

Intentions to Care, Structures That Restrain: The Reality of Secure Units in Residential Social Care Institutions in Slovenia

JUŠ ŠKRABAN AND ANDRAŽ KAPUS

Abstract

Despite ongoing criticism, the practice of involuntary admissions to locked units remains widespread globally. In this paper, we focus on secure units within residential social care institutions in Slovenia, which are intended to provide special protection for individuals deemed dangerous to themselves or others. We conducted semi-structured individual and group interviews with institutional management, secure unit staff, and residents in all secure units across the country. The findings reveal three key issues. First, the spatial congregation of residents within secure units tends to exacerbate, rather than reduce, risk. Second, instead of addressing the specific risks that prompted admission, secure units often implement generalized restrictions aimed at maintaining internal safety. Third, the overall institutional structure significantly limits the provision of individualized care and constrains both staff and resident agency. Although secure units are formally defined as protective environments, the study suggests that they function primarily as institutional containers. As such, they are not only in violation of human rights but are also ineffective in fulfilling their intended purpose due to inherent institutional limitations. We argue that secure units should be abolished and replaced by community-based services.

JUŠ ŠKRABAN, PhD, is a researcher at Social Protection Institute of the Republic of Slovenia and a former teaching assistant at the Faculty of Social Work, University of Ljubljana, Slovenia.

ANDRAŽ KAPUS, PhD, is a researcher at Social Protection Institute of the Republic of Slovenia.

Please address correspondence to Juš Škraban. Email: jus.skraban@irsvv.si.

Competing interests: None declared.

Copyright © 2026 Škraban and Kapus. This is an open access article distributed under the terms of the Creative Commons Attribution-Noncommercial License (<http://creativecommons.org/licenses/by-nc/4.0/>), which permits unrestricted noncommercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Introduction

Since the mid-20th century, social movements, especially those led by people with disabilities, have advocated for the right to live in the community, rather than in institutions.¹ This stance has been given special emphasis by article 19 of the Convention on the Rights of Persons with Disabilities (CRPD) and continuously by the activities of the Committee on the Rights of Persons with Disabilities.²

Despite the significance of the CRPD, its implementation has faced substantial challenges and obstacles.³ In practice, people's rights are often not upheld, particularly for people with the most intensive needs, who are frequently denied the opportunity to live in the community and instead remain segregated in institutional settings.⁴ This remains the case despite increased research attention in recent decades on restrictive and coercive practices and a broad international consensus on the need to reduce their use.⁵ While some disagreement persists regarding the circumstances under which nonconsensual treatment may be permissible, there is universal agreement that such treatment must not be justified on the basis of disability or perceived disability.⁶ Despite a growing body of evidence suggesting that such practices can be significantly reduced or even abolished altogether, institutionalization and coercion continue to serve as cornerstones of contemporary mental health services.⁷

Social work and other helping professions in mental health are characterized by an immanent contradiction between care and control. This tension marks a point of collision between divergent social and ethical positions and mirrors the dual mandate of these professions.⁸ On one hand, practitioners are tasked with supporting individuals in becoming as independent as possible within society, while on the other hand, they simultaneously exercise responsibilities on behalf of the state that represent a form of social control. This contradiction has been well documented in scholarship addressing risk, institutional care, and coercive practices.⁹

This paper is based on qualitative research conducted in locked “secure units” within residen-

tial social care institutions (RSCIs) in the Central European country of Slovenia. These settings offer a valuable context for examining how care and control operate in practice within institutional environments.

The paper pursues two aims. First, its scholarly aim is to examine the implications of “care” delivered behind closed doors for both residents and staff. This inquiry is urgent from a scientific point of view because this type of care is highly neglected in research while at the same time representing the most intrusive and restrictive “support” setting for people with disabilities. Second, the paper has a practical objective. Given that our research is guided by human rights and social justice perspectives, we aim to analyze the limitations of institutional care in secure units to inform and influence changes toward a rights-based mental health policy and to support the development of community-based alternatives. To address these dual aims, we ask the following research questions: (1) How does formally coercive care in secure units shape care practices? and (2) What effects does formally coercive care in secure units have on residents?

The service and legal national context

Mental health services in Slovenia are marked by a division between acute treatment in psychiatric hospitals and long-term placement in RSCIs. The number of beds in psychiatric hospitals began to decline in the 1970s, as long-term patients were increasingly transferred to RSCIs that had been established after the Second World War. Today, Slovenia—a country with around two million inhabitants—still relies heavily on institutional forms of care. As of 2023, 4,565 children and adults with intellectual and mental disabilities lived in RSCIs, with the vast majority (75%) living in facilities housing more than 25 residents.¹⁰

Institutional care in Slovenia, as defined by the Social Care Act, encompasses all forms of assistance provided in an institution, by another family, or in another organized setting that replaces or supplements the functions of a person's home and family. This includes, in particular, accom-

modation, organized meals, care, and health care. RSCIs provide institutional care for adults with intellectual and psychosocial disabilities. RSCIs predominantly consist of open units, where only voluntary placements are permitted under the Social Care Act. However, most of these institutions also include locked “secure units.”

