HUMAN RIGHTS

in Mental Health Care in Baltic Countries

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This policy paper has been produced within the framework of the project "Monitoring Human Rights and Prevention of Torture in Closed Institutions: prisons, police cells and mental health institutions in Baltic countries", financed by European Community. The views expressed herein are those of authors an can therefore in no way be taken to reflect the official opinion of the European Commission.

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MDAC Mental Disability Advocacy Center

Estonian Patient
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FOREWORD

Modernizing mental health services and developing a humane, user-focused and community-oriented mosaic of mental health care services is a long-lasting, ongoing process to which there is practically no end. As society changes, so do the needs of people; thus, services need to remain open to this changing environment and adapt themselves continuously.

This process of change is difficult in developed societies, and even more so in countries that were under totalitarian rule for more than half a century, emerging into the light of freedom only fifteen years ago. The mental health care services of these countries are unquestionably lagging behind European standards of care after being set in a society that ignored individual human rights, ostracized persons with disabilities, both physical and mental, and looked upon mental illness purely from a biological perspective and for many years declined to invest in even maintaining existing services. Monitoring visits reveal serious shortcomings and often pinpoint clear violations of human rights. Unfortunately, in spite of fifteen years of hard work by the mental health reform community, there is still a lot to criticize.

However, criticism is useless when that is all it does. The question is not that one knows what is bad – the question is how to help resolve the existing problems. Constructive criticism is essential in this respect. Only through an analysis of the current situation and the challenges faced for the future can a careful balance can be found between acknowledgement of what has been done, with or without success, and the need for further change. The needs of persons with mental illness or handicap must be taken as the central focal point.

This report is an attempt to do just that. It does not hide shortcomings, but puts them in the actual context. And it provides suggestions and recommendations to the relevant authorities and institutions as to how they can resolve the problems encountered, and, thus, contribute to a better mental health care system.

I sincerely hope the report will have this positive effect. Because, let's be honest; it is as easy to ignore this report under the pretext that it is too critical and biased, as it is to write a report that only criticizes and fails to outline possible constructive steps. And neither will do any good for those who are affected by mental illness.

Robert van Voren
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EXECUTIVE SUMMARY

Throughout the Baltic region, people with mental disabilities still lack access to community-based services and their human rights are still ignored. The conditions in mental health care institutions are somewhat similar in all three Baltic countries: Estonia, Latvia and Lithuania. However, at a policy and legislative level, Lithuania and Estonia have moved forward more rapidly than Latvia.

This policy paper has been developed under the European Commission (EC) funded project, "Monitoring Human Rights and Prevention of Torture in Closed Institutions: Prisons, Police Cells and Mental Health Care Institutions in Baltic Countries." The paper was developed by the following partner organizations: the Latvian Centre for Human Rights and its partner organizations, the Vilnius office of Global Initiative for Psychiatry, the Mental Disability Advocacy Center, and the Estonian Patient Advocacy Association.

The policy paper gives an overview of current developments in mental health care policy in all three Baltic countries and provides recommendations to move services toward the norm of least restrictive care and community-based services and away from institutions. Recommendations are geared to governments, institutions in the countries addressed, national and international human rights advocates, and private and public donors. The text serves as a source of information for program planners, an advocacy guide for human rights organizations, and guidance for funds allocation for governments and donors.

The report urges Estonia, Latvia, and Lithuania to shift the focus of support for the mentally disabled to community-based services and create a detailed timetable for the move from institutional to community services. The report recognizes the lack of well-functioning independent inspection bodies and urges the Baltic countries to establish independent human rights monitoring mechanisms.

The lack of inter-ministerial co-operation has been also recognized as a problem in these countries and the need for facilitating links with other sectors has been suggested. The report also recognizes the need for strengthening the users' participation at a policy level and providing support for users' organizations.

The report also suggests improving access to justice for mentally disabled individuals in all countries by adopting a new mental health law in Latvia and Estonia and training judges and lawyers in Latvia, Estonia and Lithuania. All three country reports urge the strengthening of protections in guardianship legislation and suggest introducing partial guardianship programs.

In order to ensure the fundamental human rights for mentally disabled persons, the report urges Latvia to ratify the Council of Europe Convention on Human Rights and Biomedicine and Optional Protocol X on the collective complaint mechanism of the European Social Charter.

Specific recommendations have been drafted for each country separately and can be found at the end of each country section. This report has been published in English; separate reports including the introduction, country report and general recommendations will be published also in the national languages of Estonian, Latvian and Lithuanian.

In late 2003 and early 2004, as part of a European Commission funded project, three partner organizations monitored psychiatric hospitals and social care homes (often called internats) in three Baltic States and the Kaliningrad region of the Russian Federation. Partners included – the Latvian Center for Human Rights (former Latvian Center for Human Rights and Ethnic Studies) – the main implementer of the project, the Vilnius Regional Office of Global Initiative for Psychiatry (former Geneva Initiative on Psychiatry), Estonian Patients Advocacy Association and the Mental Disability Advocacy Center. In 2004 – 2006, monitoring visits were continued on a regular basis in Latvia and Lithuania. This report gives an overview of current developments in mental health care policy of all three Baltic countries and provides recommendations to move services toward the norm of least restrictive care and community-based services and away from institutions. Recommendations are geared to governments, institutions in the countries addressed, national and international human rights advocates, and private and public donors. The text serves as a source of information for program planners, an advocacy guide for human rights organizations, and guidance for funds allocation for governments and donors.

People with mental disabilities in the Baltic States of Estonia, Latvia, and Lithuania and the Kaliningrad region of the Russian Federation too often reside in hospitals and long-term social care homes rather than in the community. Both those with intellectual disabilities and those with mental health problems are isolated in these facilities and denied opportunities to develop educationally, vocationally, socially, and emotionally. Apart from being deprived of their autonomy, residents may also be subject to clear human rights violations, such as being arbitrarily detained. Human and financial resources are often directed toward maintaining this damaging and costly institutionalization, rather than to developing and supporting community-based programs that would integrate, rather than exclude people with disabilities. While for the most part, living standards have improved within these facilities since the end of the Soviet Union, there has been no creation of meaningful community-based alternatives, beyond a few pilot initiatives.

Obstacles to Reform

The three Baltic States of Estonia, Latvia, and Lithuania all joined the European Union (EU) in May 2004. The only former Soviet countries in the EU, the Baltic States were required to improve human rights legislation and practice as part of the EU accession process. While many improvements were made in the treatment of ethnic and linguistic minorities and other vulnerable groups, the human rights status of the most stigmatized individuals, such as people with mental disabilities, has not significantly improved since independence. EU suggestions regarding the rights of people with mental disabilities were not always followed because: (1) the EU lacks concrete mechanisms to support compliance (2) EU recommendations are filtered through national priorities, and improving the status of people with mental disabilities was never a national priority, (3) EU human rights priorities were impacted by political expediency, and, as people with mental disabilities are generally not organized, largely disenfranchised, and isolated, they do not constitute a politically salient group.

Political will to transform the existing institutionally-based system continues to be inadequate, making persons with mental disabilities one of the groups most at-risk for human rights violations in the region Governments of the three territories addressed in this report should draw on the growing body of international human rights law and European standards and funds to develop concrete plans to integrate persons with mental disabilities into the community and to end the abusive detention and isolation of thousands of their citizens and residents.

Human rights violations occur in the Baltic States for a number of reasons: national law does not adequately reflect international law; an institution's internal policies fail to follow national law; and/or individual staff members are ignorant of the law or deliberately choose to act unlawfully.

Failure to respect human rights is due to a myriad of interlocking policy factors: the ongoing stigmatization of mental disability; state financial arrangements favouring institutionalization; resistance from institutions and professionals who fear job loss; inadequate training of mental health and social work professionals; lack of continuing education for currently employed personnel; poor knowledge among people with mental disabilities about their own rights, and the fact that health care providers, policy makers, and the public at large do not conceptualize people with mental disabilities as rights holders. Failure to perceive people with mental disabilities as deserving of human rights is arguably the biggest and most important obstacle; it explains the almost complete absence of governmental political will to make substantial improvements in the status of people with mental disabilities. Instead of participating as much as possible in family and society, thousands of individuals with mental disabilities languish in psychiatric hospitals and social care homes in the Baltic States.

Lack of community-based care means that those requiring any sort of assistance have no other alternative but to be placed into institutions, resulting in their de facto detention. Life in an institutional setting may decrease one's opportunities to ever achieve independent living, as overmedication and lack of stimulation exacerbate existing disabilities. Essentially, the hospitals and social care homes warehouse, rather than (re)habilitate, their residents, thereby perpetuating the stigma of mental disability. Suffering from discrimination, people with mental disabilities in the countries discussed live in poor conditions, are subject to abuses and have few opportunities for participation, in contravention to international law and acknowledged best practices.

INTERNATIONAL LEGAL AND POLICY CONTEXT

Opportunities and Measures for Reform

The European Year of People with Disabilities was 2003. The 1990s was the UN Decade of Disability, and the UN has begun the process of drafting a binding convention on the rights of people with disabilities. In January 2005, European Ministers of Health pledged at a World Health Organization (WHO) meeting in Helsinki, Finland, to:

> "[T]ackle stigma and discrimination, ensure the protection of human rights and dignity and implement the necessary legislation in order to empower people at risk or suffering from mental health problems and disabilities to participate fully and equally in society."[1]

And, the Council of Europe is preparing a Disability Action Plan to be signed by CoE Member States in October 2005.

Policy makers and advocates can use these and other commitments to lobby governments to follow through on their obligation to promote the integration of people with mental disabilities. Moreover, international law, policy guidance propagated by UN agencies such as WHO, and EU funding mechanisms outline practices and standards that advocates can employ to identify gaps in current government law and/or practice and to suggest direction and routes for reform.

International Law and Standards Relating to Mental Disability

As noted, while medical approaches to disability continue to be salient in the Baltic States, the prevailing international model has shifted dramatically over the past 30 years. Integrating people with disabilities has come to be understood as a human rights issue, and disability is viewed in keeping with the 'social model' or the 'human rights model.' According to this new view, impairments do not flow from individual differentiation, but from the way society is structured. In other words, the way resources are distributed, the way individuals interact, and the nature of the technologies we use in everyday life contribute to the social construction of disability. As opposed to the medical model, the social model understands discrimination, distributive injustice, and limited state capacity as unfairly limiting a person's functioning and participation. The state thus has a responsibility to alter the environment to accommodate persons with disabilities and to undertake affirmative action to facilitate equity.

These evolving concepts are manifested in international human rights law and standards. International law is binding, and is enshrined in treaties (often called 'covenants' or 'conventions'). States parties to covenants and conventions are required to respect, protect, and fulfil rights delineated therein. The Baltic States have signed both UN and CoE human rights treaties. International standards are delineated in UN, WHO, and CoE declarations and statements. They often flesh out the content of human rights law, providing greater detail regarding what constitutes respect for the human rights of people with disabilities.

All human rights treaties and declarations apply to people with mental disabilities. The Universal Declaration of Human Rights (UDHR), adopted by the UN in 1948, explains in Article 1 that: "all people are

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[1] WHO European Ministerial Conference on Mental Health. EUR/04/5047810/6 14 January 2005. 52667. http://www.euro.who.int/document/mnh/edoc06.pdf

free and equal in rights and dignity."[2] Further, the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ISECR), the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), the European Social Charter (ESC), the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), and the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine) apply to persons with mental disabilities.

A recent report of the UN Secretary General to the General Assembly makes this point clear:

"The International Covenant on Civil and Political Rights…and the International Covenant on Economic, Social Cultural Rights…include specific provisions relating to non-discrimination, and provide persons with mental disabilities with the right to liberty and security of person, to fair trial and to recognition everywhere as a person before the law, and the right to the highest attainable standard or physical and mental health, to education and to work"[3]

The governments addressed in this report have signed and ratified most of these treaties, which require that they ensure domestic law is in line with international human rights treaty obligations. The following table summarizes pertinent treaty ratifications.

Country	ICCPR	ICESCR	ECHR	ESC	CPT	Convention on Human Rights & Biomedicine
Estonia	X	X	X	X	X	X
Latvia	X	X	X	X	X	Signed but not ratified
Lithuania	X	X	X	X	X	X

While they do not have the legal force of conventions, international declarations flesh out the rights specific to persons with disabilities (or persons living in an institution). These include the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (1993) ('the Standard Rules') and the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) (the 'MI Principles').

Several major rights laid out in the above mentioned conventions and declarations are routinely violated in the institutions addressed in this report. Some of the most important of these include: the right to private life, the right to liberty and security of person, the right to be free from inhumane and degrading treatment, and the right to community integration.

The Right to Private Life

Persons with mental disabilities residing in psychiatric hospitals and social care homes are often denied the right to private life. As is the case with many mental disability rights violations, failure to respect the right to privacy is supported by stigma. Institution staff and policy makers do not believe that people with mental disabilities have the capacity to enjoy the benefits or make the decisions associated with a private life. Psychiatric hospital staff, for example, may routinely open the correspondence of residents without considering that this intrusion violates fundamental elements of privacy.

International standards unambiguously establish the right of all human beings to privacy, including the right to refuse treatment. Article 8 of the ECHR states that:

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[2] Emphasis added. Universal Declaration of Human Rights. General Assembly resolution 217 A (III) of 10 December 1948. http://www.un.org/Overview/rights.html

[3] United Nations General Assembly, 'Progress of efforts to ensure the full recognition and enjoyment of the human rights of persons with disabilities' Report of the Secretary General, 24th July 2003, pages 4 & 5

"[E]veryone has the right to respect for his private and family life, his home and his correspondence. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary… in the interests of national security, public safety… for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."[4]

Violations of the right to privacy that occur in institutions in the Baltic states and Kaliningrad often do not meet these requirements of mitigating a threat to public safety or protecting the rights and freedoms of others.

The MI Principles unequivocally state in Principle 13 that patients in mental health facilities have the right to full respect for their right to privacy and freedom of communication.[5] MI Principle 11 also establishes the right to informed consent and to refuse treatment. The Principle lays out procedural safeguards that must be met in order for persons to be treated against their will. Treatment may be forcefully administered only if a patient has been lawfully involuntarily committed to an institution, if an independent authority determines that the patient lacks the capacity to give informed consent, or, if a qualified mental health practitioner decides that without treatment a patient poses an immediate threat to himself or to others.[6]

A newer CoE instrument, the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine, enumerates the rights to privacy, informed consent, and to refuse treatment. In contrast to the MI Principles, this Convention has the force of international law, is enforceable in a court of law in states that have ratified the Convention, and is monitored by a Committee.[7]

The Right to Liberty and Security of Person

Persons with mental disabilities shall not be arbitrarily denied their liberty. However, as in the case of the right to privacy, the right to liberty is often violated because policy makers and institution staff do not believe that persons with mental disabilities are capable of making decisions about institutionalization. As will be shown in the subsequent country sections, some countries have policies that do not adequately integrate the safeguards to liberty written into European and international law. Other countries have adequate law and policy, but policies are violated by institution staff who are more concerned about expediency than they are about human rights.

Article 5 of the ECHR states that persons of "unsound mind" may be detained against their will. However, if arrest occurs, the individual in question "shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him."[8] Everyone detained has the right to appear before a court to speedily determine the lawfulness of her detention. These protections are key; in many cases in the Baltic States and Kaliningrad, persons of "unsound mind" are involuntarily committed to institutions, and are neither told why they have been committed nor given the opportunity to appear before a court.

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[4] Convention for the Protection of Human Rights and Fundamental Freedoms. Rome, 4.XI.1950. http://conventions.coe.int/Treaty/EN/CadreListeTraites.htm

[5] Principles For The Protection Of Persons With Mental Illness And The Improvement Of Mental Health Care, General Assembly resolution 46/119 of 17 December 1991. http://www.who.int/mental_health/policy/en/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf

[6] Ibid.

[7] Convention for the protection of Human Rights and dignity of the human being with regard to the application of biology and medicine: Convention on Human Rights and Biomedicine CETS No.: 164. http://conventions.coe.int/Treaty/EN/CadreListeTraites.htm Neither Latvia nor Russia has ratified this treaty. It is currently in force in Estonia and Lithuania.

[8] Convention for the Protection of Human Rights and Fundamental Freedoms. Rome, 4.XI.1950. http://conventions.coe.int/Treaty/EN/CadreListeTraites.htm

The Right to be Free from Inhuman and Degrading Treatment

Article 3 of the ECHR and Article 7 of the ICCPR state that no one shall be subject to inhuman or degrading treatment or punishment.[9]

The MI Principles further flesh out the protections against inhuman and degrading treatment that is particularly applicable to persons with mental disabilities. Principle 11 outlines the conditions under which seclusion and restraint may be used: "only when it is the only means available to prevent immediate or imminent harm to the patient or others….All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record."[10] Recording all uses of restraint and seclusion is particularly important, as it allows the hospital or social care home to monitor the frequency and duration of restraint and seclusion.

Under the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the CoE created a Committee for the Prevention of Torture to visit any facility where persons are deprived of their liberty by a public authority, including psychiatric institutions and social care homes.[11] The Committee has elaborated even greater protections for the use of restraints and seclusion. The restraint of patients should be the subject of a clearly-defined policy. Staff should be trained in non-physical and manual control techniques, so that they may employ these methods before resorting to restraint. Neither restraint nor seclusion should be used as a punishment, but rather as a physician-approved means of restraining a patient who may imminently harm herself or others. Finally, the CPT mandates that all institutions should maintain a separate register to record uses of restraint and seclusion.[12] Such a register facilitates oversight of restraint on a facility-wide basis (as opposed to patient by patient).

As shown in the subsequent country sections, living conditions in state-run hospitals and social care homes are often unhygienic and/or not conducive to individual development. These conditions may constitute degrading treatment. Individuals should not have to subject themselves to living conditions that entail inadequate food, clothing, heat, or hot water just to receive needed mental health treatment or support. Similarly, they should not have to undergo the humiliation associated with repeated violations of the right to privacy, such as shared showers or bathroom stalls.

Residents of hospitals or social care homes are often provided with little or inappropriate stimulation. In the case of the Baltic States and Kaliningrad region, this may mean being closed into a room with no activities, or being provided with a television or children's toys as the only means of entertainment. While this may not constitute degrading treatment on any single occasion, the cumulative effect may be degrading, as the social and other skills of institutionalized individuals deteriorate. Indeed, the Human Rights Committee, which is charged with reviewing states reports on the implementation of the ICCPR, has noted that the duration of a practice will be taken into account when

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[9] Convention for the Protection of Human Rights and Fundamental Freedoms. Rome, 4.XI.1950. http://conventions.coe.int/Treaty/EN/CadreListeTraites.htm; International Covenant on Civil and Political Rights. http://www.ohchr.org/english/law/ccpr.htm

[10] Principles For The Protection Of Persons With Mental Illness And The Improvement Of Mental Health Care, General Assembly resolution 46/119 of 17 December 1991. http://www.who.int/mental_health/policy/en/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf

[11] European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Strasbourg, 26.XI.1987. http://conventions.coe.int/Treaty/en/Treaties/Html/126.htm

[12] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The CPT standards "Substantive" sections of the CPT's General Reports. CPT/Inf/E (2002) 1 - Rev. 2004. http://www.cpt.coe.int/en/documents/eng-standards.doc 59.

[13] Department of Mental Health and Substance Dependence, World Health Organization. (2004). The Role of International Human Rights in National Mental Health Legislation. http://www.mdri.org/pdf/WHO%20chapter%20in%20English_r1.pdf 55.

determining if it constitutes degrading treatment.[14] Moreover, in an explanation of its interpretation of what constitutes degrading treatment, the CPT explained that:

> "[T]he CPT closely examines patients' living conditions and treatment; inadequacies in these areas can rapidly lead to situations falling within the scope of the term 'inhuman and degrading treatment.' The aim should be to offer material conditions which are conducive to the treatment and welfare of patients; in psychiatric terms, a positive therapeutic environment."[15]

The CPT goes on to clarify that these material conditions include adequate amounts of living space, the presence of personal effects, dignified eating and sanitary facilities, and the provision of lockable space to every resident.[16]

The Right to Autonomy and Community Integration

Article 1 of both the ICCPR and the ICESCR state that: "[a]ll peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development." Due to their isolation and residence in facilities with inadequate educational, cultural, and vocational resources; or to their isolation in communities with inadequate community-based services; persons with mental disabilities are often unable to freely pursue their own development. As will be shown, treatment and management practices in institutions often undermine, rather than enhance individual empowerment. Residents are regarded as wards of the institution, rather than as individuals with a right to services that develop autonomy and community participation.

General Comment 5 of the Committee on Economic, Social and Cultural Rights explains some actions that must be taken to ensure self-determination for citizens of all abilities. According to the Committee, the right to health implies that states should provide people with disabilities "with rehabilitation services which would enable them to reach and sustain their optimum level of independence and functioning."[17] In the realm of education, states should further "recognize the principle of equal primary, secondary and tertiary educational opportunities for children, youth and adults with disabilities, in integrated settings."[18] Finally, "[s]tates should ensure that persons with disabilities have the opportunity to utilize their creative, artistic and intellectual potential…[t]he same applies to… recreation, sports and tourism."[19] In short, governments have an obligation to take steps to maximize the independence and social integration of persons with disabilities. This obligation entails more than allowing the disabled to participate, but requires that states facilitate access to a range of services, activities, and resources, and make these resources appropriate to the needs of persons with mental disabilities.

Other standards elaborate the right to autonomy. The MI Principles require that "the treatment of every patient shall be directed towards preserving and enhancing personal autonomy."[20] Autonomy of persons living in institutions discussed in this report is often limited by institutional policies and practices. For example, rules prohibiting the private use of telephones or conjugal relations constrain, rather than develop, independence.

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[14] As cited in: Ibid, 56.

[15] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The CPT standards "Substantive" sections of the CPT's General Reports. CPT/Inf/E (2002) 1 - Rev. 2004. http://www.cpt.coe.int/en/documents/eng-standards.doc 53.

[16] Ibid, 54.

[17] Committee on Economic, Social, and Cultural Rights. General Comment 5. Eleventh Session. 1994. Para 34.

[18] Ibid, para 35.

[19] Ibid, para 36.

[20] Emphasis added.

Autonomy is also curbed by guardianship. In many cases, people living in an institution have been determined by a court to be legally incapacitated, and they are placed under guardianship of an individual who makes decisions regarding treatment and financial transactions, among other things. Because of guardians' wide-ranging decision-making powers, the practice of guardianship has often resulted in neglectful or even exploitative situations. The CoE Committee of Ministers has noted the importance of recognizing different degrees of incapacity, and of preserving the autonomy of people with mental disabilities to the highest possible degree. To this end, the Council of Ministers Recommendation 99(4) prohibits the automatic deprivation of a person's right to vote, to draw up a will, to enter into business transactions, and to give or refuse consent to medical interventions.[21] The following policy analyses of each country show that, in some cases, procedures for involuntary institutionalization entail the automatic revocation of these rights, arbitrarily preventing a person's participation in society.

Finally, the MI Principles explicitly establish the rights of people with mental disabilities to live in the community, wherever possible. Principle 3 states that "[e]very person with a mental illness shall have the right to live and work, to the extent possible, in the community."[22] Although the ECHR does not specifically address this issue, decisions of the European Court of Human Rights, which is mandated to ensure state compliance with the Convention, have upheld the right to live in the community. For example, in the case of Litwa v. Poland, the Court held that the detention of an individual is such a serious measure that it is only justified where other, less severe measures have been considered and found to be insufficient to safeguard the individual or public interest which might require that the person concerned be detained.[23]

Non-Discrimination, Participation, and Adequate Progress

Three norms run through most human rights treaties – non-discrimination, true participation, and adequate progress.[24] These norms are particularly significant to examining the rights of people with mental disabilities. Because persons with mental disabilities are among the most marginalised and stigmatised groups in the countries addressed in this report, they are subject to discrimination in many sectors of public life. Moreover, due in large part to their stigmatised status, people with mental disabilities are often denied the right to participate in society, as well as in setting priorities for their own care. As shown in the following sections, in practice, people with mental disabilities are often passive recipients of services. They have few chances to participate in determining the course of their own treatment, in prioritizing the services provided in the institution, or in social and cultural life. Finally, while many governments - including those examined in this report – do not have substantial financial resources, they are bound to make adequate progress toward fulfilling their rights obligations. Governments must take concrete steps toward respecting all the rights of persons with mental disabilities in the following suggested ways: passing new legislation; creating independent bodies to monitor respect for human rights within institutions; improving the university curricula for psychiatrists; and dedicating resources to the creation of community-based services. Particularly because institutionalization is often more costly than

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[21] Council of Europe Committee of Ministers. Recommendation No. 4 of 1999 "Principles Concerning the Legal Protection of Incapable Adults."

