(UN)READINESS OF THE COMMUNITY TO ACCEPT THE PERSONS ADMITTED WITH MEDICAL SECURITY MEASURES[*]

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Offenders who suffer from mental illnesses represent a vulnerable and highly marginalised group, facing everyday stigmatisation and discrimination, which has a negative impact on their re-socialisation and social reintegration and increases the risk of recidivism. It seems that adequate post-institutional assistance combined with gradual adaptation of the community and the shift in the attitude of the public towards these persons could contribute to the minimisation of their stigmatisation and discrimination and encourage their re-socialisation and social reintegration. Therefore, the author of this paper highlights the harmful impacts of stigmatisation and discrimination on the success of re-socialisation and social reintegration of offenders admitted with medical security measures, critically analyses current legislative framework of the Republic of Serbia for imposing and application of these measures as well as for post-institutional (post-penal) assistance that should follow them, suggesting ways to improve both - legislative solutions and practical aspects related to this complex issue.

KEY WORDS: medical security measures / mental illness / post-institutional assistance / discrimination / stigmatisation

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INTRODUCTION - STIGMATISATION AND DISCRIMINATION OF OFFENDERS WITH MENTAL DISEASES

Mental health issues seriously affect modern society and the improvement of mental health represents one of the challenges of global development (Backović, 2010: 833). The individuals who have been diagnosed with a mental disorder are frequently facing high levels of stigma and discrimination (Mezey *et al.,* 2016: 517) across the world and in Serbia as well (Lečić Toševski *et al*., 2005: 12). Among them, those diagnosed with schizophrenia seem to be particularly affected by discrimination (Angermeyer *et al*., 2004: 153-162; Rose *et al.,* 2011: 193), at work, by health staff, by the members of the community and even by their family members and neighbours (Koschorke *et al*., 2014: 150). Mental disorders can affect all individuals and social groups, but it seems that the risk of mental illness is higher among persons with lower incomes, unemployed persons, persons with poor education, victims of violence and abuse, children, adolescents and elderly people (Backović, 2010: 833). Stigma impacts all areas of the individuals' life, identity and functioning, but particularly the domains related to interpersonal relationships, friendships, family, intimate relationships and marriage (Mezey *et al.,* 2016: 518). Subjective perceptions of persons affected by mental illness confirm that its effects are often experienced as more troublesome and painful than the primary condition itself (Thornicroft, 2006, in Koschorke *et al*., 2014: 149).

Although the fear and prejudice against them would suggest the opposite, global statistics confirm that the percentage of mentally ill persons who commit criminal offences tends to be rather small (Batrićević, 2014: 90). Namely, only 4% of mentally ill persons in the world are registered as offenders, as well as that the criminality of persons with mental disorders represents only 1% of global crime rate (Mrvić-Petrović, 2007: 39). When it comes to forensic psychiatric patients, defined as mentally disordered individuals whose behaviour has led or may lead to offending, the research on stigma and discrimination affecting them is rather limited (Mezey *et al.,* 2016: 518). However, there are some surveys of public attitudes showing that fear, intolerance and prejudice towards mentally ill individuals who have a history of violent offending is widespread (Brooker, Ullman, 2008; TNS, 2007 in Mezey *et al.,* 2016: 518). Such attitudes and negative stereotypes contribute to the increase of stigma and discrimination, i.e. "the behavioural consequence of stigma, which is designed to exclude and create a social distance between the affected and non-effected members of the society" (Mezey *et al.,* 2016: 518). On the other hand, a research conducted by Mezey *et al.,* suggests that the levels of experienced and anticipated stigma in the general adult and forensic patients are quite similar and that there is no significant difference found between these two groups of patients (2016: 523). Nevertheless, there is still no doubt that members of the public tend to relate mental illnesses to dangerousness and unpredictability (Angermeyer *et al*., 2004: 153-162; TNS, 2007 in Mezey *et al.,* 2016: 518). At the same time, it appears that forensic psychiatric patients are amongst the most severely ill ones (who, whether forensic or not, are the most stigmatised and discriminated). Besides, they often come from the social groups that are considered the most deprived and socially excluded and have frequently been abused and neglected in childhood, which makes

them see the world as hostile and rejecting. The crime they have committed and their perceived dangerousness make them more likely to be marginalised and socially excluded (Mezey *et al.,* 2016: 525).

Numerous ex-prisoners continue to carry the mark of being a convict long after their sentences have been served (Chui, Cheng, 2013: 671). Criminal offenders represent a highly stigmatized group, marginalized via several temporary and/or permanent restrictions in various aspects of community involvement (Pogorzelski et al. 2005: 1718-1724, in Moore *et al*., 2016: 196–218). The stigma of stereotyping, labelling, discrimination, status loss, and separation (Link, Phelan, 2001, in: Chui, Cheng, 2013: 671) experienced by ex-prisoners can be seen as a form of "invisible punishment" (Henderson, 2005: 1240, in: Chui, Cheng, 2013: 671) that is likely to hold back their successful re-entry into society (Chui, Cheng, 2013: 671). Actually, it is the perceived stigma felt by former prisoners that appears to be positively correlated with the number of lifetime probation violations and a violent felony conviction, which implies that perceived stigma is related to a variety of maladaptive behaviours in both - offenders as well as other stigmatized groups (Moore *et al.*, 2016: 196–218). Namely, a study conducted by Moore *et al.* confirmed that higher perceptions of stigma toward offenders prior to release predicted poorer adjustment in the community (such as, for example, community functioning and/or employment) indirectly through anticipated stigma (Moore *et al*., 2016: 196–218).

