PUBLIC DEFENDER
(OMBUDSMAN) OF GEORGIA

NATIONAL PREVENTIVE MECHANISM (NPM)

REPORT ON THE MONITORING OF MENTAL HEALTH INSTITUTIONS

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(OMBUDSMAN) OF GEORGIA

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INTRODUCTION

The present report encompasses the results of monitoring of the mental health institutions of Georgia, carried out under the auspices and within the mandate of the National Preventive Mechanism, from 9 October 2015 to 6 November 2015, by the Special Prevention Group of the Public Defender of Georgia. The Special Prevention Group together with the Department of Protection of the Rights of Persons with Disabilities of the Public Defender carried out the monitoring of the following mental health institutions:

1. LLC „Unimedi Kakheti"– Tbilisi Referral Hospital;
2. LLC „N5 Clinical Hospital" (Tbilisi);
3. JSC „Acad. O. Ghudushauri National Medical Centre" (Tbilisi);
4. LLC „Rustavi Psychiatric health centre";
5. LLC „ Psychiatric health and drug-addiction prevention centre" (Tbilisi);
6. LLC „A. Kajaia Surami Psychiatric hospital";
7. LLC „Kutaisi Psychiatric Health Centre";
8. LLC „Acad. B. Naneishvili Psychiatric Health Centre " (Khoni, Kutiri);
9. LLC „Senaki Inter-regional Psycho-neurologic Dispensaire" ;
10. LLC „Clinical Psycho-neurologic hostpital of the Republic"(Khelvachauri);
11. LLC „Bediani Psychiatric Hospital";
12. LLC „Tbilisi Psychiatric Health Centre".

The monitoring group was created based on the multi-disciplinary method and consisted of members of the Special Prevention Group members and the employees of and the Department for Rights of Persons with Disabilities of Public Defender's Office. At the preparatory stage the monitoring group had developed the monitoring methodology[1] under the supervision of the invited local[2] and international[3] experts.

The monitoring aimed to assess the current situation regarding ill-treatment in mental health institutions, patients' rights, and the adequacy of psychiatric care in terms of identifying issues and provision of the practical recommendations directed at their resolution.

1 The said methodology was prepared with the assistance of the joint programme of European Union and Council of Europe "Human Rights in Prisons and Other Closed Institutions".

2 The development of methodology was supervised and the Report was prepared with participation of Nino Makhashvili, Head of Fund "Global Initiative on Psychiatry –Tbilisi" and member of the consulting council of the National Prevention Mechanism.

3 Dr. Clive Mew, expert of the European Committee on the Prevention of Torture (CPT) also participated in the development of the methodology.

The technical reports of the members of the monitoring group, together with other materials were used to prepare this report. Documents obtained during the visit, as well as accounts of the members of the monitoring group are stored at the Public Defender's Office. The report contains the main findings of the monitoring group and is compiled in a manner that, the respondent patients, due to the confidential nature of the interview, cannot be identified.

During the monitoring process, group members inspected the hospital's infrastructure, and interviewed patients therein in a confidential environment. Group members also interviewed the administration, medical staff, physicians, social workers. The documents and logs of relevant institutions were also inspected during the monitoring.

During the visit, the monitoring group members were freely moving around the area of mental health institutions and were not interfered by the administration and authorities therein. Mental health institution personnel duly presented the requested information and documents.

1. GENERAL OVERVIEW

In order to respond to the problems and challenges in a systematic way, the Parliament of Georgia, in December 2013 adopted the 'National Concept on Mental Health'. This is the main mental health policy document of the country. The document states that 'Georgia recognizes the importance of mental health'. Moreover, 'Georgia undertakes to organize delivery of mental health services within the country in the manner that people with mental disorders receive treatment in the least restrictive environment, to the extent possible in their own home or close by, based on their basic needs; to ensure maximum protection of their rights and dignity and their full and effective participation in society on an equal basis with others'. To reach the goals identified in the National Concept, the Ministry of Labour, Health and Social Affairs has launched a national strategy and action plan for the years 2015-2020, which was approved in December 2014. This is definitely a step forward. Despite the declared government policy, the field of mental health is still in severe condition. The monitoring has identified a number of systemic problems.

First of all, the lack of funding for mental health must be pointed out, as the amount of funds allocated is directly related to the quality of psychiatric care. Since 2006, health care spending for mental health in Georgia follows the increasing trend, but the ratio of percentage of the costs of mental health in relation to the overall costs on public health has not changed significantly. A large portion of funds is spent on inpatient psychiatric services and this figure remains high for years. The state's priority is assigned to inpatient care funding, whilst funding for psychosocial rehabilitation stands stagnant and only a small part of available financial resources is allocated to the outpatient care. Along with the lack of funding, the methodology of funding the long-term and acute cases is also a problem. 840 GEL per case is allocated for acute cases and 450 GEL per month for cases of long-term treatment. The scarcity of funding ultimately leads to the problems with insufficiency of qualified personnel at mental health institutions, the absence of adequate therapeutic environment, quality of treatment, care, psycho-social rehabilitation, as well as length of stay at hospitals and the lack of community-based services.

Georgian mental healthcare system is severely understaffed and lacks human resources. The deficit of psychiatrists is twice higher than the average European index. A 2015 study on mental health professionals found that in total, number of psychiatric health care personnel in state-funded institutions is less than 40% of the total of the employees. The training and professional development of the personnel of mental health institutionsis equally problematic. The lack of qualified staff, in turn, has a negative impact on the quality of psychiatric care, supervision of patients and safe and secure environment in the institutions. This situation increases undue physical restrictions and the risk of use of excessive force when applying such physical restrictions. In addition, extremely hard working conditions result in severe psychological state of the personnel and negative emotions can lead to ill-treatment of the patients.

The monitoring group has received numerous reports about physical and verbal abuse of patients during the visits at the mental health institutions. In addition, according to the monitoring group, patients are subjected to ill-treatment due to extremely bad conditions of stay, facts of physical and chemical restraints, the methods of physical restraints, administering injections in the presence of other patients, lack of access to timely and adequate treatment of somatic diseases, long-term hospitalization due to the neglect and involuntary medical intervention. The monitoring also revealed that there is a problem of due protection of safety in mental health institutions from the violence among the patients.

The monitoring revealed that the legislative requirements as regards the use of physical restraint are systematically breached. According to surveys of patients, it was found that they are often 'tied down' for lengthy periods of time and left without adequate oversight. It was obvious that most of the institutions do not carry out the registration of cases of application of physical restrictions and there is no clear system - in most cases the record of the use of physical restraints is made in general logs and not in the patient's medical records or *vice versa*. The requisite 15-minute interval monitoring record of the dynamics of the patient's condition is found nowhere in any records. Sometimes the time is not set at start and end of application of physical restraint. The reasons for the use of physical restraint are formulated in a manner that is not particularly informative. In many cases, it could not be determined why the physical binding was necessary and whether other alternative measures could be used. It should be noted that neither the Law of Georgia on Psychiatric Care nor the above mentioned instructions specify the maximum term for the use of physical restraint, which is dangerous, because it can lead to repetitive application of physical restrictions for 4 hours. The said normative acts also fail to establish the obligation that the information about the physical restraint be included both in the patient's medical record, as well as a special journal (special register). It is therefore important that the normative acts are brought to order, via including making changes to regulate those two issues.

It is noteworthy that neither the law nor the instructions mention chemical restraint as a measure of restriction. According to the assessment of Public Defender, the chemical restrictions are frequent and are often not documented properly. The institutions routinely apply physical restraint together with chemical restraint. There is no clear legal framework regulating chemical restraint and no justifications are provided for its application. This amounts to a violation of standards of international human rights law. The same guarantees of protection should be provided whenever chemical or mechanical means of restraint are used.

The interviews with patients and the inspection shows that the patients are placed in isolation rooms for more than a few days, and bearing in mind the conditions of the isolation rooms, such practice gives rise to concerns for the Public Defender. In the view of the Public Defender, the isolation rooms in the Republican Clinical Psycho-Neurological Hospital and Mental Health Center, as well as other mental health institutions are not specially and properly equipped and there is high risk of self-harm by patients in such rooms. In addition, the Public Defender considers that the bars on the door and the

window are unacceptable, both in terms of safety, and the disruption of the therapeutic environment and its' association with the prison and the punishment cell. Hence, placement of a person in such isolation room may amount to degrading treatment.

The Public Defender is also concerned about the fact that despite the requirements that the usage of the physical fixation and specialized isolation together with the duration of use of these measures, shall be duly reasoned and documented in accordance with Article 16 of the Law of Georgia on Psychiatric Care and similar requirements established by abovementioned instructions, the isolation of the patient is not in reasoned, properly documented and is applied for a long time in violation of applicable laws.

The Public Defender deplores the fact that the physical restrictions are applied equally to formally voluntary and involuntary patients, which is also contrary to the CPT's position, according to which patients treated on a voluntary basis should not be subject to restraint. If physical restraint is necessary, the legal procedure of the review of the patient's status (voluntary / involuntary) must be immediately initiated.

It is important that patients are provided with the material conditions which will facilitate their recovery and prosperity. It should be noted that some of the existing physical environment and sanitary conditions not only fail to contribute to a favorable therapeutic environment, but also create the situation, which in many cases amounts to inhuman and degrading treatment. In particular, old infrastructure, extremely bad sanitary and hygienic conditions, living space that does not correspond to the standards, poor sanitation and impossibility of privacy, as well as disruptions with regards to central heating and ventilation were between major problems at some institutions.

The monitoring group found that the informed consent is of the formal nature, without the explanation and provision of complete, objective, timely and comprehensive information. Obtaining of informed consent of the patient occurs to prevent the record of involuntary placement and the procedure is formally directed to place the signed consent form in the patient's medical record. Actually every inspected institution, the monitoring group members interviewed the patients formally undergoing voluntary treatment that no longer wanted to stay in the hospital and requested to be discharged.

In light of the spirit of the UN Convention on the Rights of Persons with Disabilities, the Public Defender considers that all measures must be taken that psychiatric care is predominantly applied on informed consent of duly informed patient and the practice of psychiatric care based on the person's involuntary hospitalization is gradually eliminated. The Ombudsman is concerned for vulnerable legal position of individuals who are hospitalised, actually involuntarily, based on formal informed consent. They are outside the control of the court, and thus unable to defend their rights and subjected to medical interventions and physical restriction against their will. Thus, the patients' right to personal liberty and security is violated, and being subject to conditions of arbitrary detention, in many cases, they are victims of inhuman and degrading treatment.

The Public Defender considers that in the short-term perspective, in order to avoid the vulnerable legal status, it is necessary that psychiatric institution immediately applies

to the court if the patient undergoing voluntary treatment asks to be discharged from hospital, but the criteria for involuntary inpatient psychiatric care are met. The Public Defender also underlines that since the risk of hospitalization without any grounds and/or the risk of long- term hospitalization exists even under judicial control, until the final elimination of the notion of involuntary psychiatric care, it is important, in the short term perspective to create solid security guarantees in this regard.

The problems related to the involuntary inpatient care practices surfaced during the monitoring. In several instances, the petitions submitted to the court refer to only one criterion, while at least two criteria should be fulfilled. In addition, the reasoning for the motion is blanket and so are judicial orders. In addition, in many cases the past placement carries a negative impact on decision-making process. In particular, certain "presumption of illness" operates in such situations. Monitoring has shown that judges in most cases satisfy motions of mental health institutions. They tend to agree with the doctor's opinion and disregard those of the patients'. Doctor psychiatrists believe that they know patient's needs better and the judge, because of lack of medical education, shall not adopt a decision contrary to the doctor's opinion. In such circumstances, the judicial review process, especially when it refers to assessment of a 6-month extension of involuntary psychiatric care, shall lay the importance on an independent psychiatrist 's opinion, which is not envisaged in the law, representing the essential defect in due protection of the patient's rights.

