



Mapping Exclusion

Institutional and community-based services in the mental health field in Europe

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Mental Health Europe
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List of abbreviations

CAT Committee	Committee Against Torture
CPT Committee	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
EU	European Union
ECHR	European Convention on Human Rights
ECT	Electroconvulsive therapy
MHE	Mental Health Europe
UN	United Nations
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

Table of Contents

Why this report?	5
The context of deinstitutionalisation and community-based care in mental health	7
Policies and standards	7
The process of deinstitutionalisation and community-based care	9
Trends in deinstitutionalisation and development of community-based services in Europe	13
Institutional placements – availability of data in the mental health field	13
Methods	14
Findings	16
Types of residential care	16
Personal budgets	18
Deinstitutionalisation	18
Guardianship and involuntary treatment	21
Conclusions	24
Recommendations	25
References	27
Annex	29

Why this report?

People with mental health problems are one of the most vulnerable groups of people with disabilities. Mental Health Europe (MHE) has been working closely on deinstitutionalisation as a member of the *European Expert Group on the Transition from Institutional to Community Care*¹. MHE is concerned that in some European countries where deinstitutionalisation has started, people with mental health problems living in residential care are not included in the process. Previous studies² provided some information on the number of people with mental health problems in different residential settings, but there is limited up-to-date information or knowledge about recent deinstitutionalisation initiatives across Europe.

This report aims to present information about the state of deinstitutionalisation and community living in the mental health field across Europe, and give a general overview of institutional and community-based, non-institutional residential support. The main focus of this report is to map long-term care for people with mental health problems in European countries, including long-stay hospital care, social care institutions and community-based residential arrangements.

1 Sometimes also referred to as the 'Ad hoc Expert Group', the group is composed of international non-governmental organisations working for the enhancement of the transition from institutional to community care in Europe. The group (convened by Commissioner Vladimir Spidla) issued a report in 2009 that is available here: [http://www.mhe-sme.org/assets/files/Desinstitutionalisation-English%20\(2\).pdf](http://www.mhe-sme.org/assets/files/Desinstitutionalisation-English%20(2).pdf). Mental Health Europe has been a member of the group since its establishment.

2 Freyhoff, G., Parker, C., Coue, M., & Greig, N. (Eds.). (2004). *Included in society: Results and recommendations of the European research initiative on community-based residential alternatives to disabled people*. Inclusion Europe, Brussels.

Mansell J, Knapp M, Beadle-Brown J. & Beecham, J. (2007). *Deinstitutionalisation and community living – outcomes and costs: report of a European Study. Volume 2: Main Report*. Canterbury: Tizard Centre, University of Kent.

Medeiros, H., McDaid, D., Knapp, M., & MHEEN Group. (2008). *Shifting care from hospital to the community in Europe: Economic challenges and opportunities*. MHEEN II Policy Briefing 4.

Introduction

Across Europe, considerable efforts have been made to shift the balance of care from psychiatric hospitals to a varied provision of services in the community for people with severe mental health problems. Deinstitutionalisation³ and the provision of high quality community-based services⁴ is one of the major challenges for mental health reforms. Despite far-reaching changes in some countries, institutions are still the dominant form of service provision in many countries in Europe. Nearly 1.2 million people live in residential settings for people with disabilities and facilities for people with mental health problems, many of them in large institutions or long-stay hospitals.⁵

In 2008 the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) made the unjustified segregation of persons with disabilities, including people with mental health problems, in congregate settings, a violation of human rights. By ratifying the Convention, states make a commitment to take effective and appropriate measures to facilitate the full inclusion and participation of people with disabilities in the community.

The report is divided into three parts. The first part provides an overview of the policy context of deinstitutionalisation and mental health reform in Europe as well as a brief review of the process of deinstitutionalisation and community-based care. The second part describes some of the recent trends in the transition to community-based care in Europe. This part draws on both recent research as well as information from Mental Health Europe member organisations and external experts (where member organisations were not available or could not provide the relevant information). Part three puts forward some conclusions and recommendations for European and national stakeholders. Individual country reports can be found in the Annex.

3 The word 'deinstitutionalisation' should not be understood simply as the 'closure of institutions for people with mental health problems'. In places where the term deinstitutionalisation is used, it refers to the process of developing a range of services in the community, in order to eliminate the need for institutional care (see also European Expert Group on the Transition from Institutional to Community-based Care: Common European Guidelines on the Transition from Institutional to Community-based Care, November 2012).

4 The term 'community-based services' refers to a spectrum of services that enables individuals to exercise their right to live in the community, as opposed to an institution or hospital. It encompasses both mainstream and specialised services, such as personal assistance, peer-support groups, community centres, respite care and others (ibid).

5 Mansell et al. 2007

The context of deinstitutionalisation and community-based care in mental health

Policies and standards

8 Giving an in depth analysis on the human rights of people living in institutions provided by international and European standards is outside of the scope of this report. However, some key instruments are important to mention.

Mental health has featured highly on international and national policy agendas in recent years. In 2005, the World Health Organisation (WHO) adopted a mental health declaration and action plan for Europe that set out the framework for a comprehensive mental health policy for governments, which requires action in 12 broad areas. One of these areas is the development of effective community-based services for people with severe mental health problems. The document states that there is "no place in the twenty-first century for inhumane treatment and care in large institutions".⁶

The WHO recommends that countries should restrict further investment in psychiatric hospitals, because they represent the least desirable use of the limited financial resources available for mental health due to their high costs, poor clinical outcomes and human rights violations. However, before countries embark on deinstitutionalisation, they must make sure that adequate community-based services and services in general hospitals are in place and available for people with mental health problems.⁷

The European Union published its Green Paper on Improving the Mental Health of the Population⁸ in 2005. This laid down the basis for an EU-strategy on mental health, and established a framework for the exchange of information and cooperation between Member States and the Commission. In 2008, the European Pact for Mental Health and Well-being⁹ called for action in combating stigma and social exclusion by creating mental health services that are well integrated in society and operate in ways that avoid stigmatisation and exclusion. The European Commission is also in the process of developing a Joint Action on Mental Health and Well-being, which will include the development of community-based services and socially-inclusive mental health approaches as one of its objectives.

The newest global human rights instrument, the United Nations Convention on the Rights of Persons with Disabilities, entered into force in 2008. The Convention adopts a broad definition of persons with disabilities based on the social model of disability and states that "persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"¹⁰ (Article 1). Thus, a medical diagnosis becomes a disability when an individual experiences disadvantages or discrimination in the society on the basis of that diagnosis. Therefore, under Article 1 of the CRPD people with mental

6 p 24

7 WHO (2003). *Organization of services for mental health. (Mental health policy and service guidance package)*. World Health Organisation, Geneva

8 The Green Paper is available here: http://ec.europa.eu/health/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf (in English, last accessed October 2012)

9 See the Pact here: http://ec.europa.eu/health/mental_health/policy/statements/index_en.htm (in English and 21 other languages, last accessed in October 2012)

10 The full text of the Convention: <http://www.un.org/disabilities/default.asp?navid=14&pid=150> (in English, French, Spanish, Chinese, Arabic etc., last accessed in October 2012)

health problems (also referred to as people with psychosocial disabilities) have the same rights as other groups of people with disabilities and all provisions of the Convention apply to them on an equal basis.

The Convention makes the unjustified segregation of people with disabilities in congregate settings such as institutions or psychiatric long-stay hospitals a violation of human rights and calls on states to take “effective and appropriate measures” to facilitate the full inclusion and participation of people with disabilities in the community and ensure that they:

- are not obliged to live in a particular living arrangement but have the opportunity to choose where and with whom they want to live;
- have access to a range of community-based services to support community living and inclusion and prevent isolation or segregation;
- can access community services and facilities on an equal basis with the general population and these services are responsive to their needs (Article 19).

Governments that ratify the Convention must recognise the right of people with disabilities to an adequate standard of living and to the continuous improvement of living conditions (Article 28), and make available rehabilitation services and programmes to enable persons with disabilities to maximise their independence and achieve full inclusion and participation in all aspects of life (Article 26). The Convention also calls on Governments to take appropriate action to ensure freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15), and protect persons with disabilities from exploitation, violence and abuse within and outside the home, also by monitoring facilities and programmes designed to serve persons with disabilities by independent authorities (Article 16).

Governments also agree to adopt the necessary legislation and administrative measures for the implementation of the Convention, including any legislation to modify or abolish existing laws or practices that go against the provisions of the Convention and constitute discrimination against persons with disabilities. As of October 2012 the Convention was ratified¹¹ by 125 states, including the majority of European countries and the European Union. However a significant minority of European states (altogether nine countries: Albania, Andorra, Belarus, Finland, the Netherlands, Iceland, Ireland, Norway, and Switzerland) have not yet ratified the Convention and its implementation remains to be a challenge in many of the countries that have signed up to it.¹²

As highlighted by a recent UN report:

*The introduction of the CRPD is of huge significance for the human rights of persons who are institutionalized. This is because the CRPD marks a paradigm shift in attitudes and approaches to persons with disabilities, requiring that they no longer be regarded as “objects” of charity, medical treatment and social protection. Rather, persons with disabilities have the same rights as others to enjoy all human rights and fundamental freedoms and are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.*¹³

11 When a country signs the UN CRPD, it becomes a signatory, and when a country ratifies the convention it becomes a States Party. Becoming a signatory qualifies the given country to proceed toward ratification, and also establishes an obligation to abstain from any acts that may violate the principles of the UN CRPD. Becoming a States Party means that the country agrees to be legally bound by the treaty.

12 <http://www.un.org/disabilities/countries.asp?id=166#G> (last accessed: October, 2012)

13 UN OHCHR (2011). *Forgotten Europeans – Forgotten Lives*. UN Office of the High Commissioner for Human Rights.

The Charter of Fundamental Rights of the European Union also sets out the right to live independently for people with disabilities (Article 26). Rights to participate in the life of the community, as well as social, cultural and occupational integration are also included, given their importance to achieving a life of dignity and independence.

The European Convention on Human Rights (ECHR), a treaty of the Council of Europe also describes the obligations of its States Parties in regards to community living. The Convention is of paramount significance as it is legally binding and sanctions can be applied if a right is infringed upon. Firstly, parties to the ECHR have an obligation to secure human rights for everyone within their jurisdiction.¹⁴ Furthermore, Article 3 of the ECHR states that “no one shall be subjected to torture or to inhuman or degrading treatment or punishment” without any exceptions. Infringement of this Article may occur e.g. when the person becomes a victim of a form of ill-treatment, or negligence, or when the hospital or institution fails to provide adequate standards of care.¹⁵ The ECHR also guarantees (Article 8) the right to respect for private and family life and states that any interference with this right by a public authority must be justified as being in accordance with the law and necessary in a democratic society. Article 8 can be applied in cases where a placement into an institution interferes with the person’s ability to have a private life or to remain in contact with their family.¹⁶

Based on the above mentioned human rights treaties, there is an increasing body of important case law. In recent years, the progressive jurisprudence of international courts (most prominently the European Court of Human Rights, body of the Council of Europe) advanced the human rights of people with mental health problems. Case law can instigate changes in the domestic legislation that does not comply with international human rights standards (for example Bulgaria started to develop new guardianship legislation following a judgement of the European Court of Human Rights).

The process of deinstitutionalisation and community-based care

Deinstitutionalisation in the mental health field has three main components:

- discharge or movement of individuals from hospitals into the community;
- diversion from hospital admission to alternative services;
- development of alternative community-based services.¹⁷

Many people with severe mental health problems also have additional social welfare needs. There is a distinction between short-term psychiatric treatment and long-term social care of people with mental health problems. Long-term institutionalisation is often caused by a lack of adequate residential and social support in the community. Institutionalisation happens in a variety of services and settings (such as psychiatric hospitals, psychiatric departments of general hospitals, social care institutions, residential care homes, group homes, rehabilitation centres, and secure psychiatric facilities) and leads to the discrimination and social exclusion of people with mental health problems.

Regional Office for Europe p. 7

¹⁴ Article 1.

¹⁵ Reidy, A. (2003). *The prohibition of torture. A guide to the implementation of Article 3 of the European Convention on Human Rights*. Council of Europe.

¹⁶ More information on international and European human rights standards relevant to the situation of people in institutions is available at: http://europe.ohchr.org/Documents/Press/Forgotten_Europeans_Executive_Summary.pdf

¹⁷ Bachrach 1976 cited by Medeiros et al. 2008

Institutions are defined as places where:

- residents are isolated from the broader community and/or they are forced to live together;
- residents do not have sufficient control over their lives and over decisions which affect them; and
- requirements of the organisation itself tend to take precedence over the residents' individualised needs (Ad hoc Expert Group¹⁸).

There is evidence that psychiatric hospitals or institutions increase stigmatisation and can further deteriorate mental health.¹⁹ Shorter hospital stays are as effective as longer stays and community-based programmes are more effective, or at least as effective as hospital treatment and care.²⁰ Community-based treatments and care are also associated with improved outcomes in social functioning, employment and independent living²¹ and higher user satisfaction.²²

However, it is important to emphasise that because a service is based in a non-medical or community-based setting it does not guarantee that it will support people in living a full life. Ultimately it is the manner in which a service is operated that makes the difference.

Psychiatric institutions and long-term hospitals dominated the provision of services for people with mental health problems in most European countries for a large part of the twentieth century. There were various reasons behind the adoption of this model of care and the segregation of people with mental health problems from the rest of the society: the most pervasive being the belief that psychiatric hospitals were the most effective way of providing care by concentrating financial and human resources in large settings.²³ The biomedical model of mental illness was also an important reason along with elements of social control and stigma.

After the 1950s, many countries in Western Europe saw some major changes in their mental health care system - a shift in the balance of care away from long-term segregation of people with mental health problems in psychiatric hospitals and institutions towards more varied and community-based patterns of mental health care.²⁴

Poor physical conditions and human rights violations in psychiatric hospitals and institutions became a growing concern in many countries and contributed to calls for reform. Civil rights and (ex)user and survivor movements provided additional impetus to the policy shift towards community-based care.²⁵

The ideological framework of deinstitutionalisation was shaped by community and social psychiatry that questioned the therapeutic value of isolating people with mental health problems in large institutions, and advocated that they should be actively treated or supported in the community. The detrimental effects of long-term institutionalisation became well-known through Barton's²⁶ description of institutional neurosis and Goffman's²⁷ analysis of total

18 The 'Ad hoc Expert Group' is also referred in recent years as the 'European Expert Group on the Transition from Institutional to Community Care.'

19 WHO (2005). *Mental health: facing the challenges, building solutions*. World Health Organisation, Geneva

20 WHO 2003

21 Ibid.

22 Mansell et al. 2007

23 Medeiros et al. 2008

24 Ibid.

25 Goodwin, S. (1997) *Comparative Mental Health Policy: From Institutional to Community Care*, Sage, London.

26 Barton, R. (1959). *Institutional neurosis*. Bristol: Wright.

27 Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. London: Penguin Books.

institutions and their effect on people.

As part of the mental health reforms in Western Europe, many psychiatric hospitals were closed and replaced by psychiatric departments in general hospitals, out-patient and day services, as well as by a range of community-based treatment and support facilities.²⁸ Nevertheless, the process and extent of mental health reforms varies enormously between Western European countries.

12

Meanwhile in the countries of the former Eastern bloc, mental health systems were largely unaffected by the ideas of deinstitutionalisation and community-based care before the 1990s. The countries had a dual structure based on the provision of mental health services in hospitals and the institutionalisation of people with severe mental health problems in long-stay social care facilities. Mental health policy awareness increased rapidly after the regime changes and the need for reform in mental health care was generally accepted by stakeholders.²⁹ However, mental health policy agendas are largely driven by political concerns that apply to general health system reforms (e.g. cost-cutting).

Various reports suggest that poor quality care and violations of human rights are endemic in institutions in Central and Eastern Europe.³⁰ However they can happen in any country (see for example the Winterbourne View scandal in the United Kingdom³¹, or a recent case in Salerno, Italy³²).

More recently deinstitutionalisation and community care policies across Europe are moving towards the provision of community-based residential or other services to support the independent living of people with disabilities, in line with the principles of the UN CRPD. There is a growing recognition that deinstitutionalisation and community living is about fundamental rights and that governments should provide the necessary support to enable people to enjoy these rights. Some countries introduced personalised budgets (e.g. direct payments, personal budgets etc.) that enable individuals with mental health problems to take control of their own support and purchase the services they need. The term "personal budget" describes arrangements when people with disabilities and in some countries people with mental health problems receive a certain amount of money that can be used for paying people and services that support them in their daily life, in order for them to live independently in the community.³³

Shifting the balance of care from institutions to community-based services has proved to be very challenging. In many cases deinstitutionalisation has failed to achieve the full social inclusion of

28 Novella, E. J. (2010). Mental health care and the politics of inclusion: A social systems account of psychiatric deinstitutionalization. *Theoretical Medicine and Bioethics*, 31(6), 411-427.

29 Tomov, T., Van Voren R., Keukens, R. & Puras, D (2007). Mental health policy in former eastern bloc countries. In. Knapp, M. et al. (eds.) *Mental Health Policy and Practice across Europe. The future direction of mental health care*. pp. 396-426. European Observatory on Health Systems and Policies. World Health Organisation

30 Bulgarian Helsinki Committee. (2005). *The archipelago of the forgotten: social care homes for people with mental disorders in Bulgaria*.

Freyhoff et al. 2004.

MDAC (2003). *Cage Beds. Inhuman and Degrading Treatment or Punishment in Four EU Accession Countries*. Mental Disability Advocacy Center, Budapest.

31 South Gloucestershire Safeguarding Adults Board (2012). Winterbourne View Hospital. A Serious Case Review. (<http://hosted.southglos.gov.uk/wv/summary.pdf>)

32 <http://espresso.repubblica.it/dettaglio/cosi-hanno-ucciso-mastrogiovanni/2191955/> (last accessed: October 2012)

33 In 2005-2006 Mental Health Europe conducted a survey among its member about personal budgets available for people with mental health problems in Europe. The summary of the study is available at: <http://www.mhe-sme.org/assets/files/Final%20Results%20of%20the%20MHE%20Survey%20on%20Personal%20Budget.pdf>

people with severe mental health problems.³⁴ The reality today is that people with mental health problems continue to be one of the most disadvantaged groups in societies across Europe: they live in poorer conditions than the majority, they are discriminated against and excluded from employment, and many are isolated and have limited social contacts.³⁵ In some countries there is a trend towards re-institutionalisation that is characterised by legislative initiatives that allow involuntary treatment in the community, increased forensic treatment and a rising number of places in long-stay residential care.³⁶

The complex needs of people with severe mental health problems cut across sectors and cannot be met by the mental health care sector alone. Some people require on-going social and residential support to live in the community. Collaboration with other sectors (such as social security, employment, social welfare etc.) as well as within the health sector is crucial to create effective mental health systems.³⁷

34 Fakhoury, W., & Priebe, S. (2007). Deinstitutionalization and re-institutionalization: Major changes in the provision of mental healthcare. *Psychiatry*, *6*(8), 313-316.

35 Mansell et al. 2007

36 Priebe, S. (2004). Institutionalization revisited – with and without walls. *Acta Psychiatrica Scandinavica* 2004: 110: 81–82

37 WHO 2003

Trends in de-institutionalisation and development of community-based services in Europe

Institutional placements – availability of data in the mental health field

There are some important issues that need to be considered when looking at mental health care data in Europe. First, official hospital bed data does not usually include the beds in residential social care services, although the number of people with mental health problems in social care homes may be as large as the number in psychiatric hospitals.³⁸ Many of these settings, particularly in Central and Eastern Europe are large institutions with diverse residents (including elderly people, people with intellectual and other disabilities, and people who have substance abuse issues) and offer minimal or no treatment but solely custodial care in highly regimented settings. People in institutions have no choice on how to live their lives, they are likely to receive treatment without consent and be restrained chemically and sometimes physically.

Second, the reduction in the number of beds in psychiatric hospitals alone is not necessarily a step in the right direction. In-patient care is often not replaced by the provision of services in the community and the closure of psychiatric hospitals might mean loss of services and cost cutting.³⁹ Eurostat data on psychiatric care beds in hospitals indicates a sharp decline in the number of beds in many European countries between 1999 and 2010, and in many cases this was not accompanied by an increase in the availability of community-based care.⁴⁰

Third, it is often difficult or impossible to distinguish the number of short-stay acute patients from the number of long-term patients in psychiatric hospitals. While the average length of stay in psychiatric hospitals has declined, people with chronic mental health conditions are sometimes left behind in psychiatric hospitals and institutions for indefinite periods of time, often decades.

Finally, re- or trans-institutionalisation from psychiatric units to other forms of institutions, such as forensic hospitals, prisons, and social care homes that are often outside the remit of the mental health system occur. The extent of this phenomenon varies country by country and it is difficult to estimate.⁴¹

When thinking about numbers and types of service provision it is important to remember that institutional culture is not exclusive to institutions or hospitals – it is often found in community-based services. Block-treatment in residential care and compulsory treatment orders in the community also create institutional culture.

In recent years, various studies have explored the number of institutions for people with mental health problems and people with disabilities in Europe.

In 2004 the *Included in Society* study⁴² identified a total of 2354 institutions in 29 European countries – however the number of institutions is probably higher than this as the number of

38 Muijen, M. (2008). Focus on mental health care reforms in Europe: Mental health services in Europe: An overview. *Psychiatric Services*, 59(5), 479-482.

39 Ibid.

40 Medeiros et al. 2008

41 Priebe, S., et al. (2008). Mental health care institutions in nine European countries, 2002 to 2006. *Psychiatric Services*, 59(5), 570-573.

42 Freyhoff et al. 2004

institutions was underreported in some countries. Resident numbers were available for 1586 institutions that served a total of 174,874 people. Out of the 1024 institutions where information on the type of disability was available, 242 served people with mental health problems, 58 served people with mental health problems and people with intellectual disabilities, and 45 served people with any type of disability. The study also provided an in-depth comparison of institutions in four countries (France, Hungary, Poland and Romania).

The Deinstitutionalisation and Community Living: Outcomes and Costs (DECLOC) study⁴³ collated data from 28 European countries. The data covered the structure and organisation of the service system, funding mechanisms, the number of people in institutions by disability and age, and the number and qualifications of staff. DECLOC found that there were 1,186,962 people with disabilities in residential facilities across Europe. Ten per cent of these places (n = 123,599) were for people with mental health problems, 13% (n = 161,544) were for mixed groups, and the disability type was unknown for half of the places. The study found that larger facilities - those with over 30 places - were the typical form of provision for some user groups in 21 countries. The typical size of community-based mental health facilities in countries that have already made significant progress in deinstitutionalisation and community living was larger than the typical size of residential facilities for other user groups.

