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HUMAN RIGHTS MONITORING INSTITUTE

GLOBAL INITIATIVE ON PSYCHIATRY

VILTIS: LITHUANIAN WELFARE SOCIETY FOR PERSONS WITH MENTAL DISABILITY

VILNIUS CENTRE FOR PSYCHOLOGICAL AND SOCIAL REHABILITATION

HUMAN RIGHTS MONITORING IN CLOSED MENTAL HEALTH CARE INSTITUTIONS

PROJECT REPORT

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Preface

Globally, the paradigm of mental healthcare has undergone dramatic changes in recent decades. The key factor behind these changes has been the realisation of the need to incorporate human rights into the mental healthcare system, which enables the transformation of the system's values and principles to promote respect towards patients and to enhance their chances for integration into society.

In 1991 the United Nations General Assembly ratified the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care that focused on the human rights of persons with mental disorders. The Principles provided the opportunity for the reform of mental health services by abandoning the seclusion, stigmatisation, disrespect and disregard for mentally ill patients. The recognition of human rights as a value allows empowering of mentally ill persons, their families and personal representatives.

The mental healthcare system in Lithuania does not receive adequate attention from the government and thus outdated concepts about its institutional role, functions and operation methods prevail. The reluctance to reform large residential treatment and care facilities and replace them with a more flexible system of community-based services only confirms this fact. The traditional residential facilities cannot safeguard the rights of mentally ill patients effectively since they were established according to the principle of secluding "defective" individuals. Regular investments for superficial improvements to the ineffective system have failed to improve public mental healthcare, while the results of treatment, rehabilitation and integration into community of the mentally ill have proved to be inadequate and questionable.

Recurrent cases of inappropriate treatment of patients in care homes clearly demonstrate the ineffectiveness of mental hospitals and care homes in particular. Both geographic and professional exclusion of these facilities and their staff result in closed communities within the institutions. Meanwhile, the absence of adequate monitoring and supervision procedures provides the conditions for regular violations of human rights. The procedures for treatment of patients hospitalised in residential mental healthcare facilities and their release back into the community lack transparency, while the patient's chances of leaving a care home currently are more theoretical than practical. Moreover, the stigma of mental or intellectual disorders is intensified by the negative image of mental patients in residential facilities. For this reason, many people still consider the mentally ill to be socially dangerous and are inclined to justify the long-term seclusion of these persons in special care institutions, even though this entirely contradicts the approach of modern science.

In order to protect the rights of the mentally ill effectively, an analysis of the current situation should first be conducted in order to evaluate the present situation with respect to human rights in residential mental facilities. This obviously calls for the development of monitoring and evaluation instruments to be used by related organisations and experts for analysing and monitoring changes in the future.

The four NGOs involved in this study of Lithuanian mental healthcare facilities combined their expertise and experience in different areas, such as psychiatry, mental healthcare, familiarity with functioning mechanism of care institutions, knowledge of international human rights standards with respect to mentally ill patients as well as know-how of monitoring techniques and methods. This report provides a summarised version of this analysis. The project sets a precedent for civic supervision of mental healthcare facilities and provides opportunities for interested organisations and experts to repeat the research employing the techniques developed in the analysis.

The NGOs involved in this analysis expect the information collected, the conclusions and proposals to initiate discussion among interested institutions and persons as well as to contribute to the abandonment of the current obsolete institutional system and its replacement with a modern mental healthcare system.

Henrikas Mickevičius
Executive Director of Human Rights Monitoring Institute

Vytautas Blažys
Director of Global Initiative on Psychiatry

Dana Migaliova
Director of Lithuanian Welfare Society for Persons with Mental Disability VILTIS

Rūta Lukošaitytė
Director of Vilnius Centre for Psychological and Social Rehabilitation

Dainius Pūras
Assistant Professor of the Faculty of Medicine, Vilnius University
Board Member of Human Rights Monitoring Institute

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

Lithuania is situated in the region of Eastern and Central Europe which is characterised by a mental healthcare system inherited from an ineffective system that is dependent on traditional centralised residential care and treatment institutions. Undoubtedly, this dependency largely hinders the effective development of community-based services.

Despite the obvious need to reform the mental healthcare system and recommendations set forth by international organisations, regional governments still lack the political will to initiate the process of deinstitutionalisation[1]. The powerful system of centralised institutions for children and adults with mental problems (both mental disorders and intellectual disabilities) effectively resists all efforts for reform.

According to the World Bank, at least 1.3 million people with mental disorders are placed in 7,400 large institutions, which ineffectively appropriate the limited financial resources available to them that could be allocated for the development and expansion of the infrastructure of community-based services. "Lithuania allocates 1.75% of its national budget for the institutional care of vulnerable individuals.[2]"

Different legal entities run this complex system of institutions, however the ideology of social exclusion and the negation of human rights are intrinsic to all of them. The right for patients to live in the least restrictive environment is also disregarded.

Quite a number of initiatives funded by international sponsors such as the Open Society Institute, the Geneva Initiative on Psychiatry, the Hamlet Foundation and the World Bank have already been implemented in the region. These proposals sought to improve the infrastructure of community-based social services, ensure public support, implement pilot projects in communities, introduce projects for teaching modern psychosocial techniques and provide research-generated evidence that the existing system is ineffective. Unfortunately, the success of the initiatives was heavily encumbered by the inactiveness of local governments and their avoidance to express political will. Despite the donors' examples and the recommendations of international organisations, the local governments also avoided making their own investments into this kind of service system targeted at the strengthening of vulnerable individuals' self-sustained living and their survival in the community, which could have led to an attractive and cost-effective alternative to institutional care.

So why does the Lithuanian government, just like the governments of some other countries in the region, delay the funding of new community-targeted services when the opportunity is available thanks to the general economic growth of the country? The answer is obvious. Influenced by different interest groups, the government continues to adhere to outdated principles and thus allows the stigmatising of services and a one-sided bio-medical approach to prevail. It is paradoxical that in the Caucasian and Central Asian countries suffering severe economic crises, the centralised mental facilities and care homes have collapsed, while in the countries marked by economic growth such as the Baltic states, government investments into the traditional system of residential institutions are increasing to improve care conditions in these facilities. However, the time has come when politicians have to make a strategic decision on the effectiveness of this use of resources. What is

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

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

the use of "feeding" an ineffective system and encouraging the vicious circle of sustaining the monopoly of institutions operating on the principle of social exclusion, while there are no funds left for community-based alternative services?

It is high time to ask whether this is an appropriate modern method for the mental healthcare system in Lithuania as a member of the European Union. How could the EU enlargement process be of use to end the flawed model of institutional care that is in no way compliant with either current Lithuanian principles or the country's vision?

Large closed mental care facilities reflect the tradition of social exclusion and paternalism and are incompliant with modern healthcare and social policy based on the principle of an individual's autonomy, authority granting and the right to live in the least restrictive environment. International experience has confirmed that residential care facilities are harmful, expensive and that only a minority of secluded patients are indeed unable to live in a community[3].

Unless reform is carried out, increased funding will eventually be required to ensure the quality of services provided by centralised care institutions. The culture of dependence which prevails in facilities deprives the patients of autonomy or the development of social skills. Thus, the state finances the seclusion of the individual from the community in order to sustain that individual for life by allocating more and more funds for institutional care.

Positive changes in Lithuania and membership in international organisations will sooner or later make the closed facilities redundant. The government will need to modernise and deinstitutionalise the mental healthcare system by offering community-based services as an alternative to closed mental healthcare facilities. The longer the government supports the system of closed facilities as the principal method of care and socialisation of mentally ill patients and persons with intellectual disabilities, the more funds and efforts will be eventually required for its reform. Since at the moment care homes and mental hospitals have a monopoly on services, it is not surprising that there is no motivation whatsoever to change the obsolete system. Legal instruments regulating the opportunity for providing alternative community-based services are to provide financial stimuli.

The experience of residential care in countries with strong economies shows that with the improvement of welfare and the strengthening of the social assistance sector comes the decentralisation of the social services system, while traditional residential care is no longer developed.

Since 1998 the main social services policy in Lithuania is officially supposed to target the decentralisation of services and development of outpatient services. Approved by a government resolution, the Programme for the Development of Social Services Infrastructure (SPIPP) recognises the development of an outpatient social services infrastructure as the main course of action for service development. During the implementation of the Programme in 1998-2004, 101 social services development projects were funded with LTL 29.75 million. Nonetheless, the government granted more allocations for traditional care homes within one year than it managed to allocate for the development of modern alternatives within six years.