Public Defender considers that patients should be furnished with the information on their treatment on a regular basis, in the language they understand, and this should be part of the therapeutic process. Mental Health Institutionsand their medical personnel must respect the patient's refusal of treatment, and they should try to persuade the patient by providing detailed information of the treatment and its anticipated consequences. This will guarantee the respect to the personal autonomy of the patient.

According to the assessment of Public Defender, the mental health facilities have the patients, who can be called "open-ended" or "perpetual" patients. "Perpetual" patients "in this case are the patients who for months and years, stay on inpatient treatment without in fact ever leaving the hospital. They often do not require active treatment, but cannot leave the hospital because "they do not have a place to go to", or because the family avoids taking them home. It should be noted that managements of all of the institutions with the long-term care unit, declare that such "perpetual patients" represent 30-40% of their contingent. The reasons for delayed discharge of such open-ended patients is the lack of patient support systems, economic insecurity, absence of modern housing / long-term care facilities, lack of geographical access to outpatient psychiatric services and deficit of community-based psychiatric services, as well as shortage of the skills for independent life in patients. Longer hospital stays (in deteriorating environment) deprive patients of the skills for life and the limits their abilities to such depth that it leads to serious barriers associated with their reintegration in society and lengthens this process.

The public defender shares accepted norm, those patients whose mental state no longer requires hospitalization in a mental health institution, should not be forced to stay in

hospitals due to the lack of adequate living and care conditions. Instead, their conditions should be properly evaluated and they should be deinstitutionalized. Public Defender calls upon the Government to take all necessary measures to gradually move from the large Mental Health Institutionsto the upgraded modern facilities, which requires community-based long-term care and the development of secure services.

Whilst examining standards for the treatment of people with mental disorders, the group found that in most institutions, managers, as well as staff, keep understanding of the treatment as reduced to pharmacological therapy only, which is not in compliance with the modern bio-psycho-social approach and evidence-based health care principles. Intensive pharmacotherapy method is expected to be associated in practice with emergency/high-risk departments, which aim to discharge the patient from the department as quickly as possible. According to the doctors of such emergency/high-risk cases departments, quick discharge of patients from such units is, unfortunately, not based on the medical evidence relating to severe accident management as it should be, but rather on the amount allocated for the treatment of such acute cases, as well as the period, which is optimal for spending the allocated funds. The Special Prevention Group also had the impression that the patient "Pharmacological activity" is actually the only way to control patients. Psychiatric cases are mostly managed without any complex therapeutic structure, and the involvement of the patients in meaningful activities is not ensured.

According to the Public Defender, the short period of management of the acute condition of the patient (10-14 days on average) is not enough to reach comparably solid improvements. Presumably, the improvements achieved as a result of intensive treatment start to deteriorate rapidly, as the remission stage is not achieved and the patient discharged from the hospital does not receive the due out-patient care at all, or due to lack of funding, treatment is limited much lower intensity. Out-patient services are fragmented and under-developed; therefore, none of these services are available to maintain the achieved improvements. Thus, there is a high risk of re-aggravation of the situation and repeated hospitalizations.

Monitoring shows that the purchase of high-quality medicines is prevented both by the scarcity of the resources allocated to the psychiatric care, as well as the legal framework governing public procurement. In particular, mental health institutions are buying medications through a simplified electronic tender. The winner of the tender will be the bidder, which offers the lowest price to the purchaser. Such a rule of purchase had a negative impact on the quality of the medication, because there are different producers offering the medicines with the same active substance, while the market price is directly related to the quality of the end product.

The monitoring demonstrated many shortcomings of the medical documentation. In some of the facilities, psychiatrists failed to regularly inspect the patients and thus the results their observation, are also irregularly reflected in the medical cards. Medical files did not contain data on individual treatment plan. Many entries are practically illegible because of the doctor's handwriting. In most of the institutions the records describing

the condition of the patient, the so-called “cursus” are not regularly kept. These records are of mostly blanket nature.

Based on the monitoring results, the Ombudsman concluded that there are severe problems related to the treatment of somatic diseases in mental health institutions. Situation is slightly better in the psychiatric departments / divisions of general hospitals (e.g. Acad. N. Ghudushauri National Medical Center’s Department of Psychiatry). Such psychiatric departments / divisions have access to the services available in the various departments of the general hospital. Diagnostics of somatic diseases and treatment of the problem is particularly problematic in limited liability companies established by the state, such as LLC “A. Kajaia mental hospital “, LLC ,, Senaki Dispensaire ‘’, LLC ,, Republican Clinical Psycho-Neurological Hospital ‘’, LLC ,, Bediani psychiatric hospital ‘’, LLC ,,Acad. B. Naneishvili State Mental Health Center ‘’. The administrations of the institutions state that they are not duly equipped, neither financially, or on the side of infrastructure to undertake the proper evaluation and treatment of patients with somatic diseases.

High patient mortality is of the issue of particular concern for the Public Defender. As it turns out the study of medical records of patients who died, there were many cases calling for appropriate investigation and treatment of somatic health condition, but conduct of any such examination and treatment is not confirmed by medical documentation.

Despite the efforts of staff of mental health institutions, to help beneficiaries in social issues, psychosocial support, rehabilitation and reintegration services in hospitals are barely developed. In some cases, their existence is only a formality and can be considered as a day-activity.

The monitoring showed prolonged hospitalisation of the children, which according to the Public Defender is the result of the improper performance of the social workers’ duties. No multidisciplinary work is conducted in N5 Clinical Hospital. Work towards resolution of psychological and behavioural problems is absent from the children’s individual development plans, which sticks solely to the pharmacological treatment of mental disorders. Apart from this, there is no individual service plan for each beneficiary, the fulfilment of which would be monitored by the person responsible for the dynamics to ensure that the patient receives a complete package of services. The Public Defender believes that the therapeutic activities in the children’s departments do not meet modern standards and guidelines for international intervention, intervention strategies need to be developed, appropriate competence of the personnel has to be improved etc. The Public Defender is concerned by the cases of placement of children in the hospital units for adults and urges the staff to prevent such practices in the future.

Patients subjected to forcible psychiatric care and those transferred from the penitentiary institutions to undergo involuntary treatment are subject to undifferentiated approach. Patients have limited contact with each other. This includes only pharmacotherapy. Patients are not involved in the rehabilitation and improvement of programs, sports and other activities. The monitoring group was left with the impression that no psycho-social rehabilitation work is being practiced with the patients, and the psychologist help is scarce. Days are not anyhow planned or structured by meaningful activities

and they generally run in the drab, mundane manner. Patients often engage in conflicts.

There is no individual approach towards patients in the Forensic Psychiatry Department of the National Center for Mental Health. Their individual needs are not identified and the necessary team is not created to perform the relevant multidisciplinary work. Patients are not involved in the treatment process. Patients are managed through intimidation and aggression between injections. The risk assessment procedure is not in line with international standards. It is unclear what the evidence of credibility of the instrument is, or how the degree of risk is integrated into the treatment scheme, the treatments are held in uniform, broad blanket structure.

Finally, it should be noted in particular that there is a problem of proper monitoring of psychiatric care in mental health institutions supervised by state and of protection of patients' rights. In this regard, the activities of the National Preventive Mechanism are crucial, but the Public Defender considers that bearing in mind the specific nature of the mandate of the National Preventive Mechanism, it is important to ensure effective operation of other state control mechanisms at the same time.

Mental health institutions formally have the internal complaint and feedback procedure, complaints boxes are installed, but the patients do not actually use this procedure and complaint boxes. Patients do not know their rights, and they do not know to whom to appeal. Public Defender identified the following three important problems which demand resolution: a) inform patients of their rights in a language understandable for them; b) introduction of the appeals procedure which is simple and effective taking into account the special needs of patients; c) introduction of proactive monitoring programme for both in-hospital and outside hospital (under the control of the state sector) patients. NPM also believes that in determination of the deadlines and other procedural issues of the appeals procedure the special needs of patients in mental health institutionsand the practical difficulties that may be encountered by patients with the realization of the right of appeal shall be taken into account.

2. MENTAL HEALTH IN GEORGIA – REFORMS AND CHALLENGES

2.1. IMPORTANCE OF MENTAL HEALTH

Mental health is an integral part of individual and public health. There is no health without mental health. Therefore, the public mental health care is crucial to improve the mental health of the population.[4]

In recent years a significant intensification of the mental health issues was notable on the global and European policy agenda.[5] This increased attention and awareness on the side of the World Health Organization, international research institutions, governments and professional societies is truly justified.

Approximately 450 million people worldwide are suffering from mental health disorders. At any given moment, about 10% of adults suffer from this mental disorder; 25% will have it developed at some stage of life.[6] Mental health problems are common in every country, equally within women and men, at all stages of life, within rich or poor, in rural as well as urban conditions.

Mental disorders are associated with more than 90% of the million suicides committed annually. In fact, this figure is much higher, due to the fact that in many cases the cause of death is not reported openly.[7]

Mental health problems are responsible of about 20% of total burden of disabilities caused by the illness, but the so-called "treatment gap" between supply and the real needs of the service remains quite broad.[8]

Persons with mental disorders are vulnerable, often marginalized and excluded. The World Health Organization in its report "Mental health and development," notes that

"Mental and psychosocial disorders have varied and far-reaching social and economic impact, lead to homelessness, poor educational and medical solutions and high levels of unemployment, which ultimately culminates in a higher rate of poverty".[9]

In developing countries, considerable share of burden of taking care of the relatives with mental health problems in economic and social aspects lies on families, since there are

4 Saraceno B, Freeman M. and Funk, M. (2011) Public Mental Health. Oxford University Press.

5 Knapp, M., McDaid, D., Mossialos, E. and Thornicroft, G. (2007) Mental Health Policy and Practice Across Europe. WHO on behalf of *European Observatory on Health Systems and Policies Series*. Open University Press.

6 World Health Report 2001. Mental Health: New Understanding, New Hope. Geneva, World Health Organization, 2001.

7 Suicide prevention (SUPRE). Geneva, World Health Organization, 2007.

8 Kohn R., Saxena S., Levav, I. and Saraceno, B. The treatment gap in mental health care. *Bull. World Health Org.* 2004; 82(11):858-866.

9 World Health Organization (2010). Mental health and development: Targeting people with mental health conditions as a vulnerable group. WHO Press, Geneva.

no comprehensive mental health services in the state-funded network.[10] In XXI century, the stigma is still strong and responsible for many obstacles and resistances on the path of reforms.[11]

Either way, the lack of political support, inadequate management, overwhelming burden on health services and from time to time - resistance from policy makers and health care workers, slowed down consistent, sustainable development of mental health systems in low and middle income countries.

Psychiatric services were characterized by a high level of institutionalization of the former Soviet Union, with a pronounced emphasis on biological treatment. These characteristics are maintained in the post-Soviet states – introduction of modern, customer-focused and community-based services encounter major obstacles.[12] In many cases, psychiatric reform programs stopped and were even reversed.[13] It is against this background that a critical phase of the mental health reform program started a few years ago in Georgia.[14]

2.2. MENTAL HEALTH IN GEORGIA: BRIEF OVERVIEW

A drastic reduction in the number of psychiatric beds took place in the years following the independence of the country. It was a general trend in the post-Soviet countries. Since 1995, the psychiatric beds decreased by almost 5 times, which was caused by the lack of financing of health care services.[15] Unfortunately, like in other countries, the decrease of the hospital beds was not compensated by the necessary outpatient and community-based services.