A report by the Mental Health Economics Network in 2008⁴⁴ looked at the balance of care between hospital and community-based services for people with mental health problems in 32 European countries, and identified the economic barriers to, and opportunities for, change. The study found that the number of hospital beds has fallen considerably in all European countries since the 1970s. In Western Europe the most marked decrease was pre-1990, while in Central and Eastern Europe this happened in the 1990s. Despite a reduction in the number of beds in psychiatric hospitals, the number of psychiatric hospitals increased in some countries (e.g. Poland) and the development of community-based facilities was limited or absent in Central and Eastern Europe. The report also highlighted that it was particularly difficult to obtain data for psychiatric places in social care homes, even though a large number of individuals with mental health problems may live in these facilities, particularly in Central and Eastern Europe.

Methods

For this report, data was collected from existing data sources, such as national statistics, by Mental Health Europe member organisations between November 2011 and September 2012. MHE members include a variety of organizations such as mental health advocacy groups, national mental health associations, grassroots organizations, non-governmental organisations of users of psychiatry, and organizations with a mixed profile (advocacy and service provision). In countries with no MHE members, or where members could not respond to our request for data, MHE contacted other experts from the mental health field in the given country to provide information. The list of individuals and organisations who contributed to the report is presented at the beginning of this publication.

MHE member organisations were asked to provide information about the number of long-term places and service users in psychiatric hospitals and institutions as well as community-based residential settings, using a questionnaire developed by MHE. They were asked to, where possible, use official data (e.g. national statistics or government reports etc.) and indicate the source of information. Organisations were also asked to provide information about current

⁴³ Mansell et al. 2007

⁴⁴ Medeiros et al. 2008

mental health reforms and deinstitutionalisation initiatives, and any other relevant policy developments in their country. In total, 32 countries provided information by September 2012, covering the 27 EU Member States, and Bosnia-Herzegovina, Croatia, Moldova, Serbia and Israel.

The information was then reviewed and, where available, cross-checked using other data sources (e.g. DECLOC 2007) by the authors. Draft country reports were then sent back to MHE members for final comments and approval. Information provided by MHE members was taken at face value, and although considerable efforts have been made to verify the accuracy of information, some errors may remain.

The country reports are structured in five main sections. The first section gives a general overview of the long-term care arrangements and – where available – the number of services and places or residents for each type of service. While the survey did not include children and adolescent services or forensic services, if countries provided information on any of these, it is included in the country report. The second section presents information about the availability of personal budgets. The third section gives an overview of the most recent mental health or social care reform strategies including any deinstitutionalisation initiatives. The fourth section gives an overview of the main legislation and practice concerning involuntary treatment. It highlights whether any of these apply to long-term care in social care settings and includes recommendations. The final section briefly presents the legislation concerning guardianship and legal capacity.

The reason for including sections on involuntary treatment and legal capacity is that they are linked to institutionalisation on many levels. In 2012, the European Union's Fundamental Rights Agency published a detailed report on involuntary treatment⁴⁵, therefore our report does not aim to provide a detailed comparative analysis of legislation and practice in Europe. Instead, our aim is to highlight what legal mechanisms, procedures and practices force thousands into institutional care in Europe. Involuntary treatment in the community has been a new form or (re-)institutionalization in some countries.

The links between institutionalization, guardianship and involuntary treatment are also known from the available literature.⁴⁶ Most people living in mental health institutions are under plenary or partial guardianship, the most widespread substitute decision making systems in Europe. Persons under plenary guardianship and many of those under partial guardianship are deprived of the capacity to make even simple decisions about their lives, including choosing their place of residence. Some studies show how guardianship is often used by family members to remove and place 'unwanted' family members with mental health problems in institutions.⁴⁷

The right to make one's own decisions and be equal before the law is a fundamental right, guaranteed by Art. 20 of the Fundamental Rights Charter of the European Union, and Art. 12 of the UN CRPD. Therefore, the country reports also show how countries have made or failed to make steps to bring their legislation in line with their international obligations, most

⁴⁵ Available here: <http://fra.europa.eu/en/publication/2012/involuntary-placement-and-involuntary-treatment-persons-mental-health-problems> (In English, last accessed October 2012)

⁴⁶ MDRI (2007). *Torment not Treatment: Serbia's Segregation and Abuse of Children and Adults with Disabilities*. Mental Disability Rights Initiative.

Verdes, T., Tóth M. (2008). *A per tárgya. Gondnokság alá helyezett személyek társadalmi kirekesztődésének mozgásformái a rendszerváltás utáni Magyarországon*. ELTE Budapest. (in Hungarian)

⁴⁷ MDAC & SHINE (2011). *Out of Sight – Human Rights in Psychiatric Institutions and Social Care Homes in Croatia*. Mental Disability Advocacy Center, Budapest.

prominently with the UN CRPD. The most recent case law of the European Court of Human Rights also highlights the problem of legal capacity and involuntary treatment in relation to institutional care. In the *Stanev vs. Bulgaria* case, the applicant's involuntary placement into a mental health institution, agreed by his guardian, was found unlawful by the Court.

Findings

The 32 country reports are presented in the Annex to this Report. A general finding of the survey – that coincided with findings from previous studies⁴⁸ – is that data is often not readily available, and in some countries there is very limited data available at the national level because the health and/or the social care system is decentralised (e.g. Austria, Italy, Spain).

Types of residential care

There are two main types of institutional care for people with mental health problems in Europe: psychiatric hospitals and social care institutions. The main difference between them is that psychiatric hospitals are (predominantly) medical settings, typically financed from health budgets, the basis of one's admission into a hospital is a medical diagnosis and the purpose is intended to be therapeutic. Unlike hospitals, social care institutions or residential homes for people with mental health problems are non-medical settings, often with no therapeutic purpose and are intended to respond to the individual's social care needs (e.g. housing, support for daily living etc.). They can be financed from a variety of sources but most commonly from social care budgets.

Psychiatric hospitals are still widespread in Europe. Although most of the beds in these hospitals – similarly to psychiatric wards in general hospitals – are for short-term acute patients, many individuals with mental health problems live in psychiatric hospitals for longer periods. Information on this is very limited, but in countries where data is available it shows that the length of time and the number of patients can be significant. For example 19% of the 27,900 patients in "public specialized psychiatric hospitals" (CHS) in France have been hospitalized between one and five years, and 23% have been hospitalized for over five years. In Malta, 43% of patients have been staying for five years or longer in psychiatric hospitals and a further 14% have been staying between one and five years. In Bulgaria, it is estimated that approximately 30% of the patients live in psychiatric hospitals for more than three years. Greece has around 660 long-stay patients in the five psychiatric hospitals that are still open following a major deinstitutionalisation programme in the 1980-90s, and Belgium has over 13,000 long-stay psychiatric beds in psychiatric hospitals.

Fourteen countries reported having social care institutions that have approximately 125,000 residents with mental health problems in total. However, this number should be treated carefully because social care institutions are often mixed provision – the same type of service might be provided to people with different disabilities, or people with different disabilities can be accommodated in the same institution. This is particularly common in Central and Eastern Europe. For example, in Serbia approximately 2000 people with mental health problems live in the five social care institutions of the country, and in the largest institution out of the 921 residents 534 have mental health problems, while the rest have other disabilities. In Hungary, the total number of places in social care institutions for people with mental health problems is 7140, but the real number of people with mental health problems in institutions might be

⁴⁸ Freyhoff et al. 2004, Mansell et al. 2007, Medeiros et al. 2008

considerably higher because some live in institutions for people with intellectual disabilities or in nursing homes for older people.

The number of people with mental health problems is higher in social care institutions than in long-stay psychiatric hospitals in Bulgaria, Croatia, Hungary, Poland, Romania and Moldova (information about Slovakia and Czech Republic was limited). The number of people with mental health problems receiving long-term support in the community is greater than the number of people in long-stay hospitals or institutions in 10 countries, while in 18 countries more people live in institutional or long-term hospital settings than in the community (see map below). There was limited information about four countries: Austria, Cyprus, Ireland and the Netherlands. Although community-based residential support exists in most countries, in some cases it only reaches a small minority of people with mental health problems who use residential services. For example, in Croatia approximately 4000 people live in social care institutions, while only 75 people use community-based organised housing. Or, in Moldova, there are 17 places in community sheltered housing compared to 1925 beds in long-stay psychiatric hospitals and 1688 places in social care institutions.



There is a variety of community-based residential settings that differ in size and intensity of support. Small-scale arrangements that provide residential support to up to four service users are available in many countries (for example protected apartments in Greece, assisted living in Germany, supported living in the UK and Finland, sheltered housing in Moldova etc.). Some arrangements labelled as “community-based” are larger group home settings (e.g. group homes in Hungary, Lithuania and Germany).

Some MHE members highlighted gaps in supporting the transition from hospital treatment to independent living in the community. For example, in Cyprus, individuals with mental health problems are often placed in old people’s homes temporarily before they can return to the community. Many residents are placed in social care institutions because there is no social housing or supported living arrangements.

Personal budgets

The term “personal budget” describes arrangements where people with mental health problems receive a certain amount of money that can be used to pay for support and services to assist independent living in the community, and in some cases for therapeutic services. Personal budgets enable individuals with mental health problems to take control of their own support and purchase the services they need.

Personal budgets for people with mental health problems are available in two countries – Germany and the UK. In the UK, people with mental health problems can access various forms of personalised budgets such as personal budgets and direct payments for some social care services. Personal health budgets are currently being piloted in many parts of England. Personal budgets are piloted in some parts of Italy. In three countries, the Czech Republic, Belgium and the Netherlands, although personal budgets are available for people with other disabilities, people with mental health problems cannot access them.

Deinstitutionalisation

Sixteen countries reported current mental health strategies that identify deinstitutionalisation or the strengthening of community based-care as an objective (see map on next page). For example, Belgium launched a major reform of mental health care, commonly known as article 107, in 2011. The reform aims to reduce the number of psychiatric beds by 10% and improve the organisation of care through the creation of networks of care. In Finland, the national plan for mental health and substance abuse work for 2009-2015 – also known as the “Mieli” plan – foresees a 30% reduction in psychiatric hospital beds by 2015 and the expansion of the clubhouse network of mental health rehabilitation services to cover the whole country. Moldova has a National Programme on Mental Health for the period 2012-2016 that aims to reduce the number of places in psychiatric hospitals and increase the availability of beds in general hospitals.

Some MHE members raised concerns about the commitment of governments and the implementation of deinstitutionalisation (e.g. Serbia, Latvia). In Serbia, although the closure of long-stay hospitals is mentioned in the Mental Health Strategy, it does not feature in the Action Plan that sets out its implementation.



Nine countries have a deinstitutionalisation strategy or programme in social care (Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Slovakia, Moldova, Romania and Ireland) and one country is currently preparing a strategy (Lithuania). In four of these countries (Croatia, Hungary, the Czech Republic and Slovakia), institutions for people with mental health problems are either excluded from these reforms or they are included but under less favourable conditions (see map on next page) compared to other institutions (e.g. children or adults with intellectual disabilities). This is often because people with severe mental health problems are perceived to be “more problematic,” and more opposition is expected from local communities towards the closure of social care institutions for people with mental health problems and the establishment of community-based support and housing. For example, Slovakia adopted the *National action plan for the transition from institutional to community-based care in the social services system* in 2011. The first pilot phase of the programme supports projects to replace social care institutions with community-based services for children, people with disabilities and older people –

institutions for people with mental health problems are not included. Similarly, the Czech Republic is implementing the pilot programme *Support for the Transformation of Social Services*. The programme backs up the transformation of 33 social care institutions mainly for people with intellectual disabilities – it is estimated that approximately 10-15% of their residents are people with mental health problems. Psychiatric hospitals or social residential services for people with mental health problems are not included in the programme. In Hungary, although social care institutions for people with mental health problems are eligible for funding from the capital investment programme that aims to replace institutions with community-based group homes or smaller institutions, they are excluded from the *National De-institutionalisation Strategy* that was adopted in 2011. Croatia plans to move 30% of people with disabilities from institutions to community-based settings by 2016, however only 20% of residents with mental health problems currently living in institutions are planned to move to community-based settings by 2018.



Four countries (Hungary, Romania, Latvia and Slovenia) are investing in the infrastructure of psychiatric hospitals or social care institutions – most of them using European Union Structural Funds. These investments often run counter to international human rights obligations - Hungary's capital investment programme supports the replacement of social care institutions of more than 50 places with group homes and new institutions with up to 50 places over the next 30 years. In Romania, the National Strategy for the Protection, Integration and Inclusion of Persons with Disabilities (2006-2013) sets out the "modernisation" of social care institutions – the country has been investing Structural Funds in the refurbishment of existing institutions. In Latvia, the Government guaranteed bank loans to psychiatric hospitals for reconstruction and expansion in the mid-2000s, and the current '*Programme for the development of social care and social rehabilitation services for persons with mental disabilities*' allocates funding to the further development of institutional care. Slovenia has been increasing the number of places in social care institutions. This is the case in spite of the fact that all of these countries have ratified the UN CRPD. A recent report states that such investments of European funding are illegal given the EU's ratification of the UN CRPD.⁴⁹

The involvement of civil society, including users' or disabled people's organizations in the development of new legislation on legal capacity seems limited. In most countries, government plans remain unclear, and legislative proposals are often disclosed only at the last minute, which results in a lack of information and runs counter to Article 4 (3) of the UN CRPD.⁵⁰ Hence, we were not able to collect in-depth information on the exact nature of the planned changes in every country.⁵¹

Guardianship and involuntary treatment

Twenty-five out of the 32 European countries covered by this report have guardianship regimes that implement plenary substitute decision-making, contrary to the provisions of the UN CRPD. This means that people with mental health problems are not able to make their own decisions in most areas of life, including choosing their place of residence, refusing medical treatment, or signing any type of contract. In most countries, both plenary and partial guardianship are possible, and in only two countries, Germany and Sweden, only some form of partial guardianship is used.

According to country reports on involuntary treatment, forced admission to institutions often happens simultaneously with the legal incapacitation of the person – and from then on, decisions happen behind the individuals' back. Even in those countries (e.g. Estonia, Cyprus, Germany), where the law requires the person to be present and heard at the court, there is no due process of law, or the law is complemented with a clause that allows the procedure to continue without the person's involvement, in case being heard would have a 'detrimental effect' on his/her health. In some countries (e.g. Italy, Latvia, Czech Republic) the law does not make it mandatory that the person with mental health problems is heard during the court procedures that deprive them of their legal capacity.

⁴⁹ See the report of Open Society Foundations – Mental Health Initiative (in English, last accessed in October 2012): <http://www.opensocietyfoundations.org/sites/default/files/europe-community-living-20120507.pdf>

⁵⁰ Article 4 (3) of the CRPD states that in decision-making processes relating to persons with disabilities, States Parties should actively involve people with disabilities (and people mental health problems), through their representative organizations.

⁵¹ About the lack of involvement of civil society in mental health legislation, see also Jasna Russo: Civil society involvement in mental health policy making and legislation. (Available at: http://www.antistigma.eu/sites/default/files/ASPEN_WP7_CIVIL_SOCIETY_INVOLVEMENT.pdf, in English, last accessed October 2012)

However, despite the widespread guardianship systems, seven countries (Bulgaria, Czech Republic, Ireland, Latvia, Lithuania, Malta, Moldova, Slovakia) are currently introducing or planning to introduce new, according to available information, more progressive legislation (see map below). In the Czech Republic, the new law introducing elements of supported decision-making systems has already been approved and it will enter into force in 2014. In Malta, the draft bill amending the Civil Code is awaiting the Parliament’s approval and will include more safeguards, including a Commissioner, and will also refer to supported decision-making. In Latvia, an inter-ministerial working group starts working in 2012 on the preparation of the new law and the development of support systems. In Bulgaria, a new legislative proposal was made following the judgement of the European Court of Human Rights in 2012, where, in the *Stanev v. Bulgaria* case⁵², Bulgaria was found to have breached its international obligations under the European Convention on Human Rights when a person with mental health problems was sent to an institution by his guardian. According to the proposals, the new Bulgarian legislation will introduce elements of supported decision-making and will not allow for plenary deprivation of legal capacity.



52 About the case see more here: <http://strasbourghobservers.com/2012/02/29/stanev-v-bulgaria-the-grand-chambers-cautionary-approach-to-expanding-protection-of-the-rights-of-persons-with-psycho-social-disabilities/>

In some countries, new or planned legislation is not necessarily progressive. In Hungary, a new Civil Code was proposed in 2010, introducing significant and satisfactory changes, but the law never entered into force; instead yet another new Civil Code is being developed which, according to available information from MHE members, will probably sustain plenary guardianship. In 2012, the Serbian government also set up a working group and started preparing further work on the amendment of the existing legal capacity law, however the development of the new law lacks transparency, hence the content of the changing remains unclear.

Good practices regarding supported decision-making of people with mental health problems are scarce. In Southern Sweden a civil organization maintains a network of 'personal ombudsmen,' a system that implements supported decision-making, based on Article 12 of the UN CRPD. The support system of personal ombudsmen has become a best practice based on principles that give full respect to users' rights and needs and has attracted wide international attention.

Involuntary admission and treatment are still common in institutions, and none of the countries covered by this Report prohibit it. It is also crucial to highlight that forced treatment is not limited to institutions or hospitals, but is increasingly common in the community, perpetuating the social exclusion of people with mental health problems even in countries that have made significant progress in closing psychiatric hospitals and institutions and the development of community-based care.

For example, the United Kingdom introduced 'Community Treatment Orders' (CTO) in 2007. Monitoring⁵³ the use of such orders raises serious concerns and shows that the number of people subject to CTOs has risen each year since its introduction, and represents an increasing proportion of the inpatient population. Data also shows that CTOs are being used more frequently with some ethnic communities, and are being used on over a third of patients who have no history of non-compliance with treatment or of disengagement with services. In France, a new law on involuntary treatment entered into force in 2011. Despite some improvements to previous legislation, according to the new law, psychiatric care without consent may now be imposed outside of the hospital. It allows psychiatrists to prescribe anti-psychotic drugs without the consent of the patient on an outpatient basis, violating their human rights and their human dignity. Very little effort to communicate with and inform users of psychiatry of their rights and treatment in this situation is made. Civil society organizations raised their concerns about the lack of clear definitions, safeguards, and the lack of a requirement for the person's consent.

53 See: http://www.mentalhealthalliance.org.uk/news/MHA_May2012_FINAL.pdf (in English, last accessed in October 2012)

Conclusions

Many people with long-term mental health problems live in institutions that claim to provide *social* care. Coordination between social and health care systems is often weak, therefore these institutions and their residents have so far been left out of mental health reforms. Many people with mental health problems are still hospitalised for long periods of time in psychiatric hospitals, and they are forced to use institutional services because there are no suitable alternatives in the community. People are often prevented to move on to more independent, community-based arrangements because these are simply not available.

Many European countries are currently implementing mental health and social care reforms. Some countries have deinstitutionalisation strategies that discriminate against people with mental health problems – mental health institutions are either excluded from deinstitutionalisation programmes or are otherwise disadvantaged (e.g. receive less funding etc.). This is often linked to the strong stigma attached to people with severe mental health problems.

Some countries in Central and Eastern Europe are investing EU Structural Funds to build new institutions or to renovate existing ones. The use of EU Structural Funds for renovating existing institutions or for the building of new ones also raises concerns for the European Union. The EU has ratified the UN CRPD and therefore has a responsibility to ensure that the use of Structural Funds is in line with its provisions. The use of Structural Funds to build or to renovate institutions breaches the EU's obligations under the UN CRPD but also under the European Convention on Human Rights. Furthermore, the use of EU funds to support institutions amounts to indirect discrimination.⁵⁴

Deinstitutionalisation strategies often focus on the creation of new infrastructure and their main concern is the relocation of people into smaller homes – group homes or other forms of sheltered housing. This practice runs the risk of re-creating institutions on a smaller scale.

Personal budgets that enable service users to take control of their own support and get the services they need to live independently in the community are available in only a few countries.

The majority of countries in Europe have restrictive guardianship regimes that prevent living independently in the community. Supported decision-making systems or practices are still uncommon.

Involuntary admission, a major cause of the institutionalisation of people with mental health problems, and forced treatment are widespread in Europe, and treatment practices often result in serious harm, or even in the death of patients. Residents of institutions are repeatedly victims of abuse and medical experiments in many countries. The use of compulsory treatment orders in the community is particularly troubling and results in social exclusion even for those not living in institutions, making the transition from institutional to community-based care meaningless. Involuntary admissions and forced treatment are contrary to the UN CRPD, and amount to disability discrimination under EU non-discrimination legislation and policies.

Based on the findings of this Report Mental Health Europe makes the following recommendations to the European Union and to governments across Europe:

⁵⁴ Parker and Clements 2012

Recommendations

1. Governments should improve coordination between mental health and social care systems and ensure that reforms in both areas are designed and implemented jointly to prevent the long-term institutionalisation of people with mental health problems, and to help those in institutions to return to the community and receive appropriate support. Where psychiatric hospitals exist, there is always pressure to fill them, and if long stay beds exist, they will be used. Therefore, the use of non-medical approaches should receive priority, and the structure of treatment and its setting should move people into ordinary life with support as rapidly as possible. These approaches should focus on individual needs and rehabilitation, personalised care and service user involvement in decision making
2. Governments and the European Union should strengthen the monitoring of existing programmes, especially the use of Structural Funds by involving organisations of (ex)users of psychiatry and other relevant advocacy organisations, to ensure that these reforms result in changes in the way people are supported, and that long-stay hospitals and institutions are replaced by non-institutional community-based support mechanisms. This should be complemented by the exchange of information and experiences between countries in the mental health field.
3. Governments should support anti-stigma programmes. Campaigns and awareness-raising both in the national and the local level should always be an integral part of mental health reforms, deinstitutionalisation strategies and implementation.
4. The European Union should ensure that institutional closure programmes implemented using EU Structural Funds include institutions for people with mental health problems. The EU should develop binding legislation on Structural Funds for the 2014-2020 programming period that includes rules of conditionality on investments, in order to ensure strict compliance by Member States with their legal obligations (Art. 19 of the UN CRPD). In particular, such rules should make it clear that:
 - The European Commission and Member States (in accordance with the UN CRPD) are under an obligation to safeguard the right of people with mental health problems to live in the community by investing Structural Funds in programs that promote their inclusion and independent living in the community.
 - Projects that propose to invest Structural Funds in the maintenance or extension of institutions are contrary to the UN CRPD, as well as to the EU's own policies on equal opportunities, social inclusion and discrimination, and are therefore must not be eligible for funding.
5. Member States should introduce personal budget schemes to support deinstitutionalisation and community living. Those member states that already have such schemes should ensure that these are equally available to people with mental health problems.
6. Governments should develop laws and policies to replace substitute decision-making by supported decision-making, which respects the person's autonomy, preferences and wishes. They should also ensure competent implementation of these laws and policies, for example by providing training for all relevant public officials and other stakeholders.
7. Governments should review their laws that allow for the deprivation of liberty on the basis of disability, including mental health problems, and abolish involuntary confinement linked to disability. They should also adopt provisions to ensure that mental health care services

are based on the informed consent of the individual. Governments should also introduce adequate control and monitoring mechanisms as well as independent patient information and advocacy services.

