EUROPEAN COMMITTEE FOR THE PREVENTION OF TORTURE AND INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT (CPT)

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Report

to the Romanian Government on the visit to Romania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

from 19 to 30 September 2022

The Government of Romania has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf (2023) 29.

Strasbourg, 5 October 2023

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EXECUTIVE SUMMARY

During the September 2022 visit to Romania, the CPT examined the treatment of patients held in psychiatric establishments and of residents accommodated in residential care centres. The CPT's delegation visited four civil psychiatric hospitals, where it focused on the treatment of the most acute patients and of long-term chronic patients, and the Pădureni-Grajduri Psychiatric and Safety Measures Hospital. The delegation also visited, for the first time, three different types of residential care centres.

Psychiatric establishments

There is a recognition by the Romanian authorities that fundamental reform of the mental health system is required to shift away from institutional care towards establishing mental health services in the community offering adequate social support structures. The findings of the 2022 visit reinforce the urgency for action to ensure that all persons in psychiatric establishments are offered decent living conditions and appropriate treatment for their mental disorders. Underpinning these reforms is the necessity to reinforce staffing levels in all the hospitals visited.

The delegation visited the *civil psychiatric hospitals* of Bălăceanca, Botoșani, Obregia (Bucharest) and Socola (Iaşi). In all the hospitals visited, patients spoke positively about the staff, particularly nursing staff. However, instances of alleged ill-treatment and verbal abuse by staff were received in all the hospitals visited apart from Obregia. In particular, on the male acute ward of Botoșani Psychiatric Clinic the delegation received numerous allegations of patients being ill-treated (punched, slapped, pushed, and shouted at) by auxiliary staff. Ending ill-treatment requires action to improve the training of auxiliary staff, increase the number of ward-based staff and reduce the crowding of patients.

As regards living conditions, the decency and quality varied among the different wards in the hospitals visited. As a general measure, the Romanian authorities need to put in place a refurbishment programme to assist hospital to reconfigure dormitories so that each one accommodates no more than four patients. Further, there was a lack of personalisation of the living accommodation for patients or of visual stimulation on the wards or of a day room where patients can associate. On Ward 1 of the Botoșani Psychiatric Clinic the general state of hygiene should be improved, and the sanitary facilities upgraded, and, cumulatively, the treatment patients in Room 1 of Ward 1 could, in the CPT's view, be considered as inhuman and degrading.

The CPT reiterates that the possibility to be outside, preferably in a pleasant garden area, has a beneficial impact on patients' well-being and recovery and should be a right for every patient. The aim should be for all patients to benefit from unrestricted access to the outdoors during the day unless treatment activities require their presence on the ward. In none of the hospitals visited was this the case.

Treatment on the acute wards in the hospitals visited was primarily based on pharmacotherapy. Steps should be taken to broaden the range of psychosocial and occupational therapy activities on offer to patients. Further, patients should be engaged and consulted in the drawing up and implementation of their individual treatment plans.

Deficiencies in staff resources seriously undermine the care afforded to patients and attempts to offer activities and, as the delegation found, may lead to high-risk situations notwithstanding the genuine efforts of the staff in service. In all four hospitals visited, there were high numbers of vacant staff posts reaching, for example, 20% at the Botoșani Psychiatric Clinic. Additional staff also need to be recruited to offer psychosocial and occupational therapy. Moreover, auxiliary staff working with patients need to be carefully selected and provided with appropriate training, notably in the prevention and management of aggressive behaviour in patients with psychiatric disorders.

In all four hospitals visited, the primary measure of restraint resorted to was the immobilisation of an agitated patient to a bed. The CPT considers that a number of measures are required to improve the safeguards surrounding the application of this measure. These include the comprehensive recording

of the measure, the continuous presence of a staff member in the room in which the person is being restrained and the need for a debriefing of the patient once the straps are removed.
Further, the restraint should not occur in view of other patients and if it is deemed necessary to restrain a voluntary patient and the patient disagrees, the legal status of the patient should be reviewed. The Implementing Rules to the Law on Mental Health should be revised accordingly.

As regards children accommodated in psychiatric facilities, the restraint measure of immobilisation to a bed with straps for agitated children should be ended. In parallel, the Romanian authorities should ensure that staff are trained in manual restraint techniques and that children's wards possess calming down rooms. More generally, patients must never be involved in the restraint of another patient.

A careful examination of the legal safeguards applied in the hospitals visited showed that, with the exception of Obregia Psychiatric Hospital, every effort was made to circumvent the provisions of the law regulating involuntary hospitalisation in order to admit patients on a voluntary basis. Action needs to be taken to ensure that all hospitals fully apply the provisions of the Law on Mental Health regulating the involuntary hospitalisation of patients. In addition, steps should be taken to ensure that the involuntary placement procedures function effectively for patients' rights. It is also important that persons admitted to psychiatric establishments are provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently. There is also a need to enhance the safeguards regulating consent to treatment in hospital.

At *Pădureni-Grajduri Psychiatric and Safety Measures Hospital*, the CPT found that patients were not receiving adequate care and treatment.

At the time of the delegation's visit, 452 patients were accommodated in 390 beds while the hospital had an official capacity of 251 beds. All dormitories were crammed with beds and in the admission ward, a room of 24m^2 was accommodating 18 patients in nine beds. The warehousing conditions of persons with mental disorders and intellectual disabilities found by the CPT in this hospital may well be considered as amounting to inhuman and degrading treatment.

Further, the delegation received many allegations from patients that orderlies at times pushed, slapped and punched them for minor infractions or accidents or as part of a restraint intervention or punitively in an attempt to control the patients within the often hazardous, disturbed and understaffed wards. Ending ill-treatment requires action to significantly increase the number of appropriately trained and supervised ward-based staff and to reduce the crowding of patients.

The treatment and security needs of patients with an intellectual disability should be reviewed and these patients should no longer be accommodated together with patients with a mental disorder.

Treatment was primarily based on pharmacotherapy and action needs to be taken to apply modern multi-disciplinary clinical treatment approaches which include the offer of a wide range of therapeutic, rehabilitative and recreational activities as part of the treatment plan for patients.

As for the use of means of restraint, the delegation found that the registers did not record every instance of immobilisation of a patient and that the duration of the restraint could last much longer than the times recorded. On several wards, patients with learning disabilities were tied to their beds or to a fixed object, such as a radiator in the dining room, almost daily. A comprehensive policy and approach towards restraint with the necessary supervision and oversight needs to be put in place, taking into account the CPT's recommendations.

Steps also need to be taken to strengthen legal and other safeguards such as consent to treatment, patient information and complaint procedures.

The CPT also sets out several systemic shortcomings concerning the approach to forensic mental health in Romania, all of which contribute to the inadequate care and treatment provided to patients. These include no stratification of security needs of patients, lack of a pathway of care for patients

with mental disorders, and the need to establish step-down facilities and to develop proper community psychiatric follow-up care.

Social care centres

The delegation visited, for the first time, the Neuropsychiatric Recovery and Rehabilitation Centres in Costâna and Sasca Mică, the Recovery and Rehabilitation Centre for Persons with Disabilities in Păstrăveni, and the Care and Assistance Centre in Mirceşti.

The delegation received no allegations, and found no other indications, of deliberate ill-treatment of residents by staff in the residential care centres visited. On the contrary, many residents spoke positively about staff, and the atmosphere in the centres appeared generally relaxed, which is especially commendable considering the challenges faced by the low numbers of staff. The caring attitude and commitment of staff were particularly visible in Costâna and Păstrăveni Centres.

As regards living conditions, in all centres visited, residents were accommodated in dormitories which were generally clean, well-lit, and adequately ventilated; however, the state of repair in the accommodation blocks varied considerably. In particular, the conditions in House Oscar in the Sasca Mică Centre were not acceptable for a residential care establishment.

The numbers of unit-based staff (mainly nurses and orderlies) were not fully sufficient to provide proper personalised care for the large number of dependent residents under their responsibility. The numbers of multi-disciplinary staff who could provide psycho-social, occupational, and recreational input to residents should also be increased.

The CPT noted that the majority of unit-based staff (with the notable exception of Păstrăveni Centre) had received no specialised training and therefore lacked the knowledge and skills necessary to care for persons with moderate and severe intellectual disabilities, particularly as regards sign language and other forms of communication support, support in decision making, and prevention and management of challenging behaviour.

It was positive note that the seclusion and mechanical restraint of residents was generally not practiced in the centres visited, as seriously disturbed and agitated residents were promptly transferred to a psychiatric hospital.

Although all residents were formally regarded as voluntary, only a handful could leave the centres on their own, without being accompanied by a staff member or an authorised person (such as a family member or their guardian). Moreover, none of the residents in the four centres visited was free to leave the institution permanently of their own free will.

In the CPT's opinion, such residents should be regarded as *de facto* deprived of their liberty. Their placement and stay in the residential centres, however, was not fully accompanied by appropriate safeguards. The Romanian authorities should put in place a clear and comprehensive legal framework governing the placement and stay of residents in residential centres (including situations in which any restrictions imposed may amount to *de facto* deprivation of liberty).

The CPT noted an ongoing deinstitutionalisation of people with disabilities and the adoption of the Law and the National Strategy on deinstitutionalisation and invited the Ministry of Labour and Social Solidarity to work closely with the Ministry of Health in jointly developing further the necessary full and appropriate range of residential, day and out-patient care for persons with mental disorders in the community.

I. INTRODUCTION

A. The visit, the report and follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to Romania from 19 to 30 September 2022. The visit was considered by the Committee "to be required in the circumstances" (cf. Article 7, paragraph 1, of the Convention).[1]

The main objective of the visit was to examine the treatment of patients held in psychiatric establishments and of residents accommodated in residential care centres. To this end, the CPT's delegation visited four civil psychiatric hospitals where it focused on the treatment of the most acute patients and of long-term chronic patients. The treatment and conditions of care for patients at the Pădureni-Grajduri Psychiatric and Safety Measures Hospital was a further focus. In addition, the delegation visited, for the first time, three different types of residential care centres.

A list of the establishments visited by the delegation is set out in Appendix I to this report.

2. The visit was carried out by the following members of the CPT:

- Vânia Costa Ramos (Head of Delegation)
- Marie Kmecová
- Vytautas Raškauskas
- Karin Rowhani-Wimmer
- Victor Zaharia.

They were supported by Hugh Chetwynd, Head of Division, and Dalia Žukauskienė of the CPT's Secretariat and assisted by two experts, Clive Meux, forensic psychiatrist, United Kingdom, and Jan Stuchlík, psychiatrist, Czech Republic.

The report on the visit was adopted by the CPT at its 110th meeting, held from 6 to 10 March 2023, and transmitted to the authorities of Romania on 17 March 2023. The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests the authorities from Romania to provide within three months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report.

B. Consultations held by the delegation and co-operation encountered

3. In the course of the visit, the delegation held consultations with Alexandru Rafila, Minister of Health, Cătălin Vișean, Secretary of State of Health and Cristian Vasilcoiu, Secretary of State at the Ministry of Labour and Social Solidarity as well as with Cătălina Constantin, Executive Director of the National Center for Mental Health and the Fight Against Drugs, George Cristian Curca, Director of the Institute of Forensic Medicine, and Mihai Tomescu, President of the National Authority for the Protection of Persons with Disabilities, and senior officials from the Ministry of Health and the Ministry of Labour and Social Solidarity.

The delegation also met Renate Weber, Ombudsperson, and members of the National Preventive Mechanism (NPM) within the Ombudsman's office as well as with representatives of civil society.

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1. The CPT's reports on previous visits to Romania and related Government responses are available on the Committee's website: https://www.coe.int/en/web/cpt/romania.

4. The delegation received excellent cooperation from all its interlocutors in terms of access to the establishments it wished to visit, to the documentation it wanted to consult and to individuals with whom the delegation wished to speak. The CPT's gratitude extends to the management and staff in the places visited as well as to the contact persons appointed by the Ministries of Health and Labour and Social Solidarity and to the CPT liaison officer from the Ministry of Justice.

C. Immediate observations under Article 8, paragraph 5, of the Convention

5. During the end-of-visit talks with the Romanian authorities, on 30 September 2022, the CPT delegation made three immediate observations under Article 8, paragraph 5, of the Convention. The Romanian authorities were requested to ensure that:

- all patients admitted to Botoșani Psychiatric Clinic are provided with their own bed;

- a plan is devised to guarantee that all patients held in Pădureni-Grajduri Hospital are provided with their own bed as soon as possible;

- patients held in Ward VIII of Pădureni-Grajduri Hospital are offered access to fresh air daily in a secure garden, including during winter months.

These observations were confirmed by letter of 5 October 2022 when transmitting the delegation's preliminary observations to the Romanian authorities.

On 3 February 2023, the Romanian authorities informed the CPT on the actions taken in response to these immediate observations and on other matters raised by the delegation at the end-of-visit talks. This response has been taken into account in the relevant sections of the present report.

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Psychiatric establishments

1. Preliminary remarks

a. Background

6. Longstanding deficiencies in the mental healthcare system and in the treatment of persons subject to involuntary confinement in psychiatric hospitals have been highlighted in earlier reports by the CPT and national bodies, most notably the Ombudsperson's Institution, as well as in numerous judgments by the European Court of Human Rights.

There is a recognition by the Romanian authorities that fundamental reform of the mental health policy and system is required to shift away from institutional care towards establishing mental health services in the community offering adequate social support structures. However, currently there appears to be little political will to pursue such a reform. As a consequence, mental health services are ill-equipped to provide the appropriate care and treatment for persons who are mentally unwell and far too many persons are ending up in hospital because there is a lack of mental health care provision in the community. Those hospitals are understaffed and, despite valiant efforts by many dedicated doctors, nurses and other personnel, patients are not always getting the treatment they require nor the care that they should be afforded. Overcrowding and poor material conditions exacerbate the problems.

The CPT acknowledges the challenges that the Romanian authorities face such as qualified medical professionals leaving the country to practice in other European countries or opting to work in the private sector and the ongoing need to invest in the physical infrastructure of hospitals and community healthcare centres. Nevertheless, the findings of the 2022 visit to Romania by the CPT point to a clear necessity for promoting an urgent modernisation of the mental healthcare system.

The CPT would like to be informed about the long-term action plan of the Romanian authorities to reform the mental healthcare system, including the timelines and financing for the various elements (including system evolution, infrastructure, treatment and law).

7. At the time of the visit, persons with a mental disorder might be accommodated in one of three types of in-patient psychiatric facilities, as regulated by the Law on Mental health and protection of persons with mental disorders no. 487/2002 as amended in 2012 (Law n° 129/2012):

- 36 psychiatric hospitals, located in 24 counties around the country, providing 8 841 beds;
- 91 psychiatric wards within the county hospitals with 5 427 beds;
- other structures which may provide mental health services such as crisis intervention centres, home care services, day hospitals, recovery and social reintegration centres, sheltered workshops and housing and the consulting centre on domestic violence.

In addition, there are four forensic psychiatric hospitals, known as Psychiatric and Safety Measures Hospitals, which have an official capacity of 1 805 beds. Placement in these hospitals is regulated by the Criminal Code and Criminal Procedure Code.

8. At present, there appears to be little oversight of psychiatric hospitals and the Ministry of Health was not able to provide the CPT with basic information concerning the number of patients in psychiatric hospitals compared to the official number of beds per establishment, either at the time of the visit or for a period earlier in 2022. Nor did it possess any statistics on involuntary hospitalisations or on the resort to the use of means of restraint mechanical restraint or seclusion or chemical restraint) on a monthly, quarterly or yearly basis. Such basic statistics are important for oversight and regulatory purposes and steps should be taken to collate the relevant figures.

The CPT recommends that the Romanian authorities put in place a system of regular data collation on psychiatric hospitals and psychiatric wards on *inter alia* bed capacity, the number of patients and involuntary hospitalisations and the use of means of restraint.

b. Hospitals visited

9. In the course of the September 2022 visit, the delegation visited four civil psychiatric hospitals where it focused on the treatment of the most acute patients and of long-term chronic patients. In particular, it visited Bălăceanca Psychiatric Hospital, the Psychiatric Clinic of Emergency County Hospital "Mavromati" in Botoșani and Socola Psychiatric Hospital in Iaşi. A targeted visit to several wards of the Obregia Psychiatric Hospital in Bucharest was also undertaken. Only Bălăceanca Psychiatric Hospital had been notified by the CPT in advance of the visit.

In addition, the treatment and conditions of care for patients at the Pădureni-Grajduri Psychiatric and Safety Measures Hospital were examined (see Section 3 below).

10. The ***Bălăceanca Psychiatric Hospital "Eftemie Diamandescu"***, located 18 kilometres (km) south-east of Bucharest in the settlement of Bălăceanca, is reputed to be the oldest psychiatric hospital in the country dating back to 1880 and is named after the then mayor of Bucharest. At the time of the visit, the original hospital block and another block were undergoing complete refurbishment and renovation and were fenced off from the rest of the hospital. Patients were primarily accommodated in a central block of four floors, dating from 1984. Floors 1 to 3 each contained a separate locked ward and the admission unit and unlocked drug and alcohol ward were located on the ground floor. The two-storey Block 2, dating from 1936, accommodated chronic patients on the first floor and the "Club" activities room on the ground floor. Due to the ongoing renovations, the management and administration were housed in pre-fabricated cabins on the grounds. The facility was surrounded by a perimeter wall.

The hospital had an operational capacity of 222 beds although officially the capacity was 274. At the time of the visit, there were 124 adult patients, 69 men and 55 women, of whom only five patients were undergoing an involuntary placement measure. In the first nine months of 2022, there had been 1 640 admissions and 1 631 discharges.

11. The ***Psychiatric Clinic of Emergency County Hospital "Mavromati"*** is located on the outskirts of Botoșani, in north-east Romania. The two main two-storey buildings of the Psychiatric Clinic date from the 1890s when the site was a military garrison and, after serving as a prison for political prisoners in the 1950s, it was transformed into a psychiatric hospital in the 1970s. In 2010, the hospital was incorporated into the Emergency County Hospital "Mavromati".