The number of residential facilities (for example, there were 21 psychoneurological care homes housing over 6,000 patients in Lithuania in 2004) and their personnel (for example, the number of

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

social workers in care homes increased by nearly 200 from 2000 to 2003, while only 60 social workers were employed in mental health care centres from 2000 to 2005) continued to grow[4].

Decisions of this kind do not lead to actual reforms. Instead they clearly confirm the lack of political will towards reforms and show the covert attempts to continue investing in the system of psychoneurological care homes inherited from the past and aimed at separating thousands of people from local communities for life, making them ineffectual members of society.

The research carried out in the framework of the project confirmed that living conditions in the care homes have markedly improved. New buildings have been built, residential premises were renovated and the number of persons in one room was reduced. However this only consolidated the position of the residential care system and increased the number of people using these services, since at the moment this is the only alternative for taking care of the mentally ill. This is the very reason why Lithuania is characterised in international studies as a country investing huge sums into ineffective institutional care system.

Unfortunately, investments in the modernisation of residential facilities fail to solve the issue of human rights. Despite the fact that over the last 15 years the situation of Lithuanian residential facilities has improved the most compared to other Baltic states, the human rights of the mentally ill visibly continue to be violated. A large residential institution designed to isolate "defective" members of society and marked by the features of a totalitarian institution cannot properly safeguard human rights like the respect of privacy, the right to information, freedom of movement or other fundamental human rights. Thus, it leads back to the aforementioned vicious circle: the more the human rights of mentally ill patients are violated, the more they are crippled socially by furthering absolute dependence upon care, which leads to higher costs for the government for their treatment.

Mental hospitals may also be suffering the legacy of the stigmatising seclusion of mental patients that evolved as early as the 19th century. Like the care homes, they form a segment of the complex mental healthcare system based on the previously mentioned principles of paternalism, social exclusion and stigmatisation. The fact alone that mental patients are cured in specialised mental hospitals instead of general hospitals is an obvious example. The system of large isolated mental hospitals provides conditions for various violations of human rights and deepens both social exclusion and the stigmatisation of mental patients.

In addition, human rights violations were observed that were justified by the diagnosis of a mental disorder. Any patients which seek to defend their rights set out by the law are often treated as if their condition is deteriorating. Mental patients' right to information is currently not ensured, which is justified by the idea that information provided on the person's mental illness or treatment options could lead to the potential deterioration of the patient's condition. In the existing system, the very fact of diagnosing mental illness eliminates the patient's opportunity to enjoy human rights, even though human rights have to be guaranteed for each person in Lithuania pursuant to both the Constitution of the Republic of Lithuania and the ratified international legal instruments protecting human rights.

[4] 2005 Report of the Ministry of Social Security and Labour to the Committee on Mental Health. Informal document.

In its annual statement[5] of 2001, the World Health Organisation (WHO) recommended the equal treatment of persons with mental illness with all other patients and to integrate mental units to the general hospitals as is possible. The Mental Health Declaration for Europe approved in 2005 proposes the introduction of specialised community-based services available 24 hours a day to ensure the care for persons suffering from severe mental illness as well as the provision of services in the locations where people live and work and the development of rehabilitation services aiding the optimisation of the involvement of persons with mental illness into the society[6].

WHO Member States have committed themselves from 2005 to 2010 to eliminating inhumane and degrading conduct and care, recognising legislation that sets standards for mental health activities and upholds human rights in compliance with standards and international legal norms set forth in the Conventions of the United Nations and enhancing social inclusion of persons with mental illness[7].

All of Europe is undergoing progressive reforms in mental healthcare. Special importance and support should be given to providing the human right for the most effective treatment and intervention with the least possible risk appropriate to the patient's health, needs and wishes and with regard to their culture, belief, gender and aims. Considering the evidence collected, a number of countries support the development of community-based services including hospital units. The 21st century has no place for inhumane and degrading treatment and care in large medical facilities and there is an increasing number of countries closing specialised residential care and treatment facilities and replacing them with effective community-based services.

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

- financial and organisational pressure to retain the existing facilities;
- funding of mechanisms promoting institutional care;
- positive public opinion about these forms of care;
- absence of a national infrastructure for social services;
- absence of an independent authority for monitoring and supervision;
- lack of legislation protecting the rights of vulnerable persons.

The reform strategy proposed in the study conducted by the World Bank covers the following: the changing of public opinion and ensuring community support; the enhancement of the national infrastructure for social services and the training of modern social care professionals; the implementation of pilot projects in the area of community-based services; the employment of these projects for the reduction of the numbers of patients admitted to residential facilities; the restructuring, reduction and closing of residential facilities; and the development of a national network of community-based services of mental health care and social services.

The implementation of the above strategy shall need both the appropriate legislation and changes in funding procedures. First, laws and other legal instruments should clearly regulate the procedures of providing community-based mental healthcare services and social services and the funding

[5] World Health Report 2001 - Mental Health: New Understanding, New Hope. National Mental Health Centre, 2002.
[6] *Mental Health Declaration for Europe*. WHO European Ministerial Conference on Mental Health, Helsinki, Finland, 12-15 January 2005.
[7] *Mental Health Declaration for Europe*. WHO European Ministerial Conference on Mental Health, Helsinki, Finland, 12-15 January 2005.

allocated. One way of changing the existing funding procedure and concurrently encouraging municipalities to develop a network of community-based services is to create a patient "package" that would "follow" him or her. The laws should provide the patient with the opportunity to choose whether to receive services in a residential facility or in the community, and "bring" his or her package to whichever institution he/she opts for. That would create a competitive environment and could prompt the municipalities to develop an attractive and alternative structure of community-based services instead of supporting cost-ineffective monopolistic mechanisms of services provided by residential facilities violating human rights.

One more thing to be taken into account is the recommended establishment of a review body that would aid in consolidating good practices and preventing negligent and inappropriate treatment of patients in mental healthcare facilities. In the meantime, the patients using the services of the mental healthcare system (that is, mental hospitals and psychoneurological care homes) may file complaint concerning the violation of their human rights to the Seimas Ombudsmen's Office of the Republic of Lithuania. A monitoring and supervision mechanism however still does not exist. The Audit Departments of the Ministry of Social Security and Labour (SADM) and the Ministry of Healthcare (SAM) as well as the Region Governor's Administrations conduct the audit of the psychoneurological care homes and mental hospitals. Thus, the control is retained within the boundaries of one or another system, or, in other words, no independent supervision mechanism exists. An impartial and independent authority not directly subordinate to SADM or SAM is required for the regular monitoring of patients' rights in the residential mental healthcare facilities.

2. Violations of Human Rights in Closed Mental Healthcare Facilities in Lithuania

The project *Human Rights Monitoring in Closed Mental Healthcare Facilities* is the extension of the international project *Monitoring Human Rights in Closed Institutions in the Baltic Countries*. The first stage included the monitoring of the following facilities: the Mental Health Care Centre of Vilnius City, Republican Vilnius Mental Hospital, Žiegždriai Mental Hospital, Švėkšna Mental Hospital, Prūdiškės Psychoneurological Care Home and Jurdaičiai Psychoneurological Care Home. The following institutions took part in the study: the Geneva Initiative on Psychiatry, Vilnius University, Estonian Patients' Rights Protection Organisation and the Mental Disability Advocacy Centre (Budapest, Hungary).

National monitoring in the second stage covered the investigation in the following mental healthcare facilities: Kaunas Mental Hospital, Klaipėda Mental Hospital, Šiauliai Mental Hospital, Šaukėnai Mental Hospital, Rokiškis Mental Hospital, Šilutė Care Home, Didvyžiai Care Home, Aknysta Care Home, Linkuva Care Home, Aukštelkė Care Home, Jasiuliškiai Care Home, Dūseikiai Care Home, Strėvininkai Care Home and Skėmai Care Home. The investigation was conducted in nine psychoneurological care homes housing over 50% of all patients of Lithuanian care homes (over 3,000); and five mental hospitals scattered throughout all regions of Lithuania.

