Protection mechanisms for persons with mental disabilities in medical-social institutions: Illusion to reality

Romania
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Summary

Over 10,000 people with mental health problems are beneficiaries of the health system for the chronically ill in a single year\(^1\), over 6,000 people with mental health problems and/or intellectual disabilities live in neuro-psychiatric recovery and rehabilitation centres and over 6,342 children were registered as disabled in public centres as of June 2006\(^2\). Consequently, over 20,000 persons with mental disabilities are currently in medical-social institutions (hospitals or psychiatric sections, neuro-psychiatric recovery and rehabilitation centres, medical-social centres and public centres).

This report represents the result of an analysis and evaluation of the way international and Romanian human rights standards are known and observed in 15 mental health and social assistance institutions (the phrase „medical-social institutions” will be used throughout the report) in the country, mainly in rural areas.

The first section of the report reviews the most important monitoring mechanisms, established according to international law, that are relevant for human rights protection in Romanian medical-social institutions for children and adults with mental disabilities. Section I also presents a few examples of national supervision mechanisms in European Union Member States (Finland, the Netherlands and the United Kingdom). This information can contribute to a debate on two levels. On a first level, it refers to means to improve this type of mechanisms that are in force in Romania. On a second level, it refers to the need to introduce a new, independent supervision mechanism, which would target exclusively protecting the rights of the mentally disabled.

It’s common knowledge that the priority objective in establishing an independent mechanism to monitor the way some human rights are observed is to prevent the violation of these rights. Other objectives may include:

- assessing progress in ensuring human rights protection on the basis of qualitative and quantitative data;
- establishing adequate policies to improve human rights protection, after analysing the problems and deficiencies identified in the monitoring process;
- informing the public on the current status of certain rights gives the state the possibility to cooperate with other stakeholders in society, especially those that are affected by the situation that is being monitored;
- creating opportunities for the professional development of those involved in the situation that is being monitored, as well as for an increase in public

\(^1\) According to estimates provided by the director of the National Mental Health Centre there are around 10-15,000 people with mental health problems that receive medical care in the system for the chronically ill and 10 times more people benefit from hospital care for acute illnesses.

awareness; these can lead to an improvement in the human rights situation;

• monitoring could offer a final recourse to victims of human rights violations in case the means to obtain remedies that are in force have failed.

The second section of the report covers the state of facts that monitoring team members from the Centre for Legal Resources (CLR) documented between December 2006 and March 2007 in 15 medical-social institutions in the Buzau, Hunedoara, Arad, Bihor, Mures, Valcea, Sibiu, Mehedinti, Galati, Neamt, Giurgiu and Cluj counties.

Unannounced monitoring visits have shown that the staff members in these institutions were seldom aware of the legal provisions regarding human rights and/ or quality standards in this field. At the same time, many of the beneficiaries of these institutions, either children or adults, informed the monitoring teams on a series of human rights violations in these institutions.

The monitoring process mainly targeted evaluations regarding:

a) the openness of medical-social institutions to non-governmental organisations working on the rights of disabled persons;
b) the mechanisms and procedures to register and solve the complaints and petitions of the beneficiaries/ patients in the medical-social institutions;
c) the implementation of regulations regarding the measures to restrict the liberty of movement of patients/ beneficiaries in the medical-social institutions;
d) observing the other rights of the patients/ beneficiaries in the medical-social institutions.

The monitoring teams were made up by two CLR representatives experienced in monitoring the way human rights are observed, either lawyers, psychologists or social assistants. The CLR monitoring team members conducted interviews with both the beneficiaries of the targeted institutions and the medical, care, education and psychological-social staff. Most of the interviews were conducted on a confidentiality basis, either within the targeted institutions or by phone. All the individuals who supplied information during the interviews agreed to it and they weren’t offered any sort of benefits or goods in return for the interviews. The names of children, youth, adults and staff in these institutions that pointed towards certain aspects related to the operation of the institutions or serious human rights violations in the targeted institutions have not been published in this report in order to maintain confidentiality.

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3 See Expert paper on existing monitoring mechanisms, possible relevant improvements and possible innovations in monitoring mechanisms for a comprehensive and integral international convention on the protection and promotion of the rights and dignity of persons with disabilities http://www.ohchr.org/english/issues/disability/
The third section includes an analysis of the monitoring and control mechanisms in the Romanian medical-social institutions system for the mentally disabled. The analysis covers the current legal provisions and institutional practices at the level of the Ministry of Labour, Family and Equal Opportunities and its two subordinated bodies – the National Authority for Disabled Persons and the National Authority for the Protection of Child’s Rights, at the level of the Ministry of Public Health, but also taking into account the Social Inspection and the National Council for Combating Discrimination. Section III also analyses three of the regulations that could support Romania in its selection of a national mechanism to prevent human rights violations in the medical-social institutions: Law no. 47/ 2006 regarding the establishment of the national social assistance system, the Emergency Governmental Ordinance no. 13/ 2006 regarding the Social Inspection and Optional Protocol to the Convention against torture and other forms of cruel, inhuman or degrading treatment or punishments.

The fourth section presents the report’s conclusions and proposals regarding the monitoring and control mechanisms taking into account the Social Inspection institution, the Ombudsman and the requirements of the Optional Protocol.
The monitoring mechanism at the European level and in three European States (Finland, Holland and UK)

This section of the report reviews most important monitoring mechanisms, established under international law, relevant to the protection of human rights in mental health and social care establishments for children and adults with mental disabilities in Romania. It also presents some examples of relevant national oversight mechanism in European Union member states. This information could contribute to a two-strand debate. One would be focused on how to improve the effectiveness of any such mechanisms in force in Romania. The other concerns the need to introduce a new independent oversight mechanism that would be solely focus on the protection of rights of people with mental disabilities.

It is widely recognized that an overriding objective for establishing an independent mechanism to monitor respect of certain human rights is to prevent violation of these human rights from taking place. Other objectives include:

- to assess any progress in ensuring human rights protection on the basis of collected qualitative and quantitative information;
- to design appropriate policies to improve human rights protection having analysed problems and shortcomings uncovered by the monitoring process;
- opening up to public scrutiny the situation regarding certain rights allows the state to open up cooperation with other stakeholders in society, particularly those most concerned with the monitored situation;
- to create opportunities for professional advancement of those involved in dealing with the monitored situation as well as for public awareness raising that can lead to improvements in the human rights situation;
- monitoring should allow a last recourse to victims of human rights violations should the established channels for remedy fail\(^4\).

Within Council of Europe member states, the most effective monitoring mechanism established to prevent torture and other ill-treatment in places of detention is the Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)\(^5\). Less than a year ago, in June

\(^4\) See [Expert paper on existing monitoring mechanisms, possible relevant improvements and possible innovations in monitoring mechanisms for a comprehensive and integral international convention on the protection and promotion of the rights and dignity of persons with disabilities](http://www.ohchr.org/english/issues/disability/)

\(^5\) Created in 1987 as an independent expert body CPT conducts visits to places of detention within States Parties to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, and issues recommendations for the improvement of the treatment of persons deprived of their liberty and conditions of detention. Romania ratified this convention on 4 October 1994.
2006, a CPT delegation carried out its seventh visit to Romania\(^6\). Among many places of detention visited were facilities for treatment and/or accommodation of people with mental disabilities: Oradea Psychiatric Hospital, Nucet Medical-Social Centre and Nucet Psychiatric Hospital. The CPT findings from this mission will be made public after Romanian government gives consents to the publication of the CPT report.

An examination of published reports from previous visits uncovers a number of repeated observations, apparently resulting from systematic failings to adequately protect the rights of people with mental disabilities in Romania. This examination also uncovers lack of political will of the Romanian authorities over the years to implement CPT recommendations and provide adequate protection from ill-treatment to tens of thousands of particularly vulnerable victims. Mental health facilities in Romania have been under CPT scrutiny since its first visit in 1995 to Poiana Mare Psychiatric Hospital. At the time the CPT found patients' living conditions so deplorable that it resort to Article 8 of the Convention\(^7\), a measure which a visiting delegations invokes exceptionally and only to address its most urgent concerns, demanding immediate intervention by the state. Thus, the CPT called on Romanian government to initiate an investigation into all aspects of functioning of the hospital. This unusually broad request is illustrative of the fact that the situation observed was unacceptable in every respect. Furthermore, the report noted that the observed living conditions also contributed to an alarmingly high mortality rate. In the six-month-period prior to its visit 61 patients had died; 25 death certificates cited severe malnutrition. The CPT also severely criticized reported ill-treatment of patients and the abusive use of isolation rooms and other methods of restraining agitated or violent patients. In the course of site visits, the CPT pays particular attention whether basic safeguards again ill-treatment are in place. Such safeguards include an effective complaints procedure and an independent inspectorate\(^8\). In Poiana Mare, the CPT observed that any such safeguards were inadequate and ineffective\(^9\). In its interim report the Romanian government stated that the hospital was under supervision of a committee representing the ministries of health and justice and the General Prosecutor’s Office. Interestingly, for this hospital is still operating at full capacity, the government reply also stated that the hospital “shall be gradually eliminated as a hospital as it no longer brings together acceptable

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\(^6\) News Flash: Council of Europe Anti-Torture Committee visits Romania
(http://www.cpt.coe.int/documents/rom/2006-06-23-eng.htm)

\(^7\) Article 8 (5) states: “If necessary, the Committee may immediately communicate observations to the competent authorities of the Party concerned.”

\(^8\) See paragraphs 53 and 55 in 8\(^{th}\) General Report on the CPT's activities CPT/Inf(98) 12 [EN]

\(^9\) See page 83 and 84 Rapport au Gouvernement de la Roumanie relatif à la visite effectuée par le Comité européen pour la prévention de la torture et des peines ou traitements inhumains ou dégradants (CPT) en Roumanie du 24 septembre au 6 octobre 1995, CPT/Inf (98) 5 [Partie 1]


circumstances (neither from the medical, from the penal or humanitarian point of view)\textsuperscript{10}.

Particular attention is drawn to the fact that in the report of its first visit, as well as all those subsequently published, described in more detail further on, the CPT expressed concern about the lack of, or ineffectiveness of material and procedural legal safeguards for involuntary placement and treatment and issued detailed recommendations. Although in the period under review new legislation on mental health had come into force\textsuperscript{11} in Romania, its effective enforcement with regard to involuntary treatment, which would be in line with international standards, still remains questionable.

The CPT returned to Poiana Mare on its visit to Romania in 1999. Recalling the government’s commitment to close down this establishment, the CPT noted many outstanding concerns\textsuperscript{12} including the absence of an effective complaints mechanism \textsuperscript{13}. Although the government response generally noted that CPT recommendations would be implemented no specific information was given regarding putting in place appropriate ill-treatment safeguards.

In 2001 the CPT focused exclusively on establishments for children, including children with mental disabilities. The fact that CPT for the first time in its history made an ad hoc country visit solely to children’s establishments may be indicative of the failings, at the time, of Romanian state institutions responsible for social care and protection of minors. In its report the CPT inter alia recommended that: “regular visits to placement centres for minors by an independent body (for example a judge or a supervisory committee) would be an important contribution to the prevention of ill-treatment. Such a body should be authorized, most specifically, to meet in private with the residents, receive their complaints and, if required, formulate recommendations that would be implemented”\textsuperscript{14}. The CPT then urged Romanian authorities to set up such an oversight mechanism. The Romanian authorities replied that a new law on child

\textsuperscript{11}Law N° 487/2002 on mental health and the protection of people with mental health problems.
\textsuperscript{12}Again, under Article 8, CPT demanded that heating should be immediately installed in certain hospital wards.
protection provided for an appropriately more effective mandate of child protection commissions. How effectively this mechanism protects from abuse children in institutions today has been analyzed by the Centre for Legal Resources in a recently published report.

In 2002 CPT visited Voila Psychiatric Hospital, Racaciuni Recuperation and Rehabilitation Centre, and Padureni-Grajduri High Security Psychiatric Hospital. Once again, resorting to Article 8. of the Convention, the CPT called for isolation cages in the observation ward of Voila Psychiatric Hospital to be taken out of use and dismantled immediately. Similarly to observations and recommendations made in earlier reports, the CPT expressed concern about: reported ill-treatment of patients by the staff, living conditions, inadequate staffing (both in terms of their number and skills), absence of therapies other than pharmacotherapy, which in some cases was inadequate, the lack of policies and abusive practice of means of restraint. This seems to indicate that Romanian authorities had repeatedly failed to put in place CPT recommendations which were of a more general, systematic nature and were not specifically address to a unique situation found at the time of the visit, such as the isolation cages in Voila.