The Psychiatric Clinic consisted of two locked acute wards (one male and one female) in one of the old main buildings as well as a more open acute ward, a neurosis and an addictions ward and two chronic wards, all of which were mixed gender. The larger chronic ward of 71 beds was located in the town in a two-storey building with a sizeable garden. The hospital had a capacity of 320 beds and, at the time of the visit was accommodating 257 adult patients, with the male acute and the chronic wards overcrowded. None of the patients were undergoing an involuntary placement measure. In the first eight months of 2022, there had been 3 076 admissions and 3 029 discharges.

12. The ***Prof. Dr. Alexandru Obregia Psychiatric Hospital***, located in Bucharest, opened in 1923 and is the largest psychiatric hospital in the country with 19 wards spread over a large site. There are six wards with locked male acute sections and seven wards with locked female acute sections, a male and female toxicology ward, a children's and a young person's ward (100 beds), two paediatric neurology wards (80 beds) and a general ward with a Covid-19 isolation unit. Most of the wards had been refurbished in recent years.

The hospital has a capacity of 1 160 beds and on the day of the visit the hospital was accommodating 508 adult patients (210 males; 298 females), plus over 100 children and adolescent patients. There was no specific admissions or intensive care ward. Instead, for each day, two wards (one with a male and one with a female locked acute 'special surveillance' area) was on call for admissions on

a rotation basis. The delegation undertook a targeted visit to Ward 11 (female acute) as well as to Wards 7 and 15 (male acute).

13. The ***Socola Psychiatric Hospital***, located in Iaşi, is a purpose-built psychiatric hospital opened in 1905 consisting of more than 25 buildings spread across a large site. In addition, it contains two remote annexes: Sipote Annexe, 60 km north of the city, accommodated chronic patients (with long-term mental illnesses and learning disability) in three buildings (two male and two female wards) set in extensive grounds; and the Barnova Annexe, 20 km south of the city, possessed 75 beds for chronic patients and 98 beds for palliative care patients (men and women) in a single three-storey block set in woodlands.

At the time of the visit, the official capacity of the hospital was 870 beds and it was accommodating 636 patients – 317 on the main site (175 male and 137 female), 150 at Sipote and 169 at Barnova. The delegation focused its attention on the locked acute male and female wards, the children's ward and the chronic ward on the main site. It also visited the Sipote and Barnova annexes. In the first six months of 2022, there had been 4 376 admissions[2] and 4 294 discharges[3] at the hospital.

2. Civil Psychiatric Hospitals

14. While most civil psychiatric hospitals came under the responsibility of the counties, some were under the direct authority of the Ministry of Health and a few operated at municipality level. Consequently, funding for the operation and maintenance of the hospitals was not even across the country. Further, the costs of a patient's stay in a hospital were determined by the Health Insurance House under the Diagnosis - Related Group Payment System (´DRG´) which generally meant that an acute patient was funded for a stay of 10 to 12 days in hospital and a chronic patient for 55 days. Thus, the length of treatment in a hospital was often not based upon clinical needs but the dictates of the DRG system. However, as the delegation observed in most of the hospitals visited such a financial restriction was circumvented by "fictitious" discharges whereby a patient might be taken to the front gate of the hospital or returned home for a few hours or days before being readmitted to the hospital. There was no funding time limit for the involuntary hospitalisation of patients.

Any reform of the mental healthcare system should also review the financing mechanisms for patients committed to psychiatric hospitals to ensure that the length of their treatment in hospital is based upon clinical needs. At the same time, the development of community mental health services would contribute to fewer persons having to be hospitalised. **The CPT would like to receive the views of the Romanian authorities on these matters.**

a. Ill-treatment

15. In all the hospitals visited, many patients spoke positively about the staff, particularly the nursing staff, and the delegation observed for itself instances of genuine care and support. This was notably the case in the palliative wards of Barnova Annexe of Socola Psychiatric Hospital

However, the delegation received allegations of patients receiving slaps from *infirmiers* (health care assistants) and of being shouted at by nurses and *infirmiers*. This was notably the case on the most acute wards such as Wards 1 and 4 of Socola Hospital, Wards 1 and 2 of Bălăceanca Hospital and the female ward of Botoșani Psychiatric Clinic.

There can never be any justification for the deliberate ill-treatment and verbal abuse of patients with a mental disorder. Staff need to be reminded that such behaviour is unacceptable and will not be tolerated. At the same time, it is incumbent on hospitals and the relevant authorities to ensure that there are sufficient numbers of staff on the wards of psychiatric hospitals and that all staff are properly trained to manage challenging patients, especially when they become agitated, through the provision of courses on de-escalation techniques and the use of safe and effective manual control techniques.

2. 3 865 at the main site, 123 at Șipote and 388 at Barnova.
3. 3 778 at the main site, 123 at Șipote and 393 at Barnova (of which 253 were palliative care)

16. The situation on the male acute ward of Botoșani Psychiatric Clinic was particularly alarming and the delegation received numerous allegations of patients being ill-treated (punched, slapped, pushed, and shouted at) by auxiliary staff. Patients held in the admission room of the ward (room no.1) appeared to be particularly liable to be ill-treated. One patient on the ward who alleged that he had been punched in the back by an *infirmier* a few days earlier, displayed a yellow-brown contusion (4x3cm) in the mid-line of the upper left rear thorax when examined by the delegation's doctor. The injury was consistent with his account of being punched in the back several days previously.

The delegation found that the male acute ward at Botoșani Psychiatric Clinic presented a chaotic environment which was clearly not conducive to providing a therapeutic environment. A number of factors contributed to the poor treatment observed, such as:

- overcrowded large dormitories crammed with beds which offered poor material conditions;
- the placement of patients with learning disabilities in the same rooms as patients who have a mental disorder;
- insufficient numbers of nurses and trained auxiliary staff present on the ward;
- the absence of CCTV cameras on the ward meant that the doctors and senior nurses, who were stationed outside the locked ward, could not observe what was happening on the ward which rendered supervision even more difficult;
- the absence of any management presence at the 320-bed Psychiatric Clinic, leaving the overworked and understaffed psychiatrists to devote more time to the administrative management of the facility instead of supervising their wards.

These various issues are addressed in the relevant sections of the report below but cumulatively impact on the treatment of patients to the extent that the treatment observed in Room 1 of Ward 1 could, in the CPT's view, be considered as inhuman and degrading.

17. **The CPT recommends that the Romanian authorities reiterate to all staff working in psychiatric hospitals, and notably to auxiliary personnel, that any ill-treatment (physical ill-treatment and verbal abuse) of patients with psychiatric disorders or patients with learning disabilities will not be tolerated and will be punished accordingly.**

The CPT also recommends that all staff are properly trained to manage challenging patients, especially when they become agitated, through the regular provision of courses on de-escalation techniques and the use of safe and effective manual control techniques.

In addition, urgent steps should be taken to increase staffing levels, reduce the overcrowding in acute wards and improve the living conditions (see below).

18. Inter-patient intimidation and violence was present in all the hospitals visited but for the most part it consisted of minor verbal altercations and a little bit of pushing. Staff appeared alert to potential violence and few incidents were recorded. Nevertheless, the delegation was struck by the lack of stratification of patients and particularly the mixing together of patients with learning disabilities and patients with psychiatric disorders in the same dormitories. Such a lack of separation of categories of patient is more likely to lead to inter-patient disputes as well as having a negative impact on individualised care and the promotion of an adapted environment.

The CPT recommends that all psychiatric hospitals introduce a stratification of patients to ensure that patients with learning disabilities and patients with psychiatric disorders are no longer mixed in the same dormitories.

b. Patients' living conditions

19. The aim in any psychiatric establishment should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment. Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.

Attention should also be given to the decoration of both patients' rooms and recreation areas, to give patients visual stimulation. The provision of bedside tables and wardrobes is highly desirable, and patients should be allowed to keep certain personal belongings (photographs, books, etc.). It is also important that patients be provided with lockable space in which they can keep their belongings; the failure to provide such a facility can impinge upon a patient's sense of security and autonomy.

20. At Bălăceanca Psychiatric Hospital, efforts had been made to render the living conditions generally acceptable but the dilapidated state of the buildings and the lack of space on the wards rendered the task difficult. The three locked acute wards in the central block were all of a similar layout. Six dormitories, each measuring 24m^2, equipped with six beds and unlockable bedside cabinets and wardrobes, with every two dormitories sharing an interconnecting sanitary annexe (basin, toilet and shower). Two more dormitories on the same corridor were of a similar size while two smaller dormitories, each with four beds were located on an adjoining corridor next to the nurses' station. All the rooms had good access to natural light and adequate heating and ventilation; however, the delegation received complaints that the windows could not be opened to let in fresh air and that the artificial lighting was insufficient for reading purposes. The dayroom/dining area on each of the wards had been converted into a staff changing room with staff lockers, which meant patients had to eat their meals on their beds. The rooms were impersonal and the walls bare, with no pictures. Patients mostly wore pyjamas throughout the day although they could wear their own clothes if they wanted.

The living conditions in Block 2, which accommodated 18 women with a long-term chronic mental disorders, were basic and impersonal.[4] The women, mostly over 60 years of age, only had pyjamas to wear.

Patients were offered access to fresh air in the small garden area in front of the main block twice a day for roughly one hour each time. Further, smokers were permitted to access the small open balcony on each of the locked wards to smoke.

21. The CPT acknowledges that the hospital is in a process of renovation. Nevertheless, due to a lack of funding it is not clear when the new buildings will enter into service and steps should already be taken to improve the living conditions for patients. On each of the locked wards, the dayroom should be re-opened to provide patients with a communal area for activities and watching television as well as, importantly, for taking their meals. Potentially, one dormitory could be taken out of service and used as a staff changing room. Further, the CPT considers that the number of beds in a dormitory should not exceed four. Efforts should also be made to decorate and personalise the accommodation rooms. These issues are taken up in the recommendation in paragraph 31 below.

22. At Botoșani Psychiatric Clinic, the two main buildings were old and dilapidated as was the Chronic VI Annexe. Nevertheless, the living conditions could be considered acceptable on Wards II (women acute), III (neurosis) and IV (mixed gender acute) as well as on Ward V (chronic), although it was congested.

4. Block 2 consisted of three large, cavernous dormitories (75m2), each equipped with 10 beds and two dormitories (35m2) with two and three beds respectively. Apart from a bedside cabinet the rooms were unfurnished. The two communal sanitary areas contained six toilets and eight showers.

However, the male acute Ward I provided an untherapeutic environment which was not befitting of a health care institution. On the day of the visit, the six-room ward accommodated 57 patients for an official capacity of 50 beds.[5] Room no.1 (40m^2), in which the most acute patients were placed, was crowded with 10 beds (some touching each other) and was accommodating 11 patients. There was little floor space for moving around and nearly all the patients were lying in their beds. Flies and cockroaches were visible on the beds and floor, hygiene was poor, patients were not clean, and the room reeked of urine. Several patients were lying directly on the metal frames of the beds as their mattresses had been taken outside to be dried. The plastic mattress covers, and the use of diapers were not sufficient. Further, not all patients were provided with a pillow.

Patients on Ward 1 were not provided with any lockable space and the rooms were furnished with only one bedside cabinet for every two patients. There was no personalisation or decoration of the rooms. The communal sanitary area for the ward was dank and sombre. It consisted of six floor level toilets all of which had broken flushes and patients had to use a bucket for flushing purposes. Four of the six showers worked but the lateral dividers provided no privacy for patients when they showered, and they could only take a shower twice a week. The smell in the sanitary area was compounded by the fact that it was used as a smoking area by patients.

With one or two exceptions, patients on Ward I were not offered access to daily fresh air. Access to outdoor fresh air depended on staff availability to escort patients.

23. The long-term chronic Ward VI in the town accommodated 73 men and women in 71 beds. On the ground floor, the 34 male patients were accommodated in three large dormitories (34m^2) each crammed with nine beds and one four-bed room (20m^2). In one large dormitory 12 patients were sharing nine beds. On the first floor, the 39 female patients were accommodated in four eight-bedded rooms (34m^2) and two four-bedded rooms. Access to natural light, ventilation and heating were all adequate. It was also positive that patients were provided with adjustable care beds and ripple mattresses when required. However, apart from one of the female rooms, there was no personalisation or decoration of the rooms and patients did not possess a lockable space.

Further, patients had to eat in their rooms on their beds. The door to the garden would be unlocked each day for those patients who wanted to access the fresh air for a few hours.

24. It is totally unacceptable for patients requiring care to have to share a bed with another patient while in hospital. At the end of the visit, the delegation invoked Article 8, paragraph 5, of the Convention establishing the Committee and requested the Romanian authorities to take immediate steps to ensure that all patients admitted to Botoșani Psychiatric Clinic are provided with their own bed. By communication of 3 February 2023, the Romanian authorities informed the Committee that steps were being taken to improve the living conditions and to reduce overcrowding. The authorities also provided statistics that showed that Ward 1 had not been overcrowded at all during 2022 and that occupancy levels had reached only 95% of the capacity in September 2022. Such statistics appear at odds with the reality within Ward 1 at the time of the visit when there were 56 patients for an official capacity of 50 beds. In addition to the measures recommended in paragraph 31 below, **the CPT wishes to receive confirmation that all patients admitted to Botoșani Psychiatric Clinic are, at all times, provided with their own bed**.

25. At Obregia Psychiatric Hospital, the female Ward 11 offered satisfactory living conditions for the patients in the open section (19 double rooms and one single room across two floors as well as the four double and one triple room for male patients).

The locked acute female section on the first floor consisted of six double-occupancy rooms (each 10m^2) and three triple bedded rooms (each 13.5m^2) and a small dining room, with a TV. Rooms were clean, possessed adequate access to natural light and artificial lighting, heating and ventilation. They were equipped with bedside cabinets and were all under CCTV. However, the walls were bare and there was no personalisation of the rooms.

5. The delegation was informed that earlier in the year there had been as many as 65 patients on the ward, and that prior to the Covid-19 pandemic in 2020 up to 100 patients were at times accommodated on the ward.

Further, patients were not offered any access to fresh air throughout their time on the locked ward as the courtyard, to which the section had access via stairs from the dining room, was not completely secured.

26. Ward 7 had been recently renovated and the living conditions for the patients in the open section were cramped but satisfactory.[6] However, the rooms were impersonal and undecorated, equipped only with bedside cabinets. Patients were only able to access the fresh air every afternoon for three hours (the garden area was pleasant with trees for shade and benches to sit on). Further, the majority of patients insisted that they had to wear pyjamas (and a bathrobe) during the day, including when they went outside.

The first floor also contained the locked acute section where 18 patients were accommodated in a two-bedded room ($9m^2$) and a large, cavernous dormitory ($68m^2$) with 16 beds,10 of which were jammed together. Such a large dormitory was not appropriate for accommodating acutely mentally unwell patients and the delegation observed the challenges faced by the three staff members to manage a full unit which included several large male patients in a state of mania. The sanitary annex contained three fully partitioned toilets and a shower. Patients wore pyjamas all the time, were not offered access to fresh air during their stay on the closed ward and had to eat their meals on their bed.[7]

27. At Socola Psychiatric Hospital, the living conditions in the three large acute wards[8] were of a similar standard and consisted of smaller rooms of one or two beds, dormitories of four beds and large, cavernous dormitories ($98m^2$) of 15 to 19 beds.[9] The dormitories offered adequate ventilation, heating and artificial lighting and access to natural light was good. Hygiene appeared appropriate and the bedding was clean. Meals were eaten communally in a dining hall on each ward. Patients mostly had access to a bedside table but there was no lockable space in which patients could keep their personal belongings. Moreover, the rooms were impersonal and there were no pictures on the walls. The most acute patients were held in the larger dormitories on the first floor and were not permitted access to outdoor fresh air during their stay. Other patients might be let out into the garden at the back of the ward (where one existed) during the afternoons.

28. In the renovated women's acute Ward 4 (65 beds) each of the large dormitories had been converted into two smaller rooms equipped with five beds. Staff were able to observe the room from the corridor through a large window. The rooms had good access to natural light and were more personalised than elsewhere in the hospital.

29. The delegation was informed that the older patients in the chronic wards had been diagnosed with schizophrenia, organic disorders, learning disability and personality disorders and that they mostly needed support in their daily living. Ward 9 had 31 beds and was situated at the top of the hospital up a steep road. The ground floor consisted of several inter-connecting rooms, each one equipped with four beds. Conditions were cramped but clean.

30. At the Barnova Annexe, the 74 men and women in the chronic section were mostly accommodated in rooms of three or four beds but there were three large dormitories with nine, 10 and 11 beds. The rooms had good access to natural light and were adequately heated and ventilated. However, they were impersonal, and patients had nowhere to store their belongings. Patients were able to access a large, covered terrace throughout the day which overlooked the garden and trees below and which afforded patients' fresh air. In summer, patients would be taken into the garden.

6. 7 women were accommodated in two six-bedded rooms ($18m^2$) and one two-bedded room ($8m^2$) on the ground floor and nine men were accommodated in seven two-bedded rooms ($8m^2$) and three five/six-bedded rooms ($20m^2$) on the first floor

7. The same deficiencies as Ward 7 were in evidence on Ward 15 where the closed unit on the first floor consisted of a large 12-bedded dormitory and a smaller four-bedded room.

8. Ward 1, male, 85 beds; Ward 2, mixed gender, 89 beds; Ward 3, male, 55 beds.

9. In Ward 2, screen separators had been placed between every second bed.

The living conditions at the Sipote Annexe were less good, notably in Pavilion A where the 36 men were accommodated in three rooms, the largest of which contained 20 beds crammed together.[10]

31. **The CPT recommends that the Romanian authorities take measures in the hospitals visited by the CPT:**

- **to put in place a refurbishment programme to assist hospitals to reconfigure dormitories so that they accommodate no more than four patients. In some hospitals this might only require removing a few beds while in others it will require dividing up the existing dormitories into two or three smaller ones. Such changes will require increasing staffing levels. The CPT also recalls that dormitories should offer adequate space for patients (for example, the 24m^2 dormitories at Bălăceanca Psychiatric Hospital are appropriate for accommodating four patients);**
- **to institute a programme of personalisation of the living accommodation for patients, decorating the wards and providing visual stimulation for patients. Patients should also be provided with lockable space for their belongings, and they should be encouraged to wear their own clothes during the day and not remain in pyjamas, especially those patients in the chronic wards;**
- **to ensure that every psychiatric hospital ward has a day room where patients may associate, watch television and play board games. It is also important that patients do not take their meals on their beds but are able to eat in a dedicated dining area;**
- **to ensure that on Ward 1 of Botoșani Psychiatric Clinic the general state of hygiene is improved (including greater efforts to rid the Ward of cockroaches), the sanitary facilities are upgraded, and mattresses have proper waterproof covers. Patients should not have to lie directly on the metal frames of their beds while their mattresses are drying outside. Further, every patient should be provided with a pillow.**

32. The CPT reiterates that the possibility to be outside, preferably in a pleasant garden area, should be a right for every patient. Further, spending time outdoors has a beneficial impact on patients' well-being and recovery. Hence, access to outdoors should be proactively promoted. This is not the current practice in any of the hospitals visited and notably as regards patients accommodated in the locked acute wards at Botoșani Psychiatric Clinic and Obregia and Socola Psychiatric Hospitals.

