OMBUDSMAN OF THE REPUBLIC OF LATVIA

Baznīcas iela 25, Riga, LV-1010; Tel: 67686768; Fax : 67244074; E-mail: tiesibsargs@tiesibsargs.lv

Riga

15 February 2013 Ref. No 1-12/2

Report by Ombudsman of the Republic of Latvia on State Social Care Centers for Adults with Mental Impairments

1. Preamble

1.1. Since the beginning of operation, the Ombudsman's Office have conducted about 30 inspection visits to long-term social care and rehabilitation institutions covering all regions of Latvia.

1.2. In 2010, the staff of the Ombudsman's Office visited all five State Social Care Centers[1] (hereinafter – SSCC), since the priorities set by the Ombudsman's Office for the year 2010 included monitoring the observation of the rights of persons with disabilities. The Ombudsman summarized the results of such inspections in the Opinion dated 25 February 2011 and presented the Opinion to the Ministry of Welfare, Ministry of Health, as well as to each SSCC. The key problem identified in the Opinion concerned the fact that SSCCs were providing medicinal treatment services,, in spite of the fact that SSCCs were not listed in the Register of Medicinal Treatment Institutions. The said Centers are not therefore subject to the control mechanism covering the treatment institutions either in terms of service quality or storage of records. The Opinion therefore points out that the Ombudsman finds it necessary to improve normative regulation of health care provided at social care centers. The above recommendation has not been followed until present.

[1] Five State social care centers were put into operation from 1 January 2010 comprising 33 reorganized State social care centers

1.3. A letter was sent to Mr. V. Dombrovskis, the Prime Minister, on 10 October 2011 regarding the issues of securing human rights at social care institutions to inform about the earlier opinions issued by the Ombudsman and pointing out that ignoring of the recommendations previously issued by the Ombudsman and failure to address the issues in question should be treated as negligence of the public officials in charge of handling the issues of human rights.

1.4. Visits to SSCC were arranged in 2011 and 2012 at the initiative of the Ombudsman within the framework of instituted inspection proceedings, with the objective to draw continuous attention to the following 2 key issues:
1) Obligation of the State to pursue deinstitutionalization gradually eliminating the need for SSCC services;
2) Situation of persons with mental impairments accommodated in SSCCs, with focus of the following issues: conditions, grounds for provision of long-term social care and rehabilitation services; the right to liberty; health care and social rehabilitation.

1.5. The above-mentioned inspection visits to SSCCs and their branches for adults with mental impairments were arranged in 2011 and 2012 with participation of L. Jorena, Psychiatric Expert of the Ombudsman's Office. P.Hauksson, Foreign Expert of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment with vast experience of monitoring visits to closed-type facilities, also joined the inspection visits made in late 2012 to three SSCC branches.

1.6. It should be noted that the Ombudsman's Office have been ensuing the plans of the Ministry of welfare concerning the development of social services. Certain concepts contained in the latest plans (such as the Key Approaches to Development of Social Services in 2014 – 2020 and Operational Priorities of the Ministry of Welfare in 2013) coincide with the Ombudsman's recommendations, and they deserve appreciation. The experience from previous years shows, however, that no substantial changes have taken place in practice, and the concepts contained in the Key Approaches and Operational Priorities of the Ministry of Welfare in relation to SSCCs remain unimplemented. The welfare Reform of Latvia, for example, was launched in 1996 already, and the White Book for determining the directions of social security system policy was drafted and accepted by the Cabinet on 13 May **1997**[2]. The priorities set to ensure the development of social care services included introduction of the *funding principle "funds follow the customer" and entrusting municipalities with the provision of social aid services*. The concept adopted by the Ministry of Welfare in **2002** for Development of Social Care Services stipulates that *the*

[2] Extract of Minutes No 27 of the meeting "On social welfare system reform project "Administration of social assistance system" – the White Book"

existing distribution of responsibility between the duties of the State and those of municipalities leads to the situation where municipalities are interested in taking decisions on the provision of SSCC services, which is not always the optimum type of service from the view of recipient of social care service. The most urgent issues arising from the statutory distribution of social care service provision duties between the State and municipalities are related to care of persons with mental impairments. The SSCCs frequently perform the functions that could be much more optimally implemented by alternative care institutions: home care, group apartments, or day care centers, for example; as a result, no possibility of social integration is provided to persons with mental impairments. The National Report on Social Protection and Social Inclusion Strategies for **2006 – 2008** also pointed out that: "*According to the policy of the Ministry of Welfare, State-administered social care institutions for persons with mental impairments will be reorganized into municipal institutions to facilitate th availability of social services possibly close to the customer's residence. The above-mentioned changes are intended to ensure that all social services provided by the state pass over to municipalities, as well as the funding allocated for this purpose, to enable optimization of the infrastructure of service providers and to develop alternative social care services*". At present, however, funding of SSCCs exclusively from the State budget continues, the above-mentioned funding principles have not been implemented, and alternative social care services are extremely poorly developed.

