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Methodology

The chapters and conclusions of this Report are founded on the data received by the Institute during the field survey in the residential centers, on the analysis of the existent reports and policies, on the interviews with the decision makers from the public central and local institutions.

Human Rights

According to Art. 20 on the international Treaties on Human Rights, in the Romanian Constitution, the provisions on the rights and freedoms of citizens would be interpreted and applied in conformity with the Universal Declaration of Human Rights, with the pacts and other treaties to which Romania is a party.

According to the jurisprudence of the Constitutional Court, the European Convention on Human Rights is directly applicable in national law. According to the Constitutional Court any person claiming a violation of a fundamental right as guaranteed by the Convention may rely directly on the provisions of the ECHR before the court and may formulate one's direct claims based on it as interpreted by the Court jurisprudence

Romania did not accept the provisions of article 23 – “The right of elderly persons to social protection” of the European Social Charter.

History, evolution of the legislative framework

During the communist regime, social assistance in Romania was extremely poor, being characterized by passiveness and bureaucracy. It was limited to an institutionalized aid for old people, persons with disabilities, chronically or psychically ill persons and children in special situations, which failed to provide a decent living standard. After 1985, an even stronger degradation of the assistance took place as a result of the gradual reduction of funds.

The legislative framework, adopted between 1950 and 1970, was a serious barrier against the development of the social assistance services system.

After 1989, social assistance yet continued to be a peripheral and hard-to-touch zone in terms of social policies. Even though a number of sectorial measures were taken, they did not result in a coherent and well defined system.¹¹

The legislative framework in the field was developed in several steps and focused on various vulnerable social categories (children, persons with disabilities, victims of human trafficking, etc).

The national social assistance system was initially described by Law No. 705/2001 and then redefined by Law No. 47/2006, which established the system's organizing, functioning and financing based on the European principles governing social assistance so as to promote social inclusion.

At present, *the national social assistance system*, legislated under Law No. 292/2011 - The Social Assistance Act, is defined as the whole system of institutions, measures and actions by means of which the State, represented by the authorities of the central and the local authorities,

¹ See Consiliul National al Persoanelor Varstnice, “Asistenta sociala a persoanelor varstnice”, 2015, pp. 4-5.

as well as the civil society, take action to prevent, limit or eliminate the temporary or permanent effects of the situations that may generate marginalization or the social exclusion of persons, families, groups or communities.

Law No. 17/2000 on social assistance for old persons defines the old person as the person who has reached the retirement age established by law. It also defines the community services old people can use, depending on the type of caring (at home or in residential centers) as well as the organization and the functioning of the residential centers for old persons.

According to Law No. 292/2011 on social assistance, long-term caring (longer than 60 days) shall be provided at home, in residential centers, day centers, at the domicile of the person who provides the caring and within the community. Law No. 292 stipulates that social services shall be provided for all Romania's residents, on condition that the law should be observed. Ordinance No. 194/2002 on the status of foreigners in Romania, includes provisions regulating medical and social assistance; in addition, the Asylum Act and its norms of application have been recently modified to the effect that the centers provided for in the Asylum Act shall be licensed by the Ministry of Labour, Family, Social Protection and Elderly based on Law No. 197/2012 on quality assurance, since they also offer social services (people enjoy social assistance for as long as they reside in the respective centers).

In 2006, the minimal quality standards for long-term care services in residential centers and home care units for elderly persons were elaborated. These standards were revised and adopted in 2014:

Order No. 2126/05.11.2014 on approving the Minimal Quality Standards² for the accreditation of the social services devoted to old persons, shelterless persons, young people who left the child protection system and other categories of persons in distress, as well as for the services provided by the community, the services provided in an integrated system and social canteens.³

Order No. 67/21.01.2015 on approving the Minimal Quality Standards for the accreditation of social services provided for adult persons with disabilities⁴.

Decision No. 978/2015 on approved the minimal cost standards for social services and the amount of monthly income per family member, which is the basis for the calculus of the monthly maintenance contribution owed by the legal guardians of elderly persons in residential centers.

The Government Ordinance no. 31/2015 extends the right for all economic operators with lucrative aim to be recognized as providers of social services⁵. By adopting this law, it was intended to satisfy an increasing request for long-term care services and to eliminate situations in which elderly people in difficult situations for other reasons than economic ones (disability, chronic illness, etc.) were discriminated having no access to the social services they needed and for which they were ready to pay.

Also, it was intended to protect the rights of elderly people who opt for hotel-type accommodation services by including these economic operators and accrediting them as suppliers of social services, providers who have to obtain operating license for the provision of such services, by which it is thus certified the compliance with minimum quality standards and implicitly the protection of the beneficiary as a consumer. In accordance with EU guidelines for "social services of general interest", the opening of the market is encouraged, namely the inclusion of private providers who seek profit but also of non-profit providers, thus creating equal opportunities for all suppliers.

² The Minimal Quality Standards are the reference level for the quality of social services, their achievement is mandatory and has to be certified in the form of a functioning license.

³ Appendix 1: Minimal Quality Standards for social services with accommodation organized as residential centres for old persons and Appendix 8: Minimal Quality Standards for 'at home' caring services for old persons.

⁴ Appendix 1: Social services with accommodation organized as residential centres for adult persons with disabilities and Appendix 4: 'At home' caring services for adult persons with disabilities.

⁵ From 2003 until the adoption of this law the companies could provide social services only under special circumstances through their own foundations set up for this purpose.

This legislative change should have an impact on public centers and non-profit legal persons (associations, foundations, religious institutions) by increasing their capacity to respond to requests for social services from people with no income or low income.

At the same time, the document has been strongly rejected by the main Romanian NGOs providing social services. Its adoption would allow profit-making economic operators to access public funds, including structural European funds (those assigned to the social inclusion of persons belonging to the most vulnerable groups), while the social services sector is chronically underfinanced and the existing providers can hardly maintain the financing level of social services to a minimum.

The most recently adopted document is **Decision No. 479/2016** of 6 July 2016 on approving the National Programme called "Better quality of life for elderly persons in residential centers". The Programme is meant to finance those public homes for elderly persons that are not capable to continue their activity without financial support.

Another target is to increase the proportion of the specialized personnel in the residential centers for elderly persons from 47% to 60% of the total staff; reduction of the number of pending applications for admission to the centers for elderly persons, as well as shortening the wait period for elderly persons as a priority, by implementing the case management method for these persons, in terms of identifying alternative caring solutions such as caring within the community/at the respective person's own home.

Human Rights of Older Persons Accessing Long-term Care

Long-term healthcare services and facilities in today's Romania are regulated at several governing levels and implemented by different entities. Thus, in terms of social assistance, the system is a decentralized one, the Ministry of Labour, Family, Social Protection and Elderly and the General Directorates for Social Assistance and Child Protection being responsible for the implementation and supervision of the related legislation; as far as the healthcare system is concerned, the social health insurance system is intended to be a centralized one, the Ministry of Health being responsible for the elaboration of the national health policy, regulation of the healthcare system, etc.

Even though the national strategies elaborated so far stipulated improved links between healthcare and social protection services by means of a common, unified, long-term healthcare system, they had limited success and encountered difficulties with the implementation and application of the guidelines provided at national level.

The new National Strategy for the promotion of active aging and the protection of elderly people 2015-2020 refers to two priority objectives: to create a unified long-term care system and to provide the financial, human and infrastructure resources for that system. Also, alongside the Strategy, the Strategic Plan of Action for the implementation of the National Strategy was approved. The latter is a document that just resumes the strategic objectives and the corresponding measures provided for by the Strategy, without detailing them.

In Romania, the social assistance provided by the State for elderly persons is of a subsidiary nature, while the family has the obligation to support and care for the elderly. The public sector, by its competent institutions, intervenes only in the case of elderly persons who have no family, or whose family are partly or totally incapable to provide them support and care; in such cases, the public sector provides adequate social assistance and social services according to the elderly person's strict individual needs.

According to Law No. 292/2011 on social assistance, the central public administration authorities shall elaborate the legislative framework for social assistance such as to: support disadvantaged categories; combat poverty and the risk of social exclusion; develop policies meant to sustain the family for the life span of its members; elaborate programmes and strategies in the field and also regulate, coordinate and control their application; evaluate and monitor the quality of social services.

On the other hand, it is the duty of local public administration authorities to identify and evaluate the elderly persons' needs, to organize, plan and provide financing and co-financing for social and socio-medical services, while public and private social service providers have the duty to provide such services and abide by the quality standards.

Home care services

As far as home care services are concerned, they have been promoted since 1990, particularly by non-governmental organizations, taking after the model offered by such services in Western Europe. In time, the Ministry of Labour, Family, Social Protection and Elderly issued a series of normative acts that give the possibility for public home care, both by creating the instruments required by the local authorities⁶ to organize or subcontract the services and by subsidizing the social services provided by non-governmental organizations, in the framework of a central programme administrated by the Ministry itself⁷.

In Romania, the providers of home care services may be: public (services managed by local or county public authorities); private, profit-making (companies, authorized natural persons); and private, non-profit (non-governmental organizations, organizations established by the religious cults).

Home care for elderly persons involves a combination of medical care and social services, while the regulation of these integrated services shall be so achieved as to allow for the largest possible number of persons to access high quality services, at a reasonable price. At the same time, the two types of services are regulated in different ways and by different entities in Romania.