The CPT recommends that steps be taken in all the psychiatric hospitals visited to put in place a clear policy for promoting and facilitating the possibility of all patients, including involuntary, to access the outdoors every day. The aim should be to ensure that all patients benefit from unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward. The outdoor garden area should be equipped with seating and a shelter. Appropriate clothing and footwear should be made available to patients.

33. The delegation noted that mixed gender wards were in operation in several of the hospitals visited. On some wards, such as Ward 11 at Obregia Psychiatric Hospital, the men were confined to specific areas of the ward and were not permitted to enter the areas where the women were accommodated. However, at Bălăceanca Psychiatric Hospital, the women's dormitories were in the middle of the ward with the men's dormitories on either side and male patients walked up and down the corridor outside the women's unlocked rooms.

The CPT considers that where wards accommodate both men and women, there should be distinct spaces within the ward which are reserved for each gender in addition to the communal areas where patients may associate together. Patients have different needs and history, and some patients may prefer not to have to mix with persons from a different gender. **The CPT recommends that the Romanian authorities ensure that such considerations are taken into account on those wards in psychiatric hospitals which are mixed gender.**

10. Pavilion B (ground floor) accommodated 35 men in four dormitories and Pavilion C (first floor) accommodated 49 women, both of which offered overcrowded and austere living conditions. Pavilion D offered better conditions in smaller-sized dormitories for 27 women in a more modern single-storey building.

34. The delegation received few complaints about the quality of the food in the hospitals visited and it noted that the menus were varied. It did hear a few complaints of inadequate portions.

c. Treatment

35. Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient indicating the goals of treatment, the therapeutic means used and the staff member responsible. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication. Patients should be informed of their individual treatment plans and progress; further, they should be involved in the drafting and implementation of these plans.

For those patients accommodated in the acute wards, the plan should address the patient's immediate needs and identify any risk factors as well as focusing on treatment objectives and how in broad terms these will be achieved. For patients placed in the rehabilitation wards, the plans should identify early warning signs of relapse and any known triggers, and an action plan that a patient and family members should take in response to relapse. The plan should also specify the follow-up care.

36. At Bălăceanca Psychiatric Hospital, the delegation noted that all patients had an individual written treatment plan. The patient's clinical files demonstrated sufficient details and recording (updates every few days), with outlines given of patient details, history, diagnosis, consent forms, physical examination (observation charts and Covid-19 tests), medication and social enquiries. Most patients with whom the delegation spoke stated that they knew what medication they were taking and that they could discuss their medication regime with their treating psychiatrist. That said, while care plans were shared with patients, patients were not properly involved in drawing up their treatment plans; they did not participate in the process of setting targets and discussing challenges and strengths; only the results were shared with them.

Occupational therapy was offered in the "Club" room which was open for three hours a day and consisted mainly of arts and crafts. There was also a greenhouse in which patients could work. A psychologist led several activities including a creative and personal development group and carried out individual talks with patients. The number of patients involved in occupational therapy was limited and the hospital wanted to recruit two more therapists.

37. Likewise, at Obregia Psychiatric Hospital, the delegation noted that patients had individual written treatment plans of a similar quality and that opportunities to undertake occupational therapy in a central building were on offer. Nevertheless, patients on the acute wards were not offered any activities or stimulation.

38. At Botoșani Psychiatric Clinic and Socola Psychiatric Hospital, the delegation noted that individual written treatment plans consisted essentially of the medication prescribed, and the sections of the plan for multidisciplinary treatment were left blank. Senior staff at both establishments stated that there was no funding for occupational therapy and that pharmacotherapy was the foundation of all treatment.

39. **The CPT recommends that the Romanian authorities take steps to broaden the range of psychosocial and occupational therapy activities on offer to patients in psychiatric hospitals. More specifically, the CPT would like to be informed of the measures taken in the hospitals visited. Further, the CPT recommends that every effort be made to consult and engage patients in the drawing up and implementation of their individual treatment plans.**

40. In all the hospitals visited there was a sufficient supply of medication (first generation antipsychotic medication, second generation antipsychotic medication, antidepressants). Clozapine was also administered, and the delegation noted that those receiving Clozapine initially received weekly blood tests and thereafter monthly.

Electro-convulsive therapy (ECT) was occasionally administered only at Obregia Psychiatric Hospital, in a specific room within Ward 9. Usually, a course of a maximum of 10 bifrontal treatments (three per week) were prescribed. An anaesthetist was employed part-time by the hospital and administered myorelaxants as part of the anaesthesia during the treatments. During the treatments, continuous electroencephalography (EEG) and electrocardiography (ECG), blood pressure and oximetric monitoring occurred. Patient consent was sought for the full course of treatment on a separate form but not for each individual treatment session. If the patient was unable to consent or refusing to consent, a Commission of three (internal) doctors (not including the treating doctor) would convene to consider authorisation for the treatment, which would be given in medical necessity. There would also be liaison with the patient's family. A detailed ECT register was maintained.

The CPT recommends that consent should be sought for each individual treatment session. It would also like to be informed of the criteria and policy in place for involuntary patients receiving ECT.

41. At Socola Psychiatric Hospital, the delegation found that many of the patients admitted to the acute Ward 1 were brought to the hospital by the police with alcohol related issues (acute intoxication for drying out or alcohol withdrawal / *delirium tremens*) that required intravenous infusion (IV) and close care. Consequently, Ward 1 was in part a sobering up centre for which the nurses and orderlies felt they were not suitably equipped. Persons might be brought by several police officers and the four staff on duty (at night) would be expected to manage one or more highly intoxicated patients as well as the remaining 50 patients. Staff spoke of nearly 50% of admissions to the locked acute ward being for alcohol-related issues and the delegation met many such patients.

The CPT considers that if the hospital is required to provide a sobering up service for the police, it would be preferable that a dedicated ward be set aside for such purposes and that the staffing arrangements be adapted accordingly to deal with the aggressive behaviour posed by many of these patients. **The CPT would appreciate the comments of the Romanian authorities and of Socola Psychiatric Hospital on this matter.**

d. Staff

42. The CPT has long advocated the importance of psychiatric hospitals having adequate staff resources in terms of numbers, categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.), and experience and training. Deficiencies in staff resources will often seriously undermine the care afforded to patients and attempts to offer activities; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service.

43. At Bălăceanca Psychiatric Hospital, the staffing levels would be appropriate if the vacant 4 psychiatrists and 17 nurses posts as well as an internal medicine doctor were to be filled. At the time of the visit, for an operational capacity of 222 beds, there were 198 staff members out of an official staff complement of 230 (i.e. 16% vacant posts), including:

	In post	Vacancies
Psychiatrists	8	4
Nurses	66	17
Infirmiers (health care assistants)	42	1
Cleaners (ward-based assistants)	20	1
Psychologists	5	0
Social workers	2	3
Occupational therapist	1	0
Dentist	1	0
Pharmacist	1	0
Radiologist / Dentist / Radiologist	3	0
Doctors (internal medicine, laboratory)	2	1

The three acute wards, each with 55 beds, had three nurses and three *infirmiers*/cleaners on duty during weekdays (6:00 to 18:00) as well as a head nurse while on weekends and at night, two nurses and two *infirmiers* were on duty.

44. At Botoșani Psychiatric Clinic, the staffing resources were far too low for the 320-bed facility, notably as concerns psychiatrists, nurses and trained auxiliary ward-based staff. It should be noted that all psychiatrists devoted more than one hour per day to the assessment and treatment of out-patients. For somatic care, patients would be transferred to the county hospital in the city. At the time of the visit, around 20% of posts were vacant.

	In post	Vacancies
Psychiatrists	11	9
Nurses	110	8
Infirmiers (health care assistants)	76	20
Cleaners / monitors	20	11
Stretcher bearers	3	3
Psychologists	5	4
Social workers	2	2
Occupational therapist	1	0
Pharmacist	1	0

The closed acute male 50-bed ward had five nurses and three to four auxiliary staff on duty during weekdays (7:00 to 19:00) as well as a head nurse. On the weekend day shifts, there were three nurses and two auxiliary staff and at night, two nurses and two *infirmiers* on duty. Such staffing levels are clearly insufficient. At the 71-bed Chronic VI Annexe, there were four nurses and 7-10 auxiliary staff during the weekday shifts while on the weekend day shifts there were three nurses and four auxiliary staff as well as a food orderly and at night, two nurses and two auxiliary staff on duty.

45. At Obregia Psychiatric Hospital, the delegation was informed that the official staff numbers for the 1 160 bed hospital were 1 216 posts occupied and 194 vacant (i.e. 14% of the total), notably:

	In post	Vacancies
Medical Doctors	132	36,5
Other health care with university degree	53	9
Nurses with university degree	122	9
Nurses	405	59,5
Auxiliary staff	329	51

On the 65-bed male Ward 7, there were four psychiatrists, a psychologist and a social worker shared with three other wards. On weekdays, there were five nurses and four orderlies and at weekends, four nurses and three orderlies during the 12-hour shifts. At night, there were two nurses and two orderlies on duty.

On the 74-bed female Ward 11, there were four psychiatrists, 20 nurses (including a head nurse) and 12 auxiliary staff (six *infirmiers* and six cleaners / caretakers) as well as a psychologist and a social worker shared with three other wards. On a weekday, there would be 4-5 nurses and 2-3 auxiliary staff on duty. At night, the ward was staffed by two nurses and 1-2 auxiliary staff, with one nurse and one *infirmier* always on duty within the 20-bed locked acute ward. Such numbers were considered totally insufficient as it could leave just one nurse responsible for some 40 patients.

46. At Socola Psychiatric Hospital, the delegation did not examine the staffing numbers of every ward but its observations from visits to certain wards, notably Ward 1 and the Children's Ward, showed that there was a lack of nurses and trained auxiliary staff. The official staffing numbers for the 870-bed hospital were 943 posts occupied and 334 vacant (i.e. 26% of the total), notably:

	In post	Vacancies
Psychiatrists	69	49.5
Nurses	417.5	75
Infirmiers (orderlies) / cleaners	273.5	117
Psychologists	49	18.5
Occupational therapist, masseurs, etc	4	10
Social worker	4	
Traineee psychiatrists (cannot prescribe medication)	80	
Pharmacist, dentist, Neurologists, gynaecologist, radiologists, internal medicine	7	1 (internal medicine)

The closed acute male 50-bed ward on the first floor of Ward 1 had three nurses and two auxiliary staff on duty during weekdays (7:00 to 19:00) and three nurses and one auxiliary staff on duty at night. A nurse and an *infirmier* were always on duty on the ground floor and when possible, the *infirmier* would support colleagues on the first floor. Given the patient profile on the closed acute ward and the fact that there may be up to four patients restrained at any one moment, it is evident that the staffing numbers on this ward are far too low. The delegation was also struck by the inflexible staffing arrangements whereby staff from one ward could not be seconded to another ward whenever there was an urgent need.

As regards the children's ward (Ward 6a), the delegation found that staffing levels at the weekend were particularly low with only two nurses and an *infirmier* on duty for the 20-bed unit. This compared with four or five nurses, an *infirmier*, a psychiatrist and a psychologist on weekdays as well as a creative therapist three days a week. When the weekend staff were all female and one patient or more patients became very agitated and needed to be restrained, the staff could not cope (see section on restraint below).

47. **The CPT recommends that the Romanian authorities take steps to fill the vacant posts in all the hospitals visited. Further, it considers that the official staffing levels on the most acute wards in each hospital should be increased to cope with the real needs of the service. In particular:**

- **at Botoșani Psychiatric Clinic, the number of psychiatrists should be increased and the number of nurses and trained auxiliary staff working on Ward 1 augmented. Additional staff should also be recruited to offer occupational therapy;**
- **at Socola Psychiatric Hospital, the number of nurses and auxiliary staff working on the locked acute Ward 1 should be augmented as a priority as should the staffing on the children's ward at weekends. Additional staff should also be recruited to offer psychosocial and occupational therapy and to ensure that all patients can be offered access to outdoor fresh air every day.**

48. More generally, in order to provide effective treatment, staff also need to be fully confident about their safety which, in addition to increased staff numbers, also requires having places procedures and means for calling for support when needed. **The CPT recommends that the Romanian authorities install alarm/call systems (for example, panic beepers or call buttons) for staff working in the most acute wards.**

49. In the course of the visit, the delegation learned that many of the *infirmiers* and auxiliary staff working on the wards had received little training on how to work with patients with mental disorders or how to react properly when confronted with an agitated patient.

The CPT considers it essential that auxiliary staff (*infirmiers*, cleaners, etc.) who are working on the wards with patients, be carefully selected and given appropriate training before taking up their duties, and that afterwards they receive ongoing training. Particular attention should be given to training in the prevention and management of aggressive behaviour in patients with psychiatric disorders, including verbal de-escalation skills. Further, while carrying out their duties, auxiliary staff should be closely supervised by nurses and medical staff.

The CPT recommends that the Romanian authorities ensure that auxiliary staff working with patients in psychiatric hospitals are carefully selected and provided with the appropriate training and regular ongoing training, notably in the prevention and management of aggressive behaviour in patients with psychiatric disorders.

50. At Botoșani Psychiatric Clinic, the day-to-day management of the establishment was de facto delegated to the senior psychiatrists while the hospital director and administrators were based in the Emergency County Hospital "Mavromati" in the town. The psychiatrists were doing their best but were overwhelmed given the administrative burden placed upon them, over and above their daily duties. A dedicated manager should be appointed to oversee the Clinic. This person should have the competence and authority to manage the 320-bed Clinic and should report, as appropriate, to the Director of the Emergency County Hospital "Mavromati".

The CPT recommends that a director and supporting staff, as required, be appointed to administer Botoșani Psychiatric Clinic under the authority of the Director of the Emergency County Hospital "Mavromati".

51. At all the hospitals visited, security guards were employed to control the entrances to the facility. At Botoșani Psychiatric Clinic and Socola Psychiatric Hospital, the security guards never entered the patient wards or intervened to control patients. At Obregia Psychiatric Hospital, the security guards were more numerous and on rare occasions could enter the wards at the request of the clinical staff and might be involved in restraining a patient, although apparently their mere presence would suffice to calm down a patient. A similar approach was taken at Bălăceanca Psychiatric Hospital, although one of the four guards was always stationed in the admission unit. This is not appropriate. Security guards should not enter clinical areas unless there is a major disturbance. Otherwise, nurses and auxiliary staff should be properly trained to cope with agitated patients.

The CPT recommends that security guards should not be based in clinical areas of psychiatric hospitals and that they should not have any role in the restraint of patients, unless in exceptional cases where healthcare staff are not able to control the situation themselves (e.g. in the case of particularly violent and/or agitated patients) and specifically request the intervention of security guards. In such cases, security guards must act strictly upon the instructions of healthcare staff.

52. At Socola Psychiatric Hospital, the delegation met a patient who had been brought from the local prison in Iaşi for a forensic psychiatric expert assessment. He was accommodated in a room on the first floor of the locked acute Ward 1 together with two prison officers who were equipped with firearms. This is a matter of serious concern to the CPT. The fact that a person has the formal status of a remand or sentenced prisoner cannot justify the presence of firearms on the hospital ward. The CPT has repeatedly emphasised that the carrying of firearms by staff who are in direct contact with prisoners is an undesirable and dangerous practice, which could lead to high-risk situations for both prisoners and staff. Except in an operational emergency, escorting prison officers should not carry lethal weapons within a psychiatric environment. If necessary, officers equipped with firearms should be stationed outside of the closed ward, and the room in which the patient is placed on the closed ward could be rendered more secure.

The CPT recommends that the Romanian authorities terminate the current practice by prison officers of the carrying of firearms on a secure ward of a psychiatric hospital.

e. Means of restraint

53. The Law on Mental Health sets out that the use of means of restraint (immobilisation to a bed) can only be applied when less restrictive techniques are inadequate or insufficient to prevent a risk to the person or others. It cannot be ordered for cases of risk of suicide or lack of staff or treatment or as a sanction or threat or to prevent the destruction of property (Article 39). The Law also states that any patient can be temporarily isolated, without warning, for their protection, if they represent a danger for themselves or other persons (Article 40).

During the visit, the delegation examined the use of restraint in the hospitals visited. In none of the hospitals visited was there any resort to seclusion and the primary measure of restraint resorted to was the immobilisation of an agitated patient to a bed.

54. The Implementing Rules of 15 April 2016 to the Law on Mental Health (Ordinance No. 488/2016) sets out how the immobilisation should be carried out, and the provisions of Article 9 specify that:

- The restraint position is supine with the arms at the side of the body. Immobilization of the head or neck, as well as the arms by the legs, is prohibited.
- The straps shall be applied in such a way as to allow minimal movement of the limbs and in no way affect breathing and blood circulation.
- During restraint, the patient shall keep his/her clothing on and vital needs (feeding, hydration and excretion) and communication shall be ensured without hindrance.
- The medical staff shall assess the condition of the restrained patient every 15 minutes, examining vital signs, maintenance of comfort and appearance of possible side effects.
- All information regarding the restraint measure shall be recorded in both the observation sheet and the Seclusion and Restraint Record Book.

Article 9 also sets out in detail the information that should be recorded in the Book, including the circumstances and reasons for the imposition of the restraint, and that:

- The patient and/or his/her legal/consensual representative shall be informed of the restraint measure and the procedure for its periodic review.
- Restraint shall be applied for as short a time as possible and shall not exceed 4 hours.

