MAPPING OUT FORENSIC MENTAL HEALTHCARE FOR VULNERABLE PATIENTS

A RESOURCE MANUAL FOR STAFF

Strengthening justice

Further strengthening the treatment of detained and sentenced persons in line with European standards in Bosnia and Herzegovina

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All other correspondence concerning this document should be addressed to the Cooperation in Police and Deprivation of Liberty Division, Avenue de l'Europe F-67075 Strasbourg Cedex, France, Tel. +33 (0)3 88 41 20 00, E-mail: Horizontal.Facility@coe.int

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Notes

This resource manual is part of a comprehensive professional development programme focusing on human rights modules. It is partially based on:

- *Protocols for treatment of mentally challenged offenders in forensic facilities*
- *Roadmap for the forensic patients' care - from admission to release: manual for forensic staff*

previously prepared within the European Union and Council of Europe Joint Programme Horizontal Facility for the Western Balkans and Türkiye.

This resource manual also takes into account:

- The Forensic Institute Sokolac Rulebook on House Rules (January 2017)

The languages in which the original texts are written are Serbian, Bosnian and Croatian, according to the authors' personal preferences. The scripts used are Latin and Cyrillic, as per the authors' preference.

All references to staff or patients in this document apply equally to both male and female persons, although the section on female patients refers exclusively to patients of that sex.

The definitions used in this document are not legislative definitions but were jointly agreed upon by the authors for the purpose of this document.

Also, for the purpose of this document, protocols refer to a series of steps to be taken in sequence to respond to a specific situation where there is an increased risk of human rights violations.

The authors would like to extend their gratitude to dr Clive Meux for his expertise and to the directors and staff of the Court Police of the Republika Srpska and Court Police of the Federation of BiH for their support.

The authors: the expert team of the Public Health Care Facility Institute for Forensic Psychiatry Sokolac and the Council of Europe human rights training team in Bosnia and Herzegovina.

Mistakes happen. When we find out about a mistake, we acknowledge it by correcting it. If you observe an error, please let us know.

The original text was drafted in Serbian/ Bosnian/Croatian, English translation is unofficial.

Foreword

The Public Health Care Facility Institute for Forensic Psychiatry Sokolac (Forensic Institute) is leader in the region in the field of psychiatric care, a centre of excellence and a disseminator of good practices that has evolved through active participation in several consecutive projects of the European Union (EU) and the Council of Europe (CoE), as well as projects implemented by other international and local agencies. Highly qualified and expert staff regularly conducts peer training and educates colleagues on the standards of human rights safeguards through:

- interpretation of the European Court of Human Rights (ECHR) case load
- recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and other monitoring bodies visiting the Forensic Institute.

This resource manual is part of comprehensive efforts to improve the practices and treatment of specific groups of patients at the Forensic Institute, as well as the internal framework for training and professional development[1] of medical staff, support staff and security staff. It was prepared within the framework of the Joint EU/CoE Programme Horizontal Facility for the Western Balkans and Türkiye (2023-2026).

Ethical guidelines followed by the Forensic Psychiatry Institute Sokolac staff

The staff of the Forensic Institute abides by the ethical guidelines in their work with the patients to meet their human rights safeguards, medical care needs and the goals of purposeful treatment.

These guidelines include:

- *Legal framework:* All patients' treatment protocols in the Forensic Institute are based on the current legal framewrok, in particular as concerns patient's admission (Art 30 of the Republika Srpska Law on the protection of mental health), the right to submit requests, complaints, appeals, etc., (Art 16 of the Law), consent to medical intervention of the person partially of fully mentally incompetent (Art 16 of the Law), ban on ill-treatment (Art 52 of the Law), the right to participate in developing individual recovery plan (Art 15 of the Law),etc.

1 Previously prepared manuals include "Protocols for treatment of mentally challenged offenders in forensic facilities" (the Joint EU/CoE programme Horizontal Facility for the Western Balkans and Türkiye (2016-2019) and "Roadmap for the forensic patients' care – from admission to release" (the Joint EU/CoE Programme Horizontal Facility for the Western Balkans and Türkiye (2019-2022)).

- *Patient's welfare:* All procedures and decisions are aimed at improving the somatic mental health, as well as social well-being of patients. A safe and supportive environment must facilitate effective treatment, psychosocial development and rehabilitation for all patients.
- *Information on Rights*: All patients are informed of their rights in writing and assisted as necessary in understanding their rights by using simplified explanations where required.
- *Informed consent:* All patients have the right to give informed consent to their treatment and participate in decisions regarding their treatment. They are provided with sufficient information about their health condition, treatment options and risks so that they can make informed decisions and participate in the treatment planning and its regular review. If a patient lacks capacity to make decisions (or is a juvenile), alternative arrangements are put in place to protect their rights, such as consultations with next-of-kin or independent guardians.
- *Privacy and confidentiality:* Information obtained during the patient's clinical treatment is confidential and shared only with authorised persons (e.g., court, lawyer, prosecutor, family) in accordance with legal regulations. Both juvenile and adult patients are informed about how their data will be used and who will have access to information concerning them.
- *Social integration:* All patients, including juveniles, receive support in the process of resocialisation and reintegration into the local community. They are provided with opportunities for skills development, education and social interactions to ensure their integration and successful return to the society.
- *Multidisciplinary approach:* The expert team at the Forensic Psychiatry Institute is composed of different profiles of professionals, such as psychiatrists, psychologists, nurses, social workers, psychotherapists, occupational therapists. This multidisciplinary collaboration enables holistic approach to treatment and support for all patients.

This manual was prepared based on the above-mentioned ethical principles, the existing good practices at the Forensic Institute, recommendations of the Committee of Ministers of the Council of Europe, the CPT standards and recommendations from the CPT reports to the authorities in Bosnia and Herzegovina.

Purpose and goal

One of the key goals in today's European criminal justice and health systems is to ensure the necessary level of personal safety and general security safeguarding human rights of persons deprived of liberty, as well as persons subject to sentences or sanctions. In Bosnia and Herzegovina (BiH), a signatory to European treaties and conventions, there is a deeply rooted interest to further improve treatment of these persons.

European standards in this field entail dignified and non-discriminatory treatment of vulnerable categories of persons deprived of liberty, including forensic patients[2], to ultimately assist their resocialisation and achieve their reintegration into society.

Ensuring humane treatment of the forensic patients entails important treatment phases of the admission and the risk and needs assessment for each patient individually and in the context of each specific patient category.

A multidisciplinary approach to the treatment and collaboration with other social welfare agencies in the community to prepare the patients for discharge upon completion of their treatment, is part of the rehabilitation process. It also includes providing adequate pharmacotherapy, psychotherapy and rehabilitation programmes tailored to their individual needs.

Specific categories of patients

Several specific categories of patients require special attention and tailor-made treatment at the Forensic Psychiatry Institute Sokolac.

1. Substance abusers:

Substance abusers are patients who have substance use disorder involving alcohol and/or various psychoactive substances (PAS) abuse and require a special approach and treatment tailored to their health needs. They may be hospitalised after having committed offences under the influence of alcohol or because of their dependency on PAS which caused their behaviour disorders. Treatment of substance abusers includes detoxification, substitution therapy, pharmacotherapy, individual and group psychotherapy, social rehabilitation and support to achieve total abstinence and prevent relapse.

2 In Bosnia and Herzegovina, forensic patients are persons who have committed or are suspected of having committed criminal offences in a state of partial or complete mental insanity and to whom the competent court has imposed a measure of mandatory psychiatric treatment and their placement in the hospital or ordered assessment of the need to impose such a measure via neuropsychiatric expertise.

2. Juveniles:

Juveniles[3] are persons under 18 who require a special approach and treatment due to their developmental context. Work with juveniles includes assessing their developmental needs, providing tailored therapy, occupational therapy, education and resocialisation. It is especially important to provide a safe environment and collaboration with family.

3. Women:

Women can be especially vulnerable and subjected to various forms of abuse and traumatic experiences. They may be hospitalised for having committed criminal offences and often have suffered violence before committing a criminal offence. Specific treatment programmes for women include psychotherapeutic treatment of traumatic experiences, social support, safe environment and addressing specific needs of women such as reproductive health.

4. Older age patients:

Older age patients are persons above the age of 65. Their somatic and mental changes associated with aging require special attention. Due to the increase in life expectancy, the numbers of such patients are increasing. These patients have usually committed criminal offences at an older age (e.g., dementia, other organic disorders), or had committed them much earlier and are still under the mandatory psychiatric treatment and confinement. Treatment for older age patients includes tailored care, pharmacotherapy, support, and rehabilitation and addressing the specific somatic healthcare needs of older age.

5. Persons with physical difficulties and difficulties in mental development:

Persons with physical difficulties and difficulties in mental development refers to patients with intellectual or physical disabilities and psychological or sensory difficulties. In working with them, it is important to focus on their access to the environment, as well as to understand their specific challenges and needs. Treatment of these patients includes tailored therapies in terms of mobility, support in understanding and managing their own difficulties and developing skills for independent functioning. Also, it is important to provide them with communication tools and methods tailored to their needs to facilitate therapeutic interaction and improve communication.

There is no single approach to treatment that is suitable for everyone. Treatment depends on the patient's characteristics. Aligning treatment conditions, interventions and services with the specific problems and needs of individual patients is crucial for their ultimately successful return to their family and society. Effective treatment sho-

3 According to the UN Convention on the Rights of the Child, children are young people up to the age of 18.

uld address a number of individual needs. To be effective, treatment should consider all related medical, psychological, social, professional and legal issues.

The team working with these specific categories of patients should be multidisciplinary and composed of experts from different fields, such as psychiatrists, psychologists, social workers, psychotherapists, special educators (defectologists), work and occupational therapists, etc. Such team-oriented approach enables holistic approach to the treatment and support for patients.

In working with these specific categories of patients, it is important to follow legal and ethical guidelines that protect their rights, well-being and dignity. An individualized approach, sensitivity, expertise and empathy are crucial to providing quality care and support to these patients at the Forensic Psychiatry Institute.

However, the above list of specific categories in not exhaustive as there can be a variety of specific vulnerable categories. For example, a specific category may also be women dependant on psychoactive substances („multiple" vulnerability). Treatment of specific categories should not be exhaustive either because the overlapping can take place also with respect to the diagnosis, sex and age.

Substance abusers

Addiction – definition

> periodic or continuous intoxication with a psychoactive substance. Persons with a substance dependency struggle with significant consequences affecting their physical, mental and social well-being.

Co-morbidities with other psychiatric disorders are rather frequent among this category of patients. For example, 70% of those dependent on alcohol have some sort of personality disorder, while this percentage may be even higher - 90%, among those who demonstrate drug misuse. Further, these patients often have secondary psychiatric diagnoses, mostly from the affective disorders' spectrum (depression and anxiety), or sometimes from the psychotic disorders' spectrum.

The Forensic Institute provides hospitalisation for patients imposed with mandatory addiction treatment as a security measure.

Addiction as a factor in a criminal offence

> Mental disorders and behavioural disorders caused by addiction to psychoactive substances (PAS), in some cases can be associated with criminal activities and offences. Substance abusers are often at risk of engaging in illegal activities to get the PAS to which they have developed an addiction. This may include theft, embezzlement, violence, attempted murder, murder, or other forms of criminal behaviour.

Involuntary hospitalisation[4] is not only enforced for dependencies or PAS misuse but also for the demonstrated dangerous behaviour carrying the safety risk to the patient himself or others, whereby a contributing factor could also be the use of PAS. This is regulated in the Republika Srpska Law on protection of mental health of Republika Srpska and Federation of BiH Law on protection of persons with mental disorders. When this type of hospitalisation takes place, the Forensic Institute applies principle of voluntary treatment of dependencies, i.e., the patient decides whether detoxication or the supstitution therapy treatment will apply. When substance abusers commit a criminal offence, the court or a prison psychiatrist refers them to serve a measure of treatment and care at the Forensic Psychiatry Institute which establishes a detailed diagnosis and treatment.

4 The CPT has expressed concerns regarding the forced hospitalisation of substance misusers and the mental pathologisation of their offending behaviour, but acknowledges that this happens in some states. The concerns stems from the fact that the selection for treatment of such individuals in hospital is best predicated on consent - it is very difficult to effectively treat a substance misusers who are not motivated to adress their abuse and they can then remain in hospital for a very long time with no progress. Therefore, those who misues substances who do not also have a mental disorder are not best hospitalised but treated via voluntary engagement in therapy (e.g. in prison or the community) when they wish to engage.

The most common causes and types of criminal offences committed by patients – substance abusers at the Forensic Institute

Alcohol abuse and addiction	domestic violence obstructing authorised officials in performing their official duties attempted murder or murder
Addiction to opiates and other psychoactive substances	domestic violence falsification (counterfeiting medical prescriptions) many petty *or* grand *thefts* and related criminal offences aimed at obtaining money to buy drugs

Framework treatment programme for substance abusers patients

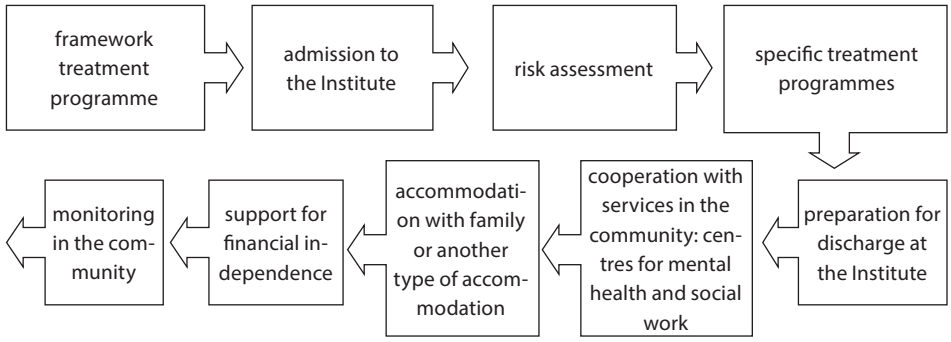
Treatment at the Forensic Institute follows a structured programme that includes pharmacotherapy, psychotherapy, social therapy, various educational activities, all aimed at preparing patients for their return to the local community and work environment.

Treatment of each patient needs continuous evaluation, while individual therapeutic plan needs to be modified from time to time to meet the changing needs of the patient.

For many patients, continuous support gives the best results, while the intensity of treatment should vary according to the changing needs of the person.

The primary goals of therapy include achieving stable total abstinence, gaining and deepening insight into the illness and its consequences, strengthening motivation for further treatment and ultimately treating the patient's secondary psycho-somatic and social side effects.

The framework treatment programme workflow for substance abusers



Admission protocols for patients - substance abusers

1. The admission and search protocols security officers follow during the admission of substance abusers/patients are laid out in*"Protocols for treatment of mentally challenged offenders in forensic facilities"*.[5]
2. The on-duty doctor receives the patient after s/he and his/her belongings are searched[6]. The doctor examines the patient (physical, neurological and psychiatric assessment) and documents it in writing, performs a whole range of baseline blood tests and, with patient's consent, tests her/him for HIV and Hepatitis C. If the test results for HIV and Hepatitis C are positive, the patient is referred to an infectologist. All these data are entered in the patients' medical file, together with an initial diagnosis and the initial pharmacotherapy. The patients are also informed about their health status without delay.

   It is important to inform the patients about their diagnosis and prescribed therapy without delay to protect their right to private and family life.[7]
3. Medical or support staff asks the patient to urinate, if possible, to enable a 10-panel drug test on the spot. This process is supervised by the same sex as patient support staff member. This test only detects the presence of any of the ten psychoactive substances, without determining their concentration.

If the patient cannot urinate immediately on admission, the patient is tested on the ward, on completion of the admission process.

4. The treatment agreement entails presentation of the patient's current circumstances, such as the legal acts referring the patient to treatment, Rulebook on House Rules, as well as the agreement between doctor and patient about the treatment the patient will undergo at the Forensic Institute. This agreement is made in the written form, signed by the patient on admission and archived in the patient's medical history. The treatment involves the prescribed pharmacotherapy and obtaining the patient's consent for the diagnostic procedures. By accepting the treatment, the patient forms a therapeutic alliance with the doctor and takes responsibility for his own recovery. In addition, the patient is given a brochure that provides information[8] about how the Forensic Institute operates and the patient's rights.

5 Duties and the role of the security service in the implementation of specific treatment programmes for vulnerable categories of forensic patients at the Institute.

6 Patients are searched as detailed in the „Protocols for dealing with forensic offenders in forensic facilities", EU/CoE Joint Programme Horizontal Facility for Western Balkans and Turkey, 2016-2019.

7 The European Convention on Human Rights (ECHR), as the fundamental instrument of the Council of Europe for protecting civil and political rights, does not guarantee the right to healthcare. However, the European Court of Human Rights broadly interprets the rights enshrined in the Convention, indicating in the context of Articles 2, 3, and 8 of the Convention that it may begin to address the issue of healthcare. In contrast to the Convention, the European Social Charter guarantees the right to healthcare under Article 11 and regulates it in great detail.

8 Following a CPT recommendation.

In some cases, the patient does not wish to sign this agreement immediately due to her/his current psychological state (acute psychosis, poor psychosomatic condition, etc). After the patient's condition has improved and the doctor is able to explain provisions of the agreement again, the patient gives his written consent.

When the patient refuses to consent to treatment, for ex., if there is a guardian, the guardian consents to treatment or other legal safeguards apply[9]"

It is important for the patient to give her/his informed consent, to allow for the most effective treatment and to protect him from the possible breach of ECHR's Article 3.

5. Men are accommodated separately from women in the addictions ward, along with their personal belongings also kept separately.

   This practice enhances the safety of female patients and ensures privacy and dignity for all patients by protecting their right to family and private life (ECHR's Article 8). It also enables them to personalise their living space. Personalisation of the patient's living space is a long-standing recommendation of the CPT to the authorities in BiH (CPT/Inf (2021) 21; CPT/Inf (2016) 17).

9 In CPT terms, these safeguards require an assessment by an independent psychiatrist, so as to agree to the proposed forced involuntary treatment (which is deemed by the CPT to be different to forced hospitalisation).

Risk assessment protocols for substance abusers patients

1. Risk assessment comprises the risk of self-harm, suicide and aggression. It also assesses information about the patient's previous treatment or hospitalisation and the patient's attitude to treatment. A multidisciplinary team[10] comprising a psychiatrist, psychologist, social worker and work-occupational therapist carries out this assessment.
2. Additional assessment is an equally important factor in the risk assessment. The assumption is that if the patient manifests a high degree of addiction (e.g., severe withdrawal syndrome, lack of insight into his condition), he is less likely to participate voluntarily in the treatment programme.

   The patient's voluntary and well-informed consent to treatment, means that the treatment itself is likely to be more effective because the patients will be more interested in their own treatment and recovery.
3. The patients are assessed for addiction in order to determine whether what they have is an abuse or an addiction to psychoactive substances (PAS), as well as what degree and severity of addiction they have, if they have been diagnosed with addiction. This assessment involves collecting detailed data on the history of alcohol or PAS use, taking blood or urine samples for PAS-presence analysis, administering a standard psychological battery of tests[11] for assessment and having a conversation with the patient about her/his symptoms and consequences of their PAS use. The expert team also identifies any associated psychiatric problems as part of this assessment.
4. The choice of treatment depends on: the patient's current clinical picture, insight into her/his own condition; the level of insight into one's own actions, desires and motivation for treatment; degree of cooperation with the staff, socioeconomic status, family support and support from the local community.
5. Information about the comprehensive risk assessment (high, medium, low - with explanations for each category) is entered into the Risk Assessment Form. Information about the level of risk that can be shared with the security service is provided on a separate form.

10 For more details see the resource manual "Roadmap for the forensic patients' care - from admission to release", Joint EU/CoE Programme Horizontal Facility for the Western Balkans and Turkiye, 2019-2022.

11 These tests inlcude: MMSE (Mini Mental State Examination), Veksler's indiviual intelligence test (version VITI), MCMI-II (Millon's clinical multiaxial personality inventory), MMPI-202 persoinality inventory, Bender-gestalt test, Mahover test – human figure sketch, Wartegg drawing test, etc.

6. Any means of restraint are only used on the basis of the risk assessment and in accordance with the safeguards and the core principles as mentioned in the separate part of this Resource manual.[12]

The patient's individual treatment plan is developed against the background of this and will be different for each patient. The multidisciplinary team (including psychologists) meets regularly to exchange information and discuss the patient's needs and therapeutic progress. Individual medical files contain all the current findings/notes about the patient's mental and somatic health status and his treatment.

Specific/individual treatment programmes – addictions

Addiction treatment aims to achieve total abstinence, prevent relapse and improve the quality of patients' lives.

Depending on the patients' individual needs, treatment may involve:

- medical detoxification,
- pharmacotherapy,
- substitution therapy,
- individual and group therapy,
- work-occupational therapy,
- social activities or support for family to assist further resocialisation.

12 Standards of the European Committee for the Prevention of Torture, Inhuman and Degrading Treatment or Punishment-CPT

Pharmacotherapy therapy	**Psychological treatment**	**Work-occupational and recreational therapy[13]**	**Social activities**
Psychopharmaco therapy[14]	Individual therapy	Creative workshop music therapy bibliotherapy art therapy sculpture wood carving	- one-on-one conversations about social needs - contact with family and relatives - pension plan and other cash payments - requesting a one-time financial support - escorting patients to administer their bank issues
Substitution therapy	Group therapy	Recreational therapy -sports -gardening -outdoor activities - walking - cinema	
Detoxification			

13 This therapy currently does not encompas work skills that would help patients find work placement after discharge due to technical and material restrictions (for ex., cooking skills, computer literacy, etc)

14 E.g., Suboxon (combination of buprenorfin and naltrekson), Metadon; Other symptomatic therapy on the recommendation of a specific specialist (this can include also medicines for hepatitis and HIV).

