosocial situation improves. As a result, the National Board of Health and Welfare (Socialstyrelsen) began to promote the PO as a new social profession. In 2013 a new regulation entered into force that established permanent funding for the PO system.

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

Please see the acknowledgments section of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

MHE MEMBER ORGANISATION

Mind Sweden | Website: www.mind.se | Email: info@mind.se

175 Swedish law "Föräldrabalken", Article 11:4

176 Swedish law "Föräldrabalken", Article 11:7

177 http://www.international-guardianship.com/pdf/GBC/GBC_Sweden.pdf

178 <https://overformyndarstatistik.lansstyrelsen.se/Statistik>



TURKEY

COUNTRY INFORMATION

- **Population:** 79,814,871 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Mental health services in Turkey are mainly provided in hospital and community-based outpatient settings. Services are over-crowded and work in a very strict medical way mainly using medication. The regulation of mental health is outdated; there is little awareness of human rights among people with mental health problems, professionals, and families.

Involuntary placement and forced treatment are particular issues, although there is little official data available. Turkey still practices the full deprivation of legal capacity and has a guardianship regime.

DETAILED INFORMATION

Institutions and psychiatric hospitals

In 2014 there were nine state and two private psychiatric hospitals in Turkey. In the same year the number of patients admitted to state hospitals was 63,282 (approximately 83 per 100,000 population). The average length of stay varied from 18 to 25 days and according to the MHA (2011) 25% of persons in psychiatric hospitals stayed one year or longer (12% stayed more than five years). There were similar inpatient capacities in general psychiatric hospitals (WHO MHA 2011) although the availability of up-to-date information is limited.

There were 11,923 people in private care homes, and 6,670 in state care homes (Ministry of Family and Social Policies, 2015). It is estimated that approximately half of these people have psychosocial disabilities.

	Total units	Total beds	Sectoral distribution
Psychiatric hospitals*	11	4,231	Mainly public
Psychiatric units in general hospitals	n.a.	4,208	Mainly public
Residential care facilities (nursing homes)**	254	n.a.	Mixed: 93 state, 161 private

*Ministry of Health, 2015;¹⁷⁹ Rusihak (2015) Human Rights in Mental Health 2013

**WHO Mental Health Atlas, Turkey country profile, 2011¹⁸⁰

***Ministry of Family and Social Policies, 2015¹⁸¹

The number of the general hospitals and total beds were 884 and 125,030 respectively in 2015.¹⁸² Neurological beds are included in these figures.

179 Available: www.sagem.gov.tr/dosyalar/SIY_2015.pdf

180 Available: http://www.who.int/mental_health/evidence/atlas/profiles/tur_mh_profile.pdf?ua=1

181 Available: http://sgb.aile.gov.tr/data/5434f307369dc31d48e42dc5/2016_Faaliyet_Raporu.pdf

182 Reference: <http://rapor.saglik.gov.tr/istatistik/rapor/index.php>



Community-based residential support

In Turkey the majority of adults with mental health problems live with their families. The availability of community-based residential support is limited. In 2016 there were 128 “hope homes” in Turkey, approximately half of these providing services for people with mental health problems.¹⁸³ The size of these homes varies between four and six. There is anecdotal evidence – from service users – that some of these homes are quite institutional in nature, all aspects of life are controlled by the service.

The 2011 Mental Health Action Plan of the government claimed that supported living would be introduced and personal communication with civil servants suggests that this has started in five cities; however, there is no further information on this.¹⁸⁴

Other community-based mental health support

Community-based mental health support primarily consists of outpatient/community mental health centres in Turkey. In 2017 there were 149 mental health centres with 32,307 active users (Ministry of Health data). There are also a few mobile teams under community mental health services. In fact the provision of mobile services is one of their duties. However, there is no data on this.

These centres are defined according to their status related to hospitals: the Instruction on Community Mental Health Centres (TRSM) dated 2014 states that “the purview of this instruction is “the community mental health centres opened to operate within the inpatient health services under Turkish Public Hospitals Institution and the personnel assigned to these centres”.¹⁸⁵ The instruction uses the term “patient” and does not mention the active participation of the user and their carers (family members or advocates), or peer support. It only mentions psychosocial prevention (without any definition), trainings and collaboration with other public institutions in relation to community based mental health services. Some articles are related to medical treatment and transferring the patient to hospital admission.

WHO Mental Health Gap Action Programme (mhGAP) for primary care professionals started in Turkey in 2017 in collaboration with the Ministry of Health¹⁸⁶. A group of trainers including psychiatrists, psychologists, counsellors, social workers train primary care health professionals.