For the immobilisation of patients under the age of 18, Articles 10 and 11 of the Implementing Rules sets out additional requirements, such as:

- The duration of restraint should be short, maximum 30 minutes, with the possibility of repetition during the same day.
- The use of protective devices such as gloves, protective helmets for children diagnosed with self-aggression

55. At Bălăceanca Psychiatric Hospital, the delegation noted that the restraint straps used on the wards were custom made and padded, with magnetic sealers. Patients would usually be immobilised to their own bed by their wrists and a strap across the chest (3 point) and sometimes also by their ankles (5 point). Efforts were made to avoid patients being restrained in front of other patients by having them alone in the room, placing a screen around the bed or putting the patient in an infection isolation room. When staffing numbers permitted, the patient would be under continuous direct supervision, otherwise they would receive 15-minute vital sign checks (some of the rooms were also under CCTV). The immobilisation would usually last between 30 minutes and four hours. Patients would rarely be debriefed on their experience.

An examination of the restraint registers on Wards 1, 2 and 3 showed that they were properly filled out and contained the information required by the Implementing Rules. Resort to restraint in these wards was limited,[11] did not exceed four hours and appeared proportionate.

11. For example, on the closed acute Ward 2, no resort to restraint in September 2022, and for the months of June, July and August the numbers were 7, 8 and 6 respectively.

56. At Obregia Psychiatric Hospital, the delegation found that on Wards 7 (male), 11 (female) and 15 (male) the resort to immobilisation was carried out in accordance with the provisions of the law. On Ward 11, patients would only be immobilised in the locked ward to their own bed with straps that had magnetic locks (usually 4 or 5 point) and it would last two to three hours. There had been 15 episodes of immobilisation between March and September 2022.

On the other hand, the resort to immobilisation on Ward 7 was much higher with 100 episodes in less than six months (18 April to 27 September 2022), the vast majority of which were of two hours duration. On Ward 15, there had been 55 episodes of restraint during the first nine months of 2022, none of which exceeded two and a half hours. The resort to restraint on both male wards often occurred in a large dormitory in front of other patients. The registers were adequately completed, although the reasoning for restraint was not always clearly recorded on either Ward 7 or Ward 15.

57. At Botoșani Psychiatric Clinic, each of the acute wards was equipped with two sets of straps with magnetic locks and patients were immobilised to their own bed (2 or 4 point) in front of other patients. Ward 1 possessed three sets of straps and the delegation was advised that it was not uncommon for two patients to be restrained at the same time, notably in rooms 1 and 2 which accommodated the patients with the most severe mental disorders. Indeed, interviews with patients referenced the frequent use of straps to tie patients to their beds. On the second day of the visit, the delegation observed two sets of straps hanging over the end of the beds of two patients who had apparently been immobilised to their beds very early that morning. Leaving the straps in such open display was an intimidating message to patients and clearly disturbed several of them. Further, the delegation noted only one of the episodes of immobilisation had been recorded in the register despite patients adamantly recounting that two of them had been restrained.

An examination of the register on the use of restraints for Ward 1 showed that there had been 34 episodes between 20 June and 23 September 2022, most of which were 60 to 90 minutes duration. This is not excessive. However, the delegation was not convinced that every use of resort to restraint was being recorded. Staff on Ward 1 had already informed the delegation that only episodes of restraint due to aggression were recorded in the register and that if a patient was restrained while undergoing intravenous treatment for alcohol withdrawal it would not be recorded. The oversight of nurses and auxiliary staff working within Ward 1 was not at all robust and the unrecorded use of means of restraint cannot be discounted.

On Chronic VI Annexe, the immobilisation of patients to a bed was no longer used which was confirmed by the register (4 episodes in 2021 and none in 2022) and by patients. On the acute female Ward 2, there had been 20 episodes of immobilisation in the first nine months of 2022. No issues were raised by the register or by patients.

58. At Socola Psychiatric Hospital, there was frequent resort to immobilisation to a bed on the acute male Wards 1 and 3. On Ward 1, there were more than 90 episodes in July, 96 episodes in August and 15 episodes up to 24 September 2022. All episodes were recorded as lasting less than four hours, but the register was lacking certain start dates and finish times. Patients were often immobilised to a bed in front of other patients. Further, due to the number of alcohol- related cases, staff stated that they might have up to five patients in alcohol withdrawal at one time, which resulted in the restraint procedures not being followed properly as there were insufficient staff to monitor every patient's vital signs every 15 minutes and, as the ward possessed only three sets of magnetic restraint belts, staff had to improvise using bed sheets or towels instead, and utilising incontinence pads for padding the limbs where the patients were fixated. On Ward 3, there were 219 episodes of restraint to a bed and on Ward 4, 54 episodes of restraint to a bed in the first nine months of 2022.

59. **The CPT recommends that the Romanian authorities ensure that whenever resort is had to the restraint measure of immobilisation to a bed with straps:**

- **patients are only restrained as a measure of last resort, to prevent imminent harm to themselves or others, and restraints are always used for the shortest possible time (usually minutes rather than hours). When the emergency resulting in the application of restraint ceases to exist, the patient should be released immediately;**
- **all registers on the use of means of restraint are comprehensively completed, including as regards the reasons for the application of the restraint measure;**
- **a trained member of staff is continuously present in the room in which the person is being restrained in order to maintain the therapeutic alliance and to provide assistance;**
- **the restraint does not occur in view of other patients (which is undignified, potentially unsafe and may be threatening to other patients);**
- **if it is deemed necessary to restrain a voluntary patient and the patient disagrees, the legal status of the patient is reviewed;**
- **patients undergoing restrictive measures are able to satisfy the needs of nature in a dignified way;**
- **it is essential that a debriefing of the patient (and other patients who have witnessed the measure) takes place once the restraint straps have been removed.**

The Implementing Rules to the Law on Mental Health should be revised accordingly.

Further, the CPT recommends that, at Botoșani Psychiatric Clinic, the hospital management ensure that the restraint straps are never left lying on patients' beds in full view of patients. They should always be stored safely in staff offices out of sight of patients.

60. More generally, the CPT considers that every psychiatric establishment should have a comprehensive, carefully developed, policy on restraint. The involvement and support of both staff and management in elaborating the policy is essential. Such a policy should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated.

The policy should also contain sections on other important issues such as: staff training; complaints policy; internal and external reporting mechanisms; and debriefing. In the CPT's opinion, such a comprehensive policy is both a major support for staff, and helpful in ensuring that patients and their guardians or proxies understand the rationale behind a measure of restraint that may be imposed.

The CPT recommends that the Romanian authorities ensure that every psychiatric establishment has a comprehensive, carefully developed, policy on restraint.

61. On the 20-bed children's Ward 6a at Socola Psychiatric Hospital, a child patient might be strapped to their bed upon authorisation of a doctor for a period of 30 minutes maximum, which could be extended following medical review. The child would be constantly monitored (including checking their vital signs), with a member of staff obligatorily always in the room.

An examination of the restraint register showed that between July and December 2021 there had been 10 restraint episodes and that between January and September 2022 there had been eight episodes (mostly 2-point, some 4-point). Restraints were recorded as lasting 15 to 40 minutes.

62. On the day of the delegation's visit, a slight 17-year-old boy became agitated after a visit by his father and 'was screaming and hitting his head on the floor' and had been fixated to his bed (4 point). The same boy had already been restrained on two occasions, five days previously. The staff said that the patient was diagnosed with 'autism' and could utter words but not participate in conversation. The restraint had been authorised by the treating doctor by phone as the duty doctor could not attend. However, the three female staff members (two nurses and an *infirmier*) were unable to apply the restraint to the agitated boy and so they had enlisted the assistance of three other boy patients (13, 15 and 16 years of age) in applying the restraint straps.

The three boys, interviewed by the delegation, were clearly affected by having participated in the restraint and both the senior hospital management and the ward staff acknowledged that patients, particularly children, should never be involved in the restraint of other patients. Such a situation had been allowed to occur by the poor and inadequate allocation of nursing and auxiliary staff to the children's ward, knowing that there was a challenging boy on the ward who might become agitated.

63. More fundamentally, the CPT is of the view that, as a matter of principle, persons under 18 years of age should not be subjected to mechanical restraint. The risks and consequences are indeed more serious considering the vulnerability of children. Where it is deemed necessary to intervene physically to avoid harm to the patient themself or others, staff should resort to manual restraint, that is, staff holding the child until they calm down. Agitated children might also be contained in an unlocked room with staff present.

The CPT recommends that the Romanian authorities take steps to end the application of the restraint of immobilisation to a bed with straps for agitated children accommodated in psychiatric facilities. In parallel, they should ensure that staff are trained in manual restraint techniques and that children's wards possess calming down rooms. More generally, patients must never be involved in the application of restraints to another patient.
Further, the relevant legal provisions should be amended accordingly.

f. Safeguards

i. placement and review

64. The procedure applicable to the compulsory placement of a person in a psychiatric hospital (involuntary civilian hospitalisation) is set out in Articles 53 to 68 of the Mental Health Law.

Under Article 54, a psychiatrist who determines that a person has a mental disorder may have that person hospitalised if they consider that:

- this person represents an imminent danger to himself or others or
- this person suffers from serious mental disorders which may lead to a deterioration of their condition if appropriate treatment is not administered.

According to Article 56, the involuntary placement of a person may be requested by the family doctor, the treating psychiatrist, the family of the person concerned, the local public administration, the police services, the fire brigade or the public prosecutor, or even a civil court.

65. In the light of the assessment, the psychiatrist can either propose involuntary hospitalisation (Article 58) or decide on emergency involuntary hospitalisation (Article 63). The psychiatrist is required to immediately inform the person concerned, and his legal representative, of the decision of involuntary hospitalisation (Article 58).

66. The psychiatrist must send the request for involuntary hospitalisation to a special Commission, composed of three members appointed by the hospital manager: two psychiatrists and a doctor from another specialty or a representative of civil society within 24 hours of the assessment of the person concerned (Article 61). The decision of the Commission on involuntary hospitalisation must be confirmed within 48 hours and must:

- include a diagnosis, an adapted solution, the motivations and the signature of all the members (Art.61.4);
- be recorded in the patient's medical file and must be communicated to them and their legal representative (Art.61.5);
- be brought to the attention of the District Court within 24 hours (Art. 61.6).

Further, according to Article 61.7, pending the court decision, the continuation of the involuntary hospitalisation is periodically reviewed by the Commission at intervals not exceeding five days.

67. Article 62 sets out that the court should decide on the involuntary hospitalisation as a matter of urgency. The patient must be heard if his state of health allows it, otherwise the hearing of the patient can be ordered at the place of hospitalisation. The patient must be assisted by a lawyer. The court's decision may be appealed within three days, but the appeal does not suspend enforcement.

68. According to Article 65, the Commission is obliged to re-examine the situation of patients hospitalised involuntarily at intervals of a maximum of one month or whenever necessary depending on their condition, or at the request of the doctor concerned, the patient, his legal representative or the prosecutor. If the Commission finds that hospitalisation is no longer necessary, it must inform the management of the establishment, who must immediately inform the District Court which took the decision on involuntary hospitalisation. Once the court confirms the discharge, the patient can immediately leave the establishment. However, there was no requirement for the court to commission a psychiatric opinion independent of the establishment where the patient is placed.

69. A careful examination of the legal procedures applied in the hospitals visited showed that, with the exception of Obregia Psychiatric Hospital, every effort was made to circumvent the provisions of the law regulating involuntary hospitalisation in order to admit patients on a voluntary basis. Consequently, in the hospitals visited the patients on the locked acute wards, who might be subjected to mechanical restraints, and who were prevented from leaving the wards to access fresh air or to go home, were all (or nearly all) considered voluntary patients.

70. At Bălăceanca Psychiatric Hospital, the duty doctor would point out the disadvantages of involuntary placement to newly admitted patients, highlighting the cumbersome and drawn-out judicial formalities which would prolong a person's stay, and persuade the patient to consent to voluntary placement. The patient must sign a single page document which is the agreement for placement and the agreement for treatment. In addition, the patient signs a third document which includes the house rules and agreement for the use of means of restraint to be applied, as well as the agreement for "communication"/processing of personal data. The documents might be counter-signed by the legal representative but there is no data on this person and the delegation was informed they might be relatives or a social worker from the place of residence.

For those patients who do not agree to voluntary hospitalisation (five at the time of the visit), the procedures set out under the law above were applied. The patient was always brought to the court for the hearing (except during the Covid-19 pandemic when a teleconference procedure was carried out) and would be assisted by an *ex-officio* lawyer in the court. However, the lawyer's role appeared purely a formality as in none of the cases examined did the lawyer meet the patient before the hearing to discuss the case, nor was additional information presented or another opinion sought by the lawyer. The court always endorsed the involuntary hospitalisation. The court delivered their decision the same day or the following day and the right to appeal was specified in the decision. However, while the court decision is communicated to the hospital promptly, the full decision is sent by post and usually only arrives at the hospital 10 or more days later, thus undermining the practicality of making an appeal in three days.

In sum, the safeguards surrounding involuntary placement are formally in place but remain illusory and ineffective in practice.

71. At Botoșani Psychiatric Clinic, no patients were under an involuntary hospital measure at the time of the visit. For 2022, out of 3 076 patients admitted to the Clinic only one had an involuntary hospitalisation measure while in 2021, there were two involuntary measures out of 3 428 admissions. The lead psychiatrists explained that the administrative work involved in processing an involuntary placement were too burdensome. Moreover, they told the delegation that following a complaint by relatives of a patient, the staff had had been admonished for proposing an involuntary placement measure.

Further, the multiple forms that the "voluntary" patients admitted to acute male Ward 1 had to sign were highly confusing in both content and language. The delegation found that patients' consent to placement and consent to treatment could not be considered as either fully informed or voluntary. The administrative files on the other Wards of the hospital were much better kept but the issue of a patient's consent to treatment was not clear.

72. A Socola Psychiatric Hospital, the number of involuntary hospitalisations was very low for the size of the hospital with 52 in 2022 (first nine months) and 43 in 2021. The delegation noted some patients admitted to the hospital did not sign their agreement to voluntary hospitalisation immediately and that it was only after a day or so on the ward that they would consent.[12]

As regards the involuntary procedure, the patient always attended the court hearing. The hospital had concluded an agreement with the court to protect the identity of the patient by not posting their names on the board of court cases being heard and for the patient to use a service entrance to the court. However, the court often took over a month to hear the case and thereafter one week for the decision to arrive by post, by which time the patients had usually been discharged. Not surprisingly, the court always approved the request for involuntary hospitalisation. The *ex officio* lawyers never met the patients and appeared from the files to endorse the involuntary hospitalisation measure and were quoted in the files as saying "the status of the patient dictates involuntary placement".

73. By contrast, at Obregia Psychiatric Hospital, there had been 4 252 involuntary placements in 2021 and 2 974 in the first nine months of 2022. This indicated that the procedure was followed for most patients placed in one of the 13 locked acute wards of the hospital.

However, the procedures offered few safeguards for the patients. The hospital Commission would send its request for involuntary hospitalisation to the Bucharest District Court no. 4 within 24 hours. A hearing would be held via videoconference with the patient represented by an *ex officio* lawyer. The patient was not present,[13] and the *ex officio* lawyer did not meet the patient beforehand. The delegation learned that in 2022 not one lawyer came to meet with their clients prior to a court hearing. The lawyers apparently never challenged the proposed involuntary hospitalisation measure or requested additional evidence or another medical opinion. The court always granted the request for involuntary hospitalisation and the decision also included permission to release or transfer the patient to another institution for medical reasons.

The delegation also learned that the District Court sends the decision on involuntary placement to the home address of the patient and that the hospital only gave a copy of the decision to the patient upon discharge. Clearly the patient was not in a position to appeal the court decision within the statutory three days. The only functioning safeguard was the obligation on the hospital commission to re-evaluate the patient within 30 days, but it appeared that in most cases the treating doctor requested such a re-evaluation be carried out sooner.

74. The delegation learned that before the COVID-19 pandemic there was an agreement in place between the Obregia Psychiatric Hospital and the Bucharest Court pursuant to which the judge, prosecutor and *ex officio* lawyer would come to the Hospital on a weekly basis and go to the wards to decide upon or review involuntary placements.

The CPT would like to be informed of the reasons for not reinstating such a procedure once the COVID-19 pandemic emergency ended.

12 Patients who had not signed the voluntary hospitalisation consent form were recorded in the ward logbooks in red pen until such time as they did sign the form.

13 Court decisions usually contained sentences such as: "there is no need to hear the person, taking into consideration the hospital which requests involuntary placement" or "it is not possible to hear the person, taking into consideration his/her health status". No attempts were made to solicit the patient's participation.

75. **The CPT recommends that the Romanian authorities take action to ensure that all hospitals fully apply the provisions of the Law on Mental Health regulating the involuntary hospitalisation of patients. More particularly, steps should be taken to ensure that patients:**

- **who are admitted to a psychiatric hospital on an involuntary basis have the effective right to be heard in person by the court during placement or appeal procedures;**
- **immediately receive a copy of any court decision on involuntary placement in a psychiatric hospital (or its prolongation);**
- **be requested to sign a statement (indicating the date) that they have received a copy of the decision;**
- **are informed verbally and in writing about the reasons for the decision and the avenues/deadlines for lodging an appeal.**

Further, **the CPT recommends that the Romanian authorities, together with the relevant Bar Association, seek ways to improve the effective representation of patients by *ex officio* lawyers during involuntary hospitalisation proceedings before the court.**

The CPT also recommends that the Romanian authorities ensure that proper information and relevant training is given, as a matter of priority, to all structures and persons involved (in particular, psychiatrists, hospital managers and judges) on the legal provisions pertaining to civil involuntary placement of patients in psychiatric hospitals in Romania.

In addition, **the CPT considers that a psychiatric expert opinion which is independent of the hospital in which the patient is held would offer an additional, important safeguard. This is of all the more relevance in respect of patients who have already spent lengthy periods of time in that hospital.**

76. **The CPT also recommends that persons admitted to psychiatric establishments are provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently.**

All voluntary patients should be required to sign a form, on admission, attesting to their voluntary status by signing a form or verbally with the necessary support. This form should expressly state that voluntary patients are free to leave the establishment and to refuse treatment they do not wish to take. Further, patients who are not able to give valid consent to their hospitalisation should be assessed in order to establish whether they fulfil the criteria for involuntary admission.

ii. safeguards during placement

77. The delegation found that in all the hospitals visited, staff considered that a decision on involuntary hospitalisation was also an authorisation for treatment without consent.