[22] Principles For The Protection Of Persons With Mental Illness And The Improvement Of Mental Health Care, General Assembly resolution 46/119 of 17 December 1991. http://www.who.int/mental_health/policy/en/UN_Resolution_on_protection_of_persons_with_mental_illness.pdf

[23] Witold Litwa v. Poland, Application no. 26629/95, Judgment 4 April 2000

[24] United Nations Development Program. (2000). Using Indicators for Human Rights Accountability. In: Human Development Report: 2000. 95. http://hdr.undp.org/reports/global/2000/en/pdf/hdr_2000_ch5.pdf

community-based care, lack of financial resources is no excuse for state inaction. Inadequate financial resources may never be used as a rationale for the violation of so-called basic rights, which include the right to be free from torture, cruel, inhumane or degrading treatment or punishment.

The right to be free from DISCRIMINATION

In addition to the non-discrimination clauses contained in international human rights treaties, The UN Committee on Economic, Social, and Cultural Rights has explained that polices that segregate and isolate persons with mental disabilities are discriminatory. "Both de jure and de facto discrimination against persons with disabilities has a long history and takes various forms. They range from invidious discrimination, such as the denial of educational opportunities, to more 'subtle' forms of discrimination such as segregation and isolation achieved through the imposition of physical and social barriers."[25]

In fact, the right to be free from discrimination in the context of disability means more than equality before the law; the right requires so-called "special measures" to ensure that citizens are equally protected.[26] Special measures include reasonable accommodation, which can be defined as policies or services that facilitate disabled access to institutions or facilities. The Committee on Economic, Social, and Cultural Rights has concluded that denial of reasonable accommodation constitutes discrimination:

"[D]isability-based discrimination' may be defined as including any distinction, exclusion, restriction or preference, or denial of reasonable accommodation based on disability which has the effect of nullifying or impairing the recognition, enjoyment or exercise of economic, social or cultural rights."[27]

The Standard Rules on the Equalization of Opportunities for Persons with Disabilities states that people with disabilities should enjoy the same rights as everyone else, and that persons with disabilities have the right to mediating services.

"Persons with disabilities are members of society and have the right to remain within their local communities. They should receive the support they need within the ordinary structures of education, health, employment and social services… the principle of equal rights implies that the needs of each and every individual are of equal importance…"[28]

The right to PARTICIPATION

The UN, among other organizations, has stressed the importance of actively facilitating participation by the mentally disabled in civil society. The 1982 UN World Programme of Action Concerning Disabled Persons (WPA) requires member states to: "eliminate barriers to full participation, … establish or mobilize relevant public and private organizations, and support the establishment and growth of organizations of disabled persons."[29]

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[25] Committee on Economic, Social, and Cultural Rights, General Comment 5, supra note 2.

[26] Department of Mental Health and Substance Dependence, World Health Organization. (2004). The Role of International Human Rights in National Mental Health Legislation. http://www.mdri.org/pdf/WHO%20chapter%20in%20English_r1.pdf 40.

[27] Committee on Economic, Social, and Cultural Rights. General Comment 5. Eleventh Session. 1994. Para 15.

[28] UN G.A. Res. 48/96, Dec. 20, 1993, at 26 & 204.

[29] As cited in: RL Metts. (2000). Disability Issues, Trends and Recommendations for the World Bank. Washington DC: World Bank. 15.

The state's role entails more than creating an enabling policy environment; governments should financially support consumer, or user groups comprised of disabled persons to participate in policy monitoring and development. Rule 18 of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities affirms that:

"States should encourage and support economically and in other ways the formation and strengthening of organizations of persons with disabilities, family members and/or advocates. States should recognize that those organizations have a role to play in the development of disability policy."[30]

At the January 2005 WHO meeting in Helsinki, Finland, European Ministers of Health stated that a priority for the next decade is to: "recognize the experience and knowledge of service users and carers as an important basis for planning and developing mental health services."[31] The Ministers pledged to "stimulate the creation of nongovernmental and service user organizations."[32] They particularly welcome organizations active in "organizing users who are engaged in 'empowering vulnerable and marginalized people and advocating their case.'"[33]

Necessity of ADEQUATE PROGRESS

Due in part to persistent lack of progress in the domain of mental disability rights, the UN, CoE, and other entities have taken steps to encourage states to actively combat the discrimination and social exclusion affecting the mentally disabled. A 2003 CoE Parliamentary Assembly Recommendation asserted that people with disabilities are:

"[D]enied full and meaningful enjoyment of rights which other people take for granted… the right to receive support and assistance… is not enough… Equal status, inclusion, full citizenship, and the right to choose should be further promoted and implemented."[34]

Other instruments stress the importance of adequate progress in the type and aim of treatment and support provided to people with mental disabilities. General Comment 14 to the International Covenant on Economic, Social and Cultural rights explains that states should take steps in developing community-based services for people with mental disabilities. "Such steps must be deliberate, concrete and targeted towards the full realization of the right to health."[35]

Finally, in recognition that states have failed to make adequate progress, in 2001, the UN General Assembly established an ad hoc committee to consider proposals for a comprehensive international convention for the protection of the rights of people with disability.[36]

Other principles and norms concerning human rights of people with mental disabilities

Apart from international law, important guidance regarding the necessity of de-institutionalization, the creation of community-based services, and standards for institutional care has originated from the World Health Organization (WHO), the European Union (EU), and the World Bank. National Action Plans or reform

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[30] Standard Rules on the Equalization of Opportunities for Persons with Disabilities, A/RES/48/96, 85th Plenary Meeting 20 December 1993. http://www1.umn.edu/humanrts/instree/disabilitystandards.html

[31] WHO European Ministerial Conference on Mental Health. EUR/04/5047810/6 14 January 2005. 52667. http://www.euro.who.int/document/mnh/edoc06.pdf Para 7.

[32] Ibid.

[33] Ibid.

[34] Emphasis added. Council of Europe Recommendation 1592 (2003). www.coe.int/T/E/Comunication_and_Research?press?events?2.-Parliamentary_Assembly_Sessions/2003/2003-01_Winter_session/ONG_Decl.asp#TopOfPage

[35] Committee on Economic, Social, and Cultural Rights. International Covenant on Economic, Social and Cultural Rights, General Comment No. 14, U.N. Doc. E/C.12/2000/4 22nd Sess., art 12 (2000).

[36] G.A. Res. !68, U.N. GAOR, 56th Sess. Agenda Item 119(b), U.N. Doc A/RES/56/168 (2001).

strategies of state Ministries of Social Welfare or Health can also be used as a yardstick for evaluating respect for the rights of people with mental disabilities. However, it is important to note that these national plans or strategies may not adequately reflect the principles enshrined in international recommendations or law. Similarly, domestic law may not incorporate – and may even directly contravene – standards articulated in international law.

WHO recommendations explain the human rights, clinical, and policy rationale for de-institutionalization and the creation of community-based services. WHO's main concerns regarding institutionalised care (many of which are similar to those iterated above) are summarised as follows:

- **Human Resources**: Institutions consume most of the available human resources for mental health. Staff are often un-motivated and unsupported, and do not possess adequate clinical skills or a human rights approach.
- **Clinical Outcomes**: Many institutions provide only custodial care of the kind found in prisons, frequently of extremely poor quality. Poor clinical care, violations of human rights, the isolating and un-stimulating nature of institutional care, and lack of rehabilitative activities result in poor clinical outcomes. In other words, rather than making progress in their overall functioning, the institutionalized often lose their capacity for autonomous decision-making.
- **Acceptability**: Because deep-seated stigma is associated with segregated mental hospitals and few community-based services are available, persons requiring assistance often do not seek mental health services, except as a last resort. This, in turn, adversely affects clinical outcomes.
- **Human Rights Abuses**: Institutions have a history of serious human rights violations. In both developed and developing countries, persons residing in institutions have been subject to violations perpetrated by staff or other residents, or to violations resulting from the lack of services provided.
- **Access**: As they are usually based at some distance from urban areas and have poor transport links, institutions, by their very nature, limit resident capacity for participation in family, social, political, and cultural life.
- **Financial Costs**: Maintaining the infrastructure and bureaucracy of institutions is expensive, and institutions often consume a substantial portion of the budget available for mental health services, leaving few resources for important community-based services. As a result, many of those who could live in the community with support end up living in institutions, and the mentally disabled who do live in the community have little or no access to needed services.[37]

WHO has outlined key elements of needed policies and programs to provide services to persons with mental disabilities living in the community. These include:

- Mental health services provided by primary care professionals
- Psychiatric services in general hospitals
- Formal out-patient community mental health services
- Specialist mental health services[38]

WHO has also explained that providing services in the community entails de-institutionalization.

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[37] The above was summarized from: World Health Organization. Mental Health Policy and Service Guidance Package: Organization of Services for Mental Health. 2003. 20-22.

[38] Ibid.

"Large custodial mental hospitals should be replaced by community care facilities, backed by general hospital psychiatric beds and home care support, which meet all the needs of the ill that were the responsibility of those hospitals. This shift towards community care requires health workers and rehabilitation services to be available at community level, along with the provision of crisis support, protected housing and sheltered employment."[39]

In the absence of community-based services, people requiring assistance are less likely to receive mental health care during the early stages of any mental health problems, and people with moderate disabilities have few options but to reside in institutions. Providing these services in the community will increase the chance that more people with mental disabilities are receiving needed services, that fewer people with mental disabilities require hospitalization, and that fewer people develop severe mental health problems.

Other opportunities for improving the lives of people with mental disabilities in the Baltic States

Laws and norms provide important monitoring tools, while EU-related social policy coordination and financial assistance mechanisms provide opportunities for mental disability rights organizations to advocate vis-à-vis their own governments or to implement their own rights-based programming. Two major EU mechanisms can be used to improve the quality and number of services available to persons with mental disabilities in the Baltic States:

1. Open Method of Coordination on Social Inclusion and the Joint Memoranda on Social Inclusion. All EU Member States have recently begun coordinating their social inclusion policy via the Open Method of Coordination. As part of this process, the newest members (which include the Baltic States) drafted the Joint Memoranda on Social Inclusion, which, upon accession, they developed into National Action Plans (NAPs). According to the EU, priority issues to be addressed in the NAPs include: homeless people, people with disabilities, migrants and ethnic minorities, children in care, and illiterate people. NAPs are often not adequately funded or supported at the governmental level. However, they do lay out governmental commitments to which NGOs can refer in efforts to hold governments accountable.[40]

2. European Social Funds. The ESF is one of the four structural funds of the EU. It supports projects in the following fields: "active labour market policies, equal opportunities and social inclusion for all, lifelong learning, adaptable workforce and adaptability in work organization, [and] women's access to and participation in the labour market."[41] It was originally designed to support the European Employment Strategy, but it is sometimes used for social inclusion projects. ESF funds have been used in several countries to support projects that increase access of persons with mental disabilities to employment.[42] NGOs and governmental agencies may apply.[43]

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[39] World Health Organization. World Health Report 2001. Mental Health: New Understanding, New Hope. http://www.who.int/whr/2001/chapter5/en/index1.html

[40] Joint Report on Social Inclusion, European Commission, 2003, 30.

[41] European Commission (2003c)

[42] See: http://europa.eu.int/comm/employment_social/news/2004/jan/esf_in_action_en.html

[43] For information on the ESF in the Baltic States, go to: http://europa.eu.int/comm/employment_social/esf2000/member_states-en.htm

ESTONIA

Eve Pilt
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1. Mental health reform in Estonia since the end of the USSR

From the former Soviet Union, Estonia inherited politicised psychiatric care, an institutionalised social welfare system and a non-existent mental health policy. The conscious and purposeful action towards introducing change into health care and social welfare systems began in early 1990s. One of the very first activities of the Ministry of Social Affairs (MSA) was drafting the Health Services Organization Act, adopted in May, 1991. To address the need for a helping hand from the state by different groups of disabled people and to cope better with their need for services and material concerns, the Social Welfare Act was drafted and became effective on 1 April 1995. The act defined goals of the Estonian social care system, including increasing resource allocation to social inclusion and participation rather than institutionalization, developing rehabilitative programming, and increasing client responsiveness.[44]

According to information provided by MSA, the Estonian social welfare system for the mentally disabled began in 1998.[45] Prior to this, state funds for the mentally disabled were dedicated entirely to institutionalization. In 1999, the state budget expanded to include day-care services, and in 2000, rehabilitation services were added.[46]

MSA is responsible for implementing state social welfare programs. From 2000 to 2003, the main goals of the program were: introducing public care services, preventive work in the social sector and reorganising of social welfare institutions.[47] In 2004, the Ministry initiated a new program valid until 2006, targeted to children and mentally disabled persons. The target group of the program is comprised of 384,212 inhabitants including disabled children and adults. The main goals of the program are to develop services that support independent management and other measures to facilitate development and social inclusion and to improve the quality of life of the target group.[48] The money provided for launching the project in all Estonian counties is 87,861.60 euro covering activities of three years.[49]

Although society acknowledged the evident need for mental health reform, the Mental Health Act wasn't adopted until 1997, mainly because of the doctors' lobby. The Mental Health Act (1) regulates the procedure and conditions for provision of psychiatric care, (2) outlines the duties of the state and local governments in the organization of psychiatric care, and (3) delineates the rights of persons receiving psychiatric care.

In March 2004, draft amendments to the Social Welfare Act were introduced. According to the explanatory letter to the draft Act, the number of persons participating in rehabilitative activities should increase from 600 in 2004 to 25,000 in 2008.

In 2005, a new regulation for providing rehabilitation services was accepted, but it did not bring the promised relief to disabled persons. The accessibility to these services by all target groups and especially of long-term

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44 Hoolekande kontseptsiooni eelnõu. Sotsiaalministeerium. 2004, p.3. Available at: http://www.sm.ee/www/gpweb_est_gr.nsf/HtmlPages/HKK08/$file/HKK%2008.04(VIIMANE).doc

45 Social care of people with psychiatric special needs in Estonia (Psüühilise erivajadustega inimeste hoolekanne Eestis). Ministry of Social Affairs in Estonia et al. 2000/2001, p. 51. Available at: http://www.sm.ee/est/HtmlPages/psüühilisteerivajadustegainimestehoolekanneEestis2000/$file/psyyherivajad.pdf

46 Ibid.

47Programs of social welfare services (Hoolekandeprogrammid), available at http://www.sm.ee/est/pages/index.html

48Ibid.

49Regulation no 10 of the Minister of Social Affairs of 30.05.2005.

inhabitants of closed institutions is still very poor. In 2006, lack of money for rehabilitation services due to over spending in 2005 has become a hot topic. Major health care providers have reported a total lack of funds to provide the rehabilitation services later this year.[50]

If a person under the age of pension with a mental disorder is admitted into a social welfare institution, the person must have been assessed by the rehabilitation team and have a valid rehabilitation plan.[51] Implementation of this regulation provided by the law still varies to a great extent. Even if a person has a valid rehabilitation plan, due to limited funding and complicated access to rehabilitation services, the closed institutions are most often not in a position to provide inhabitants active help in receiving the rehabilitation services to which they are entitled. Most of the closed institutions still carry the mentality that their role in the social welfare system is to provide their target group with food and accommodation only.

A detailed mental health system assessment was completed in 2002. The document was a result of a one-year process that involved civil society representatives (including patients' rights groups), service providers and users, relevant public bodies, political and church leaders.[52] It outlines the most pressing gaps in the current mental health system and possible solutions. Unfortunately during the following years the stakeholders who were committed to completing the assessment have experienced a lack of interest towards taking active steps in improving the situation in the mental health field in Estonia, based on findings and conclusions of this research by MSA.

MSA has been involved in the process of drafting and adopting the Green Paper by European Commission in 2005. The Ministry has acknowledged the state's obligations under the Green Paper.[53] Although the state has formally accepted the obligations under the international covenants, according to the information provided by MSA, in Estonia, the fact is that mental health funding for mental health has been reduced since 2003.

There is good research concerning the problems of suicidal behavior in the Estonian population because of the input of the Estonian-Swedish Mental Health and Suicidology Institute. Due to its sustainability and reliability, the Institute has a leading role in carrying out international and internal projects related to mental health. Unfortunately, only a few of them are targeted to mental health promotion and prevention policies (for example EMIP funded by EC). According to the Institute the latest good news are, that Estonia does not occupy any more a award-winning place in suicidal behaviour among EU nations.

Although annually celebrating World Mental Health Day on 10 October has become a traditional event with many participants, stigmatisation of mental health problems is continually a problem in Estonian society.

Structure of the mental health system

2.1 Health care services

MSA is responsible for the overall coordination of mental health policy and service provision. The hospitals in general were state-owned until 2002. Due to major ownership reform in the health care system, the state owned health care institutions were reorganised to be mostly foundations ("sihtasutus" in Estonian) and some

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50See http://www.epl.ee/artikkel.php/ID=319012
51Social welfare Act section 11.2
52 See www.sm.ee/est/HtmlPages/vaimterv/$file/vaimterv.pdf
53See http://www.sm.ee/est/pages/index.html
54See http://www.suicidology.ee/index.php/page=3

of them are private public companies. They provide services mainly on a contractual basis with Estonian Health Insurance Fund that is buying health care services as provided by the Health Care Organization Act, the Health Insurance Act, and Estonian Health Insurance Fund Act. The source of income for the Health Insurance Fund is social tax collected in the amount of 13% of income as regulated in section 2 of the Social Tax Act. Nine hospitals provide in-patient services for mental health service users. The list of the services, funded by the Health Insurance Fund is regulated by a ruling adopted by the Estonian government. The list is annually reviewed by the government and corrected according to patients' potential need for health care services. Based on funds allocated to the Health Insurance Fund, the latter concludes contracts with service providers.

Following the ownership reform of health care facilities, a profound legal reform took place in 2002 with serious consequences to patients. Until 1 July 2002, the state or the local municipality government held responsibility for medical negligence cases as owners of health care facilities. In 2002, the State Liability Act became effective stating clearly that the state is no longer responsible for violations in providing health care services due to its jurisdiction to private law.[57] The Law of Obligations Act, in effect from 1 July 2002, contains a separate chapter entitled the Contract of Providing Health Care Services. According to the provided regulation, patients have the burden of proof in medical negligence cases.[58] The health care service providers have to prove that a patient was offered relevant information concerning services provided.[59] Since the legislation does not provide any effective pre-court remedy for solving patient complaints, litigation is the only way to address violations of patients' rights. But due to long waiting periods, the burden of proof by patients and problems with accessibility to highly qualified legal assistance and un-proportionally high court expenses, few patients have filed a complaint with a court. Due to the aforementioned reasons, the court procedure may appear to be a great disappointment and an additional source of stress.

2.2 Social welfare services

The structure of the administration of social welfare services is provided in chapter 2 of the Social Welfare Act. The administrative bodies are MSA, the county governor and local governments. Until recently, social care institutions were owned either by the state or local governments. So called specialised social care homes, established for providing services to mental health services users, were owned and supervised by the state through MSA. Ordinary or general social care homes were owned and operated by the local governments. Recently there has been a shift of responsibility concerning specialised social care homes – the supervision is currently exercised by the county governor personally through the appropriate department of a county government. The main role of MSA is the development of national social welfare policy and drafting of legislative acts as well as acting as a coordinator in national welfare programs. In some cases, the MSA contracts with private businesses or NGOs to provide social welfare services. Unfortunately, due to a lack of sustainability in funding, the role of NGOs is quite modest and is one of the main obstacles in development of welfare services, made available within society. There are a few NGOs that, despite the

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55See http://www.legaltext.ee/et/andmebaas/ava.asp/m=022
56Whttp://www.tervishoiuamet.ee
57See subsection 3 of section 1 of State Liability Act
58See section 770 of Law of Obligations Act
59Ibid, section 766

uncertainty, have managed to keep providing services. To mention some of the successful survivors: Estonian Mentally Disabled People Support Organization,[60] Independent Life,[61] and the Estonian Patients Advocacy Association.[62] Twenty-four specialized welfare institutions provide 24-hour care for persons with disabilities,[63] and five of them (Kernu, Valkla, Koluvere, Võisiku and Erastvere social care homes) provide the 24-hour care service with strengthened supervision (involuntary care taking) for persons detained under court order.

According to regulation No 4 of the Minister of Social Affairs adopted on 3 January 2002, "The obligatory requirements for social welfare institutions and social welfare services" outline the role of social care institutions ("Regulation 4").[64] Apart from those services mandated by the Mental Welfare Act, the state should provide the following services:[65]

Provided by contracted businesses or NGOs in day care centers and assisted living facilities

- Case management: overseen by the Social Insurance Board with case managers employed by regional pension departments
- Supporting of everyday life
- Supported housing
- Assisted living in the community
- Supported employment
- 24-hour care taking
- 24- hour care taking with strengthened support
- 24-hour care taking with strengthened supervision

As a rule, the families are not funded for the purposes of care-taking. Until 1 April 2005, benefit was paid for the state budget to care givers of persons with profound disability. In many cases, the entitled person was a family member. After the above date, the source of the benefit is budgets of local government. Due to a lack of funds, the benefit is now usually paid only in the case the caregiver is a non-working person and is not a relative to the person with disability.

Legal and Policy Analysis

The Estonian Constitution (1992) guarantees a wide range of human rights to all inhabitants of Estonia. Particularly pertinent articles to people with mental disabilities include:

- **Article 12:** everyone is equal before the law and discrimination based on a number of factors, including "social status," or "other grounds," is illegal.
- **Article 13:** everyone has the right to state protection, but citizens are also protected from the arbitrary exercise of state authority.
- **Article 18 (in line with Article 3 of the ECHR):** no one shall be subjected to torture or to cruel or degrading treatment or punishment.
- **Article 20 (in line with Article 5 of the ECHR):** everyone has the right to liberty and security of person. No one shall be deprived of his/her liberty unless pursuant to the law. The law provides that, among other things, the state may detain a person suffering from an infectious disease, a person of unsound mind, and an alcoholic or a drug addict if the person is a danger to himself or to others.
- **Article 21:** Everyone who is deprived of his/her liberty shall be informed promptly, in a language and manner which he/she understands, of the reason for the

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60See http://www.vaimukad.ee/uus/UK/index_uk.htm
61See http://www.iseseisev-elu.ee/engind1.html
62See http://www.epey.ee/
63//whttp://www.sm.ee/est/pages/index
64See ruling of Minister of Social Affairs no 4, adopted on 03.January 2002 „ The obligatory requirements to social welfare institutions and welfare services"
65See subsection 2 of section 1 of Regulation 4

deprivation of liberty and rights. No one shall be held in custody for more than forty-eight hours without the specific authorisation of a court. The decision of the court shall be promptly communicated to the person in custody in a language and manner which he/she understands.

- **Article 24:** Everyone has the right to be present during his/her trial. Court sessions shall be public. A court may, in the cases and pursuant to procedure provided by law, declare that a session or a part thereof be held in camera to protect a state or business secret, morals or the private and family life of a person, or where the interests of a minor, a victim, or justice so require. Everyone has the right of appeal to a higher court against the judgment in his or her case pursuant to procedure provided by law.
- **Article 28:** everyone has the right to the protection of health. An Estonian citizen has the right to state assistance in the case of old age, incapacity for work, loss of a provider, or need.

Despite these legal guarantees, several Estonian laws violate the rights enshrined in the Constitution. Most importantly, the detention procedures outlined in the Mental Health Act that was in effect until 1 January 2006, in the Social Welfare Act, as well as the procedure for restricting legal capacity as outlined in the Estonian Code of Civil Procedure, conflict rights guaranteed in the Constitution and European and international human rights law.

