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Monitoring report

External Psychiatric Ward for Chronic Patients

"Dr. Valer Russu" Luduș City Hospital,

Mureș County

project conducted by:

CENTRUL DE RESURSE JURIDICE

in partnership with:

MINISTERUL PUBLIC

General aspects:

The monitoring visit took place within the framework of the "Advocacy for Dignity" Programme, which has been run since 2003 by the Centre for Legal Resources. None of the activities carried out by the Centre for Legal Resources for the purpose of monitoring and ensuring access to justice for residents with disabilities from public or private residential centres, sheltered housing, family-type homes, placement centres or psychiatric hospitals is funded by the Ministry of Labour and Social Solidarity or any other central or local public authority.

The team of the Centre for Legal Resources (CLR) made up of Georgiana Pascu ("Advocacy for Dignity" programme manager), Alina Barbu (legal expert, psychologist), Roxana Mărcoiu (clinical psychologist), Mugur Frățilă (clinical psychologist), Dan Partig (legal expert), Milena Enescu (legal expert) arrived at the *Psychiatric Ward of the Luduș City Hospital* on 03 October 2023, at 18:45, and the visit to the unit took place between 18:45 and 20:00.

The building of the external psychiatric ward was supposed to move at the end of 2022 to a new location (Strada Fabricii, nr. 1 in Luduș). The CLR team checked the new location and did not identify the new premises, but found the external ward still operating in the Banffy Castle building in Gheja district. The castle is a former aristocratic residence, the building is classified as a national monument and, according to staff members, is owned by Luduș City Hall. Although partially renovated (the space where the psychiatric ward operates), the building as a whole is in an advanced state of disrepair. At the time of the arrival of the CLR team, the gate of the castle was wide open (according to the staff, the gate has been open all the time for about 10 years). At one time there was an intercom call security service; due to road widening works the system broke down and eventually the intercom installation was decommissioned and the gate was no longer closed.

Living spaces, living conditions:

The ward has 8 lounges, of which 6 are operational (rooms 2, 3, 4, 5 on the ground floor and 6 and 7 upstairs) and 2 are disused (the two on the right tower). There are 16 surveillance cameras on the premises. The building is, as has been pointed out on many occasions, unsuitable for housing such patients, despite efforts to improve certain aspects of the infrastructure (e.g. centralized heating via its own central heating system, but with heat loss, as the rules specific to heritage buildings do not allow wooden windows to be replaced with more energy-efficient ones, etc.). Doors are old, corridors and bedrooms are dark, linen is worn but clean. The toilets are unfitted, cleanliness is minimal or not yet done. The showers have high taps, with difficult access by patients, and staff confirmed that it is not the beneficiaries who turn on the water, but the nurses or carers, and bathing is not carried out without help.

By the time the CLR team arrived, the staff shift was being rotated, and most residents were in the dining room, sitting huddled on benches around tables waiting for dinner. Some were chatting, others were lying with their heads on the table. Only a few patients reacted when they saw the CLR team and were interested in exchanging a few words.

The food is prepared in town (Luduș) and brought to the hospital daily. It is portioned and distributed (including depending on the condition - with or without salt, pasta, etc.) by the staff of the centre. On Wednesdays and weekends, dinner consists of cold food, as the hospital kitchen has no schedule, which is why the food for those days is kept in fridges in the outside ward. There is no television in this dining room (main room).

From this room, you pass into an intermediate room with numbered lockers (each patient is assigned a number), where the patients' clothes are stored (neatly) (each patient has their own clothes, pyjamas, toiletries). From the intermediate room you pass into a bathroom, where patients shower or are showered. The room is clean and the sanitary objects seem to be in functional condition (not broken, dirty, etc.).

From the main corridor, after passing through a door that is kept locked, you enter another corridor. There are two (non-communicative) patients in the corridor, walking around as much as space allows. From the corridor you enter a lounge with about 12 beds. The lounge has a television mounted on the wall. We are told by the nurse that the patients in this lounge are cooperative and do not destroy property. Some lounges have 10 beds. In one of the wards, we met a resident who had his own table, where he spent most of his time (he was also a difficult person to move according to his own statements), studying the lives of various religious personalities (Arsenie Boca). He had his own TV in the lounge, the remote control was on his table. He has been hospitalized for about 3 years. He states that he is satisfied with the behaviour of the staff.