Financing of the care services is achieved from multiple sources, given the way the various sub-components of care services (medical, social, etc.) are regulated. The general lack of facilities and services for elderly persons who need care was compensated only to a lesser extent by introducing cash paid specific tasks and the possibility to employ informal caretakers, including family members, as "personal assistants"⁸. The role of informal caretakers and the related supporting mechanisms have been hardly dealt with by the legislation.

According to the studies performed so far, the access of service providers to public financing stayed extremely unequal in time. Even though the legal framework has progressively legislated it, when it comes to practice one may find that, if we refer to the medical component⁹, there is unfair competition between the profit-making private service providers and the non-profit ones in terms of access to the sums reimbursed by the Health Insurance House. Profit-making service providers are often companies controlled by the physicians themselves or having preferential relationships with the CNAS¹⁰. As far as the social component is concerned, public funding is to low compared to local needs. Even though cost standards¹¹ have been elaborated for recent years, there has been no clear estimation so far of the amounts local budgets should make available for such services and neither has there been an evaluation of the way services of local or county interest might benefit from short-term or long-term county or national co-financing. This situation persists also because of the lack of systematic and unitary evaluations of the actual

⁶ Law No. 17/2000 with its subsequent amendments institutes the framework for the evaluation of elderly persons' care needs.

⁷ See Law No. 34/1998 on giving subsidies to the Romanian associations and foundations with legal personality that establish social assistance centers.

⁸ See the World Bank Report, *Living Long, Staying Active and Strong: Promotion of Active Ageing in Romania*, 2014.

⁹ The time span for which an insured person may enjoy home medical care services is specified by the physician who initially made the recommendation, who is also bound to specify the frequency/periodicity of the services, which shall not totalize 90 days of medical care for the last 11 months in several stages (healthcare episodes). A healthcare episode is maximum 30 days of healthcare.

¹⁰ See Organizarea sistemului si furnizarea de servicii de ingrijire la domiciliu, in Romania (2015). *Provocari, Reteaua Senior Net*, p. 12.

¹¹ See Decision No. 978/2015 of 16 December 2015 on approving the minimal cost standards for social services, Appendix 4 - Minimal cost/year standards for home care social services for elderly persons.

social needs by the local public authorities¹².

Caring in health centers vs. caring at home?

“Caring at home is preferable for the elder person who stays with the family. However, when there is no such possibility, I think that a caring centre is welcome. Here the old person is provided with permanent medical assistance, there is someone taking care of his or her health, hygiene, plus he/she socializes. There are other persons with whom he/she can communicate.”

Head of Centre F (public, rural)

According to the studies made so far, it is estimated that by the year 2060 the proportion of Romania's population aged 65 and above will double, from 15% to 30%, which may entail a strong pressure on the costs represented by pensions, medical services and long-term care services. This will be accompanied by an opposite phenomenon in relation to the population segment aged 20 to 64, which is expected to go down by 30% by the year 2060, which is one of the most severe decreases in the EU¹³.

Accessing Long-term Care

The process by which social services are provided shall include the following compulsory steps:

- a) initial evaluation;
- b) elaboration of the intervention plan;
- c) complex evaluation;
- d) elaboration of the individualized plan for assistance and healthcare;
- e) implementation of the measures laid down in the intervention and the individualized plans;
- f) monitoring and evaluation of the provided services.

The present procedure for the provision of social services to elderly persons is based on the National Chart for the evaluation of elderly persons' needs that was adopted under Government Decision No. 886/2000. The document details the criteria for including elderly persons into one of the eight degrees of dependency. The latter is defined as the situation of a person who, as a result of having lost his/her autonomy for physical, psychical or mental reasons, needs significant help and/or care so that he/she might be able to carry on the basic day-by-day activities.

It is in terms of this evaluation that residential centers for elderly people are organized into sections for: dependant persons; half-dependant persons; non-dependant persons.

During this study there were visited 6 public care homes (2 urban and 4 rural) and 2 private ones. All the visited care homes were under the direction of the General County Department of Social Assistance and Child Protection. Following the discussions and interviews with the management of the care homes and the county authorities as well as the monitoring of these centers it has been found that the care homes complied with the procedures provided by legislation regarding the access of the elderly in the care homes. There were no cases or elements of discrimination acts found.

Even if in each interviewed care home there was a waiting list of people to be admitted, 4 of the 6 public centers visited had 3-5 and respectively 16-17 vacancies, this was due either to the duration of the process of evaluation of files by the directions or to the fact that the lists were either not updated, or some persons withdrew from the list.

Regarding the private sector, a care home in the urban area had a single place vacant due to a recently deceased resident, and the beneficiaries or their relatives had opted for this center on the recommendation of friends or because they learned from the public space about its existence, after subsequently visiting several centers to see the living conditions and the offers on the market. We

¹² Idem.

¹³ See the World Bank Report, *Living Long, Staying Active and Strong: Promotion of Active Ageing in Romania*, 2014, p. 7.

mention that in urban centers, the number of private care homes considerably increased in recent years.

The private rural care home was intended to care for the elderly suffering from dementia, the number of residents exceeded with 1 person the number of places for which the care home received accreditation.

Following discussions with residents of all the visited care homes, it was found that: if we refer to private centers in the urban environment most people had opted for the quality of services compared to those offered by other private centers and especially the services offered by public care homes available in the respective town, since they had the necessary resources to financially cover monthly costs (either from the pension or from the pension and contributions by legal guardians). The interviewed residents from the public care homes did not have an alternative option, either because they lacked the financial resources to cover the monthly costs of a private Center, or because the public care home in town was the only one available in their county; other interviewed residents stated that they chose a public center due to better conditions compared to existing private centers in the respective town / county.

Costs

According to the Social Assistance Act No. 292/2011, financing of the social services shall be covered from the local budget, the beneficiary's contribution and/or, as the case may be, his/her family, as well as from the State budget.

According to The European Committee of Social Rights the situation in Romania is not in conformity with Article 13.1 of the Charter. The level of social assistance is manifestly inadequate, including for elderly persons without resources¹⁴.

For persons who achieve income and, as the case may be, their legal guardians, have the duty to contribute to the costs of the social services they use, whereas in case they have no income and no legal guardians to support them or their legal guardians have such income that does not allow them to pay the monthly contribution, the assistance services shall be provided free of charge, the related costs being covered by the public budgets.

The quota of the monthly income per family member above which the legal guardians of institutionalized elderly persons have the duty to cover the difference up to the entire amount, provided for in article 25 paragraph (5) letter (a) of Law No. 17/2000 on social assistance for elderly persons, is 782 lei¹⁵, 1982 lei/month/beneficiary.

The cover for the integral value of these contributions is established as follows: the residents of the care home pay 60% of the value of their total monthly revenues, while the difference is paid by the legal guardians if they have revenue per family member higher than the minimum national gross salary. The obligation for the legal guardian to pay the monthly contribution can also be established by Court order.

The elderly who have no income and no family do not owe this contribution, and this is provided from local or country budgets within the limits established by the local authorities.

Contributions:

“In the case of persons with disabilities there is a problem, we have only one case, but other Centers subordinated to the Directorate have several such cases. The law provides that the contribution shall be of 602 lei, the resident has a survivor's pension of 495 lei and the caregivers have no means to cover the difference. Therefore, after all his entire life he had no income and had been supported by his father, we managed to provide - through the Pensions House - a survivor's pension of which we retained 60% as contribution to the Center's costs, while he

¹⁴ See The European Committee of Social Rights, Third report on the non-accepted provisions of the European Social Charter - Romania, March 2015.

¹⁵ Art. 8 in Decision No. 978/2015 on approving the minimal cost standards for social services and the monthly quota per family member, which is the basis for the calculus of the monthly maintenance contribution owed by the legal guardians of elderly persons in residential centres.

could keep the difference; now, according to the new legislation, I have to retain his entire pension and he has nothing left for him.”

“I have no other choice and he is upset. 200 lei wouldn't have left the State poor; they could as well have kept the old regulation.

So the law-maker failed to foresee such cases when not only a person has a disability, but that person is also deprived of his/her survivor's pension.”

Head of Centre (public, urban)

The cost standards for **home care services** for dependent elderly persons is 120 lei/month/beneficiary which means it covers a frequency of 8 visits/month, as compared to the standard adopted in 2015 with a minimum cost of 15 lei/h. It is made up of:

- expenditures needed for the payment of the caretaker's salary;
- the cost of the caretaker's travel from the headquarters of the social assistance unit to the beneficiary's home;
- consumables.

Each of the three degrees of dependency established on the basis of the Chart for evaluation of the elderly persons' needs was estimated a minimum number of hours during which the home caretaker assists the dependent person to perform the basic and the instrumental activities of daily life. Estimation of the number of hours was so conceived as to correlate the provisions of the Chart for evaluation of the elderly persons' needs with the second target variables related to the access to services that the EU Member States are bound to use according to EU Regulation 2015/245 released by the European Commission on 16 February 2015.

Residents' Assessment

According to minimum standards, the care and assistance for residents in the residential center is carried out based on individual needs and depending on the personal situation of each resident.