3.1. Mental Health Act[66]

3.1.1. Regulation until 01 January 2006

The Act, adopted in 1997, contained inadequate rights protections, and in some cases, directly contravened human rights as outlined in the Estonian constitution and in international human rights instruments. The first major gap was (and continues to be) the lack of guidance regarding involuntary detention of a person with a mental disability, other than in the case of an emergency. According to ECrtHR case law, domestic mental health legislation must provide for an assessment by an expert who assesses whether a person's mental health is of a "kind or degree warranting compulsory confinement."[67]

Other major gaps in the Act included:

1. No review of detention by an independent psychiatrist
2. Detention for 14 days without a court order
3. No right to a hearing in the detention process
4. No right to a court hearing when an administrative judge reviewed the detention procedure
5. No right to present oneself before a judge
6. No provision for a patient to obtain the evidence sent by a hospital to a judge
7. No possibility for the detained to initiate a revocation procedure
8. No obligation on the judge to communicate the court's decision to a patient, nor to state reasons for the decision
9. No provisions for a patient to be legally represented at any stage in the proceeding

Thus, either through failure to outline procedures to ensure specific rights or through the elaboration of processes that encroach upon rights , the Mental Health Act violated articles 3, 12, 20, 21 and 24 of the Estonian Constitution.

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[66] http://www.legaltext.ee/et/andmebaas/ava.asp/m=022

[67] See 2 ECHR 387, Winterwerp v Holland

3.1.2. Amendments in Mental Health Act

On 1 January 2006, the amendments to the Mental Health Act became effective. The most significant change in Mental Health Law is that the involuntary treatment lasting longer than 48 hours may be exercised based on a court ruling only. The involuntary treatment cases are heard in civil courts (county courts) under chapter 54 of the Code of Civil Procedure – Placement into closed institutions. In essence, detention in a psychiatric hospital is exercising state authorities against the subjected person. Accordingly, the administrative court would have been more logical jurisdiction.

The court gives a ruling for placement mainly as an interim measure (provisional legal protection) with an initial duration of a maximum of three months, to be extended up to six months. Although the maximum duration of placement into a psychiatric hospital may last as long as three years,[68] it will likely be used in very rare cases. Combined with a fact that there are no obligatory reviews set forth by the law, this provision is clearly incompatible with relevant regulations of international law of human rights. An exception to the rule that an application for placement into a closed institution may be filed with a court only by a local government, an application for applying an interim measure to place a person into a psychiatric hospital may be filed by a chief doctor or the deputy chief doctor of the psychiatric hospital.[69]

Today all stakeholders acknowledge the fact that the Mental Health Act is in need of major repairs or a totally new Mental Health Act should be drafted. The Ministry of Social Affairs has made an unofficial promise to initiate the drafting process later in 2006 by gathering a relevant think tank.

3.2 Social Welfare Act[70]

3.2.1 Before 1 January 2006

Among the other issues, the Social Welfare Act regulates the admission of mentally and intellectually disabled patients to social care homes. Similar to the Mental Health Act, the Social Welfare Act did not contain either adequate procedures or rights protections for the subjected persons. Moreover, the rights protection theoretically provided under the old version of Code of Civil Procedure was often ignored in practice.

According to practice "unique" to Estonia, a civil court was able to order placement into a social care home for one year if the person:

1) was of unsound mind, an alcoholic, or a drug addict;

2) could otherwise pose a danger to himself or to others;

3) the application of earlier measures had not been sufficient or no other options for care existed;[71] and

4) the individual in question or his/her legal guardian did not consent to placement in a social care home.

Together with a question of involuntary placement, the court was authorised to decide (and in most cases this power was used) the question of appointing a legal guardian.

In practice, persons placed involuntarily in social care homes almost never received any information concerning their placement and their restricted legal personality. At no time were they given the opportunity to speak for themselves or to choose their legal guardian. As a rule, they did not receive decisions made by the court and were unable to file an appeal.

68See subsection 2 of section 538 of Code of civil Procedure

69See subsection 1 of section 13 of Mental Health Act and subsection 1^1 of section 534 of the Code of Civil Procedure

70http://www.legaltext.ee/et/andmebaas/ava.asp?m=022

71See subsection 1 of section 19 of Social Welfare act, valid till 01.01.2006

Finally, in most cases they did not have the opportunity to be represented by a lawyer appointed and paid by the state.

According to the Social Welfare Act, placement in a social welfare institution without his/her consent had to be terminated by the director of the social care home if any of the circumstances elaborated above ceased to exist. Unfortunately, with few exceptions, in very rare occasions the person was allowed to leave the care home before the due time until their court decision was over. The Act also provided the possibility to extend the detention period for one year each time. Continuous detention was very widespread, especially due to lack of other more relevant community services.

EPAA has evidence about the fact that in some cases local governments and next to kin of a disabled person used involuntary care as a means of becoming free of their monetary responsibilities. Provision of 24 hour care taking under one's own strengthened supervision was (and still is) exceptionally paid by the state. The subjected person had the obligation to pay monthly for food and accommodation and a fixed amount as ordered by the county governor.

Moreover, as care homes received additional state funds for offering namely 'strengthened care-taking services,' they had an economic incentive to keep residents classified as more incapacitated than they were. Violence and abuse of rights of mental health patients were caused by the fact, that together with mental health patients, drug and alcohol addicts were also target groups of the involuntary care service.

In the case of termination of detention in social care homes, the person under question could formally restore his/her capacity if the requirements for appointing a guardian had ceased to exist. The guardianship authority (local government) had the right to file an application with a court to restore the individual's legal capacity.[72] However, this process rarely occurred, as the local government often failed to file the documents or was not interested in filing them. In cases where an individual's legal personality was restored, he/she often had no place to go, and voluntarily became a resident of another department of the same social care home.

2.2.2. After 1 January 2006

In the beginning of 2006, changes where introduced into Section 19 of the Social Welfare Act. The fact that alcohol and drug addicts are not any more placed into social care homes under Section 19 of the Social Welfare Act may be mentioned as a positive change. Unfortunately, there are also negative changes to be outlined:
1) The time period for placing the person into social care homes under court order was extended from one to three years.[73] According to the regulation, the time for initial placement may be up to three years. The period of extension is obligatorily three years.
2) Only the county court is authorised to make a decision about termination of the detention, based on an application filed by a local government or using its own powers.

72See section 268 of the Code of Civil Procedure, valid till 01.01.2006

73See subsection 3 of section 19 of Social Welfare Act, valid from 01.01.2006

3.3. General Part of the Civil Code Act and Family Law

A new General Part of the Civil Code Act was enacted on 1 July 2002; the family law act took effect on 1 January 1995. According to the regulation provided by the General Part of the Civil Code Act, persons have restricted active legal capacity if they are permanently unable to understand or direct their actions due to mental illness, mental disability or other mental disorder. Consequently, restricted capacity is a question of fact. AThis conseption has positive and negative aspects:

- On the positive side, if the person suffering from mental illness, mental disability or other mental disorder has harmed his/her proprietary rights, the court may declare this transaction to be ineffective from the very beginning. The court has no obligation to solve the question of restricted capacity in a separate proceeding at first, as it used to be before 1 July 2002.
- On the negative side, despite very strict regulations for handling the confidential information of these individuals, there have been many cases when the fact that a person used the services of psychiatrist in the past was misused as a formal reason to initiate a procedure for appointing a guardian.

The person is presumed to have restricted capacity if the guardian has been appointed.[75] Guardianship is established for the protection of proprietary and personal rights and interests of an adult with restricted active legal capacity.[76] According to the construction in the law, the model of the guardianship used is partial. But in the case the legal guardian is appointed and the incapacitated person has no rights to do any kind of transactions, the person is considered to be divested of legal capacity to elect.[77]

Restricted legal capacity has many profound legal consequences. For example, adults with restricted capacity who have been appointed a guardian are not allowed to marry.[78] The governmental authorities are entitled to deny these persons access to reception and responses to their written requests need not to be given.[79] Adults with restricted capacity have no capacity in court proceedings except in cases where the procedure of appointing of a guardian or placement into closed institution is initiated. In cases where individuals are incapacitated but the requirements for involuntary placement are not fulfilled, the legal guardian is also entitled to initiate the procedure of sending the adult in question to a social welfare institution based on a contract concluded with a guardian. Usually the opinion of the person under question is not taken into account. The guardianship system, as it exists in Estonia, further breaches fundamental human rights. Estonian legislation does not offer less restrictive measures as suggested with regulation (1999)4 of the Committee of Ministers of European Council to member states: On Principles Concerning Legal Protection of Incapable Adults.

3.4. Code of Civil Procedure

3.4.1. Before 1 January 2006

Although the regulation provided in the law contained the possibility to include the person with mental health problems into the process of appointing a guardian or sending to involuntary care taking, as an interested party, it was almost never used. The Code of Civil Procedure did not contain a relevant and separate procedure for considering involuntary care taking cases. These cases were heard as a matter on

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74See subsection 2 of section 8 of General Part of the Civil Code Act

[75] See subsection 3 of section 8 of General Part of the Civil Code Act

[76] See subsection 4 of section 92 of Family Law Act

[77] See subsection 2 of section 4 of Law of Obligations Act, General Part of the Civil Code Act and Private International Law Act Implementation Act

[78] See subsection 3 of section 4 of Family Law Act

[79] See subsections 2 of section 4 and subsection 9 of section 5 of Response to Memoranda and Requests for Explanations Act

petition based on analogy with appointing a guardian. The most widespread practice was that the person in question had no information about ongoing court procedures and the judgement made. There was a case when the person under question was informed of the enforced guardianship judgement after two years had passed.

Although the Family Code Act prescribed that only a physical person could have been appointed as a guardian, in the total lack of relevant candidates, local governments were appointed to act as guardians. Since the local governments were also authorised to act as the supervisors to the appointed guardians, this practice sometimes created a severe conflict of interest.

In some cases where the person in question was incapacitated and simultaneously sent involuntarily to a care home, the court judgement was executed almost a year after the judgement had come into effect. The legislation did not provide any guaranteed interim measures to question the court's judgement, especially its proportionality and the necessity for its execution as compared to the alleged dangerousness of the person under question. To challenge this court practice, EPAA provided legal aid to nine clients in filing petitions to correct court errors in guardianship and/or involuntary care cases with the Estonian Supreme Court. In all cases, the judgements as ruled by the county or city courts were declared to be null and void and the judgements were sent for reconsideration by the first court. The Supreme Court altogether annulled 12 relevant judgements. For example, in M.V. case, the position of the Civil Chamber of the Supreme Court was as follows:

"8. According to §249, section 1 of the Code of Civil Procedure, the court will review a proceeding on petition according to the provisions of an action proceeding, taking into account the particulars specified for proceedings on petition. In section 2 of the same paragraph, the court will review a petition in a matter on petition with the participation of the petitioner and interested parties. The court must involve all parties interested in the matter even if the petitioner has not applied for their involvement. The Chamber finds that a person, for whom application is being made for the assignment of a guardian and involuntary placement in a care-giving facility, is a party interested in the matter and must be involved in the review of the matter, if his/her conditions allows. The fact that the County Court has called X.XXXXX to the hearing that took place on 20 September 2003 does not in itself mean that the City Court has fulfilled all the requirements of a civil court proceeding to involve X.XXXXX in the matter.

According to §259 of the Code of Civil Procedure, the petition for the assignment of a guardian will be reviewed in the presence of the petitioner and guardianship authority, and if his/her mental state allows, in the presence of the person for whom application is being made for the assignment of a guardian. Therefore, in the preliminary proceeding, the court must ascertain whether the mental health allows for the person to participate in the hearing and to defend his/her own interests.

To achieve this, based on §258 section 1 of the Code of Civil Procedure, the court, when assigning an expert assessment, must also present the expert with a question as to whether the person is capable of participating in the hearing. In the case of uncertainty, the court must conduct additional actions, to achieve the maximum level of conviction regarding whether to call or not call the person to the hearing. If possible, the court may ascertain the person's ability to participate in the hearing by meeting with the person together with the expert. The court may not deprive the person of a hearing if the expert is of the opinion that the person is not capable of permanently understanding the meaning of his/her actions and to direct these actions, but has no opinion regarding the ability of the person to participate in the court hearing. The Supreme Court has taken the same position with a decision on civil matter no. 3-2-3-5-03 on 13 November 2003 (RT III 2003, 35, 362) and on civil matter no. 3-2-3-2-04 on 16 November 2004 (RT III 2004, 33, 348). In this matter, the court has not presented the expert with a question regarding the ability of X. XXXXX to participate in the court hearing. From the materials regarding the matter, it does not appear that the court conducted any other actions to find an answer to this question. Thereby, the court violated §249, section 2 and 3 as well as §259 of the Code of Civil Procedure.

10. The Chamber finds it necessary to note that in this matter the expert has not personally met with the examinee. The Chamber finds that in a proceeding which restricts a person's active legal capacity and/or a person is placed in a department of a care-giving facility with increased supervision, it is unacceptable that an expert, without meeting with the examinee, provides an opinion regarding his/her mental health and also regarding the danger that he/she poses to him-/herself or others. In proceedings in which the legal consequence is the restriction of moral rights, the Chamber finds that the expert must personally examine a person who is capable of speech and contact.

11. The Chamber is of the opinion that if a person's mental state does not allow him/her to defend his/her own rights, and he/she has not appointed a representative, then based on the analogy of §83, section 3 of the Code of Civil Procedure, a lawyer must be appointed for the person. If the person is insolvent, then, according to the same provision, the lawyer will be appointed at the expense of the state.

12. The Chamber does not accede to the assertion in the petition to correct court errors that §19 of the Social Welfare Act is in conflict with the Constitution and international rights since the court is lacking rules on which to base their review of the involuntary placement of a person in a care facility. The Chamber, in its solution no. 3-2-3-2-04 on 16 November 2004 (RT III 2004, 33, 348), has found that according to §9 section 2 of the Code of Civil Procedure, in cases where the provision for regulating the procedural relationship is missing from the law, the court will apply the provision that regulates relationships that are closely related to the relationship in dispute. If such a provision of the law is missing, the court will be guided by the general meaning of the law. Also, the Chamber found in the referred solution that in proceedings on petition, the rights of people regarding whom petitions for confinement in a care-giving facility have been submitted are protected by the active role of the court in the proceeding."[80]

Unfortunately the court did not consider it necessary to address the arguments concerning violation of the international laws challenged in the same petition. After the courts started to appoint legal representatives to the subjected persons in guardianship and involuntary placement cases, there appeared to be new problems concerning bad performance and arrogance of the appointed lawyers. The attorneys, paid by the state, did not meet with their clients nor did they take instructions from them. In many cases, the attorney did not represent and protect the clients' interests but, instead, those of the opposite party.

To effectively protect her violated rights, L.N. filed an application with EcrtHR to argue that her rights under article 5 of ECHR were violated under the following circumstances. She had been detained in a social care home for a year and a half, including half a year without a court decision. Finally, the court extended

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[80] See court decision of Supreme court in a civil case no 3-2-3-3-04, www.nc.ee

her detention period. She was not provided a court judgement and could not file an appeal. Her petition for correction of court errors was rejected by the Supreme Court on the grounds that she had had an appointed lawyer.

3.4.2 After 1 January 2006

A new Code of Civil Procedure became effective on 1 January 2006. The new regulation did not bring any change into the practice of handling guardianship and involuntary placement cases as matters on petition. The court has an obligation to take an active role in these proceedings even in the case where there are no objections to the applications filed with the court. The Code expressly said that the person in guardianship and detention cases has the right to be personally heard by the judge[81] and the right to legal representations,[82] in the case of insolvency, paid by the state.

Compared to the former legislation, the right of the person in question to appeal has been reduced. Formerly the decision in guardianship and in involuntary care cases was made with a court judgement. According to the new regulation, the decision is passed with a court ruling. This means that instead of potential protection provided by an additional two court judgements (circuit courts and Supreme Court), the only remedy is an appeal against the court ruling filed with a county court and if acceptable, decided by a circuit court. In matters on petition, there is no access to the Supreme Court. In order to comply with international law (especially with article five of ECHR), Chapter 54 of the new code introduced a new regulation of placement into closed institutions. The persons subjected to placement without their consent into closed institutions are the following:

1) A mentally ill person to be placed in a psychiatric hospital or a social welfare institution against his or her will together with deprivation of the liberty of the person;
2) Persons suffering from a communicable disease, if this is necessary for the prevention of the spread of an especially dangerous infectious disease;
3) Other matters of placement of a person in a closed institution provided by law.[83]

The court shall conduct proceedings in the above matters based on a petition by the rural municipality or city government of the residence of the person. There is a correct place to outline for second time that the maximum duration for placement into a closed institution is three years as provided with subsection 2 of section 538 of the Code. EPAA has highlighted the apparent nonconformity of the aforementioned section and the absence of obligatory periodical review of the detention with the international human rights law, with the Legal Chancellor's office. As a result according to the latest information, the Ministry of Justice filed a draft law with the Parliament to decrease the possible detention time back to one year.

Although the new law seems to protect the rights of target groups subject to this regulation, already some cases have been communicated to EPAA when the procedural rights of the subjected person have been violated mainly by not providing information about initiating court procedures. The time limits (48 hours) to receive a ruling from a court, as provided by the new law, puts great pressure on every party involved, especially the local municipality government. Their obligation is to assist the court in gathering information required by the court for placement into closed institutions.[84] Chapter 53 of the Code of Civil Procedure contains a regulation for appointing a guardian by the court.

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[81] See sections 525 and 536 of the Code of Civil Procedure
[82] See subsection 2 of section 520 and secton 535 of Code of Civil Procedure
[83] See section of 533 of the Civil Procedure Code
[84] See ibid subsection 3 to section 536

As a small positive change in this regulation, the guardian may be appointed only for three years.[85] As a rule the subjected person's opinion about the proposed guardian must be taken into consideration by the court. The person's opinion is not taken into account in the case of appointing a temporary guardian as a provisional measure.[86] A temporary guardian may be appointed for a maximum period of one year.

3.5 Forensic treatment according to the Penal Code and Criminal Procedure Law

According to the Code of Criminal Procedure, enacted on 1 July 2004, in criminal trials, persons who are not able to represent themselves due to physical or mental disabilities are required to be represented by an attorney; in the case of their insolvency, by a state-provided one.[87]

According to the Penal Code, in effect since 1 September 2002, if an individual is found guilty of a criminal act, he/she is subjected to forensic psychiatric treatment if an individual "lacked capacity" at the time a crime was committed, or, if he/she "becomes mentally ill or feeble-minded or suffers from any other severe mental disorder" before serving the full sentence.[88]

Forensic treatment in Estonia is provided in the only licensed forensic hospital located in the village of Jämejala, close to Viljandi. The facility provides two different regimes and is built for 80 patients.

4. Statistics

Statistics, concerning the provision of various health care and social services, including services for adults with specific mental needs (i.e mental health service users) is available for 2002 to 2004.

Psychiatric Hospitals

Services provided	2004	2003	2002	2001
Consultations for outpatients	110997	96365	92053	96112
Inpatients, written out	14886	14465	15045	14761
Total no. of bed days	241619	239948	275177	382443
Average length of stay	16 days	17 days	18,3 days	25,9 days
No. of deaths among patients	48	54	51	51

The total number of bed days decreased enormously after the ownership reform undertaken in health care facilities in 2002. The average length of stay in hospital as an inpatient has also reduced significantly, due to the same aforementioned process.

Social Care Homes

Characteristic	2004	2003	2002
No. of specialised welfare institutions offering 24 care taking services	25	24	21
Persons receiving social welfare services	4247	4118	2457
Staff providing services for persons with specific needs	993	No information	1200

More precise information about social welfare services provided was available on MSA homepage concerning 2004.

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[85] See ibid subsection 3 of section 526
[86] See ibid subsection 4 of section 521
[87] See subsection 2 of section 45 of the Code of Criminal Procedure
[88] See section 86 of the Penal code

Service	No of persons	Total expenditure EEK
Supporting of everyday life	1668	16 656 970
Supported housing	562	12 808 682
Assisted living in the community	32	2 324 519
Supported employment	548	3873 927
24-hour care taking	2074	89 888 003
24-hour care taking with strengthened supporting	171	11 639 179
24-hour care taking with strengthened supervision	198	12 084 060
Accomodation service	37	14 361 761
Total	**5290**	**150 712 101**

There has been a very slight decrease (3.3%) in the number of places in social care homes from 2001. At the end of 2002, 2,457 intellectually disabled individuals resided in the homes, 44 of whom were receiving only general social care services. Of the 314 residents who left social care homes in 2002, 3.8% left to live independently with the support of the state or their families. The rest died, moved to another social care home, or left for other reasons.[89]

At the end of 2002, there were 1200 employees in social care homes. The majority were management or care taking staff. There were only 5 social workers, 1 physiotherapist, 8 activity therapists, and 1 psychologist. Only 21.3% of the personnel working in the social care homes had a particular professional education, higher or professional school.[90]

Community-based social services

In 2002, there were 737 social workers who provided home visits in Estonia.[91] This service was used by 5,964 persons in 2002, 49% of whom were diagnosed with some type of disability.[92]

5. Patient's rights/human rights/NGO reports on mental disability

Since Estonia gained independence, international human rights entities and national NGOs have undertaken monitoring mental disability rights in Estonia. The Estonian Patient's Advocacy Association (EPAA), established in 1994 for protecting rights of psychiatric patients, assessed conditions for those undergoing forensic psychiatric treatment. EPAA visited the Department of Forensic Psychiatric Treatment at the hospital Jämejala in September 2003. Their investigation revealed that those detained in this facility were not afforded the rights and procedures as provided by Article 6 of the ECHR (the right to a fair trial); and the Estonian constitution, penal code, and criminal procedure law. Forty-one persons (37 men and 4 women), out of 81 detained, voluntarily completed a survey.

The results of this survey revealed that only five had participated in his/her court hearing. Fourteen were not offered an opportunity to consult with their lawyer prior to the trial, and 37 did not receive any information concerning the hearing. Only four had received a copy of the court ruling ordering the forensic treatment. Five were informed of their right to appeal their detention. After receiving the information that they had the right to appeal, 17 were interested in exercising this right.

EPAA, in co-operation with Mental Disability Advocacy Center (MDAC),[93] filed a shadow report with UN Human Rights Commission addressing the nonconformity of Estonian legislation to Article 9 of International Covenant on Civil and Political Rights. EPAA has a

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[89] Täiskasvanute eritüüpi hoolekandeasutused – 2002, p. 3
[90] Täiskasvanute eritüüpi hoolekandeasutused – 2002, p. 6
[91] Koduteenust osutanud sotsiaaltöötajate arv maakonniti 1998-2002, Available at: http://www.sm.ee/est/HtmlPages/koduteen1998-2002hooldaja/$file/koduteen1998-2002hooldaja.xls
[92] Koduteenuste osutamine 2002. aastal. Available at: http://www.sm.ee/est/HtmlPages/koduteenused2002/$file/koduteenused2002.pdf
[93] http://www.mdac.info/

joint litigation project named "Watchdog" funded by European Commission, addressing guardianship and involuntary treatment cases. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has visited Estonia five times, the most recent of which was in the fall of 2003. CPT visited Ahtme Psychiatric Hospital and Kernu Social Care Home. CPT in its report gave precise instructions to the Estonian government how to address in a more compatible way to providing services in social care homes. The CPT report together with the response of Estonian Government are available at Council of Europe`s (CoE) website.[94]

The CoE Commissioner for Human Rights, Mr. Gil Robles, released a report regarding his October 2003 visit to Estonia. He outlined that although the government has increasingly emphasized independent living, lack of rehabilitative services inhibits reintegration. Moreover, only 13% of persons with disabilities are employed, and the salary paid for work at special facilities is half the minimum wage (point no 38).[95]

The Commissioner also commented on the lack of harmonisation between Estonia's international human rights obligations and national law and practice. His report criticises, in particular, the fact that, according to the Mental Health Act, those who are involuntarily committed to a psychiatric institution do not have the right to challenge the lawfulness of their detention for a period of up to 14 days. Those criminally detained, on the other hand, have the right to review after 48 hours. Apart from violating the right to a remedy, this practice constitutes discrimination against those committed to a psychiatric institution.