2. The Right to Live in Community

2.1. The right to live in community is included as a separate right in the UN Convention for the Rights of Persons with Disabilities (hereinafter – the UN Convention). The general goal of Article 19 of the UN Convention is full inclusion and participation in the community. The thee key elements of this goal are: the right to choose; individualized support facilitating inclusion and preventing isolation, and ensuring to persons with disabilities access to services designed for general public. The right to live in community is closely related with other human rights such as the right to liberty, the right to protection of private life, and the right not to be made subject to torturing or other inhuman or degrading treatment or punishment.

2.2. Council of Europe's Human Rights Commissioner points out in report of 13 March 2012 "Right of persons with disabilities to live independently and be included in community" that placement in social care institutions is the most common infringement of the right to live in community.[3]

[3] Thematic report is available at www.commissioner.coe.int

2.3. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter – the CPT) has pointed out that provision of services involving continued accommodation of persons with disabilities at psychiatric health care institutions is not acceptable since such institutions present a serious institutionalization risk to patients as well as personnel, and may have adverse effect on treatment of a patient.[4]

2.4. Provision of social services in the Republic of Latvia does not meet the needs of persons with mental impairments; community-based alternative services are only available to a small number of such people. As a result, on many occasions people with mental impairments have to select care at long-term social care and social rehabilitation institutions. Many of SSCC customers would be able to live in community if support was provided at their place of residence. Most of the visited SSCCs have expanded, however, and their deinstitutionalization attempts have been limited, if any at all.

2.5. The State has the duty to provide funding adequate to ensure that persons with mental impairments can effectively exercise their right to choose freely their place of residence on equal basis with other people, and to provide different means of support in their daily lives enabling their efficient integration in community.

2.6. The State should have deinstitutionalization strategies and corresponding action plan established to achieve gradual liquidation of large institutions, including clearly set goals and objectives for certain period of time.

3. Situation of Persons with Mental Impairments Accommodates in SSCCs

3.1. Conditions

3.1.1. Recipients of services in all visited SSCCs are provided both to customers with mental health impairments and to those with intellectual development impairments. It is relevant to note that the two groups of customers have different daily needs, and the range of required services is also different. On most occasions, the different customers accommodated at SSCCs share the wards and rooms both in day time, pursuing their respective activities and staying in living areas, and in night time, sharing the rooms. According to Paragraphs 29 and 30 of Cabinet Regulations No 291 of 3 June 2003 Concerning the Requirements Applicable to Social Service Providers, adequate conditions shall be provided in case of customers accommodated in adult care institutions to allow meaningful leisure time and to enable the customers to gain

[4] CPT standards, CPT/Inf/E (2002) 1 – Rev.2010.

the required living and self-care skills appropriate to their functional condition. Each SSCC should therefore provide to their customers daily activities appropriate to their skills. Activities appropriate to customers with serious impairments of intellectual development should not be offered to customers with mental health impairments. If people with mental health impairments are accommodated together with those suffering from impairments of intellectual development and they are all involved in similar activities, such experience may even be degrading, not only inappropriate to the individual needs of customers. Customers with impairments of intellectual development who have objective difficulties to understand the symptoms of mental health impairments may find such experience both embarrassing and deterrent. Based on the above-stated, such practice of SSCCs should be discontinued as inappropriate to the individual needs of customers. The Ministry of Welfare should thoroughly follow up the compliance with the principles established in the Cabinet Regulations No 291 of 3 June 2003 Concerning the Requirements Applicable to Social Service Providers at all SSCCs to ensure that activities available to the customers are fully appropriate to their skills, abilities and needs.

3.1.2. It has to be noted that the activities marked among the priorities of the Ministry of Welfare for the year 2013 include the SSCC pilot project "Proposals for grouping of customers and identification of the required scope of service", intended to ensure that SSCC customers are divided into groups according to the type and severity of their functional impairments. Such grouping, however, should be pursued at all SSCCs without any delay.

3.1.3. Due to objective reasons, hardly any of the visited SSCCs offers accommodation to their customers in a single room. The smallest number of customers to share a room is two; as a rule, four or five customers are accommodated in a room in most of SSCCs. Therefore, high overpopulation was observed in all of the visited SSCCs in general. This is a negative trend, moreover because the SCCC is the place of continuous or even life-time residence for most of the customers.

3.1.3. Council of Europe (hereinafter – the Council) and the UN recommend to create institutional environment and living conditions "possibly similar to the conditions enjoyed by community members of the same age, gender and cultural background."[5] Institutions should provide facilities and space for recreation and leisure time activities and learning, as well as a shop where the items required for daily life, recreation and communication are available.[6] CPT has emphasized the need to "provide sufficient space for living to each patient, as well as appropriate lighting, heating and ventilation, to maintain the establishment in satisfactory technical condition and to ensure that

[5] Council of Europe Recommendation No. REC (2004) 10 Concerning the Protection of the Human Rights and Dignity of Persons with Mental Disorder, 2004, Article 9
[6] UN Principles for the Protection of Persons with Mental Illness, 1991, principle 13 (2)

hospital hygiene requirements are met."[7] Recommendation of the CPT and the Council *Concerning Psychiatrics and Human Right* calls to avoid accommodation of people in large bedrooms that lead to restriction of their right to privacy.[8]

3.1.4. In the Ombudsman's opinion, the staff provided at SSCC branches is insufficient to ensure proper and qualitative care to such a large number of customers with so serious diseases and disabilities.