Addiction treatment is administered in three phases.

1. The first phase of treatment aims to help the patient at ***individual*** level to:
   - achieve, maintain and stabilise abstinence;
   - become familiar with the nature of her/his disorder (how the disorder occurs and how it is maintained, addictive behaviour patterns, illusion of control, dysfunctional beliefs, crises...);
   - learn to recognise and avoid risk-prone situations;
   - become sincerely motivated to partake in the treatment;
   - change her/his behaviour that disrupts daily life (improve impulse control, reduce anxiety, learn to take responsibility for own behaviour, accept the reality principle, structure time, avoid risks...);
   - change her/his system of values;
   - improve relations with partner and family;
   - recognise one's own addictive behaviour and change it;
   - organise one's own time;
   - recognise psychological crises and prevent relapse;
   - take responsibility for her/his own behaviour.
2. The treatment continues with the second phase in the ***rehabilitation*** group, where the patient:
   - learns to accept her/his full and permanent abstinence;
   - works on further improving family relations (redefining roles, improving communication and relations between the genders and generations in the family, change the addictive behaviour patterns in the family);
   - engages in society (manage risky situations, automatic thoughts and rational correction, relaxation techniques, assertive communication).
3. Treatment concludes with the third phase - ***resocialisation*** which aims to:
   - improve the patient's abilities to work, social and professional networking.

Specific needs of substance abusers include:

Pharmacotherapy	Psychotherapy
In addition to the standard range of psychotropic drugs prescribed to patients with specific mental disorders who require them, a special group consists of opioid substance abusers who - alongside this therapy - often require inclusion in the substitution therapy programmes (methadone or buprenorphine). Some of them arrive on admission with the previously prescribed doses of methadone or buprenorphine. After the admission, it becomes necessary to ensure that they continue with the substitution therapy. Since the Forensic Institute's pharmacy does not stock these drugs, the social worker, in correspondence with local health centre in the patient's place of residence, arranges for the prescription and methadone or buprenorphine[15] supply.	Psychotherapy is an integral part of the most addiction treatment modalities. It encourages changes in the behaviour and lifestyle, helps to curb cravings for alcohol or psychoactive substances (PAS) and addresses the underlying reasons that initially led to the addictive behaviour. Psychotherapy is generally a long-term process aimed at resolving internal issues and conflicts and establishing significant changes at psychological level.

The most frequently used and the most efficient types of psychotherapy for substance abusers include:

- cognitive behavioural therapy which can be conducted individually, in groups or in the presence of family members.
- group psychotherapy which allows patients struggling with the same problem to support each other, share experiences and learn from each other, in order to maintain the necessary level of motivation for recovery. Its positive effects include:
  - this is a place where substance abusers' resolve their problems that they could not have resolve on their own;
  - there is collective experience and awareness of the group's strength, the possibilities of mutual assistance from the substance abusers who have overcome this illness;
  - the power of collective commitment is transferred from the group to the individual, motivating them towards the highest goal: permanent abstinence and healthy life;
  - it encourages substance abusers to recognise their potential and set clear, realistic goals;
  - substance abusers receive full support, understanding and safety;
  - this is a place for promoting and celebrating each success achieved together;
  - there is group awareness that helps in analysing tasks;
  - all members of the group who help other substance abusers also help themselves because it fulfils them and strengthens their abstinence.

15 However, the Hospital always has minimum quantities of the substition therapy in stock. Larger supplies are not stocked as the number of patients requiring this therapy is not high and these are expensive medicines with short expiry dates.

SPECIFIC TREATMENT PROGRAMME FOR PATIENTS SUBSTANCE ABUSERS					
Type of activity	**Detailed description of activities**	**Monthly overview of patient activities**			
		1st week 1	**2nd week**	**3rd week**	**4th week**
Ind. therapy	Psychiatrist/Psychologist	1x	1x	1x	1x
Group therapy	In occupational therapy, in the presence of an occupational therapist	1x	/	1x	/
Therapeutic community	In the ward, in the presence of the multidisciplinary team	1x	1x	1x	1x
Rounds/visits	In the ward, in the presence of the multidisciplinary team	1x	1x	1x	1x
Creative workshop	Music therapy, art therapy, bibliotherapy, ,under the guidance of the work-occupational therapist	3x	3x	3x	3x
Recreational therapy[16]	Sport activities in the gym	2x	2x	2x	2x
Leisure activities[17]	A walk around in the outside yard	Daily, weather permitting, lasting between 1-3 hours			
Visits[18]	Lawyer, family, etc.	2x	2x	2x	2x
Phone calls[19]	Lawyer, family	3x	3x	3x	3x
Religious needs[20]	Friday, Saturday or Sunday depending on the religious affiliation	1x	1x	1x	1x
Hair salon[21]	Shaving, haircut	1x	1x	1x	1x
Intimate visits[22]	Spouse or common-law partner	once a month			
Escort to external institutions	Bank, hospital and other health facilities, municipality, Institute for expert analysis of med. Documentation and other institutions	Health status permitting, patient's social, judicial procedure and financial needs			
Monitoring in the Institute	Laboratory analyses, consultations with a specialist doctor, examination by the court's medical experts	In accordance with the patient's health needs			

16 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends upon the no. of patients, staff and wards. However, the Hospital management intends to increase availability and frequency of these activities, in accordance with the CPT standards.

17 The CPT standard is that patients, whose health permits it, should have daily unrestricted daily access to fresh air (which requires safe exercise yards with appropriate supervision)– with the appropriate shelter for inclement weather and appropriate warm clothes/footwear provided for the patients. The Hospital management works towards attaining this standard.

18 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for open type visits. Regardless of the pre-assigned visit days as per House Rules, if the family or a lawyer visits the patient another day, the doctor can approve the visit.

19 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for phone calls, the length thereof is not limited. The doctor can suspend phone calls for up to a month at most if they are considered harmful to the patient's health. Regardless of the pre-assigned phone call days as per House Rules, if the patient needs to call the family of lawyer another day, the doctor can approve the phone call.

20 The Institute invites religious dignitaries as needed/wished for by the patient.

21 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. This service is provided only by a qualified hairdresser. Regardless of the pre-assigned days as per House Rules, if the patient wishes to shave (his wish or the doctor's recommendation) another day, the doctor can approve this.

22 Unlimited in length, the patients do not pay for this.

EXAMPLE OF A DAILY TREATMENT SCHEDULE FOR SUBSTANCE ABUSERS	
TIME	**ACTIVITIES**
06:30-07:05	*The wake-up morning roll call*
07:05-08:00	*Personal morning hygiene, room tidying*
08:00-08:15	*Breakfast*
08:15-09:00	*Administering morning therapy, BP, temperature taking…*
09:00-10:00	*Therapy session with a psychologist, psychiatrist*
10:00-11:00	*Activities in the rehabilitation/resocialisation ward-Creative workshop*
11:00-12:00	*Group therapy*
12:00-12:30	*Lunch*
13:30-14:00	*Administering afternoon therapy*
14:00-15:00	*Afternoon break (free time for relaxation and rest)*
15:00-16:00	*Activities in the rehabilitation/resocialisation ward-Recreational therapy (gym)*
16:00-17:30	*Outdoor activities[23] - walks or exercises in the fresh air*
17:30-18:00	*Dinner*
18:00-20:30	*Free time - time for personal activities, reading, board games or socialising*
20:30-21:00	*Administering evening therapy*
21:00-22:00	*Getting ready for bed, personal hygiene*
22:00	*Sleep and night rest*

Note: The schedule may vary depending on the patients' specific therapeutic goals and dynamics at the Forensic Institute. These steps are just the guidelines and individual treatment plans are tailored to the needs and goals of each patient. The multidisciplinary team plays an important role in developing treatment plans to ensure the best possible care for patients.

23 The House Rules, as well as the CPT standards, specify that outdoor activities may also be organised in the morning, should technical and material resources allow for it. The Hospital management works towards attaining this standard.

Protocols for preparing the substance abusers' release – the pre-release programme

Patients can be referred to continue their outpatient treatment as part of the daily hospital treatment in socio-therapeutic groups (e.g., AA clubs) or communities, once they are released from the Forensic Institute. The continued support helps them maintain their recovery, prevents relapse and helps them lead satisfying and productive lives.

Patients are prepared for release and their return to the community as part of the hospital treatment, while their family members and guardians receive appropriate support in parallel. These activities follow after their clinical condition has been fully stabilised and the court decides to terminate medical intervention at the Forensic Psychiatry Institute Sokolac.

The hospital psychiatric service and community services continue to correspond to identify support services to assist the patients' recovery in the environment where they live. This is one of the prerequisites for the patient's release from the hospital.

Before release, psychologists provide support through a series of individual sessions with the patient for her/him to:

- better understand the importance of recognising one's own emotional state,
- understand her/his current preoccupations and the importance of making mature and constructive decisions that leads them to be satisfied with their own life,
- understand the importance of regular use of the prescribed therapy,
- understand the importance of regular check-ups.

The basic principles comprising pre-release treatment programmes

The pre-release programmes are mainly based on three or a combination of the three most common theoretical models:

- *deterrence*: which generally relies on the offender ceasing to offend or engage in other forms of antisocial behaviour. This model explains the process through which the forensic patients learn to live the law-abiding lives.
- *the good living model*: is a form of rehabilitation that focuses on the advantages and strengths of the forensic patients in therapeutic work. It also helps the patients develop and keep purposeful life plans that do not involve criminogenic behaviour.

- *risk-need-responsivity model*: it is based on the three principles:
  1) *risk* identifies criminogenic behaviour that can be reliably predicted, and the treatment should focus on the high-risk patients;
  2) *need* emphasises the importance of criminogenic needs when developing and implementing treatment; and
  3) *responsivity* describes how the treatment is implemented.

Goals: what the pre-release programme anticipates, plans and aims to achieve

General goal:

- Prepare patients for release on completion of their treatment

Specific goals:

- Assess the patient's progress during treatment
- Enhance motivation for change
- Develop a resocialisation/reintegration plan
- Address criminogenic needs and improve their cognitive, emotional and behavioural skills that contribute to the law-abiding life
- Assist patients in finding solutions for situations they would otherwise struggle with after release and their return to the community
- Inform the patients about issues of personal relevance to them after release
- Collect information from their family and friends that is important for their life in the community after discharge
- Recommend steps that patients should take after release regarding employment, finding accommodation, continuing treatment, securing primary healthcare coverage, etc.
- Collaborate with other agencies[24] involved in helping patients after release.

The multidisciplinary team delivering the pre-release programme

The team at the Institute leading the pre-discharge or pre-release programme is multidisciplinary (MDT), consisting of psychologists, social workers and doctors (if necessary).

The psychologist and social worker lead individual, group and joint sessions. The doctor can be involved as necessary at any point if considered beneficial for the patient.

24 Centres for Social Work, Centres for Mental Health, etc. For more details, see the appendix of the manual "Rulebook on collaborative discharge planning for persons with mental health disorders" annexed to this material.

Participation criteria: selecting the patients participating in the pre-release programme

All patients should be encouraged to apply and should be considered for the full participation in the pre-release programme, if her/his condition allows for it:

- the MDT compiles the list of patients who voluntarily apply to participate in the programme and who are considered for release from the Forensic Institute.
- the doctor gives the final approval for the patient's participation
- patients requiring a special programme to respond to their risks and specific needs should not be considered for the pre-release programmes.

The pre-release programme structure

The programme consists of three phases:[25]

1) Individual sessions-motivational and evaluation phase:

This phase has two relevant goals:

- make a resocialisation/reintegration plan in cooperation with the patient
- enhance motivation for change

Motivational interviews are scheduled for/with each patient towards achieving these goals. The interviews are recorded and evaluated so that each MDT member can easily access the forms and be informed about the progress made in working with the patient or the lack thereof. The interviews can also be evaluated during the final implementation of the programme when the MDT compares the patients' initial answers during the pre-release programme (level of motivation expressed in their own words) and their participation recorded during the intervention phase.

2) Group and joint sessions-intervention phase:

This phase consists of two or more group sessions that address relevant topics with participants. The two basic components of this phase are:

- Welcome session to the programme
- Psychoeducational sessions aimed at encouraging cognitive, behavioural and emotional elements of prosocial behaviour
- problem solving
- emotional regulation
- social skills
- preventing antisocial attitudes, etc.

25 These phases correspond to the definitions of the forms of work with patients used so far: individual, group, and frontal forms of work.

- Joint/information sessions aimed at informing patients about general issues related to discharge (four or more sessions)
- relationships with other people
- employment
- residential accommodation
- health
- self-sufficiency
- money
- education and vocational training
- free activities and hobbies
- alcohol and drugs
- avoiding criminal milieu
- services that can provide help and support.

3) Evaluation-the final phase in which the results are analysed:

The results of working with each patient individually are analysed at the end of the intervention phase or throughout the pre-release programme. The goal is to make the rehabilitation plan together with the patients themselves, preparing them better for independent life after release and to make them have a sense of "ownership" over their own reintegration into society.

"The Next Steps: Preparation for Discharge" is a standardised programme addressing the most common criminogenic needs of forensic patients based on available research (lack of social skills, antisocial attitudes, emotional regulation, problem-solving programme, etc.). However, each patient may have individual needs that need to be addressed. These specific needs are covered in the resocialisation plan developed during the motivational and evaluation phases. This plan is developed together with each patient/participant in the pre-release programme.

Example of a one-month pre-release programme for substance abusers

Time period	Individual sessions	Group sessions	Joint sessions	Evaluation
First week	Motivational interviewing	Preventing antisocial behaviour	Residential accommodation	
Second week		Emotion regulation	Health	
Third week		Social skills	Money/financial independence	
Fourth week		Problem solving	Free time	

Complaints

Substance abusers have the right to file a complaint, same as any other category of patients.

A complaint can be:

- regular – referring to daily issues in the work of the Forensic hospital, directly falling into the competence of staff (for ex., participation in activities, etc)
- confidential – complaints against staff or other patients, compising sensitive information (for ex., referring to the patient's health condition or her/his family), requiring specific and confidential handling
- health-related – confidential submissions requiring specific knowledge and expertise of the person dealing with the complaint (for ex., medical assessment and decisions, etc).
- complaints against the director of the Forensic Hospital – complaints about what the director has done/failed to do, decide, etc.

The complaints system (filing and dealing with complaints) is explained in detail in *„Protocols for treatment of mentally challenged offenders in forensic facilities".*[26]

26 Joint Programme between EU/CoE Horizontal Facility for the Western Balkans and Turkiye, 2016-2019

Checklist for the potential human rights violations – substance abusers patients

Personal data protection, which include medical data, may be misused by:

- disclosing official information related to the deprivation of liberty, criminal offence or misdemeanour for which a person is suspected to third parties;
- sharing medical/personal information related to health condition of detainees with third parties;
- sharing information gathered during contacts with or conversations between detainees/patients and their lawyer in case the staff was within earshot. **Such information cannot be shared with anyone.**

The rights that may be violated in this case, which are protected by the ECHR, are:

- Prohibition of torture according to Article 3 of the Convention
- Right to liberty and security according to Article 5 of the Convention
- Right to respect for private and family life according to Article 8 of the Convention
- Right to freedom of thought, conscience and religion according to Article 9 of the Convention
- Right to freedom of assembly and association according to Article 11 of the Convention
- Right to prohibition of discrimination according to Article 14 of the Convention

Juveniles

Juvenile patients imposed with the educational measure or treatment and care measure children and persons under the age of 18, facing various challenges concerning their development, education and rehabilitation

The Forensic Psychiatry Institute works with juvenile patients based on:

- Law on the Protection and Treatment of Children and Juveniles in Criminal Proceedings[27]
- The European Convention on Human Rights and the UN Convention on the Rights of the Child

Juvenile patients have the right to education - one of the basic characteristics distinguishing them from other vulnerable groups.

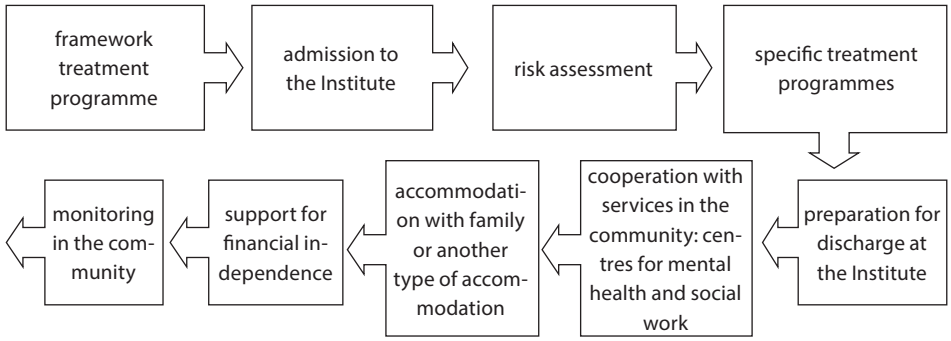
The most common causes and types of criminal offences committed by juveniles in the Forensic Institute Sokolac

lack of parental care bad influence of the community and peers bad economic or family situation	domestic violence, obstructing a person in performing official duties, falsification (counterfeiting medical prescriptions for ex.), a large number of petty *or* grand *thefts* and related criminal offences aimed at obtaining money to buy drugs attempted murder or murder.

27 The judicial system in BiH has specific laws at the entity level that apply to juvenile offenders. These laws determine the procedures, measures and sanctions applied to juvenile patients at the Institute for Forensic Psychiatry.

FRAMEWORK TRETMENT PROGRAMME FOR JUVENILES

The framework treatment programme workflow for juveniles



Protocols for admitting juvenile patients

1. The protocols followed by security officers during the admission of juvenile patients to the Institute are described later in the manual.[28]

   Essentially, they do not differ from the admission protocols for other patients, except that a juvenile may be accompanied by a parent, guardian or legal representative.

2. Juvenile patients are searched[29] while considering the specifics of their age and their level of development (level of understanding).

   It is especially important for this age group to conduct security check and search so to avoid provoking fear and stress. The staff should be sensitive and careful to create a sense of safety for the juvenile patient. The sequence of actions should be announced to juveniles, for example, *"I will now search the upper part of the body, the jacket, etc."* Juveniles are often sensitive about their privacy and may experience increased feelings of shame and discomfort. It is important to establish a clear and open dialogue with juveniles to ensure their support and understanding during the search and security check procedure.

3. The duty doctor takes over the patient after the search[30] of the person and her/his belongings is completed. The doctor examines the patient (physical, neurological and psychiatric assessment), which he then documents in the written form, enters initial diagnosis and the initial medicine therapy, at the same time informing the patient about her/his actions.

   It is important to inform the patient without delay about her/his diagnosis and therapy so to protect her/his right to personal and family life.[31]

4. The medical and support staff asks the patient to urinate if s/he can, to enable a 10-component urine test on psychoactive substances. This test only detects existence of some of 10 psychoactive substances, without the possibility of establishing their concentration. One of the same sex support staff as the patient supervises the juvenile patient while urinating. If the patient cannot urinate at that moment, this is done in the ward after the admission is completed.

5. The treatment agreement is signed on completion of the search. This agreement is signed between juvenile patients, their parents or guardians and the

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28 Duties and the role of the security service in the implementation of specific treatment programmes for vulnerable categories of forensic patients at the Institute.

29 According to the protocols described in the manual "Protocols for treatment of mentally challenged offenders in forensic facilities" (page 10).

30 Based on the procedures laid out in the ''Protocols for treatment of mentally challenged offenders in forensic facilities" (pg 10), Joint EU/CoE Programme Horizontal Facility for Western Balks and Turkiye, 2016-2019.

31 ECHR as the core CoE instrument for the protection of citizens' and human rights does not guarantee the right to health care protection. However, ECtHR interprets the Convention more widely, and within the context of Art 2, 3 and 8, it gives certain indications that it could start dealing with the issue of health care. As opposed to the Convention, European Social Charter guarantees the right to health care in Art 11, regulating it in great detail and extensively.

doctor and filed in the patient's medical history. The agreement includes presentation of the patient's circumstances, ie. legal decision based on which the patient was referred to the treatment, Rulebook on House Rules, but also an agreement between the doctor and the patient regarding implementation of treatment in the Hospital (determining the therapy, consenting to the diagnostical procedures). By accepting the treatment, the patient creates a therapeutic agreement with the doctor and accept responsibility for her/his recovery. The patient is given a brochure through which s/he can inform her/himself about the functioning of the Hospital and her/his rights.

If the patient does not immediately sign the treatment agreement due to his psychological condition, the doctor explains its contents again, once the patient's condition has improved. The patient may therefore give his written consent for the agreement therefore later.

In cases where a juvenile has legal representative or guardian, s/he signs the treatment agreement as well. The guardian must be independent from the hospital, responsible, without a conflict of interest, have regular contact with the patient and represent her or his rights and needs.

When a patient refuses consent to treatment, or has a guardian appointed to act on her/his behalf, consent is either obtained from theguardian or other legal safeguards are applied"[32]

The patient's informed consent is important to enable the most efficient treatment and to protect the patient form the possible violation of the ECHR's Art 3.