Currently, inpatient mental health services are delivered through several specialised institutions and departments within general hospitals. Noteworthy, that according to the position of the World Health Organisation, in-patient treatment of mental disorders should preferably take place in general hospitals, however, a large number of countries still rely on mental hospitals primarily.[16] The number of beds for psychiatric patients in general hospitals of Georgia amounted to 2.31 on 100 000 citizens in 2014, while in a

10 Hudson, C.G. (2005). Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses. American Journal of Orthopsychiatry, 75, 3-18.

11 Petersen I, Bhana A, Flisher A, Swartz L, & Richter L (Eds). (2010). Promoting mental health in scarce resource environments: emerging evidence and practice. Human Sciences Research Council Press, Cape Town.

12 Tomov, T., Puras, D., Keukens, R. and Van Voren, R.: Mental health policy in former Eastern Bloc countries; in: Knapp, M., et.al.: Mental health policy and practice across Europe, McGraw/Hill, New York, 2007.

13 *Mental Health Reforms (MHR*). 1-2011. Special issue on Lithuania. Global Initiative on Psychiatry.

14 Makhashvili, Nino, and van Voren, Robert. "Balancing Community and Hospital Care: A Case Study of Reforming Mental Health Services in Georgia". PLoS Med 10(1): e1001366. doi:10.1371/journal.pmed.1001366.

15 WHO, European health for all database (HFA-DB). Available at: http://data.euro.who.int/hfadb/ [last visited on 24 February 2016]

16 Available at: http://www.who.int/gho/mental_health/care_delivery/beds_hospitals/en/ [last accessed 28.03.2016].

mental hospital - 32,32 per 100 000 citizens.[17] Psychiatric hospitals beds per 100 000 inhabitants in Georgia exceeds the world average rate (17.5 beds per 100 000 inhabitants)[18], However, this figure is almost 3 times less than, for example, in Latvia (105,09). It is also noteworthy that in Georgia per 100 000 inhabitants, the number of psychiatric beds in general hospitals is twenty times less, than for example, Estonia, (47,05), which moved to rendering inpatient care in general hospitals model and has only 7.71 beds per 100 000 population in mental health hospitals.

Apart from mental health hospitals and in-patient departments of general hospitals there are 18 psychiatric outpatient clinics (called dispensaries) in the country. However, mental health services are unevenly distributed in the country: in the poor remote areas, access to services and the quality is lower. About half (48%) of the Licensed psychiatrists are registered in the capital, Tbilisi.[19]

According to WHO's Mental Health Atlas (2011), neuropsychiatric disorders amount about to 22.8% of the global burden of disease. In 2006, global health spending amounted to 10.14% of GDP, while the government's health expenditure per capita (PPP International, in US dollars), 73 dollars.

In 2006-2011 years, the costs of mental health care in Georgia was characterized by an increasing trend, but the volume percentage of the costs of mental health in relation overall costs public health have not changed significantly, and remains at approximately 2.5%.[20] Georgia's per capita mental healthcare costs reach 2.8%, which is significantly less than the countries of similar level of development(Curatio, 2014).

Mental health services are mainly financed from the state budget. Corporate and private insurance share in funding mental health services in Georgia, as well as most countries around the world, is very limited.[21]

Acute and chronic inpatient care funding have been changed and re-evaluated in recent past:

- acute inpatient services are paid for by the state, according to the actual costs, but no more than a determined value of GEL 840 per case;
- Long-term hospital services are paid for by the state via monthly vouchers, the value of which is estimated at 450 GEL.

In 1995, Georgia has developed a **Mental Health Program** (as a part of the new general health care program), under which a psychiatric patients registered in the Registry, receive free services in hospitals and outpatient clinics**.**[22]

17 Available at: http://apps.who.int/gho/data/node.main.MHBEDS?lang=en [last accessed 28.03.2016].

18 Available at: http://www.who.int/gho/mental_health/care_delivery/beds_hospitals/en/ [last accessed 28.03.2016].

19 Makhashvili, van Voren, 2013.

20 International Fund Curacio 2014, Mental Healthcare in Georgia: Barriers and Ways of Overcoming them, Tbilisi

21 The private sector service shall be noted - for example; Inpatient clinic voluntary treatment of persons with mental disorders - "Mentalvita" - does not fall under the state regulation and supervision.

22 Sharashidze, M., Naneishvili, G., Silagadze, T., Begiashvili, A. and Beria, Z. (2004). Georgia mental health country profile, *International Review of Psychiatry*, 16(1–2), 107–116.

Thus, mental health services are delivered with the annual State Mental Health Program, which is administered by the Ministry of Labour, Health and Social Affairs; The program is reviewed annually. The program's budget has been more than doubled from 2006 until 2011, to reach 12 million and continues to grow (15 645 400 GEL in 2015).

Table 1 describes the mental health care services in the state budget and changes from 2006 to 2015 period. The table shows a gradual increase in funding and diversification of services package offered in respect to persons with mental health problems. However, the table also shows that the priority is given to the financing of inpatient care, the psychosocial rehabilitation is in complete stagnation and only a small part of the funds are allocated to outpatient care.

Table 1. Mental Healthcare state budget for the years of 2006-2015 (in GEL)

Components	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Outpatient Care	1200000	2000000	2397442	2597232	2597232	2734000	2855000	2866000	2865300	2865300
Psycho-social rehabilitation		50 000	70100	70100	70100	47000	70000	70000	65700	70100
Children mental health				100688	151032	75000	151000	151000	151000	151000
Crisis intervention						14000	520500	662485	662300	662300
Community based mobile team service										96800
Inpatient care for adults and children	3750000	4900000	5882558	6933780	6933780	7457000	9244400	9280800	10420300	10778700
						99000				
Urgent inpatient care				45000	45000	45000	97600	3190	0	0
Alcohol related mental inpatient care services				48000	144000	144000	164200	225000	445900	481200
Provision of accommodation for mental patients								466500	536600	540000
total	4950000	6950000	8350100	9794800	9941144	10615500	13102700	13725000	15137100	15645400

Mental health program for children and adults needing psychiatric inpatient services includes the following components:

1. Acute inpatient care;
2. Long-term inpatient care;
3. Treatment and additional services (safety and security) of patients, who, under Article 191 of the Criminal Procedure Code, are subject to forced psychiatric treatment by hospitalization according to a court decision.

Additional services include: meals, personal care items, provision of emergency surgical and dental treatment and rehabilitation services.

Another service funded by the programme is notable – provision of accommodation to persons with mental disorders, including:

1. Service for the people with disabilities over the age of 18 with inherent and acquired mental disease resulting in dementia;

2. Service for the people under the program for persons with mental disorders in institutional patronage as of December 31, 2014.

Georgia spends a large part of the funds in-patient psychiatric services (about 70%) and this figure remains high for years. Developed European countries spend about 9-31% of inpatient psychiatric services and much more on out-patient services.

Typically, acute inpatient mental healthcare services require a major part of the budget allocated[23]. Therefore, reduction in the average length of staying in the hospital can be a significant goal of the system, especially if the resources freed up in this way can be spent on other components of the service.[24] That is the problem NPM monitoring team faced in the acute care units, which will be discussed in the results of the monitoring.

From the perspective of universal financing of the health care,[25] the dominance of the mental health hospitals limits general availability of mental health services.

In order to implement Comprehensive chain of healthcare the country needs development of out-hospital services - yet the program allocates only 28% of the funds to these services; community based services consume only 4.5% of allocated finances(-mental health reform in the National Strategy and Action Plan 2015-2020, the Government Decree N762, December 31, 2014).

The mental health care system of the country suffers severe deficiency in human resources. Deficiency of psychiatrists compared to the European average index is twice higher and in absolute numbers it equals to deficit of at least 250 psychiatrists (Curatio, 2014). This applies to other specialists, as shown in the following Table 2.

Table 2. Mental health personnel per 100 000 inhabitants (2011)[26]

	Georgia	Average European Index
Psychologist	12.8	22.2
Nurse	7.68	45.3
Social worker	2.9	60
Psychiatrist	6.87	11

23 Knapp M, Chisholm D, Astin J, Lelliott P, Audini B. The cost consequences of changing the hospital-community balance: the mental health residential care study. Psychol Med 1997 May; 27(3): 681-92.

24 Sederer LI. Inpatient psychiatry: why do we need it? Epidemiol Psychiatr Soc 2010 October;19(4):291-5.; Lelliott P, Bleksley S. Improving the quality of acute inpatient care. Epidemiol Psychiatr Soc 2010 October; 19(4):287-90.

25 The world health report: health systems financing: the path to universal coverage. Geneva, WHO, 2010.

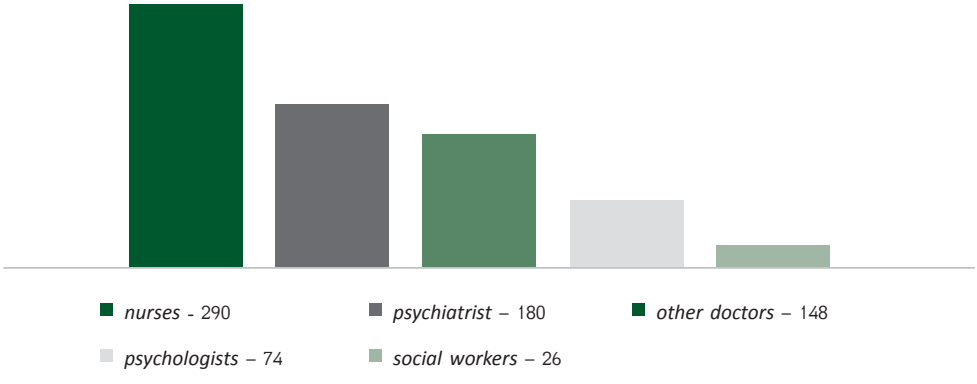
26 Adapted from International Fund Curatio. 2014. *Psychiatric Health Care in Georgia: Barriers and the ways to resolve them.Policy Document*. Tbilisi.

A research on the experts in the psychiatric field conducted in 2015[27] made it clear that, in the state-funded institutions, the mental health care personnel is less than 40% of the total number of employees. The data shows that in total, in 13 of 19 specialized (mental health) service providers mental health personnel are less than the non-specialized staff (administrative and support staff together). However, the general trend towards three types of personnel groups studied are as follows: the most numerous are the support staff (watchman, a cook, a maid, doctor / nurse assistant), then are the mental health staff, and finally - the administrative staff.

Mental health staff are employed full-time as well as part-time and hourly / consultancy basis (see. Figure 2) in service provider organizations. Overall, the most numerous of the mental health staff is group of nurses (290), while the smallest - social workers (26). In addition, all organizations interviewed had a psychiatrist, only 1 did not have a nurse, 2 did not have a psychologist, 5 did not have other doctors and 10 did not have a social worker.

As for the tax-free monthly payment for mental health staff, psychiatrists are paid significantly (by more than 50%) higher than the rest of the groups in terms of other doctors, nurses, psychologists and social workers, the median remuneration of which is not significantly different from each other. Among them, the social worker is the highest (360 GEL), while the lowest, is the compensation of the "other doctor"(325 GEL).