The objective of the project was to collect reliable information from primary sources on the existing issues of human rights with regard to national policy, legislation, practice and conditions related to the protection of human dignity and human rights in mental healthcare facilities. The project also sought to draw the attention of public and related institutions and persons in both Lithuania and abroad to the identified issues and to prompt the public to take into consideration human rights standards, living conditions and violations of human rights in closed mental healthcare facilities.

The study was conducted jointly by several NGOs including the Human Rights Monitoring Institute, the Global Initiative on Psychiatry, the Lithuanian Welfare Society for Persons with Mental Disability VILTIS and the Vilnius Centre for Psychological and Social Rehabilitation. The project was supported by the European Commission and the Embassy of the United States of America in Lithuania.

Methods

A questionnaire was compiled for the study covering the right to information (also freedom of speech), the right to the respect to privacy by eliminating discrimination, torture and inhumane treatment, the right to the freedom of movement, the right to property, the right to education, to employment, medical treatment, psychological and social rehabilitation, social and medical services received from other institutions, and the safeguarding of care and rights of incapable patients.

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

- All persons have the right to the best available mental health care, which shall be part of the health and social care system.
- All persons with a mental illness shall be treated with humanity and respect for the inherent dignity of the human person.
- Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the *Universal Declaration of Human Rights*, and in other relevant instruments related to human rights and the rights of the disabled.
- Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.
- The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.
- The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.
- No treatment shall be given to a patient without his or her informed consent. The treatment may be given to a patient without a patient's informed consent only if the following conditions are satisfied: the patient is, at the relevant time, held as an involuntary patient; the patient lacks the capacity to give informed consent to the proposed plan of treatment and when a competent impartial third person is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.
- Informed consent shall be obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on the diagnostic assessment; the purpose, method, likely duration and expected benefit of the proposed treatment; alternative modes of treatment, including those less intrusive; and possible risks and side-effects of the proposed treatment.
- Physical restraint or involuntary seclusion of a patient shall not be employed except when it is the only means available to prevent immediate or imminent harm to the patient or others. The instances shall be in accordance with the officially approved procedures of the mental health facility.

- Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others.
- A patient in a mental health facility shall be informed of all his or her rights. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age.
- A patient shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility.
- Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time.

The questionnaire had two versions, one for patients and one for staff. The survey was conducted in the form of an oral, semi-standard interview, which was unlimited in duration. Between five and ten staff members and between ten and 15 patients were questioned in each facility. The procedure of the survey included the initial submission of the questions to the facility's administration by the expert group and then individual interviews were later conducted with members of personnel and patients.

Visits to the facilities took place from November 2004 to March 2005. A five-member expert group administered each visit[8]. The completion of tasks for the experts usually took from four to eight hours in the facilities.

A report was prepared on the same day after each facility visit and a total of 14 reports were drawn up. This paper provides the final report summarising the data of all surveyed facilities.

The report provides data obtained from patients (those of psychoneurological care homes and mental hospitals), administrators and facility personnel working directly with patients. Since the objective of the study was to identify violations, the contents of the report do not disclose the names of the informants in order to protect them from persecution and pursuant to the *Law on the Legal Protection of Personal Data* of the Republic of Lithuania.

2.1. Violations of Human Rights in Psychoneurological Care Homes

A person with a mental illness or intellectual disability has the right to be admitted to a psychoneurological care home after filing a request with the local municipality. The concerned municipality forwards the case material to the Department of Social Affairs of the Regional Governor's Administration, which then includes the person on a list of persons willing to be admitted to one of the regional psychoneurological care homes.

There are also patients who are referred to the psychoneurological care homes directly by social workers from mental hospitals who recommend that the patient (or his/her personal representative) apply to the psychoneurological care home. Furthermore, some of the patients in the psychoneurological care homes are persons who are transferred from children's homes when they reach the age of majority. They are not offered any alternatives of living and care in society but are instead automatically transferred from the children's institution to one for adults. The main reason that the majority of these people spend their entire lives in care homes is not severe illness but because of the impossibility of receiving a place to live or social services in the community.

[8] Except in three facilities where the expert group consisted of four members.

Currently every care home located in remote countryside areas puts a few hundred persons with mental illness of varying degrees in seclusion. These care homes function like actual "autonomous republics" mainly maintaining relations within the system, i.e. with other mental health care facilities.

Care homes usually consist of several buildings of varying size and quality that are separated from the nearest settlement, oftentimes by a fence surrounding the grounds. Care home authorities claim that the purpose of isolation is to protect patients from hostility from the neighbouring communities and to prevent patients with poor orientation from potentially straying.

As a rule, the care homes were designed according to the seclusion principle instead of to meet the needs of patients. Some were converted from the sheltered housing or nursing homes built at the beginning of the 20th century. The establishment of sheltered housing for the disabled in the premises of estates was a usual phenomenon in the traditional agrarian society, which showed that the community assumed responsibility for weak members. However, this phenomenon has not survived in today's society which has accepted the exclusion of the mentally ill.

The personnel of the care homes are recruited based on where they live instead of their qualifications, meaning that the residents of neighbouring villages or towns who usually have no appropriate qualifications for working with mentally ill patients constitute the absolute majority of the staff. Thus, attention needs to be drawn towards the issue of competence and professional qualifications of the personnel in the care homes.

Beginning in 1997, the SADM established a new position of social worker's assistant and quickly arranged minimal training courses to provide these employees with basic qualifications, which obviously is not sufficient. Some care homes initiated co-operation with job centres, coupling the employment of unqualified people, who could not get any other kind of a job, with tax privileges from SODRA (Social Insurance Fund).

Care homes are presently the major employers in their areas and thus the reform of the care home system is hindered by the workplace re-distribution issue.

The conduct of care home personnel clearly lacks the respect for the human dignity of patients. A hierarchical structure prevails since patients are considered inferior, while ironic and degrading phrases are used when discussing them (for example, the head of one care home referred to the patients as "little dumdums"). Moreover, the attitude of exaggerated patronising dominates with the patients being deemed incapable of deciding on their lives.

A specific culture prevails in the care homes with the following key characteristics:

- The conduct of the personnel and the internal rules aim at training patients to be obedient and suppressing their independence. Patients only change when old patients die and new ones arrive, thus the flow is one-sided. A very slight percentage (1-3%) of patients leave care homes to live in the community. Even capable patients who were in theory admitted voluntarily (were persuaded to sign the agreement on living in a care home) are made to believe that they will spend their entire lives there and that they must fully depend on the personnel. To this end, persuasive arguments like "You will not manage alone." "You are incapable of taking care of yourself." "Your neighbours will cause you harm, etc." are used.

- The facility is like a closed republic with a "holy father", i.e. the Director (in the inspected facilities the directors have been in their position for an average of 16 years, so the majority of them were appointed in Soviet times), with its own traditions, values, written and unwritten laws. There exists a clear tendency to punish those who attempt to rebel against the system and to reward with privileges those who willingly co-operate. The institution tries to satisfy the patients' needs on its own by becoming involved in their education, training, law enforcement, cultural and religious needs.
- Co-operation with police occurs only in exceptional cases. The autonomy and insularity of the facility from the community is reflected in the terms used by patients, for example, "freedom" (refers to the world outside), "sweatbox" (refers to the solitary confinement ward), "dependants", etc. Interviews with capable patients from care homes concerning the option to live in a community were marked by emotional responses and a strong desire "to be released." However, it was obvious that they did not believe in it.
- Care homes have improved the physical environment but still disregard the mental and social needs of patients. In the majority of cases, modernisation is conducted only to consolidate the existing system and to further restrict the rights and freedoms of patients. For instance, the modern code locks installed have only one purpose, which is to restrict the movement inside a care home and to prevent patients from leaving.
- Patients are often deemed incapable before or after their admission and the custody of the majority of incapable patients is vested with the care home. Cases were disclosed when a person learned that he was determined incapable only after the admission to the care home or was not informed about this decision at all.
- The administration treats the groups of capable and incapable patients almost equally, that is, the rights of all patients are restricted to the maximum extent possible.

Certain aspects of life within the walls of care homes are carefully concealed. This also applies to problematic areas (abortions, regulation of intimate relations among patients, suicides, etc.) and progressive practices (permitted relations of persons of different sexes, permission to keep pets) since certain issues are not officially regulated. If the ministry does not provide specific instructions concerning various issues then they are avoided (for example, the issue of reproductive health is at the moment "frozen"). In short, the conclusion can be drawn that the administration complains about the lack of instructions from the SADM and questions whether certain traditional practices are compliant with the concept of modern social care.