Thus, the elderly person admitted by the center is assessed by specialized staff, in terms of functional physical or psychological status, state of health and the person's level of autonomy, communication skills, family and social relations, educational level, socio-economic situation, special needs treatment and recovery / rehabilitation needs, educational needs, cultural and spiritual potential risks, possible addictions (drugs, alcohol, tobacco, etc.), work capacity. At a minimum interval of one year or whenever needed, the elderly person is reassessed.

Following the assessment / reassessment of the resident's needs¹⁶ an individualized assistance and care plan is developed / the intervention plan. The activities of the center and the services provided are carried out according to this plan.

The resident must be actively involved in the assessment activity and in the preparation of the individualized assistance care plan/ the intervention plan; the resident is encouraged to express preferences / desires.¹⁷In situations when the resident has no discernment, the legal representative may participate in the assessment / reassessment process, or may ask to be informed in writing of the results of the assessment / reassessment.

Also, if the legal representative can not be present to sign the assessment and the planning of services, he or she completes together with the signing of the contract for the providing of services, a written agreement by which he or she accepts the decisions and recommendations of the center's staff with regard to the care and assistance of the resident.

The center establishes a multidisciplinary team which is responsible for the assessment / reassessment of the resident and with the assistance and care plan development as well as with the individual recovery and social integration/reintegration plan.

¹⁶ To be noted that for this study was taken into account documented data issued by the specialized structures in complex assessments, in medical evaluations and recommendations

¹⁷ According to minimum quality standards for social services with accommodation organized as residential centers for disabled adults, all results of the evaluations will be made known to the resident in an accessible format (easy to read, Braille, CD video / audio, etc).

The specialized staff of the center is either employed directly by the center, or has a service contract with the center.

Human Rights of Older Persons in Residential Long-term Care

The right to life

According to the Constitution, the right to life, as well as the right to physical and mental integrity of person is guaranteed. No one may be subjected to torture or to any kind of inhuman or degrading punishment or treatment¹⁸. Also, the new Civil Code, in force since 2013, equally guarantees and protects any person's life, health and physical and mental integrity and stipulates that the human being's interest and welfare should prevail upon the unique interest of society or science.

Prohibition of Torture, Degrading or Inhuman Treatment

The Constitution of Romania enshrines in its art. 22 the right to physical and mental integrity and the fact that no one may be subjected to torture or to any kind of inhuman or degrading punishment or treatment.

The law on mental health and the protection of persons with mental disorders¹⁹ includes a number of provisions and measures defending the rights of persons with mental disorders. Thus, the law refers to voluntary confinement and to involuntary confinement, the latter being allowed only in severe cases and on decision by a medical commission.

The law provides that confined persons may be restricted their freedom of movement, by means of adequate devices, in order to save them from a genuine danger to them or to others' life, physical integrity or health. Confinement may not be used as a form of punishment, may not be part of the medical treatment and may not be ordered for cases of suicide or self-isolation or as a solution for the lack of personnel or treatment, nor as a sanction, nor as a form of threatening nor to force good behavior and nor to prevent the destruction of assets. In extreme cases, this measure may be used, but only if the application of less restrictive techniques proves inadequate or insufficient to prevent any harm or injuring.

According to minimum quality standards - the standard on respecting the rights of residents and professional ethics - the care center must develop and implement a Charter of residents' rights. The care center must develop and implement a Charter of rights of beneficiaries. The Charter, according to the normative act, envisages the respect of a number of rights that are listed, including the right of residents "not to be abused, neglected, abandoned, punished, harassed or exploited."

Also in line with the standard on protection from abuse and neglect, the residential care center must take measures to prevent and combat all forms of abusive, negligent or degrading treatment of its residents.

In this sense the center must use its own procedure for identifying, reporting and solving cases of abuse and neglect among their residents, to encourage and support residents to report any form of abuse, neglect or ill-treatment to which they are subjected by the people they come in contact with, both at the center as well as in their family or in the community. Also, the center must organize training sessions for their staff in the field and monitor the activities undertaken by the residents during the periods when they are not in its premises, in order to prevent risk of abuse or exploitation.

Do you have a policy for inappropriate behavior?

"Such persons are deprived of liberty and of the possibility to leave the center, since according

¹⁸ The Constitution revised, art. 22.

¹⁹ Law No. 487/2002, republished in 2012, on mental health and the protection of persons with mental disorders, published in the Official Gazette of Romania, I, No. 652 of 13 September 2012.

to internal regulations there is a procedure regarding misbehavior and disciplinary sanctions may be applied for alcohol consumption, scandals etc.”

Head of A Center (public, rural)

7 of the 8 centers visited had the Chart in place, or had it incorporated in the internal regulations procedure and also had procedures on protection from abuse and neglect. Only one center has not developed such a procedure. However, the management of the center stated that periodic meetings with the staff are organized, during which the discussions focus on issues such as the appropriate behavior towards the residents or periodical dialogues with them. This approach has been highlighted also by the other visited centers.

“We also have questionnaires by which we check the possible abuses during the beneficiaries' visits. They are applied to those beneficiaries who frequently go out of the premises and pay visits and then we check if they were not abused in the community”

Head of A Center (public, rural)

Following the interviews with specialized staff of all the visited centers, a low level of knowledge regarding the Chart of residents' rights and the fundamental rights of elderly persons was noted, but in spite of this it was found that the staff has the required qualification to handle the situations when the residents refuse food or shower/bath.

In none of the visited centers were signaled cases of violence during the visits or other cases of abuse or violence against elderly persons. There were no locked rooms (the field visits were organized following a request for admittance presented to the management of the centers). Also in three of the six visited public centers, some of the interviewed persons were reluctant in expressing themselves with regard to food, living conditions or the behavior of the staff in order not to jeopardize or worsen their situation. All the other interviewed residents expressed their satisfaction or great satisfaction with the way they are treated and cared by the staff.

What if they refuse to wash/be washed?

Out of 100 residents we also have some people who are at odds with water, they don't like to wash, even though they have access to warm water and they don't have to pay for it; however, much to their dissatisfaction, we have a strict schedule, willy-nilly: twice a week, for they are old and must wash.

How do you proceed?

We've been successful so far, with diplomacy. We can't do it by force. Those who are immobilized in bed, are washed by nurses/attendants, but among those who are independent, who can walk, there are some who refuse to take a bath. Nevertheless, they eventually give in, they have to, we wouldn't like to have problems (diseases, etc.)

Head of Centre B (public, urban)

However, in Romania they were also reported violence and abuse cases, torture, excessive sedation, exploitation at the working place; these are some of the accusations launched by the Legal Resources Centre, in a criminal complaint on the living conditions of persons with disabilities living in a care center for elderly people with disabilities in Romania²⁰.

Such cases clearly highlight the lack of administrative, social and educational measures or of any other appropriate measures for the protection of persons with disabilities against all forms of exploitation, violence and abuse²¹.

Freedom of Movement, and Use of Restraint

The law on mental health and the protection of persons with mental disorders²² includes

²⁰ <http://www.gandul.info/stiri/ancheta-la-un-camin-unde-persoane-internate-ar-fi-batute-legate-de-paturi-sau-abuzate-sexual-12394136>.

²¹ See Annex to Government Decision HG 50-2015.

²² Law No. 487/2002, republished in 2012, on mental health and the protection of persons with mental disorders,

a number of provisions and measures defending the rights of persons with mental disorders. Thus, the law refers to voluntary confinement and to involuntary confinement, the latter being allowed only in severe cases and on decision by a medical commission.

The law provides that confined persons may have their freedom of movement restricted, by means of adequate devices, in order to be saved from being a genuine danger to them or to other persons' life. Confinement may not be used as a form of punishment, may not be part of the medical treatment and may not be ordered for cases of suicide or self-isolation or as a solution for the lack of personnel or treatment, nor as a sanction, nor as a form of threatening nor to forcibly impose good behavior and nor to prevent the destruction of assets. In extreme cases, this measure may be used, but only if the application of less restrictive techniques proves inadequate or insufficient to prevent any harm or injuring²³.

The use of confinement devices should be proportional with the danger, should be applied only for the needed time period and only when there is no other way to prevent the danger, and never be a sanction.

"We had situations when we had to immobilize the patient but in order to comply with the law we called 112 for the help of the police of psychiatric attendance."

In none of the visited care homes were found any reports during visits on cases of use of force for immobilization (in the sense of restraint) against residents, or of restriction of freedom of movement of elderly persons or on rooms locked with the key, but mention should be made that the visits were organized after obtaining prior agreement from the management of the respective care home.

However we encountered some situations in which freedom of movement of persons was affected. Thus, a resident (who was in the care home for 5 years) suffering from dementia, had a partially amputated leg (gangrene). He had no prosthesis since having no insurance the insurance house cannot cover the expenses for it.

In a public care home, there were bars on the windows of the upper levels, in the opinion of the management this being an attempt to protect beneficiaries suffering from a form of dementia or of other mental disability.

Last but not least, the insufficient number of existing staff, reported to the number of beneficiaries, especially residents with disabilities endangers the right to freedom of movement, the right to participation, the right to autonomy, creating conditions for possible violations of these rights. The insufficient number of staff makes residents dependent (including the mentally ill confined in bed) their programme being limited to meals, personal hygiene, provision of medication and cleaning of the rooms.