Exhibit 2. ***Mental Health Personnel***



In conclusion, this report suggests the following: in terms of numbers, the first three regular employment positions are shared by the nurses, psychiatrists and other doctors, and the last two by psychologists and social workers. However, the latter is significantly lower than the former. Workload of the specialist groups vary from one specialist to 31 beneficiaries (other doctor) to 53 beneficiaries per specialist (social worker). In general, the lack of improvement of qualification is notable.

Georgia still has to undergo a fundamental transformation from the old Soviet system of mental health care structure towards humane direction in which basic human rights

27 Association of Social Workers of Georgia (2015). *The professional of Mental Health: local tendencies, Report.Tbilisi.*

standards are satisfied (GIF-Tbilisi (2007). Situation in the Mental Health Sector, Report. Tbilisi). Georgia recently conducted studies showing the extent of the problem and the connection among mental health, social exclusion and poverty (GIP-Tbilisi, 2009).

The violations of the rights of hospital inpatients are described in the Public Defender's reports,[28] as well as in the reports of the European Committee for the Prevention of Torture (CPT), which are based on regular monitoring of the closed psychiatric institutions.

The evidence of human rights violations submitted to policy makers throughout years is a strong incentive to start reform process of the mental health care.

2.3. LEGISLATIVE FRAMEWORK

Adoption of the 2007 Law on Psychiatric Care was generally a progressive move which, among other innovations, determined the necessity of a court decision in case of involuntary hospitalization and the need of legal grounds for application of physical restraints[29]. The by-laws determined the practical procedures, such as, for example, physical restraint procedures. In 2009, Georgian experts have analyzed the implementation of the law,[30] based on which several further changes were made to the law. Significant changes were also made in 2014, the most noteworthy of which is the introduction of compulsory psychiatric treatment related provisions. In addition, the Constitutional Court decision on the legal capacity had particular beneficial effect on improvement of the legal framework.[31]

2.4. PROGRESS OF THE REFORM

Since 2004, the state budget allocated to psychiatric healthcare more than doubled and increased funding for mental health allowed the Ministry of Labour, Health and Social Affairs to gradually expand available mental health services. These included improving the quality of treatment, rehabilitation of some of the leading psychiatric institutions, improvement of living conditions of inpatients on compulsory treatment and initiation of psychosocial rehabilitation program.

In 2008, a new model of funding for hospital services (global budget) has led to the gradual reduction of the number of inpatients. However, these reforms were not implemented sufficiently.

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28 Reports, available at:: http://www.ombudsman.ge/uploads/other/0/100.pdf and: http://www.ombudsman.ge/uploads/other/1/1726.pdf, additionally: http://www.ombudsman.ge/uploads/other/2/2253.pdf [last accessed:20.03.2016].

29 The "Instruction for application of physical restriction methods on mental patients" established by Order #92/n of the Ministry of Labour, Health and Social Affairs, dated 20 March 2007

30 GIF-Tbilisi(2009). *Analytical Review of the Law of Georgia on Psychiatric Care*. Tbilisi.

31 Citizens of Georgia – Irakli Kemoklidze and David Kharadze v Parliament of Georgia, Judgement of the Constituional Court of Georgia 2/4/532,533, 8 October 2014. Available at:: https://matsne.gov.ge/ka/document/view/2549051# [last accessed:20.03.2016].

In 2011, the most important achievement of the newly initiated reform was the beginning of the process of deinstitutionalization. One important step is closing the Asatiani mental hospital, which was designed for 250 beds. The so-called "restructuring" of beds took place. Acute patients (in the form of a 30-bed unit) were redirected to the new mental health units in general hospitals (currently 3 multi-functional hospitals are operating for adults); The new, 10-bed pediatric psychiatric hospital opened in general hospital N5 in Tbilisi; established a new independent Mental Health Center (Kavtaradze Street) was also established in the capital with services, such as acute care unit, long-term care unit and outpatient services, which also included mobile teams for crisis intervention center (the location if the crisis service has changed in 2015). In addition, Rustavi Mental Health Centre for long-term care (40 beds) was opened; Crisis teams started to operate in some other cities, e.g. Batumi, Rustavi and Kutaisi.

Since 2011, a new funding model was introduced for acute and long-term patients (State Mental Health Program in 2011, the Ministry of Labour, Health and Social Affairs).

These changes immediately reflected in the sharp decline in the average length of stay for patients[32], an average of 2-3 months of delay period was reduced to an average of 14-21 days of delay.[33] On the background of these changes, experts, service providers and beneficiaries note the lack of beds for long-term patients, lack of community services and the inadequacy of the funding.

In 2011, with the support of the United Nations Development Program (UNDP) the modules for basic training for mental health staff were created. European experts conducted training sessions for local professionals. The first phase of training began in summer of 2011. Selected mental health professionals were invited to training courses, which were conducted for free. According to the results of the tests, 67% of trained persons acquired the necessary knowledge and skills. By the end of 2012 than 300 mental health care workers were trained; Basic training course included 160 hours, the Advanced - 240 hours (GIP-Tbilisi, Annual Report, 2012). The expert trainers in the process of training conducted irregular supervision / overseeing of the personnel to ensure the correct application of acquired skills in everyday practice. Unfortunately, the program was suspended due to lack of further funding and the regional mental health staff could not take part in the training activities.

In October 2011, a multidisciplinary working group reviewed the Georgian national clinical guidelines for schizophrenia and depression treatment. These revised guidelines were provided to the Ministry of Labour, Health and Social Affairs and the Ministry for approval in 2013 and were subsequently approved. The group of experts has developed guidelines for depression in children and adolescents as well.

In order to implement the desired changes, the Ministry of Labour, Health and Social Affairs, created the Consultative Council of the reform (consisting mainly of psychiatrists). In February 2015, the Ministry renewed the membership in the Council, and ap-

32 For acute patients, the average length of time encompasses time from hospitalization to discharge, or transfer to the long-term care unit.

33 International Fund Curatio. 2014. *Psychiatric Health Care in Georgia: Barriers and the ways to resolve them.Policy Document*. Tbilisi.

pointed a mental health service beneficiary's family member to the Council (the order on amendment of the decree of creation of a consultative body - Mental Health Policy Council, 01 / 53O; of February 25 2015). It should be noted that high-ranking officials of the Ministry take an active part in discussions and consultations.

The structural reform of the National System of Mental Health requires long-term dedication. One of the major challenges of the reform is integration of the fragmented programs and services, filling in the existing gaps in treatment and ensuring effective and continuous support through the development of essential services.

Overcoming this challenge is hampered by two main barriers: deficiency of psychosocial rehabilitation services and the insufficient strenght of the movement of service users - persons with mental disorders. Although the voice of persons with mental disorders is growing and increasingly taken into account in the decision-making process, but beneficiary support programs are still scarce in Georgia.

A very important challenge for mental health improvement process in Georgia, as well as many other countries in the region, is the resistance from the service providers themselves. In general, the **psychiatrists might cause significant obstacles to the filling of the gaps within the** treatment system**.**[34] This obstacle is widespread in the former Soviet Union, where the general characteristic of the anxiety about the future and **reform is** often automatically perceived as a threat to their own survival.

2.5. STATE CONCEPT, STRATEGY AND ACTION PLAN FOR 2015-2020

In order to respond to the problems and challenges in a systematic way, the Parliament of Georgia, in December 2013 adopted the "National Concept on Mental Health".[35] This is the main mental health policy document of the country. The document provides that "Georgia recognizes the importance of mental health". Moreover, "Georgia undertakes to organize delivery of mental health services within the country in the manner that people with mental disorders receive treatment in the least restrictive environment, to the extent possible in their own home or close by, based on their basic needs; to ensure maximum protection of their rights and dignity and their full and effective participation in society on an equal basis with others". This is an important provision, which defines the strategic priorities of the reform and emphasizes the affordability and access to services, which should be ensured through the principles of balanced care.

The State Concept defines directions of the balanced care: "balanced development model includes in-patient care, community-based services and strikes a balance between drug treatment and non-medicine treatement; personal, family and community interests; as well as prevention, treatment and rehabilitation methods".

34 Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, Sridhar D, Underhill C (2007). Barriers to improvement of mental health services in low-income and middle-income countries. Lancet 370, 1164–1174.

35 The Ordinance of the parliament of Georgia dated 11 December 2013 on the "National Concept of the Psychiatric Health Care", Available at: https://matsne.gov.ge/ka/document/view/2157098 [last accessed:19.03.2016].

It also declared that the effective care must be comprehensive, client-focused and continuous, " supply of a continuous chain of care and integration of mental health in different forms and methods of co-ordinated, consistent and continuous system, which focuses on maximum sustainable results, integration of the service recipients / patients in the health care and social services, as well as their involvement and participation in the community, instead of isolation. "

To reach the goals identified in the Concept the Ministry of Labour, Health and Social Affairs has launched a national strategy and action plan for the years 2015-2020, which was approved in December 2014[36].

This document is based on the action plan of the World Health Organization for the years 2013-2020, which was approved by the World Health Assembly on the 66th session.[37]

The WHO action plan has the following main objectives:

- to strengthen effective leadership and governance for mental health.
- to provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
- to implement strategies for promotion and prevention in mental health.
- to strengthen information systems, evidence and research for mental health.

The introductory part of Georgian national strategy and action plan describes the hospital sector:

The end of 80's marked significant trend of the decrease of the psychiatric beds in Georgia, as well as in former Soviet republics. The World Health Organization data provides that in 2011 the number of beds in specialized mental health hospitals in high-income countries was 3.09 / 10000, and in Georgia - 2.86 / 10000. General hospital beds built in Georgia is 0.22 / 10,000 population (high-income countries - 1.36 / 10,000 inhabitants). Residential housing community of high-income countries 1,015 / 10,000, while in Georgia, there is no such service. Day care centers and other community service beds / seats, being most in EU countries amounts approximately to ≈ 4.3 / 10000, whilst in Georgia, this figure is not more than 0.1 / 10,000.

The Action Plan also notes that according to the Public Defender's report[38] and the Council of Europe study of 2013 [39] violations of human rights still occur in the specialized mental health hospitals in Georgia; These institutions unfortunately, often do not meet

36 The Ordinance N 762 of the Government of Georgia on "Establishment of the Strategic Document of Development of Psyschiatric Health and Action Plan 2015-2020" dated 31 december 2014, Available at:: https://matsne.gov.ge/ka/document/view/2667876 [last accessed:19.03.2016].

37 WHO Mental Health Action Plan 2013-2020 (2013). WHO Geneva, Available at: http://apps.who.int/iris/bitstream/10665/89966/1/9789241506021_eng.pdf [last accessed:20.03.2016].

38 Public Defender of Georgia, National Mechanism of Prevention (2012) Report of the Situation int he Psychiatric facilities of Georgia, available at: http://www.ombudsman.ge/uploads/other/0/100.pdf [last accessed:20.03.2016].

39 Council of Europe(2013) Assessment of Mental health care services

quality standards of treatment and care (p.3).

Strategic directions of the state action plan are the following:

- State management in the mental health care sphere;
- Development of human resources;
- Provision of psychiatric health care services;
- Mental health in the penitentiary system;
- Raising the awareness of the public.