Locked units are not a recent phenomenon in Slovenia. RSCIs in which secure units operate today were traditionally—until the early 2000s—entirely closed, with residents’ movement restricted and departure from the institution permitted only with staff authorization. In addition, RSCIs had various prototypes of secure units serving different functions, such as admission units, units for persons with “challenging behavior,” and units used for disciplinary purposes.

The first Mental Health Act, adopted in 2008, defined secure units within RSCIs as the only setting in which the formal deprivation of liberty was permitted. As stated in the act’s explanatory memorandum, the key principles underlying this formalization were proportionality, the use of the least restrictive measures, and the requirement that restrictions be imposed solely on the basis of a court decision.¹¹ As we demonstrate in our paper, however, this legalization did not achieve its intended effect. While RSCIs formally opened their doors, closed and restrictive spaces within them—secure units—were preserved.¹²

Slovenia represents a rather unique legal situation in Europe since we are not aware of any other European country where it is possible to formally deprive persons of their liberty if they are not in need of acute psychiatric treatment. In most countries in which deprivation of liberty in the social care sector is lawful, it is regulated through mental capacity legislation according to which a person can be formally detained if they lack capacity to consent.¹³ However, formal social care detention internationally largely applies to “community settings,” while the Mental Health Act applies to detention in psychiatric—that is, medical—institutions.¹⁴

According to the Mental Health Act, a secure unit is a unit in a social care institution (e.g., an

RSCI) where people, due to their needs, receive continuous special protection and care and cannot leave the institution of their own free will (article 2(17)).¹⁵ As established in article 74, admission to a secure unit requires meeting the following cumulative criteria: the person has completed or does not need acute psychiatric treatment; the person requires continuous care and protection that cannot be provided elsewhere; the person poses a danger to themselves or others; the danger results from a mental disorder impairing their judgment and behavior control; the danger cannot be mitigated by other forms of care; and the person meets the other conditions for admission to a RSCI. Admission to secure units may be either voluntary or involuntary under the Mental Health Act. Additionally, the use of mechanical restraints with belts and seclusion is permitted (article 29).

Detention in secure units therefore regulates living arrangements (and is not intended to “cure” a “mental illness,” as is the case with mental health detention), which makes it aligned with the stated rationale of social care detention internationally.¹⁶ However, the fact that it is implemented within a social care institution may be explained by the institutional model, which predominated in Slovenian social care since the aftermath of the Second World War.

In Slovenia, there are 13 secure units within six RSCIs, with a total capacity of 187 beds.¹⁷ The average number of beds per unit is 14.4 (minimum 5, maximum 24). In 2023, 69% of the units were operating over capacity, with an average occupancy of 130%. Single rooms are rare; most rooms accommodate two or three residents. Because the doors are kept closed, the units are often spatially cramped, with limited common areas.

Secure units have received limited research attention to date, a gap that this paper seeks to address. A legal analysis conducted as part of this research found that secure units significantly violate the rights enshrined in the CRPD.¹⁸ Quantitative data further reveal concerning trends: a high rate of involuntary admissions (98%), a substantial proportion of residents deprived of their legal capacity (67%), and two dominant pathways to

admission—44% of residents were admitted following discharge from psychiatric hospitals and 34% were transferred from open units within the same RSCI.¹⁹ The data also point to prolonged confinement in secure units, with an average duration of 64 months and a notably low discharge rate (14%), particularly to community-based settings.

In this paper, we draw on findings from the research project “Transformation of Secure Units into Community Services for Adults and Children with Disabilities”—the first national-level study focused on secure units within RSCIs. The study addresses a significant gap in qualitative data concerning secure units, particularly in relation to the discrepancy between their legally defined role under the Mental Health Act and their implementation in practice. We seek to illuminate the everyday realities of life within secure units, with specific attention to institutional practices, obstacles to individualized care, and limitations on user autonomy.

Methods

We conducted qualitative research in secure units. We gathered empirical data in all six RSCIs with secure units in Slovenia. In each RSCI, we conducted semi-structured group interviews with the institutional management (directors, heads of staff, and head nurses) and staff members in secure units (nurses, social care assistants, and social workers). We also conducted individual semi-structured interviews with heads of the unit and group or individual semi-structured interviews with residents in secure units.

We constructed interview guidelines for each target group. Interview guidelines for the members of institutional management included the following themes: the history of the institution’s secure units; challenges in managing the secure units; views about the role of secure units in the system of health and social services; and views on the future of secure units. Interview guidelines for the staff members in secure units included the following themes: users’ needs before and during

placement in a secure unit and for a successful discharge; methods of and approaches to care; the use of seclusion and restraint; examples of successful interventions; and collaboration with other actors. Interview guidelines for the heads of secure units included the following themes: spatial characteristics of the secure units; organizational aspects of care; information about the staff; and the role of secure units within the institution. Interview guidelines for users included the following themes: life before the placement; the perception of everyday life at the unit; and hopes for future.

