2023 REPORT ON THE IMPLEMENTATION OF THE NATIONAL PREVENTION OF TORTURE

2024

2023 REPORT ON THE IMPLEMENTATION OF THE NATIONAL PREVENTION OF TORTURE

In 2023, three post-inspection reports on the situation of human rights and freedoms in different types of places of deprivation of liberty were published: one on the situation in prisons, one on a social care institution and one on a mental health institution.

This Report on the Implementation of the National Prevention of Torture provides information on the findings and recommendations made to places of deprivation of liberty in 2023 to improve the human rights and freedoms of persons deprived of their liberty, and on the progress made in these places of deprivation of liberty. During the inspections of the places of deprivation of liberty specified later in this report, violations of human rights and freedoms and other systemic problems were identified, and all responsible institutions and bodies were called upon to address them, in order to ensure that Lithuania's international obligations in the field of protection of human rights and freedoms are not violated, and that violations of the protection of human rights and freedoms do not occur again in the places visited and in similar places of deprivation of liberty.

Training was organised for staff in social care institutions to improve the competences of staff in places of deprivation of liberty, in line with the approach based on the protection of human rights and freedoms, and training was organised for representatives of non-governmental organisations working in the field of human rights in order to strengthen the involvement of experts and civil society in the field of torture prevention. In 2023, meetings were held with representatives of the European Union Agency for Fundamental Rights (FRA), the European Union Agency for Asylum (EUAA), the United Nations Refugee Agency (UNHCR), and the Schengen Evaluation and Monitoring Mechanism (SMM) to discuss topical issues related to the guarantee of human rights and freedoms and the prevention of torture in places of deprivation of liberty. It is important to mention that issues relevant to the prevention of torture are also addressed during the investigation of complaints from inmates serving a custodial sentence, as well as during own-initiative inquiries.

1. Inspections at Prisons

The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter "CPT"), in its report of 25 June 2019 on the CPT's work in Lithuania in 2018 expressed serious concern about the prevalence of drug use and related violence, intimidation and abuse among inmates in prisons, as well as about the high risk of drug dependence disease and the transmission of human immunodeficiency virus (HIV) and hepatitis C among inmates during their imprisonment by means of injection equipment. The CPT noted that the worst situation at the time of the CPT's visits was at Marijampolė Correctional Home (from 1 January 2023 - Marijampolė Prison of the Lithuanian Prison Service) (hereinafter referred to as "the Marijampolė Prison"), Alytus Correctional Home (from 1 January 2023 - "the Alytus Prison of the Lithuanian Prison Service") (hereinafter referred to as "Alytus Prison") and Pravieniškės Correctional Home - Open Colony (from 1 January 2023 - Pravieniškės 1st Prison) (hereinafter referred to as '1st Prison') (together referred to as 'prisons'). According to the CPT, in these prisons, drugs were readily available to inmates, no opioid substitution therapy was carried out, and no harm reduction

measures were taken, such as the replacement of syringes and needles, the distribution of condoms etc.

In order to find out how the prevention of communicable diseases, as well as the availability of treatment for communicable diseases and addiction to injectable narcotic, psychotropic or other psychoactive substances or toxic substances (hereinafter referred to as "narcotic substances") is ensured in the above-mentioned prisons, the Seimas Ombudsperson E. Leonaitė instructed the staff of the Human Rights Division of the Seimas Ombudspersons' Office, with the assistance of an expert, Ms Jurgita Poškevičiūtė, Director of the Administration of the Coalition of NGOs and Experts "I Can Live", to carry out thematic inspections in Marijampolė Prison, Alytus Prison and 1st Prison on 19-21 December 2022.

During the inspections issues related to the organisation of personal health care services in prisons, the organisation and implementation of the prevention of hepatitis B and hepatitis C (collectively, "hepatitis"), HIV, Acquired Immune Deficiency Syndrome (AIDS), tuberculosis, sexually transmitted infections, the treatment of inmates infected with hepatitis B, hepatitis C, tuberculosis, HIV/AIDS and sexually transmitted infections, and the treatment and rehabilitation of inmates suffering from substance abuse diseases were assessed.