8. The European Union should bring its legislation in line with UN CRPD standards and develop non-discrimination legislation and policies that cover forced admission and forced treatment.
9. Governments should implement independent monitoring mechanisms that ensure the respect of the rights of people with mental health problems living in the community, and develop legislation on monitoring that is in line with the UN CRPD and the relevant jurisprudence of the UN CRPD Committee.
10. Governments 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.

Regarding all the above recommended actions, governments and bodies of the European Union must respect the provision of Article 4 (3) of the UN CRPD which requires the involvement of people with disabilities, including people with mental health problems, in all actions concerning them, through their representative organizations.

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Annex

Austria

Population: 8.443.018¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

31

General summary

Providing services for people with mental health problems is the responsibility of the nine federal states (Bundesländer) in Austria. Each state has its own regulation and provision of services, and there is a variety of services including institutions and community-based support. Services for people with mental health problems are based in psychiatric hospitals or hospital wards and a network of community-based services such as day centres, counselling and crisis intervention services etc. Information about mental health services is collected at the level of federal states, but very limited summary data is available for the whole country. In 2008 there were 3,330 inpatient places for people with mental health problems (4 places/10,000 population).²The figures presented in this country report are only for one of the federal states: Upper Austria (Oberösterreich).

Types of residential services for people with mental health problems in Upper Austria³.

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric hospitals, psychiatric and/or neurologic departments within hospitals	1. Landesnervenklinik Wagner Jauregg (Linz) with several departments: Kinder- und Jugendpsychiatrie, Psychiatrie, Forensik, Drogen-Station etc.) 2. Klinikum Wels-Grieskirchen GmbH (Oberösterreich) 3. Psychosomatik Enns (Oberösterreich) 4. Landeskrankenhaus Vöcklabruck (Oberösterreich) 5. Krankenhaus St. Josef, Braunau (Oberösterreich)	–	Approximately 650 places

¹ Eurostat, 2012

² Gesundheit Österreich (2008). Betten-Ist-Stand in der Psychiatrie. Verfügbar unter: <http://www.goeg.at/de/Bereich/Betten-Ist-Stand-in-der-Psychiatrie.html> (Last accessed: 31 October, 2011).

³ Source: various sources, 2009/2010

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric rehabilitation center	1. „Sonnenpark“ Bad Hall (Oberösterreich)	n/a	120 places
Support in everyday life/ supported living	1. pro mente OÖ Mobile Betreuung 2. pro mente OÖ Lebensform Familie 3. pro mente OÖ Laienhilfe 4. EXITsozial Mobile Betreuung 5. ARCUS Sozialnetzwerk Mobile Dienste	–	–
Group home / residential home	1. Wohnen pro mente OÖ 2. Wohneinrichtung Neuland OÖ (Forensik) 3. EXITsozial Betreutes Wohnen 4. ARCUS Sozialnetzwerk Wohnen	15 places	28 projects

Types of residential services for people with mental health problems whole of Austria (WHO Mental Health Atlas 2011)⁴

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric hospitals (acute psychiatric beds only, rehabilitation and forensic beds excluded)	7	-	1787 beds
Psychiatric beds in general hospitals (acute psychiatric beds only, rehabilitation and forensic beds excluded)	N/A	-	1207 beds
Community residential facilities	256	-	2512 places

Personal budgets

Personal budgets are not available for people with mental health problems in Austria.

⁴ http://www.who.int/mental_health/evidence/atlas/profiles/aut_mh_profile.pdf

Deinstitutionalisation

In Austria there has been a reduction of places in psychiatric hospitals. In 1998, a mental health provision was incorporated in the Austrian Hospital Plan that set out guidelines for the decentralisation of the large psychiatric hospitals and the replacement of provision in regular hospitals (DECLOC Part 3, 2007). In Upper Austria the legal base is "Chancengleichheitsgesetz" that set out the plan to close down institutions within the Equal Opportunities Act (Planungsbeirat) and the Equality Programmes (Chancengleichheitsprogramme) (work in progress at the moment).

Involuntary placement

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. However, the explanatory report to the Bill amending the Compulsory Admission Act (Unterbringungsgesetz, 155/1990), passed in 2010, refers to the CRPD.⁵

Guardianship

The Civil Code (Allgemeines Bürgerliches Gesetzbuch) provides three types of guardianship: (a) for a single issue; (b) for several matters, this is the most-used category; (c) for all matters. A person may be put under guardianship if he/she is not able to adequately take care of his/her own affairs. The law, however, does not provide definition for 'capacity' or 'competence'.⁶ There are around 60.000 people living under guardianship in Austria.⁷ That is 0.75% of the country's population.

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⁵ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-AT.pdf>

⁶ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-AT.pdf>

⁷ http://www.international-guardianship.com/pdf/GBC/GBC_Austria.pdf

Belgium

Population: 11.041.266

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

In Belgium, hospital- and community-based provisions for people with mental health problems co-exist. The country has one of the largest number of psychiatric beds per inhabitant in the European Union. Psychiatric hospitals offer both long- and short-stay places.

Types of residential services for people with mental health problems in Belgium¹

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Long-stay psychiatric beds in psychiatric hospitals	70	110 (15-850)	13,429
Psychiatric nursing homes	12	10 – 60	3286
Psychogeriatric beds in psychiatric hospitals	36 hospitals	20 – 60	990
Psychiatric night care in hospitals	38 hospitals	5	168 (42 child)
Supported living	45 organisations (715 locations)	1 – 10	3899
Foster Family Care	2 organisations	1 – 2 per family	538

Personal budgets

Personal budgets are not available for people with mental health problems in Belgium.

Deinstitutionalisation

Belgium has been implementing a major mental health care reform since 2011. This reform programme is commonly known as article 107, and refers to article 107 of the hospital law. One of the aims is deinstitutionalisation and the reduction of the number of psychiatric beds by

¹ Source: Federal Government (F.D.D), Min. of Health 2011

"Evolutie van het aantal en de grootte van de psychiatrische Ziekenhuizen" F.O.D Volksgezondheid Directoraat Generaal Organisatie van de Gezondheidsvoorzieningen Geestelijke Gezondheid in België. November 2011.

10%. The main objective of the reform is better organisation of care through the creation of networks of care. These networks – asort of cooperation of all the organisations of care within a region – are given the responsibility to organise the mental health care in a more consistent, effective way, so that users have a smoother and matched trajectory. These networks can also establish new mobile teams (for emergency mental health care and for long-term care).²

Involuntary placement

In Belgium, forced admission in a psychiatric institution is set by law and only possible for “mentally ill” persons who are a danger to themselves or others and refuse treatment. 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. At the same time, the need for a therapeutic purpose is not stipulated in the regulation. The Patients’ Rights Act (2002) also provides for legal protection for users of mental health services, mostly covering areas such as consent to interventions, access to the best available quality service, information on one’s personal condition and lodging complaints. However, in the section on ‘Freedom to choose a healthcare practitioner,’ mandatory admissions into mental health services are excluded.³ There is no law that forces persons with a disability to live in an institution, but neither is there a law about the legal right to live independently in the community.⁴

Guardianship

For a person to be declared as “lacking capacity,” he or she has to have a permanent mental health problem or intellectual disability. An extension of minority is possible for people with intellectual disability, which can either be congenital, or have developed during early childhood. A legal adviser can be appointed for people whose condition is not serious enough to declare them incompetent.

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² For more information: http://ec.europa.eu/health/mental_health/docs/ev_20110303_co28_en.pdf (in English, last accessed: September 2012) or www.psy107.be (in Dutch and French, last accessed: September 2012).

³ http://www.health.belgium.be/eportal/Myhealth/PatientrightsandInterculturalm/Patientrights/BillRightsPatient/8294404_EN (in French, accessed on 24 September 2012); http://www.health.belgium.be/eportal/Myhealth/PatientrightsandInterculturalm/Patientrights/BillRightsPatient/8294404_FR?fodnlang=fr (in French, accessed on 24 September 2012); <http://www.health.belgium.be/eportal/Myhealth/PatientrightsandInterculturalm/Patientrights/BillRightsPatient/8294404?fodnlang=nl> (in Dutch, accessed on 24 September 2012).

⁴ http://www.disability-europe.net/dotcom?term%5B%5D=193&term%5B%5D=148&term%5B%5D=149&term%5B%5D=150&term%5B%5D=151&term%5B%5D=164&term%5B%5D=165&view_type=detail_list (last accessed 19 September 2012)

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Bosnia and Herzegovina

Population: 3.839.737¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

37

General summary

Bosnia and Herzegovina provides long-term accommodation for people with mental health problems in large institutions. There are seven institutions in Bosnia and Herzegovina and they tend to accommodate various service user groups. Often, children and adults with mental health problems and forensic patients live together in the same institution. For example a report by the Ombudsman's Office (2009)² noted that in the Institution Drin, 70 children of "all ages and diseases" lived together with persons with severe mental health problems and forensic patients who had committed offences of homicide (p 24). The report also highlighted the lack of therapeutic facilities and activities and poor access to health care for residents.

Types of residential services for people with mental health problems in Bosnia and Herzegovina³:

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Institution for people with mental disabilities "Bakovići"	1	-	350
Institution for people with mental disabilities "Drin", Fojnica	1	-	520
Institution for children and young people with mental disabilities "Pazarić"	1	-	384
Centre for the elderly and the homeless "Duje", Doboj East	1	-	324
Institution for treatment, rehabilitation and social welfare of people with chronic mental health problems "Jakeš"	1	-	290

¹ Bosnian Statistic Agency, http://www.bhas.ba/?option=com_publicacija&id=1&lang=ba (in English and Bosnian, last accessed October 2012)

² <http://www.ombudsmen.gov.ba/docs/SpecialReportontheSituationofHumanRightsintheInstitutionsforAccommodationofMentallyDisabledPersons.pdf> (in English, last accessed : August 22, 2012)

³ Source: Special Report on Conditions in Institutions for People with Mental Disabilities in Bosnia and Herzegovina, The Institution of Human Rights Ombudsman of BiH, September 2009; direct contact with institutions

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Institution for the protection of female children and young people "Višegrad"	1	-	150
Home for children and youth with developmental disabilities "Prijeđor"	1	-	211
Sheltered housing (part of the community mental health centre in Doboj)	1	-	3
Sheltered housing (part of the institution in "Jakeš")	1	-	12

Personal budgets

Personal budgets are not available for people with mental health problems in Bosnia and Herzegovina.

Deinstitutionalisation

The mental health strategies in both entities of Bosnia and Herzegovina (the Federation of Bosnia and Herzegovina and the Republika Srpska) identify the establishment of community-based services for people with mental health problems as important objectives.

Guardianship

Bosnia and Herzegovina maintains a traditional guardianship system. Most of the residents of mental health institutions are under plenary guardianship. The procedure of deprivation of legal capacity can be initiated by the court on an ex-officio basis, but also by certain persons: a guardian, the spouse of the person being deprived of legal capacity, his or her direct blood relatives etc. People under guardianship are unable to make decisions in matters such as where to live, with whom and under what conditions, and they do not have the right to parenthood. The Bosnian legislation requires that a person being deprived of legal capacity must be examined by a psychiatrist, and that the court shall make its decision based on facts established at the hearing. However, it often happens that in practice the courts make decisions on partial or complete deprivation of legal capacity based on the findings of a single psychiatrist. The person with mental health problems is often not even present at the hearing, and not even informed about the initiated procedure.⁴

Involuntary treatment

In 2010 the CAT Committee expressed its concerns about *"issues of institutional accommodation of mentally disabled persons, in particular with regard to overcrowding in institutions and lack of adequate psychosocial support by competent organs"*. The Committee recommended that *"the State party ensure that adequate psychosocial support by multidisciplinary teams is provided for patients in psychiatric institutions and that all places where mental-health patients are held for involuntary treatment are regularly visited by independent monitoring bodies to guarantee the proper implementation of the existing safeguards, and that alternative forms of treatment are developed"*.⁵

⁴ Practicing Universality of Rights: an of the implementation of the UN Convention on the Rights of Persons with Disabilities in view of persons with intellectual disabilities in Bosnia and Herzegovina, Kosovo, Serbia, People in Need, 2012, p. 37-35.

⁵ http://www2.ohchr.org/english/bodies/cat/docs/CAT.C.BIH.CO.2-5_en.pdf

Bulgaria

Population: 7,327,224¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	No

39

General summary

Most residential services for people with mental health problems are provided in institutions and psychiatric hospitals. Bulgaria has received considerable international attention for the dire physical conditions and violations of human rights in institutions for children and people with disabilities. Institutions are typically located in remote rural areas making it difficult to maintain / build social relationships and providing poor access to community facilities and employment opportunities. There are some community-based arrangements but these only reach a minority of people with mental health problems who need residential support. There are very few – if any – community based services available in larger cities, such as the capital Sofia. Some people with mental health problems live in institutions for people with intellectual disabilities or dementia but their number is not known. There is no data available for the number of chronic beds in the state psychiatric hospitals as the statistics are based on general number of beds/average use of beds per year/average stay per person. In 2008 a new system for financing hospitals was introduced, according to which the payment is calculated on the basis of patient turnover. As a result the hospitals' management adopted a procedure of formally discharging mental health patients and immediately re-admitting them again. That procedure, along with the way the data is collected, results in incorrect information. According to the official data the average stay in psychiatric hospital was approximately 60 days per patient in 2011. In reality, each of the 11 hospitals has chronic departments and it is estimated that approximately 30% of the patients have lived there for more than three years.

Types of residential services for people with mental health problems in Bulgaria²

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Social care homes for people with mental disabilities	15	60-100	1249
Social care homes for elderly with dementia	13	60-100	843
Social care homes for people with intellectual disabilities	28	60-100	2349
Psychiatric hospitals	12		2705*
Family-type housing centers	29	4-12	360

¹ Eurostat, 2012

² Source of data: Agency for Social Assistance, 2012 *WHO Mental Health Atlas 2011

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Half-way houses for people with MH problems on the grounds of institutions	2	4-5	9
Supported houses for people with mental health problems	24	10-16	241

Personal budgets

There are no personal budgets for people with mental health problems in Bulgaria.

Deinstitutionalisation

The international attention and the accession to the European Union prompted the Bulgarian government to take action towards closing institutions for children and adults and towards creating community-based services. The concept of “community based services” was introduced in 1998 with the adoption of the Social Assistance Act. The Act decentralised the provision of social services that can now be delivered in specialized institutions and in the community, and can be provided by the state, by local authorities and by registered providers. Community-based services have been developing slowly during the last 15 years but still two parallel systems of services exist. A major concern is that the newly-established community-based services are funded as institutions and often they become increasingly institutional.

The Bulgarian Government adopted a strategy “*Vision for deinstitutionalization of children*” in 2009. The development of a similar strategy for adults with mental health problems has been underway since 2009 but it has not been finalised yet. The deinstitutionalisation of children’s services is seen as a priority.

In 2012, following the judgement of the European Court of Human Rights in the *Stanev v. Bulgaria* case (see textbox) the Bulgarian government announced its commitment to close down all mental health institutions in the country. “A strategy of closing mental homes for adults, currently being worked out, will happen over a period of 10 years at least,” Valentina Simeonova, deputy social affairs minister, told a news conference in February 2012.³

Involuntary placement

In Bulgaria, there is no specific mental health law, the Bulgarian Health Act (Закон за здравето) covers both placement and treatment. The legislation provides for two types of compulsory or involuntary treatment. In the first case, treatment is provided upon committal to an inpatient facility for compulsory treatment. The second relates to emergency circumstances and conditions constituting a threat to life.

In 2004, the CAT Committee raised its concerns about “*Poor conditions in homes for persons with mental disabilities and the insufficient steps taken thus far by the authorities to address this situation, including the failure to amend the legislation relating to involuntary placement in such*

³ http://www.eubusiness.com/news-eu/bulgaria-rights.f09?utm_source=twitterfeed&utm_medium=twitter

an institution for purposes of evaluation and the lack of judicial appeal and review procedures". The Committee recommended that Bulgaria "undertake all necessary measures to address the situation in homes and hospitals of persons with mental disabilities to ensure that the living conditions, therapy and rehabilitation provided are not in violation of the requirements of the Convention (Against Torture)."⁴

Guardianship

The Bulgarian legislation, in issues related to legal capacity, is based on substitute decision making. Guardianship law is set out in the Individuals and Family Act (Законзалицата и семейството) and the Family Code (Семеенкодекс). Incompetence is the deprivation or limitation of a natural person's civil legal capacity (дееспособност) – their ability to conduct lawful legal acts, through which they initiate, preserve, amend or terminate rights and responsibilities. The Individuals and Family Act recognises only two degrees of incompetency: full and partial, where a person with partial incompetency is placed on the same level of capacity as a juvenile (14-18 years old); a person who has been declared fully incompetent is given the same status as a minor (up to 14 years of age).⁵ Approximately 85% of all people under guardianship are under plenary guardianship.⁶

Following the judgement of the ECtHR in the *Stanev v Bulgaria* case (see textbox), the Bulgarian Ministry of Justice established a working group in 2012 on the reform of the relevant legislation. The proposals for changes in the law show a will for a significant move forward to a more CRPD-compliant legislation: plenary guardianship will not be possible, and supported decision making will be enshrined in the law. However, human rights organizations raised further comments to the proposals including the calling for more safeguards, more specific definitions and the full recognition of equal legal capacity.

In the *Stanev v. Bulgaria*, often called as a landmark victory in relevant European case law, in 2012, the European Court of Human Rights found that Bulgaria violated the applicant's rights. The Court found a violation of Article 5 (1) of the European Convention on Human Rights, finding that Mr. Stanev (who had a diagnosis of schizophrenia) was "detained" in a social care institution. The Court decided that as Mr. Stanev, due to being under guardianship, was legally unable to challenge or seek compensation for his detention, Articles 5(4) and 5(5) of the European Convention on Human Rights had been violated. The Court also held that Mr. Stanev had been subjected to degrading treatment in violation of Article 3 of the Convention by being forced to live for more than seven years in unsanitary and unlivable conditions and that domestic law did not provide him any remedy for such violations.

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⁴ [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/CAT.C.CR.32.6.En?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/CAT.C.CR.32.6.En?Opendocument)

⁵ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-BG.pdf>

⁶ http://mdac.info/sites/mdac.info/files/English_Guardianship_and_Human_Rights_in_Bulgaria.pdf

Croatia

Population: 4,398,150¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

In Croatia, the majority of residential services for people with mental health problems are accommodated in social care homes. In 2011 there were 3999 service users with mental health problems living in these institutions, while only 75 people received community-based residential support, according to the official statistical data of the Ministry of Social Policies and Youth. Two recent reports – by the Mental Disability Advocacy Centre and SHINE², and Human Rights Watch³ – revealed the situation in Croatian institutions.

Types of residential services for people with mental health problems in Croatia⁴

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Psychiatric hospitals	7	-	3353
Social care institution – state provision	18		3292
Social care institution – private provision	10		1100
Organised housing	N/A	N/A	75

Personal budgets

Personal budgets are not available for people with mental health problems in Croatia.

Deinstitutionalisation

Croatia has a National De-institutionalisation strategy for the period 2011-2016 (2018). People with mental health problems are discriminated within the Strategy when compared to people with other disabilities. The Government plans to move 30% of people with disabilities from institutions to community-based settings by 2016, however only 20% of service users with mental health problems currently living in institutions by 2018. The Government argues that

1 Eurostat, 2012

2 <http://www.sjaj.hr/wp-content/uploads/2012/01/outofsight.pdf> (in English, last accessed : August 22, 2012).

3 <http://www.hrw.org/node/93103> (in English, last accessed : August 22, 2012).

4 Source: WHO Atlas 2011 (mental hospitals); Ministry of Social Policies and Youth, Statistical Report, 2011 (social care institutions and organised housing)

people with mental health problems are a more “difficult” population to deal with.

Closures will only affect institutions that are considered to have low material standards. It is planned that community-based services will replace existing care homes but there are no plans to develop community-based services aimed at preventing institutionalization.

The Government also promotes foster care for adults with mental health problems, and the Deinstitutionalization strategy gives priority to the development of foster care for adults, especially in rural areas. As reported by the Human Rights Watch in 2010, foster care for adults is not an appropriate form of support and it can be considered as a form of institutionalization.

Guardianship

There are legal forms of both plenary and partial guardianship for adults in Croatia. In 2011, plenary deprivation of legal capacity affected 16,355 people according to the statistical data of the Ministry of Social Policies and Youth. Although the majority of people deprived of legal capacity live with their families, statistics show that more than 4000 people deprived of legal capacity have been placed in institutions.

Those under plenary guardianship have no right to vote – in a legal system where even those who are convicted for severe criminal offences have the right to vote. In Croatia, the only people who are restricted from voting are persons with disabilities who are fully deprived of legal capacity.

Although both the Croatian People’s Ombudsman and the Disability Ombudswoman have warned the Croatian Parliament and the Government that reform of legislation and changes in practice are necessary to implement Art. 12 of the UN Convention on Rights of Persons with Disabilities, Croatian authorities have not made movement in that course.

In recent case law of the European Court on Human Rights (*X v Croatia*; *X and Y v Croatia*; and *Kruskovic v Croatia*), the Court found that the right to respect for private life and the right to an effective remedy, upheld by the European Convention on Human Rights, were severely violated for applicants who lacked legal capacity.

Involuntary treatment

Involuntary psychiatric treatment in Croatia is regulated by the Protection of Persons with Psychosocial Disabilities Act which establishes judicial control during the involuntary treatment. However, according to reports from civil organizations⁵, such judicial control is not applied when it comes to people fully deprived of legal capacity – when the guardian makes a decision on the need for treatment, then the law considers the treatment as voluntary so there judicial control is not established. In such circumstances, even if the person concerned does not agree with the treatment, his/her legal guardian may give consent for psychiatric treatment – this is usually considered as being “voluntary” in terms of law.

⁵ <http://www.sjaj.hr/wp-content/uploads/2012/01/outofsight.pdf> (in English, last accessed on 19 September 2012)

The Ministry of Justice has recently set up a special working group to prepare new legislation; however no representative of the civil society was involved in the team nor is it known at what stage the preparation of legislation is.

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Cyprus

Population: 862 011¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

45

General summary

There is one psychiatric hospital in Cyprus - the Athalassa Psychiatric Hospital outside the capital Nicosia – that declined in size from 18 wards with over 650 patients in the early 1990s to just over 120 in 2006. The number of patients has been increasing since the mid-2000s.² Gaps in supporting the transition from hospital treatment to independent living in the community have been noted - people with mental health problems are often placed in old people's homes temporarily before they can return to the community.³ There is very limited information on community-based residential services.