Between February-June 2017, 375 Turkish general practitioners and 150 Syrian doctors from 17 cities in which traumatic incidences are high, participated in a three-day training session with supervision support. The Ministry of Health plans to expand this training to all cities (Ministry of Health information). The stated aim of this programme is to promote psychosocial interventions and reduce unnecessary medication.¹⁸⁷

In Turkey peer support groups are more common for people with substance misuse issues (e.g. AA and NA). Some of the associations for schizophrenia – there are almost 30 of these in the country – claim that they provide peer support. Most of these associations are directed by family members. And sometimes voluntary psychiatrists, nurses or psychologists make psychoeducation groups. These associations also provide cultural and occupational opportunities. These cultural and occupational opportunities are also provided by community mental health centres and by some psychiatric hospitals.

Although there are disability-related allowances (e.g. disability benefit, carer’s allowance etc.), personal assistance and personal budget system is not available in Turkey. Family members are mainly paid as care providers of “severe” disabilities (80% or more severity has to be approved by hospitals) and the disabled person must be under guardianship. And it is suspected and voiced by some service providers and NGO members working in this area, that the guardians are usually using the incoming money for daily survival needs of themselves and rarely for the wellbeing of the patients.

183 Reference: http://sgb.aile.gov.tr/data/5434f307369dc31d48e42dc5/2016_Faaliyet_Raporu.pdf

184 Available here: <https://www.mindbank.info/collection/country/turkey> (in Turkish)

185 Available here: <https://www.tkhk.gov.tr/Dosyalar/51171887f3bc4ff9ae56b7d8b4eebd99.pdf> (in Turkish)

186 http://www.who.int/mental_health/mhgap/en/

187 Personal communication with an mhGAP trainer.



Involuntary placement and involuntary treatment

There is no mental health law in Turkey although there is legislation dealing with forced placement and treatment, even though Turkey ratified UN CRPD in 2008 and also its optional protocol in 2014. According to official criteria and procedures, involuntary placement and forced treatment must be used as the last resort. There is very little official data available; however a monitoring report by rusihak (advocacy association) in 2013¹⁸⁸ found:

- Involuntary hospitalisation happens by obtaining the signature of the person who brings the psychiatry user to the hospital/institution.
- In cases where the person accompanying the psychiatry user does not want to sign the admission papers or in cases when the person's identity is unknown, hospitalisation takes place with the approval of two doctors. In practice, most of the time the hospitalisation occurs with one doctor's signature, and the second doctor's approval later on.
- The people who bring the psychiatry user for involuntary hospitalisation are mostly family members or relatives, attendants (attendants of Care and Rehabilitation Centres, Reformatories and Shelter Homes affiliated with the Ministry of Family and Social Policies), or friends, neighbours and village headmen.
- Judicial Review of Involuntary Hospitalisation: Psychiatry users are never informed about their rights of objection, and an appeal mechanism is also not available.
- Judicial reviews of involuntary hospitalisation are reported to Civil Courts of Peace by the hospital administrations within 48 hours or up to seven days. Court approval takes 10 days at the earliest, but in practice it often comes several months after involuntary admission. There were no cases when the court refused the involuntary hospitalisation appeal. Court appeals and reviews are largely treated as a paperwork exercise.

Although there is no official data on the rate of involuntary hospitalisation and forced treatment, the rusihak report suggests that it can be between 70% and 85% (includes forensic psychiatry units) (ibid.). The same report also highlighted that mental health staff in hospitals usually regarded involuntary placement as “the approval of forced treatment” and written permission and records were only obtained for electroconvulsive therapy.

Seclusion and restraint

Seclusion, prolonged physical restraint, and chemical restraint are common practice, although no statistical information is available.

Legal capacity and guardianship¹⁸⁹

Article 405: Adult Guardianship Turkish Civil Code states that legal capacity restriction must be applied and a guardian must be appointed for any adult who is not able to adhere to his or her obligations as a rights holder. Any adult who is not able to fulfil his/her tasks due to mental illness or mental weakness or requires permanent assistance in care and protection, or puts other people's safety at risk is restricted. Restriction may be applied not only against the concerned person's will, but also upon his/her request.

Article 408: The person may request restriction, if he/she proves that he/she is not capable of duly fulfilling his/her tasks due to old age, disability, inexperience or serious disease.

Article 409: Any decision to restrict legal capacity due to “mental illness” or “mental weakness” (either against the person's will or upon his/her request) must be based on official medical board report. Before taking any decision, the judge may hear the person subject to restriction by considering the board report.

Article 474: Guardianship orders can be removed only when an official medical board reports that the reason for the restriction, such as mental illness, no longer exists.

The number of people under guardianship is not known. An information request to the Directorate General by rusihak was turned down claiming that guardianship status is personal data and thus cannot be shared.