Next to the dining room is the doctor's office, and across from it is the isolation room. Close to the isolator, there is a room (the door was open), where bed linen (disposable pillowcases) was stored in an orderly manner.

Next to this room is another lounge with 4 beds. Next to it is a sink with soap available. There were two patients in the ward. One of them, elderly, was sleeping and the other was sitting on the bed. The latter told us that he had difficulty moving around and for this reason he spent a lot of time by the bed. He also mentioned that he does not communicate much with the other patients in the lounge, as it is difficult to communicate with them. Next to this lounge, there is a clean bathroom with a toilet (with a lid) and a shower attached to the wall (there is no bathtub, water runs down the drain on the tiles).

The patients of the Psychiatry Ward for Chronic Patients:

The capacity of the ward is 55 places, at the time of the visit 42 patients (men) were hospitalized. The persons identified have different pathologies: schizophrenia, oligophrenia, dementia. Some of them have been in this facility for almost 30 years. The staff spoke about some patients about whom they had no information at the time of their arrival in this hospital (e.g. a person who was apparently brought from Bucharest North Railway Station, whom they did not know his name, nor did he have any memory, the hospital staff being the ones who gave him a name and then drew up his identity papers).

The hospital staff pointed out to the monitoring team that there are also institutionalised persons under interdiction, but that all of them have legal representatives (however, no documents were presented at the time of the monitoring visit or afterwards). All were voluntarily hospitalized. Only 10 - 15 patients are visited by relatives/acquaintances, but the visits are very rare, usually coinciding with major holidays of the year.

Rehabilitation, psycho-social, leisure activities:

The external ward has a psychologist and a social worker who come to the hospital twice a week. When the psychologist arrives at the hospital "he takes them to the doctors' room and talks to them". He tells them that if any of the residents need him (if they are sadder, if they are crying, if they would like to talk more) to let him know and he will come more often. According to the staff there was no need, because patients talk to them if they have problems. Nurses and caregivers say they know the residents so well that they notice the earliest signs of a decompensation episode, either that they are sadder and more absent or that some become more verbally and physically aggressive, so they let the staff know that one or another's condition is likely to deteriorate. Once they are notified, the doctors come to the centre, consult them and modify their treatment, either increasing the doses or introducing other drugs into the treatment regimen.

The hospital floor houses a room where there is a library with books, some games (chess, backgammon), materials that patients, according to the nurse, use when they want. He says there are some patients who have read all the books, but it doesn't appear that there is any activity programme specifically designed for patients. Besides, the main activity during the day is spending time in the hospital courtyard under the supervision of the staff.

It was found that the ward has no ramp, and access, even to the ground floor, can only be gained by climbing stairs (the better option being one of the rear exits, where there is a lower step and they can easily climb over it). Patients in wheelchairs should be lifted up when they go out, with their wheelchair.

Ward staff:

The Luduș external psychiatric ward for chronic patients has 14 nurses, 12 caregivers, 2 psychiatrists, 1 psychologist, 1 social worker, cleaning staff. The on-call line is provided at the city hospital, doctors come regularly to Luduș, whenever they are called. There are 6-7 people on the day shift (and the cleaning staff are involved in supervising patients when they spend time in the yard), and 3-5 people on the night shift.

Deaths:

During 2021 there were two deaths of patients of the ward, but they occurred at the Târgul Mureș hospital, at the covid ward.

Restraint and seclusion measures:

The psychiatric ward has a seclusion ward (a narrow room, bed in the middle, toilet bowl, sink, waste bin). At the time of the visit, there was a patient in the seclusion room who, according to the staff, needed constant supervision due to a change in medication. The resident was asleep, covered with a blanket, and during the team's conversations with the hospital staff, he did not react at all to noise, which justifies the assumption that the patient was sedated. In the discussions, the staff explained to the monitors that the "mentally ill persons" in general have "a cyclical period", sometimes they feel well, sometimes they decompensate, and now he is in a decompensation episode, which in his case is manifested by physical instability "he has no stability, he cannot stand up". "Mr. I.O., the secluded patient, (says the nurse on duty), is in such a period where he oscillates between states, i.e. he either does not

react to any stimulus (as at the time of the visit) or is hyperactive". The resident's leg was bandaged (we did not receive clear information as to why), but the nurse states that he was not physically restrained. However, he assumes it is the beginning of an eschar. In this gentleman's case, even his food is being brought to the seclusion room.