Types of residential services for people with mental health problems in Cyprus

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Long-stay psychiatric hospital with 3 closed units and 3 rehabilitation units	1	168	96
Group home	1	3	3

Personal budgets

There are no personal budgets for people with mental health problems in Cyprus.

Deinstitutionalisation

Transferring services from the psychiatric hospitals to the community is a stated objective of mental health policy in Cyprus, alongside the development of community-based services.

¹ Eurostat, 2012

² <http://www.cpt.coe.int/documents/cyp/2008-17-inf-eng.pdf>;
http://www.moh.gov.cy/moh/mhs/mhs.nsf/DMLreports_en/DMLreports_en?OpenDocument

³ Georgiades, S., Messis, C., Kalakoutas, G. (2000). Rehabilitation of people with chronic mental health problems: before and after. Nicosia, Cyprus (<http://mentalhealthcommission.org.cy/el/research/2008/03/>) (in Greek, last accessed: September 4, 2012)

Involuntary placement

The law regulating voluntary and involuntary placement is the Psychiatric Treatment Law of 1997, (N. 77(I)/1997). Its scope covers voluntary treatment, where the patient requests it, and severe “mental disorders” “expressed with violence and serious antisocial behavior or when the patient’s personal judgment has deteriorated to such an extent which renders his placement necessary for the protection of himself and of the persons close to him.” Severe mental disorders warrant involuntary placement.⁴

Guardianship

Legislation makes provision for the administration of the affairs of persons with mental health problems and persons with intellectual disabilities if they are unable to do so. In 1996 a special law was introduced to govern the administration of the property of individuals incapable of managing their property and affairs. The mental health causes determining the legal capacity of adults are specified in the Law on Administration of Property of Persons Incapable of Managing their Property and Affairs are: intellectual disabilities, abuse of toxic substances, alcoholism, brain or other bodily damage, or other condition or illness. The law, however, does not recognise different degrees of incapacity, such as total deprivation of capacity, limitation to perform certain legal acts, etc. Upon psychiatric advice, the Court determines whether a person is or is not capable of administering one’s property and affairs.⁵

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⁴ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-CY.pdf>

⁵ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-CY.pdf>

Czech Republic

Population: 10 505 445¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	No

General summary

Most residential services for people with mental health problems are provided in institutions, although a range of community-based services have been developed in the recent years. Institutions for people with disabilities and mental health problems have received considerable international attention due poor physical conditions, violation of human rights and the continued use of cage beds.²

Psychiatric hospitals offer both short-term and long-term treatment. According to the DECLOC report (Part 3, 2007), over one in ten beds in psychiatric hospitals was occupied by somebody who had been living in the hospital for one year or longer, and some had lived there for 10 years or more. The same report also suggested that nearly a third of the patients in psychiatric hospitals were hospitalised because of social problems, in the absence of adequate community-based provision (e.g. homelessness, on the waiting list for care home etc.).

In addition to service users in psychiatric hospitals, some people with mental health problems live in social care institutions. According to the DECLOC study, there were about 870 places specifically for people with mental health problems in 2005. There is no information about the number of people with mental health services using general or community-based social services. Information from two umbrella associations (Fokus and Association of Community services) shows that there were approximately 5000 admissions to social community based services (sheltered living, day activity centres, community mental health teams, etc.) in 2011. There were about 3500 places available in these community based services.

In the Czech Republic, there is an insufficient number of acute care beds in psychiatric hospital wards. On top of this, the country failed to establish a comprehensive network of community healthcare services. The development of these services is hindered by low levels of financial resources for psychiatric care. There is a lack of crisis mental health services in the community, home treatment, crisis centres, and assertive outreach mental health teams.

Psychiatric hospitals are part of the health care system, social care institutions (care homes) and community-based services are part of the social care system, and are regulated by the Social Services Act.

¹ Eurostat, 2012

² See for example: <http://praguemonitor.com/2012/01/26/pr%C3%A1vo-mental-hospital-patient-strangles-herself-caged-bed>; <http://news.bbc.co.uk/1/hi/world/europe/7181854.stm> (last accessed : August 7, 2012)

Types of residential services used by people with mental health problems in the Czech Republic³

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Social Care Home*	232	40-150	13,836
Social Care Home with special regime**	179	40-60	8396
Psychiatric hospitals	17***	50-1300	9317
Supported-shelters	153	1-15	2626****

*For people with all types of disabilities including (intellectual, physical, mental health etc.)

** Usually there is a mixture of service users that include people with intellectual disabilities and challenging behaviour, people with substance abuse problems, people with psychosis. It is estimated that people with mental health problems make up about 55% of all service users.

*** Includes four psychiatric hospitals for children.

**** Only 170 places are for people with mental health problems (Fokus and AKS data, 2011).

Personal budgets

A system of personal payment exists under the Act on Social Services. In practice, however, persons with psychosocial disabilities are very often excluded due to the assessment process that is tailored to the needs of persons with physical disabilities.

Deinstitutionalisation

The Czech Republic is currently implementing the pilot programme "Support for the Transformation of Social Services." The programme is financed from the Structural Funds of the EU and therefore limited to the funding period 2009-2013. Psychiatric hospitals or social residential services for people with mental health problems are not included in the programme. The programme supports the transformation of 33 social care institutions, mainly for people with intellectual disabilities, but where it is estimated that approximately 10-15% of residents are people with mental health problems. There are concerns regarding the sustainability of the programme after 2013.

Involuntary placement

Substantial basis for involuntary placement can be found in Code on Health Service. This Code provides for the legal basis of deprivation of liberty of persons with mental disabilities. The Bill

³ Source: Report of the Czech Ministry of Labour and Social Affairs, 2009-2010. Report is available in Czech at: http://www.mpsv.cz/files/clanky/10208/Zprava_o_plneni_za_rok_2009-2010.pdf

Institute of Health Information and Statistics of the Czech Republic, Activity of common examination and treatment units 2010. Publication is available in English at: <http://www.uzis.cz/en/publications/activity-common-examination-and-treatment-units-2010>

Institute of Health Information and Statistics of the Czech Republic, In Patient Care. Publication is available in English at: <http://www.uzis.cz/en/catalogue/health-statistic/patient-care>

Vybrané statistické údaje o financování sociálních služeb a příspěvku na péči. Report is available in Czech at: http://www.mpsv.cz/files/clanky/9198/Analyza_fin_SS.pdf

Statistic data of community based services for people with mental health problems, Fokus and Community services Association, 2011, Prague. Available in Czech.

of Rights and Freedoms and Civil Procedure Code provide for procedural rules on involuntary hospitalisation.

In 2011, the Czech Ministry of Justice set up a working group to reform the law in the area of involuntary placement and involuntary treatment, in order to enhance the protection of the rights of persons with mental health problems.

After visits to several psychiatric hospitals, the CPT noted with concern the lack of staff and therapeutic opportunities, which result in increased reliance on pharmacotherapy. It considered the regulation and recording of the use of ECT and biomedical research to be inadequate and was highly concerned by the use of coercive measures, e.g. net-beds and cage-beds, thus recommended their withdrawal. The CPT was also critical about the involuntary treatment review proceedings, noting that patients were typically not heard by the courts, the court decisions were not delivered to them, they were not adequately represented, and persons under guardianship were deprived of all legal safeguards because they were treated as voluntary patients.

In 2012 the CAT Committee expressed its concerns "about the reports of frequent placement of persons with intellectual or psychosocial disabilities in social, medical and psychiatric institutions without their informed and free consent; the continued use of cage-beds and net-beds as well as the use of other restraint measures such as bed strapping, manacles, and solitary confinement, often in unhygienic conditions and with physical neglect." The Committee was also concerned about the absence of investigations into the ill-treatment and deaths of institutionalized persons confined to cage and net-beds. The Committee recommended that the Czech Republic take appropriate measures to tackle these problems.

Guardianship

There is no special code on guardianship. The 1964 Civil Code provides for deprivation and restriction of legal capacity. In June 2011, there were 26,520 persons under plenary guardianship and 5741 persons under partial guardianship. In 2011 The Government introduced a new civil code, which will come into force in January 2014. The new Civil Code provides for supported decision making, the most limiting measure being the restriction of legal capacity.

MHE members

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Denmark

Population: 5,580,516¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	No	No

General summary

There are no long-stay psychiatric hospitals or psychiatric institutions in Denmark. The majority of people with mental health problems receive support in their own home, although some larger group homes and clustered houses do exist. Professional support in one's own home is the main form of residential support for people with mental health problems in Denmark. The numbers provided below are estimates - most community-based services support a variety of service users and not only those with mental health problems. Services are run by municipalities, regions or non-governmental organisations.

Types of residential services for people with mental health problems in Denmark²

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Special housing: Each person has their own flat, but the flats are all clustered together within one building or on one site	40	8 – 15	400
Group home	120	5 – 20	1500
Nursing home for people with mental disabilities	20	15 - 300	3000
Professional support in one's own home			5000

Personal budgets

There is no information on personal budgets in Denmark.

Deinstitutionalisation

Denmark has successfully implemented deinstitutionalisation and closed all long-stay hospitals for people with mental health problems.

¹ Eurostat, 2012

² Source: various sources, 2011

Involuntary placement

The 1989 Act (om anvendelse af tvang i psykiatrien), as amended in 2006, on deprivation of liberty and other coercion, regulates this area of law. Two criteria, the risk of harm and the need for treatment, are listed alongside having a mental health problem. The need for treatment is explicitly stipulated in the legislation.

According to Section 5 of the Act, forced hospitalization in a mental hospital must only take place if the patient is suffering from psychosis or is in a state that is similar to this. The explanation is that it would be unjustifiable not to deprive the person of his/her liberty in preparation for treatment because the prospect of recovery or a significant improvement of the condition otherwise will be considerably reduced; or the person poses an immediate and essential danger to him/herself or others.³

The CAT Committee recommended that Denmark “should limit the use of solitary confinement as a measure of last resort, for as short a time as possible under strict supervision and with a possibility of judicial review”.⁴

Guardianship

Section 5 of the Danish Act on Guardianship [Værgemålsloven] makes provision for the management of affairs of persons with “mental disorders” or intellectual disabilities if they are unable to manage their own affairs and it is deemed necessary to provide such assistance. The terms competence and capacity are not specifically defined in Danish legislation. Mental incapacity in the Act on Guardianship covers mental disorder [sindssygdom], intellectual disability [hæmmet psykisk udvikling], or other types of conditions. “Mental disorder” covers, among other things, dementia, schizophrenia, paranoid psychosis, manic depression.⁵ The Act distinguishes three different types of guardianship; one of these (in Section 6) results the loss of capacity to act legally and also the right to vote at elections.⁶

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3 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

4 <http://www.unhcr.org/refworld/publisher,CAT,,DNK,46a0b6002,0.html>

5 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-DK.pdf>

6 http://www.disability-europe.net/dotcom?term%5B%5D=197&term%5B%5D=148&term%5B%5D=149&term%5B%5D=158&term%5B%5D=164&term%5B%5D=165&view_type=detail_list

Estonia

Population: 1,339,662¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

Estonia inherited an out-dated mental health system with provisions built around psychiatric hospitals and social care institutions following its independence from the Soviet Union in 1991. Since then, major reforms have been implemented in mental health and social care. The number of psychiatric beds in both psychiatric and general hospitals has declined considerably, and so has the length of stay (Medeiros et al., 2008). However changes in the number of places and people with mental health problems living in social care institutions have been more modest. It was estimated that approximately 53% of people with mental health problems in need of residential support lived in social care institutions in 2003, and that 48% did so in 2007 (Sakkeus 2009).² Social care institutions are often located in remote rural areas making it difficult to maintain social relationships, and they provide poor access to community facilities and employment opportunities. In its 2007 recommendations, the CAT Committee was concerned about the living conditions and inadequate forms of treatment in psychiatric institutions and recommended that alternative forms of treatment, such as community based treatment, be developed.

No information is available on the number of people with mental health problems living in social care institutions or using community-based residential support, or the types of community-based residential support available in Estonia.

Types of residential services for people with mental health problems in Estonia³

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric hospitals and psychiatric departments in regional hospitals	14	–	655
Nursing homes for psychiatric patients	–	–	150- 200

¹ Eurostat, 2012

² http://www.disability-europe.net/content/aned/media/EE-7-Request-07%20ANED%202009%20Task%205%20request%20template%20MP_approved%20by%20author_to%20publish_to%20EC.pdf

³ Source: data collected by EMHS, 2011

Personal assistance budgets

No information is available on personal assistance budgets for people with mental health problems in Estonia.

Deinstitutionalisation

In 2006 a “reorganization plan” of services for people with mental health problems was adopted for the period between 2006 and 2021 (Kokk&Kurves 2006 in Sakkeus 2009). This aims to replace old social care institutions with independent living and other community based residential arrangements for people with disabilities.

Involuntary placement

In Estonia, 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. One expert opinion issued by a medical professional fulfills the legal requirement concerning the assessment of an individual’s psychiatric condition.⁴

Guardianship

The Estonian law establishes a substitute decision making system. The terminology of active and passive legal capacity is defined in Article 7 and 8 of the General Part of Civil Code [*Tsiviilseadustikuüldosaseadus*]. Passive legal capacity means the capacity to have rights and obligations under civil law; this is uniform and unlimited for everyone, it cannot be restricted. Active legal capacity means the ability to make valid transactions, and it can be either full or restricted.

The law states that persons who due to “mental illness, mental disability or other mental disorder” are permanently unable to understand or direct their actions have restricted active legal capacity. Guardianship is established for persons with restricted active legal capacity for the protection of their personal and property rights and interests (Article 92 (4) of the Family Law Act), and it involves the appointment of the guardian, who becomes the legal representative of the person. The guardian must care for the person under guardianship and act in the interests of that person.⁵

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⁴ http://fra.europa.eu/sites/default/files/2130-fra-2012-involuntary-placement-treatment_en.pdf

⁵ http://fra.europa.eu/sites/default/files/fra_uploads/2144-mental-health-study-2009-EE.pdf

Finland

Population: 5,401,267¹

	Signed	Ratified
CRPD	Yes	No
CRPD Optional Protocol	Yes	No

General summary

Finland has a varied provision of services for people with mental health problems. Some people with mental health problems live in psychiatric hospitals for 12 months or longer, and some of the community-based residential support is provided in large group home settings. Supported living services reached nearly half of service users in 2010.

Types of residential services for people with mental health problems in Finland²

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Forensic hospital	2	150-300/hospital	390 patients for 12 months or longer
Psychiatric hospital*	20	typically 20-25 patients / ward, as part of a general hospital	340 patients for 12 months or longer
Psychiatric social care homes with 24-hour staffing	approx. 175	15 – 20	2504 service users
Psychiatric social care homes with daytime-only staffing	approx. 250	around 10	2694 service users
Supported independent living	approx. 4000	1 – 3	approx. 5000 service users

*In Finland almost all psychiatric beds belong to general hospitals, even if care is organised in separate hospital units. (WHO Mental Health Atlas 2011)

Personal budgets

Personal budgets are not available for people with mental health problems in Finland.

¹ Eurostat, 2012

² Source: National Institute for Health and Welfare (THL), 2010

Deinstitutionalisation

The national plan for mental health and substance abuse work for 2009-2015 – also known as the “Mieli” plan – states that “psychiatric hospital treatment should, as a rule, be provided in conjunction with general hospitals” (Proposal #9). The plan also foresees a 30% reduction in psychiatric hospital beds by 2015 and it states that “a clear obligation for broad-based and multi-sectoral cooperation and the inclusion of service users and carers must be incorporated into the legal provisions to be drafted regarding treatment and rehabilitation plans. The main focus of rehabilitation development should be on community care. (. . .) The clubhouse network of mental health rehabilitees or corresponding activity should be expanded to cover the whole of Finland.”³

Involuntary placement

The law requires more than two medical opinions and which are sought from the referring physician, the physician in the hospital giving the treatment and the physician in charge of the hospital. The law also makes reference to the opinion of the person who is the subject of the procedure. In addition, when a person has been referred to observation, and before the observation has begun, a physician considers whether the requirements for involuntary treatment are likely to be met. According to the Finnish authorities, the number of physicians involved (up to four) properly secures the patients’ rights.⁴

In 2011, the CAT Committee recommended that any administering of electroconvulsive therapy to patients deprived of their liberty is based on free and informed consent. The Committee also concluded that Finland should ensure all mental health care and services provided to persons deprived of their liberty, including in psychiatric hospitals and social institutions, are based on the free and informed consent of the person concerned. It also recommended the establishment of an independent body to monitor hospitals and places of detention, which would have the authority to receive complaints.⁵

Guardianship

In Finland, the Guardianship Services Act [*lakiholhous-toimesta/lag omförmyndarverksamhet (442/1999)*] establishes the legal basis for the management of affairs of persons who cannot take care of their financial affairs owing to incompetency, illness, absence or any other reason. According to Section 8 of the Act, if an adult, due to the mentioned reasons, is incapable of looking after his or her interest or taking care of personal or financial affairs, a court may appoint a guardian for him or her. It has been emphasized in the Government Bill for the Act that, for instance, mental health problems do not form a sufficient basis for restricting a person’s competency.⁶

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³ The full plan is available in English at http://info.stakes.fi/NR/rdonlyres/F0094BDE-EEBE-4635-93B5-BE77571B4FE0/0/Mieli_Plan_1607.pdf (last accessed: 13/08/2012)

⁴ http://fra.europa.eu/sites/default/files/2130-fra-2012-involuntary-placement-treatment_en.pdf

⁵ <http://www2.ohchr.org/english/bodies/cat/docs/co/CAT.C.FIN.CO.5-6.pdf>

⁶ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-FI.pdf>

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France

Population: 65,397,912¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

57

General summary

People with long-term mental disabilities (including people with severe mental health problems) can benefit from different forms of housing adapted to their needs, on a temporary or a long-term basis. There are more medicalized solutions for people with high support needs, such as specialized residences with medical services. French Law No. 2007-290 of March 5, 2007 instituted the guaranteed right to healthy and independent housing by the state to any person permanently living in France who cannot access housing on his or her own or who remain in their current accommodation. The “community-based” nature of some of these structures is, however, questionable as they are in fact “institutionally” based.

In 2009, the Government decided to increase the capacity in secure residential intensive care psychiatric facilities (UMD - *Unités pour Malades Difficiles*) by 200 beds, going from 456 to 656 beds (the final beds should be opened in the beginning of 2013).

It should also be noted that a documented practice among many Paris mental health services, as well as elsewhere in France, consists in sending persons with more severe mental health problems necessitating long-term sheltered housing (in their opinion) to facilities in Belgium.

Types of residential services for people with mental health problems in France²

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Public specialized psychiatric hospitals (CHS)	90	105	27,900 (19% hospitalized between 1-5 years, 23% hospitalized for over 5 years)
Private non-profit health institutions under State contract (ESPIC)	138	varies	6100 (18% hospitalized between 1-5 years, 25% hospitalized for over 5 years)
Public general hospitals with psychiatric wards	198	105	9000

¹ Eurostat, 2012

² Sources: Cour des Comptes (psydoc-fr.broca.inserm.fr), Year: 1997; DREES études et résultats 641, June 2008, Survey ES 2006; 2010 Survey “Services d’accompagnement social du mais”, published in June 2012; Coldefy and Lepage, “Les secteurs de psychiatrie générale en 2003”, Études, Document de travail No. 70, DREES, Nov. 2007

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Private psychiatric clinics	162	50-80	12,600 (10% hospitalized between 1-5 years, 7% hospitalized for over 5 years)
Therapeutic apartments* (<i>Appartements thérapeutiques</i>)	347	3 / 7	972
After-care Centres (<i>Foyers de postcure</i>)*	72	10 / 20	936
Therapeutic / social home stay in family (<i>Accueil familial thérapeutique and accueil familial social</i>)*	969	1 / 5	3285
Other short/medium term residential facilities include: Boarding houses (<i>Pensions de famille</i>), Foster families (<i>Familles gouvernantes</i>) and Residences for persons with social and financial difficulties (<i>Maisons relais / résidence d'accueil</i>)*	n/a	n/a	n/a
Residences for persons with disabilities who work (<i>Foyers d'hébergement pour Travailleurs Handicapés</i>)**	1260	n/a	37,600 (of which 15.8% have "mental deficiencies")
Residences providing lodging, occupational therapy and medical care (<i>Foyer d'accueil polyvalent</i>)**	100	n/a	4100 (of which approx. 17% have "mental deficiencies")
Residences for disabled persons unable to work but physically and mentally autonomous to a certain extent (<i>Foyers occupationnels ou de vie</i>)**	1440	n/a	43,400 (of which approx. 16.5% have "mental deficiencies")
Residences for adults with disabilities requiring medical surveillance and constant care, treatment and physical therapy (<i>Maison d'accueil spécialisée (MAS)</i>)*	450	n/a	19,500 (of which 10.6% have "mental deficiencies" and 2588 who are "mentally disabled")
Residences for persons with severe or more than one disability unable to work (<i>Foyer d'accueil médicalisé (FAM)</i>)**	470	n/a	13,500 (of which 20% have "mental deficiencies" and 1676 are "mentally disabled")
Apartments managed by non-profit organizations (<i>Appartements associatifs</i>)**	n/a	n/a	n/a

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Supported living in ordinary housing** Home hospitalization SAVS social support SAMSAH medical-social support for adults with disabilities	109 187 22		540 5,425 2,146
Residential facilities for stabilization***	Experimental in Paris region	n/a	n/a
UMD (<i>Unités pour Malades Difficiles</i>) – secure intensive care psychiatric facility ordered by local Police Prefect	2012: 10	40-166	530 (of which 40 women)

*Short- and medium-term residential facilities

**Long-term residential services

***Experimental in Paris region

Personal budgets

There is no personal budget for people with mental health problems in France.

Deinstitutionalisation

The Mental Health Plan for 2011-2015 was adopted and presented by the Government in 2012. The main objective behind the new Mental Health Plan is to provide on-going care and prevent cut-offs in services to users, regardless of where they live, and in particular to homeless service users, service users on a low income and patients living in prison settings. The Government noted that the impact and prevalence of mental health problems are often underestimated, particularly among prisoners and young offenders in special educational follow-up programmes. The Plan has four strategic objectives:

1. Prevent and reduce cut-offs of services during the person's lifetime.
2. Prevent and reduce cut-offs of services based on the relevant populations and territories.
3. Prevent and reduce cut-offs of services between the psychiatric and the social sectors.
4. Prevent and reduce cut-offs between different types of expertise in the field.