3.1.5. It was also observed at most of SSCCs that customers only use spoons for taking food during their meals. The quality of food offered to customers in certain SSCCs is also insufficient. It was observed at most of SSCCs, for example, that fresh fruits or vegetables are offered on minimum occasions, if any. The CPT pays special attention to the quality and amount of food, pointing out that meals should be served to patients in proper conditions, at proper temperature, and with normal tableware available.[9] The fact that customers only use spoons should be treated as degrading because of lack of support to personalization and self-care skills.

3.1.6. According to Section 31, Part Two of the Law on Social Services and Social Assistance, if a person with his or her actions endangers his or her health or life or the health or life of other persons, the head of the relevant institution or his or her authorized person may take a decision, making note in the person's file regarding the isolation of the person for a period not exceeding 24 hours in a room specially arranged for such purpose, where the necessary care and continuous supervision of the person shall be ensured.

3.1.7. It was established during the visits to SSCCs that most of the SSCCs have arranged such isolation room, however such room not always meet all security considerations relevant to the customers (for example, the room is located far from the personnel in charge thus preventing the staff from prompt reacting to acute situations; on many occasions, the furniture in the room enable suicide, etc.).

3.1.8. It is also unacceptable that no WCs are provided at isolation rooms in most of SSCCs; instead, there are pails for relieving. Such practice is not acceptable, and the customers placed in isolation rooms must have access to WC.

[7] CPT, Extract of the Eighth General Report: http://www.humanrights.org.lv/upload_file/CPT_standarti_LV.pdf, see page 42.
[8] Article 7 (i)a of [CoE Recommendation 1235 (1994)1 on psychiatry and human rights]; Extract of the CPT Eighth General Report: http://www.humanrights.org.lv/upload_file/CPT_standarti_LV.pdf, see page 42.
[9] Ibid.

3.1.9. The possibility stipulated in the law to keep a person isolated in such room for up to 24 hours should also be considered as negative, and isolation of a person as incommensurably long in the conditions of such type of facility. It should be further taken into account that, according to the national regulations, an SSCC is not an imprisonment facility, and formally all customers are accommodated there on voluntary basis. The SSCCs should either discontinue such isolation practice at all or, in case of objective need, prescribe reasonable maximum duration of such isolation that should not exceed 3 hours.

3.1.10. It has been established that on specific occasions isolation rooms are used by SSCCs for the purpose of disciplining customers for breaches of internal regulations. Such practice is unacceptable from the view of human rights; the Ministry of Welfare should therefore follow that such practice is eliminated at SSCCs. The fact that placement of customers into isolation rooms is quite infrequent and normally of short duration in case of all SSCCs should be assessed as positive.

3.1.11. Use of physical restraints requires compliance with certain established procedural guarantees as well as the principle of proportionality.

3.1.12. The CPT principles concerning the use of physical restraints provide that any physical restraints applied to a person must be strictly regulated and only permissible according to the order or approval of a medicine professional. Each single occasion of fixation or isolation must be clearly documented in the patient's medical record and in special register stating "the beginning and end of application of the means in question; background circumstances; reasons for use of such means; the name of medicinal professional who has authorized or approved such means, and any injuries caused to the patients or personnel."[10] A person subject to physical restraints must be under continuous monitoring, in an appropriate, safe room where the patient is not visible to other patients. The CPT emphasizes that means of medicinal restriction (such as tranquillizers, sedative medications, etc.) are subject to similar regulations as fixing up or isolation.**[11]** *(see the section "Health Care" for detailed comment on medicinal/chemical restrictions)*

3.1.13. It should be noted that the UN Special Rapporteur on the prevention of torture in his report of 1 February 2013 calls the Member States to adopt absolute prohibition of use of restraints and isolation in case of persons with mental impairments[12].

[10] CPT Sixteenth General Report, available in English at: http://www.cpt.coe.int/en/annual/rep-16.htm, paragraphs 44 and 51. Extract of the Eighth General Report available in Latvian at: http://www.humanrights.org.lv/upload_file/CPT_standarti_LV.pdf, see p.p. 45 - 46.
[11] Ibid, paragraph 41.
[12] A/HRC/22/53 Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E Mendez.

3.1.13. The practice of appointing the staff of SSCC custodians of legally incapacitated customers was observes in nearly all of the visited SSCCs. The duties of custodian include, however, the protection of interests of incapacitated customer, including against the establishment in which the customer is deprived of liberty. Therefore, Custodian Courts, SSCCs and the Ministry of Welfare should review the present generally accepted practice and find other, more appropriate solutions to prevent any conflicts of interests.

