



CROATIA

“Once You Enter, You Never Leave”

Deinstitutionalization of Persons with Intellectual
or Mental Disabilities in Croatia

H U M A N
R I G H T S
W A T C H



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Summary

“Once you enter, you never leave,” Marija S. said of her new home—an institution for persons with intellectual and/or mental disabilities in the city of Karlovac, Croatia. Marija, a young woman in her 20s, had entered the institution, innocuously named the Center for Therapy and Rehabilitation “NADA” (meaning “Hope”), six months earlier in June 2009.

Marija’s situation is complex but not uncommon: she has both mild intellectual and mental disabilities that limit her participation in society. Since her family has not always been able to care for her, Marija has lived in institutions for most of her life—but not always. Directly before arriving at NADA, Marija lived for two-and-a-half years in an independent living program in Zagreb which provided housing and support for persons with intellectual disabilities. Here, Marija was able to experience life in the community—working, taking care of her own needs, and coming and going as she pleased.

But as Marija’s mental state deteriorated, she was forced to find another living situation, one that could support persons with mental, and not just intellectual, disabilities. Since there were no similar supportive community living programs for persons with mental disabilities in Croatia, and Marija could not live on her own without support or with her family, there was no choice but to send her back to an institution—NADA. Initially, Marija’s therapists talked with her about one day moving back into the community. “There, I was free,” Marija said. But as the months passed, such discussions waned, along with Marija’s hope that she would ever live outside an institution again.

Living in the community often seems like a remote possibility for persons with disabilities—particularly those with intellectual or mental disabilities—who live in Croatian institutions. The government has pledged to improve the lives of persons with disabilities, including moving them out of institutions and creating programs that would support them in the community. But despite these commitments, institutional care is growing rather than shrinking in Croatia, and few individuals in institutions are returning to live in the community.

While up to 30 percent of residents in some institutions are institutionalized by choice—often because there is no alternative form of support in the community—most are not. Between 70 and 100 percent of residents of some institutions for persons with intellectual or mental disabilities are institutionalized without their consent or the opportunity to challenge the decision, due to a legal process known as “deprivation of legal capacity” that robs them

of the right to make important choices for themselves. Most persons with intellectual or mental disabilities who are institutionalized remain so for the rest of their lives.

Like many European countries, Croatia has been badly affected by the global financial crisis. As a result, it has experienced significant cuts in government spending, which have likely contributed to the slow pace of reform. However, at the heart of Croatia's failure to live up to its pledge is not lack of money but lack of leadership concerning the process of deinstitutionalization. This includes the need to create a plan for deinstitutionalization and the prevention of institutionalization and to develop viable alternatives such as supportive and independent community living programs.

These alternative programs are no more expensive—and often cheaper—than comparable quality care in institutions after initial start-up costs. Despite this fact, Croatia has continued to invest in institutions—building new ones and undertaking major refurbishment projects at old ones—rather than supporting community-based services. This investment should be diverted to community support programs that better promote the rights and inclusion of persons with intellectual or mental disabilities, with the goal of closing institutions down.

The relatively few prominent cases of grave abuse in Croatian institutions do not mean that they are places where the human rights of persons with intellectual or mental disabilities are fully realized, or indeed realizable. Rather, violations of human rights standards in Croatia's institutions are subtle and persistent, stripping persons with disabilities of their privacy and individuality. It is essential to ensure that adequate community-based alternatives to housing and care exist to improve the quality of life for persons with disabilities. By not taking action, the Croatian government is not only guilty of empty rhetoric, but of also contravening international agreements—both binding and non-binding—to which it has committed and which it should be expected to honor.

By the end of 2008, approximately 5,000 adults and children with intellectual disabilities and 4,000 adults with mental disabilities lived in Croatian institutions, according to government figures. Most institutions also have waiting lists.

Persons with intellectual disabilities are people with a permanent and lifelong intellectual limitation or limitations that begin before the age of 18. These limitations usually involve significantly lower than average intellectual abilities that limit intellectual or social

functioning or adaptation to new environments and participation in society. In Croatia, persons with intellectual disabilities are referred to as persons with “mental retardation.” Mental disabilities consist of conditions which are usually associated with the need for psychiatric care. Mental health difficulties are considered disabilities when they affect a person’s full and effective participation in society, and thus they are often called psychosocial disabilities.

Most institution residents reside in three main types of facilities: social welfare homes, psychiatric hospitals, and smaller institutions known as “family homes.” In addition, many adults with disabilities live in foster families—which in some cases are equivalent to institutions because individuals are placed there without their consent and have limited interaction with the community.

All persons with intellectual or mental disabilities face barriers to full inclusion in Croatian society, including limited access to education, work, and healthcare. However, institutions are places where persons with disabilities are also deprived of the choice of where and how to live, their individuality, and their ability to join wider society—and those who live in them are more vulnerable to other human rights violations, including deprivations of privacy and physical or mental abuse. Moreover, Croatia’s guardianship system, which deprives individuals of legal capacity and substitutes the decision-making of adults with disabilities with that of a guardian, further denies individuals of the choice of where and how to live and lacks necessary safeguards to prevent abuse.

Croatia was one of the first countries in the world to sign and ratify the Convention on the Rights of Persons with Disabilities (CRPD) and thus to commit itself to the fulfilling the rights of these individuals. But the isolation from mainstream society and deprivation of legal capacity that persons with disabilities face in Croatia violates the CRPD, which enumerates the right of persons with disabilities to live in the community and to choose, on an equal basis with others, where and with whom they live. The government’s failure to make significant strides towards deinstitutionalization and to create viable alternatives also contravenes its pledge in a 2006 non-binding agreement with the European Commission, the Joint Inclusion Memorandum (JIM).

According to the United Nations Office of the High Commissioner for Human Rights, the right to live in the community obligates states parties to the CPRD to replace their system of institutional care with a range of inclusive community alternatives to institutions. One of the most effective ways of supporting individuals with disabilities in the community is through supportive and independent community living programs that provide housing in individual

or group apartments in the community, individual support for community living, and freedom to interact with the community.

There are few programs in Croatia that provide community-based support. The largest program offering supportive and independent community living to persons with intellectual disabilities in Croatia, run by the Association for Promoting Inclusion (API) and funded by the government, is contracted to serve only 125 individuals (although it serves roughly thirty more through an informal agreement with the government). Furthermore, state funding for community-based alternatives to institutions has stagnated: despite its success, API has not received a new contract from the Ministry of Health and Social Welfare since 2006—before Croatia ratified the CRPD and signed the JIM—making it hard for the program to expand its services.

The situation for persons with mental disabilities is even worse. Only two programs offer supportive and independent community living in the whole country and even then can only support a total of seven individuals—a tiny fraction of the more than 4,000 individuals with mental disabilities who live in Croatia’s institutions.

It is not easy to move people out of institutions and into care in the community. However, much can be learned from the experiences, both positive and negative, of other countries—such as the United Kingdom, United States and Sweden—that have tried to do so. These countries were motivated partly by a desire to cut social welfare costs, but they also believed that persons with both mild and profound disabilities are better off in the community. This hypothesis has continued to prove true over the years.

Amongst the lessons that Croatia can draw from these and other countries is how to plan for deinstitutionalization; how to minimize the impact of shuttering institutions on residents, employees, and the local economy; how to overcome stigma and fears that families and the individuals themselves may have about moving into the community; and how to develop alternatives to institutions that give individuals real choice and a better quality of life.

Croatia is not the only country in the Western Balkans that has done little for its population of persons with disabilities living in institutions: disability rights NGOs and the UN Human Rights Council have recently criticized Serbia, Bosnia, and Kosovo for their treatment of persons with disabilities, particularly in institutions. All three locations share a common system of institutionalization with Croatia stemming from the former Yugoslavia, so it is not surprising that they face similar issues to Croatia. However, Croatia is distinct from these

other countries in that it has been a leader in voluntarily and consistently pledging to do more for persons with disabilities.

The main barrier to deinstitutionalization in Croatia, however, is that no one in government has taken the lead in promoting deinstitutionalization and the development of community-based alternatives to the support and housing of persons with disabilities. This failure of leadership falls primarily on the Ministry of Health and Social Welfare, which has yet to even create a plan for deinstitutionalization, let alone take concrete steps to move persons with disabilities out of institutions and into community-based support programs.

As part of its leadership role, the ministry should involve persons with disabilities, disabled persons organizations, and other experts on disability rights in this entire process. Non-government and inter-government actors, such as the Croatian Ombudswoman for Persons with Disabilities, the European Union, and the United Nations Committee on the Rights of Persons with Disabilities, should help to create the political will for change by pressing the Croatian government to realize its own rhetoric. Croatia must recognize that a pledge to fulfill the rights of persons with disabilities means nothing without action to back it up.

Key Recommendations to the Croatian Government

- Develop a plan for deinstitutionalization and prevention of further institutionalization of all persons with intellectual or mental disabilities, based on the values of equality, independence, and inclusion for persons with disabilities.
- Stop building new institutions, undertaking major refurbishment projects at old institutions, and building preparation homes at institutions. Instead, invest this money in expanding the number of places in existing community-based services and creating new programs for persons with intellectual or mental disabilities. To maintain the standard of living at institutions during the process of deinstitutionalization, the cost of essential repairs should be included in the operating budget of each institution.
- Where NGOs, private actors, and local/regional governments are not developing adequate alternatives to institutions, create centralized structures from existing budget lines that provide community-based services.
- Create a body composed primarily of persons with disabilities and other experts to monitor and assess the effectiveness of community-based support services. Incorporate the conclusions of this body into future regulations on the provision of social services. Ensure that persons with disabilities, disabled persons organizations, NGOs working on deinstitutionalization, and the Ombudswoman for Persons with Disabilities are all involved in planning for deinstitutionalization.

- Reform laws on legal capacity to create a system of supported decision-making which includes court-monitored safeguards against abuse and a right to an attorney in legal capacity proceedings.
- Reform laws which permit individuals to be placed in institutions without their consent so that all processes of placement are subject to independent review and oversight by a court with a right to publicly-funded legal representation and the right to challenge the lawfulness of the detention.

Methodology

This report is based on interviews that Human Rights Watch conducted in November and December 2009 with civil society organizations, current and former residents of institutions, directors and staff at institutions, directors of Centers for Social Welfare, and government officials. These interviews were supplemented by research conducted through July 2010.

All interviews were conducted in Croatian or English by a team from Human Rights Watch, assisted by translators fluent in both Croatian and English. The primary researcher, also the author of this report, was present during all interviews. Three other staff members joined the primary researcher individually at different stages of the research.

Human Rights Watch interviewed a total of 28 current and former residents of institutions, in both group and individual interviews. When these interviews were conducted in institutions, they always took place without oversight from institution staff, and beyond their hearing. The names of institution residents have been replaced by pseudonyms.

Human Rights Watch ensured that all interviewees—especially current and former residents of institutions—were informed of the interview’s purpose, its voluntary nature, and the ways that data would be used. All consented verbally to be interviewed and were told they could decline to answer questions and end the interview at any time.

Researchers visited nine institutions in seven regions of Croatia, which housed in total approximately 1,500 individuals. Institutions were selected based on geographical diversity and type of institution. Researchers also visited institutions that have implemented deinstitutionalization programs.

Human Rights Watch visited four institutions classified as social welfare homes for persons with physical/intellectual disabilities which primarily housed persons with intellectual disabilities: the Center for Rehabilitation—Stancic (“Stancic”), the Center for Rehabilitation

located in Sveti Filip i Jakov (“Sveti Filip i Jakov”); the Center for Therapy and Rehabilitation NADA in Karlovac (“NADA”); and the Center for Rehabilitation Roman Obitelj in Bratiskovci near Skradin (“Roman Obitelj”). One of these homes, NADA, catered to persons with both intellectual and mental disabilities.

Human Rights Watch also visited a psychiatric hospital that contains a home specifically for long-term residents (Lopaca Psychiatric Hospital or “Lopaca”), as well as three social welfare homes for adults with mental disabilities: the Homes for Mentally Ill Adults in Lobar Grad (“Lobar Grad”), Mirkovec (“Mirkovec”), and Zagreb (“Zagreb home”). Researchers also visited a home for persons with autism based at the Center for Autism in Zagreb that operates under the jurisdiction of the Ministry of Science, Education, and Sport.

At each institution, directors and/or staff members were interviewed based on a questionnaire about the population, structure, and funding of the institution developed in November 2009. Where possible, researchers also spoke with residents. Researchers received a tour of the facilities, which were limited at three institutions because staff members said they feared residents would catch or spread the seasonal flu. Human Rights Watch also conducted interviews with directors of two Centers for Social Welfare in Zadar and Dugo Selo.

Human Rights Watch spoke with members of civil society in Croatia that work on disability rights issues, including: staff from the offices of the Croatian People’s Ombudsman, Ombudswoman for Persons with Disabilities, the Ombudswoman for Children; four local NGOs; and one local disabled persons organization for persons with intellectual disabilities. Human Rights Watch also consulted a local psychiatrist and a local attorney working with persons with intellectual or mental disabilities.

Human Rights Watch also conducted interviews with Croatian government officials, including the Ministry of Health and Social Welfare; the Ministry of Family, Veterans’ Affairs, and Intergenerational Solidarity; the Ministry of Foreign Affairs and European Integration; and the Governmental Office of Human Rights. We interviewed staff at the UN Development Program, the World Bank, and the European Commission in Zagreb and Brussels.

Research included review of Croatian government statistics, public information, and laws and consulted reports written by the European Commission, the UN and other intergovernmental agencies, NGOs, and Croatian ombudsperson offices.

I. Background on Deinstitutionalization

Persons with disabilities have been housed in institutions for centuries. For much of this time, psychiatric hospitals and other institutions were seen as a progressive and humane way to house and treat persons with intellectual or mental disabilities while also keeping them out of the public eye.¹ That approach changed drastically during the latter half of the 20th century, particularly in North America and Western Europe where abuse scandals, new movements pushing for equal rights for persons with disabilities, and a desire to cut costs motivated a shift from institutions to community-based services.²

Scholars have found that community-based support services and supportive living arrangements almost universally provide a better quality of life for persons with intellectual or mental disabilities than do institutions.³ This is partly because such programs allow for more social inclusion for individuals with disabilities and can provide better individual care than institutions, where services are more often group-oriented.⁴

According to a European Union-commissioned study of institutions and their alternatives in 28 countries from 2003 to 2007, community-based support programs are also usually no

¹ Gerald N. Grob, "Mental Health Policy in America," *Health Affairs*, <http://content.healthaffairs.org/cgi/reprint/11/3/>, p. 8; Kent Ericsson and Jim Mansell, "Introduction: towards deinstitutionalization," in Jim Mansell and Kent Ericsson, eds., *Deinstitutionalization and community living: intellectual disability services in Scandinavia, Britain, and the USA* (London: Chapman & Hall, 1996) (reporting on lessons learned from deinstitutionalization in those countries from 1970 to 1995), <http://www.kent.ac.uk/tizard/staff/documents/Mansell1996DeinstitutionalisationandCommunityLiving.pdf> (accessed March 8, 2010); Jim Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report* (Canterbury: Tizard Center, University of Kent, 2007), p. 1.

² Mansell et al., *Deinstitutionalization and community living—outcomes and costs*, p. 1; Valerie Bradley, "Foreword" in *Deinstitutionalization and Community Living: Intellectual disability services in Scandinavia, Britain, and the USA* (1996) (noting that many countries that have undergone deinstitutionalization have simultaneously seen a shrinking number of resources directed at social welfare generally, requiring them to "do more with less"); Grob, "Mental Health Policy in America," *Health Affairs*, <http://content.healthaffairs.org/cgi/reprint/11/3/>, p. 8; Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report*, p. 1.

³ Ericsson and Mansell, "Introduction: towards deinstitutionalization," in Mansell and Ericsson, eds., *Deinstitutionalization and community living: intellectual disability services in Scandinavia, Britain, and the USA*, <http://www.kent.ac.uk/tizard/staff/documents/Mansell1996DeinstitutionalisationandCommunityLiving.pdf>; Jim Mansell, "Deinstitutionalization and community living: Progress, problems and priorities," *Journal of Intellectual & Developmental Disability*, vol. 31(2) (2006), http://www.kent.ac.uk/tizard/staff/documents/mansell2006jidd_declprogress.pdf (accessed March 8, 2010) (reporting on progress on and obstacles in the way of deinstitutionalization in North America, Europe, and Australia up to 2006).

⁴ Julie Beadle-Brown, Jim Mansell, and Agnes Kozma, "Deinstitutionalization in intellectual disabilities," *Current Opinion in Psychiatry*, vol. 20 (2007), <http://www.kent.ac.uk/tizard/staff/documents/Beadle-Brown%202007%20COP%20Deinst%20and%20ID.pdf> (accessed March 8, 2010) (summarizing recent literature regarding deinstitutionalization in Europe, North America, and Australia from 2000 to 2007); Ericsson and Mansell, "Introduction: towards deinstitutionalization," in Mansell and Ericsson, eds., *Deinstitutionalization and community living: intellectual disability services in Scandinavia, Britain, and the USA*, <http://www.kent.ac.uk/tizard/staff/documents/Mansell1996DeinstitutionalisationandCommunityLiving.pdf>.

more expensive than comparable-quality institutional care, and when they are (such as for persons with more severe disabilities), community services are more or equally cost-effective since the increased quality of life for recipients offsets the additional cost.⁵

While there are a number of barriers to deinstitutionalization (explored below), extensive research into the experiences of other countries has shown that it is indeed a viable option for all persons with intellectual or mental disabilities. As two leading scholars said: “The major questions about services no longer concern the feasibility of replacing institutions but the nature of replacement services and the extent to which these societies are politically committed to enabling people ... to realize their potential as citizens.”⁶

Barriers and Solutions to Deinstitutionalization

One often-cited barrier to deinstitutionalization is the cost involved in transitioning to community-based care. Although care in the community tends to be less expensive in the long-term, the short-term costs of operating institutions and community programs simultaneously can be high. This challenge is best tackled by creating ambitious plans for closing institutions, as this will in the long term lead to substantial cost savings in the social welfare system.

Severe intellectual disabilities—including those that manifest in aggression, self-hitting, or other behaviors that encourage isolation—also pose challenges when it comes to moving people out of institutions. Indeed, persons with severe intellectual disabilities are often the last to be deinstitutionalized because authorities may find it hard to plan how to support them in the community. They are also the most likely to return to institutions and to suffer from lower quality of life outside them.⁷ However, research and experience have shown that even persons with the most severe intellectual disabilities and challenging behaviors can live successfully in the community if they have adequate support. For instance, one study based in the UK showed that with the right level of individual care and attention in the community, these individuals participated more in meaningful activities, such as

⁵ Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report*, pp. 63-65. The study included all EU member states and Turkey. It was conducted by four of the top scholars on deinstitutionalization as well as representatives in all 28 of the countries and included persons with intellectual, physical, and mental disabilities.

⁶ Ericsson and Mansell, “Introduction: towards deinstitutionalization” in Mansell and Ericsson, eds., *Deinstitutionalization and community living: intellectual disability services in Scandinavia, Britain, and the USA*, <http://www.kent.ac.uk/tizard/staff/documents/Mansell1996DeinstitutionalisationandCommunityLiving.pdf>.

