

Monitoring the rights of mentally disabled children and young people in public institutions

Report of Monitoring Project 2005-2006

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1 INTRODUCTION

1.1. *Background and report drafting methodology*¹

Constant monitoring of the respect of fundamental human rights is generally acknowledged as one of the main abuse prevention and investigation tools, especially in the case of persons with disabilities, who are much more vulnerable and cannot make a complaint.

For example, the *Guidelines for Drafting Periodic Reports*² on the implementation of the UN Convention on the Rights of the Child require information about “measures taken to guarantee efficient assessment of disabled children’s situation, including development of a disabled child identification and follow-up system and **creation of an adequate monitoring system...**”³ The Standard Rules on the Equalization of Opportunities for Persons with Disabilities⁴ stress the need of more detailed, correlated and shared information regarding people with disabilities, as well as the need of studying “all issues, including obstacles that people with disabilities have to deal with” (Rule 13).

Since 2003, the Centre for Legal Resources (CLR) has been running ad-hoc (on-the-spot, unannounced) visits to monitor the respect of the rights of the people suffering from mental health disorders or intellectual disabilities and who are institutionalised in psychiatric hospitals or in rehabilitation centres for disabled people. The monitoring visits helped identify a large number of people with mental disabilities who, one way or another, came from child care institutions: either they had been transferred there from such an institution or their former “hospital-home” had become an institution for adults with disabilities. It was easy to see that these young people, unlike the other beneficiaries coming from a regular family environment, were bearing the negative effects of long-term institutionalisation (for example, significant physical and mental underdevelopment). Besides these young people, in some adult care institutions (psychiatric hospitals or centres for rehabilitation and recovery of people with disabilities) there were children as well, some with mental disabilities,

¹ This paper is not a sociological research report, but a report monitoring the respect of the human rights and, consequently, it is based on different drafting principles and it is quality-oriented;

² ‘Implementation Manual of the Convention on the Rights of the Child’, UNICEF 2004, page 398;

³ Paragraph 92;

⁴ Annex to Resolution A/RES/48/96, adopted by the UN at the 85th plenary session on the 20th of December 1993;

others undiagnosed in that respect. Several of these children were residing there illegally and were not registered with child protection authorities.

The Amnesty International Memorandum from 2003 described the conditions of a number of children encountered during a monitoring visit paid at a psychiatric hospital from Mocrea, the County of Arad:

“A.C., 17 years old, was brought to hospital by the police when she was 13 years old. She was diagnosed with 2nd level oligophrenia.”⁵

In the very same document, the researcher talks about another young girl, age 24, who was admitted to the hospital from Poroschia when she was 18 years old. According to the researcher, the young girl was raised in a child care institution for mentally disabled children.

In July 2006, an answer that the representatives of NACRP and NAPH forwarded to the Human Rights Commission of the Romanian Parliament quoted the NAPH web page where there was information about over 140 disabled children who were in residential centres for handicapped adults at that time.

On the basis of Law No 544/2001 on free access to public interest information, the Centre for Legal Resources forwarded to the county child protection departments a series of questions regarding the number of children with mental disabilities living in placement centres who were to turn 18 years old in 2004-2005, where they were to be transferred, the number of HIV/AIDS-infected mentally disabled children and the institutions where they would be transferred at the age of 18. The data collected⁶ revealed that around **2,267** children with mental disabilities from placement centres were to be transferred in another residential care institution in 2005-2006, due to age limit. The type of care to be provided to **155** children with mental disabilities and HIV/AIDS could not be indicated due to lack of specialised care centres at that moment⁷.

⁵ See The 2003 Amnesty International Memorandum, page 8;

⁶ According to the answers received by the Centre for Legal Resources to its forwarded requests, between 2004-2005.

⁷ A series of documents received from a number of general departments for social care and child protection prove that it is inappropriate to send these young adults to care centres for people with handicap, as these institutions do not suit this particular group of beneficiaries;

In the light of the findings of previous institutional visits, these data made our organisation get interested in studying the transition procedure from the mentally disabled child care system to the mentally disabled adult care system and the issues regarding the respect and promotion of child rights within this transition process, which are crucial for integrating and rehabilitating such a beneficiary. As the project went on, the monitoring visits brought up data on other issues related to the children in the monitored institutions. Therefore, this report refers also to living conditions, treatment, care and protection from abuse provided to children with mental disabilities.

The Romanian Constitution guarantees special care to persons with disabilities, and the government has committed to promote a policy of equal opportunities allowing people with disabilities to fulfil their fundamental rights. The current child care legislation protects children with disabilities. When the monitoring was carried out, according to the statistics of the National Authority for Children's Rights Protection (NACRP), in Romania officially there were 73,983 children with a certificate establishing their (both physical and mental) handicap level, out of whom, 6,342 were living in placement centres and 6,694 were in other conditions⁸. The statistics of the National Authority for Persons with Handicap (NAPH) recorded a number of 14,700 children with mental disabilities and 10,257 with neuropsychiatric disorders, out of whom 175 were in NAPH-run institutions⁹. The exact number of children with mental disabilities, as well as the type of care or number of institutions accommodating them are hard to establish¹⁰ and these figures are not clearly reflected in official statistics¹¹. The child care reform started in 1997 did not initially cover the issue of children with disabilities.

The omission was due to the fact that at that moment the latter were the responsibility of the Secretary of State for the Handicapped, as the predecessor of NAPH was called, and not the

⁸ According to the NACRP statistics for June 2005 - June 2006, www.copii.ro;

⁹ Statistics Newsletter of NAPH – June 2006

<http://www.anph.ro/Statistici/august2006/BULETIN%20STATISTIC%20ANPH%20II%202006.doc>. It is unclear what 'other conditions' means;

¹⁰ A child is recorded as disabled and receives specialised care rights only if the County Commission for Child Protection issues a *certificate establishing the handicap category*. This certificate is to be renewed, but many children don't get certificate renewal help. This may partially explain why the number of children with disabilities can only be estimated. On the other hand, most of the children come to the Commission only when they reach school age to be guided to special schools. A child with disabilities under 7 years old rarely goes to the Commission, which means that they are often left out of official statistics. The Commission for Child Protection does not even issue this type of certificate for the majority of children with mild disabilities, which makes data collection even harder. In some counties, children with mild disabilities are included in the reporting system, while in others they are not recorded at all.¹⁰ Finally, an unknown number of children don't even have birth certificates and cannot meet the standards of receiving a certificate establishing the handicap category because they officially do not exist;

¹¹ For example, a part of the data received can be confusing. Some counties consider children attending special boarding schools as institutionalised children, even if they live there only because their school is far from their home and not because their family has abandoned them. Moreover, in some institutions, children with disabilities live together with healthy children. In several counties, the homes for children with disabilities are now in the charge of the Child Protection Departments (CPDs), while in others they are still run by the National Authority for Persons with Handicap (NAPH), which further complicates their overall coordination;

responsibility of the Department for Child Protection, the predecessor of NACRP. Thus, the disabled children issue was reform-included only after the year 2000, when these children and the related care institutions were transferred under the care of the county child protection departments (CPDs)¹². Minimum compulsory standards for residential child care targeting children with disabilities were adopted in 2004.

This report is based on a project that included a series of visits, run between September 2005 - July 2006, in 64 state-run residential centres providing care and treatment to persons with disabilities, both underage and grown-ups, located in 35 counties. The institutions selected had to have both teenagers and young people among beneficiaries and be located preferably in rural areas. At least one institution was selected from each county. Sometimes, it was quite hard to physically find the residential institutions selected because the public interest data provided by the central and local authorities of social care and children's rights protection were out of date¹⁴.

The five monitoring teams were made up of two members (usually a psychologist or a social worker and a lawyer or a legal adviser) with background in the area of protection of mentally disabled persons. They attended two specific training sessions on "How to Monitor the Respect of the Rights of the People with Mental Disabilities within Residential Care Institutions". Each training session included a component on the main legal provisions regulating the protection of the rights of children and young people with mental disabilities, as well as the standards applying to care and treatment of this group of beneficiaries.

During each institutional visit, the team talked to the staff and to the beneficiaries and asked for permission to look over some files or check the records of the institution.

Although the general departments of social care and child protection had received a notification from the secretary of state of the National Authority for Children's Rights Protection informing

¹² Based on Government Emergency Ordinance No 192/1999 establishing the National Authority for Children's Rights Protection and reorganising child care, and Government Decision No 261/2000 reorganising institutions, hospital units and other special child care units within specialised public services in the charge of county councils or local councils in the case of Bucharest districts (OJ 171 of 21 April 2000);

¹⁴ There were, for example, cases when the monitoring team found an adult care centre where according to NACRP data there should have been a centre for children with mental disabilities. Actually, many of these centres accommodated young people, former underage beneficiaries of child care services that had to stay in the same residential centres due to lack of community services meant to integrate and rehabilitate young people with mental disabilities;

them about the implementation of this project, the representatives of the Centre for Legal Resources faced different barriers when they asked for access to residential institutions accommodating children with mental disabilities: requirement of additional approvals from local authorities, (arbitrary) prohibition of access or refusal to visit the entire institution or to have a look at the beneficiaries' files. Due to the ignorance about children's rights protection of the personnel encountered during monitoring visits, often the data provided were insufficient for getting the big picture on the respect of the rights of the children with mental disabilities within residential care institutions¹⁵. In at least ten cases, the staff said they were afraid of losing their job if they talked about the real problems they were dealing with or the barriers that could lead to abuses of institutionalised mentally disabled children. It was difficult to get any information mainly in the placement centres where there were children with severe mental disabilities who could not communicate directly with the representatives of the Centre for Legal Resources. Additional information about a number of beneficiaries from the visited institutions or some problem-raising issues identified during the visits were also received prior to requests sent to competent authorities based on Law 544/2001 regarding public interest information.

Each monitoring visit was described in a report drafted shortly after the visit and sent to relevant central and local authorities (NACRP, NAPH, GDSCCP). In more than half of the cases, both local departments and central authorities drew up memos expressing their view on the reports. In 2006, four regional meetings were held with representatives of public institutions and authorities competent in the field of child protection and young people with mental disabilities. During these meetings, the conclusions of the monitoring reports were talked through at regional level, possible solutions were identified and recommendations were made to improve the conditions of the beneficiaries¹⁶.

The purpose of this report is to synthesize the findings of monitoring visits and raise the alarm about violation of the rights of institutionalised children and young people with mental disabilities. Moreover, the report brings together and includes recommendations to improve these situations and to prevent failure of the child care system to provide real protection and reintegrate the child with mental disabilities into the society of which he/she should become a full member. The cases presented are used as examples.

¹⁵ For example, in over 50% of the institutions visited, the staff didn't know what to answer to the questions "*how are the notifications or complaints of children with mental disabilities dealt with?*", "*who helps them write the notifications?*", "*who is responsible for collecting, sending information and investigating the reported incidents?*". We couldn't get an answer either to the questions regarding admission of children with mental disabilities to psychiatric hospitals, treatment change and application of movement restriction measures (*immobilization of children, by tying up their arms and legs and seclusion*);

¹⁶ See the "Recommendations" Chapter .

The project, as a whole, aimed at identifying real solutions so that young people and children with mental disabilities may benefit from the best of care and living standards. It is hoped that the recommendations and conclusions of this report will contribute to the achievement of this objective.

UNICEF Romania granted technical and financial support for project implementation and facilitated the dialogue with the National Authority of Children's Rights Protection and local authorities.

Note: This report constantly uses the term "child or young person with mental disabilities", although the Romanian legislation does not define the term "mental disabilities". Most of the times, the terms "mental handicap" and "mental deficiency" are used. We used mental disability to generically define the mental health disorder and intellectual deficiency¹⁷.

1.2. *National and international legal framework regarding mentally disabled children and young people*

The legal framework on which the project principles, the monitoring visits and data collection, on one hand, and report drafting, on the other, were based is described in the following pages.

1. The *International document* focusing exclusively on the protection and promotion of the rights of the child is the UN Convention on the Rights of the Child, adopted by the UN General Assembly in 1989 and ratified by Romania in 1990 by Law 18/1990. The rights stipulated in this international treaty (the most ratified of all treaties) concern all children, including disabled children. Some stipulations target mainly children with disabilities (articles 23, 24 and 25) and refer to needs-adapted special care, regular review of medical care and of institutional or family placement.

In 1990, Romania ratified the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The UN General Assembly adopted on December 2002 the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment that Romania signed as well. In 1994, Romania also ratified the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.

¹⁷ Classified by Order 725/01.10.2002 on criteria used to establish the handicap level of children and to apply special protection measures for them as 'mild intellectual disability, non-associated intellectual disability, moderate, deep and severe disability';

A regional document comprising regulations which are also relevant to the protection of children's rights, including the rights of the child with disability, is the revised European Social Charter that Romania ratified in 1999 (Part I point 15, Part II, article 15).

The above-mentioned international normative documents are complemented with other policy and technical documents that, valorising innovative experiences, offer guidance to public policies and practices in the field.

Such documents adopted by the UN, focused exclusively on the protection of the persons with disabilities/handicap and mental illness are:

- The UN Principles for the protection of persons with mental illness and the improvement of mental health care (MI Principles, 1991)
- Standard Rules on Equal Opportunities for Persons with Disabilities (Standard Rules, 1993) supporting the idea to provide needed assistance to handicapped persons within set structures of education, health care, employment and social care in order to prevent their isolation and discrimination.

The Universal Declaration of the Rights of the Child adopted by the UN General Assembly in 1959 also makes special references to the child with handicap (article 5).

A great number of technical documents are drafted based on a topic, and the protection and monitoring of the institutionalised child's rights, including those of the child with disabilities, is often discussed at the Council of Europe. Some of the recently adopted documents that exclusively address the rights of the child are:

- Rec. 1601(2003) on improving the lot of abandoned children in institutions
- Rec. (2005)5 on the institutionalised children's rights

These documents concern as well the rights of the children with disabilities from placement centres. They stress the need to complement the child's handicap diagnosis and institutional placement decision with safeguards indispensable for the respect of the children's rights, ensuring regular placement re-evaluation and setting up procedures for appeal.

To protect the rights of the children abandoned in institutions, it is recommended to get a capable ombudsman for the rights of the child, independent of the executive power. The ombudsman could be a mediator, a specialised lawyer or a NGO (Rec. 1601 (2003)).

The Council of Europe Action Plan underlines the fact that in order to promote the rights and participation of persons with handicap in social life and to improve the quality of life of people with handicap the medical point of view according to which the person with handicap is just a patient that takes without giving anything back to the society needs to be replaced with a human rights-based social approach of the person with handicap.

2. At national level, the normative documents on the protection, promotion and monitoring of the children's rights in general and of the children with disabilities in particular are the following:

- Framework Law 272/2004 on the protection and promotion of the rights of the child, stipulating, among others, that the child's best interest shall prevail in all child-related decisions and approaches;
- Government decisions issued to implement Law 272/2004, especially Government Decision 1437/2004 on organisation and operation of the child protection commission;
- NACPA Order No 12709/2002 on the criteria used to establish handicap level for children and to apply specialised care measures for them;
- NACPA Order No 18/2003 approving the Methodological Guidelines for Assessment of the Child with Disabilities and Establishing the Level of Handicap;
- Orders of the NACRP Secretary of State issued to implement Law 272/2004 on approval of minimum quality standards and working methodologies, in particular Order No 27/2004 of NACPA approving minimum compulsory standards for residential care services addressing children with disabilities.

They are supplemented with legal documents regarding mental health and protection of the persons with disabilities. Some of the most significant ones are:

- Law No 487/2002 on mental health and protection of people with mental disorders;
- Law No 95/2006 on health care reform;
- Government Emergency Ordinance 102/1999 on specialised care and employment of persons with disabilities;
- Government Decision 862/2006 on organisation and operation of the Ministry of Public Health;
- Public Health Ministerial Order No 372/2006 on implementation standards of Law No 487/2002 on mental health and protection of people with mental disorders, with later amendments.

