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GLOBAL INITIATIVE ON PSYCHIATRY

VILTIS: LITHUANIAN WELFARE SOCIETY FOR
PERSONS WITH MENTAL DISABILITY

VILNIUS CENTER FOR
PSYCHOSOCIAL REHABILITATION

HUMAN RIGHTS MONITORING IN RESIDENTIAL INSTITUTIONS FOR MENTALLY DISABLED AND PSYCHIATRIC HOSPITALS

MONITORING REPORT

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Preface

Globally, the concept of mental health and care for mentally ill has undergone dramatic changes in recent decades. The key factor behind these changes has been the realisation of the need to incorporate human rights into the mental health care system, which enables the transformation of the system's values and principles towards promoting respect for patients and thus improving their chances of integrating into society.

In 1991 the United Nations General Assembly adopted the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* that focused on the human rights of individuals with mental disorders. The Principles provided the opportunity for the reform of mental health services in order to end the isolation, stigmatisation, disrespect and disregard for mentally ill patients. The recognition of human rights as a value aims to empower the mentally ill, their families and guardians.

Until recently the Lithuanian government has not paid adequate attention to the mental healthcare system.[1] As a result, outdated ideas about the role, functions and operation of mental health and care institutions prevail. The reluctance to reform large treatment and care institutions and replace them with a more flexible system of services within the community only confirms this fact. Traditional residential facilities cannot effectively safeguard the rights of mentally ill patients since they were set up to isolate "defective" individuals. Significant investment in improving the physical infrastructure of the current institutional system has failed to improve public mental health care, while the results of treatment, rehabilitation and integration into the community of the mentally ill are poor.

Recurrent cases of inappropriate treatment and patient abuse clearly demonstrate the ineffectiveness of psychiatric hospitals and especially residential institutions for the mentally disabled. Both the geographic remoteness of residential institutions for the mentally disabled and the professional isolation of their staff create closed communities with their own culture of disrespecting human dignity and human rights, a problem which is compounded by the absence of adequate monitoring and supervision. The procedures for treatment of residents in residential institutions for the mentally disabled and their release back into the community lack transparency, while the patient's chances of leaving a care home are slim. The stigma of mental or intellectual disorder is intensified by the negative image of mental patients in psychiatric institutions held by the general population. Many people consider the mentally ill to be dangerous, justifying their long-term seclusion in special institutions, even though this stereotype contradicts the available data.

In order to protect the rights of the mentally ill effectively, first an analysis of the current situation needs to be conducted. This calls for the development of monitoring and evaluation tools to be used by relevant organisations and experts.

The four NGOs involved in this monitoring project combined their expertise and experience in different areas, such as psychiatry, mental health care management, human rights of people with mental disabilities as well as knowledge in

[1] In 2005 the Minister of Health Care has initiated preparation of the new mental health care strategy that would include human rights as a baseline and promote community based services for the mentally ill.

monitoring techniques and methods. This report provides a summary of findings by an expert team. The project sets a precedent for civil supervision of mental health and care institutions and provides opportunities for interested organisations and experts to repeat the exercise using the developed methodology.

The NGOs involved in the project hope that the collected data, conclusions and recommendations will contribute to public debate among relevant institutions and individuals and will assist in replacing the current obsolete institutional system in favour of a modern mental healthcare services network.

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1.

The transformation of the traditional centralised system of care and treatment institutions into a community-based service network

Lithuania is part of the Eastern and Central European region, which inherited an ineffective and abusive system from the former Communist system based on centralised residential care and treatment institutions. This tradition has undoubtedly hindered the effective development of community-based services.

Despite the obvious need to reform the mental healthcare system and recommendations by international institutions, governments still lack the political will to initiate the process of deinstitutionalisation.[2] The system of centralised institutions for children and adults with mental problems (both mental disorders and intellectual disabilities) has resisted all attempts to reform.

A World Bank report found that in the region of Central and Eastern Europe at least 1.3 million people with mental disorders are placed in 7,400 large institutions, which ineffectively spend limited financial resources that could be allocated for the development of community-based services. According to the report Lithuania allocates 1.75% of its national budget for the institutional care of vulnerable individuals.[3]

Although a number of different authorities (health care, social welfare and education) run this complex system of institutions, the ideology of social exclusion and the negation of human rights, including the right to live in the least restrictive environment, are intrinsic to all of them.

Quite a number of initiatives have been funded in the region by international donor-organisations such as the Open Society Institute, the Geneva Initiative on Psychiatry, the Hamlet Foundation and the World Bank. These projects sought to improve the infrastructure of community-based social services, ensure public support, to train relevant professionals in modern psychosocial techniques, and to provide research-generated evidence that the existing system is ineffective. Unfortunately, the success of the initiatives was hindered by the government's reluctance to change priorities. Despite numerous positive examples and recommendations by international organisations, government have largely failed to invest in a community-based service system that aims at strengthening the affected individuals' capacity for self-sustained living — a respectful and cost-effective alternative to institutional care.

So why does the Lithuanian government, just like the governments of other countries in the region, delay the funding of community-based services when the opportunity exists to develop such a system thanks to strong economic growth? Because influenced by powerful interest groups, the government continues to adhere to outdated principles that permit the continued dominance of traditional services and a one-sided bio-medical approach in treatment and rehabilitation. It is paradoxical that in Caucasia and Central Asia, which are suffering from severe economic crises, large mental healthcare institutions have to a large extent collapsed, while in countries marked by economic growth such as the Baltic States, government investment into the traditional

[2] *Mental Health Declaration for Europe*. WHO European Ministerial Conference on Mental Health, Helsinki, Finland, 12-15 January 2005.

[3] Tobis D., 2000. *Moving from Residential Institutions to Community-based Services in Central and Eastern Europe and the Former Soviet Union*. World Bank, Washington, DC.

system of residential institutions is increasing. The time has come for politicians to make a strategic decision on the effectiveness of this use of public resources. The main question to answer is: why should we continue maintaining an ineffective system and encouraging the vicious circle of sustaining the monopoly of institutions operating on the principle of social exclusion at the expense of community-based alternative services?

It is time to ask if this is an appropriate policy for an EU Member State and how the EU enlargement process can end the flawed model of institutional care that does not comply with the Western values and standards to which Lithuania subscribes.

Large mental health and care institutions reflect a tradition of social exclusion and paternalism and do not comply with modern health care and social policy based on the principles of individual autonomy and empowerment as well as the right to live in the least restrictive environment. International experience has demonstrated that large residential care and treatment facilities are harmful, expensive and that only a minority of isolated patients are unable to live in the community[4].

Unless reform is implemented, continually more funding will be required to ensure the quality of services provided by centralised care and treatment institutions. The culture of dependence that these institutions create deprives patients of any autonomy or ability to live in a society. In other words, the state funds the isolation of the individual from the community in order to sustain that individual for life by allocating increasing amounts of funding for institutional care.

[4] Tobis D. *Moving from Residential Institutions to Community-Based Social Services in Central and Eastern Europe and the Former Soviet Union*. 2000, The World Bank.

Positive changes in Lithuania and its membership in international organisations will sooner or later compel the government to end the near monopoly of institutional care. The government will be pressed to modernise and deinstitutionalise the mental healthcare system by offering community-based services as an alternative to large residential institutions for the mentally disabled. The longer the government supports the current institutionalised system as the main method of care and treatment of the mentally disabled, the more funds and resources will be required for proper reform at a later date. The current institutional system has no motivation whatsoever to change itself, thus the government needs to step in to reallocate resources and develop legal instruments to ensure opportunities for alternative community-based services.

Since 1998 official position of the Lithuanian government favors development of outpatient services network and decentralisation of social services. *The Programme for the Development of Infrastructure for Social Services* approved by government resolution recognises infrastructure development for outpatient social services as the main course of action for service development. However this resolution has not been followed by any meaningful action. During the implementation of the programme in 1998-2004, 101 projects aimed at the development of community-based care were funded with LTL 29.75 million (about €8, 62 million). At the same time, the government granted significantly larger sums in a period of just one year for traditional care institutions for the mentally disabled.

The number of large residential facilities remains very large: in 2004, there were 21 psycho-neurological care facilities housing over 6,000 residents. There has also been

growth in the number of personnel: the number of social workers in residential institutions for the mentally disabled increased by nearly 200 from 2000 to 2003, while only 60 social workers were employed in day-care mental health centers from 2000 to 2005[5]. This practice clearly confirms the lack of political will for reform and shows that the actual priority is to continue investing in the ineffective system inherited from the totalitarian past.

Visits to residential institutions for the mentally disabled confirmed that living conditions in these institutions have markedly improved — new buildings were constructed, older facilities were renovated, and the number of beds per room was reduced. This has only consolidated the near monopolistic position of the residential care system and did little to improve the human rights of residents.

A large residential facility designed to isolate "defective" members of society and marked by the features of a totalitarian institution by definition cannot safeguard human rights such as respect for privacy, the right to information and the freedom of movement. Instead it leads back to the aforementioned vicious circle: the more the human rights of mentally disabled residents are violated, the more socially crippled they become due to their dependence upon care, the higher are healthcare costs.

