

**DGI - Directorate General of Human Rights and Rule of Law**  
**Department for the Execution of Judgments of the ECHR**  
**F-67075 Strasbourg Cedex, FRANCE**  
[dgl-execution@coe.int](mailto:dgl-execution@coe.int)  
**+33 (0)3 88 41 27 93**

**Concerning: 1280th meeting of the Committee of Ministers, (7-9 March 2017), with regards to the Revised action plan submitted by the Romanian state for the execution of the Centre for Legal Resources on behalf of Valentin Câmpeanu against Romania (App. No. 47848/08) judgment.**

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## **COMMUNICATION UNDER RULE 9.2**

The Centre for Legal Resources (The CLR) is a non-governmental organisation established in 1998 in Romania, with the aim to observe the respect for human rights. The CLR brought Application no. 47848/08 on behalf of Mr. Câmpeanu to the European Court of Human Rights and manifests a legitimate interest in observing the execution of the Court's judgment.

The CLR would like to communicate to the Committee of Ministers its point of view regarding the Revised action plan (02/01/2017) submitted by the Romanian Government, under **Rule 9.2** of the Rules of the Committee of Ministers for the supervision of the execution of judgments and of the terms of friendly settlements.

In the following communication, the CLR would like to underline the systemic shortcomings regarding the human rights of persons with disabilities in Romania, especially persons found in similar situations with that of Mr. Câmpeanu, the applicant. At the same time, the present communication refers to the general measures presented by the Romanian Government in the Revised action plan (02/01/2017).

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## EXECUTIVE SUMMARY

Since the previous Reply to State Submission (September 2016) and up to the present, the CLR has conducted 13 unannounced visits in residential institutions for persons with mental disabilities<sup>1</sup> and psychiatric hospitals. Through its fieldwork, the CLR observed that most of the systemic problems which led to the demise of Mr. Câmpeanu still exist and that similar deaths in suspicious circumstances and abuses continue to occur in residential institutions for people with disabilities, without effective investigations or protection mechanisms.

### **The main problematic areas presented in the communication are:**

1. *People with disabilities die in state custody and there is still no policy of effective investigations in all such cases. **From the beginning of 2016 until the 28<sup>th</sup> of September 2016**, at least 886 adults with mental disabilities died while institutionalised in social care homes. Other **4699** deaths took place in psychiatry hospitals (2010-2016).*
2. *Persons who are orphans or abandoned, like Mr. Câmpeanu, are still most likely to be institutionalised all their lives, from birth until death, without due consideration of their wishes and potential. There is still a systemic problem with the way in which consent is obtained from people with mental disabilities – in judicial or administrative procedures.*
3. *The guardianship appointment procedure is still out-dated and contrary to human rights standards.*
4. *There are no practical procedures in place for supporting people with disabilities who are institutionalised and wish to complain.*
5. *Some of the general measures presented by the Government do not function in practice at the present moment.*

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<sup>1</sup> Social care homes for adults with mental disabilities, medical-social units, foster care centers for children with mental disabilities

## 1. Deaths of people with mental disabilities in State custody and lack of effective investigation

The Government submits the following: *“In accordance with internal regulations, within the PMH, an Ethic Council, a Commission for the analysis of deaths and a petitioning mechanism are put in place. The Ethic Council has the responsibility to examine if patient rights have been respected by the hospital’s personnel. In case the Council is seized with a complaint, an extraordinary meeting is convened; the council hears the patient, the other parties and possible witnesses and, after evaluating all the elements at its disposal, drafts a report, containing its final conclusions and its recommendations. The report is forwarded to the hospital’s manager, in order for him/her to apply the legal sanction or other measures of a moral or ethical nature”.*

In 2016, the CLR continued a large-scale campaign of collecting information concerning the deaths of people with disabilities in state custody. According to official replies of the local authorities to the CLR <sup>2</sup>, **from the beginning of 2016 until the 28<sup>th</sup> of September 2016, at least 886 people with mental disabilities died while institutionalised** in social care homes under the authority of the Social Assistance and Child Protection Directorate. **Only 97 cases had been subjected to a forensic autopsy.**

Regarding the situation in the psychiatry hospitals in Romania, **4699 deaths** had been reported from 2010 to 2016, but there are some specific places where the number is very high in recent years. For example, in “Elisabeta Doamna” Psychiatric Hospital in Galati, 65 people died in 2016 and 99 in 2015. In another hospital, “Sapoca” Psychiatric Hospital, according to official replies, there were 59 deaths in 2016 and 87 deaths in 2015. Also, in “Sf. Pantelimon” Psychiatric Hospital in Braila, 49 deaths had been registered in 2016, and 73 in 2015.