Recommendations:

1. Take appropriate steps to ensure that people with impairments of intellectual development are accommodated in separate rooms from people with mental health impairments.
2. Pursuant to Cabinet Regulations No 291 of 3 June 2003 Concerning the Requirements Applicable to Social Service Providers, provide appropriate circumstances for the customers to meaningful leisure time activities as well as to master the necessary living and self-care skills appropriate to the functional condition of each customer, with due regard to their skills and abilities.
3. Ensure observation of the requirements stipulated in Cabinet Regulations No 431 of 12 December 2000 Concerning Hygiene Requirements in Social Care Institutions in respect of residential area per each customer. Consider the possibility to allocate larger residential area to the customers of SSCCs as well as to reduce the number of customers sharing the room.
4. Provide sufficient number of SSCC staff to ensure that the customers have access to the necessary services and care appropriate to their needs.
5. Ensure that customers of SSCCs can use normal tableware, including forks and knives, during their meals. The Ministry of Welfare should monitor the quality and variety of food offered to the SSCC customers.
6. Introduce amendments to Section 31, Part Two of the Law on Social Services and Social Assistance that permits isolation of an individual for up to 24 hours, so that such isolation practice is either abandoned at all or limited to reasonable maximum period of no more than 3 hours.
7. Ensure that isolation rooms arranged at SSCCs meets the relevant hygiene requirements, including availability of WC at all times.
8. Discontinue the generally accepted practice of appointing SSCC staff custodians of customers with limited capacity in order to prevent potential conflicts of interests.

3.2. Restriction of the Right to Liberty

3.2.1. According to the standard regulation applicable in our country, each customer has to sign a form of voluntary consent to provision of service upon their admission to the institution. The forms to be signed by customers are

written in complicated legal language that may be difficult to understand for persons without special legal knowledge. This fact gives raise to additional doubt regarding the voluntary nature of customers' admission to SSCC since many of them have diagnosis: impairments of intellectual development.

3.2.2. Notwithstanding that formally all persons are voluntarily accommodated at SSCCs and that they have consented to the provision of services, the institutions continuously pursue different practices of restricting the customers' freedom to short-term leave from the territory of SSCC. It should be noted that at present no external regulatory acts contain either specific criteria to be used by administration of SSCC to limit their customers' freedom to leave the territory of SSCC, or the list of officials entitled to decide on such leaves and their duration (there is only a general norm that permits restriction of the right to movement). According to the observation at most of the visited SSCCs, administration of the institution divides the customers into different groups and select the customers who are authorized to go for walks unless accompanied by personnel. If even customers attempt to escape they are returned to the institution, even with the assistance of police, where appropriate. Another practice is transferring customers from open wards to closed ones because of their behavior. On certain occasions, such restrictions of liberty may be applied for the customer's own sake, yet they also mean that a customer of SSCC is not a voluntary resident, and that customers are deprived of their liberty there. Customers do not benefit from the measures of legal protection provided to those formally deprived of their liberty. The basic rights not available to such actually involuntary customers include the right to have each and every deprival of liberty reviewed by court as stipulated in the European Convention for the Protection of Human Rights and Fundamental Freedoms (hereinafter – the ECK).

3.2.3. The regulation applicable at the time of inspection visits to SSCCs stipulated that the customers may not leave the institution or terminate the contract with institution unless the relevant municipality has confirmed in written that it would provide accommodation to the person in question (Section 28, Part Three of the Law on Social Services and Social Assistance), without however imposing on municipalities the duty to provide such accommodation. The Ombudsman concludes that the above norm constitutes a material breach of the obligations of Latvia in the sphere of human rights, including the European Convention for the Protection of Human Rights and Fundamental Freedoms (hereinafter – the ECK) and the UN Convention. Taking into consideration the above-stated, the Ombudsman applied to the Parliament for excluding the requirement for mandatory criteria – obtaining from municipality the confirmation of provided accommodation – from the Law on Social Services and Social Assistance, and to stipulate instead that the municipality has the obligation to provide accommodation to a person who has no residence of his/her own. As a result, the norm in question has been amended (the

amendments took effect on 6 December 2012), and the currently applicable normative regulation does not contain the requirement for obtaining confirmation from municipality as a precondition to termination of services from SSCC any more; municipalities have the obligation to ensure accommodation to a person who is not able to return to the earlier occupied residence in accordance with the applicable procedure.

Recommendations:

1. To review the status of persons admitted to SSCCs if the consent to provision of service has been obtained from custodian on behalf of an incapacitated person;
2. To draft SSCC contracts with their customers in a simple language, avoiding complicated legal terms, or to have translation into simple language attached to the contract;
3. To review the practice of restricting of even depriving the customers of their liberty to short-term leave from the territory of SSCC. If objective reasons exist to deprive the customer of such liberty, the legal status of SSCC customers should be reviewed.

3.3. Health Care

3.3.1. According to Section 1, Paragraph 6 of the Law on Social Services and Social Assistance, long-term social care and social rehabilitation institutions shall provide accommodation, full care and social rehabilitation to individuals unable to care for themselves because of age or health condition, as well as to orphans and children left without parental care. Sub-Paragraph 2.11 of the Cabinet Regulations No 291 of 3 June 2003 Concerning the Requirements Applicable to Social Service Providers stipulates that provider of social services shall ensure the first aid available to the customer. Paragraph 31 of the said Regulations stipulates that registration of customers with Attending Physician shall be ensured as well as implementation of the medicinal treatment scheme prescribed by Attending Physician and other medical specialists. The normative regulation therefore prescribes that social care centers are responsible for making health care services available to their customers.