188 http://www.rusihak.org/download/yayinlar/rusihak_2013_turkiye_raporu.pdf

189 Source: Person – Country report on legal capacity in Turkey 2016. Available: http://www.eu-person.com/publication/person-country-report-turkey/wppa_open/



Other information

Three further issues can be highlighted in relation to mental health care in Turkey:

- Shortage of professionals and lack of availability of services
- Attitudes to mental health
- The refugee crisis

Shortage of professionals and lack of availability of services

Turkey has a large and growing population. There are lots of mental health issues in the population, but services are over-crowded and work in a very strict medical way mainly using medication and hospitalisation. The expansion of private health care providers “has resulted in “more social stratification in the consumption of health services because higher income patients are abandoning public services for private services that are often better in quality” (UNDP 2016; p. 69).¹⁹⁰

Number of psychiatrists and the number of beds is very low in comparison to other European countries (1,831 psychiatrists and 7,356 psychiatric beds for a total population of 73,722,988 people in 2011, National Mental Health Action Plan).

Numbers of other professionals working in mental health are mentioned in the same plan, and they are reported as 613 social workers and 1,677 nurses. There are 1,370 psychologists actively working in mental health area according to the 2011 Action Plan although the number of psychology students in 40 universities in the academic year 2010-11 was 2,632.

In 2009-2010 a number of psychotherapy centres run by psychologists and counsellors were closed down by the Ministry of Health based on the General Health Law of 1928, which gives exclusive treatment responsibility to doctors. There is no other law regulating mental health issues.

After this crisis the Ministry of Health required clinical psychologists to work with a psychiatrist to practise psychotherapy after having passed an exam entitled “the medical practices of psychology”.

Although counsellors also work in psychotherapy and counselling but mainly in the private sector, they were not mentioned in the action plan. There is no statistical information on their numbers but it is estimated that there are approximately 35,000 psychological counselling graduates. Since the counselling departments are under education faculties and the graduates mainly work in schools they were not regarded as a part of the mental health workforce. However some counsellors play an active role in trauma work and also in the preparation of the new mental health legislation.

Attitudes towards mental health

The Turkish Psychiatry Association has been trying to prepare mental health legislation since 1996. These proposals reflect the medical model approach. In 2011-2012 after a symposium by rusihak, a group of volunteers consisting of the representative of the Ministry of Health, Turkish Psychiatry Association, rusihak, and volunteer lawyers started to work on a human rights based mental health law draft. The work was interrupted in 2012. By December 2016, the earlier medical model based version of the bill proposed by the Turkish Psychiatry Association was brought again to discussion sponsored by a member of parliament who is a counsellor. Representatives of all mental health professional associations and rusihak are still working on it and trying to incorporate prevention and include community based and recovery oriented mental health service perspectives.

Psychosocial disability is now included in the disability legislation following its review in 2014. It has to be noted that most of the psychiatrists were not aware that some of the people with psychiatric problems are also regarded as disabled people. In meetings held during 2011-2012 to discuss draft mental health law, the psychiatrists, who had prepared the earliest draft of the law, argued against the version of the draft based on the UN CRPD. This version had been drafted by Prof. Arlene Kanter who is one of the authors of the CRPD and has conducted research on mental health laws. She attended the first two meetings.

Psychiatrists have become more aware of the fact that people with mental health problems are classed as people with disabilities, primarily through having to give approval on claims for disability allowances. However there is little awareness of human rights among people with mental health problems, families and professionals.

¹⁹⁰ Available: http://hdr.undp.org/sites/default/files/2016_human_development_report.pdf



Another issue in the Turkish society is the excessive protectiveness and fear of families. The legal situation and practices lead individuals with psychosocial disabilities to cling to their families and recreate their dependence. Yet traditional Turkish culture had a unique relationship with “lunatics”. In the past and still in some rural areas people with mental health problems lived in the community in a way and were accepted “as they were”, although there were some cases of abuse. There is still tolerance among lay people but with the increase of urbanization and scarcity of financial sources of the patient (unemployment), this is quickly eroding.

There are various estimates on the number of Syrian refugees in the country, ranging from 3.2¹⁹¹ to over 3.4¹⁹² or 3.5 million¹⁹³.

The refugee crisis

It was estimated in 2015 that only 11.5% of temporary protection beneficiaries were in the camps, 88.5% of the refugees were out of the camps, dispersed across the country, mostly in cities.¹⁹⁴

There is a lack of data regarding how many refugees have access and acceptance to the primary or community mental health services. However, a document from 2015 by Istanbul Health Directorate reported that health services were expanded to refugees across all cities. This document has been signed by the Ministry of Health and the Disaster and Emergency Management Authority (AFAD) under the Prime Ministry.¹⁹⁵

The general health survey of Syrian refugees dated 2016 does not include data on mental health.¹⁹⁶

In 2013 in collaboration with WHO a training programme¹⁹⁷ was launched that aimed to:

- train Syrian doctors and nurses to integrate into the Turkish health care system;
- assist Turkish doctors to spot the signs of psychiatric trauma and refer patients for proper care.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