Each direction is followed by a list of tasks and activities and performance dates. According to the action plan, by the end of 2015 the state should have offered to its citizens:

- operation of the special unit of coordination and supervision of the state policy of the Mental Health (process and results)
- Identification of Human resources / personnel needed
- to launch preparation of the protocols and guidelines based on the latest scientific evidence and best practices(including primary health care and penitentiary system)
- Evaluation and assessment of needs with regards to the mental health servies of inmates within penitentiary system
- integrated, unified program of mental health care in the penitentiary system
- community mobilization (mental health education and awareness) and long-term strategies
- launch of suicide prevention programs
- launch of the strengthening organizations for the persons with mental disorders and their family members
- raising the mass media awareness on key issues of mental health policy.

Unfortunately the Ministry has not presented the report on the fullfillment of these obligations by the end of 2015.

2.6. REFORM OF THE SYSTEM OF LEGAL CAPACITY

Legal Incapacity reform is an important step, encompassing changes in the legislation related to legal incapacity, as regards persons with mental disabilities. The reform was carried out in 4 main areas:

- Review of the legal capacity institute and bringing it in line with the decision of the Constitutional Court and the provisions of the Convention on the Rights of persons with Disabilities. With respect to persons who have deemed legally incapable on

the grounds of 'mental retardation' or 'mental disorder', the introduction of an individual assessment was proposed, which will not only be based on the medical model, but will also take into account social evaluation system.

- Introduction of special provisions for court proceedings on the cases related to legal capacity in order to protect procedural rights of persons with disabilities.
- Strengthening the role, duties and responsibilities of the Social Guardianship and Care Agency of the Ministry of Labour, Health and Social Affairs, as the representative of the state.
- For implementation of the individual assessment reflecting the social model, Introduction of the new individual assessment system within LEPL L.Samkharauli National Forensics Bureau, according to which the assessment / examination report is issued by a multidisciplinary team.

As a result of these amendments the system of a complete neglect was changed towards the system of support and, in exceptional cases, replacement mechanisms. Such large-scale legislative changes were due to the decision by the Constitutional Court on 8 October 2014, in which existing regulations limiting the capacity of persons with disabilities caused by mental disorders was declared unconstitutional.[40]

40 Irakli Kemoklidze and David Kharadze v. the Parliament of Georgia, the decision of the 2nd Collegium of the Georgian Constitutional Court, №2/4/532,533, 8 October 2014, Available at: https://matsne.gov.ge/ka/document/view/2549051# [last visited 19.03.2016].

3. ILL-TREATMENT

No one shall be subject to torture,[41] or to inhuman or degrading treatment or punishment.[42] According to Article 10 of International Covenant on Civil and Political Rights, all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. According to the United Nations Human Rights Council, the protection of inherent dignity represents an international norm which is non-derogable.[43]

According to Article 15 of the United Nations Convention on the Rights of the Persons with disabilities, no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his or her free consent to medical or scientific experimentation. The State Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.

During the visits at the mental health institutions the monitoring group has received numerous notices regarding physical violence and verbal abuse of patient. In addition, the Monitoring Group considers that the extremely bad conditions of patients in some mental health institution can also amount to ill-treatment, which in some cases is topped by the facts of application of physical and chemical restraints, the method of application of the restraints in the presence of other patients, inaccessibility to the timely and adequate treatment of the somatic diseases, negligence of the long hospitalization and involuntary medical intervention.[44]

In **A. Kajaia of Surami Mental Health Hospital,** the Special Prevention Group received information about the cases of violence against patients. In particular, 8 patients indicated that they had been subject to the physical abuse by nurse assistants (orderlies) side. In addition, most of the patients said that physical violence also occurs among patients.[45]

Patients explain that the violence from the orderlies is expressed by beating with the

41 According to Article 1 of the United Nations Convention against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment the term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.

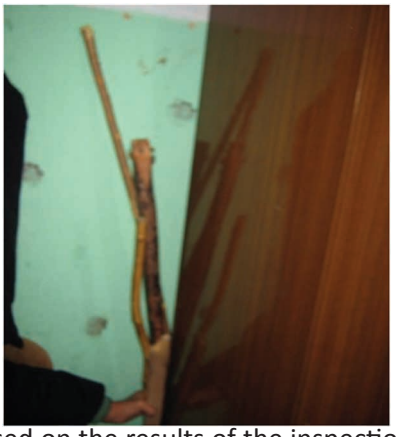
42 The European Convention on Human Rights, Article 3.

43 UN Human Rights Committee General Comment N 29, CCPR/C/21/Rev.1/Add.11 (2001), 31 August 2001 para. 13(a), available at: <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2f21%2fRev.1%2fAdd.11&Lang=en> [last accessed:29.03.2016].

44 These problems are addressed in detail below in the respective sections

45 Since the patients said they did not feel safe at this point, they refrained from application to the investigative body officially. Accordingly, due to the principle of confidentiality we can not provide the information about the identity of these patients.

hands and sticks. It is remarkable that three patients had physical injuries, such as bruises on the upper limbs and eye socket.[46] Importantly, these injuries were not mentioned in the patients' medical records. Also noteworthy is the fact that members of the Special Prevention Group discovered the sticks referred by patients in the nurse room between the wall and the wardrobe, in the one-story building of the Women's Department of this facility, which were used to beat patients.[47]



Based on the results of the inspection, the Special Prevention Group concluded that, in A.kajaia Surami Mental Health Hospital patients are at high risk of systematic violence. Inspection revealed that the facility personnel has aggressive attitude towards patients.

On October 28, 2015, the Public Defender submitted the above-mentioned facts, for the effective investigation to the Chief Prosecutor. Office of the Chief of December 25, 2015 replied to the Public Defender on 31 October 2015, that the Ministry of Internal Affairs and the Khashuri district police office launched criminal investigation N038311015001 case, [48] under Article 126 of the Criminal Code. During the investigation, the site was examined. The witnesses were questioned, together with the personnel of mental health hospital. Forensic medical examinations were held to determine the health conditions of the 53 women and 43 men inpatients.[49] The Chief Prosecutor's Office informed Public Defender on 4 February 2016, that the inpatients were not interrogated during the investigation due to their health conditions. At this stage, the investigation has not presented the charges to anyone and the case is still ongoing.

In the view of the Special Prevention Group, the approach of the Office of the Chief Prosecutor that the patients were not to be interrogated lacks substantiation and casts a reasonable doubt on the effectiveness of the investigation. Moreover, the letter shows stereotyped attitude towards patients in psychiatric institutions, as if they could not provide reliable information to the investigative body. In this regard it should be noted that

46 2 of the referred patients were females, and one male.

47 The photos of the sticks were taken by members of the Special Prevention Group. In order to prevent the destruction of evidence, the discovery of the sticks was not disclosed to the personnel of the institution.

48 N13/80119

49 N13/6551

the Criminal Procedure Code, Article 50, paragraph 2 only a person, who has a physical or mental disability which results in his/her inability to comprehend, remember and recollect the facts relevant to the matter and provide information or to give evidence shall not be interrogated as witness. As is clear from the wording of the provision, the mental disorder cannot be reason for automatic refusal to interrogate the witness. This norm instead lays focus on a person's inability to properly absorb, remember and recall all important circumstances of the case and give evidence.

It is wrong to assume that the mental health hospital patient is devoid of all the above-mentioned ability. If such assumption is to be made, it turns out that neither the monitoring nor the investigation body have to inquire and question the mental hospital patient, which is directly contrary to the rights under Article 13 (Access to Justice) of the UN Convention on the Rights of the Persons with Disabilities, which states that States Parties shall ensure effective access to justice for persons with disabilities on an equal basis with others, including through the provision of procedural and age-appropriate accommodations, in order to facilitate their effective role as direct and indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages.

In order to help to ensure effective access to justice for persons with disabilities, the said Article 13 of the convention requires that States Parties shall promote appropriate training for those working in the field of administration of justice, including police and prison staff. Thus, it is important to ensure that the prosecutors and investigators of different investigative bodies within Georgia are prepared on the issues of access to justice for the people with disabilities. It is additionally recommended to create special regulations.[50]

One of the interviewed patients of Surami Mental Health Hospital blames the violence on nurses' assistants (orderlies) and the patients which are pushed by them. According to him, the orderlies sometimes instigate violence by setting the patients against him/her and he/she may be beaten by a pot in the head or fists in his throat. The same patient says that patients "are rarely tied", but if the patient is tense, "the orderlies will surround him/her, patients are helping them, and he/she may be beaten; The patient stops and he/she gets injected to calm down; Patients chase each other with sticks and orderlies also have sticks. "

One of the patients had a scratched surface wound on the nose during an interview and a bruise on the left eye. He says that he was often beaten by other patients and blames the orderlies for that. One of the patients of the female department of the mental hospital had bruises in the left eye and forehead area, and excoriations on the right eyebrow area. The patient said that "they beat his head against the wall". In terms of women's hygiene department, the patient clarified on the trend of majority of patients with short

50 UK legislation and practice are interesting in this regard. Legislation is available at: http://www.legislation.gov.uk/ukpga/2003/44/contents
detailed information on the topic is available at:http://www.cps.gov.uk/legal/v_to_z/victims_and_witnesses_who_have_mental_health_issues_and_or_learning_disabilities_-_prosecution_guidance/ and: https://www.cps.gov.uk/publications/docs/supporting_victims_and_witnesses_with_mental_health_issues.pdf , additionally, at: https://www.judiciary.gov.uk/wp-content/uploads/JCO/Documents/judicial-college/ETBB_Mental_disability_2013+_finalised_.pdf [last accessed:26.02.2016].

hair that if the patient refused to have her hair cut, then the so-called "Uborshchiki'' (Female Patients who take up cleaning), would beat her.

At the very entrance in the **Mental Health and Drug Dependency Prevention Centre**, rough, aggressive attitude from the personnel towards patients was observed, which was expressed in referring to the patients in offensive/abusive forms. Patients recalled the cynical attitude from the nurse assistants during the interview process. According to one patient, apart from psychological violence, there is physical violence, which is mainly manifested by spanking the patients on their head. Some patients recalled kicking the patient in head with the key-chain by an orderly. According to the patient, they are often provoked and punished further. According to patients, on any matter of protest they are threatened with chemical (injection) and physical restrictions. Several patients recalled the injections being made by the nurse in the corridor, in front of other patients.

In Clinical Psycho-neurologic hostpital of the Republic (Khelvachauri) – the patients declared that they are threatened with "taking them to the cells with bars on the window and locking them up". One of the patients told the monitoring group that he was once caught by the orderlies in the corridor and injected, during which process his clothes were torn. This fact was asserted by his roommate.

One patient of the "Unimed Kakheti" Psychiatric Division said that personnel physically abused him after which he was subjected to physical restraints and injection**.**

In National Center for Mental Health (Qutiri) the conditions of treatment vary from department to department. In some departments patients do not allege any physical or verbal abuses by personnel, and state that the treatment has improved, whilst in other departments there are complaints that the staff treats patients rudely, shouts and threatens them by physical violence. Patients mention 'they fixate us in the corridors, where the security guys look at us', 'the nurse was doing injection, and the sanitarian covers us with blanket'.

In **Bediani psychiatric hospital** the fact that almost all beneficiaries had the similar very short haircut was striking. The personnel of the institution stated that this practice was adopted to prevent lice. The haircuts are made by the housewife.

Interviews with beneficiaries revealed the practice, when the beneficiaries are not informed in advance about preventive measures for which the haircut is necessary and no consent is sought from them. Sometimes a haircut is imposed involuntarily and forcibly, which is degrading for the beneficiaries and is perceived as violence and ill-treatment. Similar reports were made by several female patients of the National Center for Mental Health (Qutiri).