The Mental Health Law states that a psychiatrist has an obligation to obtain the patient's consent for treatment as well as to respect the patient's right to be assisted in giving their consent (Article 29). Further, Article 13 of the 2016 Implementing Rules sets out that the specific form on consent to treatment (Appendix 1 to the Rules) which should be signed by the patient and their legal representative. Article 30 of the Law states that consent can be withdrawn at any time although the psychiatrist may decide to continue the treatment without the patient's consent if it is considered that the interruption of the treatment would cause danger to the patient or others. At this point, the procedures for involuntary hospitalisation under Article 61 of the Law should be applied.

78. The CPT wishes to stress once again that every patient, whether voluntary or involuntary, should, as a matter of principle, be placed in a position to give their free and informed consent to treatment as well as to withdraw it at any time. The admission of a person to a psychiatric establishment on an involuntary basis – whether in the context of civil or criminal proceedings - should not preclude seeking informed consent to treatment. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

Moreover, the relevant legislation should require an external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment's doctors and it is considered necessary for such treatment to be administered to prevent danger to the patient or to others; further, patients should be able to appeal against a compulsory treatment decision to an independent outside authority and should be informed in writing of this right.

The Committee also considers that appropriate rules for evaluating patients' decision-making capacity including their informed consent to treatment should be put in place and implemented by all psychiatric hospitals in Romania.[14]

The CPT reiterates its recommendation that the Romanian authorities amend the relevant legal provisions to ensure that the above-mentioned precepts on consent to treatment are effectively implemented in practice.

79. The situation as regards contact with the outside world was generally satisfactory. Patients were allowed visits from family and friends and, if not in the locked acute wards, could use their personal mobile phones. Patients on the locked wards could either use a payphone or ask for their mobile phone to make a phone call.

80. The delegation found that very few complaints were lodged by patients in the hospitals visited. While the management pointed out that many patients regularly stayed in the hospital and therefore did not wish to complain, it was also evident that most patients had little understanding of the existing avenues to make a complaint or with whom they should speak.

In the Committee's view, a more trusted and effective, formalised complaints system should be developed, with a central register of complaints that records complaints/themes, responses within agreed timescales and actions taken. There should also be clear and confidential access for patients to external and independent bodies who also have the power to investigate complaints. Psychiatric hospitals should have systems, using clinical governance principles that demonstrate multi-disciplinary learning from complaints and investigations, so as to then improve the quality of patient care.

The CPT recommends that action be taken to enhance the effectiveness of the confidential complaints system in psychiatric hospitals.

81. The effectiveness of any complaints system is predicated on patients knowing what their rights are and to whom they should address any complaints. In none of the hospitals visited were patients provided with or able to consult simple, well laid out information brochures on the establishment in which they were accommodated. Such information brochures should cover the hospital's routine, patients' rights, legal assistance, review of placement (and the patient's right to challenge this), consent to treatment and complaints procedures. Staff should explain the contents of the brochure to those patients who have difficulties reading or understanding. The brochures should also be placed online.

The CPT recommends that the Romanian authorities ensure that information brochures in simple plain language be drawn up in each psychiatric hospital, in the light of the above remarks.

14. Reference is also made to Article 12 of the UN Convention on the Rights of Persons with Disabilities, ratified by Romania on 31 January 2011.

3. Pădureni-Grajduri Psychiatric and Safety Measures Hospital

82. As mentioned in the preliminary remarks above, the delegation visited Pădureni-Grajduri Psychiatric and Safety Measures Hospital, one of four such hospitals in the country, all of which fall under the direct authority of the Ministry of Health.

83.The Pădureni-Grajduri Psychiatric and Safety Measures Hospital, located 25 km south of Iaşi, was initially a military barracks and ammunition depot in the 1950s, then an annexe of Socola psychiatric hospital in the 1960s before being designated as a forensic psychiatric hospital in 1999. The hospital consists of seven accommodation blocks (six male and one female) and an administrative building, kitchen block and a church set in expansive woodlands. There are also three small, prefabricated buildings in a fenced in area some 250 metres from the main site which was used for accommodating Covid-19 positive patients and patients with tuberculosis. At the time of the visit, no patients were accommodated in this unit.

The official capacity of the hospital is 251 beds. However, the demand for beds was such that an additional 139 beds had been brought onto the wards to boost the capacity to 390 beds. Yet, even this increased capacity proved insufficient, and, at the time of the visit, there were 452 adult patients resident in the hospital (378 males and 74 females, none of whom were foreign nationals). The shortfall of 62 beds meant that 124 patients were having to share a bed.

In the first nine months of 2022, there had been 86 admissions and 79 discharges and in 2021, there had been 108 admissions and 58 discharges.

84. At the outset, the Committee wishes to raise several systemic shortcomings concerning the approach to forensic mental health in Romania, all of which contribute to the inadequate care and treatment provided to patients held in the Pădureni-Grajduri hospital. Increasing the bed capacity, recruiting greater numbers of appropriately trained and supervised staff, applying modern multidisciplinary clinical treatment approaches, and strengthening legal and other safeguards are all essential steps that need to be taken. However, they are not sufficient.

First, it is striking that patients who have committed minor offences are held alongside those who have committed homicide or serious violence, with no stratification of security needs. Moreover, it is questionable whether certain patients needed to be held in a secure hospital environment at all. Under Article 109 of the Criminal Code patients are recalled to hospital without any medical assessment as to whether hospitalisation is necessary and may be based purely on the fact that a patient missed an appointment with the police or clinic.

Second, urgent attention is required to provide a pathway of care for patients with psychiatric disorders who offend so that courts can send them to a broader range of hospital units with levels of security no greater than that required. Such units should also accommodate prisoners who develop a serious mental disorder who currently are not transferred to a psychiatric hospital for ongoing treatment but are kept within the prison system.

Third, systems need to be put in place for patients to step down to hospital units with lower levels of security *en route* to the community where risks can be assessed prior to care in the community.

Fourth, it is essential for proper community psychiatric follow-up care to be developed, which should tie in with the promotion of de-institutionalisation (see above).

85. The implementation of the approach sketched out above will require the investment of considerable resources and will take time to achieve. However, action is required now to initiate the reform process of the system of forensic psychiatric care. The current system is not fit for purpose.

The CPT recommends that the Romanian authorities draw up a strategy for the treatment and care of patients with psychiatric disorders who offend and for persons in prison who develop a serious mental disorder, taking into consideration the above remarks.

a. Ill-treatment

86. The delegation received many allegations from patients on all the accommodation wards, apart from Pavilion 6, that *infirmiers* at times pushed,[15] slapped and punched them for minor infractions or accidents (such as knocking over a bucket of water, or not standing in line) or as part of a restraint intervention or punitively in an attempt to control the patients within the often hazardous, disturbed and understaffed wards.

Patients also stated that *infirmiers* regularly shouted at and verbally abused them and that, on occasion, nurses also shouted. Numerous patients felt intimidated by staff. Such ill-treatment is totally unacceptable, and staff must be reminded of how to behave towards patients, offered appropriate training and properly supervised. Any allegations of ill-treatment must be investigated effectively and where confirmed punished accordingly.

87. The delegation found that several of the accommodation wards, notably Pavilions 1, 3, 4 and 8 for male patients and Pavilion 2 for female patients presented a chaotic environment which was clearly not conducive to providing a therapeutic environment. A number of factors contributed to the ill treatment observed and documented such as:

- severely overcrowded dormitories crammed with beds touching and a lack of communal areas for activities which offered poor living conditions;
- the placement of patients with learning disabilities in the same rooms as other patients;
- the woeful lack of nurses and trained auxiliary staff present on each ward to safely supervise and treat patients across the wards. For example, in Pavilion 1, there were only two nurses and two *infirmiers* (one male), caring for the 106 most disturbed male patients in the hospital across two floors.

These various issues are addressed in the relevant sections of the report below but cumulatively impact on the treatment of patients to the extent that such treatment might, in the CPT's view, be considered as inhuman and degrading.

88. **The CPT recommends that the Romanian authorities reiterate to all staff working at Pădureni-Grajduri Psychiatric and Special Measures Hospital, and notably to auxiliary personnel, that any ill-treatment (physical ill-treatment and verbal abuse) of patients with psychiatric disorders and patients with learning disabilities will not be tolerated and will be punished accordingly.**

The CPT also recommends that all staff be properly trained to manage challenging patients, especially when they become agitated, through the regular provision of courses on de-escalation techniques and the use of safe and effective manual control techniques.

In addition, urgent steps should be taken to increase staffing levels, reduce the overcrowding and improve the living conditions (see below).

89. Inter-patient violence was not a widespread serious problem in the hospital although minor incidents occurred regularly. However, inter-patient bullying and intimidation was present especially as certain patients were nominated informally to assist staff on the wards with keeping order. The development of such a situation reflected understaffing on disturbed ward environments.

The duty of care which is owed by the Romanian authorities to patients in their care includes the responsibility to protect them from other patients who might wish to cause them harm. **The authorities must act in a proactive manner to prevent violence by patients against other patients and to ensure that no patients are placed in an authoritative position over other patients. This will require hospital staff to be alert to signs of trouble, properly trained to intervene when necessary and sufficient in number to adequately supervise the activities of patients and support each other effectively in the exercise of their tasks.**

15. The delegation observed an *infirmier* brusquely push a patient out of the way when it was visiting Pavilion 8.

b. Patients' living conditions

90. None of the accommodation blocks in the hospital could be considered as complying with the minimum standards that the CPT expects to find in a psychiatric establishment as set out in paragraph 19 above).

91. The living conditions on the small stand-alone admission ward (Pavilion 8) were appalling. The pavilion consisted of two dormitories, a sanitary annexe a small dining area that could seat 8 persons and a staff office. The larger dormitory measured only 24m^2 and was crammed with nine beds on which 18 patients were sleeping. The smaller dormitory measured 13m^2 and eight patients slept on the four beds jammed between the wall and the window. A fifth bed in this dormitory was occupied by a 90-year-old man with an amputated leg. The dormitories were impersonal, and patients had no personal storage space.

Patients were offered no activities at all and spent their days sitting or lying in their beds sleeping, talking or reading. They did not have access to an outdoor exercise area; access to fresh air took place on the barred veranda area (20m²) at the entrance to the pavilion.

The veranda was too small to hold more than ten patients at the same time. Further, while patients supposedly only spent two weeks on this block, the vast majority had been held in such confined conditions for many months and nine patients for periods of 12 to 18 months. Once patient numbers exceeded 30, efforts would apparently be made to transfer some patients to another Pavilion.

In the CPT's view, Pavilion 8 should accommodate no more than six patients.

92. Pavilion 1 accommodated 106 of the most acute male patients in the hospital as well as patients with learning disabilities and some older adult patients. The dormitories, spread across two floors, were extremely overcrowded. For example, Room 12, measuring 30m^2, was filled with 11 beds and accommodated 13 patients; there was no floor space to move around the room. Such overcrowding was typical of most of the dormitories on the ward.[16]

Pavilion 3 accommodated 87 patients in the main one-storey building. Most dormitories were crowded with six (18m^2) or seven (20m^2) beds and the "Club" room (42m^2) had been turned into a dormitory with 12 beds accommodating 15 patients. The rooms all had good access to natural light and sufficient artificial lighting and heating, and were equipped with bedside cabinets or, in the "Club" room, a large cupboard for personal belongings. There was also a dining room with nine small tables and 31 chairs. The Annexe to Pavilion 3, a separate building on the other side of the secured garden area, accommodated 20 patients in two dormitories; one (32m^2) was crammed with 12 beds in which 18 patients slept and one (7.5m^2) of two beds. The larger dormitory was not equipped with personal storage space for the patients and the artificial lighting was poor and access to natural light limited. The lack of ventilation also exacerbated the stale, foul odour in the Annexe.

93. Pavilion 2 accommodated 74 female patients in 60 beds spread across two floors and it was similarly crowded. For example, Rooms 5 and 6, measuring 18m2, were equipped with six beds on which seven patients slept. The rooms were clean, had sufficient lighting (artificial and natural) and the heating was functioning; and each patient had a small cabinet in which personal belongings could be kept.

The living conditions in Pavilions 4 and 5, were in a similar state. For example, in Pavilion 4, there were 42 beds for 56 patients[17] and in Pavilion 5, the eight rooms contained 51 beds for 60 patients.

Pavilion 6 accommodated the most stable, lowest risk, patients, many of whom had work tasks in the hospital (e.g., distributing food) and was described "as the ready to leave" ward. The 20 patients were accommodated on 17 beds; one dormitory (26m^2) was equipped with five sets of bunk beds

16. Room 7 (15m2) had six beds on which seven patients slept; Rooms 3, 6, 11 and Salon 4 (13m2) each had five beds on which five or six patients slept; Room 9 (8.5m2) had three beds on which four patients slept.
17 All the rooms were crowded. For example, 14 patients were sharing 12 beds in a dormitory of 33m2.

and the other dormitory (18m^2) with three beds and two sets of bunk beds. The rooms were sombre, poorly equipped and somewhat dilapidated. However, the patients were permitted to spend most of the day outside in the small garden with minimal supervision when not working.

94. On all the wards visited, the toilets and shower rooms, located on the corridors outside the dormitories, were in an acceptable state of hygiene and repair. Patients were offered a warm shower once a week although on several wards patients stated they could access the shower more often with permission from the staff to unlock the shower rooms. However, the sanitary facilities were insufficient for the number of patients. For example, on Pavilion 3, there were three toilets and two showers for 87 patients in the main building and one toilet for 20 patients in the Annexe which is hardly sufficient.

95. Pâdureni-Grajduri is supposed to be a hospital to treat persons with mental disorders in a therapeutic environment. The situation described in the above paragraphs is an affront to human dignity and represents a throwback to a bygone era when society's most vulnerable members would be warehoused out of sight. In the CPT's view, these conditions raise clear issues under Article 3 of the European Convention on Human Rights and may well be considered as amounting to inhuman and degrading treatment.

As mentioned in paragraph 5 above, the delegation invoked Article 8, paragraph 5, of the Convention establishing the Committee and requested that the Romanian authorities take immediate steps to devise a plan which will guarantee that all patients held in Pădureni-Grajduri Hospital are provided with their own bed as soon as possible.

96. By communication of 3 February 2023, the Romanian authorities responded that they had implemented a new patient allocation policy for the hospitals applying safety measures which had resulted in the number of patients accommodated at Pâdureni-Grajduri Hospital being reduced to 387 as of January 2023. While this far exceeds the official capacity of 251 beds for the hospital, it does mean that every patient now has their own bed, albeit in very crowded conditions. This is a start. The challenge going forward will be to decongest the pavilions to enable the hospital to offer patients an appropriate therapeutic environment. To this end, the Romanian authorities referred in their response to the construction of a new accommodation pavilion with a capacity of 300 beds.

Such a large extension raises a series of questions. Considering the new allocation policy and further measures to ensure that only persons who need to be accommodated in a safety measures hospital are detained at Pâdureni-Grajduri Hospital, **the CPT would like to be informed of the rationale for an additional 300 beds, which will more than double the official capacity of the establishment. Further, the CPT wishes to receive detailed information on the design and layout of the new pavilion, which it trusts will take into account fully the standards elaborated by the Committee. It also wishes to be informed of the proposed additional staffing complement and of the timeline for the completion of the new pavilion.**

Further, once the number of patients on each of the Pavilions has been lowered, separate areas should be designated on each Pavilion as a dayroom space and as a dining area.

97. The delegation found that patients with an intellectual disability were accommodated in each of the pavilions together with patients with a mental disorder. The authorities informed the delegation that at the time of the visit nearly 20% of patients were diagnosed with "mental retardation, oligophrenia, dementia and Alzheimer's disease". They had been transferred to the Hospital from neuropsychiatric recovery and rehabilitation centres by court order due to their challenging behaviour. The delegation was also informed that there was no strategy or pathway for these patients to be released back into the community or to a social care centre.

The CPT recommends that the Romanian authorities undertake a review both as to the necessity of the placement of persons with an intellectual disability at Pâdureni-Grajduri Hospital and whether the treatment and security needs of these patients are being met. Further, patients with an intellectual disability should be accommodated separately from patients with a mental disorder, to enable both categories of patient to benefit from better targeted and specific treatment regimes.

98. Apart from the admission Pavilion 8, all the accommodation blocks had a fenced-in outdoor garden area to which patients could be granted access. The garden areas for Pavilions 1, 2 and 3 were spacious and contained several tables and benches, and a gazebo in the garden of Pavilion 3 provided shelter from sun and rain. However, from interviews with patients and staff, it became evident that during winter months patients might not be granted the possibility to access the outdoor garden areas for periods of several weeks at a time, other than for short periods to smoke a cigarette.

At the end of the visit, the delegation invoked Article 8, paragraph 5, of the Convention establishing the Committee and requested that the Romanian authorities take immediate steps to ensure that patients held in Ward VIII are offered access to fresh air daily in a secure garden, including during winter months. By communication of 3 February 2023, the Romanian authorities responded that a 100m^2 outdoor recreation area had been established for patients on Ward VIII.

99. As noted above (see paragraph 32), spending time outdoors has a beneficial impact on patients' well-being and recovery and access to outdoors should be proactively promoted.

The CPT recommends that patients at Pădureni-Grajduri Hospital be offered access to the outdoor gardens every day. The aim should be to ensure that all patients benefit from unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward. Consideration should be given to providing additional sheltered areas in the gardens.

c. Treatment

100. In a forensic psychiatric hospital, psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient, indicating the goals of treatment, the therapeutic means used and the staff member responsible. The treatment plan should also contain the outcome of a regular review of the patient's mental health condition and a review of the patient's medication.

The treatment should involve a wide range of therapeutic, rehabilitative and recreational activities – including appropriate medication and medical care – and should be aimed at both controlling the symptoms of the illness and reducing the risk of re-offending. Procedures must be in place to ensure that medication prescribed is in fact provided, and that a regular supply of appropriate medicines is guaranteed.