- Public Health Ministerial Order No 373/2005 on establishment and functioning of the National Centre for Mental Health within the National Institute for Health Research-Development from Bucharest.
- Public Health Ministerial Order on raising efficiency of social care and on the respect of human rights in psychiatric health care units.

1.3. Institutional framework regarding care of mentally disabled children and young people

1.3.1 At central level

The National Authority for Children's Rights Protection (NACRP) has the overall jurisdiction to monitor the respect of the principles and rights stipulated in the UN Convention on the Rights of the Child and Law No 272/2004 (article 100). The monitoring process is centred mostly on activities, programmes, projects, strategies, measures, policies of public authorities and licensed private organisations which implement children's rights. NACRP runs regular evaluations of the services, including of residential services addressed to children with disabilities¹⁸, in order to make sure they meet minimum compulsory standards. Any public or private organisation providing services to children must be licensed as according to the law¹⁹. At the same time, NACRP finances/co-finances services/institutions working for children with handicap and sets up standards, strategies and working methodologies in this area.

The National Authority for Persons with Handicap (NAPH) is the specialised body of the central public administration, with own legal personality, reporting directly to the Ministry of Labour, Social Solidarity and Family, which manages at central level the protection and promotion of the rights of the persons with handicap and oversees specialised care delivered to persons with handicap.

The Ministry of Public Health, as central public health care authority, *drafts organisation and operating standards for public health care units, authorises and oversees the work of public health care institutions and provides funds to subordinate units; ensures quality control of health care through local public health authorities and gets involved in family protection work, (...) and*

¹⁸ Article 116 of Law 272/2004;

¹⁹ Article 115 of Law 272/2004;

*child protection*²⁰. The National Centre for Mental Health is a technical and methodological forum without legal personality, set up by the Ministry of Public Health as part of the National Institute for Health Research and Development from Bucharest. The Centre holds responsibilities related also to monitoring and evaluation of mental health care services²¹.

The specialty commission (the psychiatric and paediatric psychiatric commission - rank 23 of Annex 1 of Law 95/2006)²², as a technical body of the Ministry of Public Health, *is involved in organizing and carrying out activities to control and evaluate the specialised work run by the Ministry of Health in health care institutions* (point (f)), *works with the health care units accreditation commission to draft and set performance criteria and standards for hospital accreditation and authorisation* (point (g)) and *drafts evaluation criteria for specialised institutions or units* (point (l))²³.

The Ministry of Education must provide access to pre-school education and ensure free compulsory schooling to all children²⁴.

The People's Ombudsman is the main extrajudicial tool of defending and monitoring individual cases and it is independent of any other public authority. One of the ombudsman's assistants is specialised in a large field of expertise, more precisely "*the rights of the child, family, young people, pensioners, and persons with handicap*".

1.3.2. At local level

Locally, the **County Council** provides and finances welfare and child protection services. In accordance with the provisions of Law 272/2004 on the protection and promotion of the children's rights, and with those of Local Public Administration Law No 215/2001, "the organisational structure, the number of employees and funds of the general department for social care and child protection shall be approved by decision of the *county council*, of the Bucharest district local council respectively, that has set it up, to guarantee proper completion of all its attributions as well as full respect and real exercise of the rights of the child."

²⁰ Article 16, point (i), point (j) and point (t) of Law 95 of 14 April 2006 on health care reform;

²¹ Article 3, point (g) of Order on establishment and functioning of the National Centre for Mental Health within the National Institute of Health Research-Development from Bucharest, accessed on the webpage of the Ministry of Public Health www.ms.ro available on 1.11.2006;

²² Annex 2, Composition of Specialty Commissions, Order establishing specialty commissions of the Ministry of Health;

²³ Article 8, points (f), (g) and (l), Chapter 2 Responsibilities of the Specialty Commission from Annex 1 – Organisation and Operating Rules of Advisory Commissions of the Ministry of Health taken from the Order establishing advisory commissions of the Ministry of Health;

²⁴ Article 48 of Law 272/2004;

The president of the county council is responsible for the public service specialised body, used to guide the work of the guardianship authority and to take measures regarding public service assessment and control. The parental rights and duties related to the institutionalised child are fulfilled by the **president of the county council, Bucharest district mayor** respectively²⁵.

The General Departments for Social Care and Child Protection (GDSCCP) are state-run institutions, with own legal personality, set up and in the charge of the county council or of local councils in the case of Bucharest districts²⁶. They have overall child care-related responsibilities. GDSCCP draws up the initial child and family assessment report and suggests a specialised care measure, reassesses, at least every 3 months and whenever necessary, the circumstances having led to the specialised care measures and recommends, if necessary, their maintenance, change or cancellation²⁷. GDSCCP also holds the duty to monitor specialised care measures, including those concerning children with handicap. The monitoring comprises quarterly assessment of the circumstances that have led to child placement, including of children with disabilities, plus individual reports.

The Child Protection Commission, subordinate to county councils and to the local councils of Bucharest districts respectively, works as a specialised body of these authorities, without legal personality, and holds the following tasks: to take specialised care measures for the child without family care, to establish the level of handicap of the children with disabilities and, according to the case, to school guide them, to periodically reassess the care measures-related decisions, as well as the children's level of handicap and school guidance based on the notification of the general department for social care and child protection, to cancel or replace the measure taken, according to the law, if the circumstances having led to that measure have changed. The Commission also addresses the children's complaints, unless the law stipulates that they should be addressed by other institutions, and promotes the rights of the child in everything it does²⁸.

According to the local public administration law No 215/2001, amended and extended by Law No 286/2006, the **local council** provides, based on its tasks, "*the necessary background for delivery of county interest public services regarding (...) social services*

²⁵ Article 62 (2) of Law 272/2004;

²⁶ Article 105 (2) of Law 274/2004;

²⁷ Article 2 point (b) of the Organisation and Operating Rules of GDSCCP, approved by Government Decision 1434/2006;

²⁸ Article 2 of Government Decision 1437/2004;

*related to care of children, people with disabilities, aged people, family and other socially disadvantaged people or groups (2)*²⁹.

The Social Care Public Service is an administrative body reporting to the Local Council that assesses and monitors the situation of the children under their territorial jurisdiction, acts on clarifying the child's legal status and delivers and supports social welfare services.

The Guardianship Authority is an administrative body whose responsibilities are carried out by the mayor and acts as protector and guardian of minors and persons under interdiction³⁰.

The County Public Health Authority, an independent public service, with legal personality and managed by the Ministry of Public Health, implements the national public health policy and programmes at local level, identifies and prioritises public health problems, draws up and implements local public health actions. The county public health authorities and Bucharest public health authority *contribute to solving any public health problem of disadvantaged people and cooperate with institutions and organisations in order to run joint public health actions*³¹.

²⁹ Article 104, paragraph 5;

³⁰ Articles 158 and article 159 of Family Code;

³¹ Article 1, paragraph 1 and paragraph 2 point (k) and (m) of Law 95 of 14 April 2006 on health care reform;

2. RESULTS OF MONITORING VISITS

2.1. *Living conditions in care institutions for children with mental disabilities*

The visited institutions of residential care and assistance for mentally disabled children have different names: placement centre, residential centre, centre of services for the child with neuropsychiatric disorders, centre of community services, placement centre for school children with disabilities, helping centre for the child with special educational needs, residential service for the rehabilitation of the disabled child, centre of specialised services for the child with handicap, etc.

Some 'centres of services' mix up services for both disabled children and 'healthy' children, for families and even for the elderly.

The physical state of the institutions varies according to the interest of the community which reflects in funding, donations or NGO support. Some placement centres are refurbished and modernly equipped buildings that comply with the required standards:

"Between 2001-2002, the County Council renovated and restructured the placement centre (...). Currently, the building comprises a 3-story residential unit: a floor with group home type units: double-bed rooms and bathroom (for boys) and a floor with 3 or 4-bedded rooms (for girls). There is another floor with living rooms and 3 activity rooms, 1 social work office, 1 medical practice and nursery, physical therapy room, 1 parents meeting room, offices, warehouses, 1 kitchen and dining room, agricultural land, laundry room, playground. Everything is spotless and the sanitary facilities work³³."

Other institutions are located in old, badly managed buildings.

*"**Building I 1** was actually a one floor school that was turned into a boarding place. The entrance to the hall where the dormitories were located was locked up. Inside, one could feel a distasteful smell of unclean toilet.*

³³ The placement centre from the county N., taken from the monitoring report;

At the entrance, to the right, there are the toilets (4 squat toilets for 40 children) and on the same floor there are four dormitories placed in the former classrooms. Also on the ground floor, between the children's washing rooms and toilets, they have the teachers' restroom which is very well endowed (floor and wall tiles, wash bowl and flush toilet).

Each dormitory include 10 beds, a TV, fitted carpets, table and 4 chairs. The sanitary facilities were only partially working: the sinks had no pipes or faucets. At the time of visit, only cold water was running. We were told that they had hot water only twice a week when the children would take a shower. The showers did not have separating walls.

*The first floor had the same structure as the ground floor, but it also comprised an 8-shower room for all **80 children** accommodated in this part of the building³⁴.*

In more than two thirds of the visited institutions, the accommodating conditions do not meet the minimum compulsory standards set out for residential care services addressing disabled children³⁵. In some cases, the same centre of services worked with intellectually disabled children and healthy children; it could be noticed that the part accommodating disabled children was less taken care of and less modern than the one hosting healthy children.

In some institutions, the living conditions were extremely precarious.

"The temperature at the second floor (where the boys live) is extremely low. The hall windows on that floor are broken, and the residents from one of the rooms were using a self-made improvised electric stove for heating (...) The toilet and the showers are completely unheated and there is no hot water. Due to very low temperatures, it was practically impossible to use that utility³⁶.

The interviews revealed that the high costs of managing such institutions made management usually try to find ways to save as much as they could. One way is hot water rationing, restricting the shower programme to 1-2 hours, twice a week, regardless the season. Thus, in some institutions, the children are forced to take a shower only during shower hours, which repeatedly generates conflicts.

³⁴ The placement centre from the county of I., taken from the monitoring report;

³⁵ Requiring a space of 6 square metres /child and maximum 4 children in a dormitory;

³⁶ Visited residential centre from the county of V., taken from the monitoring report;

“The centre manager says that the shower programme is the following: twice a week, Tuesdays and Fridays. There is hot water in the showers only these two days, for saving reasons. However, the residents complained that the hot water programme was too short and not all of them managed to wash themselves³⁷.”

“The children go into the shared showers naked based on age groups, organised in “series” of 12-14 children. They don’t have their own soap or shampoo as these are held by the staff who gives them to the children while they are washing. Orderlies supervise all children (boys and girls) while they take the shower [at the time of the monitoring visit, the children were aged between 10 and 20 years old]”³⁸.

In addition, during the monitoring visits it was noticed that, often, the children didn’t have wardrobes or a place to stock their personal belongings in the dormitory. When children have such items, these are locked up so that they don’t get stolen by other children and staff.

Holding personal belongings is a basic component of the right to private life and it is vital to the minors’ psychological welfare. The right of each minor to personal belongings and to be able to keep them adequately must be acknowledged and fully respected³⁹.

In some institutions, we could see children sharing their clothes. Their physical appearance is sometimes terrible:

“The children from the centre have their hair cut the same way, no matter the gender. The clothes are excessively worn out. Many of the children don’t have shoes and the clothes they are wearing are greatly torn and overused”⁴⁰.

Even if some institutions have special rooms for leisure and/or child activities, the monitors found most of them locked and they seemed little or not used at all.

³⁷ Visited residential centre from the county of S., taken from the monitoring report;

³⁸ Visited residential centre from the county of M., taken from the monitoring report;

³⁹ United Nations Rules for the Protection of Juveniles Deprived of their Liberty, Rule 35;

⁴⁰ Placement centre from the county of O., taken from the monitoring report;

2.2. Admission of mentally disabled children to psychiatric units

During a monitoring visit carried out in a previously implemented project (June 2004–November 2005) at the (external) child neuropsychiatry unit of a psychiatric hospital from Brăila, 51 children were identified living in despicable and degrading conditions, deprived of any treatment or care. The report of that visit reads:

“In the first ward, there are 7 children in the first room and 4 in the second room. Half of these children have their arms and/or legs tied with girths or laces to the bed bars. Some children show self-mutilation signs but also bruises or signs of aggression that they couldn’t have inflicted on themselves. They are all lying down horizontally, but they can get up if helped. A part of them show signs of bedsore because their dirty underwear hasn’t been changed in time. In the second ward, there are 17 patients, 7 in each room. They also have signs of physical aggression and some of them are tied to the bed bars by girths and laces. There are 4 patients in the third ward. One of the patients, who is 8 years old, has her arms and legs tied to the bed protection bars by girths. Some of the 14 patients from the ground floor ward have their legs tied up with shoelaces so that they can’t move and they are sitting barefoot on the floor, in a semi-dark room”⁴¹.

In June 2005, the children were in the same condition, although notifications were repeatedly sent to the GDSCCP Brăila and NACRP to act on their legal responsibility and transfer these children into the child welfare system. The correspondence with public authorities showed that these children were free of parental care and that was the main reason why they had been in the psychiatric hospital for years.

Scientists have proved that a long stay in a hospital environment seriously, and sometimes permanently, harms the child’s development. Therefore, long hospitalisation can occur exclusively when there is need of specialised care.

During August–September 2005, an expert was invited to take part in the monitoring project in order to assess the children from the neuropsychiatric unit from Brăila. The purpose of this

⁴¹ Extract from the notification that the Centre for Legal Resources sent in July 2004 to the National Authority for Child Protection and Adoption;

activity was to find solutions for the rehabilitation of the disabled children from that unit and to make the representatives of GDSCCP and of the County Council close down the neuropsychiatric unit and transfer those children to facilities providing appropriate rehabilitation and care. By the end of November, all the children from the neuropsychiatric unit were transferred to two placement centres (from Brăila and Bărgăanu).

The Law on mental health stipulates that “hospitalisation in a psychiatric unit shall be undertaken based only on medical grounds, in other words on **diagnosis and treatment procedures**”⁴².

The monitoring visits and some notifications of public authorities⁴³ highlighted hospital admissions and long hospitalisations of mentally disabled children from childcare institutions to psychiatric hospitals. Voluntary or involuntary admission to a psychiatric hospital involves certain freedom privation and, therefore, it must be carried out according to some rules that guarantee legitimacy and non-arbitrary decisions.

“V. [who was in this sort of situation] is very aggressive, she beats up the staff, she is talking back, she apologises afterwards but then she goes back to the same behaviour; everything depends on how she behaves: if she is a good girl then she will go home in a week”⁴⁴.