Psychiatric hospitals also suffer from the legacy of the stigmatising isolation of mental patients that evolved as early as the 19th century. Like the residential institutions for the mentally disabled, they form a segment of the complex mental healthcare system based on the previously mentioned principles of paternalism, social exclusion and stigmatisation. The fact that mentally ill patients are treated in specialised psychiatric hospitals instead of general hospitals is an obvious example of the stigma. The system of large isolated psychiatric hospitals provides conditions for various violations of human rights and deepens both social exclusion and the stigmatisation of the mentally disabled.

Monitoring has shown that in both types of institutions — psychiatric hospitals and residential institutions for the mentally disabled — human rights violations are justified by the diagnosis of a mental disorder. Patients who seek to be informed about their rights and try to defend them are often treated as if their condition is deteriorating. The right to information is currently not ensured, which is justified by the outdated notion that information about mental illness or treatment options may lead to the deterioration of the patient's condition.

In its 2001 annual report,[6] the World Health Organisation (WHO) suggested that psychiatric patients should be treated as all other patients and recommended integration of psychiatric units into general hospitals wherever possible. The Mental Health Declaration for Europe approved in 2005 proposes the introduction of community-based services available 24 hours a day for individuals suffering from mental illness or intellectual disability. The services would be available in locations where these individuals live and work and assist their return into society through rehabilitation.[7]

[5] 2005 Report of the Ministry of Social Security and Labour to the Committee on Mental Health. Informal document.

[6] World Health Report 2001 — Mental Health: New Understanding, New Hope. National Mental Health Centre, 2002.

[7] *Mental Health Declaration for Europe*. WHO European Ministerial Conference on Mental Health, Helsinki, Finland, 12-15 January 2005.

European WHO Member States committed themselves to eliminating inhuman and degrading treatment of the mentally disabled by 2010 through the adoption of legislation that upholds human rights and promotes social inclusion of the mentally disabled.[8]

All of Europe is undergoing progressive reform in mental health care. Special importance should be given to upholding a person's right to the most effective treatment and intervention with the least possible risk, in line with the patient's health, needs and wishes and with regard to their culture, belief, gender and other individual requirements. Considering the evidence collected, a growing number of states support the development of community-based services. There is no place in the 21st century for inhuman or degrading care and treatment in large medical and social care facilities.

In Lithuania, as in other countries of Eastern and Central Europe, the following obstacles to successful deinstitutionalisation have been identified:

- professional pressure to retain the existing facilities;
- funding schemes promoting institutional care and treatment;
- positive public opinion about these forms of care and treatment based on stigma and intolerance of large part of population to vulnerable groups such as mentally ill people;
- absence of a national infrastructure for effective community-based services;
- absence of an independent authority for monitoring and supervision;
- lack of legislation protecting the rights of mentally disabled.

This corresponds to the step by step reforms strategy proposed by the World Bank: to change public opinion and ensure community support for community-based care and treatment; to enhance the national infrastructure for community-based services; to retrain social care professionals; to implement pilot projects providing community-based services; to use these projects to reduce the number of patients admitted to large residential institutions; to restructure, reduce and close large residential facilities; and through these steps to develop a national network of community-based social care and treatment services for the mentally disabled.

To implement this strategy will require the development of appropriate policies and legislation as well as changes in funding priorities. One way of modifying the existing funding scheme and concurrently encouraging municipalities to develop a network of community-based services is to create a patient "package," giving an opportunity to choose whether to receive services in a residential facility or in the community. This would create a competitive environment and could promptly stimulate the municipalities to develop an attractive and alternative structure of community-based services instead of supporting cost-ineffective services provided by large residential facilities which violate human rights.

As an immediate step, relevant government institutions should initiate the creation of a monitoring mechanism that would assist in the consolidation of good practice and in the prevention of negligent and inappropriate institutional treatment of the mentally disabled.

[8] *Mental Health Declaration for Europe*. WHO European Ministerial Conference on Mental Health, Helsinki, Finland, 12-15 January 2005.

2.

Violations of Human Rights in Mental Health Care Institutions in Lithuania

The project *Human Rights Monitoring in Mental Healthcare Institutions* is the extension of the international project *Monitoring Human Rights in Closed Institutions in the Baltic States*. The first stage included the monitoring of the following facilities: the Psychiatric Centre of Vilnius, National Psychiatric hospital in Vilnius, regional psychiatric hospitals in Žiegždriai and, Švėkšna, and residential institutions for mentally disabled in Prūdiškės and Jurdaičiai. The following institutions took part in the study: Geneva Initiative on Psychiatry, Vilnius University, Estonian Association for Protection of Patients' Rights, and the Mental Disability Advocacy Centre in Hungary.

The second, national monitoring stage covered psychiatric hospitals in Kaunas, Klaipėda, Šiauliai, Šaukėnai, and Rokiškis, as well as residential institutions for mentally disabled in Šilutė, Didvydžiai, Aknysta, Linkuva, Aukštelkė, Jasiuliškiai, Dūseikiai, Strėvininkai, and Skėmai. Altogether, monitoring was conducted in nine residential institutions for the mentally disabled housing over 50% of all residents of these institutions in Lithuania (over 3,000), and five psychiatric hospitals scattered throughout all regions of Lithuania.

The objective of the project was to collect reliable information from primary sources on existing human rights-related problems, keeping in mind relevant national policy, the legislative framework as well as practices and conditions in mental healthcare institutions. The monitoring team and involved experts intended to unveil systemic problems rather to document specific cases of violations. The project seeks to draw public attention to the identified issues and problems and to prompt improvements in mental healthcare standards.

The monitoring was conducted jointly by four NGOs — the Human Rights Monitoring Institute, the Global Initiative on Psychiatry, the Lithuanian Welfare Society for Persons with Mental Disability VILTIS and the Vilnius Center for Psychosocial Rehabilitation. The European Commission and the Embassy of the United States of America in Lithuania provided support for the project.

Methodology

Monitoring was based on a questionnaire that covered: the right to information, including freedom of expression, the right for respect of private life; the right not to be discriminated against; the prohibition of torture, cruel and inhuman treatment; the right to freedom of movement; the right to property; the right to education; labour rights; the right to adequate medical treatment and social rehabilitation (including the right to receive needed social and medical services from outside institutions); and the rights of the legally incapacitated.

The questionnaire was based on the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*, adopted by the United Nations:

- Everyone has the right to the best available mental health care, which shall be part of the health and social care system.
- The mentally disabled should be treated with humanity and respect for the inherent dignity of the human person.
- The mentally disabled have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights and in other human rights instruments.

- Every mentally disabled patient should have the right to be treated in the least restrictive environment and in the least intrusive manner appropriate for their needs and the need to protect their physical safety and the safety of others.
- The treatment and care of every patient should be based on an individually developed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
- The treatment of every patient should be directed towards preserving and enhancing personal autonomy.
- No treatment should be carried out without a patient's informed consent. The treatment may be carried out without a patient's informed consent only if the following conditions are satisfied: the patient is, at the relevant time, held as an involuntary patient; the patient lacks the capacity to give informed consent to the proposed plan of treatment and when a competent impartial third person is satisfied that the proposed plan of treatment is in the best interest of the patient's health.
- Informed consent should be obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient, in particular regarding the purpose, method, likely duration and expected benefit of the proposed treatment, alternative modes of treatment, including those less intrusive, and possible risks and side-effects of the proposed treatment.
- Physical restraint or involuntary seclusion of a patient should not be practised except when it is the only means available to prevent immediate or imminent harm to the patient or others. Medication should meet the health needs of the patient, will be given to a patient only for therapeutic or diagnostic purposes and should never be administered as a punishment or for the convenience of others.
- Patients in mental health facilities should be informed of all their rights. The environment and living conditions in mental healthcare facilities should resemble as closely as possible the home environment and conditions.
- Every patient is entitled to have access to personal records maintained by mental healthcare institutions, including information about his or her health.
- Every patient not admitted involuntarily has the right to leave the mental health facility at any time.

The questionnaire had two versions – one for patients and one for the staff. The survey was conducted in the form of an oral, informal interview for an unspecified time. Between five and ten staff members and between ten and fifteen patients were questioned in each facility. The monitoring procedure included the initial questioning of staff and administration, followed by individual interviews with patients.

Visits to the facilities took place between November 2004 and March 2005. The expert group spent four to eight hours in each institution and after each visit the expert group prepared a report, with a total of 14 reports being drawn up. This paper provides the final overview summarising the data of all surveyed facilities.

The report provides data obtained from residents of residential institutions for the mentally disabled and patients in psychiatric hospitals, administration and personnel. Since the objective of the project was to identify systemic problems, this report does not disclose the sources – names of

institutions or persons — in order to protect them from possible negative consequences. The majority of mentally disabled patients requested anonymity.

2.1. Violations of Human Rights in Residential Institutions for the Mentally Disabled

In Lithuania residential institutions for the mentally disabled are called psycho-neurological pensions. These are not medical but residential institutions where people with mental health problems or intellectual disabilities usually spend their entire lives. A person suffering from a mental illness or intellectual disability is admitted to a this facility after filing a request with the local municipality. The municipality forwards the case material to the relevant regional administration, which then includes the applicant on the list of candidates wishing to be placed in one of the residential institutions for the mentally disabled.

