MEETING OF THE SOUTH EAST EUROPE NPM NETWORK IN PODGORICA

Health Protection in Prisons and Psychiatric Institutions

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Crna Gora
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KEYNOTE SPEECHES

(Report from the Ombudsperson's website)

Montenegro's National Preventive Mechanism (NPM) hosted a two-day conference of the Medical Group of the SEE NPM Network, held in Podgorica.

The meeting on "Health Protection and Care in Penitentiary and Psychiatric Institutions" was organised thanks to the PREDIM (Support to the National Institutions in Preventing Discrimination in Montenegro) project, supported by the European Union and the Council of Europe, as implemented by the Council of Europe.

Montenegro's Protector of Human Rights and Freedoms, Šućko Baković stated in his keynote address that healthcare of detained persons was in the particular focus of NPM's attention.

"We have not observed any serious issues at the level of primary healthcare provided within the penitentiary institution (ZIKS). There are complaints, but in each case that we examined, acting within the Ombudsperson's capacities, we noted either misunderstanding or improper approaches by the inmates themselves. In principle, we noted no problems, which is very good and commendable", he reported.

As for tertiary protection, Baković noted the existence of problems, but largely similar to the ones encountered by ordinary members of the public.

He reminded that inadequate healthcare may lead to actions which can be seen as "inhuman and degrading treatment".

"The stay of detained persons in the institutions where they cannot receive proper health protection due to the absence of appropriate rooms, unhealthy conditions, overcrowdedness, long isolations and inactivity or because such institutions refuse to accept them is unacceptable", warned the Protector.

He noted that the European Court of Human Rights (ECtHR) established violation of Art 3 to the European Convention on Human Rights (ECHR) on multiple occasions.

According to Baković, healthcare services in closed institutions might play a major role in fight against maltreatment. "Medical staff within the penitentiary system are potentially in conflict of loyalties between their employer and their professional obligations to report torture or maltreatment out of fear of retribution which would affect their employment status".

The Protector stated that the respect for fundamental rights of detained persons implies the provision of preventive treatments and healthcare services equivalent to the ones provided to community at large.

"It is the duty of healthcare services not only to provide treatments but also to monitor nutrition (quality and quantity of food, its preparation and distribution), hygiene (cleanliness of clothes and linen, access to drinking water, sanitation, heating, lighting and ventilation), mental healthcare, particularly in preventing harmful psychological impacts of being deprived of one's liberty. They are also

entrusted with the social and preventive medicine responsibilities.

He reminded that in case of failure to give consent or in case of refusal, a physician must make sure that patients comprehends the effects of their decision and are aware of the possibility to change their mind at any time.

"Any deviation from the principle of free consent could be justified only if done in accordance with the law, for instance in case of psychiatric patients incapable of comprehending the consequences or in case of urgent interventions on unconscious patients", noted the Protector.

The Deputy Protector of Human Rights and Freedoms of Montenegro and the Chair of the Medical Group in the NPM Network, Zdenka Perović, noted that detainees enjoy all human rights that belong to them by birth, by the fact that they were born as human beings.

"The fact that they are deprived of their liberty, the single most significant and the holiest of all human rights, whose importance we seem unaware of until the unwanted moment in life when we lose it, makes this group of people particularly vulnerable", she noted.

Perović stressed health protection and care as one of the most fundamental rights and needs of all, particularly of this vulnerable group.

"In Montenegro recently, both the detainees and NGOs dealing with their human rights assessed healthcare in closed institutions as unsatisfactory, which led us to particularly focus on these issues", she explained.

The Protector of Citizens of Serbia a.i. and the Chair to the SEE NPM Network, Miloš Janković stressed it is the NPM's role to assist those in an unenviable situation, detained in closed institutions, away from the public eye, and as such susceptible to torture.

He reminded that visits are one of the main tools envisaged by OPCAT.

According to Janković, what matters in terms of visits to places where people are deprived of liberty or have their movements restricted (places of detention), is not the quality of work, but the quantity.

"Quantity brings about quality. The more we are present in places of detention, the more we prevent torture", he stated, noting that it is the NPM task to be within prisons as much as possible.

He reported that in Serbia it is believed that health protection of persons deprived of their liberty is quite well covered, but that prevention of maltreatment in psychiatric hospitals is more of a problem.

"Health protection and care in prisons must be at the same level as in community at large in public healthcare services", noted Janković.

He noted that people come to places of detention without their medical histories, thus seeing the existence of and access to, medical records as essential.

"We are aware that in prison security staff are present during medical examinations and have access to medical records, which is unacceptable, just like the situations when medication is administered by non-medical staff", concluded Janković.

The Deputy Ombudsman of Slovenia and the Chair to the Legal Group of the SEE NPM Network, Ivan Šelih, noted that only proper health protection may ensure proper life in confinement, and the contrary may constitute inhuman treatment.

"The starting point in assessing the level of health protection and care provided should be the principle that inmates enjoy the same right to health protection and care as other citizens. It is an unalienable right ", stressed Šelih.

As he noted, the aim of the NPM Network is to establish synergies, provide assistance and put in place the assumptions for efficient pursuit of the NPM mandate.

Šelih pointed out to some of the outstanding issues that need to be discussed, such as the availability of doctors, consent to examination, equal treatment, prevention, assistance to people with disabilities, as well as the principles of independence and competence.

The Council of Europe representative and the PREDIM project coordinator, Stephanie Jung, reminded that the project aims at fostering the protection of human rights.

She explained that the project was primarily focused on supressing discrimination of vulnerable groups, "which are vulnerable everywhere, particularly in prisons – these include the Roma, ethnic minorities and people with disabilities".

Jung stated that the Council of Europe had a number of activities in the field, making it possible for representatives of different institutions in Montenegro to go on study visits, or bringing experts over, helping with the IT development, etc.

She noted that, in reference to the rights of inmates, they cooperated with the Ombudsperson's Office, but also with the penitentiary system by delivering training for the prison staff.

Jung noted that the focus should be on resocialisation and rehabilitation of former inmates.

A short promotional video on the Optional Protocol to the UN Convention against Torture – OPCAT, provided by the APT, and dubbed thanks to the Council of Europe and the PREDIM project, was shown at the beginning of the event.

During the two-day conference of the SEE NPM Network Medical Group on health protection and care in penitentiary and psychiatric institutions the NPMs of Austria, Bulgaria, Macedonia, Romania, Slovenia, Bosnia and Herzegovina, Kosovo* and Montenegro shared their pertinent experiences.

THEME 1 – HEALTH PROTECTION AND CARE IN PENITENTIARY INSTITUTIONS (CURRENT ISSUES, EXPERIENCES, GOOD PRACTICES, CHALLENGES)

1. Dr Peter Kastner,
Austrian Ombudsman Board

Dr Kastner pointed out that patients in psychiatric institutions may be admitted voluntarily or involuntarily. Given the NMP mandate, he focused on involuntary admission. In this regard, he noted that involuntary admission is for persons endangering themselves or others, when there is a fear they may be suicidal or have already attempted suicide or when they have committed crimes punishable by imprisonment in excess of one year.