Findings: when reviewing the restraint and seclusion register, we note that the presence of Mr I.O. in seclusion room at the time of the visit is not recorded. Also, although staff state that Mr. I.O. was often brought to the seclusion room, only 3 situations (13 June 2022, 27 June 2022 and 01 July 2022) concerning Mr. I.O. are recorded in the restraint and seclusion register, and in all 3 of them, partial restraint is involved.

It is a rule for staff to use the seclusion room for periods when some residents need to be supervised, either because they are having problems with treatment or blood pressure. According to statements from staff on shift, they rarely use it to seclude a person in a state of psychomotor agitation (this correlates with analysis of the restraint and seclusion register from which it appears that out of a total of 115 records for 2018 to 2023, only 11 situations refer to the measure of seclusion). Incidents are specifically noted in each patient's *Care Plan*, but unit staff claim they rarely have problems. Also, hospital staff said they had more incidents when the unit also housed the acute patients ward, but now with chronic patients there are no major problems.

One of the patients told CLR experts that when some colleagues become aggressive or agitated, the staff first try to calm them down by talking to them, then give them medication. They psychiatrist prescribed them "in case of, for cases of... they have a cabinet where they keep these drugs, they give them an injection and after that they fall asleep immediately". Patients also state that there are situations where people are physically restrained if they try to harm themselves and are tied either by the hand or by the leg, often in the dining room so that they can be easily supervised, only in the most serious cases are they taken to seclusion room. There is one patient who is restrained more often (even during the night) to prevent him from hurting himself (according to the shift manager, he bangs his head against the walls, etc.).

At the time of the visit, the CLR team identified a 4-point restrained person in a bedroom, next to which was a bed with no mattresses or bedding, and another bed with restraint straps attached. The restrained person had a pronounced intellectual disability, a reduced level of contextual awareness and was unable to communicate.

"**Restraint and/or seclusion register**", with "**Unique No. 5704/24.05.2021**" of the "Dr. Valer Russu" Luduș City Hospital, Mureș county, psychiatry ward, contains the records of the situations of restraint/seclusion for a period of 6 years, from 23.08.2018 to 10.09.2023.

Analysis of the restraint and seclusion register revealed the following:

There are a total of 115 records distributed by years as follows: 2018 - 9 records, 2019 - 30 records (of which one, the last - is deleted), 2020 - 03 records (of which one, the last, with serial number 3 - contains only names), 2021 - 42 records (number 17 is repeated), 2022 - 12 records, 2023 - 19 records (up to the date of the visit). Out of 115 measures instituted, 56 are full restraint measures, 45 are partial restraint measures, 11 were seclusion measures, 1 seclusion and partial restraint measure and 2 seclusion and full restraint measures.

In 2019 the 30 records (one of which, the last one, is deleted) referred to 5 persons as follows: M.E. - 22 records, V.M. - 4 records, S.P. - 1 record, T.R. - 1 record and R.M. - 1 record.

We have encountered the following **situations/errors**: **double order numbers, deleted records, a record with only the patient's name, a record without stating the reason for the measure, inconsistency in the notation, long periods without records**. We also observed a significant fluctuation in annual records (9/year, 30/year, 3/year, 42/year, 12/year, 19/year).

For each year (except as described below) the records start from 1 (the first record of that year) to the last. At the beginning of each year, the numbering of the records starts again from 1. The exception is in the years 2021 and 2022 where the records continue from one year to the next. Thus, the year 2021 contains 42 records (from 1 to 41 instead of 42 because the number 17 is used twice consecutively for two different records), and the year 2022 contains 12 records (from 42 to 53).

Conclusions on restraint and seclusion:

The records in the restraint and seclusion register do not allow for a precise retrospective assessment of the context in which the seclusion measure was taken for a particular patient, the persons involved, the necessity and appropriateness of the measure, the precise details of the monitoring, etc., and appear to be of a formal nature, fulfilling a mandatory task.