The aforementioned findings suggest that the perpetrators of criminal offences (i.e. offences incriminated by the law as criminal offences) who suffer from mental diseases are definitely facing double marginalisation - as offenders as well as persons with mental issues (Bejatović, 2017: 316), which has a negative impact on their re-socialisation and social reintegration.

1. MEDICAL SECURITY MEASURES IN CRIMINAL LEGISLATION OF THE REPUBLIC OF SERBIA

Current criminal legislation of the Republic of Serbia is familiar with eleven security measures enumerated in Article 79 of the Criminal Code of the Republic of Serbia[1] (hereinafter: CCRS): 1) compulsory psychiatric treatment and confinement in a medical institution; 2) compulsory psychiatric treatment at liberty; 3) compulsory drug addiction treatment; 4) compulsory alcohol addiction treatment; 5) prohibition from practicing a profession, activity or duty; 6) prohibition to drive a motor vehicle; 7) confiscation of objects; 8) expulsion of a foreigner from the country; 9) publishing of judgement; 10) restraint order to approach and communicate with injured party, 11) ban to attend certain sporting events. The first four are referred to as medical security measures (Bejatović, 2017: 320).

Paragraph 2 of Article 4 of CCRS defines the general purpose of criminal sanctions as the suppression of the acts that violate and threaten the values protected by criminal legislation. Within this general purpose of criminal sanctions, Paragraph 78 of CCRS defines the purpose of security measures as the elimination of conditions or circumstances that may influence the commission of criminal offences

[1] Criminal Code of the Republic of Serbia, *Official Gazette of the Republic of Serbia*, No. 85/2005, 88/2005, 107/2005, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014 and 94/2016.

in the future. Article 80 of CCRC prescribes that the court may impose one or more security measures on an offender if conditions prescribed by the CCRS are met (Article 80, Paragraph 1, CCRC). Compulsory psychiatric treatment and confinement in a medical institution and compulsory psychiatric treatment at liberty shall be imposed as an individual sanction on a mentally incompetent criminal offender. In addition to these measures, ban on practising certain profession, activity or duty, ban on driving a motor vehicle and confiscation of objects may also be ordered (Article 80, Paragraph 2, CCRS). The aforementioned measures may be ordered to an offender whose mental capacity is substantially impaired, if under pronouncement of a penalty or suspended sentence (Article 80, Paragraph 3, CCRS). Compulsory drug addiction treatment, compulsory alcohol addiction treatment, ban to practice particular profession, activity or duty, ban on driving a motor vehicle, confiscation of objects and publishing of judgement may be ordered if the offender is under pronouncement of penalty, suspended sentence, judicial caution or if the offender is remitted from punishment (Article 80, Paragraph 4, CCRS) .

Compulsory psychiatric treatment and confinement in a medical institution is ordered by the court to an offender who committed a criminal offence in a state of substantially impaired mental capacity if, due to the committed offence and the state of mental disturbance, it determines that there is a risk that the offender may commit a more serious criminal offence and that in order to eliminate this risk they require medical treatment in such institution (Article 81, Paragraph 1, CCRS). If the aforementioned requirements are met, the court shall order compulsory treatment and confinement in a medical institution to an offender who, in state of mental incompetence, committed an unlawful act provided under law as a criminal offence (Article 81, Paragraph 2, CCRS). When the court determines that the need for treatment and confinement of the offender in a medical institution no longer exist, the court discontinues the measure (Article 81, Paragraph 3, CCRS). When ordered together with a term of imprisonment, this measure may last longer than the pronounced sentence (Article 81, Paragraph 4, CCRS). Time spent in a medical institution by the offender who committed a criminal offence in a state of substantially impaired mental capacity and who has been sentenced to prison, shall be credited to serving of the pronounced sentence. If time spent in a medical institution is less than the pronounced prison sentence, the court shall order, upon termination of the security measure, that the convicted person is remanded to prison to serve the remainder of the sentence or released him/her on parole. In deliberating to grant parole the court shall, in addition to requirements set forth in Article 46 of CCRS, particularly take into consideration the degree of success of treatment of the convicted person, his/her medical condition, time spent in the medical institution and the remaining part of the sentence (Article 81, Paragraph 5 CCRS).

Compulsory Psychiatric Treatment at Liberty is ordered by the court to an offender who has committed an unlawful act provided under law as a criminal offence in a state of mental incapacity, if the court determines that danger exists that the offender may again commit an unlawful act provided under law as a criminal offence, and that treatment at liberty is sufficient to eliminate such danger (Article 82, Paragraph 1, CCRS). This measure may be ordered to a mentally incompetent perpetrator under compulsory psychiatric treatment and confinement in a medical institution when the court determines, based on results of medical treatment, that his further treatment and confinement in a medical institution is no longer required

and that treatment at liberty would be sufficient (Article 82, Paragraph 2, CCRS). Under the aforementioned conditions, the court may also order compulsory psychiatric treatment at liberty to an offender whose mental competence is substantially impaired if he/she is under a suspended sentence or released on probation pursuant to Article 81, paragraph 5 of CCRS (Article 82, Paragraph 3). Compulsory psychiatric treatment at liberty may be undertaken periodically in a particular medical institution if necessary for a successful treatment, with the proviso that periodical institutional treatment may not exceed fifteen days in continuity or two months in aggregate (Article 82, Paragraph 4). Compulsory psychiatric treatment at liberty shall last as long as there is a need for treatment, but may not exceed three years (Article 82, Paragraph 5). If the offender does not comply with treatment at liberty or abandons it of his own volition, or if despite treatment, danger of committing an unlawful act provided under law as a criminal offence is reasserted, which necessitates his treatment and confinement in an appropriate medical institution, the court may order compulsory psychiatric treatment and confinement in such institution (Article 82, Paragraph 6 CCRS).