The following deficiencies identified during the inspections should be noted:

- all the personal health care units of the inspected prisons had staff shortage, including lack of general practice nurses, a doctor of internal medicine in Alytus Prison, a general practitioner in 1st Prison, and all the posts of the Psychiatric Centre, which provides services to the inspected prisons, were unfulfilled;
- all the prisons visited had inmates using intravenous drugs, however sterile syringes and needles were not distributed to inmates (as they should be according to the international recommendations on the prevention of blood-borne diseases in prisons), so inmates were using non-sterile means to inject these substances and sharing the used means with each other;
- not all inmates' Individual Resocialisation Plans were updated on the basis of records relating the established fact of substance use or risk of substance use made in journals on individual work with inmates', and the inmate's acknowledged history of addiction to psychoactive or narcotic substances was not always taken into account in the development of Individual Resocialisation Plans and the incorporation of the institution's resocialisation programmes into these plans;
- in Alytus Prison, the door of the room in which, inter alia, tests for drug intoxication are carried out was open during the taking of the sample and the video recorder was pointed at the inmate from whom the sample was taken, thus disregarding respect for human dignity;
- in all the prisons inspected, after receiving a copy of the Act on the Determination of Intoxication of Inmates with Psychoactive Substances, the personal health care professionals inserted it into the medical record of the inmate, however, no further action was taken in relation to the organisation of additional (i.e. unscheduled) tests for

blood-borne infections of injecting drug users, the organisation of education of inmates on the risks, the prevention and the treatment of drug use;

- in all the prisons visited, education on communicable disease prevention, including dissemination of information about the health effects of substance use, sex education, was inadequate: there was a lack of more information material on the harms of injecting drug use and communicable disease prevention in the common areas accessible to inmates (leaflets, leaflets, etc.) All available written information is only available in Lithuanian, no seminars or training on communicable disease prevention is provided to inmates;

Nebūk priklausomas

Priemaišos heroine guldo vieną narkomaną po kito

50

Sulaikyta didžiausia šiemet narkotikų siunta

TARP KITKO:

Information on the use of intravenous drugs in Marijampolė prison.

- training on communicable disease prevention was not planned and organised for the staff of the inspected prisons, nor was there any provision for upgrading the competence of the staff of the prisons on this issue;
- all three prisons had unfilled posts in the Resocialisation Units, including Head of Unit, Deputy Heads of Unit and psychologists;
- in all the prisons visited, condoms were only provided to those inmates who were entitled to long-term visits with their spouse or partner, while no condoms were provided to other inmates;
- all the prisons did not have a plan of action in place to provide the necessary assistance to a victim of sexual violence in the prison and to prevent sexually transmitted infections in such cases;
- all the prisons did not have an approved Communicable Disease Prevention Strategy and its Implementation Plan;
- in all the prisons inspected, when a case of HIV infection was detected in a prison, neither medical staff nor officials took any measures to identify the source of infection, the routes of transmission, or the infected person's contact with other inmates;
- in all the prisons visited, vaccinations against communicable diseases were only organised upon the inmates request and if the inmate had the resources to pay for them, but information on the availability, benefits and possibilities of vaccination was not provided to the inmates, or it was insufficient;
- when they found tattooing equipment, the officials confiscated it, but did not take additional action to prevent blood-borne infections, and medical staff, when they noticed that an inmate had recently been tattooed, took action only at the request of the inmate, but did not initiate a consultation on the prevention of infectious diseases themselves in such cases;