The European Court of Human Rights, in the judgment on the case *Yankov v. Bulgaria*, declared that shaving the prisoner's hair forcibly, violently without any legal basis and justification may be qualified as degrading treatment considering the particular circumstances of the case.[51] Although personnel states that the haircut is necessary for lice removal, *i.e*. for the protection of hygienic conditions, the Special Prevention Group

51 Yankov v. Bulgaria, ECtHR Judgement of 11 December 2013, application No 39084/97, para. 114-121.

considers that involuntary and forcible haircuts/shaving constitute unjustified use of force. If it is important to ensure the hygiene and the use of alternative measures is not enough, this should be explained to the patient and his consent shall be obtained.

RECOMMENDATIONS

RECOMMENDATIONS TO THE CHIEF PROSECUTOR

- Ensure the investigation of the cases of physical violence both from the personnel and instigated by the personnel
- Ensure the preparation of the prosecutors in the specificities of interrogation of persons with mental disorders
- Create the guidelines for interrogation of persons with mental disorders

RECOMMENDATIONS TO THE MINISTER OF THE INTERNAL AFFAIRS

- Ensure the adequate addressing of the cases of violence against patients within mental institutions
- Ensure the preparation of the investigators in the specificities of interrogation of persons with mental disorders

RECOMMENDATIONS TO THE MINISTER OF HEALTH AND SOCIAL AFFAIRS

- Provide regular training in mental institutions on the issues of protection of human rights, management of agitated/tense patients, non-violent de-escalation and physical restraint measures
- Develop and implement the plan of elimination of deplorable and degrading conditions and ill-treatment in the A.Kajaia Surami Psychiatric Hospital, National Center of Mental Health (Qutiri) and Bediani psychiatric hospital and ensure that patients of these facilities are placed in conditions compatible with human dignity compatible and therapeutic environment; At the same time take all necessary measures to facilitate the discharge of the patients, which are staying in the hospital without necessary medical evidence.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Maintain vigilant surveillance of their own staff, especially on the behaviour nurse assistants, and regularly remind them that any forms of ill-treatment

of patients is not acceptable and will be severely punished; In case of such treatment respond adequately, including notifying investigative bodies

- Provide regular training of their staff on the issues of protection of human rights, management of agitated/tense patients, non-violent de-escalation and physical restraint measures
- Improve living conditions in the facility, so that patients live in the conditions compatible with human dignity and therapeutic environment
- Eradicate and prevent any practice abusive to human dignity
- Ensure the discharge of the patients, which are staying in the hospital without necessary medical evidence

4. VIOLENCE AMONG THE PATIENTS AND THEIR SAFETY

As a matter of principle, hospitals should be safe places for both patients and staff. Psychiatric patients should be treated with respect and dignity, and in a safe, humane manner that respects their choices and self-determination. The absence of violence and abuse, of patients by staff or between patients, constitutes a minimum requirement.[52]

Monitoring has revealed the problem of due protection of security of patients and proper protection from violence in mental health institutions. For example, conflict situations among patients are common in **Mental Health and Drug Dependence Prevention Centre**. Some informal hierarchy is observed among some patients. One patient said that conflicts occur for the usage of the TV as well. One of the young man interviewed by the monitoring team in acute care unit had an eye bruise, which was not documented in the patient's physical condition at hospitalization. Examination of the documents revealed that the patient was physically restrained twice, because of the conflict with other patients.

Patients of **National Centre of Mental Health** complain that medical and security personnel adopt the selective "biased" attitude towards patients; there are "elite patients." Patients also talk about the conflict between the patients and the facts of physical confrontation.

At **A. Kajaia Surami Psychiatric Hospital** the violence among the patients is of systematic nature. During the visit of the Monitoring group, a large portion of patients were in the condition of psycho-motoric agitation in the men's section of the corridor, they shouted at each other and argued loudly. Cries and shouting were heard from the Women's section as well. One patient threatened another patient, whilst the latter begged not to hit her. The monitoring team observed that the staff was not able to timely and adequate respond, which raises concern to the Special Prevention Group.

Some of the men patients interviewed had excoriations and bruises on the face, and they said they were beaten by patients. The interviewed men talk about the violence among patients, and identified the order lies two of the 'privileged' male patients as the main source of violence in men's department, and so called 'Uborshchiks' (cleaners) in the women's section.

Patients often have conflicts and resort to violence in the dining room. The cause of the conflict between the patients is the extortion of food by others, and there are cases when some patients remain without food. The reason for the quarrel with one another is sometimes the theft of snacks, cigarettes or clothing from the rooms.

According to the Special Prevention Group, the facility is not documenting the cases of conflict and violence, and the measures taken in response to these facts, which raises serious doubts that the staff is trying to cover up the problems and / or has created a

52 16th General Report of the CPT [CPT/Inf (2006) 35], para. 37, available in English language at: http://www.cpt.coe.int/en/annual/rep-16.htm [last accessed:10.03.2016].

conciliatory attitude towards the situation.

Bediani mental health hospital personnel state that there are quite a few cases when patients resort to conflicts and violence. For example, once a patient hit another in the face with a piece of wood. According to personnel, such cases are unexpected and sudden and prevention becomes impossible. The doctors and nurses do not keep official log about such cases, although doctor keeps notes unofficially, on separate pieces of paper. According to him, the medical staff daily, orally reports to him information about what is happening in the department. In the view of Special Prevention Group, the situation is precarious in the facility with regards to the prevention of violence and the conflicts between the patients. It is important that staff have conflict and violence prevention strategy and a pre-determined action plan as far as possible, and the personnel shall be conducting direct supervision and monitoring of patients as much as possible. It is also important that all cases of conflict and violence, together with the measures taken in response are duly documented.

Tbilisi Mental Health Center nurses register the cases of the violence among patients as well as cases of the patient's aggression towards staff in the physical restraints log. Despite the existence of the problem of documentation of the conflicts and violence in the facility, the monitoring group has identified several important cases. In one case, the patient was aggressive towards nurse assistants, and tried to jump out the window, after which the physical restraints were applied. In other cases, one patient jumped from the window, but, fortunately, the case did not end fatally. There were also cases where a physically restrained patient managed to set fire to mattresses and remove restraints. This event was noted in the physical restraints' log and the nurse's diary as the 'check of the quality of fixation', *i.e.* the observation was conducted, but nonetheless the patient managed remove binding means and put the mattress on fire. Therefore, the Special Prevention Group concludes that in spite of the record, in fact, physically restrained patient was not under proper supervision, which is unacceptable.

It should also be noted In connection with this incident that the staff of the institution, in order to avoid similar cases, took away the lighters and matches from the patients who are smokers. Special Prevention Group believes that the facility is subject to certain restrictions imposed by the security regulations, but these restrictions, in all cases, should be adequate and proportionate and should not be imposed on the patients for the comfort of the staff of the institution and the failure of the personnel to fulfil their basic function - proper supervision and observation of patients cannot be justified by the mere mention of the impossibility of performance.

Based on the results of the monitoring, the Special Prevention Group concludes that there is no common approach formed within mental health institutions as to the treatment of the conflict among the patients and general security issues. Accordingly, the institutions are not protected from violence, and do not constitute a safe environment. The risk factors of conflicts, violence and other incidents are tight distribution of the patients within the chambers, existing living conditions and social problems, non-existence of the risk assessment scheme related to specific patients on the side of the per-

sonnel, insufficient number of qualified staff, improper monitoring / observation[53] and absence of immediate and adequate response at the initiation of the threat, absence of pre-defined strategy of intervention and de-escalation, as well as the lack of personal accountability and responsibility. Especially noteworthy is an attempt of personnel to establish the order and security within the facility via a certain group of patients, referred to as "privileged" patients by interviewees. This practice is deemed unacceptable by the Special Prevention Group. Based on the foregoing, it is crucial to adopt measures directed at the elimination of the risk factors listed above.

RECOMMENDATIONS

RECOMMENDATIONS TO THE MINISTER OF LABOUR, HEALTH AND SOCIAL AFFAIRS

- Take all necessary measures to prevent violence among patients in mental hospitals and ensure the security, including the creation of regulatory framework by regulating mechanisms of assessment of risks arising from specific patients by mental institutions and a preliminary evaluation system, multi-disciplinary work, the protection of the patients and security via preventive activities, proper supervision/ surveillance of the patients by the staff, the proper training of the personnel, standard operating procedures and de-escalation strategy, as well as timely and adequate intervention whenever the threat emerges, documentation of abuse cases/incidents and the measures taken in their response, accountability and liability of personnel.
- Create internal mechanism in the healthcare system that will ensure proper supervision of the violence and security situation patients in mental health institutions
- Provide regular training in mental health institutions on the issues of management of agitated/tense patients, non-violent de-escalation and physical restraint measure, mediation, security and other issues

RECOMMENDATION TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Ensure prevention of violence among patients and protection of the security including introduction of mechanisms of assessment of risks arising from specific patients by mental health institutions and a preliminary evaluation sys-

53 According to the Report of the European Committee for the Prevention of Torture, based on the visit of 1-11 December 2014 in Georgia, at the psychiatric institution of Kutiri (National Centre for Mental Health), the delegation witnessed episodes of inter-patient aggression, which was hardly surprising considering the low staffing numbers and the chaotic living environment. The Report is accessible in English at: http://www.cpt.coe.int/documents/geo/2015-42-inf-eng.pdf [last visited on 28 February 2016]

tem, multi-disciplinary work, the protection of the patients and security via preventive activities, proper supervision / surveillance of the patients by the staff, the proper training of the personnel, standard operating procedures and de-escalation strategy, as well as timely and adequate intervention to address the threat, documentation of abuse cases / incidents and the measures taken in their response, accountability and liability of personnel.

- Provide regular training in mental health institutions on the issues of management of agitated/tense patients, non-violent de-escalation and physical restraint measure, mediation, and other issues of protection of the security.

5. PHYSICAL RESTRAINTS, ISOLATION AND CHEMICAL RESTRAINTS

In any mental health facility, there is a need to apply restraining methods towards agitated and/or aggressive patients.[54] Thus, it is important to have clearly defined policy on the issue of the usage of restraints. Such policies shall be made to ensure that at the initial stage, non-physical methods of limiting aggressive or agitated patient (e.g. verbal instruction) are applied as far as possible, and, if necessary, the use of physical restraint methods is limited to manual binding.[55] The mental health institutions staff should be trained in the techniques of non-physical dealing and of manual binding of the aggressive and agitated patients. Such techniques would allow the staff, a room for choice how to act into a difficult situation, to assess and choose the most matching method for the situation, which will greatly reduce the risk of injury to personnel and patients.[56]

The use of means of physical restraints (belts, strait jackets, etc.) is justified only in extreme cases, only upon the direct order of a physician, or the doctor should be notified immediately after the use of such means. If, as an exception, the use of physical restraint methods is allowed, restraint should be discontinued at the earliest opportunity[57]; the use of methods of restraint or protraction of their use for punishment is prohibited. The restraints shall not be used because of convenience to staff, relatives or other persons.[58]

According to standards established in international human rights law, the isolation or physical binding of the patient should be used in adequate infrastructural conditions, to avoid immediate and imminent threat of harm to the patient or other patients and its application must be sizeable and proportionate to the risk. Isolation[59] and physical bind-

54 Notable that the Special Rapporteur of the UN Special Sub-Committee Against Torture calls upon the states to Impose an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including the non-consensual use of restraint and solitary confinement, for both long- and short-term application. Report of the Special Rapporteur Juan Mendez, A/HRC/22/53, para. 89(b) Available in English language at:: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf [last accessed:27.02.2016].