This "new generation" Plan is based on the principles and instruments set out in the 2009 "HPST" (*Hôpital, Patients, Santé et Territoires*) Law that lays down the main strategic objectives and then entrusts the "ARS" – Regional health authorities (*Agences régionales de santé*) and players in the field with the responsibility of implementing the above objectives in a way that is appropriate for their local territories. Currently 26, out of France's 27 Regions, are planning to implement such programmes. The Central Government and national agencies were also asked to report on how they plan to include the provisions of the new Mental Health Plan in their own roadmaps. An annual conference to present the results of monitoring the implementation of this Plan will be organised by the Ministry of Health and Solidarity, and the initial results of the Plan are scheduled to be reported in 2016. However, no measures have been taken to close down psychiatric hospitals or institutions per se.

It should be noted that the HPST Law meant to reform the organisation of hospitals in France was highly criticized by stakeholders (health professionals and patients), who believed it was a policy related aimed at downsizing services, in favour of the private sector and to the detriment of the public sector.

Involuntary placement

On July 5, 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 main innovations in this Law are:

- Psychiatric care without consent may now be dispensed outside of the hospital. This allows psychiatrists to prescribe anti-psychotic drugs, for example without the consent of the patient, on an outpatient basis, thus violating their human dignity. Very little effort to communicate with and inform users of their rights and treatment in this situation is made.
- A 72-hour observation period has been established before deciding if the person will be hospitalized or treated on an out-patient basis without their consent.
- For the first time in French history, this Law requires the intervention of a "Judge of Liberties and detentions" who must render a decision confirming or striking down the hospitalization of a person without consent within 15 days of their date of hospitalization. Following a challenge of the constitutionality of this new Law by a non-profit organization defending the rights of users hospitalized without their consent, the French Constitutional Council required that a judge be called on and the Government simply added this provision to their already existing bill. Moreover, if hospitalization without consent were truly subject to the judge's oversight, the judge should render a decision on the deprivation of the person's freedom at the time the person is detained without consent and not 15 days later and dependent on whether the person's health justifies depriving their freedom (which is discriminatory within the meaning of the UNCRPD).

There are now four forms of involuntary placement: the classic form requiring two medical certificates (at least one from a doctor outside of the institution where the person will be hospitalized) and a written request from a third party (usually a family member), the "imminent peril" form requiring only one medical certificate from a doctor outside of the institution where the person will be hospitalized, and an urgent form requiring one medical certificate and the written request of a third party. The final form is ordered by 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.

The controversy surrounding the new Law and the pressure from mental health care professionals, judges and users' organizations may lead to further reform in the near future. In its observations in 2010, the CPT Committee recommended that the State Party take measures regarding violence, perpetrated by personnel, against patients in psychiatric hospitals.³

Guardianship

The legal framework for adult legal protection in France consists of three levels of legal supervision for 'protected adults': (1) judicial safeguard (*Sauvegarde de justice* – caretaking with full capacity), (2) 'curatorship' (*curatelle* – partial guardianship) and (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."⁴ Guardianship in France is still a widespread solution, and used much more than in other European countries, in spite of the Government reform of guardianship measures in 2007. Indeed, 700,000 people in France were under one of these forms of guardianship in 2010, running contrary to the provisions of support and independence prescribed in the UNCRPD.

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³ "The CPT recommends that all medical personnel working at the secured psychiatric facilities UMD Henri Colin, at secured wards in the Paul Guiraud psychiatric hospital in Villejuif and at the EPSM Val de Lys-Artois be clearly and regularly reminded that no form of violence whatsoever (either physical or verbal) against patients will be tolerated. Any staff member aware of this type of behaviour must report it via the appropriate channels." http://www.cpt.coe.int/documents/fra/2012-13-inf-fra.htm#_Toc299713188, para 130

⁴ http://www.disability-europe.net/dotcom?term%5B%5D=200&term%5B%5D=140&term%5B%5D=148&term%5B%5D=149&term%5B%5D=150&term%5B%5D=158&term%5B%5D=164&term%5B%5D=165&view_type=detail_list

Germany

Population: 81,843,743¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

There were a total of nearly 60,000 places in psychiatric clinics in Germany. The average length of stay in psychiatric hospitals was 23 days/patient; however, some estimated that there were up to 20,000 long-stay patients in psychiatric hospitals (DECLOC Part 3, 2007, p 180). In addition, there were approximately 40,000 users in institutions - large care home settings.

Types of residential services for people with mental health problems in Germany²

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric Hospital	155	100 - 200	50,078
Psychiatric Hospital	63	200 - 400	9304
Group homes	620	1 - 20	7649
Group homes	560	21 - 40	16,176
Group homes	174	41 - 100	15,837
Care homes	59	100 -	8177
Assisted Living			approx. 56,149

Personal assistance budgets

Personal budgets are available for people with mental health problems in Germany.

Deinstitutionalisation

The number and size of large psychiatric hospitals have been gradually reduced in Germany since the psychiatry reforms of the 1970s. In the mid-1970s there were around 600,000 long-term patients in psychiatric hospitals living in poor conditions. As a result of the reforms, regional hospitals were built and the majority of psychiatric beds shifted to these. Also, many places in care homes were created, some of these in large institutions. Recently, the number of people in assisted living in the community has been rising steadily.

¹ Eurostat, 2012

² Source: data on hospitals and care homes from 2005, Minister of Health Conference Germany 2007
Assisted Living: Social Welfare Institutions Analyser 2009

Currently, psychiatric clinics consume around 70% of funding and there are insufficient community-based outpatient and after-care services. Nearly 730,000 people in Germany need integration assistance.

A new remuneration system for psychiatric hospitals to improve the supply structure was introduced. This should provide incentives to strengthen the comprehensive regional coverage, prevention and opportunities for building more outpatient care structures.

Germany also introduced integrated care for people with mental health problems, as a response to the fragmented delivery of health and social services. Integrated care is based on the following principles:

- People with mental illness get their help early to prevent chronicity
- The focus is on people and not on the institutions
- The focus is on recovery
- Networking of regional actors and on every level
- People with mental health problem get help to live independently in their own home
- As much assistance as necessary.

In September 2012, over 4,200 people were receiving this new system of support. The Ministry of Health will launch a study in 2012 to evaluate the efficiency of this model.

Involuntary placement

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.³ 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.

Guardianship

In Germany, legal custodianship (guardianship) can be established if a person is not able to manage his or her own affairs in daily life. The legal basis is the Civil Code Book (section 1896 ff. *Bürgerliches Gesetzbuch, BGB*). It is dependent on an individual's condition, and in most cases restricted to certain areas of agency (e.g. health, financial care) and will power. Reasons for guardianship are: mental illness, dementia, a high degree of intellectual disability (cognitive impairments) or other chronic conditions that make a person unable to take care of his or her life affairs.⁴ However, no full (or plenary) guardianship exists. Limited guardianship for court specified duties is possible. In the majority of cases, guardians are responsible for oversight of medical treatment and financial management.⁵ The number of people living under guardianship is approximately 1.3 million.⁶

3 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

4 http://www.disability-europe.net/dotcom?term%5B%5D=201&term%5B%5D=140&term%5B%5D=148&term%5B%5D=149&term%5B%5D=150&term%5B%5D=158&term%5B%5D=164&term%5B%5D=165&view_type=detail_list

5 http://www.international-guardianship.com/pdf/GBC/GBC_Germany.pdf

6 http://www.international-guardianship.com/pdf/GBC/GBC_Germany.pdf

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Greece

Population: 11,290,935¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

65

General summary

Five psychiatric hospitals remain in operation in Greece with a total of around 660 long-stay patients. In addition, there are approximately 2,689 people using a variety of community-based residential services, mainly boarding homes and hostels. Mobile Psychiatric Units offer support to people with mental health problems in their home environment, as well as support to their families, and to a certain extent to the neighbourhood, in order to avoid involuntary hospitalization, especially during a crisis.

Types of residential services for people with mental health problems in Greece²

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric hospital	5	Leros Psychiatric Hospital: approx. 338 patients Dafni Psychiatric Hospital: approx. 160 patients Dromokaiteio Psychiatric Hospital: approx. 70 patients Thessaloniki Psychiatric Hospital: 75 patients Tripoli Psychiatric Hospital: 19	659
Boarding homes	136	10-15(max) patients	2689 service users in total
Hostels	85	10-15(max) patients	
Protected apartments	226	1-4 patients	

Personal assistance budgets

There are no personal budgets for people with mental health problems in Greece.

¹ Eurostat, 2012

² Source: Ministry of Health and Social Solidarity, 2011

Deinstitutionalisation³

EU Regulation 815/84 as extended by Regulation 4130/88 changed the orbit of psychiatric care in the country by reducing the number of beds in psychiatric hospitals, developing structures for prevention and treatment in the community, increasing the number of staff in community services, training the staff in new models of care and integrating psychiatrists in primary care.

To ensure the continuity of mental health reforms, the Ministry of Health launched a long-term project for psychiatric reform ("Psychargos") and enacted the Mental Health Reform Act. So far, the implementation of the Psychargos Programme has been foreseen in three phases (Phase A: 1997-2001 / Phase B: 2001 – 2010 and Phase C: 2010-2020). The objectives of the programme are:

- Deinstitutionalization of patients from large psychiatric hospitals and return to their place of origin,
- Creation of services in the community in order to meet all the needs of the population for mental health services,
- Training and upgrade of skills of both professionals and patients.

As a result of the reform programme, four out of the nine psychiatric hospitals have been closed. Between 1980-2000, the number of long-stay patients in psychiatric hospitals decreased from 5,677 to 2,922. Moreover, the number of psychiatric beds available in general hospitals increased from 16 to 361 and the number of mobile psychiatric units (in rural areas and small islands, with no other access to mental health services) to 25. The five remaining hospitals still have long-stay units but they mostly provide psychosocial rehabilitation, community mental health services and specialized centres (e.g. day centres, prevocational training workshops etc.). Non-governmental organisations had a major part in the reforms. There are 66 non-governmental organisations in the mental health sector that provide mainly rehabilitation services, supported living housing services, day centres, mobile units and social cooperatives (KOISPE).

The Committee for the Revision of the "Psychargos" Programme for the period 2010-2020 has prepared a new plan for the completion of the psychiatric reform, which will soon be launched.

Finally through the implementation of the National Strategic Reference Framework (NSRF) that is co-founded by the EU, the following three projects are foreseen for supporting the community – based mental health services:

- The creation of 100 new protected apartments
- 160 Programmes for Assertive Community Care
- 60 Centres for the Support of the Unemployed

Involuntary placement

In Greece, it is the Civil Code that is applicable to involuntary treatment, including involuntary placement. Two criteria, the risk of harm and the need for treatment are listed alongside having a mental health problem. The law does not refer to the person's opinion in the course of an involuntary measure.

³ References: Ministry of Health and Social Solidarity, "Evaluation report (draft) of the interventions for the implementation of mental health reform for the period 2000-2009". Project: "Ex-post evaluation of the implementation of National Action Plan "Psychargos" from 2000 to 2009"; Draft for Consultation for the Revision of the Psychargos Programme; Revision Plan of the Psychargos Programme; Report of the Workteam for the Revision of the Psychargos Programme; These documents are published at the Ministry's official website www.yyka.gov.gr

Guardianship

There is no definition and no distinction between capacity and competence in Greek law. Article 1666 of the Greek Civil Code states: "An adult is placed under guardianship, when: 1. because of psychological or mental disorder or physical disability, he/she is not able, in whole or in part, to manage his/her own affairs on his/her own." In the case where the person is deprived of capacity for some, or all legal transactions, the guardian represents the person in these legal acts. The court judgment placing a person under guardianship and the need for a guardian are not reviewed periodically.

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Hungary

Population: 9,957,731¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

Although Hungary does not have long-stay psychiatric hospitals, most residential services for people with mental health problems are provided in social care institutions. Service users in institutions tend to be people with chronic conditions who either require a higher level of support with daily living or those who are in need of housing (e.g. they are homeless) in the absence of social housing.

Institutions are typically located in remote rural areas making it difficult to maintain / build social relationships and providing poor access to community facilities and employment opportunities. Physical conditions in mental health institutions are particularly poor, for example according to the 2001 Census, 44% of the rooms in institutions for people with mental health problems had five or more beds.

In addition to service users in psychiatric institutions, a large number of people with mental health problems live in other institutions, typically in institutions for people with intellectual disabilities or institutions for older people. There are some community-based initiatives but these reach only a small minority of people with mental health problems in need of residential support.

Types of residential services for people with mental health problems in Hungary²

Type of service	Number of services	Typical size (min-max number of places)	Total numbers of service users
Social care home for psychiatric patients	59	50-900	7140
Social care home for people with addiction problems	n/a	100-200	1900
Special homes for children and adolescents with psychiatric disability	n/a	16-65	354
Group homes for psychiatric patients	n/a	8-14	300

¹ Eurostat, 2012

² Source: Central Statistical Office, 2010

Personal assistance budgets

There are no personal budgets for people with mental health problems in Hungary.

Deinstitutionalisation

Hungary adopted a "Deinstitutionalisation Strategy" in 2011 for the replacement of institutions with more than 50 places with group homes and new institutions with up to 50 places over the next 30 years. This strategy excludes institutions (social care homes) for people with mental health or addiction problems. In 2012, the Government launched a capital investment programme, using EU Structural Funds, to support the implementation of the "Deinstitutionalisation Strategy". This programme supports both the development of community-based living arrangements and the building of new institutions (termed "residential centres" and "supported accommodation") for people with disabilities and mental health problems.

In its Concluding Observations, the UN CRPD Committee expressed concern about the 30-year timeframe of the deinstitutionalisation strategy and the dedication of resources to the renovation of large institutions. The Committee urged the Government to create sufficient and adequate support services to enable people with disabilities to live independently in the community.³

Involuntary treatment

There is no specific mental health act in Hungary. The aim of involuntary psychiatric treatment (and therefore admission into psychiatric institutions) is to protect the patient and other persons from harm to life, health and personal integrity (Healthcare Act, 15 December 1997, Art. 191 (1))⁴ In practice, civil organizations of users of psychiatry remain very critical about the system - they claim that, in most cases, no sufficient assessment is made before the admission, no regular review is provided, and abuses during the procedure are often reported.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) recommended to the Hungarian Government that *"the procedures to be reviewed with the aim of ensuring that all patients, whether voluntary or involuntary, are provided systematically with information about their condition and the treatment prescribed for them, and doctors to be instructed that they should always seek the patient's consent to treatment prior to its commencement. The form concerning informed consent to treatment should be signed by the patient or (if he is incompetent) by his legal representative. Relevant information should also be provided to patients (and their legal representatives) during and following treatment."*⁵

In its Concluding Observations in 2012, the UN CRPD Committee urged the Hungarian Government to *"amend Act CLIV on Healthcare and abolish its provisions that provide a legal framework for subjecting persons with disabilities with restricted legal capacity to medical experimentation without their free and informed consent."* The Committee also recommended *"that the State party review provisions in legislation that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities, and adopt measures to ensure that health care services, including all mental health care services, are based on the free and informed consent of the person concerned."*⁶

³ Para.33-35, CRPD/C/HU/CO/1, Advance unedited version, 27/09/2012 (available in English at http://www.ohchr.org/Documents/HRBodies/CRPD/8thSession/CRPD-C-HUN-CO-1_en.doc) (last accessed on 30/09/12).

⁴ http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

⁵ http://www.cpt.coe.int/documents/hun/2010-16-inf-eng.htm#_Toc262635866

⁶ Para 30 and para 28. <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session8.aspx> (last accessed on 28 September 2012)

Guardianship

Hungary maintains an old fashioned substitute decision-making system. According to Act IV of 1959 on the Civil Code, persons may be under plenary and partial guardianship, and their right is extremely limited to enter into legal commitments.

In 2010, the government developed a new Civil Code which abolished plenary guardianship and introduced elements of supported decision making. However, the Code never entered into force. Instead, a new Civil Code is planned which – according to the draft – will sustain the institution of plenary guardianship.

In 2012, the UN CRPD Committee published its Concluding Observations about Hungary and recommended that *“the State party use effectively the current review process of its Civil Code and related laws to take immediate steps to derogate guardianship in order to move from substitute decision-making to supported decision-making, which respects the person’s autonomy, will and preferences and is in full conformity with article 12 of the Convention, including with respect to the individual’s right, on their own, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry, to work, and to choose their place of residence.”*

The Committee also recommended Hungary *“to provide training, in consultation and cooperation with persons with disabilities and their representative organizations, at the national, regional and local levels for all actors, including civil servants, judges, and social workers on the recognition of the legal capacity of persons with disabilities and on mechanisms of supported decision-making.”*⁷ Currently there are around 60,000 people (0.6% of the population) under plenary guardianship in the country.

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⁷ Para 26. <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session8.aspx> (last accessed on 28 September 2012)

Ireland

Population: 4,582,769¹

	Signed	Ratified
CRPD	Yes	No
CRPD Optional Protocol	No	No

71

General summary

There are approximately 3,000 places in psychiatric hospitals in Ireland. In 2004, just under a third of the patients were in the hospital for longer than five years – nearly half of these were people aged over 65 years. In addition, 17% of service users were classified as “new long-stay” who lived in the hospital for more than 12 months but less than five years. There were over 3,100 community residential places under the care of the mental health services in 2004 (A Vision for Change 2006).²

Types of residential services for people with mental health problems in Ireland³

Type of service	Number of services	Typical size	Total number of places
Approved centres, majority of which are long-stay psychiatric hospitals and acute psychiatric units	63	–	2812
Community services – no data available for subdivision	800		

Personal budgets

Personal budgets are not available for people with mental health problems in Ireland.

Deinstitutionalisation

The policy for the future development of mental health services is outlined in the 2006 Report of the Expert Group on Mental Health Policy ‘A Vision for Change’. The aim is to migrate from the traditional institutional based model to a patient-centred, flexible and community-based mental health service, where need for hospital admission is greatly reduced. The document recommends that “a plan to bring about the closure of all mental hospitals should be drawn up and implemented. The resources released by these closures should be protected for reinvestment in the mental health service” (p 9).

¹ Eurostat, 2012

² http://www.dohc.ie/publications/pdf/vision_for_change.pdf?direct=1

³ Source: Mental Health Commission: Register of Approved Centres (as at 7th October 2011); Reports of the Inspector of Mental Health Services 2010-11; Department of Health, Mental Health Services (including Suicide Prevention) Fact Sheet, January 2011.

Involuntary placement

Two criteria – the risk of harm and the need for treatment – are listed alongside having a mental health problem in the assessment criteria for involuntary placement, while the Mental Health Act (2001) speaks about “serious likelihood” of harm. The law requires more than two medical opinions. When the decision is made, a Mental Health Tribunal sits with a panel composed of a consultant psychiatrist, a barrister or solicitor with at least seven years’ experience in practice, and a layperson who cannot be a doctor or a nurse.⁴

In its concluding observations in 2011, the CAT Committee stated: “*The Committee recommends that the State party review its Mental Health Act of 2001 in order to ensure that it complies with international standards.*”⁵

Guardianship

There is a common law presumption that persons over the age of 18 have legal capacity to make decisions. However, this is not enshrined in legislation with specific regard to persons with disabilities. Ireland does not have modern legal capacity legislation (as highlighted in the section on ratification of the Convention). The only legal mechanism currently available for restricting capacity to make decisions is the Ward of Court system, which is a form of substitute decision-making. A new mental capacity legislation, adopting a functional approach to capacity and introducing an adult guardianship system to replace the ward of court process, has been drafted by the Department of Justice and is currently awaiting publication as a bill.⁶

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4 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

5 <http://www2.ohchr.org/english/bodies/cat/cats46.htm>

6 http://www.disability-europe.net/dotcom?term%5B%5D=205&term%5B%5D=148&term%5B%5D=149&term%5B%5D=150&term%5B%5D=158&term%5B%5D=164&term%5B%5D=165&view_type=detail_list

Israel

Population: 7,848,800¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	No	No

73

General summary

Israel has long-stay psychiatric hospital beds as well as community-based group home provision.

Types of residential services for people with mental health problems in Israel²

Type of service	Number of services	Typical size	Total number of places
Long-stay psychiatric hospital (also includes short-term and day care)	14	-	3120
Community residential facilities (including group homes)	258 (group homes: 120)	-	16,396 (around 3000 places in group homes)

Personal budgets

There are no personal budgets for people with mental health problems in Israel.

Deinstitutionalisation

Israel has a mental health plan (last amended in 2010) that aims to reduce long-stay residential beds, improve community care, and also to mainstream mental health services into primary care. ³The trend of de-institutionalization created changes in the field of psychiatric rehabilitation in Israel. The trend has led to a significant decrease in the number of beds in psychiatric hospitals, a number which currently stands at approximately 3,150, compared with more than 7,000 beds at the beginning of the previous decade. As a result, Israel established diverse areas of community-based housing, employment, leisure, support and guidance for people with mental health problems.

Guardianship

An individual above 18 may have a guardian only if it was approved by a court. A professional's opinion is required (psychiatrist or social worker etc.).

¹ Israel Central Bureau of Statistics, 2012

² Source: WHO Mental Health Atlas 2011 and personal communication with an ex-civil servant of the Ministry of Health

³ http://www.who.int/mental_health/evidence/atlas/profiles/isr_mh_profile.pdf

Involuntary treatment

Involuntary treatment order is issued by a provincial psychiatric only if he/she decided that the person concerned might impose potential harm to himself or herself or others. Statistics show very few involuntary treatment orders from 2011.

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Italy

Population: 60,820,764¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

75

General summary

The closure of all the psychiatric hospitals in Italy (law, 180, 1978) can be considered an important step in the deinstitutionalization process. However, this step is not sufficient by itself if many other actions do not take place before and after the psychiatric hospital closure. The situation in Italy varies in each of the twenty Italian regions which are responsible for social and health care. Italy is planning to launch a single national information system for mental health in 2012. Approximately 17 per cent of community-based residential services were provided in flats, 60 per cent in separate houses and 18 per cent in health-social buildings (ISS 2003).²

Types of residential services for people with mental health problems in Italy³

Type of service	Number of services	Typical size(min-max number of places in each type of service)	Total number of service users
Forensic hospitals		178-355	1448
Community-based residential services	1370	1-10	Approx. 17,500

Personal assistance budgets

The availability of personal budgets for people with mental health problems in Italy is not very common. In some places, such as Trieste, they began to work on personal budgets. To find out more http://www.triestesalutementale.it/english/mhd_programmes.htm⁴

Deinstitutionalisation

Italy closed its psychiatric state hospitals in (law 180, 1978) and transferred services to the community. As of 1980, new admissions to psychiatric hospitals stopped and people who needed hospital treatment were treated in the psychiatric service of general hospitals. Existing service users were discharged gradually and relocated in alternative settings (group homes, nursing home, etc.). The new territorial mental health services had to work both on providing

1 Eurostat, 2012

2 <http://www.iss.it/binary/publ/publi/0302.1107334814.pdf> (in Italian, last accessed: August 22, 2012).