- during the inspections, the common areas for the use on inmates in Marijampolė Prison and Alytus Prison, as well as some cells, were not properly ventilated;
- not all prisons had planned to cooperate with organisations working in the field of substance abuse prevention and rehabilitation support;
- the labelling of the medical records of people diagnosed with HIV may not have adequately ensured the confidentiality of HIV diagnoses;
- no prison collected statistics on the exact number of people refusing HIV/AIDS testing;
- about 20% of people diagnosed with HIV/AIDS in Alytus Prison have not received treatment;
- doubts have been raised if the inmates diagnosed with HIV/AIDS are properly informed about the disease and motivated to get treatment;
- statistics on the effectiveness of antiretroviral therapy applied on inmates living with HIV were not collected;
- in all prisons, there were challenges in bringing inmates to Pravieniškės 2nd Prison for consultations with specialists (including infectologists), due to the prison's ban on smoking and the likelihood of inmates losing their jobs;
- the information gathered indicated a possible high prevalence of hepatitis C in the prisons, but the extent of this prevalence was not clear; moreover, some of the inmates diagnosed with hepatitis C during the inspection were not given treatment, as the morphological signs of inflammation or fibrosis of the liver required by national legislation for treatment had not yet been established, which posed a risk of transmission to others; some of the inmates diagnosed with hepatitis C chose not to be treated because they believed that the prevalence of the virus in the prisons would make them infected again;
- up-to-date statistics on communicable disease cases recorded in prisons were not communicated to the National Centre for Public Health under the Ministry of Health;
- in Marijampolė Prison, inmates seeking diversionary treatment were faced with excessive requirements, i.e. to be found using opioids three times;
- given the number of inmates serving sentences and the prevalence of substance use, the number of places available in rehabilitation centres in all the prisons was disproportionately low for people seeking to overcome substance dependence;
- not all approved posts were filled in the Rehabilitation Centres of all the prisons inspected;
- persons who were taking medically prescribed sedatives or mental stimulants could not be admitted to the Rehabilitation Centre of Alytus Prison and the Rehabilitation Centre of Marijampolė Prison;
- in the Rehabilitation Centres services were provided by addiction counsellors, who, according to the Description of Procedures for the Provision of Addiction Counselling Services to Persons Risky and Harmfully Consuming Alcohol Consumption, were only allowed to provide services to persons who were risky and harmfully consuming alcohol, and not to persons with substance dependence, which was the most common type of addiction in the Rehabilitation Centre;

- in all the prisons, persons wishing to enter institutional rehabilitation centres had to be drug-free for 6 weeks during an introductory programme while living in a unit where drug use was prevalent;
- Alytus Prison did not have a post-rehabilitation unit where inmates who had completed a rehabilitation programme could serve the remainder of their sentence in an environment where drug use was not prevalent;
- In Pravieniškės 1st Prison there was a long list of inmates who wanted to enter the Rehabilitation Centre, and for some people seeking treatment for drug addiction, there was a wait of up to 1 year.

Taking into account these circumstances, it was concluded that the shortage of human resources in the personal health care units of the prisons visited may have led to violations of the right to quality and accessible personal health care, and that the lack of guarantee of this right in the prisons may have led to a risk of inhuman and degrading treatment; the organisation and implementation of the prevention of hepatitis B, hepatitis C, tuberculosis, HIV/AIDS and sexually transmitted infections in all the prisons visited was not sufficient, which may have led to inadequate conditions for preventing the timely and appropriate spread of communicable diseases and the related negative consequences on the health of inmates; treatment of hepatitis B, hepatitis C, tuberculosis, HIV/AIDS and sexually transmitted infections was formally provided in the prisons, but without data on the prevalence of some diseases (especially hepatitis C) and the extent of its treatment in the prisons, and in addition, a significant proportion of persons diagnosed with HIV/AIDS, the refusal of treatment and the challenges of bringing patients to Pravieniškės 2 Prison for specialist consultations raised doubts about the effectiveness of the organisation of the treatment of communicable diseases, which led to the risk that the further spread of communicable diseases was not prevented and that inmates were not protected from the adverse effects on their health; the treatment and rehabilitation of inmates suffering from injecting drug dependence diseases was not adequately ensured, which could lead to a violation of the right to quality and accessible personal health care.