In 2004, following publication of NGO reports about critical conditions in Poiana Mare Psychiatric Hospital, the CPT sent a delegation to revisit this institution for the third time. In view of the high mortality rate of patients in 2003 and the beginning of 2004, the CPT investigation focused on the following: medical services, patient nourishment and the heating in patient wards. The CPT found all of these had been inadequate and concluded that: “[A]fter third visit in less than a decade, it is high time that the authorities finally take real measure to address the situation in this establishment.”

The CPT once again made extensive observations and recommendations regarding ill-treatment of patients, staffing, lack of a full range of therapies, inadequate living conditions and the absence of ill-treatment safeguards.

The second international monitoring mechanism to be considered here is yet to be ratified by Romania. An informed public debate on its ratification and implementation has the potential to significantly promote human rights protection of children and adults with mental disabilities. The Option Protocol to UN

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16 Monitoring the rights of mentally disabled children and young people in public institutions, Bucharest, April 2007.

Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment (further referred to as OPCAT)\(^{18}\) is an international legal instrument that strengthens protection against torture and other ill-treatment by reinforcing international and national monitoring procedures. The OPCAT focuses on prevention of abuse through regular and period monitoring of places of detention by establishing a two-level system of monitoring bodies at international and national levels.

The OPCAT places greater emphasis on cooperation of State Parties to prevent violations, rather than public condemnation for violations already committed. The latter is a primary function of the UN Committee Against Torture, responsible for the monitoring of the enforcement of the basic treaty\(^{19}\). The OPCAT helps State Parties implement their commitment under the basic treaty to take measures to prevent torture and other ill-treatment\(^{20}\). Introducing national monitoring bodies under OPCAT, should ensure that the State Parties effectively and with sustained efforts implement international standards in this field.

A variety of mechanism mandated to prevent torture and other ill-treatment already exist in most countries. These include human rights commissions, ombudsmen, parliamentary commissions, detention-place-visiting-schemes by lay people or experts, as well as non-governmental organizations that carry out monitoring programmes. The OPCAT mandates the Subcommittee on Prevention, at the international level\(^{21}\), and national mechanisms to visit without prior consent any place of detention.

In this brief overview of the OPCAT the focus is on provisions of particular concern to those in Romania who endeavour to introduce an effective, independent monitoring mechanism of mental health and other facilities for people with mental disabilities\(^{22}\). Firstly, the OPCAT gives the broadest possible definition for ‘deprivation of liberty’ as “any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that persons is not permitted to leave at will by order of any judicial administrative or other authority”[Article 4]. This definition would include in Romanian context all


\(^{19}\) Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment adopted by General Assembly resolution 39/46 of 10 December 1984 and ratified by Romania on 18 December 1990.

\(^{20}\) In its Preamble OPCAT, notes: “Recalling that articles 2 and 16 of the Convention oblige each State Party to take effective measures to prevent acts of torture and other cruel, inhuman or degrading treatment or punishment in any territory under its jurisdiction”. For full text of OPCAT see http://www.ohchr.org/english/law/cat-one.htm.

\(^{21}\) Articles 5 to 16 of the OPCAT regulate the establishment and mandate of the Subcommittee on Prevention which is not of primary concern in this review.

\(^{22}\) For further reading see Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or the Association for the Prevention of Torture in 2005. An electronic version is available on: http://www.apt.ch/publications/opcat_manual.shtml
mental health establishments, including social medical centres under the local public health authorities where patients are placed for treatment or care, as well as all residential establishments under ANPH and ANPDC. These establishments, as noted above, have already been under international scrutiny by the CPT. Once Romania ratifies the OPCAT these institutions would be subject to visits from both the Subcommittee on Prevention as well as any one or more designated national monitoring body.

Part IV of the OPCAT provides detailed guidance on setting up of and the effective operation of the national preventive mechanisms. Within a year of ratifying the OPCAT, Romania would be committed to: “maintain, designate or establish... one or several independent national preventive mechanisms [emphasis added] for the prevention of torture at the domestic level”\textsuperscript{23}. National mechanisms must be capable of acting independently and without hindrance from state authorities and they must also be perceived by the public as independent. To achieve this, Article 18 would commit Romania to ensure:

- **functional independence** of national mechanisms as well as independence of their personnel;
- its **experts should have required capabilities and professional knowledge**, gender balance and adequate representation of ethnic and monitory groups in the country;
- **necessary resources** for the functioning of national mechanisms;
- due consideration to Principles relating to the status of national institutions for the promotion and protection of Human Rights\textsuperscript{24}.

With regard to its mandate, Article 19 provides that national preventive mechanisms shall have the power: to regularly examine the treatment of persons deprived of their liberty; to make recommendations to relevant authorities with the aim of improving the treatment and conditions of persons deprived of their liberty; to submit proposals and observations concerning existing or draft legislation.

In order for the national mechanisms to effectively exercise their mandate, State Parties undertake, under provision of Article 20, to grant these mechanisms:

- access to information concerning the number of persons deprived of their liberty in places of detention, the number of places and their location;
- access to all information referring to the treatment of these persons as well as their conditions of detention;
- access to all places of detention;
- opportunity to have private interviews with the persons deprived of their liberty without witnesses;

\textsuperscript{23} Articles 3 and 17.  
\textsuperscript{24} Also known as the Paris Principles, For full text see: http://www.unhchr.ch/html/menu6/2/fs19.htm#annex
• liberty to choose the places it wants to visit and the persons it wants to interview;
• the right to have contact with the Subcommittee on Prevention, to send it information and meet with it.

To protect its sources of information, Article 21 provides for safeguards against threats and harassment of anyone communicating with national mechanism. These provisions also ensure confidentiality of information. No personal data shall be published without the express consent of the person concerned.

Article 22 obliges state authorities to examine recommendations and enter into a dialogue on implementation with the national preventive mechanism. Finally, under Article 23, the State Party is committed to publish and disseminate annual reports of the national preventive mechanism.

Last but not least in this section on international mechanism, a brief mention is in order of yet another international standard, adopted recently, which imposes an obligation to monitor and prevent any abuse that people with mental disabilities may be subjected to, whatever the setting in which these violations take place. Article 16 of the Convention on the Rights of People with Disabilities (CRPWD) requires States “to take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects”. Such measures extend to the provision of assistance to disabled people, ‘their families and caregivers’ on how to ‘avoid, recognize and report’ it and to the promotion of the ‘physical, cognitive and psychological recovery, rehabilitation and social reintegration’ of victims. Finally, it should be noted that the convention stipulates that “[i]n order to prevent the occurrence of all forms of exploitation, violence and abuse, States Parties shall ensure that all facilities and programs designed to serve persons with disabilities are effectively monitored by independent authorities”. It should also be noted that in the drafting of the CRPWD, the UN Office of the High Commissioner on Human Rights submitted an expert briefing document which inter alia recommended: “representation of persons with disabilities in the mechanism”.

The performance of national monitoring mechanisms exercising oversight of mental health care and social care institutions in states of the European Union is...
subject of a recently published report by Mental Disability Advocacy Center (MDAC), a regional non-governmental organization promoting human rights of children and adults with mental disabilities\textsuperscript{30}. The report assesses practice in six countries\textsuperscript{31} against criteria largely devised along the lines of the OPCAT requirements for the successful establishment and operation of national monitoring mechanisms. The report concluded that although the quality of the work and the effectiveness of the reviewed national mechanism widely varied, improvements to fully meet OPCAT standards are required in all examined states; strengthening the effectiveness of national oversight mechanisms and reducing human rights violations.

The practices in three states, Finland, the Netherlands and the United Kingdom, would seem particularly relevant to any public debate in Romania on improving current mechanisms of oversight in mental health and social care institutions. The statutory role and performance of the Parliamentary Ombudsman in Finland could provide inspiration for strengthening the institution of Ombudsman in Romania. Examining the practices of the Dutch Healthcare Inspectorate would assist the Ministry of Health and the Ministry of Labour and Social Policy\textsuperscript{32} in Romania in ensuring that their own inspection systems are more effective. Some aspects of the complex system of mental disability rights protection in the UK could provide models for a new mechanism required in Romania with a mandate to solely safeguard rights of people with mental disabilities.

The Finish Constitution mandates the Parliamentary Ombudsman to “ensure that the courts of law, other authorities and civil servants, public employees and other persons, when … performing a public task, obey the law and fulfill their obligations. In the performance of his or her duties, the Ombudsman monitors the implementation of basic rights and liberties and human rights”\textsuperscript{33}. The Ombudsman submits an annual report to the Parliament on his or her work, including observations on the state of the administration of justice and on any shortcomings in legislation.

The Parliamentary Ombudsman Act (197/2002)\textsuperscript{34} gives everyone a right to file a complaint if they consider that someone had acted unlawfully or neglected their duty in the performance of their task\textsuperscript{35}. On-duty lawyers at the Ombudsman Office are available to give advice either by phone or in person\textsuperscript{36}. All complaints

\textsuperscript{30} INSPECT! Inspectorates of Mental Health and Social Care Institutions in the European Unon, published in Budapest in November 2006.
\textsuperscript{31} The Czech Republic, Estonia, Finland, Hungary, the Netherlands and the United Kingdom.
\textsuperscript{32} Ultimately responsible for establishments under the supervision of ANPH and ANPDC
\textsuperscript{34} Full text is available on http://www.oikeusasiamies.fi:80/Resource.phx/eea/english/lawlinks/act-ombudsman.htm
\textsuperscript{35} Article 2(1).
\textsuperscript{36} http://www.oikeusasiamies.fi:80/Resource.phx/eea/english/faq.htm
within Ombudsman’s remit are investigated. Furthermore, the Ombudsman may investigate a matter on his/her own initiative.

Inspections form an important part of Ombudsman’s work. Under Article 5 of the Act, Ombudsman is committed to “carry out inspections in prisons and other closed institutions to oversee the treatment of inmates”. “In the context of an inspection, the Ombudsman and his or her representatives have the right of access to all premises and information systems of the public office or institution, as well as the right to have confidential discussions with the personnel of the office or institution and the inmates there”. When required, Ombudsman may order a police investigation or a preliminary investigation. When he/she considers that a criminal charge or disciplinary proceedings are not warranted a reprimand and opinion may be issued. The Ombudsman also issues recommendations and can address the government and other authorities with proposals to improve existing legislation or practices. It should also be noted that the staff receive ongoing training, including four sessions annually on human rights topics; and that, although there is no specific legal requirement, Ombudsman Office collaborates with national and local non-governmental organizations.

The Ombudsman in her 2005 Annual Report inter alia elaborated on her visits to psychiatric hospitals, noting that she had particular interest in inspecting “conditions in which patients involuntarily receiving treatment are kept and the treatment they receive”. The report further describes how information was collected in the course of discussions with the hospital management, patient’s representatives, staff and patients themselves, as well as by examination of documents, inspection of closed wards and their isolation rooms. “A feature given special attention during these visits last year was the fulfillment of the treatment guarantee in the sector of psychiatric treatment for children and adolescents as well as restrictions on the right of self-determination and other fundamental rights of psychiatric patients. The rights of also other patients, including their opportunities for outdoor exercise, were likewise examined during inspections”. During her inspection visits the Ombudsman drew attention to the key task which the State Provincial Offices have in relation to overseeing limitation of the fundamental rights of patients involuntarily receiving psychiatric treatment. She emphasized that a psychiatric hospital must have written and sufficiently detailed guidelines setting forth how restrictions of the right of self-determination, in the meaning of Article 4(a) of the Mental Health Act, are to be implemented and that the specific regulations for the various departments of a psychiatric hospital must be in accordance with law. She also drew the attention of hospitals to the specific

37 Article 5(2).
38 Article 8.
39 Same as at 27, page 27.
distinctions in the conditions required by law for the enforcement of isolation and restraint.\textsuperscript{40}

Lastly, let us briefly examine how Ombudsman maintains her independence and what is the scale of the challenges she has to respond to in Finland. To carry out her statutory duties effectively and independently, the Ombudsman drafts her own budgetary proposal, subject to parliamentary approval, and is in full control over its allocation. To date, the Finish parliament has granted all requested funds to sustain the work of Ombudsman Office comprising 55 staff members.\textsuperscript{41} To put into context the work of this sophisticated human rights protection mechanism let us also note that Finland has a population of about 5.2 million and that 7.4\% of its gross domestic product is spent on health care.\textsuperscript{42} Finland’s concern for the healthcare and wellbeing of its citizens reflects the country’s long record in the progressive realization of economic, social and cultural rights. A developed network of social services includes community-based mental health care. Following a rapid deinstitutionalization of long-term psychiatric patients in Finland in the early 1990s about 70\% of those patients had been provided with alternative residential arrangements, leaving no one homeless.\textsuperscript{43} If we are to draw any lessons from the Finish experience it would be to conclude that effective and adequate protection of basic rights of people with mental disabilities is not possible without consistent and long-term commitment by the state to significantly improve public health and all other social care services, as well as rights protection mechanisms that comply with all international human rights standards.