A total of 30 members of institutional management, 31 secure unit staff members, 10 heads of secure units, and 30 residents in secure units participated in the study. Interviews with institutional management were conducted without sampling, as the intention was to include all members of the management team. For interviews with staff members in secure units, we sought participation from key roles, including the head of the unit, a social worker, a nurse, and a social care assistant. In the case of residents within secure units, we employed a more flexible, convenience sampling approach. Upon entering the unit, we spent time engaging with residents and explaining the purpose of the interview. We interviewed only those who expressed interest in participating. Interviews took place in a location of their choice within the unit, without the presence of staff members. Additionally, we conducted rapid participant observation (up to two hours) in each secure unit. We produced thick descriptions immediately after each observation.

Data collection lasted from March to September 2024. Interviews were audio recorded and transcribed. In a few cases in which participants (mostly residents) did not want to be audio recorded, a thick description of the interview was written. We analyzed the data using thematic analysis.

All participants received information about the study and provided either their written or oral informed consent. The study was granted ethics approval by the University of Ljubljana Faculty of Social Work Ethics Committee (approval no. 033-3/2023-26).

Results

Theme 1: Congregation of residents and consequent problems

Residents of secure units represent a highly diverse population, with the sole common denominator being that they meet the legal requirements for involuntary placement—namely, that they pose a danger to themselves or others. This heterogeneity is often perceived by staff as a significant challenge: “There is the problem that our secure units are too mixed. There are people with addictions, older people, younger people, and each needs specific support, and also people who have had forensic treatment” (head of staff).

The accumulation of residents with diverse needs has numerous consequences, ranging from minor everyday challenges in the provision of care to serious safety issues: “There is a woman with intellectual disability. She is undressing herself and there is a young guy after forensic treatment who can get irritated by a smallest thing” (head nurse).

This congregation of people in closed space complicates the provision of care; it also significantly impacts the daily life within the unit and can lead to increased tensions and frequent disturbances. A resident of a secure unit reported that “we hardly get any rest because we have no room for it, only in seclusion room you can be alone, but there is always a camera.” Rapid participant observation in secure units clearly showed that these problems are structural in nature and depend less on how the units are arranged, the type of spaces they offer, how modern or welcoming these spaces are, or how overcrowded they are.

In some cases, tensions escalate into the use of restrictive practices. In one unit, staff reported a case of a resident constantly banging on the door, throwing himself on the floor, crying, and screaming for hours on end. Staff reported:

In the case of our loud resident who disturbs the whole unit—in most cases we put him in the seclusion room for the very reason of protecting him. We withdraw him so that he does not get hurt by other residents. Sometimes we do it more to calm

the whole unit down, to leave him alone and to get him to back off. (head of secure unit)

Theme 2: Controlling risk in secure units

Generalized restrictions. In order to manage potential risks, all secure units implement generalized restrictions, which include the prohibition of belts, shoelaces, cables and cords, and any object that could potentially cause injury. In some units, plates are made of unbreakable material. Cigarettes are distributed according to a schedule and lit by staff, while lighters are attached to the courtyard fence because residents are not allowed to have them on their person. There are also restrictions on the use of phones, which residents are allowed to use only at certain times.

Some restrictions are written in house rules. In some cases, house rules appear to override legislation, since they restrict residents more than is required by law and deprive them of important rights guaranteed by the law. During our research, we detected notable restrictions on phone and internet access, along with limitations on visits. In one case, phone use was limited to twice a day for half an hour, and visits were limited to one hour daily. Some users considered the measures too strict, while staff emphasized that all measures were implemented in the best interest of the residents, as they help prevent dangerous situations.

Crisis management. In secure units, verbal communication is the primary method employed by staff to manage crisis situations. During interviews, staff emphasized their awareness of the importance of providing individualized support during such episodes. In addition to conversation, staff also employ various non-verbal strategies to help residents de-escalate, including engagement in structured activities, participation in interest groups, and accompanied walks—all aimed at promoting relaxation and redirecting attention.

When these approaches are insufficient, more intensive interventions are used, such as admission to a psychiatric hospital or the use of seclusion and mechanical restraint. These measures are used,

according to interviewees, only in exceptional situations—primarily in cases of severe self-harm, repeated suicide attempts, or aggression toward others. However, admissions to acute treatment in psychiatric hospitals during placement in a secure unit remain relatively infrequent, affecting only 14% of residents per year.²⁰ The use of seclusion and restraint varies significantly across secure units. An analysis of secondary data obtained from the competent ministry indicated that in 2023, one institution did not employ any such measures, a second used seclusion with one resident, a third with two residents, and a fourth institution applied both seclusion and mechanical restraint with twenty-one residents. Data from two institutions are unavailable. Our study identified the need for improvements in both the ministry’s methodology for obtaining official records and the record-keeping practices of the institutions themselves.