191 <http://data.unhcr.org/syrianrefugees/country.php?id=224>

192 http://ec.europa.eu/echo/files/aid/countries/factsheets/turkey_syrian_crisis_en.pdf

193 <http://www.aljazeera.com.tr/haber/soylu-turkiyede-3-milyon-551-bin-78-gocmen-ve-multeci-var>

194 <http://www.asylumineurope.org/reports/country/turkey/statistics>

195 Available: http://www.istanbulsaglik.gov.tr/w/sb/saggel/belge/Av_Elif_Selen_AY.pdf

196 Available: https://www.afad.gov.tr/upload/Node/14019/xfiles/Health_Status_Survey_of_Syrian_Refugees_in_Turkey.pdf

197 <http://www.euro.who.int/en/health-topics/emergencies/syria-crisis-health-response-from-turkey/health-services-for-syrian-refugees-in-turkey>

UKRAINE

COUNTRY INFORMATION

- **Population:** 42,590,879 (Eurostat, 2016)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

Ukraine has a predominantly institutional system of mental health care based on psychiatric hospitals and long-stay social care institutions. Although the country does not have a deinstitutionalisation policy, there are attempts to develop local – primarily social – services. Ukraine has a guardianship system that allows the full deprivation of legal capacity. The country has some legal and procedural safeguards around the use of involuntary hospitalisation and forced treatment; however there is limited information about practices.

DETAILED INFORMATION

Institutions and psychiatric hospitals

The majority of mental health and social care services are provided in hospital or institutional settings. The number of psychiatric hospitals fell from 88 in 2007 to 62 in 2016, with a corresponding drop in bed numbers from 42,125 to 29,243 (MoH statistics). However, this was not matched by an increase in the number of places in daytime inpatient care, which also declined in this period considerably from 5,137 in 2007 to just over 3,200 places.

Mental health care facilities include psychiatric hospitals, psycho-neurological hospitals, psychiatric inpatient wards, psycho-neurological inpatient wards, local medical associated units, psychiatric ward / unit, mental health clinics. Majority of these facilities / units / wards are stand-alone facilities often on outskirts of the city with very difficult access in terms of transportation (time and costs). All of them are publicly funded either through central national budget or a combination of national and regional budgets. No information on private clinics providing inpatients mental/psychiatric help. Some outpatient services are provided by private clinics but they are minimal and located only in large few cities. Public psychiatric facilities provide in- and outpatient psychiatric care.

People with long-term mental health problems who need residential / social care support are accommodated in psycho-neurological nursing homes, typically for the rest of their life. The number of hospitals and institutions is shown in the table.

Type of institution	Number of units	Number of beds/ places	Number of patients/ clients per year	Average stay
Psychiatric hospital	62	29,243	198,197	49.8 days
Psycho-neurological inpatient hospital	22	1,145	16,537	23.5 days
Daytime inpatient care for psychiatric patient	75	3,214	24,555	34.2 days



Social care institutions: psycho-neurological nursing homes	145	28,385	27,815	Life-long (from hospitalisation on)
Other: boarding schools	49	6,768	5,805	Also for adults up to the age of 35.

Source: Response from the Ministry of Health of Ukraine (25.07.2017 #3.46-17/916/3ПІ-17) for an information request Information provided by the Ombudsman Office:

<http://www.ukrstat.gov.ua>

All data from 2016

Community-based mental health and residential support

Although there are some mental health services that provide support for those who live in the community (e.g. mental health clinics), there is no information about these.

The state does not provide community-based residential support in Ukraine. There might be community-based supports for people with mental health problems created by charity funds and operated by NGOs but they are not included in the national statistics because they are not publically funded.

Ukraine is currently introducing the provision of domiciliary care for people with disabilities. There are approximately 735 local social service centres with 40,000 staff providing 50 types of social services to nearly 1.5 million persons in difficult circumstances (CRPD/C/UKR/1 2014).¹⁹⁸ The proportion of people with mental health difficulties among these is not reported.

There are no personal budget/direct payments schemes in Ukraine. Disability social benefits are provided to patients but if they are placed into long-term inpatient care about 70% of their benefits (pension) is going towards the facility, the rest could be used by a patient.

Involuntary placement and involuntary treatment

The criteria for involuntary placement are:

- The individual has a mental health conditions and there is a serious risk of harm to either oneself or another person;
- Diagnosis or treatment is only possible in an inpatient setting.

In Ukraine involuntary hospitalisation is construed as an authorisation for forced treatment.

There are some procedural and legal safeguards regarding involuntary placement and forced treatment, including a legal judgement, treatment reviews by a medical commission consisting of psychiatrists, and a right to appeal. Individuals or legal representatives should attend the court proceedings.