Compulsory drug addiction treatment is ordered by the court to an offender who has committed a criminal offence due to addiction to narcotics and if there is a serious danger that he/she may continue committing criminal offences due to this addiction (Article 83, Paragraph 1, CCRS). This measure is carried out either in a penitentiary institution or in an appropriate medical or other specialised institution and it lasts as long as there is a need for treatment, but not more than three years (Article 83, Paragraph 2, CCRS). If this measure is ordered together with a term of imprisonment, duration thereof may exceed the pronounced sentence but its overall duration cannot exceed three years (Article 83, Paragraph 3, CCRS). The time spent in the institution for medical treatment is credited to the prison sentence (Article 83, Paragraph 4, CCRS). If this measure is pronounced together with a fine, a suspended sentence, judicial caution or remittance of punishment, it is carried out at liberty and may not exceed three years (Article 83, Paragraph 5, CCRS). If the offender fails to undertake treatment at liberty or abandons treatment at his own volition without justifiable reasons, the court shall order coercive enforcement of such measure in an appropriate medical or other specialised institution (Article 83, Paragraph 6, CCRS).

Compulsory alcohol addiction treatment is ordered by the court to an offender who has committed a criminal offence due to addiction on alcohol abuse and if there is serious threat that he may continue to commit offences due to such addiction (Article 84, Paragraph 1, CCRS). This measure is carried out in a penitentiary institution or an appropriate medical or other specialised institution and lasts as long as there is need for treatment, but may not exceed the duration of the pronounced prison sentence (Article 84, Paragraph 2, CCRS). The time spent in an institution for medical treatment shall be credited against the prison sentence (Article 84, Paragraph 3, CCRS). If this measure is ordered together with a fine, suspended sentence, judicial caution or remittance of punishment, it is carried out at liberty and cannot exceed two years (Article 84, Paragraph 4, CCRS). If the offender fails to undertake treatment at liberty or abandons treatment at his own volition without justified reasons, the court shall order the coercive enforcement of the measure in an appropriate medical or other specialised institution (Article 84, Paragraph 5, CCRS).

2. POST-INSTITUTIONAL ASSISTANCE FOR OFFENDERS WITH MENTAL HEALTH ISSUES IN SERBIA

2.1. Normative Framework for Post-institutional Assistance for Offenders with Mental Health Issues in Serbia

The adoption of the Law on the Protection of Persons with Mental Impairments[2] (hereinafter: LPPMI), after many years of preparation, represents an important step towards the establishment of a better system of these persons` rights protection, at least on the normative level (Protector of Citizens, 2018: 61). According to this law, the term person with mental impairments refers to: 1) insufficiently mentally developed persons, 2) persons with mental health issues and 3) persons suffering from addiction (Article 2, Paragraph 1, LPPMI). This means that the aforementioned term also includes offenders with mental health issues. This law prohibits the discrimination based upon mental impairments and declares that the protection of persons with mental impairments should be provided regardless of their personal characteristics (Article 4, LPPMI). Furthermore, the law prescribes that a person with mental impairments (including offenders) has the right to the protection and improvement of his/her mental health through: prevention, care, treatment and psycho-social rehabilitation in appropriate medical or other institutions, recovery and inclusion in family, working and social environment with the respect of his/her choice (Article 7 LPPMI). When it comes to the procedure in the cases of the enforcement of security measures imposed on the offenders with mental health impairments, the aforementioned law refers to the legal provisions regulating the execution of criminal sanctions, i.e. Law on the Execution of Criminal Sanctions[3] (hereinafter: LECS) (Articles 58-60, LPPMI).

Two bylaws relevant to the application of LPPMI have been adopted so far (Jović *et al.*, 2016: 24): 1) Bylaw on more detailed conditions for the application of physical restrain and isolation of the persons with mental disorders on treatment in psychiatric institutions[4] and 2) Bylaw on the types and more detailed conditions for the establishment of organisational units and providing for community-based mental health care services[5]. However, in spite of the fact that LPPMI creates a normative framework for the establishment and organisation of community based mental health care services and supports the protection of patients' human rights, an action plan that would define the term for their organisation, their structure, responsibilities and financial resources, has not yet been adopted, which slows down the application of LPPMI (Jović *et al.*, 2016: 24). In 2014, there were 5 community-based mental health care centres in Serbia and medical workers have attended