The reasons recorded as justifying the imposition of restraint/seclusion are general, vague and, by themselves, as recorded, do not explain or justify the need for the imposition of restraint and/or seclusion. Reasons such as "hallucinations, delusions, running away, restlessness, irritability, drowsiness", etc. cannot by themselves represent clinical arguments for the imposition of restrictive measures such as restraint and/or seclusion.

With regard to the finding of "psychomotor agitation" and its recording as the (sometimes sole) reason justifying restraint/seclusion measure, we consider that this situation needs to be assessed very carefully. We place particular emphasis on this aspect because "psychomotor agitation" is found as a reason justifying the imposition of restraint or seclusion measures in approximately 95% of the 115 measures imposed during the period analysed (often in association with other reasons, such as those already listed: irritability, delusions, etc., but also heteroaggressiveness - frequently - or self-aggressiveness). The fact that a person is agitated, by itself, does not constitute a reason, a justification and a clinical and legal basis for the institution of restraint and/or seclusion measures.

It should be recalled that the Mental Health Law No 487/2002 (Article 39 para.(1)) and its Implementing Rules (Article 21 para.(2)) explicitly and unequivocally state that measures restricting freedom may be applied only if the following two conditions are cumulatively met: 1) the life or health of the person concerned or of other persons is endangered and 2) no other method/technique/intervention has been successful in managing the situation. In view of these legal and methodological issues, the analysis of the restraint and/or seclusion register does not highlight, record or describe the situations in which restraint or seclusion measures were taken, so as to show unequivocally the need for the imposition of restrictive measures, the seriousness of the situation, the immediate danger to life or health and the interventions, the approaches, methods used to manage the situation other than by taking measures restricting freedom.

We have found that there are periods when a particular patient is frequently restrained (daily or even several times in the same day). These situations need to be analysed very

carefully. The therapeutic strategy must be appropriately constructed according to a patient's diagnosis and symptoms so that it represents the best solution for that patient. If a person has to be restrained even 3 times a day, at intervals of several hours, several days in a row, it must be understood that there may be a problem of diagnosis, there may be a problem of therapeutic strategy, of treatment scheme or of resource lack to implement therapeutic methods complementary to psychiatric drug therapy.

Principles/rules on restraint and seclusion from the perspective of applicable legal rules:

The findings of the monitoring team (in terms of non-compliance with established international and domestic principles and rules) are as follows.

As regards physical restraint measures taken against patients in psychiatric hospitals**,** in the *Aggerholm v. Denmark* judgment (No. 45439/18) of 15.12.2020, § 84 and in the *M.S. v. Croatia* judgment (no. 75450/12) of 19.05.2015, §104, §105, the European Court of Human Rights ruled as follows:

- measures of physical restraint should only be taken when they are the last resort, to remove the imminent danger of the patient harming himself or another person;
- the use of such measures must be accompanied by adequate safeguards against abuse. There must be sufficient procedural rules requiring justification that the measure was a last resort and that the principle of proportionality in the application of the measure was respected. It must also be demonstrated (argued) that all other reasonable options (to the measure of restraint) have failed to satisfactorily limit the risk of harm to the patient or others.
- It should also be emphasised that the measures of constraint have not been extended beyond the period strictly necessary for the purpose for which they were taken.

Also, patients who are subjected to physical restraint should be kept under close supervision and each case of restraint should be properly recorded/documented. See *Bureš v. Czech Republic* (no. 37679/08) dated 18.01.2013, §101-103.

Both the measure of restraint and the measure of seclusion, according to Recommendation Rec (2004)10 of 22.09.2004 of the Committee of Ministers of the Council of Europe (to member states) on the protection of the human rights and dignity of persons with mental disabilities:

- must be justified by the danger that the person with a disability would endanger his or her life, health or physical integrity or endanger the life, health or physical integrity of another person;
- can only be implemented under supervision and must be properly documented;
- the person subject to the measures must be regularly monitored. The reasons for taking the measures and the duration for which they were ordered must be recorded in the patient's medical history and in a register.

The above-mentioned provisions, together with other similar provisions, are also found in the Recommendation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT); extract from the 8th General Report (CPT/Inf. (98) 12. Also in the Recommendation of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT); extract from the 16th General Report published in 2006 (CPT/Inf (2006) 35, respectively in the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, adopted by the United Nations General Assembly (Resolution 46/119 of 17.12.1991).