Compared with other European states, the Netherlands has one of the highest rates of residential care for people with mental health problems, people with intellectual disabilities and the elderly.\textsuperscript{45} There are approximately 800 nursing homes for people with dementia, 47 institutions for people with intellectual disabilities, 100 psychiatric hospitals and 90 psychiatric departments in general hospitals.\textsuperscript{46} It is therefore important to examine more carefully what role state inspection agencies play in protecting the rights of people with mental disabilities who are placed for care in this large network of institutions.

\textsuperscript{41} Same as at 27, page 26.
\textsuperscript{42} http://www.who.int/countries/fin/en/
\textsuperscript{43} The others, given appropriate support, returned to their homes and or/joined their families.
\textsuperscript{44} Sami Räsänen, M.D and others Community Placement of Long-Stay Psychiatric Patients in Northern Finland, Psychiatric Services 51:383-385, March 2000, http://www.psychservices.psychiatryonline.org/cgi/content/full/51/3/383
\textsuperscript{46} As at 27, page 38.
Health care inspectors, as a matter of national concern in the Netherlands have a 200-year-long tradition. In the most recent of many service reforms, on 1 January 1995, the Medical Inspectorate of Health, the Medical Inspectorate of Mental Health and the Inspectorate of Drugs were joined to form the Health Care Inspectorate (the Inspectorate).

The Inspectorate supervises the quality and accessibility of health care and is an autonomous organization within the Ministry of Health, Welfare and Sport. The Minister is formally responsible for activities undertaken by the Inspectorate and is held responsible by the Parliament for the Inspectorate’s activities.

The Inspectorate is subdivided into three sub-inspectorates: one for preventive and curative health care, one for mental health care, and one for pharmacy and medical technology. The mental health care sub-inspectorate has three departments: 13 inspectors responsible for pediatric and general psychiatric hospitals as well as establishments that provide treatment for drug and alcohol addiction; seven inspectors monitoring institutions for people with intellectual disabilities; and 10 inspectors who supervises nursing homes for the elderly.

The Inspectorate carries out general supervision through regular visits to care institutions to ensure that the quality of care is up to the prescribed standards. The Inspectorate is working on a new risk-driven working methodology which comprises three phases. In the first phase, designed to identify institutions with higher risks, initial assessments are made by the Inspectorate on the basis of information collected via an electronic inspection questionnaire completed by all institution. The second phase concerns an on-site inspection of the institutions. If it is established that the quality of care is insufficient, the Inspectorate will proceed to the third phase when measures will be taken to ensure quality of care meets the required standards.

At the same time the Inspectorate initiates thorough investigations into any reported serious problems, adverse events or other crisis in the provision of care and other services. After establishing the causes of the problem or crisis, recommendations would be issued to avoid any recurrence of the incident in the future.

Thirdly, thematic reports are prepared by the Inspectorate on issues that are of more general nature. The objective of thematic supervision may be to assess government policy on a certain issues, or to minimize specific risks of certain

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47 http://www.igz.nl/uk/organization/94964/
48 Ibid.
49 As at 27, page 38.
50 http://www.igz.nl/uk/supervision/ukworkingmethods/
51 http://www.igz.nl/uk/supervision/ukworkingmethods/
52 Ibid.
care practices, or to determine any structural failings and thus improve the quality of care and safety of patients/residents\textsuperscript{53}.

The Inspectorate also publishes an annual report on developments in healthcare and accounts for its work\textsuperscript{54}.

Furthermore, the Inspectorate has a special role in the supervision of involuntary placement and treatment in psychiatric institutions. The 1994 Psychiatric Hospitals (Compulsory Admissions) Act has specifically designated inspectors to investigate any of the reported cases of involuntary placement and treatment. “There are approximately 2,500 such cases annually and of these about 10% involve [are subjected to] a formal inspection, and examination of medical records, and discussions with treatment teams, a patient and or his or her representative\textsuperscript{55}.

With regard to other safeguards of patients’ and residents’ basic rights, it is also important to note that within the Dutch health and social care system patients and residents have several options for filing complaints. Under the provisions of 1995 General Complaints in Healthcare Act complaints committees are established in each institution. Three members and the committee chairperson must be independent of the institution. The complainant has a right to be represented by a lawyer or another trusted person. However, the recommendations of the committee are not legally binding.

A more effective procedure is provided under the Psychiatric Hospitals (Compulsory Admissions) Act. Those involuntarily placed for treatment can file complaints about various aspects of their treatment, including treatment without consent and the use of means of restraint. The patient can seek assistance from an independent patients’ advocate. Complaints committee hearings are held in the presence of a psychiatrist and a lawyer. Committee decisions are binding on the institution and cannot be appealed. On the other hand, the complainant can appeal the decision to a judge and is provided with free legal assistance. The judge can instruct the institution how to remedy the situation\textsuperscript{56}.

A complaint can also be addressed directly to the Inspectorate, which if appropriate can forward it to the medical disciplinary tribunal or a criminal court\textsuperscript{57}.

As long as long-stay residential institutions operate in the health and social care system, it is imperative upon the state to ensure that patients’ and residents’ rights are effectively protected by internal, as well as independent, oversight

\textsuperscript{53} Ibid.
\textsuperscript{54} http://www.igz.nl/uk/organization/inspectorateproducts/
\textsuperscript{55} As at 27, page 40.
\textsuperscript{56} As at 27, page 41.
\textsuperscript{57} Ibid.
mechanisms\textsuperscript{58}. In that sense, as efforts for deinstitutionalization in Romania take root, the responsible state authorities must ensure that internal oversight mechanisms and procedures are appropriate to effectively protect the rights of those placed and treated in all health and social care institutions. It is important not only to grant these mechanisms adequate mandate but also to adequately resource them to ensure that patients’ and residents’ rights are effectively protected and standards of care enforced.

The United Kingdom has the most developed system of monitoring mental health and social care institutions. There would be many aspects of this complex system that need to be closely examined when deliberating what independent oversight mechanism would be most appropriate to Romania. Among these are features in the system that ensures the independence and effective operation of oversight mechanism and setting in place appropriate safeguards for all service users. As the United Kingdom experience confirms these can best be achieved with participation of service users and users groups at every level and every stage of decision-making that may affect them.

Given the very limited scope of this review it is possible to focus only on one of several bodies in this complex system of oversight of mental health and social care services: the Mental Health Act Commission (MHAC). Other bodies include the Commission for Social Care Inspection which regulates social care institutions and domiciliary care services provided by the public, private and voluntary sector. The Healthcare Commission promotes improvements in healthcare and public health in England and Wales\textsuperscript{59}; ensuring that healthcare services are meeting standards and assessing the performance of healthcare organizations. It also deals with complaints regarding the National Health Service\textsuperscript{60}. The National Patient Safety Agency co-ordinates the efforts of the entire country to report, and more importantly to learn from mistakes and problems that affect patient safety\textsuperscript{61}. The Parliamentary and Health Service Ombudsman, with a unit for mental health care, deals with particularly serious complaint cases\textsuperscript{62}.

The MHAC is responsible for monitoring the implementation of the Mental Health Act 1983, as it relates to patients who are placed for treatment on involuntary basis. It consists of about 100 members (commissioners), including laypersons, lawyers, doctors, nurses, social workers, psychologists and other specialists\textsuperscript{63}. In addition the Commission has a panel of approximately 150 Consultant Psychiatrists appointed by the Commission as Second Opinion Doctors.

\textsuperscript{58} Principle 22, Principles for the protection of persons with mental illness and the improvement of mental health care, adopted by General Assembly resolution 46/119 of 17 December 1991.
\textsuperscript{59} There are specific features to human rights protection and oversight mechanisms in this field in Northern Ireland and Scotland.
\textsuperscript{60} http://www.healthcarecommission.org.uk/homepage.cfm
\textsuperscript{61} http://www.npsa.nhs.uk/
\textsuperscript{62} http://www.ombudsman.org.uk/
\textsuperscript{63} http://www.mhac.org.uk/Pages/about.html
The MHAC mandate includes: review of the enforcement of the Mental Health Act 1983 in respect of patients who are subjected to involuntarily placement and treatment; visits and interviews, in private, with patients held against their will in hospitals and mental nursing homes; investigation of complaints which fall within the Commission's remit (i.e. concern involuntary placement and/or treatment); review of decisions to withhold the mail of patients detained in the High Security Hospitals; appointment of medical practitioners and others to give second opinions in cases where this is required by the Act; publication of a report to Parliament every 2 years. The Commission can also advise the Secretary of State for Health on policy matters that fall within its remit.\textsuperscript{64}

Members of the Commission, with the exception of the Chairman and Vice Chairman, work within regional teams. Each regional team is responsible for a particular geographical area and is managed by a Regional Director who is responsible for arranging and monitoring the teams' activities.\textsuperscript{65}

The Commission has a staff of approximately 40 people, directed by the Commission's Chief Executive. The staff is divided into teams which provide administrative support to the Commission Management Board, the Regional Visiting Teams, the Second Opinion Services and all other Commission activities including training. The Commission also has a dedicated team responsible for directing the work on complaints submitted to the Commission. This team also handles the work arising from all notified deaths of detained patients.

Commissioners are asked to devote approximately two days each month to on-site visits and work on complaints. Within their assigned region they aim to visit each hospital or unit every 12 months, and every ward within those hospital or units every 18 months. Most visits are unannounced and can take place at any time of the day, any day of the week. On an average visit a commissioner may be able to interview up to six patients. “Verbal and handwritten feedback can, and often is, given on the day of a visit, and can lead to resolution of issues, particularly those at hospital department level.”\textsuperscript{66}

Because the MHAC remit is to help safeguard the interests of people who are placed and treated in psychiatric institutions against their will, it is this group of service users MHAC is most determined to involve in its work through Service User Reference Panel. This panel has its own newsletter providing feedback to SURP members on work they are involved with.

Given the high or unusual mortality rates in some psychiatric hospitals in Romania it is interesting to note that MHAC has a specific role to play in this respect. The MHAC, under its general remit, is notified of the death of all patients

\textsuperscript{64} Ibid.
\textsuperscript{65} http://www.mhac.org.uk/Pages/composition.html
\textsuperscript{66} As at 27, page 48.
who had been placed and/or treated on involuntary basis. The MHAC records all deaths of detained patients and reviews the deaths of patients who have died from non-natural causes to establish whether good practice, as defined in the Code of Practice attached to the Mental Health Act 1983, has been followed and whether lessons for future practice and policy need to be learned. This review may include sending a representative to the inquest, which considers the circumstances of the death or arranging a visit to the hospital to consider the issues arising.

Between April 2004 and March 2005, the Commission received 322 notifications of the deaths of detained patients. Of those the Commission raised 70 unnatural deaths cases to be reviewed and recorded 252 natural deaths. The Commission attended 72 inquests over the period.

At the end of this brief overview of some international and national oversight mechanisms it may be useful to reiterate several key conclusions. Romania needs to show much firmer political will in implementing its international commitments to effectively protect people from torture and other ill-treatment. Therefore, Romania needs to immediately implement all CPT recommendations, particularly those regarding safeguards for the rights of patients and residents in psychiatric institutions, many of which have been repeatedly issued by the CPT since 1995.

A more resolute commitment to effective rights protection would also be demonstrated by a speedy ratification of the OPCAT. However, this would only be possible if Romania undertakes an urgent review of the existing human rights protection mechanisms, both those that are independent and those that operate under government supervision, to ensure that they comply with all of the OPCAT requirements regarding its mandate, professional competency, representation and independence. In this process Romania should bear in mind that the most effective protection of the rights of people with mental disabilities might be achieved only by a specifically designated new mechanism. A mechanism that should be appropriately mandated, staffed, including service users and representatives of their organizations, and adequately funded.