[2] Law on the Protection of Persons with Mental Impairments, *Official Gazette of the Republic of Serbia,* No. 45/2013.
[3] Law on the Execution of Criminal Sanctions, *Official Gazette of the Republic of Serbia,* No. 55/2014.
[4] Bylaw on more detailed conditions for the application of physical restrain and isolation of the persons with mental disorders on treatment in psychiatric institutions, *Official Gazette of the Republic of Serbia,* No. 94/2013.
[5] Bylaw on the types and more detailed conditions for the establishment of organisational units and providing for community-based mental health care services, *Official Gazette of the Republic of Serbia,* No. 106/2103.

professional training and education related to the treatment of persons with mental health impairments (Screening report for Serbia - Chapter 28: Consumer and health protection, 2016: 11). However there is still space for progress in this area, especially when it comes to offenders with mental health issues. Namely, it seems that the insufficient number of community-based mental health care services is not in accordance with the recommendations of the World Health Organisation, according to which the development of these services should be based upon the idea of recovery, support, cooperation with the informal mental health care services providers, including religious organisations, healers, teachers/educators etc (Jović *et al.*, 2016: 26).

LECS prescribes that Social welfare centre closest to the place of permanent or temporary residence of the offender is in charge of taking care of that person after he/she has left the medical institution where the measure of compulsory psychiatric treatment and confinement in a medical institution was being applied, provided that aftercare cannot be provided within his/her family (Article 201, LECS). This means that the social welfare centre is in charge of taking care of these persons only if their family cannot participate in their aftercare, i.e. that the possibility of aftercare within the family practically excludes the participation of social welfare centre, which is not correct. Instead, these two entities should cooperate and provide for adequate post-institutional care together with the support of the entire community.

The Rulebook on House Rules of Special Prison Hospital[6] (hereinafter: RHRSPH) emphasizes that the activities that are conducted in this medical institution include, *inter alia,* medical rehabilitation and re-socialisation as well as that they are applied with the purpose to prevent dangerous behaviour, to enhance mental and social rehabilitation and to facilitate the return of the offender to the community (Article 15, RHRSPH). Moreover, the Rulebook prescribes that the person admitted to security measure of compulsory psychiatric treatment and confinement in a medical institution should actively participate in his/her treatment, recovery and re-socialisation (Article 16, RHRSPH). It is important to mention that the Rulebook obliges the Hospital to design the program of post-institutional assistance for each offender prior to his/her release (Article 72, RHRSPH). However, the Rulebook does not provide for more precise or detailed provisions or instructions pertinent to the contents of such programme.

It is also worth mentioning that the Mental Health Protection Development Strategy[7] (hereinafter: MHPDS), adopted in 2005[8] with the purpose to make the treatment more humane and provide a more efficient prevention of mental health, prescribed that mental health care services should offer a modern and comprehensive treatment based upon a bio-psycho-social approach, which should take place within community as close to the family of the patient as possible (Petrović, 2016: 63). Among other principles, the Strategy proclaimed

[6] Rulebook on House Rules of Special Prison Hospital, *Official Gazette of the Republic of Serbia,* No. 145/2014.
[7] Mental Health Protection Development Strategy, *Official Gazette of the Republic of Serbia*, No. 55/ 2005 and 71/2005.
[8] Public Health Strategy in the Republic of Serbia between 2018 and 2026 (*Official Gazette of the Republic of Serbia*, No. 61/2018) suggests that a new Mental Health Protection Development Strategy for the period after 2018 should be adopted, together with the action plan that is necessary for its implementation.

that hospitals should serve as a part of community-based services (such as mental health centres, "protected housing" "patients communities" etc.), that these services should be mobile and flexible and adaptable to the needs of the users and their families and caretakers (Jović *et al.*, 2016: 22). Unfortunately, it seems that this principle was not adequately been applied in practice, which has been criticised by relevant institutions (including the Protector of Citizens and expert associations) for several times (Petrović, 2016: 354). MHPDS represented an appropriate document, defining numerous important and necessary terms and issues. It was accompanied by the Action Plan of Reform, which has never been applied and for which adequate political and expert support has never been provided (Jović *et al.*, 2016: 22).

Current situation in the area of post-institutional assistance for offenders with mental disease could be compared with the one that exists in the field of post-institutional care of juveniles in conflict with the law. Namely, draft version of Strategy for Social Reintegration and Aftercare of Convicted Persons for the Period between 2015 and 2020 (which was presented at the end of 2015) underlines that post-institutional care represents the weakest spot when it comes to juveniles placed in correctional institution (Batrićević, Srnić-Nerac, Marković, 2018: 252). When it comes to juveniles placed in the correctional institution, the draft Strategy gives high priority to the following activities: designing a programme of psycho-social support in order to facilitate their active participation in social life after leaving the institution, analysing their needs in the period after leaving the institution and improving the cooperation between social welfare centres and the representatives of local self-government (Srnić, Vulević, 2016: 17). Similar conclusions could be applied in the cases of offenders with mental disease in order to improve the conditions for their aftercare and return to the community.

In the cases when the security measure of compulsory medical treatment and confinement in a medical institution or security measure of compulsory psychiatric treatment at liberty is imposed together with conditional sentence (Article 80, Paragraph 3 CCRS), the involvement of the Probation Office in the supervision of the application of this measure exist if protective supervision is imposed together with conditional sentence in accordance with Article 5, Paragraph 1, Subparagraph 5 of the Law on the Execution of Extra-judicial Sanctions and Measures[9] (hereinafter: LEEJSM). Namely, according to this legal provision, the Probation Officer is, among the rest, in charge of organising, conducting and tracking the enforcement of protective supervision imposed together with conditional sentence.