For example:

- restraint measures in psychiatric facilities should be clearly regulated. These should stipulate that in the first instance, attempts will be made to reassure the patient (e.g. staff will give the patient verbal instructions) etc;
- when the emergency situation which led to the application of the restraint ceases to exist, the patient must be released immediately;
- the staff of a psychiatric hospital must take the utmost care to ensure that the circumstances and conditions under which the means of physical restraint are used do not aggravate the physical and mental health of the patient;
- training is essential and courses should be organised at regular intervals. Such training should not only focus on training care staff in the use of restraint but, equally important, ensure that they understand the impact that the use of restraint can have on a patient and that they know how to care for a patient under restraint.

As for the domestic rules, they are also clear on restrictive measures. Thus, with regard to restraint, Law No 487 of 11.07.2002 on mental health and protection of persons with mental disorders provides:

- persons in detention may be restricted in their freedom of movement, by the use of appropriate means, in order to save their life, physical integrity or health or that of another person from real and concrete danger (Article 39(1));
- the measure of restraint may not be used as a sanction, may not be part of the treatment program, and may not be ordered for cases of suicide or self-isolation or as a remedy for lack of staff or treatment, as a sanction or form of threat or to force good behaviour or to prevent destruction of property. This measure may only be used if the application of the least restrictive techniques was inadequate or insufficient to prevent any injury or harm (Art. 39 para. 3);

- the use of means of restraint must be proportionate to the state of danger, be applied only for the time necessary only when there is no other means of removing the danger and never have the character of a sanction (Art. 39(5)), etc.

The rules (of 15.04.2016) implementing the Law on Mental Health and Protection of Persons with Mental Disorders No 487/2002 also provide, among other things:

- when restraining the patient, every effort must be made to avoid pain or injury and any unworthy or abusive behaviour towards the patient (verbal aggression, intentional hitting, presence of other patients or unauthorised persons) is prohibited (art. 9 para. 5);
- restraint may not be used as a punishment or as a means of making up for lack of staff or treatment (Article 9 para. 2);
- medical staff will assess the condition of the restrained patient every 15 minutes, examining vital signs, maintenance of comfort and the appearance of possible side effects (Article 9 para. 9);
- the following information will be recorded on the observation sheet and in the Seclusion and Restraint Register:
  a) the time and minute when the restrictive measure was taken;
  b) the degree of restriction (partially or totally) in the case of restraint;
  c) the circumstances and reasons for the restrictive measure;
  d) the name of the doctor who ordered the restrictive measure;
  e) the names of the members of the medical staff who participated in the application of the restrictive measure;
  f) the presence of any physical injury suffered by the patient or medical staff in connection with the application of the restrictive measure;
  g) the time and minute of each monitoring visit of the patient, specifying the vital function values, the fulfilment of physiological or other needs as appropriate;
  h) time and minute of the termination of the restraining order.
  The patient and/or his/her legal/consensual representative will be informed of the measure of restraint and the procedure its periodic review (Art. 9 para. 11 and 12);
- restraint must be applied for as short a time as possible and may not exceed 4 hours (Article 9 para. 14);
- if the immobilisation has not been initiated on the doctor's instructions, the doctor will be informed within 30 minutes. (Article 9 para.15).

Summary recommendation on restraint and seclusion:

The moment of restraint or seclusion of a person is a moment of extreme gravity, with extraordinary medical, psychological and legal consequences. Therefore, restraint and seclusion must not become common practice designed to replace the lack of staff, the lack of specialists, the lack of alternative methods, the lack of skills, the lack of time resources, the lack of information or, even worse, to become forms of punishment or forms of manifestation of routines. In order to prevent any abuse and to maintain the obligatory vigilance and thoroughness associated with such extreme measures, records and descriptions of when restraint and/or seclusion measures were instituted must be carefully, thoroughly, responsibly and accurately made, so that anyone subsequently reviewing the history of the restrictive measures imposed, to be able to gain a clear picture of the contexts which medically justified the imposition of restrictive measures. In its current form, the unit's restraint and

seclusion register does not meet these criteria.