These are not easy tasks but they are easily within Romania’s human and material capacities. Also, considering that they result from Romania’s freely-entered-into international commitments, these tasks are not an option - Romania has no alternative but to implement them. People with mental disabilities have been neglected and ‘invisible’ victims of human rights violations for far too long.

67 See http://www.mhac.org.uk/Pages/deaths.html
II. The state of facts in the Romanian medical-social institutions for the persons with mental disabilities

Monitoring medical-social institutions for persons with mental disabilities: practice and legislation

The Centre for Legal Resources organised monitoring visits to 15 medical-social institutions (hospitals and psychiatric sections, centres for mentally disabled children, neuro-psychiatric recovery and rehabilitation centres, centres for integration through occupational therapy and medical-social centres) for persons with mental disabilities between December 2006 and March 2007. The monitoring process mainly targeted evaluations regarding:

a) the openness of medical-social institutions to non-governmental organisations working on the rights of persons with mental disabilities;
b) the mechanisms and procedures to register and solve the complaints and petitions of the beneficiaries/patients in the medical-social institutions;
c) the implementation of regulations regarding the measures to restrict the liberty of movement of patients/beneficiaries in the medical-social institutions;
d) observing the other rights of the patients/beneficiaries in the medical-social institutions.

The institutions that were targeted in the monitoring process were the following:
- the Services Complex for disabled children no. 14 in Ramnicu Sarat, Buzau County;
- the Centre for disabled children in Siria, Arad County;
- the Centre for abandoned children or orphans with mental retardation and behaviour disorders in Popesti, Bihor County;
- Centre no. 8 in Reghin, Mures County, for children and youth with mental retardation;
- The recovery and rehabilitation centre for disabled persons in Pâclisă, Hunedoara County;
- The neuro-psychiatric recovery and rehabilitation centre no. 1 in Babeni, Valcea County;
- The centre for integration through occupational therapy in Dumbraveni, Sibiu County;
- The psychiatric hospital in Gura Vâii, an external section of the Drobeta Turnu Severin County Hospital, Mehedinti County;
- The Ganesti medical-social centre, Galați County;
- The Gadinti psychiatric hospital, Neamt County;
- The Vadul Lat psychiatric hospital, Giurgiu County;
- The Nucet medical-social centre, Bihor County;
- The chronic illnesses hospital in Borsa, Cluj County;
- The external section in Boita of the „Gheorghe Preda” psychiatric hospital, Sibiu.

The main observations, conclusions and recommendations coming from the monitoring process are the following:

a) **the openness of medical-social institutions to non-governmental organisations working on the rights of persons with mental disabilities**

The management representatives in the medical-social institutions have shown greater openness to CLR’s monitoring activities, compared to previous years. There were also cases when the access of CLR representatives in the institutions met with unjustified reticence. We consider this reticence as unjustified mainly due to the fact that prior to the monitoring visits CLR obtained from the authorities governing those institutions an approval to enter the respective institutions. In this respect, a relevant case is that of a visit to the „Gheorghe Preda” psychiatric hospital in Sibiu that was impeded by the refusal of the institution’s management representatives. On the one hand, they ignored the agreement between CLR and the Ministry of Public Health, and, on the other hand, to justify their refusal, they brought up „provisions of the internal regulations”, which allegedly prevent third parties from visiting the institution without the manager’s approval. Upon further proceedings from the monitoring team members to gain access to the regulations that were brought up, they were given a document that was in fact the institution’s daily programme.

There were also situations where managers of the institutions considered that the visits should have been announced in due time, a requirement that contravenes the sudden character such visits should have, so that the observations may reflect reality as much as possible, not situations that can be improved through preparations prior to the visits.

We also need to underline the serious reservation of residents in some of the institutions – and sometimes of staff even – in communicating with the monitoring team members, reservations that have to do especially with the consequences they would have to bear afterwards in relation with the management of the institutions. CLR’s monitoring visits the last few years, including those that are referred to in this Report, have underlined the fact that the residents’ fear of communicating with visiting persons and of complaining regarding violations of their rights is definitely much easier to observe in the institutions where these problems are more numerous and more serious. As an example, we reproduce some of the observations of the monitoring team that visited the Sacel centre (reference will also be made to the situation in this centre in the section regarding the way residents’ rights are observed):
When we talked to the residents, they were afraid to speak to us with all the other residents present about the problems they have with the staff, and asked us to discuss the issue in smaller groups. During the second monitoring visit, dated 30.03.2007, we tried to talk to a group of residents. We gathered together several children from the centre and asked them about how they felt there. Surprisingly, all residents told us they felt fine in the centre and that everything was perfect. In fact, all answers to our questions contained either „fine” or „perfect”. The residents didn’t wish anything to change in the centre, not even the obvious things, such as clogged toilets or defective showers. We need to underline that the attitude of these children gave the impression they had visibly been „formed” to say only good things about the centre, and they were clearly afraid of a part of the centre’s staff. When we tried to talk to the residents, the psychologist refused to leave the room and she tried to convince us that they can only talk to us in her presence, especially as she gets along so well with the children, and they can discuss anything. It was only upon our intervention at the manager and his arrival that the psychologist accepted to leave the room and let us talk to the residents. All this time, she continued to tell us, the residents present, how much they wanted her to be present at the discussions, and kept asking them whether that was true, in order to enforce this fact. The children, obviously intimidated, answered yes, the lady psychologist should stay. The discussion we tried to have with the staff members went the same way as the discussion with the residents. They were very quiet, didn’t wish to make any comments on any problems at the centre, denied there had been any problems, the discussion we tried to have with them was mainly with the lady psychologist actually, and she obviously tried hard to make the centre’s activity seem like a „model of good practice”. We received information that the psychologist (who is also the director’s wife) started asking the residents for statements regarding the abuse the staff subject them to, and the psychologist encouraged them to submit such statements. It’s curious that only part of the statements are kept in the complaints file, those that refer to certain persons the director of the centre has a problem with. The other statements simply disappear from the file, and there are suspicions that they are extracted by the director of the centre and his wife. We were also informed that the director of the centre is also the union leader. Moreover, the staff complained he constantly threatens to fire them, especially if they complain or don’t do as the director indicates. We received information that the director of the centre gathered together the children that would have wanted to speak to us (e.n. members of the monitoring team), took them all to one room in the centre and he had one of the employees guard them and prevent them from coming to us. Two of the children that had been locked away managed to „escape” so that they can talk to us, but the rest remained under guard.”

The fact that employees in some of the institutions are afraid to submit complaints regarding the disorders in their organisations suggests that the managers of those institutions are hostile to the staff’s legitimate wish in this respect. Such an attitude contravenes the letter and spirit of Law no. 571/ 2004 regarding the protection of personnel in public institutions that signal violations of
the law. According to these regulations, staff members in these institutions have
the right to „complain about violations committed by management or executive
persons”, as well as the right to be protected against any sanctions that could be
applied for the lawful use of this right. These regulations need to be known, and
the personnel in the medical-social institutions for disable persons, including their
union organisation, need to use them in their defense in cases where the rights
they establish are violated in any way.

We also need to underline that the discussions of residents with persons coming
for inspection or monitoring visits need to be confidential. In numerous cases, the
current practice is that staff members in these institutions take part in the
discussions with the residents, and there is a strong impression sometimes that
the aim is to discourage the residents from having an open approach to the
problems they wish to point out to the visiting persons.

According to observations of the monitoring team members, there were also
problems at the centre in Popesti, Bihor County: „Although we identified
ourselves, we presented the schedule and aim of our visit as well as the approval
of the National Authority for the Protection of Child’s Rights, signed by the State
Secretary in 2005, the manager asked whether we notified the management of
the General Protection Department, and whether we had its approval. Upon our
answer that the procedure includes unannounced visits yet the National
Authority’s notification had been sent to all the Departments, and consequently
the General Manager of DGASPD Bihor should be aware of this fact, she told
us she cannot release any information unless we talk to the General Manager
first, in Oradea. As the trip to Oradea and back would have taken us around 4
hours, we asked her to call the department and inform the management. Both the
manager of the centre and us held negotiations with the general manager over
the phone, and we were eventually told to wait for the deputy manager to come
visit the centre and speak to the children in his presence.”

The need for non-governmental organisations working on the protection of
disabled persons’ rights to have access to the institutions is justified both by the
fact that such practices are in line with the international standards in the field
(e.g. the Optional Protocol to the Convention against torture includes these
institutions among those where the residents are deprived of liberty) and the fact
that the representatives of non-governmental organisations can and must
monitor the way the rights of residents without families or other external contact
are observed. Such cases are not rare at all. Two such examples are the
Psychiatric Hospital in Gura Vaii, Mehedinti County („Less than 10% of the
patients receive family visits. Most patients have no legal representative, tutor or
trustee to check how their rights are observed”), and the Medical-Social Centre in
Nucet, Bihor County („Out of 178 residents only 25 are visited by their families or
friends”).
Another argument that pleads in favour of greater openness in the medical-social institutions is the number of serious violations of residents' rights that continues to be very large – which can be seen in the observations of the monitoring teams, presented further on in this section.

One aspect that also has to do with the openness of the management of the medical-social institutions towards monitoring from the non-governmental organisations is their access to resident files, first of all to their medical files. There were cases where representatives of the institutions refused access of the monitoring teams to these files (one example is that of the Services Complex for disabled children no. 14 in Ramnicu Sarat, Buzau County: „We couldn’t gain access to the medical files of the children in the centre, and the justification was „they are confidential”. Upon the intervention of the deputy manager, we could see one file, after the monitoring team’s express request for permission. Permission was also requested from a young girl who was in the medical office at the time, as the file was hers. On the follow-up visit, during discussions with the children/ youth, we tried to obtain their approval to study their personal files, but they were reserved, so that they don’t compromise their relationship with the employees in the centre.” We also have to underline that access to the files was unrestricted in some cases – one example is that of the Hospital for chronic mental illnesses in Borsa, Cluj County.

We consider under this aspect that the provisions of article 22 of the Law on patient’s rights no. 46/ 2003 (and article 24 in the Norm of 10 April 2006 to apply the Law on mental health and the protection of persons with mental disorders no. 487/ 2002) fully apply, and they state that the confidential information regarding patients is accessible upon their consent. Consequently, medical-social institutions have to ensure that, on the one hand, representatives of non-governmental organisations have access to it, and, on the other hand, representatives of the institutions must refrain from influencing the residents’ decision in any way. At the same time, in case the residents cannot discern on such consent, consent should be assumed considering that the representatives of legally established non-governmental organisations working to protect the rights of disabled persons are assumed to act exclusively to protect the residents and their legitimate rights and interests.

b) the mechanisms and procedures to register and solve the complaints and petitions of the beneficiaries/ patients in the medical-social institutions

The domestic regulations in the field (article 25 of the Norm of the Ministry of Public Health of 10 April 2006 for the application of the Law on mental health and the protection of persons with mental disorders no. 487/ 2002) establish that the institutions that supply mental health care „have the obligation to establish a special register to record all complaints submitted by patients or their
representatives. The unit management has the obligation to answer all complaints regarding violations of patients’ rights in written.” The regulations also establish that the means to solve the complaints also need to be written down in the above-mentioned register.

CLR’s monitoring showed that these provisions are only observed to a small extent. Many of the units that were visited don’t have the register required by the act mentioned above, and here are a few of such examples: the Dumbraveni Centre for integration through occupational therapy, the Nucet Medical-social centre, the Borsa Hospital for chronic mental illnesses, the Gura Vaii Psychiatric hospital (representatives of the hospital stated that the complaints are made orally and such a registry isn’t necessary, although the law provides for the contrary). There is no such procedure at the Ganesti Medical-social centre either. The attitude of representatives of the Centre shows that such situations are treated from the perspective of residents’ lack of capacity to submit complaints and protect their rights. At the Nucet centre, in case the residents are discontent with various aspects regarding their life in the institution, they complain orally to the director, chief-nurse, social assistant or doctors. The staff members claim they can solve most of the requests, a fact that cannot be demonstrated in the absence of documents certifying the existence of the problems and their resolution, as the legal provisions in force establish explicitly. At the Borsa hospital, the staff also claimed that residents address oral complaints to the management of the institution and that they are fully solved, a fact that cannot be demonstrated in the absence of documents supporting these claims. At the Dumbraveni centre, there isn’t any register for residents’ complaints, but there is a „complaints book” at the gate with no complaints in it (the administrator of the centre says the reason for that situation is that the residents „can’t write”). The head of the centre underlined that „being the first in contact with the beneficiaries, the instructor collects all complaints and tries to solve them, while special events are recorded in the shift turn in/ take over book”, a procedure quite far from the legal norms and the requirements of an adequate and efficient mechanism to register and solve complaints.