When it comes to post-institutional assistance, it is worth mentioning that LEEJSM regulates the cases of post-penal assistance, i.e. providing assistance for ex-prisoners after they have served prison sentence (Articles 56 and 57 LEESJM). Such option is important because it refers to the prisoners who have been admitted to some of medical security measures together with prison sentence. This kind of assistance can be given to former prisoners, provided that the Probation Officer estimates that there is the need for such assistance or if the former prisoner asks for it (Article 56 LEESJM). The program of assistance represents a group of measures and procedures that a former prisoner accepts on a voluntary basis after the prison

[9] Law on the Execution of Extra-judicial Sanctions and Measures, *Official Gazette of the Republic of Serbia*, No. 55/2014 and 87/2018.

sentence has been completed and that is applied with the purpose of his/her inclusion in regular life courses outside the prison. The programme consists of: 1) assistance regarding the accommodation and nutrition, 2) assistance in the realisation of the right to health and social welfare protection, 3) giving advice related to resolving family issues, 4) providing help and support in the field of employment, education or professional training, 5) establishing cooperation with social welfare centre with the aim of obtaining financial support, 6) providing support and assistance in the restrain from drugs and alcohol abuse and 7) other forms of help and support (Article 57 LEESJM). However, it should be stressed once again that this type of aftercare is accessible only to the offenders with mental diseases who have been admitted to medical security measures together with prison sentence, i.e. to those whose mental competence was only substantially impaired at the time of the commission of criminal offence (Article 80, Paragraph 3, CCRS) because only then can medical security measures be imposed together with punishment. On the other hand, in the cases of mentally incompetent offenders, obviously, this kind of post-institutional assistance cannot be applied, because they cannot serve prison sentence.

2.2. Practical Problems Regarding Post-institutional Assistance for Offenders with Mental Health Issues in Serbia

Although LPPMI creates normative framework for the protection of persons with mental health issues, including the offenders, the Protector of Citizens of the Republic of Serbia suggests that it is necessary to make amendments to this Law in order to create an efficient and sustainable system of "deinstitutionalisation"[10], which would also take into consideration the social aspect of mental health care, besides the medical aspect (Protector of Citizens, 2018: 62). As the Protector of Citizens highlighted in his Regular Annual Report for 2017, in the cases of long-term and lifelong accommodation of patients in psychiatric institutions, the distance of these institutions from inhabited places significantly holds back the patients' contact with the family and community. Moreover, the Protector of Citizens emphasized that inadequate conditions for accommodation of such institutions give them a character of an asylum, which may in some individual cases, take on the context of inhuman or degrading treatment (Protector of Citizens, 2018: 62).

It is estimated that there are altogether around 3000 people placed in various mental health care institution in Serbia (including both - those who committed criminal offences, as well as those who did not). Former Protector of Citizens once stated that almost 50% of them could be released from these institutions if they had support. Namely, the thing that lacks at this moment is the support of the community instead of the outdated system of organisation of mental health care services that is based upon the exclusion of persons with mental disorders from the community (Beogradski centar za ljudska prava, 2014). This situation continues, and, as it is stated in the Progress Report for Serbia adopted by the

[10] Deinstitutionalisation is sometimes misinterpreted as simple displacement of beneficiaries (i.e. patients) from large residential institutions to residential units of smaller capacity. But, deinstitutionalisation actually represents a complex process that is based upon the shift in approach to providing support for persons with mental impairments through the development of community-based services including prevention aimed the minimisation of institutional care (Ćirić-Milovanović, 2017: 7).

European Commission in 2018, there has been no progress in the development of community-based mental health services (European Commission, 2018: 82). Moreover, it could be said that the process of deinstitutionalisation in Serbia has merely just begun as well as that not much has been achieved when it comes to the transformation of large psychiatric institutions and establishment of community-based mental health services (Jović *et al.*, 2016: 6). One of the reasons for such condition is the fact that Serbian mental health care system is still based upon the so-called biological model of treatment, which implies that, instead of being prepared for life outside the hospital, the patients are treated by excessive use of medication and gradually become dependent on their caretakers, in this case - psychiatrists. As it has already been mentioned, this approach is not in accordance with the principles proclaimed in the MHPDS (Petrović, 2016: 354). Instead of such approach, the psychiatrists should teach the patients to take care of themselves, to recognise their symptoms as well as to obtain professional knowledge and skills, through various social activities, workshops and working therapies (Beogradski centar za ljudska prava, 2014).

The key reason for such weak achievement in the area of deinstitutionalisation lies in the lack of political support, but also in the lack of support by the professionals entitled to decide on the process of deinstitutionalisation as well as in the insufficient inclusion of the entities that have been actively monitoring the conditions in psychiatric institutions in Serbia non-governmental sector, (such as Protector of Citizens and National Preventive Mechanism) in this process (Jović *et al.*, 2016: 6). Nevertheless, nowadays there appears to be more institutions and individuals working on the improvement of life conditions in psychiatric institutions, on the development of community-based mental health care services as well as on the improvement of the position and human rights of persons with mental health issues (Jović *et al.*, 2016: 6).