6. Accommodation represents the final step in the admission process for juvenile patients to the Forensic Psychiatry Institute. Juvenile patients are allocated to appropriate accommodation units, in the ward dedicated to children and adolescents and with their personal belongings safely stored, in view of their specific needs and gender.

   This ensures patient's privacy and the personalisation of space, as prescribed by the UN Convention on the Rights of the Child, the ECHR, CPT standards for treatment of juveniles, etc.

It is important to note the special attention given to the protection of personal data upon admission of juvenile patients.

The data collected is strictly kept in accordance with privacy and confidentiality regulations.

Additionally, if juvenile patients successfully rehabilitate, the process of erasing their data from criminal records can be carried out, depending on the laws and regulations of the country.

This step is crucial to give patients another chance to start a new life after their stay at the Forensic Institute.

32 In CPT terms, these safeguards would require an assessment by an independent psychiatrist, so as to agree to the proposed forced involuntary treatment (which is deemed by the CPT to be different to forced hospitalisation.

Risk assessment protocols for juvenile patients

Risk assessment for juvenile patients[33] is crucial to ensure their personal safety, safe environment, well-being and adequate treatment planning.

1. Risk assessment for juveniles includes considering the risk of self-harm, suicidality, aggression, gathering information about previous treatment or hospitalisation and patients' attitude towards treatment.
2. To ensure a complete and comprehensive risk assessment, the process is carried out by multidisciplinary team comprising a psychiatrist, psychologist, social worker and work-occupational therapist.

   The multidisciplinary team guarantees that the specific different types of needs of juvenile patients are taken into account when adjusting their individual treatment plans. This enables holistic approach to treatment.
3. If the assessed risk level is high on juvenile's admission, a recommendation on the use of restraint measures is entered in the juvenile's dossier. In accordance with the CPT standards, juveniles can be only restrained manually or segregated in a separate room, albeit under constant supervision in that room (staff is positioned in front of a slightly ajar door).

   Controlling and restraining juveniles requires special approaches due to various factors such as age, vulnerability, level of development and understanding, physical strength, as well as the need for psychological support after any use of restraint, medical assistance, and other relevant methods[34]. This is a recommendation from the CPT in its 24th General Report[35] published in 2015.
4. The use of alternative interventions is considered before resorting to controlling and restraining juveniles. This includes attempts to calm them through verbal de-escalation, establishing a safe environment, providing support and empathy.

   The CPT standards for the use of restraint are in Annex 1 of this Manual.
5. If the above-mentioned verbal de-escalation fails, pharmacotherapy should be attempted before resorting to manual restraint methods or segregation in a separate room.

33 For detailed protocols, see the manual "Roadmap for the forensic patients' care- from admission to release".

34 The Hospital management is working towards introducing psychological support after the use of restraints for all patients, as per the CPT standard.

35 CPT/Inf (2015)1-part

6. The choice of treatment options depends upon the patient's current clinical status, her/his insight into her/his own situation and how critical it is in relation to her/his actions, wishes and motives to undergo treatment, the level of patient's cooperation with staff, socio-economic status, family support and support from the local community.

   The patient's voluntary and informed consent to treatment makes it even more effective. The patient will also be more interested in her/his own treatment and recovery. This is particualarly important for juvenile patients because of their age and the life ahead of them.

7. Information about the overall risk level (high, medium, low – with explanantions of each category) is entered in the risk assessment form. Information about the risk level that can be shared with the security staff are shared on the specific form.
8. Means of restraint are applied only on the basis of the completed risk assessment and in accordance with the core principles for their use and safeguards mentioned in the separate part of this manual.[36]

Individual treatment plan is drawn for each patient separately based on the above information. The multidisciplinary team (including a psychologist) meets regularly to exchange information and discuss patient's needs and therapeuetic progress. Individual medical files contain all the findings/notes on the patient's mental and somatic health and their treatment.

36 CPT standards

Specific/individual treatment programme – therapeutic approach adapted to juvenile patients

In working with juvenile patients in forensic psychiatry, the therapeutic approach is adapted to their specific needs and goals. It consists of pharmacotherapy, individual and group therapy, occupational therapy and social treatment, i.e., family support aimed at their further resocialisation.

It is important to adapt the therapeutic approach to each juvenile according to their specific needs, developmental stage, emotional state and goals.

Additionally, the types and appropriate doses of drugs, adapted to their age are carefully managed along with potential side effects.

Pharmacotherapy therapy	Psychological treatment	Occupational therapy	Social treatment
Psychopharmacotherapy	*Individual* -psychological testing -supportive conversations -psychoeducation -Individual psychotherapy (*Cognitive behavioural therapy,* -group psychotherapy -family therapy	Creative workshop music therapy bibliotherapy art therapy sculpturing wood carving education, academic skills and knowledge	- collecting socio-anamnestic data - individual conversations about social needs - contact with family and relatives
	Group therapy	Recreational therapy -sports -gardening -outdoor activities -walks -cinema	

Juveniles' special needs

1. Safety and social support: Juveniles need to feel especially safe and protected during their stay in the forensic psychiatry. This includes ensuring physical safety, as well as a sense of emotional safety in relation to other patients and staff.

Regarding social support, juveniles may face numerous mental challenges while serving the measure. Providing individual therapy, group therapy or counselling can help in processing trauma, developing emotional skills and preventing further problematic behaviour.

2. Education: Ensuring access to quality education, with the support of teachers and tailored educational programmes, is important for their intellectual development and future.

3. Social skills and support: Juveniles need to develop social skills and learn healthy ways to interact with other patients and staff. Providing group activities, workshops or therapy can help develop these skills and encourage positive social connections.

4. Recreation and leisure time: Ensuring opportunities for recreation, leisure time and engagement in positive activities can help juveniles relax, develop interests and spend their time constructively[37].

5. Discharge planning: It includes collaboration with family, schools, social services and other relevant institutions to ensure continuity of care, support and integration in the community.

37 All persons, but even more so teenagers, use social media to socialise. The Forensic Institute's management is working on introducing the possibilities for the supervised use of social media, to harmonise protocols in the Institute with moderns trends in the treatment of patients with mental difficulties.

SPECIFIC TREATMENT PROGRAMME FOR JUVENILE PATIENTS					
Type of activity	**Detailed description of activities**	**Monthly overview of patient activities**			
		1st week	**2nd week**	**3rd week**	**4th week**
Ind. therapy	Psychiatrist/Psychologist	2x	2x	2x	2x
Group therapy	In occupational therapy, in the presence of an occupational therapist	1x	/	1x	/
Academic skills and knowledge	Work with a special educator	5x	5x	5x	5x
Therapeutic community	In the ward, in the presence of a multidisciplinary team (psychologist, social worker, occupational therapist and ward technician, pedagogue, defectologist).	1x	1x	1x	1x
Rounds/visits	In the ward ,in the presence of multidisciplinary team (psychiatrist, general practitioner, psychologist, social worker, occupational therapist, ward technician and medical technician)	1x	1x	1x	1x
Creative workshop	Music therapy, art therapy, sculpture, cinema, librarianship, etc.	4x	4x	4x	4x
Recreational therapy[38]	Sport activities in the gym	2x	2x	2x	2x
Leisure activities[39]	A walk on the grounds of the Institute	Daily, weather permitting			
Visits[40]	Lawyer, family, etc.	2x	2x	2x	2x
Phone calls[41]	Lawyer, family	3x	3x	3x	3x
Religious needs[42]	Friday, Saturday or Sunday depending on religious affiliation	1x	1x	1x	1x
Hair salon[43]	Shaving, haircut, hair colouring	1x	1x	1x	1x
Escort to external institutions	Hospital and other health facilities, Institute for expert analysis of med. documentation and other institutions	In accordance with the patient's needs			
Monitoring at the Institute	Laboratory analyses, examination by a consulting specialist, examination by experts	In accordance with patient's health care needs			

38 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. However, the Hospital management intends to increase availability and frequency of these activities, in accordance with the CPT standards.

39 The CPT standard is that patients, whose health allows for it, can have unrestricted daily access to fresh air (which requires safe exercise yards with appropriate supervision), they need to have access to open air exercise daily – with the apporpriate shelter for inclement weather and appropriate warm clothes/footwear provided for the patients. The Hospital management works towards attaining this standard.

40 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for open type visits. Regardless of the pre-assigned visit days as per House Rules, if the family or a lawyer visits the patient another day, the doctor can approve the visit.

41 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for phone calls, the length thereof is not limited. The doctor can suspend phone calls for up to a month the most if they are harmful for the patient's health. Regardless of the pre-assigned phone call days as per House Rules, if the patient needs to call the family of lawyer another day, the doctor can approve the phone call.

42 The Institute invites religious dignitaries as needed/wished for by the patient.

43 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. This service is provided only by a qualified hairdresser. Regardless of the pre-assigned days as per House Rules, if the patient wishes to shave (his wish or the doctor's recommendation) another day, the doctor can approve this.

EXAMPLE OF A DAILY TREATMENT SCHEDULE FOR JUVENILE PATIENTS	
TIME	**ACTIVITIES**
06:30-07:05	*Morning wake- up roll call*
07:05-08:00	*Morning personal hygiene, room tidying*
08:00-08:15	*Breakfast*
08:15-09:00	*Administering morning therapy, BP and temperature taking…*
09:00-10:00	*Therapy session with a psychologist, psychiatrist*
10:00-11:00	*Activities in the rehabilitation/resocialisation ward- Creative workshop*
11:00-12:00	*Special educator and pedagogue (school activities and duties)*
12:00-12:30	*Lunch*
12:30-13:30	*Daily exercise-walk*[44]
13:30-14:00	*Administering afternoon therapy*
14:00-17:00	*Afternoon break (free time for relaxation and rest)*
17:30-18:00	*Dinner*
18:00-20:30	*Free time (school activities, time for personal activities, reading, social games or socializing)*
20:30-21:00	*Administering evening therapy*
21:00-22:00	*Getting ready for bed, personal hygiene*
22:00	Sleep and night rest

Note: This example is just an illustration and can be adapted to the juveniles' specific needs and requirements. Additionally, the schedule may vary depending on the therapeutic plans and juveniles' individual needs and their interests.

44 The Rulebook on House Rules and the CPT standard specify that activities out in the open can be organised in the morning hours as well, provided material and technical conditions are met. The Hospital management works towards implementing this standard.

Protocols for preparing juvenile patients' release - pre-release programme

The juvenile patients' release plan includes several key steps and factors.

Factors:

- the special role of family, foster family and guardians,
- training for independent living,
- professional training,
- continuation of education.

Steps:

- rehabilitation as a recovery process. Therapeutic programmes for rehabilitating juvenile patients include individual therapy, group therapy, family therapy, art therapy, behavioural therapy and other therapeutic modalities. An important part of rehabilitating juvenile patients is the provision of educational opportunities. This may involve continuing education in the Forensic Institute, organising special educational programmes or collaborating with the schools outside. The goal is to ensure that patients acquire education and qualifications that will help them in their future.

  The therapeutic goal is to help patients understand and cope with their problems, develop positive skills and change their destructive behaviour patterns.
- resocialisation as a process of returning to society. Various programmes and activities lead to their reintegration in society: job training, financial literacy, time management, household skills, social skills and other practical skills necessary for everyday life. The goal is to ensure that patients are independent and capable of living outside the Institute.

The rehabilitation plan is regularly evaluated to assess patients' progress. Evaluation is conducted by monitoring the achievement of goals and progress in various areas covered by the plan. The professional team uses objective measures and assessment methods to obtain relevant information about patients' progress. This evaluation also enables patients to be aware of their progress and motivates them for further development.

On the other hand, the resocialisation plan requires collaboration and information exchange with community services that monitor juveniles after discharge from the Forensic Institute. Continuous support is a key element in the discharge plan for juvenile patients and it is the only guarantee of their successful integration in the community and maintaining positive changes in the juveniles' lives.

Continuous support may include:

1. *Monitoring and supervision*: Monitoring of the juvenile patients' progress after discharge is carried out by the relevant institutions (Centre for Mental Health and Centre for Social Work) to ensure compliance with the discharge plan and to prevent relapse into problematic behaviour. This may involve regular meetings, check-ups and testing to ensure that juvenile patients stay on the right track.
2. *Counselling and therapy:* Juvenile patients have access to individual or group counselling and therapy to address emotional, mental and social challenges. This may include anger management therapy, stress management, development of social skills, etc.
3. *Access to resources and support network:* Juvenile patients should be informed about available resources and support network in the community. This may include organisations that provide housing assistance, financial support, educational programmes or other services that may be beneficial for their reintegration.

Example of a one-month pre-release programme for juveniles[45]

Time period	Individual sessions	Group sessions	Joint sessions	Evaluation
First week	Motivational interviews	Preventing anti-social behaviour	Residential accommodation	
Second week		Emotions regulation	Education and professional training	
Third week		Social skills	Avoiding criminal milieu	
Fourth week		Problem solving	Free time	

45 For more detailed description of the structure and goals of the pre-discharge programme see page 16 of this resource manual.

Complaints

Juveniles have the right to file a complaint, same as any other category of patients.

A complaint can be:

- regular – referring to daily issues in the work of the Forensic hospital, directly falling into the competence of staff (for ex., participation in activities, etc)
- confidential – complaints againt staff or other patients, compising sensitive information (for ex., referring to the patient's health condition or her/his family), requiring special and confidential processing
- health-related – confidential complaints requiring specific knowledge and expertise of the person dealing with the complaint (for ex., medical assessment and decisions, etc).
- Complaints against the director of the Forensic Hospital – complaints against what the director has done/failed to do, decide, etc.

The complaints system (filing and dealing with complaints) is explained in detail in the *„Protocols for treatment of mentally challenged offenders in forensic facilities".*[46]

46 Joint Programme between European Union/ Council of Europe Horizontal Facility forWestern Balkans and Turkiye, 2016-2019

Checklist for the potential human rights violations – juveniles

The human rights of juveniles in conflict with the law may be violated by:

- sharing personal information about their health or criminal offence committed
- failure to collaborate with their family or guardians in the resocialisation process
- lack of purposeful and educational activities when planning individual treatment plans for juveniles
- inappropriate use of means of control and restraint, e.g. for the purpose of punishment
- inadequate staff approach or insufficient training to work with juveniles.

The rights protected by the European Convention on Human Rights, are:

- Prohibition of torture according to Article 3 of the Convention
- Right to liberty and security according to Article 5 of the Convention
- Right to respect for private and family life according to Article 8 of the Convention
- Right to freedom of thought, conscience and religion according to Article 9 of the Convention
- Right to prohibition of discrimination according to Article 14 of the Convention

Women

Women

Are a group of patients who have additional and specific needs and can be especially vulnerable to violence (physical and sexual) and many have had past traumatic experiences, often involving men. Also, they encounter numerous challenges associated with pregnancy and motherhood, which in the overall affects their health condition.

Statistically speaking, women with mental illnesses are less prone to committing criminal offences than men. This is confirmed by the fact that female patients comprise around 1/10 of hospitalised patients at the Forensic Institute.

Characteristics and specificities of female patients

Some of the key factors to consider when working with female patients compared to male patients include:

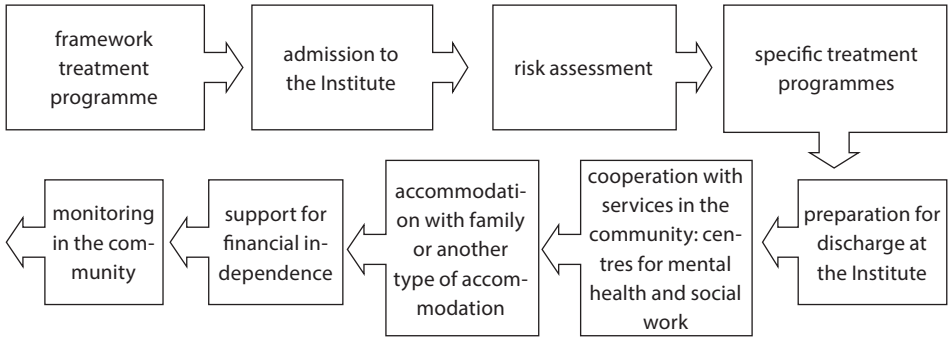
- *Trauma history*: Female patients often carry higher likelihood of having experienced physical, sexual or emotional abuse in the past. Therefore, it is important to approach diagnosis and treatment with special sensitivity to their traumatic experiences.
- *Health characteristics:* Women are more susceptible to certain mental disorders, such as affective, neurotic and eating disorders. It is important to conduct a comprehensive assessment of mental health for female patients to ensure appropriate treatment and support. Also, in terms of somatic issues, women should be provided with regular gynaecological check-ups to prevent cancer (cervical and breast cancer).
- *Motherhood*: Many female patients are mothers. Providing support and resources to maintain relationships with their children, as well as offering opportunities to develop parenting skills, can be crucial for their rehabilitation and resocialisation.
- *Social support*: Women often rely on social support and network connections. Therefore, it is important to ensure access to family support, therapy and rehabilitation to strengthen their social ties and connection with the outside world.

The most common causes and types of criminal offences committed by female patients in the Forensic Institute

• domestic violence • economic dependence/deprivation • lack of education	• obstructing an official in performing duties, • falsification (counterfeiting medical prescriptions for ex.), • a large number of petty or grand thefts and related criminal offences aimed at obtaining money to buy drugs, • attempted murder or murder, • infanticide.

Framework treatment programme for female patients

The framework treatment programme workflow for female patients



Admission protocols for female patients

1. Admission protocols for female patients are laid out in the later parts of this resource manual.[47]
2. Security check and search[48] are aligned with the protocols, while an absolute imperative is that these tasks are performed by persons of the same gender, i.e. by female staff.

   This is important for protection from abuse, the right prescribed in Article 3 of the ECHR. It is also important for protecting the staff from potential later allegations of abuse that may be made by female patients, their relatives or their lawyers.
3. The duty doctor takes over the patient after the patient's search[49] and search of her/his belongings. The doctor examines the patient (physical, neurological and psychiatric assessment), which s/he then documents in the written form, entering the initial diagnosis and the initial pharmacotherapy, at the same time also informing the patient about her/his actions.

   It is important to inform the patient about his diagnosis and therapy without delay, to protect his right to personal and family life[50].
4. The medical or support staff requests patients to urinate, if they can, to perform a 10-panel drug test on psychoactive substances on the spot. The process is supervised by the same sex as the patient support staff. This test only detects the presence of any of 10 psychoactive substances, without determining their concentration. If patients cannot urinate now, they are tested in the ward, after the admission is completed.

   It is important that the female patient gives an informed consent to enable the best possible treatment and protect the female patient from the violation of ECHR's Art 3.
5. The treatment agreement is a written document signed by the patient and her doctor. The agreement includes presentation of the patient's circumstances, ie. legal decision based on which the patient was referred to the treatment, Rulebook on House Rules, but also an agreement between the doctor and the

47 Tasks and role of the security service in implementing specific treatment programmes for vulnerable categories of forensic patients in the Forensic Hospital.

48 "Protocols for treatment of mentally challenged dealing with forensic offenders in forensic facilities", Joint EU/CoE Programme Horizontal Facility for the Western Balakans and Turkiye, 2016-2019.

49 Based on the procedures laid out in the "Protocols for treatment of mentally challenged offenders in forensic facilities" (pg 10), Joint EU/CoE Programme Horizontal Facility for Western Balks and Turkiye 2016-2019.

50 ECHR as the CoE core instrument for the protection of citizens' and human rights does not guarantee the right to health care protection. However, ECtHR interprets the Convention more widely, and within the context of Art 2, 3 and 8, it gives certain indications that it could start dealing with the issue of health care. As opposed to the Convention, the European Social Charter guarantees the right to health care in Art 11 and regulates it in great detail.

patient regarding implementation of treatment in the Hospital (determining therapy, consenting to diagnostical procedures), By accepting treatment, the patient creates a therapeutic agreement with her doctor and accepts responsibility for her recovery. The patient is given a brochure[51] through which she can inform herself about the functioning of the Hospital and its wards, as well as her rights.

If the patient does not immediately sign the treatment agreement due to her actual psychological condition, the doctor explains its contents again, once the patient calms down and feels better. The patient gives her written consent to the agreement therefore later.

When a patient refuses to consent to treatment, if they have guardians he can give consent or alternatively, other legal safeguards apply[52]."

The patient's informed consent is important to enable the most efficient treatment and to protect the patient form the possible violation of Art 3 of the ECHR.

6. Female patients are accommodated in the female ward, with only female medical technicians and care female staff (female support staff) caring for them. Their personal belongings are deposited based on the same principles.

Besides potentially improving personal safety of female patients, this also enables privacy and dignity of female patients, ie. Protection of the right to family and personal life (Art 8 ECHR), as well as personalisation of space. Personalisation of space in which female patients are accommodated is one of the frequent CPT recommendations to the BiH authorities.[53]

51 Based on the CPT recommendations.

52 In CPT terms, these safeguards would require an assessment by an independent psychiatrist, so as to agree to the proposed forced involuntary treatment (which is deemed by the CPT to be different to forced hospitalisation).

53 (CPT/Inf (2021) 21; CPT/Inf (2016) 17)

Risk assessment protocols for female patients

1. Risk assessment involves assessing the risk of self-harm, suicidality, aggression, gathering information about previous treatment or hospitalisation and the patient's attitude towards treatment. This assessment is carried out by multidisciplinary team[54] comprising a psychiatrist, psychologist, social worker and work-occupational therapist.