If this involves persons proclaimed not guilty by reason of insanity, then there must exist foreseeable danger that those persons, under the influence of their mental state, would commit a punishable offence. The designation NON COMPUS MENTIS is used for such perpetrators of crimes and there are two specialised institutions for them with specialised staff to provide for their professional treatment and supervision, and they are admitted and treated in forensic units of psychiatric institutions across Austria. The number of these persons has increased by 80% over the last 10 years, and their average stay in institutions ranges between 5 and 7 years. There is no time limitation for their admission, since they may stay in the psychiatric institution until the time when the danger of them committing a crime with severe consequences ceases to exist. This decision undergoes judicial review each year.

Dr Kastner particularly stressed that medical treatment is better in psychiatric institutions than in prisons, since psychiatrists focus more on mental health issues of their patients, and their overall health status goes rather neglected. He indicated that health care in psychiatric institutions implies the patients to get well and do not leave the institution in a poorer state of physical health. He also stressed the importance of investing in orientation training, in visual aids, furniture, in promoting the principle of participatory decision-making, occupational therapy, the importance of talking to the patients in reference to his or her treatment, and preserving patient's privacy.

He emphasises that the use of force and means of restraint are not therapeutic, but rather security measures, when the therapeutic ones prove to be impossible, and must be undertaken with respect for human dignity and legal certainty, for as short time as possible and with as little intensity as possible, and patients must not see it as a threat nor be made to feel helpless. He stressed the need for having in all institutions a central register of any measures restricting the freedom of movement, how many and when they were pronounced. He mentioned examples of good practices referring to daily routines for patients (personal hygiene, daily outdoor sessions combined with physical exercise, use of cigarettes), as a part of overall health protection.

2. Dejana Kozomara,
Expert Adviser in the Division for Monitoring the Rights of Detainees/Inmates, Office of the Human Rights Ombudsperson of Bosnia and Herzegovina

Kozomara noted the absence of the national preventive mechanism in Bosnia and Herzegovina. As regards the Ombudsperson's activities, she highlighted visits to places of detention, particularly focusing on health protection and care for persons with mental disabilities. However, given that these activities were not fully implemented, no report was made.

The last report concerning the rights of detained persons dates back to 2009. As regards the responsibility of the state on these grounds, i.e. civil deprivation of liberty, she pointed out to the Hadžimejlić and others v. BiH case (committal to a mental health institution without a court decision), in which the ECtHR established violation of the right to liberty and safety of person guaranteed under Art. 5 of the ECHR and recognised the right to compensation for non-pecuniary damages to applicants.

3. Silvia Slaveva,
Adviser in the NPM and Fundamental Freedoms and Rights Directorate, Office of the Ombudsperson of Bulgaria

Slaveva reported that Bulgaria had 12 psychiatric hospitals and 12 mental health institutes with the total of 130,000 beneficiaries. She stressed that the recommendations given to relevant institutions were not followed through. She noted the need for a general reform in the system, given that the state hospitals were old and inappropriate, located out of the urban areas, with poor access roads. She also indicated the lack of pertinent competencies and standards, which affected the quality of service. She particularly stressed low salaries for doctors and the persistence of unfavourable trends in this field.

Slaveva noted that in order to provide healthcare, hospitals enter into agreements with specialists (of cardiology, internal medicine), and there are no problems with supplies of pharmaceuticals. She noted the absence of proper treatment of these persons within the social protection system. There are no social protection institutions where these people would be admitted both for treatment and work. Thus, the NPM in its reports indicated to the Ministry of Labour and Social Welfare the need to improve mental health protection and care and increase budgetary appropriations to that purpose.

She reported that they encountered resistance on the part of the Ministry of Health as regards the need to reform the system and set standards. Within their mandate concerning mental health and the protection of patient rights, they hosted a number of round table discussions with relevant institutions in the field.

4. Niman Hajdari,
Legal Adviser, Office of the Ombudsperson of Kosovo *

Hajdari talked about the transfer of authorities from the Ministry of Justice to the Ministry of Health which took place in 2013, when a separate department was set up within the Ministry of Health to deal with health protection and care in prisons.

Current problems they face include the lack of psychiatrists employed full time, lack of psychologists in some institutions (Dubrava prison with 1,000 inmates, Correctional Facility for Juveniles, at least one more psychologist needed), lack of space in the forensic psychiatric institution (court mandated committal).

Good practice: transferal of authorities from the Ministry of Justice to the Ministry of Health completed, good cooperation with the NPM, the Council of Europe training on provision of healthcare services in prisons (procedures).

Challenges: Lack of financial resources and medical staff.

5. Martin Duvnjak,
Legal Adviser to the NPM division, Office of the Ombudsperson of the Former Yugoslav Republic of Macedonia

Duvnjak reported that the Ombudsman was always on the alert and criticising the (non)functioning of the healthcare system in the form supposed to have been put in place following the amendments to the Law on Enforcement of Sanctions. He also noted they insisted on the Ministry of Health providing proper healthcare services in prisons as a part of the public healthcare system, i.e. that the prison healthcare services be put under the Health Ministry.

Prisons lack healthcare professionals, with usually one doctor per shift, and after 4 pm and on weekends inmates are left to themselves and play the role of doctors among themselves, measuring blood pressure, etc. The inmates who need assistance in the afternoon and on weekends usually give a call to emergency services, since it is the only way to respond quickly to the needs of persons with any health issues.

The NPM team concluded in the "Idrisov" penitentiary institution that healthcare services were provided to inmates by prison staff or persons under a contract. At the same time, the number of nurses was inadequate, and the provision of healthcare services in the prison unsatisfactory. The largest share of complaints concern specialist examinations outside the prison. Inmates report that they are not allowed access to such types of examinations, noting that access to secondary and tertiary healthcare services is available only to inmates of extremely poor status of health.

No less alarming or disconcerting is the situation in the women's ward at "Idrisov", also lacking medical staff.

6. Istvan Sarkozy,
Senior Legal Adviser to the NPM division, Parliamentary Commissioner for Fundamental Human Rights of Hungary

Speaking of the central prison hospital, he reported that they made a visit in April 2015 (a follow-up on the 2013 CPT visit) of dual purpose, examining both the hospital and the place of detention, with the focus on material conditions. They noted the insufficient number of doctors and improper nutrition. Following the recommendation, more doctors were hired, and the hospital refurbished.

The juvenile detention centre was visited in 2016. It resulted in allegations of maltreatment, with particular focus given to the protection of rights of children, mandatory education and contacts with the outside world.

7. Doru Adrian Seicaru,
Adviser (Physician), People's Advocate Institution of Romania

Seicaru noted that the work of penitentiary healthcare services was not perfect. He explained that certain level of quality needs to be achieved and some services provided outside of the prison. He noted that the primary purpose of the prison healthcare services is the welfare of inmates and respect for their fundamental rights, and that forcing inmates to medical research was unacceptable.

Medication should be administered by healthcare professionals only. During the night and over the weekends medication can be dispensed only by properly trained staff. Prison healthcare services must include mental health. Screening for communicable diseases is paramount. The examination upon admission is mandatory; however, during its visit, the NPM noted certain problems: absence of preventive examinations for certain diseases. Persons with disabilities may not be placed at the safest areas of the prison.

During its visit, the NPM noted a number of issues, such as the inadequate number of staff in prison healthcare services, no minimisation of shock of confinement, and no psychological support.