The variation in practices across institutions indicates that the use of seclusion and restraint depends largely on the working methods in individual secure units. In one interview, it was noted that staff tend to prefer using the seclusion room over physical restraint. Staff explained that they perceive seclusion as a “softer” form of restriction. Interviewees at several other institutions pointed out that physical restraint is also more demanding to implement from an organizational perspective, given that it requires at least five staff members. This may be another reason why staff more often choose seclusion over restraint.

Theme 3: Institutional limits to care

Restricted time for individual support. Staff believe that having a good relationship with users plays an important role in ensuring quality care and a pleasant environment. They consider it important to adapt to individual needs, build trust, and create a positive atmosphere that enables cooperation. In interviews, staff highlighted their efforts to establish an individualized approach to each resident, paying attention to specific needs, communication styles, and personal characteristics. They see staff flexibility and in-depth knowledge of the residents as the key to a successful relationship.

Spending the entire day with residents allows them to gain insight into residents’ current mood and to focus on what matters in the moment, rather than on past incidents. As one head of unit—reflecting a broader sentiment among interviewees—noted, “We engage in a lot of conversation and strive for cooperation. It is the only way we can function” (head of unit). In order to create a pleasant atmosphere, staff also spend time with users through shared activities such as board games, walks, and watching television.

Staff provide care to residents within a fixed institutional schedule, which includes medication dispensation, meals, escorted leave from the unit, occupational therapy, and other structured activities. As described by one head of unit, service delivery is heavily dependent on daily staff routines, which are primarily institution-centered rather than person-centered:

I must arrange in the morning to distribute 21 residents to three employees. But if two residents have one-to-one attention, there’s a big difference, don’t you think? It would provide much better-quality care. But in the morning, you are tied to certain hours, for example already in terms of medication ... Basically, the problem is that there is not much time to spend with users, to be honest.

More focused attention is typically provided only in acute crises or in situations of residents’ increased needs, when a staff member works individually with a resident to de-escalate and provide emotional support: “Residents always come to us because of deteriorating health or mental health—threats of self-harm or even attempted suicide or whatever. Above all, they need us. To take your time, but that’s the hardest thing” (head of unit). However, such responses are reactive rather than part of a sustained, individualized care approach.

Limitations to person-centered care. Staff in secure units reported that, in addition to their general approaches, they primarily use two social work methods to assess situations and provide individualized care: individual planning and risk assessment, both required by national sub-reg-

ulations. Individual care plans are created by multidisciplinary teams—including social workers, therapists, and care staff—and aim to reflect a particular user’s interests, needs, and goals. Users are involved in the planning process when they express preferences, and relatives or key staff may contribute based on their close knowledge of the individual. Risk assessments are used to identify individual risks and tailor the environment and support strategies—for example, adapting furniture or checking footwear to prevent falls. Staff make adjustments such as lowering beds or providing helmets, cushions, or railings, and regularly reevaluate these measures as residents’ conditions change. In cases where a safety measure presents more risk than benefit, alternatives are sought. The overarching goal is to ensure safety while respecting the individual’s needs and supporting a more autonomous and meaningful life.

A pronounced institutional paradox is evident within secure units. On one hand, staff operate within a framework of rules, regulations, and structured daily schedules that shape their routines and constrain available time. On the other, some staff members express a clear commitment to providing individualized support to residents; however, such personalized care is often constrained by the institutional context itself. This tension becomes particularly salient in light of residents’ expressed needs and desires, which predominantly concern life outside the unit. In interviews, residents frequently articulated wishes such as being able to visit shops, attend events, reconnect with family or friends, or return home. In essence, they were articulating a desire for ordinary, everyday experiences. Yet secure units can offer only controlled activities that mimic such experiences—a regulated simulacrum of everyday life.

Theme 4: Challenges to user choice, agency, and empowerment

Doing time

Residents in secure units mostly spend time in common areas or hallways with couches (watching television or playing board games); some remain in

bed after breakfast until the next meal or smoking time. This pattern of “hanging around” was observed across all secure units included in the study. Residents participate in various activities, usually within the secure unit itself, including occupational therapy sessions where they can draw, create, and occasionally earn small allowances. They may also help with daily tasks such as folding bibs or cleaning floors. For those unable or unwilling to attend occupational therapy, there are alternatives aimed at encouraging independence, such as the supervised use of the kitchen to prepare food or coffee, as observed in two units. Overall, the lives of residents remain largely confined to the secure unit.

Institutions differ in the extent to which they prioritize activities outside the unit—such as vacations, excursions, public events, sports activities, religious gatherings, performances, or shopping trips—which staff consider important for socialization. However, data show that there is no uniform practice across institutions; access to such activities varies from one unit to another and depends on the willingness of the management and staff.

Restricted capacity for activities outside the unit.