3.3.2. Paragraph 27 of the said Regulations prescribes that social workers, social caretakers, nurses registered in qualified nurse register, and caretakers shall work with the customers of adult care institutions. The head of adult care institution shall be entitled to attract other specialists for the provision of social care and social rehabilitation services. No clarification is found in the normative regulation concerning the additional specialists the head of center may attract,

however the norm prescribes that such specialists may be attracted for the provision of social care and social rehabilitation services. The above-mentioned normative regulation does not provide for attracting specialists for the provision of health care services to the SSCC customers.

3.3.3. It was identified during the visits to SSCCs that there was no common practice established in the given matter: some SSCCs retain full-time psychiatrists and other medicine professionals, while others outsource psychiatrists and Attending Physicians for provision of contract-based services, and they are not treated as full-time staff members. Heads of SSCCs also have different opinions: some of them believe that social rehabilitation may not be separated from treatment, and therefore it is necessary to attract medicine professionals to their work, while others believe that no full-time psychiatrist is necessary in the institution.

3.3.4. Records of SSCC customers contain information about their health condition, diagnosis and treatment; the entries are made by medicine professionals: Attending Physician and Psychiatrist. The administered medicines are distributed by SSCFC nurses. It may be therefore concluded that SSCCs also provide treatment, including secondary health care (psychiatric aid) services that are not among the functions of SSCCs. The SSCCs also fill in and store records that correspond by their nature to medicinal records. At the same time, no legal grounds can be established for performance of the above-listed treatment functions and storage of the customers' medicinal information because SSCCs are not registered as treatment facilities and they are not supposed to provide the services of medicinal practice. Therefore, such institutions normally are not subject to the control mechanism of treatment facilities in terms of health care from the aspect of service quality as well as storage of the relevant records.

3.3.5. It should be pointed out that psychiatrists in certain SSCCs prescribe State-compensated medicines to their customers on the prescription forms of treatment facilities; such practice indicates to lack or proper procedure in this aspect. It was therefore complicated to drive at and assess the ultimate conclusions regarding the suitability of therapy to the objective health condition of each individual patient. In case of SSCCs employing a psychiatrist, the compensated medicines are prescribed by Attending Physician, however no reasonable grounds of specific prescriptions can be found in customer records. It may be therefore concluded that no unified, regulated medicinal record-keeping is established at the visited SSCCs, and that the existing practice is non-transparent and difficult to check.

3.3.6. Medicinal records of SSCC customers are superficial; they do not include individual treatment plans. The records kept by SSCCs are not arranged according to any unified recording system. The records are excessively detailed, and keeping of such records is excessively time-consuming for the officials in

charge. At the same time, the records provide no clear picture of the needs and relevant medicinal details of the customer concerned. Therefore, neither the SSCC personnel not the controlling institutions are able to conduct efficient, individual-focused analysis and monitoring. The excessive load related to record-keeping has also been mentioned by the nurses interviewed during the visits to SSCCs. According to them, the time spent to fill in the – frequently overlapping – records is therefore devoted to re-writing of multiple similar documents, rather than to the objective needs of the customers.

3.3.7. SSCCs provide no regular monthly blood tests in case of those who take Clozapine[13] that may lead on seldom occasions to potentially fatal deficit of white blood cells, i.e., to lethal outcome. Safety considerations require monthly control of leucocyte formula in order to prevent the eventual threat to the health and lives of customers. It should be noted that blood tests of SSCC customers in Latvia are taken on irregular, unwilling basis, probably once a year or even less. In addition, the SSCC customers are not aware of the potential side effects. According to the information provided by heads of SSCCs, no cause analysis is conducted in case of death of a customer, and therefore it is not possible to assess whether or not the taking of such medicine has been a factor contributing to death. Given the above-stated, it may be concluded that instructions for use of Clozapine are not complied with at most of SSCCs.

3.3.8. SSCCs should stop the common, contraindicated and careless use of this potentially lethal medicine, and prescription of other medicines should be preferred for treatment of psychosis, where appropriate. On the very few occasions when prescription of Clozapine to customers is objectively reasonable, monthly blood tests should be a must. Otherwise, exposure of the SSCC customers to unnecessary risk of serious diseases or even death may be treated as inhuman and inexorable treatment of customers and a serious infringement of their rights.

3.3.9. SSCCs in Latvia are long-term care and social rehabilitation institutions, yet a major part of their budget is spent on medicines. Several situations have been observed where the Attending Physician of SSCC prescribes compensated medicines to the customers for a lengthy period of time (at least 3 months); this is permissible according to the prescription procedure applicable to psychotropic medicines; however such prescriptions take place without previous examination of the patient. It may be further concluded from the inspected customer records that the frequency of examination by Psychiatrists is insufficient for continuous application of such therapies. No regulatory documents can be found at SSCCs governing the frequency of

[13] **Leponex (Clozapine)** indications and usage 17917-250608- "Regular blood tests are absolutely necessary throughout the period of administration of Leponex® to ensure early identification of damages to blood cells; otherwise severe complications and even death can occur. Blood tests must be also taken four weeks after complete discontinuation of Clozapine treatment."

examination by medicine professionals, as well as no instructions regarding the treatment plans, their coordination with the customer (or custodian) and notification of customers of such plans. The foregoing constitutes non-compliance with the Guidelines of Latvian Association of Psychiatrists[14] and breach of the UN *Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care*[15].