Forced treatment is regulated by the Criminal Code of Ukraine (Art.94) (2341-14), the Criminal Procedure Code of Ukraine (4651-17), this Law and other laws (such as Part I of the Article 19 with amendments implied by the Law #4652-VI (4652-17) from 13.04.2012).

- Involuntary placement can take place in the following settings (MoH):
- forced outpatient mental care;
- hospitalisation to inpatient mental health facility with general supervision;
- hospitalisation to inpatient mental health facility with strengthened supervision;
- hospitalisation to inpatient mental health facility with strict supervision.

In 2016 there were a total of 960 involuntary patients on imposed/court ordered treatment, out of which 663 were with general supervision, 148 with strengthened supervision, and 149 with strict supervision (information provided by the Ministry of Health, letter on 25.07.2017 #3.46-17/916/3ПІ-17 information request).

¹⁹⁸ <https://www.mindbank.info/item/6591>



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Overall, there is limited information about the use of involuntary placement, seclusion, and restraint in Ukraine, although concerns were noted by the CPT (CPT/Inf (2011) 29).¹⁹⁹

Legal capacity and guardianship

Ukraine has a legal system that allows both full and partial deprivation of legal capacity. Guardianship is regulated by the National Committee of Family and Youth of Ukraine, Ministry of Education of Ukraine, Ministry of Health of Ukraine, Ministry of Labour and Social Policy of Ukraine Decree # 34/166/131/88 from 26.05.1999 On Affirmation of the Rules for Guardianship and Care, and Chapter 6 of the Civil Code of Ukraine.

Articles 31-42 of the Civil Code set out the following degrees of legal competence, from the least to the most restricted: 1) full competence 2) not full competence 3) partial competence 4) restricted competence 5) recognition of a person as incompetent.

Legal capacity can be reinstated by the court.

In January 2016 there were 39,300 people are under full guardianship, deprived of legal capacity by legal judgement (Information from the Ministry of Social Policy of Ukraine, letter from 20.07.2017 p #23/0/133-17/175).

There is limited information on the implementation of guardianship in Ukraine, however the CPT (ibid. p. 71) noted cases where the psychiatrist providing treatment also fulfilled the role of the legal guardian- a clear conflict of interest.

Please see the [acknowledgments section](#) at the beginning of this report to see a full list of organisations/individuals who graciously contributed their time and energy to the drafting of the Country Reports.

¹⁹⁹ <https://rm.coe.int/1680698430>



UNITED KINGDOM

COUNTRY INFORMATION

- **Population:** 65,808,573 (Eurostat, 2017)
- **CRPD signatory:** YES, CRPD ratification: YES

GENERAL SUMMARY

People with mental health problems in the United Kingdom can receive mental health services and social care in a variety of settings including hospitals, psychiatric units, community mental health services, and supported accommodation arrangements. People with long-term mental health problems are also supported to live independently in their own home or in supported housing.

Health and social care are devolved issues; therefore policy and practice vary across the UK's constituent countries: England, Northern Ireland, Scotland, and Wales.

England has a new mental health strategy which was published in February 2016. The Five Year Forward View for Mental Health was developed by an independent taskforce and its findings and recommendations have been accepted by the Government, the National Health Service (NHS) and its Bodies in England.²⁰⁰ We have also seen the publication of a mental health dashboard to help monitor progress of the strategy's delivery.²⁰¹

In October 2016, the Welsh Government published Together for Mental Health, the delivery plan for 2016-19 for its 10 year mental health strategy.²⁰²

In Northern Ireland, we are still awaiting the Government's evaluation of the Bamford Review action plan 2012-15 (extended up until March 2016). This followed the Bamford Review in 2006 which was a comprehensive examination of mental health and learning disability services and recommended increased funding and more community care.²⁰³

Scotland has a Mental Health Strategy for 2017-2027.²⁰⁴

The future of social care continues to be discussed across the UK. A five year social care strategic plan for Wales is expected to be published in September 2017 and a Green Paper looking at social care in England is expected in 2018. Scotland has just published new standards for Health and Social Care services, using a rights-based approach.²⁰⁵

This country profile provides updates in key areas for England and Scotland.

200 Available: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

201 <https://www.england.nhs.uk/mental-health/taskforce/imp/mh-dashboard/>

202 Available: <http://gov.wales/topics/health/nhswales/plans/mental-health/?lang=en>

203 <https://www.health-ni.gov.uk/news/health-minister-honoured-champion-mental-health>

204 Available: <http://www.gov.scot/Resource/0051/00516047.pdf>

205 Available: <http://www.gov.scot/Resource/0052/00520693.pdf>



ENGLAND

Population: 55,268,100 (Office for National Statistics, 2016)

According to the OECD's country profile "the English mental health care system can be regarded as one of the clearest examples of a "community care" approach to mental illness, with relatively well established links and networks between mental health care providers and social care providers" (Hewlett & Horner 2015, p. 6).²⁰⁶

Mental health and social care services

NHS England publishes regular data on the availability and occupancy of overnight hospital beds,²⁰⁷ the activity of mental health community teams,²⁰⁸ as well as adult social care,²⁰⁹ including personal budgets and direct payments.