Patients should also be involved in the drafting of their individual treatment plans and be informed of their progress. Those managers and clinicians entrusted with the delivery of these programmes should be empowered with the necessary resources.

101. At Pădureni-Grajduri Hospital, the above precepts were not followed. The delegation noted that individual written treatment plans consisted essentially of the medication prescribed with the sections for multidisciplinary treatment left blank. Patients were also not involved in the development of their treatment plans. No therapeutic or rehabilitative activities were on offer (individual psychotherapy, support and group therapy, special education, work therapy, life skills training, art, sports, etc.) and daytime activities consisted of only a few board games and perhaps watching television. Newly admitted patients were not rapidly assessed to determine whether they needed to be in the hospital.

There was a sufficient supply of medication (first generation antipsychotic medication, second generation antipsychotic medication, antidepressants). Clozapine was also administered, and the delegation noted that those receiving Clozapine initially received blood tests weekly and thereafter every three weeks.

102. **The CPT recommends that the Romanian authorities take steps to introduce a wide range of therapeutic, rehabilitative and recreational activities at Pădureni-Grajduri Hospital as part of the treatment plan for patients.**

Further, the CPT recommends that every effort be made to engage and support patients in drawing up their individual treatment plans.

103. Five patients who were confined to their beds, including one who required oxygen, were accommodated in one dormitory in Pavilion 3. They had ripple mattresses. During the day, an able-bodied patient would remain in the room and keep a watch on them, alerting staff if it appeared that they required moving or assistance while the staff passed by from time to time when not taken up elsewhere**. Patients should not be requested to supervise other patients.**

d. Staff

104. At Pădureni-Grajduri Hospital, the staffing resources were far too low for the official 251-bed facility, notably as concerns psychiatrists, nurses and trained orderlies (*infirmiers*). At the time of the visit, the official number of vacant posts stood at 18%. However, for the actual number of 452 patients it was at negligently low levels. The lack of a general practitioner or internal medicine specialist at the hospital meant that patients had to be transported to Iaşi general hospital when required and once a year a chest X-ray examination was performed on each patient. An infectious diseases doctor visited the hospital under contract. The other staffing resources were as follows:

	In post	Vacancies
Psychiatrists	7	8
Nurses	63	13
Infirmiers (orderlies)	46	2
Caretakers	14	8
Supervisors	17	1
Psychologists	1	1
Social workers	1	0
Occupational therapist[18]	0	0
Pharmacist	1	0
Dentist	1	0
Epidemiologist	0.5	0

As mentioned in paragraph 87, the staffing presence on Pavilion 1 was dire and the situation was comparable on the other pavilions. For example, on Pavilion 2, there were two nurses and three auxiliary staff on duty for 74 female patients and on Pavilion 3, there were three nurses and three auxiliary staff for 107 male patients in two different buildings. On Pavilions 4 and 5, there were two nurses and three auxiliary staff on duty for 56 and 60 male patients, respectively. In addition, two head nurses, responsible for three Pavilions each, worked weekdays from 8:00 to 16:00. Staff shifts were 12 hours (6:00 to 18:00), and the working schedule on all the wards was a 12-hour day shift, 24 hours free, 12-hour night shift, 48 hours free. Many nurses and *infirmers* met by the delegation stated that they were exhausted.

Given the remote location of the hospital, it is evident that additional efforts are required to attract qualified staff.

105. **The CPT recommends that the Romanian authorities take active steps to fill the vacant posts of psychiatrists and to increase the number of nurses and trained auxiliary staff working at Pădureni-Grajduri Hospital. Additionally, staff should also be recruited to provide a wide range of therapeutic, rehabilitative, and recreational activities.**

The CPT also recommends that the Romanian authorities ensure that auxiliary staff working with patients at Pădureni-Grajduri Hospital are carefully selected and provided with the appropriate training and regular ongoing training, notably in the prevention and management of aggressive behaviour in patients with psychiatric disorders.

18. In their communication of 3 February 2023, the Romanian authorities informed the CPT that the Staff Regulations had been amended to provide for three posts of occupational therapist.

e. Means of restraint

106. The Law on Mental Health does not apply to the Psychiatric and Safety Measures Hospitals. However, at Pădureni-Grajduri Hospital, the rules set out in the Law and the Implementing Rules of 15 April 2016 as regards the use of means of restraint appeared to be applied (see paragraphs 53 and 54 above). The delegation was informed by the director that the immobilisation of a patient to a bed could last for a maximum of two hours and that, if the patient was still agitated, sedative medication (diazepam and haloperidol) would be administered intramuscularly.

On the pavilions visited, staff informed the delegation that restrained patients would be provided with diapers or a bed pan for the purposes of urinating or defecating. They also stated that the staff would sometimes elicit the assistance of other patients to help them tie a patient to a bed using cloth straps with magnetic locks. Patients would be restrained in their own beds in front of other patients; if the patient was sharing a bed, the second patient would be moved to another bed during the period of restraint. Those patients who assisted the staff would be rewarded with cigarettes or sweets.

107. In all the Pavilions visited, patients met by the delegation spoke about the regular resort to the immobilisation of patients to a bed, notably on Pavilions 1, 2 and 3, and that the patients with learning disabilities on these wards were tied to their beds or to a fixed object, such as a radiator in the dining room, almost daily. Similar allegations were also received on Pavilions 4 and 5 although patients stated that it was less routine.

However, the registers on the use of means of restraint did not reflect such a state of affairs. For example, on Pavilion 3, the register recorded that patients had been immobilised to a bed on 38 occasions in 2021 and 23 times in the first nine months of 2022 while on Pavilion 1, the register showed that in the months of July, August and September 2022, restraint had been resorted to on 5, 6 and 7 occasions, respectively. On Pavilion 2, the most challenging patient with intellectual disabilities, who was apparently frequently immobilised, was recorded as last having been restrained in May 2022. The length of the restraint measures on all the Pavilions was mostly recorded as being between 30 and 60 minutes, with a few for periods of three to four hours.[19] In December 2021, a patient on Pavilion 1 had been officially restrained on two consecutive days for four hours each time.

108. Further probing of the registers, and interviews with patients and staff revealed that the restraint registers did not record every instance of immobilisation of a patient and that the duration of the restraint could last much longer than the times recorded. Indeed, staff confirmed that the patients with learning disabilities were regularly tied to a fixed object but “only for 15 to 30 minutes” to provide staff some respite. Staff also told the delegation that the longest physical restraint in the previous two years had been around two to three days. None of this was recorded in the restraint registers.

In addition, the supervision of patients who were restrained was supposedly every 15 minutes, but the registers were not always accurately filled out. In any case, such monitoring would not be adequate as the CPT requires continuous direct supervision by a staff member of a patient immobilised to a bed. Patients were also not debriefed when the restraints were removed.

109. Such a situation regarding the immobilisation of patients is totally unacceptable and immediate steps should be taken to put in place a comprehensive policy and approach towards restraint with the necessary supervision and oversight.

The CPT recommends that the Romanian authorities ensure that whenever resort is had to the restraint measure of immobilisation to a bed with straps:

- **patients are only restrained as a measure of last resort, to prevent imminent harm to themselves or others, and restraints are always used for the shortest possible time (usually minutes rather than hours). When the emergency resulting in the application of restraint ceases to exist, the patient should be released immediately;**

19 A patient in Pavilion 5 had been officially restrained 11 times in 2021 for periods of three to four hours and three times in 2022, twice for periods of four and four and half hours.

- **all registers on the use of means of restraint are comprehensively completed, including as regards the reasons for the application of the restraint measure;**
- **a trained member of staff is continuously present in order to maintain the therapeutic alliance and to provide assistance;**
- **the restraint does not occur in view of other patients (which is undignified, potentially unsafe and may be threatening to other patients);**
- **patients are not involved in the application of restraints to another patient;**
- **patients undergoing restrictive measures are able to satisfy the needs of nature in a dignified way**
- **a debriefing of the patient (and other patients who have witnessed the measure) takes place once the restraint straps have been removed.**

It is also essential that there are both sufficient numbers of staff and that staff are trained in manual restraint techniques.

Further, as set out in paragraph 59 above, **the CPT recommends that a comprehensive, carefully developed, policy on the use of means of restraint be drawn up at Pădureni-Grajduri Hospital. Moreover, the use of means of restraint in Psychiatric and Safety Measures Hospitals should be regulated by law.**

f. Safeguards

i. placement and review

110. The Criminal Code (CC) and Criminal Procedure Code (CPC) lay down the legal basis and procedures for compulsory hospitalisation and treatment measures for persons placed in the context of the criminal procedures.[20] Those texts provide that persons in that situation may be placed in a secure psychiatric hospital by a court decision following a forensic medical examination. The compulsory hospitalisation measure has to be reviewed every 12 months, and the court commissions a forensic medical expert report for this purpose.

All patients held at Pădureni-Grajduri Hospital were committed under Article 110 of the CC and none were undergoing a forensic psychiatric assessment. However, many of the patients held in the hospital had come from the community and were interned in the hospital because they had not complied with the conditions of taking their medical treatment in the community. In these latter cases, Article 568 of the CCP states clearly that where a person does not follow the treatment or avoids the treatment (Article 567 1.a and b. of the CPC) the relevant court shall order medical treatment in a hospital. These patients did not undergo a new psychiatric expertise prior to being compulsorily admitted to Pădureni-Grajduri Hospital.

111. The hospital where the measure is effected may at any time notify the court of any change in the condition of the person detained, and particularly of any request to end the hospitalisation. Otherwise, the enforcement judge of the District Court shall verify on a regular basis and no later than every 12 months whether the hospitalisation is still necessary. For this purpose, a medical expert assessment is undertaken. The judge interviews the detained person, who is assisted by a lawyer, and also interviews the public prosecutor and the forensic medical expert. The ending of the measure is based on a compulsory forensic medical expert report. The decision may be appealed by the person concerned, their family or the public prosecutor, without suspensive effect (see Article 569 and 571 of the CPC).

112. At Pădureni-Grajduri Hospital, a Commission of three doctors (two from the hospital and one from the Forensic Medical Institute) assessed each patient every six to 12 months. The assessment occurred within the hospital with each patient interviewed by the panel. The court hearing occurred remotely with the patient in attendance. A lawyer rarely came to the hospital to assist the patient. In

20. See Articles 109 (compulsory medical treatment in the community or prison) and 110 (compulsory hospitalisation) of the Criminal Code (Law No.286 of 17 July 2009) which entered into force on 12 November 2012, and Articles 245 to 248 and 566 to 572 of the Criminal Procedure Code (Law No.135 of 1 July 2010) which entered into force on 7 February 2014.

addition to the medical expertise, the judge also took in account the report from the social worker which included a social inquiry report, details of the patient's history and crimes. The court's decision was communicated to the hospital by fax or mail anywhere between a few days and a month after the hearing. The patient was shown the court decision, signed it and could keep a copy.

An examination of a selected number of patient files revealed the following issues:

- the reviews are often performed at intervals of more than 12 months which is not in line with Article 569 of the CPC;
- *ex-officio* lawyers do not actively support their clients by for example requesting a second medical expertise or challenging a social worker's report;
- in their decisions, judges too often make reference to the crime committed rather than focusing on the mental health of the patient and whether they constitute an ongoing danger to themselves or the community;
- the likely social situation of the patient as set out by the social worker and local authority appears to have a preponderant influence in the decision-making process; many patients do not have family, or their relatives do not want to assume the burden for their welfare but this should not result in these patients having to remain in a closed secure forensic psychiatric hospital. Alternative support mechanisms in the community should be offered.

113. **The CPT recommends that the Romanian authorities take the necessary steps to ensure that only those patients that require in-patient treatment for their mental disorder to protect themselves or others from harm are detained at Pădureni-Grajduri Hospital. In particular the following action should be taken:**

- **persons subject to compulsory treatment under Article 109 of the CC should not be automatically committed to a Special Measures Psychiatric Hospital without undergoing a new forensic medical expertise which concludes that compulsory hospital treatment is necessary;**
- **patients' detention in hospital should not be extended if their mental disorder is no longer considered by the medical experts and the court to represent a danger to themselves or to others; the social enquiry reports should be oriented towards finding a solution for the care and support of the patient in the community and not a justification for maintaining the hospital measure when it is not required;**
- **effective representation of patients by *ex officio* lawyers during review proceedings should be ensured, in cooperation with the relevant Bar Association;**
- **courts should ensure that all patient reviews on continued hospitalisation take place within 12-month intervals, in accordance with the CPC.**

ii. safeguards during placement

114. The delegation found that, as was the case in the civil psychiatric hospitals visited, staff considered that a decision on involuntary hospitalisation was also an authorisation for treatment without consent. **The recommendation set out in paragraph 78 above applies equally to Pădureni-Grajduri Hospital.**

115. The situation as regards contact with the outside world was generally satisfactory. Patients were allowed visits from family and friends and, each Pavilion had two mobile phones and a payphone which patients could use to make a phone call.

116. The delegation found that few complaints by patients were noted down in the complaints register. The management stated that most complaints concerned transfer requests, cigarettes, staffing problems and were sorted out directly. It was evident to the delegation that most patients had little understanding of the avenues to make a complaint or with whom they should speak, and that some were afraid to make complaints. Nor did any information brochure for patients or relatives exist covering the hospital's routine, patients' rights, legal assistance, review of placement (and the patient's right to challenge this), consent to treatment and complaints procedures. **The recommendations set out in paragraphs 80 and 81 above apply equally to Pădureni-Grajduri Hospital.**

B. Social care homes

1. Preliminary remarks

117. In Romania, approximately 17 500 persons live in residential services under the coordination of the National Authority for the Protection of the Rights of Persons with Disabilities (NAPD), more than 16 000 of whom are accommodated in residential centres, while the rest live in supportive housing facilities. Most of those living in the residential centres are persons with learning disabilities or mental disorders (51% and 14% respectively), while the remainder have other types of disabilities.[21] As described in paragraphs 158 and 159 below, in the CPT's view, many residents in the centres visited were *de facto* deprived of their liberty.

In addition to the residential centres under the NAPD, people with disabilities are also accommodated in other types of institutions – psychiatric hospitals, psychiatric and safety measures hospitals, and in medico-social units under the coordination of the Ministry of Health. As described in paragraph 6 above, long-term institutionalisation in such specialised establishments is often due to a lack of disability-specific services in the community.

118. The residential care system for people with disabilities in Romania included several types of residential centres, each designed to provide specific care and activities according to the needs of residents. At the time of the 2022 visit, adults with disabilities lived in six types of residential centres:

(i) habilitation and rehabilitation centres for adults with disabilities (*Centru de abilitare și reabilitare pentru persoane adulte cu dizabilități*, CAbR);
(ii) centres for independent living for adults with disabilities (*Centru pentru viață independentă pentru persoane adulte cu dizabilități*, CPVI);
(iii) care and assistance centres for adults with disabilities (*Centru de îngrijire și asistență pentru persoane adulte cu dizabilități*, CIA);
(iv) recovery and rehabilitation centres for people with disabilities (*Centru de recuperare și reabilitare persoane cu handicap*, CRRPH);
(v) neuropsychiatric recovery and rehabilitation centres (*Centru de recuperare și reabilitare neuropsihiatrică*, CRRN); and
(vi) integration centres for occupational therapy (*Centru de integrare prin terapie ocupațională*, CITO).

The two main types of centres, both in terms of number of institutions and capacity, were the CIA CRRN. [22]

119. In 2018, traditional residential centres had been mandated by the Romanian Government to undergo a restructuring process (if the centre had a capacity of more than 50 residents) or a reorganisation process (for centres with a capacity of fewer than 50 residents). At the end of this process, they either had to be reaccredited as new centres or close and transfer their residents to other types of newly created residential services or into the community.

The delegation was informed by the Romanian authorities that, starting from January 2022, the centres which had not completed their restructuring had had their state funding reduced by 25%, and that from January 2024 they would no longer be funded from the state budget.[23] It is noteworthy that none of the centres visited by the CPT had yet had their budgets reduced as their deadlines for restructuring had been extended by the Ministry.

21. Statistics taken from the 2021 report of the World Bank.
22. It should be noted that since 2019 only CAbRs, CIAs, and CPVIs can be licensed as residential centres that provide specific types of services to their residents. There were still a number of CRRPHs, CRRNs, and CITOs that accommodated adults with disabilities, despite the fact that the operation of these residential centres was no longer regulated by specific legislation.
23. The delegation understood that normally state funding would provide roughly 80% of an institution's budget, with the remaining 20% being provided by the relevant county.

120. Order No. 82/2019 of the Minister of Labour and Social Solidarity lays down standards for two types of residential centres which could accommodate up to 50 residents (namely, CAbR and CIA), as well as for centres for independent living with up to 20 residents, supportive housing facilities with up to 10 residents, and respite or crisis centres.[24]

121. In January 2023, the Parliament of Romania adopted a Law supporting the process of deinstitutionalisation of adults with disabilities and implementing measures to accelerate this process and prevent institutionalisation. In the same month, the Government of Romania approved a National Strategy on the prevention of institutionalisation of adults with disabilities and accelerating the deinstitutionalisation process for the period of 2022-2030, together with the Action Plan for its implementation.

122. During the 2022 visit, the delegation visited, for the first time, the Neuropsychiatric Recovery and Rehabilitation Centres in Costâna and Sasca Mică, the Recovery and Rehabilitation Centre for Persons with Disabilities in Păstrăveni, and the Care and Assistance Centre in Mirceşti.

123. The Neuropsychiatric Recovery and Rehabilitation Centre in Costâna (Costâna Centre) is situated in the village of Costâna, some 20 km from the city of Suceava, a municipal centre, in the north of Romania.

With an official capacity of 139 beds,[25] at the time of the visit the establishment was accommodating 130 adult residents with disabilities – 69 men and 61 women.[26] Half the residents' primary diagnosis was learning disability, while the other half was mental disorder.

124. The delegation was informed about the process of the restructuring of the institution. The relevant plan had been approved by the NAPD and the Suceava County Council and the deadline for its implementation had been extended until the end of 2023.

According to this plan, a number of services will be created – three maximum protected housing facilities (each with a capacity of eight beds) in Cacica (Suceava County), a day centre in Cacica (with a capacity of 30), and three residential care centres in place of the current one (a care and assistance centre in the current Pavilion A with a capacity of 33 beds, and two habilitation and rehabilitation centres in the current Pavilions B and C with capacities of 36 and 41 beds respectively).