3.3.10. It was identified during the inspection of SSCCs that significant number of customers were taking medicines in substantial doses; polypragmasia (concurrent taking of a number of medicines) was frequently observed, and alternative care approaches were substituted by prescription of medicines on most occasions. Nearly all customers were taking psychotropic medicines, mainly neuroleptic preparations (normally used to treat symptoms of psychosis such as schizophrenia), benzodiazepines (used to treat anxiety), and anti-convulsants (normally indicated in case of epilepsy). Many SSCC customers are simultaneously taking full doses of several of the above-described medicines. It should be noted that, according to the customer records, many of the customers taking such combinations of medicines have no appropriate diagnosis. This means that many people taking the medicines designed for treatment of psychosis have not any psychotic impairment diagnosed, such as schizophrenia, for example; many of those taking anti-convulsants have diagnosed epilepsy, etc. The above-stated shows that such medicines are prescribed on most occasions with the view to minimize disturbing behavior of the customers, such as anxiety, alarm, aggression, etc. The above-listed observations by the staff of Ombudsman's Office were also confirmed by the staff of SSCCs. Such a common practice in SSCCs directly indicates to application of chemical restrictions[16] that constitute a form of restraints, as well as use of belts to fix a

[14] According to the **Guidelines for Diagnosis and Treatment of Schizophrenia issued by the Latvian Association of Psychiatrists** (2008): "The most common mistakes observed in treatment of schizophrenia"
1. Administration of clinically unreasonable heavy phenothiazines NL in the maximum dosage.
2. Insufficient control of side effects and complications.
3. Excessively long administration of neuroleptic preparations in high dosage in spite of reduced productive symptoms:
• Neuroleptic depression;
• Neuroleptic encephalophathy;
• Aggravation of apato-abulic symptomatic;
• Lack of elementary cooperation with the patient
• Intolerance during explanatory discussions with the patient's relatives."

[15] **Principles for protection of persons with mental illness and improvement of mental health care.** *Adopted by General Assembly by resolution 46/119 of 17 December 1991*

[16] **Chemical restriction** means a medicine-based form of restraints where medicine is used to restrict the freedom of movement of patient, or to achieve sedative (calmative) effect on certain occasions. It is used for urgent, acute conditions at psychiatric institutions to control unmanageable patients who trend to disturb their care or otherwise present hazard to themselves and surrounding people in their vicinity. In legal terms, chemical restraints are also called "Psycho-Pharmacologic agents", "Psychotropic drugs", "Therapeutic means of restriction". Preparations frequently used as chemical restraints include benzodiazepines (Ativan), Midazolam,(Versed) or Diazepam (used in Latvia L.J.) (Valium). Haloperidol is a medicine that does not belong to the group of benzodiazepines; it is also used for chemical restriction purposes without the typical side effects of benzodiazepines. Haloperidol, however, has a set of certain serious side effects including some side effects

customer on the bed, or isolation. Chemical restrictions should be regulated and controlled in a similar manner to any other means of restriction, for example, by fixing in a special record, like in case of placement of a customer in the isolation room.

3.3.11. The staff of SSCCs also told to the personnel of Ombudsman's Office that the need for means of chemical restriction could be largely minimized if the SSCCs would offer activities and care appropriate to the needs of their customers. In other words, this means that at present customers of SSCCs are taking medicines in large doses and subject to isolation solely because of lack of meaningful activities and efficient process of rehabilitation.

3.3.12. It was also observed at SSCCs that medicines were prepared for taking in dissolved form. Nurses at SSCCs explained that such practice was recommended by physician in case of customers who used to hide tablets instead of taking them. The above-mentioned indicates that customers of SSCCs are not sufficiently aware of the applied therapy and the possible side effects, and occasionally they are not in position to refuse such therapy. This means in fact that certain customers receive treatment against their own will. The Patient Rights Law stipulates that treatment is permissible if informed consent is obtained from the patient. The Medicinal Treatment Law stipulates that psychiatric aid is based on the principle of voluntarism. Treatment without obtaining consent of the person is only possible on specific exceptional occasions, subject to court ruling, where treatment is provided at psycho-neurological hospital. It may be therefore concluded that such treatment practiced at SSCCs without obtaining the customers' consent contradicts with the law.

3.3.13. Autopsies are performed on all occasions when a customer of SSCC dies, unless the relatives refuse autopsy. The results of autopsy are made available to the Attending Physician, yet normally they are not available to the institution. It would be appropriate to make the results of autopsy available to the institution to enable the latter to review information regarding the actual causes of death of their customer and take the appropriate preventive measures.