CONCLUSION - KEY PROBLEMS AND SOME RECOMMENDATIONS

The legislative reform in the area of medical security measures in the Republic of Serbia seems to be necessary, since current solution (which has not been changed since 1977) is not fully in line with contemporary scientific findings and trends in the field of mental health protection and mental diseases treatment (Bejatović, 2017: 318). The reform would tackle several sensitive issues, such as the justification of their undetermined length, the scope of their application, the possibility to introduce the institute of conditional release from mental health care institutions etc (Bejatović, 2017: 318). Actually, such legislative reform would represent the result of a particular shift in the paradigm of treatment which consists of the transfer from institutional psychiatry to community based mental health care system (Jović *et al.*, 2016: 26). These changes do not include only the displacement of mental health care services from hospitals to the community, but also their dispersion and inter-sectoral cooperation (medical, social, educational, judicial, police etc.), as well as functional alterations referring to the methods and aims of treatment, key entities (doctors, nurses, patients, their families etc.) and their roles and responsibilities (Jović *et al.*, 2016: 26). Also, it could be questioned whether security measures of

psychiatric treatment should still remain a part of the system for the execution of criminal sanctions or conducted within the compulsory hospitalisation of persons with mental impairments. Depending on the answer to this dilemma, these medical security measures should either remain within the CCRS and LECS or become regulated by LPPMI (Janković, 2015: 77).

Another very important stage refers to post-institutional assistance, i.e. aftercare of the offenders with mental diseases, which represents the key step on their path towards re-socialisation and complete social re-integration. Normative framework regulating the issue of post penal treatment in the Republic of Serbia does not cover the post-institutional acceptance of the offenders who have been admitted to medical security measures and the provisions, contained in the laws and bylaws, pertinent to the treatment of all persons with mental diseases do not seem to meet all the specific needs of this category of users of mental health care services. Therefore, this issue should be regulated in a detailed and comprehensive manner either by the alteration of current laws from the area of criminal law, the enforcement of criminal sanctions and the application of extrajudicial sanctions and measures, or the laws dedicated to the care and treatment of persons with mental health issues.

Revised normative framework can represent only the first step towards the improvement of the position of the offenders with mental diseases and their better re-socialisation and social reintegration. What is much more important is the reality these persons are facing after leaving the institutions or/and during/after non-institutional treatment. The reality is that many offenders will face considerable structural and social barriers to community involvement after release, and so, they ought to find out how to adjust their psychological responses to these barriers in order to successfully return to the community (Moore *et al.*, 2016). Unfortunately, their reality is comprised of constant rejection, stigmatisation, discrimination, marginalisation, lack of support etc. It is the reality in which they cannot protect their fundamental human rights and rebuild their confidence, dignity, self-esteem; the reality that pushes them back to their old potentially harmful emotional and behavioural patterns and opens the door to reoffending. The question is: "Can this reality be changed?" and the answer to it depends on the readiness, and, even more important, the willingness of the entire community, which still has not reached the sufficient level of empathy for these persons (Janković, 2018: 857), to overcome fears and prejudice and give these persons a second chance.

Post-release success can be enhanced by providing correctional treatment services for inmates targeted at reducing anticipated stigma and adjusting expectations for community re-entry (Moore *et al.*, 2016). It also seems possible to modify social attitudes towards all persons with mental illnesses, including offenders, through a combination of contact, education and protest. In spite of that, there are currently very few interventions designed to challenge their stigmatisation and discrimination (Mezey *et al.,* 2016: 518). Some of the means that could be used to do so include the media, social networks, formal and informal education and activism of non-governmental organisations. Television (programmes with national frequency, in particular), for example, is considered a very suitable medium to promote mental health, especially in the context of overcoming prejudice and stigmatisation, raising public awareness and providing the support of the public for

the application of prevention (Milošević, 2011: 228-229). Changing the attitude of the public towards mental health issues in general, including the emergence of mental health issues among the offenders, would gradually decrease their stigmatisation and discrimination, and facilitate their re-socialization and social reintegration in a supportive and encouraging environment. The benefits of such approach would impact the offenders (who would be encouraged to overcome their mental problems and become useful members of the community), as well as by their families, the community (that would be facing a lower recidivism rate), the institutions for the enforcement of medical security measures (that would be less overcrowded and enabled to provide better living conditions).

The double marginalisation of the offenders with mental diseases represents a serious obstacle on their road to healing, re-socialisation and social reintegration. Therefore, it is necessary to find and maintain a fine balance between two groups of interests that might at first glance seem to be opposite: 1) the interests of the society to be protected from crime and 2) the interest of the offenders with mental diseases who definitely represent a particularly vulnerable and marginalised category with limited capabilities to protect their fundamental human rights (Bejatović, 2017: 316). This goal can be accomplished through an adequately regulated and organised system of medical security measures (Stojanović, 2014: 145-172), but, at the same time it also requires a radical shift in the attitude of the community towards this category of citizens, which requires time, patience and political will to be accomplished.

Finally, it is important to accentuate the fact that the independent services developed in community in wide partnership can give enormous results for the relative small investments. It appears that meaningful user participation combined with the professional support of experienced mentors can contribute to the success in the majority of the activities ranging from art therapy to crisis interventions (Cvetković Jović, Glušac, 2015: 26). But, this requires the shift in paradigm, which includes the change of: 1) the general attitude towards persons with mental disorders, 2) the treatment methods and 3) social action. For this to be achieved, the community, i.e. the general and expert public should start treating mental illnesses as any other illness, the treatment should be based on a comprehensive interdisciplinary approach, whereas social exclusion should be replaced with social inclusion and acceptance (Jović *et al.*, 2016: 29).