Another category of institutions was that where the monitoring teams had the impression that norms related to complaints are treated formally. Thus, at the Sacel centre for mentally-deficient and abnormal behaviour children there has been a complaints register since 2005, but it doesn’t contain any complaints („The social assistant told us there aren’t any major problems at the centre, all complaints are related to minor issues and they have always been solved by talking to the residents and staff. Regarding complaints, practice at the Centre is that residents, when they have any discontent, talk about the issue with the educators or staff, so that there is nothing in written about the cases and the way they were solved”). Contrary to the claims of the personnel, discussions with the residents revealed that there are some problems, „especially related to physical violence the personnel subject them to”.
Better practice was encountered at the centre for disabled children in Siria, Arad County: „In case the residents have any complaints to make, they take them to a mailbox. Their complaints are registered in a notebook, and the solutions are written down for each of them. All complaints coming from the residents are sent to the Department, where a council hears the complaints and communicates the solution.” At the time of the visit, there were three complaints in the register, the most important of which was that of a lady resident, L., who complained about being beaten by one of the centre’s education assistants. According to the monitoring team members, „the complaint was registered on June 6th 2006. The Residential Service within the Department was notified, and the Abuse Service within the Department conducted an investigation. The disciplinary investigation revealed that the education assistant hadn’t committed any physical abuse. The assistant gave a statement and she underwent a psychological examination with a psychologist at the Department. At the same time, there were discussions with a night attendant, A.P., and several residents from the centre, P.S., M.C., C.V.A. We found the statements of the persons mentioned above in the resident’s file. They stated that the education assistant didn’t beat the resident, but she fell one evening while playing around the bicycle stand, and that is how she got the bruise on her leg. During our discussions with the resident, she continued to claim that the education assistant struck her leg with a stick because she didn’t listen when she told her to stand on her knees as punishment for leaving the Centre for two hours without telling anyone.” We used the case above to underline an example of practice that is much closer to what should be a „complaint mechanism”, rather than to offer an example of objectivity on the part of the personnel in these institutions in solving residents’ complaints.

At the Centre for neuro-psychiatric recovery and rehabilitation in Babeni, Valcea County, a complaints book was established in the summer of 2006. It’s only record was that of a complaint regarding the bad food in the centre. The fact that there was only one complaint, as well as the fact that it had been submitted by the centre’s personnel, also suggest a formal character of the complaint and resolution procedures. The conclusion of the monitoring team for the Babeni centre was also that „there isn’t any written, clear procedure that the beneficiaries are informed about, to register, investigate and solve complaints”.

A frequent problem in the institutions that were visited was that the residents are afraid to complain because of the consequences they would have to bear from the part of the personnel (but also the colleagues that the complaints refer to). As an example, we relate the conclusion formulated in this respect by the monitoring team that visited the Services Complex for disabled children in Ramnicu Sarat: „Although there is a complaints register, children and youth don’t call on it to solve a problem, as they don’t want anyone to know they were the ones to signal the respective situation, thus protecting themselves from children’s or educators’ reactions”. 
There aren’t any clear procedures in the institutions that were visited for the cases where the residents in these institutions – persons with special needs – would like to submit petitions to public institutions/ authorities, according to the provisions of the Governmental Ordinance no. 27/ 2002 regarding the resolution of petitions, approved with modifications through Law no. 322/ 2002. (At the same time, CLR signals the fact that the medical-social institutions for persons with mental disabilities have themselves the statute of „public institutions”, in the sense of article 2 of the Governmental Ordinance no. 27/ 2002, and they must proceed themselves to solve the petitions of the residents according to the provisions of the act mentioned above). Residents in these institutions should be informed regarding the public authorities these institutions are subordinated to, which have the legal competence to solve the petitions they can submit regarding the way their legal rights are observed: the Ministry of Public Health, the county public health authorities, the county councils, the county general departments for social assistance and child protection, the National Authority for Disabled Persons, the National Authority for the Protection of Child’s Rights, the Social Inspection. Considering the fact that the residents of these units are persons with special needs, who are supposed to have difficulties in knowing the legislation and legal procedures that need to be followed in formulating a petition, these persons need to be informed regarding both the specific regulations and the contact data of the authorities/institutions that cover the petitions they formulate, including those referring to violations of their rights and interests through deeds of a criminal nature (contact data for the central and local Police and Prosecutor’s offices). When the management representatives of the medical-social institutions, and the authorities coordinating them, learn about residents’ complaints about violations of their legal rights and interests through deeds of a criminal nature, they must ensure their complaints are submitted to the competent institutions. As seen on visits to the institutions, there were cases when residents have shown interest in the contact data of the non-governmental organisations whose mission is to protect the rights of mentally disabled persons. Residents must also be informed on how to contact these organisations. The situation in many of the institutions that were visited renders evident the necessity of the facts mentioned above. To give an example, we present two of the observations the teams had while visiting the centre for disabled children in Siria, Arad County and the centre in Reginh, Mures County: „We spoke to 16 residents during the monitoring visit” (e.n. The team’s report gives the names of the residents). „They told us there is a series of problems in the Centre that they don’t complain about because they don’t know where to go and they are convinced that if they call on the Department nothing would be solved.” „During the discussions we had with the beneficiaries, they were revolted about the fact that the Centre’s management doesn’t take into account many of their complaints (some of them critical).”

One highly controversial aspect consists of the cases where the staff members of these institutions treat the petitions/ correspondence the residents address to other institutions totally inadequately (illegally). Thus, the hospital for chronic
ment illnesses in Borsa had a case where the unit’s personnel retained in the resident’s file a letter he had addressed to the public television station. As the medical-social institutions for persons with mental disabilities are considered to enter the category of institutions depriving individuals from liberty, residents in these institutions must be provided with envelopes, stamps and paper to exercise their constitutional and legal right to petitions, as well as access to mailboxes of the „Romanian Post” company.

As possible good practices, we can mention the cases where „Children’s councils” were created in the centres (the Popenesti centre and the Services Complex for disabled children in Ramnicu Sarat), by means of which „residents can express their opinion, discontent, make suggestions related to all aspects that concern them. If the residents have any conflicts, they don’t call on the social assistant or the educators to mediate, they are taught to solve them themselves, independently. The institution’s management only intervenes if the conflicts are between the residents and the personnel, and only when the two parties haven’t found a means to settle the conflict by themselves.” In principle, we consider such practices can prove beneficial if the children like it, if it isn’t formal, if it were the children that designated the members of these bodies, without any intervention from the personnel of the institutions, and without the participation in these councils being considered as additional responsibilities established by the personnel for some of the children (at the Services Complex for disabled children in Ramnicu Sarat the children’s representatives in the council, including its president, had been designated by the centre’s management without any criteria – which cannot constitute good practice, on the contrary).

During a visit to the Medical-social centre in Nucet, members of the CLR monitoring team met with a case that originally, before 1989, may have been political forced hospitalization68. CLR will address the Institute for the Investigation of Communism Crimes in Romania suggesting that it does the necessary verifications to clarify this case, on the basis of the attributes conferred to it by the Governmental Decision no. 1724/ 2005 regarding the establishment of the Institute for the Investigation of Communism Crimes in Romania.

68 Resident T.S., age 75, born in the Suraia commune, Vrancea County, claimed she was sent to the psychiatric section on political reasons, because she protested against the persecution she had been a victim of as a student, and then as a young teacher, because her parents refused to register in the farming cooperative. According to her account, she was first arrested in March 1958 by the Militia in a commune where she taught (she was retained for a few weeks, interrogated, threatened, then they let her go), then she was arrested again in May 1958 and taken to the detention centre of the Secret Police in Galati and released after a few months. She was arrested again in 1961, this time in Bucharest, on April 19, and taken to the psychiatric hospital after being examined by a medical commission. In 1965, on January 5, she was transferred to the Zalau Penitenciary, where she was held until 1968, then she was transferred to the Psychiatric hospital for security measures in Jebel, Timis County, and then to the Psychiatric hospital in Gataia, then to the Psychiatric hospital in Stei (on 22 November 1974), where she was held until 2003, i.e. 29 years.
c) the implementation of regulations regarding the measures to restrict
the liberty of movement of patients/ beneficiaries in the medical-
social institutions

A series of problems regarding the measures to restrict the residents’ liberty of
movement were identified by the CLR monitoring teams in the institutions they
visited. What causes this situation is the lack of awareness concerning the legal
provisions in the field on the one hand (article 20 – article 22 of the Norm of the
Ministry of Public Health of 10 April 2006 to apply the Law on mental health and
the protection of persons with mental disorders no. 487/ 2002), and their poor
implementation, on the other hand.

Although it was found that in some of the institutions that were visited the
isolation measure is used, no isolation rooms had been fitted (article 22 of the
Norm of the Ministry of Public Health stipulates that this measure can only be
applied if the psychiatric institution has a special room that was fitted and
equipped to this end). Thus, in the case of the Integration Centre in Dumbraveni
it was found that: „The centre doesn’t have an isolation room and the personnel
initially denied such measures are taken. During subsequent discussions with the
personnel and beneficiaries, as well as after studying a series of documents that
were made available (the records stated „I took him to the gate”), it was found
that a room in the gate building was sometimes used as an isolation room. This
room has a double door with iron grate, it is 2x3 m, there are two bunk beds, and
the room has access to a „closet“ that, according to the administrator and gate-
keeper, is used as storage room for dangerous waste resulting from the activities
in the medical office. We noticed that access to this room is through the room
used for isolation, the access door is not as high as the walls, so complete
isolation from the waste storage is not ensured, which is even more concerning
as one of the beneficiaries, C., stated: „They keep them for one day (e.n. – the
beneficiaries that are brought to the isolation room), but there were cases when
they were there for a month“. Such practices exist even though the Norm of the
Ministry of Public Health established that an isolation room „must allow for
continuous observation of the patient, it must be adequately lighted and
ventilated, it must have access to a toilet and washing room, and it must be
protected so as to prevent any injuries to the isolated individual. “ There weren’t
any isolation rooms at the Psychiatric Hospital in Gura Vaii, nor at the Services
Complex in Ramnicu Sarat, the Medical-Social Centre in Ganesti, the Hospital for
chronic mental illnesses in Brosa and the Centre for neuro-psychiatric recovery
and rehabilitation in Babeni. Practices that came closer to the specific regulations
were identified at the External Section in Boita of the „Gheorghe Preda“
Psychiatric Hospital of Sibiu, but there were disorders there also, e.g. the legal or
personal representatives of the patients weren’t informed on the seclusion/
restraint measure (in violation of the Norm of the Ministry of Public Health, which
stipulates that the patient and/ or his legal or personal representative must be
informed regarding the isolation measure).
Regarding the restraint measure, the most frequent disorders consisted in a lack of restraints registers, which constitutes a violation of the Norm of the Ministry of Public Health (article 21, paragraph 8 – „The restraint measures that are applied to patients, including all doctor’s written provisions that established them, are recorded in the Register for restraint and seclusion measures applied to patients.”), at the Reghin centre, the Centre for recovery and rehabilitation in Paclisa, the Psychiatric Hospital in Gadinti and the Hospital for chronic mental illnesses in Borsa. There are cases when the restraint measure isn’t recorded in the patient’s observation sheet either, as established by article 27, paragraph 7 of the Norm of the Ministry of Public Health – e.g. at the Reghin centre.

d) **Observing the other rights of the patients/beneficiaries in the medical-social institutions**

One of the conclusions of the team that visited the Medical-social Centre in Ganesti, Galati County, („In general, very few of the assisted persons’ rights and necessities are observed“) can constitute a valid quasi-general characterization for the system we refer to.