   The multidisciplinary nature of the team implies that different types of needs that female patients have are considered when tailoring an individual treatment plan. This enables a comprehensive approach to treatment.

2. During the assessment, special attention is paid to assessing the risk of suicide, especially self-harming tendencies, as female patients are more prone to self-harm. This is supported by the research indicating that men are more likely to commit suicide, while women more frequently attempt it.
3. The type of treatment depends upon the patient's actual/current clinical status, her own insight into the situation and how critical it is in terms of her actions, wishes and motives to undergo treatment, the level of her cooperation with the staff, socio-economic status, support from the family and local community.
4. Information about the comprehensive risk assessment (high, medium, low - with explanations of each category) is entered into the Risk Assessment Form. Information about the level of risk that can be shared with the security staff are entered in a separate form.
5. Means of restraint are applied only on the basis of the completed risk assessment and in accordance with the core principles for their use and safeguards mentioned in the separate part of this manual.[55]

   Individual treatment plan is drawn for each patient separately based on the above information. The multidisciplinary team (including a psychologist) meets regularly to exchange information and discuss patient's needs and therapeutic progress. Individual medical files contain all the findings/notes on the patient's mental and somatic health and their treatment.

54 For more details see the manual "Roadmap for the forensic patients' care- from admission to release", Joint EU/CoE Programme Horizontal Facility for Western Balkans and Turkiye, 2019-2022.

55 Standards of the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment - CPT

Specific/individual treatment programmes – therapeutic approach adapted to female patients

Based on the risk assessment results, individual treatment plan draft considers specific needs of female population. These specificities relate to:

1. Ensuring trauma-informed approach in therapy and treatment, paying special attention to women's traumatic experiences, past violence and abuse and other sensitive issues.
2. Assessment of reproductive health, including menstrual cycles, contraceptive use and potential pregnancy and needs for cervical and breast screening.
3. Psychoeducation about mental health, diagnosis and treatment to enable female patients to understand their own condition and actively participate in treatment. Mental state is assessed with the special focus on disorders such as depression, anxiety, eating disorders and other mental disorders that are more common for women.
4. Focusing on processing traumatic experiences, developing emotional skills, building self-confidence and empowerment.
5. Providing support in maintaining contact with family, especially maintaining relationships with children, including visits and resources for developing parenting skills. In this regard, the multidisciplinary team can be particularly helpful by offering solutions without insisting on choosing a specific one, thereby assisting in harmonising dysfunctional family dynamics.
6. Within occupational therapy, besides activities involving traditional female tasks (such as cooking, knitting, gardening, etc.), female patients are encouraged to engage in other activities that strengthen their independence and self-confidence. Primarily, they are encouraged to participate in physical activities through various sports to achieve balance in psychosomatic health. Additionally, to the extent possible, they are encouraged to acquire new skills to attain a certain level of economic independence.

SPECIFIC TREATMENT PROGRAMME FOR FEMALE PATIENTS					
Type of activity	**Detailed description of activity**	**Monthly overview of patient activities**			
		1st week	**2nd week**	**3rd week**	**4th week**
Ind. therapy	Psychiatrist/Psychologist	1x	1x	1x	1x
Group therapy	In occupational therapy, in the presence of a work-occupational therapist	1x	/	1x	/
Therapeutic community	In the ward, in the presence of multidisciplinary team	1x	1x	1x	1x
Rounds	In the ward, in the presence of multidisciplinary team	1x	1x	1x	1x
Creative workshop	Music therapy, art therapy, librarianship, etc.	3x	3x	3x	3x
Recreational therapy[56]	Sport activities in the gym	2x	2x	2x	2x
Leisure activities[57]	A walk on the grounds of the Institute	Daily, weather permitting			
Visits[58]	Lawyer, family, etc.	2x	2x	2x	2x
Phone calls[59]	Lawyer, family	3x	3x	3x	3x
Religious needs[60]	Friday, Saturday or Sunday depending on religious affiliation	1x	1x	1x	1x
Hair salon[61]	Haircut, hair colouring	1x	1x	1x	1x
Intimate visits[62]	Spouse or common-law partner	Once a month			
Escort to external institutions	Bank, hospital and other health facilities, municipality, Institute for expert analysis of med. documentation and other institutions	In accordance with the health, social, judicial procedure and financial needs of the patient			
Monitoring in the Institute	Laboratory analyses, examination by a consulting specialist, examination by experts	In accordance with the patient's health care needs			

56 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. However, the Hospital management intends to increase availability and frequency of these activities, in accordance with the CPT standards.

57 The CPT standard is that patients, whose health allows, can have unrestricted daily access to fresh air (which requires safe exercise yards with appropriate supervision), they need to have access to open air exercise daily – with the apporpriate shelter for inclement weather and appropriate warm clothes/footwear provided for the patients. The Hospital management works on attaining this standard.

58 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for open type visits. Regardless of the pre-assigned visit days as per House Rules, if family or a lawyer visits the patient another day, the doctor can approve the visit.

59 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for phone calls, the length thereof is not limited. The doctor can suspend phone calls for up to a month the most if they are harmful for the patient's health. Regardless of the pre-assigned phone call days as per House Rules, if the patient needs to call family or a lawyer another day, the doctor can approve the phone call.

60 The Institute invites religious dignitaries as needed/wished for by the patient.

61 The hairdresser services for female patients are provided on as needed basis, without restrictions.

62 Unlimited in length, the patients do not pay for this.

EXAMPLE OF A DAILY TREATMENT SCHEDULE FOR FEMALE PATIENTS	
TIME	**ACTIVITIES**
06:30-07:05	*Morning wake-up roll call*
07:05-08:00	*Morning personal hygiene, room tidying*
08:00-08:15	*Breakfast*
08:15-09:00	*Administering of morning therapy, BP and temperature taking...*
09:00-10:00	*Therapy session with a psychologist, psychiatrist*
10:00-11:00	*Activities in the rehabilitation/resocialisation ward-Recreational therapy (gym)*
11:00-12:00	*Group therapy*
12:00-12:30	*Lunch*
13:30-14:00	*Administering afternoon therapy*
14:00-15:00	*Afternoon break (free time for relaxation and rest)*
15:00-16:00	*Activities in the rehabilitation/resocialization ward- Creative workshop (knitting, cooking...)*
16:00-17:00	*Psycho-education*
17:00-18:00	*Outdoor activities[63] – walking, daily exercise out in the open*
17:30-18:00	*Dinner*
18:00-20:30	*Free time - time for personal activities, reading, social games or socializing*
20:30-21:00	*Administering evening therapy*
21:00-22:00	*Getting ready for bed, personal hygiene*
22:00	Sleep and night rest

Note: This daily treatment schedule is just an example and should be tailored to individual needs and preferences of each patient in the Institute. Furthermore, including additional activities such as art therapy, group exercises or confidence-building, can be beneficial to the treatment of women.

63 The House Rules/Rulebook on House Rules of the Institute, as well as the CPT standards, specify that activities out in the open can be organised in the morning hours as well, if technically possible. The Institute's management works towards enabling these options.

Protocols for preparing female patients' release – pre-release programme

It is crucially important to apply approach that respects and supports the protection and promotion of women's health, leading to better rehabilitation and reintegration of women after release from the outset of hospitalisation.

Gender-sensitive training for the staff involved in the treatment of female patients must consider their specific roles and needs. It is particularly important for female patients to master psychotherapeutic techniques for stress management and emotional control to effectively respond to traumatic experiences they are prone to experience. This ensures a higher likelihood of preventing relapse of mental illness and facilitates smoother, safer and more sustainable integration in the family and local community.

Example of a one-month pre-release programme for female patients[64]

Time period	Individual sessions	Group sessions	Joint sessions	Evaluation
First week	Motivational interview	Preventing antisocial behaviour	Residential accommodation	
Second week		Emotions regulation	Money/financial independence	
Third week		Social skills	Avoiding criminal milieu	
Fourth week		Problem solving	Health	

64 For detailed description of the structure and goals of the pre-release programme see page 16 of this manual.

Complaints

Female patients have the right to file a complaint, same as any other category of patients.

A complaint can be:

- regular – referring to daily issues in the work of the Forensic hospital, directly falling into the competence of staff (for ex., participation in activities, etc)
- confidential – complaints againt staff or other patients, compising sensitive information (for ex., referring to the patient's health condition or her/his family), requiring special and confidential processing
- health-related – confidential complaints requiring specific knowledge and expertise of the person dealing with the complaint (for ex., medical assessment and decisions, etc).
- Complaints against the director of the Forensic Hospital – complaint against what the director has done/failed to do, decide, etc.

The complaints system (filing and dealing with complaints) is explained in detail in the *„Protocols for treatment of mentally challenged offenders in forensic facilities"*.[65]

65 Joint Programme between EU/CoE Horizontal Facility for the Western Balkans and Turkiye, 2016-2019

Checklist for the potential human rights violations for female patients

The possible human rights violations specific to women are:

- failure to address specific healthcare needs of female population
- standardisation of purposeful activities offered to women in individual treatment plans (e.g., insisting on "women's tasks/activities")
- inappropriate use of restraint measures
- failure to offer the opportunity for additional contact(s) with family, especially children
- Not addressing specific somatic healthcare needs

The rights that may be violated in this case, which are protected by the ECHR, are:

- Prohibition of torture according to Article 3 of the Convention
- Right to liberty and security according to Article 5 of the Convention
- Right to respect for private and family life according to Article 8 of the Convention
- Right to freedom of thought, conscience and religion according to Article 9 of the Convention
- Right to prohibition of discrimination according to Article 14 of the Convention

Older Age patients

Older age patients

Persons over the age of 65.

According to the World Health Organization (WHO) old age is classified into:

1. early old age (65-74 years)
2. middle old age (75-84 years)
3. late old age (over 85 years)

This classification is often applied in gerontological public analyses to determine, study or monitor healthcare needs and functional abilities of elderly persons.

The most common causes and types of criminal offences committed by older age patients in the Forensic Institute

• feeling lonely • economic situation • domestic violence • life dissatisfaction	• domestic violence • attempted murder or murder • theft • arson • sexual abuse of children

Specific challenges in working with older age patients

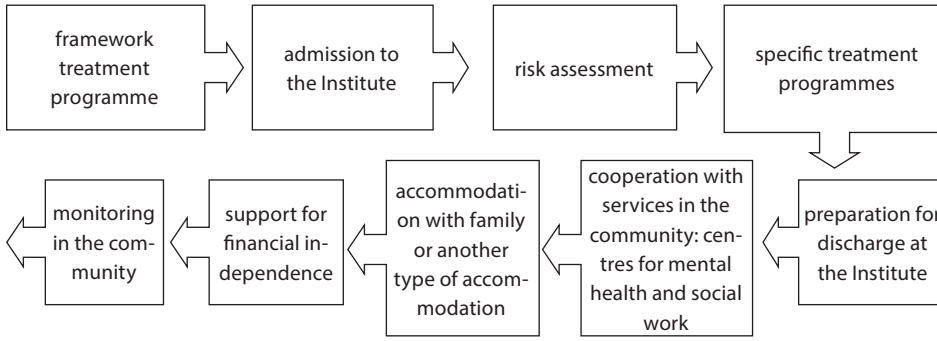
1. *Physical health:* Older age patients often have various medical issues, chronic somatic illnesses and mobility issues that can affect their mental health. It is important to ensure adequate medical care and collaboration with other experts to ensure comprehensive healthcare.
2. *Mental health:* Elderly patients often experience difficulties with cognitive functions (e.g., dementia or other neurocognitive disorders). This can affect their ability to participate in therapy, requiring adjustments to therapeutic approaches and the use of strategies adapted to their cognitive abilities.
3. *Social support:* Older age patients often have limited social networks and support. It is important to provide support in maintaining connections with family and friends, as well as to offer opportunities for social interactions in the Forensic Institute.

Framework treatment programme for older age patients

Guidelines for working with older age patients

1. *Individual treatment:* It is important to tailor treatment and therapeutic interventions according to their individual needs, abilities and goals. This may involve adapting communication style, using visual aids and repeating information.
2. *Continuity of care:* Older age patients generally require longer-term care and specific treatments. It is important to ensure continuity, including monitoring and evaluating treatment, as well as collaborating with other experts.
3. *Specialised staff*: Working with older age patients requires expertise and staff sensitisation to the specific needs of this population.

The framework treatment programme workflow for older age patients



Admission protocols for older age patients

1. Admission protocols for older age patients are contained in an earlier manual and again in a separate part of this manual[66]. Additional attention is paid to the appropriate communication with elderly persons.

   It is important to be more patient with elderly persons and to communicate very clearly in a gentler manner to ensure that they do not feel humiliated or mistreated.

2. Security check and search are based on the protocols[67] with an absolute imperative being that these activities are carried out by persons of the same gender as the person being searched or checked.

   This is important for protection against abuse, the right prescribed in Article 3 of the ECHR. Additionally, it is crucially important for protecting staff from potential subsequent allegations of abuse that may be raised by patients, their relatives or their lawyers.

3. After completing security procedures, the on-duty doctor takes the anamnesis (heteroanamnesis) from the patient, determines what health issues and comorbidities the patient has, assesses the patient's physical condition, evaluates the ability to perform daily life activities (feeding, dressing, bathing), assesses sensory abilities (hearing, vision, etc.) and evaluates whether there are symptoms of geriatric syndrome "4N":[68] dementia, delirium, depression or tendency to falls. The doctor examines the patient (physical, neurological and psychiatric assessment), which is then documented in writing, the doctor adds the initial diagnosis and pharmacotherapy, at the same time informing the patient about this.

   It is important to inform the patient without delay about her/his diagnosis and therapy to protect her/his right to personal and family life.[69]

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66 Duties and role of the security staff in implementing specific treatment programmes for vulnerable categories of forensic patients in the Forensic Institute.

67 "Protocols for treatment of mentally challenged offenders in forensic facilites" Joint EU/CoE Programme Horizontal Facility for the Western Balkans and Turkiye, 2016-2019.

68 The "4N" are: immobility, dependence, instability and urinary incontinence. In geriatrics, there are four main multifactorial syndromes that specifically occur in elderly patients. These syndromes often occur together and can be the cause and consequence of other syndromes in geriatric patients. The leading four syndromes in geriatrics, common to many diseases occurring in older age, relate to immobility - geriatric immobilisation syndrome in elderly persons, followed by instability as the main cause of injuries and falls in older age, then dependence with an increasing prevalence of dementia and Alzheimer's disease in the oldest-old, and uncontrolled urination, i.e., urinary incontinence in older age patients.

69 Ibid.

4. The treatment agreement entails presentation of the patient's circumstances, i.e., legal acts by which the patient is referred for treatment, regulations regarding House Rules, as well as the agreement between the doctor and the patient regarding the implementation of treatment at the Forensic Institute (deciding on the therapy and consenting to diagnostic procedures). By accepting the treatment, patients form therapeutic alliance with the doctor and accept responsibility for their recovery. Patients are given a brochure[70] that provides information about the functioning of the Forensic Institute and their rights.

   If the patient does not sign the treatment agreement immediately due to her/his current psychological status (acute psychosis, poor psychosomatic condition, etc), the doctor explains everything again, once the patient calms down. The patient then signs the treatment agreement.

   When patient refuses to consent to treatment, for example when a guardian has been appointed to act on her/his behalf, the guardian gives consent or alternatively, other legal safeguards apply.[71]

   It is important that the patient gives her/his informed consent to enable the best possible treatment and protect the patient from possible violations of the ECHR's Art 3.

5. Elderly persons are accommodated in the separate ward, with men separated from women and accordingly, their personal belongings are also kept separately.

   This method of admission and accommodation ensures humane treatment and respect for the special needs that older age patients have, compared to the general population. Additionally, it protects, in the worst-case scenario, the right of elderly persons not to feel discriminated against, humiliated or abused. These rights are guaranteed under ECHR's Articles 3 and 14. Patient privacy, dignity and personalisation of space are particularly important for this group of patients, as in old age, both routine and the sense of belonging and personal safety are very important to them.

70 As per CPT recommendation.

71 In CPT terms, these guidelines would require an assessment by an independent psychiatrist, so as to agree to the proposed forced involuntary treatment (which is deemed by the CPT to be different to forced hospitalisation).

Risk assessment protocols for older age patients

1. Risk assessment involves assessment of the risk of self-harm, suicide, aggression, information about previous treatment or hospitalisation and patient's attitude towards treatment. This assessment is carried out by multidisciplinary team[72] comprising a psychiatrist, psychologist, social worker and work-occupational therapist.

   The patient's voluntary and informed consent to treatment makes the treatment more effective because the patient will be more interested in her/his own treatment and recovery.

2. Comprehensive assessment of the older age patients is based on a bio-psycho-social approach to elderly persons aimed at prevention, treatment and rehabilitation of older age patients, contributing thereby to timely and appropriate healthcare intervention. Hidden difficulties may be disclosed during comprehensive assessment of this category of patients. These findings can be useful later in the treatment when addressing the deterioration of the older age patients' state in crisis situations (e.g., family bereavement).

3. Although older age patients may appear to have reduced mobility or give the impression of physical weakness, risk assessment for their personal safety and general security of their environment is carried out with the same level of detail and thoroughness as for other patient categories.

   This is crucial for protecting the rights prescribed in ECHR's Article 3 which prohibits abuse, inhuman and degrading treatment either towards other patients or staff.

4. The choice of treatment depends on the patient's actual/current clinical status, her/his own insight into the situation and how critical it is in terms of her/his actions, wishes and motives to undergo treatment, the level of cooperation with staff, socio-economic status, support from family and local community.

5. Information about the comprehensive risk assessment (high, medium, low - with explanations of each category) is entered into the Risk Assessment Form. Information about the level of risk that can be shared with the security staff are entered in a separate form.

6. Means of restraint are applied only on the basis of the completed risk assessment and in accordance with the core principles for their use and safeguards mentioned in the separate part of this manual.[73]

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72 For more details see the manual "Roadmap for the forensic patients' care- from admission to release".

73 Standards of the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment - CPT

Individual treatment plan is drawn for each patient separately based on the above information. The multidisciplinary team (including a psychologist) meets regularly to exchange information and discuss patient's needs and therapeuetic progress. Individual medical files contain all the findings/notes on the patient's mental and somatic health and their treatment.

Specific/individual treatment programmes for older age patients

The elderly population suffers from a range of psychosomatic diseases that are treated with drug therapy, but it is necessary to rationalise the number of drugs to the lowest possible with known side effects.

The most common mental disorders	The most common somatic disorders
• depressive disorders	• malnutrition
• cognitive disorders	• decubitus
• anxiety disorders	• urinary incontinence
• somatoform disorders	• osteoporosis
• delusional disorders	• osteoporotic fractures

Doctors play a crucial role in reviewing and prescribing drug therapy for elderly persons with comorbidities. It is well-known that chronic diseases are more prevalent in the older population, and they often take more drugs than middle-aged persons. There are numerous specificities in prescribing drugs for older age patients, and there is great heterogeneity in how older persons react to drugs. Due to changes in pharmacokinetics in older age, there is a higher likelihood of reactions and sensitivity among older age patients to standard drug doses (typically administered to younger age groups), so lower doses of drugs are usually administered to elderly persons. Various factors (prolonged bed rest, dehydration, thyroid disease, among others) influence the alteration of pharmacokinetic parameters in older age.

Elderly persons are often hospitalised due to **polypragmasia**, drug side effects, and interactions between multiple drugs. It is known from clinical practice that drug side effects in elderly persons can manifest as confusion, nausea, depression, loss of appetite, etc.

Knowing that this group of patients is more prone to different somatic disorders (listed in the above table), special efforts will be made to ensure patients, when required, receive assisstance with feeding (including solid food), ripple mattresses and turning procedures are followed to avoid decubitus, incontinence pads/catheterisation is applied when required and efforts are made to avoid falls (& thus osteoporotic fractures). This need for drug therapy is well balanced with purposeful activities, at least in patients who are sufficiently mobile.

SPECIFIC TREATMENT PROGRAMME FOR OLDER AGE PATIENTS					
Type of activity	**Detailed description of activities**	**Monthly overview of patient activities**			
		1st week	**2nd week**	**3rd week**	**4th week**
Ind. therapy	Psychiatrist/Psychologist	1x	1x	1x	1x
Group therapy	In occupational therapy, in presence of an occupational therapist	1x	1x	1x	1x
Therapeutic community	In the ward, with multidisciplinary team	1x	1x	1x	1x
Rounds	In the ward, with multidisciplinary team	1x	1x	1x	1x
Creative workshop	Music therapy, art therapy, bibliotherapy etc.	3x	3x	3x	3x
Recreational therapy[74]	Sport activities in the gym	In accordance with the MDT's assessment			
Leisure activities[75]	A walk, out on the grounds of the Institute	Daily, weather permitting			
Visits[75]	Lawyer, family, etc.	2x	2x	2x	2x
Phone contacts[77]	Lawyer, family	3x	3x	3x	3x
Religious needs[78]	Friday, Saturday or Sunday depending on religious affiliation	1x	1x	1x	1x
Intimate visits[79]	Spouse or common-law partner	Once a month			
Escort to external institutions	Bank, hospital and other health facilities, municipality, Institute for expert analysis of med. documentation and other institutions	In accordance with the health, social, judicial procedure needs and financial needs of the patient			
Monitoring in the Institute	Hair beauty parlour, laboratory, restaurant, specialist, experts	In accordance with the patient's health care needs			

74 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. However, the Hospital management intends to increase availability and frequency of these activities, in accordance with the CPT standards. The exercise programme in the fitness room is adjusted with the physiotherapist present in the room, based on the physical medicine specialist doctor's recommendation.