REFERENCES

1. Angermeyer, M., Beck, M., Deitriech, S., Holzinger, A. (2004) The stigma of mental illness: Patients' anticipations and experiences. *International Journal of Social Psychiatry*, *50*, pp. 153-162.
2. Backović, D. (2010) Mentalno zdravlje i mentalna higijena između dva milenijuma. *Medicinski pregled, 63*(11-12), pp. 833-838.
3. Batrićević, A. (2014) Obavezno psihijatrijsko lečenje prestupnika u Srbiji, zakonski okviri, trenutno stanje i preporuke. *Zbornik Instituta za kriminološka i sociološka istraživanja, 33*(2), pp. 89-114.
4. Batrićević, A., Srnić-Nerac, J., Marković, Lj. (2018) Post-institutional Care of Juvenile Perpetrators of Criminal Offences in Serbia-Key Problems in Legislation

and Practice. In: Stevanović, I. (Ed.) *Child Friendly Justice*. Beograd: Institut za kriminološka i sociološka istraživanja, pp. 241-253.

5. Bejatović, S. (2017) Mere bezbednosti medicinskog karaktera (krivičnopravni aspekt). *Crimen* (3), pp. 315-339.
6. Beogradski centar za ljudska prava (2014) *Donošenje Zakona o zaštiti prava osoba sa mentalnim smetnjama U tišini javne rasprave*, http://www.bgcentar.org.rs/bgcentar/wp-content/uploads/2014/01/Dono%C5%A1enje_Zakona_o_za%C5%A1titi_prava_osoba_sa_mentalnim_smetnjama.pdf, accessed 18.03.2019.
7. Brooker, C., Ullman, B. (2008) *Out of sight, out of mind. The state of mental health care in prison*. London: Policy Exchange.
8. Bylaw on more detailed conditions for the application of physical restrain and isolation of the persons with mental disorders on treatment in psychiatric institutions, *Official Gazette of the Republic of Serbia,* No. 94/2013.
9. Bylaw on the types and more detailed conditions for the establishment of organisational units and providing for community-based mental health care services, *Official Gazette of the Republic of Serbia,* No. 106/2103.
10. Chui, W.H., Cheng, K.K.Y. (2013) The Mark of an Ex-Prisoner: Perceived Discrimination and Self- Stigma of Young Men after Prison in Hong Kong. *Deviant Behavior, 34*(8), pp. 671-684.
11. Criminal Code of the Republic of Serbia, *Official Gazette of the Republic of Serbia,* No. 85/2005, 88/2005, 107/2005, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014 and 94/2016.
12. Cvetković Jović, N., Glušac, B. (2015) *Recovery within Community Supporting Recovery of Persons with Mental Disorders and their Full Inclusion in the Community Consultative Evaluation of the Project Activities*. IAN International Aid Network, http://crtv.ian.org.rs/download/230/, accessed 18.03.2019.
13. Ćirić-Milovanović, D. (2017) *Modeli deinstitucionalizacije i zaštite mentalnog zdravlja u zajednici*. Podgorica: Akcija za ljudska prava.
14. European Commission (2018) Serbia 2018 Report Accompanying the document Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions 2018 Communication on EU Enlargement Policy{COM(2018) 450 final}, Strasbourg, 17.4.2018 SWD(2018) 152 final, https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/20180417-serbia-report.pdf, accessed 18.03.2019.
15. Henderson, T (2005) New Frontiers in Fair Lending: Confronting Lending Discrimination against Ex-Offenders. *New York University Law Review*, *80*, pp. 1237–1271.
16. Janković, M. (2015) Slobode i prava lica sa mentalnim smetnjama – nedostaci Zakona o zaštiti lica sa mentalnim smetnjama. *Crimen, 6*(1), pp. 61-80.
17. Janković, M. (2018) Položaj osoba sa mentalnim smetnjama lišenih slobode. *Sociologija, 60*(4), pp. 856-879.
18. Jović, V., Palibrk, Lj., Mirkov, J. (2016) *Priručnik za uspostavljanje i razvoj centara za zaštitu mentalnog zdravlja u zajednici*. Beograd: Helsinški odbor za ljudska prava u Srbiji, IAN Međunarodna mreža pomoći.
19. Koschorke, M., Padmavati, R., Kumar, S., Cohen, A. Weiss, H., Chatterjee, S., Pereira, J., Naik, S., John, S., Dabholkar, H., Balaji, M., Chavan, A., Varghese, M., Thara, R., Thornicroft, G., Patel, V. (2014) Experiences of stigma and discrimination of people with schizophrenia in India. *Social Science and Medicine, 123*, pp. 149-159.
20. Law on the Execution of Criminal Sanctions, *Official Gazette of the Republic of Serbia,* No. 55/2014.