125. The Neuropsychiatric Recovery and Rehabilitation Centre in Sasca Mică (Sasca Mică Centre) is situated in the village of Sasca Mică, some 40 km from the city of Suceava.

With an official capacity of 308 beds,[27] at the time of the visit, the establishment was accommodating 298 adult residents with disabilities – 180 men and 118 women. More than half the residents were persons with learning disabilities, while the rest were persons with mental disorders; a number of residents also had physical disabilities.

126. The plan for restructuring the institution had been approved by the NAPD and the Suceava County Council, with the deadline for its implementation having been extended until the end of 2023.

The plan envisages opening a habilitation and rehabilitation centre with a capacity of 50 beds in one of the two current accommodation blocks, Casa Erika. Residents who would not remain in the new centre, would reportedly be transferred to newly created or already existing services, including maximum protected housing facilities, sheltered houses, care and assistance centres, or habilitation and rehabilitation centres; or, for some, reintegration with their family, or assisted living aided by the services of professional personal assistants was envisaged.

24. However, according to the Romanian authorities, most counties are still in the process of restructuring or reorganising residential centres and this process will continue until the end of 2023. Lack of support services in the communities is, reportedly, one of the most significant challenges.
25. Capacity had reportedly been reduced gradually since 2002 (when it stood at 254) and all new admissions had stopped since 2018, when the institution was instructed to start restructuring.
26. One resident was away in a psychiatric hospital receiving treatment.
27. Due to an envisaged reorganisation, all new admissions had stopped since 2021.

127. The Recovery and Rehabilitation Centre for Persons with Disabilities in Păstrăveni (Păstrăveni Centre) is situated in the village of Păstrăveni, some 40 km from the city of Piatra Neamț, a municipal centre.

With an official capacity of 200 beds,[28] at the time of the visit the establishment was accommodating 199 adult residents with disabilities – 95 men and 104 women,[29] the vast majority of whom were persons with learning disability.

128. The plan for restructuring the institution was approved by the NAPD and the Neamț County Council, and the deadline for its implementation had been extended until the end of 2023.

According to the plan, after restructuring the institution, each of the six current pavilions would become separate residential care centres (with capacities ranging from 17 to 38 beds) – with four as habilitation and rehabilitation centres, one as a care and assistance centre, and one as a centre for independent living – accommodating 180 residents in total. The remaining 20 residents would move to live in maximum protected housing facilities in the community.

129. The Care and Assistance Centre in Mircești (Mirceşti Centre) is situated in the village of Mirceşti, some 60 km from the city of Piatra Neamț.

With an official capacity of 50 beds, at the time of the visit the establishment was accommodating 50 adult residents with disabilities[30] – 20 men and 30 women,[31] the majority of them were persons with mental disorders or organic disorders such as dementia.[32]

2. Ill-treatment

130. At the outset, the Committee wishes to stress that it received no allegations, and found no other indications, of deliberate ill-treatment of residents by staff in the residential care centres visited.

On the contrary, many residents spoke positively about staff, and the atmosphere in the centres appeared generally relaxed, which is especially commendable considering the challenges faced by the low numbers of staff caring for the many residents with multiple needs.

The caring attitude and commitment of staff were particularly visible in Costâna and Păstrăveni Centres. The delegation was positively impressed by the individual attention paid to the residents, the empathy and kindness, and the dedication of the staff, visibly influenced by the attitude of senior management, for whom caring for persons with disabilities appeared not just a mere job but a life's calling.

131. Inter-resident violence did not appear to be a major problem in any of the centres visited, though some quarrels and physical conflicts allegedly occurred between residents in Costâna and Sasca Mică Centres. The delegation noted that staff intervened immediately with residents to calm tensions and prevent escalation.

132. However, it is important to remember that violence in an institution for persons with severe disabilities might be hidden. Institutionalisation carries inherent risks for residents' safety and well-being (for example, mixed-sex wards, frequent shortages of staff to provide sufficient supervision, social isolation of some residents and their limited ability to communicate and complain, etc.), therefore, not only a reactive but also a proactive approach is necessary to protect them from harm.

28. Due to an envisaged reorganisation, all new admissions had stopped since 2021.
29. Two residents were away in a psychiatric hospital receiving treatment.
30. Two residents were away in a hospital for somatic treatment.
31. A 74-year-old female resident died of a cardiac arrest during the CPT visit to the institution.
32. As a purpose-built CIA opened in 2009 with a capacity of 50, the centre was not undergoing any reorganisation.

The Committee notes that specific minimum mandatory quality standards approved by the Ministry of Labour and Social Solidarity require annual training of staff of residential centres on how to prevent, identify and report forms of exploitation, violence, and abuse, as well as torture or cruel, inhuman, or degrading treatment. However, as the delegation learned during interviews with staff, the number of such trainings, as well as other forms of training relevant to the prevention of violence, such as de-escalation techniques, was insufficient, with a large percentage of staff untrained.

To strengthen the prevention of ill-treatment by staff, as well as the prevention of violence between residents, **the CPT recommends that steps be taken in all residential care centres to provide staff with ongoing relevant training.**

Furthermore, **bearing in mind that the prevention of ill-treatment and violence is fully effective if residents are enabled to communicate and to express their feelings and needs, programmes should be developed to enable residents to express themselves and to be understood (see more in paragraph 164 and 165 below).**

3. Residents' living conditions

133. In all centres visited, residents were accommodated in dormitories which were generally clean, well-lit, and adequately ventilated; however, the state of repair in the accommodation blocks varied considerably.

134. The Costâna Centre was originally constructed as a neuropsychiatric hospital, 50 years ago. In 1992 it had become a neuropsychiatric recovery and rehabilitation centre with three accommodation blocks.

The single-storey Pavilion A with multiple occupancy rooms (from three to five beds) and a big common space was accommodating men with the most severe or multiple disabilities. The two-storey Pavilion B for male and female residents had activity rooms, a kitchen, and a dining room on the ground floor, and multiple occupancy rooms (from two to four beds) on the first floor. The two-storey Pavilion C for female residents had activity rooms and staff offices in the basement, a dining room and five multiple occupancy rooms (from two to four beds) for the residents with the most severe disabilities on the ground floor, and further multiple occupancy rooms on the first floor.

135. Although the rooms in pavilions A and C had some limited decoration, they lacked personal items (photos, books, etc.) and were rather bare. Residents had individual lockers and could access the keys to them. However, regarding socialisation, none of the pavilions had proper common dayrooms for residents to meet and thus, outside the time of organised activities, many of them were seen sitting on chairs in the corridors.

Furthermore, a number of residents with learning disabilities and residents with mental disorders were sharing rooms. In the Committee's view, there should be stratification of residents separating those with mental disorders from those with learning disabilities, so that both categories can best benefit from tailored individualised care and environments.

In the light of the above, **the Committee recommends that the Romanian authorities take steps at the Costâna Centre to:**

- **provide more visual stimulation and personalisation in the rooms;**
- **provide suitably spacious and comfortable indoor day areas for residents to congregate, should they so wish;**
- **accommodate residents with learning disabilities in rooms where the environment can be better adapted to their specific individual needs.**

136. The Sasca Mică Centre was originally constructed as a hospital, which opened in 1962 and, after going through a number of changes in the type of care offered, finally became a neuropsychiatric recovery and rehabilitation centre in 2002. The residents now reside in two accommodation blocks – House Erika and House Oskar.

House Erika, a three-storey building with attic space, had multiple occupancy rooms for male or female residents on the ground floor, together with a nurses' office, a pharmacy, and a physiotherapy room. The first floor accommodated female residents only, the second floor only male residents. The youngest and most self-sufficient female residents were accommodated in the multiple occupancy rooms in the attic, which also housed several activity rooms and the centre's own radio station.

The corridors and the rooms were pleasantly decorated and personalised. However, a number of rooms (with up to seven beds) were cramped,[33] with beds (some of them worn-out) practically touching each other and with very little space left for the residents to move around; some residents were also not provided with bedside tables. Furthermore, despite residents being accommodated across four floors and some activity rooms being in the attic, the elevator in the building was not functioning (allegedly, it never had) and staff therefore had to assist some residents to climb the stairs or even carry them on occasion.

137. House Oskar, a two-storey building, was mainly accommodating male and female residents with multiple severe disabilities (learning, physical and mental disorders). The cramped rooms (with up to eight beds, many worn-out, some of them touching) and the sanitary facilities were very dilapidated, and the environmental conditions were not acceptable for a residential care establishment (a number of wheelchairs were broken, the bathrooms on the ground floor were not accessible in a wheelchair, hot water in the residents' bathrooms was only available for a couple of hours three times a week, the bathrooms were shared by men and women and did not ensure privacy, and were also not adapted for residents with severe physical disabilities).

In the Committee's opinion, in view of these and other deficiencies (shortage of staff, lack of activities etc., see below), House Oskar should be closed as soon as possible. The Committee takes note of the plans to close it in 2023 and **would like to receive confirmation of its closure without delay. In the meantime, it recommends that the Romanian authorities take urgent steps to ensure that residents in House Oskar have continuous access to hot water**.

138. Further, as regards House Erika, **the Committee recommends that the Romanian authorities take steps to:**

- **reduce occupancy levels in the residents' rooms to provide them with sufficient living space, as per minimum quality standards approved by the Ministry of Labour and Social Solidarity; moreover, the aim should be to ensure that no room accommodates more than four residents;**
- **equip rooms with bedside tables commensurate with the number of residents accommodated in the room; residents should also have access to personal lockable storage space for their belongings;[34]**
- **repair the lift, so as to ensure that the frailer residents and/or residents with physical disability have as much access as possible to fresh air, outdoor exercise and activities;**
- **replace the worn-out beds and broken wheelchairs.**

139. The Păstrăveni Centre was originally constructed as a "hospital for incurable children", which opened in 1966. In 2002 it has become a pilot centre for the recovery of persons with disabilities, and, in 2007, a centre for recovery and rehabilitation of persons with disabilities. The delegation was informed that material conditions had been continuously improving since 1990 due to substantial aid provided by international donors, especially the Bavarian State Government.[35]

33. Approximately 23 m^2 for six beds or 25 m^2 for seven beds. It is noteworthy that minimum quality standards approved by the Ministry of Labour and Social Solidarity require a minimum of 6 m^2 living space per resident (and a minimum of 8 m^2 for a resident requiring a wheelchair).
34. The minimum quality standards require that each resident has access to personal furnishings in their bedroom, which they can use independently to store their clothes and other personal belongings.
35. The donors have also reportedly been providing continuous professional advice, training, and supervision.

The residents were accommodated in six houses, organised according to their degree of disability and gender.[36] Each house had two wings with six or seven multiple occupancy bedrooms (from one to four beds), activity rooms, sanitary facilities, and common day areas. The houses were in a good state or repair and the rooms and communal areas were spacious, homely, pleasantly decorated, and personalised.

140. The Mirceşti Centre is a purpose-built residential care centre which opened in 2009.[37] The residents were accommodated in three one-storey T-shaped pavilions – Pavilion A for men and Pavilions B and C for women. All rooms were double occupancy, decorated and personalised to a certain extent, and furnished with beds, wardrobes, nightstands, and a sink; there was also a TV set and a fridge in every room. However, there was no personal lockable space for residents (and some residents complained about their things disappearing).

The activity room (the "Club") in the administrative building was not big enough to seat all residents and there were no common day areas in the pavilions, beyond some sofas in the corridors.

In the light of the above, **the Committee recommends that the Romanian authorities take steps at the Mirceşti Centre to provide:**

- **greater visual stimulation and personalisation in residents' rooms;**
- **suitably spacious and comfortable indoor day areas in the pavilions for residents to congregate, should they so wish;**
- **all residents with personal lockable space in which they can keep their belongings.**

141. More generally, as regards accommodating residents in multiple occupancy rooms, in the CPT's view, it can on occasion have a potentially counter-therapeutic, depersonalising effect on residents, impeding the creation of a caring environment and compromising privacy. In the dormitory accommodating residents with severe learning and physical disabilities in House Oskar in Sasca Mică Centre, the delegation observed a physically disabled resident defecate in their room, in full view of other residents and staff. Such a situation should not be allowed to occur. Staff need to be more aware of the needs of the residents and be able to intervene and care proactively as necessary.

The CPT recommends that the Romanian authorities take steps to ensure that the privacy of residents is ensured when they comply with the needs of nature. This could be achieved, for example, by using mobile privacy screens or curtains to partition their bed from the rest of the room for the time during which residents receive care-related services and respond to the calls of nature.

4. Staff and care provided to residents

142. The Costâna Centre employed 20 nurses and 29 orderlies working 12-hour shifts; day and night, there were three to four nurses and some ten orderlies in the institution to care for up to 139 residents. As regards other staff, there was one social worker, one psychologist, one recovery pedagogue, and 25 occupational therapists.[38]

A general practitioner visited the centre three times a week (for a total of 20 hours); visits from a psychiatrist, according to the medical documentation examined by the delegation, varied from once per week to once in three weeks.

36. House Barbara housed male and female residents with the most severe disabilities (accommodated in separate wings), the majority of whom needed wheelchairs. House Augustinum was for women, House Star Hours was for men, and House Haas was for young men as well as 11 residents with HIV and AIDS (one man and 10 women; 10 residents were receiving anti-retroviral treatment and one was under supervision). House Ecumenica accommodated young women, and House Bavaria was for those male and female residents with the best self-care skills.

37. Reportedly, the centre has also benefitted from the financial support of the Bavarian State Government over the years.

38. Some of the occupational therapists were assisting the residents with their self-care routines, such as with dressing.

143. In the Sasca Mică Centre, there were 42 nurses and 82 orderlies working eight-hour and 12-hour shifts; during the day, there were usually 26 nurses and 24 orderlies to provide care for up to 308 residents. At night, there were two to three nurses and some 11 orderlies (of those, only one nurse and four orderlies were allocated to care for the 99 residents with more severe learning disabilities in House Oskar), which is clearly not sufficient.

The psycho-social rehabilitation staff included four social workers, two psychologists, three pedagogues, two recovery pedagogues, and 15 occupational therapists.

An internal medicine specialist was at the centre every working day for four hours, and a psychiatrist visited once in two weeks.

144. The Păstrăveni Centre employed 15 nurses and 37 orderlies working 12-hour shifts to provide care for up to 200 residents. The rehabilitation staff included two social workers, two psychologists, two psycho-pedagogues, four physiotherapists, one logo therapist, 24 occupational therapists, and 49 recovery pedagogues.

Staff numbers in different houses varied depending upon the severity of residents' disabilities. For example, in House Augustinum, during the day, there were two occupational therapists, one recovery pedagogue, and two orderlies on duty, and during the night, one occupational therapist and one orderly. In House Bavaria, where residents had the best self-care skills, there were no orderlies, just two recovery pedagogues during the day and one during the night.

A general practitioner visited the centre three times a week, for half a day; a psychiatrist visited once in two weeks for a full day, and a neurologist visited four times per month.

145. In the Mircești Centre, in total there were four nurses and 19 orderlies working 12-hour shifts to provide care for 50 residents; during the day, there were usually two or three nurses and five to seven orderlies on duty while at night there were only two orderlies in the institution and no nurses.

As regards the psycho-social rehabilitation staff, there was one psychologist and two recovery pedagogues; a social worker (who was on maternity leave) and no posts for occupational therapists.

A general practitioner whose office was near the centre visited once a week for three hours, a psychiatrist visited once a month for four hours, and a neurologist visited once a month for an hour.

146. In summary, the numbers of unit-based staff (mainly nurses and orderlies) were not fully sufficient to provide proper personalised care for the large number of dependent residents under their responsibility. The numbers of multi-disciplinary staff who could provide psycho-social, occupational, and recreational input to residents should also be further increased.

The CPT recommends that the Romanian authorities further increase staff numbers at residential care centres and further improve the recruitment (including via review of the terms and conditions, and salaries) of such staff to ensure that there are sufficient numbers of clinical and pedagogical staff of appropriate quality across all grades and disciplines, including at night and on weekends.

147. The delegation noted that the majority of unit-based staff (with the notable exception of Păstrăveni Centre[39]) had received no specialised training and therefore lacked the knowledge and skills necessary to care for persons with moderate and severe learning disabilities, particularly as regards sign language and other forms of communication support, support in decision making, and prevention and management of challenging behaviour.

In the Committee's view, it is important to enable persons with speech/language impairments to communicate with alternative communication methods. If persons are not enabled to communicate, their needs might not be properly identified, and this may lead to frustration, social isolation, and challenging behaviour. Further, it might affect staff's ability to detect and prevent abuse and/or aggression.

Bearing in mind the challenging nature of their work and the needs of residents, it is of crucial importance that care staff receive appropriate initial and on-going training on the above-mentioned topics.

The CPT recommends that the Romanian authorities take urgent steps to ensure that such training is provided in all residential care centres. Further, staff caring for residents living with dementia (Mirceşti Centre) should receive training in meeting their special needs.

148. As regards somatic healthcare, the arrangements were made for all residents to have at least one annual general somatic healthcare check. However, the delegation was concerned to find that there was no regular preventive mammographic or gynaecological screening available for female residents in the four centres visited. There was also no preventive or prosthetic dental treatment available for most residents (and in House Oskar of Sasca Mică Centre, the majority of residents with severe learning disabilities did not even have toothbrushes). Furthermore, none of the four centres possessed a defibrillator and an oxygen cylinder.

The CPT recommends that the Romanian authorities take steps, in all residential care centres, to provide residents with adequate dental care (including daily oral hygiene routines, as well as preventative/conservative treatment) and to ensure that female residents also undergo regular health screening (for example, cervical smears, mammography) as appropriate.

Moreover, **steps should be taken to ensure that all residential care centres have at least one oxygen cylinder and an automated external defibrillator (with a charged battery) accessible 24/7 and that at least one staff member competent to provide first aid (which should include being trained in the application of cardiopulmonary resuscitation and the use of automated external defibrillators) is always present, including at night and on weekends.**

149. In all centres visited, the delegation found that residents receiving Clozapine were not having blood tests with the regularity recommended in international guidelines (some had blood tests only once or twice a year, in other centres such tests were not done at all).