8. Ivan Šelih,
Deputy Ombudsperson of the Republic of Slovenia

Šelih reported the total prison population in Slovenia to be around 1,000, with 300 to 400 detainees. Slovenia disposes of six prisons at 13 locations, with special prisons for women and juveniles.

Primary healthcare is provided by regional primary healthcare centres, pursuant to agreements entered into between primary healthcare centres and prisons. Inmates hold health insurance under the general health insurance legislation, with the difference for full health protection being paid by the Ministry of Health. Inmates enjoy greater scope of rights than citizens in communities with regard to healthcare. They have no free choice of doctors since they are bound by the given regional healthcare centre, and are not provided with treatment at home, abroad or spa treatments. Primary healthcare centres have GPs, psychiatrists, dentists, addiction treatment and gynaecologists available. Primary healthcare doctors decide on any referrals to secondary level of care. Every penitentiary institution must have proper hospital rooms meeting the general requirements. Old, ill and disabled inmates who need extra assistance to meet the basic needs and extra care may, according to the law, stay in specially adapted rooms (a legal requirement, but still not existing in practice). The Law on Enforcement of Criminal Sanctions stipulates that the inmates who pose a flight risks, and who cannot be treated in general hospitals, may be treated in specially designated rooms within the prison (again only a legal requirement, still not existing in practice).

Chosen pharmacies do hold adequate stocks of supplies for treating inmates. The good practice is that prison healthcare services are a part of the public health system; however, the provision of staff is problematic, since the prison may not affect the choice of staff. There is also a problem between prisons and primary healthcare centres as regards who is responsible for maintaining healthcare premises. Another problem that was noted referred to recording and reporting on injuries and taking the statements of prisoners. Addicts of psychoactive substances (drugs, alcohol) account for one third of the prison population, with a notable problem of urine testing and dispensation of medication, done by the prison staff, which is not acceptable. The budget for inmates is 34 mil euros, with 10% appropriated for their healthcare needs. This year there have been 16 attempted suicides and two suicide deaths in prisons. There were more than 6,000 external specialist examinations performed outside prison, and they spent over 3,000 days in general hospitals. The total of 136 inmates were voluntarily tested on HIV and hepatitis. Suicide prevention strategy should operate under a number of indicators to be monitored.

9. **Jelena Unijat,**
Secretary to the NPM, Protector of Citizens of Republic of Serbia

Unijat stated that the NPM of Serbia does not proceed as per complaints, but according to their response division (torture protection division), more than 30% of complaints refer to absence of proper healthcare protection in prisons. So far, the NPM issued around 200 recommendations pertinent to healthcare and protection. Only the doctors hired by the NPM are entrusted with these tasks. The organisational issue in Serbia refers to the fact that the prison healthcare service is not under the Ministry of Health, but the penitentiary institution itself. The doctors working in prisons depend on the prison management, since they have the status of civil servants, not doctors, and by extension, their salaries are much lower than the salaries of doctors in the public health system, and many of them are employed as per fixed term contracts, thus in fear of losing their job. The Law on Enforcement of Criminal Sanctions stipulates that each penitentiary institution should have at least one doctor and two nurses, one psychiatrist not constantly on the premises; however, in actual practice, doctors are periodically hired as per service contracts, usually retired doctors. Examinations upon admission are also delayed, for instance if a person is brought on Friday, he or she will be examined not sooner than on Monday. The same applies for solitary confinement.

No medical examinations are done following the use of means of restraint. There are not enough nurses, so prison staff dispense medication. As for the quality of medical examinations upon admission, they tend to be superficial. Such examinations must be detailed and preventative, particularly if the person was escorted by the police. Another shortcoming noted refers to the provision from the previous law on enforcement of criminal sanctions requiring periodic thorough examinations once in every three months (although not applied in practice) which is missing from the current law. However, the NPM refers to the provision of Article 116, obligating doctors to periodically report to the management on health status of inmates.

Doctors are obliged to report to the management on the quality of food, hygiene, give recommendations how to improve the prison conditions, all of which is not actually done in practice. The NPM pays the greatest attention to mandatory examinations following the use of means of restraint, since frequently doctors do not properly describe the injuries and do not take the statements from the persons subjected to restraint. Now they recommend in line with the CPT standards, to take photographs of the injuries. Non-medical staff is present during examinations. Medical examinations outside of the prison are also problematic, since usually there are not enough staff to escort patients or enough vehicles. There are also problems regarding lack of medication and medical equipment, as systemic failures, given that they are subject to public procurement processes. An example: the case of an HIV positive inmate receiving no therapy since the tender to procure medication was cancelled.

10. Ksenija Bauer,
Adviser, Ombudsperson of the Republic of Croatia

Baurer reported that Croatia had 14 prisons, seven jails and two correctional facilities. The provision of health protection and care in prisons is the minimum standard, governed by the law on health protection and care. Health protection and care should be better developed, the quality of healthcare provided to persons deprived of their liberty must be equal to the ones available to citizens in community with health insurance. The main law governing this field is the Law on Health Protection, with some special provisions for inmates found in the Law on Enforcement of Criminal Sanctions. Healthcare practices within the prison system are not in line with the Health Protection Law, which generates problems in this field. The issues preventing proper health protection and care include: insufficient number of health professionals (impossible to ensure having staff available 24/7, dispensing medication and provision of urgent dentistry services); lack of doctors. The problems pertaining to availability of healthcare include:

- availability of dentistry services (occasionally available only for urgent procedures, tooth filling services available upon longer waiting periods, particularly so for dental aids covered by the health insurance)

- difficulties in having physical therapies available.

Particular problems exist with stationary physical therapy. In some cases physical therapies are postponed for after having served the prison term (doctor's finding).

Another problem which was observed concerns the understaffing of the bailiff escort service (leading to postponed appointments for diagnostic testing or specialist examinations due to absence of bailiffs to escort inmates to external healthcare establishments). Bailiffs are present in the examination rooms during examination of inmates, with the exception of psychiatric examinations (as a violation of the right to privacy). The CPT standpoint is that there are no justifications for constant presence of non-medical staff during examinations; such presence also undermines the doctor-patient relationship, and often is unnecessary from the security standpoint. Problems with long waiting times for specialist examinations and surgeries cause great dissatisfaction among the inmates. There is an increasing number of complaints by inmates for being placed against their will in the same rooms with smokers, being non-smokers themselves, thus constantly exposed to passive smoking and in fear of their own health. Although Croatia has a law limiting the use of tobacco products, given the large share of smokers among the prison population, the NPM of Croatia is considering introducing the programmes for quitting smoking.

The Law on Enforcement of Criminal Sanctions envisages that inmates who, together with the imprisonment, were also pronounced compulsory addiction treatment and the inmate addicts who have joined the rehabilitation programmes while serving the prison term, serve the term in a special social therapy jail or a special social therapy section. Here the NPM noted the problem of placing the persons on Suboxon in a separate section. Isolation is justified only in case of specific treatments based on the principles of therapeutic communities, modified for in-prison use.

The method of transporting inmates to external healthcare institutions by driving them at the back of a specialised van where it is possible to sit only on a side bench without hand rests, often handcuffed, sometimes even shackled, without a safety belt, may further aggravate the medical condition of inmates, at times even lead to injuries.