Individual patient rehabilitation plans are not drawn up. Paradoxically, all the care homes actually do is guarantee the regression of their patients' social skills and absolute seclusion from the community (family ties and friend are lost, links to former environments and the ability to take care of oneself are not preserved), even though the officially declared objectives of the care homes (for example, those indicated in the job instructions of a social worker) include, for instance, integration of patients into society. Care homes conduct adaptation programmes meant to reduce expectations of patients, reconcile them with living in the facility and lose the skills that they previously had.

A perfect care home patient is perceived as one who unconditionally fulfils all the instructions given by administrators, shows satisfaction, has no personal ideas or wishes, is absolutely indifferent to information about him or herself, feels no sexual attraction, seeks to please the personnel and to express him or herself through crocheting and making lace.

Pursuant to the decision of the former Minister of Social Security and Labour, all care homes were required to identify at least ten patients who could live within the community. Unfortunately, a year later the majority of them returned to the homes, which is used as an argument against a patient

living in a community where they are given more independence. However, this experiment did not provide alternative services in the community and thus the opinion that the patients were unable to live in a community is unfounded.

According to a rather biased assessment of the administration, about 20% of patients in care homes could live in the community if provided with additional services (the percentage varies from 10% to 30% depending on the care home), which shows that people are admitted to care homes irrespective of their social skills and needs. In the meantime, it is unavoidable that people's social skills diminish in the care homes which try to teach them obedience. As a result, the return of the care home patients into the community first necessitates the restoration of their social skills.

The admission of persons with mental illness into care homes is encouraged on the national level since the mentally ill (often also having somatic disorders) living in the community receive no support to assist their needs such as medication, social services, etc. For this reason, the placement of these people in a care home is the only option for the family in order to guarantee medical and social help for them.

Long waiting lists for those willing to be admitted to the care homes are due to the absence of funding from municipalities for community-based services. The municipalities decide on the need for the care home services and include persons on the regional list, while the Regional Governor's Administration decides on the placement of a person in a particular care home. Usually, people from different municipalities are put on waiting lists for the care homes in the same region but sometimes people are also on a list for the care homes for different regions. Actually, the phenomenon of waiting lists contributes to the popularity of care homes since people fear if they ask to be removed from a certain list, later they will have to wait for a very long time.

The services provided by care homes is formalised by an agreement between the care home and the patient. Before or after admission, the patient signs an agreement and pays for the services received. However, this system is far from transparent since there are no clear regulations concerning the procedure of refusal for admission into a care home, appealing against the decision or revoking one's signature in case the person is not willing to stay in a care home any longer. Since the agreements contain no termination clause, the legality of the very system raises doubts. Cases have arisen where the administration had an agreement with a person's signature although the person claimed he or she never signed it.

The Audit Department of the Ministry of Social Security and Labour (SADM) as well as the Regional Governor's Administrations conduct the audit of the psychoneurological care homes, meaning that supervision remains within the boundaries of the system and that no independent supervision mechanism exists.

2.1.1. The Right to Information

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

Persons suffering from mental illness are entitled to the same right to information as all other members of society. The information provided must inform them about their illness, treatment methods and required medicines in order to enable them to make decisions and feedback must constitute an integral element of the information process. Patients must take an active part in the discussion with assistance providers and share the responsibility with them regarding their future life.

Nonetheless the scope of information accessible to patients in a care home is rigorously controlled, which consolidates the power hierarchy and control of the patient. For instance, it took a few weeks for a patient in one care home to receive an answer to a written enquiry concerning care home charges, although this same information is publicly accessible to external information seekers. When the group of experts visited the facility, the patient had not yet received an answer.

Patients tend to be passive and do not request information and staff members do not directly provide the information about illnesses or treatment methods to them. The minimal information received by patients partially depends on the knowledge of individual staff members about patients' rights or on their good will. Patient inquiries usually receive an answer, but the information provided is minimal. For example, a patient might be informed that his or her medication was changed but will not be given the reasons why or the effect of the new medication. Psychiatrists usually inform patients about their prescribed medicines and consider their opinion in selecting the medication.

The right to file appeals and to receive an answer is not upheld. In the majority of care homes, formal mechanisms for the investigation of complaints are in place, but patients have no actual opportunity to file a complaint or receive a corresponding response. Claims addressed to higher organisations are not tolerated, while the response of the administration in these cases usually varies from disregard to punishments such as a transfer to a mental hospital.

Care homes provide patients with activities based on the patients' needs as understood by the personnel. However, the activities in the fields of art or sport often fail to meet the needs of the patients and many complain of boredom or consider the available activities inappropriate for their experience or needs. Information on the options for activities outside the care home is almost nonexistent, while the opportunities for outside activities depend on the decision of administrators. This means that the staff decides on the activities of patients.

2.1.2. The Right to Privacy

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

The right to the respect of privacy for patients in care homes is harshly violated since their entire lives are public, being regularly supervised by the personnel and other patients, with very few possibilities to remain alone. Paradoxically, persons experiencing mental difficulties as a result of constantly being in public often ask to be placed into solitary confinement wards or supervision rooms.

Telephone communication is usually available to patients and some have mobile phones. The staff allows patients to make calls on their own mobile phones or fixed line telephones in exceptional cases. However, some information showed that some patients do have restricted contact with the

outside world. In one example, a patient who had recently given birth was not allowed to make telephone calls or leave the care home.

Only one care home provides its patients with the opportunity to subscribe to periodicals.

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

Partitions are not generally used to provide privacy for patients who cannot walk during hygienic procedures and these procedures are administered in the open in front of other patients irrespective of their sex. In some care homes patients are not allowed to use the bathroom or shower and the majority of care homes provide no possibility to close the doors in these facilities.

Care homes violate the patients' rights to enter into a relationship with a person of the opposite sex. Since neither national nor regional policy regulates the intimate relations of the patient, the situation in the care homes varies depending on the attitudes of the staff and administration. Some care homes have a more liberal atmosphere and relationships between opposite sexes are tolerated, while in other care homes the units of women and men are separated and the communication is rigorously restricted. Irregardless if a couple is allowed to have intimate relationships and live together, pregnancy is seen as a problem and measures are taken to avoid it. Methods of contraception vary a great deal (from intervention procedures to birth control pills). For women who are seen as belonging to a risk group the use of birth control is obligatory, while the menstrual cycle of other women is usually monitored.

Care home administrators reluctantly speak about abortions and information regarding them is not disclosed. Abortion is obligatory in these homes and if the woman does not agree to one, various pressure measures are used or a forced abortion is administered. There were cases reported of women who were taken for an abortion without their consent under false pretences, for example, being told that they were going to see a psychologist. In other cases, abortions were carried out in advanced stages of pregnancy, even into the sixth month.

One of the reasons for this tight control of pregnancy is the rule set down by the SADM that care homes can only house persons above 21 years of age meaning that children are formally not allowed to stay in the care home. But even if these regulations were modified, one of the fundamental human rights – the right to procreate – is not upheld in the care homes. Well-developed institutionalisation, i.e. the placement of people into closed facilities, deprives them of their right to have children, start families and live together with another person.

2.1.3. Discrimination

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

Key areas of violations are the following:

- granting privileges to obedient patients favoured by the administration;
- improvement of living conditions at the expense of relatives' support;
- discrimination against more serious patients.

As mentioned earlier, staff conduct and internal rules in care homes aim to train patients to be obedient and to curb their autonomy. Compliant patients actively co-operating with the personnel who take part in leisure activity programmes and help staff members to perform household duties, are encouraged and granted privileges unavailable to other patients. Incentive methods include:

- more freedom of movement (for instance, unrestricted leave outside the care home);
- granting of greater autonomy (for example, room keys are given);
- more opportunities to leave the care home (for excursions or events in other care homes);
- extra food (for example, a slice of sausage);
- awards during events arranged by the care homes (for example, in the Autumn Festival the most diligent helper is given a stereo);
- various other incentives.

Another form of discrimination is to provide certain patients with better living conditions, for example, by furnishing individual rooms with better furniture if funded by the patient's family.