The Commissioner consequently recommended that Estonian law be modified to afford protections consistent with ECHR Article 5 to all who are detained in Estonia. The report goes on to criticise the fact that the Mental Health Act does not clearly differentiate between the procedures for involuntary admission to a psychiatric facility and medical treatment without consent.(point no 43).[96]

The UN Human Rights Commission has also criticised the 14-day allowance for review of detention.[97] Moreover, the Commission noted that the number of detentions terminated after the 14-day period calls into question the legitimacy of the detentions in the first place.[98]

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[94] http://www.cpt.coe.int/en/states/est.htm

[95] http://www.coe.int/T/E/Commissioner_H.R/Communication_Unit/Documents/pdf.CommDH(2004)5_E.pdf

[96] ibid

[97] Concluding Observations of the Human Rights Committee: Estonia 15/04/2003 CCPR/CO/77/EST. The Committee found the procedure to contravene Article 9 of the ICCPR.

[98] Ibid.

RECOMMENDATIONS

As Introduced in 2004

To the Estonian Ministry of Social Affairs

1. To initiate a process of vast changes in legislation and in the attitude of society concerning the human and procedural rights of persons of unsound mind and restricted legal capacity. In execution of a mental health policy, the Ministry should rely on the principles of international human rights law and on those introduced in the basic document of mental health adopted in 2002 by a wide and prominent range of stakeholders. Recommendations for activities that this process should involve follow:

- In Article 10 of its Concluding Observations concerning Estonia from 3 April 2003, the UN Committee on Human Rights declared that the state party should ensure that measures depriving an individual form his/her liberty, including for mental health reasons, comply with Article 9 of CCPR. The COE Commissioner of Human Rights in Article 43 of his final conclusions CommDH(2004)5 concerning Estonia states that the Estonian Mental Health Act is in controversy with Article 5 of the European Convention of Human Rights and Liberties.
- With reference to aforementioned facts – recommendation is made to annul the Mental Health Act (Psühhiaatrilise abi seadus) and urgently start the drafting process of a new relevant law that will be in compliance with the international treaties ratified by the Estonian state as well as with recommendations approved by international organizations, especially UN Committee on Human Rights and the Committee of Ministries of the European Council. All measures must be taken and each stakeholder invited to participate in order to guarantee that the new Mental Health Act draft law will be in compliance with the following:
- UN resolution No. 46/119 from 19 December 1991 and Recommendation No. R(99) 4 on Principles Concerning the Legal Protection of Adults with restricted legal capacity,
- Rec (2004)10 on Principles of Protection Human Rights and Dignity of Persons with Mental Disorder,
- Rec (2006)5 Council of Europe Action Plan to promote the rights and full participation of people with disabilities in society: improving the quality of life of people with disabilities in Europe 2006-2015 of the Committee of Ministers of Council of Europe.

2. To annul Article 19 of the effective Social Care Act stipulating that the persons may be deprived of their liberty by sending them to social care homes without the consent of the person in question or his/her legal guardian. As the procedure itself is not regulated by any of the Estonian procedural codes, there have been several cases of malpractice. In some cases, the persons have been deprived of liberty even based on an order of an County Governor (representative of the Estonian State in each County) that is in clear contradiction with the Estonian Constitution.

3. To stipulate that a person may be placed into a closed institution only by the decision of the court, provided that a rehabilitation team is of the opinion that this is the only relevant and necessary service to the client and other means do not exist or are not effective enough. It must be also clearly stipulated in the law that a person may be admitted into a social care home based on a contract with a legal guardian of the person provided the rehabilitation team has clearly indicated it.

4. To regulate clearly and unambiguously how much a resident of a social care home has to pay for the services provided in the care home to avoid cases when

residents are billed differently for services of the same amount and quality.

5. To avoid cases when placement of persons with restricted legal capacity into social care homes under the court order is evidently unfounded, it should be clearly stipulated that when a legal guardian and/or local community initiates the admission of a person into a social care home, they are obliged to pay part of the expenses of said services in the home.

6. In cooperation with the Ministry of Science and Education and local communities concrete measures should be taken to enable the offering of broad range mental health services in various population groups, especially those of a preventive and supportive nature and educational programs for children and adults aimed at maintaining and/or achieving good mental health.

7. In cooperation with local communities, the range of offered public services should be broadened (especially public care taking services and the system of supportive persons, supported living and working) to include the maximum services corresponding to the different individual needs of the person in question.

8. The State should determine that a certain amount of financing is guaranteed to every person who is in need of services to increase the expenses related to the appropriate level of coping with everyday life. Instead of connecting the allocated money with a certain service to be provided, the rehabilitation team in cooperation with the person in question should have relatively free to use the money for the best interests of the individual. The provided type of services should be reviewed every six months to estimate whether or not the needs of the person have changed. This is a good method to use money provided by the state more effectively and in accordance with individually determined needs.

9. The person should be involved in the process of creating the rehabilitation plan and the person should sign it if the plan is acceptable. Any rehabilitation plan not agreed to by the person in question should not be implemented as it would violate the person's right to self determination.

10. Improve the accessibility to different types of service, including a rehabilitation service, and to guarantee a sufficient amount of financing from the State budget.

11. Propitiate participation of NGOs in providing social care services funded from the State budget by extending the range of social care services and pronouncement of long-term (for a period at least 5 years) public procurement of relevant services.

12. NGOs providing services to persons with mental disorders MUST BE TREATED AS EQUAL PARTNERS.

13. All residents of closed institutions are entitled to receive special medical care (including dental care) funded by the State.

14. Take measures for establishing an automatic and independent control mechanism with the purpose of reviewing whether or not the placement of a person into a closed institution without his/her consent has been warranted. The Ministry should also encourage the directors of special social care homes and psychiatric hospitals to terminate the involuntary hospitalization on their own initiative in the cases they consider to be unwarranted.

15. Initiate a law with relevant regulations to establish a transparent and independent system of guardianship authority.

To the Estonian Ministry of Justice

1. Stipulate in the draft law of Civil Procedural Code that a process of appointing a legal guardian may be initiated only on a decision of the rehabilitation team. The court`s judgment regarding restriction of a person`s civil capacity should be based on a relevant evaluation of the individual's particular needs by the rehabilitation team (for example - entering into civil contracts, decisions about using money, ability to marry and to vote) according to the person`s individual needs. It must be clearly explained to court practitioners that making a decision of inclusive restriction of a person`s legal capacity without having handled evidences referring to one particular right is a very clear violation of human rights. The court's practice of making decisions to restrict civil capacity based on the opinion of a single psychiatric expert resolutely must be stopped. According to the Civil Procedural Law, the court has the obligation to collect other evidence on its own initiative.

2. It is strongly recommended to change the formulation of Article 8(2) of the General Part of Civil Code Act stipulating that persons who are under 18 years of age (minors) and persons who due to mental illness, mental disability or other mental disorder are permanently unable to understand or direct their actions, have restricted active legal capacity. This article clearly discriminates against persons having any sort of psychiatric diagnosis or even having visited a psychiatrist.

3. Validate explicitly the requirements that the opinion of the court psychiatric expertise should meet or to diminish decisively the role of this document in favor of the decision of rehabilitation team expressed in the rehabilitation plan. To change relevantly Articles 257 and 258(1) of Civil Procedural Law and stipulate that the rehabilitation plan is an obligatory annex to the appointment of a legal guardian filed into Court. This recommendation has many positive sides:

- The court will receive a complex document evaluating an individual's mental health state and management skills level;
- The same document indicates clearly the proper means and services for the person;
- Helps to cut expenditure to psychiatric expert opinions (as a rehabilitation team also includes a psychiatrist).

4. Annul Article 4(3) of the Family Law Act stipulating that a marriage shall not be contracted between persons of whom at least one is an adult who has been placed under guardianship due to his or her restricted active legal capacity. The ability to marry must be a separate object of evaluation in every particular case.

5. The Family Law Act should clearly stipulate that only a physical person can be appointed as a legal guardian by the court. Malpractice in accordance to what local communities, being at the same time institutions of guardianship authority, are appointed as legal guardians, should be resolutely stopped to avoid possible corruption. The State should consider establishing an independent institution being part of Chancellor of Justices office, to provide services to protect personal and proprietary rights of incapable persons, funded from the State budget.

6. Annul Article 262(1) of the Civil Procedural Law stipulating that only a guardianship authority is entitled to submit a petition for the termination of the authorisation of a guardian to the court of the residence of the ward. In cases where the guardianship authority is at the same time the legal guardian, it is evident that the guardianship authority is not able to exercise this right and to act in protection of the rights of the person with restricted capacity.

7. Prevent and minimize cases when the persons with restricted capacity do not receive legal help, they are entitled to be provided assistance by the members of Estonian Bar Association, based on Article 31 of the State Provided Legal Assistance Law to enter into contracts with NGOs who are experienced in providing legal assistance to persons of unsound mind, familiar with relevant laws, and willing to do this work. These contracts entered into with NGOs should include pre-court legal counselling as well as legal assistance in cases of appointing of legal guardian and/or placement of a person into closed institutions (such as involuntary treatment of patients having infectious diseases or psychiatric patients, involuntary placement into care homes, forensic treatment in criminal cases, etc.).

To the Estonian Chancellor of Justice

1. Visit regularly closed departments of special care homes and psychiatric hospitals. To provide closed institutions with written informational material for the purpose of increasing the awareness of residents and patients concerning their rights and possibility of filing a written complaint to the Chancellor of Justice office in the case of violation of their human rights.

2. Exercise constant controls and review procedures regarding decisions restricting and/or violating individual rights with a purpose of finding out if deprivation of liberty is unfounded or not.

3. With reference to the Chancellor of Justice letter No. 6-8/736 from 9 September 2003, to declare that Articles 1(1), 12(3), 13(1, 3-6.2) are in nonconformity with Articles 3, 11, 13, 14, 15, 20 and 21 of the Estonian Constitution and to start the constitutional review procedure concerning the Mental Health Act as prescribed in Article 1(1) of the Chancellor of Justice Act.

To the Estonian Health Insurance Fund

1. Increase funding for psychological counselling and psychotherapy for both in-and out-patients.

2. Approve funding for inpatient voluntary treatment longer than 14 days in the case of medical necessity.

3. Fund supervision services for psychiatrists to prevent their burn-out syndrome.

To the Estonian Health Care Board

Exercise thorough (not only formal) supervision over involuntary treatment as implemented in Article 13(9) of Mental Health Act.

To the County Governments

1. Exercise better control in care homes and pay more attention to complaints of residents and their family members.

2. Decisively deny the attempts of courts to delegate to county governments the decision-making regarding the involuntary placement of persons into special care homes.

To Local Community Governments

1. Exercise constant control over legal guardians appointed by the court and demand from legal guardians the filing of annual reports as stipulated in Section 101(1) in the Family Law Act.

2. Take measures for establishing a separate institution for dealing with property of persons placed into closed institutions (i.e. maintenance of the property during the period when the person is in the closed institution).

3. Make strong efforts to provide all possible help and the best level of services to persons having difficulties with their subsistence.

4. In cooperation with the Ministry of Social Affairs, support the preservation of farms, gardens, and orchards in care homes as one of most important sources of providing the residents with a job and the opportunity to supplement their food ration.

To Care Homes

1. Or different and accessible activities for improving the level of subsistence for the residents of care homes.

2. Take all measures to fulfil rehabilitation plans – to compose an individual plan for each resident to improve his/her level of subsistence and mobilize all possibilities to implement this plan by offering appropriate assistance services and creating conditions with the goal of better self-management and return to society.

3. Charge residents an equal amount of money for equal services provided.

4. The contracts that residents and care homes enter into should contain a detailed description of services offered and also an in-house and pre-court complaint mechanism.

5. Make efforts to find vacant jobs for the residents outside of care homes and provide help to residents in the negotiation process with employers.

6. In the event that a resident is provided with a job inside the care home, management of the care home and the resident should enter into an employment contract. The amount of the money earned should be equal to the amount paid for similar work done in other organizations

7. Improve accessibility to special medical treatment in care homes in cooperation with medical professionals with relevant diagnoses and proper treatment in due time.

8. Patients should not be treated against their will, nor should unfounded doses of neuroleptics be used with the sole purpose of strengthening control over residents and tranquillizing them with purposes other than treatment prescribed by a licensed psychiatrist.

9. Residents should be provided accurate information concerning their rights.

10. Residents should be encouraged to participate in the decision-making process (for example, through a representatives elected among the residents or an elected resident as a member of some counselling body).

11. A transparent complaint mechanism should be introduced that is publicly accessible for all residents.

12. Separate registries should be introduced to register cases of the use of seclusion.

To Psychiatric Hospitals

1. Establish in-house rules for assessing the level of dangerousness of a patient with a purpose to make the decision making more transparent in cases where involuntary treatment is necessary. The decision that a patient is dangerous has to be made with a good cause relying on concrete facts and evidence based on law and by using a relevant, internationally recognized assessment tool.

2. All patients (in-door and out-door) should be provided all necessary information regarding their diagnosis and treatment in a comprehensible way.

3. All patients should be enabled to exercise their will to participate in the decision-making process during treatment and they should be allowed to give their informed consent (irrespective of the fact if the person is treated involuntarily or has a legal guardian).

4. In-house principles and rules should be composed and implemented for measuring the patients' capacity for exercising their will and if a patient is lacking this specific capacity, a substitute person should be appointed to make decisions for the patient, according to patient's best interest.

5. Separate registries should be introduced to register cases of the use of seclusion and/or restraint.

6. A transparent complaint mechanism that is publicly accessible for all patients should be introduced and should provide information about the authorities exercising supervision (as Health Care Board and Chancellor of Justice).

7. The practice of using restraints should be changed (to reduce the fixed time of the patient to the minimum amount needed).

8. Better in-house training (including psychology) should be provided for assistance personnel.

As Introduced in 2006

Most of the recommendations made in 2004 are valid in 2006 as well. There have been slight positive changes in the rising awareness of society concerning mental health issues. For example, the judges and the state provided attorneys have understood that deprivation of a person's liberty and restricting his/her personal and proprietary rights are not formal issues and should be considered very seriously.

There have been some positive changes in the Code of Civil Procedure; especially that persons with restricted capacity have the civil procedural capacity in the case of the appointment of a guardian and placement into closed institutions. The procedural rights of incapacitated persons are more closely followed, etc. There has not been enough time for testing this new law in practice yet to introduce ideas for change, except the strong demand that the possible three year detention period set forth in subsection 2 of section 538 of the Code of Civil Procedure and subsection 4 of section 19 the Social Welfare Act should be changed as quickly as possible.

Although the regulation addressing rehabilitation services in the Social Welfare Act is very precise compared with the regulation in 2004, the problems with accessing the services and funding still continue to exist.

According to the European Green Paper, Estonia is one of the very few countries that does not have a separate budget for mental health services. According to unofficial information, funding of mental health services has been reduced since 2003. The Ministry of Social Affairs should take measures to approve using of some internationally recognized method (like HCR-20) of assessing the potential dangerousness of persons with mental disorder.

LATVIA

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1. Mental Health Reform in Latvia since the end of the USSR

Reform of the mental health care system in Latvia has been slow. Changes in the overall health care system began in 1989, with the development of a new concept of health care system protection. In 1991, the project of both so-called 'Regional Sickness Funds'[99] and state compulsory health insurance system was initiated.

A system of primary health care was developed and implemented in 1997, and, in 1998, the Latvian government made an agreement with the World Bank regarding further reform of the health care system in the period of 1999 to 2004.[100] This agreement indicated that Bank funding would be used to fund the implementation of a long-term health services restructuring strategy, including the development of a State Health Care Master Plan, which aims to improve primary, outpatient, and emergency care services, and decrease the number of hospitals. Although the draft of the Master Plan was developed in 2002, the Implementation Program of the Master Plan was approved by the Cabinet of Ministers only on December 2004. A year later, on 27 December 2005, the Cabinet of Ministers adopted the Action Plan for period of 2005 – 2010 of the Development Program of Providers of Outpatient and Inpatient Health Care Services. The Action Plan foresees to decrease the number of psychiatric beds from 3048 beds in 2004 to 2540 beds in 2010. A certain part of the budget for 2005 and 2006 has been planned to invest in reconstructing works of several psychiatric hospitals, as well as in building new premises in two psychiatric hospitals. Moreover, the Law on State Budget for 2006 envisages the State warranty for reconstruction and renovation works at five psychiatric hospitals ("Gintermuiza", Strenci, Daugavpils, Ainazi and Akniste). The envisaged State warranty varies from 1.9 million lats (2.7 million euros) for Strenci psychiatric hospital to 10 million lats (around 14 million euros) for Daugavpils, as well "Gintermuiza."[101] These plans for reconstruction and building new premises raise serious concern if the current developments in mental health care do not contradict other policy documents, such as a draft National Mental Health Policy, as well to World Health Organization's Helsinki Declaration and Action Plan of 2005. From an effective policy and budget planning perspective, it would be more reasonable to start investments in psychiatric hospitals only when clear National Mental Health Policy and Action Plan are adopted.

The following donors have funded projects to reform mental health care in Latvia by providing community based services to people with mental illness: the Open Society Institute, the Soros Foundation-Latvia, the Canadian International Development Agency (CIDA), the Co-operating Netherlands Foundations for Central and Eastern Europe (Queen Juliana Foundation) and the Swedish International Development Agency (SIDA). However, all of these projects remain only at the pilot level.

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[99] Regional Sickness funds are responsible for coordinating health care services and for ensuring cost-effective health care services to inhabitants. In 1993, the system of Sickness funds was created all over Latvia. By the end of 1993, it was defined which health care services should be funded from the State budget, the amount of patient payments, and which patient groups should be exempted from patient's payments. Since January 2005 the system has been reorganized and functions of Sickness funds have been taken over by Health Compulsory Insurance State Agency.

[100] SIA DEABALTIKA, Veselības aprūpes pakalpojumu groza pašreizējā stāvokļa izvērtējums, tā ietekmējošo faktoru analīze un nākotnes tendence, Rīga, 2002, <http://www.politika.lv/polit_real/files/lv/vesel_grozs2002.pdf > (last accessed on the web at 03.02.2005.)

[101] The Law on State budget for 2006 (in Latvian), [Likums par Valsts budžetu 2006. gadam], <http://www.fm.gov.lv/page.php?id=4> (last accessed on the web at 05.05.2006.)

Mental health care reform included changing diagnostic classifications from the International Classification of Disease-9 (ICD-9) to ICD-10. Reform also entailed a drastic reduction in the number of beds in psychiatric hospitals. During the period of 1998 to 2002, the number of beds in psychiatric hospitals has been reduced by 20% due to the more effective usage of existing resources and the reduction of length of stay of acute patients.[102] According to data from the Mental Health Government Agency, the number of psychiatric beds per 10 000 population has decreased from 16.4 in 2000 to 13.8 in 2004, while the number of beds per one in-patient psychiatrist has been reduced from 26 in 2000 to 22 in 2004. The average bed occupancy was 94.75% in 2004.[103] Although Latvia has been successful in decreasing the number of beds, the development of community-based care has not kept pace. Thousands of the mentally disabled living in the community lack access to quality and community residential services.

2. Structure of the mental health system

Mental health care in Latvia is financed from different sources, depending on the type of services provided. The health care budget funds psychiatric hospitals and outpatient psychiatric care, while the Ministry of Welfare (MoW) budget supports social care homes and day centers for persons with intellectual disabilities. Additionally, a few municipalities support NGOs to operate community services for the intellectually disabled. With one exception, municipalities have not funded psychiatric care. Jelgava municipality (the 4th largest city in Latvia) took over the management of a day center for persons with schizophrenia from the Jelgava Psychiatric Hospital in 2003.

Psychiatric care in Latvia is provided under the aegis of the Ministry of Health. There are nine psychiatric hospitals, and psychiatric departments in 3 general hospitals. Outpatient care is provided by four outpatient consultative departments by four mental hospitals in Riga, Daugavpils, Liepaja (Piejuras Hospital) and Jelgava ("Gintermuiza"), 22 mental health care consulting-rooms at municipal medical out-patient institutions. Outpatient care to an undetermined number of patients is also provided by 55 additional private psychiatrists' practices of which sixteen practices in 2004 fulfilled public procurement.[104] Of the nine hospitals, one is for children, and two are for long-term residents with mental illness.

Long-term institutionalized care for people with disorders of a mental nature[105] is organized and funded by the MoW, and is provided in 31 social care home for adults. Because of lack of community-based care, social care homes are the major source of services for those with intellectual disabilities, as well as for people diagnosed with schizophrenia. In 2005, approximately 850 people were on a waiting list for a place in a care home.

The MoW has delegated the responsibility to local municipalities to provide home care, day care, and group homes for people with disorders of a mental nature, mainly for people with intellectual disability. When municipal reform is completed (by 31 December 2007), the MoW will transfer responsibility for all state social care homes to the municipalities.

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[102] Draft National Mental Health policy document (in Latvian), [Veselības ministrija, Pamatnostādnes "Iedzīvotāju garīgās veselības uzlabošana no 2006. gada līdz 2016. gadam], p.8, <http://www.mk.gov.lv/index.php/lv/28/search?search=37ed01630bf5c80a81840a9c68c4afba> (last accessed on the web at 05.05.2006.)

[103] The Statistics Yearbook, 5th issue, of Mental Health Government Agency, Ministry of Health of Latvia, Mental Health Care in Latvia in 2004, Riga, 2005, p.44, <http://www.gvva.gov.lv/en_publik/2004.pdf> (last accessed on the web at 05.05.2006.)

[104] Draft National Mental Health policy document (in Latvian), [Veselības ministrija, Pamatnostādnes "Iedzīvotāju garīgās veselības uzlabošana no 2006. gada līdz 2016. gadam], p.7-8, <http://www.mk.gov.lv/index.php/lv/28/search?search=37ed01630bf5c80a81840a9c68c4afba> (last accessed on the web at 05.05.2006.)

[105] The MoW in all its legislative acts regards persons with mental disabilities is using the term "persons with disorders of a mental nature". However this term is not defined in any legislative act and there is no clear policy from MoW on whether it may also include people with mental health problems, because in practice the term is mainly related to persons with intellectual disabilities.

Despite the fact that an inadequate number of services exist, the MoW through the Social Services Board together with respective municipalities has funded some community-based services for those with intellectual disabilities, including 18 day care centers and two group homes. However, the Ministry has been reluctant in providing similar services for the psychiatrically disabled[106], because the mental health problems (psychiatric disabilities) until now have been perceived as diseases that should be addressed by the MoH. Social welfare professionals generally do not believe that people with mental problems could benefit from multi-disciplinary services.

3. Legal and policy analysis (psychiatry and social care)

3.1 Health Care

The mental health care system is regulated by the 1997 law "On Medical Treatment." Article 65 of the law states that "all persons with mental disorders and mental diseases must be provided all civil, political, economic and social rights envisaged by law. Mental disorder and mental diseases cannot be grounds for discrimination." However, the law does not detail the rights of the psychiatrically disabled, nor does it specify any mechanisms for rights enforcements or remedy.

Over the last ten years, the Latvian government is in the process of developing a new mental health law – the Law on Psychiatric Assistance. The first draft with assistance of the experts, funded by the Canadian government, was completed in 1998. The draft has subsequently been changed several times, but has not yet been adopted. In 2003, the Latvian Centre for Human Rights (LCHR – former Latvian Centre for Human Rights and Ethnic Studies) and the Mental Disability Advocacy Center (Budapest) urged the government of Latvia to revise the draft law, stating that "the review procedure for detention on the grounds of mental disability fails to meet human rights standards – the draft does not meet conditions mandated by Article 5 of the European Convention on Human Rights (ECHR)."[107] Because of these requests, the draft had been altered, and had been submitted to the Cabinet of Ministers on 30 December 2004. Afterwards the draft law was repeatedly reviewed at the Cabinet's Meeting of State Secretaries on 14 July 2005 and it was decided to revoke the draft law. There have been no further developments after 14 July 2005 and the Action Plan of MoH for 2006 currently does not foresee any further activities regarding the adoption of the Law on Psychiatric Assistance. Since in October 2006 Latvia will have new parliament elections, it is likely that further developments regarding adoption of a new mental health law can be expected only in 2007.