75 The CPT standard is that patients, whose health allows for it, can have unrestricted daily access to fresh air (which requires safe exercise yards with appropriate supervision), they need to have access to open air exercise daily – with the apporpriate shelter for inclement weather and appropriate warm clothes/footwear provided for the patients. The Hospital management works towards attaining this standard.

76 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for open type visits. Regardless of the pre-assigned visit days as per House Rules, if family or a lawyer visits the patient another day, the doctor can approve the visit.

77 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for phone calls, the length thereof is not limited. The doctor can suspend phone calls for up to a month the most if they are harmful for the patient's health. Regardless of the pre-assigned phone call days as per House Rules, if the patient needs to call family or a awyer anogther day, the doctor can approve the phone call.

78 The Institute invites religious dignitaries as needed/wished for by the patient.

79 Duration not limited, free of charge for the patients.

EXAMPLE OF A DAILY TREATMENT SCHEDULE FOR OLDER AGE PATIENTS	
TIME	**ACTIVITIES**
06:30-07:05	*Morning wake-up roll call*
07:05-08:00	*Help with the morning personal hygiene and room tidying*
08:00-08:15	*Breakfast*
08:15-09:00	*Administering morning therapy, BP and temperature taking...*
09:00-10:00	*Group therapy*
10:00-11:00	*Activities in the rehabilitation/resocialisation ward- Creative workshop*
11:00-12:00	*Therapy session with a psychologist, psychiatrist*
12:00-12:30	*Lunch*
13:30-14:00	*Administering afternoon therapy*
14:00-16:00	*Afternoon break (leisure time for relaxation and rest)*
16:00-17:00	*Outdoor activities*[80] *- exercising, walking outdoor*s
17:30-18:00	*Dinner*
18:00-20:30	*Free time - time for personal activities, reading, chess, board games or socializing*
20:30-21:00	*Administering evening therapy*
21:00-22:00	*Getting ready for bed, personal hygiene*
22:00	Sleep and night rest

Note: This is just an example, individual treatment plan should be adapted to the specific needs and goals of each patient and the schedule of activities at the Institute. Additionally, depending on the individual needs of patients, it is possible to add or remove certain activities, which is done by the multidisciplinary team to ensure the best possible treatment for patients.

80 Joint Programme between the European Union/Council of Europe Horizontal Facility for the Western Balkans and Turkiye, 2016-2019.

Protocols for preparing older age patients' release – pre-release programme

Rehabilitation and resocialisation play an important role in treatment of older age patients at the Institute for Forensic Psychiatry. This includes development of skills to cope with challenges, stress, improvement of self-control and making healthy-choice decisions. Additionally, support is available to assist their return to society and reintegration in community.

Continuous support helps maintain recovery and assists patients in living a satisfying and productive life. Social support for elderly persons plays a crucial role in reducing stress, leading to better physical health and psychological well-being, thereby prolonging their life. Social support can decrease the likelihood of stressful events, modify the perception of stressors and reduce potential for stress.

Example of a one-month pre-release programme for older age patients[81]

Time period	Individual sessions	Group sessions	Joint sessions	Evaluation
First week	Motivational interview	Preventing antisocial behaviour	Residential accommodation	
Second week		Emotions regulation	Free time	
Third week		Social skills	Agencies providing help and support	
Fourth week		Problem solving	Health	

81 For detailed description of the structure and goals of pre-release programme see page 16 of this manual.

Complaints

Older age patients have the right to file a complaint, same as any other category of patients.

A complaint can be:

- regular – referring to daily issues in the work of the Forensic hospital, directly falling into the competence of staff (for ex., participation in activities, etc)
- confidential – complaints againt staff or other patients, compising sensitive information (for ex., referring to the patient's health condition or her/his family), requiring special and confidential processing
- health-related – confidential complaint requiring specific knowledge and expertise of the person dealing with the complaint (for ex., medical assessment and decisions, etc).
- Complaints against the director of the Forensic Hospital – complaints against what the director has done/failed to do, decide, etc.

The complaints system (filing and dealing with complaints) is explained in detail in the *„Protocols for treatment of mentally challenged offenders in forensic facilities"*.[82]

82 Joint Programme between the European Union/Council of Europe Horizontal Facility for the Western Balkans and Turkiye, 2016-2019.

Checklist for the potential human rights violations for older age patients

Violations of older age patients' human rights include:

- failure to respond to the specific somatic and psychiatric healthcare needs of the older age population
- typification of purposeful activities offered to elderly persons in the individual treatment plan (e.g. insisting on activities for which they do not have the physical capacity because the institution "has no other options")
- lack of adaptation to sensory deficits found in older adults
- lack of adaptation of the environment resulting in falls or other injuries
- inappropriate use of restraint measures
- failure to offer the possibility of additional contacts with family

The rights protected by the ECHR, are:

- Prohibition of torture according to Article 3 of the Convention
- Right to liberty and security according to Article 5 of the Convention
- Right to respect for private and family life according to Article 8 of the Convention
- Right to freedom of thought, conscience and religion according to Article 9 of the Convention
- Right to prohibition of discrimination according to Article 14 of the Convention

End of Life

When older age patients reach the end of their lives due to a terminal diagnosis such as cancer or Alzheimer disease, the doctor issues an instruction to transfer the patient to an appropriate care institution where the patient can receive the best possible palliative care and live the rest of his life in a dignified manner.

The doctor asks the court to suspend the treatment measure.

The patient is escorted to the care institution by his family and centre for social welfare.

Patients with physical difficulties and difficulties with mental development

Persons with physical difficulties and difficulties with mental development

encompass different groups, including persons with intellectual and developmental disabilities and persons with physical disabilities. They may experience additional physical and psychological challenges in adapting to life in the Forensic Institute, participating in therapy and rehabilitation and integrating in the community after release from the forensic facility.

The specific needs of this category of population include:

1. *Physical needs:* Persons with physical disabilities may require adapted spaces and mobility aids.
2. *Cognitive needs:* Persons with intellectual or developmental disabilities may require special communication methods, tailored therapies, adapted education and support in daily activities.
3. *Social needs:* Persons with physical difficulties and difficulties with mental development may have limited social skills and require support in building relationships and integrating into the community.
4. *Psychological needs:* Persons with mental disorders require individualised therapeutic approaches, as well as support.

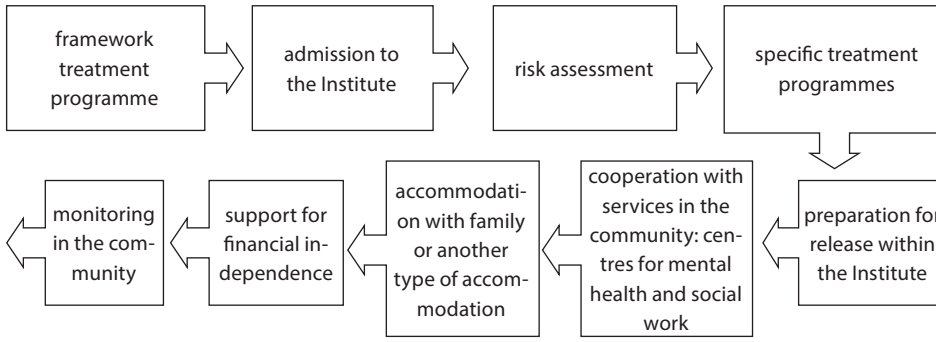
Special physical or psychological needs as a factor in committing a criminal offence

Considering the insufficient psychosomatic functioning of persons with physical difficulties and difficulties with mental disorders, they are more prone to committing some categories of criminal offences. For example, persons with intellectual disability in the Institute more often commit offences/acts of arson, rape and other illegal sexual acts.

The most common causes and types of criminal offences committed by patients with physical difficulties and difficulties with mental development in the Forensic Institute

• physical disability • intellectual and developmental difficulties • learning problems	• domestic violence, • many petty or grand thefts, • arson, • rape and other illegal sexual acts, • attempted murder or murder.

Framework treatment programme for patients with physical difficulties and difficulties with mental development



The framewok treatment programme workflow for patients with physical difficulties and difficulties with mental development

Persons with physical difficulties and difficulties with mental development need to be encouraged, motivated and supported. Resocialisation of these persons is crucial for the progress in recovery after rehabilitation.

Quality resocialisation can be achieved through inclusion in various activities, which will help them to function independently after leaving the facility and to become capable of engaging in work activities, to improve their quality of life and ensure that their life is lived to their full potential.

Continuous support from family, close friends and institutions that can provide specialised types of support is crucial for encouraging the independence of these persons.

Admission protocols for patients with physical difficulties and difficulties with mental development

1. Admission protocols for persons with physical difficulties and difficulties in mental development are laid out in an earlier manual and in later part of this manual.[83]

   It is important to be more patient and communicate in a gentler manner and with greater clarity, possibly using simpler language and explanations and repetitions if necessary (as some of them may have hearing impaired).

2. Security check and search are carried out based on the protocols[84] with an absolute imperative being that these procedures are carried out by persons of the same gender as the person being searched and checked.

   This is important for protection against abuse, the right prescribed in Article 3 of the ECHR. Additionally, it is crucial for protecting the staff from potential later allegations of abuse that may be made by patients, their relatives or lawyers.

3. After the patient has been security checked and searched,[85] together with her/his belongings, the medical staff or duty doctor takes over the patient and carries out physical, neurological and psychiatric examinations and assessments. It is of great importance to obtain a comprehensive medical history (heteroanamnesis) and perform a physical examination, comprising of:

   - determining patients' health problems,
   - assessing their ability to perform daily life activities (feeding, dressing, bathing, etc.),
   - examining sensory abilities of hearing and vision,
   - examining social factors (family relationships, patient support, financial resources, signs of neglect and rejection).

   In majority of cases these patients are alone on admission, not accompanied by family members. Hetero data are obtained though social anamnesis and additional phone calls with the family. This manner of collecting information is specifically important for patients with difficulties with mental development.

   On completion of the medical examination which is documented in writing, the doctor enters the initial diagnosis and the initial pharmacotherapy, at the same time informing the patient about it.

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83 Duties and the role of the security service in the implementation of specific treatment programmes for vulnerable categories of forensic patients at the Institute.

84 „Protocols for dealing with forensic offenders in forensic facilities", Joint EU/CoE Programme Horizontal Facility for Western Balkans and Turkey, 2016-2019

85 "Protocols for dealing with forensic patients in forensic facilites" Joint EU/CoE programme Horizontal Facility for Western Balkans and Turkey, 2016-2019

It is important to inform the patient about the diagnosis without delay and therapy to protect the right to family and personal life.

4. The treatment agreement is signed by the patient with physical difficulties and difficulties with mental development and the doctor. The treatment agreement comprises presentation of the circumstances, i.e., legal acts by which the patient is referred for treatment, regulations regarding house rules, as well as the agreement between the doctor and the patient regarding the implementation of treatment at the Forensic Institute (determined therapy and consenting to diagnostic procedures). By accepting the treatment, patients form a therapeutic alliance with the doctor and accept responsibility for their recovery. Patients receive a brochure providing information about the functioning of the Forensic Institute and how to exercise their rights.

   If the patient does not sign the treatment agreement immediately due to his current psychological status (acute psychosis, poor psychosomatic condition, etc), the doctor explains everything once again, after the patient has calmed down. The patient then signs the treatment agreement. If the patients have a legal representative or a guardian, this person also signs the agreement.

   Legal guardian must be appointed to act on behalf of persons who are mentally incompetent. The guardian is independent from the hospital (Institute), responsible, without conflict of interest and maintains regular contact with the patient, representing her/his needs and rights.

   It is important that the patient gives her/his informed consent to enable the most efficient treatment and protect the patient from possible violations of the ECHR's Art 3.[86]

5. Persons with physical difficulties and difficulties with mental development are accommodated in acute wards and separated based on their gender.[87]

6. Patients with physical difficulties and difficulties with mental development are assigned to rooms/dormitories that are more easily accessible or in wards/rooms with wheelchair-accessible facilities.

   This type of accommodation is important to protect the rights of persons with special needs from abuse, humiliation or inhumane treatment, in accordance with the ECHR's Article 3.

86 European Convention on Human Rights (ECHR) as the key instrument of the CoE for the protection of citizens' and political rights does not guarantee the right to health care. However, European Court for Human Rights interpretes rights form the Convention in wider sense. Therefore, within the context of Art 2, 3 and 8 of the Convention, it gives certain indications thatit could start also considering the issue of health care. Unlike the Connvention, the European Social Charter guarantees the right to health care in Art 11, elaborating it in detail.

87 The Institute's management is working towards aligning its practices with the CPT standards based on which patients with intelectual disabilities should not be accommodated or mixed with regular adult patients. They should be placed in separate units with specially trained staff, treatment programmes and the environment are specially adjusted and where such vulnerable patients must be protected from others.

Risk assessment protocols for patients with physical difficulties and difficulties with mental development

1. Risk assessment consists of the risk of self-harm, suicide, aggression, information about prior treatment or hospitalisation and patient's attitude toward treatment. This assessment is carried out by multidisciplinary team[88] comprising a psychiatrist, psychologist, social worker and work-occupational therapist.
2. Special attention in the risk assessment process is paid to potential aggressive outbursts, which are often a defence mechanism due to intellectual and developmental disabilities. Consequently, the patient's relationship with other patients is assessed and appropriate room and space in the ward for that particular patient (lower bed, rooms closer to the infirmary, etc.) is allocated.
3. Although persons with physical difficulties and difficulties with mental development may appear to have reduced mobility or give the impression of physical weakness or inability to understand conventional communication channels, risk assessment for their personal safety and safety of environment is done with the same level of detail and thoroughness as for other patient categories.

   This is important for protecting the right prescribed in the ECHR's Article 3 which prohibits abuse, inhuman and degrading treatment either towards other patients or towards the staff.
4. The choice of treatment depends on the patient's actual/current clinical status, her/his own insight into the situation and how critical it is in terms of patients's actions, wishes and motives to undergo treatment, the level of cooperation with staff, socio-economic status, support from the family and local community.
5. Information about the comprehensive risk assessment (high, medium, low - with explanations of each category) is entered in the Risk Assessment Form. Information about the level of risk that can be shared with the security staff are entered in a separate form.
6. Means of restraint are applied only on the basis of the completed risk assessment and in accordance with the core principles for their use and safeguards mentioned in the separate part of this manual.[89]

   Individual treatment plan is drawn for each patient separately based on the above information. The multidisciplinary team (including a psychologist) meets regularly to exchange information and discuss patient's needs and therapeuetic progress. Individual medical files contain all the findings/notes on the patient's mental and somatic health and their treatment.

88 For more details see the manual "Roadmap for the forensic patients' care- from admission to release", Joint EU/CoE Programme Horizontal Facility for the Western Balkans and Turkiye 2019-2022.

89 Standards of the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment or Punishment - CPT

Specific/individual treatment programmes for patients with physical difficulties and difficulties with mental development

Individual treatment plan for persons with physical difficulties and difficulties with mental development at the Institute for Forensic Psychiatry

1. Morning activities:

- Assistance with personal hygiene, dressing and breakfast, adapted to patient's needs.
- Therapeutic activities: individual or group therapies adapted to patient's specific needs.
- Physical exercises: exercises adapted to patient's needs, supervised by MDT.

2. Therapy sessions:

- Psychotherapy: individual sessions with a psychiatrist or psychologist to improve state of patient's mental health.
- Group therapies: participation in group therapy sessions to improve social interaction, communication skills and support among patients.

3. Educational activities:

- Workshops and lectures: participation in educational activities on various topics, such as stress management, understanding one's emotions, social skills and relapse prevention.
- Educational programmes: providing opportunities for education and acquiring new skills, such as reading, writing or mathematics.

4. Social activities:

- Recreation and leisure time: organising activities such as sports games, board games, art workshops, music therapy or social events to encourage social interaction and integration in the community.

5. Medical care:

- Regular check-ups and monitoring of the patient's health condition.
- Drugs management: proper dosage, monitoring side effects and adapting therapy according to the patient's needs. Depending on the patient's psychological status, the psychiatrist ordinates the necessary pharmacotherapy or decides on the chemical or mechanical restraint measures in case of need.

Patients with intelectual difficulties should only be treated with antipsychotic medicines if they are acutely psychotic, in minimum dosage and with limited duration.

Medical tranquilizers (chemical restraints) can be used only in exceptional cases and for the shortest periods of time when the patient is very aggitated and his behaviour represents a risk to her/himself or others.

6. Independence and planning for the future:

- Skills training for independence: learning skills such as cooking, keeping space clean and planning one's own schedule.

SPECIFIC TREATMENT PROGRAMME FOR PATIENTS WITH PHYSICAL DIFFICULTIES AND DIFFICULTIES WITH MENTAL DEVELOPMENT					
Type of activity	**Detailed description of activity**	**Monthly overview of the patient activities**			
		1st week	**2nd week**	**3rd week**	**4th week**
Ind. therapy	Psychiatrist/Psychologist	1x	1x	1x	1x
Special educator	Special education treatment	Once a week or more often in accordance with the assessment of the multidisciplinary team			
Group therapy	In occupational therapy, in presence of occupational therapist	1x	/	1x	/
Therapeutic community	In the ward, in presence of MDT	1x	1x	1x	1x
Rounds/visits	In the ward, in presence of MDT	1x	1x	1x	1x
Creative workshop	Music therapy, art therapy, bibliotherapy, etc.	3x	3x	3x	3x
Recreational therapy[90]	Sport activities in the gym	Depends on the type and severity of intellectual and developmental impairment/difficulties			
Leisure activities[91]	Daily walk in the Institute's exercise area	Daily, weather permitting			
Visits[92]	Lawyer, family, etc.	2x	2x	2x	2x
Phone calls[93]	Lawyer, family	3x	3x	3x	3x
Religious needs[94]	Friday, Saturday or Sunday, depending on religious affiliation	1x	1x	1x	1x
Hair salon[95]	Shaving, haircut, hair colouring	1x	1x	1x	1x
Intimate visits[96]	Spouse or common-law partner	Once a month (in accordance with MDT's assessment)			
Escort to external institutions	Bank, hospital and other health facilities, municipality, Institute for expert analysis of med. documentation, and other institutions	In accordance with the patient's health, social, judicial procedure needs and financial needs			
Monitoring in the Institute	Laboratory analyses, examination by a consulting specialist, examination by experts	In accordance with the patient's healthcare needs			

90 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. However, the Hospital management intends to increase availability and frequency of these activities, in accordance with the CPT standards.

91 The CPT standard is that patients, whose health allows for it, can have unrestricted daily access to fresh air (which requires safe exercise yards with appropriate supervision), they need to have access to open air exercise daily – with the appropriate shelter for inclement weather and appropriate warm clothes/footwear provided for the patients. The Hospital management works towards attaining this standard.

92 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for open type visits. Regardless of the pre-assigned visit days as per House Rules, if family of a lawyer visits the patient another day, the doctor can approve the visit.

93 Based on the legal provisions and due to available technical and material resources, this is currently limited and depends on the no. of patients, staff and wards. Each ward has specific days for phone calls, the length thereof is not limited. The doctor can suspend phone calls for up to a month the most if they are harmful for the patient's health. Regardless of the pre-assigned phone call days as per House Rules, if the patient needs to call family or a lawyer another day, the doctor can approve the phone call.

94 The Institute invites religious dignitaries as needed/wished for by the patient.

95 Based on the current legal provisions and due to technical and material shortages, this is limited in duration and depends on the number of patients, staff and wards. This service is provided in the Institute solely by qualified hairdresser. Irrespective of the days foreseen for shaving as per House Rules, the patients shave as needed (patient's wish or doctor's recommendation) also on other days, with doctor's approval.

96 Unlimited length, the patients do not pay for this.

EXAMPLE OF A DAILY TREATMENT SCHEDULE FOR PATIENTS WITH PHYSICAL DIFFICULTIES AND DIFFICULTIES WITH MENTAL DEVELOPMENT	
TIME	**ACTIVITIES**
06:30-07:05	*Morning wake-up roll call*
07:05-08:00	*Assistance with personal hygiene and room tidying*
08:00-08:15	*Breakfast*
08:15-09:00	*Administering morning therapy, BP and temperature taking...*
09:00-10:00	*Therapy session with a psychologist, psychiatrist*
10:00-11:00	*Activities in the rehabilitation/resocialisation ward-Recreational therapy*
11:00-12:00	*Special education programmes as part of treatment plan*
12:00-12:30	*Lunch*
12:30-13:30	*Spending time outdoors*[97]
13:30-14:00	*Administering afternoon therapy*
14:00-17:00	*Afternoon break (free time for relaxation and rest)*
17:00-18:00	*Skills training enabling independent life post-release*
18:00-18:30	*Dinner*
18:30-20:30	*Free time - time for personal activities, reading, social games or socializing*
20:30-21:00	*Administering evening therapy*
21:00-22:00	*Getting ready for bed, personal hygiene*
22:00	Sleep and night rest

Note: This is just an example and should be adapted to the specific needs and schedule of activities at the Institute. In addition, depending on patient's individual needs, it is possible to add or remove some activities.

97 Rulebook on the Institution's House Rules, as well as the CPT standards, specify that activities out in the open can be organised also in the morning hours, if technically possible. The Institute's management works towards attaining these standards.