In the period between 2010 and 2015, out of 4142 deaths that took place in psychiatry hospitals, **only 1793 cases had been subjected to a forensic autopsy.**

The mortality in the medical-social units<sup>3</sup> at the national level is more difficult to ascertain because these institutions are under the subordination of the local councils. Even the number of such institutions is uncertain and information

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<sup>2</sup> Data provided in January 2016 by the local General Directorates for Social Assistance and Child Protection (*Direcția Generală de Asistență Socială și Protecția Copilului*), available at: <http://www.crj.ro/harta-deceselor-cate-persoane-cu-dizabilitati-mintale-au-murit-in-custodia-statului-intre-anii-2011-2014/>

<sup>3</sup> The Medical-Social units are different than the social care homes for persons with mental disabilities.

on the number of residents and any mortality is apparently not centrally collated. The CLR has incomplete information for the first eight months of 2016. According to the responses received from one local authority, , in the county of Bihor, 45 people had died in medical-social units in 2016. (Mr. Campeanu was held at Cetate medical-social unit, following his discharge from the orphanage and before he was transferred to the Poiana Mare psychiatric hospital).

Joint Orders no. 1134/25.05.2000, issued by the Minister of Justice, and no. 255/4.04.2000, issued by the Minister of Health, on the procedures relating to medical opinions and other forensic medical services are still not appropriately applied in practice. The ministries apparently took few steps to ensure that the orders were well publicised and effectively implemented. In 2016 the CLR organized several meetings to raise awareness about these legal documents. Although these procedures specify that deaths in the custody of the state are considered *de plano* suspicious and must be followed by a forensic autopsy, they are either not known at the local level, or they are circumvented by the residential centres' management. According to official replies, **only 97 deaths** (of which 26 were in Constanta County) were followed by a forensic autopsy in 2016 from the total of 886 deaths in the first eight months of the year.

The lack of systematic collection of information regarding mortality in social care homes and in medical-social units and the ineffective way of implementing regulations to investigate all death in these facilities clearly indicate the Government's failure to effectively protect the lives of all people with mental disabilities held in state custody.

## **2. Arbitrary institutionalisation of people with mental disabilities and no effective representation, support and protection for people with mental disabilities who are institutionalised**

The chronic lack of community services means that institutionalisation is the most common social path for people with mental disabilities in Romania. Official statistics show that the number of people with disabilities who become institutionalised is on a growing trend (17,983 in the first three trimesters of 2016)<sup>4</sup>.

The CLR monitoring Reports from September 2016 to February 2017, show that there is still a **systemic problem with the way in which consent is obtained** from people with mental disabilities – in judicial or administrative procedures regarding their placement in state care. The CLR found numerous cases where people's wishes were not considered when deciding the

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<sup>4</sup> Ministry of Labour and Social Justice, Statistics, available at:  
[http://www.mmuncii.ro/j33/images/buletin\\_statistic/dizabilitati\\_III2016.pdf](http://www.mmuncii.ro/j33/images/buletin_statistic/dizabilitati_III2016.pdf)

institutionalisation or transfer and where the persons concerned were not asked at all for their opinions (even when the public authorities claim to have heard the opinions of the person, there is no evidence to support this). In addition, since there is no support for decision-making, the residential centre's staff resorts to forging institutionalised adults' signatures on social services contracts – as reported by CLR teams that have found contracts and other documents signed, or even fingerprinted, by people with severe mental disabilities who were obviously not capable of doing this voluntarily.

Criminal investigations concerning victims who are institutionalized persons with disabilities are still not effective and proceed at a very slow pace. The investigative authorities do not know the applicable legislation and often hold prejudices against persons with mental disabilities. Despite the Government's claim to be reviewing *ex officio* all decisions not to prosecute cases of crimes perpetrated against persons with mental disabilities, the CLR has not observed any consequences of such a review, as no decisions not to prosecute have been overturned.