As for the supervision over the healthcare services, a 2010 Constitutional Court judgment ordered the Government, among other things, to set up and effectively implement supervision over the quality of health protection and care in the whole prison system. To the NPM knowledge, this has not been done yet. Any supervision made so far focused on premises, medical and technical equipment, and licences of healthcare professionals working with inmates in the prison system. It was established that primary healthcare offices do not meet current healthcare regulations. Most of these shortcomings would be dealt with more efficiently should the Ministry of Health be in charge of the provision of healthcare to inmates, i.e. when the prison healthcare services would be part of the public health system. That would ensure independence of doctors and autonomy of patients, which is essential within the prison system.

As a rule, the inmates who fall ill are treated in the Prison Hospital used also for compulsory psychiatric treatment pronounced as a security measure. Prison Hospital has a status of a jail of closed type in terms of security levels and restriction of movements. Prisons and jails have healthcare wards for inmates provided internally, with medical staff working there with the status of civil servants, licensed to provide services autonomously. They are employed with the Ministry of Justice, recruited by the prison governor. At times, prison governors conclude service agreements with some healthcare professionals who are not employees of the Prison System Authority.

Under the agreement with the Croatian Public Health Institute, inmates may receive treatment in public health institutions within the territory of the given prison or jail.

All inmates residing in the Republic of Croatia since 01 January 2015 enjoy health insurance, and for others penitentiary institutions bear pertinent healthcare costs. Inmates without additional health

insurance, just like all other Croatian citizens, during hospitalisations (except in the Prison Hospital) and visits to family doctors or dentists are obliged to bear a 20% share of the full price. Since inmates have limited work opportunities, the NPM proposed to reconsider paying additional insurance to those inmates without regular income, and those who are not beneficiaries of a contract of lifelong care.

The NPM proposed that prison doctors, as civil servants and employees of penitentiary institutions, given that they have no contracts with the Croatian Health Insurance Fund, should not be allowed to issue prescription drugs or make referrals to external healthcare institutions, and that all inmates must have their chosen GPs.

11. **Danijela Brajković,** NPM of Montenegro

Brajković pointed out that Montenegro, although a small country, has a large population of detainees and inmates ranging between 1200 and 1400. In Montenegro, healthcare is provided to inmates from two prisons, Podgorica and Bijelo Polje.

The healthcare service of the penitentiary institution in Podgorica is run by doctors, nurses, a dentist, a physical therapist, a laboratory technician and pharmaceutical technicians as per open-ended contracts. In addition, experts in psychiatry, internal medicine and radiology are commissioned occasionally.

In penitentiary institution in Bijelo Polje there is no in-house doctor, only doctors engaged occasionally. The lack of medical staff is a persisting problem, since doctors are not motivated to work in the prison system and often leave for other jobs. There is also a problem of provision of mental health services. The number of engaged psychiatrists is insufficient, and there is no psychologist to provide psycho-social support to inmates in need such services.

During its visits, the NPM of Montenegro pays particular attention to healthcare provided in prisons. In late 2016, the NPM performed a thematic visit on the availability of secondary and tertiary healthcare services to persons deprived of liberty. NPM noted that the first examination takes place within 24 hours from admission for serving prison time, which is a good practice.

The conclusions reached during the visits and assessment of the situation seen are that inmates enjoy the same level of healthcare as all citizens. Inmates wait for some specialist examinations at the Clinical Centre of Montenegro due to CC's limited technical and staffing capacities, which is an issue faced by all citizens. Another reason for occasional postponements of extramural specialist examinations refers to the number of bailiffs, number of vehicles available and other tasks to be performed – escorting inmates to court hearings, for interviews by prosecutors, etc. NPM gave recommendations for improving healthcare provided in prisons.

THEME 2 – HEALTH PROTECTION AND CARE IN PSYCHIATRIC INSTITUTIONS (CURRENT ISSUES, EXPERIENCES, GOOD PRACTICES, CHALLENGES)

1. Dr Peter Kastner,
Austrian Ombudsman Board

Dr Kastner reported that the total population of the country is 8.7 million, and the prison population over 9,000, with 800 of them with mental disorders. He noted that healthcare must be guaranteed to all inmates and that is the responsibility of the state. The Ministry of Justice is in charge of persons deprived of liberty and confined to prisons. Austria has 27 prisons. Most of them are designed for between 250 and 350 inmates. Some are double the size. The largest is found in Vienna, designed for 990 inmates, but persistently overcrowded and actually having 1,200 inmates. Each prison, independent of its size, must have one or several GPs working in shifts. Specialists are invited as necessary. Larger prisons have medical sections for treatment of ill inmates. Smaller prisons have treatment rooms where ill inmates can stay. In addition, the number of qualified orderlies employed with medical sections has increased.

There are closed wards in state prisons or a separate room with prison guards in front for inmates who need hospitalisation. Public hospitals are obliged to accept inmates and must allow the presence of guards. Social protection institutions do not charge for treatment of inmates, unless they are treated in private establishments and then the costs are borne by prisons. The total costs for treatment of inmates amounted to 445.6 million last year.

Healthcare for inmates is a challenge for many reasons:

- Austria generally lacks doctors, primarily psychiatrists. It is almost impossible to find a psychiatrist in the western part of Austria. It is particularly difficult to engage doctors to work in prisons if the budget does not allow for employment according to the market conditions.

- The problem with the lack of doctors starts with the examination upon admission, which should take place within the first 24 hours. This is an established international standard reiterated by the CPT on multiple occasions. In Austrian penitentiary institutions, guards ask inmates about their health status and complaints, and relay the information to the doctor. Given that in many prisons doctors work for several hours only once or twice a week, at times inmates have to wait for half a week before being examined by a doctor. However, whenever an inmate complains of some health issues, guards will immediately take him to the nearest public hospital, which is a huge logistic burden on the prison administration and incurs huge costs. The money could be much better spent for increasing the salary for doctors, thus improving the chances of recruiting prison doctors.

- It is difficult to establish a doctor-patient relationship because inmates do not have a free choice of doctors. Should they complain and ask for a doctor of their choice, they would be obliged to pay

for the treatment, and usually they do not have the money to do so. They often have contracted diseases like tuberculosis, hepatitis or HIV, but running blood tests is not envisaged, hence, the Austrian NPM recommended not to do any medical examinations before running blood tests.

- After the first prison inquiry, women were enabled a gynaecological examination, and men aged more than 50, examination by an urologist. Inmates must have a specific complaint to be presented to the doctor, because they are not entitled to preventive testing. They would pay for the costs of any preventive testing themselves. Austrian NPM recommended that preventive testing is included in the standard healthcare package.

- A large share of prisoners have prominent mental health problems. Over the past 10 years the share of inmates with serious mental illnesses, i.e. psychoses, increased significantly. Important factors conducive to emotional stress of inmates are: unsatisfactory social environment and interpersonal conflicts in their environment, and arrest may also mean constant exposure to emotional stress. Surveys have shown that inmates are much more affected by psychosomatic disorders compared to the general population (e.g. cardiac diseases: inmates 39%, control group 8%,)

- Psychiatric and psychological care are part of the healthcare and as such must be guaranteed to inmates.

- Regular visitation should help prevent physical and emotional neglect of inmates serving long term sentences.