The Right to Autonomy

According to active life and social contacts standard, the residential centre must encourage and promote an active and independent lifestyle. In this regard, the centre must have a plan of activities and staff should encourage and support residents to participate in the daily activities of the centre, in order to preserve functional autonomy and independent living.

The centre must respect the intimate life of the residents and, where appropriate, to ensure proper conditions for the couples formed in the centre.

Also in accordance with the Chart of residents' rights, they and their representatives, as beneficiaries of the residential care centre have the right to be informed on their rights and responsibilities. They have the right to be consulted with regard to all decisions concerning them.

In all the visited centers, the management and the specialized staff reported that they organize meetings with the residents periodically informing them on the current legislative amendments in the field of social assistance (changes concerning the calculation of maintenance contributions), on the organization of activities in the centre, or discussing with the residents about their food

preferences (for the following period or for a special forthcoming event). They also explained that the residents are consulted on purchasing hygiene and personal items, pajamas etc.

The principle of autonomy and the persons with disabilities. Autonomy refers to the capacity of the persons with disabilities to manage themselves by their own means, without the help of others in line with the right to "be free and make one's own choices". The idea of autonomy is linked with "the personal mobility" and "accessibility", with the "right to live and independent life", with measures of "habilitation and rehabilitation" with the aim "to obtain and maintain maximum autonomy and to fully develop the physical, mental social and professional potential" but most of all autonomy means "recognition of the juridical capacity of persons with disabilities" this representing the culmination of being an autonomous person.

According to the Constitution, the exercise of certain rights or freedoms may only be restricted by law, and only if necessary, as the case may be, for: the defense of national security, of public order, health, or morals, of the citizens' rights and freedoms etc.

Such restriction shall only be ordered if necessary in a democratic society. The measure shall be proportional to the situation having caused it, applied without discrimination, and without infringing on the existence of any right or freedom. Therefore, the Civil Code acknowledges civil capacity to all persons, any person having legal capacity and, except for the cases provided for by the law, legal competence. Also, the Civil Code stipulates that no one may be limited in his/her legal capacity, nor can he/she be deprived, entirely or partly, by his/her legal competence, except for the cases and the conditions expressly provided for by the law.

For those who have no legal competence (juveniles younger than 14 years old and persons under judicial disability), legal documents shall be signed, on their behalf, by their legal representatives, under the conditions provided for by the law.

A person who has not the required power of discernment to take care of its interests, because of mental alienation or mental debility, shall be adjudicated of legal incapacity.

Although the new civil legislation provides for certain guaranties with regard to the prohibition of legal capacity, including the obligation of the Court to hear the respective person, sometimes Courts omit to do so. The law does not provide for automatic periodic reviews of the decision of legal capacity deprivation and placement under guardianship, a fact also remarked by the Council of Europe Human Rights Commissioner who, in the special Report on his visit to Romania pointed out that the new civil legislation failed to provide abrogation of total incapacity and guardianship and replace them with measures that might provide persons with disabilities with the support they could need in the exercise of their legal capacity. He urges the Romanian authorities to elaborate laws and policies that should replace the substituted decision making by a supported decision making mechanism, in order to make sure that persons placed under guardianship have real access to jurisdictional control procedures of challenging the guardianship or the way it is administrated, and to make sure that the support given to persons with disabilities respects their preferences, and is free from conflicts of interests and subject to jurisdictional control. The Commissioner also urges the authorities to take measures to make sure that persons with disabilities are acknowledged as persons with an equal status before the Courts as any other persons and that they be able to challenge efficiently any violation of their right to legal capacity.

Communication with the legal representative/guardian/caregivers?

Even though some residents are not put under interdiction, they don't trouble anyone, when you speak with them they will repeat the same thing over and over again. So it's still the caregivers that we speak with.

Head of Centre B (public, urban)

The Right to Dignity

In the Constitution of Romania it is not regulated a fundamental right to dignity, but human dignity is considered as being a constitutional principle and represents a supreme value, thus being

guaranteed.²⁴

Also the Law of social assistance no. 292/2011, is based on a series of principles among which that of respect for human dignity, according to which free and full development of personality is guaranteed for each person with respect for the individual and social status and for the right to privacy and protection against any physical psychological, intellectual, political or economic abuse²⁵. The Law also provides that the staff working in the field of social assistance has the obligation to respect the dignity and uniqueness of the person.

As mentioned in the first part of the Report, before being received in a nursing home, the elderly persons are evaluated and classified by various dependency grades. According to this initial evaluation the residential centers are organized by sections for dependant and non-dependant persons.

From the perspective of autonomous individuals all the visited care centers met in general according to minimum quality standards a series of necessary criteria for the respect of the right to dignity (with the exception of the private center for people diagnosed with dementia).

From the perspective of a semi dependant or dependant person, during the field visits there were found some elements that can be considered as not respecting the right to dignity, to private life or to autonomy such as too small spaces between beds, the lack of partitions between beds, the rooms of the residents being left with doors opened or the access in the room being done without waiting for the approval of the resident.

“The general perception is that in a home for the elders one finds only self dependent persons. But this is not the case, since such persons are in their own homes. We have here people with chronic diseases, with disabilities or social problems.”

Head of A Center (public, rural)

Food

The menu is designed for one week. According to the regulation is displayed on a daily basis. In 2 centers (public) the management opted for food outsourcing, this being provided on a daily basis by private catering companies while food is only heated at the centre. In the other 6 centres (4 public, 2 private) the food is prepared in their own kitchen.

7 of the visited centers were offering food in accordance with each resident diet (for diabetes etc.), with 3 meals and 2 supplements (especially for diabetics).

Just in one centre (public, urban) the diet consisted only in food with or without salt, while the residents did not have an adequate space enabling them to cook for themselves according to their own special diet.

Only in one care centre (public) each wing was provided with a small kitchen office offering the residents the possibility to prepare warm food. Some of the residents of the 4 visited centers (public) were dissatisfied with the quality and taste of food, while others stated that they were satisfied with it.

The Right to Privacy and Family Life

In four out of the 8 care centers (3 public, 1 private) there were some couples that were either formed during the stay at the center (married or unmarried), or that came and were admitted together at the center. In either of cases these had their own room, in line with the right to family life.

Is there a meeting space for socializing with the family?

“Yes, we have such a space.. I have not restricted going to the person's room. They can come in the evening 19 hrs. We can say that we monitor and have a situation of visits, their frequency differs, for some the visits are paid weekly, for others monthly, depending on the children availability. We have people who are not visited, either because they have not relatives, or because

²⁴ See Gheorghe Iancu, Teoria ciclurilor constitutionale, (the Theory of Constitutional Cycles) Editura Universul juridic, Bucuresti, 2015.

²⁵ See art. 5 point, d) of Law nr. 292/2011.

they are not in good relations with them.

For example a touching meeting of a son who has not seen his mother for 30 years. We managed to trace him. We had his birth date from his mother and we were working with population census data. Their meeting was shocking with reproaches and accusations from both sides, but in the end the son is willing to have a relationship with his mother, to come and visit her. It remains to evaluate the payment contribution, now that he has legal obligations. But it was a very touching meeting. The beneficiary was very pleased to see her child”

Head of A Center (public, rural)

“They have their special needs, here there is no privacy (B wing) in the other part there are rooms but those with serious disabilities here receive proper care in the other building they would not receive this type of care since it is for the self dependant. In any case they are not disturbed by the open space (B wing has 3 rooms out of which 2 are opened with 5 beds on the sides.) With only one exception all wear pampers and they are not bothered from the perspective of privacy, they are used with one another. Had they been taken to a new environment they would surely mind because here they feel like home”

Head of H Center (private rural)

The Right to Participation and Social Inclusion

According to the minimum standards the care centers must promote the social integration/reintegration of residents. Thus they must have the capacity (space and appropriate staff) in order to facilitate family integration/reintegration, in the community, on the labor market and in society at large, on the basis of a social integration/reintegration programme. The individual integration/reintegration programme is established by the specialized staff on the basis of evaluating the residents' needs. The resident subscribes to the individualized assistance and care intervention plan.

The majority of the visited centers highlighted that they organize various types of in-house activities such as gardening- all the centers (public/private) had the minimum required space for growing vegetables, flowers etc. However, in 3 public centers (2 rural and 1 urban) the management stated that the residents are not keen to perform such activities although there were several attempts to organize several activities (cards games, chess, dance etc.) or media activities such as watching movies - in 2 public centers. A centre stressed that it provides residents with materials required for crocheting, knitting activities.

Do you organize workshops?

“Those who wish to perform activities can go to the club, but most residents do so in their rooms (particularly old ladies who enjoy knitting); in case the weather is fine, then in the open, on a bench. They are offered the materials needed for knitting (kinetic activities - mainly ladies).”

Centre E psychologist (public, rural)

Only 3 centers (1 private, rural and 2 public rural/urban) organized workshops for integration/reintegration therapies (ergo therapy, extra curricula educational activities, vocational orientation also having the appropriate furniture and equipment.

Also all the visited care centers reported that they organize events on several occasions, birthdays, religious or cultural holidays (the day of elderly persons, the day of people with disabilities etc.) 4 out of the 6 public centers (3 rural, 1 urban) cooperate constantly in the organization of such events with different non-governmental organizations.