55 Importance of the training of the personnel is also emphasized in the Recommendation of the Committee of Ministers of the Council of Europe Rec (2004)10 "On the protection of the rights and dignity of the persons with mental disorders"", Art. 11, Available in English language at:: https://wcd.coe.int/ViewDoc.jsp?id=775685 [last accessed:27.02.2016].

56 CPT standards, para. 47. Available in Georgian language at:: http://www.cpt.coe.int/lang/geo/geo-standards.pdf [last accessed:27.02.2016].

57 UN Subcommittee on Prevention of Torture, considers that the physical restriction is a form of restriction of freedom, and therefore it should benefit from the guarantees of legal protection for restrition of freedom. It shall be applied only in extreme cases, and safety considerations should be used. Since these measures are at high risk of violence, it is better not to apply them, but if it has to be used , it should be under strict legal regulations of the relevant criteria, including, the maximum term, supervision, control and right of apeal.(Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on the rights of persons institutionalized and medically treated without informed consent, para. 9, Available in English language at: http://www.ohchr.org/EN/HRBodies/OPCAT/Pages/OPCATIndex.aspx [last accessed:29.02.2016]).

58 ibid.

59 According to the Subcommittee on Prevention of Torture, in case of isolation of the patient, constant

ing should be used only under medical supervision and proper documentation of the conditions. The cause and duration of the measures should be included in the patient's medical record and a special register.[60] The record on the patient's physical restraints or isolation should additionally include the circumstances of the use of this measure, the name of the doctor who issued the order or authorization and the information about the patient or staff if they received any trauma. This will greatly simplify the management of such situations, as well as the control of the frequency of usage of these methods.[61]

According to Article 16 of the Law of Georgia on Psychiatric Care, Psychiatrist has the right to apply methods of physical restriction to the hospitalized patient if there is a real danger that the latter inflicts harm to him/her or others and this danger may not be otherwise avoided. Methods of physical restriction are: isolation of the patient in a specialized ward and/or physical restraint. Applying the methods of physical restriction shall be terminated once the danger stipulated above ends. Applying methods of physical restriction or prescribing medicines for the purpose of punishment or intimidation of the patient is inadmissible. Decision on applying methods of physical restriction of patient shall be made by the doctor-in-charge or duty physician that is fixed in medical records. A patient who was subject to the physical restriction, his/her legal representative or in case of the absence of the latter – a relative, may appeal to the court challenging the legalityof the physical restraint.

According to the "Instruction for application of physical restriction methods on mental patients" established by Order #92/n of the Ministry of Labour, Health and Social Affairs, dated 20 March 2007 the physical restraint is designed to reduce the patient's aggression and expose the patient to the necessary treatment. Isolation wards where the patients are placed have to be specially equipped in order to prevent the patient's self-inflicted harm. The physical restraints are carried out via special means for such restriction. Permit for application of physical restraint is issued for 4 hours.

According to the same instructions, the physical restriction is carried out by the specific personnel designated under the internal rules of the institution, with the necessary qualifications and experience in the use of physical restraint methods. The internal regulations of the institution shall designate the person responsible for supervising the patient who is physically restrained. The person responsible for monitoring the patient's condition shall check every 15 minutes if needed her help. The attention shall be paid to the following factors: whether the patient needs additional medical care; whether the patient has any signs of mechanical-traumatic injury; suffers from a serious inconvenience; are the needs for food, water and other physiological necessities met to the acceptable level. The patient, subjected to physical restraint, should be kept in proper conditions. If after 4 hours the patient's condition is still in need of physical restraint

supervision shall be carried out and the isolation shall be managed in the manner that the patient has the possibility to interact with other patients. Isolation shall be used for the smallest periods of time possible and it shall be properly documented and controlled, including with the possibility of appeal and review by an independent organ and a court. (Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or DegradingTreatment or Punishment on the rights of persons institutionalized and medically treated without informed consent, para. 10).

60 Recommendation of the Committee of Ministers of the Council of Europe Rec (2004)10, Art. 27.

61 CPT standards, para. 50.

methods psychiatrist shall re-make the record and follow-up continues in the same conditions.

It should be noted that neither the Law of Georgia on Psychiatric Care nor the above mentioned instructions include the upper limit on the maximum period for the use of physical restraint, which is dangerous, because it can formally lead to repetitive physical restrictions formally that continue for 4 hours. The said normative acts also fail to establish the obligation that the information on the physical restriction be included both in the patient's medical record, as well as a special journal (special register). It is therefore important that the normative acts are brought to order, via including making changes in the way to regulate those two issues.

It is noteworthy that neither the law nor the instructions mention chemical restrictions as a measure of restriction. The concept of chemical restriction[62] lies on the distinction whether the patient is taking medication as part of the treatment, or the medications are given to control his/her actions. If drug is part of treatment, assigned after the evaluation of the status and the rational part of the plan of care, there is a conventional treatment process, and, if on the other hand the patient is given the medicine, as the response/reaction to the patient's behaviour, it is a chemical restriction.

Accordingly, the same drug in different cases can be described as a treatment or chemical restriction. The use of the chemical restriction is not allowed to punish the patient or to prevent the discomfort of staff.

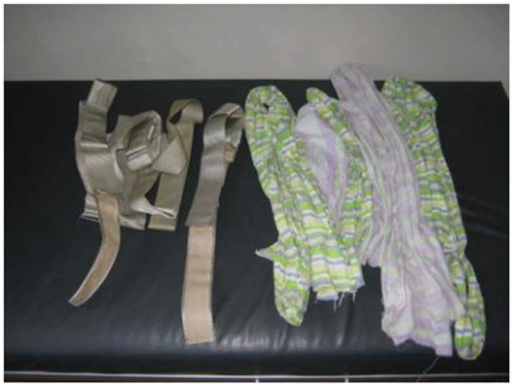
According to the assessment of the Special Prevention Group, the use of chemical restraint is widespread in these institutions and is not documented properly. The institutions routinely apply physical restraint together with chemical restraint. There is no clear legal framework regulating chemical restraint and no justifications are provided for its application. This amounts to a violation of standards of international human rights law.[63] The same guarantees of protection should be provided whenever chemical or mechanical means of restraint are used.[64]

Monitoring results reveal that the physical restriction is applied via the wide wrappings made out of the bed linen / sheets and the restriction usually lasts an average of 20 to 60 minutes, which corresponds to the required time of effectiveness of the sedative substance after its introduction / injection. Almost all the institutions have special shiny belts. According to Personnel, these belts are "rough and squirt the skin." The Monitoring Group has received several reports of physical restraint being applied with the use of excessive force and physical violence.

62 „Care for Agitated Patient" – Training Module (2011). GIF-Tbilisi.

63 "If recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillizers, they should be subjected to the same safeguards as mechanical restraints. The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion." (CPT standards, p. 96, para. 41, Available in Georgian language at: http://www.cpt.coe.int/lang/geo/geo-standards.pdf [last visited on 28 February 2016]).

64 CPT Report to Georgian Government on the Visit in Georgia on 1-11 December 2014, para. 152.



"Unimedi Kakheti" Mental Health Centre involuntary inpatient patient said he's been subject to the physical violence (slam in the face) from the personnel whilst applying physical restraints. According to the patient, the binding process occurs with excessive use of force and nurse assistants "do not know how to approach a patient". According to him, some of them are "particularly aggressive".

According to patients, the physical restrictions are often used in cases of self-injury. According to information received from patients, each of them had been at least once subject to the physical restriction for more than 4 hours, without due justification. One patient said that he spent the whole night in the tied condition, while he had to satisfy his physiological needs in the bed, because the staff did not pay attention. One patient said he was offered to put on sanitary napkins before physical restriction, what he perceived as humiliation.

Physical restrictions are applied in the three chambers near the procedural ward, mainly in the fifth ward, because according to the personnel nurses' directly watch this chamber. Despite the fact that the patients are placed in the chamber, if necessary they are removed in order to apply restrictions to others with soft bands. Before applying physical restraints sanitary napkins are put on the patients, since, according to the staff "some are lying that they need to go to the toilet to get released of physical restraint."

The Mental Health and Drug Dependence Prevention Center has the Order of the Director General of the September 17, 2015 №01 / 109, which regulates the physical restraints and the allocation of the special room in short and long term psychiatric departments. According to the order of the Director, room has to be allocated in each of the short and long-term departments for psychiatric patients with physical restraints. Nevertheless, the monitoring revealed that no room had been allocated in the acute care unit. In addition, according to the order, the patient's physical restrictions should be implemented in a specially designated room for patient safety and protection of personnel, in the presence of physician / doctor on duty and 3 procedural nurses and nurse assistants (or nurse on duty). Junior staff can be involved in the process, having passed the proper training. According to the named order, authorized persons can register the decision on use of physical restraints on the patient in the patient's medical record with indication of the reasons and timing of the physical restraints. Records must be made after the physical restriction as well. The force shall be applied proportionally whilst

binding the patient, so that it does not grow into violence. Supervision of Physical restriction is the responsibility of the heads of the short-term and long-term departments, and the control on the implementation of the order shall be carried out by the clinical director of the Centre.

The monitoring revealed that the systematic character of the breaches of the legislative requirements for the physical restriction in the facility. According to surveys of patients, they are often subject to 'fixation' for a long time, during which they are left without adequate oversight. According to the patient, because of the lack of supervision, they often manage to release themselves. In addition, a long restriction via the sheets results in various types of injuries.

According to one patient, he once demanded release from the physical restraints to go to the toilet, after being restrained for long time, which was rejected by the staff and he had to satisfy the physiological needs in bed. In the view of the Special Prevention Group, this is unacceptable and constitutes degrading treatment.

The monitoring revealed significant shortcomings in the process of keeping the log of physical restraints and filling the patients' medical records, in the view of their compliance with the logs of the doctor on duty. The records are less informative on why it was necessary to apply the physical restraint and whether there was possibility of using alternative measures. For example, a patient's medical record states reasons for his physical restriction in the following way: 'he was jumping on the window frames and pulling eyes'. Record does not contain information as to why the alternative measures could not be applied. It should be noted that, in this case physical restraints were used in parallel with the chemical restrictions. In particular, the patient has been injected "tizertsin" and "CARDIAMINE" at 17:30. He was injected again with "tizertsine", "Cordiamine", "Relanium "and" haloperidol" at 18:00. The same patient on February 3, 2015, in the first half has been injected with "Cordiamin", "Relanium", "Aminazin", "haloperidol", and later - "Cordiamin", "Relanium", "tizertsine" and "haloperidol".

According to the medical card of one of the patients the patient was physically bound on October 1, 2015, 04:00 am to 05:40 pm, but there is no record in the relevant physical restrictions log. In addition, the physical restrictions log states that on October 2, physical restraints were applied to the same patient, a fact which is not reflected in the medical card. The same is true of physical restraints on October 3 incident. According to the patient's medical record on October 5, the patients had a fixation strap as a result of injures received after being physically restrained, which is not specified in the physical restraints log.

Another patient, who was placed in a hospital for medical treatment voluntarily, was physically bound from 23:30 am to 00:15 pm, on which the medical record and the doctor on duty in the journal are silent. Accordingly, it is not clear what the cause of applying restraint was, whether the requirements established by law were met and whether it occurred under proper supervision.