Recommendations:

1. To discontinue the existing practice of common, contraindicated and even careless use of *Clozapine* at SSCCs. If medicines have to be prescribed

---

that can lead to fatal outcome. The US Food and Drug Administration, FDA has not approved any medicinal preparation for administration as a "chemical restraint". OBRA-1987 (The US Federal Nursing Home Reform Act) stipulates that the customers have the right to be free from any means of physical and chemical restriction. Such means are still used, however, and FDA believes that unnecessary administration of anti-psychotic preparations is a cause of death of about 15 000 elder individuals every year)

for treatment of psychosis, preference should be given to other medicines, and monthly blood tests shall be conducted as a must on the few occasions when *Clozapine* is still indicated;

2. To ensure that informed consent is obtained from the customers, to the practicable extent, to the treatment process offered to them within the framework of SSCC services;
3. To ensure that individual treatment plans are established in case of customers subject to regular medicinal treatment;
4. To provide properly qualified personnel in sufficient number to ensure that customers can engage in activities appropriate to their objective needs, instead of making them take medicines and sedatives to control their behavioral problems resulting primarily from the shortage of qualified personnel, lack of appropriate rehabilitation measures and overpopulation of the institutions;

5. To review the status of SSCCs and to authorize SSCCs to provide health care services, given that the institutions accommodate a large number of customers with mental health impairments and the fact that SSCCs are actually providing health care services. Separate medicinal records should also be kept for each individual customer.
6. To discontinue the present practice of dissolving in water the medicines administered to a large number of customers. If it is objectively necessary to administer medicines in dissolved form, an informed consent should be obtained from the customer (see item 2 above)).
7. To assess the need for making the results of autopsy available to SSCCs to enable reviewing of the information regarding the actual causes of death of their customers and taking the appropriate preventive measures.

3.4. Social Care and Social Rehabilitation

3.4.1 According to the Law on Social Services and Social Assistance, shall provide accommodation, full care and social rehabilitation to individuals unable to care for themselves because of age or health condition. According to the definition contained in the Law on Social Services and Social Assistance, social rehabilitation service means the set of measures aimed at restoration or improvement of social functioning skills in order to regain the social status and provide integration in community.

3.4.2. The services provided by SSCCs therefore comprise both social care and social rehabilitation. The quality of social rehabilitation services is a crucial precondition to the restoration and improvement of functional abilities of an individual. Regaining of social status and returning to community is facilitated by alternative care services: half-way homes and group homes that support customers in gaining the skills required for unassisted living. Regaining

of social status and returning to community provides independence of the individual, and therefore effective social rehabilitation is a relevant matter from the aspect of human rights.

3.4.3. Preparing of the institution customers to transfer to alternative social services is a factor indicative of quality of social rehabilitation services provided by SSCCs. The staff of SSCCs occasionally express their understanding that social rehabilitation provided at the institutions is not aimed at preparing the customers to unassisted living.

3.4.4. In general, the information obtained at SSCCs indicates to the following issues:

1) The services provided by institutions are primarily understood by the staff of SSCCs as care services not aimed at returning the accommodated individuals back to community;
2) The rate of transfer to alternative forms of care or returning to unassisted living is very low in proportion to the number of SSCC customers;
3) The number of alternative care recipients trends to decrease;
4) Social rehabilitation services provided by SSCCs on most occasions fail to achieve the goal of social rehabilitation – regaining of social status and integration in community.
5) The number of staff at SSCCs is insufficient to ensure proper care of such a large number of customers with serious diseases and disabilities.

3.4.5. The Ministry of Welfare has set among the goals defined in Key Concepts of Development of Social Services in 2014 – 2020 the need for developing effective, qualitative and sustainable system of community-based, inclusive social services appropriate to the individual needs of customers. The task force has defined three directions of action for achievement of the above-stated goal: 1) decreasing of the number of long-term social care and social rehabilitation institutions and the people accommodated in such institutions; 2) community-based, successive social services tailored to the individual needs of customers; and 3) effective management of social services. The fact that the ministry in charge has identified the issue deserves appreciation, however, in the Ombudsman's opinion, transitional period of seven years is excessively long for achievement of results, and in certain spheres notable improvement can be achieved in foreseeable future already.

Recommendations:

1. Alternative social care services – half-way homes, group homes and home care – need rapid development (in 2 – 3 years) to minimize the skeptic

approach of municipalities to the concept and process of deinstitutionalization.

2. Referral of new customers to SSCCs should be discontinued in foreseeable future.
3. Administration and staff of SSCCs should receive immediate additional training on the primary goal of social rehabilitation, namely, not only to provide care to customers but, primarily, to provide social rehabilitation enabling the customers to regain their social status and integrate in community as soon as practicable.

3.5. Substantiation of Long-Term Social Care and Social Rehabilitation Services

3.5.1. According to the Cabinet Regulations No 288 of 21 April 2008 "Procedure for Provision of Social Services and Social Assistance", where an individual applies for social care service funded from the State budget, the municipal social service shall assess against defined criteria whether of not the applicant is eligible to such services and decide on the need for such services. The social service shall present to the Social Integration State Agency a medicinal report issued by the attending physician, the opinion of psychiatrist and copy of the disability document within one month. Decision on granting social care and social rehabilitation services shall be made by Social Integration State Agency on the grounds of provided information.