Protocols for preparing patients with physical difficulties and difficulties with mental development for release – the pre-release programme

Example of a one-month pre-release programme for patients with physical difficulties and difficulties with mental development[98]

Time period	Individual sessions	Group sessions	Joint sessions	Evaluation
First week	Motivational interview		Residential accommodation	
Second week		Emotions regulation	Health	
Third week		Social skills	Money/personal finances	
Fourth week			Free time	

98 For detailed description of the structure and goals of pre-release programme see page 16 of this resource manual.

Complaints

Patients with physical difficulties and diffciulties with mental development have the right to file complaint, same as any other category of patients.

A complaint can be:

- regular – referring to daily issues in the work of the Forensic hospital, directly falling into the competence of staff (for ex., participation in activities, etc)
- confidential – complaints againt staff or other patients, compising sensitive information (for ex., referring to the patient's health condition or her/his family), requiring special and confidential processing
- health-related – confidential complaints requiring specific knowledge and expertise of the person dealing with the complaint (for ex., medical assessment and decisions, etc).
- Complaints against the director of the Forensic Hospital – complaint against what the director has done/failed to do, decide, etc.

The complaints system (filing and dealing with complaints) is explained in detail in *„Protocols for treatment of mentally challenged offenders in forensic facilities".*[99]

99 Joint EU/CoE Programme Horizontal Facility for the Western Balkans and Turkiye, 2016-2019.

Checklist for the potential human rights violations for patients with physical difficulties and difficulties with mental development

Human rights of persons with physical or mental development difficulties, as a category with additional vulnerability, may be violated by:

- failure to address the specific somatic and psychiatric/psychological healthcare needs of persons with physical disabilities
- standardisation of purposeful activities offered to patients with specific needs in the individual treatment plan (e.g., insisting on activities for which they do not have the physical capacity because the institution "has no other options")
- Not adapting to their communication abilities
- inappropriate use of restraint measures
- failure to offer the opportunity for additional contacts with family

The rights protected by the ECHR, are:

- Prohibition of torture according to Article 3 of the Convention
- Right to liberty and security according to Article 5 of the Convention
- Right to respect for private and family life according to Article 8 of the Convention
- Right to freedom of thought, conscience and religion according to Article 9 of the Convention
- Right to prohibition of discrimination according to Article 14 of the Convention

STANDARDS OF THE EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT

Individual treatment programmes

The CPT considers that the treatment of psychiatric patients should involve, in addition to appropriate medication and medical care, a wide range of therapeutic, rehabilitative and recreational activities. It should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient (taking into account the special needs of acute, long-term and forensic patients including, with respect to the last-mentioned, the need to reduce any risk they may pose), indicating the goals of treatment, the therapeutic means used and the staff member responsible. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should be involved in the drafting of their individual treatment plans and their subsequent modifications and informed of their therapeutic progress.

For those patients accommodated in the acute wards, the plan should address the patient's immediate needs and identify any risk factors as well as focusing on treatment objectives and how in broad terms these will be achieved. For patients placed in the rehabilitation wards, the plans should identify early warning signs of relapse and any known triggers, and an action plan that a patient and family members should take in response to relapse. The plan should also specify the follow-up care. For forensic psychiatric patients, the treatment should be aimed at both controlling the symptoms of the illness and reducing the risk of re-offending.

CPT/Inf(2021)21

Control and restraint safeguards

Principles to keep in mind when considering options for the use of means of control and restraint for juveniles

1. *Adapting approach:*

   The first step in controlling and restraining juveniles is to adapt the approach to their specific needs. Their age and level of development should be considered to determine the most appropriate method of control. Younger juveniles require a gentler approach, focusing on verbal communication and calming techniques, while older juveniles may be more aware and responsive to various interventions.

2. *Risk assessment:*

   In controlling and restraining juveniles, it is important to conduct risk assessment to ensure safety for everyone involved, including juveniles. The risk may vary depending on the situation, the nature of the problem, and the circumstances. Gathering information about past experiences of violence, aggression, or self-harm can help identify potential risk factors.

3. *Education and staff support:*

   The staff responsible for controlling and restraining juveniles must be properly trained in intervention techniques and situational awareness. They need to understand the specificities of juvenile age, emotional vulnerabilities, and the need to respect the rights and dignity of juveniles.

   Additionally, they should be aware of the psychological consequences for juveniles after being controlled and restrained and provide initial psychological support and guidance. After each control and restraint of juveniles, it is important to provide adequate psychological support from the psychologist of the Forensic Institute. Juveniles may experience various feelings, including inner turmoil, anger, or frustration.

   Providing a safe space to express these feelings, therapy, or counselling can help alleviate the emotional consequences arising from such situations.

Restraints in the psychiatric facilities for adults

Every psychiatric establishment should have a comprehensive, carefully developed policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential.

Such a policy should be aimed at preventing as far as possible the resort to means of restraint and should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated.

The policy should also contain sections on other important issues such as: staff training; recording; internal and external reporting mechanisms; debriefing; and complaints procedures.

Further, patients should be provided with relevant information on the establishment's restraint policy.

Every resort to means of restraint should always be expressly ordered by a doctor after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his/her approval.

To this end, the doctor should examine the patient concerned as soon as possible. No blanket authorisation should be accepted.

Excerpt from the CPT document "Means of restraint in psychiatric establishments for adults"

CPT/Inf(2017)6

The precepts be effectively implemented in practice at the Special Hospital for

Forensic Psychiatry in Sokolac

The CPT recommends that that these precepts be effectively implemented in practice at the Special Hospital for Forensic Psychiatry in Sokolac and at the Special Hospital for Psychiatry in Sokolac, as well as, as appropriate, in other psychiatric establishments.

In particular, steps should be taken in both establishments visited to ensure that:

- all instances of recourse to means of restraint (including chemical restraint) are registered in a dedicated register;
- patients subjected to mechanical restraint are subjected to continuous, direct and personal supervision by a qualified member of staff and are not mechanically restrained in view of other patients;
- staff are never assisted by other patients when applying means of restraint to a patient.

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DUTIES AND THE ROLE OF THE SECURITY SERVICE IN THE IMPLEMENTATION OF SPECIFIC TREATMENT PROGRAMMES FOR VULNERABLE CATEGORIES OF FORENSIC PATIENTS AT THE INSTITUTE

Admission

1. The patient's admission takes place at the Forensic Institute's entrance gate where her/his identity is established by checking the patient's documentation, the court order or director's decision issued based on the prison doctor's consent (for those referred from prisons).
2. The doctor checks the documents at the gate. In this case, the security officer follows the doctor's instructions.
3. The security officer verifies patient's identity based on a personal identification document with a photograph or by checking another public document. Alternatively, the patient's identity may be verified by a statement of another person whose identity was verified as previously described or through available records at the relevant institution. The statement form is included in Appendix 1 of this manual.
4. The statement from point 3 is signed by the officer who is handing over the person, the doctor who takes over the person and the security officer of the Forensic Institute. The statement is then shared with the director and archived in the patient's personal file.
5. Verification of identity may also involve verification of the patient's place of residence through contacts with the relevant institution (Civil Registry of the CIPS project). The head of security verifies this by submitting a written request to the relevant institution. The information obtained thereby is stored in the patient's file and constitutes personal data.

   It is important to accurately identify patient to be able to protect his right to private and family life (Article 8 of the ECHR), liberty and security of person (Article 5 of the ECHR).
6. Two security officers in the escort formation escort the patient to the admission clinic after the identity verification. The patient is searched by doing a pat-down on the surface of her/his body parts, clothing and belongings, all the while respecting his/her privacy. A detailed search of belongings takes place in the patient's presence and s/he countersigns receipt for the confiscated illicit/unauthorised items.

A separate search premise is secluded from the view of other staff and patients, as well as video surveillance, to protect from abuse (Article 3 of the ECHR) and to protect the right to private and family life (Article 8 of the ECHR). Two officers of the same sex as the patient carry out the search to protect the patient's dignity (see details in *"Protocols for treatment of mentally challenged offenders in forensic facility"*). Two officers carrying out the search is also a form of protection of the security officers from allegations of abuse (Article 3 of the ECHR). The search is carried out as per *"Protocols for dealing with forensic offenders in forensic facilities"*.

7. The public relations officer[100] takes the patient's photo (en face and profile photos) after the search and examination by the doctor. The photos are filed in the patient's medical history.

   To protect the right to private and family life, only the staff directly involved with the patient have access to these photos. Access is denied to third parties (Article 8 of the ECHR).

8. Security officers may physically restrain[101] patients in the forensic ward in exceptional and emergency cases. They may also assist colleagues in the forensic ward upon their request (medical and support staff).

9. Upon termination of the restraint measure, security officers who were physically restraining the patient immediately inform the doctor and the head of the security department verbally. A comprehensive and accurate written report is provided as soon as possible.

   Physical restraint must be proportional, gradual, lawful, of the shortest possible duration and must respect the pain threshold to protect the patient from abuse (Article 3 of the ECHR). Additionally, lawful conduct by security officers guarantees their protection against allegations of abuse, disciplinary action that the management may initiate against them and ultimately against criminal proceedings in court.

10. On doctor's order and when the patient's condition deteriorates, officers can postpone the search until further assessment and instructions from the doctor. The security officer escorts the patient to the ward where he or she will be accommodated, based on doctor's instructions. Once the patient was escorted to the assigned premise, the officer immediately informs his/her direct supervisor verbally and with an official note as soon as possible.

    It is important to postpone the search in this case and wait for doctor's further instructions to protect the right to life (Article 2 of the ECHR).

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100 Based on the staffing situation and distribution of tasks specific for the Forensic Institute Sokolac, this was the easiest solution. It may not be appropriate for other facilities.

101 For more details on physical restraint procedure see the manual "Protocols for treatment of mentally challenged offenders in forensic facilities".

11. If the security officer finds unauthorised items on the patient, s/he informs the head of security without delay, who then informs the relevant Ministry of Interior or police station, according to the existing cooperation protocols.
12. Security officer remains within visual range of the examination room during medical examinations, outside the doors. The presence of the security service is explicitly and verbally requested by the doctor examining the patient.
13. If the security officer is standing outside the room, he/she is on standby, observing the situation.
14. Any medical and personal data security officers hear or notice during the patient's medical examination are confidential and considered secure data. This means they are not shared with third parties or colleagues who have no contact with the patient.

    Unauthorised sharing of personal data and medical information entails disciplinary and ultimately criminal liability. Additionally, it violates Article 5 of the ECHR, which protects the right to private and family life.

Risk assessment

1. The security service does not participate in the risk assessment which records the level of risk that patient poses to himself/herself or the environment.
2. The Multidisciplinary (MDT) risk assessment team shares written information about the risk assessment with the head of the security. This information is recorded in the specific and separate information exchange form. The ward/on-call doctor or staff member authorised by them, submits this form to the head of the security.
3. This form includes both en face and profile photographs of the patient (or detainee in the forensic ward), along with morphological data (physical characteristics).

   Information from this form is considered secure/personal and is not shared with the third parties or colleagues who have no contact with the patient. This protects the right to private and family life (Article 8 of the ECHR).
4. Based on the information provided (by the MDT) about the assessed level of risk, along with the information in the form about the risk of self-harm, suicidality, aggression. The security plan can be prepared for securing the patient on-site or during transport (escorting).
5. The security plan, prepared by the head of security and approved by the director of the Forensic Institute, includes:
   - Form for information exchange about the assessed risks (the MDT shares it with the head of security)
   - Security information (see points 7 and 8)
   - Number of security officers, their names and tasks
   - Comprehensive security management plan (hierarchically structured system of issuing orders)
   - Schedule and specific tasks of police officers and other immediate officials/agents from whom assistance is requested for securing high-risk patients
   - Phone numbers and contacts of all police agencies, emergency medical services, health care facilities located along the escort route
   - List of equipment approved for use during security operations
   - Reporting and documentation (without delay upon completion of security operations)

6. The security officer assigned to manage implementation of the security plan prepares a report on the work order form. Based on the work order, the head of security prepares a report on the implementation of the security plan. This report is then submitted to the ward doctor or on-duty doctor.
7. All working documents, such as requests for assistance from the Ministry of Interior related to the specific security plan, are attached to the plan. In emergency situations, this request is made over the phone and it is submitted in writing, once conditions allow for it.
8. The security plan includes gathering of other security-relevant information. This information may include specifics such as whether the patient has a criminal record, whether there are persons with whom the patient may potentially cooperate, or persons with whom the patient may have close ties and who could assist in organising an escape, etc. This information is obtained by making a phone call to the relevant police station or agency. Drafting of the official note follows, which then becomes an integral part of the security plan and its attachment.
9. This information can also be obtained from other patients being treated at the Forensic Institute, family members, other employees, etc. This information is made available to the MDT, which takes it into account when reviewing the risk assessment.
10. The security service implements security measures independently or in collaboration and coordination with the relevant law enforcement authorities.

    A detailed, precise, and updated security plan protects the patient's right to life (Article 2 of the ECHR).

Specific treatment programmes

The security service participates to an extent in the implementation of specific treatment programmes as part of the multidisciplinary team. The tasks performed by the security service are divided into two groups: regular and emergency.

Regular tasks of the security service during the implementation of specific treatment programmes

Lawyers' visits, family visits, social services, diplomatic and consular missions, body monitoring, etc.

1. The security officer at the entrance gate identifies visitors and informs colleagues in the lobby. The security officer in the lobby then informs the relevant doctor, management of the Forensic Institute, or the ward staff where the patient who has a visitor is hospitalised (depending on the type of visit, the officer decides which colleagues to inform). This notification is given verbally over the phone or radio communication.
2. The security officer from the lobby escorts the visitor from the entrance gate to the main building of the Forensic Institute upon each departure and arrival.
3. The security officer in the lobby visually checks the visitor using a handheld metal detector and monitors his/her passage through the metal detector door. The visitor's belongings are screened through an x-ray machine for screening hand luggage.
4. If the officer suspects unauthorised items are to be brought into the Forensic Institute, s/he searches the visitor based on the procedures valid at the Forensic Institute.

   The security staff does not carry out detailed search (including search of body cavities) to protect human rights, particularly Article 3 of the ECHR - prohibition of torture, inhuman and degrading treatment or punishment.
5. The patient is escorted to the room where the visit takes place by the support care staff, not the security officer.

Work and occupational therapy (creative workshop and recreational therapy)

1. The security officer in the lobby visually monitors the arrival and departure of patients to creative workshops and recreational therapies via video surveillance. Patients are not escorted by security officers but by WOT staff. If the security officer notices via video surveillance any emergency circumstances threatening physical and psychological integrity of other patients and the staff, he/she immediately informs the head of security.

   This is important for the protection of the right to life under Article 2 of the ECHR.

2. With a handheld metal detector, the security officer supervising the room also checks patients, their clothes, footwear, and belongings when entering and exiting the room. If s/he discovers unauthorised items, this is documented in an official note in accordance with procedures of the Forensic Institute.
3. The security officer designated by the head of the security service supervises the room where creative workshops and recreational therapies take place via CCTV. In case of emergency, he/she follows the protocols described in the section on emergency preparedness of the security service during the implementation of specific treatment programmes.

Leisure activities within the Institute (walking outdoors, gardening, etc.)

1. The procedures are the same as when going to the WOT/occupational therapy, except that patients pass through a metal detector door upon returning to the wards.
2. Patients are accompanied/escorted by medical staff and support workers, not security officers.

Phone calls in the forensic ward (collaboration of the Forensic Institute's security service with the security service in the forensic ward)

1. The security officer must verify the court approval for the patient to make a phone call to a specific person before allowing the phone call to take place. Management of the Forensic Institute provides the list of approved phone calls to the forensic ward (the social service of the Institute forwards a copy to the security service, which files it according to the protocols of the Institute).
2. The security officer dials a phone number from the approved list as requested by the person from the forensic ward. Once the security officer reaches the number, he/she hands over the phone receiver to the patient so that the patient can have a conversation.
3. During the conversation, the security officer stands in close proximity to the person from the forensic ward who is talking, positioned out of earshot but still in sight.
4. After the conversation ends, the security officer records the completed phone calls in the internal records, with his/her own signature.
5. If an emergency arises during a phone conversation (such as the person becoming upset by the news during the conversation, etc.), the security officer begins verbal de-escalation of the person's behaviour, calming him/her down, or applies gradual control and restraint measures according to the procedures specified in the manual *"Roadmap for the forensic patients' care - from admission to release"*.
6. On suspension of the control and restraint measures, the security officer must immediately contact the medical staff via communication means to request examination of the person for any potential injuries incurred. A written report on the use of control and restraint measures is prepared without delay and handled according to the protocols of the Forensic Institute.

Meeting religious needs

1. The support care staff, not the security officer, escorts the patient to the room where his/her religious needs are met.
2. The security officer indirectly supervises the entrance to the room for religious needs via video surveillance.

    It is important to enable the practice of religious and traditional needs in a non-intrusive manner to protect the rights under Article 9 of the ECHR, which guarantees the right to freedom of thought, conscience, and religion.

Escort outside the Forensic Institute

1. The security officer restrains the patient by taking and placing restraint devices on the patient's wrists (magnetic fasteners) solely based on the assessed risk provided in writing by the doctor to the head of security or the person authorised by him/her.
2. Restraint is always done with the patient's arms extended forward, and the patient must not be tied to bars, poles, etc., in the transport vehicle under any circumstances. The security officer does not question the assessment but verifies whether an appropriate level of risk is recorded in the patient's file.
3. In emergency situations when the patient becomes agitated during escort, the security officer may restrain the patient, as assessed necessary and in consultation with the attending medical technician.
4. In case of a potential need for patient's treatment in another health care facility, the security service ensures patient security in coordination with the medical staff of that facility. Detailed procedures will be prescribed by the internal regulations of the Institute.

    Such thorough documentation of the patient's treatment and restraint based solely on the four fundamental principles (legality, proportionality, strictly necessary duration, and respect for the pain threshold) is necessary for the protection of patient rights against abuse (Article 3 of the ECHR), as well as to protect officers from possible later unfounded allegations of abuse. If an investigation proves that a security officer arbitrarily made decision about restraint, that officer may be held criminally liable.
5. The search of the patient who is escorted outside the Institute is conducted upon departure and return to the Institute according to the internal procedures.
6. Patient's escort to other institutions is carried out by the security service and a medical technician. Additionally, escorting to the bank involves the presence of a social worker.

7. During the escort, the medical technician and the security officer must be in the back of the official vehicle.
8. In case of necessary emergency stopping during the escort, the stopping can only be done at police stations, judicial police stations, or any other similar safe houses (judicial institutions) or health care facilities. Prior to this, the team leader escorting the patient announces the route according to the protocols of the Institute.
9. The security officer remains with the patient throughout the duration of the escort, visually supervising his/her movements.

    Continuous monitoring and the presence of a medical technician or social worker is mandatory to protect the patient's right to protection from abuse (Article 3 of the ECH), as well as to protect the security staff from potential allegations of abuse later on. Additionally, stopping only at predetermined and agreed-upon locations along the route protects the patient's right to life in the event of an attack on the vehicle or other unforeseen circumstances (Article 2 of the ECHR).

Emergency preparedness of the security service during the implementation of specific treatment programmes

Individual therapy

1. Individual therapy consists of one-on-one sessions with patients, which can be with a psychologist, social worker, doctor and include pharmacotherapy.

    In the pharmacotherapy, security officers are in not involved in any form (they do not administer drugs, discuss treatment, exchange opinions with colleagues regarding patient treatment, contact patient families, engage with them beyond their foreseen duties, disclose personal or health information, or share patient photos outside the workplace, etc. It is crucial to delineate the roles and tasks of different staff profiles in the Institute to protect the patient's rights to life (Article 2 of the ECHR), protection from abuse (Article 3 of the ECHR), the right to security and liberty of the person (Article 5 of the ECHR) and the right to privacy and family life (Article 8 of the ECHR).
2. Security officers participate in individual sessions to the extent requested by members of the MDT. These requests may involve being present in the room where the session takes place to monitor the security situation (in the case of high-risk patients), strictly upon the doctor's request.

    In such cases, patient privacy rules are respected, as explained under point 1.

Group therapy

1. Group therapies are managed as part of occupational therapy under the video surveillance of security officers.

   This protects the patient's right to liberty and security (Article 5 of the ECHR), and the right to private and family life (Article 8 of the ECHR).

2. If the security officer notices any signs of agitation in the patient or the beginning of argument or similar dispute, the security officer promptly removes the patient from the room and hands him over to colleagues who return him to the ward.
3. If intervention is needed to restrain the patient and escort him/her to the ward, colleagues are called for assistance via the radio communication system. Officers summoned for assistance escort the patient to the ward.
4. When restraining the patient, procedures outlined in the manual *"Protocols for treatment of mentally challenged offenders in forensic facilities"* (the principle of gradualness, proportionality, legality, and respect for the pain threshold) and the manual *"Roadmap for the forensic patient's care: from admission to release"* (verbal de-escalation) are followed.

It is crucially important to respect the principles of the use of means of restraint to protect the patient's rights against abuse (Article 3 of the ECHR), the right to life (Article 2 of the ECHR). This is also a mechanism to protect the staff from potential allegations of abuse later.

5. Security officers are not present in therapeutic communities. If necessary, they respond to any incident according to the instructions of the head of security or the person authorised by him/her.
6. The security service monitors the situation in the therapeutic community via video surveillance from the control room. If they notice an incident, they respond based on their own assessment of the situation.