A number of residents are transferred to these facilities directly from psychiatric hospitals because they do not have anywhere to go. Residential institutions for the mentally disabled also receive young adults from residential institutions for children when they reach the age of maturity and are automatically transferred from the children's institution to one for adults due to lack of any other alternatives. Thus, the main reason that the majority of residents coming from these two groups spend the rest of their lives in large residential institutions is not severity of mental illness or intellectual disability but the lack of housing and social services in the community.

Currently each residential institution for the mentally disabled accommodates a few hundred individuals and all are located in remote rural areas. They function like closed "states" mainly maintaining relations with other mental health care facilities within the system.

Residential institutions for the mentally disabled usually consist of several buildings of varying sizes that are separated from the nearest settlement, oftentimes by a fence surrounding the grounds. Residential institutions authorities claim that the purpose of this isolation is to protect patients from hostility from the neighbouring communities and to prevent patients with poor orientation from straying.

The facilities are thus designed to isolate people with mental problems rather than to meet their needs, some residential institutions for the mentally disabled were converted from sheltered housing or nursing homes built mostly at the beginning of the 20th century. In the traditional agrarian society of that time, the aristocracy assumed responsibility for weak members of the society and established housing for the mentally disabled near estates, a philosophy that is totally obsolete nowadays.

Recruitment of residential institutions for the mentally disabled personnel (especially of the social workers' assistants) is based on their place of residence rather than their qualifications: most are residents of neighbouring villages and towns and many lack the necessary training to work with the mentally ill. Thus attention needs to be drawn to the issue of the professional qualifications of the staff.

In 1997, the Ministry of Labour and Social Affairs introduced the position of social worker assistant and arranged short training courses to provide these new employees with basic knowledge and skills. Some residential institutions for the mentally disabled initiated co-operation with employment

centres, combining the hiring of unqualified individuals, who could not get any other kind of job, with tax privileges.

Residential institutions for the mentally disabled currently provide the main source of employment in the areas where they are located, which hinders the reform of the system due to employment redistribution issues.

Personnel at residential institutions for the mentally disabled lack respect for the human dignity of residents. A clear hierarchy prevails at these institutions, with residents being considered inferior. Rude and degrading phrases are used when talking about them (for example, the head of one of the care homes referred to residents as "little dumdums" or mockingly called them "professors") and residents are patronisingly deemed incapable of making decisions regarding their own lives.

In summary, the key characteristics of the inner culture of a residential institution for the mentally disabled are:

- Internal rules and practices aim at developing residents' dependence, obedience and suppressing their personal autonomy. The flow of residents is one-sided — older residents die and are replaced by new arrivals. A minute percentage (1-3%) of residents ever leave residential institutions to live in the community. Even capable residents who were admitted voluntarily — usually persuaded to sign an agreement to live in the institution — are made to believe that they will spend there the rest of their lives, and that they are dependent on the personnel. Typical arguments are: "You will not manage alone." "You are incapable of taking care of yourself." "Your neighbours will harm you."

- Facilities are run like closed institutions with their own traditions, values, and written and unwritten rules. These institutions are usually led by a "father" — the head of a residential institution for the mentally disabled (directors of the visited institutions were in their position for an average of 16 years and many of them were hired during the Soviet era). Patients who attempt to rebel against the system are often punished and those who willingly co-operate are rewarded with privileges. The institutions attempt at providing for all residents' needs by becoming involved in education, training and law enforcement issues as well as their cultural and religious lives.

- The insularity and the repressive character of residential institutions for the mentally disabled is reflected in the language used by patients, such as "freedom" (referring to the outside world) and "sweat box" (referring to the solitary confinement room). Emotional responses and a strong desire "to be released" were noted in many interviews; however it was obvious that they did not believe in this option.

- Residential institutions for the mentally disabled have improved their physical environment but still disregard the mental and social needs of patients. In the majority of cases, modernisation is carried out only to consolidate the existing system and to further restrict the rights and freedoms of patients. For instance, the installation of modern code locks serves only to restrict the movement inside the institution and to prevent patients from leaving.

- Patients are often declared legally incapable before or after their admission and the guardianship rights are often vested with the residential institution

for the mentally disabled. In some cases patients learn about the court decision to declare them legally incapacitated only after admission to the residential institutions for the mentally disabled and some are not informed about such a decision at all.

- The administration restricts the rights of all patients, both legally and medically, to the maximum extent of the law.

Since some issues are not formally regulated, certain aspects of life within the walls of these institutions are carefully concealed, including problematic areas like abortions, intimate relations among patients, suicides, as well as unregulated progressive practices, such as allowing patients of different sexes to pursue relationships or permission to keep pets. In general, the administration often informed us about the lack of instructions from the Ministry of Labour and Social Affairs and some expressed doubts about the conformity of certain traditional practices with the modern concept of social care for the mentally disabled.

Individual rehabilitation plans for residents are rare. Paradoxically, although the job descriptions of social workers who are employed by residential institutions for the mentally disabled declare that one of the main objectives is an integration of residents into society, in fact the longer they stay in these institutions the greater the regression of their social skills. The institutions conduct adaptation programmes which are meant to lower the expectations of residents, reconcile them with living in the facility and effectively remove any skills that they previously had.

An ideal resident is the one who unconditionally follows the instructions given by staff, shows satisfaction, has no personal ideas or wishes, is indifferent to information about him/herself, has no sexual instincts, seeks to please the personnel and to express him/herself through crocheting and unseaming the lace.

A conservative assessment by the staff indicated that on average about 20% of residential institution for the mentally disabled residents are able live in the community if provided with standard services. Arguably, this percentage will be higher if the restoration of patients' social skills becomes an actual priority. A few years ago the Ministry of Labour and Social Affairs implemented a plan whereby all residential institutions for the mentally disabled were required to release at least ten residents who were capable of living in the community. A year into the programme, the majority of the former residents were returned to care facilities, which boosted the argument against allowing patients to live independently in society. Indeed, it is difficult for individuals accustomed to institutional care to live on their own without proper care services and support in the community.

The lack of municipal funding for community-based services results in long waiting lists of those seeking admission to care homes. The phenomenon of waiting lists contributes to the popularity of care facilities. It is often overlooked however, that the placement of a mentally disabled person in a residential institution is the only option for a family to guarantee medical (many of these mentally disabled patients have physical disorders) and social help.

Services provided to residents by residential institutions for the mentally disabled are formalised by an agreement signed between the institution and the patient. There were cases when the administration had a

contract with a person's signature although the person claimed he never signed it. It remains unclear how administration deals with situations when mentally disabled patients refuse to sign contracts or wish to terminate them (provided such an option is possible and the patient is informed about it).

2.1.1. The Right to Information and Expression

Individuals must not be hindered from seeking, obtaining, or disseminating information or ideas… Citizens shall have the right to obtain any available information from state agencies which concerns them in the manner established by law… Freedom to express opinions, as well as to obtain and disseminate information, may not be restricted in any way other than as established by law, when it is necessary for the safeguard of health… (Article 25, the Constitution of the Republic of Lithuania).

Individuals suffering from mental illness are entitled to the same right to information as all other members of society and they have the right to receive information about their illness, treatment and medication in order to enable them to make informed decisions. Patients must take an active part in the discussion with care providers and share the responsibility with them regarding their future.

Nonetheless the scope of information accessible to patients in a residential institution for the mentally disabled is rigorously controlled, which leads to the consolidation of the power hierarchy and control over the patient. For instance, it took several weeks for the patients board in one institution to receive an answer to a written enquiry concerning care charges, although this same information is publicly accessible to external information seekers. When we visited the facility, the patients had not received an answer yet.

Residents tend to be passive and do not usually request information and staff members do not usually provide them with comprehensive information about their illnesses or treatment. When patient enquiries do receive an answer, the information provided is minimal and depends on the understanding of individual staff members about patients' rights as well as on their good will to share the information. For example, residents might be told that their medication has been changed but will not be given the reasons why or the effect of a new drug regime. There had been cases when the patients were informed that information about their condition and treatment is confidential, i.e. available only for the medical staff.

In the majority of institutions formal mechanisms for the investigation of complaints exist, but residents rarely file a complaint or receive an adequate response. Claims addressed to higher level authorities and organisations are not tolerated. In these cases, the administration has been found to resort to punishments such as a transfer to a psychiatric hospital.

These institutions offer activities for residents based on their needs as understood by the personnel. However, art or sport activities often fail to meet the requirements of residents and many complain of boredom or consider the available activities inappropriate for their skills or needs. Information on activities outside the residential institution for the mentally disabled is almost non-existent and availability depends on the decision of the administration, meaning that the staff

decides what activities residents can be involved in.

2.1.2. The Right to Respect for Private Life

The private life of an individual shall be inviolable… Personal correspondence, telephone conversations, telegrams and other communications shall be inviolable… (Article 22, the Constitution of the Republic of Lithuania).

Residents' right to privacy is seriously violated in residential institutions for the mentally disabled as their entire lives are continually supervised by the personnel and watched by other patients. Paradoxically, individuals experiencing mental difficulties as a result of constantly being around others often ask to be placed into solitary confinement wards or supervision rooms to spend some time alone.

Telephone communication is usually available to patients and some have mobile phones, however sometimes telephone contact to the outside world is restricted. In one case, a woman who had recently given birth was not allowed to make telephone calls or leave the institution (the child was given away to the children's residential facility).