3 out of the 6 public centers (2 rural, 1 urban) organize either by themselves or in partnership with different foundations periodical trips (once a month or once in two months) to visit tourist objectives in the vicinity of the centers or in the country, by offering their own transportation. The private centre from the urban area facilitates the residents' access to different cultural events that take place in the locality or in the respective county where the care centre is located (theatre, movies, concerts etc.)

In one of the care homes some of the beneficiaries stated that they spent their free time walking, reading and watching TV, stressing that for the moment, there are no other activities organized by the care home. (the questioned persons had been in the care home for an average 3 months' time)

Only 3 centers (1 private, rural and 2 public, rural/urban) organized workshops for activities/therapies of integration/reintegration (ergo therapy, extracurricular education etc.) having the appropriate furniture and equipment. In the private centre for elderly person with psychiatric disorders the residents able to move alone are encouraged to participate in the preparation of food, or of canned food for winter. Also it has been noticed that in other centers (public ones) the residents were encouraged to help with the food serving in the dining room.

However, the activities organized in the majority of the visited care centers are few and address especially to autonomous or semi dependant persons. The daily programme is rigid and fixed determined by the hours of meals and by the personal hygiene program (the schedule of bathroom hours). The insufficient specialized staff (nurses, social assistants, and teachers) has an important impact on the organization of the daily schedule.

Do you perform any activities here?

"I have no activity. This is my concern, sometimes I look for something to do, there are some trees to be grafted downstairs, I taught the porter and janitor how to clean the trees, I was not content with what they did, you do not clean a tree as peacock's feathers for export."

Beneficiary D. From F Center (public, rural)

In most of the centers, the programme of dependant persons is limited, they are fed and helped with the personal hygiene but they are not involved or attracted in activities of recuperation or integration. There are also centers in which special attention is given to the recuperation activities, such as the private centre for the persons suffering from dementia.

Freedom of Expression

In all visited centers (private/public) the residents had access to a source of information (TV, radio) and means of communication. Most of the residents had a cell phone (purchased with own funds) to get in touch with their family, friends etc.

The right to vote is ensured either by transporting the autonomous residents to the voting stations either by mobile ballot box.

There was no reported violation of the right to freedom of conscience and religion; the residents had access to religious services of the community to which the care center belonged. For those of another denomination / religious cult that had no access to religious services either because they were not available in the respective community or because they were unable to leave the center, access to religious literature was ensured and they also received visits from the priest. Inside the four public centers (three rural, one urban) a church/chapel has been built.

The Right to the Highest Attainable Standard of Health

Right to health

Article 34 of the Constitution provides that "The right to the protection of health is guaranteed." Therefore, the State is bound to take measures to ensure public hygiene and health. As a result of the application of art. 20 para (1) of the Constitution, interpretation of this article should take into account the provisions of art. 12 of the International Covenant on Economic, Social and Cultural Rights²⁶, art. 25 of the Convention on the Rights of Persons with Disabilities and art. 11 of the revised European Social Charter.

The right to the protection of health is closely related to other fundamental rights: the right to life and physical and psychic integrity; the right to privacy and family life; the right to information;

²⁶ See I. Muraru, E. S. Tanasescu (coord), Constituția României. Comentariu pe articole, Ch Beck, 2008, p. 319.

the right to a healthy environment.

According to the legal document on preventing and combating all forms of discrimination, the following are classified as infractions: discrimination of a natural person, a group of persons on the grounds of their affiliation [...] with a certain race, nationality, ethnicity, religion, social category [...], age, gender or sexual orientation of the respective persons consisting of the denial of a person's or group of persons' access to public healthcare services - choice of the GP, medical assistance, health insurances, emergency services or other healthcare services²⁷.

Law No. 95/2006 on the reform in the field of healthcare is the normative act defining and specifying the State's constitutional and legal obligations to guarantee the right provided by art. 34 of the Constitution²⁸. It details the way medical assistance and the healthcare social insurance systems are organized in Romania, on the basis of contributiveness.

At the same time, the rights of patients were legislated under Law No. 462/2003, which stipulates that they "are entitled to medical caring of the highest quality that society can provide, in conformity with its human, financial and material resources". The patients' rights law acknowledges a wide range of patients' rights such as the right to refuse a medical intervention and the right to be informed about the consequences of his/her refusing or stopping the medical treatments. Also, in case the legal representative is requested to give his/her consent, the patient has to be involved in the decision making process, to the extent allowed by the patient's comprehension capacity.

However, the studies achieved so far show that in spite of the fact that there have been issued norms for the application of this law, it is hardly known by patients, either out of ignorance or the insufficient information efforts taken by the Ministry of Health²⁹.

Also, Law No. 448/2006 on the protection and promotion of the rights of persons with disabilities provides that persons with disabilities, their families or their legal representatives are entitled to all information related to the medical diagnosis and the recovery/rehabilitation, all available services and programmes, in whatever stage the latter might be, as well as the rights and the duties in the field. In Romania, persons with disabilities enjoy free medical care, including free drugs, both for the ambulatory treatment and throughout hospitalization, in the framework of the social health insurance system.

According to art. 14 of Law No. 17/2000, centers for old persons provide both socio-medical services consisting of: assistance for keeping or readapting one's physical or intellectual capacities; ergotherapy programmes; assistance for the achievement of personal hygiene; and medical services consisting of: consultations and treatments in the surgery, in medical institutions or at the person's bed in case he/she is immobilized; infirmary caring services; acquisition of the medication; acquisition of medical devices; as well as dental care consultations and treatments. The costs of the medical services, sanitary materials, medical devices and drugs are covered according to the legal provisions regarding the healthcare social insurance regulations.

At the same time, according to Government Decision No. 867/2015 on approving the Register of social services as well as the framework-regulations for the organization and functioning of social services, old persons homes also include among their services/activities current healthcare services provided by medical assistants or as the case may be and healthcare provided by a geriatrician, an internist or a GP, therapies for physical/psychic/mental recovery.

According to the legislation in effect, persons with disabilities are entitled to free-of-charge medical assistance, including free drugs, both for the ambulatory treatment and for hospital treatments, in the framework of the healthcare social insurance system.

In its Country Report, the United Nations Committee on Economic, Social and Cultural Rights recommended that the State party should intensify its efforts to ensure de facto access to affordable, good quality and timely health care and medical treatment for all segments of the population, including persons living in rural and remote areas, as well as disadvantaged and marginalized

²⁷ See art. 10 of Ordinance No. 137 of 31 August 2000 on preventing and sanctioning all forms of deiscrimination.

²⁸ See I. Muraru, E. S. Tanasescu (coord), *op. cit.*, p. 320.

²⁹ See O. Popescu, *Sistemul de sanatate si drepturile sociale*, IRDO, 2009, p. 49.

individuals and groups³⁰.

According to the new Official List of social services³¹, the homes for elderly persons provide current medical care services ensured by medical assistants as well as other medical assistance activities, as the case may be, ensured by geriatrists, internists or GPs and consisting of physical/psychic/mental recovery therapies.

At the same time, according to the Minimal Quality Standards - Standard on healthcare assistance, "the Centre shall enroll the residents with a GP or facilitate their access to a GP surgery". Also, where Organization and Functioning Regulation of a Centre provides for medical services ensured by physicians, the Centre/service provider may employ one or several specialist physicians or may conclude service agreements with them.

In order for a person to enjoy free medical services (recommendation for examination by a specialist physician) and, at the same time, to enjoy subsidized drugs, that person has to be registered with a GP who has an agreement with the Health Insurance Company.³²

All visited centers have a form of collaboration with a GP/GP clinic where the residents are registered at the time of their admission. The actual possibility to choose a certain GP only exists in urban areas, where several medical services providers are available and where the residents coming from the same place as the Centre can keep their GP with whom they have already established a certain relationship.

"A resident may choose to keep his/her GP or, if he/she so wishes, to be transferred to the GP of the respective Center. They have this latter possibility; it is easier for them to get their subsidized medication. 80% of the residents are registered with the Centre's GP, the rest of them preferred to keep their GP but they bring the medical prescriptions to the Centre as well."

Head of Centre B (public, urban)

"I'm stuck with my old physician for we know each other. Here the doctor comes and goes."

Resident Centre B (public, urban)

On the contrary, the rural areas are facing a scarcity of physicians which often results in one single physician taking care of the health of the citizens of 2-3 villages, communes, sometimes even more.³³ Nevertheless, two centers of the five visited in rural areas reported collaboration with two GPs with whom they had half time medical services agreements.

"The working hours of the physicians are everyday in the morning or in the afternoon, depending on the working hours at the private clinic. No physician would come full time because the salaries are very low. It was quite hard to find two persons willing to collaborate".

Head of Centre A (public, rural) (at the moment of the visit, neither physician was in the Centre)

The personnel in the visited centers reported various types of collaboration with the GPs. Thus, in four centers the physicians paid weekly visits observing the clinic schedule and whenever they were requested by the medical assistants. The interviewed residents confirmed that the GP paid visits when he was summoned. For more thorough examinations they were sent to the hospitals in the neighborhood.

³⁰ See CESCR, Concluding observations on the combined third to fifth periodic reports of Romania, E/C.12/ROU/CO/3-5, p. 7.