It is absurd that the most serious patients are usually accommodated in the care home blocks which are in the poorest condition. The scope and quality of care they are given is often insufficient (a foul smell usually lingers in the units of the most serious patients; the patients are socially neglected; no individual rehabilitation therapy is given to them, etc.). The unit of the most serious patients in only one of visited care homes was the most modern and was even equipped with heated floors. Better opportunities for individual therapy exist when there is a smaller number of patients.

2.1.4. Torture and Inhuman Treatment

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

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

Characteristics of torture:
- causes physical or mental suffering;
- suffering is severe and inflicted on purpose;
- suffering is unjustified in the given situation.

The term "torture" also refers to the use of such methods against a person that are aimed at the destruction of the person's personality or depletion of his or her physical or mental abilities but that

do not cause physical pain or mental suffering. Inhuman or cruel treatment differs from torture in that the infliction of pain and suffering has no clear objectives[9].

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

Concerning inhuman treatment and torture in the psychoneurological care homes, it is important to take into account the context of living in these care facilities as the majority of patients are going to spend the rest of their lives there. As mentioned above, a negative view of living in a care home prevails among patients who consider their presence there as imprisonment. With no prospects of a meaningful life, they are entirely unmotivated to show prosocial behaviour. The main problematic issues among patients include alcohol abuse and abuse of unprescribed medicines, aggression and unsanctioned sexual relations (abuse of incapable women). Naturally, the punishments imposed by the care home personnel on the patients for violating discipline and order often are mere attempts to prevent inappropriate behaviour. Yet, the methods employed by the staff (see below) are undoubtedly inappropriate in terms of human rights.

The internal care home rules even include punishment procedures and specify responsible persons for the administration of one or another kind of punishment. For example, in one of the care homes, social workers are in charge of restraining the patients in a conflict situation (set forth in Point 2.8 [Solution of Conflict Situations] of their job instructions).

The primary instances of inappropriate treatment of patients by staff members include disregard (of both health and social issues), frequent restriction of the patients' right to free movement (placing them in a solitary confinement ward; prohibiting them to leave the territory of the care home), violence against patients (mental, physical, sexual), making decisions on behalf of the patient on the issues of his or her personal life (forced abortions).

The response to the patients' pain (both physical or mental) is inadequate in some care homes. For example, when a patient complains about being in pain, no measures are taken and he or she is even mocked and laughed at. In one instance, a physician of a care home failed to adhere to the confidentiality requirements for the patient's personal data, mocked the patients and refused to believe their complaints about health issues (the patient's letter about his specific somatic disorders was shown to the experts as a joke).

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

The detrimental effects of the physical environment on the patients are also not taken into account. For instance, one of the care homes only turned on its heating system in mid-November.

The restriction of free movement is used as a punishment in a number of the care homes. The patients are usually kept in secluded premises such as supervision rooms, solitary confinement

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

wards, etc. Before the arrival of the group of experts, one of the care homes used a room without a toilet for solitary confinement (patients were forced to use a "potty" which was not emptied until their release from the ward, which in certain cases lasted for as long as two weeks).

Long-term punishments are also used. For example, in case a prisoner leaves the grounds of the care home without a permit or fails to return at the agreed time, he or she is put into pyjamas which carry a stigmatising meaning and thus the patient does not dare leave the room.

Among the most severe violations of human rights in the care homes, the worst is abortion and these instances of torture and inhuman treatment are usually not disclosed to the public. During the inspection by the expert group, the administration and staff avoided speaking about abortions, refused to answer questions about the subject and generally denied the existence of this problem. Meanwhile, patients from all care homes mentioned the use of abortions, giving the names of the women who had undergone this procedure. The same applied to contraception and information was also received on the forced use of invasive contraceptives such as IUDs.

Pregnancies are always aborted in the care homes (except in cases when a woman is at the end of the second trimester). All sexually active women, the number of which varies from 15 to 50 depending on the care home, are closely supervised by nurses and assistants of social workers. Nurses record the menstrual cycle of these patients in special registers, a measure which cannot be explained as a mere method of passive observation. In response to experts' question on what the nurses do when they determine that a patient's menstrual cycle is irregular, the majority of nurses replied that they administer a pregnancy test. They also said that there were no positive pregnancy tests within the last five years. In some facilities, nurses lied claiming that there were no cases of pregnancies, while the interviewed patients informed the experts that there were quite a few cases. Usually, the patients are subject to various measures ranging from persuasion to psychological pressure, deception or even outright coercion to get them to undergo an abortion. In one care home, a woman in her sixth month of pregnancy had to abort the baby. When the woman contacted *Lietuvos Rytas TV* and told them about this and other similar cases, she was punished, meaning transferred to a mental hospital.

2.1.5. The Right to Free Movement

The private life of an individual shall be inviolable... (Article 22, the Constitution of the Republic of Lithuania). Citizens may move and choose their place of residence in Lithuania freely... (Article 32, the Constitution of the Republic of Lithuania)

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

The majority of patients may leave the territory of the care home for a few hours, but periods of a day or longer period are generally restricted. Those wanting to leave must follow a certain procedure:

- submit a written request stating the reasons for the leave;
- submit a written consent of other persons outside the care home who will take care of the patient during his or her absence in the care home (often a written consent or invitation letter is also required).

As a rule, patients with drug or alcohol problems are not allowed to leave the grounds of the care home, however there is no clearly defined procedure determining which patients can leave the grounds and why. Generally, the administration finds the criteria of a "disoriented patient" sufficient to keep them from leaving the home alone, stating that is if for their own good. This results in grave violations of freedom of movement during cold weather as patients with serious disorders and walking problems (or those not able to walk at all) are not taken outside for about six months (from the second half of the autumn to the second half of the spring).

Experts obtained information on the restrictions imposed on some patients' freedom of movement (for example, a patient with limited capabilities was not allowed to visit his father's grave, while a woman who had given birth could not leave the territory of the care home). Furthermore, data shows that the right of certain patients to see their children is restricted (for example, a patient was not allowed to go visit her baby without any reason for the restriction).

Care homes are generally fenced in and some even look like prisons. For example, staff members use intercoms to communicate in an area enclosed with high fences.

Restrictions are also placed to some degree depending on the facility on the use of personal money by patients. Officially no restrictions apply to patients "capable of using money." However, a clear-cut mechanism for appointing someone to decide on the patient's capacity with respect to money does not exist.

Concerning patients who, in the opinion of the staff, are incapable of making decisions on how to spend their money, they are provided with opportunities to indirectly purchase goods. This usually means that a staff member buys the goods required by the patient, however patients have said that in these cases they have no control over choice or delivery time. Furthermore, patients have almost no possibility to control the change they receive back since the receipts provided do not always contain the full information or they do not get a receipt at all, which leads to disagreements and feelings of deception. One of the reasons for this is their lack of financial resources, yet, the training of patients to understand the value of money or make decisions about it is either not conducted at all or is very superficial.

As already mentioned above, patients from all care homes use the term "freedom" referring to life beyond the walls of their care homes. For example, they use such phrases as "I will never be free," "They will never release me to freedom," etc. Meanwhile, the popular measure of restricting freedom of movement at the solitary confinement ward is referred to as the "sweatbox."

2.1.6. The Right to Property

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

The possession of personal items is not restricted except for in the solitary confinement ward where the patients are not usually allowed to have any personal belongings. In some care homes, patients are allowed to keep pets such as cats, dogs or guinea pigs. However, the security of personal property is not commonly ensured (usually no locks are installed for rooms or lockers, no record journals are kept, etc.) and no compensation system for loss or theft is in place. Patients in certain care homes complain about frequent thefts which as a rule are committed by patients abusing

alcohol. Some complained to experts that their things were stolen while they were intoxicated and accused the orderlies of the care home.

The patients of some care homes are allowed to open personal bank accounts and use them freely (for example, a patient who is earning money unofficially is regularly depositing earnings in Šiauliai Bank). Yet, other care homes keep patients' money in a general account of the care home and distribute money to patients in accordance with the internal rules which are not always clearly defined.

Some reports of severe violations were discovered regarding the right to property. Patients in some homes are under pressure to give their money to nurses who justify the move by promises of security ("it will not be stolen"), convenience ("I will buy whatever you want, whenever you want it"), which provides opportunities for personnel to abuse personal funds of the patients. In one of the reported abuse cases, the nurse asked the patient to buy her a chocolate when the patient was purchasing goods for himself. Information was received about cases when the usage of personal things (for example, clothes) kept in lockers was obstructed as the personnel that had the keys ignored the requests of the patients to unlock the locker.