3.5.2. The procedure prescribed by normative regulations at the time of inspection visits to SSCCs provided that no consent was required to admission of an incapacitated person to a SSCC, and consent of custodian was sufficient (the custodian would make contract with the SSCC). The opinion of custodian was also relevant for a person to leave the SSCC: if the custodian was of the opinion that the individual in question has to stay at SSCC, the possibility to leave the SSCC was subject to no further discussion. The custodian could also decide on referral and accommodation of individual at social care institution against such individual's will, while in fact the individual was treated as referred to and accommodated there voluntarily. Such normative regulation and the practice of its application contradicted with human rights and lead to the situation where an individual was actually deprived of liberty at the institution. The right to liberty also includes compulsory care of persons with mental impairments where the person is subject to continuous care and control without the possibility to refuse such her at the person's own will.[17] The fact that a person is incapacitated *de jure* does not exclude the need for consent *de facto*.[18]

[17] Ruling of ECHR in Ashingdane v. UK , 28.05.1985, para 42.
[18] Ruling of ECHR in Shtukaturov v. Russia, 27.03.2008, para 106.

the foregoing conclusion also follows from the ruling of ECHR in *Mihailovs v Latvia*[19].

3.5.3. It should be noted that the above-described procedure has been amended from 1 January 2013 with enactment of amendments to Civil Law and Civil Procedure Law. According to the new regulation, the institution of full incapacity shall be replaced to the institution of partial restriction of capacity, i.e., restriction of capacity in certain field of fields, while personal non-proprietary rights shall be subject to no restrictions at all. Therefore, it will be no more possible to refer a person to SSCC without the person's consent solely on the grounds of custodian's approval.

3.5.4. The present procedure and existence or availability of alternative services lead to the situation that a person is first placed in an institution and then only re-socialization and returning to community is decided upon, though it should be just the other way round: any other alternatives available at the person's place of residence should be first exhausted. Institutional service should only be selected if such alternative services are exhausted with no success.

3.5.5. Opinion issued by a single psychiatrist concerning the form of social service most appropriate to person with mental impairments plays a substantial role in the process of decision-making;

3.5.6. Decision of social service on the need for social care and social rehabilitation service may be influenced by financial considerations: provision of social service at the person's place of residence, for example, may be related to funding from municipal budget, or the municipality may have the obligation to provide social assistance. Biased decision, on the turn, may result in referral to long-term social care and social rehabilitation institutions even in case of persons who have no need for such services or who should receive inpatient treatment at hospital.

Recommendations:

1. The principle that referral to SSCC is treated as the last resort when the alternative services available in community have been exhausted should be implemented in normative regulation as well as in practice.
2. The Ministry of Welfare as the ministry supervising the Social Integration State Agency should exercise increased control over the decisions made by the Agency in terms of substantiation of the granting of long-term social care and social rehabilitation services.

[19] Ruling of ECHR in Mihailovs v. Latvia, 22.01.2013, para 137.

4. Conclusion

4.1. As mentioned before, the objective of social rehabilitation is restoration or improvement of social functioning abilities of an individual to enable regaining of social status and inclusion in community. Social care centers must not become the accommodations where people with mental impairments are isolated from the general community. Social care centers trend to become such place of isolation unless the social rehabilitation services are effective and really aimed at integration of persons in community.

4.2. It should also be noted that the above-made conclusions in general should not be considered in relation to the quality or efficiency of work of the SSCC staff. The above-made conclusions indicate to the shortcomings identified in long-term social care and social rehabilitation system. The visits to SSCCs revealed that, in spite of poor salaries and lack of social guarantees, most of employees are performing their job duties with responsibility and enthusiasm, seeking to provide possibly wholesome and meaningful life to their customers at the institutions.

4.3. The responsible authorities are hereby encouraged to address the issues identified in this Report, to eliminate the established breaches, and in particular to support measures aimed at integration of persons with mental impairments in community and provision of their right to independent living. The Ombudsman's Office hereby confirms the willingness to collaborate in handling the above-described matters within the scope of our competence.

Please find enclosed copies of documents concerning the provision of human rights at social care institutions to facilitate assessment of the work done by the Ombudsman's Office.

Enclosed:

1. Copy of the Ombudsman's report on provision of human rights at SSCC "Vidzeme" branch "Ropaži" on 15 pages.;

2. Copy of the Ombudsman's report on provision of human rights at SSCC "Kurzeme" branch "Iļģi" on 19 pages.;

3. Copy of the Ombudsman's report on provision of human rights at SSCC "Zemgale" branch "Jelgava" on 14 pages.;

4. Copy of the letter No 6-8/476 of 19 June 2012 addressed by the Ombudsman to the Parliament (Saeima) concerning the required amendments to the law on Social Services and Social Assistance on 3 pages.;

5. Copy of the letter No 1-5/236 of 10 October 2011 addressed by the Ombudsman to Mr. V. Dombrovskis, the Prime Minister, on 2 pages;

6. Copy of the letter No 18/TA-2538 of 7 December 2011 addressed by the Cabinet to the Ombudsman on 11 pages;

7. Copy of the Ombudsman's letter No 1-8/3 of 25 February 2011 on 8 pages.

8. Copy of the letter No 16.7-02/811 of 1 April 2011 addressed by the Ministry of welfare to the Ombudsman's Office on 6 pages.

The Ombudsman J.Jansons

S.Garsvāne, 67686768
sandra.garsvane@tiesibsargs.lv
G.Bruņeniece, 67201401
gundega.bruneniece@tiesibsargs.lv
L.Jorena
P.Hauksson