Considering the identified shortcomings, the Seimas Ombudsperson made 41 recommendations to the responsible state bodies and institutions (the Lithuanian Prison Service, the Ministry of Justice of the Republic of Lithuania, the Ministry of Health of the Republic of Lithuania) to remedy them.

Most of the recommendations made have been fully or partially implemented, including the removal of barriers to access to rehabilitation centres for inmates who are taking medically prescribed sedatives or stimulants. The amendments to the regulations on rehabilitation centres include the removal of the mandatory requirement that admission to a rehabilitation centre should be limited to persons who have completed a six-week introductory programme during which they had to be drug-free while living in a unit where drug use is prevalent. The draft regulations on rehabilitation centres under preparation provide that inmates who have completed the introductory phase of the rehabilitation programme for persons addicted to psychoactive substances (which includes a 2-week psychosocial rehabilitation or an introductory group programme) and who have expressed in writing their willingness to take part in a rehabilitation programme will be admitted

to the rehabilitation centre, if possible. Furthermore, in order to take measures to make free condoms available to all inmates, the Lithuanian Prison Service has undertaken to implement a pilot project to assess the need for such a measure and its possible scope. The Lithuanian Prison Service also indicated that continuous efforts are being made to recruit staff shortages.

It should be noted that the implementation of some of the recommendations was hampered by a lack of financial resources. For example, the Ministry of Health informed that, following the recommendation of the Seimas Ombudsperson, it would be appropriate to supplement the conditions for the treatment of viral hepatitis C (HCV) reimbursed by the Compulsory Health Insurance Fund (hereinafter referred to as the "CHIF"), by stipulating that reimbursable medicines could be prescribed irrespective of the histological index of activity (HAI) or the level of fibrosis, with the provision of additional funds in the CHIF budget or a significant reduction in the price of medicines for HCV treatment by manufacturers. However, the decision to amend the relevant Orders of the Minister of Health[1] was linked to the availability of the PSDF budget in 2024 and was not taken in 2023.

Further cooperation with the Lithuanian Prison Service is foreseen for the full implementation of some of the recommendations in 2024.

2. Inspection in a social care institution

Jurdaičiai Social Care Home is one of the largest social care institutions in Lithuania, which has not been visited by the staff of the Seimas Ombudspersons' Office until 2023. For the year 2023, 247 places for long-term social care, 13 places for short-term social care and 4 places for temporary respite care have been approved for the Jurdaičiai Social Care Home. At the time of the inspection, 246 persons with disabilities were receiving long-term social care and 10 persons were receiving short-term social care.

During the inspection carried out on 26-29 June 2023, issues related to the structure and staffing of the institution, the adaptation of the environment and information for persons with disabilities and the installation of an emergency call system, the privacy of residents, the freedom of movement of the residents, the promotion of independence, the provision of activities, the accessibility of psychological services to residents, , the implementation of violence prevention, intervention and post-intervention and the provision of dental prosthetics services were assessed.

During the inspection of Jurdaičiai Social Care Home, no signs of improper organisation of work in violation of legal acts were found, which would have a negative impact on the well-being of the residents and could lead to violations of their human rights, but the Seimas Ombudsperson E. Leonaitė pointed out that the care home lacked a strategic orientation towards the transformation of social care institutions, preparing persons to live in the community, for example, by developing

[1] Order No 49 of 28 January 2000 "On the Approval of the Lists of Compensated Medicines" and Order No V-960 of 24 October 2012 of the Minister of Health of the Republic of Lithuania "On the Approval of the Description of the Procedures for the Diagnosis of Chronic Viral Hepatitis C and the Outpatient Treatment of Chronic Viral Hepatitis C with Compensated Medicines".

their financial literacy, their ability to use public transport, and by educating staff and residents about the rights of persons with disabilities, including the right to live independently.