In fact, any effective review would have resulted only from an intervention by a civil society organisation. In one such case, the CLR filed a criminal complaint on 29 October 2013, concerning abused children in an foster care center in Oradea, Bihor County. The Prosecutor's Office dismissed the complaint on 17 March 2014, arguing that the children are untrustworthy and that, in any case, using violence against children is sometimes permitted and necessary. The CLR overturned this decision in court on 6 January 2015. The investigation then dragged on for almost two more years, until on 21 December 2016, the Prosecutor's Office finally indicted several persons. However, the indictment has several flaws, including the fact that the perpetrators have been accused of abuse of official authority, which is not consistent with the circumstances of the case<sup>5</sup>.

In another case, the CLR filed a criminal complaint on 18 February 2014 regarding several suspicious deaths and cases of inhuman and degrading treatment that occurred in a social care home for teenagers and elderly in Aldeni, Buzău County. The Prosecutor's Office took more than 7 months to perform the first onsite visit (by which time the institution was on the verge of being closed down) and did not interview any of the residents. It dismissed the complaint on 11 September 2014. The CLR overturned this decision in court on 27 January 2015. The court ordered the Prosecutor's Office to complete the investigation and to interview all residents and staff. Despite this, the Prosecutor's Office again rejected the complaint on 29 February 2016, without complying with all the requirements imposed by the court.

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<sup>5</sup> Eg: One method of abuse, which was confirmed by the Prosecutor's Office, was crushing a child's fingers with a door reportedly in order to find out who stole a dessert. Such abuse clearly represents a criminal offence more serious than an abuse of official authority.

In another case, the CLR filed two separate criminal complaints regarding a social care home in Breaza, Prahova County. The first complaint was submitted on 30 June 2014 and it concerned six suspicious deaths as well the inhuman and degrading treatment to which the residents had been subjected. The first response from the Prosecutor's Office was issued only on 16 February 2017, and it dismissed the complaint regarding the suspicious deaths while ordering the commencement of an investigation into inhuman and degrading treatments (it is not clear why this part of the investigation was not ordered earlier). The second complaint was also filed on 30 June 2014 and it concerned the forgery of the death certificates for the six deceased residents as well as an illegal contract concluded between the institution in Breaza and the Social Assistance and Child Protection Directorate of Bucharest, Sector 4. The CLR has not yet received any decision from the Prosecutor's Office in this case.

### **3. Denying access to the CLR in ad-hoc visits**

Several Social Assistance and Child Protection Directorates (Romanian: *DGASPC*) are refusing to allow the CLR to perform monitoring visits in social care homes for persons with mental disabilities or in foster care centres for children with mental disabilities. Although the CLR's right to monitor institutions derives directly from art. 33 of the UNCRPD, some DGASPCs are making access to institutions subject to a formal agreement between the CLR and the relevant DGASPC. Recently, this has been the case with the DGASPCs of Suceava County (16 November 2016), Bucharest Sector 2 (14 December 2016), Bucharest Sector 3 (14 December 2016) and Mures County (20 December 2016). Of particular relevance is the case of DGASPC Sector 2 Bucharest, which denied the CLR's access to the Gheorghe Serban social care home in Bucharest on 14 December 2016, despite the fact that on 24 February 2014 a court affirmed the CLR's right to visit the same institution, based solely on art. 33 of the UNCRPD.

Some DGASPCs also hamper monitoring activity by refusing to respond to or by delaying their response to requests for public interest information with regard to the causes of deaths in a social care home. In one such case, the CLR filed a request for information with DGASPC Sector 2 on 2 March 2016. At the time of writing this submission, the CLR has not received all the requested documents, despite paying the fee required by law.