⁷ Beadle-Brown, Mansell, and Kozma, “Deinstitutionalization in intellectual disabilities,” *Current Opinion in Psychiatry*, <http://www.kent.ac.uk/tizard/staff/documents/Beadle-Brown%202007%20COP%20Deinst%20and%20ID.pdf>.

educational activities or socializing with others, and displayed fewer challenging behavior.⁸ While such individual attention may be more expensive than institutional care, individuals enjoy a commensurate improvement in their quality of life.

Another hurdle to deinstitutionalization is the stigma often associated with mental disabilities. Stereotypes—including that persons with mental disabilities are responsible for their own illness, are dangerous, or are child-like and need to be treated as such—often impact the broader community's willingness to accept such individuals. Research has shown that the best way to combat this antipathy is to promote contact between the general public and persons with mental disabilities, but this contact is difficult to achieve as long as persons with mental disabilities remain institutionalized.⁹

Resistance to deinstitutionalization may not only come from the community but from institution residents reluctant to leave a place that they have come to see as home. Research has shown, however, that even individuals who are initially unwilling to leave institutions later report that they prefer life in the community, and that it is important they are involved in their own future care to ensure that service providers cater efficiently to individual needs.¹⁰

Yet another stumbling block to deinstitutionalization can sometimes come from staff and the community in which the institution is based. Institutions are often large, remotely-located, employ many individuals, and frequently form the backbone of the local economy in which they are situated.¹¹ Resistance from staff and local residents to moving institution residents into community support programs is therefore understandable but also surmountable by retraining staff to provide support in the community. Past experience has shown that providing staff with these skills boosts staff morale and motivation to deinstitutionalize.¹²

⁸ Jim Mansell, Peter McGill, and Eric Emerson, "Development and evaluation of innovative residential services for people with severe intellectual disability and serious challenging behavior," in L. M. Glidden, ed., *International Review of Research in Mental Retardation* (New York: Academic Press, 2001), <http://www.kent.ac.uk/tizard/staff/documents/Mansell%202001%20IRRM2.pdf> (accessed March 8, 2010) (reporting on results from a study of community-based programs in south-east England from 1985 to 2000).

⁹ Patrick W. Corrigan and Amy C. Watson, "Understanding the impact of stigma on people with mental illness," *World Psychology*, February 2002, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489832/> (accessed March 8, 2010).

¹⁰ Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report*, p. 50.

¹¹ Ericsson and Mansell, "Introduction: towards deinstitutionalization" in Mansell and Ericsson, eds., *Deinstitutionalization and community living: intellectual disability services in Scandinavia, Britain, and the USA*, <http://www.kent.ac.uk/tizard/staff/documents/Mansell1996DeinstitutionalisationandCommunityLiving.pdf>.

¹² Donald Shumway, "Closing Laconia," in Mansell and Ericsson, eds., *Deinstitutionalization and community living: intellectual disability services in Scandinavia, Britain, and the USA*, <http://www.kent.ac.uk/tizard/staff/documents/Mansell1996DeinstitutionalisationandCommunityLiving.pdf> (reporting from experience in closing an institution for persons with intellectual disabilities in New Hampshire from 1975 to 1991).

II. Croatia's Obligations under International Law

Croatia is a party to all major international human rights conventions, including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the European Convention on the Protection of Human Rights and Fundamental Freedoms (ECHR).¹³ As previously noted, Croatia has also ratified the Convention on the Rights of Persons with Disabilities (CRPD).¹⁴

The Universal Declaration of Human Rights recognizes that all persons are equal in dignity and rights; however, states have not always applied existing human rights standards to persons with disabilities. The CRPD makes explicit that the human rights enumerated in other major human rights documents apply with equal force and in particularly important ways to individuals with disabilities. It also elaborates on how the rights of persons with disabilities should be particularly protected.

The CRPD was adopted by the UN General Assembly on December 13, 2006, and entered into force on May 3, 2008. At time of writing, it had been signed by more than 146 countries and ratified by 89 countries.¹⁵ Croatia was among the first countries to ratify the CRPD on August 15, 2007. The European Union has also signed and agreed to accede to the CRPD, but has not yet deposited its ratification with the UN.¹⁶

Article 3 of the CRPD sets out the convention's guiding principles, which include dignity, autonomy, non-discrimination, participation, inclusion, respect and acceptance, equality of opportunity, and accessibility for persons with disabilities. The CRPD shifts the paradigm of

¹³ European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), 213 U.N.T.S. 222, entered into force September 3, 1953, as amended by Protocols Nos. 3, 5, 8, and 11 which entered into force on September 21, 1970, December 20, 1971, January 1, 1990, and November 1, 1998, respectively, ratified by Croatia November 5, 1997.

¹⁴ Convention on the Rights of Persons with Disabilities (CRPD), adopted December 13, 2006, G.A. Res. 61/106, Annex I, U.N. GAOR, 61st Sess., Supp. (No. 49) at 65, U.N. Doc. A/61/49 (2006), entered into force May 3, 2008, ratified by Croatia August 15, 2007.

¹⁵ United Nations Treaty Collection, UN Convention on the Rights of Persons with Disabilities, available at http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&lang=en (accessed August 12, 2010).

¹⁶ United Nations Enable, List of Signatories to the CRPD, <http://www.un.org/disabilities/countries.asp?id=166> (accessed April 16, 2010); United Nations Enable, Newsletter, December 2009, <http://www.un.org/disabilities/documents/newsletter/december2009.doc> (accessed April 16, 2010). The CRPD provides an unusual clause in human rights treaties to date that allow "regional integration organizations" to sign and become a party to the treaty, CRPD art. 42-47. As of April 2010, only 14 of the 27 EU member states had ratified the CRPD, including Austria, Belgium, the Czech Republic, Denmark, France, Germany, Hungary, Italy, Latvia, Portugal, Slovenia, Spain, Sweden, and the United Kingdom. United Nations Enable, List of Ratifications of the CRPD, <http://www.un.org/disabilities/default.asp?id=257> (accessed April 18, 2010).

disability rights: that is, disability is no longer viewed as a medical condition of which someone needs to be “cured.” Rather the text of the CRPD emphasizes that disability is inherently human, requiring society itself to adapt.¹⁷ The primary message of the CRPD is that persons with disabilities should be able to participate fully and equally in society.

Definition of Disability

The CRPD does not explicitly define “persons with disabilities” but instead describes this group as including “those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”¹⁸ This description, according to the UN Office of the High Commissioner for Human Rights (OHCHR), “reflect[s] an understanding of disability as a social phenomenon.”¹⁹ Although persons with mental disabilities are not always included in definitions of disability, the CRPD makes explicit that persons with mental impairments are persons with disabilities and thus are entitled to all of the same protections. Indeed, OHCHR stated in a recent study about implementation of the CRPD that “national disability legislation must unequivocally protect all persons with disabilities, including persons with mental and intellectual disabilities.”²⁰

The Right to Live in the Community

The explicit right to live in the community contained in the convention stems from a long history of institutionalization of persons with disabilities, which has increasingly been recognized as discriminatory and unnecessary. According to Article 19, “States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community...”²¹ To promote equality of choice in living arrangements, states parties should ensure persons with disabilities are not forced to live in any particular arrangement and can choose where and with whom they live.²²

¹⁷ CRPD, Preamble.

¹⁸ *Ibid.*, art. 1

¹⁹ United Nations Office of the High Commissioner for Human Rights (OHCHR), “Thematic Study on enhancing awareness and understanding of the Convention on the Rights of Persons with Disabilities,” January 26, 2009, <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf> (accessed March 8, 2010), para. 36.

²⁰ *Ibid.*

²¹ CRPD, art. 19.

²² CRPD, art. 19(a).

States should also facilitate the right to live in the community by offering “a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community.”²³ States should also respect an individual’s right to privacy in any type of living situation.²⁴ While full realization of this right is subject to available resources, a state should nevertheless undertake the steps necessary towards its realization.

Although the CRPD is a new convention, the right to live in the community and receive community-based support is not new. It first appeared in 1971 with the U.N. General Assembly Declaration on the Rights of Mentally Retarded Persons (“mentally retarded persons” is an outdated term for persons with intellectual disabilities), which provides that, “Whenever possible, the mentally retarded person should live with his own family or with foster parents and participate in different forms of community life.”²⁵ The U.N. General Assembly repeats the same sentiment in the 1991 U.N. Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care (MI Principles): “Every person with a mental illness shall have the right to live and work, as far as possible, in the community”²⁶; and “Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.”²⁷ No similar principles exist for persons with physical disabilities.

According to the OHCHR’s national implementation criteria for the CRPD, parties to the CRPD need to shift social service systems for persons with disabilities away from those focused on institutional care towards a system of community-based support services, including housing.²⁸ Such a system should allow for equal choice, independence, and full inclusion and participation in the community. The lack of any reference in Article 19 to institutional housing and care reflects an evolving body of research and experience that over the last 40

²³ CRPD, art. 19(b).

²⁴ CRPD, art. 22.

²⁵ United Nations Declaration on the Rights of Mentally Retarded Persons, December 20, 1971, G.A. res. 2857 (XXVI), 26 U.N. GAOR Supp. (No. 29) at 93, U.N. Doc A/8429 (1971), para. 4.

²⁶ United Nations Principles for the Protection of Persons with Mental Illnesses and the Improvement of Mental Health Care (MI Principles), December 17, 1991, G.A. res. 46/119, 46 U.N. GAOR Supp. (No. 49) at 189, U.N. Doc. A/46/49 (1991), principle 3.

²⁷ *Ibid.*, principle 7(1).

²⁸ OHCHR, “Thematic Study,” <http://www2.ohchr.org/english/bodies/hrcouncil/docs/10session/A.HRC.10.48.pdf>, para. 50 (“The recognition of the right of persons with disabilities to independent living and community inclusion requires the shift of government policies away from institutions and towards in-home, residential and other community support services.”).

years has shown that even those with the most severe disabilities can live and integrate into the community if given adequate support.²⁹

Legal Capacity and Arbitrary Detention

The right to live in the community is linked to two other important human rights principles: the right to exercise legal capacity contained in Article 12 of the CRPD; and the right against arbitrary detention contained in Article 9 of the ICCPR, Article 5 of the ECHR, and Article 14 of the CRPD.

Individuals with intellectual and/or mental disabilities are particularly vulnerable to placement in institutions because they are often deprived of their ability to make important life decisions. Therefore, to ensure the right to live in the community, states should also respect the right to the full exercise of legal capacity. Under international human rights law, every person has the right to recognition as a person under the law.³⁰ This recognition as a person comes with the presumption that a person can make life decisions on his or her own behalf. Because persons with intellectual or mental disabilities have historically been subject to legal and actual limitations on their exercise of legal capacity, the right to self-determination and recognition as a person under the law has particular significance for this population. Accordingly, Article 12 of the CRPD provides that “States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life” and “shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.”³¹

The UN General Assembly in 1971 and 1991 took for granted that individuals with certain degrees of intellectual or mental disability would not be capable of exercising some rights on their own and needed to be protected. Courts could thus deprive individuals of the capacity to make important decisions and exercise rights on their own behalves.³² The CRPD fundamentally shifts the discourse on legal capacity by removing “deprivation” and “protection” from its provisions. The text of Article 12 instead creates the assumption that

²⁹ See Section II above.

³⁰ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by Croatia on October 12, 1992, art. 16; Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A(III), U.N. Doc. A/810 at 71 (1948), art. 6.

³¹ CRPD, art. 12(2); CRPD, art. 12(3).

³² MI Principles, principle 1(6); Declaration on the Rights of Mentally Retarded Persons, paras. 5, 7.

persons with disabilities can act in their own best interests and that, when needed, they should be given support to do so.

However, the text of Article 12 does not foreclose the possibility of a support system in which a third party may advise or assist a person in making decisions and exercising rights. Again, this system should be a regime of support for the individual's exercise of rights, a process by which the will and the preferences of the person are fully respected. Within this support system, a state must ensure safeguards to prevent abuse. These safeguards should ensure that the support provided is proportionate to the person's circumstances, limited in duration, free from conflicts of interest, and subject to regular, impartial review by a judicial body.³³ Additionally, the state should guarantee the individual a right to counsel in any proceedings concerning the need for support.³⁴

As the state supports the right of persons with disabilities to live in the community, it should also review its own procedures for compulsory placement of individuals into institutions, which is a deprivation of liberty. The guarantees of liberty and security of the person, and the right to challenge any deprivations of those liberties, have long been safeguards against arbitrary detention and are considered some of the most fundamental rights.

The right to liberty and security of the person in its modern formulation is embodied in Article 9 of the ICCPR, which states, "No one shall be subjected to arbitrary arrest or detention" and "no one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law."³⁵ Article 9 also mandates that an individual have the opportunity to challenge his or her detention, such that "[a]nyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful."³⁶

According to the UN Human Rights Committee, these provisions apply not only to those accused of crimes but also "to all persons deprived of their liberty by arrest or detention" including those detained because of, "for example, mental health difficulties, vagrancy, drug addiction, immigration control, etc."³⁷

³³ CPD, art. 12(4).

³⁴ MI Principles, principle 1.

³⁵ ICCPR, art. 9(1).

³⁶ ICCPR, art. 9(4).

³⁷ UN Human Rights Committee, General Comment 8, Article 9, U.N. Doc HRI/GEN/1/Rev.1 at 8 (1994), para. 1.

Article 5 of the ECHR provides similar protections to Article 9 of the ICCPR, except that it explicitly enumerates that those with “unsound mind,” a term which neither the convention nor the European Court of Human Rights have defined with precision but appears only to refer to persons with mental disabilities, may be lawfully detained on that basis.³⁸ Those detained for “unsound mind” must also have recourse to a court to decide on the lawfulness of the detention.³⁹

Article 14 of the CPRD, however, provides even greater protections against deprivations of liberty to persons with disabilities. Article 14 not only forbids arbitrary detention but also states that detention cannot be justified on the basis of the existence of a disability. There should therefore be some basis, one that does not discriminate based on disability, underlying the deprivation of liberty.

Article 14 of the CRPD thus goes further than the previous regime of arbitrary detention enumerated in Article 9 of the ICCPR. For states that have ratified the CRPD, Article 14 sets the higher standard with respect to safeguards against detention than its equivalent provision in the ICCPR or ECHR, and should be applied under the doctrine that the combined effect of any treaties or domestic norms should be interpreted so as to offer the greatest protection to the individual.⁴⁰ Additionally, Article 14, particularly when read in combination with Article 19 of the CRPD (the right to live in the community), provides a strong basis for the end of forced institutionalization on the grounds of disability.

Regardless of the reasons for detention, the European Court of Human Rights (ECtHR) has decided a number of cases based on Article 5 of the ECHR about when “detention” has occurred, and the safeguards needed to prevent arbitrary detention. According to the ECtHR’s jurisprudence, people who have been placed in institutions are “deprived of liberty” within the meaning of Article 5 when they have not consented to placement in the institution, and staff at the institution exercise “complete and effective control over [their] care and

³⁸ European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), 213 U.N.T.S. 222, entered into force September 3, 1953, as amended by Protocols Nos 3, 5, 8, and 11 which entered into force on September 21, 1970, December 20, 1971, January 1, 1990, and November 1, 1998, respectively, ratified by Croatia November 5, 1997, art. 5(1)(e).

³⁹ European Court of Human Rights, *Winterwerp v. Netherlands*, (no. 6301/73), judgment of October 24, 1979, Series A no. 33, available at www.echr.coe.int, para. 37 (“The Convention does not state what is to be understood by the words ‘persons of unsound mind.’ This term is not one that can be given a definitive definition ... it is a term whose meaning is continually evolving as research in psychiatry progresses, an increasing flexibility in treatment is developing and society’s attitudes to mental illness changes, in particular so that a greater understanding of the problems of mental patients is becoming more wide-spread.”); ECHR art. 5(4).

⁴⁰ See Article 5(2) of the ICCPR and Article 53 of the ECHR. The so-called “savings clauses” of the treaties set out that the standards in the respective treaties cannot be used to undermine a higher standard or protection provided elsewhere in law (either international or domestic), and therefore represent only the minimum standard and may be improved.

movements.”⁴¹ Additionally, a person is deprived of liberty when placed in an institution against his or her will even if that person is not actively resisting institutionalization, the facility is not locked or lockable, or the person has been permitted to frequently leave the facility unsupervised.⁴² Thus, under the European Convention, the prohibition on arbitrary detention applies even to those facilities that claim they are not detaining individuals, as long as those housed within them are not free to leave. This interpretation is further supported by Article 12 of the CRPD, which provides for the respect for “rights, will and preferences” of persons with disabilities.

According to the jurisprudence of the European Court, when a person is placed in an institution for any reason, the decision to place that person must contain certain safeguards. It must be made by a competent body, usually a court.⁴³ If the decision is instead made by another branch of the government, such as an executive administrative agency, the state must allow for review by a court.⁴⁴ Court review is necessary to protect the individual from executive branch authority, and is the most important procedural safeguard against arbitrary detention in the process of compulsory institutionalization.⁴⁵

The Right to Health

Article 12 of the ICESCR provides “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁴⁶ However, since states have different levels of resources, international law does not mandate the kind of healthcare to be provided. To this end, Article 12 of the ICESCR goes on to state that parties must take certain steps to “achieve full realization of this right.”⁴⁷ While the right to health is considered a right of progressive realization, states parties have a “specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of [the right].”⁴⁸

⁴¹ European Court of Human Rights, *Storck v. Germany*, para. 74; European Court of Human Rights, *H.L. v. United Kingdom*, (no. 45508/99), judgment of October 5, 2004, ECHR 2004-IX, available at www.echr.coe.int, para. 191.

⁴² *Ibid.*, para. 191. (H.L. v. UK); European Court of Human Rights, *Ashingdane v. the United Kingdom*, (no. 8223/78), judgment of May 28, 1985, Series A no. 93, available at www.echr.coe.int, para. 42.

⁴³ European Court of Human Rights, *Winterwerp v. Netherlands*, (no. 6301/73), judgment of October 24, 1979, Series A no. 33, available at www.echr.coe.int, paras. 45, 60.

⁴⁴ European Court of Human Rights, *De Wilde, Ooms, and Versyp v. Belgium*, (no. 2832/66), judgment of June 18, 1971, Series A no. 12, available at www.echr.coe.int, para. 76.

⁴⁵ *Ibid.*, para. 78. (De Wilde)

⁴⁶ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, art. 12(1).

⁴⁷ ICESCR, art. 12(2).

⁴⁸ UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The right to the highest attainable standard of health, U.N. Doc. HRI/GEN/1/Rev.6 at 85 (2003), para. 30-31.

The concept of available resources is intended to include available assistance from international sources.⁴⁹

The Committee on Economic, Social and Cultural Rights, the body charged with monitoring compliance with the ICESCR, has held that there are certain core obligations that are so fundamental that states must fulfill them. While resource constraints may justify only partial fulfillment of some aspects of the right to health, the Committee has observed with respect to the core obligations that “a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations ... which are non-derogable.” The Committee has identified, among others, the right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalized groups,⁵⁰ which includes individuals with physical or mental disabilities.⁵¹

Additionally, the CRPD requires that delivery of health services not discriminate on the basis of disability, and that states should provide persons with disabilities with the same types and range of services provided to other persons.⁵² It also explicitly requires that persons with disabilities give their full and informed consent to medical treatment.⁵³

However, governments should do more for persons with disabilities to ensure equal access to health and health care than for the general population. For instance, the CRPD also requires states parties to provide health care that persons with disabilities need specifically because of their disabilities, and in locations that are as close as possible to their communities.⁵⁴

The U.N. Committee on Economic, Social, and Cultural Rights has stated that the state’s obligation “is to take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objectives of full participation and equality within society for all persons with disabilities.”⁵⁵ As a result, a state is required to provide specially-tailored programs to fit the needs of

⁴⁹ Ryszard Cholewinski, “Economic and Social Rights of Refugees and Asylum Seekers in Europe,” *Georgetown Immigration Law Journal*, vol. 14 (2000), pp. 709-55, 714-19.