3 Source: http://it.wikipedia.org/wiki/Ospedale_Psichiatrico_Giudiziario, 2010 (forensic hospitals); Istituto Superiore Sanità <http://www.iss.it/binary/publ/publi/0302.1107334814.pdf> 2003 (community-based services).

4 http://www.triestesalutementale.it/english/mhd_programmes.htm

new structures (residential, day center, etc.) and to work with the local communities to actively involve them in mental health issues.

Currently the process of closure of the six forensic hospitals is underway. A national law states that people in prison, in case of health problems, have to be treated by the ordinary health services, and that there should be no discrimination between them and other citizens. The same happens for the forensic hospitals - patients in forensic hospitals need to be treated by the ordinary mental health services, which in Italy are all territorial. There is a national campaign to close the forensic hospitals because of the very bad and inhumane conditions and even the president of the country has been directly involved in this issue. A national commission (Comitato paritetico inter-istituzionale) within the State-Regions Conference and six inter-regional commissions (Aree di Bacino) have been established to find alternative solutions to forensic hospitals for each patient. The said patients are in the process of being discharged gradually.

Involuntary placement

The “need” for the therapeutic treatment of the person, combined with a mental health problem, can justify involuntary placement. The legislation, however, does not list the criteria of presenting a danger to oneself or others as a condition for involuntary placement.⁵ Compulsory placement in a hospital for purposes of psychiatric treatment requires two medical assessments. Administrative and judicial control of medical assessments are sometimes quite deferential and of a formal nature.⁶

The CPT Committee stated in 2004 that (a) patients’ treatment was mainly pharmacological and behavioural, although service organisation allowed for a more multidisciplinary, flexible and individualised approach; (b) medical certifications of psychiatric conditions requiring compulsory placement were somewhat laconic and vague; (c) accordingly, administrative and judicial control on the actual existence of the legal and medical requirements for compulsory placement appeared mostly bureaucratic and formal.⁷

Guardianship

In Italy, no statutory definition is given to ‘capacity’, but reference is made to doctrinal explanations: (a) legal capacity [capacità giuridica] is the capacity, belonging to any person, to have individual rights and obligations (b) capacity to act [capacità di agire] is the capacity to enter into legally binding agreements and more generally to perform any act which may entail rights and obligations.⁸

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 be placed under full guardianship; a person whose mental impairment is not

5 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

6 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-IT.pdf>

7 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-IT.pdf>

8 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-IT.pdf>

so severe as to require full guardianship can be placed under limited guardianship.⁹ 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 decisionmaking concept of the old law (Interdizione e Curatela – Interdiction and care). However, the old legislation is still in place, and is often used in juridical procedures.

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⁹ http://www.international-guardianship.com/pdf/GBC/GBC_Italy.pdf

Latvia

Population: 2,041,763¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

Latvia provides institutional care for people with mental health problems in seven psychiatric hospitals and over 30 specialised social care homes. There was no information on the number of long-stay patients in psychiatric hospital or the total number of people with mental health problems in social care homes. Various reports have noted poor conditions and violations of human rights in psychiatric hospitals and social care homes.²

Community-based residential support systems are not developed. According to a report by the Resource Centre for People with Mental Disability – ZELDA³, there were 13 group homes / apartments for persons with mental disabilities and six “half-way houses” built on the grounds of social care homes.⁴ There was no information on the number of service users in these settings.

Types of residential services for people with mental health problems in Latvia⁵

Type of service	Number of services	Typical size(min-max number of places)	Total number of services
Psychiatric hospital for adults	6	60 - 680	2403
Psychiatric hospital for children	1	300	300
Group homes	13	-	-
Half-way houses	6	-	-

1 Eurostat, 2012

2 See for example: Monitoring Report on Closed Institutions in Latvia 2006, Latvian Centre for Human Rights (available in English: http://www.humanrights.org.lv/upload_file/Final_monitoring_reportEN.pdf, last accessed: September, 2012).

3 Report on the Implementation of the World Health Organisation’s Mental Health Declaration and Action Plan in Latvia, ZELDA, 2009. (available in English: <http://zelda.org.lv/wp-content/uploads/file/REPORT-86lpp-10dec-2.pdf>; last accessed: September, 2012).

4 Wasted Time, Wasted Money, Wasted Lives ... A Wasted Opportunity? – A Focus Report on how the current use of Structural Funds perpetuates the social exclusion of disabled people in Central and Eastern Europe by failing to support the transition from institutional care to community-based services. ECCL 2010 (available in English: <http://www.community-living.info/documents/ECCL-StructuralFundsReport-final-WEB.pdf>, last accessed: September, 2012).

5 Source: Ministry of Health, department responsible for statistics, 2011
WHO Mental Health Atlas 2011 http://www.who.int/mental_health/evidence/atlas/profiles/lva_mh_profile.pdf (last accessed 30 September 2012)

Personal assistance budgets

There are no personal budgets for people with mental health problems in Latvia.

Deinstitutionalisation

Latvia has no plans to replace psychiatric hospitals or social care homes with community-based arrangements. According to ZELDA's report, in 2006-2007 the Government guaranteed bank loans for psychiatric hospitals for reconstruction and expansion. The "Improvement of Inhabitants' Mental Health for 2009-2014" strategy mapped out the creation of six community-based mental health care centres, six half-way homes and 12 group homes, however there is no information on the implementation of the plan.⁶ Latvia has been using the Structural Funds of the EU to refurbish existing social care homes and build new ones. The current 'Programme for the development of social care and social rehabilitation services for persons with mental disabilities allocates funding to the development of institutional care.'⁷

Involuntary treatment

In the Latvian legislation two criteria, the risk of harm and the need for treatment, are listed alongside having a mental health problem, but the prerequisites of exhausting all less restrictive measures are not explicitly mentioned. The law does not refer to the person's opinion in the course of an involuntary measure, the decision is made with the involvement of professionals only. Section 1(6) of the Latvian Medical Treatment Law (Ārstniecībaslikums) 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.⁸

In 2007, the CAT Committee urged Latvia to 'review the use of physical restraints, consider establishing guidelines on the use of such restraints and limit the use of solitary confinement as a measure of last resort, for as short a time as possible under strict supervision and with a possibility of judicial review.' The Committee also recommended that Latvia should 'promptly adopt the draft Programme on improvement of the mental health of the population for 2008-2013.'⁹

The programme on the improvement of the mental health of the population 2008(2009)-2013 is implemented with support from the European Social Funds. The monitoring of the programme, however, doesn't give sufficient information about the actions taken.

Guardianship

The Latvian legislation currently provides only for the total deprivation of capacity, there are no other alternatives (e.g. partial capacity or supported decision making mechanisms available). The law does not provide for minimum or maximum time limits for placing a person under trusteeship. The law also does not require periodic reviews of incapacity or the need for

6 ZELDA

7 ECCL

8 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf (last accessed 18 September 2012)

9 <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/Go8/4o6/09/PDF/Go84o6o9.pdf?OpenElement> (last accessed 18 September 2012)

a trustee. In the context of the ratification of the CRPD and its Article 12, discussions started between the Welfare, Justice Ministries and NGOs on the needed legal reform concerning legal capacity and trusteeship issues.¹⁰

In March 2012, the Ministry of Justice prepared an information paper about relevant changes in the Civil Code. The Ministry pointed out the lack of support systems for people with mental health problems (supported decision making mechanisms). Later in 2012, further steps are expected including inter-ministerial cooperation with the Ministry of Welfare, with the aim to establish a more advanced support system. However, the scope and the terminology of the new regulation are a matter of debate, having both the terms 'people with disabilities' and 'people with mental disorders' among the proposals.

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¹⁰ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-LV.pdf> (last accessed on 18 September 2012)

Lithuania

Population: 3,007,758¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

81

General summary

There is limited information about the number of places in psychiatric hospitals and residential care settings. There were approximately 4,500 places in large social care institutions. There were 25 psychiatric hospitals or psychiatric departments in general hospitals, with a total of 3,300 beds in 2011.² There was no information on the number of long-stay patients in psychiatric hospitals.

Types of residential services for people with mental health problems in Lithuania

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Social care institutions	20	99 – 380	4,500
Group homes	10	about 20	212*

* These are group homes for people with mental health problems, elderly people, or people with physical disability. This is the total number of service users; the exact number of service users with mental health problems is not available.

Personal assistance budgets

There are no personal budgets for people with mental health problems in Lithuania.

Deinstitutionalisation

In 2007 Lithuania adopted a National Mental Health strategy that covers a wide range of principles, priorities and recommendations. The principles of the strategy are:

- A special focus on the human rights of people with mental health problems.
- Deinstitutionalisation and modern services that meet the needs of the patients.
- A balance within the development of a bio-psycho-social model.
- Promoting autonomy and participation.
- Shifting the treatment of some mental health problems to the primary and other non-specialist care sectors.
- Mental health promotion and prevention of mental illness should become an integrated part in the implementation of general health, education and social welfare policies
- Strengthening the role of service users and non-governmental organisations.

¹ Eurostat, 2012

² Health Statistics of Lithuania 2011 (<http://sic.hi.lt/html/en/lhic.htm>; last accessed: September 2012)

Lithuania is using EU Structural Funds to support the development of mental health services, in particular the establishment of five crisis intervention centres, five psychiatric centres for children and family and 27 day care centres.

The Ministry of Social Security and Labour is currently preparing a deinstitutionalisation strategy.

Involuntary placement

In the Law on Mental Health Care/1995, Nr. I-924, amendment 2005 (Psichikosveikatos priežiūros įstatymas), the existence of a significant risk of serious harm to oneself or others and a confirmed mental health problem are the two main attributes justifying involuntary placement. However, the need for a therapeutic purpose is not explicitly stipulated. The law requires more than two medical opinions, two psychiatrists and one doctor to contribute to the assessment.³ The patient may be involuntarily hospitalised and receive treatment in a mental health facility for a period not exceeding 48 hours without the authorisation of the court. If the court does not grant the authorisation within 48 hours, the involuntary hospitalisation and involuntary treatment must be terminated.

Guardianship

Legal incapacity is defined in Article 2.10 of the Civil Code. The mentioned article states that "a natural person who as a result of mental illness or dementia is not able to understand the meaning of his actions or control them may be declared incapable." Lithuania has a plenary guardianship system where full incapacity means that individuals lose civil, economic, political and other rights usually enjoyed by other adults. Limited incapacity also exists in the legal system, but such limitation may only be imposed in cases of alcohol or drug abuse.

Article 3.239 of the Civil Code provides that curatorship shall be established with the aim of "protecting and defending the rights and interests of a person" of limited active capacity. Article 2.10 of the Civil Code allows the spouse of the person concerned, parents, adult children, care institution or a public prosecutor to request the declaration of person's incapacity.⁴

The Lithuanian Civil Code is going to be amended in the close future, and, according to plans, it will introduce partial guardianship for people with mental health problems.

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³ http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf and http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=262177

⁴ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-LT.pdf>

Luxembourg

Population: 524,853¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

83

General summary

Luxembourg has one psychiatric hospital that provides in-patient, out-patient, rehabilitation and forensic services. There is at least one general hospital with a psychiatric ward, psychiatric services and day services in each of the three regions.

According to the organisation of psychiatric hospitalisation in Luxembourg, everybody should first be hospitalised in the psychiatric service of a general hospital. Only when the hospitalisation takes more than four weeks, the person can be transferred to the psychiatric hospital in Ettelbruck. The average length of stay for persons with the diagnosis of psychotic disorders was 487 days in 2011 and there were 78 patients.² Some patients have lived in the CHNP for decades – according to data from the WHO Mental Health Atlas (Luxembourg country profile)³, 15% of patients stayed for more than five years in the hospital. There are community health services, with sheltered living, work and leisure facilities. The four community health services provide a total of 220 places in sheltered living in different types of residential accommodation: mostly individual, some in small groups. These places are funded by the National Health Fund (Caisse Nationale de la Santé).

Types of residential services for people with mental health problems in Luxembourg⁴

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Psychiatric hospital : Ettelbrück Neuropsychiatric Hospital	1	165	78
Different types of supported living (individual or small groups)	–	–	220

Personal budgets

There are no personal assistance budgets for people with mental health problems in Luxembourg.

¹ Eurostat, 2012

² CHNP Annual Report 2011 (in French, http://www.chnp.lu/fr/corporate/documentation/rapport_annuel; last accessed : September 2012).

³ http://www.who.int/mental_health/evidence/atlas/profiles/lux_mh_profile.pdf (in English, last accessed: September 2012).

⁴ Source of data : CHNP Rapport Annuel, 2011

Deinstitutionalisation

Luxembourg is considering psychiatric reform that includes the decentralisation of psychiatric services.⁵

Involuntary placement

Forced admission is possible in Luxembourg, defined by the 'Law on hospitalisation without the consent of persons with mental disorders' (relative a l'hospitalisation sans leur consentement de personnes atteintes de troubles mentaux). There are two main conditions that have to be present at the time of involuntary admission- the existence of a significant risk of serious harm to oneself or others and a confirmed mental health problem. However, the definition of 'danger' is not specified. The regular procedure – a placement upon request by a family member or a guardian – simply refers to a notion of 'danger' while, in exceptional cases, the placement can take place in situations of 'imminent danger.' The need for a therapeutic purpose is not explicitly stipulated either.⁶

In its concluding observations in 2009, the CPT Committee recommended that Luxembourg should review its regulations on forced admission.⁷

Guardianship

In Luxembourg, the General Civil Code (Code Civile) recognises legal capacity (capacité de jouissance) for all citizens. There are three categories of legal capacity. Guardianship (Tutelle) is the most restrictive procedure, involving the loss of all important civil rights. Curatorship (Curatelle) is less restrictive. The third category is Legal protection (Sauvegarde de justice). A certificate from a neurologist/psychiatrist is needed, while the judge can make his own investigation, or can invite the person with mental health problems for the hearing.

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5 For further information: <http://www.sante.public.lu/fr/exposes/sante-mentale/2010/4eme-journee-transfrontaliere/2010-02-18-Consbruck-Roger.pdf> (in French, last accessed September 2012) or <http://www.sante.public.lu/fr/catalogue-publications/systeme-sante/politique-nationale-sante/rapport-rossler-psychiatrie-luxembourg-2009/index.html> (in German, last accessed September 2012).

6 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

7 <http://www.cpt.coe.int/documents/lux/2010-31-inf-fra.pdf>

Malta

Population: 416,110¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

85

General summary

Services for people with mental health problems are provided by two psychiatric hospitals in Malta. The main hospital is the Mount Carmel hospital, which has both out-patient and in-patient units, including long-stay wards. According to WHO data (country profile, Mental Health Atlas 2011)², 43% of patients stayed five years or longer in the psychiatric hospitals, and a further 14 % stayed there between one and five years. More recently, some community-based residential arrangements have been developed for people who require long-term support.

Types of residential services for people with mental health problems in Malta³:

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric hospital	2	-	581
Hostels	4	15	60
Flats	4	3	12
Community-based rehabilitation house (Villa Chelsea)	1	12	12

Personal budgets

There is no information on the availability of personal assistance budgets for people with mental health problems in Malta.

Deinstitutionalisation

There are no plans to close psychiatric hospitals in Malta.

Involuntary placement

In Malta, 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. According to Section 14 (3) of the

¹ Eurostat, 2012

² http://www.who.int/mental_health/evidence/atlas/profiles/mlt_mh_profile.pdf (last accessed : 30/09/2012).

³ Source : WHO Mental Health Atlas 2011, Malta country profile (psychiatric hospital)

Mental Health Act (1981) the two medical practitioners applying for an involuntary treatment measure “must specify whether other methods of dealing with the patient are available and, if so, why such methods are not appropriate”. The law doesn’t refer to the patient’s opinion when regulating involuntary placement and treatment.⁴

The old and widely criticized Mental Health Act (1981) is going to be replaced by the New Mental Health Act (2012) which has been approved by the cabinet office and is awaiting its second reading (in October 2012) in the Maltese parliament. The proposed Mental Health Act is more user-focused and establishes the Commissioner for Mental Health for the promotion of rights of persons with mental disorders. The proposed legislation promotes treatment in the least restrictive manner and for the shortest possible duration, thus favouring voluntary instead of involuntary care, and community care instead of care in a mental health facility. Moreover, the Act regulates restrictive care, special treatments and medical research on such persons and specifically includes provisions for minors admitted to hospital for treatment of mental health problems.

Below are the salient differences between the Old and New Acts concerning involuntary care:

Old Act	New Act (proposal)
<p>An application for compulsory admission to hospital is issued:</p> <ul style="list-style-type: none"> • if the patient has a mental health problem of a nature or degree which warrants the detention of the patient in a hospital, and • if it is in the patient’s own health or safety interest to be detained or for the protection of other persons. 	<ul style="list-style-type: none"> • An application for involuntary care is issued: if the person concerned has a ‘severe mental disorder’ • if the person concerned shows, as a result of a serious mental health problem, a serious risk of physical harm to self or to other persons • to prevent the possibility of serious deterioration in the patient’s condition, or if failure to admit would prevent the administration of appropriate treatment that cannot be given in the community.
<p>Two medical practitioners applying for an involuntary treatment must ensure that the above conditions for compulsory admission are fulfilled and “must specify whether other methods of dealing with the patient are available and, if so, why such methods are not appropriate”.</p>	<p>An application for involuntary admission to a licensed facility must be issued by two medical practitioners, one of whom must be a specialist in psychiatry. The application form is to be forwarded to the Commissioner who shall review, grant and extend any Order issued in terms of this Act.</p>
<p>The law doesn’t refer to the patient’s opinion when regulating involuntary placement and treatment.⁴</p>	<p>The patient is to give informed consent before any treatment or care is provided, unless the patient lacks the mental capacity to do so. Introduces the concept of the responsible carer who would be accountable for the patient if the patient is unable to do so. He may give consent and participate in the care plan.</p>

⁴ http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

The CPT Committee in 2008 recommended that the Maltese Government take appropriate steps to ensure access to mental health care for detainees in immigrants' detention centres and also recommended that they solve the problem of shortage in qualified nursing staff in psychiatric hospitals. According to the CPT Committee, in 2008 the Maltese press uncovered cases of abuse in psychiatric hospitals' Young People's Unit.⁵

Guardianship

The Constitution of Malta establishes exceptions where it is justifiable to restrict the civil and political rights of citizens, such as in the case of certain "mental conditions." For example, with reference to the right to vote, one of the situations which might invalidate this right includes "If he is interdicted or incapacitated for any mental infirmity or for prodigality by a court in Malta, or is otherwise determined in Malta to be of unsound mind" (Article VI: {b} of the Constitution).⁶

The proposed new Mental Health Act will bring significant changes. The New 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 New Act provides for the revocation of a certificate of lack of mental capacity. This revocation is to be 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 shall 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.

In October 2012, the draft bill amending the Civil Code was awaiting parliamentary discussion and approval. In this bill, it is proposed to extend the principle of supported decision-making to persons with mental health problems who do not merit referral to courts of law for interdiction or incapacitation.

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⁵ <http://www.cpt.coe.int/documents/mlt/2011-05-inf-eng.pdf>

⁶ [http://www.disability-europe.net/dotcom?term\[\]=210&term\[\]=148&term\[\]=149&term\[\]=150&term\[\]=158&term\[\]=164&term\[\]=165&view_type=detail_list](http://www.disability-europe.net/dotcom?term[]=210&term[]=148&term[]=149&term[]=150&term[]=158&term[]=164&term[]=165&view_type=detail_list)

Republic of Moldova

Population: 3,559,500¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	No	No

General summary

The Republic of Moldova has both psychiatric hospitals and social care institutions for people with mental health problems. According to report by the WHO (2006) 32% of patients in psychiatric hospitals spent at least one year or longer in the hospital, 26% of all patients spent between one and four years, 4% spent between five and 10 years, and 2% spent more than 10 years (p 10).² Over 2,000 people with mental health problems live in large institutions. There is no national information system on community-based residential support in Moldova. All data about community-based services presented here was collected from the reports presented by the Ministry of Labour, Social Protection and Family, and other public reports made by several NGOs³ active in the field. According to these findings, available support services to assist individuals with mental and intellectual disabilities and their families and prevent institutionalization include Mobile Teams⁴, Respite Services, Community Homes, and Supported Living Services.

Types of residential services for people with mental health problems in the Republic of Moldova:

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
long-stay psychiatric hospitals (under the Ministry of Health)	3	min. 200 max. 1110	1,925 ⁵
Psycho-neurologic residential institution for adults (under the Ministry of Social Protection)	4	min. 311 max. 549	1,688 ⁶
Psycho-neurologic residential institutions for children (under the Ministry of Social Protection)	2	min. 332 max. 343	675 ⁷
Sheltered house	4	2-6	approx. 17

¹ National Bureau of Statistics of the Republic of Moldova, 2012

² http://www.who.int/mental_health/republic_of_moldova_who_aims_report.pdf (in English, last accessed : August 22, 2012)

³ Keystone Human Services International Moldova Association

⁴ Republic of Moldova, Governmental Decision regarding the adoption of the Regulations and Quality Standards of the Mobile Team service nr.722 from September 22, 2011

⁵ Republic of Moldova, Annual Statistical Book (2011) presented by the Ministry of Health, p.32
<http://www.ms.gov.md/>

⁶ Republic of Moldova, Annual Social Report (2011) presented by the Ministry of Labour Social Protection and Family

⁷ According to the data presented on the official web site of the Ministry of Labour Social Protection and Family of Moldova <http://www.mmprsf.gov.md/en/institut/>

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Community Mental Health Centres: • National Mental Health Center, Chisinau • CMHC, Buiucani • MHC Somato, Balti • Center for children DANKO • CMHC Ungheni • CMHC Rezina	6	10-50	200

Source: Ministry of Health and Ministry of Social Protection, 2010 (hospital and institutions); evaluation report by NGO SOMATO, 2011 (community-based services)

Personal budgets / supported living services

The newly adopted Law on Social Inclusion of Persons with Disabilities⁸ establishes the Personal Assistance Service aimed to enable people with extensive disabilities, requiring permanent support and care, to live in the community with self-determination and full participation. The law also stipulates that, upon request, cash benefits can be entitled for organizing care and support services by the beneficiaries themselves in exchange for the available assistance services in kind⁹.

Deinstitutionalisation

Moldova has a National Programme on Mental Health for the period 2012-2016. The main objectives of the programme are:

- Reducing the number of places in psychiatric hospitals and increasing the availability of beds in general hospitals;
- Creating new community-based services, such as outreach services including mobile units.
- Incorporating mental health services in primary care.

Moldova also has a deinstitutionalisation strategy for social care institutions for children and adults with disabilities. A new regulation approved in 2012 will re-direct resources from institutions to community-based services.⁹

Involuntary admission

In the Republic of Moldova, the Law on Mental Health¹⁰ regulates involuntary treatment, and the Code of Civil Procedure¹¹ regulates involuntary placement.