CLR finds that there are still cases where residents in medical-social institutions complain about **aggressive behaviour of the personnel and some of the colleagues**. Beating residents and „sanctioning“ through illegal measures is almost common practice in some of the institutions. Although such deeds constitute violations in the Penal Code, CLR practically doesn’t know any case where those guilty of such behaviour have been held responsible according to the provisions of the law. We present a few of the observations of the CLR monitoring teams regarding such complaints among the residents:

- The Sace centre: „Several residents told us that one of the educators, D.L., beats them. Thus, he beat S.D. „and put him in the hospital”. They also indicated that the head of the centre also beats children. He invites them to his office where he gives them corporal punishments. Last summer, C.M., together with other residents (P.I., N and S.D.) ran away from the Centre. When they were found, on 04.08.2006, as punishment, the head of the Centre took them to his office and beat them. He struck C.M. in the testicles really badly. Although he didn't feel well, the head of the Centre didn't want to send him to the hospital, so he wouldn't get into any trouble when people there asked what had happened to the boy. For this reason, C.M. received medical care in the Centre’s infirmary for two weeks. Some of the residents stated the marks are still visible. The Centre’s driver also beats the residents, and according to them he uses an aluminum pipe or a stick to strike them on their backs. On 05.12.2005, while the educator that was supposed to take care of the residents left them unsupervised, a group of 12 children beat L.A., who’s only 12, very badly, and left him unconscious. He was taken to the hospital in Hateg in a state of emergency, and the statement there was that he had fallen on some stairs. Children also say that in case they run away from the Centre, they are punished when they are brought back, they are
forced to chop wood all night long, they are denied any sleep, and their food ration is reduced to a slice of bread and pate. Thus, we found that on 26.10.2006, P.I. and D.C. were forced to chop wood until 3 am as punishment for having run away. If the residents run away from the Centre, their allocations are withheld, and the justification is the gas costs for bringing them back to the Centre. The most recent case is that of M.B., where RON 75 was withheld in September 2006. It was the same with P.I., RON 21, and D.C., RON 42. S.E. told us that the director of the Centre confiscated his mobile phone without giving any reason, and he refuses to return it. At the end of May, one of the beneficiaries of the centre, 17 years old, ran away from the institution when she received the permission to go buy juice in the village. When she was found, the adolescent's punishment was to clean up the entire centre during the night. CLR was informed that the main reason the adolescent ran away from the centre was that she was being beaten frequently by one of the educators. The respective educator was also the one to apply the punishment when the girl returned to the centre. The information CLR received doesn't show that the girl was guided to analyse the problems together with a representative of the specialised staff (psychologist, social assistant) after running away from the institution."

- The centre for disabled children in Siria, Arad County: „We learnt during discussions with the residents that some of the supervisors beat them, Mrs. Z, Mrs. D, Mr. N.T. and Mrs. I.T. The residents told us they beat them very badly, often using various objects (stick, cable) or they pull their hair. One of the residents (R.) has marks on her back and the residents we talked to called her to our meeting to confirm it. During the discussions, we also learnt that such behaviour among the supervisors is frequent. Following the last monitoring visit where we signaled several cases of physical abuse on the residents, the head of the Centre notified the Department, which ordered an investigation, two of the staff members that the children had accused of being violent resigned in result – Mrs. I.T. and Mr. N.T. – and Mrs. D filed a request for retirement, and until that time she was transferred to a cleaning position, not having any relation with the residents. Both the small and older children said there are persons that sometimes strike them or use bad language, among them Mrs. A, Mrs. N, the latter a teacher in the special school. They told us that a week before, on Sunday, Mrs. A took F. by the neck and threw him on the bed. The older children told us that the week before, on Thursday or Friday, one of the school educators, A.P., beat one of the girls, R., in the classroom, with the other beneficiaries present. It happened because the resident told him he was late for the classes. Many of the girls also complained that when their period is late and they go to the medical office, one of the nurses, Mrs. M, accuses them of being pregnant, and the girls are disturbed and offended by this attitude.”

There also complaints regarding aggressive behavior among staff members at the Centre for the recovery and rehabilitation of disabled persons in Paclisa, the Psychiatric Hospital in Gadinti, the Reghin Centre etc.
CLR considers that aggressions among the residents are treated entirely superficially, while some of them have very serious consequences, especially sexual aggressions among residents. The members of the CLR monitoring teams have learnt about numerous grievances of this type among the residents, who also complained that the staff members in their institutions don’t take the necessary measures to avoid, discourage and sanction such cases (on the contrary, they sometimes encourage these acts). To give an example, we present the notes that the monitoring team took during a visit to the External Section in Boita of the „Gheorghe Preda” Psychiatric Hospital in Sibiu regarding a resident’s account (Mrs. T.) that the CLR considers extremely serious: „Two-three years ago, one of the patients, O.A., bit another patient by the nose, and the medical nurse, L.A., took her to the isolation room, three patients were already there, and she urged them to have sexual intercourse with her so she would be taught a lesson not to bite people’s noses anymore. Mrs. T was the one to call the police, but the investigation had no results. The patient also mentioned she hadn’t witnessed this event, another patient, C.I., saw what happened but the police didn’t interview him. According to Mrs. T, the medical nurse L.A. was sanctioned for negligence during service. Later on, at the director’s office, we received confirmation that, one year earlier, O.A. bit another patient by the nose and L.A., the medical nurse, is sometimes irritated by the patients and yells at them, but the incident Mrs. T described wasn’t refuted entirely. The head of the section and the medical nurse didn’t see the event the way Mrs. T described it. Neither the director nor the nurse believed what Mrs. T. told the monitoring team, and from their point of view the event wasn’t worth further investigation.”

Regarding the residents’ food and accommodation, the complaints are especially related to food quality, the fact that staff members sometimes steal part of the residents’ food, overcrowding in the accommodation areas, cold, deficient maintenance of the accommodation areas etc. Here are some of the observations during the visits to the institutions: „Regarding the endowment and conditions for the patients, we saw that there’s nothing but metal beds in most of the rooms. There are no curtains at the windows, no parquet, in some of the rooms there isn’t even linoleum on the flooring. One of the rooms didn’t have a light bulb, and the staff claimed it had blown that morning. The same room had a broken window. In one of the other rooms, a broken window had been replaced with plywood, so we conclude that this sort of problems is solved neither rapidly nor adequately. It is very cold in the rooms and a part of the windows (double glazing) were broken, they didn’t seem to close well, as they were old and the wood was rotten” (the Gura Vaiii psychiatric section); „The dormitories weren’t ventilated, fetid air persisted. We saw two rooms that had no windows, no lighting and no electricity” – the Medical-social centre in Ganesti. Overcrowding is also an issue in some institutions: for example, at the Gura Vaiii psychiatric section, 84 patients were accommodated while there were 75 beds; at the Gadinti psychiatric hospital, in most of the rooms for male patients two people shared a bed; the medical-social centre in Ganesti has a capacity of 121 beds and 145 patients, etc. Food complaints were registered in institutions such as the Centre for
disabled children in Siria ("Nearly all residents we talked to stated that the cooks steal food. They told us they saw the kitchen employees leave work with bags of food on several occasions."). CLR considers that one cause of the food problems is also the legal daily allocation, RON 7, which is insufficient. Besides food quality and quantity problems, many of the institutions have poor, unsanitary conditions for preparing and serving food (for example, at the Centre for reintegration in Dumbraveni: "The canteen has two large rooms: one of them is a club and the other is a dinning room. Upon entering this building (club and dinning room) there was a strong stench of faeces and urine, and the personnel’s explanation was that „the cesspit had just been cleaned” (in the courtyard, approximately 30 metres away from the canteen, one could still notice waste stains on the asphalt, near a sewer). F., a beneficiary, explained that „the sewerage leaks”. The stench was the same in the club, where approximately 20 beneficiaries stood by themselves, without any supervision or preoccupation; one of the beneficiaries walked barefoot on concrete. In the room where the dishes are washed, large recipients that had just been washed laid on the ground. In one of the other rooms, pudding lay on a shelf [...] Boxes full of cups that had been washed recently were on the upper shelf, above the uncovered food, and water dripped onto the pudding fresh out of the oven, and the bottom of the boxes was dirty.” "In the food block, there was a large recipient with sour cabbage in the first room, the recipient was stored on the ground, on tiles. In the second room of the food block, the food preparation room, there was a water flask near the sink, and we were told that was reserve water. Upon opening this flask, we noticed a few dozen cockroaches, then we saw more such roaches on the floor. We asked the head of the centre whether he was aware of this situation, and he replied: „What, don't you have cockroaches at home?” We tasted the food that was on the menu at the time of the visit; beans and pork, the food was tasteless, which confirmed (subjectively) the numerous complaints of the beneficiaries related to the bad food at the Centre. The kitchen staff couldn’t show us the day’s menu, they claim it is formed according to the daily caloric requirements. According to the head of the Centre, several kitchen employees were sanctioned in 2006, 10% salary cut, for trying to steal food” (the Centre for neuro-psychiatric recovery and rehabilitation in Babeni).

One cause of the deficiencies that were identified is that the staff of these institutions is definitely insufficiently aware of the rights residents have in this respect: „During the discussions with the medical and care personnel we concluded that they are not aware of the minimum standards regarding life conditions, the rights and obligations of the personnel and patients, and they are observed according to common sense. Thus, the answers to the questions were limited to „yes” and „no” (the Psychiatric Hospital in Vadu Lat, Giurgiu County).

There are also serious difficulties with the staff number in medical-social institutions. At the hospital in Gadinti, for example, the following situation was documented: "The medical norm related to the number of patients includes 9 doctors, 40 nurses (medium-level training) and 30 orderlies. Currently there are
only 2 psychiatry doctors, 11 nurses and 12 orderlies. Half of the nurses have a post-high school education. The orderlies are high school graduates. At the time of the visit, the manager of the institution was the only active medical doctor." At the Centre for integration through occupational therapy in Dumbraveni, the following situation was documented: „The staff is massively undersized and lacking skills to deliver recovery, rehabilitation and reintegration services. The severe staff undersizing (1 instructor for a minimum of 30 beneficiaries, 2 nurses for 376 beneficiaries at the time of the monitoring visit) and the complex of disabilities and pathologies (visual, motion, mental, combined etc.) determines a drastic decrease in the quality of services for the beneficiaries. The head of the centre stated: „What we offer in reality is care, feeding and partial occupation of time. We feed and wash them. That’s our capacity given the conditions and staff that we have.” The acute lack of psychiatry doctors causes some of the most serious problems in these institutions. A practically generalized problem is the lack of staff specialisation, one such example is that of the Medical-social centre in Nucet: „Most of the staff members aren’t qualified to work in a medical-social centre with a psychiatric character; they don’t have an adequate training to allow them to confront residents’ behaviour in a professional manner. Personnel training is currently attempted, 19 orderlies are taking a course organised by the Medical Board in Felix, and they are trained in matters of communication with the patients and means to protect themselves against their aggressiveness, means to solve incidents among residents without calling on humiliating treatment or physical abuse.”

The insufficient staff number and the precarious specialisation of the care and supervision personnel constitute one of the causes that affect the quality of medical care. CLR considers that significant improvements in the salary system are also required, first of all for the medical staff working in these institutions. At the same time, the personnel needs to ensure high quality standards in their work, much closer to the legal provisions (first of all regarding patients’ rights) and medical ethics. Greater attention needs to be given to knowing and observing the legal provisions regarding involuntary hospitalization (CLR will tackle this issue in a subsequent report). Although they understand very well the specifics around residents in the institutions that are the focus of this report, the CLR representatives and members of the monitoring teams have found time and again that the medical staff makes minimum efforts most of the times to inform patients regarding their diagnosis and treatment and obtain their consent and collaboration in the necessary proceedings. Thus, there were frequent cases (e.g. the Service complex for disabled children in Ramnicu Sarat) where the CLR monitoring teams found that: „Although the social assistant says that the youth/children are informed about their diagnosis and treatment, a part of the children claimed they didn’t know what their treatment was. Some of them knew that the medication they took was to prevent headaches.”