⁵⁰ CESCR, General Comment No. 14, para. 12(b).

⁵¹ *Ibid.*, para 18.

⁵² CRPD, art. 25(a).

⁵³ CRPD, art. 25(d).

⁵⁴ CRPD, art. 25(b); CRPD, art. 25(c).

⁵⁵ CESCR, General Comment No. 5, Persons with disabilities, U.N. Doc. HRI/GEN/1/Rev.6 at 24 (2003), para. 9.

persons with disabilities so that they may achieve equality. The Committee has also ruled that “the duty of States parties to protect the vulnerable members of their societies assumes greater rather than less importance in times of severe resource constraints.”⁵⁶

The U.N. General Assembly also links the right to health with the right of persons with disabilities to inclusion in the community. In the Declaration on the Rights of Disabled Persons from 1974, the General Assembly states “[d]isabled persons have the right to medical, psychological and functional treatment ... which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration.”⁵⁷ Since it is usually a person’s health that has historically justified his or her institutionalization, ensuring the right to health is particularly important to also securing a person’s right to live in the community.

Statistics

Under the CRPD, parties are required to keep statistics that allow them to create policies and give effect to the various articles of the Convention.⁵⁸ These statistics must be disaggregated and useful to “identify and address barriers faced by persons with disabilities in exercising their rights.”⁵⁹ Additionally, parties must disseminate those statistics and make sure that they are accessible to persons with disabilities and others.⁶⁰ As enumerated more fully in Section V, Croatia’s statistics on disability and deinstitutionalization do not meet these standards.

⁵⁶ Ibid., para. 10.

⁵⁷ Declaration on the Rights of Disabled Persons, December 9, 1975, G.A. res. 3447 (XXX), 30 U.N. GAOR Supp. (No. 34) at 88, U.N. Doc. A/10034 (1975), para. 6.

⁵⁸ CRPD, art. 31(1).

⁵⁹ Ibid., art. 31(2).

⁶⁰ Ibid., art. 31(3).

III. Institutions in Croatia Today

Structure of Institutions in Croatia for Persons with Disabilities

For the purposes of this report, the term “institution” refers to any residential arrangement, regardless of size or structure, which includes one or more of the following characteristics: (1) housing in conditions of segregation from society, often accompanied by depersonalization of services, rigidity of routine, lack of individual treatment, and social distancing of staff from residents; or (2) placement at a facility without consent.⁶¹

The first kind of institution, in which the vast majority of individuals with disabilities in Croatian institutions reside, is the social welfare home. These are facilities that house more than 20 people in a single site and are specialized, depending on the needs of the persons housed within them. This report focuses on the two types of social welfare homes in which persons with intellectual or mental disabilities are primarily housed: homes for adults and children with physical/intellectual disabilities and homes for adults with mental disabilities.⁶² By the end of 2008, there were 37 homes for persons with physical or intellectual disabilities in Croatia of which eleven were non-state homes. There were also 27 homes for adults with mental disabilities, of which nine were non-state homes.⁶³ Non-state homes, run by private entities or local/regional governments, will generally also receive funding from the state via contracts to run their institutions.

Social welfare homes for persons with physical/intellectual disabilities are further subdivided into four categories: Rehabilitation Centers, Centers for Occupational Therapy and Rehabilitation, Living Centers for Occupational Therapy and Rehabilitation, and what are termed “Homes for Independent Living.”⁶⁴ According to government regulations, the first

⁶¹ Commission of the European, “Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care,” September 9, 2009, <http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=614&furtherNews=yes> (accessed March 8, 2010), p. 8.

⁶² In Croatia, these homes are called Homes for Adults and Children with Physical or Intellectual Handicaps and Homes for Mentally Ill Adults.

⁶³ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008 (accessed March 8, 2010), Table 1-5. In Croatia, these homes are called Homes for Intellectually or Physically “Damaged” People or Homes for Mentally-Ill Adults.

⁶⁴ Regulation on types of homes for children and adults, their tasks, and conditions in facilities, equipment and necessary technical and other employees of Social Welfare Homes (Regulation on Social Welfare Homes), *Official Gazette*, 101/99, 1999, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi/pravilnik_o_vrsti_doma_za_djecu_i_doma_za_odrasle_osobe_i_njihovim_zadacama_te_uvjetima_u_pogledu_prostora_opreme_i_potrebnih_strucnih_i_drugih_djelatnika_doma_socijalne_skrbi_nn_101_99 (accessed March 8, 2010), art. 40.

three types of homes provide mostly the same institution-based services to residents. The Homes for Independent Living are different: they provide support to people living in apartments in the community and are thus not “institutions.”⁶⁵ At the time of writing, there were three homes called Homes for Independent Living for persons with physical/intellectual disabilities in Croatia.⁶⁶ There are no such distinctions in homes for adults with mental disabilities and thus also no separate category of homes for independent living.⁶⁷

Summary of Types of Institutions in Croatia

Social Welfare Homes: Facilities run by the social welfare side of the Ministry of Health and Social Welfare (and in some cases private companies in contract with the ministry) that house more than 20 people in a single site. The vast majority of persons with intellectual or mental disabilities living in institutions live in these homes.

“Family Homes”: Facilities run or funded by the social welfare side of the Ministry of Health and Social Welfare that house between 6 and 20 individuals in a single site. The term “family home” is a misnomer in that residents of a particular home are not usually related to one another or to those who run the homes. Some family homes are not institutions, as the Ministry of Health and Social Welfare does not separate institutional “family homes” from homes for 6 to 20 people that are actually community-based programs. Human Rights Watch considers “family homes” to be institutions when residents are not placed there by choice, they are closed to outsiders, and they restrict interactions between residents and the community. According to official government reports, there were 100 family homes for persons with disabilities in Croatia as of the end of 2008.

Psychiatric Hospitals: Facilities run by the Ministry of Health and Social Welfare that provide short- and long-term in-patient psychiatric care to persons with mental disabilities. These psychiatric hospitals are de facto institutions for those who have lived in the facilities for more than six months. There are six psychiatric hospitals in Croatia, although there is no publicly available data on long-term residents of these hospitals.

Foster Families for Adults with Disabilities: Placements of up to three children or four adults in families in the community. Human Rights Watch considers foster families to be institutions when people are placed into them without their consent, they are closed to outsiders, and/or they limit interactions between residents and the community.

⁶⁵ Ibid., art. 54.

⁶⁶ Ministry of Health and Social Welfare, *Directory of Institutions*, http://www.mzss.hr/hr/adresar_ustanova (accessed on March 8, 2010).

⁶⁷ Regulation on Social Welfare Homes, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi/pravilnik_o_vrsti_doma_za_djecu_i_doma_za_odrasle_osobe_i_njihovim_zadacama_te_uvjetima_u_pogledu_prostora_opreme_i_potrebnih_strucnih_i_drugih_djelatnika_doma_socijalne_skrbi_nn_101_99, arts. 62 and 63.

The second type of institution, known as a “family home,” can house between 6 and 20 individuals.⁶⁸ Like social welfare homes, these usually specialize in one type of disability group (for instance, adults with mental disabilities or with physical/intellectual disabilities).⁶⁹ Despite their smaller size, many are similar to social welfare homes in that people are often there involuntarily, they are often closed to outsiders, and they often limit interactions between residents and the community. Like social welfare homes, some facilities classified as “family homes” also provide supportive and independent community living arrangements and thus are not institutions. However, unlike social welfare homes, the Ministry of Health and Social Welfare does not keep a publicly available registry of these “family homes,” nor does it maintain statistics about these smaller homes to the same degree as it does for social welfare homes.

The third type of institution, psychiatric hospitals, contains a mixture of short-term and long-term in-patients and residents, including forensic psychiatric patients who are in institutions because of crime. These facilities provide in-patient psychiatric care, and forced placement into them is usually governed by a court. These psychiatric hospitals are de facto institutions for those for whom they provide long-term placement (more than six months).⁷⁰ They are not governed by the same laws and regulations as social welfare homes and family homes, nor could Human Rights Watch identify any statistics on long-term residents of these homes. However, based on in-country observations and interviews, there appear to be six large psychiatric hospitals in Croatia.⁷¹

Croatia also runs a system of foster family placements for persons with disabilities, including adults. Under the Law on Foster Care, foster families are not only available to children who need of parental care, but also adults who cannot take care of their own needs.⁷² Indeed, the number of adults living in foster families in Croatia far exceeds the number of children (3,213 adults versus 1,940 children).⁷³ A foster family, like a social

⁶⁸ Rules on service delivery in family homes and conditions in terms of space, equipment, professional and other workers (Rules on Family Homes), *Official Gazette*, 92/04, 2004, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi/pravilnik_o_nacinu_pruzanja_usluga_obiteljskog_doma_te_uvjetima_glede_prostora_opreme_strucnih_i_drugih_radnika_nn_92_04 (accessed on March 8, 2010), art. 1.

⁶⁹ *Ibid.*, art. 4.

⁷⁰ Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report*, p. 64.

⁷¹ These include Vrapce, Jankomir, Ugljan, Rab, Lopaca, and Popovaca Psychiatric Hospitals.

⁷² Law on Foster Care, *Official Gazette*, No. 79/07, 2007, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi (accessed on March 8, 2010), art. 2(4).

⁷³ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 1-2.

welfare home or family home, is generally required to specialize in the care of persons with particular types of disabilities (e.g. adults with physical/intellectual disabilities or mental disabilities), although Centers for Social Welfare can waive this requirement.⁷⁴ Foster families can accommodate up to three children or four adults and according to regulation, must be licensed and trained by the state.⁷⁵ As with social welfare or family homes, people are placed in foster families by a determination of the Centers for Social Welfare.

Not all foster families operate like institutions, and with adequate training for the families involved and support for the people who are placed in them, they offer a potential way to integrate persons with disabilities into the community. For purposes of this report, foster families are discussed with institutions because the current system of foster family placement is the same as for other types of social welfare institutions in that individuals are often placed without their consent, and foster families are often closed to outsiders and/or limit interactions between residents and the community.

According to the most recently available official government statistics from the end of 2008, there were at least 4,357 people living in homes and families sponsored by the social welfare system for persons with mental disabilities. Residents of social welfare homes accounted for 3,882 of this total.⁷⁶ There appeared to be 221 adults with mental disabilities living in family homes and at least 254 adults with some form of mental disability living in foster families.⁷⁷ There were no statistics on the number of persons who are long-term residents of psychiatric hospitals.

There were also a total of at least 7,319 persons with physical or intellectual disabilities living in institutions or foster families in Croatia. While it is difficult to know for certain, available statistics indicate that approximately two-thirds of the residents of these homes have primarily intellectual, as opposed to physical, disabilities.⁷⁸ At the end of 2008, there

⁷⁴ Law on Foster Care, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 7.

⁷⁵ Ibid., arts. 8 and 9. (Law on Foster Care); Ibid., arts. 12 and 15. The Law on Foster Care specifies that Centers for Social Welfare will provide training and education, but does not specify the type. Ibid., art. 15.

⁷⁶ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 1-5.

⁷⁷ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 1-2. Elsewhere, however, the Ministry of Health and Social Welfare reported that, at the end of 2008, there were only 216 people in total (including persons with other types of disabilities, as well as the elderly) living in family homes. Ministry of Health and Social Welfare, "JIM Progress Report," p. 27; Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 4-3.

⁷⁸ The Statistics as taken from Ibid, Tables 4-2, 4-3, 4-4, and 4-5, indicate that there were 1,768 adults and children with "mental retardation" (equivalent to intellectual disability) in institutions in Croatia, representing 18% of the total population

were 4,858 children and adults living in social welfare homes for persons with physical or intellectual disabilities.⁷⁹ There were 215 additional adults with physical or intellectual disabilities under the age of 50 living in social welfare homes called Homes for the Elderly or Infirm; 1,437 people with physical or intellectual disabilities living in homes for adults with mental disabilities; and 130 children with either physical or intellectual disabilities placed in homes for children without adequate parental care.⁸⁰ There were also at least 18 individuals with physical or intellectual disabilities living in family homes, and at least 661 persons with physical or intellectual disabilities living in foster families.⁸¹

The Ministry of Health and Social Welfare does not keep track of the number of individuals who move into or out of institutions in any given year, but there has been an increase in the population of social welfare homes for persons with physical or intellectual disabilities (from 4,468 to 4,858) since the ministry began reporting statistics on the capacity of its institutions at the end of 2004.⁸² There has also been an increase in the population of social welfare homes for adults with mental disabilities (from 3,794 to 3,882).⁸³

At least six of the institutions that Human Rights visited had accepted new residents in 2009, and all had waiting lists.⁸⁴ Several said that they felt pressure to accept new residents, even though they were already filled beyond capacity.⁸⁵ The two private institutions that researchers visited are not taking new residents because they have already reached the maximum capacity allowed under their contracts with the Ministry of Health and Social Welfare.⁸⁶ These numbers and circumstances suggest that the trend is towards more, not less, institutionalization— a major failing on the part of the government given its ratification of the CRPD.

of persons with intellectual disabilities in Croatia. There were 881 persons with physical disabilities in institutions, representing 3 percent of persons with physical disabilities in Croatia.

⁷⁹ Ibid., Table 1-5.

⁸⁰ Ibid., Table 4-1.

⁸¹ Ibid., Table 1-2; Ibid., Tables 4-2 and 4-3.

⁸² Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 1-5, to Ministry of Health and Social Welfare, *Annual Statistical Report 2004*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2004 (accessed March 8, 2010), Table 1-5.

⁸³ Ibid.

⁸⁴ Human Rights Watch interviews with directors at NADA, Roman Obitelj, Stancic, Lobor Grad, Mirkovec, and Center for Autism, December 7, 9, 10, 11, and 16. The Zagreb home had no new residents, and Lopaca and Sveti did not report.

⁸⁵ Human Rights Watch interviews with directors of Sveti Filip i Jakov, Mirkovec, Lobor Grad, and Zagreb home, December 8, 11, and 17.

⁸⁶ Human Rights Watch interviews with directors of NADA and Roman Obitelj, December 7 and 9.

Placement into Institutions

The way that many persons with disabilities are placed into institutions and foster families poses several problems from a human rights perspective. Particularly concerning is that most individuals do not consent to placement in institutions, making institutionalization a form of detention. They are also unable to challenge their placement, which puts them at risk for arbitrary detention. The current system also denies all persons with intellectual or mental disabilities the choice of where and how to live, which is part of their right to live in the community.

Under the Law on Social Welfare, a guardian's consent for placement in an institution can substitute for the consent of the person him/herself.⁸⁷ At no stage is a court involved in the process of placing a person deprived of legal capacity in an institution, and nowhere in the law is there a provision by which a person can challenge, in a court or otherwise, a decision to place him or her in an institution or foster family.⁸⁸ Even those who retain their legal capacity and enter institutions of their own volition in order to receive support have virtually no choice when it comes to what kind of support they receive or where they end up.

Placement in an institution or foster family is considered a “right” under Croatian law—the right to live outside of one's own family. The hubs of the whole social welfare system are Centers for Social Welfare, which determine whether a person has a disability and is thus eligible for placement.⁸⁹ According to Article 76 of the Social Welfare Act, placement in an institution or foster family requires consent of the individual or a legal guardian.⁹⁰ No distinction is made under the law between the placement of children and adults.⁹¹

The institutionalization process begins when an individual or legal guardian submits a request to a Center for Social Welfare for placement in an institution or foster family. The Center assesses whether the individual is “eligible” for the “right” to be placed in an institution. No court is involved in this decision. Rather, the Center seeks a doctor's assessment as to whether a person can care for themselves. This is then used to make a final decision about the type of care to which the person has a “right,” including placement

⁸⁷ Law on Social Welfare, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 76.

⁸⁸ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.

⁸⁹ Law on Social Welfare, *Official Gazette*, No. 73/97, 1997, as amended by Law of July 2007, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi (accessed March 8, 2010), arts. 12, 72, and 73.

⁹⁰ Law on Social Welfare, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 76.

⁹¹ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.

in an institution, which the particular Center oversees.⁹² Placement in an institution or foster family (or on their waiting lists) almost always occurs if the doctor recommends it.⁹³

Placements in psychiatric hospitals—which offer mainly short-term treatment—follow a different process. Persons are placed in hospitals in three ways: (1) voluntarily at their own request, (2) involuntarily but with the consent of a guardian, or (3) forcibly via court proceeding initiated by the hospital into which the person is placed.⁹⁴ A court is supposed to periodically review the cases of people who have been placed there involuntarily by a court, in order to determine whether there is a continued need for placement.⁹⁵ Placement by a legal guardian in a psychiatric hospital is not considered “forced,” and such cases are therefore not referred to a court for review.⁹⁶

Once a Center has determined a person should be placed in an institution or foster family, it is simply a matter of finding an open slot. This can be challenging given that social welfare homes typically have long waiting lists, and foster families and “family homes” fill up quickly. According to Marica Belaic, director of the Center for Social Welfare in the town of Dugo Selo outside of Zagreb, there are no “family homes” and only three foster families in the city that accept adults with intellectual or mental disabilities—none of which were able to take new residents at time of the interview.⁹⁷ A similar situation exists in the city of Zadar, along the Croatian coast, where there is only one foster family that accepts adults with disabilities. There are no publicly-available records indicating the number of “family homes” in Zadar, but Tomislav Orovic, director of Center for Social Welfare in Zadar said there were “not enough” to accommodate the needs of persons with disabilities in his community.⁹⁸ As a result, even if individuals consented to some form of institutionalization or placement in a foster family and retained their legal capacity, they would have little choice regarding the type of service received—an integral part of the right to live in the community.

The process of placement into an institution conflicts with Croatia’s obligations under the CRPD and other human rights treaties. Croatian laws view placement in an institution or foster family as a “right” and do not recognize, particularly as regards placement in a social

⁹² Ibid.

⁹³ Human Rights Watch interview with Marica Belaic, director of Center for Social Welfare – Dugo Selo, December 10, 2009.

⁹⁴ Human Rights Watch interview with Dr. Radmir Rakun, director of Lopaca, December 3, 2009.

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ Human Rights Watch interview with Marica Belaic, director of Center for Social Welfare – Dugo Selo, December 10, 2009.

⁹⁸ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.

welfare home, “family home,” or foster family, that institutionalization without the individual’s consent is a form of detention. Furthermore, the ultimate decision to place someone in an institution is made by an executive body (the Centers for Social Welfare) with no recourse to a court, no access to a publicly-funded lawyer, and no periodic review of the decision to detain. This process contravenes requirements set out by the authoritative interpretations of the ICCPR and ECHR, which require at the least these minimal safeguards to limit the risk of arbitrary detention. The fact that the doctors and the Centers base their decision about institutional placement on disability further violates the arbitrary detention protections of Article 14 of the CRPD.