Since secure units operate under locked-door policies that restrict residents’ movement, the question of leave from the unit (e.g., short walks, day trips, or weekend stays with family) often arises in practice. Leave may be accompanied or unaccompanied. Some institutions allow one staff member to accompany all residents at a time, while others limit accompaniment to no more than three residents per staff member. One institution allowed three residents unaccompanied leave, reportedly following a court suggestion. Another had a resident who regularly went home for several days at a time: “It is not just going out for a coffee, it is going home for several days” (head of staff).

Participation in outside activities was repeatedly highlighted by staff and management as good practice. An important part of the activities in institutions are daily leave or walks; however, they also expose the limitations of secure units in providing individualized support. Staff reported that although they try to ensure that residents go

outside daily, not all residents have this opportunity: “Those who do not get a turn on a given day can go next time” (social worker). Limited staff and the unit’s organization restrict residents’ opportunities to exit the unit: “They don’t allow it. They don’t even allow me visits without their escort ... So, it is very poorly arranged for me” (resident). In one institution, the lack of physical accessibility was the primary reason some residents did not go outside—the secure units were on the first and second floors, there was no elevator, and there was no terrace attached to the units. We observed that residents with limited mobility who used wheelchairs had not been outside the unit for a long time.

Decision-making concerning leave varies across secure units. In one institution, a professional board approve leave requests; in others, the psychiatrist’s opinion is decisive. As one social worker noted, “The previous psychiatrist used to approve unaccompanied exits. Now the current psychiatrist does not choose to do that” (social worker). In some cases, institutions have deferred leave decisions to the courts, which may approve or reject requests based on their interpretation of movement restrictions. However, the Supreme Court has held that the courts are responsible only for determining whether admission to a secure unit complies with the conditions set out in the Mental Health Act, leaving decisions about (un)accompanied leave to the discretion of professionals within the institution.²¹

General lack of autonomy. Similar to the issue of exits, other examples demonstrate that residents in secure units lack autonomy in decision-making about their own lives. Institutional control extends to daily activities, care provision, medication, and living arrangements: “You cannot choose who you are in a room with ... They just make sure men and women are not mixed” (resident). Consequently, residents’ freedom to make decisions is significantly limited. While some residents have contact with mental health advocates, their efforts often fail to bring about meaningful change, as ultimate decisions rest with the professional team in agreement with the psychiatrist.

However, some positive examples exist. In one institution, assemblies allow residents to express wishes and needs, fostering increased participation—for example, a resident who had previously avoided going out expressed a desire to spend more time outside. Another institution holds group discussions to gather residents’ feelings and opinions, including those of non-verbal residents, whose perspectives are gleaned through facial expressions and behavior: “Yes, they are present. We observe their facial expressions—they express discomfort very clearly” (registered nurse). One institution reported that residents participate in all decisions, including financial matters, with written and signed agreements on money for cigarettes, coffee, and personal needs, which residents can review anytime.

Discussion

As we can deduce from the findings, the concept of risk is central to understanding the function and rationale of secure units. These facilities can be characterized as “containers” for individuals deemed “risky,” a designation rooted in the Mental Health Act, which permits admission to secure units only for those assessed as posing a risk to themselves or others. This approach is not unique to Slovenia; rather, it reflects a broader trend, both across European Union member states and globally, where risk or danger constitutes a common criterion for involuntary admission to mental health facilities.²² Our findings strongly suggest that the concentration of “risky” users exacerbates, rather than mitigates, risk.

As has been suggested, a court order that places a person in a secure unit makes care more vigilant to risks, and, ultimately, the notion of risk is likely to overrule the notion of care.²³ This reflects a well-documented trend in health and social care, whereby care practices become “defensive” in the face of an intensified focus on risk.²⁴ Consequently, the concept of risk has been heavily criticized as morally conservative and repressive.²⁵ In the context of secure units, this critique is particularly relevant, as the management of “risky” residents

renders care more defensive and less inclined to embrace risk-taking, resulting in generalized restrictions, limited activities outside the unit, constrained leave, and a general lack of user autonomy.

The presence of generalized restrictions and other risk-management strategies within secure units might appear logical due to their stated protective role implied by their legal definition. However, social work theory emphasizes that risk is situated primarily within situations and contexts rather than being an inherent characteristic of an individual.²⁶ Admission to a secure unit does not, in itself, alter or address the underlying risk-related situations that initially led to the admission; rather, it removes the person from those contexts and places them behind the closed doors of the unit. For example, while the data are rich about general restrictions within the unit, no professional reported efforts to address the risks identified as the reason for placement as defined by a court order. This has important implications for social policy, particularly in relation to the effectiveness and appropriateness of secure care as a means of managing risk.