### **4. Out-dated guardianship appointment procedure shows poor understanding of how people with disabilities should exercise their human rights**



- a) The guardianship system has not been reformed and there are no concrete proposals to amend the Civil Code in order to align it with the provisions of the UNCRPD. **Amending the Civil Code would not have raised any substantial procedural difficulties, given that similar laws (the Criminal Code and the Criminal Procedure Code) have been frequently amended in the past years.**
- b) The CLR's monitoring visits show several flaws of the current guardianship system. During a monitoring visit conducted between 31 August and 1 September 2016 in a social care home for persons with mental disabilities in Jucu de Sus, Cluj County, the CLR's monitors observed, among others, that (i) the appointed guardian for several beneficiaries is the Jucu Town Hall, but this local authority does not have the necessary staff to fulfil this role, leaving the residents of the institution without effective legal representation, (ii) the courts do not take this into consideration, and refuse to appoint a specific person as legal representative, preferring to leave this task to the Town Hall, delaying the entire process, (iii) the representative of the residents during the guardianship procedure is an employee of DGASPC with no legal training, (iv) this situation raises an important issue of conflict of interest, as an employee of the plaintiff (DGASPC) in the guardianship case also represents the defendant (the person whose placement under guardianship is requested), (v) the lack of effective legal representation means that some residents cannot validly consent to enter into contracts with DGASPC or agree with their placement in another institution, but the DGASPC ignores this, sometimes using a fingerprint signature of the resident as proof of consent.
- c) Another monitoring visit conducted on 14 December 2016 in the Casa Max social care home in Bucharest, Sector 3, shows that for one resident the DGASPC has been appointed as legal guardian. This raises a serious conflict of interest concern, as the DGASPC is both the representative of the resident and the authority most likely to abuse him.
- d) The lack of effective legal representation also means that institutionalized persons with mental disabilities cannot have effective access to justice, even when their rights are seriously breached.

## **5. Still no access to justice and effective protection for people with disabilities found in State custody**

- a). During a visit performed on 26 January 2017 in a social care home in Maciuca village, Valcea County, the CLR's monitors confirmed several serious abuses of residents' rights, including the fact that some residents had been tied and restrained in breach of the applicable legislation and



that some residents were used to help build a house for the institution's manager<sup>6</sup>. Moreover, no autopsy was performed for any of the deaths which occurred in the institution, contrary to the mandatory provisions of the law. According to **the death certificates** of the five persons concerned the cause of death was pneumonia and acute bronchitis. The files of the deceased residents did not record any information about any requests for emergency medical help or emergency admission in an appropriate hospital. In this Center the **restraint measures** were applied even when the residents were experiencing psychomotoric anxiety crisis; the employees did not properly record isolation and restraint measures; and the instruments used for restraining the residents were not provided with linings or any other protective material. The social care home does not have a **psychiatrist** although all the residents receive psychiatric treatment; and there were no records that the center had ever requested emergency medical treatment by dialing 112.

b). In addition, although a large number of residents (47) were transferred from the social care home in December 2016, the institution's staff offered contradictory statements concerning the reasons for the transfer and whether and how the residents' consent had been obtained<sup>7</sup>.

c). Residents' rooms were sparsely furnished; the residents had no personal clothing and were poorly dressed; both men and women had their hair cut short; the walls were damp, the indoor temperature low, the dining room located in a different building to the one where the residents live, and the bathroom had no products for personal hygiene. The room in the middle of the center which was used as an seclusion room did not have the necessary equipment; no room had been designated for the purpose of respecting the intimate rights of the residents; there was no access ramp to the second floor used by the bedridden residents. In the social care home there was no occupational or any other programs that can stimulate the residents' development.

d). The social care home was about to receive a **new license** as a social service provider from the Ministry of Labor and Social Justice until the publication of photos from the facility in January 2017. It was also claimed that the social care home's application did not have approval from three

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<sup>6</sup> Press article, last checked on 16 February 2017, available at:

<http://www.tolo.ro/2017/01/23/oameni-legati-cu-chingi-de-tir-de-paturi-si-banci-la-centrul-de-boli-psihiice-maciuca-pentru-ca-infirmierii-ii-amenajeaza-casa-managerului/>

<sup>7</sup> Monitoring Report, CLR, February 2017, available at: [http://www.crj.ro/wp-content/uploads/2017/02/Raport-de-monitorizare-CRRN-Maciuca\\_ANO.pdf](http://www.crj.ro/wp-content/uploads/2017/02/Raport-de-monitorizare-CRRN-Maciuca_ANO.pdf)

public authorities which have no relevance to the living conditions of the residents in this institution.

e). Despite such serious abuses, the residents could not effectively file a complaint due to (i) lack of information about the complaint procedure, (ii) lack of specialized support for writing and filing a complaint and (iii) lack of effective legal representation for residents placed under guardianship.