But even for those individuals who retain their legal capacity or have otherwise been consulted about their placement in an institution or foster family, there is little opportunity to choose the type of living arrangement they want to live in, an important part of the right to live in the community. And indeed, as will be explored more in Section IV, no real choice beyond an institution or foster family is available in most cases, and even amongst these options the individual has little choice of where he or she is placed. These deprivations make persons with intellectual and mental disabilities especially vulnerable to violations of their right to live in the community in Croatia.

Legal Capacity

The right to live in the community mandates a choice for persons with disabilities as to where and how they live. However, in order to have a real choice, such people must not only have a wide variety of community-based support from which to choose but also the ability to make choices that have legal force about where and how to live. In Croatia, depriving persons with disabilities of legal capacity robs them of this ability (in addition to removing their right to make other important life decisions, such as the decisions to marry, vote, or enter a job contract), and reduces their chances of preventing future institutionalization.

Legal capacity issues are governed by the Family Act of Croatia, which establishes a system of guardianship for those deprived of legal capacity. Croatian courts can either “fully” deprive someone of legal capacity—meaning they lose all ability to act on their own behalves—or “partially” do so, meaning they only lose the ability to exercise certain rights, as determined by the court.⁹⁹

⁹⁹ Family Law, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 159.

Of the 17,810 persons deprived of legal capacity in Croatia at the end of 2008, about half (8,301) were adults with physical or intellectual disabilities, and an unknown but significant number of the remainder were persons with mental disabilities.¹⁰⁰ The vast majority of persons deprived of legal capacity (16,006) were fully deprived of their ability to exercise their own will.¹⁰¹ Many end up in institutions: of the nearly 18,000 people without legal capacity by the end of 2008, at least 6,485 (36 percent) lived in institutions or foster families.¹⁰²

Centers for Social Welfare start legal capacity proceedings by referring cases to a court, usually at the request of a family member.¹⁰³ The court adjudicates whether an adult needs full or partial guardianship based on “medical expert opinion” regarding “the health of the person” and “his ability to protect all or some of his personal needs, rights, and interests.”¹⁰⁴ The individual with a disability has no right to a lawyer in these proceedings. Indeed, the only assistance to which he or she does have a legal right is that provided by temporary guardian appointed by the Centers for Social Welfare, the same body that brings the proceedings.¹⁰⁵

The Centers for Social Welfare are also responsible for appointing full-time guardians for adults if a court decides to deprive them of legal capacity.¹⁰⁶ Guardians can be family members, friends, or—when none of those are available—staff at the Centers for Social Welfare, an arrangement that poses a serious conflict of interest because Centers are also

¹⁰⁰ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 3. It is unclear how many of the remaining people deprived of legal capacity have mental disabilities, because no disaggregated statistics exist for this group; *Ibid.*, Table 4-1.

¹⁰¹ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 3; In 2008 alone, 1,681 people were fully deprived, and 290 partially deprived, of legal capacity; *Ibid.*, Table 4-1;

¹⁰² In the institutions that Human Rights Watch visited, which catered primarily to persons with intellectual or mental disabilities and had very few residents with only physical disabilities, between 70 and 100 percent of residents were deprived of legal capacity, according to interviews with directors and staff at Lopaca, NADA, Sveti Filip i Jakov, Stancic, Lobar Grad, Mirkovec, Zagreb home, and Center for Autism, December 3, 7-11, 16-17, 2009; , Of the 6,485 (36 percent) people with disabilities who lived in institutions or foster families 4,866 lived in what are officially called “institutions” (although definition of term is unclear), 500 lived in hospitals, and 1,119 lived in foster families, many of which operate similarly to institutions.

¹⁰³ Family Law, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 160(1).

¹⁰⁴ *Ibid.*, arts. 159(1) and (2); Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare– Zadar, December 9, 2009.

¹⁰⁵ Human Rights Watch interview with Lovorka Kusan, attorney, December 4, 2009; Family Law, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 161.

¹⁰⁶ Family Law, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 162.

required to ensure that guardians are acting in the ward's best interests.¹⁰⁷ Under the law, these guardians are responsible for protecting and caring for the person; must be conscious of his or her best interests, especially when making decisions about protecting the person and property; and must consult the Centers for Social Welfare about other important life decisions, including institutionalizing or placing a ward in foster families.¹⁰⁸ In such cases, the final decision regarding placement rests with the Centers for Social Welfare, in conjunction with doctors.¹⁰⁹

The Centers for Social Welfare are supposed to request that a physician assess every three years whether a person needs to remain under guardianship.¹¹⁰ In theory, it is possible that a person's legal capacity can be restored as a result of this review. In practice, these reviews rarely take place, and restoration of legal capacity is even less common. Human Rights Watch heard of only two cases during its research in which someone's legal capacity had been restored, in both cases for persons with mental disabilities. No person deprived of legal capacity who was interviewed knew of any procedure by which their legal capacity was reviewed.¹¹¹

Both staff and people under guardianship complained about the lack of interaction between guardians and their wards. Indeed, many people under guardianship in institutions rarely see their guardian, particularly when he or she is a staff member at a Center for Social Welfare.¹¹² For example, one woman at the home for adults with mental disabilities in Lobar Grad said her guardian had only visited once in eight years; another said her guardian only visits about once every other year.¹¹³ Such limited contact is problematic, compromising the

¹⁰⁷ *Ibid.*, art. 151.

¹⁰⁸ *Ibid.*, art. 150(2); *Ibid.*, art. 179(b); *Ibid.*, art. 185.

¹⁰⁹ Regulations on the composition and working methods of expert bodies in the process of implementation of social welfare rights and other rights under special regulations (Regulation on Social Welfare Rights), *Official Gazette*, 64/02, 2002, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi/pravilnik_o_sastavu_i_nacinu_rada_tijela_vjes_tacenja_u_postupku_ostvarivanja_prava_iz_socijalne_skrbi_i_drugih_prava_po_posebnim_propisima_nn_64_02 (accessed March 9, 2010), art. 3.

¹¹⁰ Family Law, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 165.

¹¹¹ An attorney we spoke with who handles many legal capacity cases stated that she had never heard of someone's legal capacity being restored. Human Rights Watch interview with Lovorka Kusan, attorney, December 2, 2009. The directors of Lobar Grad and Mirkovec each reported one person whose legal capacity had been restored. Human Rights Watch interviews with directors of Lobar Grad and Mirkovec, December 11, 2009.

¹¹² For instance, an older woman from Zagreb interviewed at NADA, the privately-run social welfare home in Karlovac, said she had never even seen her guardian, a staff member at a Center for Social Welfare; Human Rights Watch interview with C.D., resident of NADA, December 7, 2009.

¹¹³ Human Rights Watch conversation with a G.G., resident at Lobar Grad, December 11, 2009; We heard complaints about the lack of interaction between residents and guardians at eight of the nine institutions visited, including complaints from a resident at Lopaca, from residents at NADA, from directors at Roman Obitelj, from directors and staff at Stancic, from residents at Lobar Grad, from the director of Mirkovec, from staff at the Center for Autism, and from social workers at the Zagreb home.

ability of a guardian to determine whether it is in the best interests of the individual to be institutionalized and to accurately report on the ward's status twice a year as required by law.¹¹⁴ Indeed, if guardians interacted more frequently with their wards, they might learn that many would rather live in the community.¹¹⁵

One reason for this lack of guardian-ward interaction is the fact that the Centers for Social Welfare, which sometimes act as guardians and are always supposed to oversee the actions of other guardians, are often overburdened. According to one director, Centers have approximately 140 different functions, and there is only one social worker for every 10,000 people in the country.¹¹⁶ In addition, staff at Centers can have as many as 10 full-time wards who are often placed in institutions far away.

This system of guardianship for adults with disabilities, which substitutes the decision-making of an individual with a guardian, conflicts with a number of Croatia's international human rights obligations and runs counter to the supportive decision-making regime set out in Article 12 of the CRPD. Additionally, the guardianship system does not have safeguards necessary to prevent abuse, such as the right to a lawyer when the decision to appoint a guardian is made; regular review of the decision to deprive the person of legal capacity; and a requirement that deprivation should be for the shortest time period necessary. The Centers for Social Welfare are required to ensure that guardians are acting in their wards' best interests. However, since staff members at the Centers are often overburdened with work, their oversight of guardians is often lacking, and since Center staff are sometimes guardians themselves, this poses a serious conflict of interest to their oversight of the system.

The Ministry of Family, Veterans' Affairs, and Intergenerational Solidarity (or "Ministry of Family"), which is responsible for proposing reforms to the legal capacity law, has been organizing a working group for legal capacity reform since early 2009. According to Zdenko Zunic, director of the Directorate of Family at the ministry and the person in charge of the working group, "We are not satisfied with the way the guardianship issue has been

At the ninth institution, Center for Rehabilitation Sveti Filip i Jakov, we did not hear complaints but this may have been because researchers did not have the opportunity to ask staff the question, and residents at this institution were unable to communicate with researchers about their relationships with their guardians.

¹¹⁴ Family Law, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 187; Law on Social Welfare, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi, art. 77 (requiring the Centers for Social Welfare to report on the status of persons placed in institutions or foster families every six months).

¹¹⁵ Human Rights Watch conversations and interviews with residents of NADA and Sveti Filip i Jakov (names withheld), December 7-8, 2009.

¹¹⁶ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.

resolved.”¹¹⁷ To date, however, this group has still not completed its investigation and has made no proposals for legislative reform.¹¹⁸

Life in an Institution

Human Rights Watch visited nine institutions housing a total of approximately 1,500 individuals in seven regions throughout Croatia. During these visits, and through interviews conducted with former residents of institutions, Human Rights Watch learned that while there are relatively few prominent cases of grave abuse in Croatia, violations of human rights standards at Croatian institutions are subtle and persistent.

Forced routines, lack of privacy, and limited freedom of movement all play a part in depriving individuals in institutions of their dignity. Many individuals in institutions live in poor conditions that could cause, and have caused, physical or mental harm, while lack of oversight and isolation creates vulnerability to abuse by staff—although such incidents do not appear to be widespread at present based on Human Rights Watch research.

A common feature of these institutions is a compulsory daily routine, and residents’ lack of control over their own activities. Curtailed flexibility is to some extent inevitable in institutional life, as staff must try to care for all residents in restricted facilities and with limited time. But routine also deprives individuals of the ability to make even the most basic choices for themselves, or to develop preferences and learn skills to care for themselves.

At Mirkovec, the social welfare home for adults with mental disabilities, the schedule is the same each day, with specific blocks of time allotted for meals, occupational therapy, hygiene, and sleep.¹¹⁹ Kornelia Videc, the director of NADA, a privately-run home for persons with both mild intellectual and mental disabilities, called her home one of “organized living, but with more control.”¹²⁰ Ante G., a NADA resident who had been at the facility for about two months, said that he liked the control. “I have never had that in my life before,” he said.¹²¹ But not everyone, especially longer-term residents, is as positive about such highly regulated living. Petar G., a resident of the Roman Obitelj institution who has a mild-to-moderate intellectual disability, said that although he was generally satisfied with life in his

¹¹⁷ Human Rights Watch interview with Ministry of Family, statement by Zdenko Zunic, director of Directorate of Family, December 17, 2009.

¹¹⁸ Ibid.

¹¹⁹ Human Rights Watch interview with branch director of Mirkovec (name withheld), December 11, 2009.

¹²⁰ Human Rights Watch interview with Kornelia Videc, director of NADA, December 7, 2009.

¹²¹ Human Rights Watch interview with Ante G., resident of NADA, December 7, 2009.

institution, he did not like the caregivers' strict timetables. For instance, when he is playing chess, he sometimes gets interrupted and told he must take a bath instead—decisions that he wishes he could make for himself.¹²²

Another common feature of institutions in Croatia is their lack of privacy. For instance, extensive regulations on space requirements for social welfare homes appear to be rarely met or enforced. Regulations state there should only be five beds in a residential room at homes for persons with physical/intellectual or mental disabilities.¹²³ Human Rights Watch found as many as twelve people being housed in a single room at one home for adults with mental disabilities, ten at another, and another ten in a home for persons with physical/intellectual disabilities.¹²⁴

Bathroom facilities also tend to offer little privacy. Senada H., a former resident of the Center for Occupational Therapy and Rehabilitation in Oborovo ("Oborovo"), reported that the building she used to live in only had one bathroom for twenty people, both men and women. If a resident wanted to take a shower, another resident would have to stand guard to make sure no one walked in.¹²⁵ Human Rights Watch found similar conditions at Mirkovec, where one of the bathrooms was not working, leaving only two others for 93 residents.¹²⁶

Surveillance can also deprive people of their privacy. At Lopaca Psychiatric Hospital, researchers observed that, in addition to overcrowding, people temporarily housed in isolation rooms (because of construction work in one of the wards and not because of a diagnosed need for isolation) had absolutely no privacy because cameras in the room were turned on and monitored by staff—even though the hospital was not using the rooms for isolation at the time.¹²⁷

Life in institutions is also characterized by limited freedom of movement. While some institution residents and staff reported that residents could come and go as they pleased, movement was limited at all facilities that Human Right Watch visited, including in the form of locks on doors and other barriers that would require residents to seek permission to enter

¹²² Human Rights Watch interview with Petar G., resident of Roman Obitelj, December 9, 2009.

¹²³ Family Law, *Official Gazette*, No. 116/03, 2003, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi (accessed on March 8, 2010), arts. 77(8) and 83.

¹²⁴ Human Rights Watch observations from tour of Mirkovec, December 11, 2009; Human Rights Watch observations from tour of Lobar Grad, December 11, 2009; Human Rights Watch interview with Ivan Vrgoc, director of Stancic, December 10, 2009.

¹²⁵ Human Rights Watch interview with Senada H., former institution resident, November 30, 2009.

¹²⁶ Human Rights Watch observations from tour of Mirkovec, December 11, 2009.

¹²⁷ Human Rights Watch observations from tour of Lopaca, December 3, 2009.

and leave the institution. At NADA, for instance, researchers not only saw door locks, but observed that residents had to tell staff members about their movements, which are subject to limitation depending on circumstance. When Human Rights Watch visited NADA, for example, residents were no longer allowed to go into town, reportedly because of fears that they would catch and spread the flu.¹²⁸ Residents could certainly not choose to leave the facility to live somewhere else.¹²⁹

Even those who ostensibly did have the privilege of moving freely into the community still faced significant barriers to doing so, mainly due to their institution's remote rural location. For example, Senada was allowed to come and go from Oborovo as she pleased, because as she explained she retained her legal capacity and was in the institution only due to lack of alternatives. However, in reality, she found that Oborovo's remote location and lack of transportation left her nowhere to go.¹³⁰ Several residents of Lopaca who were free to wander around the hospital premises also had nowhere else to go since Lopaca is located high in the mountains, about a thirty minute drive outside the northern city of Rijeka. This situation looked set to improve when in December 2009, Rijeka began running a bus to Lopaca. However, according to Lopaca's director, the bus is often cancelled due to the low volume of passengers and, he speculates, the cost of running the service in a recession.¹³¹

Such problems are not unique to Lopaca and Oborovo. Most institutions that researchers visited were far from cities and towns and difficult to access by public transportation or even car. This not only makes visits by family difficult but strains residents' connection with home and makes the idea of life in the community hard to imagine. It is thus hardly surprising that, for many, the institution has become their home.

At most visited institutions, staff did a good job of keeping the residents occupied. Residents participated in occupational therapy, work regiments, and at one facility, some even went to a small school. Indeed, Petar G., a resident at the Roman Obitelj home, reported that at the institution, "at least I have something to do." He told us that when he lived in the community, where he was unemployed, he was often bored.¹³² The fact that institutions can keep residents occupied, however, does not necessarily support their use

¹²⁸ Human Rights Watch group interview with residents at NADA (names withheld), December 7, 2009.

¹²⁹ Human Rights Watch group interview with residents at NADA (names withheld), December 7, 2009.

¹³⁰ Human Rights Watch interview with Senada H., former institution resident, November 30, 2009.

¹³¹ E-mail from Dr. Radmir Rakun, director of Lopaca, to Human Rights Watch, April 18, 2010.

¹³² Human Rights Watch interview with Petar G., resident of Roman Obitelj, December 9, 2009.

for housing and care. Instead, it illustrates the need to improve opportunities for persons with intellectual or mental disabilities outside their walls.

Most institutions that researchers saw were in good physical condition, although some required repairs, especially Lobar Grad and Mirkovec, the two large homes for adults with mental disabilities. Located in old castles, both were literally falling apart. Chunks of the walls in hallways and stairwells had fallen off. The rooms were huge and cavernous, making them hard to heat during the winter and also requiring, due to the low number of rooms available to house individuals, that up to 12 beds be placed in the same room. Staff at both facilities reported they could not make repairs or improvements without permission from the Ministry of Culture because the castles are historic landmarks.¹³³ At Mirkovec, however, the branch director replaced a floor without waiting for permission from the Ministry of Culture, since the wooden planks were rotting and posed a danger to residents.¹³⁴

Similar restrictions prevailed at the home in Sveti Filip i Jakov, which serves mainly persons with severe intellectual and/or physical disabilities. The home in which the residents are housed is leased from a church, which restricts staff from making improvements and adapting the premises to residents' needs.¹³⁵

At Stancic, a social welfare home for persons with mainly intellectual disabilities, staff members cited concerns about the kitchen, which they said needed significant updating and replacement.¹³⁶ In 2004, at least three people died and more than 100 residents became sick from food prepared in the kitchen.¹³⁷ No improvements have been made to the kitchen since that time.¹³⁸ Stancic was one of the facilities that limited the access that Human Rights Watch had to some buildings because, staff said, they had concerns about spreading the seasonal flu. As a result, researchers were unable to observe living conditions experienced by most residents.

¹³³ Human Rights Watch interview with Mirkovec branch director (name withheld), December 11, 2009; Human Rights Watch interview with Dubravko Zerjavic, director of Lobar Grad, December 11, 2009.

¹³⁴ Human Rights Watch interview with Mirkovec branch director (name withheld), December 11, 2009.

¹³⁵ Human Rights Watch interview with social worker at Sveti Filip i Jakov (name withheld), December 8, 2009.

¹³⁶ Human Rights Watch interview with Ivan Vrgoc, director of Stancic, December 10, 2009.

¹³⁷ "Scandalous finding of Medical Chamber in Stancic Case" (*Skandalozni nalaz Liječnicke komore u "slučaju Stancic"*), *Vjesnik Online*, November 5, 2004, <http://ns1.vjesnik.com/Html/2004/11/05/Clanak.asp?r=unu&c=3> (accessed on March 8, 2010); "7 Days in Croatia" (*7 dana u Hrvatskoj*), *Glas Koncila*, March 21, 2004, http://www.glas-koncila.hr/print_news.html?news_ID=812&parentt_ID= (accessed on March 8, 2010).

¹³⁸ Human Rights Watch interview with Ivan Vrgoc, director of Stancic, December 10, 2009.