3.2 Involuntary Commitment

According to the current law regarding medical treatment, "Psychiatric assistance shall be on a voluntary basis. In-patient assistance shall be provided by mental institutions if, due to the state of health of the patient, such assistance cannot be provided on an outpatient basis or at the place of residence (Section 67)."[108] Section 68 (1) of the law also states the principles for involuntary commitment: "outpatient or in-patient examination and medical treatment against the will of a patient may be performed only in the following cases:

1. If, due to a mental disorder, the behavior of the patient is dangerous to his or her health or life, or to the health or life of other persons;

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[106] In 2005 for the first time MoW (through Social Services Board) provided the funding for opening the day care center "Gaismas stars" for persons with schizophrenia in Riga.

[107] Press Release of MDAC, <http://www.mdac.info/documents/Latvia%20Press%20Release.doc> (last accessed on the web at 03.02.2005). Article 5 of the European Convention on Human Rights lays out the rights to liberty and security of person.

[108] Law on Medical Treatment of 1997, <http://www.ttc.lv/New/lv/tulkojumi/E0233.doc> (last accessed on the web at 18.10.2004).

2. If, due to a mental disorder or its clinical dynamics, the psychiatrist prognoses that such behavior of the patient is dangerous to his or her health or life or to the health or life of other persons; and
3. If the mental disorder of the patient is such as to prevent him or her from making informed decisions, and refusal to undergo medical treatment may lead to a serious deterioration in health and social status, as well as to public disturbances."

According to Article 68 (2), if a patient is hospitalized against his or her will, a council of psychiatrists shall, within a 72-hour period, examine the patient and speak with his or her family members or lawful representatives. If the psychiatrists are unable to meet with family or lawful representatives within 72 hours, the family shall be sent a notice in writing, which shall be recorded in the patient's registration card.

The law governing involuntary commitment, as well as the law governing medical care provision, fails to provide for the right of the patient to challenge his or her involuntary detention and treatment before an independent and impartial tribunal. Thereby, Latvia still violates Article 5 of the ECHR.

3.3 Psychiatric Care Policy

The first comprehensive psychiatric care policy in Latvia was approved in 2000. The need for developing a psychiatric care policy was mentioned also in the National Programme for Integration into the European Union, as the European Commission had indicated shortcomings in mental health care in its 1999 report of Latvian progress toward EU accession. Covering the period of 2000 to 2003, the Government Strategy for Psychiatric Assistance aimed to reform the existing mental health care system through the introduction of community based services and a reduction in the number of psychiatric beds. However, no implementation plan and no funding were foreseen for the reform.[109]

Following the WHO Helsinki Declaration and Action Plan of 2005, the Ministry of Health of Latvia decided to develop a new Mental Health Policy document and Action Plan for the period of 2006 to 2016. The draft policy document "The Improvement of Mental Health of Inhabitants of Latvia for Period of 2006 -2016" was placed in the public domain in May 2005. The draft Mental Health Policy document envisages to shift the focus of support for mentally disabled from institutional care to community based services, including residential community services (e.g. half-way houses and small size group homes for 4-12 individuals, etc.). It is planned to develop 40 community based centers, including 10 community mental health centers, 10 half-way houses and 20 group homes. Although the Cabinet of Ministers was scheduled to adopt the Mental Health Policy document in July 2005, the submission of draft policy document to the government was rescheduled for 2006. The World Health Organization and its experts provided significant assistance to Latvia when drafting the policy document. The WHO will continue its support in drafting the National Action Plan, which is the next step after adopting the Mental Health Policy. In January 2006 the Biennial Collaboration Agreement for 2006-2007[110] between MoH and the Regional Office for Europe of the WHO was signed. Agreement sets the main priorities for WHO's assistance, including the development of the National Action Plan for mental health and substance use disorders, as well developing the mental health promotion and anti-stigma strategies.

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[109] Leimane (2000), A.Kamenska & Leimane-Veldmeijere (2003)

[110] <www.euro.who.int/eprise/main/WHO/Progs/BCA/agreements/20060309_22> (last accessed on the web at 05.05.2006.)

Although during drafting the Mental Health Policy some non-governmental organizations were consulted, the Latvian Centre for Human Rights considered that the users' opinion on needed services is missing. Therefore, in 2005 the Latvian Centre for Human Rights in cooperation with Latvian Psychiatric Nurses Union carried out the survey of psychiatrically disabled users of mental health services in six psychiatric hospitals and seven social care homes for mentally disabled to discern their needs and opinions on current services. The survey results are to be published in June 2006 and will be submitted to the Ministries of Health and Welfare in order to introduce consumer priorities to the reform agenda.

3.4 Social Care Policy

Policy and principles of the current social care system were defined by the 1997 White Book,[111] which identified three main principles for the reform of social care:

- financial principle: money should follow the client (as opposed to being used to maintain beds in psychiatric institutions);
- all social assistance services should be delegated to local municipalities;
- community-based alternatives to institutional care should be developed.

In 1998, the government approved the concept "Equal Opportunities for All,"[112] which outlined government goals and a 10-year action program for the integration of people with disabilities, including also people with intellectual disabilities. As part of this, the government passed a new law on social services and social assistance in 2003. The law addresses social care for people with intellectual disabilities as well as people with mental health problems, residing in long-term social care and social rehabilitation institutions.[113] In August 2005 the government adopted the Policy Guidelines for Reduction of Disability and its Consequences for period of 2006 to 2010.[114] The main goal of the Policy Guidelines is to improve the state social security system in order to reduce a risk of becoming a disabled people for those of potential disability, as well to reduce a social exclusion risk of persons already having a disability. Besides other tasks, the new policy guidelines intend to provide assistance for 10 thousand disabled people with severe functional disorders (including people with severe mental disorders) and implement support programs (for example, workshops, various classes) for persons with severe mental disorders, who are placed in medical or long-term social care and rehabilitation institutions. Following the Policy Guidelines, the government has to adopt also the Action Plan and budget for implementation of the adopted Guidelines.

3.5 Deinstitutionalization

In 2003, Latvia and the European Commission signed the Joint Memorandum on Social Inclusion in Latvia.[115] The Memorandum defines key social policy challenges, including income inequality. Those identified as most at risk for social exclusion included unemployed people with disabilities.[116] The Memorandum discusses policies for inclusion in areas such as the labour market and employment, health care, housing, education and social security.

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[111] Pamatnostādnes "Sociālās palīdzības sistēmas attīstības Baltā grāmata", 13.05.1997., http://ppd.mk.gov.lv/ui/DocumentContent.aspx?ID=1519 (last accessed on the web at 03.03.2005).

[112] Koncepcija "Vienādas iespējas visiem", 30.06.1998., <http://ppd.mk.gov.lv/ui/DocumentContent.aspx?ID=1539> (last accessed on the web at 03.02.2005).

[113] Law On Social Services and Social Assistance, 31.10.2002., <http://www.ttc.lv/New/lv/tulkojumi/E0667.doc> (last accessed on the web at 20.02.2005.)

[114] Press Release, Government approves the Policy Guidelines for Reduction of Disability and it's Consequences, http://www.lm.gov.lv/index.php?sadala=640&id=1689 (last accessed on the web at 05.05.2006.)

[115] The Joint Memorandum on Social Inclusion in Latvia, <http://www.lm.gov.lv/doc_upl/JIM_Latvia_Final_11_12_03.pdf> (last accessed on the web at 05.06.04).

[116] The Joint Memorandum on Social Inclusion in Latvia, accessed on the web at <http://www.lm.gov.lv/doc_upl/JIM_Latvia_Final_11_12_03.pdf> (last accessed on the web at 05.06.04).

Despite this public acknowledgement of exclusion, the government has not shown real political will to facilitate de-institutionalization on a national scale. With World Bank support, an evaluation of clients of all social care homes was undertaken in 2002. The study concluded that out of 4,138 evaluated mentally disabled clients of social care homes at least 4% or 183 could live in the community, and 5% or 189 could live in general care homes for the elderly. However, no action to de-institutionalize those identified has been undertaken. Of the 624 clients who left social care homes in 1999, only 4% returned to their families, and only 2.7% started independent lives.[117]

The MoW has however, developed a national program to increase the scope and number of community-based services available. The program, "Improvement of infrastructure and equipment of social care and social rehabilitation institutions," will be implemented with financial support from the European Regional Development Fund. Planned activities include the development of day care centers, social rehabilitation programs, life skills programs, sheltered workshops, group homes, and half-way houses in each of Latvia's five administrative regions.

Half-way houses will be developed within six existing social care homes for the mentally disabled in Liepaja district, Valka district, Daugavpils district, Jelgava and Riga district (Allazi, and Ropazi).[118] On 28 December 2005, the first half-way house was opened in Kalupe (Latgale region). In its annual report of 2004, the Latvian Centre for Human Rights (LCHR) raised concern that MoW National programme does not envisage a mechanism on re-training of staff to facilitate transition to community based residential services.[119] Therefore, in 2005, the Open Society Institute and Soros Foundation-Latvia funded the Mental Disability Advocacy Program of LCHR that decided to provide funding to union "Pasparne"[120] for staff training and preparing of a training manual. The staff training is scheduled to start during the first half of 2006.

Another disadvantage of the MoW National program is that it does not envision working with long-term clients of psychiatric hospitals, as these clients are currently living in facilities managed by the MoH (as opposed to the MoW).

Example of Good Practice

Union "Pasparne" has been co-operating with one of the MoH-run long-term psychiatric hospitals, Akniste, and since 2002 has been managing a half-way apartment, life-skills programs, and a community based consumer-run crafts shop and café. Many of the users involved in these activities are ready to transition to life in the community. With support from the local government of Garsene village, OSI, Soros Foundation-Latvia and the Latvian Centre for Human Rights, the development of a group home in the community for these users has begun. However, the renovation of premises provided for the group home by Garsene local government needs a lot of additional financial investment. Therefore, the project developers currently are still in a process of fundraising. "Pasparne" is looking forward to state funding which should be available for development of group homes in the amount of up to 50% from January 2007 after amending the Social Services and Social Assistance Law.

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[117] Data of Social Assistance Foundation.

[118] Nacionālā programma "Sociālās aprūpes un sociālās rehabilitācijas institūciju infrastruktūras un aprīkojuma uzlabošana (Eiropas Reģionālās attīstības fonds)", 21.07.2004., <http://www.lm.gov.lv/doc_upl/soc.pr.un_soc.rehab.(2).doc> (last accessed on the web at 20.2.2005.)

[119] LCHRES, Human Rights in Latvia in 2004, p. 19-20, <http://www.humanrights.org.lv/html/news/publications/28368.html?yr=2005> (last accessed on the web at 05.05.2006.)

[120] Union "Pasparne" (based in Garsene village, co-operating with Akniste psychiatric hospital) has developed the first half-way housing program, as well together with the Latvian Psychiatric Nurses union has developed life skills training program for people with mental disabilities.

Unfortunately, all of these innovative programs at Akniste have been supported only by foreign donors. The MoW has shown no interest in assuming financial responsibility for the programs, or in applying for European Union Structural Funds. This oversight is not due to ill-will on the part of the MoW, but more likely to the persistent belief that those residing in psychiatric hospitals require health, rather than social assistance.

Because of the perceived split between medical and social assistance, government efforts in de-institutionalization have focused on persons with intellectual, as opposed to psychiatric, disabilities. As a result, psychiatric rehabilitation (and thus de-institutionalization of persons with mental health problems) is not a concept in Latvian law or policy strategy. According to the current policy, rehabilitation programs are provided only by large national rehabilitation centers, which mostly provide rehabilitation to the physically disabled. However, several hospitals, mainly through efforts of the Latvian Psychiatric Nurses Union, have adopted rehabilitation models from Sweden, the Czech Republic, and the Netherlands. In 2003, for example, the rehabilitation center "Rasa" was opened in Strenci mental hospital. The Center provides occupational therapy, art therapy, music therapy, and life skills training for clients of Strenci psychiatric hospital as well as for clients living in several local municipalities. Thus, although 'on paper' there is no psychiatric rehabilitation, some services are available.

Disability rights advocates hoped that European Structural Funds for the period 2004-2006 would be available for developing rehabilitation programs in psychiatry. However, possible grantees have already been disappointed, because Structural Funds can only be used to create rehabilitation programs for persons who already fall into a so-called 'disability group.'[121] Since it may take several years from the time of the first episode of mental illness to classify an individual with a psychiatric illness into a 'disability group,' many of those who require psychiatric rehabilitation are in fact ineligible to participate in programs supported by Structural Funds.

Example of Good Practice

In 2004, a pilot project for the social integration of individuals with mental disabilities was initiated in Vidzeme[122] region. The project aims to overcome the traditional split between medical and social assistance by providing both services to persons with intellectual disabilities and to persons with mental health problems. Although the program has been developed, it has not been implemented yet, as it needs further financial support from the local governments.

4. Statistics

4.1 Psychiatric Care

Latvia has approximately 2.3 million inhabitants and around 64,452 registered people with mental disabilities (including about 14,686 persons with intellectual disability).[123] Each year, around 6,000 new patients are diagnosed as having a mental disability.

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[121] Disability is defined by the Law on the Medical and Social Protection of Disabled Persons 1992. Article 4 states that "a disabled person is a person who, due to the impairment of the functions of the system of organs caused by diseases, traumas or innate defects needs additional medical and social assistance and to whom a disability status has been attributed in the procedure set in this Law and other normative acts." In accordance with the Law on the Medical and Social Protection of Disabled Persons 1992, a person with disabilities is classified as having either severe disabilities (for people within Disability Group I (the most severe) and Disability Group II) or mild disabilities (Disability Group III).

[122] Latvia is divided in 5 administrative regions: Vidzeme, Zemgale, Latgale, Kurzeme and Riga district.

[123] The Statistics Yearbook, 5th issue, of Mental Health Government Agency, Ministry of Health of Latvia, Mental Health Care in Latvia in 2004, Riga, 2005, p.19 <http://www.gvva.gov.lv/en_publik/2004.pdf> (last accessed on the web at 05.05.2006.)

According to 2004 data from the Mental Health Government Agency, the highest registered morbidity is with schizophrenia, schizotypal and delusional disorders - 29% (18,095), organic mental disorders – 24% (15,477) and mental retardation – 23% (14,686).

In 2004, Latvia had 64 psychiatrists working in out-patient care. This translated into 813 patients per outpatient care psychiatrist. The total number of psychiatric beds in 2004 was 3197 or 13.9 per 10 000 population. In 2004, out of nine mental hospitals of Latvia, two hospitals had fewer than 100 beds, two hospitals had fewer than 200 beds, three hospitals had 200 to 500 beds, and two hospitals had 500 to 800 beds.[124]

4.2 Social Care

In 2005, there were 4,133 persons in 30 social care homes for the people with intellectual disabilities or mental health problems, accommodating 1764 persons with intellectual disabilities, 1502 with schizophrenia and 642 persons with dementia.[125] Additionally there were 3 social care homes for children with intellectual disabilities, accommodating 359 children in 2005.[126] In 2005, approximately 850 persons were on a waiting list for a place in a social care home. In 2004, there were 19 day care centers and group homes for persons with intellectual disabilities, providing services to a total of 651 clients.[127] In 2005, out of 4,133 residents of 30 social care homes, 517 persons were declared as legally incapable and 462 persons had been appointed guardian.[128]

5. Patient's rights, human rights, NGO reports and activities

After regaining its independence from the Soviet Union in 1990, Latvia renewed its historical Constitution (Satversme) of 1922. As the 1922 Constitution did not contain any human rights provisions, in 1998, Parliament (Saeima)[129] added a Chapter on "Fundamental Human Rights" to the Constitution,[130] thereby "bringing Latvia's Constitution into line with European standards and ending uncertainty about the place of human rights in Latvia's legislative hierarchy."[131]

Patients' rights are outlined by the Law on Medical Treatment of 1997, which includes the patient's "right to receive information from a doctor in a way that s/he can comprehend regarding the diagnosis of his or her illness, examination and medical treatment plans, as well as regarding other medical treatment methods and the prognosis (Section 20);" and, "the right to refuse, in full or in part, examination or medical treatment offered by certifying such refusal with his or her signature (Section 23)." These standards have been criticized by outside observers, including the CoE, which objected to the fact that "Section 23 says nothing about securing informed consent (…), which is not the same as the right to refuse – if informed consent cannot be obtained or is withdrawn then whatever is being offered cannot be done."[132]

In response, a new law on patients' rights was drafted and placed in the public domain in 2003 and it was adopted by the Parliament in 1st reading on 5 May 2005.

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[124] All the statistical data are taken from the Statistics Yearbook, 5th issue, of Mental Health Government Agency, Ministry of Health of Latvia, Mental Health Care in Latvia in 2004, Riga, 2005, pp.105 <http://www.gvva.gov.lv/en_publik/2004.pdf> (last accessed on the web at 05.05.2006.)

[125] Data from Social Services Board, <http://www.socpp.lv/lv/files/Tab_1_1.xls>, <http://www.socpp.lv/lv/files/Tab_7.xls>, (last accessed on the web at 05.05.2006)

[126] Data from the Social Services Board, <http://www.socpp.lv/lv/files/1.1.%20Bērnu%20skaits%20iestādē.xls>, (last accessed on the web at 05.05.2006.)

[127] LM Sociālo pakalpojumu pārvalde, Sociālie pakalpojumi un sociālā palīdzība Latvijā 2004. gadā, 47.lpp., <http://www.socpp.gov.lv/lv/?a=396>, (last accessed on the web at 05.05.2006.)

[128] Data from the Social Services Board, <http://www.socpp.lv/lv/files/Tab_9.xls>, (last accessed on the web at 05.05.2006.)

[129] The Saeima is the Parliament of the Republic of Latvia and has 100 parliamentarians.

[130] Chapter VIII on "Fundamental Human Rights", Constitution (Satversme) 1998, accessed on the web at <http://www.ttc.lv/New/lv/tulkojumi/E0013.doc> (last accessed on the web at 18.10.04).

[131] N.Muiznieks, A.Kamenska, I.Leimane, S.Garsvane, Human Rights in Latvia in 1998, Riga: Latvian Center for Human Rights and Ethnic Studies, 1999, p.33.

[132] Dr. Michael Abrams (United Kingdom), Comments of the Draft Law on Medical Treatment of Latvia, Council of Europe, Strasbourg, 16 September 1998, p.2

It was expected that also a new draft law on psychiatric assistance would be submitted to the Parliament by the end of 2004, but, unfortunately, the draft law on psychiatric assistance still has to go through the process of review by the Cabinet of Ministers as of early 2006.

Thus far, there have only been a few cases of persons with a mental health problem applying to the Court for a remedy. Only one of those cases was regarding the right to see one's medical file and to receive information regarding diagnosis and treatment.

Several State institutions are responsible for reviewing complaints and controlling quality of care in mental health care institutions. For instance, the National Human Rights Office (NHRO) - an ombudsman-like institution, receives and analyses complaints regarding human rights of mentally disabled individuals and carries out visits to psychiatric hospitals and social care homes for mentally disabled. In 2004, NHRO received 13 written and 37 oral complaints regards violation of rights in mental health care institutions.[133]

Issues regarding quality of medical care are controlled by a state institution – the Ministry of Health's Medical Care and Work Quality Control Inspectorate. The Inspectorate must investigate every oral or written complaint regarding the quality of medical care, and, if wrongdoing or neglect is found, may levy monetary fines or annul licenses. The decision of the Inspectorate can be appealed in court. In 2004, the Inspectorate reviewed 892 complaints and 55 percent were recognized as well-founded. The majority of complaints referred to primary care, followed by medical care in prisons and psychiatric treatment related issues.[134] In 2005, the Inspectorate reviewed 1224 complaints and only 20 percent were recognized as well-founded. Out of all the complaints – 33 were on mental health care and only 10 of those were recognized as well-founded.[135]

Issues regarding conditions and care in social care homes for mentally disabled are controlled by another state institution – the Ministry of Welfare's Social Services Board, which has to investigate complaints and carry out regular control visits to state and municipal institutions providing all kinds of social services. In 2004, apart from controlling the quality of care in social care homes, the Social Services Board analysed the services provided by day care centers.[136] In 2005, the Social Services Board carried out around 85 visits to state and municipal institutions providing social services and received 206 complaints from the clients. Unfortunately, there were no data available on number of complaints received particularly from the clients of social care homes for mentally disabled.[137]

Non-governmental organizations (NGOs)

There are several NGOs with interest in advocacy for various patients groups in Latvia. However, there is only one NGO in Latvia specializing in general patients' rights issues and providing legal aid – the Latvian Patients Rights Office - and one NGO specializing in rights advocacy for mentally disabled – the Latvian Centre for Human Rights (LCHR) – formerly the Latvian Centre for Human Rights and Ethnic Studies. Both organizations provide free legal aid to any inhabitant of Latvia. LCHR has undertaken monitoring of psychiatric hospitals and social care homes on a regular basis.

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[133] Valsts Cilvektiesibu birojs, Valsts Cilvektiesibu biroja 2004. gada zinojums, Riga, 2005, 90.lpp. <http://www.vcb.lv/zinojumi/2004.gada_zinojums.pdf> (last accessed on the web at 05.05.2006.)

[134] Latvian Center for Human Rights and Ethnic Studies, Human Rights in Latvia in 2004, Riga: Puse Plus, 2005, p.40, <http://www.humanrights.org.lv/html/news/publications/28368.html?yr=2005> (last accessed on the web at 05.05.2006.)

[135] MADEKKI, 2005. gada Inspekcijas darba rezultati, <http://www.madekki.gov.lv/index.php?sadala=120&id=98>, (last accessed on the web at 05.05.2006.)

[136] Socialo pakalpojumu parvalde, 2004. gada parskats, Riga, 2005, 19.lpp., <http://www.socpp.gov.lv/lv/files/SPP_2004_gada_publ_paarskats_viss.doc>, (last accessed on the web at 05.05.2006.)

[137] Interview of Ieva Leimane-Veldmijere with Dzintra Mihailova and Kaspars Jasinkevics from Social Services Board, Riga, 25 January 2006.

The findings are included in LCHR' Annual Reports on Human Rights, and are sometimes disseminated as separate reports. In 2002 - 2003, with financial support from the Danish Embassy, the LCHR team conducted extensive monitoring of 18 social care homes for mentally disabled. In 2003-2006 LCHR continued monitoring psychiatric institutions also under the EC project "Monitoring Human Rights and Prevention of Torture in Closed Institutions: Prisons, Police Cells and Mental Health Care Institutions in Baltic Countries."

Monitoring of mental health care institutions, carried out by LCHR in 2003 - 2006

During the project's first year (2003), monitoring visits were carried out together with international experts from 26 to 31 October 2003.[138] The team visited three psychiatric hospitals and a forensic department of the Mental Health Care Center (all under the MoH), and 3 social care homes (under the MoW).[139]

After the visits of 2003, the project's team had concerns about the human rights situation in Daugavpils Mental Hospital and Litene Social Care Home; therefore, LCHR had an informal meeting with MoH representatives and suggested that the MoH should carry out their own inspection visit to follow up the situation at Daugavpils Mental Hospital. Similarly following the monitoring visit at Litene Social Care Home, LCHR contacted the Social Services Board and stated that the conditions of intellectually disabled men labelled as "severely aggressive" were unacceptable and should be changed.[140] A follow-up visit to both institutions were made by a LCHR team – in 2005 (Litene Social Care Home) and in 2006 (Daugavpils Mental Hospital).

During 2004 – 2006, monitoring was continued on a regular basis by the LCHR monitoring team[141] which, in 2004-2005, carried out twenty monitoring visits to social care homes and, in 2005-2006, ten monitoring visits to mental hospitals. Based on monitoring results in social care homes, a staff seminar was organized in order to discuss the quality of medical care and the need for guidelines regarding isolation rooms and use of restraints. The project's monitoring report is to be published in June 2006.