Only one residential institution for the mentally disabled provides its patients with the opportunity to subscribe to periodicals.

Communication with visitors is not restricted; nevertheless the total number of guests is rather small since the majority of the residents have no visitors. In practice, communication with persons outside the walls of a residential institution is limited to family only and social workers do not encourage patients to maintain previous contacts and do not help residents to make new acquaintances. Thus, once in the isolated environment of the institution, patients gradually lose all contact with the external world since earlier relationships eventually end, while new contacts are impossible to establish.

Partitions are not generally used to provide privacy for residents who cannot walk during hygienic procedures, which are administered publicly in front of other patients irrespective of their gender. In some residential institutions for the mentally disabled residents are not allowed to use the bathroom or shower without permission and the majority of institutions do not allow the doors to be closed and/or locked.

Residential institutions for the mentally disabled violate the residents' rights to enter into a relationship with another person. Since there are no national policy regulations on the intimate relations of residents, the situation in the residential institutions for the mentally disabled varies depending on the attitudes of the staff and administration. Some institutions have a more liberal atmosphere and relationships between men and women are tolerated, while in the other the units of women and men are separated and communication is rigorously controlled. Even if a couple is allowed to have an intimate relationship and live together, pregnancy is seen as a problem and measures are taken to avoid it. Methods of contraception vary greatly — from intervention procedures to birth control pills. For women who are seen as belonging to a risk group the use of birth control is obligatory, while the menstrual cycle of all the women able to have a sexual relationship is usually monitored.

Administration and personnel reluctantly speak about abortions and relevant information is hardly disclosed. Abortion is obligatory in these institutions and if

the woman does not agree to one, various pressures are asserted or a forced abortion is administered. There were reports of women who were taken for an abortion without their consent under false pretences, for example, being told that they were going to see a psychologist. In one case, abortion was carried out in advanced stage of pregnancy (the sixth month). (See more in 2.1.4. p. 19)

One of the reasons for the strict control of pregnancy is the rule that residential institutions for the mentally disabled can only house persons above 21 years of age, meaning that children are not formally allowed to stay in the institution. But even if these regulations were modified, one of the fundamental human rights – the right to procreate — is not upheld in the residential institutions for the mentally disabled. Well-developed institutionalisation, i.e. the placement of people into these types of facilities, deprives them of their right to have children, start families and live together with another person.

2.1.3. Discrimination

A person may not have his or her rights restricted in any way, or be granted any privileges, on the basis of his or her sex, race, nationality, language, origin, social status, religion, convictions, or opinions... (Article 29, the Constitution of the Republic of Lithuania).

Discriminatory practices can be summarized as:

- granting privileges to obedient patients favoured by the administration;
- improvement of living conditions through payments by relatives;
- discrimination against more serious patients.

As previously mentioned, staff implements internal rules in residential institutions for the mentally disabled that aim to train residents to be obedient and to curb their independence. Compliant residents actively co-operating with the personnel, and who take part in leisure activity programmes and help staff members to perform household duties are encouraged and are granted privileges unavailable to other residents. Incentives include:

- more freedom of movement (for instance, unrestricted leave outside the institution);
- granting of greater autonomy (for example, granting of room keys);
- more opportunities to participate in cultural activities (excursions or events at other residential institutions for the mentally disabled);
- extra food (for example, a slice of sausage);
- awards during events arranged by the institution (for example, during the Autumn Festival the most diligent helper was given a stereo).

Certain residents are provided with better living conditions — for example, by furnishing individual rooms with better furniture if funded by the resident's family.

Commonly, the most seriously ill residents are accommodated in the blocks of the poorest condition. The scope and quality of care they are given is often insufficient (a foul smell usually lingers in the units of the most serious patients; the patients are socially neglected; no individual rehabilitation therapy is given to them, etc.). In only one of the institutions visited was the unit of the most serious patients the most modern, even equipped with heated floors.

2.1.4. Torture, Inhuman and Degrading Treatment

The person shall be inviolable… Human dignity shall be protected by law… It shall be prohibited to torture, injure, degrade, or mistreat a person, as well as to establish such punishments… (Article 21, the Constitution of the Republic of Lithuania).

In line with the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (United Nations, 1984), the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining a confession, punishment, or intimidation or coercion, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Characteristics of torture:

- causing physical or mental suffering;
- suffering is severe and inflicted intentionally;
- suffering is unjustified in the given situation.

The term torture also refers to the use of such methods that are aimed at the destruction of the person's personality or depletion of his/her physical or mental abilities but does not cause physical pain or mental suffering. Inhuman or degrading treatment differs from torture in that the infliction of pain and suffering has no clear objectives[9].

The use of torture or inhuman treatment in the medical field is considered especially cruel since the goal of medicine is to help people.

Concerning inhuman and degrading treatment and torture in the residential institutions for the mentally disabled, it is important to take into account how life is perceived at these institutions as the majority of residents spend the rest of their lives there. As mentioned above, a negative view of living in a residential institution for the mentally disabled prevails among residents who consider their presence there as imprisonment. With no prospects of a meaningful life, they are unmotivated to show proper social behaviour, which can lead to problematic issues such as alcohol and drug abuse, aggression and unsanctioned sexual relations (abuse of incapacitated women). The punishments imposed by the institution personnel on residents for violating discipline and order are often mere attempts to prevent inappropriate behaviour. Yet, the methods employed by the staff are undoubtedly inappropriate in terms of human rights.

The internal residential institutions for the mentally disabled rules include punishment procedures and specify responsible staff members for the administration of one or another kind of punishment. For example, in one of the institutions, social workers are in charge of restraining the patients in a conflict situation.

The primary instances of inappropriate treatment of residents by staff members include disregard of both health and social issues, unsound restriction of the residents' right to free movement (placing them in a solitary confinement ward; prohibiting them from leaving the territory of the institution), violence against patients (mental, physical, sexual) and making decisions on behalf of the patient on personal issues (abortions).

[9] British Medical Association. *The Medical Profession & Human Rights: handbook for a changing agenda*. Zed books, 2001.

The response to the residents' pain (both physical and mental) is inadequate in some residential institutions for the mentally disabled. For example, in one institution when a resident complains about being in pain, no measures are taken and they are even mocked and laughed at. In one instance, a physician of a residential institution for the mentally disabled failed to adhere to the confidentiality requirements for the resident's personal data, mocked the patients and refused to believe their complaints about health issues (the resident's letter about specific physical disorders was shown to the monitoring team as a joke).

In certain cases, the residents are forced to wait too long for adequate medical treatment, sometimes up to a few months. Cases were discovered where residents had to wait for a week until a dentist could fix a sore tooth, while another person had to wait three months for a medical consultation and surgery for a spinal hernia. In another case a resident was not given a pair of glasses for two years despite the fact that without them he could neither read nor perform any other tasks he needed to do.

The detrimental effects of the physical environment on the residents are also not taken into account. For instance, one of the residential institutions for the mentally disabled only turned on its heating system in mid-November.

The restriction of free movement is used as a punishment in a number of the residential institutions for the mentally disabled. The residents are usually kept in secluded premises such as supervision rooms, solitary confinement wards, etc. Before our arrival, one of the residential institutions for the mentally disabled used a room without a toilet for solitary confinement (residents were forced to use a makeshift toilet which was not emptied until their release from the ward, which in certain cases lasted for as long as two weeks).

Long-term punishments are also used. For example, if a resident leaves the grounds of the residential institution for the mentally disabled without a permit or fails to return at the agreed time, they are put into pyjamas and thus the resident does not dare leave their room.

Abortion is one of the most severe violations of human rights in the residential institutions for the mentally disabled. During the monitoring, the administration and staff avoided speaking about abortions, refused to answer questions about the subject and generally denied the existence of the problem. Meanwhile, residents from all residential institutions for the mentally disabled mentioned the use of abortions, giving the names of the women who had undergone the procedure. The same applied to contraception, where we received information on the forced use of invasive contraceptives such as IUDs.

Pregnancies are always aborted in residential institutions for the mentally disabled, except in cases when the woman is at the end of the second trimester. All sexually active women, the number of which varies from 15 to 50 depending on the residential institution for the mentally disabled, are closely supervised by nurses and social worker assistants. Nurses record the menstrual cycle of these residents in special registers, a measure which cannot be explained as a mere method of passive observation. In response to questions on what the nurses do to determine why a resident's menstrual cycle is irregular, the majority of nurses replied that they administer a pregnancy test. They also said that there were no positive pregnancy tests

within the last five years. In some facilities nurses did not say the truth, claiming that there were no cases of pregnancies — the interviewed residents informed that there were quite a few cases. Usually, the residents are subjected to various measures ranging from persuasion to psychological pressure, deception or even outright coercion to get them to undergo an abortion. In one residential institution for the mentally disabled, a woman in her sixth month of pregnancy had to abort her baby. When the woman contacted *Lietuvos Rytas TV* and told journalists about this and other similar cases, she was punished, by being transferred to a psychiatric hospital.