Personal budgets

Personal health budgets pilots in England have now been completed and the evaluation identified particularly positive impacts for people with mental health problems.²¹⁰ However, we know that despite the evidence people with mental health problems are less likely to be offered personal budgets either for social care or health care.

Involuntary placement

Involuntary placement is regulated by The Mental Health Act (England and Wales).

According to information from the NHS (2016):²¹¹

- On March 31, 2016 there were a total of 25,577 people detained under the Mental Health Act. Out of these 20,151 (78%) were placed in hospital and 5,426 were subject to compulsory treatment in the community. This represents the highest number since data collection began in 2006.
- In 2015/16 a total of 63,622 detentions were made under The Act, which represented an increase of nine per cent compared to the previous year, and has been steadily rising over recent years.
- The number and use of independent sector – private and not-for-profit – hospitals for involuntary placement under the Mental Health Act has been steadily increasing. Thirty per cent of patients detained on March 31, 2016 were in independent sector hospitals.
- A total of 4,361 community treatment orders were issued in 2015-16 – a decrease of 4% compared to the number issued in the previous year (4,564 in 2014-15).

In a recent survey, the Mental Health Alliance (2017) found that:²¹²

- 49% of respondents disagreed that people are treated with dignity under the Mental Health Act
- 50% said that they would not be confident that their human rights would be protected under the Mental Health Act if they were detained under it
- 72% disagreed that the rights of people living with mental illness are protected and enforced as effectively as those for people living with a physical illness
- 86% of respondents felt that it was very important that people be allowed to specify people close to them to be involved in decisions.

206 Hewlett, E. and K. Horner (2015). Mental Health Analysis Profiles (MhAPs: England, OECD Health Working Papers, No. 81, OECD Publishing, Paris. Available: <http://dx.doi.org/10.1787/5jrxr7vj1g9v-en>

207 <https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/>

208 <https://www.england.nhs.uk/statistics/statistical-work-areas/mental-health-community-teams-activity/>

209 <http://content.digital.nhs.uk/social-care>

210 <https://www.england.nhs.uk/personal-health-budgets/personal-health-budgets-for-mental-health/>

211 <http://www.content.digital.nhs.uk/catalogue/PUB22571/inp-det-m-h-a-1983-sup-com-eng-15-16-rep.pdf>

212 <http://www.mentalhealthalliance.org.uk/news/2017-a-mental-health-act-fit-for-tomorrow.html>



The Care Quality Commission – the independent regulator of health and adult social care in England – also monitors the use of the Mental Health Act. In their 2016 report they highlighted that in nearly a third of the cases they found no evidence of patient involvement in care planning.²¹³

Following calls from the Alliance and other leading mental health organisations, the Conservative Party in its manifesto for the 2017 General Election committed to scrapping the Mental Health Act and replacing it with a ‘Mental Health Treatment Bill’. In October 2017 the Prime Minister announced an Independent Review of the Mental Health Act 1983 given the rising rates of detention under the Act, the disproportionate number of people from Black and Minority Ethnic communities detained under the Act, and stakeholder concerns that some processes relating to the Act are out of step with a modern mental health system.²¹⁴ Further concerns to be addressed in the Review include the balance of safeguards available to patients, the ability of a detained person to determine which family or carers have a say in their care, the use of detention to detain rather than treat, questions around the effectiveness of community treatment and difficulties in getting discharged, and the time required to take decisions and arrange transfers for patients subject to criminal proceedings.

SCOTLAND

Population: 5,404,700 (Office for National Statistics 2016)

It is Scottish Government policy to shift the balance of care to the community. Most long stay hospitals and wards for people with mental health problems have been shut or significantly reduced in size and the average length of stay recorded in the Hospital Census in 2016 was four months. The vision in the Mental Health Strategy 2017-2027 is of ‘a Scotland where people can get the right help at the right time, expect recovery, and fully enjoy their rights, free from discrimination and stigma’.²¹⁵ However, the continuing rise in compulsory detention in hospital is of concern as well as the number of people who are on long term guardianship orders or compulsory community treatment orders.

Psychiatric hospitals and institutions

The Scottish Government ran a hospital bed census in 2016.²¹⁶ The total number of beds available was 4,254. Of this approximately 42% were “general psychiatry beds”, 41% were occupied by people over 65 years and therefore a significant number is likely to relate to dementia; 11% were related to forensic services, and seven per cent related to learning disability. The average (median) length of stay for people with mental health problems was approximately four months.

Community-based residential support

There is a variety of long- and short-term accommodation support arrangements available in Scotland. The majority of people with mental health problems are supported to live in their own homes.