Human Rights Watch heard very few claims of recent physical abuse in the facilities visited. One exception was the Center for Autism in Zagreb. This facility has a poor reputation when it comes to how it treats its residents, and there have been multiple allegations of abuse against both children who are students at the facility's school and adults who are permanent residents. These allegations have been investigated in the past and are still under investigation by the Ombudsperson offices and the UN Development Program.¹³⁹ In the most recent incident, which occurred in May 2009, a resident received severe burns from hot water in a shower. Staff could not tell Human Rights Watch why the incident had occurred and said they had not changed any of their practices or behavior as a result of the incident.¹⁴⁰

Former residents of institutions also reported abuses they had endured when they were residents. Ana D., a patient/resident at Lopaca Psychiatric Hospital from October 2003 to June 2005 and again from September 2005 to May 2008, spoke of her experiences in long-term isolation, forced work regimes where she was required to provide care to other patients, and the use of restraints for non-medical purposes.¹⁴¹ Current staff at Lopaca admitted that the law was likely broken with regards to younger patients like Ana at the time she was in the institution. They maintained, however, that since May 2008 they have not used punishments on patients, forced patients to work, or used restraints without proper authorization and documentation.¹⁴²

Since the Croatian media highlighted the concerns raised by Ana and other patients about treatment in Lopaca from 2003 to 2008, the facility has come under new leadership and, according to its directors, has had 18 visits from various national and international monitoring bodies in the last 18 months.¹⁴³ Current patients/residents did not report any abuse to Human Rights Watch researchers. A current patient who had also had a stint in the hospital in 2007-2008 and was readmitted a few months before researchers spoke with her in December 2009 reported that treatment had improved significantly since her previous stay.¹⁴⁴

¹³⁹ Human Rights Watch interview with Jasmina Papa, United Nations Development Program, December 5, 2009; Human Rights Watch interview with Ombudswoman for Children's office, December 17, 2009; Human Rights Watch interview with Ombudswoman for Persons with Disabilities office, December 19, 2009.

¹⁴⁰ Human Rights Watch interview with Zarka Klopota, director of preschool and elementary programs, and other staff members at Center for Autism, Zagreb, Croatia, December 16, 2009.

¹⁴¹ Human Rights Watch interview with Ana Dragicevic, former Lopaca resident, December 3, 2009.

¹⁴² Human Rights Watch interview with Dr. Radmir Rakun and Dr. Dragan Lovrovic, December 3, 2009.

¹⁴³ Human Rights Watch interview with Dr. Radmir Rakun, December 3, 2009.

¹⁴⁴ Human Rights Watch interview with resident A.B. of Lopaca, December 3, 2009.

It is encouraging to hear that many former problems have been addressed in recent years, but Lopaca's troubles illustrate the fact that the institutional system, without proper oversight or accountability, can facilitate abuses that go unnoticed for years. Moreover, a number of problems were still visible during Human Rights Watch's visit. For instance, children as young as 12 were locked up on the top floor of a ward and placed in former isolation rooms. Conditions in this part of the facility were the worst that researchers saw: dirty linens, floors, and living spaces (including the bathroom), as well as crowded living rooms and residence rooms. When researchers arrived at the ward, the director of the institution yelled at staff members for not having cleaned that area of the facility, as they had been told that people were visiting that day.¹⁴⁵

At the home in Sveti Filip i Jakov, staff members reported that nurses sometimes used improvised restraints on residents, without a doctor's orders and without recording their use as required under Croatian regulations.¹⁴⁶ According to one nurse, the institution cannot buy the types of restraints required by regulations because there is no one on staff authorized to prescribe them, and the nurses have therefore had to improvise with bandages and other available tools. Human Rights Watch was not allowed to tour the facility during its visit because researchers arrived outside visiting hours. As a result, researchers were unable to observe any use of restraints that would bypass regulations and create clear potential for abuse.

A backlash following a few well-publicized incidents of abuse at Lopaca and elsewhere in the past five years, combined with increased funding for the infrastructure of institutions, have led to improvements in institutional conditions. The use of cage beds in some institutions was the only concern about conditions that the UN Human Rights Committee identified in its 2009 report on Croatia.¹⁴⁷

¹⁴⁵ Human Rights Watch observations during tour of Lopaca, December 3, 2009.

¹⁴⁶ Human Rights Watch interviews with nurse and social worker at Sveti Filip i Jakov (names withheld), December 8, 2009.

¹⁴⁷ United Nations Human Rights Committee, "Consideration of Reports Submitted by States Parties Under Article 40 of the Covenant, Concluding observations of the Human Rights Committee, Croatia," CCPR/C/HRV/CO/2, October 29, 2009, para. 12.

IV. Alternatives to Institutions

Alternatives to institutions are crucial in order to give residents choice and independence, and to promote their inclusion in the surrounding community.¹⁴⁸ By ratifying the CRPD and signing onto the JIM with the European Union, Croatia has pledged to move individuals out of institutions and provide them with a choice of a wide range of community-based alternatives to their housing and care. While alternatives to institutions do exist in Croatia, and several groups have experience running them, there are not enough to provide support for more than a handful of people currently living in institutions or at risk of being institutionalized. Furthermore, the government has done little since signing these pledges to expand the programs that currently do operate, despite their proven success.

Community-based Alternatives to Institutions in Croatia

Supportive and Independent Community Living Environments: These homes provide individuals with apartments, support and care in the community, outside the grounds of institutions). Such assistance, including help buying groceries, cooking, house cleaning, personal grooming, and finding employment, is based on individual needs and requests. For persons with mental disabilities, it might also include access to mental health care, if requested. Sometimes called “organized housing” by the Ministry of Health and Social Welfare, these programs also include some facilities otherwise classified as “family homes” or social welfare homes called Homes for Independent Living.

Mobile Support: These programs provide individual support to persons with disabilities living in the community in their own homes. Program participation requires the individual to have their own place to live, or the ability to live with family.

Day Centers and Temporary Accommodations: These programs provide day or overnight accommodations and support at a facility outside the individual’s home, often to offer a respite to primary caregivers. Participation in these programs requires that individuals have their own permanent place to live, or are able to live with family.

Family-based Support: Individuals can live with their family, and primary caregivers in the family can receive a stipend for providing necessary support.

Moving Out of an Institution

Many alternatives to institutions are funded and monitored by the Ministry of Health and Social Welfare, yet unlike institutions, these alternatives are not yet fully integrated into the social welfare system. For instance, the process of leaving an institution to enter one of

¹⁴⁸ See Section II above.

these programs is cumbersome and not yet formalized. According to Marica Belaic, director of the Center for Social Welfare in Dugo Selo, individuals who want to leave institutions must first have a medical assessment to see whether they are capable of doing so.¹⁴⁹ However, even if a doctor determines that a person can live outside an institution or foster family, the resident's ability to do so often depends on whether alternative support and housing is available. If not, the individual must remain institutionalized. "Sometimes we have to be like wizards," said Belaic, referring to placing persons with disabilities who need support in any type of housing or care since there are not enough places in community-based alternatives to even begin to meet the demand.¹⁵⁰

According to Senada H., it took five months for her to be able to move from the Oborovo institution to the Association for Promoting Inclusion (API), the organization that runs supportive and independent community housing program where she currently lives—even though she retained her legal capacity throughout the process and had voluntarily institutionalized herself.¹⁵¹ The director of API told Human Rights Watch that transfer times today are not typically as long, although transfers do tend to take a few months to complete due to bureaucratic procedures.¹⁵²

For persons deprived of legal capacity, moving from an institution to the community can be far more complex and take much longer. In the case of two residents at the homes in Lobar Grad and Mirkovec, it was only once their legal capacity was restored—a process that can take years and is rarely successful—that they were able to leave their institutions and return to their apartments in the community.¹⁵³

It also appears that Centers for Social Welfare may not be aware of the alternatives to institutions and foster families that exist in Croatia, or else simply regard them as unrealistic options for placement. When asked about alternatives to institutions, directors of the Centers for Social Welfare (who are in charge of placement into all social welfare programs) mention only two options: "family homes," which can be still institutional in character; and foster families, into which individuals are still placed, often without their consent or the

¹⁴⁹ Human Rights Watch interview with Marica Belaic, director of Center for Social Welfare – Dugo Selo, December 10, 2009.

¹⁵⁰ Ibid.

¹⁵¹ Human Rights Watch interview with Senada H., former Oborovo resident, November 30, 2009.

¹⁵² Human Rights Watch interview with Borka Teodorovic, director of Association for Promoting Inclusion, December 2, 2009.

¹⁵³ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009; Human Rights Watch interview with Marica Belaic, director of Center for Social Welfare - Dugo Selo, December 10, 2009.

ability to leave.¹⁵⁴ The directors' outlook is likely reinforced by the Ministry of Health and Social Welfare, which has touted the expansion of family homes and foster family programs as a successful alternative to institutions.¹⁵⁵

Neither director who was interviewed mentioned supportive and independent community living environments, such as API, as alternatives to institutions, even these alternatives they provide a better quality of life for individuals with intellectual and mental disabilities who cannot otherwise live with their families.¹⁵⁶ This is not because Centers for Social Welfare do not know about these arrangements; on the contrary, the director of API said that API has a good relationship with some local Centers. Rather, it seems that supportive and independent living arrangements are not considered viable alternatives to institutions, perhaps because there are not enough and they do not receive enough financial and logistical state support to expand.

Individuals who live in psychiatric hospitals have at least one advantage over those in other types of institutions and foster families: consistent access to psychiatric care. The 20 long-term residents who live in a social welfare home at Lopaca Psychiatric Hospital all have the opportunity to take part in daily psychotherapy activities. They also have direct access to care from the hospital's five psychiatrists and four general practitioners who specialize in psychiatry.¹⁵⁷ In contrast, no such treatment exists at the Lobar Grad, Mirkovec, and the Zagreb social welfare homes for adults with mental disabilities: one psychiatrist from Vrapce Psychiatric Hospital provides care for all 355 residents of Lobar Grad and 93 residents of Mirkovec during one weekly visit at each facility.¹⁵⁸ At the home in Zagreb, a psychiatrist is called in only when one of its 25 residents becomes unstable.¹⁵⁹ The lack of consistent psychiatric care for residents who are living in institutions precisely because of their mental disabilities impedes deinstitutionalization and violates residents' right to the highest attainable physical and mental health.

¹⁵⁴ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009; Human Rights Watch interview with Marica Belaic, director of Center for Social Welfare - Dugo Selo, December 10, 2009.

¹⁵⁵ Ministry of Health and Social Welfare, "JIM Progress Report," p. 27.

¹⁵⁶ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.; Human Rights Watch interview with Marica Belaic, director of Center for Social Welfare - Dugo Selo, December 10, 2009.

¹⁵⁷ Human Rights Watch interview with Dr. Radmir Rakun, director of Lopaca, December 3, 2009.

¹⁵⁸ Human Rights Watch interview with Mirkovec branch director (name withheld), December 11, 2009; Human Rights Watch interview with Dubravko Zerjavic, director of Lobar Grad, December 11, 2009.

¹⁵⁹ Human Rights Watch interview with social workers at Zagreb home (names withheld), December 17, 2009.

Rates of Deinstitutionalization and Community-Based Alternatives to Institutions

It appears that few persons with intellectual or mental disabilities have left institutions to live in the community since Croatia signed the JIM agreement in 2006 and ratified the CRPD in 2007.

Of the nine institutions that Human Rights Watch visited—housing some 1,500 persons with disabilities in total—Lopaca Psychiatric Hospital, where most patients receive short-term in-patient care—has the most fluid population.¹⁶⁰ However, none of its 20 long-term residents have recently left to live in the community, and few have ever done so, according to Dr Ramir Rakun, the facility's director.¹⁶¹

At the eight other institutions, movement into the community was also at a trickle: in 2009, only one person from all eight facilities left to live in the community.¹⁶² In 2008, three people in total left the eight facilities to live with family, foster families, or move into supportive independent living programs.¹⁶³ Two individuals left in 2006 and 2007 from the home for adults with mental disabilities in Lobar Grad, and four individuals moved into a community house run by the institution.¹⁶⁴ Additionally, about 30 residents of the home for persons with physical/intellectual disabilities in Stancic moved into the API program in the past few years.¹⁶⁵ In sum, in the four years from 2006-2009, only around 40 people successfully moved into the community from nine institutions with populations totaling nearly 1,500 individuals. At current rates of deinstitutionalization, the vast majority of individuals still in institutions will remain so for the rest of their lives.

Organizations and local governments in Croatia have developed a range of community-based alternatives to institutions, outlined in the text box at the beginning of Section IV. As long as these programs provide quality care to their participants, allow participants to choose the programs that are best for them, and promote interaction between participants

¹⁶⁰ Number of residents in each institution broke down as follows: Lopaca – 160-170; NADA – 194; Sveti Filip i Jakov – 98; Roman Obitelj – 100; Stancic – 360; Lobar Grad – 355; Mirkovec – 93; Zagreb home – 25; Center for Autism – 61.

¹⁶¹ Human Rights Watch interview with Dr. Radmir Rakun, director of Lopaca, December 3, 2009.

¹⁶² This was a resident of Mirkovec who went to live in his own apartment. Human Rights Watch interview with social workers at Zagreb home (names withheld), December 17, 2009. This was one of only four people who have left Mirkovec to live in the community in the last 15 years. Human Rights Watch Interview with Mirkovec branch director (name withheld), December 11, 2009.

¹⁶³ One of these was from Sveti Filip i Jakov, Human Rights Watch Interview with social worker at Sveti Filip i Jakov (name withheld), December 8, 2009. Two were from the Zagreb home, Human Rights Watch interview with social workers at Zagreb home (names withheld), December 17, 2009.

¹⁶⁴ Human Rights Watch interview with Dubravko Zerjavic, director of Lobar Grad, December 11, 2009.

¹⁶⁵ Human Rights Watch interview with Ivan Vrgoc, director of Stancic, December 10, 2009.

and the community, they can be excellent alternatives to institutions. These are all characteristics that the Croatian government should continue to monitor and promote.

But these programs do not yet exist in sufficient numbers to provide housing and care to the vast majority of current institution residents. The programs specifically aimed at preventing institutionalization, such as mobile and family-based support, are also not yet sufficiently widespread to do so and are not applicable to large numbers of persons with intellectual or mental disabilities who do not have their own homes and cannot live with family. Instead, the population of persons with disabilities in institutions continues to grow, and institutions are asked to accept more and more residents.¹⁶⁶

The lack of progress on deinstitutionalization of persons with mental disabilities is particularly concerning. There are at least 4,357 adults with mental disabilities living in institutions and foster families in Croatia, and many more are long-term patients in psychiatric hospitals. But the Ministry of Health and Social Welfare's statistics cite only three slots in what is categorized as "organized housing" or support independent living programs for adults with mental disabilities.¹⁶⁷ Human Rights Watch identified only seven slots in supportive independent living arrangements for people with a history of mental disabilities.¹⁶⁸

Four of these slots are offered by the Home for Mentally Ill Adults at Lobar Grad. Lobar Grad, located in a small, rural community in the mountains north of Zagreb, is Croatia's largest home for adults with mental disabilities, housing 355 residents.¹⁶⁹ Unlike most Croatian institutions, it has taken at least some steps towards deinstitutionalization. A few years ago, Lobar Grad's director used money from the Swedish government to rent and refurbish an apartment in the town of Lobar, outside of the institution's grounds, to house four residents in a supportive independent living arrangement.¹⁷⁰ However, this program, one of only two such initiatives in the country, remains limited to only those four individuals.

For persons with intellectual disabilities, there are at least three NGO-run programs that offer supportive independent living environments as alternatives to institutionalization. These

¹⁶⁶ See Section III above.

¹⁶⁷ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Table 4-3.

¹⁶⁸ This number includes the three slots mentioned in the ministry's statistics as well as a program run by Lobar Grad in which four persons live.

¹⁶⁹ Human Rights Watch interview with Dubravko Zerjavic, director of Lobar Grad, December 11, 2009.

¹⁷⁰ Ibid.

include the Association for Promoting Inclusion (API), which accommodates 152 people living in apartments in five communities across Croatia and provides other support for people already living in the community to prevent their institutionalization.¹⁷¹ There is a similar supportive independent living program in Osijek, which benefits approximately 30 individuals, and a small program in Split for another 16 to 20.¹⁷² The Ministry of Health and Social Welfare told Human Rights Watch about a program at the Mir social welfare home in Rudine near Split that provides a supportive community living program for eight individuals in the town of Rudine.¹⁷³ Researchers also heard of such a program at the Slobostina branch of the Center for Rehabilitation in Zagreb; however, requests to the institution for further information about its deinstitutionalization programs have not yet met with a response.¹⁷⁴

It is unclear to what extent these non-institutional arrangements are growing since government statistics do not track the number of people leaving institutions to live in community-based programs. A Ministry of Health and Social Welfare official said she thought Human Rights Watch's estimate, that around 200 persons with intellectual or mental disabilities had left institutions to live in one of these arrangements since 1996, was too low, but she could not provide another figure.¹⁷⁵

In addition to the seven slots in supportive independent living programs in Croatia for persons with mental disabilities, Human Rights Watch also identified one day center for adults with mental disabilities in Zadar. According to the director of the Center for Social Welfare in Zadar, this day center can accommodate 10-12 people for day therapy and care.¹⁷⁶ The ministry also mentioned that it is building another day center for adults with mental disabilities in Bjelovar, which was not yet open and operational at time of writing.¹⁷⁷ Ministry of Health and Social Welfare statistics from 2008 show that 13 adults and 10 children with

¹⁷¹ Human Rights Watch interview with Borka Teodorovic, director of Association for Promoting Inclusion, December 17, 2009.

¹⁷² Human Rights Watch interview with Borka Teodorovic, director of Association for Promoting Inclusion, December 2, 2009.

¹⁷³ Human Rights Watch interview with Ministry of Health and Social Welfare, statement by Zvezdana Janicar, head of Section for Social Welfare, December 18, 2009.

¹⁷⁴ Letter from Human Rights Watch to Teodora Not, director of the Slobostina branch of the Center for Rehabilitation Zagreb, January 25, 2010.

¹⁷⁵ Human Rights Watch interview with officials from the Ministry of Health and Social Welfare, statement by Zvezdana Janicar, head of Section for Social Welfare, December 18, 2009.

¹⁷⁶ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.

¹⁷⁷ Human Rights Watch interview with Ministry of Health and Social Welfare, statement by Jasenica Pozega, head of Section for Social Services, December 18, 2009.

mental disabilities receive some kind of day or half-day care in Croatia, but do not specify where that care is received.¹⁷⁸

Staff at the social welfare home Stancic run a day center in the town of Dugo Selo for persons with intellectual disabilities. This day center accommodates ten children and nine adults and provides occupational programs for its attendees during the day while returning them to their families at night. The children who attend the day center are those who cannot attend regular or special schools (usually classified by regulations as “unlearnable”, or incapable of learning anything through formal education). They can attend the day center until they turn 21, at which time they must try to enter the adult program if slots are available.¹⁷⁹

Day centers are a potentially useful way to prevent institutionalization, so long as they promote social inclusion and do more than provide simple day care. In total, according to the ministry’s official statistics from the end of 2008, 451 persons with intellectual disabilities (288 adults and 163 children) received some kind of day or half-day support.¹⁸⁰ However, it is unclear what effect these day centers have on the process of deinstitutionalizing current institution residents, since they are usually geared towards individuals who already live with their families.

Regardless of their effectiveness, day centers for persons with intellectual or mental disabilities currently do not have a significant reach. The day center in Dugo Selo, for instance, is currently full and has a waiting list.¹⁸¹ The parent of a 16-year-old boy with epilepsy and intellectual disability who attends the day center told Human Rights Watch that she did not know what to do with her son before the Dugo Selo facility opened in 2005—a situation she fears will repeat itself when he becomes too old to attend. “Once he turns 21, we have to move somewhere else [to ensure he gets care],” she said.¹⁸²

¹⁷⁸ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Tables 4-2 and 4-3.