While the Mental Health Act defines secure units not only in terms of risk but also with reference to the provision of continuous protection and care, our findings suggest a significant divergence between this stated objective and the realities of practice. The research did not reveal deficiencies in staff capacity or motivation to deliver individualized support. Rather, it is the structural and institutional design of secure units that inherently limits the possibility of such care by constraining attention to specific needs, communication styles, and personal characteristics due to scheduled activities such as medication dispensation, meals, and escorted group leaves. The institutional context, defined by fixed daily schedules and house rules (which in some cases override restrictions posed by the legislation), offers little opportunity for spontaneous, authentic human interaction between staff and residents, which is essential for recovery.²⁷ Moreover, the secure setting imposes significant constraints on the application of core so-

cial work methods—particularly person-centered planning—which were developed for, and are most effectively implemented within, community-based and non-restrictive environments.²⁸

As our research demonstrates, residents in secure units are offered limited access to daily activities, face significant restrictions in accessing external services, and are generally deprived of opportunities for meaningful agency. These conditions reflect the enduring influence of an institutional model of “care,” which continues to shape practice despite longstanding critiques. Indeed, the experiences documented in our study closely mirror the dynamics described by Erving Goffman in his seminal analysis of total institutions, suggesting that despite the passage of time, many of the core features he identified remain present in contemporary secure care settings.²⁹ The institutional environment, routines, and enclosed spaces do not support residents in recovery but instead require them to adapt to the rules and restrictions imposed by secure units. In other words, our study suggests that care is not the main task but a secondary activity within the framework of protection and institutional management in secure units. Care adapts to security and institutional culture, and not the other way around. Despite the introduction and widespread influence of normalization theory several decades ago, the aspiration of “gloriously ordinary lives” remains elusive for many individuals with disabilities, particularly those with high or complex support needs.³⁰

While staff noted that limited personnel constrain their ability to devote sufficient time to individual residents, we contend that increasing staffing levels would only partially address the underlying structural problems. The challenges are primarily structural in nature and do not depend on staffing level and unit design; rather, they stem from the institutional character of the units. In short, secure units not only breach the human rights of residents but fundamentally undermine residents’ recovery and the ability of staff to facilitate that recovery.

Implications for practice and research

Our implications for practice are grounded in human rights as articulated in the CRPD. The noncompliance of secure units with the CRPD, together with the ineffectiveness of institutional “containment” strategies for individuals deemed “risky,” as suggested by our findings, carries significant implications for social policy in Slovenia. In particular, the Mental Health Act, which currently provides the legal basis for secure units, requires fundamental reform. Our research highlights the urgent need to establish intensive, community-based care that avoids congregating users; ensures housing and support within the community; eliminates generalized restrictions; delivers individualized, person-centered care (addressing people’s diverse needs); and promotes meaningful activities, community inclusion, and flexible support without imposing unnecessary limitations on residents’ freedom of movement.

We believe that such a shift would ensure compliance with article 19 of the CRPD. Beyond their indisputable noncompliance with the CRPD, secure units should be abolished due to their inherent structural limitations in providing care and their prioritization of protection over individualized support; efforts should focus on replacing these units, as opposed to merely improving conditions within them.³¹ Intensive, community care, once established, must be fully integrated into networks of community-based services. An increase in users’ needs should not result in institutionalization. Additionally, any service designed to provide intensive support should be grounded in principles other than “risk,” considering the substantial criticism of this concept and its repressive implications in practice.³² This approach aligns with the CRPD’s emphasis on autonomy and inclusion.³³

In short, while human rights provide a crucial normative foundation, deinstitutionalization offers a practical framework for implementing necessary future reforms. Within the broader framework of the deinstitutionalization of RSCIs, residents in secure units must be prioritized for resettlement, and secure units themselves should be prioritized for closure. This is imperative, as these settings are

associated with the most severe breaches of human rights enshrined in the CRPD, particularly articles 12, 14, 15, and 19. Establishing this priority is particularly important given international evidence indicating that, in practice, individuals with less complex support needs are often prioritized in deinstitutionalization processes, while those in secure units are frequently overlooked.³⁴ We recognize that this entails a fundamental shift in society’s approach to long-term mental health crises—one that extends well beyond incremental reform.³⁵

Our implications for future research arise from the observation that secure units have received limited scholarly attention. First and foremost, sustained research on secure units and their alternatives is urgently needed at the national level to build a robust evidence base for reform. To support this process, it is essential that decision-makers, service users, practitioners, and researchers collaboratively develop a core set of indicators to guide and evaluate reform. This dataset should include high-quality data on the use of seclusion and mechanical restraint, as these are the most invasive and restrictive practices currently in use. Crucially, the minimal dataset must incorporate both quantitative and qualitative data to ensure a comprehensive understanding of the practices, their impacts, and potential alternatives.

Strengths and limitations

While the sample included all RSCIs with secure units and key staff members within them, making the data representative of secure units in RSCIs, the study does have some limitations. First, the study design did not adequately capture the perspectives of residents themselves. Consequently, it may be critiqued as yet another study conducted about people with disabilities rather than with them, lacking a collaborative or participatory research approach.³⁶ Second, a more ethnographic methodology involving long-term researcher presence might have yielded richer, more nuanced, and contextually grounded data, thereby reducing reliance on staff-reported accounts.³⁷ Third, there is a need for concrete strategies to facilitate meaningful in-

ternational comparison. This remains challenging due to the structural organization of mental health care provision in Slovenia, particularly the division between acute care provided in psychiatric hospitals and long-term care in RSCIs.