In more than a third of the institutions visited, the conversations with the children (most of them were teenagers when the monitoring visits were run) and with some of the psychiatric clinic staff revealed that admissions of disabled children from placement centres to psychiatric hospitals were made arbitrarily, as a punishment:

“In November 2005, during a monitoring visit run in a placement centre for disabled girls from H. (the interviewed teenagers were 16 to 17 years old at the time), the interviewed girls informed the monitors that they were often threatened to be admitted to the psychiatric clinic from the town of C. unless they “behaved” (the word used by the interviewed girls). Three of

⁴² Article 40 of Law 487/2002 on Mental Health and protection of people with mental disorders;

⁴³ For example, notification No 10448/24.08.06 of the Psychiatric Hospital from B. (48 underage patients coming from GDSCCP’s childcare centres, admitted between 01.01.2005-31.07.2006), or of G. County Public Health Department No 25/29.08.2006 (128 children admitted between 01.01.2005-31.07.2006 coming from childcare centres);

⁴⁴ The reasons for hospital admission of an underage girl from a placement centre, as well as treatment and discharge reasons, described by the medical nurse from the psychiatric hospital;

the interviewed minors confessed that, in the summer of 2004, they had been sent to the psychiatric clinic of C. One of them said she had been admitted against her will for 4 days because she had talked back to one of the educators (minor X's statement). The minor added that she had not received medication during hospitalisation (in 2004). The same minors told monitors that at the beginning of November they had been threatened again with psychiatric clinic admission [by the placement centre employees] if they had talked about a resident who had tried to kill herself."⁴⁵

In November 2005, an employee of the Psychiatric Clinic from the town of C. reported to the representatives of CLR the following case recorded on the 5th of November 2005 in the clinic where she was working:

*"The teenager X. from the placement centre from H., diagnosed with mild mental deficiency, confessed that she had taken the pills (10 pills of Carbamazepin) just to see what would happen. The pills had been stolen from the medical nurse's office while she was filling in the medical charts. She got to our clinic quite dizzy, due to the high dose, and I think she was also taken to the emergency room for gastric lavage. The girl's admission can be checked by consulting her observation chart. These days [November 2005] they should let her out; they have come to take her today but we have kept her here for a while because I have told them I want to talk to her. Anyway the centre staff came ready to admit her and they even had a paper proving she was living at the placement centre as well as the last child psychiatric unit discharge letter. All this was pretty strange for an emergency admission on weekend. The girl said she didn't get along with her colleagues and that the older ones were aggressive to her. She hates it at the centre (she came there 4 years ago from another county), the parents abandoned her, but anyway she doesn't want to go back to them. She says that they are often threatened that if they don't behave, they will be "thrown back to their parents" (teenager X.' statement). She gave me the name of an employee that talks bad, threatens them and beats them frequently."*⁴⁶

⁴⁵ Taken from the monitoring report of the visit run in November 2005 at the No 8 Placement Centre from H., the County of C.;

⁴⁶ E-mail notification received by the programme manager at CLR on November 7 2005. The head of the centre, the psychologist and the social worker from the placement centre from H. were asked about the number of children admitted to the psychiatric clinic/unit and about beneficiaries' suicide attempts. The answers were negative.

The admission of disabled children from placement centres to psychiatric hospitals were also justified by lack of staff over some periods of time:

“Placement centre children would come frequently to our hospital, brought by Ambulance or the Police, usually on Friday evening or Saturday. After a first check up and after having talked to the children, it was obvious that there was no reason for admitting them and we would send them back. I later understood that, on week-ends, there was only one orderly to look after a great number of children, so they were trying to get rid of the most problematic ones⁴⁷.”

The law⁴⁸ stipulates a specific procedure regarding admission of a person (regardless age) to a psychiatric hospital. One may be hospitalised based on his/her consent or the consent of his/her legal guardian. According to Law 272/2004, it is the president of the County Council who fulfils the parental rights and duties in the case of a child that has been placed in the child care system (institutionalised child). CLR forwarded official requests to the presidents of county councils⁴⁹ in order to find out how these rights had been fulfilled as to the consent of admitting a child to a psychiatric hospital and received negative answers to almost all of them; the county councils passed on this responsibility to GDSCCP, although this is against the law⁵⁰.

Most of the county council representatives' answers to the third section of the request, *“the number of minors from specialised care institutions for whom the County Council president asked to or was asked to give his consent for their admission to psychiatric hospitals between 2005-2006”* revealed that *“the CLR notification was redirected to be analysed and answered by GDSCCP, which will communicate their answer to you”⁵¹* or *“the GDSCCP from the county of A. did not receive such notifications”⁵²*. *“GDSCCP from the county of S. does not run psychiatric units within specialised care institutions and consequently the Assessment Service of GDSCCP from S. cannot give its consent of admitting disabled*

⁴⁷ Statement of a neuropsychiatrist from B.;

⁴⁸ Law 487/2002 on Mental Health;

⁴⁹ From the counties where monitoring visits were run and where there have been identified cases of placement centre children admitted to psychiatric hospitals/units for children or for adults.

⁵⁰ CLR received and recorded 24 answers signed either by representatives of GDSCCP, or by county council presidents or general secretaries.

⁵¹ Answer No 7099/29.08.2006 of County Council from A.;

⁵² Answer No 9833/14.09.2006 of County Council from A.;

children to such units".⁵³ Another answer received from the representatives of the County Council from the county of C., where lots of children had been admitted to the psychiatric clinic of the county, reads that:

*"During 2005-2006, the C. County Council did not receive any complaints from or on behalf of minors from child care institutions for mentally disabled/handicapped children about violation of the rights of institutionalised children. In addition, we were not asked the consent to admit minors to psychiatric institutions over that period of time."*⁵⁴

A similar answer was given by the general secretary of the M. County Council, although both the CLR monitoring teams and the local media found out about children from county placement centres being frequently admitted to psychiatric hospitals for adult patients.

Only one answer of the president of the M. County Council sent to CLR stated:

*"During 2005-2006, the M. County Council received only one request to admit a minor to a psychiatric institution. The Town Hall of R. contacted the M. County Council on 10.10.2005 and after this intervention, X., with a 1st level handicap, was admitted to the T. Psychiatric Hospital from the county of M. [psychiatric hospital for male chronic adults]."*⁵⁵

Hospital admission against one's will may be carried out **only if a qualified psychiatrist decides that the person suffers from a psychiatric disorder** and in his/her opinion there is an imminent danger of this person hurting himself/herself or others or that unless hospitalised the person's state would deteriorate or he/she would not get access to adequate treatment⁵⁶. According to the law in force, only few people may request hospital admission against the patient's will⁵⁷.

"At the proposal of the psychologist, medical nurse and some educators, in 2005, 8 minors were hospitalised for treatment for one or two weeks at the neuropsychiatric hospital".⁵⁸

⁵³ Answer No 13028/15.09.2006 from GDSCCP of the county of S. and sent by CLR to the S. County Council president;

⁵⁴ Answer No 9869/11.09.2006 from the C. County Council to the CLR request;

⁵⁵ Answer No 30076/07.09.2006 of the M. County Council.

⁵⁶ Article 45 of Law;

⁵⁷ The general practitioner or the psychiatrist of the person, family, representatives of competent local public administration services, police, public order unit, prosecutor's office or fire brigade;

⁵⁸ Placement centre from the county of C., taken from the monitoring report;

The current legislation - Law 487/2002 on Mental Health and protection of people with mental disorders - stipulates that the legal representative of the person with mental disorders has to be informed about hospital admission. The decision of involuntary hospital admission shall be confirmed by a procedure review commission and shall be periodically reassessed. The legislature adopted these provisions to underline that such hospitalisation should be run in exceptional cases as it seriously restricts a number of fundamental rights, to prevent abuses as much as possible and minimize the negative effects it might have on the patient.

After having studied relevant documents and having talked to residential home employees, it was clear that the visited institutions did not comply with the provisions of the Law on Mental Health. There were cases in which both the institutional staff and the beneficiaries were unaware of the legal provisions on involuntary hospitalisation decision making, the need to have the decision reviewed by a special commission⁵⁹ and the fact that involuntary hospitalisation decisions must be notified within 24 hours and reviewed by the prosecutor's office of the relevant court of justice⁶⁰.

In order to find out more details about admission of institutionalised children to neuropsychiatric hospitals, we requested information about the matter to county public health authorities. The data received indicated that, in the last two years, over 400 minors, mostly teenagers, were admitted to psychiatric hospitals at the request of placement centre employees. From talking to the minors aged between 14-17 years, living in the visited institutions, some of whom had been previously admitted to psychiatric hospitals, it was clear that none of them had been informed about the right to report any involuntary hospitalisation to the competent court of justice or about other rights they have in that respect.

As the beneficiaries of the institution are minors, they can make a notification to the court only with the consent of their legal representative or through the legal representative on their behalf. In most cases, the latter was appointed among the placement centre staff. For example, during June-September 2006, the T. General Department for Social Care and Child Protection answered to a request for public information provision that the Centre for Legal Resources had sent to the T. County Council:

⁵⁹ Article 52 of Law 487/2002;

⁶⁰ Article 53 of Law 487/2002;

“The president of the County Council was not requested the consent for hospitalisation of minors in a psychiatric hospital, as the centre manager is empowered by court order to fulfil the parental rights regarding the minor”⁶¹.

Under these circumstances, we need to underline the fact that the legal representative would clearly face a conflict of interests.

Although according to the law⁶² “the parental rights and duties in the case of a child for whom guardianship could not be established and for whom the court has decided childcare placement are represented and fulfilled by the president of the county council or the district mayor in the case of Bucharest”, actually the stipulation is not complied with and the parental rights and duties are fulfilled by various institutional staff members. In this case, the *de facto* legal guardianship is illegal because it is fulfilled by the specialised public service staff.

Children institutionalised based on their mental illness must benefit from the care measures stipulated in the UN Convention on the Rights of the Child and relevant UN rules and guidelines. In line with article 37 of the Convention, any restriction of freedom must be law-stipulated, must not be arbitrary and must be a measure of last resort and taken for the shortest period possible. Article 37 (c) stipulates that every child deprived of freedom “*must be separated from adults, unless this is in the child’s best interest*”. According to the Children’s Rights Committee, in the case of any child care placement, disabled children must be separated from adults and, based on article 25, the Committee stresses the importance of periodically reviewing the placement and treatment⁶³.

The data received from county public health authorities during the visits and as an answer to our requests show that mentally disabled children are still hospitalised in psychiatric hospitals for adult chronic patients.

“From October 2005 to January 2006, minor A was transferred as a result of treatment change from a centre of services for the child with neuropsychiatric disorders to the psychiatric unit for adult male chronic patients from T.”⁶⁴

⁶¹ Answer of the T. County Council/General Department for Social Care and Child Protection bearing the Centre for Legal Resources registration number 582/09.10.2006;

⁶² Law 272/2004;

⁶³ Hodgkin, R. and Newell, P., *Implementation Handbook for the Convention on the Rights of the Child*, UNICEF, 2004, page 403, “Supervised freedom of disabled children”;

⁶⁴ Centre of services for the child with neuropsychiatric disorders from the county of M., taken from the monitoring report;

In the summer of 2006, CLR officially requested to the public health authorities (PHAs) from the counties where placement centre monitoring visits had been run data regarding the number of mentally disabled children, on age groups, coming from GDSCCP-run placement centres who had been admitted to psychiatric hospitals (child neuropsychiatric units and/or psychiatric units for adults) between 2005-2006. On 25.08.2006, PHA from the county of T. answered to the CLR request that, in 2005-July 2006, 58 placement centre children from the County of T. were hospitalised but it did not mention the age groups. It also asserted that there was a total of 109 under 1-year-olds and 534 1 to 4-years olds [including all children, not only institutionalised children]. At the same time, the PHA from the County of B. answered to the CLR request that, in 2005, 19 children were admitted to psychiatric hospitals, and in the first seven months of the year 2006, other 29 institutionalised children were admitted to psychiatric units; 38 of the hospitalised children were aged between 1 and 4 (PHA from the County of B. didn't mention how many of these children came from placement centres). PHA of the County of V. informed CLR that 63 children from child care institutions were admitted to psychiatric hospitals. The same answer shows that 10 children were under 1-year-olds and 94 were 1 to 4-year-olds, without however specifying whether they were institutionalised children or not. One of the children had been admitted to a psychiatric hospital for adult patients from M.

Direct observation and the documents recorded indicate that sometimes children are admitted to psychiatric hospitals even if they don't have a diagnosis requiring this measure.

Article 60 paragraph (1) of Law No 272/2004 prohibits the placement of an under 2-year-old child in residential care. A child with severe handicap may however be institutionalised before turning 2 years old.

Thus, according to current legislation, any hospital admission which is not backed up by a medical diagnosis is not only illegal but it is also an intervention that may endanger the child's development, regardless the reasons behind this procedure.

2.3. *Physical restraint of mentally disabled children in specialised care institutions*

The terms "*physical restraint*" and "*seclusion*" are defined in the UN Principles for the Protection of Persons with Mental Illness and in the implementation standards of the Law on Mental Health⁶⁶. Physical restraint, defined as *restriction of a person's freedom of movement by using*

⁶⁶ Minister of Health Order 372 / 2006;

*adequate means to prevent free movement of an arm, of both arms, of a leg or both legs or to fully immobilise the patient, **through protected specific means that don't induce physical harms**, cannot be used as punishment or as a means to make up for lack of staff or treatment⁶⁷.*

The general restraint conditions for persons with mental disorders are set out in the standards and Law on Mental Health⁶⁸, which however don't stipulate criteria and specific measures to be adopted in the case of small children or teenagers that need to be protected from their own actions. Still, the UN Convention on the Rights of the Child (hereinafter called the Convention) includes relevant provisions for mentally disabled children and teenagers from residential child care. Among them, there is the child's right to be protected from any kind of abuse and maltreatment.

Although the measure of restraint may be used only when it is absolutely necessary, under strict monitoring (to make sure the physical, comfort and safety needs of the restrained person are met), only based on the written recommendation of a psychiatrist, and recorded in details in a special chart⁶⁹, the monitoring teams from the Centre for Legal Resources encountered cases that didn't comply with these provisions.

"The resident M.X., aged 10, was identified in one of the building dormitories where the 'vegetables' were kept (statement of medical nurse X). She was diagnosed with childhood autism and mental retardation.(....) The resident, sedated and immobilised, was found tied up to the bed by pieces of linen and lint crossed all over her body. The first bond crossed her body at shoulder level, the second at hip level and the third between her knees and ankles (...) Her hands were hidden, tied up behind her back at the wrist level. With her hands tied up this way, M.X. was fully immobilised and could not move at all. During the visit, there wasn't any member of the staff in the ward"⁷⁰.

In order to prevent abuses and unjustified use of physical restraint means, the institution needs to be authorised for putting into practice such measures and to hold adequate facilities and specialised staff. Moreover, when applying the physical restraint measure, the medical staff

⁶⁷ Article 21 (3) of Implementation Standards of the Mental Health Law, approved by Minister of Health Order No 372/2004;

⁶⁸ Law 487/2002 on Mental Health;

⁶⁹ Article 21 (8) of Implementation Standards of the Law on Mental Health, see above footnote 12;

⁷⁰ Centre for rehabilitation of the child with special needs, the county of V., taken from the monitoring report;

must do their best to avoid pain⁷¹. The written instructions of the doctor who has recommended the measure must detail all factors having led to restraint and the nature of the restraint measure. This document also has to indicate the exact time when the restraint measure was taken because the restraint shall not last for more than 4 hours.

According to Romanian legislation⁷², all restrictive measures applied to children must be recorded in a special chart, enclosed to the individual health care plan, stating at least: the name of the child, date, hour and place of incident; measures taken; names of staff members doing the procedure; names of other witnesses, including children; possible consequences of the measures; signature of the person authorised to record the facts. After the restrictive measure has been applied, the child has to be examined by a doctor within 24 hours. However, this goes against the UN Principles for Mental Illness, which underline that “any restraint shall be carried out **only based on the written recommendation of a physician.**”

This inconsistency cancels an important safeguard against abuse, which has serious effects on the child’s physical and mental development.