All these circumstances set high standards for prison doctors. It is very important that they do not work in prisons only (in time this could lead to narrowmindedness and rigid views of the doctors themselves), rather they should practice in other healthcare contexts as well. (Special requirements for the psychiatric service include: out-patient crisis treatment, depot treatment, crisis intervention, conversational therapy, reporting. Annual costs for healthcare in prisons are 30 million, with the upward trend).

Examples of good practices:

Inadequate healthcare may lead to situations of inhuman and degrading treatment. Thus, Austrian NPM stresses that inmates enjoy the same level of healthcare as persons in community at large.

There is a need for professional supervision of doctors in penitentiary institutions and institutions for confinement of mentally ill offenders to ensure quality of care. The NPM requested on several occasions to set up a prison supervision office, eventually established in 2014.

The second example of good practice is that the Ministry of Justice has finally seen to it that video translators can be used in all doctor's offices. In actual fact, 70% of inmates and detainees are from abroad, and none even speak English. Thus, it is not easy to communicate with those people. Other inmates or guards should not serve as interpreters. They should not be present during the doctor-patient conversation. Only upon doctor's insistence, for the reasons of security, a guard must be present in the room or ready in front of the room to step in at any moment when called.

2. Dejana Kozomara,
Expert Adviser in the Division for Monitoring the Rights of Detainees/Inmates, Office of the Human Rights Ombudsperson of Bosnia and Herzegovina

Kozomara reminded that Bosnia and Herzegovina still does not have its NPM established. The draft Ombudsman Law envisages its establishment; however, the legislature was not responsive enough and the draft has not been adopted yet. Meanwhile the Ministry of Finance asked the Ombudsperson's office for the estimation of financial costs for the NPM establishment, so she hopes that after the financial estimate and the law adoption, BiH will have its NPM in place by the next network meeting. The Ombudsperson's Office has a division for monitoring the rights of detainees and inmates supervising treatment in prisons. This division has only two members of staff, both lawyers, and there are 15 prisons in the country. The 2016 data show an increase in the number of complaints by 50% compared to 2015, which is indicative of the need to step up monitoring. The largest share of complaints refer to healthcare, both its quality and availability.

Out of 15 penitentiary institutions in BiH, only 5 have doctors employed full time. Other institutions engage doctors as per service agreements and as necessary. Thus, in its last report, the Ombudsperson recommended to secure funding and ensure provision of healthcare for all detainees and inmates by having at least one doctor in each prison. When examining complaints of inmates regarding healthcare, we insist on receiving statistics on the number of regular and specialist examinations and the supporting documents. There is a need to make a separate report to indicate the state of human rights in penitentiary institutions in BiH, given that the last one was done back in 2012. "We truly hope that we will be able to commence these activities this year, since we need such data to assess the state of human rights in prisons, particularly given that there was no comprehensive assessment done over the past five years", said Kozomara.

3. Niman Hajdari,
Legal Adviser, Office of the Ombudsperson of Kosovo *

In his presentation, he noted that Kosovo* has four regional mental health hospitals and two mental health institutes. NPM Kosovo* performs visits of these institutions, together with the Council of Europe experts.

Although they did not visit all such places, just the one in Pristina, they found some unsatisfactory circumstances and situations. There are patients brought in by the police. In such cases, under the Law on Non-Contentious Procedure, the hospital is obliged to notify court of involuntary admission. Although the hospital does so in due time, in most cases the court fails to observe the deadline in passing its decision.

In 2015, Kosovo* adopted the Mental Health Law. However, the ensuing secondary legislation has not been adopted yet. Although the NPM suggested this should be done as soon as possible, this has not been observed.

4. Aleksandar Trenkoski,
Legal Adviser to the NPM division, Office of the Ombudsperson of the Former Yugoslav Republic of Macedonia

Trenkoski reported the existence of three psychiatric hospitals in his country for treatment of persons with mental health issues. He noted the following as current issues:

Lack of staff, primarily experts, and by extension they have less time to focus on rehabilitation of those persons. This is particularly true of patients already hospitalised for a long time, forgotten, no individual treatment plans for them, or if they exist, have not been changed in years. Staff is overburdened leading to their burn-out. Most often nurses and carers are not trained to establish the interaction between the physical and psychological approach to patients. Inpatients in psychiatric institutions have no access to health protection (particularly not regarding their physical health) the same as people living in the community, they cannot use dentistry services without prior court approval. Consent to treatment is problematic, they lack information and are not informed of their treatment. They stopped using ECT.

There are six mental health centres, but quite limited and unable to meet the demand.

Challenges: Deinstitutionalisation

5. Kristina Izso,
Senior Legal Adviser to the NPM division, Parliamentary Commissioner for Fundamental Human Rights of Hungary

Izso reported that the Hungarian NPM had two visits so far, one to the closed wards of psychiatric institutions, and the other to a social welfare home. In the closed ward of a psychiatric institution they found a patient tied to the bed, and one to a radiator; checking the records of means of restraint, whether chemical or physical, it was established the records were incomplete. They concluded that the Protector of Patient Rights was not visiting the hospital regularly and was not monitoring the observance of patients' rights properly. Visits are done with the assistance of external experts, they examine even the dosages of medication, and have established that these met the rules of psychiatry. There is no on-going control or supervision of patients. Although on medication, when they realise they are not being controlled, they stop taking the medication.

Informed consent is mostly missing from the documentation. Involuntary admission is approved by court, and the Hungarian Ombudsperson does not have the mandate to review this, and thus could not have issued any recommendations to that effect, but did make some remarks.

Patient's representatives are rarely present during court review. Patient is given the court decision to read it, but the question raised is whether patients are able to decide whether to be admitted or not.

Istvan talked about forensic patients and indicated the shortcomings. In 2016 they made visits and established the following:

- Lack of toilets, showers, poor hygiene, no hot water, indoor smoking without designated smoking areas, no ventilation and the general issue of large wards - over crowdedness.
- Lack of professional staff and working in inappropriate conditions, which has a negative effect on patients. Another problem – staff are not motivated to work in such institutions.
- Deinstitutionalisation
- Patients are treated badly, there is stigma, using bad language, like "retards", "mentally retarded" which is unacceptable.

This year the NPM examined nutrition and established it was not at a satisfactory level. A nutritionist was included as a member of the team and analysed the menus and the type of food received by patients.

6. **Doru Adrian Seicaru,**
Adviser (Physician), People's Advocate Institution of Romania

Seicaru said that voluntary admission is done the same like any other hospital admission for any other complaint or illness, in line with healthcare rules and patient rights set in law. Each patient voluntarily admitted to a mental health institution is entitled to leave it upon his or her request at any point in time, unless conditions are met not allowing for admission as per the will of the patient.

Involuntary admission is applied only as a measure of last resort, when all attempts for voluntary admission have been exhausted and only if the psychiatrist deems it necessary for the reason that the person, given his or her mental disorder, poses an imminent danger to oneself or others or in case of a person suffering from a severe mental disorder and whose reasoning is diminished that without hospitalisation would see a severe deterioration of their health status or interference with the provision of proper treatment.

A request for involuntary admission may be filed by a family doctor or a psychiatrist treating the person, family members, representatives of relevant local services and members of the police, gendarmerie, prosecution or fire department.