2.1.5. The Right to Freedom of Movement

Citizens may move and choose their place of residence in Lithuania freely... (Article 32, the Constitution of the Republic of Lithuania)

Residents' personal documents are usually kept by the administration, and passports or other ID documents are handed to them only in exceptional cases after a formal request has been submitted. According to data, controlling passports is a means to restrict the personal lives of residents (for example, a young couple may not have their passports if they want to get married).

The majority of residents may leave the territory of the residential institution for the mentally disabled for a few hours, but periods of a day or longer are generally restricted. Those wanting to leave must follow a certain procedure that includes submission of a written request stating the reasons for leaving the premises and a written letter from a person/institution from outside of the residential institution for the mentally disabled that will take care of the resident during the leave.

As a rule, residents with drug or alcohol problems are not allowed to leave the grounds of the residential institution, however there is no clearly defined procedure determining which residents can or cannot leave and why. Generally, the administration does not allow "disoriented residents" to leave the facility alone, stating that this is for their own good. A serious violation of freedom of movement occurs during cold weather as residents with serious disorders and walking problems are not taken outside for about six months (from the second half of autumn to the second half of spring). Some residents were restricted from seeing their children, including a woman who had just given birth, without clear reason.

Depending on the facility, restrictions are also placed on the use of personal money. Formally, no restrictions apply to residents "capable of using money." However, a clear-cut mechanism for appointing someone to decide on the resident's capacity with respect to money does not exist.

Residents, who, in the opinion of the staff, are unable to make decisions on how to spend their money, can indirectly purchase goods through a staff member. However residents have said that in these cases they have no control over choice or delivery time or whether they get a receipt and the proper change back, resulting in disagreements and feelings of deception. Although residents have limited financial resources, there is almost no training to help residents understand how to deal with money.

As already mentioned, patients from all residential institutions for the mentally disabled use the term "freedom" referring to life beyond the walls of their residential institution for the mentally disabled. For example, they use such phrases as "I will never be free," "They will never release me

to freedom," etc. Meanwhile, the popular measure of restricting freedom of movement at the solitary confinement ward is referred to as the "sweat box".

2.1.6. The Right to Property

Property shall be inviolable. The rights of ownership shall be protected by law... (Article 23, the Constitution of the Republic of Lithuania)

The possession of personal items is not restricted except in the solitary confinement ward. In some residential institutions for the mentally disabled residents are even allowed to keep pets such as cats, dogs or guinea pigs. However, the security of personal property is not commonly ensured (usually no locks are installed for rooms or lockers, no record journals kept, etc.) and no compensation system for loss or theft is in place. Residents in certain residential institutions for the mentally disabled complain about frequent thefts, which as a rule are committed by residents abusing alcohol. Some complained that their belongings were stolen while they were intoxicated and accused the orderlies of the theft.

Some residents are allowed to open personal bank accounts and use them, while other insitutions keep residents' money in a general account and distribute it in accordance with sometimes poorly defined internal rules.

Residents in some facilities are under pressure to give their money to nurses who justify the move by the promise of security ("it will not be stolen"), convenience ("I will buy whatever you want, whenever you want"), which provides opportunities for personnel to abuse personal funds. In one of the reported abuse cases, the nurse asked the resident to buy her chocolate while the resident was purchasing goods for himself. Information was received about cases when the usage of personal belongings (for example, clothes) kept in lockers was obstructed when the personnel with the keys ignored the requests of the patient to unlock the locker.

2.1.7. The Right to Education

Everyone shall have an equal opportunity to attain education according to their individual abilities. (Article 41, the Constitution of the Republic of Lithuania)

The right to education is not upheld since residential institutions for the mentally disabled prefer to promote the regression of patients' autonomy. Residents are not encouraged to study and the staff does not support the initiatives of those wanting to study and do not search for opportunities to realise these initiatives.

Only seven individuals out of over 3,000 patients living in visited institutions had acquired some level of education through the help of institution staff or are still studying.

Certain training courses, for example in financial management or computer skills, are conducted in some of the residential institutions for the mentally disabled, but, this is the exception rather than the rule. Leisure programmes (sports, dance, singing, etc.) are generally perceived as educational activities.

2.1.8. Labour Rights

Every person may freely choose an occupation or business, and shall have the right to adequate, safe and healthy working conditions, adequate compensation for work and social security in the event of unemployment... Forced labour shall be

prohibited... (Article 48, the Constitution of the Republic of Lithuania)

The administration at residential institutions for the mentally disabled still have no mechanism for protecting residents from exploitation by employers, who generally live in the surrounding townships or are the staff of the residential institutions for the mentally disabled themselves. This issue is usually tackled by applying two methods: either the patients are prohibited from working for the people in the area, or administration of the residential institutions for the mentally disabled have individual conversations with the employers trying to arrange non-abusive labour conditions.

Generally, employment activities are not rehabilitative and there is no adequate payment for residents' work because no official employment contract is signed. Residents willing to work are not singled out for employment opportunities. In rare cases, employment contracts for part-time employment have been signed but the pay is quite low — it is justified by claims that if the amount is higher, taxes would be imposed.

2.1.9. Treatment and Psycho-Social Rehabilitation

The State shall take care of people's health and shall guarantee medical aid and services in the event of sickness... (Article 53, the Constitution of the Republic of Lithuania)

As residents spend their entire lives in residential institutions for the mentally disabled, it is pointless to consider their integration into the society. However, this goal is formally declared in the job description of social workers. Commonly, no personalised rehabilitation plans are drawn up for residents. Only one residential institution for the mentally disabled could provide documented psycho-social rehabilitation plans, yet the contents and the implementation of these plans raised doubts. No techniques to enhance or restore social skills are employed. One exception is the Aknysta Care Home where patients with adequate skills for living independently are accommodated in five annexes located near the central building and allowed relative autonomy.

The main form of treatment is medication. For residents who are admitted from a psychiatric hospital, the treatment prescribed there is generally continued. In cases when the resident is admitted directly to the facility, there is a tendency to start immediate treatment with medications instead of observing the patient's condition and seeking alternative methods. As a rule, ordinary medication (earlier generation medicines, especially those with strong suppressive or sedative effects) is prescribed but modern neuroleptics and other medicines are also available. In addition, medicines with a prolonged effect are given to residents, which can cause problems in cases when the effect of medication must be terminated immediately.

Residents are deprived of the opportunity to control their own right to adequate treatment. They usually have as much information about the medicines they take as the doctor in charge (psychiatrist or physician) believes they should have. Furthermore, the lack of psychiatrists in rural areas makes it impossible for residents to receive an external evaluation of their mental condition or alternative consultation by someone outside the facility. This has created a paradoxical situation: although a patient of a residential institution for the mentally disabled is registered with the regional Centre of Mental Health, often the same psychiatrist works for both the

residential institution for the mentally disabled and the concerned Centre of Mental Health.

Monitoring team determined that there was a substantial shortage of adequate psychological consulting and psychotherapy services. Most of the residential institutions for the mentally disabled employ a part-time psychologist. The information provided by patients of practically all residential institutions for the mentally disabled reveal that the quality of services is unsatisfactory, that there is a lack of choice (no opportunity to get assistance outside the residential institution for the mentally disabled) and a general shortage of services. In a few cases, capable patients did not know about the opportunity to receive psychological consulting and psychotherapy services or about the specialists providing these services.

The nursing staff ensures satisfactory healthcare to patients suffering from chronic physical illnesses. Those ill with bronchial asthma, epilepsy, diabetes, cardiovascular, articular or ophthalmic disorders are provided with adequate treatment through medicine. The availability of physiotherapy depends on the particular residential institution for the mentally disabled.

Mobility devices are available to residents but all wheelchairs are mechanical. Glasses and dentures are usually provided at the expense of the residential institutions for the mentally disabled, yet sometimes there are problems if the patients lose or damage them and in such cases they must wait for a long time to have them replaced.

Certain residential institutions for the mentally disabled have entirely eliminated preventive medical examinations, while others traditionally organise annual preventive examinations that include laboratory tests or x-rays. Only one residential institution for the mentally disabled identifies target groups with an increased risk of illness and arranges appropriate examination. In addition, patients and staff of only a few residential institutions for the mentally disabled are vaccinated against the flu once a year.

2.1.10. Outside Assistance

Residential institutions for the mentally disabled co-operate with various institutions in fields ranging from treatment to education and law enforcement. Yet, the aim of this co-operation serves essentially the needs of administration instead of meeting patients' needs and reducing their exclusion from society.

In certain regions, the police refuse to take care of violations that take place in residential institutions for the mentally disabled saying that the staff should settle their own problems and that the police cannot control the disabled.

Co-operation with educational institutions (for example, schools) in the nearby townships is limited to certain recreational activities, such as the use of a school swimming pool. However no opportunities are sought for young patients to attend courses at these schools.

Co-operation with other healthcare institutions usually relies on the good will of the administration of the residential institution for the mentally disabled. Generally, residents are taken to doctors who are not working at the residential institution for the mentally disabled, but the patients have no real choice. The information obtained in the majority of institutions reveals that there is a lack of

gynaecological services. In addition, certain problems arise due to the reluctance of other healthcare institutions to admit the residents of residential institutions for the mentally disabled because of both mental or intellectual disabilities and alcohol addiction.