As to the case of M.X.,

“the employees were asked about M.X. The medical nurse panicked and started to deny that the girl was tied up. At the same time, she started to untie the resident, repeating that she was not tied up’. Another medical nurse, responsible for residential conduct got angry and asked if the monitors even knew the child’s diagnosis. She said that if they did, they wouldn’t be shocked about the measures used by the personnel. Immediately after, the ward supervisor explained that M.X. “self-mutilates when not tied up” [the statement of the nurse supervising the ward]. To show that she was right about the child’s self-aggression, at the end of the monitoring visit, she proposed to untie the child. After 30-40 minutes, the nurse invited the monitors “come and see M.X. now”⁷³. I have untied her and now she is all covered in blood.” [statement of the nurse supervising the ward].

⁷¹ Article 21 (4) of Standards, see above footnote 12;

⁷² Standard 20.5 of Minimum Quality Standards for Residential Care Services for Children with Disabilities, approved by NACRP Order No 27 of 10/03/2004;

⁷³ Taken from the report of the monitoring visit run on the 6th of May 2006 at the Service for Children with Special Medical Needs and the Centre of Neuromotor Recovery and Rehabilitation from the County of V.;

⁷⁵ Standard 20 – “Behaviour Control” of NACPA Order No 27/10.03.2004;

The CLR monitoring teams identified conditions endangering the child's physical and mental integrity (although less serious than the above-mentioned case) in a great number of the visited residential care institutions for disabled children. Moreover, the discussions held with the **staff present and interviewed during the visits revealed that they were not even acquainted with the minimum provisions related to child "physical restraint"**.

Therefore, a method meant to protect a mentally disabled child may turn into an (abusive and harmful) method of managing difficult child behaviour. The absence of records related to the number and conditions of physical restraint measures applied, lack of a neuropsychiatrist's written and specific recommendations on freedom of movement restrictions, and lack of means to protect these children's physical and mental integrity at least through recordings control and evaluation⁷⁵ by the RCD coordinator⁷⁶, may put in danger the life and physical integrity of children as seen in the case of M.X..

Thus, staff training, knowledge of behaviour psychology and of the legislation in force, capacity building, behaviour adjustment and interventions based on the child's best interest become vital to ensure proper care to disabled children.

"S.S. is 21 years old and at the time of visit she had a textile ribbon tied around her arms to immobilise her upper limbs. The young girl confessed that she had been tied up because "she beats up the employees" and pointed at one of the educators that she had struck that day. The physical restraint measure was not recorded in a special chart and there wasn't any information available about its duration or monitoring of the immobilised young girl's health condition⁷⁷."

The national standard provisions regarding "difficult behaviour" control or management are scarce. The current legislation⁷⁸ does not draw a clear line between "control" of difficult behaviours and "physical restraint" so that physical restraint measures are not interpreted as means to punish children. These measures should be adopted to ensure that physical restraint techniques are applied to protect children from physical harms *"only if the less restrictive techniques proved to be inadequate or not enough to prevent battery or harm"*⁷⁹. Moreover,

⁷⁶ RCD= residential care for disabled children from the Annex of 10/03/2004 to NACPA Order No 27/10.03.2004;

⁷⁷ Centre of services from the North of country, taken from the monitoring report;

⁷⁸ Mainly the NACRP Order No 27 of 10/03/2004 approving Minimum compulsory standards for residential care services for disabled children and Public Health Ministerial Order No 372/10.04.2006 on implementation standards of Law 487/2002;

⁷⁹ Article 21 (2) of Implementation Standards of Mental Health Law;

there are no clear stipulations regarding emergency situations in which physical restraint measures may be taken, which are the least restrictive measures or accepted behaviour (in the case of children with severe mental disabilities). In addition, there aren't enough explanations about what restrictive measures mean and, moreover, the institutional staff is the one who has to choose the best restrictive measure, although it is often not trained for this.

*“M.O., aged 14 years old, is biologically developed like a 5-year-old, (...) She was wearing a very long-sleeved sweater used as a straight jacket, with her hands immobilised inside the sweater. M. had bleeding wounds on her cheeks, **undressed and untaken care of**. The staff said she was self-aggressive and at that moment things were normal as compared to before (the restraint) when M. “was screaming on and on that she was all one could hear”⁸⁰.*

In the context of legislation gaps, lack of professional codes of conduct or practice guidelines, and many times of quantitative and qualitative training deficiencies of the staff, it is obvious that ‘*difficult behaviour*’ (or a behaviour requiring attention) of a child cannot be tackled properly. Some staff think that such behaviour may be “*taken under control*” only by physical restraint techniques that the medical personnel (medical nurse and orderly/carer) improvise, which at the same time become a type of punishment, from the point of view of the interviewed children.

2.4. Mentally disabled child seclusion methods in specialised care institutions

‘*Seclusion*’ is a means to protect the patients that are a danger to themselves or to the others. The seclusion measure may be applied only if the psychiatric unit has a special facility adequately endowed and used for this purpose. The facility should allow continuous patient observation, should be well lighted and aired, it should have toilet and washing facility access and be proofed to prevent the secluded patient from getting hurt⁸². The same normative document stipulates additional protection measures from abusive use of patient seclusion, mentioning that the measure “*shall be periodically reviewed, every 2 hours at most*” and that it has to be applied for the shortest period possible.

⁸⁰ Placement centre from the county of C., taken from the monitoring report;

⁸² Article 22 (2) of Implementation Standards of Law 487/2002;

The methods of underage child seclusion used in the institutions visited by the Centre for Legal Resources representatives did not meet international standards or Romanian legislation provisions, and in some cases, the treatment was considered degrading and inhuman.

*“V.M., aged 17 years old, diagnosed with **severe mental disability**, behavioural disorders and heteroaggression, was found all alone in a “seclusion room” from a placement centre. V.M. was on a mattress, with strings coming out and no bed linen. The centre personnel claimed that V.M. usually tied himself up with ropes made of torn clothes, that he had wrapped and tied up around his hips and chest. The “Book of Restrictive Measures Applied to Children” reads: 07.05.2005 – in the case of V.M., checked in several times to the Neuropsychiatric Hospital from the town of C., with severe neuropsychiatric retardation and seizures, it was decided to seclude the child, replace glass windows, install window grids, remove objects, permanently supervise him and administer appropriate treatment⁸³.*

Like for physical restraint, in the case of seclusion of mentally disabled minors there are no standards or practice guidelines to be used by all care and educational staff at country level, nor institutional staff training and awareness programmes on the dangers children may be exposed to if these methods are used arbitrarily and continuously.

2.5. Access of institutionalised mentally disabled children to health care

2.5.1. Primary health care and non-psychiatric specialised care

Article 24 of the UN Convention on the Rights of the Child imposes on the Romanian State to acknowledge the child’s right to benefit from the highest attainable health standard and adequate health care and rehabilitation services. Consequently, Romania must do its best to make sure that no child is deprived of his/her right to have access to such healthcare services. Moreover, the Romanian State has committed to provide to children with mental and physical disabilities, in particular, “a full and decent life and living conditions which guarantee dignity, promote autonomy and facilitate active participation in community life”⁸⁴.

⁸³ Placement centre from the county of C., taken from the monitoring report;

⁸⁴ Article 23 of the Convention;

Rule 2.3. of the UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities specifies that “The States must guarantee that disabled people, mainly new-born and children, receive the same level of health care as the other members of the society”.⁸⁵

According to Law 272/2005, all children, including institutionalised children, have the right at least to a basic benefit package covered by the national health insurance system. Access to adequate health care is crucial for mentally disabled children, mostly for those bearing an associated handicap. Still, in most of the cases monitored, it was noticed that this right was restricted, which the staff and the representatives of the authorities argued by lack of resources or untrained institutional staff.

The monitoring reports indicate that, in the visited institutions, primary health care is provided by periodical family physician visits to the institution or by taking the children to the closest family physician. However, there are times when the physician cannot examine the child because there are no transportation means.

Several institutions have planned a general practitioner position in their organisational chart, but in more than half of the visited institutions this position is vacant. Generally, primary health care is delivered by allied health personnel hired by the institution (orderlies or, in the best case, medical nurses).

During field data collection and regional meetings, it was mentioned that usually, problems arose when it came to specialised health care, especially dental care, that only few institutions could deliver. Stories were related about dentists who refused to treat the children because of their disability, which can be interpreted as a form of discrimination.

“The majority of children have great dental problems. Because of their handicap, they don’t receive dental treatment as the dentists from the closest town turn them down. In case of emergency, they are administered analgesics and antibiotics. The manager told us he was planning to start up a dental practice right in the centre to benefit exclusively the residents. However, he was not clear about where he would get the funds from⁸⁶.”

⁸⁵ UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities;

⁸⁶ Centre of services from the county of M., taken from the monitoring report;

When they were on the field, the monitors were presented cases of children needing specialised health care, as an emergency or otherwise, who were admitted to the closest hospital even only for a simple check-up. The institutional employees said that sometimes, due to lack of transportation means, they had to call a specialised medical service, like the ambulance, to take the child to the hospital,. Nevertheless, at least three of the visited institutions talked about cases when the ambulance refused to come.

In a few institutions, we identified HIV/AIDS children who could not benefit from the medical treatment needed for somatic care due to HIV-related causes. Moreover, the institutional staff were not taking measures regarding information and prevention of disease transmission.

2.5.2. *Psychiatric health care*

Mental disability⁸⁷ reflects, from a medical point of view, in a diagnosis of mental underdevelopment or retardation (moderate, severe or deep) and may or may not entail psychoses with deep or serious behaviour disorders⁸⁸. Some types of disability need medication, while other types basically require only care and behavioural therapy.

To treat their mental disorders, the beneficiary children from the visited institutions get mainly a medication-based treatment established by a psychiatrist or neurologist. During the monitoring visits, cases were recorded of institution employees who, even if they were unqualified, changed medication or administration, saying this was triggered mostly by budget restrictions.

“The prescribed medicine (Depakine) was too expensive and the institution couldn’t afford it, so it was replaced with Fenobarbital, which induced significant alteration in the state of the residents. As a consequence, Depakine was immediately administered⁸⁹.”

⁸⁷ The Order 725/01.10.2002 on criteria used to establish the level of handicap for children and to apply specialised care measures in their case, drafted by the Ministry of Health and the National Authority for Children’s Rights Protection and Adoption, sets out three functional categories used to establish a child’s handicap level: *mild intellectual disability, non-associated intellectual disability, moderate, deep and severe disability*⁸⁷. This classification is taken from the International Classification of Diseases, the tenth edition (ICD – 10), and it is mainly based on IQ level;

⁸⁸ For example, childhood autism, schizophrenia, mental disorders due to acquired brain damage, with/without personality disorders; a social enquiry must be carried out to objectify behavioural disorders;

⁸⁹ The placement centre from the county of A., taken from the monitoring report. The two pharmaceuticals have different active ingredients;

The treatment of a person with mental disorders must aim at “*preserving and developing self-autonomy*”⁹⁰, and “*the medication has to be administered to the patient only for therapeutic and diagnosis reasons*”⁹¹, usually to ease therapy. It is also mandatory to get the informed consent⁹² of the patient or his/her legal guardian regarding the treatment to be used. For underage patients, the legal representative’s consent is needed. **The investigations run in this respect during the CLR monitoring visits could not prove that these requirements were met** when the patients were institutionalised children.

The law⁹³ stipulates that specialised bodies have the duty to ensure access to health care and proper treatment, and “to periodically check the treatment used for children placed with them for care, protection or treatment”⁹⁴.

“In the file of a child diagnosed with spastic tetraparesis and severe mental disability, the last physician stamp dated from 2002” (this was noticed during a visit which took place in 2006). *“When investigating the case, the staff informed us that if the treatment went well there was no need for medical examination because the centre nurses took care of that.”*⁹⁵

The conversations that the CLR monitors had with the institutions’ staff and GDSCCP representatives indicated that the child care institutions rarely had the chance to hire a full-time psychiatrist. The monitoring visits showed that in many of the visited institutions, the medical records of children were not up-to-date. There were cases when, in order to be diagnosed or reassessed, the children were admitted for long periods of time to paediatric psychiatric hospitals or psychiatric units for adult chronic patients, only to have their medical treatment changed or readjusted.

It is scientifically proved and well-known that spending a lot of time in an unknown environment with improper resources for child care or in a hospital where the child is not properly stimulated may have a negative impact on the children’s psychological development.

⁹⁰ UN Principle 9 (4) MI;

⁹¹ Principle 10 (1) MI;;

⁹² Informed consent means the freely given consent, without threats or suggestions, after proper information of the patient, in an easy to grasp language and layout, about diagnosis evaluation; purpose, method, time and expected positive results of the proposed treatment; alternative treatment, including less restrictive measures; possible pain or discomfort, risks and side effects of the proposed treatment;

⁹³ Law No 272/2004 on children’s rights protection and promotion and Law No 487/2002 on Mental Health;

⁹⁴ Article 43, paragraph (3), point (g) of Law 272/2004;

⁹⁵ See above, footnote 75;

During regional meetings attended by directors of county departments of social care and child protection, the latter pointed out that sometimes the psychiatrists refused to admit placement centre minors to units for acute patients and sent them to rural area units for chronic patients, while in other cases they simply refused to admit the children.

During monitoring visits, several cases were identified where children were administered antipsychotic medication that, according to the neuropsychiatrist who was the project consultant, didn't go with the diagnosis:

“The head of the centre considers M.M., who talked about his attempts to protest for what the children perceive as staff abuses, ‘the most difficult resident’. When asked to tell us the child’s diagnosis, the head of the centre stated he didn’t know that or the treatment administered to the resident. In the end he said that the medication used was Zeldox, Fenobarbital, Haloperidol. The child’s personal file recorded the diagnosis of severe mental retardation (I.Q. <5), without any other specification”⁹⁶.

As mentioned by the project specialist, all the above-mentioned pharmaceuticals are antipsychotics used to sedate the patient and administered mostly to treat schizophrenia and, thus, the need to administer these drugs is questionable. Moreover, the specialist added that these medicines were meant to facilitate rehabilitation therapy and could not be used as an only treatment.

Taking into account the specialised literature, psychotropic drugs have a sedative effect and in some very specific cases they are used as a de facto chemical restraint. However, the deontological code of general practitioners and pharmacists sets out clear limitations for this type of therapy, which violates the basic freedoms of a human being when it is used for other reasons than medical ones.

2.6. Care, rehabilitation and assistance of mentally disabled children

The disabled child has the right to special care and assistance adapted to his/her condition and to that of his/her parents or of the ones he/she has been entrusted with⁹⁷. The State has

⁹⁶ Placement centre from the county of O., taken from the monitoring report;

⁹⁷ Article 23 (2) of the UN Convention on the Rights of the Child;

acknowledged it must guarantee to the disabled child a full, decent life and living conditions which guarantee dignity, promote autonomy and facilitate active participation in community life⁹⁸. The ultimate goal is the child's fullest individual development, rehabilitation and social integration. A child with disabilities has the right to recovery, compensation, rehabilitation and integration so that his personality may develop properly⁹⁹.

In order to reach the above-mentioned objectives, mentally disabled children have to receive constant care and specialised therapy aiming at their rehabilitation and social reintegration. These are embedded in the service plan and, later, in the individual care plan or rehabilitation plan (based on specific indicators).

The first objective is to prevent the child from being separated from his/her parents. In that respect, the central and local public administration specialised bodies have to start programmes and provide the resources necessary to the development of services addressing the needs of disabled children and their families¹⁰⁰. When the efforts to prevent the child from being separated from his/her family fail, the child care measures must be adopted considering a personal care plan drafted for the child's best interest.

The examination of the files of the children from the project monitored homes revealed that some of them had a long institutionalised past, sometimes even a winding one.

"S. X., aged 18, was raised in the orphanage from the town T, then moved to a centre for pre-school children in L., later transferred to the helping school from T. and in the last 2 years – in line with the national decision to move the children to their native counties – he was transferred to the placement centre where he was staying at the time of the monitoring visit.