The social, rehabilitation and leisure activities are highly deficient, especially as their share in the daily programme in these institutions is practically
The situation at the Centre for neuro-psychiatric recovery and rehabilitation in Babeni, is somewhat characteristic for all institutions: “the residents are locked up most of the times in the two sections of the main building, especially during the cold season; the therapy team hasn’t elaborated individual therapy programmes according to the norms; most of the residents aren’t in any way involved in rehabilitation and socialization programmes, and they have little contact with the community.” The situation is similar at the Hospital for mental illnesses in Borsa: “The residents are rarely taken out of the institution, and then not all of them are, most of them spend almost the entire day in bed. Most of the residents aren’t involved in rehabilitation and socialization programmes, and they have little contact with the community.” In very few cases the residents receive newspapers. The number of television sets is very low, and they aren’t accessible to residents in some cases. The situation at the Psychiatric hospital in Gadinti is also representative to a large extent for the institutions in the system: „According to the statements of the psychiatry doctor we talked to, there aren’t any subscriptions for newspapers or magazines, as no budget has been allocated for that. As to reading, only 10 patients have this preoccupation, and they get books from their families. The club has a television set, a stereo and a video tape player, but the club is locked up, the patients don’t have access to it. At the time of the visit, we found that this room destined for leisure activities is kept locked and used as a storage room. None of the dormitories had any radio or television equipment.” A similar situation was met at the Medical-social centre in Nucet: „The centre doesn’t have subscriptions to newspapers or magazines. There are 10 television sets, some of which have been brought in by the

69 For example, the daily programme at the External Section in Boita of the “Gheorghe Preda” Psychiatric Hospital in Sibiu:
06:00-06:45 cleaning the treatment room, locker-room, observatory, club, halls, staircases.
06:45 –07:15 shift end/ take-over
07:15 –08:00 washing and dressing patients
08:00-0:30 breakfast, morning treatment, observation of the way patients eat and drink
08:30 –13:00 cleaning the rooms, patients supervision, various occupational activities
13:00-14:00 lunch, noon treatment
14:00 –18:00 various specific activities for each day of the week with the patients: shaving, bathing, clipping nails, cleaning the rooms, cleaning the dinning room, sleep for the patients that want it, leisure activities in the club, supervision of the patients
18:00– 18:30 serving dinner in the dining room or in bed, observation of the way patients eat and drink
18:30 – 18:45 recording the important events of the shift in the report
18:45 – 19:15 shift end/ take-over, inspection of the rooms, halls, toilets, clubs
19:15 – 20:00 various activities with the patients
20:00 – 20:30 evening treatment
20:30 – 21:30 various activities with the patients, watching TV
21:30 – 22:00 washing patients and preparing them for sleep
22:00-22:15 night treatment
22:15 –05:00 supervision of the patients over the night
residents. Most of the residents, especially in the main location, don’t have access to TV.” The lack of social and integration activities has severe consequences, the more so as only a relatively small number of residents are visited by their families and maintain relationships. At the Popesti centre, for example, less than 20% of the children receive family visits and less than 10% are taken by their families on vacation (a positive aspect is that the representatives of the centre facilitate children’s relationship with the community: „Regarding the relationship with friends, the community, discussions with the director, educators and residents have revealed that they have many friends in Popesti, they are encouraged to maintain relationships with the children in the community, they get permission to go to these families and even spend a few days there, during week-ends or holidays”). Although family connections are very weak, the cases are few when the institutions facilitate their improvement. At the Popesti centre, for example, there was a case of a child (G.S.A.) who „wrote his grandmother over a year ago and received no answer. „Perhaps she changed address or died, grandmother is old, I think she is 85”, G.S.A. said. He intends to send another letter, but the envelope is expensive and they don’t get envelopes from the Centre”. CLR considers it is absolutely unacceptable for residents in these institutions – depriving of liberty through their statute – not be supplied with envelopes for correspondence with their families and exertion of their right to petitions.
III.
Analysis of the monitoring and control mechanisms in the system of medical-social institutions for persons with mental disabilities in Romania

Modern management theoreticians constantly identify the control activity as one of the most important resources in institutional, organisational and administrative management. In the context of general good practice principles, the control activity is given a broader meaning, as it is regarded as part of the management process, alongside programming, organising, guidance and coordination. By means of monitoring and control, the management identifies the deviation of results from the objectives, analyses their causes and adopts the necessary corrective and prevention measures.

The importance of these principles is acknowledged at the level of the Romanian strategies on mental health, but there is progress to be made in the legislative field, as well as in organising and the institutional practice.

III. 1. Current legal provisions and institutional practices

1.1 At the level of the Ministry of Labour, Family and Equal Opportunities (MLFEO), two authorities have monitoring and control among their responsibilities:

a) The National Authority for Disabled Persons (NADP) operates according to the provisions of the Governmental Ordinance no. 14/2003 regarding the establishment, structure and operation of the NADP. Among the Authority’s main responsibilities (article 4) there are the following two: „x) conducts inspections of the services supplied to disabled persons within the special protection institutions for disabled persons; y) controls compliance with the legal provisions in force regarding the special protection of disabled persons.”

The authority has a maximum number of positions of 138 (excluding the president and vice-president), and its organisational structure includes a General Department for inspection and control. According to article 11 of the same act (as amended through Article I point 4 of the Governmental Ordinance no. 51/2005), in each county/sector of Bucharest „there is an inspector, a public officer, part of the General Department for inspection and control within the Authority”. In October 2005, a set of methodological regulations was adopted at the level of the NADP in order to organise and conduct control and inspection actions71 (we

70 Among others, Samuel C. Certo, Modern management, diversity, quality, ethics and the global environment, the „Teora” publishing house, 2004
71 Methodology for control, inspection and monitoring, applicable in the competence area of the National Authority for Disabled Persons, published in the Official Gazette, Part I no. 912 of 12/10/2005.
believe these regulations are pertinent and capable of establishing good practices in the field).

CLR’s monitoring the last few years has revealed that the Authority’s institutional resources were generally insufficient for the institution to be able to fulfill its obligations related to the inspection/ control of services and treatment that need to be secured for disabled adults. One of the problems was the Authority’s low level of independence in carrying on its monitoring and control/ inspection responsibilities. According to the provisions in force, the NADP is a „specialised body of the central public administration with legal personality” subordinated to the MLFEO. In its turn, the ministry has legal obligations – especially those related to the „social assistance and inclusion” – that constitute the object of NADP’s control/ inspections. Under these circumstances, the level of independence and impartiality of NADP’s inspectors in exerting their control responsibilities is obviously questionable.

b) The National Authority for the Protection of Child’s Rights (NAPCR) is structured and operates on the basis of the Governmental Decision no. 1432/ 2004. According to the act, there is a control body on a department level (it usually has 2 inspectors – Law no. 272/ 2004 regarding the protection and promotion of child’s rights (article 116) establishes that the NAPCR does periodic inspections of the services, including the residential services for disabled children, in order to establish compliance with the minimum mandatory standards. Article 100 of the same act also establishes that the NAPCR monitors how the rights established by the UN Convention on children’s rights (that Romania ratified through Law no. 18/ 1990) are observed. The Governmental Decision no. 1432/ 2004 (article 3, letter a, paragraph 11) also establishes that while exerting its functions regarding the protection and promotion of child’s rights, the Authority „ensures control regarding the application of legislation in its field and the way public institutions and the other legal and natural persons observe child’s rights, in compliance with the legislation in force; it proposes to the competent institutions the establishment of the disciplinary, material, infringement or criminal accountability, according to case, of responsible persons”.

In its monitoring experience the last few years, CLR found that NAPCR’s resources, especially its human resources, have also been insufficient for the Authority to fulfill its obligations regarding the monitoring/ control of the services and treatment of mentally disabled children in a satisfactory manner. Similarly,

72 Governmental Ordinance no. 14/2003 regarding the establishment, structure and operation of the NADP, corroborated with the Emergency Governmental Ordinance no. 64/ 2003 setting measures regarding the establishment, structure, restructuring or operation of structures in the Government’s operation body, ministries, other specialised bodies of the central public administration and public institutions.
the NAPCR’ level of independence in exerting its monitoring and control/inspection attributions has also been a problem – mainly because the Authority is subordinated to the MLFEO on the one hand, and the Ministry has legal obligations that constitute the object of NAPCR’s monitoring and control/inspections; according to the legal provisions in force\(^3\), the NAPCR is a specialised body of the central public administration with legal personality, subordinated to the MLFEO.

1.2 **At the level of the Ministry of Public Health (MPH)**. Law no. 95/2006 regarding the reform in the health sector stipulates that the MPH ensures, on the one hand, control over the quality of medical services through the local public health authorities (article 16, letter j), and it organises and coordinates the state sanitary inspection activity (article 16, letter u), on the other hand. The Governmental Decision no. 862/2006 regarding the MPG’s structure and operation establishes that the State Sanitary Inspection is organised and operates on a department level within this authority. An analysis of the two acts brings out the fact that the MPH’s monitoring, inspection and control functions target the system of persons with mental disabilities to an irrelevant extent. In this respect, Law no. 95, article 25, paragraph 2, establishes that the state sanitary inspection activity consists mainly of: „a) verifying compliance of the locations, activities, processes, services, products, environmental factors; b) verifying compliance with the regulations regarding the staff’s health, knowledge, attitudes and practice in relation with the hygiene-sanitary norms; c) the identification and evaluation of health risks and enforcing elimination or mitigation measures, according to the case; d) communicating data on the existence and mitigation of identified risks to the persons that are responsible for risk management, to consumers and other potentially interested factors”.

**III. 2. Future legal provisions and institutional practices**

Considering the future of monitoring and control mechanisms in the system for mentally disabled persons, the following regulations are relevant in particular:

2.1 **Law no. 47/2006 regarding the national social assistance system and the Emergency Governmental Ordinance no. 130/2006 regarding the Social Inspection**

Law no. 47 stipulated the establishment of a new authority that would also monitor and control the system of mentally disabled persons, the Social Inspection (SI). The new authority, „a specialised body of the central public administration with legal personality, subordinated to the MLFEO” is set to „control the implementation of the legislation in the field, as well as to inspect the

\(^3\) Emergency Governmental Ordinance no. 64/203 setting measures regarding the establishment, structure, restructuring or operation of structures in the Government’s operation body, ministries, other specialised bodies of the central public administration and public institutions.
activity of public and private institutions that are responsible for providing social services” (article 29, paragraph 2 of the law). The SI’s structure and operation, as well as its main responsibilities were established through the Emergency Governmental Ordinance no. 130/ 2006 (among other responsibilities: inspection of the way the legal provisions regarding the establishment, award and promotion of citizens’ social rights are observed by the central and local administration, as well as other legal or natural persons, public or private, as suppliers of social services; theme inspections for specific evaluations of some aspects of the social policies, of the measures included in the national strategies regarding social assistance and inclusion; unannounced inspections to prevent, unveil and combat any acts and deeds in the field of social assistance and inclusion that have led to violations of citizens’ social rights etc. – article 6 of the Emergency Governmental Ordinance no. 130). It was established that the SI is headed by a state general inspector (high public official) and that „regional inspectorates” are organised within the SI. The institution’s organisational chart is established through its organising and operation regulations (article 21) and „in 90 days from the moment the present emergency ordinance comes into force, the MLFEO will elaborate, upon SI’s proposal, its organising and operation regulations, which are approved through a governmental ordinance” (article 28).

Law no. 47/ 2006 (article 50) stipulates that, starting January 1st 2007, the SI takes over the inspection attributions and responsibilities, as well as the associated staff, from the NAPC and the NAPCR – i.e. the General Control and Inspection Department within the NAPC and the Control Body of the NAPCR. On the other hand, the Emergency Governmental Ordinance no. 130 (article 22, paragraph 1) established that the SI „will start operating with the attributions established by the present ordinance 6 months after the present emergency ordinance enters into force” (i.e. starting July 3rd 2007); the literal corroborated interpretation of the two acts reveals that, between January 1st 2007 and July 3rd 2007, the control bodies within the NAPC and NAPCR were taken over by the SI, but neither the SI nor the two control structures functioned for half a year, which is obviously a regulatory deficiency.

A few considerations on SI’s opportunity and utility will be presented in the section containing conclusions and proposals regarding the monitoring and control mechanisms in the system for mentally disabled persons.

2.2 Optional Protocol to the Convention against torture and other cruel, inhuman or degrading treatment

The Protocol was adopted on December 18th 2002 in the 57th session of the United Nations General Assembly, it entered into force on June 22nd 2006, and Romania signed it on September 24th 2003. The Protocol established a Subcommittee on the Prevention of Torture and Inhuman or Degrading Punishment or Treatment („Prevention Subcommittee”) within the Committee for the Prevention of Torture. It was also decided that each State-Party to the
Protocol establishes, designates or maintains one or more bodies for the prevention of torture, inhuman or degrading punishment or treatment on a national level („national prevention mechanisms”); this obligation was established for each State-Party to the Protocol „the latest one year after the present Protocol enters into force or from the ratification or adhesion”.