Other deficiencies identified during the inspection are also noted:

- not all facilities of the Jurdaičiai Social Care Home (e.g. gym, library) were accessible to persons with mobility disabilities;
- not all information relevant to residents was in easy-to-understand language and large print;
- the residents access to psychological services was insufficient;
- in most of the living rooms and some hygiene facilities inspected, the emergency call buttons were located in inconvenient and hard-to-reach locations for the residents in case of emergency;
- staff did not always knock before entering residents' rooms or wait a few moments after knocking;
- social workers did not have specific knowledge about how to talk to people with disabilities about sex education and reproductive health;
- there were no procedures or arrangements in place for escorting or taking residents with severe mobility impairments and frail health conditions outdoors, thereby risking unjustified isolation;
- not all leisure spaces, such as the library, the gym, the chapel, were available to residents after 5pm on weekdays and at weekends;
- activities after 5pm on weekdays and at weekends were mostly not organised;

Barrier to the gym changing room

- most residents rarely (only 1-4 times in 18 months) or not at all participated in outings organised by the care home, and the procedure for drawing up the list of residents taking part in outings did not meet the needs of all residents;
- no physiotherapy services were provided for residents;
- the residents of Jurdaičiai Social Care Home were not provided with education in order to develop their ability to recognise all forms of violence or other unacceptable actions towards them, to ask for help and to protect themselves from violence or other inappropriate behaviour;
- The Violence Reaction Log did not contain records of all the conflicts and cases of aggression during which material property of Jurdaičiai Social Care Home or residents was damaged;
- the Procedure for the Application of Physical Restraint in force at the time of the inspection did not comply with national legislation as regards the entity authorised to apply physical restraint, as there were no general practice nurses in the institution who had obtained a specialisation in mental health nursing and who had the necessary qualification to decide on the application of physical restraint measures to the residents in the manner laid down in national legislation.

Emergency call system installed in an inconvenient position

Taking into account the improved aspects, the Seimas Ombudsperson made 42 recommendations to the responsible state institutions and bodies (the Ministry of Social Security and Labour of the Republic of Lithuania, the Social Services Supervision Department under the Ministry of Social Security and Labour, and the Jurdaičiai Social Care Home) to improve the human rights situation in the Jurdaičiai Social Care Home.

In order to inform about the implementation of these recommendations, Jurdaičiai Social Care Home submitted an implementation plan and additional information on the implementation of the recommendations. The Jurdaičiai Social Care Home indicated that many of the recommendations had been implemented, including that information relevant to residents (including internal rules of procedure, privacy rules, violence prevention procedures, complaints/applications procedures) was provided in an easily understandable language; emergency call buttons were installed in all living rooms and hygiene facilities in places accessible to the residents; reminder knock signs were posted near the doors of residents' rooms; some social workers and general practice nurses received training on sexual education and reproductive health for persons with disabilities, a designated staff member in charge of the residents' sexual education was appointed, and a sex education programme was approved; a psychologist has been recruited full-time instead of part time to ensure greater access to psychological services; physiotherapy services have been introduced for residents; activity schedules have been adopted, which include activities not only on weekdays but also at weekends; the Physical Restraints Schedule has been amended to comply with national

legislation and requirements and all staff working directly with residents have been informed of the changes by signature; the list of social skills activities has been extended to include the development of skills in using public transport, banking services and a bank card, also a plan for the development and maintenance of the independent living and social skills of the residents of the Jurdaičiai Social Care Home for the year 2024 has been approved. The aim of the plan is to create the right conditions for social integration into the community, taking into account each person's individual abilities, by developing the skills needed for independent living.

The implementation of some of the recommendations will continue in 2024, including the installation of a hoist at the beginning of the year to allow residents with reduced mobility freely access the reading room and the library; further changes to the information boards in the common areas used by residents, from which information will be displayed in easy-to-understand language and large print; and, starting in January 2024, once a month, social workers will provide training to the residents on their rights as disabled persons, including the right to independent living and voting.