³¹ Government Decision No. 867/2015 of 14 October 2015 on approving the Official List of social services, as well as the framework rules for the organization and functioning of social services.

³² According to art. X in the Framework Agreement stipulating the conditions to be met for enjoying medical assistance within the healthcare social insurance system for the years 2014-2015, patients are entitled to choose the medical service provider as well as health insurance company with which they register, in compliance with the effective legislation and the Framework Agreement. They are also entitled to register with a GP of their own choice, provided that all the provisions of the effective legislation are met and covering the transportation costs if they choose a physician in a different place.

³³ See CNPV, *Problematika varstnicilor din mediul rural*, 2015, p. 30.

“Every time I come here I see them all, I prescribe the medication. Half of them are registered with me as their GP, the other half with another physician. I collect their health cards, prescribe their medical prescriptions, and bring the cards back while the Centre takes care to acquire the medication on the basis of the prescriptions. A needed minimum of drugs can be found in the home itself. They possess a small pharmacy.”

What are the medical services you provide?

“Periodic examination and prevention. In case of acute diseases or controls for chronic diseases, we send them to the hospital (the ambulance or, for the regular controls, the Center’s car takes them there).”

Centre H halftime GP (public, rural)

“I wish I had a physician here, preferably a geriatrician, but a GP would also do; it is good for their mental state to have him see them every one or two days (it increases their pleasure of living, this means a lot). The physician who sees them at present is a GP and has a lot of patients, her clinic is 6 km away from the Centre (she is to be found there everyday); if needed we phone, take a car and go there, but usually I ask her to come round. We have a good collaboration relationship. On the average, she comes to the Centre once a week, sometimes she comes twice a week, but then the next week she does not show up.

She has 3,000 patients, it's difficult. We tried unsuccessfully to find another physician. We collaborate a lot through the phone, we send the files to her; in case of chronic diseases, we agreed to send the file 2-3 days in advance, she writes the medical prescription and sends it back to us.”

Head of Centre C (public, urban).

In one of the visited public centers in the rural area, there was a collaboration with the physician in the commune to which the village belonged (10 km away). It was mainly collaboration in terms of providing the residents with subsidized prescriptions, while the physician did not pay visits to the Centre to examine the patients. For any problem beyond the training of the medical assistants they used to call for an ambulance as the village was 30-40 kilometers away from the nearest hospital. The interviewed residents confirmed that they hadn't been visited by the physician for several months. At the same time, the specialized personnel believed that there was no need for a permanent physician within the Centre.

A particular situation is that of a private centre for old persons with somatic, neurological, associated and other diseases (hearing, visual) where, because of their diseases the residents enjoyed a caring and recovery programme carefully monitored by physicians. The Centre collaborated with two GPs, a psychiatrist and a neuropsychiatrist, while one physician was in the Centre every day.

According to the United Nations Committee on Economic, Social and Cultural Rights, healthcare services should be physically and safely accessible for all segments of population, particularly so for older people and persons with disabilities.³⁴

Access to specialized services/physicians

The international human rights standards emphasize on the need for an integrated approach to the caring of older persons that should combine elements of preventive treatment with curative treatment and rehabilitation/health recovery treatments.³⁵ In this respect, older persons should have access to additional specialized physicians when needed, such as psychiatrists, geriatricians, stomatologists, gynecologists, etc.

Access to a geriatrician was practically inexistent in all the visited centers, from the absence of such a specialist from the multidisciplinary team initially evaluating older persons for admission in the Centre down to his/her absence from the hospitals where the residents were sent for various

³⁴ See CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), para 12. b.

³⁵ See CESCR, General Comment No. 6 on the Economic, Social and Cultural Rights of Older Persons.

medical tests.

As far as the psychiatrist is concerned, most public centers provide access to such a specialist via the Directorates to which they are subordinated. Either the specialist is brought to the centre to evaluate/re-evaluate the residents periodically (some centers reported re-evaluations made every month while others couldn't specify a clear time period) or the residents are sent to the surgery when there are changes in their behavior and they need to have their treatment altered.

“There was a resident who became violent because of his disease, so we called for an ambulance to take him to specialized hospital Y; we would call for an ambulance when the working hours are over or in special cases. The patient was examined by the physician in the hospital and was given a different treatment, he was not hospitalized. There haven't been any problems with that patient ever since”.

In a private centre for older persons with neurological diseases, the residents are carefully monitored, the psychiatrist collaborating with the centre having special training for insanity cases.

All the visited centers, public and private, reported that residents presenting changes of behavior were sent to be examined by a specialist.

According to the Minimal Quality Standards, a residential centre should provide **recovery/rehabilitation programmes** in order to maintain or improve the resident's functional autonomy. Access to physiotherapy and chineto therapy services, which could have an important role in the recovery of the residents, is achieved in different ways. Thus, four of the six visited public centers for older persons offer, through the DGASPC to which they are subordinated, access to such services organized within recovery centers. Access is achieved on the basis of appointments and waiting lists, in some centers the number of those who come to actually benefit from such services being relatively small. One single centre had its own clinic equipped for such services and the residents confirmed that they used them.

In a single visited public centre the residents did not have access to such services. A woman who could walk with the help of a walking frame explained that she was discontent with the fact that there was no room devoted to such services and that she had to give her the massage herself. The personnel confirmed that the centre lodged several residents with sequelae of stroke who needed chineto therapy services but “generally it's the family who takes care of that when a person needs to practice recovery exercises, and then they bring the patient to us. We do not cover such things, what we can cover is ENT old age diseases, ophthalmology, for which we go to a specialist physician and the recovery to a lesser extent”.

All the visited centers ensure current medical care services through nurses. The working programme by rotation is 14 / 24h 14 / 48h. It should be stressed that the number of nurses per number of residents varies from one center to another (see Annex x), especially in the public sector where lack of funding and low salaries have led to a shortage of specialized staff³⁶³⁵.

Also, according to quality standards, in most of the visited centers there is a medical cabinet with the minimum equipment. Some of these were refurbished together with the respective centers and were provided with the necessary equipment as a result of accessing the European Regional Development Funds by the local authorities.

The visited private centres provide such services for the older persons under their care at their own premises. This is achieved either by the voluntary work of specialists in the field, or the collaboration with a Faculty of medicine offering the students the possibility to perform their compulsory practice activities in the Centre, or a paid collaboration with a specialist.

Transportation to the places where specialized services are provided is made by the Centre's/Directorate's car if the resources are sufficient. Where there are public transportation services, and the Centre's resources are limited, autonomous persons also use the public transportation system.

³⁶ For services provided in centers for the elderly, classified according to the scale of assessment needs of older people in 1MB and MIC grades dependency ratio employee / beneficiary is 1/10. For services provided in centers for the elderly dependent ratio employee / beneficiary is 1/2. For services provided in residential centers for people with disabilities, the ratio employee / beneficiary is 1/1.

“If we need anything, we make a purchase requisition and get it. The medical cabinet has been equipped as a result of the rehabilitation. It didn't use to look like that - computer, blood pressure monitors, echoscope, blood glucose meter - we hadn't had them before.”

Medical assistant, Centre F (public, rural).

In one of the visited private centers, the medical cabinet was provided with the minimal equipment and organized in an open space (a part of the main entrance hall) thus failing to provide the necessary intimacy for a medical consultation (right to privacy and personal life).

In all the visited centers the specialized staff reported that when emergencies occur with regard to the health condition of their residents, they dial 112 ambulance service and they inform the ambulance crew about the condition of the respective resident.

Medication

According to minimum standards the residents with discernment, take the recommended oral medication alone. If individuals refuse the recommended medication, the situation is recorded in the file of services monitoring and is signed by the resident.

When the residents are not able to take their own medication this is administered by the medical staff. In all the visited centers, the nurses follow the administration of medication procedure according to the treatment schedule issued by the physician for each resident and according to the patient's medical history recorded in the patient's personal file of monitoring services.

Has the resident the right to refuse the prescribed medication? “Yes, of course Even when one is recommended to go to a hospital there are many occasions when they refuse by saying: "no, offence, but I am not going". I would insist explaining the benefits of the treatment and if they don't understand, it is their own decision. This is the case for rational, reasonable residents; it is more complicated with the others. We do what we have to do, We do what is right.”

Doctor Center H (public, rural).

The Right to an Adequate Standard of Living

According to minimum quality standards, each resident should have a personal bedroom in one room.

Thus, the bedroom of the residents can have maximum 4 beds and minimal furniture, each resident having 6 square meters for the personal bedroom/room. For the people that need permanent care and surveillance, the centre can accommodate bedrooms with more beds providing that they are separated by curtains³⁷.

In a public centre visited, the wing for autonomous and semi dependent persons the majority of rooms had 3 beds, there were also rooms with 2 and respectively 1 bed. Some of the interviewed residents who were accommodated in rooms with 3 beds considered that their private space was too small.

How do you find the room?

“It's good that you ask, my only objection - I also spoke to the Director about it - is that it is a room for two persons. By no means a room for three persons (the third bed was unoccupied) For two persons it is OK, three persons are already too many for the size of the room. The toilet is shared with another room, but this is not a problem (If it were possible to have one toilet in every room it would be better, but this is not a problem). I also had a discussion with the Director, I have read somewhere that according to the European standards, there has to be a minimum distance of 60 cm between the beds.”