Article 19 of the Protocol establishes that the main attributions of the national prevention mechanisms will be: „the regular examination of the way persons deprived of liberty are treated; the formulation of recommendations to the competent authorities in order to improve treatment and conditions for persons deprived of liberty and prevent torture and inhuman or degrading punishment or treatment; the formulation of proposals and observations regarding the existing legislation or legislative projects.” Article 4, paragraph 2 of the Protocol establishes that „depriving of liberty means any form of detention or imprisonment, or placing a person in a public or private restraint environment that he isn’t allowed to leave according to his will, by order of any judicial, administrative or any other kind of authority”, a fact that makes the Protocol’s provisions applicable to the system of mentally disabled persons, the object of the present report.

The Protocol contains standards that the States-Parties to the Protocol must ensure for institutional independence and the adequate organising and operation of the national prevention mechanisms. Thus, article 20 establishes that, in order to allow the national prevention mechanisms to fulfill their attributions, the Parties need to grant them, among other: access to information regarding the way „persons deprived of liberty” are treated, the possibility to interview these persons, the right to maintain contact with the Prevention Subcommittee, to transmit information to it and meet with it etc. The minimum independence standards that the Parties need to ensure for the national prevention mechanisms are established in article 18 of the Protocol.
IV. Conclusions and proposals regarding the monitoring and control mechanisms in the system for persons with mental disabilities in Romania

In terms of legislation and institutional structure and practice, we consider that the monitoring and control system for the treatment and rights of persons with mental disabilities has been largely deficient until the decision was taken to establish the Social Inspection.

SI’s establishment constitutes a step forward, but that is not sufficient for a satisfactory improvement of the situation in this field. For example, this authority’s level of institutional independence and impartiality is questionable, to say the least, from several perspectives. On the one hand, this authority’s subordination to a ministry (MLFEO) that has legal obligations in a field that the authority monitors and controls cannot ensure a satisfactory level of independence for a body with such responsibilities. The Emergency Governmental Ordinance no. 130/2006 (article 1, paragraph 2) stipulates that the SI’s subordination to the MLFEO includes „The SI’s organising and operation expenditures, both on a central level and for the regional inspection offices, are ensured by funds allocated from the state budget, through the budget of the MLFEO”. It is also problematic that the MLFEO is the authority that elaborates the organising and operation regulations of the Social Inspection.

As to the SI management and number of staff, the fact that these persons have the statute of public officials can constitute, in principle, a starting point for their independence and objectivity in exerting control. On the other hand, the fact that this staff is subordinated to a ministry (and one that has legal obligations subjected to the SI control) can render this starting point vulnerable. Certain imprecise formulations, improper even, can add to this issue, by relating to the legislative technicalities – which the text of the Emergency Governmental Ordinance no. 130/2006 uses to regulate the statute of management positions within the SI (for example, article 8, paragraph 5, which stipulates that „The position of state general inspector isn’t subjected to political influence”, without defining what the „political influence” interdiction on the SI manager position actually consists of). It was decided through the Emergency Governmental Ordinance no. 130/2006 that the SI, on its first year, operates with a total of 350 positions. Until proven otherwise, the regulation may prove adequate for the substantial work volume that the monitoring and control of such an institutional system involves.

CLR considers that the issue of SI’s institutional independence has several solutions. One of the options is to organise this institution as an „autonomous administrative authority”, as defined by article 117, paragraph 3 of the Romanian Constitution. An institutional model, mainly in terms of control over their organising and operation, could be that of the authorities and institutions under
parliamentary control – e.g. the National Council for Combating Discrimination (the NCCD was established as a „specialised body of the central public administration, subordinated to the Government”, through the Governmental Ordinance no. 137/2000 regarding the prevention and sanction of all of forms of discrimination, and according to Law no. 324/2006 that amends and supplements the Governmental Ordinance no. 137/2000, it currently has the statute of „state authority in the field of discrimination, autonomous, with legal personality, under parliamentary control, and guarantor of observing and the application of the non-discrimination principle, in compliance with the domestic legislation in force and the international documents Romania is a party to”). As an alternative to this solution, maintaining the current status of the SI can be considered („a specialised body of the central public administration, with legal personality”), but it should be subordinated to the Government, not to the MLFEO (we consider such a solution would solve the authority’s independence problem only to a small extent though).

We need to mention that there are already some delays in the legislative schedule regarding the establishment of the SI, as of the date of this report. Thus, although article 27 of the Emergency Governmental Ordinance no. 130/2006 established that, 120 days from the date the Ordinance enters into force (i.e. May 5th 2007), the MLFEO will elaborate the draft law regarding the social inspector statute, „according to MLFEO’s legislative programme for 2007, the date of completion for the draft law regarding the social inspector’s statute was postponed to July 2007”\(^{74}\).

The delay in SI’s operation according to the provisions of the Emergency Governmental Ordinance no. 130/2006 is also caused by the fact that the draft Governmental Decision regarding the structure and operation regulations of the Social Inspection (stipulated in article 28 of the emergency ordinance) wasn’t approved by the Ministry of Public Finance „considering the existing inconsistency in the above-mentioned Governmental decision with the necessary financing possibilities for the Social Inspection to be organised and operate starting June 30\(^{th}\) 2007”\(^{75}\).

Regarding the requirement in the optional Protocol to establish „national prevention mechanisms” that Romania will have to fulfill in the coming period, a series of legislative and institutional measures are also needed. According to article 17 of the Protocol, each Party has to establish „one or more national prevention mechanisms” for torture and other inhuman or degrading treatment. For reasons already mentioned, we consider that Social Inspection currently does not correspond to a sufficient extent to the standards the optional Protocol introduces, especially those regarding the institutional independence, for

\(^{74}\) Information extracted from MLFEO’s letter no. 3056 of May 21st 2007, transmitted in response to the request for access to public information that was sent to the MLFEO on May 8th 2007 as part of the research process for the present report.

\(^{75}\) See footnote 5.
institutions/mechanisms of this type. Assuming that all corrective measures were taken, we consider that the SI could constitute one of the mechanisms stipulated in the optional Protocol. Given the concrete case of Romania, over 20,000 persons with mental disabilities in medical-social institutions, most of them in rural areas, we consider that the SI should/could constitute, among other, one of the national-level mechanisms stipulated in the optional Protocol.

CLR believes that in order to cover the entire system of persons with mental disabilities (monitoring, control and inspection) in a satisfactory manner – by themes and by region – it is necessary to establish regional authorities to monitor the system. As it would be excessive to establish such an authority in each county, they could be organised on a regional level, for example alongside each Court of Appeal (there are 15 such courts in Romania). Organising the regional authorities alongside the Courts of Appeal is justified by the assumption that – as one of the examples – these authorities are given legal competence (which we consider highly necessary) to take to court the measure of „involuntary hospitalization of persons with mental disorders”.

These authorities need to be established by law, and their structure needs to ensure, on the one hand, the necessary professional skills and knowledge, and on the other hand guarantee the institutional independence and the objectivity of the monitoring and control activities. The real independence of these structures, and their effectiveness after all, cannot be achieved without securing the independence of their staff as well as the necessary resources for their operation (part of these standards are explicit in the optional Protocol regarding the establishment and operation of the national prevention mechanisms).

CLR also underlines that according to article 17 of the optional Protocol, „the national, independent prevention mechanism(s) to prevent torture on a national level" can only be institutions/authorities with permanent activity destined exclusively to „preventing torture on a national level". According to article 18, paragraph 2 of the Protocol, these bodies also need to meet a series of requirements regarding the adequate professional training, as well as gender balance and the representation of ethnic groups and minorities („The Parties take the necessary measures to ensure that the experts in the national prevention mechanism have the necessary professional skills and knowledge. They will endeavor to ensure gender balance and the adequate representation of the country’s ethnic groups and minorities"). Consequently, in order to meet the requirements of the optional Protocol, such specialised mechanisms cannot be one with the Ombudsman institution or one of the permanent commissions in the Chamber of Representatives or the Senate – the Commission for human rights, religions and national minorities in the Chamber of Representatives, for example. In the first case, the Ombudsman institution would prove inadequate for such a mission through the specific character of its statute, as defined by the Romanian

76 See articles 44-59 of Law no. 487/2002, the law on mental health and the protection of persons with mental disorders, as well as the comments in the section on involuntary hospitalization in this report.
Constitution and Law no. 35/1997 regarding the structure and operation of the Ombudsman institution. This institution has a general mission regarding the protection of all rights and liberties of individuals, not a particular, more specialised mission, as defined by the optional Protocol regarding the rights and liberties of residents in medical-social institutions for persons with mental disabilities, persons considered as deprived of liberty. The Ombudsman would also be inadequate for the goal established by the optional Protocol for the „national, independent prevention mechanism/mechanisms to prevent torture on a national level” through its institutional structure and operation – it obviously has insufficient, non-specialised staff, the institution practically runs exclusively on receiving „requests from individuals whose citizens' rights and liberties have been violated by public administration authorities”, i.e. „follow the legal resolution of the requests it receives” etc. The optional Protocol, on the other hand, has specific requirements that largely differ, including the procedures to „regularly examine the way persons deprived of liberty are treated in the detention locations in the sense of article 4, in order to strengthen, if necessary, their protection against torture and inhuman or degrading punishments or treatment”. Regarding the permanent parliamentary commissions, we consider they can meet the requirements of the optional Protocol to an even smaller extent. In this sense we consider it is sufficient to compare those requirements with the legal attributions of these bodies: „The permanent commissions of the Chamber of Representatives examine draft laws, legislative proposals, in order to elaborate reports and approvals, according to the case; they debate and decide on other issues that are sent to the Permanent Office of the Chamber of Representatives; they can conduct parliamentary investigations, as well as other activities, in compliance with the provisions of the present regulation and the Regulation of the common sessions of the Chamber of Representatives and Senate” (article 61 of the Chamber of Representatives Regulation).

The Romanian Ministry of Health’s strategy in the field of mental health grants special attention to „developing partnerships with the civil society to promote mental health”. This principle is also found in the legal provisions in this field (e.g. Law no. 487/2002, the law on mental health and the protection of persons with mental disorders, stipulates – article 7 – that in order to enforce the measure adopted to protect mental health, „the Ministry of Public Health will collaborate with non-governmental organisations, professional associations and other interested bodies”). Taking these principles into account, which can ensure the independence of these mechanisms, we consider that non-governmental organisations working on the protection of the rights of disabled persons need to be able, by law, to designate a number of representatives that would guarantee the local authorities function properly and the impartial exertion of the control and monitoring activities. It is also necessary to avoid having representatives of the authorities/institutions that are being monitored within the regional authorities. In the future structure and operation of such bodies, it is necessary to avoid, both
on a legislative level and in institutional practice, the counter-productive experience that was registered in similar cases.\textsuperscript{77}

In order to expect these bodies to prove really efficient, their reports and decisions must be mandatory, not optional. To allow them to fulfill their tasks, it is also necessary to provide them with unrestrained access to all the necessary information and the locations they want to visit, as well as all the other rights stipulated in article 20 of the optional Protocol.

At the same time, CLR considers that if the regional monitoring authorities are constituted on the basis of criteria and principles (including those defined by the optional Protocol) really ensuring independence and effectiveness, the dissolution of the Social Inspection can be taken into account. In case it is opted to maintain the SI, the future legal provisions need to be unequivocal, avoid overlapping of competence as well as interferences that would affect the consolidation of the role, independence and authority of the regional bodies.

\textsuperscript{77} For example, Law no. 218/ 2002 regarding the structure and operation of the Romanian Police and the Governmental Decision no. 787/ 2002 established the Regional Authority for Public Order (RAPO, a body that was meant to function at county level, with a consultative role, aiming to „monitor the police activity”). Serious legislative and practical problems have turned RAPOs into formal, inefficient bodies, which can undermine the idea of independent mechanisms to monitor, control and prevent deficiencies in systems that are related to the fundamental rights and liberties. For relevant criticism on this issue, which can also be useful in designing the regional monitoring authorities for persons with mental disabilities, see the analysis \textit{The Regional Authority for Public Order in Romania – why and how?}, the Association for the Defense of Human Rights in Romania-the Helsinki Committee, 2007.