3. Inspection in a mental health facility

The Human Rights Division staff carried out the first inspection of the Psychiatric Branch of Klaipėda Republican Hospital (hereinafter - the Hospital) in 2019. During this inspection, a number of shortcomings were identified, which indicate that the standards of human rights protection are not sufficiently met. In light of this, 30 recommendations were made in the 2020 report to address these shortcomings.

Taking into account the nature of the deficiencies identified (e.g., the fact that the recording of the application of the use of physical restraint measures was not properly ensured; not all patients were provided with the opportunity to be outdoors every day; and patients were not properly informed about the right to refuse to continue hospitalisation and treatment) and the results of the examination and implementation of the recommendations made by the Hospital, on the instructions of the Seimas Ombudsperson E. Leonaitė, on 22-24 August 2023, the staff of the Human Rights Office carried out a follow-up inspection of the Psychiatric Branch of the Hospital, during which the implementation of the recommendations made in 2020 was assessed.

During the follow-up it was found that some of the recommendations had been fully or partially implemented. For example, nursing staff's communication skills with patients were continuously improved through periodic meetings both in this Ward and in its individual units, and staff members were given the opportunity to attend training; the recommended maximum number of patients per nurse in a specialised psychiatric care facility was met; measures were also taken to ensure adequate availability of information on the institution's internal rules of procedure, the rights and obligations of patients, and the institution's ethics committees: information on the procedure for submitting requests, complaints, feedback and other non-anonymous appeals to the hospital administration was posted in large print on the information boards in the utits of the Psychiatric Branch, Information on the availability of the Hospital's internal rules of procedure, the procedure for handling requests and complaints from a patient (his/her representative), the Hospital's Code of Ethics, the Code of Conduct for employees of a personal healthcare institution,

the list of patient organisations with their contact details, the price list for paid services, and other documents indicated on the notice board were available in the nurses' stations or in the boxes next to them. These documents were easily accessible to the patients at the indicated locations.

During the follow-up inspection issues related to the composition of the staff of the Psychiatric Branch of the Hospital, the staff's treatment of patients, patients' awareness of the Hospital's internal rules of procedure, their rights and obligations and access to other information, the provision and handling of the right to lodge complaints, and the use of physical restraint measures, ensuring treatment conditions, adapting the environment for persons with reduced mobility, access to psychological and psychosocial rehabilitation services, ensuring patients' activities, dealing with patients' smoking problems, ensuring patients' consent to receive personal health care services and the right to refuse treatment were also assessed.

The following deficiencies identified during the follow-up should be noted:

- the approved workloads for medical staff did not include the workloads of psychiatrists;
- the use of a privacy screen in the procedure rooms and in the wards of the patients was not always used during the procedures, without ensuring that other patients could not observe the procedures being performed;
- not all wards had sufficient spacing between adjacent beds and between the ends of beds to allow free movement and care;
- Not all units had properly marked female and male hygiene facilities;
- The wards of the Child Psychiatry Unit and the first floor wards of the Acute Psychiatry Unit were not adequately equipped with curtains, roller blinds or other means to fully block sunlight or artificial light from the outdoors when needed by patients and to ensure the privacy of the patient(s) and their undisturbed rest at night;
- the number of beds in the Child Psychiatric Unit exceeded the maximum number of beds set by law;
- not all premises were accessible to people with reduced mobility;
- not all wards had the minimum space per bed per ward;
- The Hospital's internal rules of procedure, the Code of Ethics and other documents regulating the Hospital's internal procedures did not explicitly provide for the right of patients and their relatives to address the Hospital's committees without the mediation of the Hospital's Registry, and patients were not adequately informed of this possibility;
- the hospital's internal procedures did not provide for a procedure for the submission, registration and handling of oral complaints from patients;
- most of the information boards in the chapters were hung too high and much of the information was printed in small print (difficult to read);
- not all units had boxes for anonymous complaints, requests and feedback, which were hung in conditions ensuring anonymity, nor was there a clear procedure on the action to be taken if a patient's complaint or other appeal was found in the anonymous box;
- no clock in any of the isolation wards were hung so patients under restraint can not see the duration of their restraint;