P. X. (18 years old) was placed in an orphanage from C., then to a centre for pre-school children from C., then to a helping school from B, and finally to the placement centre from V..

None of these young persons knows what will happen next, especially that they are about to leave child care¹⁰¹."

⁹⁸ Idem, article 23 (1);

⁹⁹ Article 46 (2) of Law 272/2004;

¹⁰⁰ Idem, Article 46 (4);

¹⁰¹ Placement centre from the county of C., taken from the monitoring report;

The talks with the employees of the institutions indicated some cases in which the care planning for 18-year-olds and persons with disabilities was influenced by other criteria (mostly administrative ones) than the real needs of these beneficiaries:

“The fate of the residents of the centre (which is being turned into an adult care centre), who will turn 18 years old in 2006, will be the following:

- 1. In July 2006, they will leave the placement centre (where they have been living for almost 6 years) together with the centre staff;*
- 2. They will be sent (the criteria could not be identified) to group homes and will start to readapt to the new environment;*
- 3. After a few weeks or months (when turning 18) they will be sent back to the placement centre which will have become an adult care centre by then and where they will meet new staff and other residents¹⁰².”*

Small children aged between just a few months and 2 years old as well as under-7-year-old children had been placed in some of the visited institutions where most residents were teenagers or even under 23-year-old young adults¹⁰³.

Accommodating and caring for small children together with teenagers and young adults endangers the pre-school aged children’s physical and mental development, especially that the carers, educators and supervisors were untrained in that respect.

“The 5 children aged 0 to 2.5 years old don’t seem to have a handicap. The only problem here could be engendered by their lack of physical stimulation and age appropriate learning. These children are placed in a separate room and kept in barred beds; this treatment was justified as used: “for their enhanced protection”. The children were supervised by a staff member. One child, of almost two, was laid on the fitted carpet so that we could see his level of autonomy and he wasn’t even able to sit without help, which the specialists thought it was also due to lack of practice and physical exercise¹⁰⁴.”

¹⁰² Placement centre from C., the county of D., taken from the monitoring report;

¹⁰³ On the 4th of May 2006, in a placement centre from the county of I., the monitoring team from the Centre for Legal Resources identified a number of 5-year-olds together with youngsters aged between 18-20 years old. Seven of the children did not have a diagnosis establishing a handicap level. In a territorial centre from T., 7-year-olds were living with 23-year-olds at the time of visit;

¹⁰⁴ Placement centre from G., taken from the monitoring report;

As it affects extremely seriously the child's mental and emotional development, institutionalisation of under-2-year-old children is prohibited by law¹⁰⁵, except for the case when the child is diagnosed with severe handicap. The monitoring project revealed some cases that went against this stipulation.

For example, on the 28th of November 2005, in a centre of community services for the disabled from the county of V., (providing services of care and rehabilitation to disabled children, youth and adults) 7 minors aged between 5 months and 5 years old were identified without a diagnosis to justify their presence in such an institution. On the 2nd of March 2006, in a placement centre from G., there were 5 children aged between just a few months and 2.5 years that haven't been diagnosed with a level of handicap which could justify their being in that centre.

The child's level of handicap is established by the Child Protection Commission¹⁰⁶; for 0 to 3-year-olds "the biopsychosocial development is very complex, requiring very thorough analysis and caution when establishing the handicap level"¹⁰⁷. The Commission decisions may be appealed solely by the child's legal guardian, at the court from the child's domicile, and the cases are settled based on the special procedure rules stipulated by Law 272/2004.

The monitoring visit interviews showed that in the above-mentioned identified cases the carers either knew nothing about the child's legal situation or they declared those children had been abandoned, which could endanger the children's later development and abuse prevention.

Any child, with or without disabilities, from child care must be granted services according to a personal care plan based on the child's best interest and legislation in force. Any infringement of this principle, whether justified or not, violates the child's fundamental rights.

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT 1998) recommends a series of criteria to be used to evaluate health care provided to everyone who is cared for in an institution (especially to those who have been

¹⁰⁵ Law 272/2004, article 62 paragraph (1) and (2);

¹⁰⁶ According to the provisions of article 2, paragraph 1, point (a) of Government Decision No 1427/2004, based on medical and psychosocial criteria stipulated by joint Order No 12.709 /2002 of the Ministry of Health and of Family and National Authority for Child Protection and Adoption No 725/2002;

¹⁰⁷ General medical-psychosocial criteria to identify and establish children (0-18) with deficiencies and handicap. (disabilities), Order 12907/2002 of NACPA;

checked in against their will). These criteria may set standards that could also apply to those that are checked in residential care with their consent.

Some of the criteria are:

- Access to an independent and properly trained medical doctor;
- Respect of patient's consent and confidentiality;
- Access to preventive health care;
- Medical doctor's professional independence and competence (CPT/Inf (98) 12).

A number of legal safeguards are specified to protect the disabled child's rights like: periodical re-evaluation of placement and medical care; the possibility to appeal the placement and handicap level establishment; access of the disabled child to a complaint solving system.

The evaluations run during the monitoring process revealed dysfunctions regarding how these safeguards were put into practice, like the level of handicap being established by the Child Protection Commission, which is not even required to hear or see the child. Disabled adults can appeal the handicap level establishment to an administrative body before taking the case to court, whereas children cannot do that. In the light of this, periodical evaluations can be considered only formal.

As to the application of legal provisions which guarantee rehabilitation care for the child, during their visits, the monitors could not identify **rehabilitation plans in place for all institutionalised children**. The children's records were often incomplete or incompliant with legal requirements. For example, it was hard for the monitors to identify the case manager.

"The director said that the Child Protection Department had named 5-6 case managers based on the child's origins, but they didn't come to see the children. He said that if he were asked who the case manager of a child was, he couldn't give a straight answer because he would first have to find out where the child was coming from and only then he could see who the case manager was¹⁰⁸."

¹⁰⁸ Placement centre from the county of I., taken from the monitoring report;

Moreover, according to the monitoring visits, many of the visited institutions were struggling with lack of staff and untrained personnel. The organizational structure varies from one institution to another; some don't have basic positions for child rehabilitation, like a psychiatrist, a psychologist, a speech therapist or a physical therapist. In addition, in the case of some institutions, even if the organizational chart comprises a specialist position, in over 50% of the homes this was vacant. According to the interviewed employee this was due to low wages, working conditions or location of the institution (for example, in difficult to access rural areas). Most of the times, the provisions concerning the number of staff required for a number of children are not met.

In other institutions, the monitors noticed lack of proper training, sometimes doubled by little attention paid to the beneficiaries' needs or interests, which may lead to highly negative consequences:

“A young man was found with a wound in the left frontal area and scars from other healed wounds. The staff couldn't come up with proper means and tools to be used in order to prevent the young adult from getting hurt in the future, like a “special safety helmet”¹⁰⁹.”

“The staff says that the girl has frequent autoaggressive behaviour, banging her head to the floor, while the carers and educators don't do anything to stop her or to find solutions for protecting the girl¹¹⁰.”

In many monitored institutions that hosted children with different mental disability levels, the monitors noticed the poor quality of care and services provided to the children with a severe or deep disability. In the context of the visits paid to institutions for mentally disabled children and to the centres of recovery and rehabilitation of mentally disabled youth and adults, it is important to stress that this type of treatment dramatically reduces the child's chances of rehabilitation or reintegration.

“The children with severe handicap are accommodated in the other building. All 19 children are enuretic and wear diapers (...) The children sleep two in bed and are begging for the visitors' affection. The last ward hosts children suffering from (motor) associated handicap, all aged between 12 and 20 years old, although physically they are extremely under-developed. None of them

¹⁰⁹ Rehabilitation centre from the county of N., taken from the monitoring report;

¹¹⁰ Placement centre from the county of C. taken from the monitoring report;

can communicate articulately .(...) All children have atrophied limp muscles and never leave the room, not even to take a breath of fresh air in the yard of the recovery and rehabilitation centre.”

In general, the monitors could see there was little interest in the children’s rehabilitation, education or socialization.

“The allied health personnel (the orderlies) spend the most time with the residents and confirm that the planned (educational, play, therapeutic) activities are run for very short periods of time – 30 minutes – or in some days they are not carried out at all. Thus, the children are under their care for practically 24 hours a day although the institution has 6 full-time educators¹¹¹.”

“The psychologist said that her work consisted in counselling and evaluating the beneficiaries (...). She couldn’t name the tests she was using or the type of therapy interventions used for children with behavioural disorders¹¹².”

The monitoring visits showed that in almost all of the visited care institutions where there were severely mentally disabled children urgent actions must be taken to inform about and apply the measures and minimum quality standards of care and rehabilitation provided to mentally handicapped children.

As to the education of special school students, who are required to follow a school curriculum, the monitoring visits brought to light different situations:

- From talking to the children, the monitors could identify various types of child labour bearing the name of occupational therapy:

“The boys from the institution claimed that during the whole winter the educators from the homes had made them chop and pile up wood even when the children were complaining about the outside cold and their freezing hands”¹¹³.

- In many institutions, the monitors noticed that the children’s goings out of the institutions were usually controlled and restricted. It is well-known that

¹¹¹ Placement centre from the county of M., taken from the monitoring report;

¹¹² Placement centre from the county of G., taken from the monitoring report;

¹¹³ Centre from the county of M.;

children's integration into the local community greatly depends on their access to community life and if they are restricted or not allowed at all to take part in societal events they will not acquire independent life skills and implicitly will not be able to integrate into the society.

When talking to the monitors during the project visits, the children generally expressed their wish to lead a normal life, to start a family, but the employees of the institution didn't show any interest in their wishes.

As far as deinstitutionalisation is concerned, many times the employees mentioned that a part of the beneficiaries started to be directed to group homes. Almost all of the group homes studied belonged to/were managed/were financed by nongovernmental organisations.

As to family reintegration, the data collected from the visited institutions indicate that this is possible for some beneficiaries, mainly for children with a mild handicap. Nevertheless, the monitors found out about children who, even if they were already 18, came back to the institution after a while complaining about family abuses or difficulties in reintegrating into a society that they claimed they hadn't been prepared for and/or that it did not always accept them.

"I. was reintegrated in her biological family at the request of her mother. After approximately 3 weeks, the mother brought her back to the centre saying she couldn't take care of her anymore (due to financial issues). When asked how she had felt during her stay with her family, the girl said that her mother was living in a rented room, in poor conditions. Her mother forbade her to tell anyone she was her daughter and kept her locked in the house most of the time"¹¹⁴. "

The monitoring reports underlined cases when labour, under its various forms, was promoted as means of integration.

"Older children claimed that they were working in town, on the black market. A great part of institutionalised children without disabilities work at the request of the child protection department: they unload food products from trucks"¹¹⁵.

¹¹⁴ Placement centre from the county of V., taken from the monitoring report;

¹¹⁵ Placement centre from the county of C., taken from the monitoring report;

The reports also indicated that, in general, the institutionalised children from the visited institutions were not prepared for reintegration even when the community held proper resources, like services ensuring an independent life or vacancies in apartments addressing youth leaving child care. The monitors also encountered circumstances when, according to the children, the employees used the institution discharge as a threat, which only makes children get even more afraid to leave the institution.

“The children talked about the fact that one of the educators was very often threatening them this way: ”Just wait until you end up in the streets and then come to my door to beg for a piece of bread. You won’t get anything else from me than a good broom spank”, “you have everything you need here, and from here you will just end up in the streets”¹¹⁶.

We couldn’t detect constant and efficient monitoring of young adults leaving child care institutions from talking to the social workers or psychologists working in the placement centres or specialised services of GDSCCP. Many of the answers received from GDSCCP representatives during 2004-2005 proved that the youth who had left child care were not monitored. The regional meetings with GDSCCP representatives, held in 2006, revealed that the institutional employees and the youth themselves knew little about how to prepare a placement centre discharge and about future integration.

2.7. Lack of effective safeguards to protect mentally disabled children from violence and abuse in specialised care institutions

2.7.1. Protection from abuse

Every child has the right to protection from any form of violence or physical or mental abuse¹¹⁷. State level implementation of this right means to condemn and punish any kind of violence against a child, to establish an accessible and efficient procedure to report violent acts, as well as prevention measures to protect the child from violence.

The monitoring visits also identified circumstances that had little to do with these principles.

¹¹⁶ Idem, see above footnote 102;

¹¹⁷ Article 19 of the UN Convention on the Rights of the Child;

“The children talked about an incident regarding a girl being dragged by her hair out of the dining room and being forbidden to have dinner because she hadn’t obeyed the supervisors’ rule to keep quiet during dinner. The children said that 3 – 4 staff members teamed up and locked the “guilty” girl in another room and beat her up. Some beneficiaries complained about being hit with sticks, bed boards or broom sticks, causing bruises to some of them. The last victim the girls could remember was in the summer holiday of 2005. One girl told monitors that they had seriously cut her hand with scissors because she went against the punishment to have all her hair shaved off, punishment used by the staff to correct bad behaviour. The children also mentioned that the staff talked to them in a vulgar and humiliating way: “suckers” or “retarded”¹¹⁸.

In Romania, the Law on the children’s rights protection and promotion defines abuse on child as:

“any deliberate action of someone holding responsibility, trust or authority over a child that may endanger the child’s life, physical, mental, spiritual, moral or social development, physical integrity, physical and mental health”¹¹⁹.

Romanian criminal code condemns all acts that may engender violence or abuse of a child¹²⁰.

Previous research shows that the rate of abuse and violence against people with disabilities is considerably higher than in the case of healthy population and even higher in the case of women with disabilities. Such abuses may come up in institutions or other types of care, like group homes, for example. They may be carried out by people that the disabled persons know or don’t know and may go from verbal violence to physical violence or refusal to meet the basic needs of mentally disabled persons.

The report “Safeguard Adults and Children against Abuse” mentions that many people consider institutional abuse as endemic and that it can be triggered by depersonalisation practices, lack of privacy, insufficient food and heat, under-trained staff and lack of supervisors, as well as by shunning beneficiaries from community life.¹²¹ In the above-mentioned report, H. Brown, the

¹¹⁸ Placement centre from the county of C., taken from the monitoring report;

¹¹⁹ Article 89, paragraph (1) of Law 272/2004;

¹²⁰ For example, article 174 – homicide and 175 – first degree murder; article 178 – involuntary manslaughter; 180 – battery and bodily injury; article 181 and 183 – bodily injury; article 306 – maltreatment of a minor; article 203.1 – sexual harassment; article 197 – rape; article 198 – sexual intercourse with a minor; article 210 – sexual perversity, etc.;

¹²¹ Brown Hillary « Safeguards adults and children with disabilities against abuse », Council of Europe, February, 2003

author, and the Working Group against Violence, Maltreatment and Abuse against Disabled Persons present a typology of abuse:

- **Physical violence**, which includes abusive physical punishment, confinement – like locking a person in a room and forbidding them to get out – , overmedication or wrongful administration, medical experiments or invasive research against one’s will;
- **Sexual abuse and exploitation**, which includes kidnapping, sexual aggression, harassment, indecent exposure, pornography and prostitution;
- **Psychological threat**, usually consisting in verbal abuse, bullying, harassment, humiliation, threat to abandon someone or to punish them, emotional blackmail, adult infantilisation;
- **Infringement of one’s integrity**, which includes therapeutic, educational or behavioural programmes;
- **Financial abuse**, fraud, seizure of goods, money or property;
- **Neglect, abandonment or privation**, which may be physical or emotional and which usually involve a series of factors like lack of health care, food or water privation or ignorance of other daily needs, educational or behavioural programmes comprised.