A psychiatrist may administer therapy without patient's consent in case of a minor or if a person is under guardianship – the case in which psychiatrist is obliged to request the consents of the legal representative Within 24 hours from performing the evaluation, psychiatrist sends supporting documents for the proposed involuntary admission to the Review Board, consisting of three members appointed by the hospital director, including: two psychiatrists, if possible, without the referring psychiatrist, and an expert doctor or a member of the civil society. The Board reviews the proposed admission within 48 hour from receiving the proposal.

The decision of involuntary admission is sent to the court of relevant jurisdiction within 24 hours and is reviewed by the prosecution. If prosecution believes that involuntary admission was unjustified, it will order new psychiatric evaluation by another forensic board, as envisaged by law. Patient or his legal representative may appeal against the involuntary admission decision, according to the law. If the court does not approve involuntary admission or withdraws the approval, the person may immediately leave the hospital unit or may, after providing consent in writing, continue with the treatment.

In 2016, Romanian NPM had two visits to psychiatric hospitals resulting in recommendations, including, among other things, the need to finalise the legal procedures for extending the capacities to avoid overcrowding and ensure enough sanitary facilities according to the number of inpatients. It was also recommended to ensure adequate space for administrative staff and continuous professional development and training of staff providing care and supervision.

7. Jure Markič,
Adviser, Office of the Ombudsperson of the Republic of Slovenia

Markič reported that there are 5 psychiatric hospitals in Slovenia, the largest being the University Clinic in Ljubljana. The total capacity is around 1300 hospital beds, out of which 425 in closed wards. Forensic unit disposes of 48 beds.

With the deinstitutionalisation trends, increasingly more focus is given to out-patient treatment, performed locally, and thus much closer and much more accessible to people living further away from hospitals. Some hospitals have also their outreach teams, always with a psychiatrist as a team member, engaged in case of emergencies anywhere within the territory covered by the hospital.

The NPM visits psychiatric hospitals regularly, at least once in two to three years, with one follow-up visit in-between the regular ones to see how recommendations are followed through. Based on the visits, the NPM assesses physical conditions as good. Wards are occasionally overcrowded when extra beds are pulled in or fixation beds are used; both the NPM and the CPT criticised this practice.

Staff is more of a problem, since there is never enough of them. This is most visible by the end of the week, when most hospitals have one psychiatrist only, and it was also noted that fewer activities are organised by the end of the week due to the absence of the occupational therapist. This prompted the NPM to thematic visits in several social welfare institutions and two psychiatric hospitals, establishing that there are fewer activities or not at all, leaving the patients to themselves, with activity lists empty.

An example of good practice was observed in one of the hospitals where the occupational therapist gave an assignment to patients on Friday to be completed by Monday. Patients also got the materials and tools needed, and if something was dangerous for patients it was left with the staff on the ward.

A special challenge to which both the Ombudsperson and the NPM have been drawing attention for a while lies in the fact that Slovenia still does not have proper provision for treatment of minors. The Ministry of Health announced such a ward would be set up shortly in Ljibljana. The NPM is concerned with the fact that in addition to proper material conditions and equipment adapted to children, there is also a need for properly trained staff, which the NPM intends to monitor.

A challenge faced by the NPM when visiting psychiatric hospitals is to differentiate between confinement at the closed ward based on consent or the court decision and the consent to treatment. It has been established that doctors often take the existence of grounds for confinement to be at the same time grounds for treatment. Admission to psychiatric hospitals in Slovenia is governed by the Law on Mental Health, and the consent to treatment by patients themselves or exceptionally somebody else on their behalf is governed by the Law on Rights of Patients. Treatment is not allowed without consent, except in emergencies, when patients are unable to decide for themselves or if not able to express their views.

8. Miloš Janković,
Protector of Citizens of the Republic of Serbia a.i.

Janković reported that Serbia has five large psychiatric hospitals accommodating approximately 4,000 persons with mental disorders. At least the same number, or as much as 50% more than that are accommodated in residential social institutions. Almost 10,000 persons with mental health issues are placed in residential institutions. This is a sign that deinstitutionalisation has not yet taken place in Serbia, because of the absence of proper community-based and family support systems.

NPM argues in favour of establishing community-based mental health centres, at the local level, designed as multi-disciplinary teams. The current concept in Serbia proved to be ineffective, since it is not centred around the person in need of support, but rather based on administering services and placement.

The NPM mandate is to make visits of places of detention. The findings of such visits indicate that freedom of movement of most patients is limited, many are kept locked, or in essence, deprived of their liberty. Most patients are officially voluntarily admitted, and the NPM notes they are deprived of their liberty.

Two essential arguments put forward by the NPM:

1. There can be no consent to deprivation of one's liberty – there is not an option that someone may have been deprived of their liberty as of their own free will;

2. The fact that someone was deprived of the ability to transact legal dealings is not and may not be used as a ground for deprivation of liberty.

Serbia has a Law on Protection of Persons with Mental Disorders which makes a distinction between voluntary and involuntary admission. As for voluntary admission, Serbian NPM issued a number of recommendations to relevant authorities. Among other things, voluntary admission statement must be clear, unambiguous and given by the person who at the time had a clear understanding of its consequences; a voluntarily admitted person must not be deprived of his or her liberty; a person locked and with restricted movements may not be regarded as voluntarily admitted and should fall under the provisions of the Law on Involuntary Admission; consent to voluntary admission does not constitute the consent to medical treatment; consent to medical treatment (independent of the consent to admission) must be given before doing each medical intervention.

One problem in Serbia is posed stems from the fact that under the Law on Patient Rights for persons deprived of legal capacity, this consent is given by their guardian. However, the Law on the Rights of People with Mental Disorders has a provision requesting the opinion of the person who is to receive the treatment.

It was noted during the visits that such guardians of people with mental disorders are not necessarily close relatives, often an employee of the Centre for Social Work and often unavailable (an example: a person whose guardian is located down south is placed in a psychiatric ward up north).

As regards involuntary admission, psychiatrist is obliged to order involuntary admission of a person posing a danger to oneself and others, because it is in their best interest.

The system in place in Serbia is such that the on-duty doctor in a psychiatric hospital may order involuntary admission up to one day, which may be extended by the Medical Board on the following day. After that, the hospital is obliged to inform the court and that is what the NPM has achieved. At the time, criminals had the right to be brought before the court within 48 hours, and a mentally ill person did not have a court decision, but a decision by a psychiatrist or a medical board.

Courts are rather diligent in performing this function. NPM insists to always ensure the person is actually brought before the judge when deciding on involuntary admission.

It was noted that court appointed expert witnesses are usually psychiatrists from the same hospital. This constitutes conflict of interests, and NPM recommends to always hire an expert not affiliated with the hospital.

NPM insists on periodic review of decisions made by doctors.

There is also compulsory committal as a security measure for compulsory treatment and confinement of perpetrators of crimes in psychiatric institutions – the ones who were not sane at the moment of committing crime.

The issue raised here is whether the persons on compulsory treatment in psychiatric hospitals are patients or, as is the case in Serbia, treated as perpetrators of crimes. In Serbia this issue is under regulated, resulting in prolonged confinement to psychiatric institutions (an example: a person who stole a bicycle from a church port has been kept for the past 12 years on compulsory psychiatric treatment. Doctors would release him, but he has nowhere to go, being on social allowance, of deteriorated health, no family).