¹⁷⁹ Human Rights Watch interview with Jasna Lesicki, social worker at Stancic and Dugo Selo day center, December 10, 2009.

¹⁸⁰ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Tables 4-2 and 4-3.

¹⁸¹ Human Rights Watch interview with Jasna Lesicki, social worker at Stancic and Dugo Selo day center, December 10, 2009.

¹⁸² Human Rights Watch interview with parent of child attending the Dugo Selo day center (name withheld), December 10, 2009.

A few institutions run community-living “preparation” programs for adults with intellectual or mental disabilities, including the social welfare home for persons with intellectual disabilities in the rural community of Stancic, near Dugo Selo. At Stancic, there are three community living preparation homes for two, six, and eight residents, located on the institution’s premises. People in these homes have more freedom than those who live in the ward and are allowed to cook their own food, do their own laundry, and bathe themselves. Many also have part-time jobs in the community.¹⁸³ Even so, their lives in many ways do not resemble those of persons living outside institutions because they are mostly housed in rooms with three to four other individuals and are isolated from free interaction with the community. Staff at Stancic told Human Rights Watch they hoped to start a supportive independent living program in the community in the near future, but they had not yet received approval or funding from the Ministry of Health and Social Welfare.¹⁸⁴

The social welfare home for adults with mental disabilities in Lobar Grad also runs a small community living preparation home on its campus. Three of the four residents of this preparation home have lived there for four years, while the fourth arrived one month prior to Human Rights Watch’s visit.¹⁸⁵ Lobar Grad’s director plans to build a large number of new preparation homes and hopes to eventually buy a new apartment in the community of Lobar with financial support from the Ministry of Health and Social Welfare. The ministry has formally committed to building the new preparation houses but has not yet officially consented to buying the apartment in the community.¹⁸⁶

Living in a preparation home, on the campus of an institution where the general public is not likely to visit, is not residence in the community. Individual residents of these preparation homes still face restricted freedom of movement and interaction with the general public. At best, the benefits of a preparation house over movement into a community-based support program are not clear. At worst, they serve as a distraction from committing the effort and resources to creating viable community-based care for institution residents.

Investment in Institutions and Alternatives in Croatia

The Ministry of Health and Social Welfare does not cite finances as a primary obstacle to fulfilling the right for persons with intellectual or mental disabilities to live in the community.

¹⁸³ Human Rights Watch conversations with residents (names withheld) and observations at preparation homes at Stancic, December 10, 2009.

¹⁸⁴ Human Rights Watch interview with Ivan Vrgoc, director of Stancic, December 10, 2009.

¹⁸⁵ Human Rights Watch interview with Dubravko Zerjavic, director of Lobar Grad, December 11, 2009.

¹⁸⁶ Ibid.

In reality, however, the structure of finances within the social welfare system has contributed to lack of progress on deinstitutionalization, with far more resources going to institutions than community-based programs.

In the JIM Progress Report 2008-2009, the Ministry of Health and Social Welfare reported a substantial investment in improving the conditions of institutions.¹⁸⁷ Indeed, the World Bank gave the government loan assistance money for the social welfare system starting in 2006, and much of that money was used to this end. According to the World Bank, the ministry received €20 million in assistance, matched by €10 million of the government's own funds, for improving infrastructure in the social welfare system, part of which involved refurbishing 44 social welfare homes.¹⁸⁸ While investing money in improving conditions at these institutions has improved the quality of life for residents, it is a lost opportunity to invest in supportive and independent community living programs that could provide even greater benefits.

Not only is the government funneling money towards longstanding institutions, it also appears to be building new ones. Since ratifying the CRPD and signing the JIM, Croatia has completed construction and began to operate at least one new social welfare home for persons with intellectual disabilities—a home in Dubrovnik, opened in 2008. When confronted with this example, the ministry responded that they had started construction on the building in 1995, and “we had to finish that.” The ministry also stated that the facility in Dubrovnik was previously just a day center, but “because there was a greater need for placement, the residential part was built up.”¹⁸⁹ Now it operates as a social welfare home for persons with intellectual disabilities and is fully funded by the state.

While in Croatia, Human Rights Watch was told by institutions and civil society groups of plans for the construction of at least three more institutions. One of these would replace the current home for persons with intellectual and physical disabilities in Sveti Filip i Jakov. Although this new building is expected to have a community center and therefore be better integrated into the community, there will still be a substantial institutional portion.¹⁹⁰ Researchers also heard plans from the Center for Autism in Zagreb to build new mass

¹⁸⁷ Ministry of Health and Social Welfare, “JIM Progress Report,” p. 52.

¹⁸⁸ Ibid., Human Rights Watch interview with Ivan Drabek, World Bank, Zagreb, Croatia, December 16, 2009.

¹⁸⁹ Human Rights Watch interview with Ministry of Health and Social Welfare, statement by Jasenica Pozega, head of Section for Social Services, December 18, 2009.¹⁹⁰ Human Rights Watch interview with Mara Batur, director of Sveti Filip i Jakov, December 8, 2009.

¹⁹⁰ Human Rights Watch interview with Mara Batur, director of Sveti Filip i Jakov, December 8, 2009.

residential institutions at its branches in Split and Rijeka.¹⁹¹ Finally, the Ombudswoman for Children's office said that developers of a new school and day center for children with disabilities in Virovitica are also planning to include a residential portion on the premises.¹⁹² When asked about this last example, Ministry of Health and Social Welfare officials denied knowledge of this plan.¹⁹³

Additionally, smaller institutions known as "family homes" have almost doubled in number in recent years, growing from 53 to 100 between 2008 and 2009 according to the most recent JIM Progress Report.¹⁹⁴ This increase also represents funding and planning that could have been put into developing alternatives to institutions.

Meanwhile, there has been little to no progress on deinstitutionalization of persons with intellectual or mental disabilities, as the ministry itself reported in the JIM Progress Report 2008-2009, and the European Commission assessed in its 2009 Croatia Accession Progress Report.¹⁹⁵ Indeed, several successful community-based programs have had to seek funding from sources other than the Croatian government in order to maintain their operations. For instance, in contrast to the World Bank infrastructure program mentioned above, a similar partnership between the World Bank and the Ministry of Health and Social Welfare to create community programs during the same interval only received €4 million in funding, with no matching funds from the government. Five of these programs were aimed at persons with intellectual or mental disabilities, including the Dugo Selo day center, Lobar Grad community living home, Zadar day center, and one of API's community living programs.¹⁹⁶ According to a World Bank representative, the Croatian government was not enthusiastic about these projects: "They did not want to borrow or use loan money for these projects at all."¹⁹⁷ The partnership between the World Bank and the Ministry of Health and Social Welfare to fund and support community-based programs ended in 2009, and not because of a lack of interest from the World Bank in continuing it.

¹⁹¹ Human Rights Watch interview with Zarka Klopota, director of preschool and elementary school programs, and staff at Center for Autism in Zagreb, December 17, 2009.

¹⁹² Human Rights Watch interview with Tatjana Opacak, advisor to Ombudswoman for Children, December 17, 2009.

¹⁹³ Human Rights Watch interview with Ministry of Health and Social Welfare, statement by Jasenica Pozega, head of Section for Social Services, December 18, 2009.

¹⁹⁴ Ministry of Health and Social Welfare, "JIM Progress Report," p. 27.

¹⁹⁵ Ibid.; Commission of the European Communities, "Croatia 2009 Progress Report," October 14, 2009, p. 64.

¹⁹⁶ Human Rights Watch interview with Ivan Drabek, World Bank, December 16, 2009.

¹⁹⁷ Ibid. (Human Rights Watch interview with Ivan Drabek, World Bank, December 16, 2009.)

The funding structure for institutions and community-based alternatives to institutions further illustrates the lack of enthusiasm for community-based programs. State-run institutions receive their funding in a yearly lump sum, but for purposes of comparison with NGO programs and non-state institutions (which calculate their costs on a resident/month basis), this report states their funding in terms of the amount they receive each month per resident.

At the seven state-run institutions that Human Rights Watch visited, approximately 7,100 kuna per month was spent on housing and care for each resident with intellectual or mental disabilities.¹⁹⁸ In contrast API receives only 5,400 kuna each month for each of its residents from the Ministry of Health and Social Welfare.¹⁹⁹ The amount allocated to API is meant to cover the cost of renting apartments, meeting basic needs of residents, and providing the staff support and care that each individual resident needs on a daily basis to maintain an independent life. API receives the same amount for each person, regardless of the level of disability or how much care he or she requires (API places no restrictions on the level of intellectual disability it accepts for community-based care), and it reports that since the government money covers only 80 percent of its costs, it is compelled to seek other funds to keep the program going.²⁰⁰

Even if the government did give API all the funding it needed, it would still be paying less per person to house and support individuals in the API program than it does for individuals in state-run institutions. This corroborates findings from studies in other European countries that find housing and care in the community for persons with disabilities tends to be less expensive than running institutions.

API has also not received a new government contract to house persons with disabilities since 2006, despite the government citing API as its primary deinstitutionalization success story. Under API's current contract, it can provide care and housing for 125 people in total in its various apartments, and it must get special permission to serve more individuals.²⁰¹ It

¹⁹⁸ Calculated by dividing the total yearly budgets of the seven state-run facilities (68.532 million kuna) by the total number of users in the facilities (802) and dividing by 12 (number of months in a year). Human Rights Watch obtained the yearly budget for these institutions and the number and the number of current residents from interviews with institution directors and staff members.

¹⁹⁹ Human Rights Watch interview with Neda Miscevic, director of finances at Association for Promoting Inclusion, December 4, 2009.

²⁰⁰ Human Rights Watch interview with Borka Teodorovic, director of Association for Promoting Inclusion, and Neda Miscevic, director of finances at Association for Promoting Inclusion, December 17, 2009; Human Rights Watch interview with Neda Miscevic, director of finances at Association for Promoting Inclusion, December 4, 2009.

²⁰¹ Human Rights Watch interview with Borka Teodorovic, director of Association for Promoting Inclusion, December 2, 2009.

now serves 152 people. So far, the Ministry of Health and Social Welfare has given special permission to API to take on new residents in every case, although obtaining that permission sometimes takes a few months and requires extra effort from API staff.²⁰² The lack of a contract specifying support for a particular number of individuals puts API in a difficult position: API is unable to effectively plan for the future by renting new apartments and accepting new residents, and the API housing system appears “full” to Centers for Social Welfare or institutions that might wish to refer their residents there.

On the other hand, the two privately-run institutions that Human Rights Watch visited—NADA and Roman Obitelj—which are also under contract with the state, receive 5,300 kuna each month for every resident to provide the same type of care as state-run institutions. This is almost as much as API receives to run its programs in the community, and yet the directors of both NADA and Roman Obitelj complained that it was often too little for them to run their institutional facilities.²⁰³

Such a low level of funding for non-state programs, regardless of the quality of life they give residents, provides a perverse incentive to NGOs and private actors who want to enter the social welfare system: acquire as many residents as possible who require the least amount of care, and provide them with the cheapest care possible.

It is also a missed opportunity to invest in community-based support services. When Human Rights Watch visited NADA and Roman Obitelj, these two institutions housed a total of 294 residents with almost exclusively mild-to-moderate intellectual and/or mental disabilities.²⁰⁴ These are the persons that it would be the cheapest and least complicated to provide support for in the community.²⁰⁵ Indeed, the directors at one of these facilities acknowledged that most residents there could probably live in the community if given support.²⁰⁶ Both of these institutions have opened within the last ten years and, given the right government incentives, could have provided community-based support rather than institutional housing and care. However, lack of funding, incentives, or understanding means that neither facility has started a program to move their residents into the community.

²⁰² Ibid.

²⁰³ Human Rights Watch interviews with Marin Roman, director of Roman Obitelj, December 9, 2009; and Kornelia Videc, director of NADA, December 7, 2009.

²⁰⁴ Ibid.

²⁰⁵ Jim Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 1: Executive Summary* (Canterbury: Tizard Center, University of Kent, 2007), p. 8.

²⁰⁶ Human Rights Watch interview with Marin Roman, director of Roman Obitelj, December 9, 2009.

The Ministry of Health and Social Welfare does not have a specific budget line for deinstitutionalization programs, unlike for institutions, and so it is unclear how or whether it spends money on alternatives to institutional housing and care.²⁰⁷ This lack of direct funding also makes it difficult to track its investment in programs like supportive and independent community living, day centers, personal assistants, and other innovative community-based support programs for persons with intellectual or mental disabilities.

Life in the Community with Support

“Now I live like a normal person,” said Dražan P., a former long-time resident of an institution for persons with intellectual disabilities who now lives in a supportive independent community living arrangement. These days, he can go out on his own, walk around Zagreb, and visit his old foster family without any restrictions.²⁰⁸

Living outside an institution, particularly in a supportive and independent living arrangement, means that persons with intellectual and mental disabilities can live on an equal basis with others. Senada H., who lived in Oborovo for seven-and-a-half years, has now lived in the community since 2006. She lives alone, has her own key, buys her own food, and cooks. She works, gets paid, and decides how she spends her own money.²⁰⁹ In other words, she lives like everyone else.

Even long-term residents of institutions have shown they can successfully transition into community life. Milica C. lived at Stancic for 18 to 24 years²¹⁰ and left a few years ago to join a community living program. Milica and her husband, whom she met in the institution, are able to cook, go to the market together, and take care of their daily living needs.²¹¹

It is vital that individuals with disabilities living in the community still receive help when they need it. Because Milica has trouble with numbers, for instance, she receives assistance with financial matters such as paying her bills and buying groceries.²¹² Senada H. receives some support from staff who run programs where she lives, but this has decreased over the years as she has adapted to community life; when Human Rights Watch spoke to her, she

²⁰⁷ Human Rights Watch interview with officials from the Ministry of Health and Social Welfare, December 18, 2009.

²⁰⁸ Human Rights Watch interview with Dražan P., Zagreb, Croatia, December 4, 2009.

²⁰⁹ Human Rights Watch interview with Senada H., former Oborovo resident, November 30, 2009.

²¹⁰ Milica C.’s intellectual disability means that she has trouble with numbers, and she did not know the exact amount of time she lived at Stancic or how long ago she left.

²¹¹ Human Rights Watch interview with Milica C., former Stancic resident, November 30, 2009.

²¹² Ibid. (Human Rights Watch interview with Milica C., former Stancic resident, November 30, 2009.)

had not needed any support in two weeks.²¹³ Drazan P., who needs more help, receives a more intense level of support for his daily activities, such as cooking and cleaning.²¹⁴ It was evident from interviews with former residents of institutions that they took particular pride in their ability to live in the community, even if they did need some support to make that possible. For them, community living has led to a better and more productive life and given them a purpose and reason to live.

Some of those who have had to move from the community into institutions told Human Rights Watch that they missed or wanted to return to community life. Marija S., who currently lives at the institution NADA, had a job while she lived in a supportive independent living program in the community; she said that she was involved in a supportive employment program and worked as a secretary for a company in Zagreb. When living in the community, before she was placed back into an institution because she could not find adequate community-based support for her mental disability, Marija could do what she wanted and come and go as she pleased, while now she is much more restricted in the institution. “Before, I was free,” she explained.²¹⁵ Two older women at NADA who had previously lived in the community but were institutionalized by their guardians were unaware that community living was an option for them, but were enthusiastic to try again.²¹⁶ Even two individuals at the home in Sveti Filip i Jakov, both in their 20s and who had lived in institutions for all but a few years of their lives, found the idea of community living appealing and were interested in trying it.²¹⁷

²¹³ Human Rights Watch interview with Senada H., former Oborovo resident, November 30, 2009.

²¹⁴ Human Rights Watch interview with Drazan P., Zagreb, Croatia, December 4, 2009.

²¹⁵ Human Rights Watch interview with Marija R., resident of NADA, December 7, 2009.

²¹⁶ Human Rights Watch interview with C.D. and H.H., residents of NADA, December 7, 2009.

²¹⁷ Human Rights Watch Interviews with J.J. and K.K., residents of Sveti Filip i Jakov, December 8, 2009.

V. The Need for Leadership

Human Rights Watch research in Croatia found a serious lack of progress with regard to deinstitutionalization, combined with limited investment in development and financing of community-based alternatives to institutional care and housing, particularly for those with mental disabilities. Despite positive examples, such as the homes run by API and the community home run by Lobar Grad, the pace of reform has been exceptionally slow. This reality clearly contradicts Croatia's obligations under the CRPD and the JIM.

Human Rights Watch research indicates the primary reason for the failings described in this report is not lack of financial resources dedicated to deinstitutionalization but rather lack of leadership, including no plan to close institutions and create community-based alternatives, no political will to mobilize financial and other resources, and no effective action to tackle the practical obstacles.²¹⁸

The Failures of Leadership

The lack of leadership when it comes to deinstitutionalization manifests in many ways. For instance, several staff members at institutions told Human Rights Watch that they were unaware of any programs offered by the Ministry of Health and Social Welfare to retrain or prepare them for the transition from institutional to community-based care,²¹⁹ even though the ministry recognized fear of losing jobs as a major obstacle to reform.²²⁰ Also, although Ministry of Health and Social Welfare officials and many others identified stigma towards persons with disabilities as one of the major obstacles to reform,²²¹ and the ministry stated that it had set aside funding for NGO-run programs that would help address stigma against persons with mental disabilities, they did not identify any such programs currently underway, and saw no role for the ministry to be directly involved in solving the problem.²²² Instead, the

²¹⁸ Human Rights Watch interview with officials from the Ministry of Health and Social Welfare, December 18, 2009.

²¹⁹ Human Rights Watch interviews with social workers at the Zagreb home (names withheld), December 17, 2009; social worker and nurse at Sveti Filip i Jakov (names withheld), December 8, 2009; Mirkovec branch director (name withheld), December 11, 2009; and with Ivan Vrgoc, director of Stancic, December 10, 2009.

²²⁰ Human Rights Watch interview with Anica Jezic, head of Center for Social Workers, Ministry of Health and Social Welfare, December 17, 2009.

²²¹ Human Rights Watch interviews with officials from the Ministry of Health and Social Welfare, statement by Tatjana Katkic-Stanic, director of Directorate for Social Welfare, December 18, 2009; Zrinka Percin, director of programming at Sjai, December 2, 2009; Marin Roman, director of Roman Obitelj home, December 9, 2009; Dr. Sladjana Ivezić, director of Center for Rehabilitation in the Community, November 30, 2009; and Mirkovec branch director (name withheld), December 11, 2009.