- in the Acute Psychiatric Unit, there were no activities for the male patients organised due to staff leave;
- patients in the Acute Psychiatric Unit were not allowed to go outdoors for walks;
- when isolating a patient with mental and behavioural disorders in a separate room (isolation ward), no additional measures were used to help the patient calm down (soothing music, calming images, etc.);
- the Children's psychiatric Unit was not equipped with anti-vandal equipment.

Complaint box near the guard post

During the follow-up visit it was also found that each year the Psychiatric Unit admits about 10 patients who no longer require active treatment, but who, due to their health condition, are no longer able to live independently and are not discharged from the hospital because they do not have relatives or a place of residence able to care for them. As a result, unattended or lonely people may be kept in the Psychiatric Unit for months without needing treatment and/or tests.

During the visit it was also highlighted shortcomings in ensuring the rights of incapacitated persons during hospitalisation and treatment. It was found that, in most cases, the person whose hospitalisation is at issue is not present at court hearings and the lawyer representing him or her also does not meet with the represented person prior to the hearing. These circumstances raised doubts about the practice of the provision of lawyers' services to these persons when their hospitalisation and treatment is at issue in court, i.e. whether the current practice is in the best interests of the represented person.

Taking into account the identified shortcomings, the Seimas Ombudsperson made 33 recommendations to the responsible state bodies, municipalities and institutions (the Hospital, the Ministry of Health, the Ministry of Justice, the Municipality of Kretinga and the Municipality of Klaipėda City) to improve the human rights situation in the Psychiatric Branch of the Hospital.

The Hospital provided information on the implementation of the recommendations, stating that measures had been taken to implement most of the recommendations, including: the need to use privacy screens during procedures to ensure patients' privacy had been highlighted to mental health nurses during the meetings of the Psychiatric Branche’s units; the head of the Psychiatric Branch had been instructed to ensure that the spaces between beds and the ends of beds were such as to allow free movement and care of the patient; also to ensure that the maximum number of beds in the Children's Psychiatric Unit does not exceed the legal requirements and that a minimum ward area of $7m^2$ per bed is ensured in inpatient wards; that the male and female hygiene rooms are

properly signposted; that additional light-blocking film is placed on windows to ensure residents' privacy and undisturbed rest at night; and that clocks are hung in isolation rooms. The hospital also informed that, in order to improve the implementation of the right to lodge complaints, requests and other appeals, the information on the boards in the units would be supplemented by the possibility for patients/their relatives to refer to the committees operating in the institution, and that a procedure for the lodging and handling of anonymous appeals would be developed.

The implementation of some of the recommendations is linked to the financial capacity of the Hospital, including the decision to carry out a market study and/or market consultation to assess the value of the proposed works, following an assessment of the condition of the wards in the Psychiatric Branch for patients with reduced mobility, and to schedule the works in the procurement plan for the year 2024, subject to the availability of financial means. The purchase of additional tools to help patients calm down (video projectors, music centres, etc.) and the adaptation of the infrastructure of the Acute Psychiatric Unit to allow patients to spend time outside on a daily basis will also depend on the financial possibilities, among other things.