## **6. The UN CRPD Monitoring Council is still not active**

The CLR would like to point out to the Committee of Ministers that the Monitoring Council has not been “put in place”, as the Government contends. After the adoption, in January 2016, of Law no. 8/2016, the administrative steps for the effective establishment of the Monitoring Council have been delayed and there is still no appointed staff for the functioning of the Council and much less any sign of its activity.

## **7. The collaborative protocol between the CLR and the POHCCJ, mentioned in Government submission has not been renewed**

The Government submits that the collaborative protocol signed with the CLR is *“in view of assuring bilateral communication, consolidating the aspects of prevention and awareness, the enhancement of investigation techniques, continuous training, the assessment and promotion of adequate legislative solutions.”*

The CLR points out that the abovementioned protocol has not yet been used as a base for any activities in the interest of protecting the rights of people with mental disabilities who are found in state custody.

The Government states that after the CLR’s reports of crimes committed against institutionalised people, *“[s]everal shortcomings were identified (the decision to discontinue the criminal investigation is based on a superficial investigation, no reasons are given and the hierarchical oversight is without substance)”*.

The CLR underlines that the abovementioned statement is not a *measure* taken in response to our reports but a mere *observation*. The issue of superficial criminal investigations into the deaths and other cases of abuse of people with mental disabilities has been the thrust of the CLR’s advocacy since the death of Mr. Câmpeanu in 2004. The Government should not present such an observation

as its own in 2017 without explaining what measures it had introduced in order to remedy its own failure to respect the basic tenants of the European Convention of Human Rights.

## **8. Summary of the ad-hoc monitoring visit in Poiana Mare Psychiatric Hospital (15 February 2017)**

a). On 15th of February 2017, following an ad-hoc visit to the Psychiatric Hospital in Poiana Mare, Dolj, the CLR observed an improvement of living conditions, particularly regarding cleanliness both inside and outside the building.. The patients are dressed in clean day clothes (not in pyjamas) and the management is more open, allowing us to visit without restrictions. However, our team discovered that in some rooms, the temperature was low, that there was no hot water or heating in the bathrooms, no soap or towels, although we found these in the store room. There were no shower curtains to assure the privacy of the patients (the shower rooms have two shower taps each, but no separation between them and somewhere to put clothes or towels).

b.) Thirty of the 500 places in the hospital are designated for temporary or compulsory psychiatric treatment. On the day of our visit, there were 487 patients in the hospital. 24 of these have been in the hospital since 1999. However, in 2014 there was only one patient admitted for compulsory medical treatment , another four in 2015 and another four in 2016. None so far in 2017.

c). According to the records kept by medical assistants when changing shifts, when the patients become agitated, they are given sedatives. This information, regarding the supplementary medication administered, is mentioned in the medical files of the patients and in the reports filled when shifts change. They are not mentioned separately, in a special restraint registry, though they clearly represent a means of chemical restraint.

d). Continuing inappropriate placement of people with intellectual disabilities in Poiana Mare is illustrated by the following example. A 30-years-old patient called M.A. with severe intellectual disabilities and behavioural disorder was visited by the CLR monitors in Section Psychiatry II. From the patient's file, we established that he came from the Complex of Residential Specialised Services for Adults – The social care home "Muntenia", which is under the authority of DGASPC Dolj, and that he was admitted to Poiana Mare upon his own request, on 20th of September 2013, with a referral note from a local surgery. From our discussions with the staff we couldn't find out the clear reason why the patient was brought to Poiana Mare: was it because the place where he was living was being renovated and he was brought here temporarily, until the end of the works,

or because the social care home was closed down? All the people we spoke to said that DGASPC Dolj refused to take back the patient even though his diagnosis does not fit under the competence of a psychiatric hospital and the patient actually needed specialised care. Although the patient is not placed under guardianship (it was obvious that his disability severely restricted his legal capacity), the admission to Poiana Mare hospital was done upon his request. The documents in his medical file mentioned B.C., “representing Centre for Recuperation and Neuropsychiatric Rehabilitation” (as if acting on behalf of M.A.). This person signed in M.A.'s place the admission consent and the informed consent forms. The patient's doctor told the CLR that his place is not in a psychiatric hospital and that they cannot offer him appropriate care. Regarding the fact that the patient has obviously reduced capacity for legal reasoning but has not been placed under guardianship, the doctor stated that the decisions on behalf of M.A. are taken by the medical staff and that they "had been lucky that a surgical or a similar procedure had not been required so far, as these require an express consent of the legal representative".