The question raised here is whether persons suffering from severe mental illness should fall under the ambit of criminal legislation or be treated in line with their condition.

Numerous NPM findings and recommendations: end placing persons with severe mental conditions in regular prisons, which lack proper conditions; it is both dangerous to do so and the staff has no capacity to deal with such severe cases.

As regards means of restraint, some improvements have been made. NPM recommended not resorting to isolation and got into a clash with CPT in the sense that the NPM standard exceeds the one set by CPT. CPT gives recommendations how to perform isolation, notwithstanding the fact that the NPM Serbia recommends not to impose isolation and the fact that most psychiatric institutions ceased to do so.

9. Ksenija Bauer,
Psychology Prof., Adviser to the Ombudsperson of the Republic of Croatia

Bauer noted that no mental illness in itself may constitute reason enough to be compulsorily committed to a psychiatric institution; the precondition for that has to be that a person with serious mental disorders, due to their state of mind, pose a serious and imminent threat to one's life or health or the life, health or safety of other persons.

During its visits, Croatian NPM has identified no treatments that could constitute torture, but did identify those that may be degrading, or even inhuman. The unnecessary restriction or violation of rights of persons with mental health issues stem from: legal shortcomings, inadequate material and human resources, and at times also lack of understanding of international standards and provisions of the national Law on Protection of Persons with Mental Disorders. Hence, in order to prevent further violation of their rights, legislation needs to be improved, healthcare professionals need to undergo continuous training, and proper funding needs to be secured.

The current situation as regards involuntary admissions is such that the set deadlines for notifying the court and passing the pertinent decision are, as a rule, observed; except in emergencies, hearings are held in psychiatric institutions and are, as a rule, attended by the person whose admission is being decided upon. If the person requests so, court is obliged to obtain the expert witness opinion of a psychiatrist not affiliated with the institution where the person was involuntarily admitted (exceptionally, a psychiatrist from the same institution, but who has not decided on the involuntary admission in the first instance).

A problem noted refers to the fact that although all persons must have their attorney, the ones appointed ex officio very often are just formally involved. Some problems have been observed in involuntary admissions which may lead to inconsistent treatment of involuntarily admitted persons with mental disorders and the violation of their rights. One of the reasons for such inconsistency lies in the fact that some psychiatric institutions do not have closed wards for enforcing compulsory psychiatric treatment as a security measure. It has been established in some cases that it might be one of the underpinning reasons for applying means of physical restraint.

NPM recommended to the Ministry of Health to set forth in the Rulebook on Minimum Requirements concerning Space, Staff and Medical Technical Equipment for Provision of Healthcare Services the requirements to be met by all healthcare institutions or units thereof for performing specialist and hospital treatment in psychiatry for involuntary admission and committal of persons with mental disorders.

Persons with mental disorders who do not hold additional health insurance are charged with a share of costs for involuntary committal to psychiatric institutions if their diagnosis is not included in the Croatian Health Insurance Fund decision on the list of diagnoses fully covered by mandatory health insurance. This is unacceptable and the NPM requested the law be amended (pending).

There were some complains of involuntary administering of psych pharmaceuticals. The right to co-decision may only exceptionally be restricted when so justified due to the patient's state of health solely in the cases and in the manner set in Law on the Protection of Patient Rights. A patient is entitled to either accept or refuse certain diagnostic procedures or therapies, except in cases of medical

interventions which can't be postponed, where the failure to proceed with them would endanger patient's life and health or cause permanent damage to health that psychiatric institutions invoke in such cases.

The Ministry of Justice's recommendation is to consider returning the provision on compulsory psychiatric treatment as a security measure back to the Misdemeanour Law; the deletion of these provisions from the Misdemeanour Law created a legal void. The recommendations state that this security measure may be applied only against the perpetrators who committed an offence solely in the state of significantly diminished sanity if there existed a danger that the reasons for such a state could in future incite the person to commit further offences. It should be borne in mind, though, that this refers to involuntary treatment, not involuntary admission or committal.

If a person with mental disorders incapable of giving his or her consent, this being done in his or her stead by their legal representative, opposes admission, the procedure of involuntary admission or committal is instigated, where the same set of preconditions has to be met as in cases of persons not deprived of their legal capacity.

Another problem noted is frequent asking for consent in cases of patients suffering from dementia (where no incapacitating procedure was instigated). They expected this could be resolved by introducing a "person of trust". This is a new provision in the Croatian legal system to avoid unnecessary placing under guardianship of people with mental disorders for the sole purpose of treatment, but it is still largely underused in practice.

There is still no uniform position whether the NPM should enter this area or would that be the issue solely for the Ombudsperson, but in any case, it does not bring into question that in certain cases there are medical reasons for certain restrictions. They believe stronger control mechanisms are needed to prevent possible violations of patient rights.

10. Dr Aleksandar Tomčuk,
Panel of external experts of Montenegro's NPM

Dr Tomčuk noted that according to the report of the Euro Health Consumer Index (EHCI), Montenegro ranks last among 35 European healthcare systems in 2015. Among former Yugoslav republics, Slovenia is best ranked at 15, followed by Croatia as 16th, Macedonia 18th, while Serbia is 30th.

Montenegro has fewest doctors per capita (2.2 / 1000) compared to all other EU candidate countries and member states (3.4 / 1000). Per capita expenditure in the health system amount to 265 euros. Montenegro decreased public expenditures for health from 6.0% of GDP down to 4.8%.

The Strategy for Mental Health Promotion in Montenegro was first adopted in 2003 (the new strategy paper has been adopted in 2017). Mental healthcare providers include the National Mental Health Commission, the Psychotic Drugs Commission, the Centre for Promotion of Mental Health and International Cooperation, and as for registers, the National Drug Abuse Register exists since 2015, and the National Register of Psychoses is currently being developed.

Psychiatric services are organised as follows: the psychiatric clinic within the Clinical Centre of Montenegro is the tertiary level of care, and disposes of 40 beds. Secondary healthcare is provided by the Special Psychiatric Hospital Kotor with 241 beds, the psychiatric ward of the General Hospital Nikšić with 26 beds and the psychiatric ward in Bijelo Polje with 5 beds. Primary mental healthcare is provided in 9 primary healthcare centres.

The Special Psychiatric Hospital Kotor has existed since 1953 and admits patients from all parts of Montenegro. It has the total of 149 staff and 241 beds. The annual budget is 2.25 mil euros. It has 1,200 admissions a year, and 3,200 outpatient examinations.

The breakdown of patients:
Crisis wards: men (closed ward) - 30 beds, women (closed) - 21 bed, men (open) - 10 beds.
Addiction Treatment ward - 21 beds.
Forensic Ward - 21 beds.
Chronic wards: men (closed ward) - 46 beds, women (closed) - 40 beds, chronic men (open) - 52 beds.
The above breakdown shows that chronic patients occupy 138 beds, or 57% of the total.

The plan for establishing community-based therapy has its weaknesses and strengths. The weaknesses refer to the lack of interest among decision-makers, existing service packages, limited funding, lack of social services and support for living within community, poor inter-agency cooperation, and stigma. The strengths include small system, existing psychiatric services well distributed and available throughout the country, well-trained and motivated staff.