International organizations

International organizations have also assessed respect for human rights in Latvian closed institutions. For instance, the CoE Committee for the Prevention of Torture (CPT) regularly visited Latvia in 1999 and 2002, and once on an ad hoc visit in 2004. The reports from 1999 and 2002 have been published thus far. Having visited the Riga Neuropsychiatric Hospital in 1999, the Delegation "heard no allegations of ill-treatment – and gathered no other evidence of such treatment – of patients by staff at RNH or in other psychiatric institutions in Latvia."[142] The Committee made recommendations in several areas, including the importance of separating juveniles from adults, moving

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[138] The team consisted of Ieva Leimane-Veldmeijere - Human Rights Researcher, Mental Disability Advocacy Program Director of the Latvian Center for Human Rights, Eva Ikauniece - Social Worker, Assistant of Mental Disability Advocacy Program of the Latvian Center for Human Rights, Lauris Neikens - 4th year law student of the University of Latvia, Oliver Lewis - international human rights lawyer, Legal Director of the Mental Disability Advocacy Center (Budapest), Arunas Germanavicius - psychiatrist, Consultant of Vilnius Regional Office of Global Initiative for Psychiatry, Dainius Puras - psychiatrist, Consultant of Vilnius Regional Office of Global Initiative for Psychiatry.

[139] The Daugavpils Psychiatric Hospital, Akniste Psychiatric Hospital, Jelgava Psychiatric Hospital, and the Department for Forensic Examination and Coercive Treatment at the Mental Health Government Agency; Piltene social care home, Litene social care home and social care home "Atsauciba" were visited.

[140] One of rooms at Litene care home was designated for men who were labelled "severely aggressive." This room measured approximately 4m x 6m, and had metal sheeting covering the empty walls. At least some remedial action was taken after LCHR applied to Social Services Board and since 2004 the room was determined to be unsuitable for patients and is now used only as a storeroom.

[141] LCHR mental health care institutions' monitoring team: Ieva Leimane-Veldmeijere – team leader, human rights researcher, Eva Ikauniece – social worker, outside experts - Uldis Veits – psychiatrist and Lauris Neikens – lawyer.

[142] Committee for the Prevention of Torture, (2001). Report to the Latvian Government on the Visit to Latvia. CPT/Inf (2001) 27. <http://www.cpt.coe.int/documents/lva/2001-27-inf-eng.pdf> (last accessed on the web at 03.02.2005).

forensic patients to a newly built Forensic Department, establishing a separate register for the use of restraints and ECT, providing and allowing individualized clothing, and creating more opportunities for rehabilitative and therapeutic activities.[143] Some of these recommendations have been addressed by the Latvian government. After visiting two mental health care institutions for children in 2002, the Committee in its report recommended that "steps be taken to ensure that patients/residents who are admitted without their consent to a psychiatric hospital/social welfare institution are granted the right to be heard in person during the process of appeal against such placement." Furthermore, the Committee recommended that "steps be taken to ensure that the need for such placement is reviewed by an appropriate authority at regular intervals."[144]

Human rights reports on mentally disabled

The following is a list of available reports on human rights that address the rights of the mentally disabled in Latvia.

1. Market Lab, Opportunities in Labour Market for the People with Disorders of Mental Nature, May 2006 (available only in Latvian).[145]
2. Open Society Institute, EU Monitoring and Advocacy Program, Mental Health Initiative, reporter - Ieva Leimane-Veldmeijere, Monitoring Report Human Rights of People with Intellectual Disabilities. Access to Employment and Education. December 2005[146]
3. Latvian Centre for Human Rights and Ethnic Studies, Annual Reports on Human Rights of 1997 - 2004[147]
4. Inclusion Europe, Latvian Association "Rupju berns", Human Rights of Persons with Intellectual Disability, April 2004.
5. Latvian Centre for Rights and Ethnic Studies, Monitoring Closed Institutions in Latvia, May 2003[148]
6. Latvian Centre for Human Rights and Ethnic Studies, Report to UN Committee Against Torture, submitted before the review of Latvia Report in 2003
7. Report of CoE Committee for the Prevention of Torture, visit to Latvia in 2002[149]
8. Ieva Leimane, Needs Assessment for the Mental Disability Advocacy Program, July 2000[150]
9. Report of CoE Committee for the Prevention of Torture, visit to Latvia in 1999[151]

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[143] Ibid.

[144] Committee for the Prevention of Torture. (2005). Report to the Latvian Government on the visit to Latvia. CPT/Inf (2005) 8. <http://www.cpt.coe.int/documents/lva/2005-08-inf-eng.pdf > (last accessed on the web at 26.05.2005.)

[145] < http://www.research.lv/projects/20050501-20060430/default.htm> (last accessed on the web at 05.05.2006.)

[146] Available in English and Latvian on <http://www.eumap.org/topics/inteldis/reports/national/latvia/id_lat.pdf> and <http://www.humanrights.org.lv/html/news/publications/28564.html?yr=2005>, (last accessed on the web at 05.05.2006)

[147] The reports from the last years are available in English on a web page of LCHR – <http://www.humanrights.org.lv>. The shortened versions of LCHR Annual reports have been included in the Report of International Helsinki Federation for Human Rights every year.

[148] Available in English on <http://www.cpt.coe.int/documents/lva/2005-08-inf-eng.pdf >

[149] Available in English on <http://www.cpt.coe.int/documents/lva/2001-27-inf-eng.pdf>

[150] Available in English on <http://www.politika.lv/polit_real/files/lv/0_HumMentalDis.pdf> and on <http://www.humanrights.org.lv/html/news/publications/28498.html>

[151] Available in English on <http://www.cpt.coe.int/documents/lva/2001-27-inf-eng.pdf>

RECOMMENDATIONS

To the Latvian Government:

1. Shift the focus of support for the mentally disabled to community-based services. While needs exist at the level of psychiatric hospitals and care homes, the main priority in policy, legislation, and funding should be the creation of community-based care for persons with psychiatric and intellectual disabilities. The government (and pertinent ministries) should create a realistic action plan that includes details of implementation and a funding strategy. Policy planners can leverage the experience of pilot de-institutionalization projects, such as the life skills training and half way house at Akniste, the community outreach project operated by Strenci Mental Hospital, and the Jelgava mobile treatment team project. Funds should be sought for service development and provision, particularly mobile multidisciplinary mental health treatment teams, day care centers for the psychiatrically and intellectually disabled, group homes, programs of supported employment, and support for users' advocacy and self-help groups. The need for community-based services is large; staff at hospitals and social care homes noted that as many as 25% of their residents could live in the community with support. Facilities are overcrowded and over 800 Latvians are on a waiting list for a place in a social care home.

2. Establish an independent monitoring mechanism. Monitoring of mental health care institutions should occur regularly. The government should fund an independent entity comprised of relevant ministry staff and representatives of human rights NGOs that regularly monitors all hospitals and social care homes, and, in the future, community-based services.

3. The government should ratify the Council of Europe Convention on Human Rights and Biomedicine. The purpose of this Convention is to: "Protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine."[152] Ratifying it would require that the Latvian government ensure that domestic legislation is in keeping with Convention laws relating to access to medical care, informed consent, involuntary treatment of the mentally disabled, and right to information.

4. The government should ratify the revised European Social Charter and Optional Protocol X, the collective complaint mechanism. Currently Latvia has ratified only an older version of the Charter dating from 1961. Moreover, when it ratified the 1961 version, the government did not consider as binding Article 15, which states that states must "take adequate measures for placing of disabled persons in employment, such as placement services, facilities for sheltered employment and measures to encourage employers to admit disabled persons to employment."[153]

5. The government should sign and ratify the Optional Protocol to the United Nations Convention against Torture (OPCAT). The aim of the OPCAT is to prevent torture and other forms of ill-treatment by establishing a system of regular visits to places of detention, including psychiatric institutions, carried out by independent international and national bodies.

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152 Convention on Human Rights and Biomedicine. Article 1. http://conventions.coe.int/treaty/en/treaties/html/164.htm

153 See: http://conventions.coe.int/Treaty/en/Treaties/Html/163.htm

To the Ministry of Health:

1. Adopt a new mental health law. Latvia does not have adequate mental health care legislation. The chapter on psychiatry in the existing law on Medical Treatment is not in compliance with relevant international human rights standards. Moreover, due to lack of judicial review, Latvian procedures violate Article 5 of the European Convention on Human Rights. To remedy this and other gaps, the Ministry of Health should develop and seek passage of a new mental health law.

2. Ensure civil society participation in the development of the new ministerial strategy on mental health care development. The strategy is currently submitted to the government and will be followed by development of the Action plan. The Ministry of Health should take concrete steps to actively involve human rights NGOs, professional associations, and consumer organizations in preparing an action plan for the new Mental Health policy.

3. Create a mechanism to ensure the right to a review/second opinion. Currently, psychiatric hospital or social care home residents (or those in the process of being involuntarily committed) do not have the possibility to apply to independent experts/psychiatrists in order to seek a second opinion or to appeal to a decision made by a psychiatrist.

4. Develop regulations on the use of restraints and isolation rooms. LCHR monitoring team noted that each psychiatric hospital has their own understanding and practice of documenting the use of restraints and isolation. Staff in several hospitals mentioned the lack of clear rules regarding isolation and use of restraints.

To the Ministry of Welfare:

1. Develop regulations for isolation and restraint use. The new law on Social Assistance and Social Services allows for social care homes to have isolation rooms. Several care homes are also regularly using physical restraints. However, there are no detailed MoW regulations detailing what an isolation room should look like, what kind of documentation is required to confine a resident to such a room, who may make decisions regarding the use of physical restraints, how long restraints can be used, and so on. In developing such guidelines, the Ministry should consult with stakeholders, including the State Agency of Mental Health, which has similar experience in this field.

2. Implement the recommendations made following the 2002 evaluation of social care home clients. According to European standards, a facility with 30 places is an institution.[154] Latvia has not made sufficient efforts to phase out facilities of this size. In 2002, the MoW undertook an evaluation of residents of all care homes to discern how many could live in the community and with what level of support. The Ministry has not taken adequate steps to respond to the results of this study.

3. Social care homes should have adequate rehabilitation and occupational therapy programs.

4. All deaths should be investigated. As a matter of policy, as opposed to on an ad hoc basis, there should be an autopsy of all cadavers, and a comprehensive investigation should be carried out.

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[154] See the report and recommendations from „Included in Society", Results and Recommendations of the European Research Initiative on Community –Based Residential Alternatives for Disabled People, EC project report.

5. Strengthen cooperation with NGOs. The Ministry should increase its interactions and support of NGOs. This could include the development of a small-grants program to support self-help groups or psychiatrically and intellectually disabled persons.

6. Strengthen links with other Ministries, particularly the Ministry of Health. The Ministry should work actively to erode the dichotomy between those who fall under the tutelage of the MoH (primarily persons residing in psychiatric hospitals) and those residing in social care homes.

To the Ministry of Justice:

1. Train judges, prosecutors, and other MoJ staff in the procedures for involuntary hospitalization.

2. Establish legal protections for commitment and treatment consistent with European standards. Ensure the right to review by an independent judicial authority and access to a lawyer before a trial or hearing begins. In addition, ensure that in cases of defining someone as legally incapable, the person in question has the right to a fair trial, meaning that he/she has the right to participate in the court hearing and to receive and appeal the court' s judgement.

3. Restrict the naming of social care home staff as legal guardians. In cases where there is no family member to act as guardian, the MoW has suggested naming social care home staff as guardians. However, this could engender conflicts of interest, and should be avoided. The Child Custody Court should monitor guardianship relationships where this is currently the case. The Ministry should dedicate resources to reform of the guardianship system, such as declaring fewer people incapacitated, hiring professional guardians, and introducing the concept of partial guardianship.

To Local Municipalities:

1. Begin planning for assuming control of social care homes (taking over responsibility from the national government). Municipalities should decrease the size of these social care homes by establishing community-based services, increasing cooperation with the health and social welfare sectors, and training additional social workers. The Vidzeme program for social integration can be used as a model for coordinating health and social care services in order to respond to the needs of each individual client with mental or intellectual disabilities.[155]

To Psychiatric Hospitals:

1. Operationalize the right to informed consent. The LCHR monitoring team saw few cases where residents of hospitals were able to say that they had been briefed and accepted their treatment. Hospitals should ensure that all residents have the opportunity to speak to a psychiatrist (as opposed to a nurse), hear and ask questions about their treatment, and refuse treatment.

2. Develop individualized rehabilitation plans for all residents.

3. Ensure the support for users' activities. In some psychiatric hospitals, there is good support from administration for users' activities. The experience of Akniste Psychiatric Hospital in a work with Patients' Council can be consulted.

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[155] The program in Latvian is available on the web page of LCHR - http://www.humanrights.org.lv/html/lv/jomas/garigi/28616.html

4. Ensure that patients' rights information is available. LCHR has noted that one of major complaints from hospitalized patients is a lack of information regarding their rights and where to turn for assistance. Since currently there are no materials produced on mentally ill rights by state, ensure that information leaflets produced by NGOs are accessible.

LITHUANIA

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Mental health care reforms since USSR

The objectives of Lithuania's health care system are to create and implement health care policy that will ensure public health, high quality of health care services and the rational use of resources based on health insurance and the right of permanent residents to free basic treatment, as well as the right of the patients to choose their doctor or a medical establishment[156].

In the case of Lithuania, as well as of other post-communist states, a difficult threefold task is emerging in the reform of mental health care[157]:

1. Firstly, difficulties in the transitional period, experienced in the last decade of the 20th century, revealed a very unfavorable mental health situation, which is expressed through high suicide rates, the prevalence of alcoholism and a sharp increase in the number of drug addicts.
2. Secondly, the model of psychiatric care was inherited from the previous system, which was mostly based on the isolation of persons with mental disorders. This model reflects the attempts of the closed society to ignore severe mental health problems and also reveals strong discriminatory tendencies towards mental health patients, treating them as dangerous people for the society.
3. Thirdly, there is resistance to the approach that mental health problems are problems of communities and modern public health efforts are needed to solve such problems. These attitudes are predetermined by habitudes or myths about mental disorders and mental patients. Financial constraints faced by municipalities, lack of social support, and traditions at the local-community level also are important factors.

Since 1989, four stages can be distinguished in efforts to create a modern mental health care system relevant to international standards:[158]

1. The first stage (1989-1993) is described as the period when severe problems hidden by Soviet ideology were disclosed. New mental health services, NGOs, and professional associations were established in the early 1990s. Identification of newly emerging mental health problems and increasing prevalence of suicides, violence, and substance abuse attracted attention from governmental and nongovernmental sectors.
2. The most important achievement of the second stage (1994-1996) was the Law on the Mental Health Care adopted by the Lithuanian Parliament (Seimas) in 1995. The foundations for reforms in the mental health care system, prevention of mental illness, and proper use of psychiatry were laid down in the law.
3. In the third stage, from 1997 to 2000, a few steps towards the formation of the state mental health policy were achieved: the State Mental Health Center was established; the State Program on Prevention of Mental Disorders was adopted; and the State Mental Health Commission was established. The National Health Board also paid a lot of attention to mental health issues. In 1999, the board prepared the strategic proposals on the development of the mental health care system and the prevention of mental disorders. During this period, several attempts to introduce the institution of the General Practitioner (GP) were made. Hundreds of physicians, who formerly have been

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[156] www.sam.lt

[157] International mental health policy, programs and services project. Country profile Lithuania. Issues to consider in the assessment and further development of mental health policy, programs and services.

[158] International mental health policy, programs and services project. Country profile Lithuania. Issues to consider in the assessment and further development of mental health policy, programs and services

working as internists or specialized care providers (i.e. pediatricians) in state polyclinics, were trained in diagnostics and treatment of most prevalent ill-health conditions (including mental disorders) in the general population. Part of them used loans from the World Bank and opened relatively small private group practices; however, in reality they very rarely provide services for mentally ill patients. With the development of mental health care centers at the primary care level, the amount of services for this target population has been constantly shrinking. This is also due to the financing of primary care, where all mental health care budgets pay for specialized primary mental health care teams, rather than for GPs.

4. When WHO issued its annual report, "Mental Health: New Understanding, New Hope," a new period in mental health development started, both at the international and national level. Mental health became a main part and priority within the public health system. After WHO's Helsinki conference in 2005, Lithuania started developing its National Mental Health Strategy. Its aim is to create a mental health system that would effectively and rationally strengthen public mental health and provide overall support to persons with psychiatric and behavioral disorders.

One of the most important components of mental health reform, indicated in the Law on Mental Health Care, is the establishment and development of mental health care centers at the local (municipality) level. Nowadays, such mental health centers based on teams of specialists are operating in the majority of municipalities. Currently, 65 (including two private ones)[159] mental health centers are functioning in Lithuania. Outpatient services in these centers are provided by psychiatrists (some of them do have licenses for treatment of people with chemical dependencies), child and adolescent psychiatrists, social workers, psychologists, mental health nurses. Although the number of psychiatric and child psychiatric beds is slowly increasing in general hospitals, the majority of stationary psychiatric services are still provided by specialized psychiatric hospitals, where treatment conditions improved.

There are still significant problems among people with chronic mental illnesses. It continues to be difficult to find an alternative for the traditional place, inherited from the previous system (long - term isolation in social care homes). Reintegration of mental patients is encumbered by the lack of social rehabilitation traditions in the community, and to the absence of inter-sectorial collaboration crucial to achieving good results in the field. It is important to acknowledge the fact that even after investments had been made in the early treatment of the disorders, the immediate effect is hardly expected. Such investments include the establishment of a network of psychosocial services at the community level and education of specialists at the primary level (teachers and general practitioners) as to how to work with problematic children.

Legal and policy analysis of mental health care and social care systems in Lithuania

Mental health care

Overall Organizational Structure of Health Services

In Lithuania, the health care system is organized on national (state), regional (counties) and local (municipality) levels and health care services are provided on primary, secondary and tertiary health

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[159] Data from the State Mental Health Center website accessed at http://www.vpsc.lt/centrai2.html

care levels. Secondary health services (inpatient care and specialist outpatient care) by law are under county administrations; but, in reality, most municipalities continue to run both hospitals and policlinics with a mixture of primary and secondary outpatient care. The chief institution of the county organizes secondary personal and public health care while the dimension and character of activities is regulated according to the Ministry of Health. The Ministry of Health and other respective state institutions under its supervision (e.g. State Mental Health Care Center) execute and organize the personal and public health care activities of the State. Health care institutions of the tertiary level are certified by the Ministry of Health. They can provide primary and secondary health care services only for the purpose of the science and training. The specialized health care institutions established by the Internal Affairs and Defense Ministries are organizing personal health care services independently.

In Lithuania, certain legal mechanisms exist foreseeing health activities management, coordination and control subjects and their competencies (since Government and the Ministry of Health represent the national level, county physician, the regional level, and the municipality physician, the local level), there economic mechanisms also exist anticipating peculiarities of health activities financing and regulation; however, the respective mechanisms are not developed well enough yet[160]. Budget allocation in the past was controlled more on the local level. However, after the recent move towards a single payer insurance scheme, changes are developing in the control of health care budgets. The licensing process has traditionally been centralized, but it is moving towards control at the local level. Price setting is also very centralized. The Ministry of Health has maintained control over this aspect of the system.

Currently, in Lithuania, there are 10 administrative units (counties) and 60 municipalities. The majority of health care institutions are public, i.e. non-profit institutions. The Ministry of Health is responsible for the general supervision of the health care system. It also prepares legal documents in the field of health care. Maintenance and development of tertiary level health care institutions are also under the competence of the Ministry of Health.[161]

Legal analysis of mental health care system

All fundamental human rights are specified in the Constitution of the Republic of Lithuania.[162] The Constitution provides that the person shall be inviolable; human dignity shall be protected by law. It shall be prohibited to torture, injure, degrade, or maltreat a person, as well as to establish such punishments. No person may be subjected to scientific or medical testing without his or her knowledge thereof and consent thereto. All people shall be equal before the law, the court, and other State institutions and officers. A person may not have his rights restricted in any way, or be granted any privileges, on the basis of his or her sex, race, nationality, language, origin, social status, religion, convictions, or opinions.

Article 53 of the Constitution of the Republic of Lithuania specifies that the State takes care of people's health and guarantees medical aid and services in the event of sickness. The Law provides free medical aid to citizens at state medical facilities. Health care of persons with disabilities is carried out according to the functioning health care system with mental health care being a part of it, within the framework of the functioning system of determining disability.[163] The Law on Social Integration of People with Disabilities 2004 specifically indicates, that "in order to secure equal opportunities of persons

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[160] International mental health policy, programs and services project. Country profile Lithuania. Issues to consider in the assessment and further development of mental health policy, programs and services

[161] International mental health policy, programs and services project. Country profile Lithuania. Issues to consider in the assessment and further development of mental health policy, programs and services

[162] The Constitution of the Republic of Lithuania//State News. 1992, No. 33-1014

with disabilities within the sphere of health care, the health care services to the persons with disabilities are provided of the same level and within the same system as for other society members."[164]

The health care system in Lithuania is regulated by a number of different laws and other legislation. Most of them are of a general nature and encompass the health care of all Lithuanian residents, including persons with disabilities. The Law on Health Care System[165] establishes the entire Lithuanian national health care system and the main principles of its organization and functioning. The Law on Health Care Institutions[166] (1998 edition) establishes the qualifications of health care institutions, requirements for their licensing, activity, basis of state regulation, control mechanisms, intercourse between health care institutions and patients, grounds of liability for breach of laws, etc.

Psychiatric hospitals are currently the main health care institutions that provide in-patient services for persons with mental disability. Psychiatric hospitals, like all other health care institutions, have the right, in accordance with the procedure set by laws and other legislation, to provide health care services only when they have received their license and have registered with the State Health Care Institutions Register. The Ministry of Health of Lithuania is responsible for the licensing of institutions and maintains the register. Following national laws and international standards, the Ministry of Health regulates the different medical and hygienic norms, health care methodologies, etc., of these institutions.

The Lithuanian Law on Health Insurance[167] was approved in 1996 (new addition is in effect from 1 January 2003). It foresees a compulsory health insurance for all permanent residents in Lithuania, independent of their citizenship. This compulsory health insurance is executed by one state institution – the State Patients' Fund (SPF). Visits to the doctor, treatment at the hospital (including medicine) and rehabilitation (physical rehabilitation or treatment programs in sanatoriums, but not psychosocial rehabilitation) are completely compensated from the Compulsory Health Insurance Fund. Depending on the health status and disability group[168] (working capacity) level established, expenses of basic prices of medicine and means of medical care, as well as basic prices of medical rehabilitation and sanatorium treatment are compensated fully for persons with no working capacity established, and partially for persons with partial working capacity. In 2003, the SPF spent 158,8 Euro on average per one insured person. Those who are not insured may apply only for a necessary medical aid. Such persons should pay for other services under the prices set by the Ministry of Health. An additional private health insurance is foreseen in the Health Insurance Law; however, it is still not popular in Lithuania and is used only by a small part of the population with high income.

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[163] Until recently the Law on Social Integration of People with Disabilities 1991 (this version of the Law was valid until 1 July 2005) established the functioning system of determining disability. The Law regulated the establishment of disability, medical, vocational and social rehabilitation for disabled persons, the adjustment of conditions for the disabled, as well as the development and education of the disabled. Disability establishment procedure was based on medical evaluation criteria not taking into account the loss of the capability to work and income and the possibility to apply rehabilitation measures. The disability assessment procedures for adults (age 18 and over) established an individual's disability according to one of three disability groups, I, II or III. Indicated group of disability provided the right to receive state social insurance and other pensions, benefits, privileges. Disability is established in accordance with medical evaluation criteria not taking into account the loss of the capability to work and income and the possibility to apply rehabilitation measures.

[164] The Law on the Social Integration of People with Disabilities, No. IX-2228//State News, 2004, No. 83-2983, (hereafter, Law on Social Integration 2004).

[165] Law on Health care system. New edition of 1 December 1998 No. VIII-946//State News, 1998, No.112-3099

[166] Law on Health care institutions. New edition of 24 November 1998 No. VIII-940//State News, 1998, Nr. 109-2995

[167] Law on health insurance. New edition 3 December 2002, No. IX-1219//State News, 2002, No. 123-5512

[168] According to the Law on social integration 2004 instead of disability group individual's working capacity (graded in percentage) is established, when the person is considered as having no working capacity (0-25 percent of working capacity), having partial working capacity (30-55 percent) and full working capacity (60-100 percent).