8 Republic of Moldova, Law on Social Inclusion of Persons with Disabilities nr.60 from March 30,2012, art.53 para(1).

9 <http://www.soros.org/press-releases/moldovan-government-takes-historic-step-move-people-disabilities-out-institutions> (last accessed : August 22, 2012)

10 Republic of Moldova, Law on Mental Health nr.1402 from December 16, 1997

11 Republic of Moldova, Civil Procedure Code nr.225 from May 30

After repeated visits to the psychiatric hospitals and psycho-neurological social institutions, the CPT noted with concern the lack of staff and the over populated psychiatric hospitals and psycho-neurological social care institutions throughout the country. In its reports¹² the CPT delegation also revealed the fact that residents lacked therapeutic opportunities other than pharmacological treatment, were denied access to the outdoor surroundings and performed work which clearly could not be considered occupational therapy. Moreover, the numerous allegations of verbal and physical ill-treatment of residents by staff and the high number of deaths in these institutions, the absence of investigations into the ill-treatment and deaths of institutionalized persons rose particularly high concerns. The CPT was also critical about the inexistence of a comprehensive regulation and accurate recording of the use and instances of mechanical and chemical restraint.

From the observation visits of the CPT, it emerged that the patients' consent to hospitalization was constantly abused by forcing them to sign enrolment papers under high doses of tranquilizers, or, in some cases, allowing the relatives to put their signatures instead of the patients. The lawfully prescribed procedures safeguarding the involuntary treatment were also found to be seriously infringed. The patients were typically not heard by the courts, the decisions were not delivered to them, they were not adequately represented, and persons under guardianship were deprived of all legal safeguards because they lacked capacity to appeal and exercise procedural rights.

Guardianship

The Republic of Moldova relies on plenary guardianship governed by the provisions of the 2002 Civil Code. According to the Law, the guardianship is established through a two-step procedure.

First, the judicial procedure for declaring an adult 'incapable' must be initiated before the national Courts. Proceedings can be initiated by the guardian authority body, by a psychiatric institution, by a prosecutor or by the family of a person deemed to have a 'mental disturbance'. The person whose legal capacity is alleged can be denied the right to be informed and to participate in the initiated proceeding on the grounds of his/her health status.¹³ The decision taken by the judge is based on the forensic psychiatric report prepared by a commission of psychiatric experts. If the person whose legal capacity is alleged does not consent to undergo a psychiatric medical examination, the judge can order a forced detention of the person for in-patient psychiatric examination. The second step is an administrative procedure. Unlimited in time, guardianship is instituted without the participation of the person deprived of legal capacity. His/her consent to the appointed guardian is not required. Guardianship subjects lose the right to personally exercise and benefit from civil and political rights in the following areas: disposition over financial resources and patrimonial benefits, disposition concerning property, entering into contracts, family law matters, inheritance matters, health decisions, choosing of residency and domicile, exercising voting rights, exercising procedural rights before courts of justice and self determination in all aspects of life.

In December 2011, an Inter-Governmental Working Group¹⁴ on reforming guardianship and providing alternative legislation for supported decision-making in conformity with the UN CRPD Article 12 started its activity.

¹² Council of Europe anti-torture Committee reports on periodic visits to Moldova in September 2007 and June 2011. <http://www.cpt.coe.int/en/states/mda.htm>

¹³ No clarification on what is presumed under the "health status" preventing participation in the trial and the way in which the judge assess this condition are provided is offered neither in legislation nor in the official interpretations of the law.

¹⁴ Republic of Moldova, Ministerial Order nr.533/948/351 from December 9, 2011

The Netherlands

Population: 16,730,348¹

	Signed	Ratified
CRPD	Yes	No
CRPD Optional Protocol	No	No

91

General summary

In 2009, there were 82 service providers, including 31 integrated mental health care institutions, 20 regional institutes for sheltered housing and seven psychiatric hospitals (including forensic care) (GGZ Nederland, 2009) in The Netherlands. The figures in the table include short term as well as long term stay – there is no information on the number of long-term places.

The number of places in sheltered housing tripled between 1993 and 2009, while the number of hospital beds for adults and elderly declined by 17%.

Types of residential services for people with mental health problems in the Netherlands²

Type of service	Number of services	Typical size (min-max number of places in each type of service)	Total number of places*
Clinical beds out of which :	-	-	21,596
• Adults&elderly	-	-	17,786
• Children&youth	-	-	1,772
• Addiction care	-	-	2,038
Sheltered housing, mainly group homes (care)	-	-	12,978

*The data is for the year 2009 and relates to « beds » or « places ». A « bed » is defined as the total number of days that are paid for by public or private insurance, divided by 365 days.

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 (AWBZ), dedicated municipal funds for support and rehabilitation (WMO) and the Department of Justice for forensic care (WFZ). At this moment, personal budgets are only available in the AWBZ on official medical grounds. Nowadays, in mental health care, these 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.

¹ Eurostat, 2012

² Source: Van Hoof F. et al, *Bedden tellen – afbouw van de intramurale ggz, MGv, jaargang 67 (2012) 6, 298-310.*

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 approximately 8,000-10,000 institutionalized places between 2012 and 2020.

Involuntary placement

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 lists a set of dangerous situations - amongst others the possibility that the person will kill him/herself or cause severe bodily harm to him/herself, will completely ruin his/her social position and circumstances, or will seriously neglect him/herself. It also lists a set of dangers such as the person's "problematic behaviour" inciting aggressive acts by others, that the person will kill somebody else or will cause severe bodily harm to another person or to the mental well-being of others, or that the person will harm a person who is under his/her care or endanger the safety of other people or their property.

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.³

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 under involuntary treatment e.g. seclusion. The patients' advocate is an employee of a national organisation of patients' advocates and his/her services are free of charge.

The Dutch government is in the process of attempting to replace this Act by two pieces of legislation. The Care and Coercion Act (*Wet zorg en dwang*) deals with institutions for persons with intellectual disabilities and persons with dementia. The Act on Compulsory Mental Health Care (*Wet verplichte geestelijke gezondheidszorg*) deals with psychiatric hospitals. If both of these Bills are adopted by Parliament, this will result in major changes in the Dutch legal framework regarding involuntary placement and involuntary treatment.

Guardianship

The Civil Code of 1992 (*Burgerlijk Wetboek*) sets up a gradual system based on substitute decision making. Where in general every person is considered to be capable of making his 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, are not able to take care of their own affairs) executor (*bewindvoering*) covers issues concerning the

3 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

property and financial matters of the person, mentorship (mentorschap) aims at protecting the interests of the person regarding care and treatment, and finally 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) most limits the possibilities of the person involved to make their own decisions. For that reason, it is common practice to apply for executorship or mentorship. Wardship is seen as a legal measure of last resort.⁴

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.⁵ For every verdict in which a guardianship of any kind is established, the person who is placed under guardianship may appeal to the District Court.

Each year, Dutch courts deal with approximately 27,000 requests for one of the above mentioned guardianship categories.⁶ However, since there is no official registry, the breakdown between persons with psychogeriatric disorders (dementia), intellectual disorders, somatic disorders, debt problems and mental health problems is not available. Mental health problems probably constitute only a fraction of the aforementioned number.

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⁴ <http://www.disability-europe.net>

⁵ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-NL.pdf>

⁶ http://www.international-guardianship.com/pdf/GBC/GBC_Netherlands.pdf

Poland

Population: 38,538,447¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

In Poland, there were 47 psychiatric hospitals with a total of 17,750 beds in 2010. The average length of stay was 31 days.² Eight psychiatric hospitals had more than 600 places and 14 hospitals had more than 300 but less than 600 beds. Psychiatric hospitals are usually overcrowded, without an adequate space for rehabilitation. People with long-term mental health problems live in a variety of institutional and community-based settings. "Self-help community homes" are either organised by local governments supported by health professional, or by self-help oriented associations or charities (for example, "Self-help Community Home – Fountain House" in Poznan, organized by Association "To Understand and to Help"). Although "self-help community homes" are included in the statistics for "stationary social welfare facilities" together with long term institutions named "social assistance houses," these community-based services are very different. The users of self-help homes use such homes usually for about eight hours daily. However, it is possible – according to local needs and wishes of organisers and participants, to offer accommodation within the self-help home (usually- but not always - temporary, separately from its main functions, and for a small number of interested persons).

Types of residential services for people with mental health problems in Poland³

Type of service	Number of services	Typical size (min-max number of places)	Total number of places
Psychiatric chronic medical care home	44	-	4543 beds
Psychiatric nursing home	5	-	320 beds
Social assistance houses for people with long-term mental health problems	198	on average 100+ places	20634
Home-care in foster families (not related to the individual), organised and supervised by a hospital			Less than 20
Sheltered accommodation (group homes)	5	3-4	15
"Self-help community homes"	690	20-70	22791*

* This includes all service users, there is no information on the number of those using residential supports in self-help community homes.

1 Eurostat, 2012

2 Health and Health Care in 2010. Central Statistical Office 2012 (available in English and Polish: http://www.stat.gov.pl/gus/5840_12706_ENG_HTML.htm, last accessed: September, 2012)

3 Source of data : Health and Health Care in 2010. Central Statistical Office 2012 (medical care homes and nursing homes); Social Assistance – Infrastructure, Beneficiaries, Benefits in 2010. Central Statistical Office 2012 (social care institutions).

Personal budgets

Personal budgets are not available for people with mental health problems in Poland.

Deinstitutionalisation

There are no plans to replace hospitals and institutions with community-based services in Poland. According to the National Mental Health Programme implementation schedule, the number of places in psychiatric hospital should be reduced to at most 300 per hospital.

Involuntary placement

In Poland, two criteria – the risk of harm and the need for treatment – are listed alongside having a mental health problem in the requirements of the involuntary placement procedure. These, together with one expert opinion issued by a medical professional, fulfill the legal obligations concerning the assessment of an individual's psychiatric condition. The Law on Protection of Mental Health does not provide free legal support to the person concerned in each case, however, if the court considers that the participation of a lawyer is required then it is allowed to grant free legal aid.⁴

In 2012, Poland's Supreme Audit Office (NIK) issued a report on the abusive use of coercion and restraint that was everyday practice in many psychiatric hospitals. According to the report, solitary confinement was often used without the supervision of a medical professional.⁵ There was no evidence that patients admitted under a court ruling were informed of the reasons for hospitalisation and of what treatment was planned. Half of the audited psychiatric wards were unkempt and overcrowded and 70% of hospital rooms did not meet the standards of treatment.⁶

Guardianship

The Civil Code (1964) in Poland recognises both plenary guardianship and partial guardianship. A person may be placed under plenary guardianship because of mental health problems, mental deficiency or other 'mental disorders,' particularly if due to alcoholism or drug addiction they cannot 'control their behaviour.' If the circumstances do not warrant plenary guardianship, but a person needs assistance to manage their affairs, partial guardianship may be declared.

Persons placed under plenary guardianship do not have the right to conclude any legal acts, and any legal actions they take are deemed invalid. Guardians are appointed by the court to act for such persons. The legal capacity of a person under 'partial' guardianship is partially restricted, and for such a person a curator is appointed. The main role of the curator is to support or assist the person who has partially restricted legal capacity in his/her affairs. The agreement of the curator is essential for the validity of most legal acts made by the person.⁷

4 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

5 <http://www.thenews.pl/1/9/Artykul/104655,Inspectors-alarmed-by-Polands-psychiatric-hospitals> (accessed on 12 September 2012)

6 <http://www.nik.gov.pl/aktualnosci/nik-o-szpitalach-psychiatrycznych.html>

7 <http://www.disability-europe.net> (accessed on 12 September 2012)

In October 2012, the European Court of Human Rights delivered a judgment in the case of *Kędzior v. Poland*. Mr Kędzior was placed under the guardianship of his brother in 2000. Two years later, the guardian arranged for him to be transferred from his home to a social care institution against his will, where he remained for ten years with no way to challenge his detention in court. The Court noted that Mr Kędzior *“was not free to leave the institution without the management’s permission. Nor could the applicant himself request leave of absence from the home, as such requests had to be made by the applicant’s official guardian.”* Moreover, the applicant *“was under constant supervision.”*

Despite Polish legislation, which allows people under plenary guardianship to request restoration of their legal capacity, the applicant himself was curtailed in challenging his guardianship, so the ECtHR found a violation of the right to access to court as guaranteed by Article 6(1) of the European Convention on Human Rights.

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Portugal

Population: 10,541,840¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

97

General summary

The majority of residential services for people with mental health problems in Portugal are concentrated in large psychiatric hospitals, although in recent years some community-based alternatives have developed. Community-based services are mainly run by non-governmental organisations and are classified according to the support needs of service users (WHO proMIND 2009).²

Types of residential services for people with mental health problems in Portugal³

Type of service	Number of services	Typical size (min-max number of places in each type of service)	Total number of service users
Psychiatric Hospital	3	400	1015
Maximum support home	4	10-20	67
Medium support home	20	4-7	114
Minimum support home	4	3-7	23
Social-Occupational Unit	29	10-42	710

Personal budgets

Personal budgets are not available for people with mental health problems in Portugal.

Deinstitutionalisation

In 2007, Portugal adopted a National Mental Health Plan for 2007-2016 that identified deinstitutionalisation, the transfer of psychiatric hospital services to the community and the establishment of community-based services as some of its key objectives.⁴

¹ Eurostat, 2012

² http://www.who.int/mental_health/policy/country/Portugal_CountrySummaryFINAL_MOH.pdf (last accessed: August 20, 2012).

³ Source: National Mental Health Programme, 2012 (hospital data)
Integrated Continuity Mental Health Care Project Team, 2010 (community-based settings)

⁴ http://www.adeb.pt/destaque/legislacao/cnsm_planonacionalsaudemental2007-2016_resumoexecutivo.pdf and <http://www.portaldasaude.pt/NR/rdonlyres/AC8E136F-50E4-44F0-817F-879187BD2915/0/relatorioplanoaccoservicossaudemental.pdf> (both in Portuguese, last accessed: August 20, 2012).

Involuntary placement

When deciding over a person's involuntary admission to a hospital, two criteria, the risk of harm and the need for treatment are listed alongside having a mental health problem. Regular reviews of placement measures take place only every three months.⁵

At the beginning of 2008, the Portuguese government approved a National Plan on the future of public mental health care. The Plan advocated for further integration of psychiatry into the regular health care and social service system and stated that integration should be achieved through gradually dismantling the public psychiatric hospitals.

In 2008, the CPT Committee recommended "that the necessary steps should be taken to put an end to the practice of over-sedating newly arrived patients"; "other means than pyjamas are sought to dress patients without proper clothing"; "that steps be taken to ensure, in practice, the effectiveness of the right of access to a lawyer, in the context of involuntary placement under the Mental Health Act."⁶

Guardianship

The Civil Code of Portugal establishes a substitute decision-making system. It defines two ways in which legal capacity can be limited or suppressed, the regimes of *inability* (inabilitação) and *interdiction* (interdição). Legal incapacity is based, same as other disabilities such as deafness or visual impairment, upon "psychical anomaly" (anomaliapsíquica), or upon prodigality or excessive use of alcohol or drugs (inability). The term "psychic anomaly" is not specifically defined, but it is usually more closely associated with intellectual disability than with mental health problems.⁷

The regime of interdiction implies severe control over one's rights. Regardless of age, people who are subjected to this regime carry the legal the status of minors, and, for instance cannot exercise the right to vote. If interdiction is ascribed on the basis of a 'mental anomaly,' they are prevented from exercising paternity and testifying in court, and although they can marry, the marriage can be annulled.⁸

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5 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

6 <http://www.cpt.coe.int/documents/prt/2009-13-inf-eng.pdf>

7 http://www.disability-europe.net/dotcom?term%5B%5D=214&term%5B%5D=148&term%5B%5D=149&term%5B%5D=150&term%5B%5D=158&view_type=detail_list

8 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-PT.pdf>

Romania

Population: 21,355,849¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	No

General summary

Romania has psychiatric hospitals and social care institutions for people with mental health problems. People with mental health problems also live in a variety of other institutional settings such as care homes for older people.

Social care institutions and psychiatric hospitals for chronic patients are typically located in rural areas, making it difficult to maintain or build family and social relationships. Patients thus have poor access to community facilities and employment opportunities. Service users in social care homes tend to be people with chronic conditions, who either require a higher level of support with daily living or who are in need of housing or social support. Physical conditions in in psychiatric hospitals and institutions are bleak, as highlighted by various reports² and recent cases brought to the European Court of Human Rights related to the death of patients in psychiatric hospitals due to neglect and maltreatment.³ There are some community-based initiatives, but these reach only a small minority of people with mental health problems in need of residential support.

Types of residential services for people with mental health problems in Romania⁴

Type of service	Number of services	Typical size (min-max number of places)	Total number of service users
Psychiatric hospital	39	-	8107
Care and assistance centre	102*	-	1138**
Integration centre by occupational therapy	21*	-	376**
Recovery and rehabilitation centre	56*	-	2473**
Neuropsychiatric recovery and rehabilitation centres	52*	-	5457**

¹ Eurostat, 2012

² See for example: Report concerning the observance of the rights and liberties of persons committed to healthcare and social establishments for people with mental disabilities. Centre for Legal Resources, 2009. (Available in English: <http://www.crj.ro/EN/Report-concerning-the-observance-of-the-rights-and-liberties-of-persons-committed-to-healthcare-and-social-establishments-for-people-with-mental-disabilities>, last accessed: September, 2012); Protection mechanisms for persons with mental disabilities in medical-social institutions - Illusion to reality. Centre for Legal Resources, 2007. (Available in English: <http://www.crj.ro/EN/Protection-mechanisms-for-persons-with-mental-disabilities-in-medical-social-institutions-Illusion-to-reality/>, last accessed: September, 2012)

³ <http://www.crj.ro/EN/First-case-concerning-patients-deaths-at-the-Poiana-Mare-Psychiatric-Hospital-communicated-to-the-Romanian-Government-826/> (Available in English, last accessed : September, 2012).

⁴ Source of data: Mental Health WHO Atlas 2011 (psychiatric hospitals); Quarterly Statistical Bulletin, June 2012, Ministry of Labour, Family and Social Protection, General Directorate Protection of Persons with Handicap.

Type of service	Number of services	Typical size (min-max number of places in each type of service)	Total number of service users
Shelter houses	87*	-	53**

*Indicates the total number of services in this category.

**Indicates the number of service users with mental health problems (“psychiatric disabilities”).

Personal assistance budgets

There is no information on the availability of personal budgets for people with mental health problems in Romania.

Deinstitutionalisation

The National Strategy for the Protection, Integration and Inclusion of Persons with Disabilities (2006-2013) sets out the “modernisation” of social care institutions in Romania. The country has been using the Structural Funds of the European Union to invest in the refurbishment of existing institutions.⁵

Involuntary placement

In Romania, two criteria, the risk of harm and the need for treatment are listed alongside having a mental health problem as causes for involuntary placement. Article 45 of the Mental Health Law lists the following three conditions, which should be met for a lawful involuntary admission— serious mental disorder and reduced discernment, imminent danger of causing injuries to himself/herself or to other persons, a serious deterioration in health or obstruction of the administration of adequate treatment would result from failure to be admitted to a psychiatric hospital. According to the Mental Health Law (Law 487/2002, Art. 52), a “competent psychiatrist” makes a decision which is ultimately confirmed by a revision commission (*comisie de revizie*) formed of three members appointed by the hospital director – two psychiatrists, “if possible others than the one who took the decision in the first place,” and one doctor of another specialty or a representative of civil society.

The CPT Committee in 2008 observed that that the commissions in charge of assessing involuntary placement are established ad-hoc, doctors member of the first instance commissions are appointed also in the revision commissions, patients are not heard during the procedures, and the prosecutor’s supervision of the legality of decisions is missing or ineffective, although prescribed by the law. There is also a lack of periodic revisions of the involuntary placement decisions, a lack of application of the procedure for transforming the voluntary placement into involuntary placement, there is no special procedure for persons placed under interdiction, and there is no procedure for involuntary placement in social institutions or rehabilitation centers. Moreover, both the inhuman use of ECT and the use of physical constraints are unregulated and put in practice. The Committee also observed that an abusive biomedical research program was in place, carried out by the pharmaceutical industry. Patients presumed incapable of consent (although not ‘placed under interdiction’) were included in

⁵ Wasted Time, Wasted Money, Wasted Lives ... A Wasted Opportunity? – A Focus Report on how the current use of Structural Funds perpetuates the social exclusion of disabled people in Central and Eastern Europe by failing to support the transition from institutional care to community-based services. ECCL 2010 (available in English: <http://www.community-living.info/documents/ECCL-StructuralFundsReport-final-WEB.pdf>, last accessed: September, 2012).

research programs upon signing a consent form, or were not informed of the consequences of the treatment using antipsychotic medicines. Consequently, there is not enough information on patients' rights and there is a lack of effective complaint procedures. Placements in mental health hospitals are also carried out despite a lack of medical indication.⁶

The Mental Health Law was amended in June 2012, and now the prosecutor is the one who decides on the involuntary placement. The terms of implementation will be elaborated by a working group that will gather in October 2012.

Guardianship

Romania has a traditional guardianship system based on substitute decision-making. The New Civil Code adopted in 2009 did not improve this situation, though it was amended in 2011. The institution of placing a person under 'interdiction' (*punere sub interdicție*) creates a complete removal of capacity.

People with mental health problems or with disabilities, whose legal capacity is restricted through court orders, do not enjoy full liberties in Romania - they cannot vote or sign legal documents, they cannot decide about a number of juridical matters and cannot marry. Two possible juridical protection measures are available: '*tutela*' (guardianship) and '*curatela*' (trusteeship). The new Civil Code (2011) introduced a new measure called a 'family council,' which advises the legal guardian in all matters related to the protection of rights and interests of persons with mental health problems or disabilities. Guardianship is usually a permanent measure, and the law does not mention a regular (mandatory) review of decisions, or the possibility of specific exemptions related to the legal rights of a person with severe intellectual disabilities.⁷

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⁶ <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-RO.pdf>

⁷ <http://www.disability-europe.net> (last accessed on 11 September 2012)

Serbia

Population: 7,120,666¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

Serbia has both long-stay psychiatric hospitals and social care institutions. There are a total of 6247 psychiatric beds in a variety of settings including long stay psychiatric hospitals, psychiatric clinics, psychiatric institutes, psychiatric clinics for children and adolescents and psychiatric units in general hospitals. Approximately 50% of these are in large psychiatric hospitals, such as the one in Niš with 700 beds, or in Kovin with 500 beds.

Institutions provide accommodation to a mixture of service user groups. There are five social care institutions in Serbia that provide services for approximately 2000 people with mental health problems. The largest one is in Kragujevac, where out of the 921 residents 534 have mental health problems (Helsinki Committee for Human Rights in Serbia, 2009).² Social care institutions are typically located in remote rural areas making it difficult to maintain or build social relationships, and providing poor access to community facilities and employment opportunities. There are some community-based initiatives, but these only reach a small minority of people with mental health problems in need of residential support.