²²² Human Rights Watch interviews with officials from the Ministry of Health and Social Welfare, statement by Tatjana Katkic-Stanic, director of Directorate for Social Welfare, December 18, 2009.

ministry attributed the lack of progress to the absence of NGOs focused on service provision to persons with mental disabilities.²²³

Indeed, although there are certainly external barriers to deinstitutionalization, the failure to mobilize commitment and resources to overcome those barriers stems primarily from officials within the Ministry of Health and Social Welfare itself. While officials are seemingly aware of barriers to reform, they have not exercised their leadership to work with staff on the ground to combat them. Indeed, almost four years after signing the JIM and the CRPD, Croatia has not even finalized a comprehensive plan to deinstitutionalize and provide community-based social services to persons with intellectual or mental disabilities.²²⁴

Without leadership translating into concrete guidelines and action from the Ministry of Health and Social Welfare, it is difficult for service providers themselves to know how to proceed. For instance, a director of one institution in Croatia told us that, although he knew deinstitutionalization was supposed to be a priority, the Ministry of Health and Social Welfare had yet to tell him how his institution should be involved. “Everyone is expecting something from the ministry,” he said.²²⁵ The director of the Center for Social Welfare in Zadar assumed the Centers would only play a minor role in the process of deinstitutionalization and would instead work on preventing institutionalization, but he did not have any guidance from the Ministry of Health and Social Welfare on government policy.²²⁶

Indeed, the lack of guidance from the Ministry of Health and Social Welfare has translated into a lack of vision and action on the part of institutions in identifying the residents who could most obviously live in the community. At NADA, for instance, despite the fact that almost all residents have mild intellectual and mental disabilities, the director of the institution thought that none of them would be able to live in the community even with support.²²⁷ The social worker at Sveti Filip i Jakov also thought that none of the residents at that facility could ever live in the community on their own, even though there was one resident with a mild intellectual disability and ten with only moderate levels of disability.²²⁸

²²³ Human Rights Watch interview with officials from the Ministry of Health and Social Welfare, statement by Danica Kramaric, head of Section of Health Protection, December 18, 2009.

²²⁴ Human Rights Watch e-mail correspondence with Zvezdana Janicar, head of Section for Social Welfare, January 27, 2010 (stating that the master plan for transformation of institutions would be released on June 30, 2010).

²²⁵ Human Rights Watch interview with Mara Batur, director of Sveti Filip i Jakov, December 8, 2009.

²²⁶ Human Rights Watch interview with Tomislav Orovic, director of Center for Social Welfare – Zadar, December 9, 2009.

²²⁷ Human Rights Watch interview with Kornelia Videc, director of NADA, December 7, 2009.

²²⁸ Human Rights Watch interview with social worker at Sveti Filip i Jakov (name withheld), December 8, 2009.

On the other hand, the social workers at the Zagreb home for adults with mental disabilities thought that 10 of their 25 residents could live in the community, given adequate support. They told Human Rights Watch, however, that many of these people were under guardianship and had had their property sold to pay for their institutionalization, so they would not be able to move into the community unless given a place to live.²²⁹

The Ministry of Health and Social Welfare is not the only ministry responsible for the slow pace of reform. The Ministry of Family is in charge of implementation of the CRPD and of Croatia's national strategy for persons with disabilities.²³⁰ This monitoring and implementation has fallen short on several fronts. For instance, unlike the English and other language versions, the official Croatian translation of Article 19 of the CRPD for which the Ministry of Family is in charge of proposing amendments, still allows for institutions to be considered to be a form of community care.²³¹ This inaccurate Croatia translation, which includes reference to the use of institutions that is not included in the English and other versions, has the potential to misdirect resources by purporting to allow for the continued use of institutions in Croatia.

When asked to explain this translation, the Ministry of Family blamed parliament for refusing to change the Croatian translation. But the ministry also stated that a new translation would make no difference: "An institution might not just be a social welfare home but also organized housing or a home for independent living."²³² When asked if there was a continued need for placement in "closed" institutions like social welfare homes, the head of the department for disabilities responded, "To some degree, it is necessary for them to be in the system, not only in Croatia but also in the world."²³³

It is a common misconception that some people, especially persons with the most severe intellectual disabilities, mental disabilities, and multiple impairments, cannot be deinstitutionalized.²³⁴ Care in the community for these groups is necessarily more

²²⁹ Human Rights Watch interview with social workers from Zagreb home (names withheld), December 17, 2009).

²³⁰ Human Rights Watch interview with Ministry of Family, statement by Zvezdana Bogdanovic, head of Department for Persons with Disabilities, December 17, 2009.

²³¹ The Croatian translation of Article 19 of the CRPD refers to "accommodation facilities" as options for community living. CRPD, art. 19(b) (Croatian translation). Accommodation facilities are not included in the English and other language translations of Article 19.

²³² Human Rights Watch interview with Ministry of Family, statement by Zvezdana Bogdanovic, head of Department for Persons with Disabilities, December 17, 2009.

²³³ Ibid.

²³⁴ See Section IV(A)(3) above.

complicated, but it is possible—as illustrated in Sections I and III—to provide such care in the community, as the experience of other countries and of API confirms. The opinion expressed by the head of disabilities in the Ministry of Family is thus short-sighted.

The lack of vision and leadership concerning the process of deinstitutionalization and development of community-based support services has also led to an imbalance in the provision of community-based services. To date, the primary beneficiaries of community-based support programs have been people with physical disabilities, even though there are many fewer such persons than there are with intellectual or mental disabilities living in institutions in Croatia.²³⁵

Croatia’s personal assistance program—identified by the Ministry of Family as a success in developing community-based support—provides a concrete example. This program, which provides a personal assistant to help persons with the most severe disabilities, benefits 338 people, all of whom have severe *physical* disabilities.²³⁶ The director of the Directorate of Family in the Ministry of Family explained that this discrepancy was because persons with severe physical disabilities were most in need since they have no other way to be involved in the community, and “are most often excluded from their families.”²³⁷ However, he was unable to give a clear answer when asked if such people are more excluded than persons with severe intellectual or mental disabilities.²³⁸ Today, 338 persons with physical disabilities benefit from the personal assistants program alone while only about 250 persons with intellectual or mental disabilities live in supportive, independent community living arrangements, which can provide a similar level of care. Although persons with intellectual or mental disabilities could also benefit from the personal assistants program, officials from the Ministry of Family told Human Rights Watch that there are no plans to expand the scope of beneficiaries of this program.²³⁹

Without the leadership to deinstitutionalize and create community-based support services for persons with intellectual or mental disabilities, Croatia will potentially miss opportunities

²³⁵ See Section IV(A)(3) above.

²³⁶ Human Rights Watch interview with Ministry of Family, statements by Zvezdana Bogdanovic, head of Department for Persons with Disabilities, December 17, 2009.

²³⁷ Human Rights Watch interview with Ministry of Family, statement Zdenko Zunic, director of Directorate for Family, December 17, 2009.

²³⁸ Human Rights Watch interview with officials from the Ministry of Family, statements by Zdenko Zunic, director of Directorate for Family, and Zvezdana Bogdanovic, head of Department for Persons with Disabilities, December 17, 2009.

²³⁹ Human Rights Watch interview with Ministry of Family, statement by Zvezdana Bogdanovic, head of Department for Persons with Disabilities, December 17, 2009.

for assistance in the process. For example, in 2006 and 2007, the Open Society Institute (OSI) offered to provide the necessary funds to close down one of Croatia's largest institutions, Stancic. According to Stancic's director, the Croatian government turned down the money because OSI wanted the government to move too fast in closing the institution, leaving residence unprepared for the move.²⁴⁰ OSI mandated that, in order to receive the funds, Stancic would have to close and persons would need to be moved from the institution into expanded and newly-developed community living programs. But OSI also provided a detailed plan about how this transition would take place, provided sufficient time to implement the plan (five years), and offered full funding for the transition and development of community-based programs.²⁴¹ Indeed, Croatia pledged to close down institutions and create community-based alternatives when it signed onto the CRPD and the JIM. By refusing the Open Society Institute's offer, it turned down an opportunity to fulfill its own pledge.

As it stands now, there has been more preparation for community living in institutions throughout Croatia than there has been actual movement. However, creating institutionally-based "preparation homes" to help residents "prepare" for life in the community is not the solution and can stand in the way of financing and planning for community-based programs. At Lohor Grad and Stancic, social welfare homes that also run preparation homes, there is little possibility for movement from these homes into the community. Instead, the transition from institutions into the community can be better achieved through day centers, community visits, and extra assistance when a person first moves from an institution into the community. Experience from Croatia indicates that directing resources at the creation of preparation homes can stand in the way of financing for community-based programs.

Without leadership and a vision for the deinstitutionalization process, it will also be hard to plan for long-term residents of institutions who do not want to leave.²⁴² The reluctance of some residents to leave not only presents a challenge in terms of logistics but also of values: if a central value of the right to live in the community is choice, then should the choice to stay at an institution be respected, even when the goal is deinstitutionalization of all individuals? We think it should. But individuals should be allowed to make a meaningful

²⁴⁰ Human Rights Watch interview with Ivan Vrgoc, director of Stancic, December 10, 2009.

²⁴¹ Letter from Judith Klein, director of Open Society Mental Health Initiative, to Dr. Neven Ljubcic, then-minister of Ministry of Health and Social Welfare, February 16, 2007; Human Rights Watch e-mail correspondence with Judith Klein, director of Open Society Mental Health Initiative, July 26, 2010.

²⁴² Human Rights Watch interviews and conversations with resident at Stancic (name withheld), December 10, 2009; residents at Sveti Filip i Jakov (names withheld), December 8, 2009; and residents at Roman Obitelj (names withheld), December 9, 2009.

choice by being exposed to, and made aware of, community-based alternatives for their housing and care.

Moving anyone from an institution in which they have lived for years can be traumatic, particularly for those who do not want to move. A coherent government strategy is needed to prepare for such a move and to provide possible extra assistance afterward. This preparation may involve visits, day or overnight, to supportive living environments or family so that individuals can observe what living outside of an institution might be like. Such exposure would allow these individuals to make a meaningful choice, rather than defaulting to their familiar life in institutions, and would reduce the stress placed on them during any move. Experience from across Europe indicates that most former residents of institutions who once objected to being moved from institutions now report being more satisfied with their lives in the community.²⁴³

Social welfare homes, family homes, and foster families lack psychiatric treatment services. Instead, the homes rely on occupational therapy as well as nursing and caretaking staff to treat residents; but, as one home branch director told us, the goal of care for the residents is stability, not necessarily to make them better.²⁴⁴ For persons who are deemed to have mental disabilities and are institutionalized on that basis, the option of psychiatric treatment should be available as part of their rehabilitation. Denial of that treatment, which is the reality in most types of institutions, is a violation of their right to highest attainable level of physical and mental health.

Following its research on deinstitutionalization in Croatia, Human Rights Watch believes that the lack of leadership causing these problems can be overcome by: understanding the problem; forging a comprehensive plan to address the problem; and taking concrete action at the leadership level. These steps should not be seen as mutually exclusive, but should rather be undertaken simultaneously in order to accomplish the goal of deinstitutionalization as quickly and efficiently as possible.

The Need to Understand the Problem

A key element to tackling the problem of the institutionalization of persons with intellectual or mental disabilities in Croatia is to acquire a continually-updated and accurate picture of Croatia's institutions and community based programs. Such a picture would allow for

²⁴³ Jim Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report* (Canterbury: Tizard Center, University of Kent, 2007), p. 50.

²⁴⁴ Human Rights Watch interview with Mirkovec branch director (name withheld), December 11, 2009.

detailed planning for deinstitutionalization and would also create a mechanism to monitor progress on deinstitutionalization in the future. Also, good recordkeeping, including a good and full set of statistics, is one means by which governments can make good policy. The situation in Croatia today concerning statistics about the right to live in the community, however, paints a confusing, inaccurate, and incomplete picture that makes it impossible for anyone to know the full scale of the problem or attempt to address it.

Article 31 of the CRPD sought to avoid this situation. By mandating that statistics be accessible and disaggregated, the article envisions that statistics will be a tool for highlighting rights violations, and thus be used to inform more effective policies and laws. However, the incomplete and contradictory statistics about housing in institutions and foster families in Croatia do nothing to advance the right to live in the community and policy of deinstitutionalization.

Expert researchers on deinstitutionalization have proposed ways to collect and disaggregate statistics concerning the right to live in the community in order to make them more accessible for policymakers and persons with disabilities and to ensure that no groups are left behind in exercising their rights. For instance, they recommended that data is kept of the different types of services provided, including institutions and community-based services, in order to be able to gauge progress. Psychiatric hospitals should be included in this data.²⁴⁵ Additionally, data about residents of institutions and users of community-based services should be disaggregated in several different ways, such as by gender, ethnicity, or primary disability.²⁴⁶ In addition to data on persons with physical, intellectual, and sensory disabilities, data should also include residents of institutions and users of community-based services who have mental disabilities.²⁴⁷ It should avoid classifying persons with disabilities as having “multiple disabilities” without describing or disaggregating by primary disability.²⁴⁸

Croatian statistical reporting falls short of these standards in several ways. First, the total number of people living in individual institutions, and the total number of people with certain types of disabilities living in institutions do not match in the annual statistical report

²⁴⁵ Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report*, pp. 12-13.

²⁴⁶ *Ibid.*, p. 95.

²⁴⁷ *Ibid.*, p. 15 (example of Ireland).

²⁴⁸ *Ibid.*, p. 17 (example of Latvia).

of the Ministry of Health and Social Welfare.²⁴⁹ As noted in Section III above and illustrated in Table 1 below, according to one set of statistics, the number of persons living in institutions and foster families for persons with mental disabilities is 4,357, while there are 7,319 people living in institutions or foster families for persons with intellectual or physical disabilities:

Table 1: Total Number of Residents of Institutions for Persons with Disabilities as of the end of 2008²⁵⁰

Type of Disability	# in Social Welfare Homes	# in Family Homes	# in Foster Families	# in Psychiatric Hospitals	Total
Mental	3,882	221	254	Unknown	4,357
Intellectual/Physical	6,640	18	661	Unknown	7,319

However, when the data is reported by type of disability rather than type of institution, as Table 2 below illustrates, the numbers are much less. For persons with mental disabilities, the total number drops by nearly 3,000.

Table 2: Total Number of Persons with Mental Disabilities in Institutions and Foster Families by Type of Disability as of the end of 2008²⁵¹

Type of Mental Disability	# in Social Welfare Homes	# in Family Homes	# in Foster Families	Total
Psychosis	594	28	152	774
Personality Disorder	77	19	84	180
Organic Mental Disorder	411	1	18	430
Total	1,082	48	254	1,384

This discrepancy also occurs for persons with intellectual or physical disabilities. According to one set of statistics the total number of persons living in institutions and foster families for persons with physical or intellectual disabilities is 7,319. However, when the data is reported by type of disability rather than type of institution, as in Table 3 below, the numbers are a lot smaller: only a total of 2,648 persons with intellectual or physical disabilities. This is a difference of 4,670 persons.

²⁴⁹ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008 (accessed on March 8, 2010), Table 1-5; *Ibid.*, Tables 4-2 and 4-3.

²⁵⁰ *Ibid.*, Tables 1-2, 1-5, 4-1, 4-2, and 4-3.

²⁵¹ *Ibid.*, Tables 4-2, 4-3, 4-4, and 4-5.

Table 3: Total Number of Persons with Intellectual Disabilities Living in Institutions and Foster Families as of the end of 2008²⁵²

Type of Disability	# in Social Welfare Homes	# in Family Homes	# in Foster Families	Total # in permanent accommodation
Intellectual ²⁵³	1,329	40	399	1,768
Physical	58	30	262	880
Total	1,387	70	661	2,648

The discrepancies in this data are cause for concern, as they create confusion about the number of persons who actually live in institutions. Without accurate data as to the number of persons living in institutions and foster families, it is incredibly difficult to hold governments accountable to decreasing that number.

A second way that Croatian statistical reporting falls short concerns classifications. There are a large number of people classified as having “multiple or other impairments” living in institutions and foster families in Croatia, although the numbers are not large enough to compensate for the statistical discrepancies described above. The definition of multiple or other impairments is governed by Ministry of Health and Social Welfare regulations, but this definition is vague and does little to elucidate who falls into this category.²⁵⁴

Table 4: Total Number of Persons with Multiple or Other Impairments Living in Institutions and Foster Families as of the end of 2008²⁵⁵

Type of Impairment	# in Social Welfare Homes	# in Family Homes	# in Foster Families	Total
Multiple or Other	1,687	99	629	2,415

Persons with multiple impairments accounted for 32 percent of adults living in social welfare homes and nearly half (48 percent) of children living in those homes. Persons with multiple or other impairments also accounted for 44 percent of the adults and 42 percent of the children living in family homes as well as 40 percent of adults and 36 percent of children

²⁵² Ibid., Tables 4-2, 4-3, 4-4, and 4-5.

²⁵³ As noted above, “mental retardation” is the Ministry of Health and Social Welfare’s term for intellectual disability.

²⁵⁴ Regulation on Social Welfare Rights, http://www.mzss.hr/hr/ministarstvo/zakonodavstvo/uprava_socijalne_skrbi/pravilnik_o_sastavu_i_nacinu_rada_tijela_vjes_tacenja_u_postupku_ostvarivanja_prava_iz_socijalne_skrbi_i_drugih_prava_po_posebnim_propisima_nn_64_02, art. 37 (classifying “multiple or other impairments” as including any combination of two or more physical, intellectual, or mental disabilities at varying levels of severity).

²⁵⁵ Ministry of Health and Social Welfare, *Annual Statistical Report 2008*, http://www.mzss.hr/hr/zdravstvo_i_socijalna_skrb/socijalna_skrb/statisticka_izvjesca/godisnje_izvjesce_2008, Tables 4-2 and 4-3.

living in foster families. The statistics do not disaggregate “multiple impairments” by the types or impairments the individual has nor by the person’s primary impairment. The fact that such a large percentage of persons living in institutions and foster families are persons with multiple or other impairments makes it difficult to determine exactly who is living in these accommodations.

Third, the statistics on alternatives to institutions are incomplete and reflect many of the same problems as the statistics on institutions. For instance, according to government data, there were a total of 70 adults and children with intellectual disabilities and three adults with mental disabilities living in organized housing programs in Croatia at the end of 2008. There were also according to government statistics 46 adults and children with multiple or other impairments living in organized housing, but it was unclear what types of impairments they had. There are also individuals who live in community-based Homes for Independent Living and in other smaller supportive independent community living programs, but the numbers of people living in such community-based housing and care arrangements are included in, and not separated from, the statistics on institutional social welfare and family homes. It is hard to tell from this data how many people with disabilities live in community-based alternatives, and thus hard to track the growth of these programs.

The government’s statistics about institutionalization and deinstitutionalization paint an inaccurate and confusing picture of the extent of the problem in Croatia. At best, they are an example of careless disregard for recordkeeping in the Ministry of Health and Social Welfare and at worst, they are an attempt to obfuscate the extent of institutionalization and the lack of progress in fulfilling the right of persons with disabilities to live in the community.

One begins to assume the worst when looking at how the Croatian government interprets its own statistics. Each year, the government updates the European Commission on its progress in implementing the JIM. In the 2008-2009 progress report, the government reported there had been progress on deinstitutionalization, noting a change in “status” of two social welfare homes from “welfare home” to “non-governmental organization,” without providing further details. It also stated that “beneficiaries of organized housing increased by 54%.”²⁵⁶ In fact, the two institutions mentioned had always been NGO-run independent living programs: the only change was their reclassification by the Ministry of Health and Social Welfare from institutions to NGOs, a move that had no impact on the number of persons in Croatia subject to institutional care. Yet the reported 54 percent increase in persons in

²⁵⁶ Ministry of Health and Social Welfare, “JIM Progress Report,” pp. 26, 51.

organized housing programs came almost entirely from the reclassification of these two homes.²⁵⁷

The Need for a Plan

Another necessary, although not sufficient, step that the government needs to take is to create a comprehensive plan for deinstitutionalization. This is part of Croatia's pledge under the JIM and necessary for it to fulfill its obligations under the CRPD.