CONCLUSIONS FROM THE SEE NPM NETWORK CONFERENCE

Health Protection and Care in Penitentiary Institutions

Starting from the general principle that detained persons should enjoy the same degree of health protection and care as the citizens living in communities, we make the following conclusions:

1. The quality of health protection and care in prisons would increase if it were to fall under the purview of the Ministry of Health. It means that doctors providing healthcare services in prisons would be able to provide their services in line with their professional ethics, without the influence of the prison management, should healthcare services within penitentiary institutions be a part of the public health services under the Ministry of Health, not the Ministry of Justice.

2. In order to make the posts of prison doctors more appealing, they need to be granted the same position and opportunities enjoyed by those working in the public health system (employment status, training, opportunities for residency and advancement, etc.).

3. The role of doctors in prevention of torture needs to be highlighted. Special engagement in this field requires more customised training for prison doctors. This could be achieved, among other things, with the support of the SEE NPM Network, should proper financial support be provided.

In order to contribute to the Conclusion no. 2, future training needs first to be accredited by a relevant chamber of medical doctors.

Health Protection and Care in Psychiatric Institutions

1. No one may give his or her consent to be detained, i.e. no consent may be given for deprivation of liberty;

2. Consent to commitment does not imply consent to treatment;

3. If someone is involuntarily committed, the consent for the application of medical procedures should be requested as soon as possible, except in cases envisaged by Law (forensic patients).

4. If a person is deprived of his or her legal capacity, the consent is to be given by the guardian, provided that the physician is obliged to ask for patient's opinion if the patient is able to give it.

Annex I

AGENDA

MEETING OF THE SOUTH EAST EUROPE NPM NETWORK IN PODGORICA

Health Care at Penitentiary and Psychiatric Institutions

Hotel Centre Ville
05 – 06 July 2017

09:00-09:30	Registration of participants
09:30-10:00	Short promotional video on prevention of torture Welcoming speeches Zdenka Perović, Deputy Protector of human Rights and Freedoms of Montenegro and Chair of the Medical Group of the SEE NPM Network (Moderator) Sucko Bakovic, Protector of human rights and freedoms of Montenegro Milos Jankovic, Acting Protector of Citizens and Chairperson of the South East Europe NPM Network Ivan Selih, Deputy Ombudsman of Slovenia and Chairperson of the Legal Working Group of the South East Europe NPM Network Stephanie Jung, Project Coordinator, Council of Europe
10:00-10.15	Group photo
10:15-11:30	Theme 1 Healthcare in Penitentiary Institutions (current issues, experiences, good practices, challenges) Moderator: Milana Bojovic Presentations: Austria, Bosnia and Herzegovina, Bulgaria, Kosovo, FYR Macedonia, Hungary
11.30-12.00	Coffee Break

12.00-13.15	Theme 1 Cont. Healthcare in Penitentiary Institutions (current issues, experiences, good practices, challenges) Presentations: Romania, Slovenia, Serbia, Croatia and Montenegro
13.15-14.15	Lunch break
14.15-15.30	Theme 2 Healthcare in Psychiatric Institutions (current issues, experiences, good practices, challenges) Moderator: Danijela Brajkovic Presentations: Austria, Bosnia and Herzegovina, Bulgaria, Kosovo, FYR Macedonia, Hungary
15.30-15.45	Coffee break
15.45-17.00	Theme 2 Cont. Healthcare in Psychiatric Institutions (current issues, experiences, good practices, challenges) Presentations: Romania, Slovenia, Serbia, Croatia and Montenegro
19.00	Dinner

ORGANISATIONAL ISSUES OF THE SOUTH EAST EUROPE NPM NETWORK – MEDICAL GROUP

10.00-11.30	Discussion and recap of the discussions form Day 1 Moderator: Jelena Unijat
11:30-11.45	Coffee break
11:45-13:00	Briefing and discussion of the work and plans of the South East Europe NPM Network (activities, meetings, conferences)
13:00-14:00	Lunch break
14:00-15:00	Moderator: Ksenija Bauer Adoption of conclusions on health protection and care in prisons and psychiatric institutions

Annex II

LIST OF PARTICIPANTS

1. Peter Kastner, Austrian Ombudsman Board
2. Dejana Kozomara, Office of the Human Rights Ombudsperson of Bosnia and Herzegovina
3. Aleksandar Mudrinic, Office of the Human Rights Ombudsperson of Bosnia and Herzegovina
4. Mariana Patrikova, Office of the Ombudsperson of Bulgaria
5. Silviya Slaveva, Office of the Ombudsperson of Bulgaria
6. Ksenija Bauer, Ombudsperson of the Republic of Croatia
7. Snježana Stanić, Ombudsperson of the Republic of Croatia
8. Tomislav Ćupac, Ombudsperson of the Republic of Croatia
9. István Sárközy, Parliamentary Commissioner for Fundamental Human Rights of Hungary
10. Krisztina Izsó, Parliamentary Commissioner for Fundamental Human Rights of Hungary
11. Isa Hasani, Office of the Ombudsperson of Kosovo*
12. Niman Hajdari, Office of the Ombudsperson of Kosovo*
13. Gani Kçiku, Office of the Ombudsperson of Kosovo*
14. Doru-Adrian Şeicaru, People's Advocate Institution of Romania
15. Aleksandar Trenkoski, Office of the Ombudsperson of the Former Yugoslav Republic of Macedonia
16. Martin Duvnjak, Office of the Ombudsperson of the Former Yugoslav Republic of Macedonia
17. Dragan Radenkovic, Office of the Ombudsperson of the Former Yugoslav Republic of Macedonia
18. Miloš Janković, Protector of Citizens of Republic of Serbia
19. Jelena Unijat, Protector of Citizens of Republic of Serbia
20. Ivan Šelih, Office of the Ombudsperson of the Republic of Slovenia
21. Jure Markič, Office of the Ombudsperson of the Republic of Slovenia
22. Sucko Bakovic, Ombudsperson's Office of Montenegro
23. Zdenka Perovic, Ombudsperson's Office of Montenegro
24. Snežana Mijušković, Ombudsperson's Office of Montenegro
25. Petar Ivezić, Ombudsperson's Office of Montenegro
26. Nik Gašaj, Ombudsperson's Office of Montenegro
27. Marijana Sinđić, Ombudsperson's Office of Montenegro
28. Milena Perišić, Ombudsperson's Office of Montenegro
29. Milena Krsmanović, Ombudsperson's Office of Montenegro
30. Dragan Radović, Ombudsperson's Office of Montenegro
31. Milana Bojović, Ombudsperson's Office of Montenegro
32. Jovana Đurović, Ombudsperson's Office of Montenegro
33. Milica Bogojević, Ombudsperson's Office of Montenegro
34. Danijela Brajković, Ombudsperson's Office of Montenegro
35. Saša Čubranović, Ombudsperson's Office of Montenegro
36. Jelena Nedović, Ombudsperson's Office of Montenegro
37. Tatjana Radović, Ombudsperson's Office of Montenegro
38. Ivan Krkeljić, Ombudsperson's Office of Montenegro
39. Aleksandar Tomčuk, Panel of external experts of Ombudsperson's Office of Montenegro
40. Dina Knežević, Ombudsperson's Office of Montenegro
41. Stephanie Jung, Council of Europe/PREDIM project
42. Boris Ristović, Council of Europe/PREDIM project
43. Ana Krušić, Council of Europe/PREDIM project