General conclusions from the monitoring visit:

- The space where the psychiatric ward operates is unsuitable for its intended purpose. Much of the building is degraded and has the appearance of a ruin, a derelict building. The location of the psychiatric ward in an isolated place, next to a cemetery, is totally inappropriate;

- Renovations (due to the building's status as a historical monument) are very difficult to be carried out and can only concern certain aspects (for example, the windows of the part of the building where the ward operates could only be changed after a lot of administrative effort);

- Certain areas of the ward (e.g. the main room), by their layout/compartmentalisation etc., lead to overcrowding. The original purpose of the building was not as a hospital but as a living space, and this clearly appears from the lack of functionality;

- Even if it was substantially renovated, the premises would still not really meet the requirements of a modern psychiatric hospital;

- There are no recreational, educational activities, etc. for patients. Most patients do not even have access to TV, etc;

- Certain rules/procedures (with regard to restraint, seclusion) are not respected; this results, among other things, in the violation of some fundamental rights of the patients.

Development of the general conclusions (summarised above) by reference to the applicable regulatory provisions:

As previously mentioned, the building in which the external psychiatric ward for chronic patients operates is totally inadequate for its current purpose. This observation, which is also obvious, was supported by discussions with some of the staff members who mentioned that they too have to cope with the conditions, which are sometimes difficult even for them (cold, limited space, unsuitable for the purpose, etc.).

It should be noted that the location of this medical facility is also geographically inappropriate. The former aristocratic residence is located at one of the isolated ends of the Gheja district (which, in fact, has only houses).

The patient who goes out "to the air", using the main access road, into the courtyard - otherwise generous in space and vegetation - will see a few dozen meters away, a few houses and roofs of houses on the outskirts of the neighbourhood. If he turns his head to the right, he will see the local cemetery. If he takes a tour of the building, which is in an advanced and visible state of decay, he comes to the back courtyard, where staff cars are usually parked. From here, the patient will see another part of the cemetery and more or less wooded hills.

Taking as a reference the provisions of the Law no. 487 of 11.07.2002 on mental health and protection of persons with mental disorders, several glaring irregularities stand out:

- in relation to Article 25 letter a) of the Law, **the ward is not geographically**

accessible to ensure that it functions to the standards of a psychiatric unit. This has a negative impact on the quality of the health services provided. We reiterate that **the ward line is not actually in the ward but in the premises of the city hospital** (there are about 7 km between the ward and the hospital);

- with reference to Article 25 letter b), **the ward does not have the spaces, facilities and equipment to enable adequate and active assessment and treatment procedures to provide comprehensive care** in accordance with international standards;
- contrary to Art. 25 letter c), **the ward, by its structure/arrangement, does not allow respect for the privacy of patients**;
- contrary to Article 35 of the Law, the **space in which the ward operates** (a seriously degraded building, partly in disrepair, located next to a cemetery) **precludes the idea that patient care is carried out in conditions ensuring respect for human dignity**. Consequently, the provisions of Article 24 of the Law, which states that persons with mental disabilities shall benefit from health services of the same quality as those applied to other categories of patients and adapted to their health requirements, are also violated;
- contrary to the provisions of Article 41 of the Law, it is obvious that **"the right to the best medical and mental health care available" of the patients admitted to the external psychiatric ward in Gheja, is violated by the competent decision-making structures,** (even compared to the "average" domestic standard).

In this context, we would like to mention that during the monitoring visit we were informed that administrative efforts are being made to move patients to a new building, more "adapted" for use as a psychiatric unit, i.e. according to press information: Luduș, str. Fabricii, nr.1. The monitoring team went to the above-mentioned area but was not able to identify the building. On the spot checks revealed that Fabricii Street is located at one of the extremities of Luduș, **right in the industrial area**, far from the city centre, facilities, etc.

We would like to mention that the concrete aspects of the external ward located in Gheja, as observed by the team of monitors, are also in contradiction with the principles stated in the normative provisions in force, concerning the modern conception of mental illness and care of the person with mental disabilities:

- the aim of care for any person with a mental disorder is to strengthen personal autonomy (Article 27 of the Mental Health Law);
- everyone suffering from a mental disorder has the right, as far as possible, to live and work in society (Article 41 para. 3);
- the environment and living conditions in mental health services should be as close as possible to the normal life of persons of appropriate age (Art. 42 para. 2).