Four other 'patients' referred to the hospital by DGASPC Dolj are in a similar situation. **They had been sent to and abandoned in the psychiatry hospital in Poiana Mare on 19th and 20th of September 2013.** The management of the Poiana Mare Psychiatric Hospital wrote to the manager of Directorate of Social Work and Child Protection of Dolj, on few occasions starting with 17 December 2013 stating that:

*"The above mentioned patients have improved psychologically but are unable to care for themselves and require permanent supervision and support, general medical and social assistance in an appropriately specialised social care home."*

h). *Living in the community:* organised trips to church services from the hospital have to be paid for. Therefore, only some of the patients can participate in even these very limited visits to the community.

i). *Complaints:* despite the fact that, every ward has complaint boxes, the patients, who generally know and understand their rights, do not exercise their right to complain. Thus, none of the complaint registers verified by the CLR monitors contained any complaints. The patients did not consider complaining, saying it would be useless. *"Who can help us? We sometimes tell the doctor, but do nothing more"*. The main problems that the patients mentioned to the CLR monitors included the following:

- lack of hot water at the sinks in the bathrooms and on the wards;
- the possibility to undress in private before showering (now, they undress in the entrance hallway, where there is also a video camera);
- telephone access (to be able to contact family or friends);

- possibility to write letters ("*If we buy paper and pencils ourselves, we write. If not, we don't*");
- access to a social care worker to assist with information about patients' property, including inheritance, now at disposal of siblings or other relatives;
- organised social activities ("*There is nothing to do all day; if it is cold, we are not allowed outside; we sometimes watch TV and that is all*").

j). *Medical services. Activities complementary to the medication (psychological and occupational therapies, etc.).* Some of the patients know the name of their diagnosis, but they don't have information about what it means or how it affects them; the majority don't know or understand the treatment they are given: "*I take nine pills a day, one of them is big and my colleague helps me break it*". The daily schedule of the patients includes eating, being given the treatment, cleaning the wards in the first part of the day, resting after lunch, watching TV. They either stay in bed or talk to each other. One 'instruments' used by nurses, referred to as therapeutic communication, simply means "*any discussion with the patients or among each other; for instance: 'How are you?'*"

During our visit, the staff gave us a list with the patients that take part in occupational therapy activities. However, there is no information, regarding the type of activities, the structure of the programme (schedule and frequency of participation, duration), objectives of the therapy, indicators, patients' evolution as a consequence of taking part in ergo therapy, results, evaluation instruments, participation in groups or individual etc.

The hospital has no specialists for educational or occupational therapy; the patients involved in such activities are accompanied by nurses or psychologists. During the visit, there was no activity in progress in the wards the CLR visited. From what the patients told us, we found out that they spent the days prior to our visit **simply sitting in their wards**.

After analysing the information we have been given (documents, discussions with patients and staff of the unit/visited sections), we expressed the following **concerns**:

- The vision expressed by the hospital staff, the equipment we observed and the scarce information we were given indicate that the main therapy for psychiatric diagnoses still consist of only pharmacological treatment with psychotropic active substances.

- Alternative and complementary activities and therapies are seen as of little use and are considered as secondary activities, unstructured, unsystematic and vague, used only to fill the patients' free time.
- Bearing in mind that Poiana Mare Psychiatric Hospital is designated for continuous and long term hospitalization, the CLR is concerned that the hospital's practice has demonstrated how in a socially isolated and institutionally restricted environment, where complex psychotropic treatments are given over a long-term period, the patients suffer significant deterioration (psychologically, socially and even physiologically). Therefore, their social destiny and their medical and psychological conditions are at risk. This type of treatment is in violation of the patients' right to the enjoyment of the highest possible standard of health. Furthermore, such treatment poses a serious risk of permanent institutionalization for anyone submitted to such a lifestyle in the medium or long term.