2.1.7. The Right to Education

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

The right of patients to receive an education is not upheld, which is a result of the anti-integration attitude of care homes; care homes find it troublesome to take care of educational or vocational training since they instead promote the regression of patients' autonomy. Therefore, the personnel of care homes do not encourage patients to study, do not support the initiative of those willing to study and do not search for opportunities to realise these initiatives.

Very few patients in care homes have graduated from some educational institution for the training of people with special needs or are currently studying. Only seven persons out of over 3,000 patients visited by the experts had acquired some level of education (or are still studying) which was supported by the care home.

Certain training courses, for example, in important financial management skills or computer skills, are conducted in some of the care homes. Yet, this is more the exception than a rule. Leisure programmes (sports, dance, singing, etc.) are generally perceived as educational.

2.1.8. The Right to Employment

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

The administration at care homes still has no mechanism for protecting patients from exploitation by employers who are generally inhabitants of the surrounding settlements or the staff of the care homes. This issue is usually tackled by applying two paradoxical methods: either the patients are

prohibited from working for the people in the area or the heads of the care homes talk to their employees and residents personally.

Generally, working activities are not rehabilitative and no opportunity is provided to receive adequate payment for the work as no official employment contracts are concluded and no opportunities to employ willing patients are sought. In rare cases, employment contracts for part-time employment have been signed with a few patients. As an alternative in some care homes agreements have been made for a few tens of Litas a month, claiming that if this amount is exceeded, the conclusion of the contract would become complicated and taxes would be imposed.

2.1.9. Treatment and Psychosocial Rehabilitation

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

Considering the fact that practically all patients of care homes (with very rare exceptions) spend their entire lives there, it is pointless to consider their integration into the society, even though this goal is formally declared in the job description of social workers. Thus, the issue of psychosocial rehabilitation becomes very complicated. No individual rehabilitation plans are drawn up for the patients (only one care home could provide documented psychosocial rehabilitation plans, yet the contents and the realisation of these raised doubts) and no techniques to enhance or restore social skills exist. As previously mentioned, care home objectives do not include preparing patients to live independently in a community. One exception is the Aknysta Care Home where patients with adequate skills for living independently are accommodated in five annexes located near the central building and are allowed relatively more autonomy.

Treatment with medications prevails in the care homes and generally the treatment prescribed in a mental hospital is continued. In cases when the patient arrives straight to the home, there is a tendency to start immediate treatment with medications instead of observing the patient's condition and seeking alternative methods. As a rule, ordinary medication (earlier generation medicines, esp. those with strong suppressive or sedative effects) is prescribed but modern neuroleptics and other medicines can also be given. In addition, medicines with a prolonged effect are given to patients to ensure that they receive a sufficient dose, although this can cause a complicated termination of the medicine, since the effect of one dose may last for as long as three weeks.

Patients are in fact deprived of any chance to control their own right to adequate treatment. They usually have as much information about the medicines they take as the doctor in charge (psychiatrist or physician) believes they should have. Furthermore, the lack of psychiatrists in the countryside makes it impossible for patients in regional care homes to receive an external evaluation of their mental condition or alternative consulting by someone outside the care home. This has created a paradoxical situation: although a patient of a care home is registered with the regional Centre of Mental Health, often the same psychiatrist works for both the care home and the concerned Centre of Mental Health.

While conducting the investigation, experts determined that there was a substantial shortage of adequate psychological consulting and psychotherapy services. Most of the care homes employ a part-time psychologist. The information provided by patients of practically all care homes reveals that the quality of services provided is unsatisfactory, that there is a lack of choice (no opportunity to get mental health assistance outside the care home) and a general shortage of these services. In a

few cases, capable patients did not know about the opportunity to receive psychological consulting and psychotherapy services or about the specialist providing these services.

The nursing staff ensures satisfactory healthcare to patients suffering from chronic somatic illnesses in care homes. Those ill with bronchial asthma, epilepsy, diabetes, cardiovascular, articular or ophthalmic disorders are provided with adequate treatment with medicine. In the meantime, the availability of physiotherapy techniques varies greatly: some care homes do not have any at all, while others offer physiotherapy or physical rehabilitation procedures.

Mobility products are available to patients but all wheelchairs are mechanical. Glasses and dentures are usually provided at the expense of the care homes, yet sometimes there occur problems if the patients lose or damage them and in such cases they must wait for these aids for a longer time.

Certain care homes have entirely eliminated preventive medical examinations, while others traditionally organise annual preventive examinations with laboratory tests or x-rays. Only one care home identifies target groups with an increased risk of illnesses and arranges their respective examination. In addition, patients and staff of only a few care homes are vaccinated against the flu once a year.

2.1.10. Outside Assistance

Care homes co-operate with various institutions in fields ranging from treatment to education and law enforcement. Yet, the aim of this co-operation lies not in the enhancement of patients' needs and reducing their exclusion but serves essentially administrative purposes.

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

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

Co-operation with other healthcare institutions usually relies on the good will of the administration of the care home. Generally, patients are taken to those doctors who are not working at the care home. However, the patients have no choice. The information obtained in the majority of the care homes reveals that there is a lack of gynaecological services. In addition, certain problems arise due to the reluctance of other healthcare institutions to admit the patients of care homes because of both mental or intellectual disabilities and alcohol addiction.

Care homes work in close collaboration with mental hospitals. The majority of employees interviewed in the care homes expressed their dissatisfaction with the treatment of patients in these hospitals in terms of both the duration of the treatment (too short), and the lack of changes in the patients' behaviour after returning from a mental hospital to a care home.

The person is usually referred to the care home by a psychiatrist who works for the regional Mental Health Care Centre and the care home at the same time which provides conditions for abuse. The administration may have a say in the referral of "unsuitable" patients to a mental hospital.

2.1.11. Care and Right Safeguarding of Incapable Patients

Custody is established in order to implement, protect and defend the rights and interests of an incapable natural person. (Article 3.238 of the Civil Code of the Republic of Lithuania)
Provided a person determined as incapable recovers or his/her health condition substantially improves, the Court recognises him/her capable. After the Court decision enters into effect, the custody in respect of this person is annulled (Article 2.10 of the Civil Code of the Republic of Lithuania).

The rights of incapable patients are restricted to a maximum. In cases where the patient's custody is entrusted to the care home, the patient has no opportunity to file a complaint about inadequate care or failure to safeguard his or her right representation.

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

Patients being deemed incapable questionably was another problem observed. Both the experts and the administration of the care homes concur that the incapability of some patients is uncertain. Some who were deemed incapable by the courts communicate adequately with other people and thus this raise doubts as to the transparency of the mechanism to determine this. The administration believes that in some cases property interests have had a certain influence on the determination of incapability. In other cases, it seems that the determination of incapability is used in order to allow persons charged with criminal offences to avoid imprisonment.

2.2. Violations of Human Rights in Mental Hospitals

Regarding actual geographic location, mental hospitals are less secluded than care homes. The majority of mental hospitals are situated in cities and were traditionally set up as individual facilities unrelated to general hospitals. In terms of isolation, mental hospitals do not differ from psychoneurological care homes: although they are surrounded by residential areas, life in hospitals is isolated.

In Soviet times, outpatient assistance was vested with hospitals, while services were very much centralised, i.e. concentrated in the so-called psychoneurological dispensaries. For this reason, hospitals were situated in the city centres so that they were easily accessible to residents. Privatisation and medical reform made the localisation of mental hospitals in city centres troublesome since people attempted to relocate them to the city suburbs.

In the late 1970s, an individual aid system was implemented for persons with addiction problems, so the treatment of these patients in mental hospitals was rather an exception than the rule. Currently certain mental hospitals house separate units for these patients but, for example, in one hospital only men are admitted into this unit.

Beginning in 1997 when the establishment of outpatient mental healthcare centres was initiated, the number of places in hospitals was continuously reduced. The traditional Soviet practice of treating men and women in separate institutions still prevails. In addition to the restriction of movement, i.e. separate units and the isolation of the hospital, this markedly reduces the opportunities for patients to communicate.