The Helsinki Committee for Human Rights in Serbia published a series of reports describing the situation in social care institutions in Serbia in 2009.³

Data by type of services was not available.

Personal budgets / supported living services

There are no personal budgets for people with mental health problems in Serbia.

Deinstitutionalisation

Serbia adopted the Strategy and Action Plan for Mental Health Protection Development in 2007. The Strategy set out to establish services in the community for people with mental health problems, as well as to decrease the number of beds in big psychiatric hospitals within the process of deinstitutionalisation. The deadline to establish services in the community is December 2014 and the deadline to downscale the number of hospital beds in big psychiatric hospitals is December 2017. Although the closure of long-stay hospitals is mentioned in the Strategy, it does not feature in the Action Plan.

¹ Statistical Office of the Republic of Serbia, 2011

² <http://www.helsinki.org.rs/doc/People%20On%20The%20Margins%20-%204.pdf> (in English, last accessed August 22, 2012)

³ http://www.helsinki.org.rs/projects_osi1.html (in English, last accessed : August 22, 2012)

Involuntary treatment

People can be forcibly admitted in a psychiatric hospital if a doctor believes that the nature of their mental health problem is such that it may endanger their own life, or that of others, or that it may endanger property. Such a decision must be reviewed by a panel of doctors within 24 hours. Adults can be detained without judicial review for as long as 33 days.⁴

In 2008, the CAT Committee stated that “the Committee is concerned that no investigation seems to have been initiated with respect to treatment of persons with disability in institutions amounting to torture or inhuman or degrading treatment.” It also recommended that Serbia should “initiate social reforms and alternative community-based support systems in parallel with the ongoing process of deinstitutionalization of persons with disability, and strengthen professional training in both social-protection institutions for persons with mental disability and in psychiatric hospitals; and investigate reports of torture or cruel, inhuman or degrading treatment or punishment of persons with disability in institutions.”⁵

Guardianship

In Serbia, there are two types of guardianship. There is both plenary and partial guardianship in Serbia. Temporary guardianship (or guardianship for a special situation) means that a temporary guardian is appointed for an adult if the authority believes that there are special circumstances warranting protection of the adult, their rights and their interests. The length of this form of guardianship is decided with regards to the specific circumstances of each case. Regular guardianship is a special form of legal protection for adults who are not able to exercise their rights. By establishing forms of guardianship, the law aims to protect the interests of people with psycho-social disabilities (mental health problems).

In 2012, the Serbian government set up a working group and started preparing further work on the amendment of the existing legal capacity law. The plans and the direction of the reforms have not been disclosed.

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⁴ http://mdac.info/sites/mdac.info/files/English_Guardianship_and_Human_Rights_in_Serbia.pdf

⁵ <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G09/402/77/PDF/G0940277.pdf?OpenElement>

Slovakia

Population: 5,404,322¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

Slovakia has a number of long-stay psychiatric hospitals and also provides residential services for people with mental health problems in large social care institutions. Service users in institutions tend to be people with chronic conditions, who either require a higher level of support with daily living or those who are in need of housing (e.g. homeless people) in the absence of social housing. However, there is no information on the number of people with mental health problems living in social care institutions.

Institutions are often located in remote rural areas making it difficult to maintain or build social relationships and providing poor access to community facilities and employment opportunities. Community-based initiatives reach only a small minority of people with mental health problems in need of residential support.

Types of residential services for people with mental health problems in Slovakia²

Type of service	Number of services	Typical size (min-max number of places in each type of service)	Total number of service users
Psychiatric hospital	8	200 - 461	2411
Psychiatric hospital for children	1	90	90
Supported living	2	14-16	30
Rehabilitation centres	3	15-20	50

Personal budgets

Personal budgets are not available for people with mental health problems in Slovakia.

Deinstitutionalisation

Deinstitutionalisation is an official policy of the Slovak government. At the end of 2011, the country adopted the National action plan for the transition from institutional to community-

¹ Eurostat, 2012

² Source: National Coordinating Body for Mental Health, 2011 (hospital data)
Residential Support and Community Treatment National Network, 2011 (community-based settings)

based care in the social services system that set out the objectives of the first, pilot phase of deinstitutionalisation for the period between 2012 and 2015. Using the Structural Funds of the European Union, the programme supports the implementation of pilot projects to replace social care institutions with community-based services for children, people with disabilities and older people. Institutions for people with mental health problems are not included.

Involuntary placement

In Slovakia, two criteria, the risk of harm and the need for treatment are listed alongside having a mental health problem. According to the Health Act, two separate combinations of criteria have to be fulfilled for the authorisation of involuntary placement: a mental health problem / symptoms of a mental health problem plus the risk of danger to the person concerned and his/her vicinity; a mental health problem / symptoms of a mental health problem and the danger of a serious deterioration in the mental health status of the person concerned.

Any physician can prepare the evaluation for the involuntary placement and the law does not explicitly require the physician to have any specific expertise in psychiatry. The law does not refer to the person's opinion in the course of an involuntary measure.³

The CAT Committee in 2009 recommended that Slovakia "should improve the living conditions for patients in psychiatric institutions and ensure that all places where mental-health patients are held for involuntary treatment are regularly visited by independent monitoring bodies to guarantee the proper implementation of the safeguards laid down to secure their rights, and that alternative forms of treatment are developed."⁴ According to the CPT Committee, in 2006, the use of net-beds was widespread in the Slovak Republic and that there were 312 net-beds in psychiatric facilities throughout the country.⁵

Guardianship

The court may restrict a person's legal capacity according to section 10 of the Civil Code (No. 40/1964 Coll., and its amendments) so that he/she is unable to make decisions due to his/her mental health problems. However, these persons are, even with full or partial restriction of legal capacity, legal subjects. This means that the Civil Code differs between the capacity to have rights and the capacity to act independently. There are two degrees of legal incapacity recognised by the Civil Code- restriction of the legal capacity, with the result that the person is not capable of carrying out certain legal acts, and full deprivation of legal capacity, with the result that the person is entirely incapable of carrying out legal acts.⁶

In deciding on deprivation of legal capacity or its restriction, the court appoints a guardian, many times the director of the large residential institution the person is placed in. The court monitors the guardian's work and evaluates his/her performance at least twice a year.

The Ministry of Justice confirmed the political will to synchronise the relevant article of the Civil Code with the relevant articles of the UN Convention (letter of Minister of Justice, 16 March 2011).⁷

3 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

4 <http://www2.ohchr.org/english/bodies/cat/cats43.htm>

5 <http://www.cpt.coe.int/documents/svk/2006-05-inf-eng.pdf>

6 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-SK.pdf>

7 [http://www.disability-europe.net/dotcom?term\[\]=216&term\[\]=148&term\[\]=149&term\[\]=150&term\[\]=158&term\[\]=164&term\[\]=165&view_type=detail_list](http://www.disability-europe.net/dotcom?term[]=216&term[]=148&term[]=149&term[]=150&term[]=158&term[]=164&term[]=165&view_type=detail_list)

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Slovenia

Population: 2,055,496¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

107

General summary

Slovenia provides long-term residential services for people with mental health problems in social care institutions, where people with mental health problems often live together with other groups of service users such as elderly people and people with intellectual disabilities. Some of the group homes are provided by institutions near or on their site and away from the original communities of service users.

Types of residential services for people with mental health problems in Slovenia²

Type of service	Number of services	Typical size (min-max number of places in each type of service)	Total number of service users
Social care institutions – old peoples' homes	89	150	17,571
Social care institution for people with mental disabilities	5	200 – 500	1516
Group home	48	4-10	248

Personal budgets

There is no information on the availability of personal budgets for people with mental health problems in Slovenia.

Deinstitutionalisation

Deinstitutionalisation is not an official policy of the Slovenian government although some social policy documents make reference to it. The number of beds in social care institutions and homes for elderly people has been increasing.

¹ Eurostat, 2012

² Source: Skupnostsocialnihzavodov (2010)
National Mental HealthResolution (2011)

Involuntary placement

In Slovenia, two criteria – the risk of harm and the need for treatment – are listed alongside having a mental health problem. Article 39 of the Slovenian Mental Health Act allows for lawful detention if the described threats cannot be prevented by using other less intrusive means, such as treatment in an open department of a psychiatric hospital, ambulant treatment or treatment under medical surveillance. Regular reviews take place after one year.³ The Act requires that the person concerned must be represented by an advocate throughout the judicial phase of deciding on involuntary treatment or placement.⁴

In 2011, the CAT Committee admitted that it „regrets the lack of information on use of measures such as electroconvulsive therapy and psychotropic drugs, and on complaints against such special measures“. It also recommended “that all places where mental-health patients are held for involuntary treatment are regularly visited by independent monitoring bodies to guarantee the proper implementation of the existing safeguards” and “that the State party undertakes a serious review of the application of electroconvulsive treatment (ECT), and any other treatment which could be in violation of the Convention (Against Torture).”⁵

Guardianship

Legal capacity can be withdrawn in cases of “mental illness”, intellectual disability, alcohol or drug addiction or other reasons that make a person incapable of looking after their own rights and interests. The procedure starts at the initiative of social care services, a public attorney, spouse, or other close relative. The Centre for social work is obliged to find a guardian for the person whose legal capacity has been taken away and to define his/her obligations and mandate. The centre for social work also takes into consideration the wishes of the person whose legal capacity has been taken away, if the person is able to express them, as well as the wishes of his/her relatives. The guardianship ends if the court gives back the person’s legal capacity. This is a formal possibility which is almost never implemented.⁶

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3 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

4 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-SI.pdf>

5 <http://www2.ohchr.org/english/bodies/cat/docs/co/CAT.C.SVN.CO.3.pdf>

6 [http://www.disability-europe.net/dotcom?term\[\]=217&term\[\]=148&term\[\]=149&term\[\]=150&term\[\]=158&term\[\]=164&term\[\]=165&view_type=detail_list](http://www.disability-europe.net/dotcom?term[]=217&term[]=148&term[]=149&term[]=150&term[]=158&term[]=164&term[]=165&view_type=detail_list)

Spain

Population: 46,196,276¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

There is limited information on long-term residential services for people with mental health problems, particularly those provided in the community. This is because responsibilities for mental health services were transferred from the Central Administration to regions and, as a consequence, there is a great variety of typology and descriptions for these services, depending on the region. According to National Directory of Hospitals there were 88 psychiatric hospitals in Spain in 2011 with a total of 14,440 beds.² There is no information on how many of these were long stay.

In some regions, the services are run by the public authorities, in some regions services, particularly community-based services, are run by private or NGO service providers. It is very difficult to get a complete picture of available resources. According to the AEN OBSERVATORY there were 2588 acute beds in general hospitals and 748 beds in psychiatric hospitals. The number of places in hospital rehabilitation units was 2724 and in long-stay hospital units it was 3090. In addition there were 4964 psychogeriatric beds.

Types of residential services for people with mental health problems in Spain³

Type of service	Number of services	Typical size (min-max number of places in each type of service)	Total number of places
Group homes	-	-	5327
Supported homes	-	-	2008
Supported lodging	-	-	148
Mini Residences	-	-	2005

Personal budgets

There is no information on the availability of personal budgets for people with mental health problems in Spain.

¹ Eurostat, 2012

² Catálogo Nacional de Hospitales 2012 (in Spanish, <http://www.msc.es/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/docs/CNH2012.pdf>, last accessed September 5, 2012).

³ Source: Mental Health Observatory of the Spanish Association of Neuropsychiatry, 2010

Deinstitutionalisation

The National Health Law of 1985 established that anyone in need of hospitalization for mental health problems should be treated in Acute General Hospital Units and that community resources should be developed for long term care. These made deinstitutionalization part of the law (following the Italian model), but its implementation has been irregular depending on regions. In 2006, Spain adopted a mental health strategy (*Estrategia en Salud Mental del Sistema Nacional de Salud* – Mental Health Strategy of the National Health System) and – based on the evaluation of the first strategy – a new Strategy in 2009⁴. This strategy is based on the philosophy and contents of the Helsinki Declaration in Mental Health Spain signed in 2005. The Strategy adopts an integrated approach that combines the promotion of mental health, the prevention of mental health problems, the diagnosis and the treatment of patients, the coordination of services, as well as measures to support the social inclusion of people with mental health problems. The new Strategy emphasises the need to develop adequate community-based housing for people with severe mental health problems to prevent (re-) hospitalisation and promote social inclusion (p. 41). The Strategy makes no explicit reference to deinstitutionalization – assuming that community mental health is the norm and quality is the main problem. Figures however do not suggest this. One of the main problems is that community services are run in an institutional way and there is a lack of support for independent living.

Involuntary placement

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.⁵

In 2011, the CRPD Committee recommended that Spain should review “its laws that allow for the deprivation of liberty on the basis of disability, including a psychosocial or intellectual disabilities; repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability; and adopt measures to ensure that health-care services, including all mental-health-care services, are based on the informed consent of the person concerned”. The CRPD committee said that “[w]ith reference to article 14 of the Convention, the Committee is concerned at the fact that having a disability, including an intellectual, or psychosocial disability, can constitute a basis for the deprivation of liberty under current legislation”.⁶

Guardianship

In Spain there is a traditional guardianship system in place, which runs counter to Article 12 of the UN Convention, concerning equal recognition before the law and support to exercise

⁴ <http://www.msps.es/organizacion/sns/planCalidadSNS/docs/saludmental/SaludMental2009-2013.pdf> (in Spanish, last accessed: August 21, 2012)

⁵ http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

⁶ <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/Session6.aspx>

legal capacity. There is also a lack of state regulation concerning support for decision making. Support for self-determination mainly comes from organisations of people with disabilities.⁷

The declaration of incapacity implies a limitation of the patient's capacity to act, and his/her subjection to a representative (guardianship) or assistance (curatorship) regime, or a regime which may be either (extended or reinstated parental authority), depending on the content of the judgment. The guardianship is compulsory, stable, potentially remunerated, and may be exercised by a single person, or jointly with the person concerned. Curatorship is a financial protection system, aiming to provide assistance (no representation) regarding the acts determined by a Court decision or, failing that, by the law. The "incapable" person maintains his full capacity to act, however, the Court orders him to act in certain cases jointly with the curator, who complements his capacity.

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⁷ <http://www.disability-europe.net/dotcom>

Sweden

Population: 9,482,855¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

Sweden no longer has mental health institutions or long-stay psychiatric hospitals. Hospital care is provided in the psychiatric wards of ordinary hospitals (approximately 32500 beds). There are places for forensic psychiatric care (1113 beds) and specialist places for the psychiatric treatment of children (157 beds).² 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.

Deinstitutionalisation

Sweden implemented a mental health reform and closed a large number of 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 (see below) and forensic psychiatric care.

Involuntary placement

In Sweden, 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.³

The CAT Committee stated in 2008 that “the State party should review the use of physical restraints and further limit the use of solitary confinement as a measure of last resort and for as short a time as possible under strict supervision.”⁴

1 Eurostat, 2012

2 WHO Mental Health Atlas 2011, Sweden country profile (http://www.who.int/mental_health/evidence/atlas/profiles/swe_mh_profile.pdf) (last accessed: 30/09/2012).

3 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

4 <http://www2.ohchr.org/english/bodies/cat/cats40.htm>

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.

If someone, due to illness, mental health problems, a weak state of health or similar circumstances, needs help to manage his/her affairs a curator or “*godman*” 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.

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, a 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. Even when a person has a trustee he/she is still able to perform legal actions, such as entering into a contract for services or employment.⁵ There are approximately 95,000 people under some type of guardianship in Sweden.⁶

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5 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-SE.pdf>

6 http://www.international-guardianship.com/pdf/GBC/GBC_Sweden.pdf

United Kingdom

Population: 62,989,550¹

	Signed	Ratified
CRPD	Yes	Yes
CRPD Optional Protocol	Yes	Yes

General summary

People with mental health problems in the United Kingdom can receive residential support in a variety of settings including care homes, with or without nursing. Many people are supported to live independently in their own home or in supported housing. There are also some mental health wards and hospitals, as well as secure (also known as forensic) mental health services. Service provision can vary between the four constituent countries of the UK.² There is no information on the number of settings and the number of service users in different settings.

Personal assistance budgets

Various forms of personalised budgets are available for people with mental health problems in the UK, including personal budgets and direct payments to cover some social care services. Personal health budgets are currently being piloted in many parts of England.

Deinstitutionalisation

The UK has implemented deinstitutionalisation, including the closure of long-stay mental health hospitals, and many services are provided in community-based settings.

As health is a devolved issue, mental health policy and practice varies across the UK's constituent countries. The Government has recently published an implementation framework to aid the delivery of the strategy *No health without mental health* (February 2011) for England at the local level. The Scottish Government published its *Mental Health Strategy for Scotland, 2012-15* in August 2012, the Welsh Assembly Government launched its mental health strategy *Together for Mental Health* in October 2012, and the Northern Ireland Executive published its *Service Framework for Mental Health and Wellbeing* in October 2011.

The future of social care, including its funding, is currently being discussed in England and Wales. July 2012 saw the publication of the Government's White Paper *Caring for our future: reforming care and support*, together with draft legislation.

Involuntary placement

In each of the jurisdictions within the United Kingdom, legislation provides decision makers various justifications for involuntary placement, based on one or more of the following grounds: the patient's welfare, the patient's health, or public protection.

¹ Eurostat, 2012

² England, Northern Ireland, Scotland and Wales

Whilst services and provision differ across the UK, all have some form of acute mental health care. The vast majority of people receiving treatment in acute wards are in hospital on an informal basis and have usually agreed to come into hospital – they are called informal or voluntary patients. Wards may be locked, even though not all patients are detained. People who are deemed to need closer supervision for their own or others' safety may be admitted to a psychiatric intensive care unit.

The Mental Health Act (England and Wales)

A quarter of people are admitted, detained and treated in hospital against their wishes. This is because they have been 'sectioned' or 'detained' under the Mental Health Act 1983, which was recently amended by the Mental Health Act 2007. People detained are called formal patients and are not free to leave hospital, as well as losing other important rights available to informal patients, such as being given treatment, including medication, against their will.

An approved mental health professional (AMHP) can make an application to admit someone to hospital under the Mental Health Act, following an interview with the individual. AMHPs are usually social workers, occupational therapists, psychologists, and nurses with practical experience in mental health. Involuntary placement can also be initiated by the nearest relative of the person to be detained, usually through an AMHP who would then make the application. Usually two doctors will then examine and assess an individual and complete recommendations to confirm that, in their opinion, that individual fits the criteria for being sectioned under the Act. A person is then admitted onto a ward and remains in hospital until their section finishes.

In England, there were 16,647 people detained in hospital at the end of 2010-11³. In Wales, 1,453 people were detained in hospital under the powers of the Mental Health Act during 2009-10.

There are different sections of the Act which have different purposes and an individual is legally entitled to get support from an Independent Mental Health Advocate (IMHA).

The Mental Health Act 2007 also introduced community treatment orders (CTOs), giving clinicians powers to recall patients following their discharge from detention in hospital if they relapse or have a change of circumstances and pose a high risk to themselves or others on account of their mental health problem. People on a CTO are given 'supervised community treatment.' This means patients can, at their clinician's discretion, be returned to hospital for compulsory treatment if they stop taking their medication and/or disengage with services. In March 2011, an estimated 4291 people in England were subject to a CTO⁴. In Wales in 2010-11 there were 233 patients subjected to CTOs.

An assessment by the Mental Health Alliance in May 2012⁵ highlighted particular concerns about the current usage of the Act, including:

- The number of people subject to detention under the powers of the Act has risen each year since 2000 and they are an increasing proportion of the inpatient population.
- Higher, disproportionate and inappropriate use of CTOs. CTOs are being used at much higher rates than predicted by the responsible authorities. CTOs are being used more frequently with

3 Health and Social Care Information Centre, 2011a

4 NHS Information Centre

5 Mental Health Alliance, *The Mental Health Act 2007: a review of its implementation*, May 2012

- some black and minority ethnic communities, and are being used on over a third of patients who have no history of non-compliance with treatment or of disengagement with services⁶.
- The rights people technically have are not being consistently upheld. Some people are being denied their rights as IMHA services are not commissioned adequately or hospital staff aren't informing patients about the services.

A similar system applies in Northern Ireland, with the exception that the application of admission for assessment can be made only by the nearest relative or a social worker, and no other professional. In Scotland, all applications must be heard by the Mental Health Tribunal. The Tribunal has powers to issue various compulsory orders including involuntary placement and the provision of medical treatment. A Tribunal is made up of three persons, one of whom will be a lawyer, one a doctor and one a "general member".⁷

Guardianship

The Mental Capacity Act (England and Wales)

The Mental Capacity Act (England and Wales) 2005, which came into force in 2007, emphasises the process by which substitute decisions are made. A range of people can make decisions on another's behalf, including service professionals and family members. Those immediately involved in assisting persons judged to lack capacity are expected to help with most day to day decisions, as long as they follow certain procedures. Independent Mental Capacity Advocates (IMCAs) are appointed in particular instances, and specific guidance is provided in the Code of Practice. A functional test of capacity is included in the Mental Capacity Act.

The legislation which applies in England and Wales provides a definition of a 'person lacking capacity'. This states that 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of, the mind or brain'. The number of people under any kind of guardianship regime in England and Wales is approximately 35,000.⁸

The Deprivation of Liberty Safeguards (DOLs) is an addition to the Act, introduced as part of the 2007 Mental Health Act. The safeguards were designed to remedy the incompatibility between English law and the European Convention on Human Rights identified in *HL v UK*, known as the "Bournewood" case. The Mental Health Alliance has also expressed concerns about the use of DOLs on a broad range of issues⁹.

Adults with Incapacity (Scotland) Act 2000

The Adults with Incapacity (Scotland) Act 2000 (amended in 2007 and 2008) applies in Scotland. Its provisions allow for a substitute decision maker. The focus is on attributes (characteristics and relationship to the person being assisted) and the situations where guardians may and may not decide on matters¹⁰.

In Scotland, 'incapable' is defined to mean incapable of acting, making decisions, communicating

6 Care Quality Commission, 2010

7 http://fra.europa.eu/fraWebsite/attachments/FRA-2012-involuntary-placement-treatment_EN.pdf

8 <http://fra.europa.eu/fraWebsite/attachments/mental-health-study-2009-UK.pdf>

9 Mental Health Alliance, *The Mental health Act 2007: a review of its implementation*, May 2012

10 <http://www.disability-europe.net> (accessed on 12 September 2012)

decisions, understanding decisions, or retaining the memory of decisions by reason of mental disorder or of inability to communicate because of physical disability.

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The British Psychological Society

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The Centre for Mental Health

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