213 Available: <http://www.cqc.org.uk/publications/major-report/monitoring-mental-health-act-report>

214 <https://www.gov.uk/government/publications/mental-health-act-independent-review/terms-of-reference-independent-review-of-the-mental-health-act-1983>

215 Available: <http://www.gov.scot/Resource/0051/00516047.pdf>

216 Available: <http://www.gov.scot/Resource/0050/00505394.pdf>



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Type of community-based service	Number of units	Total beds/places	Total number of users (per year)	Length of stay	Sectoral distribution	Groups served
group home	61	Unknown, but likely to be around 600 in small scale domestic type accommodation		Medium to Long-term	Private: 19 homes Not for Profit: 42 homes	Adults (18+ years) with mental health problems
Supported living	Not recorded as people are supported in their own homes		This figure is not available but likely to be around 6,000+ people	Long-term	Mainly the not for profit sector with a small number of private providers	Support provided to adults with mental health problems. The support can range from a few hours per week to 24/7.
Places of sanctuary for persons in crisis	One (in Edinburgh)	4 bed spaces plus 24 hour helpline and 1:1 appointments	Approximately 1,600 people make contact with the crisis centre each year, which covers the Edinburgh area (pop. Approx. 500,000 people)	People can only stay a maximum of 7 nights each visit (most will stay 1 or 2 nights)	Not for profit	All adults 18+ with a mental health problem as the primary issue
Respite homes	One	6 bedrooms	255	People stay for one week at a time but can visit up to 4 times a year if desired	Not for profit	All adults 18+ with a mental health problem as the primary issue

Source: Quarterly Statistical Summary Report – Qtr 4 (2016-17), Care Inspectorate for supported accommodation/care home data (June 2017).²¹⁷ The data on supported living, crisis and respite houses is based on Penumbra's knowledge of services in Scotland.

Personal budgets

Personal budgets and direct payments are available for people with mental health problems to arrange their own support in Scotland. Legislation²¹⁸ gives people four options in terms of individual payments:

- receive a personal budget and purchase support independently;
- have an individual service fund held by a third party (service provider) to provide individualised support;
- receive services organised/purchased by the local authority
- a combination of these.

The number of people with mental health problems who use these options is not available.

Community-based mental health supports

Data on community based mental health services is either recorded locally or not gathered. It is very difficult to get data specific to mental health services as services often provide for people with a wide range of issues such as homelessness,

²¹⁷ <http://www.careinspectorate.com/index.php/publications-statistics/94-public/statistics/quarterly-statistical-summary-report>

²¹⁸ http://www.legislation.gov.uk/asp/2013/11/contents/enacted?utm_source=Update&utm_campaign=2a041b3951-Update_Bulletin6_14_2011&utm_medium=email



alcohol, drugs use, learning disabilities etc. General Practitioners are supposed to record how many people they have registered who have long term mental health problems; this is estimated at around 40,000 people (not all need or require ongoing community support / services).

Type of community-based service	Number of units	Total number of patients/users (per year)	Sectoral distribution	Funding
Mental health centres (outpatient)	All Mental Health hospitals have outpatient clinics. Some of these are located in general practices or other community settings	n.a.		National Health Service (NHS)
Mobile units/community mental health teams	Community Mental Health teams are employing around 2,581 staff	n.a.	Public	NHS funding of around £195,000,000 in 2013 (table 9 page 33)
Peer support/peer support networks	We estimate there are about 80 peer support workers employed across Scotland	n.a.	Mainly not for profit organisations but some public	Funded by NHS and local authorities
User/Survivor organisations	15 (estimate)	n.a.		Public funding
Club Houses	1 (estimate)	n.a.		Public funding
Hearing voices networks	3 local networks (estimate)	n.a.		Public funding
Cultural support networks (theatre, sports clubs etc.)	unknown	n.a.		

Source: Mental Health in Scotland 2014²¹⁹

Involuntary placement and forced treatment

Detention and forced treatment for mental disorder are authorised by the Mental Health (Care and Treatment) (Scotland) Act 2003. This distinguishes three main kinds of compulsory powers:

- Emergency detention (EDC) for up to 72 hours in a hospital.
- Short-term detention (STDC) for up to 28 days in a hospital.
- Compulsory Treatment Order (CTO) for periods of six or 12 months in a hospital or the community.

Each option is associated with different criteria, as well as procedural requirements and safeguards.²²⁰

Emergency detention and short-term detention both authorise forced treatment. Detention under a longer-term Compulsory Treatment Order does not automatically imply that forced treatment can be given. This requires specific authorisation by the Mental Health Tribunal. However, it is almost invariably the case that an order authorising detention will also authorise compulsory treatment.