Mental hospitals and care homes are closely related:

- Patients are referred to care homes from mental hospitals. In certain cases, the decision to place a patient in a care home is made while the patient is still being treated in a mental hospital. In other instances, the decision to transfer the patient into a care home has been made before hospitalisation in a mental hospital. Thus the patient simply waits in the mental hospital until there is a vacancy in a care home[10].
- Care home patients whose behaviour seems troublesome to the staff are hospitalised in mental hospitals. This transfer to a mental hospital may be viewed by patients as a necessary treatment in case of the deterioration of a person's condition, as a punishment for disobedience or as a money-saving measure (at the time of hospitalisation in a mental hospital, a care home receives 100% of the patient's pension, instead of just 20% when the inmate lives in a care home).
- In certain cases, mental hospitals temporarily perform the function of a care home since some patients actually stay in the hospital for a few months or longer. Yet, these are rare cases that usually end in the patient's transfer to a care home.

A psychiatrist from the regional Mental Healthcare Centre where a care home is located is among the decision-makers for the referral of a patient to a mental hospital. But since the psychiatrist is also employed by a care home, he or she is entirely dependent on the care home authorities and, therefore, generally adopts decisions on the behalf of the home. In this case we see the institutionalisation of community assistance: performing his or her functions in a care home, the psychiatrist fills in the documents of the Mental Healthcare Centre. Thus, the patient who has actually not even visited a Mental Healthcare Centre is referred to a mental hospital by the psychiatrist. As a result, a person institutionalised in a care home has no opportunity to receive mental healthcare services in the community as he or she is automatically referred to a residential institution, that is, a mental hospital, in case of mental health problems. There is a prevailing attitude that a person placed in a care home should be content with the services received there.

Mental hospitals (and care homes) follow an illegal but traditional practice for deciding on the treatment of a patient, meaning that the medical staff does not change the diagnosis of patients even if they know that it is wrong. They reluctantly talk about these cases and prescribe treatment according to the wrong diagnosis. As a rule, the diagnosis determined by forensic psychiatrists or the Doctor Consulting Group is not questioned.

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

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

[10] The methods of solving the problems of patients on the waiting list are different in two mental hospitals. One hospital has an agreement concluded with a municipal nursing hospital for a few places for patients on a waiting list. Another hospital has concluded an agreement with the municipality and, in addition, with the patient's family for the additionally sponsored places (provision of residential social services) for patients of this kind.

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

The patient in the first and second regimes must wear hospital issued pyjamas. The regime defines the patient's freedom to use his or her rights to privacy, freedom of movement and property. Torture and inhuman treatment also are related to the type of regime implemented.

Occupational therapy in hospitals does not address the specific needs of patients. For example, unskilled mechanical tasks may be useful to certain groups of patients such as those with intellectual disability, while it confuses mentally ill patients and slows their convalescence. In Soviet times, certain hospitals like the psychoneurological care homes had well-developed occupational therapy units (activities in agriculture and industry) engaging the patients. At that time occupational activities had a certain role in the treatment procedure but did not address the development of individual skills and were instead limited to leisure. After their treatment was finished, the patients would keep going to these workshops and continue their previous activities. The fact that the workshops or occupational units have survived in one or another form today clearly shows that priority is still given to supervision rather than training. Thus, hospitals simply meet the minimal needs of the patients without involving them into the decision-making process, thus, further promoting their self-insufficiency and dependence on the system.

2.2.1. The Right to Information

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

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

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

Despite laws requiring personnel to provide the patient with information about his or her illness, modes of treatment and side effects, in practice the patient still cannot enjoy his or her right to

information. Staff members lack the necessary knowledge about the patients' right to information and thus the majority of patients are not given enough facts about their treatment. Doctors are the only ones with the authority to provide the information but patients can expect to be informed only if they persistently ask for it and depending on the doctor's goodwill and respect for the patient. Usually, the patients do not even know that they can read their medical records although the staff does not deny the possibility to show it to the patient, except for information concerning third persons. Patients are not encouraged to view their medical records but they can get an extract upon furnishing a written request to the head of personnel (involuntary patients are especially interested in this opportunity). The staff considers giving information to patients as a potential threat which might cause the deterioration of their condition.

The administration of Rokiškis Mental Hospital has drawn up a form for informing patients of involuntary treatment used when patients do not give their consent to treatment in this residential facility. However this hospital has very few involuntary patients.

There is no procedure for submitting complaints and receiving the corresponding written feedback. Complaints can be made only orally and are usually made about the personnel's conduct restricting patient's freedoms and inadequate environment conditions (for example, security issues, hospital units have no electricity outlets). In one hospital, patients can express their opinion by filling out an anonymous questionnaire assessing the services. However the administration does not think that the survey results could be relied on in the discussion on the quality of provided services with the patients.

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

Each unit has an occupational manager responsible for activities both inside and outside the units. The majority of activities take place outside the units and are consequently accessible to the patients in freer regimes. The patients may take part in activities in the standard therapeutic groups but it is not so easy for them to be admitted to these groups (this especially refers to patients treated in acute illness units). This leads to speculation that the administration does not place much importance on patients' need for self-expression. For example, a librarian who is on a sick leave is not replaced for a month, and the patients, therefore, cannot use the library.

2.2.2. The Right to Privacy

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

The right to privacy is a fundamental human right and for the mentally ill this right is undoubtedly very important. The right to privacy is closely related to autonomy for persons suffering from mental illness, while autonomy is one of the key principles of mental healthcare organisations since it promotes the recovery of patients. Paradoxically, all mental hospitals visited gravely violate this right.

Mental hospitals restrict the patients' right to privacy to as much as possible, while the patients of acute illness units in practice cannot enjoy it whatsoever. This right is violated by breaching a

patient's right to personal data protection, by providing no conditions for private hygienic procedures and telephone calls, by not meeting the requirements of patients' number in a ward and not allowing the patient solitude when required.

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

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

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

In the Lithuanian mental hospitals visited, the number of patients in one room sometimes reached as many as twenty. Some rooms had no doors, while others remained opened at all times, depriving patients of any opportunity to be alone. Some patients who were tired of being around others asked to be put in the solitary confinement ward in order to have a short rest from the noise or to be left alone for a while. The corridor of one of the men's acute illness units, for example, was very noisy, with the personnel shouting loudly and the patients complaining that the continuous noise tired them out. Meanwhile the activity room meant for meeting privacy needs was usually locked. The continuous exposure, noise and forced presence of other people not only fail to contribute to the patient's convalescence but even hinder it. This renders all talk of a therapeutic environment meaningless.

Switching off lights in units at a set time is a very popular practice observed in hospitals and patients are strictly forbidden to switch on the light themselves, which is usually not even possible since fuse-boxes are locked and the keys are kept by the nurses. On the other hand, a dim light is left on in rooms throughout the night meaning that patients have to sleep in light. Consequently, patients have no possibility to choose what light they want and when they want.

2.2.3. Discrimination

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

As set forth in the Constitution of the Republic of Lithuania, every patient has a right to adequate healthcare. However in the mental hospitals visited, there was no differentiation of the patients, meaning that those treated for the first time and those treated on a regular basis, involuntary patients

(convicts) and voluntary patients with lesser or greater disabilities were treated together according to the same rules.

Certain patients are given privileges in mental hospitals like in care homes. Obedient patients favoured by the personnel receive more freedoms and privileges unavailable to other patients. For example, they are allowed to go to the city, given the key to the bathroom, can freely use their mobile phones, are issued an extra ration of cigarettes or permitted to smoke outside or in another room, etc.

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

2.2.4. Torture and Inhuman Treatment

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

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

The lack of knowledge about aggression management leads staff members to seek easy methods to suppress patients' aggression. Unfortunately these methods often prove inappropriate. Since the hospitals are understaffed and not equipped to take an aggressive patient to the bathroom safely, they simply use a bedpan and diapers.

In certain cases, restraint is imposed as a prevention measure. In situations where there is not enough staff or in the event the staff want to prevent potential eruptions of aggression, they also restrain those patients who are agitated. Restraint is also used as punishment.