Lady resident, Centre B (public, urban)

In the wing for dependant persons, there were 6 beds and this situation was argued by the need

³⁷ According to Order No. 2126/05.11.2014 the centres that do not comply with the above mentioned conditions in maximum 3 years, must rearrange the bedrooms according to standards in order to be reaccredited

for better surveillance of residents, the beds were close enough and there were no dividing curtains or partitions, thus not respecting the right to private life and dignity. The management of the centre highlighted that gradually in the last 20 years the number of residents with disabilities increased and efforts are made to maintain them as much as possible in the wing for autonomous persons. These people would become semi dependent with time but they are kept in the wing for autonomous persons to avoid cases of severe depression.

With the exception of the centre for elderly people suffering from dementia, in which there are open spaces, in the other visited centres, prevail the rooms with 3 beds, there are also rooms with 2 beds and a smaller number of rooms for 4 persons.

Which were the conclusions of the latest Social inspection Report?

They did not like the fact that there is not enough space (6 m²) and, indeed they are right.. Five years ago when we started, we had 11 places and many requests are now on the waiting list (everybody says it does not matter where they are accommodated but they badly need a place and thus we cannot fit into the criteria of 6 m². Here in this room are 2 additional; beds, which is why next month we begin the construction of a new wing to be added to the initial building and which was initially intended to be destined to youth only. We intend to widen the space for the elderly, since the most requests for accommodation are for the elderly.

Head of H Center (private rural)

In the 4 (3 public and 1 private) of the 8 visited centres the semi - mobile or immobile persons were at the upper floors, none of these centres having elevator or mobile platform. Also, in other two public centres there were cases of semi-mobile persons who were accommodated at the upper floors. Thus we found a restriction of freedom of movement and the lack of participation in the social activities of the centre for these persons.

“I like my room, is beautiful and big, I have a problem with the stairs but downstairs it is too noisy, here I get along well with the others.”

Beneficiary D Center (public private)

“Accommodation is made depending on vacancies, after which we study the behavior, the attitude, we analyze compatibilities. We make changes according to how we can switch persons from one room to another. A vacancy is available following a person's death; there are few cases of reintegration into the community because there are no such possibilities in the county communities. There are no home caring services for elderly persons, the mayor's offices did not develop such services and, therefore they cannot be defined as service providers.”

Head of A Center A (public, rural)

Only in one centre the 2 person's rooms prevailed. The furniture was standard and in line with the period when the centre had been modernized. Thus we encountered new care centres, relatively new care centres and obsolete ones. In a public centre, a wing was provided with new furniture and rooms for 1 or 2 persons, while in another wing the aspect of rooms was outdated with worn out and out of order furniture. A resident bought a refrigerator from the relatives of a deceased resident. This refrigerator had an added external lock since it did not closed properly. Parts of the clothes were kept in boxes under the bed.

Would you change anything?

“The cupboards. We have too little space for storage. We need a big cupboard so that we do not have to keep boxes with our things under the bed.. The fridge we bought from someone who died.”

Beneficiary Z. From F Center (public private)

A public centre in the rural area benefited of a vast rehabilitation and modernization project financed through a regional operational program co-financed by the European Union. Thus the 6

beds, the rooms and the bathrooms on the hall were reorganized and became rooms with 3 beds and with private bathrooms (bathtub/shower). However, the corridors and bathrooms were not provided with supporting bars/struts, all the new furniture in the rooms had labels with the project title and the EU flag, which can constitute an offence to the right to private life, since the rooms were not personalized. The psychologist's office had only one desk and a chair and during our two visits to this respective centre we could not find the psychologist in the office.

The wing for dependent persons (all residents there had a certain degree of physical or mental disability) was rehabilitated also with EU funds and in comparison with another public centre in which there were 6 beds rooms, there were better living conditions (rooms of 2-3 persons, with private bathroom new and labeled furniture). However there were only 2 nurses taking care of all those residents. The rooms had no personal touch, the residents were not involved in any activities and depending on the weather conditions they were taken out in the garden occasionally.

In 3 (public) out of the 8 visited centres, most of the rooms have their own bathrooms, while in the other centres, there was either one bathroom for 2 rooms (i.e. for 5-6 persons) or one bathroom on the corridor for more persons.

Which are the difficulties in you activity?

“Some investments would be needed. The building was not designed for such a center; we tried to adapt it step by step but with little money. For approximately 1,5 years we received some funds and we started to make some changes, the carpet the antibacterial, struts on the halls and in the toilets. We intend to adapt the showers for persons with disabilities and we also need an elevator.”

Head of C Center (public urban)

Access to Justice, and the Right to an Effective Remedy

Free access to justice is guaranteed by the Constitution of Romania, which provides that every person is entitled to bring cases before the courts for the defense of his legitimate rights, liberties and interests. Also, the Constitution provides for the right to a fair trial and for solutions to the cases within a reasonable term.

According to the Law of social assistance if the beneficiary of the social service considers has been wronged by the way the social services were provided and since these services should be performed as it was established under the terms of the contract for delivery of social services, the beneficiary can address the issue to the competent Courts for resolving disputes in relation to the provision of social services. The actions, appeals and procedural documents on this area are exempted from stamp duty.

According to the minimum quality standards regarding notifications and complaints, the care home must ensure the necessary conditions to enable residents to express their opinions with regard to the received services. The care home establishes its own procedure with regard to the submission of notifications and complaints, establishing the modality of communication with the residents, samples for the formulation of the complaints, to whom they should be addressed the way in which they are recorded, the modality of receiving answers to these complaints and the ways of solving the complaints.

7 of the 8 visited care homes had such a procedure adopted, while in 5 centers there was a complaints box which was checked in average once a week. However, most of the residents stressed that many complaints are orally expressed and when they are founded, solutions are sought to satisfy the residents.

Are the residents informed on the possibility to formulate complaints and to whom?

“Of course, there is a notification and information box on the wall, a register, all that is needed, All is according to standards. Until now, there were no complaints, I don't know why. Sometimes the social inspection comes and distributes thematic questionnaires. In general everything turns out well; we strive to offer them everything that stays in our power but it is hard to satisfy everyone.”

Manager Care Home E(public, rural)

All the care homes reported that at the residents' admission in the care home they and their relatives were informed on their rights, including the right to submit a complaint.

During our visit to a public urban center, there was a resident in the office of the manager. We interviewed her and she said that she repeatedly complained against a resident who often used to drink and be violent. Therefore she also asked the representatives of the Romanian Institute for Human Rights to help her. The management admitted that there had been a problem in the care home regarding the respective violent resident and that it was not his first offense. It thus became necessary to take measures to move him to another care home.

"Last year we had a suspicion of abuse against a resident, he indeed was very agitated and sometimes he punches his own head causing self-inflicted pain. A care taker committed the imprudence to kindly ask him to carry a garbage dustbin and the resident punched himself in the head. The care taker was sent to the discipline commission but there were no proves against him. It is normal that we react. The care staff is monitored by the medical staff; it is one of their obligations. I also monitor them. We did not have abuse cases."

Manager Care Home H(public, rural)

Most beneficiaries interviewed reported that they had no grounds to complain to the management. However some beneficiaries did not wish to comment further on the conditions of accommodation, their relationship with other beneficiaries or staff for fear they may jeopardize their status in the care home. Also, some did not seem to be informed of the possibility to complain elsewhere, to another institution, than the care center.

The Law on the protection and the promotion of the rights of persons with disabilities devotes an article to legal assistance according to which persons with disabilities are entitled to protection against being neglected and abused, irrespective of the place where they are. In case persons with disabilities, irrespective of age, are in a position of total or partial impossibility to administrate their personal assets, they should enjoy legal protection in the form of trusteeship or guardianship and legal assistance.

Procedural adjustments adequate for the age of the disabled person in order to facilitate persons with disabilities an active role as direct and indirect participants, also as witnesses, in all legal procedures, including the investigation phase and other preliminary phases, are not provided - the legislation (the Civil and the Criminal Codes, as well as the Civil Procedure and the Criminal Procedure Codes) does not include special provisions meant to promote persons with disabilities as active parties involved in the juridical procedures and only the conditions excluding persons with disabilities are explicitly mentioned (e. g.: persons adjudicated with legal incapacity, called "forbidden"). Likewise, there is no legal obligation of special training in the field of the rights of persons with disabilities in the judicial system, in the police or in penitentiaries³⁸.

Regarding the situation of persons with mental disabilities in the visited care homes, the interviewed staff reported that upon admission, their belonging relatives are informed of the rights of beneficiaries. Also, they are informed when a decision is taken with regard to the resident.

Specific Challenges for Older Persons with Dementia (See the right to autonomy) Exit from Care: Voluntary Discharge and Palliative Care

According to minimum quality standards, the care center ensures the necessary assistance to the terminally ill residents and in case of death. In this sense, the center must develop a procedure that must take into account the following aspects:

- permanent surveillance of the terminally ill resident, health-care services and appropriate

³⁸ In this respect, see the jurisprudence of European Court of Human Rights, cases related to Romania, presented in the volume „Nediscriminare Autonomie Incluziune. Instrumente privind drepturile persoanelor cu handicap si jurisprudenta în materie" and in „Drepturile Omului" nos. 2/2012 and 1/2013.

treatment, including medication for pain therapy;

- a mandatory placement of a screen / dividing curtain or, where appropriate, the transfer of the resident in a room with the necessary medical equipment;
- providing spiritual assistance requested by the resident (religious services pertaining to the religious cult of the resident).