Conclusion

Although secure units are formally defined as protective environments for individuals whose support needs cannot be met elsewhere, our findings indicate that they primarily function as institutional containers for individuals labelled as “risky” or “challenging.” Rather than providing meaningful support, these units serve to isolate service users from the community and congregate them for the purposes of control and management.

Our data indicate that care adapts to security and institutional culture, which enforces a form of control that goes beyond what the law anticipates, significantly restricting the individual and violating their human rights. Secure units, therefore, are not only rights-violating but also ineffective due to their structural limitations, which prioritize protection and containment over individualized, person-centered support. These observations are informed by a human rights perspective grounded in the CRPD, as well as by empirical evidence and the structural constraints of institutional care, which is disabling for both residents and staff.

We argue that secure units, like other institutional forms of care, should be abolished and replaced with community-based services. The deinstitutionalization of residential social care institutions must start with residents in secure units because they endure the most severe rights violations and are often neglected in reform efforts that favor individuals with less complex support needs.

Funding

This paper is a result of the research project “Transformation of Secure Units into Community Services for Adults and Children with Disabilities” (V5-2335), funded by the Slovenian Research and Innovation Agency.

References

1. D. F. Stroman, *The Disability Rights Movement: From Deinstitutionalization to Self-Determination* (University Press of America, 2003).
2. Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106 (2006); Committee on the Rights of Persons with Disabilities, General Comment No. 5, UN Doc. CRPD/C/GC/5 (2017).
3. L. Davidson, “A Key, Not a Straitjacket,” *Health and Human Rights* 22/1 (2020).
4. A. Thomas, *The State of Play of Independent Living and Deinstitutionalisation for Persons with Disabilities in the EU* (European Union, 2024).
5. N. Hallett, R. Whittington, D. Richter, and E. Eneje (eds), *Coercion and Violence in Mental Health Settings: Causes, Consequences, Management*, 2nd edition (Springer, 2024); D. Richter, *Human Rights in Psychiatry: Prospects and Dilemmas of Abolishing Coercion in Mental Health Care* (Springer Nature Switzerland, 2025); S. P. Sashidharan, R. Mezzina, and D. Puras, “Reducing Coercion in Mental Healthcare,” *Epidemiology and Psychiatric Sciences* 28/6 (2019).
6. W. Martin and S. Gurbai, “Surveying the Geneva Impasse: Coercive Care and Human Rights,” *International Journal of Law and Psychiatry* 64 (2019); C. Maylea, “Does New Mental Health Legislation in Victoria, Australia, Advance Human Rights?” *Health and Human Rights* 25/1 (2023); S. Gurbai, “Beyond the Pragmatic Definition? The Right to Non-Discrimination of Persons with Disabilities in the Context of Coercive Interventions,” *Health and Human Rights* 22/1 (2020).
7. P. Gooding, B. McSherry, and C. Roper, “Preventing and Reducing ‘Coercion’ in Mental Health Services: An International Scoping Review of English-Language Studies,” *Acta Psychiatrica Scandinavica* 142/1 (2020).
8. F. Kessler, “Soziale Arbeit als Regierung. Eine machtanalytische Perspektive,” in S. M. Weber and S. Maurer (eds), *Gouvernementalität und Erziehungswissenschaft* (S Verlag, 2006).
9. R. Alfandari, B. J. Taylor, M. Baginsky, et al., “Making Sense of Risk: Social Work at the Boundary Between Care and Control,” *Health, Risk and Society* 25/1–2 (2023); A. Milne and S. Nieman, “Revisioning Social Work with Older People Living in a Care Home: Promoting Rights and Reducing Social Control,” *Critical and Radical Social Work* 13/1 (2025); W. Qiang, “Care and Control in Mental Health Social Work: A Case Study,” *Academic Journal of Management and Social Sciences* 7/3 (2024); R. Hawkins, M. Redley, and A. J. Holland, “Duty of Care and Autonomy: How Support Workers Managed the Tension Between Protecting Service Users from Risk and Promoting Their Independence in a Specialist Group Home,” *Journal of Intellectual Disability Research* 55/9 (2011).