The physical and mental integrity of patients is not guaranteed as cases of violence used against patients were documented in the majority of hospitals. Violence was initiated by both the personnel and other patients and it was discovered that certain patients use violence and even torture against other patients, although the staff failed to take to any measures or merely subject all parties of the conflict, including the victim, to restraint. The fact of recurrent violence against a certain patient was revealed in one of the hospitals according to information provided by both the staff and patients. The reason for violence was the nuisance caused by the victim who was as a result placed repeatedly in the solitary confinement ward, in restraint and given sedatives.

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

Generally, the patients are subject to a variety of punishments. Prevailing punishments include straitjacket, restraint, injections, forbidding coffee and smoking or a stricter regime. In the majority of cases, mid-level medical personnel decide on the punishments (including medicines).

The experts obtained information that a woman who recently gave birth was not allowed to take a shower situated in a general regime unit in spite of the fact that due to physiological reasons she could not wash herself in the bathroom.

2.2.5. The Right to Free Movement

The private life of an individual shall be inviolable... (Article 22, the Constitution of the Republic of Lithuania). Citizens may move and choose their place of residence in Lithuania freely... (Article 32, the Constitution of the Republic of Lithuania)

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

Mental hospitals restrict the patients' right to free movement. The release of patients to go home during treatment is not legal in Lithuania. In line with a widespread belief, the patient is not allowed to leave the territory of the hospital and usually the walls of the unit during his or her treatment. For example, the administration of one hospital said that a patient's presence in a mental hospital automatically implies the restriction of the patient's right to move freely.

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

Another hospital uses a system of permits issued by the doctor. This hospital is surrounded by a prison-like fence (concrete walls more than two metres high with steel beams covered with barbed wire) and a watch tower. The majority of patients must acquire permits to leave the territory of the hospital (there is only one exit where the patients must show their permit), which can be either permanent or temporary, for one or two times per day (with exact hours specified). The permits can be withheld in two cases, either as a result of the deterioration of the patient's illness, or when the person is hospitalised to treat alcohol addiction.

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

2.2.6. The Right to Property

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

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

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

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

Accountability issues also occur according to information gathered. Patients are not always given receipts when personnel buys them food or toiletries, who say that the items were purchased at a market. Patients' requests to buy goods in stores and provide them with receipts are ignored. Certain patients (such as those transferred from care homes or involuntary patients) are not allowed to have their money and the amount is debited from the patient's bank account.

2.2.7. The Right to Education

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

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

The visit to the children's ward of one of the mental hospitals revealed that the patients are not provided an education, that is, no teachers visit them and no lessons take place.

2.2.8. The Right to Employment

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

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

Following the practice prevailing in other hospitals, patients voluntarily help the personnel. Yet, the patients' assistance in nursing or restraining other patients violates professional ethics.

2.2.9. Treatment and Psychosocial Rehabilitation

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

Deficiencies in the procedure for medicine reimbursement lead to the falsification of some patients' personal data. For example, an incorrect diagnosis can be entered into medical records in order to allow the patients to receive the proper treatment since otherwise the medicines would not be reimbursed for patients with certain severe mental disorders (such as temporal and short-term psychotic disorders, delirium disorders, etc.).

Treatment with medications prevails in the mental hospitals, where the main tendency is to start treatment with medications right away instead of observing the patient's condition and seeking alternative methods of treatment. As a rule, ordinary medication (earlier generation medicines) is prescribed but modern neuroleptics and other medicines can be also prescribed. In addition, medicines with a more prolonged effect are also given to the patients to ensure that they receive a sufficient dose in case they are not motivated to take medicines themselves. Yet, these cases can lead to a risk of complicated termination of the medicine, since the effect of one dose may last for as long as three weeks.

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

Mid-level medical personnel are vested with too much responsibility in some of the mental hospitals. In some cases, medicines that should have been given to the patients during the deterioration of their condition or eruption of aggression were indicated in the patients' medical records. However, such "treatment" was risky since the prescription of these medicines was entrusted to the mid-level medical personnel, which may diagnose the patient's condition incorrectly.

Mental hospitals follow an illegal but traditional practice for prescribing treatments for patients; doctors do not change the diagnosis even if it is incorrect. They reluctantly talk about these cases and decide on treatment based on the wrong diagnosis. As a rule, the diagnosis determined by forensic psychiatrists or Doctor Consulting Group is not questioned.

Cases of long-term hospitalisation (from 104 days to 20 years) were discovered in all mental hospitals visited. These patients mainly suffer from the restriction of human rights in the residential treatment facilities since they lose their skills required for integration in the society and thus need rehabilitation. Here we come across a paradox once again: these patients are the most neglected and are not provided with sufficient services or psychosocial rehabilitation. Individual rehabilitation plans for patients are not drawn up in any mental hospitals.

The organisation of occupational therapy and the responsibility for its implementation have not been regulated in mental hospitals thus far. In some facilities it is the task of the psychologists, while in others the nursing staff and social workers are responsible. Occupational therapy is usually meant for communication and leisure only and there is a clear shortage of activities to provide skill training and maintenance. There is no continuity either: even if the hospital offers some rehabilitation activities, they are not available to the patient after his or her release.

The functions of social workers vary from hospital to hospital but everywhere they are in charge of preserving patients' contacts with both the external world (for example, they take care of patients' allowances and pensions) and other institutions.

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

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

2.2.10. Outside Assistance

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

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

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

2.2.11. Care and Safeguarding of Rights of Incapable Patients

Custody is established in order to implement, protect and defend the rights and interests of an incapable physical person. (Article 3.238 of the Civil Code of the Republic of Lithuania)
Provided a person determined as incapable recovers or his/her health condition substantially improves, the Court recognises him/her capable. After the Court decision enters into effect, the custody in respect of this person is annulled (Article 2.10 of the Civil Code of the Republic of Lithuania).

There exists no clearly regulated procedure for the hospitalisation of incapable patients in case their guardian refuses to give consent and there are no mechanisms in place to force the guardians of incapable patients to perform their duties. Generally, the practice of custody of incapable patients is

faulty, which provides favourable conditions for the violations of patient's rights and hinders adequate assistance. The fact that an incapable patient has no right to initiate the replacement of his or her guardian or appeal against inadequate care provided by the guardian is an obvious legal loophole.

In one of the identified cases, involuntary treatment was extended for one patient merely because his guardian failed to arrive for a discussion, even though in the opinion of the specialists there were no medical reasons for an extension. This problem also raises concerns about the doctors who asked for advice on how to tackle the situation.

In the aforementioned case, not only the right of the patient to live in the least restrictive environment was violated by ignoring his will and choice, but tax payers' money was also wasted since the person was forced to live and be treated in a mental hospital for at least six additional months.

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

Conclusive Notes

International experience has shown that residential care facilities are harmful, too expensive and that only a minority of secluded patients are indeed incapable of living in society.

Large residential institutions, designed for isolating "defective" members of society, cannot properly safeguard basic human rights such as the right to privacy, information, the least restrictive environment, free movement and other fundamental human rights.

This leads to a vicious circle: the more the human rights of mentally ill patients are violated, the more they are crippled socially by furthering their absolute dependence upon the care provided to them, which leads to higher costs for the government for their sustenance.

Conclusions

- The Lithuanian system of residential mental healthcare facilities and treatment is not cost-effective; therefore, it is advisable to conduct an external analysis of its expenditures and benefits.
- The system is also ineffective in terms of treatment and/or rehabilitation since it promotes social exclusion, stigmatisation and the inability to integrate into the community. The immediate deinstitutionalisation of the system is recommended and the development of a widespread network of community-based services.
- The traditional centralised system of isolated mental hospitals and care homes provides conditions for various violations of human rights and furthers patients' social exclusion and stigmatisation. It is recommended to introduce community-based services available around the clock and to ensure the care of persons with serious mental illnesses, to offer services in places where people live and work, and to develop rehabilitation services that would aid in optimising the involvement of mental patients into the society.

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

The implementation of this strategy shall require changes in both legislation and funding procedures. First, laws and other legal instruments should plainly regulate the procedures of providing community-based mental healthcare services and social services and the funding to be allocated. One way of changing the existing funding procedure and concurrently encouraging municipalities to develop the network of community-based services is to create a "package" for the patient that would "follow" him or her. Laws should provide the patient with the opportunity to choose whether to receive services in a residential facility or in the community and "bring" his/her package to whichever institution he/she opts for. That would create a competitive environment and could prompt the municipalities to develop an attractive, alternative structure of community-based services instead of giving the patient's package to a residential facility.