As a result of the field visits it has been concluded that 3 (2 public 1 private) out of the 8 centers had no such special procedure in writing, although from the interviews of staff and of the management it was found that these procedures were known and in place and the stages for ensuring assistance for the terminally ill residents and in cases of death were correctly followed.

Even if not all centers had available rooms for one person to take care of a terminally ill resident, care staff sought to establish the necessary conditions to ensure the patient's privacy and to respect the right to dignity and to inform the family, for those patients who have relatives, with regard to the health condition of the resident.

In case of death, the interviewed staff highlighted that the residents' wishes or those of their families are taken into account with regard to the funeral, religious services etc. All the centers (public and private) in cooperation with the local community ensure the funeral services for the deceased residents who have no relatives or have no relations with these. Also, 2 public centers in rural areas have their own cemeteries where the residents can be buried according to their own wish.

Care Workers' Rights and Conditions of Work

Both management and staff of the care homes visited indicated that they have not attended courses in human rights. Only two centers (one public, one private) of the 8 visited did not consider necessary training in human rights. However, the management of the other 6 centers stated that it would be useful to organize training courses on this topic for their staff. But in only four centers (three public, one private) nursing staff felt that they needed training courses on human rights and on the rights and care of the elderly. When they were questioned on what they understand by the rights of the elderly in the care homes most have thought of the right to life, food, health or dignity.

The management of the private care home stressed that it sends its specialized staff to training courses which are connected with the specificity of the home care. During the month in which this study was conducted 5 out of the 6 nurses subscribed for palliative care courses, taking into account that some residents needed this type of care.

The staff must behave as if they were the residents' parents. This is our policy. Being a private care home we considered that by this we make the difference between us and a state care home. In the private care home everything should be different: politeness, food and the staff ethics.

According to applicable laws, specialized staff from the care homes for elderly people must represent 60% of the total staff. If we refer to the relation employee/resident of the care home, the staff must ensure the provision of services in the care home and to achieve them depending on the residents' needs by respecting the minimum quality standards.

Thus the following classification is made:

- for services provided in centers for the elderly, classified according to the scale of assessment needs of older people in dependency grades MB and IIC, the ratio employee / beneficiary is 1/10;
- for services provided in centers for the elderly who are dependent residents the ratio employee / beneficiary is 1/2.

-for services provided in residential centers for people with disabilities, the ratio employee / beneficiary is 1/1, with the exception of protected housing in which the ratio employee / beneficiary is 1/2³⁹.

Regarding the percentage of 60% specialized staff only in private care homes monitored this

³⁹ According to the Regulation Framework on the organization and functioning of social services with accommodation, art. 8 on the organizational structure, the number of posts and categories of staff. Annex 01 to the Decision No 867/2015 of 14 October 2015 for proving the classification of social services and the regulation framework on organization and functioning of social services

threshold was met. In most of the visited care homes this scale varied between 30% and 47%, and in a care home was of 52%. Despite all these reported to the number and types of beneficiaries, it has been found that the staff was insufficient, especially during the night shift. In one center to a total of 35 residents (including 18 certified with disability - 6 with various forms of dementia) most often on the night shift was present only one nurse and occasionally one assistant and two nurses respectively.

“We have 3 nurses for 50 residents (working in shifts the report is 1/50) there are 3 or 4 nurses for 50 residents depending on shifts and annual leave, Generally the standard is 1/10, but there is a shortage of staff when there are days off or annual leaves and it is then when the problems occur”.

In each public care home there were vacancies and the number of vacancies varied between 2-3 in some care homes there were 4 -5 vacancies, The majority were jobs of carers, nurses but in some care homes there were also vacancies for teacher or psychologist. There were no contests organized for these jobs due to the lack of funds and the unattractive salaries were the main reasons for the lack of applications.

Wages:

“We were at the lowest. I could hardly imagine how to make people stay. Many wanted to leave. An attendant earned 900 lei [per month] and as I said, I have about 10 residents who have to be changed, turned over from one side to another.”

Head of Centre (public, urban)

Do you think there is need for more information related to human rights, training courses?

“Definitely yes, particularly in relation to the notion of abuse (examples, practices). This term is used too often - abuse, emotional abuse - and we would like further clarification as to the difference between the two notions: negligence vs. abuse.”

Public local authority

What do human rights mean to you?

“Much talk, less action, but we are satisfied with the facilities we have now.”

Resident Centre B (public, urban)

Conclusions

The socio-medical assistance for elderly faces the problem of the lack of specialists (social workers, geriatric physician), who should initially and periodically evaluate the elderly people and make recommendations for the development of the individual intervention plan.

It was noted that the multidisciplinary team envisaged for the resident's evaluation and reevaluation stages does not function properly so that in most of the cases the evaluation, the decision and the implementation of the care needed by the respective resident becomes fractioned without an efficient communication between specialists.

It was concluded that at national level the distribution of service providers is unequal, the offer for services being much lower in small localities and in the rural ones were only non-governmental organizations are active while the public institutions organize care services for the elderly only to a small extent.

Romania's long-term care system is characterized by relatively poor policies and practices, given the low level of financing, the reduced size and the poor quality of the facilities and the services involved, as well as the coverage and the legislative framework. The level of formal long-term care services is low, while the system is divided into healthcare/social services, making distinctions between persons with disabilities and elderly persons as well as distinctions based on the development and background level of the community they come from, which makes access to the services quite unequal.

Recommendations

There is a need for a higher degree of consultation with the elderly regarding all aspects concerning them directly and at the level of public policies. It is necessary to empower all the groups of representatives at all levels (local, county, national) since their involvement is needed in the evaluation of the services needs at the community level.

It is important to diminish the massive phenomenon of migration of qualified staff and it is necessary to correlate strategic actions in the field of services for the elderly with those of youth employment, combating poverty and migration.

It is necessary to increase the level of funding allocated to associations and foundations implementing home care programs addressed to the elderly in order to expand this network and to improve the quality of services.

A better legislation on the rights of elderly persons should be in place having as priorities to define the elderly person in his or her complexity as well as to specify the social rights of such persons.

For common coordination and financing there is a need to correlate the normative acts in the social field with those in the medical field.

Identification of new financing sources as well as attracting funds from the private sector remain a must.

There is a need for diversification of source of information for older people about the benefit of home care under the law.

Care Centers	A Center (public, rural)	B Center (public, urban)	C Center (public, urban)	D Center (private, urban)	E Center (public, rural)	F Center (public, rural)	G Center (private, rural/urban)	H Center (public, rural with t components disability and ol persons)
Capacity	78	105	35	50	50	60	20 (no. Of residents 23)	110/68
Number of residents	77	101	37	49	45	44	Vizited corp B (capacity 10) with HBenef	80: 33 persons \l disabilities - inclunc older persons women /17 men); older persons
Women	41 (53,25%)	64 (63,36%)	22 (59,5%)	26 (53%)	20 (44,44%)	21 (47,73%)	9 (81,81%)	28 (59,58%)
Men	36 (46,75%)	37 (36,64%)	15 (41,5%)	23 (47%)	25 (55,56%)	23 (52,27%)	2 (28,19%)	19 (40,42%)
Persons with dementia		1		7	Oficial nu exista	1	11 (corpul B)	
Persons with disability certificate		1	18 (different types of disabilities)	10 (5 with dementia)	Cazurile de dizabilitate sunt in alt centru	1	11	36(different types disabilities)
Nurses	3	10 (+ 2vacancy)	4	6	3 (1 vacancy)	5	1	5
Attender/ca retake r	5	8 (+4 vacancy)	5/1	6/1	10	7/3	4	17/1 (7/1)
Personal de specialitate	9		14		14	16		
Number of staff	24	77	20	20	26	36	11	62
Women	19 (19%)	66 (85,7%) 3 administrativ staff 63 care workers	13 (65%)	16 (80%)	18 (69,23%)	19 (52,77%)	7 (63,63%)	36 (58,0f 6 administrativ s 30 care work
Men	5 (21%)	11 (14,3%) 1 administrativ staff	7 (35%)	4 (20%)	8 (40,17%)	17 (47,32%)	4 (36,34%)	26 (41,9' 21 administrativ s1 5 care work

		10 care workers						
Cost contribution	740lei	900lei	1428 lei	1500 lei Nu se asigura medicamentel e	502lei	1475 lei	1700lei +200lei (medicine, pampers)	749 lei (1717 lei olderpersonswithdis lities)
Cazuri sociale	38	1	7		2	9	Pensii de handicap	

Table A2.3: Stakeholders Consulted

	Residents	Familymembers	Staff/ Management	KeyMakers	Total
A	6		3	1	10
B	7		3	1	11
C	7		4	3	14
D	6	1			9
E	16		5		21
F	10		5		15
G	5				7
H	6		5	1	12
Others				5	5
Total	63	1	29	11	104

Table A2.2: SelectionCriteria for Site Visits				
	Public	Private (for profit)	Private (not for profit)	Total
Romania	6		2	8
Total				