Residential institutions for the mentally disabled work in close collaboration with psychiatric hospitals. The majority of employees interviewed expressed their dissatisfaction with the treatment of patients in these hospitals in terms of both the duration of the treatment (too short), and the lack of changes in the patients' behaviour after returning from a psychiatric hospital to a residential institution for the mentally disabled.

2.1.11. The Rights of Incapacitated Residents

Custody is established in order to implement, protect and defend the rights and interests of an incapable natural person. (Article 3.238 of the Civil Code of the Republic of Lithuania)

Provided a person determined as incapable recovers or his/her health condition substantially improves, the Court recognises him/her capable. After the Court decision enters into effect, the custody in respect of this person is annulled (Article 2.10 of the Civil Code of the Republic of Lithuania).

Political and civil rights of legally incapable patients are totally taken away. In cases where the patient's custody is entrusted to the residential institution for the mentally disabled, the patient has no possibility of filing a complaint about inadequate care or the failure to safeguard remaining rights.

In the event a patient's custody is entrusted to the family, the institution usually takes no measures to ensure adequate representation of the incapable patient's rights.

Another problem observed was that residents are sometimes inexplicably deemed incapable and both the monitoring team and the administration of the residential institutions for the mentally disabled concur that incapacity of some patients was questionable. Some who were deemed incapable by the courts communicate adequately with other people and thus this raise doubts as to the transparency of the mechanism to determine this condition. The administration believes that in some cases property interests have had a certain influence, while in other cases, incapacity is used in order to allow persons charged with criminal offences to avoid imprisonment.

2.2. Violations of Human Rights in Psychiatric Hospitals

Psychiatric hospitals are less secluded than residential institutions for the mentally disabled and most are situated in cities as separate facilities unrelated to general hospitals. Unlike psycho-neurological residential institutions, psychiatric hospitals are surrounded by residential areas but life there remains isolated.

During the Soviet era, outpatient assistance was vested with hospitals, while services were centralised in so-called psycho-neurological dispensaries. For this reason, hospitals were situated in the city centres so that they were easily accessible to residents. Privatisation and reforms made the localisation of psychiatric hospitals in city centres troublesome and thus attempts are made to relocate them to the city suburbs.

In the late 1970s, an individual aid system was implemented for persons with addiction problems, so the treatment of these patients in mental hospitals was the exception rather than the rule. Currently certain psychiatric hospitals house separate units for addiction patients. Since the establishment of outpatient mental healthcare centres in 1997, the number of beds in hospitals has been continuously decreasing, but the traditional Soviet practice of treating men and women in separate units still prevails.

Psychiatric hospitals and residential institutions for the mentally disabled are closely related:

- Patients are referred to residential institutions for the mentally disabled from psychiatric hospitals. In certain cases, the decision to place a patient in a residential institution for the mentally disabled is made while the patient is still being treated in a psychiatric hospital. In other instances, the decision to transfer the patient into a residential institution for the mentally disabled has been made before hospitalisation, thus the patient simply waits in the hospital until there is a vacancy in the institution[10].
- Troublesome residents of residential institutions for the mentally disabled usually are hospitalised in psychiatric hospitals. This transfer was viewed by patients either as necessary treatment in case a person's condition deteriorates, as a punishment for disobedience or as a money-saving measure (during hospitalisation in a psychiatric hospital the patient receives 100% of the his pension, instead of just 20% when the person lives in a residential institution for the mentally disabled).
- In certain cases, psychiatric hospitals temporarily perform the function of a residential institution for the mentally disabled because some patients actually stay in the hospital for a few months or longer. Yet, these are rare cases that usually end in the patient's transfer to a residential institution for the mentally disabled.

A psychiatrist from the regional Mental Healthcare Centre where a residential institution for the mentally disabled is located is among the decision-makers for the referral of a patient to a psychiatric hospital. But since the psychiatrist is often also employed by a residential institution for the mentally disabled, he/she usually satisfies a request by the administration of the residential institution. This is actual institutionalisation of community assistance: performing his/her functions in a residential institution for the mentally disabled, the psychiatrist fills in the documents on behalf of the Mental Healthcare Centre. The patient who has not even visited a Mental Healthcare Centre is referred to a psychiatric hospital. As a result, an individual institutionalised in a residential institution for the mentally disabled has no opportunity to receive mental healthcare services in the community – he/she is automatically referred to a psychiatric hospital, in case of mental health problems. Psychiatric hospitals (and residential institutions for the mentally disabled) follow an illegal but traditional practice of not questioning diagnosis of patients even if they know that it is incorrect. As a rule, the diagnosis determined by forensic psychiatrists is not questioned later even

[10] Two hospitals employ different methods of solving the problems of patients on the waiting list for the placement in care facilities. One hospital has an agreement with a municipal nursing hospital for a few places for patients on a waiting list. Another hospital has concluded an agreement with the municipality and, in addition, with the patient's family for the additionally sponsored places - municipality and relatives share the financial burden of patient's stay in the hospital while on the waiting list.

if there a re serious doubts about that diagnosis.

Another general practice is to make a decision regarding the involuntary treatment (or extension of the involuntary treatment) of a patient in court in the patient's absence. Often judges refuse to see a patient. For instance, a director of one of the hospitals frequently offers to bring the patients to court but the judges always refuse. In the majority of cases the psychiatrists, in preparing the recommendation for involuntary treatment include the comment that the patient is incapable of taking part in a court hearing. This gravely violates both the patient's right to a fair trial and the right to receive adequate treatment (subsequently enforcing the court decision based on information from a mental health specialist and disregarding the patient's opinion).

Human rights and freedoms in a psychiatric hospital are determined by the regime prescribed for the mental condition. Currently four types of regimes exist:

(1) intense observation regime: the person diagnosed with a mental illness is not allowed to leave the ward and is even escorted to the lavatory;
(2) mid-intensity observation regime: the person may leave the ward and use the premises of the mental unit but cannot actually leave the unit. Sometimes a person in this regime is allowed to leave the unit with family for a short period but then the personnel confers all responsibility for this patient to the family and requests them to bring the patient back into the unit;
(3) low-intensity observation regime: the patient is allowed to have a short walk alone on hospital grounds;
(4) free regime: the patient is allowed to leave the territory of the hospital.

Patients in the first and second regimes must wear hospital-issued pyjamas. The regime defines patients' freedom to enjoy their rights to respect for private life, to freedom of movement and to protection of property. The cases of inhuman or degrading treatment are also related to the type of regime assigned.

Occupational therapy in hospitals does not address the specific needs of patients. For example, unskilled mechanical tasks may be useful to certain groups of patients such as those with intellectual disability, while it confuses mentally ill patients and slows their convalescence. During the Soviet era, certain hospitals, like the psycho-neurological residential institutions, had well-developed occupational therapy units (activities in agriculture and industry) to engage the patients. Occupational activities played a certain role in the treatment but did not address the development of individual skills. After their treatment was finished, the patients would continue attending these workshops and their previous activities. The fact that the workshops or occupational units have survived in one form or another clearly shows that priority is still given to supervision rather than rehabilitation. Thus, hospitals simply meet the minimal needs of the patients without involving them into the decision-making process, thus further promoting their self-insufficiency and dependence on the system.

2.2.1. The Right to Information and Expression

Individuals must not be hindered from seeking, obtaining, or disseminating information or ideas… Citizens shall have the right to obtain any available information which concerns them from State agencies in the manner established by law… Freedom to express convictions, as well

as to obtain and disseminate information, may not be restricted in any way other than as established by law, when it is necessary for the safeguard of the health... (Article 25, the Constitution of the Republic of Lithuania).

The treatment consent form is formally signed but staff members fail to ensure that the patient understands the contents of the documents (for example, a patient who forgot his glasses at home signed documents without being able to read them). Nevertheless, the administration considers the signature to be unconditional evidence of the patient's awareness.

If patients refuse to sign the consent form for treatment in the admission room, they may still be hospitalised for 48 hours during which time personnel will try to coerce them into signing the document (by psychological pressure or the inducement of certain prescription drugs). Sometimes treatment is also given within those 48 hours even if there is no consent from the patient.

Despite laws requiring personnel to provide the patient with information about their illness, types of treatment and side effects, in practice the patient still cannot enjoy this right. Staff members lack the necessary knowledge about patients' right to information and thus the majority of patients are not given enough facts about their treatment. The staff considers giving information to patients as a potential threat which might cause the deterioration of their condition.

Doctors are the only ones with the authority to provide the information, but patients can only expect to be informed if they persistently ask for it and it still depends on the doctor's goodwill and respect for the patient. Usually, the patients are not aware that they have the right to read their own medical records although the staff do not deny the possibility of showing these records to the patient, unless it also contains information concerning a third person. Patients are not encouraged to view their medical records but they can get an extract upon furnishing a written request to the head of administration (involuntary patients are especially interested in this opportunity).

The administration of one psychiatric hospital has drawn up a form for informing patients of the involuntary treatment used when patients do not give their consent to treatment. However this hospital has very few involuntary patients.

There is no procedure for submitting complaints or receiving any written feedback. Orally made complaints are usually about the personnel's conduct of restricting the patient's freedom and the provision of inadequate conditions (for example, for security reasons hospital units have no electricity outlets). In one hospital, patients can express their opinion by filling out an anonymous questionnaire assessing the services, however the administration does not think that the survey results can be relied upon so are not used in any discussion on the quality of services.