The monitoring reports revealed that violence against disabled children was an issue for most of the visited institutions. Generally, children with mental disabilities are more vulnerable to violence and abuse and have problems defending themselves. The monitors identified and reported cases in which the children considered various types of abuse as punishment used for disability-related reasons, examples that were mentioned even by the institutional employees:

“The personnel of the centre admitted that they used physical punishment on enuretic beneficiaries”¹²².

arguing that their gesture was a violent reaction to actions over which the children have no control and which should be addressed with additional care.

Both children and employees admitted that verbal abuses were extremely frequent, from humiliating and degrading names and nicknames to vulgar and coarse talk to children.

¹²² Placement centre from the county of C., taken from the monitoring report;

The monitoring reports wrote that at the time of visits in almost all institutions there were physical abuses going on of the staff or young people with mental disabilities who beat up smaller children¹²³. In some cases, the children said that the staff either took part in these beatings or “instigated” and encouraged young people to start them when they wanted to punish small children without being held responsible for it. During the monitoring visits, the children told monitors about child sexual abuses carried out either by some of the supervisors,

“One of the girls had been sexually abused by an educator. According to the statements of other children (and later of the minor herself) the rape took place in the centre and both the staff and the children knew about the abuse. After almost a year, the minor made a complaint to the General Department for Social Care and Child Protection which started an investigation with the police and prosecutor’s office and suspended the educator. We were told that under the pressure of some staff members, the young girl (who meanwhile turned 18 years old) changed her statement and all legal action was dropped. Later, the educator got his job back and he is currently working at the centre”¹²⁴.

or by family members during their visit

“We were told about a young girl, raped by her guardian, during a holiday spent away from the centre. After the rape, she got pregnant. From the centre for mothers she was sent to the Hospital of Psychiatry and later placed in the centre. At that moment, she was apart from her child who had been placed with a foster carer. Her discharge diagnosis from the Hospital of Psychiatry was functional seizures. We didn’t receive information about the legal procedures used by the General Department for Social Care and Child Protection regarding the complaint and investigation of the girl’s sexual abuse by the guardian or if the representatives of the Guardianship Authority had been informed”¹²⁵.

or in some cases even by young institutionalised residents.

“In a private conversation, one of the employees said that sometimes “younger residents were sexually abused by older residents”, even naming a child that had been a victim of such an abuse”¹²⁶.

¹²³ Based both on the children’s statements and their physical appearance;

¹²⁴ Placement centre for children with disabilities from the county of T., taken from the monitoring report;

¹²⁵ Residential centre from the county of V., taken from the monitoring report;

¹²⁶ Placement centre from the county of V., taken from the monitoring report;

Situations like the ones previously described may be prevented if abuse protection tools are created and implemented like sexual education for children adapted to age and level of understanding, child placement based on age and needs, as well as increased number of properly trained staff.

The monitoring reports also present cases in which the personnel's behaviour represents degrading treatment as set out by the European Court of Human Rights.

"The children confessed that one of the educators, angry because they had been loud, made them get fully undressed and beat them up with his shoes"¹²⁷.

The project monitors didn't manage to identify the abuse or violence prevention measures taken by institutional staff. On the contrary, their reports record that in most of the institutions they noticed the staff's violent behaviour, which was accepted and tolerated by colleagues and managers.

Children and young people with mental disabilities, especially those from rural child care institutions, are extremely vulnerable to abuse or other degrading treatment. These crimes have an impact on children's and young people's physical and emotional development, they are an affront to their dignity and slow down the process of reaching autonomy and independence from child care institutions. Legal protection from such abuses or degrading treatment plays a major role in protecting children and young people with mental disabilities and guaranteeing their physical and mental integrity regardless the institution or environment in which they live.

2.7.2. Abuse reporting

The Law on children's rights protection and promotion stipulates means of protection from *"any kind of physical punishment, as well as privation of the child of his/her rights which could endanger the child's life, physical, mental, spiritual, moral and social development, physical integrity, physical and mental health, within his/her family and in all institutions providing child protection, care and education"¹²⁸*. It is also mentioned that *everyone who, by nature of their*

¹²⁷ Placement centre from the county of M., taken from the monitoring report;

¹²⁸ Article 90 of Law 272/2004;

*work, has to work directly with a child*¹²⁹ is **obligated to report** all suspicion or the abuse itself to the public service of social care or to the general department for social care and child protection. **Compliance with this provision is very important because, ever so often, due to the nature and seriousness of their handicap, institutionalised children have little direct access to complaint settling tools.**

Nevertheless, in the context of intra-institutional abuse, the reporting responsibility is held by the person or persons committing the abuse and who have no interest in reporting the incident. Besides, there is also the tendency of the staff (obvious during the visits) to deny or cover up reported cases and problems related to abuse reporting in the child care system.

*“On 01.05.2005, an employee physically abused a child and fractured his arm. The little girl needed to have her arm plastered which was done at the Municipal Hospital. There, the institutional staff stated that the girl had slipped in the bathroom (the physician doubted that but couldn’t find the real causes as the patient had speech problems). Another staff member reported the incident to the general department for social care and child protection. One of the centre’s professionals told us that she got inside threats to stop reporting physical violence”*¹³⁰.

Notifications are investigated and settled by the representatives of the general department for social care and child protection¹³¹. However, as to notification settling, the only relevant provision generally states that *“the employers must instantly notify the criminal prosecution authorities and separate the person in question from the children under his/her care”*.¹³²

In reality, the data collected in this project showed that, in the visited residential care homes, the abuse reporting and protection mechanism used by the public authorities for children and young people with mental disabilities was not efficient..

“The residents’ statements reveal that the employees use physical violence against them, mainly against the youngest. A relevant case is that of a boy that was beat up by the driver of the institution. The resident escaped from the centre and reported the incident to the general department for social care and

¹²⁹ Idem, article 91;

¹³⁰ Placement centre from the county of I., taken from the monitoring report;

¹³¹ Article 92 and article 93 of Law 272/2004;

¹³² Idem, article 96;

*child protection. Although an investigation was started, the aggressor-driver was not sanctioned and he is still working at the centre*¹³³.

One of the abuse protection safeguards is to give the child the possibility to make a complaint to qualified authorities. The law stipulates as an abuse prevention method setting up “a child helpline”. However, the monitors reported that the beneficiaries that they had met and talked to in all the visited centres didn’t know anything about such a service. Moreover, in many of the cases identified by the monitors, it was noticed that the beneficiaries didn’t possess the right communication skills to be able to use that sort of service.

*“There haven’t been and there aren’t any reporting and complaint making procedures (...). Because of the special medical circumstances of the residents (severe mental retardation) it is unlikely that they could be aware of possible abuses. At the time of visit, the residents’ communication skills were extremely poor. (...) The director stated that out of 50 residents (aged between 6 and 20 years old), only 5 could communicate verbally (...). The head of the centre confessed that she had full trust in the subordinate staff’s ethical and professional behaviour and was not concerned about potential abuses that the centre staff could run on children. (...) The centre management didn’t show us any procedure they used to supervise and find out about potential abuses*¹³⁴.

Article 85, paragraph 2 of the Law on children’s rights protection and promotion gives the child the chance to turn to qualified authorities to take proper measures to protect him/her from any form of violence, including sexual violence, harm or physical or mental abuse, maltreatment or exploitation, abandonment or neglect. The child also has the right to be informed about his/her rights and ways to fulfil them, and the right to make a complaint on his/her own about any violation of his/her basic rights.¹³⁵

During the visits run, from talking to the institutionalised children and employees of the centres it was clear that, in those institutions, there wasn’t any practice or procedure in place to support the respect of these rights.

¹³³ Placement centre from the county of T., taken from the monitoring report;

¹³⁴ Placement centre from the county of O., visit from 28.03.2006, taken from the monitoring report;

¹³⁵ Article 29, paragraphs 1 and 2 of Law 272/2004, provision detailed by the minimum compulsory standards of residential care for disabled children;

“The children said they didn’t know their basic rights and they hadn’t been informed about them. The social worker declared there was a list of the basic rights displayed on the wall of the school where the children were studying, meant to inform them about their rights. However, this was denied by the interviewed minors. There wasn’t any board displaying the residents’ rights in the placement centre. Many of the interviewed beneficiaries said that if they were not pleased with something or wanted to make a complaint, they were ignored and their complaints didn’t get settled. Moreover, they told us that they accidentally found out from one of the beneficiaries about the possibility to report an abuse to the representatives of the general department for social care and child protection”¹³⁶.

According to the minimum quality standards for residential care, all institutions must adopt procedures for making and investigating notifications or complaints, as well as related to the rights of the children, of their parents or legal guardians to be informed about the steps to be made for settling the case and getting an answer. The procedures have to guarantee at least the following: a.) Means to record notifications and complaints; b) Inform the one that has made the notification/complaint about the case settlement stage and tools; c.) Deadline for getting a final answer; d.) The possibility to have someone else make a notification/complaint on behalf of the child; e) Reduce all chances of having the complaint maker involved in case settlement; f) Means to address complaints related to the RCD coordinator; g) Reduce any possible attack on notification/complaint makers. The standard also stipulates that an employee should be appointed to provide information about the complaint making system to anyone interested and hold clear records of notifications and complaints.

In less than ten of the centres visited by the monitors and the representatives of the Centre for Legal Resources, the children and young adults were properly informed about the effective means that they could use to report any suspicion or abuses, violence, neglect to the authorities. At the same time, only in few circumstances could the placement centre employees and directors of general departments of social care and child protection provide relevant information about the tools used to guarantee respect of the children’s right to make a notification and get an answer in that respect.

¹³⁶ Placement centre from the county of T., taken from the monitoring report;

“The head of the centre described the procedure that children could turn to as “a matter of children wanting to make a complaint” and that actually the minors “make up irrelevant complaints meant to harm the employees”.(...) The underage girls complained that they were sometimes beat up with “the broom stick by the educators” and that a beneficiary even committed suicide because she had not been allowed to leave the institution.(...) The beneficiaries would make verbal notifications to the head of the centre because she said that there used to be a notification mail box but it was removed because no one would use it”¹³⁷.

“The manager of the placement centre stated the residents never had any reason to complain about the way the centre employees were treating them although the interviews with the beneficiaries indicated that many residents were complaining about the staff’s violent behaviour. One of the girls complained that she had been beat up by an employee because she refused to go to the bathroom with the other beneficiaries. The children also said that if they complained about it to the school headmaster the night supervisors would threaten them to beat them up when she was out of the centre or of the school”¹³⁸.

We are all equal in the face of law and have, without discrimination, the right to the same protection. Anyone harmed by any violation of their rights has the right to turn to national bodies even if the violation has been made by people acting on their official duties”.¹³⁹

“The majority of the interviewed children said they were afraid to make a complaint; moreover, they were sure that their complaints were ignored because of their mental disability”.

Although the Law on children’s rights protection and promotion grants to county council presidents the right to report any violation of the rights of the children from specialised care residential institutions, in none of the abuse cases identified by the monitors during project implementation did they [the presidents] report the abuse on behalf of the mentally disabled children to the qualified authorities from their county. In addition, the answers to the CLR requests made¹⁴⁰ to a great number of county council presidents asking them information on the number of notifications and complaints made on behalf of mentally disabled children, were that

¹³⁷ Placement centre from the county of B., taken from the monitoring report;

¹³⁸ Placement centre from the county of S., taken from the monitoring report;

¹³⁹ Article 13 of the European Court of Human Rights ECHR, « the right to an effective remedy »;

¹⁴⁰ Between the months of July -August 2006;

they had never taken up such an action. There were even circumstances where the county councils forwarded the Centre for Legal Resources request to the services from the general departments for social care and child protection, saying that the county council held no information about such complaints. Nevertheless, according to the Law on the children's rights protection and promotion "*if guardianship cannot be established, the parental rights and duties are fulfilled by the county council president*"¹⁴¹. These rights and duties comprise the duty to watch over the welfare, full development and protection of a minor.

The departments for social care and child protection, reporting to the county councils in line with the provisions of the Organisation and Operating Framework Rules, "*support and develop information and counselling systems accessible (...) to disabled persons and any other people in need, (...) regarding the exercise of all rights stipulated by the legislation in force*".¹⁴² The Child Protection Commission, county council specialised body, without legal personality, also holds duties related to children's rights protection and promotion: "*it establishes the handicap level of children and, according to the case, guides them to proper schools*" and "*it settles complaints made by children unless the law stipulates this is under the jurisdiction of other institutions*"¹⁴³.

The monitors visiting the institutions didn't find out about any child or young person with mental disabilities making a complaint to the Commission. During regional meetings organised in May-June, the directors or representatives of general departments for social care and child protection didn't point out the *Commission* as a major role player in settling children's complaints although the members of the Commission were appointed to represent institutions like the police department, public health authority, the county council via its general secretary, the county school inspectorate, the department for dialogue, family and social solidarity and licensed private organisations.

In line with the provisions of Article 6, paragraph (2) of Government Decision No 1437 of 2004, "*the members of the Commission represent their appointing institutions and they must exclusively base all their decisions on the child's best interest.*" Despite the fact that the commission members have the duty to settle complaints, CLR didn't receive any information,

¹⁴¹ Article 62 paragraph 2 of Law 272/2004;

¹⁴² Article 2, point (c), paragraph (12) of Decision No 1434 of 2 September 2004 on the duties and Organisation and Operating Framework Rules of the General Department for Social Care and Child Protection;

¹⁴³ Article 1 and article 2, paragraphs (a), (f) and (g) of Decision No 1437/2004 on organisation and operating methodology of the Child Protection Commission;

although it had requested it, regarding the practical and effective way to write and forward a complaint to the commission members, except for the provisions of the law on children's rights protection and promotion that makes reference to notifications of staff members or other persons.

The monitors' findings and the information gathered by CLR reveal that, in the visited institutions, the authorities, whose responsibilities unfortunately overlap, ensure poor child protection from abuse. The cases that CLR identified during monitoring visits and the correspondence with GDSCCP representatives underline that lack of coordination and of involvement of all public authorities responsible for the care of mentally disabled children and young people placed in specialised care institutions may lead to constant violation of children's fundamental rights.

Under these circumstances, monitoring procedures of the respect of the mentally disabled children's rights play a significant role.

2.7.3. Procedures to monitor the respect of the mentally disabled child's rights

Despite the fact that all international tools recommend (some even impose) to draft independent and unbiased procedures for monitoring the respect of the child's rights, in Romania such procedures have not been drafted and implemented yet.

The National Authority for Children's Rights Protection (NACRP) monitors compliance with the principles and rights set out in the UN Convention on the Rights of the Child. The information received during project implementation from NACRP representatives indicate that the NACRP intervention in the area is however limited due to reasons related to human resources and its authority over decentralised institutions.

For example, NACRP requires licence to specialised care services for parent care free children¹⁴⁴. In that respect, NACRP runs service inspection. The licensed service inspection procedure comprises an announced visit of the service and an unannounced one¹⁴⁵. "In the case of unannounced visits, proper measures shall be taken to keep confidentiality over the

¹⁴⁴ Chapter IX of Law 272/2004, Licensing and inspection of the preventive services related to child's separation from family, as well as specialised care for the child, temporarily or permanently, lacking parent care;

¹⁴⁵ Article 21, paragraph (1) of Government Decision No 1440/2004;

purpose and date of the visit and the proxy of inspecting team shall clearly specify the on-the-spot nature of the visit”¹⁴⁶.

In accordance with national legislation in force, by the end of 2006 each “temporarily licensed” child care social service was to be paid an NACRP inspection visit in order to be granted “the operating licence”, valid for 36 months¹⁴⁷. A background note signed by the Minister of Labour, Social Solidarity and Family proposes to extend the date (by 24 months from when the Government Decision No 31/12.01.2006 came into force) to which the child care services are considered “temporarily licensed”. This was triggered by the fact that to that date (12.01.2006), due to lack of staff, the NACRP Inspection Department had visited only 15% of all the child care social services (2011)¹⁴⁸. The background note in question does not clearly mention the number of care services for disabled children that had already been inspected and licensed or the number of children benefiting from these services who could get at risk if service inspection and licensing are delayed.