Moreover, in the Păstrăveni Centre, the use of this potentially high-risk medication did not seem to be in line with internationally accepted indications (namely, treatment-resistant schizophrenia and psychotic symptoms that may occur during Parkinson's disease), since the majority of residents receiving Clozapine had a sole diagnosis of learning disability. **The CPT would like to receive clarification regarding this situation from the Romanian authorities.**

39. In Păstrăveni Centre, the delegation noted the considerable efforts of the staff to maximise the potential of the residents and support them in decision making. Information to residents was provided in an accessible form and the residents and staff were aiming to learn one word in sign language each month. In the morning, every house had a meeting where staff, using pictograms, would talk to the residents about the day and how they feel (for example, happy or sad, is it sunny or raining, what season is it, which day of the week, etc.). The centre also had a cinema with a timetable for each house (the residents would get tickets, and there was a popcorn machine) and it also minted its own money which residents could use in the in-house shop, which was stocked with donated products. Further, during the week of the delegation's visit, the centre was preparing for their annual Special Olympics in which residents from the centre and other residential care centres across the county were participating.

The Committee further wishes to emphasise that Clozapine can have severe side-effects such as a potentially lethal reduction of white blood cells (granulocytopenia, with substantially reduced resistance to infection). Therefore, **the CPT recommends that the Romanian authorities ensure that a protocol for a system of mandatory monitoring of the white blood cell count of residents treated with Clozapine be drawn up at the national level, in line with international guidelines. Further, staff should be educated about the early signs of the potentially lethal side-effects of Clozapine.**

150. The examination of relevant documentation and interviews with medical staff revealed that autopsies were not systematically being carried out following the unexpected death of a resident. In the Committee's view, just as is the case for other establishments in which persons may be deprived of their liberty by a public authority, when a resident in a residential care centre dies unexpectedly, an autopsy should always follow, unless a medical authority independent of the establishment indicates that an autopsy is unnecessary.[40]

Further, when a resident dies after having been hospitalised in an outside healthcare facility, the clinical causes of their death (and if an autopsy is performed, its conclusions) should be systematically communicated to the residential care centre.

The CPT recommends that, whenever a resident dies in a residential care centre or, following a transfer from it, in a hospital, the Romanian authorities take the necessary steps – including at the legislative level – to ensure that:

- **the death is promptly certified by a medical doctor on the basis of the patient's medical history, the circumstances of their death and a physical examination;**
- **an autopsy is carried out unless a clear diagnosis of a fatal disease has been established prior to death by a doctor and that disease led to their death. In order to prevent any potential conflict of interest, this assessment should be performed by a medical authority that is independent of the residential care centre;**
- **whenever an autopsy is performed, its conclusions are systematically communicated to the management of the residential care centre, with a view to ascertaining whether there are lessons to be learned as regards operating procedures;**
- **a record of the clinical causes of residents' deaths is kept at the residential care centre.**

Further, when a resident dies under suspicious circumstances or following an injury, relevant investigative authorities should always be informed.

151. Regarding the daily regime for residents, there was a range of occupational, rehabilitative, and recreational activities on offer in all centres visited; the quantity and variety was particularly impressive in the Sasca Mică Centre, where most residents were occupied in different therapy workshops throughout the day.[41]

However, in the Costâna and Sasca Mică Centres, activities and stimulation specifically tailored to persons with severe learning disabilities were lacking and should be developed. These activities should be personalised, focused on maintaining normality in daily regime, including getting outdoors regularly and development in basic abilities. Care and support should integrate input of physiotherapist and occupational therapist. **The CPT recommends that steps be taken to develop such activities for residents with severe learning disabilities at these two centres.**

40. See also the Council of Europe Committee of Ministers Rec R(99)3 Recommendation on Harmonisation of Medico-Legal Autopsy Roles.

41. The centre had rooms for board games and table tennis, and workshops for knitting, weaving, sewing, cross stitching, shoe repair, painting, candle making, ceramics, phytotherapy, carpentry, etc.

152. In all centres visited, the residents had ready access to the grounds throughout the day. However, in Costâna and Sasca Mică centres, the residents confined to their beds due to physical illness were rarely taken outside. **Steps should be taken to ensure that residents confined to their beds due to physical illness benefit from daily access to fresh air (with appropriate support and/or supervision if required).**

153. Every resident possessed an individual written care plan which demonstrated an individualised approach in terms of therapeutic interventions, occupational and recreational activities, and was subject to a periodic review every six months (involving the resident whenever possible). The plans provided a clear overview of multi-disciplinary interventions, their goals within the relevant timeline and achievements. However, the involvement of a psychiatrist (who in all cases was an external one) in the work of multi-disciplinary teams in the centres visited, especially as regards residents with mental disorders, was not sufficient. Furthermore, the assessment of clinical risks, the management of a crisis or challenging behaviour, and the use of movement-restricting measures, as well as measures for violence prevention were not included in these plans.[42]

The CPT recommends that the Romanian authorities take steps to address these shortcomings.

5. Restrictive measures

154. The delegation was pleased to note that the seclusion and mechanical restraint of residents was generally not practiced in the centres visited, as seriously disturbed and agitated residents were promptly transferred to a psychiatric hospital. Moreover, in the Păstrăveni Centre, the delegation got the positive impression that individualised attention by staff often prevented episodes of agitation escalating.

155. In the Costâna Centre, the delegation was told that in very rare cases a nurse would tie the wrists of an agitated resident with a wide elastic bandage (in front or behind their back) while waiting for an ambulance to arrive. When asked, staff told the delegation that they had not received training in manual control (holding) techniques. To prevent any injuries occurring to the resident or others in cases where a resident is agitated, **the CPT recommends that national guidelines on safe holding techniques should be developed, relevant care staff trained accordingly, and such practice implemented when required.**

156. The delegation noted the use of movement-restricting measures (attaching residents to a wheelchair with a seat belt or the raising of rails on the sides of a bed) in the centres visited. However, the delegation was not able to obtain a clear picture of the frequency of their use and the procedure followed in practice, as decisions and dates of decisions concerning movement-restricting measures were not properly documented, since none of the centres had internal guidelines regarding the use of such measures.

The CPT recommends that the Romanian authorities ensure that all residential care centres in the country develop written guidelines on the use of movement-restricting measures. Such guidelines should make clear which movement-restricting measures may be used, under what circumstances they may be applied, the need for a preventive risk assessment and the exploration of less restrictive alternatives. They should also contain sections on the involvement and consultation of different categories of staff prior to their application, medical prescription and nursing intervention, recording of the measure, periodic monitoring and re-assessment, the supervision required, and consent forms. The care staff should be provided with initial and on-going training on the use of movement-restricting measures.

Moreover, **when using bed rails, due consideration should be given to protecting residents from entangling themselves in bed rails and injuring themselves as a result** (bed bumpers or side rail protectors could be used for this purpose)**.**

42. For example, in the Păstrăveni Centre, the use of special beds for two residents (with high sides, individually tailored) was not covered in their respective individual plans.

6. Safeguards

157. Placement in a residential centre is regulated by the Law on the protection and promotion of the rights of persons with disabilities.

The placement is decided by a county commission for the evaluation of adults with disabilities, following a request by a resident or, more often, their relatives or a guardian, and a social assessment carried out by the county directorate for social assistance and child protection, as well as a comprehensive medical assessment. A person with disabilities has a right to appeal the placement decision, within 30 days, before a local court and will be provided with free legal assistance.

The provision of social services is based on a contract concluded between the residential centre and the beneficiary (or their guardian). The contract is renewed annually by the commission, following a social assessment. The residents interviewed confirmed that they met their case manager during this process.

158. Although all residents were formally regarded as voluntary, only a handful could leave the centres on their own, without being accompanied by a staff member or an authorised person (such as a family member or their guardian).

Moreover, none of the residents in the four centres visited was free to leave the institution permanently of their own free will; discharge from the establishment was only possible if a county commission so decided, following a social assessment which showed that there was an alternative for accommodation and care. Such a decision could theoretically be challenged at the court but, reportedly, that never happened.

The delegation met several residents who clearly indicated that they did not want to stay in the centres but could not leave, allegedly because of a lack of alternative accommodation.

159. In light of the circumstances summarised in the preceding paragraphs, the CPT considers that these residents should be regarded as *de facto* deprived of their liberty. Their placement and stay in the residential centres, however, was not fully accompanied by appropriate safeguards.

The CPT considers that the involuntary placement and stay of residents (including situations in which the restrictions imposed amount to *de facto* deprivation of liberty)[43] in social care establishments should be regulated by law and accompanied by appropriate safeguards. In particular, placement must be made in light of an objective medical assessment, including of a psychiatric nature. Further, all residents who are involuntarily placed in this type of establishment (including situations in which the restrictions imposed amount to *de facto* deprivation of liberty), whether or not they have a legal guardian, must enjoy an effective right to bring proceedings to have the lawfulness of their placement and stay decided speedily and reviewed regularly by a court and, in this context, must be given the opportunity to be heard in person by a judge and represented by a lawyer. The Committee also wishes to underline that, if it is considered that a given resident, who has been voluntarily admitted and who expresses a wish to leave the establishment, still requires care to be provided in the establishment, then the involuntary placement procedure provided by the law should be fully applied.

The CPT recommends that the Romanian authorities put in place a clear and comprehensive legal framework governing the placement and stay of residents (including situations in which the restrictions imposed amount to *de facto* deprivation of liberty) in residential centres, in light of the preceding remarks.

43. The CPT notes in this context that the ECtHR has concluded in several cases concerning the placement in a closed establishment of a legally incapacitated person under guardianship from whose conduct it was obvious that they did not consent to their placement, that they must be regarded as being "deprived of their liberty" within the meaning of Article 5, paragraph 1, of the ECHR, despite the approval of the guardian (see, for example, the Grand Chamber judgment in the case of *Stanev v. Bulgaria*, no. 36760/06, § 132, 17 January 2012, and *Červenka v. the Czech Republic*, no. 62507/12, §§ 103-104, 13 October 2016).

160. In July 2020 the Constitutional Court of Romania declared unconstitutional the Civil Code provisions on incapacitation and guardianship for adults.[44] As a result, in spring 2022 the Romanian authorities reformed the legal protection system for vulnerable adults,[45] including by introducing alternatives to guardianship – assistance in concluding legal acts,[46] legal counselling,[47] and special guardianship.[48] Following these changes, the legal capacity of adults under guardianship will reportedly have to be reassessed during the next three years.

161. In the Păstrăveni Centre, the delegation noted that almost all residents deprived of their legal capacity (158 out of 160) were placed under the centre's guardianship (their guardian was a social worker).

In the view of the Committee, entrusting guardianship to staff of the same establishment within which the resident resides may easily lead to a conflict of interest and compromise the independence and impartiality of the guardian.[49]

The CPT recommends that the Romanian authorities search for alternative solutions to placing residents under the guardianship of their centre, which would better guarantee the independence and impartiality of the guardian.

162. The delegation also found that residents with severe learning disabilities or serious mental disorders, who clearly do not have a decision-making capacity but whose legal capacity has not been assessed by a court,[50] annually sign contracts regarding their placement in the residential centres (even if sometimes this is just drawing a line on the paper). In the Committee's view, such a practice should be ended forthwith as it deprives the residents concerned of the key legal safeguards pertaining to their status. **The CPT recommends that the Romanian authorities put an end to this practice.**

163. As regards consent to treatment, in the centres visited, the delegation observed a formalistic practice of asking residents to sign blanket consent forms without providing them with information necessary to make a decision.

44. The Constitutional Court declared that Article 164(1) of the Civil Code stating that "a person who does not have the necessary mental capacity to take care of personal affairs, because of psychosocial or intellectual disabilities, will be put under judicial interdiction" is unconstitutional since it contravenes Romania's obligation under Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Judicial interdiction is a legal term that is also known as "full guardianship" or "plenary guardianship" under which adults with disabilities are denied the right to make decisions about their own lives and a substitute decision-maker is appointed to make choices on their behalf.

45. By adopting Law No 140/2022 on some protection measures for persons with intellectual and psychosocial disabilities and amendment and completion of some normative acts.

46. The assistant is appointed by a notary for a maximum of two years.

47. In cases when adequate protection of a person cannot be ensured by assistance in concluding legal acts, a court establishes legal counselling (following a medical and psychosocial assessment) for a maximum of three years.

48. In cases when a deterioration of a person's mental faculties is total and permanent and it is necessary to have continuous representation to exercise their rights, following a medical and psychosocial assessment, a court establishes special guardianship for a maximum of five years with a possibility of extensions for up to 15 years.

49. The CRPD requires that any measures relating to the exercise of legal capacity should be free from conflict of interest to avoid decisions contrary to the wishes and preferences of individuals.

50. The delegation's impression was that the staff were often reluctant to start the process of determining a resident's legal capacity and appointing a guardian.

In this context, the CPT recommends that all residents (and, if they are incompetent, their guardians) be provided systematically with information about their condition and the treatment prescribed for them, and that doctors be instructed that they should always seek the resident's consent to treatment prior to its commencement. This could be done by means of a special form for informed consent to treatment, signed by the resident and (if they are incompetent) by their legal representative. If a resident is competent and refuses treatment, legal provisions should guarantee the possibility of another, independent, medical assessment to authorise administration of specific medication on an involuntary basis for a shortest possible time. Relevant information should also be provided to residents (and their legal representatives) during and following treatment.

164. The Committee considers that an easy-to-understand information brochure, setting out the establishment's routine, the rules for admission and discharge, residents' rights, and the possibilities for lodging formal complaints on a confidential basis with clearly designated outside bodies, should be issued to the residents and their families/guardians, with assistance provided in comprehending this as appropriate. Such a brochure was lacking in the centres visited by the delegation.

165. As regards complaints mechanisms, each centre had an internal procedure which required that a complaint register was kept with a social worker, that complaint boxes were opened twice a month by a commission consisting of two staff members and two representatives of the residents, that complaints were investigated by a multidisciplinary team and that responses were provided within 30 days. The complaints registers checked by the delegation were empty however, most likely because the complaint boxes were not easily accessible (too high on the wall or access prevented with some furniture) and residents were not properly informed about the procedure.

The Committee would like to stress that although some residents have comprehension and communication difficulties, whenever possible, they should be informed of their rights, using repeated, simplified, individualised, verbal formats, if necessary. Similarly, accessible and comprehensible complaints systems should be in place. **The CPT recommends that the Romanian authorities ensure that these precepts are effectively implemented in practice.**

166. Arrangements concerning contact with the outside world were satisfactory in all centres visited. Residents had a virtually unrestricted possibility to receive visits, could keep mobile phones, and could also use one of the institution's phones.

167. Romania has ratified the United Nations Convention on the Rights of Persons with Disabilities in 2011 and has undertaken to carry out the deinstitutionalisation of people with disabilities.[51]

As mentioned in paragraph 121 above, in January 2023 the Romanian authorities adopted the Law and the National Strategy on deinstitutionalisation, with an aim to ensure that the right to independent living of adults with disabilities is exercised within a clearly defined time period.[52]

168. It is noteworthy that the National Strategy self-critically acknowledges that a comprehensive county mapping of available services, including the profile of the activities carried out in each of them along with the type of eligible beneficiaries, has not been completed. It further recognises that needs assessments and joint planning of interventions needed for adults with disabilities in each community have not been organised, and that there is currently no comprehensive coordination, monitoring and evaluation framework for this process to ensure a standardised approach at national, county, and residential centre level.

51. Article 19 of the CRPD – Independent living and community integration – recognises the equal right of all persons with disabilities to live in the community with opportunities equal to others.

52. The key targets set by the Law are these: a) by 30 June 2026, at least 32% of adults with disabilities in institutions are supported to deinstitutionalise and independent living pathways are implemented;
b) by 30 June 2026, the percentage of adults with disabilities in residential care is reduced to 32% of the total number of people in residential care at the end of 2020;
c) between 1 July 2026 and 31 December 2030, the percentage of adults with disabilities in residential care is reduced by 10% of the total number of people in residential care on 30 June 2026.

During the 2022 visit, the delegation witnessed the stress and anxiety that the lack of information and the absence of a carefully planned timetable for the deinstitutionalisation process was causing to both residents and staff alike. **The Committee trusts that the new legislative and strategic documents will serve as an impetus to address these issues and residents will be provided with a clearer perspective on their future.**

169. As frequently emphasised by the CPT in its reports, for persons without family support, social care accommodation in the community should consist of more personal, small group home living units, ideally in urban areas where all the relevant facilities are close to hand. Such accommodation should be appropriately staffed with well trained personnel who can fulfil the care needs of their clients in a decent environment.

At the same time, the Committee would like to caution the Romanian authorities against falling into the trap of trans-institutionalisation, which the CPT has encountered elsewhere, whereby the only thing that actually changes (apart from the official number of beds) is the title of the institution. In such cases, the same residents continue to live on the same site, and are cared for by the same staff, in near identical regimes, with no real change in the opportunities for the re-integration of such residents into the community.

170. In this context**, the CPT invites the Ministry of Labour and Social Solidarity to work closely with the Ministry of Health in jointly developing further the necessary full and appropriate range of residential, day and out-patient care for persons with psychiatric disorders in the community.** This should alleviate the burden on psychiatric hospitals, many of which have a significant number of psychiatric patients who no longer need to be hospitalised but who remain in the hospitals as there is no alternative place for them to reside in the community (see more in paragraphs 6, 84 and 97). There needs to be sufficiently robust community care to allow patients to leave hospital when their need for in-patient treatment ceases.

APPENDIX I
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LIST OF THE ESTABLISHMENTS VISITED BY THE CPT'S DELEGATION

Psychiatric hospitals

- Bălăceanca Psychiatric Hospital
- Psychiatric Clinic of Emergency County Hospital "Mavromati", Botoșani
- Obregia Psychiatric Hospital, Bucharest (targeted visit)
- Socola Psychiatric Hospital, Iaşi

and

- Pădureni-Grajduri Psychiatric and Safety Measures Hospital, Iași

Residential Care Homes

- Neuropsychiatric Recovery and Rehabilitation Centre in Costâna
- Neuropsychiatric Recovery and Rehabilitation Centre in Sasca Mică
- Centre for the Recovery and Rehabilitation of Disabled Persons in Păstrăveni
- Care and Assistance Centre in Mirceşti.