The provisions of Law no. 7 of 04.01.2023 on supporting the process of deinstitutionalization of adults with disabilities and implementing measures to accelerate it and prevent institutionalization, are also in line with the mentions above. According to Article 2 of the Law, the process of deinstitutionalisation and prevention of institutionalisation of adults with disabilities is a **national priority and responsibility**. According to Article 3, this process aims to ensure the exercise of the right to independent living of adults with disabilities.

However, the way patients are kept in Gheja's external psychiatric ward reflects precisely the opposite of this modern and scientifically rigorous orientation, which is incompatible with: isolating patients from society, overcrowding them in spaces unsuited to their needs, stigmatising the illness and the patient, dehumanising them, etc.

Without going into details, we would like to mention that according to the United Nations standard, i.e. Article 4 paragraph 2 of the Optional Protocol (hereinafter, OPCAT) to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment: "deprivation of liberty means any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority."

Thus, the notion of "place of detention" is much broader than the classical one and includes also places where institutionalised persons are held: psychiatric hospitals; public residential institutions, social care institutions for adults with disabilities, etc.

It is well known that the Romanian state has been condemned on numerous occasions by the European Court of Human Rights (ECHR) for the conditions of detention in prisons and places of detention (in the classical sense) in Romania. The problem has been recognised as systemic and is one that is still waiting to be resolved.

Given that, as we have shown, psychiatric hospitals/sections are considered "places of detention" (in the sense of OPCAT) and institutionalized patients can be considered as persons "deprived of liberty", the idea of filing complaints to the European Court of Human Rights concerning living conditions in psychiatric units in Romania is not excluded.

The living conditions mentioned (overcrowding; the volume of air in the rooms in relation to the number of patients accommodated; old buildings not suited to their purpose; sometimes extremely poor hygiene conditions, etc.) in some psychiatric units are sometimes worse than those offered to some detainees in places of detention, who have lodged complaints with the ECHR and obtained recognition of their rights.

Therefore, beyond the restriction some of fundamental rights and freedoms, so-called "inherent" to institutionalisation, the question of violation of fundamental rights guaranteed by the European Convention on Human Rights (right to life, prohibition of torture and inhuman and degrading treatment, respect for privacy, etc.) can be raised with sufficient justification in relation to the patients in question.

Returning to the external ward in Gheja, we conclude that many of the sensitive issues, from the perspective of the Convention, have also been noted here: **overcrowding, small and inadequate spaces, lack of privacy for patients**, etc.

We recall that recently, the Council of Europe's Committee for the Prevention of Torture (CPT) published a Report (05.10.2023) on the visits made to Romania between 19-30 September 2022. Psychiatric units and residential care centres were targeted.

Without going into details, we would like to mention that CPT has recommended the Romanian State to take measures to remedy some aspects that are not in line with European and international standards. Many of these irregularities, which translate into violations of patients' fundamental rights, were also observed at the Gheja External Ward: **inadequate spaces, overcrowding, lack of personalisation of spaces, lack of recreational activities, lack of privacy, lack of staff providing psychosocial activities and occupational therapy**, etc.

General recommendations:

- Designing a **programme of daily activities for patients of the psychiatric ward for chronic patients and training them in these activities** so that daily life and living can take on a minimum of meaning, other than waiting for morning treatment, waiting for breakfast, waiting for lunch, waiting for midday treatment, waiting for afternoon sleep, waiting for dinner, waiting for bedtime;

- **Urgent relocation of the psychiatric ward to a building built and equipped to meet the real and appropriate needs of accommodation** (lounges with a smaller number of beds, its own sanitary facilities, etc.), **care and rehabilitation** (occupational therapy workshops, group therapy room, etc.) **of the patients hospitalized**;

- Identify solutions to ensure that **patients hospitalized benefit from the constant and intensive professional services of psychologists**. The sporadic and time-limited presence of a psychologist "talking" to them is a practice and a reality designed to justify the budgetary costs of such an activity rather than to provide genuinely and responsibly professional services that visibly and measurably improve the quality of life of the patients of the psychiatric ward visited;

- Take swift action to **keep the Restraint Registers in accordance with the relevant legal provisions.;**