The announced and unannounced inspection visits, run by the representatives of the NACRP, could guarantee a minimum safeguard against abuse and neglect of mentally disabled children and young people from residential care. The fact that they were postponed by 24 months may mean an extension of the period over which the Romanian Government may be held accountable if mentally disabled children and young people’s living conditions and care do not meet minimum compulsory standards. In line with international conventions and national legislation, the government is responsible for providing to children living conditions and care that respect their rights.

The county departments for social care and child protection (GDSCCP) are empowered by law¹⁴⁹ to intervene in cases of abuse and neglect. The information collected and the regional meetings with the representatives of these authorities show that, nevertheless, as they have few resources, GDSCCPs don’t always manage to monitor the children and promptly address complaints.

Some monitoring and intervention is carried out by *non-governmental organisations* working for the protection of the rights of the child. However, the experience that CLR acquired while

¹⁴⁶ Article 21, paragraph (4) of Government Decision No 1440/2004;

¹⁴⁷ Article 4 point (b), article 27 of Government Decision No 1440/2004;

¹⁴⁸ Background note – Government Decision No 31/12.01.2006 amending article 27 paragraph (1) and paragraph (2) of Government Decision No 1440 /2004;

¹⁴⁹ Law 272/2004 on children’s rights protection and promotion;

implementing the institutionalised disabled children's rights monitoring project highlights the fact that NGO's may face difficulties, first of all related to access to institutions. Although theoretically the Romanian State has committed to inspect and monitor child care institutions and services and there is no legal provision that prohibits third parties' access to residential care institutions, in practice the access is often limited and restricted by approvals of local authorities. All these make it hard for nongovernmental organisations, independent from state-run services, to carry out unannounced visits. At the same time, this monitoring has some limitations which, due to the type of disability on one hand, and to ethical and deontological reasons on the other, may generate a difficult process of direct communication with children and collection of important information from children to identify if their rights have been infringed.

3. WHERE ARE WE HEADING TO NOW? YOUNG ADULTS LEAVING CHILD CARE INSTITUTIONS

3.1 *Question: What happens to children turning 18 years old? Answer: They get their things and they are seen to the door. We don't know what happens to them*¹⁵⁰.

Once they turn 18 years old, institutionalised youngsters are no longer under the care of child care authorities which raises the problem of where they should head to.

Between 2000-2006, state central institutions qualified in the area of mentally disabled people care and protection drew up strategies and documents containing measures to reorganize and close down some centres for recovery and rehabilitation of people with neuropsychiatric handicap and set up other 10 residential centres with the financial loan World Bank granted to Romania (NAPH). The Strategy of the National Authority for Persons with Handicap, financed with PHARE funds, laid down the gradual closing of big institutions to make the transition to community services.

In May 2004, following the Amnesty International organisation Memorandum sent to the Romanian Government, the latter committed to reassess national psychiatric care and, implicitly, chronic patients, who were mostly former youngsters with intellectual disabilities (without medical treatment) transferred from placement centres as a solution to lack of vacancies in the residential care centres for disabled adults. Starting with 2003, as part of the psychiatric care reform set off by the Ministry of Health and due to pressures from international institutions and organisations regarding the high number of adults with mental disabilities or social issues checked in rural psychiatric units or hospitals, some of these became "medical-social units/centres". Two of them (The Medical-Social Centre from the county of B. and the Medical-Social Centre from the county of G.) have operating authorisation issued by the Ministry of Health but are funded by County Councils and County Health Insurance Houses to cover pharmaceutical costs. In May 2006, the Minister of Public Health signed the Order turning the former mental health laboratories into mental health community centres with 30 to 40 beds.

¹⁵⁰ Educator from a placement centre from the county of M, taken from the monitoring report;

The National Children's Rights Protection and Promotion Strategy for 2006-2013 and the National Strategy for Social Inclusion of Youngsters Leaving Child Care talk about housing or creation of new centres hosting youngsters that leave placement centres.

Both the 2006-2008 Operational Plan for implementing *The National Children's Rights Protection and Promotion Strategy for 2006-2013* and *The National Strategy for Social Inclusion of Youngsters Leaving Child Care* (hereinafter called the National Strategy) include a series of care measures for this target group, like:

- Measures guaranteeing job access;
- Measures guaranteeing house access:
- Guaranteed access to health care;
- Guaranteed access to education.

The National Strategy also mentions that all programmes targeting post-institutionalised youngsters follow two main directions: housing access (in assisted apartments, half-way homes, temporary shelters, night shelter, etc.) and employment access. The same document specifies as well that *as to housing, approximately a fifth of the programmes are shelter-like, and only few programmes include assisted housing.*

Still, the National Strategy doesn't set as a 2006 operational objective to increase the number of assisted apartments, but "[the Ministry of Labour, Social Solidarity and Family] *to adopt during the year of 2006 a legal document on setting up assisted dwellings for the social inclusion of the target group young people*".

The monitoring has brought to light the fact that many of the objectives of these strategies are not known or embedded in proper local measures. Almost all the GDSCCP representatives reported lack of (financial and human) resources needed to provide efficient after-care services. Moreover, the documents adopted don't include clear stipulations about special measures and the need for care of the minors and youngsters with severe mental disabilities.

The monitoring visits run in the County of V. in 2006 and the memos of 5 former beneficiaries of a placement centre from that county revealed a case of two former beneficiaries of the centre, with mild mental disability, that, after placement centre restructuring and due to lack of community level alternatives, refused to be transferred together with the other 3 former beneficiaries in a rehabilitation centre for people with severe mental disabilities from another

location. The youth, who eventually had to accept the transfer, wrote to CLR to find alternative care for them. The five youngsters also complained about the fact that they hadn't been prepared for being transferred in another centre and that two of them had to quit their jobs because of the long distance between the two towns [their salary was not enough to cover their rent, household costs and everyday needs]. ,

As previously mentioned (in chapter 2.6.), in the visited institutions, the CLR monitors didn't see constant attention being paid to the mentally disabled children's rehabilitation and social reintegration. Thus, reintegration of these children might be difficult to achieve:

“The centre manager and the psychologist said that jobs had been found for a part of the residents with behaviour disorders, but they hadn't succeeded to adapt to the working hours and had come back to the centre”¹⁵¹.

The information collected show that the alternatives to institutionalisation (for example, assisted housing) for the children from the institutions visited by the CLR monitoring teams are insufficient (in terms of capacity and resources), inadequate (to disability-related special needs) or they are missing completely.

“About 25 over 18-year-old residents were sent to group homes. The physician told us that the youngsters transferred there didn't manage to integrate. Consequently, some of them were admitted to the psychiatric hospital from V., and most of the transferred young people complained to the physician that they weren't getting along with the staff and wanted to leave town”¹⁵².

Of all the cases examined during monitoring visits, family reintegration was possible only for few children that we met. Therefore, it seems there is little chance for the over 18-year-old beneficiaries to follow a different track than institutionalisation.

Throughout the project, the monitors and CLR representatives recorded in less than ten of the visited institutions, the young people were assisted to integrate into the community (independent life skills and social housing) or to get and keep a job. We have to mention the fact that most of the youngsters who could be interviewed and the employees from a series of

¹⁵¹ Placement centre from the county of O., taken from the monitoring report;

¹⁵² Placement centre from the county of B., taken from the monitoring report;

placement centres didn't know the name and contact data of the case manager, who is supposed to support the young person in his/her attempts to integrate into the community.

During their visits, the monitors didn't identify any clear or generally applied procedures regarding the transfer of children who turn 18 to adult care institutions. As there aren't any legal provisions and practice guidelines in that respect, it is confusing who would have to decide where the beneficiary should be transferred to. According to the practices observed during monitoring visits, a little while before the young person has to leave the institution, the head of the centre, sometimes together with GDSCCP, proceeds to finding a place in an institution with vacancies, based on criteria like location and number of beneficiaries. The monitors couldn't identify transfer priorities related to the young adults' personal evolution and development or to his/her choice. The cases met and examined showed that these young persons were seldom informed or asked for their consent for the transfer or his/her future destination.

In accordance with the provisions of the Government Decision No 1437/2004 on organisation and operating methodology of the Child Protection Commission, the Commission issues the expertise certificate and decides on school/vocational guidance also for the young person who has turned 18 and who is at least 3 years older than the appropriate school age¹⁵³. Moreover, the Commission can cancel or replace the previously set measure if the circumstances having led to it have changed.¹⁵⁴

In all the visited child care institutions which also hosted young people with mental disabilities to be transferred to adult care, the ones that the monitors managed to interview confessed that they had never been asked about where they would like to go or if they agreed with being transferred to a centre for recovery and rehabilitation of handicapped adults. The young people that could be interviewed and that the monitors considered not to have a mental disability said that, if they were to choose, they would like to live in an apartment from a small centre and never in a residential centre of 300-400 beds.

Thus, in these particular circumstances, the provision which states that "*the child's presence and hearing occur only when deliberately required by the Commission*"¹⁵⁵ when they have to approve on vocational guidance and establishment of handicap level for the disabled child, must

¹⁵³ Article 3, paragraph 3 of Government Decision No 1437 / 2004;

¹⁵⁴ Article 2, paragraph 1, point (d), Government Decision No 1437 / 2004;

¹⁵⁵ Article 16, paragraph 5, Government Decision No 1437 / 2004 published in the Official Journal, Part I, No 872 of 24.09.2004;

be seriously taken into account and in the child's best interest, mostly when deciding on the mentally disabled young person's future.

As these beneficiaries bear mental disabilities, when looking for a place in specialised institutions, one should keep in mind a couple of criteria meeting the special needs of the beneficiary, which makes this process harder than in the case of a healthy child. As to the cases examined, due to the specificity and difficulty of this process, some visited child care centres still host, using different pretexts related mostly to transfer problems, the over-18-year-old beneficiaries even if they should have left child care. Thus, in a third of residential care centres for mentally disabled children that the monitors visited, there were mentally disabled young persons aged between 18 and 23. The employees and the authorities said that most of them were there because there were no community services addressing their needs. Under these circumstances, the monitors couldn't find out future viable solutions from the representatives of the general departments of social care and child protection or the employees of the visited centres. .

The law stipulates the possibility for a child that has turned 18 to benefit from specialised care in a placement centre. Article 51, paragraph (3) reads that *"The young person acquiring full capacity to exercise his/her rights and having benefited from a specialised care measure, who doesn't continue school and cannot be reunited with his/her own family, and facing the risk of social exclusion, may benefit, at request, for maximum 2 years, from specialised care in order to ease his/her social integration."*¹⁵⁶ Moreover, the young person may continue to benefit from care until the age of 26 if he/she attends a form of school. However, throughout the project it came out that this was possible only in the case of young persons with mild mental disabilities, who, thus, have the highest chances of social integration.

Another problem identified during the monitoring of the institutions visited within the project was children living together with young people which seemed to sometimes make life more difficult for the former.

In some cases encountered by the monitors and explained by the employees as a result of no alternatives, the latter tried to improvise various solutions:

¹⁵⁶ Law No 272/21.06.2004, published in the Official Journal, Part I No 557 of 23.06.2004, on the children's rights protection and promotion, Chapter III, Section 1, article 51, paragraph (3);

“Due to lack of assisted dwellings or vacancies in centres for rehabilitation of disabled adults, 11 young people who had been released from the centre had to live in its former stables. The unclean and improper facility where the 11 young people were living was not connected to the water supply and heat networks. During the summer, they would get daily jobs in the village, and during the winter they would get food from the centre staff. The centre employees and the young persons were afraid that if caught living in the yard of the centre they would get in trouble with the local authorities”¹⁵⁷.

The data gathered during the project visits monitoring the way in which mentally disabled youth that had left child care were integrated revealed that the residential care centres for disabled adults were in general overcrowded. It was also noticed that the staff of these centres tried to find solutions that they thought could be justified:

“X, who is merely 19 years old and has severe retardation (under 40 IQ) was placed in a care home for the elderly (...) The psychologist who was asked about the young woman’s presence in the centre for the aged said it had been decided to integrate the girl in this centre so that she could be better supervised because she was sharing a room with three other women who could take care of her”¹⁵⁸.

or that placement centres for children with severe mental disabilities were turned into centres of neuropsychiatric recovery and rehabilitation for disabled adults (with the same facilities and employees).

In this second case, these centres for adults can no longer be inspected by child protection authorities and lose county council funding on one hand and, on the other hand, they are not embedded in the reform of the rehabilitation care for disabled adults. All these only worsen the conditions of the beneficiaries.

“The Placement Centre, as it was described on the GDSCCP webpage, changed its name in September 2004 to The Centre for Neuropsychiatric Recovery and Rehabilitation, accommodating 47 young persons with severe mental retardation, aged between 18 and 23 years old.(...) The building and

¹⁵⁷ Placement centre from the county of V., taken from the monitoring report;

¹⁵⁸ Centre of services from the county of P., taken from the monitoring report;

sanitary facilities were seriously damaged and dirty at the time of visit, while the dormitories were overcrowded.(...) The manager of the centre asserted that since the placement centre had been turned into a disabled adult care centre there hadn't been funds available for building refurbishment and maintenance.(...) The psychiatrist and social worker came to the centre only when called for, and speech therapy, physical therapy and psychological counselling could not be carried out because they didn't have specialised staff. There are no standard procedures to be applied when the young people decompensate or get violent, and the staff say that they immobilise them to their arms until they calm down”¹⁵⁹.

The CLR monitors encountered another situation that they considered unacceptable: the transfer of mentally disabled young persons to psychiatric hospitals and units for chronic patients, which the employees said was due to lack of proper alternative solutions for those youngsters. As mentioned in other monitoring reports, including the one drafted by the UN Rapporteur for the right to health, Prof. Paul Hunt Ph.D., in some psychiatric hospitals and units for chronic patients, the abuses are extremely serious and there is much less concern for beneficiary rehabilitation.

“A great number of young persons with severe mental disabilities from a placement and rehabilitation centre for disabled children were transferred to the external psychiatric unit of the County Hospital. (...) As to the hospital living conditions and care, at the time of the monitoring visit most beds had no bed linen, and the patients had to sleep on uncovered extremely torn mattresses. The external unit was not kitchen-endowed and consequently the patients' food was brought by car from town. At the time of visit, the lunch menu of the health care unit comprised only rice and bread. Sanitary facilities were in terrible shape, with no running water, while the shower programme was once a week. Both women and men had their hair cut very short to avoid parasite infection as there was no hot water to bathe the patients. A staff member said the patients used to fight each other and that, when the staff couldn't stop them, they would tie their arms and legs up with bed sheets and an orderly would supervise them until they calmed down. When there was sufficient pharmaceutical supply, the staff supplemented the treatment with

¹⁵⁹ Rehabilitation centre from the county of C., taken from the monitoring report;

sedatives to calm the patients. The young persons with intellectual disabilities (whom the physician had diagnosed with oligophrenia), transferred in the last years from the placement centre, didn't benefit from rehabilitation and recovery meant to help them integrate into the society because 'this unit is a health care unit, not a social care one'¹⁶⁰.

As a conclusion, the cases identified throughout the monitoring project and presented in this report reveal that the child care leaving of a mentally disabled person may be problematic and may offer few chances of real recovery and rehabilitation. In these particular cases, the mentally disabled young person going through such an experience is seldom given the chance to become an active member of the society and live a full life.