Telephone accessibility is not assured to all patients and some are not allowed to have mobile phones. Pay phones are barely accessible to patients in the isolation regime (to buy a phone card, they must ask someone permitted to leave the hospital grounds or make calls at someone else's expense).

Each unit has an occupational manager responsible for activities both inside and outside the units. The majority of activities

take place outside the units and are consequently only accessible to the patients in freer regimes. The patients may take part in activities in standard therapeutic groups but it is not so easy for them to be admitted to these groups (this especially refers to patients treated in acute illness units). This leads to conclusion that the administration does not place much importance on patients' need for self-expression.

2.2.2. The Right to Respect for Private Life

The private life of an individual shall be inviolable… Personal correspondence, telephone conversations and other intercommunications shall be inviolable… (Article 22, the Constitution of the Republic of Lithuania).

The right to respect for private life is closely related to the autonomy of individuals suffering from mental illness, while autonomy is also one of the key principles of mental healthcare treatment since it promotes the recovery of patients. However, all the psychiatric hospitals we visited violate this right.

Psychiatric hospitals restrict the patients' right to private life as much as possible, while the patients in acute illness units in practice enjoy no privacy whatsoever. This right is violated by breaching a patient's right to the protection of personal data, by providing no facilities for private hygiene or telephone calls, by not abiding by the limits concerning the number of patients in a ward and not allowing the patient solitude when required.

Very few specialists have their own offices, but even when they do they fail to use them for the confidential discussion of issues related to the patient. A patient's diagnosis and social concerns are usually discussed publicly in the presence of both patients and staff members.

Frequently patients have no opportunity to use lavatory or bathing facilities alone and there are no locks on the doors of the bathrooms, toilets or showers. According to a patient released from one hospital, patients there can only take showers in twos, thus patients are forced to find a "companion." In the acute illness unit, showering is not allowed at all, while taking a bath is only allowed twice a week. Another hospital has its bathroom, shower, toilets and smoking room in the one area without any screens.

Telephone calls are limited. Although all hospitals are equipped with payphones, they are generally found in crowded areas leaving the caller no privacy, and in one hospital patients are taken to the payphone in groups. Interviews with patients in acute illness units revealed that the personnel tend to limit their telephone use, and do not always allow patients to use mobile phones even though they have no access to the payphones installed in general units. They can only call from a fixed-line phone used by the personnel in the unit, and only in exceptional cases. In addition, staff members unavoidably hear the entire conversation.

In the Lithuanian psychiatric hospitals monitored, the number of patients in one room sometimes reached as many as twenty. Some rooms had no doors, while others remained opened at all times, depriving patients of any opportunity to be alone. Some patients who were tired of being around others asked to be put in the solitary confinement ward in order to have a short rest from the prevailing noise or just be alone for a while. The corridor of one of the men's acute illness units, for example, was very noisy, with the personnel shouting

loudly and the patients complaining that the continuous noise tired them out. Meanwhile the activity room, designated for meeting their privacy needs, was usually locked. The continuous exposure, noise and forced presence of other people not only fail to contribute to the patient's convalescence but actually hinder it. This renders all talk of a therapeutic environment meaningless.

Switching off lights in units at a set time is a very popular practice observed in hospitals and patients are strictly forbidden to turn on the light themselves, which is usually not even possible since switches are locked and the keys are kept by the nurses. And often a dim light is left on in rooms throughout the night meaning that patients have to sleep with the light. Consequently, patients have no choice of what light they want or when they want it.

2.2.3. Discrimination

A person may not have his or her rights restricted in any way, or be granted any privileges, on the basis of his or her sex, race, nationality, language, origin, social status, religion, convictions, or opinions... (Article 29, the Constitution of the Republic of Lithuania).

As set forth in the Constitution of Lithuania, every patient has a right to adequate healthcare. However in the psychiatric hospitals visited, there was no differentiation between patients, meaning that those treated for the first time and those treated on a regular basis, involuntary patients and voluntary patients with lesser or greater disabilities, they were all treated together according to the same rules.

Selected patients are given privileges in psychiatric hospitals like in residential institutions for the mentally disabled. Obedient patients favoured by the personnel receive more freedom and privileges unavailable to other patients. For example, they are allowed to go to the city, given the key to the bathroom, can freely use their mobile phones, are issued extra cigarettes or permitted to smoke outside or in another room.

Some institutions lack separate premises for smoking. This violates both the right of non-smokers for fresh air and the right of the smokers for adequate conditions to smoke.

2.2.4. Torture and Inhuman Treatment

The person shall be inviolable... Human dignity shall be protected by law... It shall be prohibited to torture, injure, degrade, or mistreat a person, as well as to establish such punishments... (Article 21, the Constitution of the Republic of Lithuania).

The majority of hospitals have no standard procedures for imposing physical exclusion, physical or chemical restrictions and the revocation of these restrictions. Nonetheless some hospitals do have official rules regulating these procedures, although defects in their implementation were detected. For example, the requirements for filling in a restraint protocol are not met (it should be signed every 30 minutes); patients are restrained for over two hours (we were told that patients are sometimes left restrained overnight). Interviews with patients also revealed that the personnel failed to supervise the patients during their restraint period, left them for a few hours without supervision, and failed to keep contact with the patient during the period of restraint.

Ignorance of aggression management leads staff members to seek easy and often inappropriate methods to suppress patients'

aggressive behaviour. Since hospitals are understaffed and not equipped to safely escort an aggressive patient to the bathroom, they simply give the patient a bedpan or diapers.

In certain cases, restraint is imposed as a preventive measure in situations where there is a shortage of staff or in order to prevent potential eruptions of aggressive behaviour. Restraint is also used as punishment.

The physical and mental integrity of patients is not guaranteed as cases of violence used against patients were documented in the majority of psychiatric hospitals. Both personnel and other patients resorted to violence. Some patients even tortured other patients, while the staff either failed to take any measures or simply punished all people involved, including the victim. Recurrent violence against one patient was revealed in one hospital according to information provided by both the staff and patients. The reason for violence was the nuisance caused by the victim who was as a result repeatedly placed in the solitary confinement ward, in restraint and given sedatives.

If a patient refuses to take medicine, the staff at the majority of hospitals use psychological pressure and physical coercion (for instance, medicines are forced into the mouth by securing the nose) to make the person swallow the medicine or to have it injected.

Generally, the patients are subject to a variety of punishments including restraint, injections, or a stricter freedom regime. In the majority of cases, mid-level medical personnel decide the punishments, as well as the medication.

Monitoring team was informed that a woman who had recently given birth was not allowed to take a shower in the general regime unit in spite of the fact that due to physiological reasons she could not wash herself in the bathtub available to her.

2.2.5. The Right to Free Movement

Citizens may move and choose their place of residence in Lithuania freely... (Article 32, the Constitution of the Republic of Lithuania)

The right to free movement is often violated in psychiatric hospitals since the principle of the least restrictive environment is not applied. Patients are not provided with adequate information of their opportunities to move freely within the territory of the hospital and beyond. Moreover patients do not always know where their personal documents are kept.

Psychiatric hospitals restrict the patients' right to free movement and the release of patients during treatment because, according to the staff, is not legal in Lithuania. The administration of one hospital said that a patient's presence in a psychiatric hospital automatically implies the restriction of the patient's right to move freely.

Patients are generally allowed to go to the city subject to the good will of the personnel. Hospitals independently set the rules for the patients' release from hospital grounds by establishing different levels of free movement, for example, in the framework the four aforementioned regimes (from movement within the ward to going to the city). For instance, only one hospital on the doctor's recommendation, allows patients to go home on weekends to re-adapt to a home environment before their release.

Another hospital uses a system of permits issued by the doctor. This hospital is

surrounded by a prison-like fence, concrete walls more than two metres high with steel beams covered with barbed wire, and a watchtower. The majority of patients must acquire permits to leave the grounds of the hospital, there is only one exit where the patients must show their permit which can be either permanent or temporary, and for one or two times per day with exact hours specified. These permits can be withheld for two reasons, either as a result of the deterioration of the patient's illness, or when the person is hospitalised for alcohol addiction.

Inside the hospitals, the doors usually have no handles, meaning that only personnel may walk unrestricted around the building. On the other hand, no automatic locks are found in the acute illness units which causes problems because the patients can escape. Therefore, security and adequate care are not guaranteed. This leads to the conclusion that this primitive system restricts the free movement of certain patients too much, while the necessary security is not guaranteed to other patients.

2.2.6. The Right to Property

Property shall be inviolable. The rights of ownership shall be protected by law... (Article 23, the Constitution of the Republic of Lithuania)

The patients' right to property is restricted as they are not allowed to even keep objects which cannot possibly harm them (paper, pens, etc.) or electric appliances such as hair dryers. The use of a patient's own personal belongings is also restricted (for example, mobile phones cannot be kept in the wards for security reasons; there are no electric outlets to charge them, etc.). In a few cases, personal items were taken away from patients (for example, a patient's copy of the Criminal Code was taken away and torn up, or shoes were taken away). The protection and registration of items used by patients is non-existent.

The number of personal belongings is also restricted due to a shortage of storage space. For example, in a five bed ward there is no room to place a TV set.