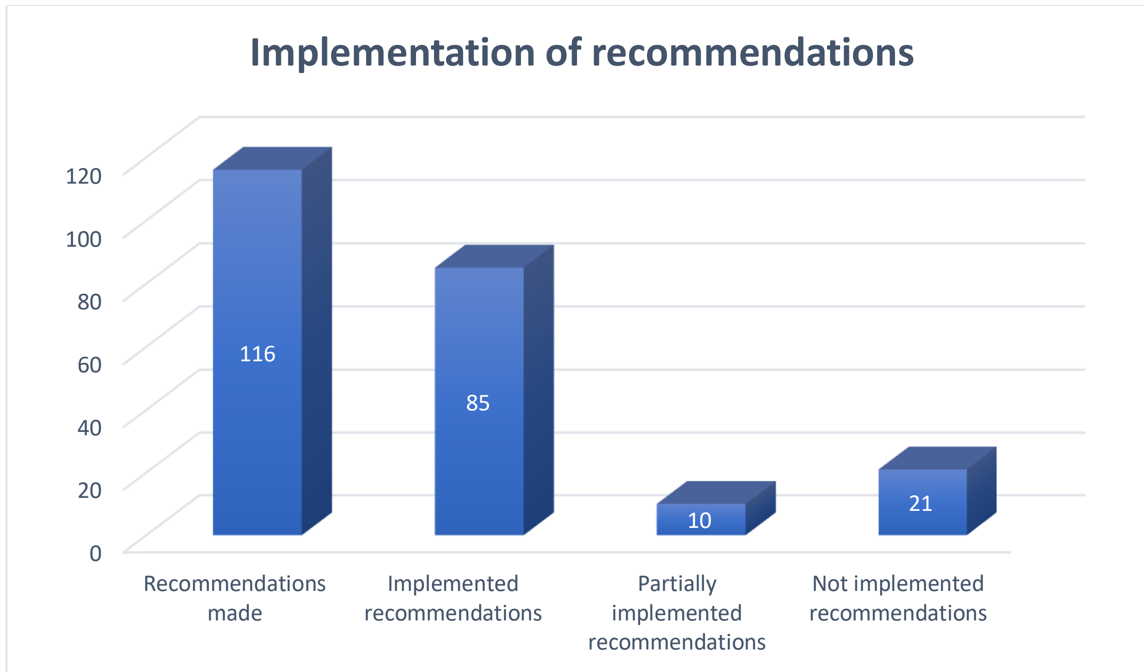
Taking into account the recommendation of the Seimas Ombudsperson to organise, in cooperation with the Hospital, the provision of social services to persons who no longer require personal health care services at the Hospital's Psychiatric Branch, but who need to be provided with social services in the municipality, Klaipėda City Municipality has indicated that, after communication with the Hospital, it has been decided to strengthen the cooperation on in this matter by looking for providers of not only long-term, but also short-term social care services.

Monitoring of outstanding and follow-up recommendations will continue in 2024.

4. Follow-up of recommendations

The implementation of the National Prevention of Torture in 2023 was significantly affected by the insufficient material and human resources of the Seimas Ombudsperson's Office, which led to a lack of visits to places of deprivation of liberty. The staff of the Human Rights Division used a variety of methods to monitor the implementation of the recommendations contained in the reports. The responsible institutions were consulted by telephone, e-mail and other means of communication, and, following an analysis of the implementation plans submitted to the Seimas Ombudsperson's Office, the institutions were provided with proposals for improving and implementing the implementation plans and were asked to revise the plans where there was a lack of information.

As regards the implementation of the recommendations made following the inspections of places of deprivation of liberty, 116 recommendations were made to the relevant public authorities in 2023, the majority of which concerned the adaptation of premises for persons with reduced mobility, the right to lodge complaints, requests and other appeals and the right to information, and the organisation of more diverse and tailored activities for persons deprived of their liberty.



Of the recommendations made during the 2023 , 73.3% were fully implemented, while 8.62% were partially implemented and 18.1% were not implemented. The implementation of some of the recommendations, in particular those related to the adaptation of premises for persons with reduced mobility, was hampered by a lack of financial resources, as well as by the challenges of attracting staff for certain posts and the reluctance of the institutions and bodies to which the recommendations were addressed to initiate changes in the legal framework or to modify the established practice. The monitoring of not implemented and partially implemented recommendations is foreseen to continue in 2024.