The rights of individuals who enter the health care system are regulated by the 1996 Law on the Rights of Patients and Compensation of the Damage to their Health (revised edition is in effect from 1 January 2005).[169] The Law provides patients with the following rights: the right to accessible health care, the right to select a physician, nursing staff member, health care institution, the right to information, the right to refuse treatment, the right of complaint, and the right to inviolability of Personal Privacy. In addition, the law establishes the rights of patients and the procedure of assessing and compensating the damage inflicted on their health. New amendments[170] to the law, which came into effect in the beginning of 2005, focus on compensation for damage endured during the provision of treatment or services. Compensation is based on the culpable actions of healthcare specialists[171] and the actions of individuals conducting examinations who do not comply with biomedical research standards.[172] The law particularly stresses the importance of the patient's choice and consent to his/her treatment.[173]

There are some laws that provide the priority of medical help for persons with disabilities. The Law on Mental Health Care[174] of the Republic of Lithuania adopted in 1995 is aimed at regulating the procedure and control of mental health care, as well as the rights of persons within the mental health care system. The Law on Mental Health Care insures mentally ill patients of all political, economic, social and cultural rights and non-discrimination on the grounds of mental illness. The State must provide mentally ill persons with possibilities for development, help them acquire work skills, change their qualifications, rehabilitate and return them into community life. This law also establishes the rights of hospitalized patients to communicate with other persons (including other patients); freedom of access to all means of communications; to receive, in private, regular visits from their representatives and other visitors; to study and expand their knowledge and to take part in activities suited to their social and cultural background which are aimed at promoting rehabilitation and reintegration in the community, etc. Patients have the right to receive appropriate, accessible and suitable health care. The conditions of a patient's mental health care at the time of his/her hospitalization must not be inferior to the treatment and nursing conditions of any person being treated. The administration of a psychiatric hospital is responsible for the implementation of the rights of its patients. Specific patients' rights may be restricted on the psychiatrist's decision only in the event of a real threat to the patient himself or to others and in other cases established by laws of the Republic of Lithuania. The patients have a right to access their medical information and all medical documents. Patients have the right to refuse treatment; no treatment shall be given to a patient without his consent (to the minor - without the consent of one of the parents or guardians). This right may be restricted in cases when involuntary hospitalization is needed, also when mental health care services are provided for convicted persons with mental health problems.

In-patient hospitalization is the last resort for a person's health care. A patient can be admitted to the in-patient institution in accordance with the recommendation of

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[169] Law on the Rights of Patients and Compensation of the Damage to their Health, 3 October 1996, No. I-1562//State News, 1996, No.102-2317.

[170] Law on the Amendment of the Law on Patients Rights and Compensation for the Damage Caused to the Health, No. IX-2361//State News, 2004. No. 115-4284.

[171] Healthcare institutions and relevant staff are deemed at fault when a patient's health is partially or fatally impaired as a result of failure to comply with legal regulations governing provision of health care services and treatment and/or in the methods used for diagnosis and treatment. Healthcare institutions and relevant staff are further at fault when a patient's health is impaired due to deliberate actions of health care providers which may not necessarily violate legal requirements and/or when healthcare providers have been negligent in their duty.

[172] The respective law issued on 13 July 2004 amended the Law on Ethics of Biomedical Research by focusing responsibility on the technician conducting biomedical research for liability in physical damage due to impairment or death and moral damage resulting from the research, unless evidence shows that the damage occurred to reasons unrelated to the biomedical research or the deliberate actions of the examined person.

[173] Lithuanian Mental Health Policy: shifting from deinstitutionalization towards community integration. Vilnius, 2005.

[174] Law on Mental health care, 6 June 1995, No. I-924//State News, 1995, No. 53-1290

the psychiatrist. The patient has to be informed about his rights within the institution, goals of hospitalization, the right to leave the institutions and potential incidents when this right is restricted. The Law on Mental Health care specifies cases when an involuntary hospitalization which restricts person's freedom is legitimate. A person who has a severe mental illness and refuses hospitalization may be admitted involuntarily to the custody of the hospital only if there is real danger that by his/her actions, he/she is likely to be a physical danger to him/herself or to others.

The Civil Code that is upper-level law also describes a third possibility for involuntary hospitalization of a mentally ill person and that is when the person's behavior may constitute a damage of property. In such cases, the patient may be involuntary hospitalized and treated within the psychiatric institution not longer then two days without the permission from the court. The Administration of psychiatric institutions must immediately inform the representative of the patient about the involuntary hospitalization. After the patient's involuntary hospitalization, the Administration is obligated to approach the court no later than within two days. If, within two days, the court does not issue permission to hold the patient, involuntary hospitalization and treatment must be discontinued. The court, after considering recommendations provided by psychiatrists, is entitled to issue a decision of involuntary hospitalization and treatment of the patient, but not longer then one month from the beginning of such hospitalization.

In a case when the patient's involuntary hospitalization and treatment must be prolonged, the Administration of the respective psychiatric institution has to approach the court due to the prolongation. According to the conclusion provided by the psychiatric institution, the court may discontinue or prolong involuntary hospitalization and treatment, but no longer than for 6 months at a time. Depending on the recommendations of the treating psychiatrist, the Administration of psychiatric institutions is entitled to suspend involuntary hospitalization and treatment earlier.

Upon involuntary hospitalization, the patient has to sign that he is informed by the Administration of psychiatric institution about his involuntary hospitalization and his rights within the institution. If the patient refuses or is not able to sign, his conveyance about involuntary hospitalization is confirmed in written by two witnesses, who may be from psychiatric institution personnel, but not psychiatrists. A person's hospitalization provided in breach of these requirements is illegal. The patient or his representative shall have the right to appeal to the Administration of the psychiatric institution, the Ministry of Health or the court against the conditions of health care or any violations of his rights. They shall have the right to be present and to be heard by said Administration, the Ministry of Health and court when the issues concerning his involuntary hospitalization, treatment, etc. are being decided.

Care for persons with mental disorders who committed crimes and were acknowledged legally irresponsible, are brought from all over Lithuania for treatment in the special forensic psychiatric hospital in Rokiskis (North-East corner of Lithuania). This hospital jurisdiction is responsible directly to Ministry of Health. Aftercare procedures are not well-described in Lithuanian documents; therefore, many inpatients face prolongations of hospitalization just because there are not any community services able to care for them after discharge from Rokiskis psychiatric hospital. In addition, the Administration of psycho-neurological pensions are not taking responsibility for these people, even though they do not have their home in the community.

The separate requirements and procedures for the provision of psychiatric and psychotherapy services to children, teenagers and adults, and the tariffs of payment for services are approved by orders of the Minister of Health of the Republic of Lithuania.[175] The average treatment period (in days) of services of secondary and tertiary levels[176]; the cost of one day at the hospital[177] and the basic treatment price depending on the profile of the treatment of the illness are separately approved.[178] Each in-patient psychiatric institution is financed in accordance with these norms depending on the profile of the hospital (the number of beds, patients accepted and treatment services provided).

The organization and functioning of mental health centers are regulated by the 1996 Government Order on confirming the Regulation of Mental Health Care Center.[179] They are accredited by the State to provide mental health care and social support to patients with mental health problems and other persons.
On 18 March 2003, the Government of the Republic of Lithuania approved the Strategy for the Restructuring of Health Care Institutions,[180] that had the main goals of: reforming the quality and accessibility of health care services; coordinating an optimum range and structure of services provided with the needs of residents' health care services, while restructuring the network of health care institutions and forming an effective relationship of county and municipal health care institutions in order to increase the work efficiency of all health care institutions.

National Policy

Insights of reforming mental health

Policies of health, mental health, and social affairs are developed and implemented according to the following factors:
a) Stakeholders lobbying;
b) Common sense or intuition; and
c) Evidence based mental health policy formulation and development.

In Lithuania as well as in other countries in the region, the first two factors are traditionally the major ones. The lobbying of stakeholders affects the administrators of traditional centralized institutions who usually have a huge influence on policy decisions and try hard to increase the weight of their institutions in policy making. This fact definitely is opposite to the idea of deinstitutionalization. Common sense or intuition is based on historical principles and the long tradition of stigmatization; e.g. common sense dictates specific terms to the whole society and to politicians who make decisions. It argues that the current situation should remain as it is; i.e., people with mental health problems should be treated or nursed in specialized institutions, since any reforms may cause huge problems. Common sense is against change, especially when we are talking about resistance to the change of paradigm.

Our case reform is closely connected to changes of paradigms: instead of taking a paternalistic approach to the care of people with mental health problems, suppressing their autonomy, the new paradigm suggests helping them learn to live as independently

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175 Order of the Minister of Health on the Requirements of the Principles of Organizing of psychiatric and psychotherapeutic services for Children and Teenagers, their Description and Provision 14 December 2000 No. 109-3489.
176 The average length of treatment in year 2005 was 29,4 days (in year 2002 it was 33,3 days)
177 The the cost of one day at the hospital according to levels: secondary level is 87,70 Litas (25,4 euro); tertiary level is 105,70 Litas (30,60 euro).
178 Order of the Minister of Health on the list of the inpatient health care services and basic prices, funded from the obligatory health insurance fund // State News, 2006 04 27 No. 338.
179 Regulation of Mental health care center of 9 February 1996 No. 234//State news, 1996 No.15-399.
180 Strategy for restucturization of Health care institutions of 18 March 2003 No. 335//State News, 2003, No. 28-1147

and self sufficiently as possible because the people themselves as well as the whole society will gain from it. Common sense is very mistrustful in this case.

The third factor is evidence-based knowledge. Until now, in our state (and in the states of our region) there is no tradition of research systems using objective methods and making independent conclusions about their effectiveness. This shows that the area of system research is not encouraged and is even blocked by hospital administrations, who are interested in preserving the existing infrastructure of services. For example, international mental health policy, programs and services projects, made according to international scientific recommendations and the questionnaire "Country Profile"[181] was very criticized by the former leadership and officials of the Ministry of Health in 2002-2003.

The unfavorable context distinguished by many stigmatizing, discriminating attitudes and tendencies towards corrupt mechanisms creates a situation in which new financial resources do not determine the clear indicators, based on science, but, rather, the statistics of the process related to the quantity of services. Until now, the public statistics dominate data about the process (how many beds, psychiatrists, medicine, etc…) without considering if those services increase or decrease autonomy of the patients, their self-sufficiency and quality of life. There are no indicators that clearly monitor and show if the current processes and investments increase or decrease social exclusion.

Lithuania is different from other countries by the very improved conditions in the psychiatric hospitals and social care homes. It is evident that many investments were made. The quality of the residents' lives has increased. Such investments can be justified if a decision is made to remain with the current system of institutions. However, we can assume that this successful investment in the system blocks the development of an alternative system of community based services because there are no financial resources left and because of the society's belief in these institutions, shown by the fact that there are long waiting lists for entrance. We can identify here a vicious circle: the more that is invested in the current unreformed system, the more difficult it will be to implement the process of deinstitutionalization.

Mental health policy development

Main principles and priorities of a new Lithuanian mental health policy are the following:

- Centrality of mental health as a strategically important component of public health and general health services;
- Priority of mental health promotion/prevention activities;
- Human rights in mental health;
- Development of a spectrum of community based mental health services;
- Restore a healthy balance within the biopsychosocial paradigm;
- Promote and implement a principle of users' autonomy and participation;
- Develop a new system of funding of mental health services with effective incentives for deinstitutionalization, involvement of primary care and intersectorial cooperation;
- Develop a system of continuous evaluation and monitoring of indicators of public mental health and system performance;
- Be proactive, also in the activities of the European Union.

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[181] As a part of international mental health policy, programs and services project, "International mental health policy and services development" the "Country profile" instrument was used for assessment of mental health policy and services in the Republic of Lithuania.

Lithuania is one of the leading countries in drafting its modern National Mental Health Strategy, based on new priorities and values putting mental health in the center of general health care. This follows the European mental health development trends from the Declaration and Action Plan on Mental Health for Europe 2005, WHO, and the European Commission Green Paper Promoting the Mental Health of the Population towards a Strategy on Mental Health for the European Union 2005. Basically, these positive developments can be explained by active participation of the stakeholders, especially open minded professionals, and NGOs working in the field of mental health.

The main principles within the Strategy are the following: human rights, modern services meeting users' needs; sustainable development of a bio-psycho-social model; promotion of autonomy and participation; treatment of minor mental health disorders in non-specialized health care services; mental health strengthening and prevention of mental disorders; and strengthening of the roles of users and NGO sector.

Social care

The program for development of a social services infrastructure[182] from 1998 proclaimed that the main policy trend of social services is the decentralization and development of ambulatory (community) services. Since 2002, the Ministry of Social Security and Labour has been implementing reform of the provision of social services. This reform aims at creating legal, administrative, and financial foundations for an effective planning, provision and organization of social services, thereby ensuring basic human needs and encouraging an individual to search for ways of self-help. Social services aim at satisfying the needs of individuals and creating living conditions that do not debase human dignity, when the individual himself is incapable of accomplishing this. Social services are divided into general and special social services. General social services are provided to help persons with disabilities to live independently at home and in the community. Special social services are provided for in-patient care, out-patient care institutions and rehabilitation institutions: day care institutions, temporary residence institutions, in-patient care and nursing institutions and institutions of mixed services. They may be provided when general social services are ineffective.

The main task for the social care homes is to provide social care services to those people who cannot fend for themselves, including temporary or permanent residence for the disabled who are in need of care, nursing, and who cannot live in their homes independently.

Structure of administration of social care

Different institutions share responsibility for the administration of inpatient social services in Lithuania. The sphere of competence of the Ministry of Social Security and Labor covers the issues of social integration of the disabled, financial social support, social services, employment and social insurance. The founders of the institutions of social services are county governors, municipalities, and non-governmental institutions. Municipalities, which are responsible for the provision of social services to the disabled persons residing in their territories, act as the main organizers of social services in a community.[183] Persons are sent to the in-patient care institution only with the recommendation of the founder if according to the type and degree of the disability, as well as age and other criteria, correspond to the profile of the institution.

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[182] Government decision on approving of the program for development of social services infrastructure 1998-2003//State News, 1998, No. 19-478

[183] www.socmin.lt

Counties are responsible for implementing the policy of social integration of the disabled in the spheres of social maintenance, education, culture, sports, and health care. They also carry out national and regional programs. Municipalities are responsible for carrying out public administration and for the provision of public services for all individuals who reside in the municipality's territory, including the disabled. Municipalities are obligated to ensure the discharge of the functions assigned to them by virtue of laws with regard to the disabled: organization of general education for the disabled children, youth and adults; provision of social services and other social support to the disabled; creation of conditions for the integration of the disabled into the community; development and implementation of municipal health programs; and primary individual and public health care.

The Department of Disabled Affairs under the Ministry of Social Security and Labor[184] is established to help implement the social integration policy that corresponds to the needs of people with disabilities. The Department coordinates, monitors, and controls the national program for social integration of the disabled and other measures related to the social integration policy, and administers finances allocated for implementation of the Law on Social integration for disabled.

Non-governmental organizations for the disabled maintain cooperation with the Department of Disabled Affairs and implement the programs of social integration of the disabled according to the priority directions. These organizations are well aware of the lack of certain services and the need for such services; therefore, their programs are aimed at providing assistance to the individuals with the most severe disability through programs of social services, formation of independent life, medical rehabilitation, and availability of communications and information.[185]

National legislation

Social services in Lithuania were legally established in the Social Support Conception adopted by the Government of the Republic of Lithuania in 1994. Social services were identified as one of the three social support forms. Further development of social services to different groups of individuals was set forth in the Law on Social Services of the Republic of Lithuania.[186] A new version of the Law on Social Services was adopted in the beginning of 2006, but will come into force on 1st of July 2006.

On 4 September 1998, the Ministry of Social Security and Labor issued an Order on the development of trends for providing social services at homes and regulations related to the improvement of work efficiency of social care homes[187] that gave the priority for providing social services at homes within the community, and stated that the person must be referred to the social care home only in cases when social services provided at home are not efficient and do not secure the level of independency needed by the individual. Special in-patient social services are provided to children and adults with intellectual disability in social care homes. The Requirements for In-patient Social Care Institutions and the Procedure for Sending Persons to In-patient Social Care Institutions (hereinafter referred to as the Order) were approved by the Order of the Minister of Social Security and Labour on 9 July 2002.[188] The Order regulates the organization of the work of in-patient social care institutions, norms of the personnel, defines the services provided, the rights and duties of residents,

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[184] Until 1 January 2006 Lithuanian Council of the Disabled Affairs under the Government of the Republic of Lithuania was responsible the the affairs of the disabled.

[185] Ministry of social security and labor, The Report on the Lithuanian Social Security System, Vilnius 2003

[186] Law on Social services of 9 October 1996 No. I-1579//State News, 1996, No. 104-2367

[187] Development of trends for providing social services at homes and regulations of increase of work efficiency of social care homes of 4 September 1998, No. 137//State News 1998 No.94-2621

[188] Requirements for In-patient Social Care Institutions and the Procedure for Sending Persons to In-patient Social Care Institutions of 9 July 2002 No. 97//State News,2002, No. 76-3274

requirements for the building of care institutions and environment, acceptance and departure from these institutions and the contingent for accommodated persons. These requirements are applied to care institutions for children, young people, adults and older people with intellectual disability and are mandatory for the in-patient social care institutions established by county governors and local governments. They are recommended to in-patient social care institutions established by non-governmental organizations, religious communities and general communities.

When accepting a capable person into the care institution, an agreement is signed between the person and the authorized representative of the administration of the care institution. The latter must provide the newly arrived person with detailed information about its activities, services, rights of residents, responsibilities and duties, in order to make him/her familiar with the internal procedures. Persons are accepted into the care institutions on a voluntary basis. The resident can leave the care institution for a short period of time (up to three months per year) or for good if he/she is recognized as capable and willing to do so. When releasing a resident, it must be ensured that services will be ensured for him/her in the community; with proper living conditions and the ability to live independently. Residents who are recognized as incompetent or capable to a limited extent may only leave the institution permanently if they are going to live with a custodian or a guardian assigned by the court.

The Order consolidates the provision stipulating that the residents of care institutions must be provided with housing, catering, utilities, personal hygiene support, social work, communication and consultation services. Minimum housing adaptations, catering, etc., requirements are identified. The residents have the right to address the administration of the institution regarding different issues. The procedure for filing complaints and tabling proposals must be established in the care institution. The residents must be provided with the possibility to safely keep their personal belongings and money and enjoy their privacy. The resident has the right to become familiar with all documents related to him/her, which are kept at the care institution.

The strategy for reorganization of state social care institutions 2002[189] foresees the trends of reorganization of state care institutions for 2003-2008 year. The necessity for such reorganization is conditioned by the facts, that: according to the data of the Ministry of Social Security and Labor, state care institutions house approximately 30% (this number include both old age persons and persons with disabilities) of people who could live independently receiving social services in community.[190] The majority of state care institutions are overcrowded; the largest having up to 550 residents.[191] Upon implementation of the strategy, it is foreseen that every year the network of social services provided in community will be gradually expanded, the number of places within institutions will decrease, the living conditions and quality of services provided will be improved. It is hoped that, in 2008, the number of residents would not exceed 300 in one institution and not more than four persons would live in one room.[192]

There are requirements for the outpatient social services institutions, adopted in 2003,[193] that establish

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[189] Order of the Minister of Social security and Labor on approval of the Strategy for reorganization of state social care institutions 2002//State News 2002, No.: 71-2991.

[190] Lithuanian Mental Health Policy: shifting from deinstitutionalization towards community integration. Vilnius, 2005.

[191] Items 5.2, 5.3, 5.4. Order of the Minister of Social security and Labor on approval of the Strategy for reorganization of state social care institutions 2002//State News 2002, No.: 71-2991.

[192] Despite of the decrease of the total number of places in state social care institutions from 5363 on the 1 January 2004 to 5359 on 1 July 2004 and to 5316 on 1 January 2005, the total number of individuals residing in institutions is yet not decreasing but balancing between 5348, 5344 and 5349 accordingly. Data received from Department of Audit and supervision of social establishments, accessed at website http://www.sipad.lt

[193] Order of the Ministry of Social security and labor on Requirements for the outpatient social services institutions//State News 2003, No. 43-1990

minimal standards for such outpatient institutions where the main activity is social work and the provision of social services.[194] The description of such institutions, requirements for personnel, social services, buildings, rights and obligations of clients are included. Though the trend for decentralization of institutions and the provision of social services within the community was proclaimed in 1998, only in 2005 was the definition of independent living homes included in the Catalog of Social Services,[195] to house old age persons or people with disabilities not requiring intensive social care services, and who are able to live independently, only with part time support of social worker.[196]

Statistics

Expenditure on health as percentage of GDP in 2002 was 5.75% (in 1998 it was 6.2%). The number of psychiatrists per 10,000 population is 1,6 (in 1999 – 1,3).[197] In 2002, there were 556 psychiatrists working (in contrast to 1996, when the number was 505; in 1997, 527; in 1998, 519; and in 1999, 488).

According to data of the State Mental Health Center, in 2002, there were 11 psychiatric hospitals in Lithuania. Admissions per population in psychiatry are 10,5 per 1000 population. Bed occupancy is 296,3, average length of stay in psychiatric hospital is 32,4 days, bed turnover is 9,1. In 2002, there were 3816 beds in psychiatry, i.e. 11,0 per 10,000 population. Percentage of deaths is 0.39%. Registered in outpatient clinics per 1000 population (adults) in 2002, mental and behavioral disorders had an incidence of 24,9 and prevalence of 76,5.

The most comprehensive official data on people with disabilities comes from the 2001 population census,[198] where it was reported that there were 22,121 people with mental disabilities in Lithuania.[199] [200] A total of approximately 19,584 adults with disabilities indicated that the main cause of their disabilities was mental (or 7.4 per cent of all adults with disabilities).[201] The majority of these (67.5 per cent) were diagnosed as being in disability group II. A total of 2,537 children (18.6 per cent of all children with disabilities) indicated mental disabilities.

Statistics from the State Mental Health Center indicate a higher number of people with mental disabilities in Lithuania than was indicated in the 2001 Census. According to the center, the number of people of all ages with established mental disabilities has gradually increased over the last decade, from 18,937 in 1990 to 28,697 in 2003, and 31,201 in 2004.[202] According to the data from the Ministry of Social Security and Labor, the total number of disabled persons receiving disability pensions for 2002 was 221,577 (in comparison with 2001, this number increased by 4.1%). There were 31,351 people designated as having a disability for the first time in 2002. Out of this group, approximately 2,540 people, or 8.1 per cent of the total, had mental disabilities as their primary disability.[203]

A significant portion of people with mental disabilities permanently live and are treated in social care homes. Recently, all counties together own 22 state social care homes for adults and three for children and

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194 Requirements are applied to such types of institutions: establishments for day social services (family support centers, day social care centers) and temporal living establishments.

195 Order of the Minister of Social security and Labor on approval of Catalog of Social services 2000//State News 2000, No. 65-1968.

196 Item 19-1. Amendments to Social services Catalog 2005// State News, 2005, No. 15-481

197 http://www.lsic.lt/html/en/lhic.htm

198 Department of Statistics, results of the 2001 Population and Housing Census, available in English and Lithuanian on the website of the Department of Statistics at http://www.std.lt (accessed 23 September 2004), (hereafter, 2001 Census).

199 Department of Statistics, Information circular No. 2, 20 November 2003 (hereafter, Department of Statistics, Information circular No. 2)

200 According to the 2001 census, Lithuania's population in 2000 was 3,620,756 people.

201 The total number of persons with disabilities was 263 thousand, and constituted 7,5 percent of the total population of Lithuania. 2001 Census; and Department of Statistics, Information circular No. 2.

202 Information from the website of the State Mental Health Center, available at http://www.vpsc.lt. The State Mental Health Center was established in 1999 by the Ministry of Health Care. The Center organises the implementation of mental health care policy and strategy.

203 Ministry of Social Security and Labor, Social Report 2002, Vilnius, 2003.

young people under the age of 21 with intellectual disabilities.[204] A comparison of two years reveals that:

- On average, for every 10,000 people, there were 14,6 places in social care homes as of 1 January 2004 and 15,3 places as of 1 January 2005.[205]
- On 1 January 2004, there were 5348 adult residents in state social care homes; by 1 January 2005, there were 5349 adults (2882 male and 2467 female) in these homes and 659 children (373 boys and 286 girls).[206]
- On 1 January 2004, 1553 (29%) adults received intensive nursing services and the figures for similar services were 1407 (26.3 %) adults and 244 (37%) children as of 1 January 2005).[207]
- On 1 January 2004, 638 residents had restricted capacity; and 697 adults were in this category on 1 January 2005.