The average duration of hospitalisation in a psychiatric hospital is thirty days (whereas, the treatment in general hospital lasts from seven to ten days), therefore, the restrictions imposed on using personal items clearly hinder the quality of a patient's stay in a hospital and violates human dignity.

Accountability issues also occur according to our information. Patients are not always given receipts when personnel buy them food or toiletries. Certain patients (such as those transferred from residential institutions for the mentally disabled or involuntary patients) are not allowed to keep their own money and the amount is debited from the patient's bank account.

2.2.7. The Right to Education

Everyone shall have an equal opportunity to attain education according to their individual abilities. (Article 41, the Constitution of the Republic of Lithuania)

It is hard to speak about the integration of persons with mental illness into the community when patients treated for five or seven years are not provided an education, trained or prepared for their return to society.

The visit to the children's ward of one of the psychiatric hospitals revealed that teachers never visit them and no lessons are conducted.

2.2.8. Labour Rights

Every person may freely choose an occupation or business, and shall have the right to adequate, safe and healthy working conditions, adequate compensation for work, and social security in the event of unemployment… Forced labour shall be prohibited… (Article 48, the Constitution of the Republic of Lithuania)

Patients have an opportunity to work for pay in only one psychiatric hospital, but this opportunity is only available when the production unit has orders to fill. The rest of the patients cannot exercise this right at all.

The practice prevailing throughout most hospitals is that patients voluntarily help the personnel. Yet, the patients' assistance in nursing or restraining other patients violates professional ethics.

2.2.9. Treatment and Psycho-Social Rehabilitation

The State shall take care of people's health and shall guarantee medical aid and services in the event of sickness… (Article 53, the Constitution of the Republic of Lithuania)

Deficiencies in the system of reimbursement for pharmaceutical costs lead to the falsification of some patients' personal records. For example, an incorrect diagnosis is sometimes entered into medical records in order to provide patients with the proper treatment since otherwise the medication would not be reimbursed for patients with certain severe mental disorders (such as temporal and short-term psychotic disorders or delirium disorders).

Treatment using medication prevails in psychiatric hospitals, where drugs are immediately administered to a new patient instead of observing the patient's condition and seeking alternative methods of treatment. As a rule, ordinary medication (earlier generation medicines) is prescribed even though modern neuroleptics and other medicines can be also prescribed. In addition, medicines with a prolonged effect are usually given to patients to ensure that they receive a sufficient dose in case they do not want to take medicine themselves.

Patients have no actual control over their right to proper treatment. Usually they do not even know what medicines they are taking ("I take three white tablets and one red tablet").

Mid-level medical personnel are given too much responsibility in some of the psychiatric hospitals, and are sometimes entrusted with providing medication to patients, even though they could diagnose the patient's condition incorrectly.

Doctors at psychiatric hospitals follow an illegal but traditional practice of not changing a diagnosis even if it is incorrect. They reluctantly talk about these cases and decide on treatment based on the diagnosis determined by forensic psychiatrists or medical consillium.

Cases of long-term hospitalisation (from 104 days to 20 years) were discovered in all psychiatric hospitals visited. The rights of these patients are restricted the most and the loss of the skills required for integration in society is the most advanced. Here we come across a paradox once again: these patients are the most neglected and are not provided with sufficient services or psychosocial rehabilitation. Personalised rehabilitation plans for patients are not drawn up in any psychiatric hospitals.

The organisation of occupational therapy and the responsibility for its implementation have not been regulated in psychiatric hospitals thus far. In some facilities it is the task of the psychologists, while in others the nursing staff and social workers are responsible. Occupational therapy is usually meant for communication and leisure only and there is a clear shortage of activities to provide skills training and maintenance. There is also a lack of continuity, since even if the hospital offers some rehabilitation activities; they are not available to the patient after release.

The functions of social workers differ at each hospital but at all facilities they are in charge of acting on behalf of patients in their contacts with both the external world (for example, they take care of patients' allowances and pensions) and other institutions.

The monitoring revealed a serious problem; there is a clear shortage of psychologists who could provide the patients in residential facilities with adequate psychotherapy and psychological services and these services are not available at all to a patient's family. In most cases, the patients have no information about the psychologists employed by the hospital and the services they provide (in one of the hospitals the patients were very surprised to learn that a psychologist was working in their hospital).

The hospitals still have no occupational therapists. Although these specialists are already trained in the country's educational institutions, psychiatric hospitals cannot yet employ them because of insufficient specialisation.

2.2.10. Outside Assistance

As a rule, if a physical disorder is more serious than the mental illness, the patient is transferred to a general hospital and practically all psychiatric hospitals invite doctors for consultations. Although the assistance is not always timely, the consultations of various specialists are available for patients. Usual complaints concern the quality of in-house dentists. For example, the patients in one of the hospitals said that the most popular method of dental treatment in their hospital is tooth removal.

Psychiatric hospitals co-operate with the police and aggressive patients are escorted to the admission room and, if required, to the unit. They also co-operate with Children's Rights Protection Service, municipalities, neighbourhoods, regions, etc. In one of the hospitals, a private security service was hired to watch involuntary patients hospitalised as the result of court rulings.

In specific cases there were concerns when communicating with individual institutions, most of which arose with regional administrations about patients' placements in residential institutions for the mentally disabled. For instance, in a few known cases the residential institutions for the mentally disabled prolonged patients' admissions or refused to admit them entirely. In all these cases, medical records of the patient contained indications of criminal offences. Furthermore, not all patients are willing to live in a residential institution for the mentally disabled which again leads to the lack of alternative community-based social services.

2.2.11. Rights of Legally Incapacitated Patients

Custody is established in order to implement, protect and defend the rights and interests of an incapable physical person. (Article 3.238 of the Civil Code of the Republic of Lithuania)

Provided a person determined as incapable recovers or his/her health condition substantially improves, the Court recognises him/her capable. After the Court decision enters into effect, the custody in respect of this person is annulled (Article 2.10 of the Civil Code of the Republic of Lithuania).

No clearly regulated procedure for the hospitalisation of legally incapacitated patients is in place in cases when their guardian refuses to give consent and there are no mechanisms in place to force the guardians to perform their duties. Generally, the practice of custody of incapacitated patients is faulty, and provides conditions for the violation of patient's rights and hinders adequate assistance. The fact that an incapacitated patient has no right to initiate the replacement of their guardian or appeal against inadequate care provided by the guardian is an obvious legal loophole.

In one of the identified cases, involuntary treatment was extended for one patient merely because his guardian failed to arrive for a meeting, even though in the opinion of the specialists there were no medical reasons for an extension. This problem also raises concerns about the doctors who asked for advice on how to tackle the situation.
In the aforementioned case, not only the right of the patient to live in the least restrictive environment was violated by ignoring his will and choice, but tax payers' money was also wasted since the person was forced to live and be treated in a psychiatric hospital for at least six additional months.

There is also the general practice of adopting a decision on the involuntary treatment (or extension of the involuntary treatment) of a patient in court in the patient's absence. This seriously violates both the patient's right to a fair trial and the right to receive adequate treatment.

3.
Concluding Notes

Immediate attention should be given to the system of social care in large institutions. International experience has shown that residential residential institutions for the mentally disabled are harmful, too expensive and that only a minority of residents are incapable of living in society.

Large residential institutions set up to isolate "defective" members of society, cannot properly safeguard basic human rights such as the right to respect for private life, the right to information and expression, the right to the least restrictive environment, the right to free movement and other fundamental human rights.

This leads to a vicious circle: the more the human rights of mentally ill patients are violated, the more they are socially crippled by their dependence upon the institutional care system, the higher are costs for the society.

Conclusions

- In all probability, the Lithuanian system of residential residential institutions for the mentally disabled and treatment is not cost-effective; it is advisable to conduct an independent cost–benefit analysis of the system.
- The system is ineffective in terms of treatment and/or rehabilitation since it promotes social exclusion, stigmatisation and the inability of residents to re-integrate into the community. Immediate steps to start deinstitutionalisation of the systemdeinstitutiolize the system and to develop a widespread network of community-based services is recommended.
- The traditional centralised system of isolated psychiatric hospitals and residential institutions for the mentally disabled provides the conditions for the violation of human rights and contributes to patients' social exclusion and stigmatisation. Community-based services available around the clock should be introduced to ensure the care of persons with serious mental illnesses, to offer services in places where people live and work, and to develop rehabilitation programmes that would assist the mentally ill to re-integrate into society.

The government should take measures to reduce the number of patients admitted to residential facilities and develop a national network of community-based services for mental healthcare and social services as well as initiate the restructuring, reduction and gradual abandonment of residential facilities.

The implementation of this strategy shall require changes in both legislation and funding procedures. Laws and other legal instruments should plainly regulate the procedures of providing community-based mental healthcare services and social services and for the funding to be allocated. One way of changing the existing funding procedure and concurrently encouraging municipalities to develop the network of community-based services is to create a "package" for patients that would allow them to choose whether to receive services in a residential facility or in the community. This type of system would create a competitive environment and could prompt the municipalities to develop an attractive, alternative structure of community-based services.

HUMAN RIGHTS MONITORING
IN RESIDENTIAL INSTITUTIONS
FOR MENTALLY DISABLED
AND PSYCHIATRIC HOSPITALS

MONITORING REPORT

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