   This protects the patient's right to life (Article 2 of the ECHR), protection from torture (Article 3 of the ECHR), the right to liberty and security (Article 5 of the ECHR), and the right to private and family life (Article 8 of the ECHR).

Rounds/visits

1. Security officers are not present during rounds.
2. Security staff monitors the situation during rounds via video surveillance from the control room. If they observe any incident, they respond based on their own assessment of the situation.

   This protects the patient's right to life (Article 2 of the ECHR), protection from torture (Article 3 of the ECHR), the right to liberty and security (Article 5 of the ECHR) and the right to private and family life (Article 8 of the ECHR).

Leisure activities organised inside the Forensic Institute

1. Security officers are not present during leisure activities inside the Institute or on the grounds of the Institute.
2. The security service monitors the situation during leisure activities via video surveillance from the control room. If they observe any incident, they respond based on their own assessment of the situation.
3. If a security officer notices that a patient attempts to bring into the Forensic Institute any unauthorised items (tools, sharp objects, stones, or anything that the patient can use to injure himself or others) while passing through the metal detector, the item is confiscated and the ward doctor or on-duty doctor is informed.
4. A note is made about the confiscated item or it is entered in the Log Book. The item is safely discarded (based on the security officer's assessment and instructions of the head of security).

   This protects the patient's right to life (Article 2 of the ECHR), protection from torture (Article 3 of the ECHR), the right to liberty and security (Article 5 of the ECHR), and the right to private and family life (Article 8 of the ECHR).

Preparation for discharge and discharge

1. All items confiscated on admission are returned to the patient at release, with the patient signing a handover form acknowledging the receipt of confiscated items.
2. Certificate of release is signed by both the security officer and the patient. One copy of the certificate is given to the patient, and the other is placed in the patient's file.

3. In agreement with the director of the Forensic Institute, the MDT and the head of security, the security officer may be instructed to escort the patient to his/her place of residence after discharge from the Forensic Institute. Such tasks are assigned if the patient is financially disadvantaged and this decision rests upon the management of the Forensic Institute.
4. An escort plan is prepared for such situations, as well as for any other situation when an escort would be necessary.

Example of good practice from the Public Health Care Facility of the Institute for Forensic Psychiatry Sokolac

In the best interest of the patient being discharged from the Institute who does not have family or someone in the community who can provide material or financial support, or if the patient does not have means of transportation, the management of the Institute may decide that the team of the Institute accompanies the patient to his/her place of residence or domicile (or to the nearest bus station). This is an exclusive and discretionary decision of the management of the Institute aimed at a more humane and ethical treatment of vulnerable persons. Such a decision is preceded by detailed consultations with the MDT team and is only made as a last resort.

This is an extraordinary procedure decided upon by the management of the Institute until official mechanisms and conditions are established that allow for greater involvement of other community services such as centres for social work, centres for mental health, and other social services.

This ensures the protection of the patient's rights under Article 3 of the ECHR which prescribes protection from inhuman and degrading treatment.

Appendix 1:

Brief Guidance: Adjustments Required to Current Practices in The Forensic Psychiatry Hospital, Sokolac to Achieve Improved Compliance with CPT Standards[102]

Introduction

During its periodic visit to Bosnia & Herzegovina in June 2019, the CPT visited the Forensic Psychiatry Hospital, Sokolac. This was their most recent visit to the establishment and the CPT's report on that visit, including their findings, observations and recommendations regarding the hospital, was published in September 2021.

It is clear from that CPT report (and their earlier reports) that, over the years, great efforts have been made to improve the treatment of forensic psychiatric patients in Bosnia & Herzegovina and, specifically, at Sokolac Hospital. However, there does appear to be some scope for further improvement.

At the request of the Council of Europe (CoE), and following a review of current legally imposed and other practices at the hospital (as stipulated in several procedural documents provided to me), this brief guidance identifies a number of areas where adjustments to practice would lead to improved (and then full) compliance with CPT standards (in both the context of the CPT's findings and recommendations in their most recent report on the hospital, and when considering relevant wider CPT standards more generally, including more contemporary ones). Where adjustments to practice are needed, if that requires a stepwise approach, those steps are indicated.

The aim of the guidance is to promote discussion and assist staff at the hospital to continue to review certain practices and procedures, overcome obstacles, and to plan and implement adjustments, which will not only benefit patients at the hospital but will also attempt to ensure that, when the CPT next visits the hospital, practices will be recognised as being fully compliant with CPT standards and CPT past recommendations (or, if not all the required adjustments have been implemented by the time of the next visit, a clear plan can be presented on progress and how full compliance will be achieved, with timescales).

Background Information Considered

In the context of my past visits to Bosnia & Herzegovina with the CPT (including to the Forensic Psychiatric Hospital, Sokolac), all be that many years ago, I have also now reviewed the following documents:

102 Dr Clive Meux, Consultant Forensic Psychiatrist and CPT Expert, 9th August 2024

- The CPT Report of their Periodic Visit to Bosnia & Herzegovina in June 2019 (& the Government Response).[103]
- The Forensic Psychiatric Hospital, Sokolac, document entitled 'Duties and the Role of the Security Service in the Implementation of Specific Treatment Programmes for Vulnerable Categories of Forensic Patients at the Institute'.
- The Forensic Psychiatric Hospital, Sokolac, document entitled 'Rulebook on House Rules'.
- The Forensic Psychiatric Hospital, Sokolac, document entitled 'Draft Resource Manual' (upon which I had already commented).
- The CoE document relating to The Forensic Psychiatric Hospital, Sokolac, entitled 'Protocols for Treatment of Mentally Challenged Offenders in Forensic Facilities'.

Areas of Practice Requiring Adjustments

Issues identified in the 2019 CPT report which required adjustments in practice[104] to be made at the hospital can be grouped into ten areas: staffing issues; medication; rehabilitation activities; individual treatment planning; environmental/material issues; outdoor exercise; searching; restraint; consent to treatment; and legal safeguards.

Although the CPT also recommends that steps be taken to ensure that involuntary civil psychiatric patients in the hospital are not subjected to the same security measures as forensic psychiatric patients, I will not specifically comment upon this. In many forensic psychiatric hospitals in Europe, such classes of patients do co-exist in such hospitals because of clinical necessity or legal process and the CPT has not always passed recommendations on this issue. I believe that when other adjustments (described below) are made, and an overall individualised approach to patient care is even more greatly emphasised in the hospital, this broad issue would then be satisfactorily addressed.

Having reviewed the background documentation provided to me; it appears that the following adjustments to practice are still required[105] to align practice with the following summarised CPT recommendations (although I realise that some may already have been made but have not yet been reflected in the documentation provided to me).

103 It is noted that, unfortunately, the authorities did not make any meaningful response to any of the CPT recommendations relating to psychiatry.

104 I have not addressed CPT recommendations in the report relating to placement of patients from Sarajevo canton in the hospital, the financial situation of the hospital and legal employment rights, as these are not practice issues and are state issues beyond the competence of the hospital.

105 Suggestions regarding some of them have also been made in my comments on the 'Draft Resource Manual'.

Staffing Issues

The CPT recommends that the psychiatrist staffing in the hospital should be reinforced.

Although there is no specific CPT standard for the number of psychiatrists per number of patients (due to qualitative differences between patient's clinical conditions, the varying presence of other multidisciplinary clinical staff etc.), the psychiatric staffing levels in the hospital should be reviewed and increased as required.

The CPT notes the presence of security staff at the hospital. Further, it specifically recommends that the current practice (by judicial police officers) of the carrying of firearms on the Expertise ward is terminated.

Although the presence of security staff[106] at the hospital did not lead to any specific recommendation in the report, in the intervening years, CPT standards on this issue have evolved. The CPT now tends to recommend that, to best safeguard patients, there would ideally be no separate security staff (state or private, even ununiformed) working in a hospital (including a forensic psychiatric hospital); indeed such security staff-free situations can be found in several European states, with all treatment and security being closely integrated and clinically provided solely by highly trained clinical staff (even regarding the external escorting of patients).

As an interim measure, the CPT now tends to recommend that, where security staff are employed at a forensic psychiatric hospital, they remain solely at the entrance or on the perimeter, only entering clinical areas at the express invitation of clinical staff in an emergency (e.g., where a patient is threatening to imminently harm others). However, at the forensic hospital in Sokolac, it is noted that security staff are not just present at the entrance and perimeter, or even just involved in supervising visits, searches and checking phone contacts, but are also involved in clinical areas. For example, it is stated that they are present during group therapy and in occupational therapy and may be present in clinical interviews between clinical staff and patients (it not being clear if this may only occur at the request of the clinician,[107] nor whether clinicians understand that such situations should be avoided, if at all possible, except in high-risk situations). Further, it is explicitly stated (e.g., Paras 2 & 4 of the Admission Section of the document 'Duties and the Role of the Security Service…') that a patient's clinical team will share clinical information regarding the patient (e.g., regarding past clinical history, risk of self-harm, clinical judgements on risks to others etc.) with the Head of Security, and that this information will be used to developed individual (non-clinical) security plans for patients.[108]

106 The report stated that at the time of the visit there were 14 such staff.

107 E.g. Para 12 & 13 of the Admission Section of the document 'Duties and the Role of the Security Service…'.

108 E.g., when interventions are required, for transportation etc.

Regarding confidentiality issues, it therefore appears that security staff oversee clinical interactions and have wide access to clinically confidential information, which would be outside CPT guidelines. It is noted that the CoE document entitled 'Protocols for Treatment of Mentally Challenged Offenders in Forensic Facilities', although outlining confidentiality issues, does not comment specifically regarding security staff.

When the CPT revisits the hospital, it is therefore likely to make recommendations on the presence of security staff in the hospital and related confidentiality issues. It is therefore suggested that discussion is initiated as to how, in a phased way, the role of security staff in the hospital can initially be more delineated (e.g. only entering clinical areas in an emergency, reducing breaches of clinical information via stricter clinical information sharing) and then phased out over time, with security being provided by clinical staff (albeit, potentially, with a security manager in post). If security staff must remain at the entrance of the Expertise Ward, their role would need to be very clearly delineated.

Of course, if a plan were agreed to evolve this matter towards the phasing out of security staff in the hospital, there will be various clinical, security, legal and even potentially political issues to be overcome. There may be redundancies (and the need to employ more clinical staff), plus contingency plans for when additional emergency security is required on a ward (e.g., protocols for the role of the police). Much discussion and planning would therefore need to occur.

Regarding the carrying of firearms by judicial police officers at the Expertise ward, the CPT outlines clearly why the carrying of firearms withing in a hospital is unsafe and inappropriate. To comply with their recommendation regarding firearms and their other standards regarding the use of special means in hospitals, arrangements should be made that firearms do not enter the hospital, and all other special means (e.g., handcuffs, pepper spray etc.) are stored safely and out of sight of patients (albeit still easily accessible to security staff).

Medication

The CPT recommends that the range of new generation antipsychotics available to patients is broadened and that, whenever Clozapine is used, regular blood tests are mandatory (with staff being educated about the potentially lethal side effects of clozapine).

This is a long-standing and common CPT recommendation regarding pharmacotherapy in psychiatric hospitals and will need to be addressed. A broader range of medication needs to be made available (with appropriate changes to the pharmacopoeia). A clear protocol will need to be developed regarding the requirement for blood tests (particularly white blood count) for patients receiving Clozapine.[109] There will be some revenue expenditure required, with change of practice (and available laboratory test facilities).[110]

Rehabilitation Activities

The CPT recommends that the programme of psychosocial rehabilitative activities is further developed, with staff motivating all patients to participate regularly in such activities. Further, they suggest consideration be given to also providing psychosocial rehabilitative activities in the afternoon (not just the mornings), stating that occupational staff resources will need to be reinforced.

As the CPT noted that only slightly more than half of the patients were involved in an activity. (with no activity provided to patients on the Expertise Ward, nor to any patient in the afternoon).[111] Action to address this will require staff to more actively engage in motivating patients and making activities available for a period in the afternoon. This will require strengthening the staff resources so as to be able to encourage and support patients attendance (and be available for to patients for longer periods). This will entail some increase in revenue expenditure. Further, although there will be rules regarding provision of treatment to patients on the Expertise ward (including the avoidance of pharmacological treatment for example), some activities (such as ward based) should be made available. This is likely to require strengthening of the staff resources on the ward (and provision of a space for activities to occur), with some increase in revenue expenditure.

Further, it is noted from the 'Rulebook on House Rules' and the Duties and the 'Role of the Security Service…' document that security staff are present observing patients in the activities areas. As discussed above, the CPT recommends that security staff should not be routinely present in clinical areas and the cessation of this practice will need to be addressed.

109 E.g., initially weekly testing, fortnightly after 18 weeks of therapy and monthly after 12 months.

110 As stated by the CPT.

111 As confirmed in Art. 11 of the Rulebook on House Rules.

Individual Treatment Planning

The CPT recommends that multi-disciplinary individual treatment plans are drawn up for all patients and that the multidisciplinary clinical team (including psychologists) should meet regularly to share information and discuss patients' needs and therapeutic progress and also recommends that individual medical files contain an ongoing record of a patient's mental and somatic state of health and of their treatment.

This is a long-standing and common CPT recommendation regarding treatment in psychiatric hospitals and will need to be addressed. Regular recording of a patients state of health must occur. Further, individual multidisciplinary written treatment plans need to be instituted for all patients, with regular multidisciplinary clinical meetings (including psychologists) reviewing them (with the involvement of the patient and the patient agreeing and signing such plans, in the spirit of co-production). The CoE document 'Protocols for Treatment of Mentally Challenged Offenders in Forensic Facilities' describes such treatment plans well (and gives a model form) and could be used as guide for this.

Environmental/Material Issues

The CPT recommends that the occupancy levels in patients' rooms be decreased so that no room accommodates more than four patients.

This is a long-standing and common CPT recommendation regarding psychiatric hospitals and will need to be addressed. To achieve it, steps will need to be taken that will include ensuring the best use of patient accommodation in the hospital with appropriate safe reallocation of patients, and the reduction in any overcrowding.

The CPT recommends that patients' rooms and the communal areas at hospital be decorated to provide a more suitable therapeutic environment for the patients.

This is a long-standing and common CPT recommendation regarding psychiatric hospitals and will need to be addressed. The CPT expects the environment for patients to be personalised and not be austere. Actions which can be taken to address this can include using different paint colours, painting wall murals and having posters or pictures on the walls. This will involve some relatively minor capital expenditure. Further, allowing patients to have more personal possessions (e.g., photographs, plants etc.) is also relevant but must be balanced against security considerations.

The CPT recommends that missing curtains in the showers and damaged/missing toilet seats be rectified.

Such ongoing repairs will need to be addressed. This will involve some minor capital expenditure.

The CPT recommends that the blanket use of CCTV cameras within patients' rooms ceases (and wished to be informed of the legal basis for installing CCTV).

Although the CPT accepts that CCTV in certain rooms can be a useful safeguard in (e.g., when a patient is at risk of self-harm or suicide), due to their gross intrusion on patients' privacy, they oppose the routine and systematic installation and use of CCTV cameras in all patients' rooms (and state that the best way to reduce the risk posed by an individual patients is personal interaction with them by staff). The CPT recommends that a decision to impose CCTV surveillance on a particular patient should always be based on an individual risk assessment and should be reviewed on a regular basis.

Therefore, practice and systems will need to be adjusted so that, where a CCTV camera is in a patient's room, it is only switched on and operational when an individual risk assessment has been made to do so (and justified and recorded in writing in the patient's clinical file), and that the decision is regularly reviewed (with that review also recorded with justification). This will require technical adjustments to be made and written recording systems put in place. Further, the legal basis for the use of CCTV will need to be clear (further, Art. 8 of the Rulebook on House Rules does not specify patient rooms and would need elaborating).

Outdoor Exercise

The CPT suggests that patients accommodated on the first floor of the hospital should be able to benefit from unrestricted[112] access to outdoor exercise during the day (unless treatment activities require them to be present on the ward).

This is a long-standing and common CPT recommendation regarding all patients in psychiatric hospitals and will need to be addressed. The CPT notes that such access is available to all patients on the first floor. It is likely that the only way that this will be achievable for patients on the second floor (as there is unlikely to be enough staff available all day to escort patients out whenever they want), is for a secure and safe stairway to be available from the second floor to the secure garden area. This will involve capital expenditure and appropriate environmental risk assessments to be made.

Further, as I interpret Art 5.1 of the 'Rulebook on House Rules', new patients are not allowed outdoor exercise for the first 8–12 weeks following their admission. Whilst caution in allowing freedoms for new, yet unassessed and potentially unpredictable patients is understandable, the CPT would likely recommend that such a blanket rule should be replaced with a more individualised approach to risk, so that some patients may be allowed outdoors after just a few days of assessment. To achieve this, changes would need to be made to the risk assessment and management of newly admitted patients.

112 Art 5.6 of the 'Rulebook on House Rules' suggest 3 hours/day for patients on the first floor.

Additionally, Art 5.6 of the 'Rulebook on House Rules' suggests that patients' exercise is suspended during inclement weather. The CPT standard is clear that all patients should have access to fresh air regardless of the weather. Although cover form the elements is said to be available in the exercise areas, it may therefore be necessary to provide patients with waterproof or warm clothing (at minor capital expense), if required, and amend the relevant rule.

Searching

The CPT recommends that arrangements concerning strip-searches of patients are urgently reviewed.

The CPT expressed concerns that patients were being strip searched (fully naked) and in view of other patients (being searched in pairs), as this is an affront to their dignity. To comply with CPT standards, apart from being searched by staff of the same gender, patients should only be strip searched when absolutely necessary, rather than routinely, and in privacy (not in view of patients), and then using a two-part process so that the patient is never wholly naked without any clothes on either half of the body. A change to the procedures and protocol for searching will need to be made to reflect this (as compliant rules are not clearly state in Art. 7 of the 'Rulebook on House Rules' nor in Para. 6 of the Admission Section of the document 'Duties and the Role of the Security Service…'). The CoE document 'Protocols for Treatment of Mentally Challenged Offenders in Forensic Facilities' elaborates on search guidelines well and could be used as guide.

Restraint

The CPT recommends that their standards on restraint (mechanical and chemical) are fully adhered to in the hospital.

The CPT standards on restraint are delineated in their report and the CoE document 'Protocols for Treatment of Mentally Challenged Offenders in Forensic Facilities' elaborates on restraint well and could be used as guide. Together, these guidance could be used to ensure that current practice in the hospital is compliant with CPT standards and, if certain practices are deficient, they should be rectified and appropriate protocols amended/elaborated s appropriate (e.g., regarding Para 8 & 9 of the Admission Section of the document 'Duties and the Role of the Security Service…').

Consent to Treatment

The CPT recommends that safeguards surrounding patients consent to treatment are enhanced.

The CPT outlines in some detail how patients need to be more fully and continuously informed regarding their treatment and not just encouraged to give blanket agreement to treatment soon after arrival, with little understanding of their right to withdraw consent. Further, they outline how processes to overcome a lack of consent to treatment need to be strengthened. Protocols (e.g., Paras 3.3 & 3.4 of the Admission Section of the document 'Duties and the Role of the Security Service…') and practices regarding consent to treatment will therefore require amendment to ensure compliance, with patients being provided with more information regarding their diagnosis and treatment (including the side-effects of medication).

Although the CPT notes that, upon admission, patients are provided in writing (and orally) with very basic information about the complaints mechanisms and house rules, greater detail is required [e.g., regarding legal assistance, review of placement (and the patient's right to challenge this), consent to treatment etc.]. Therefore, the relevant information supplied to patients will need to be enhanced (whilst remaining suitably concise and comprehensible).

Legal Safeguards

The CPT recommends improvements to various legal safeguards, including:

- **Ensuring that the courts render decisions on involuntary placement and its extension within the time limits set out by the relevant legislation.**
- **Ensuring that patients have the effective right to be heard in person by the court during the procedures on their involuntary placement or its extension, as well as during the appeals procedures.**
- **Ensuring that patients have a real opportunity to consult with their ex officio lawyer.**
- **Altering the period of involuntary placement so that it is shorter than one year.**
- **Commissioning a psychiatric expert opinion which is independent of the hospital, at reasonable intervals, in the context of the review of the measure of compulsory hospitalisation.**

Whilst instituting these recommendations to ensure compliance on legal safeguards are beyond the competence of the hospital and its staff, (as the law and legal processes will need to be consulted upon and amended nationally), staff should nonetheless be cogniscent of them and play their part (via management and their professional organisations) in pressing for the relevant amendments to practice.

Conclusions

Whilst realising that some of the CPT recommendations referred to above and made some years ago may have already been addressed, it is hoped that this brief guidance highlights areas where further adjustments to practice may still be required, and therefore planned and instituted, with updating of relevant protocols, rule books and procedures.

To enhance further discussion of the areas discussed and assist progression of the issues, it is suggested that a video meeting with relevant working group staff could be productive.