Out of the residents in social nursing homes, 18% could live in the community.[208] The number of places in state social care homes according to counties (as of 1 July 2005) is:[209]

1. Kaunas – 382
2. Klaipeda – 540
3. Marijampole – 706
4. Panevežys – 811
5. Siauliai – 987
6. Taurage – 200
7. Telsiai – 476
8. Utena – 515
9. Vilnius – 690

Main violations of human rights of people with mental illness and intellectual disability

There are a number of NGOs working in the field of mental health; however, some legal aspects in monitoring and protecting human rights of people with mental disabilities still need to be addressed. The monitoring project is aimed at specifically highlighting human rights violations of people with mental illness and intellectual disability in closed institutions. Within the monitoring project, the following human rights violations could be distinguished:

- The right to information is subject to regular violations – the quantity of information received by residents of social care homes often depends on the goodwill of individual staff members and their knowledge about human rights of the residents. Questions of the residents are normally answered, but the answers are usually confined to minimal information. Formal in-home mechanisms of complaint review do not ensure enforcement of the right to lodge complaints and to receive answers thereto. Though the law obligates staff members of psychiatric hospitals to provide the patients with information about their illnesses, information giving has been depending so far on doctors' goodwill and respect for the patients. At present, informing the patient about his/her illness, forecasts, recommended ways of treatment and available alternatives as well as maximal involvement of the patient into decision making is more episodic than the usual practice.

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204 Data provided by The Supervision and Audit Department at the Ministry of Social Security and Labor, available at http://www.sipad.lt/

205 This number increased, since data for 1st of January 2004 showed that for 10 000 population there were 14,6 places in social care homes.

206 This number is increasing, since on 1 July 2004, there were 5344 persons (2865 male and 2479 female) living in social care institutions for adults with mental disabilities. Data received from Department of Audit and supervision of social establishments, accessed at website http://www.sipad.lt/main/index.php?act=menu&id=57.

207. For 1st of July 2004, 1616 (30,2 %) adults and 241 (36,9 %) children had the need for constant nursing. Department of Audit and supervision of social establishments, accessed at website http://www.sipad.lt/main/index.php?act=menu&id=57

208 Mental Health in Lithuania Report of Assessment mission, 16-17 October 2000

209 http://sipad.lt/wt_sip/customfiles/lt/stacionari1.doc

- The right of residents of social care homes for respect of private life is being violated, in essence: their entire lives are public, constantly watched by the personnel and other residents. They rarely have an opportunity to be alone. Their right to make and maintain intimate relations is being violated. In psychiatric hospitals, the right of patients for respect of private life is limited to a maximal extent, and is nearly absolutely absent in acute wards. This right is being violated in terms of adhering to requirements applied to security of personal data of patients, making it impossible for patients to take care of personal hygiene and to use telephones privately, adhering to requirements as to the number of patients in a ward/room, concurrently depriving them of a possibility to be alone.
- Discrimination: Obedient residents of social care homes, actively co-operating with staff members, are encouraged and given privileges inaccessible to other residents. Extremely severe residents are most often exposed to discrimination and placed in the poorest wards. Some patients in psychiatric hospitals, too, are obviously given privileges. Staff members like obedient patients and give them more freedom and privileges not accessible to other patients. For example, obedient patients are allowed to leave the hospital, given keys to bath rooms, allowed to use a mobile phone whenever they want to, given additional allowance of cigarettes or allowed to smoke in an outdoor/indoor smoking room, etc.
- Torture and inhumane behavior: Most frequently met forms of improper treatment of residents by staff members are neglect, too infrequent freedom of movement, psychological, physical, sexual violence against the patients, and staff decision making on behalf of the patients on the issues of their personal life. One of the most brutal violations of human rights in asylums is forced abortion. These cases of torture and inhumane behavior are usually hidden from society. During the research, administrations and staff members also avoided discussion of the issue of interruption of pregnancy or negated the problem at all. Residents in all asylums, on the contrary, specifically named cases of interruption of pregnancy, specified women exposed to such a procedure.

Most psychiatric hospitals don't have a standardised procedure for imposition of physical exclusion, physical or chemical restrictions as well as a mechanism for revocation of the mentioned measures. On the other hand, in hospitals, where the mentioned procedures are officially regulated, a number of shortages in implementation thereof have been detected: requirements for filling in the protocols of restraints are violated; patients are fixated for periods exceeding two hours, personnel don't take care of the patients during fixation thereof, the patients are left unattended for several hours; no contacts are kept with the patients during the fixation, measures with chemical effect are always applied in parallel to fixation. There are cases of preventive fixation in order to prevent outbursts of likely aggression. Fixation is also applied as a penalty.

- In principle, the right into ownership is not limited in residential institutions, but cases of violation of this right have been recorded. In psychiatric hospitals, the right into ownership is subject to stricter limitation; there are cases when patients are not allowed to keep personal things that are not dangerous; usage of sanctioned personal things is often restricted.
- The right to education is not given to residents of social care homes. It is difficult to think about reintegration of individuals with mental disorders, when patients treated in psychiatric hospitals for five or seven years have not been educated or trained in a profession or skills necessary for their reintegration to the society. A visit to a children's department in one psychiatric hospital revealed that patients there are not trained at all; no teachers are coming, no classes are held either.
- The right to employment and adequate pay for

work is very rarely provided to residents of social care homes. In most cases, official employment contracts are not made with residents who are employed, no opportunities are sought to employ them, and there is no mechanism to ensure protection from exploitation of residents hired by neighbouring farmers. Only in one psychiatric hospital do patients of a production-rehabilitation department have an opportunity to work and to receive pay, and such employment is not ensured on a regular basis, but only when the hospital gets orders. Other patients are not able to exercise this right.

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RECOMMENDATIONS

To the Lithuanian Government:

1. Take concrete steps toward planning and implementing deinstitutionalization. Treatment of those residing in Lithuania's psychiatric hospitals and social care homes is adequate in many respects. However, by virtue of their institutionalization, thousands of Lithuanians are denied their human rights to education, employment, and social and civic participation. Instead of supporting the expansion of these facilities, the governments need to create day and other support services that will allow residents to return to the community and that will support those currently on social care home waiting lists to stay in the community. While this may require more financial investment in the short-run, in the long-run, costs will be decreased as the government will no longer support so many closed institutions. A few key steps are as follows:

a. Create a detailed timetable for the closure of the biggest psychiatric hospitals and social care homes. Creating a timetable is one important concrete step towards deinstitutionalization. The plan should detail how funds will be transitioned from inpatient to outpatient services, consistent with WHO guidelines. In the absence of clear guidelines outlining funds allocation, the traditional method of allocating resources to in-patient care will likely continue. Emphasis on in-patient care perpetuates exclusion and supports stigmatization of the mentally disabled.

b. Develop a comprehensive plan to establish community-based services that include those with intellectual and psychiatric disabilities, that provide services for those currently residing in institutions, that builds on the support provided by NGOs and families, and that creates community support for individuals without families or in abusive family situations. Given the intersectorial nature of mental health reform and service provision, there is a danger that no entity will clearly take the decision-making initiative, ensure that adequate funds are dedicated to various programming, and ensure that all populations requiring community-based services are included. The Ministries of Health and Social Security and Labour should cooperate to develop a comprehensive plan that clearly delineates responsibility for various elements of community-based service development. Such a plan should include all of the essential components of community-based care support, including physical and mental health care, accommodation, social support, and income and occupation.

c. Strengthening and developing services for mentally ill and intellectually disabled individuals in the community, and a network of informal care givers (particularly – family members) should be supported by:

- Providing "carer – blind" services, including home care, meals, personal care and home nursing, in order to reduce the levels of support expected from family carers;
- Providing respite care services, both home-based and in institutions, in order to give a break for carers;
- Giving payments that reward the work of care – giving, based on assessment of the amount of help required by the care – receiver;
- Organizing "soft forms" of support, such as information, advice, and membership in support groups;
- Recognizing the tensions between care-giving and paid employment, like social security benefits to replace lost income, quasi employment as a paid care-giver, protection from loss of employment –and related social rights.

2. Support with human and financial resources relevant analytical and scientific research. Such research should include independent analysis of existing attitudinal, managerial, and financial obstacles to de-institutionalization and community-based care development. This will ensure that the development of mental health policy is based on a realistic assessment of knowledge and service provision, as opposed to recommendations made by lobbying entities favouring institutionalization or to the biases and stigma held by some policy planners. Scientific analysis of current gaps will also facilitate the development of clear evaluation criteria that can be applied to new community-based programming. Evaluative indicators can look at the quality and effectiveness of services provided, quality of life, human rights protection, and decreased social exclusion and stigma.

3. Establish an independent human rights monitoring body. This body should be financially supported by the state, but functionally independent. It should monitor respect for human rights within institutions and community programs. The body should use international standards as human rights measures, as well as the evaluative criteria developed by government supported research efforts.

4. Improve the prevention capacity of primary mental health centers. These centers were initially intended to be community integration centers that would provide out-patient services. Instead, they have become sites of referral to hospitals and social care homes, as they do not have adequate human and financial resources to provide individual support to clients.

5. Support the development of non-governmental community support systems. The government should financially and otherwise support the development of peer support groups, user advocacy organizations, and other NGOs. Support could entail training for peer support programs and facilitation for organizations of family members of persons with disabilities. Governmental investment in these initiatives will provide committed and cost-effective partners who can assist in the development of effective, culturally appropriate, and sustainable programs.

6. Support advocacy services for the human rights protection of persons with mental disabilities. These services could provide individuals with legal, social, and psychological information and support.

7. Improve access to justice for the mentally disabled. Access to justice would improve individual capacity to ensure their own rights protection. The Lithuanian government should train lawyers and judges on new laws relating to patient's rights and the disabled and human rights. Establishing a system of legal aid whereby mentally disabled individuals can receive pro bono legal assistance would ensure that those residing in institutions with few financial resources can benefit. Moreover, the government should create guidelines regulating hospital and social care home responsibilities to inform residents about their rights to access justice.

8. Conduct anti-stigma/public awareness campaigns. The general public holds incorrect and degrading stereotypes about the mentally disabled. The government should actively combat these pervasive myths, which allow, and even encourage, the current patterns of institutionalization.

Recommendations for the Mental Health Care System:

1. Facilitate the integration of mental health and general health services.

Strengthen guardianship legislation. Under international and national law, people with mental disabilities have the same rights as other citizens. Thus, guardianship should be limited to those activities for which an individual is found to be mentally incompetent; government should create a system whereby partial guardianship can be designated by the courts, on an individual basis. Persons could then exercise their rights according to the extent of their ability. Our suggestions are following:

a. To avoid total guardianship,;
b. To implement it in a tailored and flexible fashion,;
c. To recognize guardianship as a last resort and the need to preserve the rights and status of the disabled,;
d. To have alternatives to guardianship (the experience of other countries would be useful here, such as:

- In Sweden it is possible to have the appointment of a special representative or trustee;
- In Canada, there is an umbrella tool covering various individual legal tools for planning ahead and anticipating needs, a trustee can be appointed without resorting to formal guardianship, and there are mechanisms like joint bank accounts or joint ownership of property;
- In the USA, the court can grant the guardian only the powers necessary to provide for the demonstrated need; appointment of a guardian does not indicate general incompetence or modify civil rights unless the court so orders.

2. Provide continuing education to care providers.

Physicians, psychologists, social workers, nurses and others employed in community-based and institutional services should receive additional training in the importance of rights-based care, individual rehabilitation, and overall trends in de-institutionalization. All care providers should be acknowledged and trained (as opposed to just physicians). Training and oversight is also needed to ensure that staff is actively and fully engaged with patients.

3. Re-orient financing to follow individuals.

The current system of funding hospitals or care homes according to the number of residents provides incentives for institutions to maintain or increase the population of their facility. Instead, money should follow individuals, so that community-based service providers can also be funded on this basis.

Recommendations for the Social Care System:

1. Accept a Long Term Care Act, which foresees community based services and home care services as alternatives to institutional care and provides, support for carers. This act should include a patient's rights bill with clear descriptions of client's rights, such as: the right to be dealt with in the manner that is courteous, respectful and free from abuse that respects dignity and privacy, promotes autonomy, recognizes individuality, is sensitive and responds to needs and personal preferences. Recipients have the right to information about the community services provided; to be told who will be providing services; to participate in the assessment and development of the personal plan of service; to give or refuse consent; to raise concerns or recommend changes; to be informed about the laws, rules and policies affecting the operation of the service provider; and be informed in writing about the complaint procedure and have records kept confidential.

2. Develop policy to remedy barriers to social inclusion. The government should create explicit legislation and policies aiming to promote social inclusion of the mentally disabled. These measures, such as an anti-discrimination law and social services, should be outlined in a comprehensive national action plan that also specifies ministerial responsibility.

3. Amend existing legislation to improve procedures for assessing disability. Following the recommendations of pertinent ministries, the government should change existing policy regarding the determination of disability. Assessment procedures for both children and adults should not only be based on medical indicators, but should also take into account social and environmental factors and each individual's special needs, especially those relating to rehabilitation and educational support and assistance.

4. Improve access to services to be specific to individual needs and capacities. The government should develop measures to facilitate access to services for those who require it. These measures should be determined to be part of an improved process of assessing disability.

5. Review and amend the system for sending persons to social care homes. Sending a person with mental disabilities to a social care home should be viewed as a last resort. Local authorities should be responsible for ensuring the provision of the least restrictive care.

6. Clearly plan for residents' to leave social care home. Social workers should support and develop this process by establishing and strengthening the resident's relations with family and relatives The long term goal of a resident rehabilitation plan should be self-sufficient living in the community and attempts should be made to achieve it by strengthening everyday and working skills, teaching household work with the orientation towards leaving social care home and returning to the community.

7. Outreach to the community. A specific person should be employed to ensure that residents maintain connections with the outside world.

8. Facilitate links with other sectors. The Ministry of Labor and Social Security should actively forge links with other pertinent ministries, such as the Ministries of Education, Labor, Welfare, Law, and non-governmental organizations to improve the mental health and social care systems. A key part of improved services should be more access to education, employment, and a higher level of social benefits and allowances.

"We believe that the primary aim of mental health policy is to enhance people's well-being and functioning by focusing their strengths and resources, reinforcing resilience and enhancing protective external factors."[210]

So pledged the Ministers of Health from European countries at the January 2005 World Health Organization (WHO) Ministerial Conference on Mental Health. The Ministers went on to welcome the fact that policy and practice now cover:

i. The promotion of mental well-being;
ii. The tackling of stigma, discrimination and social exclusion;
iii. The prevention of mental health problems;
iv. Care for people with mental health problems, providing comprehensive and effective services and interventions, offering service users and carers involvement and choice;
v. The recovery and inclusion into society of those who have experienced serious mental health problems.[211]

Policy and practice in the Baltic States do not adequately reflect these stated priorities. The following recommendations to governments, institutions (psychiatric hospitals and social care homes), and donors are intended to guide the reallocation of governmental human and financial resources to better support these priorities set forth at the 2005 Ministerial Conference on Mental Health. While governments are ultimately responsible for the care provided in institutions in their territory, recommendations are made to institutional administrations as well, since many of the suggested changes must occur at the level of individual institutions. Implementing these suggestions will result in the prevention of unnecessary institutionalization and the needed de-institutionalization of many of those currently institutionalized.

To Respective National Governments:

1. Shift the focus of support for the mentally disabled to community-based services and create a detailed timetable for the move from residential to community services. The need for community-based services is great; many residents of residential care institutions could live in the community with support. Thus, the main priority in policy, legislation, and funding should be the creation of community-based care for persons with intellectual disabilities and persons with mental health problems. EU structural funds (the European Social Fund) should be sought for service development and provision, particularly mobile multidisciplinary mental health treatment teams, day care centers for people with intellectual disabilities or mental health problems, group homes, programs of supported employment, and support for peer advocacy and self-help groups.

2. Take concrete steps toward planning and implementing deinstitutionalization. A key part of re-orienting resources toward community-based care is the creation of day and other support services that allow residents to return to the community and that support those currently on social care home waiting lists to stay in the community. While this may require more financial investment in the short-run, in the long-run, costs will be decreased as the government funding of large institutions decreases. A few key steps are as follows:

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[210] WHO European Ministerial Conference on Mental Health. January 2005. Para 1. EUR/04/5047810/6

[211] Ibid, Para 6.

a. Work collaboratively in developing an inter-sectoral plan to establish community-based services that can provide services for those currently residing in institutions, that build on the support provided by NGOs and families, and that create community support for individuals without families or in abusive family situations. Given the inter-sectoral nature of mental health reform and service provision, there is a danger that no entity will definitively take the decision-making initiative, ensure that adequate funds are dedicated to various programs, and ensure that all populations requiring community-based services are addressed. Pertinent ministries should cooperate to develop a comprehensive plan that clearly delineates responsibility for various elements of community-based service development.

b. Support existing networks of informal care givers. These activities should decrease the time and financial burden of care-giving and support caregivers to develop their skills. In-home care, such as meals, visiting mental health or nurse support, and vocational or educational enrichment should be provided regardless of whether or not a person with mental disabilities has a family member assuming primary caretaking responsibilities. Respite services should be made available through home stays or short-term institutionalization, in order to give care providers short breaks. The State should also formally recognize the economic value of care-giving. This could include ‘soft support,’ such as information, advice and membership in support groups; or ‘hard support,’ such as social security benefits to replace lost income, quasi-employment as a paid care-giver, and protection of one‘s loss of employment-related social rights.

3. Establish independent human rights monitoring mechanisms. Monitoring of mental health care institutions by independent organizations should occur regularly. Governments should fund independent entities comprised of relevant ministry staff and representatives of human rights NGOs and users'/disabled people organizations. These entities should regularly monitor all hospitals, social care homes, and community-based programming and should have uninhibited access to institutional staff as well as to clients. They should use monitoring tools that are based on international standards elaborated by WHO and others. Monitoring should seek to identify human rights violations, as well as areas for improvement in rehabilitation and community integration.

4. Establish legal protections for commitment and treatment consistent with European standards. Ensure the right to review by an independent judicial authority and access to a lawyer before a trial or hearing begins. Train judges, hospital administration, and psychiatrists in these protections.

5. Support the development of users’ organizations. Government ministries should make the consultation with users a regular aspect of policy development, implementation, and evaluation. In cases where no users’ groups exist or where policy capacity is inadequate, governments should support the creation and training of such groups. Attention must be paid to ensure that any existing disability organizations include persons with intellectual disability and mental health problems (as opposed to organizations that address only physical disabilities). Formal mechanisms of participation should be created and should facilitate broad participation. Rather than just consulting with a few individuals who are regularly contacted to represent people with mental disabilities, planners should use participatory tools to ensure that a large number of residents of institutions and community-based service users are able to voice their needs and desires.

6. Implement national campaigns to end stigma. Ministries of health and other pertinent ministries should spearhead media and other awareness campaigns that undermine stigma among the medical and social work professions, as well as among the public at large.

7. Create inter-ministerial teams to support the development of a workforce that is knowledgeable about and committed to rights-based approaches to persons with mental disability. University curricula for psychiatrists as well as for social workers should be updated to reflect WHO policy and international human rights standards pertinent to people with mental disabilities. Continuing education should be provided to new and existing professionals in these fields. Lay staff of hospitals, social care homes, and community-based services should be trained in the rights-based approach to disability. These teams should also address the training and work of those who often 'diagnose' mental health problems or intellectual disabilities – primary care physicians. Primary care physicians should be appropriately trained, and should have effective mechanisms of referral to specialized medical and non-medical care.

8. Allocate funding to replicate successful pilot programs on the national level. Several examples of pilot projects or institution level efforts to support true participation or community integration were cited in country sections. Governments should make these efforts the rule, rather than the exception. Human and financial resources should be dedicated to documenting and replicating successful pilot projects in institutions and communities throughout the country.

9. Improve access to justice for people with mental disabilities. Access to justice would improve individuals' capacity to ensure their own rights protection. Establishing a system of legal aid whereby individuals labelled with mental disabilities can receive pro bono legal assistance would ensure that those residing in institutions with few financial resources can benefit from protections. Moreover, the government should create guidelines regulating hospital and social care home responsibilities to inform residents about their rights to access justice.

10. Support with human and financial resources relevant analytical and scientific research. Such research should include independent analysis of existing attitudinal, managerial, and financial obstacles to de-institutionalization and community-based care development. This will ensure that the development of mental health policy is based on a realistic assessment of knowledge and service provision, as opposed to recommendations made by lobbying entities favouring institutionalization or to the biases and stigma held by some policy planners. Scientific analysis of current gaps will also facilitate the development of clear evaluation criteria that can be applied to new community-based programming. Evaluative indicators can look at the quality and effectiveness of services provided, quality of life, human rights protection, and decreased social exclusion and stigma.

11. Strengthen protections in guardianship legislation. Under international and national law, people with mental disabilities have the same rights as other citizens. Thus, guardianship should be limited to those activities for which an individual is found by a court to be incapacitated, government should create a system whereby partial guardianship can be designated by the courts, on an individually-tailored basis. Persons could then exercise their rights according to the extent of their ability. These changes would entail:

a. Avoiding plenary guardianship as much as possible

b. Designating guardianship in an individually-tailored and flexible fashion

c. Recognising guardianship as a last resort that inherently infringes on the rights and status of the disabled

d. Developing alternatives to guardianship such as those developed in Sweden, Canada, and the United States. In Sweden, a special representative or trustee may be designated, who has fewer rights than a guardian. In Canada, there is an umbrella tool that includes various ways of planning ahead and anticipating needs without resorting to guardianship (supported decision-making); while in the United States, the court has the possibility to grant the guardian only the powers necessary to provide for demonstrated needs.

12. All countries should ratify the Council of Europe Convention on Human Rights and Biomedicine. The purpose of this Convention is to: "Protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine."[212] Latvia has not yet ratified the Convention, and Russia has neither signed nor ratified it. Doing so would require that Member State governments ensure that domestic legislation is in keeping with Convention laws relating to access to medical care, informed consent, involuntary treatment of persons with mental disabilities, and the right to information.

13. All countries should sign and ratify the European Social Charter, including optional Protocol X, the collective complaint mechanism. Article 11 of the European Social Charter states that "[e]veryone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable." Article 13 continues: "[a]nyone without adequate resources has the right to social and medical assistance."[213] The collective complaints procedure allows individuals and/or NGOs to bring a complaint to the Committee, and if the Committee deems the complaint to be admissible, it will hear the merits, and issue a decision. The European Council of Ministers will subsequently adopt a resolution. Such a mechanism would facilitate the activism/involvement of human rights organizations and users' organizations.

To Psychiatric Hospitals and Social Care Homes:

1. Make (and monitor the implementation of) clear directives regarding the implementation of national legislation relating to patient's rights, prohibitions against inhuman and degrading treatment, the right to informed consent, and so on. In cases where national law is adequate, failures often occur in implementation. Staff members are either unaware of national policies; or they decide for reasons of time, lack of understanding about importance, or stigma, not to implement them. Dissemination of directives should be accompanied by training, as well as clear retribution for not following directives.

2. Develop rehabilitation and occupational therapy programs as well as individualized rehabilitation plans for all residents. Staff in institutions should redirect some of their time and energy from caretaking to rehabilitation. Programs should include a range of services, and should respond to a range of abilities. All persons residing in an institution should have a plan for rehabilitation that corresponds to their needs and capacities.

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[212] Convention on Human Rights and Biomedicine. Article 1. http://conventions.coe.int/treaty/en/treaties/html/164.htm

[213] European Social Charter, Council of Europe. Available online at http://conventions.coe.int/treaty/en/treaties/html/163.htm Accessed April 15, 2004.

To Donors:

1. Direct funding to support government human and financial resources capacity to implement the above.

2. Publicize the availability of collaborative funding mechanisms that allow NGO participation. Often, service-providing NGOs, local grassroots organizations, and municipalities are unaware of multilateral funding opportunities. The EU should publicize their existence and build the capacity of users' organizations to apply.