¹⁶⁰ External unit of a psychiatric hospital from the county of M., taken from the monitoring report;

4 CONCLUSIONS

Romanian legislation embedded, although not always in a full manner, most of the international provisions regarding the rights of mentally disabled children and young persons. In addition, strategies, action plans, primary and secondary legislation, standards and implementation methodologies, etc. were drawn up to protect and promote the rights of institutionalised children and young people. As far as the status of institutionalised mentally disabled child and young person is concerned, the legal framework is quite lacking and it doesn't provide enough safeguards to this vulnerable category.

The field work showed that the few legal provisions in the area are not always known and implemented. According to the information collected, this is due to numerous reasons that vary from legislative gaps leaving fundamental principles without implementation support, to the practitioners' ignorance and/or lack of application of legal documents to lack of professional human resources or material resources of the mentally disabled child and young person care system.

In almost all the homes visited, the monitoring teams of the Centre for Legal Resources (CLR) identified or were reported cases of violation of the fundamental rights of mentally disabled children and young people, which may go from lack of food, adequate clothing and footwear, of sheets, pillows or beds and lack of activity and stimulation, of adequate medication and treatment to under-trained and unmotivated staff and abusive application of individual freedom restriction methods and isolation from the rest of the community.

Care institutions for mentally disabled children are generally required to provide living conditions that bring comfort and safety to children, which constructively contribute to their rehabilitation. NACRP issued the Order 27/2004 adopting minimum quality standards in this respect. However, the monitoring visits showed that such conditions are not always provided. In at least a third of the institutions visited, the living conditions are even appalling. In almost half of the visited institutions, the children and youngsters don't have personal belongings or a place to keep them. In at least one third of them, the bathroom and restroom disposal infringes the right

to intimacy. Usually the institutional employees are the ones who decide on the food provided to children, mostly based on budgets.

The team was reported cases of children from homes for mentally disabled children that were arbitrarily admitted to psychiatric hospitals for reasons that had nothing to do with a specific treatment or diagnosis. Moreover, some data indicate placement of parentless children in psychiatric hospitals that the local authorities explained by temporary lack of alternative care, although this type of institutionalisation is the most harmful of all. Other cases were identified of under-2-year-old children, without an established handicap level, who were placed in institutions providing care or treatment to mentally disabled people (including psychiatric hospitals).

The monitoring visits revealed cases in which the child physical restraint and seclusion methods, non-compliant with legal stipulations in terms of characteristics and purpose, were mostly physical abuses on children. This may be due to both legislation gaps, as the law is not clear enough about the terms under which such measures should be taken, and indifferent or untrained staff.

The reports of the monitoring visits show that the child's right to proper medical care is often defied by scarce access to health care services and lack of resources. According to the representatives of the visited institutions, a great number of problems concerning specialised medical care, especially dental treatment, are raised by discriminatory attitudes towards mentally disabled persons.

Mentally disabled children don't always need psychiatric treatment. Still, many children receive antipsychotic medication which is not always backed up by a diagnosis or followed by therapy. The talks with the staff of the visited institutions revealed that the main purpose of this measure was to gain better control of the child and to relieve the staff from having to involve the child in activities. Such treatment is prescribed without the prior informed consent of the legal guardian or of the youngster, and it is very rarely revised.

The discussions held during monitoring visits and during regional meetings showed that many of the visited institutions had to deal with insufficient or under-trained staff. The poor quality of care and services reduces dramatically the children's chances of rehabilitation and

reintegration. In general, it was noticed that there were few activities that targeted children's rehabilitation, education or socialisation.

Physical and verbal violence used against disabled children is a problem for the majority of the visited homes (according to the children and to the employees). The employees' violent behaviour is, generally, accepted and tolerated by colleagues and managers, who don't take measures. As a result of abuse reporting system gaps, child's prevention from making a complaint and no independent and unbiased monitoring procedures in place, the mentally disabled child doesn't get protection from abuse as required by relevant national and international documents.

As found out during monitoring visits, once they turn 18, some youngsters with mental disabilities have problems integrating into the society and benefit from no alternatives to institutionalisation. The welfare and social care system hasn't come yet with the right answer to this problem.

In this context:

- We draw the attention of the Romanian Government that strong political will is needed to draft and adopt policies in order to effectively implement measures ensuring reintegration of mentally disabled children and young persons from residential care.
- Central and local authorities are recommended to grant more support to nongovernmental organisations developing and implementing community services for mentally disabled children and young persons.
- The Romanian Government is asked to endeavour to change negative attitudes towards mentally disabled persons.
- The Romanian Government is also asked to draft effective policies to support children from socially marginalised families.
- The Government needs to immediately proceed to the drafting and implementation of a national interdepartmental programme to guarantee safety and care to mentally disabled children and young persons from any kind of residential institution for mentally disabled people and to grant them free access to justice and solutions when their fundamental rights are infringed.

5. RECOMMENDATIONS

5.1. *Overall recommendations*

In the light of the cases identified and of the previously presented data and recommendations, during regional meetings attended by representatives of the visited institutions, of GDSCCP's from the project counties and of NACRP, possible recommendations were talked through to improve the overall situation of disabled persons (children, youth or adults). They are summarised as follows:

- i. To provide the support needed to set up and sustain a multi-sectoral commission for drafting and managing implementation of integrated policies of promotion, implementation, protection and monitoring the rights of the disabled (that could be organised in specialised committees for children, for mental disability, etc.);
- ii. Strong support through monitoring and close evaluation and allocation of proper resources to efficiently implement the drafted policies and to adopt new coherent policies to diagnose and intervene in favour of new-born babies and disabled small children and to prevent them from being separated from their family;
- iii. To provide technical and financial assistance needed to develop integrated community services for mentally disabled children and youth and their families;
These services proved to be very useful (where they were developed) to socially marginalised children and families and they helped reintegrate institutionalised mentally disabled children and youth.
Previous experience shows that the best practices in the area were based on the expertise of NGO's whose contribution should be fully used to extend these practices at national level;

- iv. To grant proper support to change discriminatory and negative attitudes towards mentally disabled people.

This may include:

- To organise education campaigns, training sessions and media campaigns meant to change the discriminatory attitude towards persons with mental disabilities;¹⁶¹
- To start training programmes for representatives of police and judicial bodies on how to take testimonies from disabled persons and investigate abuses thoroughly¹⁶²;

- v. To allocate sufficient resources needed to ensure decent living conditions to institutionalised children and young people suffering from mental disabilities.

These comprise:

- To guarantee compliance with national and international standards in the area of health care delivery, respecting each patient's right to information and adequate individualised care and continuous (re)evaluation;
This also implies regular monitoring run by central or local authorities to make sure Law 272/2004 and its standards are respected.
- To take effective measures to guarantee nationwide ongoing, permanent and homogenised staff training on best practices in working with mentally impaired children and young persons and on effective ways to respect their rights;
- To identify and apply measures ensuring specialised medical staff (psychiatrist, psychologist, physical therapist, speech therapist, etc.) so that the children may have access to specialised care when this is needed for their treatment, recovery, re-evaluation or other circumstances;

¹⁶¹ Special Rapporteur, professor Paul Hunt, on the right of everyone to the highest standards of physical and mental health, delivered at the 62nd session of the Commission on Human Rights on the 21st of February 2005: *Such an action is crucial to trigger increased level of information among people and communities and to understand that discrimination against these persons, (...) is unacceptable and violates fundamental human rights;*

¹⁶² Recommendation Rec (2006)5 of the Committee of Ministers of the Council of Europe on the Action Plan to promote the rights and full participation of people with disabilities in society;

- To increase efforts to rehabilitate and socially integrate mentally disabled children who are about to leave child care;
- To create and diversify alternatives to institutionalisation for youth leaving child care;
- To draw up and implement a national interdepartmental programme to guarantee safety and care to mentally disabled children and young persons from any kind of residential institution for mentally disabled people and to grant them free access to justice and solutions when fundamental human rights are infringed.

This measure should also include monitoring of application of legislation regarding child abuse reporting and child's right to make a complaint in such cases;

- To develop and put into practice real measures to prevent abusive and arbitrary admission of children, with or without disabilities, into psychiatric hospitals;

vi. To have the Romanian State support and acknowledge an independent and unbiased tool of monitoring the respect of the rights of mentally disabled children from child care institutions¹⁶³;

vii. To ratify the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

5.2. Specific recommendations

Between May-June 2006, the representatives of the Centre for Legal Resources and of UNICEF organised in this project four regional meetings at Sibiu, Cluj-Napoca, Timisoara and Bucharest, attended by 64 representatives of general departments for social care and child protection (GDSCCP) together with those of the National Authority for Children's Rights Protection. These

¹⁶³ In this respect, the representatives of the Committee for the Prevention of Torture, Cruel, Inhuman and Degrading Treatment (CPT) who visited institutions for mentally disabled people from our country, in the last report made public on January 2006, recommended to the Romanian Government "*to remind very clearly to the employees of the visited institutions that insulting a beneficiary is unacceptable*", to allow periodical visits of institutions for mentally disabled people and allow monitoring teams to have private talks with the institution beneficiaries, to ask for access to files and recommend proper measures to be adopted (CPT, Report to the Romanian Government on the visit made by the European Committee for Prevention of Torture and Cruel, Inhuman and Degrading Treatment (CPT) of 15-21 June 2004, published on the 19th January 2006 (pages 20 and 23).

meetings aimed not only at analysing and recommending immediate solutions to the specific and individual cases presented in the monitoring reports, but also at consulting the participants as to the opportunity, utility and efficacy of a monitoring intervention like the one carried out by CLR. The talks and conclusions drawn at these meetings recommended the following measures to prevent and identify violation of the fundamental rights of institutionalised children and youth but also to promote these rights. The measures are summarised below and it is recommended that they be looked over and adopted at national level:

5.2.1. Measures to PREVENT violation of the fundamental rights of mentally disabled children and young persons placed under specialized care (placement centres, residential care, group homes, foster care, family placement, etc.):

- i. To facilitate and encourage information collection and sharing within the child care system about violation of the rights of the mentally disabled child and young adult.

A great number of managers of GDSCCP recommended heads of care centres to be trained, and later monitored and assessed, to report in time notifications and complaints about alleged or real cases of child rights violation. The representatives of general departments also recommended as measures unannounced visits and disciplinary sanctions, when necessary.

Special attention was paid to basic and continuous training of the staff delivering services within residential care centres. Thus, the participants recommended:

- To support staff training and professional development programmes;
- To draft, start and monitor implementation of institutional practice guidelines and of staff deontological code.

- ii. To encourage and support data and information being collected from institutionalised children and young people with mental disabilities about their rights. This measure would first of all imply:

- To inform and train every child, according to their potential, about their rights and encourage children to express their thoughts and opinions;
as well as other interventions, like:

- To organize an information and training campaign, using language accessible to mentally disabled children and young persons from institutions, regarding the acts that infringe their rights and the means to report them;
 - To implement an effective system of reporting the complaints of the mentally disabled children and young persons from care institutions so that the notification be addressed in due time and the complaint maker be kept anonymous;
 - Inform parents and all mentally disabled children and young people about the rights their family members have at institution level and the legal means they can use to contribute to protection from abuse.
- iii. To support, acknowledge and cooperate within an independent and unbiased body monitoring the rights of institutionalised mentally impaired people. During each of the four regional meetings, the majority of the GDSCCP representatives identified positive aspects of the CLR project and talked about setting up a body which should work similarly to the one from the monitoring project, carried out at national level by the Centre for Legal Resources and UNICEF, but which, in order to avoid some aspects that could have a negative impact, should hold the following responsibilities:
- Sign a memorandum of understanding with each GDSCCP prior to any intervention;
 - Previously inform the GDSCCP manager about the team members running the unannounced monitoring visit;
 - To inform the GDSCCP manager, before starting a monitoring action, about interviewing and observation methods which will be used during monitoring visits and data collection techniques;

The recommendation of the participants to the regional meetings was complemented by the recommendation of the UN Special Rapporteur on the right of everyone to the highest standards of physical and mental health, stating that:

“The Romanian Government must considerably strengthen national mechanisms regarding liability for the respect of the right to health. The Government must start analysing current mechanisms holding liability for

the respect of the right to health, and then consider all options to strengthen this liable mechanism. A possibility would be to keep the existing institutions with the same mandate and attributions, but with increased resources. The second possibility would be to keep the existing institutions, but widen their mandate and attributions as well as increase their resources. The third possibility would be to set up a new human rights watching institution working mostly to promote and protect the right to health and qualified to run investigations and record complaints. This third option may be put into practice either through a new institution focusing solely on protection of the right to health, like an Ombudsman for Health, or through a human rights watching institution with wider mandate and attributions, in accordance with the Principles of Paris. After consultations, the Government will have to decide on the best option.

The Special Rapporteur truly believes such measure to enhance liability for the respect of the right to health is needed, as the existing devices, including courts and professional colleges, cannot come up with the right solution to establish liability for patient problems and for the overall respect of the right to health” (Recommendation 27).

5.2.2. *Measures to encourage FAST IDENTIFICATION, REPORTING AND INVESTIGATION of any violation of the rights of institutionalised mentally disabled children and young persons:*

- i. To develop and implement procedures meant to help institutionalised mentally disabled children and young people identify and report any violation of their rights. These procedures may include:
 - To inform institutionalised mentally disabled children and young people, using accessible language and tools, about how to identify and recognize any violation of fundamental human rights;
 - To set out and effectively use a notification and complaint making system adapted to persons with mental disabilities and facilitate their access to independent human rights bodies; rare accessing of such a body or lack of complaints would not necessarily mean that the rights

of institutionalised mentally disabled children and young persons are not violated;

- To protect mentally disabled children and young people who have made a complaint about their rights being violated from any “attacks” undertaken by the staff or other institution beneficiaries if they don’t stay anonymous or their identity comes out.

But they should also include direct participation of mentally disabled children and youth in monitoring actions concerning them:

- To encourage participation of institutionalised mentally disabled children and young persons in councils within the institutions where they have been placed but also in the monitoring teams or notification investigation commissions;
- To consult mentally disabled children and young persons about the problems they face and encourage them to find solutions or suggestions;
- To make sure mentally impaired children and young persons go periodically to the County Child Protection Commission and are heard;

ii. Train the staff and representatives of qualified authorities to identify and report any violation of children’s rights:

- To organize training sessions for the entire personnel, not only for the teaching staff, on the respect of the fundamental rights of mentally disabled children and young people and on detection and reporting of violation of these rights;
- To ensure *Guidelines* for the institutional staff containing what they have to do in order to unbiasedly investigate a notification of infringement of the rights of mentally disabled children and young persons;
- To draw up and implement a set of criteria and standards, in partnership with the representatives of the National Council against Discrimination, so that mental disability-based discrimination cases be identified and reported.

5.2.3 *Measures to GUARANTEE SAFETY and PROTECTION FROM ANY ABUSE to institutionalised mentally disabled children and young persons, especially to children and young persons with severe mental disabilities:*

- i. To draft and implement efficient and effective measures to ensure nationwide ongoing, constant and homogenous staff training on child protection from any form of abuse. This implies to train the staff and monitor practices regarding the following issues:
 - to let mentally disabled children express their opinion (and listen to it) about hospital admission and psychiatric care administration, except for the cases when legal documents prove they lack legal capacity;
 - the need to get the informed consent for hospital admission and treatment when the mentally disabled young person is transferred for treatment to a psychiatric hospital or unit;
- ii. To draw up and implement a set of measures regarding transfer of a mentally disabled child/young person from a child care centre to a psychiatric hospital;
- iii. To draw up a set of standards and practice guidelines/deontological code as well as of a compliance monitoring system regarding the application of freedom of movement restriction methods to mentally disabled children/young persons both within child care institutions and health care units;
- iv. To ensure access to an independent body revising hospital admission of a mentally disabled child/young person who has been transferred against his/her will from a placement centre to a psychiatric hospital.