Appendix 2:

Rulebook on the joint planning of discharge for persons with mental health disorders

REPUBLIKA SRPSKA
MINISTRY OF HEALTH AND SOCIAL WELFARE

RULEBOOK

ON THE JOINT PLANNING OF DISCHARGE FOR PERSONS WITH MENTAL HEALTH DISORDERS

Banja Luka, November 2020

Pursuant to Article 42 paragraph 4 of the Law on Mental Health (Official Gazette of Republika Srpska, 67/20) and Article 76 paragraph 2 of the Law on Public Administration of Republika Srpska (Official Gazette of Republika Srpska, 115/18), on 17 November 2020, the Minister of Health and Social Protection enacted the

RULEBOOK ON JOINT PLANNING OF DISCHARGE
FOR PERSONS WITH MENTAL HEALTH DISORDERS

Article 1

This Rulebook regulates joint discharge planning, planning methodology, needs assessment for persons with mental health disorders, types of discharge plans, and coordination.

Article 2

Joint discharge planning for persons with mental health disorders shall be conducted upon the admission of a person with mental health disorders to a psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute.

Article 3

Joint discharge planning for persons with mental health disorders shall consist of the following:

1) initial treatment planning,
2) comprehensive planning,
3) discharge planning,
4) post-discharge planning.

Article 4

(1) Initial treatment planning shall start upon the admission of a person with mental health disorders to a psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute following the alleviation of symptoms which indicated the person's admission.
(2) Initial treatment planning shall be based on a risk reassessment and initial individual needs assessment for the person with mental health disorders.
(3) Assessed individual needs of the person with mental health disorders referred to in paragraph (2) of this Article shall include:
    1) medical needs,
    2) social needs,
    3) economic needs.

(4) Initial treatment planning referred to in paragraph (1) of this Article shall include:
   1) definition of a general initial plan of diagnostic and treatment activities, as well as other activities aimed at stabilising the clinical status established upon the admission of the person with mental health disorders to a psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry by a medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry,
   2) appointment of a discharge coordinator – graduate healthcare medic or graduate nurse or nurse or medical technician or graduate social worker,
   3) discharge coordinator's contact with the family members of the person with mental health disorders, their legal representative and/or a person of trust,
   4) discharge coordinator's contact with the healthcare centre mental healthcare unit and/or the healthcare centre family doctor unit to obtain additional information about the functioning of the person with mental health disorders prior to the current episode, immediately after the admission and no later than two working days after that,
   5) identification of individual needs and goals of initial treatment planning, as well as support to be provided to the person with mental health disorders, his/her family member, legal representative and/or the person of trust,
   6) involvement of the person with mental health disorders in the identification of individual needs and goals for discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute,
   7) designing a draft discharge plan.

(5) Risk reassessment for the person with mental health disorders referred to in paragraph (2) of this Article shall be conducted in the second week after the stabilisation of the person's mental state.

(6) Individual needs assessment for the person with mental health disorders referred to in paragraph (2) of this Article shall be based on standardised principles of coordinated care which includes:
   1) establishing contacts with persons with mental health disorders in the community,
   2) comprehensive assessment of the needs of the person with mental health disorders,
   3) preparation of an individual recovery plan,
   4) effective coordination of services and treatments between the partners in the community to increase the potentials for the recovery of the person with mental health disorders.

Article 5

(1) Comprehensive planning shall include elaboration of the general initial plan of diagnostic and treatment activities referred to in Article 4, paragraph (4), item 1) of this Rulebook, and rehabilitation activities that should help the person with mental health disorders during the medical intervention with a view to achieving recovery.

(2) Comprehensive planning referred to in paragraph (1) of this Article shall be performed by persons referred to in Article 4, paragraph (4), item 1) and 2) of this Rulebook in cooperation with the care coordinator from the healthcare centre mental healthcare unit.

(3) Comprehensive planning referred to in paragraph (1) of this Article shall include:

1) elaboration of the initial treatment plan, including identification of individual needs of the person with mental health disorders,
2) continuous involvement of the person with mental health disorders, his/her family member, legal representative and/or the person of trust in comprehensive planning,
3) assessment of post-discharge needs of the person with mental health disorders,
4) discharge plan based on the individual needs assessment for the person with mental health disorders,
5) continuous cooperation with the healthcare centre mental healthcare unit,
6) psychoeducation,
7) direct contact, via visits or virtual communication platforms, of the person with mental health disorders and the discharge coordinator with the care coordinator and other members of the team in the relevant healthcare centre mental healthcare unit, and when required also with the representative of the relevant social welfare centre.

Article 6

(1) The planning of discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute shall commence after the full stabilisation of the clinical status, i.e. after the recovery of the person with mental health disorders.

(2) The planning of discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute referred to in paragraph (1) of this Article shall include:

1) details about the continuation of the treatment at the healthcare centre mental healthcare unit and arrangements for post-hospital monitoring,
2) advice regarding action in case of initial signs of recurrence or relapse,

3) designation of a person responsible for emergency situations:
    1. Name of the person responsible for emergency situations,
    2. Phone number of the person responsible for emergency situations,
4) self-care plan for the person with mental health disorders,
5) crisis management plan,
6) information on the assessed risk, with the consent of the person with mental health disorders,
7) defined plan for coordination of services, based on the needs assessment. Person with mental health disorders, his/her family member, legal representative and/or the person of trust should always be included in the preparation of this plan.

(3) Discharge planning shall be checked against the Planning Checklist for the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute, and shall be filed in the medical history of the person with mental health disorders.

(4) The form of the Discharge Planning Checklist referred to in paragraph (3) of this Article is given in Annex 1 and represents an integral part of this Rulebook.

(5) Medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry and the discharge coordinator shall communicate the discharge date by phone to the person with mental health disorders, care coordinator from the healthcare centre mental healthcare unit, representative of the relevant social welfare centre, family or legal representative and/or the person of trust of the person with mental health disorders no later than 48 hours prior to the discharge.

(6) On the day of discharge, the person with mental health disorders shall receive a Discharge Letter with the discharge plan and recommendations.

(7) The Discharge Letter with the discharge plan and recommendations shall be forwarded to the relevant healthcare centre mental healthcare unit and social welfare centre, or the social welfare service in the relevant local administration unit.

Article 7

Depending on the assessed individual needs of the person with mental health disorders, the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute can be:

1) routine discharge, i.e. a simple discharge if the needs assessment has identified medical needs, or
2) complex, if the needs assessment has identified medical, social and economic needs.

Article 8

Post-discharge planning for a routine/simple discharge shall include the following activities:

1) person with mental health disorders going home where they have the support of a family member/legal representative or a person of trust; or going to another community where the person with mental health disorders had lived prior to the medical intervention,
2) receiving information and recommendations for the continuation of the medical intervention at the relevant healthcare centre mental healthcare unit.

Article 9

(1) Post-discharge planning for a complex discharge shall include the following activities:
    1) the discharge coordinator informing the care coordinator at the healthcare centre mental healthcare unit about the discharge of the person with mental health disorders from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute, with prior consent of the person,
    2) the medical doctor - specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry providing the discharge letter with recommendations regarding the continuation of the medical intervention at the relevant healthcare centre mental healthcare unit,
    3) contacting the care coordinator at the healthcare centre mental healthcare unit by phone no later than 72 hours after notifying the person with mental health disorders, his/her family member, legal representative and/or the person of trust about the discharge, and making an appointment for the first medical intervention at the healthcare centre mental healthcare unit,
    4) arranging the interview of the care coordinator with the person with mental health disorders as part of the first medical intervention for the person with mental health disorders at the healthcare centre mental healthcare unit,
    5) defining the schedule for the implementation of the discharge plan jointly prepared by the person with mental health disorders, his/her family member, legal representative and/or the person of trust and the care coordinator and, if necessary, the representative of the relevant social welfare centre at a team meeting held at the healthcare centre mental healthcare unit, as well as the schedule for the engagement of the community that provides support in the continued post-discharge care for the person with mental health disorders,

6) continuous monitoring of the achievement of the results from the discharge plan, including its regular review in accordance with the results achieved (or not achieved),
7) defining the schedule for house calls by the care coordinator and, if required, the representative of the relevant social welfare centre to the person with mental health disorders (on-site monitoring of achievements, review of the care and treatment plan, direct inspection of the environmental factors, etc.),
8) post-hospital monitoring of the person with mental health disorders included in the coordinated care, and regular reporting to the discharge coordinator (minimum monthly) by the care coordinator at the healthcare centre mental healthcare unit,
9) the care coordinator at the healthcare centre mental health protection service notifying by phone the discharge coordinator about an acute worsening of the underlying condition of the person with mental health disorders, and arranging the person's readmission to the psychiatric hospital ward, psychiatric clinic at the clinical centre of specialised hospital.

(2) Post-discharge planning after the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute to the relevant healthcare centre mental healthcare unit shall be performed in accordance with the Check List after the discharge from the from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute to the relevant healthcare centre mental healthcare unit.

(3) The form of the Post-discharge Checklist referred to in paragraph (1) of this Article is given in Annex 2 and represents an integral part of this Rulebook an integral part of this Rulebook.

Article 10

(1) The social welfare centre shall, in accordance with the law, perform an assessment of individual social needs of the person with mental health disorders, an assessment of the support provided by the person's family, and an assessment of the support provided by the person's immediate community.

(2) The social welfare centre shall, in accordance with the law, participate in designing and providing the social support to the person with mental health disorders and his/her family.

(3) The social welfare centre shall, in accordance with the law, designate a representative responsible for cooperation with the discharge coordinator during the time the person with mental health disorders spends at the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute, and with the care coordinator after the person's discharge.

(4) The form of the Post-discharge Checklist referred to in paragraph (1) of this Article is given in Annex 3 and represents an integral part of this Rulebook.

Article 11

This Rulebook shall enter into force on the eight day following its publication in the Official Gazette of Republika Srpska.

Number: ..... MINISTER
Banja Luka, ...2020 Alen Šeranić, dr med.

Annex 1

Checklist for the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute*

Name of healthcare institution and city: _____

Number of medical history: _____

Name of the person being discharged from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute:

_____

Personal identification No.: _____ Place of residence: _____

Date and time of admission: _____/__ /____ at ____ hours

Date and time of discharge: _____/__ /____ at ____ hours

Documentation	YES/NO
Discharge Letter prepared	
Joint planning team for the discharge of person with mental health disorders:	
medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry	
graduate healthcare medic or graduate nurse or nurse or medical technician / graduate social worker – discharge coordinator	
healthcare professional or healthcare assistant – care coordinator at the healthcare centre mental healthcare unit,	
representative of the relevant social welfare centre	
Other (please specify):	
Discharge Letter includes recommendations regarding the continuation of the medical intervention at the relevant healthcare centre mental healthcare unit given by the medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry	
Discharge Letter forwarded to the mental health protection centre and the team for joint planning of the discharge of the person with mental health disorders after his/her discharge	
Healthcare centre mental healthcare unit contacted, post-discharge monitoring of the person with mental health disorders arranged, and first contact arranged (name of contacted person at the mental healthcare unit)	
Social welfare centre contacted, and arranged date for contact with the person with mental health disorders who is being discharged (name of contacted person at the social welfare centre)	
Information on the discharge of the person with mental health disorders forwarded to the social welfare centre	

Family / legal representative / person of trust informed about the discharge of the person with mental health disorders	
Written information forwarded to identified partners in the community for the purpose of providing support	
BPRS/HoNOS/AVON (please underline the relevant) completed	
Risks assessed	
Discharge plan with recommendations for the continuation of the medical intervention at the healthcare centre mental healthcare unit prepared by the medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry	
Documentation	YES/NO
Medications for three days issued to the person with mental health disorders	
A copy of the Discharge Letter with recommendations for the continuation of the medical intervention at the healthcare centre mental healthcare unit prepared by the medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry issued to the person with mental health disorders and/or person's family / legal representative / person of trust together with the discharge plan	
Discharged person with mental health disorders is informed about the medications, signs of worsening etc. (verbally and/or in writing in the form of instructions)	
Family / legal representative / person of trust are informed about the medications, signs of worsening etc. (verbally and/or in writing in the form of instructions)	
Discharge Plan prepared	
A copy of the Discharge Plan provided to the discharged person with mental health disorders or the person's family / legal representative / person of trust	
Transportation arranged	

Date: _____ /__/ _____ L. S. Discharge Coordinator:

_____

* *The Checklist for the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute shall be filed in the Medical History of the person with mental health disorders*

Annex 2

Checklist for post-hospital monitoring after the discharge of the person with mental health disorders from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute (MHU)*

Healthcare Centre, Mental Healthcare Unit _____

Name of the person discharged from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute: _____

Personal identification No.: _____

Date of discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute: _____ /__/ _____

Date and time of the first appointment at the healthcare centre, mental health protection service: _____ /__/ _____ at _____hours

Documentation	YES/NO
Mental healthcare unit contacted prior to the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute regarding post-hospital monitoring (name of the person who contacted the mental healthcare unit)	
Date of first appointment at the mental healthcare unit arranged	
Person checks in for the appointment	
Discharge Letter with recommendations for the continuation of the medical intervention at the healthcare centre mental healthcare unit prepared by the medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry and issued to the person with mental health disorders and/or person's family / legal representative / person of trust together with the discharge plan received before the first appointment	
The Discharge Letter includes information about recommended medications, assessed risk and needs	
Discharge Plan includes information about the medical intervention provided at the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	
Person with mental health disorders agrees with the proposed discharge plan which includes information about the medical intervention provided at the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	
Care coordinator at the mental healthcare unit appointed (name of the person)	

Person with mental health disorders agrees with the for the continuation of the medical intervention at the healthcare centre mental healthcare unit given by the medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry	
Contact between the mental healthcare unit and the social welfare centre established after the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	
Discharge coordinator informed about the first appointment at the mental healthcare unit after the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	

Date: _____ /__/ _____ Care Coordinator at the Mental Healthcare Unit:

_____

* *The Checklist for post-hospital monitoring shall be filed in the medical documentation of the person with mental health disorders kept at the Mental Healthcare Unit*

Annex 3

Checklist for post-hospital monitoring after the discharge of the person with mental health disorders from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute (SWC)*

Social welfare centre or social welfare service in the relevant local administration unit

Name of the person discharged from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute:

Personal identification No.: _____

Date of discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute: _____ /__/ _____.

Date and time of the first appointment at the social welfare centre, or social welfare service in the relevant local administration unit: _____ /__/ _____ at _____ hours.

Documentation	YES/NO
Social welfare centre contacted prior to the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute regarding post-hospital monitoring (name of the person who contacted the social welfare centre, or the social welfare service of the relevant local administration unit)	
Representative of the social welfare centre, or the social welfare service of the relevant local administration unit who participated in the meetings of the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	
Date of first appointment at the social welfare centre, or the social welfare service of the relevant local administration unit arranged	
Person checks in for the appointment	
Discharge coordinator informed about the first appointment at the social welfare centre, or the social welfare service of the relevant local administration unit after the discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	
Discharge Letter with recommendations for the continuation of the medical intervention at the relevant healthcare centre mental healthcare unit prepared by the medical doctor – specialist in psychiatry or a medical doctor – specialist in child and adolescent psychiatry and issued to the person with mental health disorders and/or person's family / legal representative / person of trust together with the discharge plan received at the social welfare centre, or the social welfare service of the relevant local administration unit before the first appointment	

The Discharge Letter includes information about recommended medications, assessed risk and needs	
Discharge Plan includes information about the medical intervention provided at the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute	
Client history completed (please mark/underline): at the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute at the mental healthcare unit, at the social welfare centre, or the social welfare service of the relevant local administration unit	
Representative of the social welfare centre, or the social welfare service of the relevant local administration unit (name of the person)	

The discharged person exercises his/her rights at the social welfare centre, or the social welfare service of the relevant local administration unit – social assistance (please circle, add):

cash benefit,

long-term care and support benefit,

support for equalisation of opportunities for children and youth,

with developmental disabilities, placement in residential care facilities,

placement in foster families, home assistance and care,

day care,

one-off cash benefit, personal disability benefit, counselling.

(total BAM _____ per month)

The discharged person exercises extended rights at the social welfare centre, or the social welfare service of the relevant local administration unit (please circle, add):

food, medicines, house appliances, personal assistance, other extended rights:

The discharged person exercises his/her rights at the social welfare centre, or the social welfare service of the relevant local administration unit – child care (please circle, add):

assistance for new-born babies, maternity allowance,

child allowance,

refund for salary paid during maternity leave,

refund for salary paid for half-day work in case of increased child care until 3 years of age,

refund for salary paid for half-day work in case of increased care for a child with developmental disabilities,

meeting developmental needs of children,

pronatal benefits for a third-born and fourth-born child,parental/carer benefits

The discharged person uses community services (please circle, add):
day-care at
occupational therapy at
beneficiary groups, associations...
assisted living, organised living, protected houses, houses – clubs
professional rehabilitation, employment
recreational/sports activities at
counselling centre
therapeutic community
safe house
art, cultural, educational activities and content
ASSESSMENT:
Beneficiary is:
a) motivated for support b) disinterested c) not motivated for support
Beneficiary's family:
a) supportive b) disinterested c) unsupportive
Work with the family:
a) initiated by SWC b) initiated by the family
Field visits (number):
a) at household b) at hospital c) at MHPS
d) other (please specify)
Person of trust for the person with mental health disorders:
Care coordinator at the mental healthcare unit contacted (name of the person)

Date: _____ /__/ _____

Representative of the social welfare centre, or the social welfare service of the relevant local administration unit:

_____

* *The Checklist for post-hospital monitoring shall be filed in the documentation of the person with mental health disorders kept at the social welfare centre*

RATIONALE FOR THE RULEBOOK ON JOINT PLANNING OF DISCHARGE FOR PERSONS WITH MENTAL HEALTH DISORDERS

I LEGAL BASIS

The legal basis for the enactment of the Rulebook on joint planning of discharge for persons with mental health disorders is found in the provisions of Article 42 paragraph 4 of the Law on Mental Health (Official Gazette of Republika Srpska, 67/20), which prescribes that the Minister of Health and Social Protection shall enact a document regulating the types of discharge plans, needs assessment for persons with mental health disorders, planning methodology, coordination and implementation of the discharge plan; and in provisions of Article 76 paragraph 2 Law on Public Administration of Republika Srpska (Official Gazette of Republika Srpska, 115/18), which prescribes that the Minister shall represent the Ministry, enact regulations and decisions in administrative and other individual matters, decide on the rights and responsibilities of employees at the Ministry, and decide on other matters falling within the remit of the Ministry.

II COMPLIANCE WITH THE CONSTITUTION, LEGAL SYSTEM AND THE RULES OF LEGISLATIVE DRAFTING

III ALIGNMENT WITH THE LEGAL ORDER OF THE EUROPEAN UNION

According to the opinion given by the Ministry for European Integration and International Cooperation number and date after the review of the European Union regulations and the analysis of the provisions of the Rulebook on joint planning of discharge for persons with mental health disorders, it has not been established that the EU law contains secondary sources related to the scope of the submitted Rulebook, therefore the assessment given in the Statement of Compatibility is “non-applicable”.

IV RATIONALE FOR THE ENACTMENT OF THE RULEBOOK

The reason for the issuance of the Rulebook on joint planning of discharge for persons with mental health disorders lies in the fact that the Law on Mental Health (Official Gazette of Republika Srpska, 67/20) has entered into force and Article 65 paragraph 1 of the Law prescribes that the Minister of Health and Social Protection shall enact a document on joint planning of discharge for persons with mental health disorders within one year from the entry into force of this Law, and therefore the Rulebook has been drafted.

V EXPLANATION OF PROPOSED SOLUTIONS

Article 1 regulates the scope of the Rulebook.

Article 2 regulates the timing of the joint planning of discharge for persons with mental health disorders.

Article 3 regulates the contents of the joint planning.

Article 4 regulates initial treatment planning.

Article 5 regulates comprehensive planning.

Article 6 prescribes that the planning of discharge from the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute shall commence after the full stabilisation of the clinical status, i.e. after the recovery of the person with mental health disorders.

Article 7 regulates types of discharge.

Article 8 regulates activities included in post-discharge planning for a routine/simple discharge.

Article 9 regulates activities included in post-discharge planning for a complex discharge.

Article 10 prescribes that the social welfare centre shall perform an assessment of individual social needs of the person with mental health disorders, an assessment of the support provided by the person's family, and an assessment of the support provided by the person's immediate community, designation of a representative responsible for cooperation with the discharge coordinator during the time the person with mental health disorders spends at the psychiatric hospital ward, psychiatric clinic at the clinical centre, specialised hospital or forensic psychiatry institute, and with the care coordinator after the person's discharge.

Article 11 regulates the entry into force of this Rulebook.

VI PUBLIC PARTICIPATION AND CONSULTATIONS

In accordance with Article 36 paragraph 1 item 9) of the Rules of Procedure of the Government of Republika Srpska (Official Gazette of Republika Srpska, 123/18) and items 4 and 15 of the Guidelines on the procedure in administrative bodies of Republika Srpska regarding public participation and consultations in the law-drafting process (Official Gazette of Republika Srpska, 123/08 and 73/12), the drafter of the Rulebook on joint planning of discharge for persons with mental health disorders has conducted public consultations, since the matters regulated by the Rulebook affect the public and are subject to consultations. Also, the Draft Rulebook has been published on the website of the Ministry and has thus been made available to all interested authorities, organisations and individuals.

VII FINANCIAL RESOURCES AND ECONOMIC RATIONALE FOR THE ENACTMENT OF THE RULEBOOK

Implementation of this Rulebook does not require any financial resources.

This material was produced with the financial support of the European Union and Council of Europe. Its contents are the sole responsibility of the author(s).

Views expressed herein can in no way be taken to reflect the official opinion of the European Union or the Council of Europe.

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