10. Ministrstvo za solidarno prihodnost (Ministry of Solidarity-Based Future), *Strategija Republike Slovenije za deinstitucionalizacijo v socialnem varstvu za obdobje 2024–2034 (Strategy of the Republic of Slovenia of deinstitutionalization in social care 2024–2034)* (2024), <https://www.gov.si/assets/ministrstva/MSP/Dolgotrajna-oskrba/Strategija-RS-za-deinstitucionalizacijo-v-socialnem-varstvu-za-obdobje-20242034.pdf>.
11. Vlada Republike Slovenije (Government of the Republic of Slovenia), *Predlog zakona o duševnem zdravju (The Proposal of the Mental Health Act)*, EVA no. 1999-2711-0006.
12. V. Flaker and A. Rafaelič, *Deinstitucionalizacija II: nedokončana (Deinstitutionalization II: Unfinished)* (University of Ljubljana Press, 2023), p. 306.
13. L. Series, *Deprivation of Liberty in the Shadows of the Institution* (Bristol University Press, 2022), pp. 12–31.
14. *Ibid.*, p. 18.
15. Zakon o duševnem zdravju (Mental Health Act), *Uradni list RS, št. 77/362 08, 46/15 – odl. US in 44/19–US 2008*, <http://www.pisrs.si/Pis.web/pregledPredpisa?id=ZAKO2157>.
16. Series (see note 13), p. 20.
17. J. Škraban and V. Grebenc (eds), *Preobrazba varovanih oddelkov v skupnostne oblike oskrbe odraslih in otrok z oviranostmi: Poročilo o raziskavi (Transformation of Secure Wards into Community-Based Care for Adults and Children with Disabilities: Research Report)* (Založba Univerze v Ljubljani, 2025).
18. L. G. Prestor, J. Arnež, and M. M. Plesničar, “Putting People Behind Closed Doors: An Analysis of Social Care Detention in Slovenia,” *Revija za kriminalistiko in kriminologijo* 75/4 (2024).
19. J. Škraban, K. Prevodnik, and A. Rafaelič, “User, Admission and Discharge Characteristics in Secure Units in Residential Social Care Institutions in Slovenia,” *Slovenian Journal of Public Health* 64/4 (2025).
20. *Ibid.*
21. A. A. v. Slovenia, Vrhovno sodišče (Supreme Court), judgment of February 22, 2018, case no. II Ips 31/2018.
22. European Union Agency for Fundamental Rights, *Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems* (Publications Office of the European Union, 2012); A. Saya, C. Brugnoli, and G. Piazza, et al., “Criteria, Procedures, and Future Prospects of Involuntary Treatment in Psychiatry Around the World: A Narrative Review,” *Frontiers in Psychiatry* 10/271 (2019).
23. J. Škraban, “Kritični pogled na postopke namestitve na varovani oddelek in odpustov z njega v posebnem socialnovarstvenem zavodu” (“A Critical Look at the Procedures for Admission to and Discharge from a Secure Ward in a Special Social Welfare Institution”), *Socialno delo* 64/1–2 (2025).
24. H. Kemshall, *Risk, Social Policy and Welfare*, 1st edition (Open University Press, 2002); D. Green, “Risk and Social Work Practice,” *Australian Social Work* 60/4 (2007).
25. S. Stanford, “Taking a Stand or Playing It Safe? Resisting the Moral Conservatism of Risk in Social Work Practice,” *European Journal of Social Work* 11/3 (2008).
26. V. Flaker, “Analiza tveganja” (“Risk Analysis”), *Socialno delo* 33/3 (1994).
27. A. Topor, M. Borg, R. Mezzina, et al., “Others: The Role of Family, Friends, and Professionals in the Recovery Process,” *American Journal of Psychiatric Rehabilitation* 9/1 (2006).
28. P. Beresford, J. Fleming, and M. Glynn et al., *Supporting People: Towards a Person-Centred Approach* (Policy Press, 2011).
29. E. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor Books, 1961).
30. W. Wolfensberger, *The Principle of Normalization in Human Services* (National Institute of Mental Retardation, 1972).
31. C. H. Maylea, “A Rejection of Involuntary Treatment in Mental Health Social Work,” *Ethics and Social Welfare* 11/4 (2017).
32. Kemshall (see note 24); Stanford (see note 25).
33. Convention on the Rights of Persons with Disabilities and Committee on the Rights of Persons with Disabilities (see note 2); cf. Martin and Gurbai (see note 6).
34. European Expert Group on the Transition from Institutional to Community-Based Care, *Common European Guidelines on the Transition from Institutional to Community-Based Care: Guidance on Implementing and Supporting a Sustained Transition from Institutional Care to Family-Based and Community-Based Alternatives for Children, Persons with Disabilities, Persons with Mental Health Problems and Older Persons in Europe* (European Expert Group on the Transition from Institutional to Community-Based Care, 2012).
35. J. Russo and S. Wooley, “The Implementation of the Convention on the Rights of Persons with Disabilities: More Than Just Another Reform of Psychiatry,” *Health and Human Rights* 22/1 (2020).
36. P. Beresford, “Developing the Theoretical Basis for Service User/Survivor-Led Research and Equal Involvement in Research,” *Epidemiologia e Psichiatria Sociale* 14/1 (2005).
37. K. Featherstone and A. Northcott, *Wandering the Wards: An Ethnography of Hospital Care and Its Consequences for People Living with Dementia* (Routledge, 2020); E. Rossero, *Care in a Time of Crisis: An Ethnography of Coercive Practices in Italian Acute Mental Health Provision* (Palgrave Macmillan, 2023).