This plan should include ambitious timetables for closing down institutions and creating community-based programs to support persons with disabilities. It should take special care to move persons with mild-to-moderate disabilities out of institutions as soon as possible and plan community-based programs aimed at persons with the most severe and profound disabilities so that they do not remain in institutions for longer than necessary. It should also include detailed plans to retrain staff at institutions to provide community-based support and ensure that persons with disabilities and the general public interact with each other in order to prepare communities that will accept persons with disabilities and decrease stigma. Careful research and consultation with all relevant parties—including persons with disabilities (especially those currently living in institutions) and their representatives—is also an essential part of the planning process.

At the time of writing, however, Croatia had yet to produce such a plan, even though Ministry of Health and Social Welfare officials told Human Rights Watch in December 2009 that they had one and would provide researchers with a copy.²⁵⁸ In January and February 2010, a representative of the ministry said the plan would be finalized by the end of June 2010.²⁵⁹ In mid-July 2010, an international organization representative based in Croatia said that the ministry was due to finalize the plan by the end of July, although the ministry itself failed to respond to an inquiry about the time frame for the plan's release.²⁶⁰ Local NGOs in Croatia and the Ombudswoman for Persons with Disabilities all said they had not been consulted

²⁵⁷ Human Rights Watch Interview with Borka Teodorovic, director of Association for Promoting Inclusion, December 5, 2009.

²⁵⁸ Human Rights Watch interview with officials from the Ministry of Health and Social Welfare, statement by Zvezdana Janicar, head of Section for Social Welfare, December 19, 2009.

²⁵⁹ E-mail communication from Zvezdana Janicar, head of Section for Social Welfare, January 27, 2010.

²⁶⁰ E-mail correspondence from Jasmina Papa, Social Inclusion officer of UNDP Croatia, July 15, 2010; Human Rights Watch e-mail to Zvezdana Janicar, head of Section for Social Welfare, July 14, 2010.

regarding formulation of such a plan.²⁶¹ As of mid-August 2010, the plan had not yet been completed, more than three years after ratifying the CRPD and four years after signing the JIM.

The Need for Action

It is essential that any commitment to deinstitutionalization be backed by concrete action. This will require leadership on the part of the government, someone who is willing to take responsibility for creating political will and utilizing political capital to take action on deinstitutionalization.

At present, this type of leadership does not exist in Croatia, as evidenced by the slow rate of deinstitutionalization and the growth of institutions. Croatia must begin in earnest to create community-based programs for persons with intellectual or mental disabilities, consulting with institution residents about where they want to live, and moving these individuals from institutions into the programs that they choose. The government must start retraining staff at institutions to provide community-based support so that they will be prepared when institutions close. And the government needs to do more than offer funding to NGOs to help combat stigma against persons with disabilities: when NGOs do not accept this offer, the government itself should create and promote anti-stigma programs so that communities will be prepared to receive and include persons with disabilities who are leaving institutions.

The Ministry of Health and Social Welfare—the ministry with the most experience and knowledge of the system of institutions in Croatia—should be taking the lead. In order to do so, it is essential that the ministry receive the staff and resources necessary to undertake the important and complex task of deinstitutionalization, as well as the full support and complete oversight of other government bodies.

The Ministry of Family, the entity in charge of monitoring compliance with the CRPD, should hold the Ministry of Health and Social Welfare accountable to fulfilling the convention’s provisions, but has not done so. For example, the head of the disabilities section at the Ministry of Family told Human Rights Watch that Croatia’s progress in implementing the rights enumerated in the convention had been “good,” although “we can never be fully satisfied, because we can always do more.” She then blamed what slowness there had been

²⁶¹ E-mail communications from Kristijan Grdjan, policy director of Sjaj, July 15, 2010, Damjan Janusovic, officer of Association for Self-Advocacy, July 15, 2010; Branka Meic, spokeswoman and policy officer for the Ombudswoman for Persons with Disabilities, July 16, 2010.

on deinstitutionalization on the financial crisis rather than any lack of planning or action.²⁶² This type of oversight by the Ministry of Family falls short of its monitoring obligations under the CRPD.

The Ombudswoman for Persons with Disabilities, an office that has been operating since mid-2008, has the potential to be a leader in promoting deinstitutionalization and in representing to the government the interests of persons with intellectual or mental disabilities who live in or are at risk for placement in Croatian institutions. To date, however, it has not substantially performed this function, mainly because its small staff and lack of resources severely restrict its activities. It is essential that the Croatian parliament, which allocates the Ombudswoman's annual budget, increase its allocation so the Ombudswoman can more effectively advocate for the rights of persons with all types of disabilities.

The European Union (EU) could also take a leadership role in creating political will in Croatia for reform. Croatia is currently in the final phase of negotiations to join the European Union, and as such the EU has substantial influence over Croatian policy. The European Union has funded studies to promote community living in its member states and is well on its way to ratifying the CRPD.²⁶³ The European Commission has also been monitoring Croatia's progress on its pledge to deinstitutionalize persons with disabilities. However, the EU delegation office in Zagreb has not created links with NGOs and disabled persons organizations working on the rights of persons with intellectual or mental disabilities which could provide the EU with a valuable perspective on this topic.²⁶⁴

Additionally, deinstitutionalization and the development of community-based support services are not part of the accession negotiations, limiting the EU's leverage in relation to these changes in Croatia. The European Commission has put pressure on Croatia to fully execute the JIM, but Croatia is not bound by the terms of this document. Now that the EU has signed the CRPD, it should hold prospective member states to CRPD standards as a prerequisite to joining its ranks.²⁶⁵ It should also recognize that although Croatia's pledges

²⁶² Human Rights Watch interview with Ministry of Family, statement by Zvezdana Bogdanovic, head of Department for Persons with Disabilities, December 17, 2009.

²⁶³ The European Commission commissioned the study, Jim Mansell et al., *Deinstitutionalization and community living—outcomes and costs: report of a European Study, Volume 2: Main Report* (Canterbury: Tizard Center, University of Kent, 2007); United Nations Enable, List of Signatories to the CRPD, <http://www.un.org/disabilities/countries.asp?id=166> (accessed April 16, 2010); United Nations Enable, Newsletter, December 2009, <http://www.un.org/disabilities/documents/newsletter/december2009.doc> (accessed April 16, 2010).

²⁶⁴ Human Rights Watch Interview with Dijana Kuzman, European Commission, December 2, 2009.

²⁶⁵ United Nations Enable, List of Signatories to the CRPD, <http://www.un.org/disabilities/countries.asp?id=166> (accessed April 16, 2010); United Nations Enable, Newsletter, December 2009, <http://www.un.org/disabilities/documents/newsletter/december2009.doc> (accessed April 16, 2010).

to the EU concerning deinstitutionalization are not binding, its pledges under the CRPD are, and the EU can be a powerful force in ensuring that Croatia lives up to its international obligations.

Finally, the UN Committee on the Rights of Persons with Disabilities—the expert treaty monitoring body for the CRPD—should hold Croatia accountable to its pledges under the CRPD and lead the way to creating the political will for change in Croatia. The committee will soon review states’ initial reports on their implementation of the convention and should seize this opportunity to call attention to Croatia’s lack of progress in fulfilling the right to live in the community and the right to liberty and security of the person, which are so integral to achieving other rights enshrined in the CRPD.

VI. Recommendations

To the Government of Croatia

International Law

- Ensure that all legislation aimed at persons with disabilities specifically includes persons with mental disabilities, in line with the CPRD. Recognize institutionalization based on disability as a form of discrimination.
- Amend the official Croatian translation of Article 19 of the CRPD to exclude the implication that institutional care could be considered a community living option. Ensure that the amended translation guides implementation of legislation in Croatia.
- Submit timely reports to the UN Committee on the Rights of Persons with Disabilities, and involve persons with disabilities in the process of developing these reports.
- Train judges and lawyers about the rights enumerated in the CRPD so that they can correctly apply the law.

Social Welfare Reform

- Enact comprehensive Social Welfare reform that requires an increase in places in and provides a budget line for community support programs for persons with disabilities.
- Recognize institutionalization without the consent of the individual as a form of detention, even where the person is deprived of legal capacity. Reduce the risk of arbitrary detention, a violation of international law, for this group by ensuring at a minimum the following procedural safeguards:
 - o Require that an independent judicial tribunal, rather than a Center for Social Welfare, makes the decision to place someone in an institution, and that people placed in institutions have the right to challenge their institutionalization.
 - o Create a legal presumption against institutionalization and require that the tribunal consider all other alternatives to institutions before placement.
 - o Ensure that all persons subject to this type of detention have access to publicly-funded lawyers at all stages.
 - o Where a judge deems institutionalization necessary, require that institutionalization be for the shortest possible time and subject to regular review by an independent judicial tribunal
- Legislate a definition of institutions that is not based on size or type of building but rather includes all social welfare homes, “family homes,” psychiatric hospitals with long-term residents, and any other arrangements that segregate individuals from society

or limit their choice of where and how they live. Include foster families for adults in the process of deinstitutionalization.

- Mandate that no funding provided to the Ministry of Health and Social Welfare is spent on building new institutions, major refurbishment projects for existing institutions, building preparation homes, or funding new or renewed contracts with institutions run by NGOs, private individuals/corporations, or local/regional governments. The cost of essential repairs for existing institutions should be included in the operating budget of each institution.
- Increase funding allocated to the office of the Ombudswoman for Persons with Disabilities so that this office can be a more effective advocate for all persons with disabilities.

Legal Capacity Reform

- Fundamentally reform the law on legal capacity to create a system in which persons with intellectual or mental disabilities are supported in making decisions rather than deprived of the ability to exercise their rights. Ensure that any legislative measures regarding legal capacity are not directed at persons with disabilities but apply with equal force to all persons in Croatia, and not on the basis of disability.
- Pending implementation of such reform, undertake the following improvements to the current system to ensure the rights of persons with disabilities:
 - o Create a right to publicly-funded legal representation for all individuals who are going through any type of legal capacity proceedings.
 - o Amend Article 159 of the Family Law to so that full and permanent deprivation of legal capacity is no longer an option.
 - o Amend Article 165 of the Family Law to require an annual independent expert review of any limitations on legal capacity. All cases where independent expert review recommends continuation of limitations on legal capacity should be subject to judicial review.
 - o Amend Article 174 of the Family Law to allow persons placed under guardianship or in need of decision-making assistance to choose their own guardian or assistant. Include that any challenges to this decision should be brought in front of a court of law.

To the Ministry of Health and Social Welfare

Directorate of Social Welfare

Planning

- Put together a concrete action plan for deinstitutionalization, based on the values of equality, independence, and inclusion for persons with disabilities. Ensure that this plan is not about the “transformation” of institutions but is rather about closing institutions, developing a wide range of alternatives, and providing choices to persons with disabilities. Ensure that the prevention of institutionalization for persons with disabilities is an essential part of this plan. Include far-reaching but achievable benchmarks and deadlines that challenge individuals working the social welfare system, punish them for failure, and reward them for success.
- Provide guidance to local/regional governments, institutions, Centers for Social Welfare, and private actors concerning the roles they will play in the deinstitutionalization process.
- Ensure that persons with disabilities, disabled persons organizations, NGOs that work on deinstitutionalization projects, and the Ombudswoman for Persons with Disabilities are invited to participate in the formation of this plan.

Creation of Community-based Services

- Visit, learn from, and expand models for deinstitutionalization that are already in place in Croatia. When necessary, seek out the experiences of other countries that have more fully undergone deinstitutionalization.
- Reallocate existing ministry budget lines to enable the creation of new contracts and renewal of existing contracts with NGOs, private actors, and local/regional governments to provide socially-inclusive care in the community for persons with intellectual or mental disabilities, particularly independent and supportive living arrangements.
- Where NGOs, private actors, and local/regional governments are not developing adequate community-based services to meet the needs of the population, as for persons with mental disabilities, create centralized programs from existing budget lines that provide these community-based services, particularly independent and supportive living arrangements. Make running and funding community-based services for persons with disabilities a top priority.
- Create a body composed primarily of persons with disabilities and other experts to monitor and assess the effectiveness of community-based support services. Incorporate the conclusions of this body into future regulations on the provision of social services.

Individualization of Services

- Develop a care plan for each individual with a disability in the social welfare system. Prioritize planning for persons with disabilities currently living in institutions or foster families while ensuring that those persons with disabilities at risk for institutionalization are also part of this planning process. Consult with individuals about the specific services and care they need to live and participate in the community. To the extent that families are involved in the lives of institution residents, consult with them in the planning process. Periodically re-evaluate the plans and individualized budgets to ensure that individuals receive the correct level of care for life in the community.
- Allow individuals to choose the services they need, including where and with whom they live, and regardless of who runs those services (the state, local governments, NGOs, or other private entities). Ensure that individuals are fully informed of available options and provide assistance in making decisions about care.

Overcoming Barriers to Deinstitutionalization

- Develop plans for closing institutions that include specific provisions about how staff will be retrained to provide community-based support services and how any economic effect on the local community will be offset. Follow up these plans with action.
- Involve institutions in the process of deinstitutionalization by empowering staff members to develop alternative programs to institutions, prepare individuals for life in the community, and gradually transition themselves into community-based support services.
- Re-train current institution employees to provide care in the community for persons with intellectual and mental disabilities.
- Create government-directed programs to combat stigma targeted at persons with mental or intellectual disabilities. Recognize that contact between persons with mental or intellectual disabilities and the rest of society is the most effective means of combating stigma.
- Remove from regulations any restrictions on moving individuals from institutions to the community, including a doctor's assessment of "readiness" to live in the community.
- Take control over the residential parts of the Centers for Autism from the Ministry of Science, Education, and Sport. Ensure that the Centers for Autism are included in any plans for deinstitutionalization.

Statistics and Records

- Identify how many people in social welfare homes for persons with physical/intellectual or mental disabilities actually have the impairments for which the home was designed.

- Record and publish disaggregated statistics on persons with multiple or “other” impairments living in institutions. Enumerate the types of impairments they have, including primary impairment, and in which types of homes they are receiving care.
- Keep publicly-available records of contact information for “family homes” so that they can be monitored more effectively by independent bodies.
- Create a statistical database that tracks independent and supportive living arrangements for persons with disabilities. Do not include in this category any restrictive housing, such as housing on the premises of institutions. Keep statistics on supportive living arrangements in the community separate from those of social welfare homes and “family homes.” With data disaggregated by type of disability, track and report on the number of such arrangements and the amount of funding they receive.

Centers for Social Welfare

- Stop referring persons with disabilities to institutions and placing them on waiting lists to enter institutions. Instead, focus staff resources on creating programs for the prevention of institutionalization for these individuals.
- Become better aware of, and refer persons with disabilities to, the alternatives to institutions and foster families that are available in the community.
- Stop referring cases to court for full, permanent denial of legal capacity. Until fundamental legal capacity reform is passed, recommend that any deprivation of legal capacity is temporary and limited. Recommend that persons retain the right to choose where they live.

Institution Directors and Staff

- Inform persons with disabilities about their right to live in the community, among other rights, and the alternatives to institutions.
- Immediately identify the current residents most capable of living in the community with support. Work with them to find out whether and where they want to live in the community, and work with Centers for Social Welfare to place them accordingly.
- Encourage relationship-building between family members and residents of institutions, and encourage family to support moving individuals into the community.
- Stop building houses on the premises of institutions to prepare residents for community living. Instead, recommend that potential residents of preparation houses be moved into independent and supportive community living arrangements.

Directorate of Health

Mental Health Treatment

- Provide access to consistent care from a qualified psychiatrist to individuals living in social welfare homes, particularly those homes for adults with mental disabilities. Ensure that the goal of this care is rehabilitation toward living in the community.
- Work with the Directorate for Social Welfare to create plans for community care of persons with mental or intellectual disabilities. Ensure that access to comprehensive medical, particularly mental health, treatment is included.

Planning for Deinstitutionalization

- Keep comprehensive, publicly-available statistics on the number of long-term (more than six months) residents of psychiatric hospitals. Integrate these statistics with annual statistics provided by the Directorate of Social Welfare.
- Coordinate with the Directorate of Social Welfare to make plans to provide community-based support to long-term residents of psychiatric hospitals.

To the Ministry of Family, Veterans' Affairs, and Intergenerational Solidarity

Personal Assistance

- Expand the beneficiaries of the program of personal assistance to include individuals with intellectual or mental disabilities, not only those with physical or sensory disabilities. Involve persons with intellectual or mental disabilities in planning for the expansion of the personal assistants program.

Legal Capacity Reform Working Group

- Involve persons with disabilities, particularly those affected by deprivations of legal capacity, in the process of developing legal capacity reforms.
- Without further delay, bring recommended amendments to the law on legal capacity, including those outlined above, before the Croatian Parliament for legislative review.

Monitoring of Compliance with the CRPD and JIM

- Strengthen mechanisms to monitor and report on Croatia's compliance with the right to live in the community and other rights enumerated in the CRPD. Report critically on Croatia's performance when progress is minimal.

To the Ombudswoman for Persons with Disabilities

- Recognize and pursue the essential role played by the Ombudswoman's office in moving the government towards deinstitutionalization of persons with intellectual or mental disabilities. Investigate and critically report on the progress of deinstitutionalization in Croatia.

To the European Union

- Create direct links between the in-country delegation and local NGOs and disabled persons organizations that provide community-based support services and supportive community living arrangements for persons with intellectual or mental disabilities. Include the viewpoints of these NGOs in the European Commission's assessment of Croatia's progress on deinstitutionalization.
- As part of future accession negotiations with EU candidate countries, ensure that the rights enumerated in the CRPD are part of the accession requirements (*acquis*) and integrated into negotiations on the chapters on Judiciary and Fundamental Rights, Employment and Social Welfare, and Consumer and Health Protection.

To the World Bank

- Ensure that no World Bank assistance to the Croatian government is used to build new institutions or for major refurbishment projects at existing institutions. Focus provision of social assistance development funds on building community-based support services for persons with intellectual or mental disabilities

To the UN Committee on the Rights of Persons with Disabilities

- Critically assess Croatia's compliance with Article 19 of the CRPD, the right to live in the community, in light of its lack of progress on vindicating the choice and equality of persons with disabilities in housing, as well as Articles 12, 14, 25, and 31, and make positive recommendations on how to address the problems identified in this report.

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“Once You Enter, You Never Leave”

Deinstitutionalization of Persons with Intellectual or Mental Disabilities in Croatia

More than 9,000 persons with intellectual or mental disabilities in Croatia live in institutions. Some live in poor conditions. But even when conditions are satisfactory and staff members treat residents well, their rights are neither fully realized nor realizable. Denied privacy and autonomy to make even the most simple life choices, they cannot lead anything like normal lives.

Few persons with intellectual or mental disabilities living in Croatian institutions have ever left to live in the community. Life for the few that have has greatly improved. With assistance, many do their own shopping, cooking, and cleaning. Some even work. Yet the government has offered little commitment to expanding these community-based programs, despite their proven success.

Croatia was one of the first countries in the world to ratify the UN Convention on the Rights of Persons with Disabilities, a document that explicitly applies basic human rights standards to persons with disabilities, including the right to live in the community. In 2006, Croatia also pledged with the European Union to move persons with disabilities from institutions into the community.

This report details the stark contrast between Croatia’s commitments and its actions in fulfilling the rights of some of its most vulnerable people. It recommends that Croatia draws on the experiences of other countries and its own community-based support programs to create and implement a plan to deinstitutionalize and move persons with disabilities into the community. It also recommends that persons with disabilities should be involved in every part of the process, and that the European Union take a more active role in promoting community living and deinstitutionalization in Croatia.