It is also possible for a community-based Compulsory Treatment Order (CCTO) to be imposed. This does not authorise detention but may authorise a requirement that the person attend for medical treatment. However, forced treatment can only be given in a hospital, and would require further steps, following non-compliance with the community based order, to admit the person for treatment.

The Mental Welfare Commission for Scotland (MWCS) publishes annual statistics on the use of mental health detention.²²¹ In 2015/16, there were 5,008 new episodes of compulsory treatment: 2,159 (43%) were EDC; 2,754 (55%) were STDC, and less than 2% were CTOs. Overall the number of compulsory treatment episodes increased by 3.2% compared to the

219 Available: <http://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB.14-36.pdf>

220 Available: <http://www.gov.scot/Resource/Doc/26487/0013533.pdf>



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previous year; however there are important differences: EDCs increased by nearly 10% while STDC episodes fell by 1.5%. In 2016/17 there was an 8.2% in compulsory measures.²²² Overall both forms of detention have been steadily increasing since 2009/10. The reasons for this are unknown, but are likely to include demographic trends (increased elderly population), changes in service delivery (more people in community means more crisis admissions) and possibly greater awareness of the need to use legislation to protect rights where person may not be fully consenting to treatment. The MWCS report also highlights that only 54% of EDCs were approved by a mental health officer (MHO, a specialist social worker). Over 10 years this has dropped from 68% to current level. The use of an MHO aims to offer safeguards for the person. It is likely that doctors find it difficult to get an MHO quickly enough as there is a shortage of suitably qualified MHOs. The raised eligibility criteria for social care support (due to cuts in local government funding) mean that people will only receive support if they have critical or substantial needs. This may have had an impact on the ability of people to seek help at an earlier stage.

It is not possible to provide a robust figure for the proportion of hospital admissions that are involuntary, because individual datasets are not comparable. However, data on psychiatric inpatient admissions shows that there were around 21,550 admissions and discharges in psychiatric specialties in 2015/16.²²³

As regards compulsory treatment in the community, approximately 40% of extant compulsory treatment orders were community based in 2015/16 (MWCS 2016).

Use of seclusion and restraint

There is non-statutory guidance on the use of seclusion and restraint published by the MWCS (2014, 2013).²²⁴ Data is generally collected at service level, but not aggregated.

Guardianship

The Adults with Incapacity (Scotland) Act 2000 (amended in 2007 and 2008) sets out the rules of guardianship in Scotland (Part 6). Its provisions allow for a substitute decision-making and the deprivation of legal capacity. Guardianship can cover property and financial matters or personal welfare, including health, or a combination of these, and it is mostly used with individuals who have long-term needs in relation to these matters. The Act also allows for intervention orders in relation to a single action or decision (for more information see Scottish Government 2008).²²⁵

Annual statistics on the use of the adults with incapacity legislation are published by the Mental Welfare Commission for Scotland.²²⁶ For 2016/2017 there were a total of 12,082 extant guardianship orders, which was an increase of 12.5% from 10,735 in 2015/16. There were 2,835 orders granted during 2016/2017.²²⁷ These figures include all disability groups.

The Mental Health (Care and Treatment) (Scotland) Act 2003 provides a right to advocacy, but there is no general legal provision for supported decision making. Legal capacity can be reinstated and free legal aid is available in relation to guardianship or mental health proceedings.²²⁸

For further reading, see Annex 2 in the Mapping Exclusion section of Mental Health Europe's website (<http://www.mhe-sme.org/>).

221 Available at <http://www.mwscot.org.uk/publications/statistical-monitoring-reports/>

222 Available: http://www.mwscot.org.uk/media/387603/mental_health_act_monitoring_report_2016-17.pdf

223 Available: <http://www.isdscotland.org/Health-Topics/Mental-Health/Psychiatric-Hospital-Activity/>

224 MWCS (2014). Good practice guide: The use of seclusion. Available: http://www.mwscot.org.uk/media/191573/final_use_of_seclusion.pdf; MWCS (2013). Good practice guide: Rights, risks and limits to freedom. Available: http://www.mwscot.org.uk/media/125247/rights_risks_2013_edition_web_version.pdf

225 Scottish Government (2008). Adults with Incapacity (Scotland) Act 2000. A short guide to the Act. Scottish Government, Edinburgh. Available: <http://www.gov.scot/Resource/Doc/217194/0058194.pdf>

226 <http://www.mwscot.org.uk/publications/statistical-monitoring-reports/>

227 http://www.mwscot.org.uk/media/389068/awi_monitoring_report_2016-17.pdf

228 Please note that the Mental Health Act (Scotland) 2015 updated parts of the 2003 Act. These include new provision over a named person, the provision of a register of advance statements and a duty to provide the mental welfare commission with details on advocacy services provided by NHS bodies. See <http://www.gov.scot/Topics/Health/Services/Mental-Health/Law/2015Act-provisions> for details.



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