21. Law on the Execution of Extra-judicial Sanctions and Measures, *Official Gazette of the Republic of Serbia*, No. 55/2014 and 87/2018.
22. Law on the Protection of Persons with Mental Impairments, *Official Gazette of the Republic of Serbia,* No. 45/2013.
23. Lečić Toševski, D., Ćurčić, V., Grbeša, G., Išpanović Radojković, V., Jović, V., Kokora, G., Mihailović, G., Milićević Kalašić, A., Stanković, Z., Stanojković, M., Vučković, N. (2005) Zaštita mentalnog zdravlja u Srbiji - izazovi i rešenje. *Psihijatrija danas (supp.), 37*(1), pp. 9-15.
24. Link, B., Phelan. J. (2001) Conceptualizing Stigma. *Annual Review of Sociology*, *27*, pp. 363-385.
25. Mental Health Protection Development Strategy, *Official Gazette of the Republic of Serbia*, No. 55/ 2005 and 71/2005.
26. Mezey, G., Youngmanb, H., Kretzschmarc, I., Whitea, S. (2016) Stigma and discrimination in mentally disordered offender patients – a comparison with a non-forensic population. *The Journal of Forensic Psychiatry and Psychology*, *27*(4), pp. 517-529.
27. Milošević, Lj. (2011) Televizija i promocija mentalnog zdravlja. *Sociologija, 53*(2), pp. 213-230.
28. Moore, K., Stuewig, J., Tangney, J. (2016) The Effect of Stigma on Criminal Offenders' Functioning: a Longitudinal Mediational Model. *Deviant Behavior*, *37*(2), pp. 196-218.
29. Mrvić-Petrović, N. (2007) Krivičnopravni položaj lica sa mentalnim poremećajima, *Temida (10)*3, pp. 39-47.
30. Petrović, V. (Ed.) (2016) *Ljudska prava u Srbiji: pravo, praksa i međunarodni standardi ljudskih prava*. Beograd: Beogradski centar za ljudska prava.
31. Pogorzelski, W., Wolff, N., Pan, K.Y., Blitz, C. (2005) Behavioral Health Problems, Exoffender Reentry Policies, and the "Second Chance Act". *Public Health Consequences of Imprisonment*, 95, pp. 1718-1724.
32. Protector of Citizens (2018) *Regular Annual Report of the Protector of Citizens for 2017.* Ref. No. 6251, 15.03.2018. Belgrade: Protector of Citizens, https://www.ombudsman.rs/attachments/article/5671/Regular%20Annual%20Report%20of%20the%20Protector%20of%20Citizens%20for%202017.pdf, accessed 18.03.2019.
33. Public Health Strategy in the Republic of Serbia between 2018 and 2026 (*Official Gazette of the Republic of Serbia*, No. 61/2018.
34. Rose, D., Willis, R., Brohan, E., Sartorius, N., Leese, M. (2011) Reported stigma and discrimination by people with a diagnosis of schizophrenia. *Epidemiology and Psychiatric Sciences*, *20*(2), pp. 193–204.
35. Rulebook on House Rules of Special Prison Hospital, *Official Gazette of the Republic of Serbia,* No. 145/2014.
36. Screening Report for Serbia - Chapter 28: COnsumer and Health Protection, https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/screening_report_serbia_-_chapter_28_-_consumer_and_health_protection.pdf, accessed 21.03.2019.
37. Srnić, J., Vulević, D. (2016) *Moderno društvo i postpenalna praksa*. Beograd: Centar za prevenciju kriminala i postpenalnu pomoć NEOSTART.
38. Stojanović, Z. (2014) Mere bezbednosti psihijatrijskog lečenja - prinudno psihijatrijsko lečenje kao pkrivična sankcija. *Crimen*, (2), pp. 145-172
39. Thornicroft, G. (2006) *Shunned: Discrimination against People with Mental Illness*. Oxford: Oxford University Press.

40. Thornicroft, G., Rose, D., Kassam, A., Sartorius, N. (2007) Stigma: Ignorance, prejudice or discrimination? *The British Journal of Psychiatry*, *190*(3), pp. 192–193.
41. TNS (2007) *Attitudes to mental illness 2008 research report*. London: TNS UK.

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NE(SPREMNOST) ZAJEDNICE ZA PRIHVAT LICA KOJIMA SU IZREČENE MERE BEZBEDNOSTI MEDICINSKOG KARAKTERA

Prestupnici koji boluju od nekeog oblika duševne poremećenosti predstavljaju ranjivu i visoko marginalizovanu grupu koja se svakodnevno susreće sa stigmatizacijom i marginalizacijom, što se negativno odražava na njihovu resocijalizaciju i socijalnu reintegraciju i povećava rizik od recidivizma. Čini se da adekvatna post-institucionalna pomoć u kombinaciji sa postepenim prilagođavanjem zajednice i promenom stavova javnosti prema ovim licima može da doprinese smanjenju njihove stigmatizacije i diskriminacije kao i da podstakne njihovu resocijalizaciju i socijalnu reintegraciju. Zbog toga autor u radu naglašava negativne uticaje stigmatizacije i diskriminacije na uspeh resocijalizacije i socijalne reintegracije prestupnika kojima je izrečena neka od medicinskih mera bezbednosti, kritički analizira postojeći zakonski okvir Republike Srbije za izricanje i primenu ovih mera, kao i za pružanje postinstitucionalne (post-penalne) pomoći koja treba da ih prati, sugerišući načine da se unaprede kako zakonsko rešenje tako i praktični aspekti ove kompleksne problematike.

KLJUČNE REČI: medicinske mere bezbednosti / duševna bolest / post-institucionalna pomoć / diskriminacija / stigmatizacija