In **Rustavi Mental Health Centre**, the monitoring team found the case of the physical injury of the patient, which was not fully documented. There is a log in the physical

restriction journal on 1 July 2015 about the use of the restraints on the patient. Physical restraint is also recorded in the patient's medical record and a nurse's dairy. The nurse's diary describes the injury of the patient, which is not specified in the medical card. Nurse's dairyholds the record that in the first half of the day the patient was calm, but in the evening he started aggressive actions, shouting, biting lips and hands, was not oriented in time and setting. When trying to escape he fell on the stairs, which is why his left eye area is injured. On 18:20 pm he was restrained with a physician's consent and underwent "tizertsine" injection of one ampoule. On 18.30, the patient received 1 pill of "Anapriline." The patient shouted, and cursed with abusive language. On 19:30 pm he was given "Relanium." After he turned relatively calm, on 19:55 he was released from restraints. He had difficulty to fall asleep, and on 22:30 he was injected 1 ampoule "tizertsine" and 1 "Cordiamine." it should be noted that there are no requisite 15 minute records in the physical restrictions journal to observe the dynamics of the patient. The Deputy Director noted that this case was considered suspicious by the administration and the incident was therefore, subject to the close study, but they could not identify physical abuse. No materials evidencing such study were submitted to the monitoring group.

In **A.Kajaia Surami Psychiatric Hospital,** the physical restraints log was studied, which encompassed three cases of physical restraints in 2015 without specifying dates. In one case, nurse's diary entry made on September 16, 2015 reads as follows: The patient became ill late at night, requested to be tied, the doctor on duty gave permission and "Aminazin" 4.0 ml, left for the cases of necessity was injected. The accident record is absent from the patient's medical card, since the last record on the card is dated September 15, 2015. This shows requirements of the law with respect to the physical restrictions are grossly neglected.

Acute Care Unit of Ghudushauri Republic Hospital registered 40 cases of physical restraints in 2015, for the majority of which the medical records are incomplete. It should also be noted that the monitoring group witnessed the fact of physical restriction of one of the patients. Female patient to whom staff referred as the "demential patient" was asking to go out, but the guards refused. The patient, who was hospitalized formally voluntarily, asked staff when she would be released to go home. Monitoring Group felt that the patient got agitated, when the staff asked her to calm down and began her manual binding. The head of psychiatric department immediately gave an indication to apply the physical restraints. Monitoring Group estimates that for that moment there was no legal basis of physical restraint and the decision was taken hastily, which in the end led to the patient's extreme agitation.

Agitated patient was taken to the second floor. When ascending the stairs, the patient resisted and there was a risk of physical injury to the patient. In the second-floor hallway the patient, for a while, sat on the floor near the wall, when due to the closeness to the wall there was a high risk of self-harm. The special concern of the monitoring group was caused by the fact that before reaching the place where she was supposed to be fixated the personnel had to drag the patient on the floor. The patient has been injected after being fixated on the bed and she calmed down after a little while. She was kept under constant surveillance.

The Special Prevention Group is concerned with the above accident. It believes that this case reveals an unjustified practice of applying physical restraint at this institution. The problem of hasty decision-making is apparent, if physical restraint is not urgently needed and there are other means of managing the case. At the same time, the problem of applying physical restraint safely and in a manner that does not undermine human dignity got revealed. The Special Prevention Group urges the staff to do everything in order to avoid such cases. It is essential that the personnel receive appropriate training and strict supervision exercised on the competent performance of their functions.

In the **National Center for Mental Health (Qutiri),** during the interviews with the Monitoring Group the patients were especially cautious when talking about physical and chemical restraints. The Special Prevention Group considered this as self-censorship. Interviews with patients revealed that physical restrictions 'are not applied as often as before', but they are still applied. The patients perceive this not as the procedure directed to their own safety and safety of those around, but as a method for securing obedience and/or punishment.

According to patients, there are cases when the physical restrictions and chemical restrictions (as they call 'tying', 'binding', 'injecting') are applied in combination in the degrading form and for long-term, when the bed-ridden patients have to satisfy their physiological demand in the bed with their clothes on.

According to the patients, they receive pills in the crushed form, and they do not know the name of the medications. If patients refuse to take the medication or request the information, complained about the side effects or it is noticed that they try to avoid taking the medication, the staff threatens them with injection. If they still refuse to take it, they are given an injection. Patients say that the staff (guards, nurses, orderlies) manually restricts the patient and the nurse administers an injection. If the patient attempts to resist aggressively, then physical restraint is applied in the corridor in front of other patients, in the ward or very rarely in the isolated ward. The Special Prevention Group finds such practices unacceptable. It is impermissible for security guards that are not adequately trained[65] to participate in applying physical restraint and forced injection process. It is equally unacceptable to apply physical restraint in front of other patients.[66] As regards involuntary medical interventions, it is worth noting that international human rights law standards generally call for avoiding involuntary medical intervention[67] in the absence of an informed consent, because it is at odds with the patient's personal autonomy.[68] Only in clearly and strictly exceptional circumstances defined by the law can

65 According to the European Committee for the Prevention of Torture, it is desirable to limit the function of security guards to the protection of the outside perimeter, because their presence in the units hinders creation of therapeutic environment. CPT Report to Georgian Government on the Visit in Georgia on 1-11 December 2014, para. 143.

66 *Ibid*. para 152.

67 The UN Convention on the Rights of Persons with Disabilities, Article 24 (d).

68 Dignity must prevail" – An appeal to do away with non-consensual psychiatric treatment World Mental Health Day – Saturday 10 October 2015, United Nations Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras, Available at http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=16583&LangID=E [last visited on 1 March 2016].

patients be subject to such intervention.[69]

Patients also claim that complaints on the living environment and conditions of the existing regime, uncomfortable questions to the staff, objection, application to human rights defenders can lead to physical and chemical restraints; If the patient resists to the staff, "the procedure" of physical restriction is long (e.g. Two days) or ends in isolation.

As a result of interviewing different patients on the physical restrains issue, the narratives obtained by the monitoring group are identical, but the requisite records of the cases of physical restriction in the physical restraint registration journal, medical cards and staff blogs are either non-existent or much less time is recorded.

According to the Physical restraint registration journal, one patient was restrained twice in 2015, in one case for 2 hours, and the second time for 2 hours and 15 minutes which does not correspond with the narrative of the patient. According to the patient, because the room was cold and the water was leaking, he entered the nurse room for heating; he expressed affective reactions and verbal aggression, when nurses gave him a warning, which resulted in his physical and chemical restriction (from 14:00 pm to next morning, 19 hours a day) and a month of isolation in the locked room. The staff did not give him access to a toilet and he had to pee in bed during physical restriction. He refused food in protest to the physical restrictions.

One patient describes physical restraint procedures similarly: when expressing discontent to the staff's and he "insists", he is tied with sheets in front of other patients in isolator or bedroom, and there were cases when the isolation with physical restriction lasted for 2 days and the patient had to pee in bed. He refused food in protest to the physical restrictions. Personnel did not change the urine soaked underwear and bed linen to any of the patients during their physical restriction.

Patients of the **Senaki Psycho-Neurological Hospital in-patient department** say that "they're never fixed"; "those who feel bad – get the injections and sleep." The nurse explained to the monitoring group, that the physical restraint log is empty, as they had no cases of physical restraint. The monitoring group has the impression that due to the use of the chemical restraints in the facility, there is no need for physical restraints.

No entries to the physical restraints log were made in 2015 in the **Acute Care Unit of the N5 hospital of Tbilisi.** Administration representatives state that physical restraints are used only with the extreme cases and are not applied almost at all. If application is unavoidable, it will be recorded in the relevant documentation. Instead of physical restraints, if necessary, agitated patients are placed in the 1 person Chamber under the special supervision conditions.

69 According to the European Committee for the Prevention of Torture, 'Patients should, as a matter of principle, be placed in a position to give their free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.' The European Committee for the Prevention of Torture, p. 84, para. 41.

Acute care unit of the **Republican Clinical Psycho-Neurologic Hospital (Khelvachauri)** has 3 isolation rooms, which have metal door grills and can be locked by padlocks. The isolation rooms, according to the personnel, are used to "calm the agitated patients, for therapeutic purposes", but the placement in these rooms is perceived as some form of punishment by patients.

Transfers to the isolation rooms are not recorded in medical logs. According to the staff, "officially it is the same department, so it's simple transfer from the chamber to chamber". In a few days, the patient is transferred back to his/her ward. One patient said she was "they transfer people from calm to agitated to intimidate them, they do the injections, block the lock, but they do not bind them."

Isolation room ("isolator") is also used at the **National Center for Mental Health**. The interviews with patients and the inspection show that patients are placed in the isolation room for a few days, which bearing in mind the conditions of the rooms causes the concern of the Special Prevention Group.

There is a clear trend in modern psychiatric practice in favor of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact;

the need for staff to be especially attentive. Isolation should never be used as a punishment. [70] It should be noted that according to CPT, the same obligations of documenting apply to seclusion in the isolation as to the other methods of physical restraint.[71]

According to the "Instruction for application of physical restriction methods on mental patients" established by Order #92/n of the Ministry of Labour, Health and Social Affairs dated 20 March 2007 Isolation wards need to be specially equipped to prevent the patient's self-inflicted harm. In the view of the Special Prevention Group, in the National Center for Mental Health and Republican Clinical Psycho-Neurologic Hospital, as well as in other mental health institutions, the isolation rooms are not specially and properly equipped and the patient placed in those room faces with a high risk of self-harm. In addition, the Special Prevention Group believes that the bars on the door and the window are unacceptable, both in terms of safety, and the disruption of the therapeutic environment and its' association with the prison and the punishment cell. Hence, placement of a person in such isolation room may amount to degrading treatment.

The Special Prevention Group is also concerned about the fact that despite the requirements that the use of the physical fixation and specialized isolation together with the duration of use of these measures, shall be duly reasoned and documented in accordance with Article 16 of the Law of Georgia on Psychiatric Care and similar requirements established by abovementioned instructions, the isolation of the patient is not in reasoned, properly documented and is applied for a long time in violation of applicable laws. Special Prevention Group calls on the Ministry of Labour, Health and Social Affairs, as well as the directors of psychiatric institutions, to take all necessary measures to eliminate the vicious practice. They also call not to use the isolation rooms before the proper infrastructure and special equipment to ensure the protection of the patient from self-harm and compliance with the legal requirements is not ensured.

Based on the foregoing, the Special Prevention Group came to the conclusion that the requirements of the rules and procedures of physical restriction are systematically breached. It was obvious that most of the institutions there is no clear system of registration of restrictions applied - in most cases the record of physical restraints on the use of physical restraint is made in the journals and not in the patient's medical record or - on the contrary. The requisite 15-minute interval monitoring record of the dynamics of the patient's condition is nowhere to be found in any record and sometimes the time is not set at start and end of application of physical restraints.

The Special Preventive Group deplores the fact that the physical restrictions are applied equally to formally voluntary and involuntary patients, which is also contrary to the CPT's position, according to which formally voluntary treatment of patients should not be subject to restraint. If physical restraint is necessary, the legal procedure of the review of the patient's status (voluntary / involuntary) must be immediately initiated.[72]

The Special Preventive Group believes that the instructions on the use of physical restraints should be broadened by adding instruction on the use of the chemical restraints.

70 The European Committee for the Prevention of Torture, standards, para. 49.

71 *ibid*, para. 50.

72 CPT Report to Georgian Government on the Visit in Georgia on 1-11 December 2014, para. 151.

In addition, regular training should be provided in agitated patient management, tension de-escalation and restriction techniques, which should involve the whole staff (doctors, nurses, nurse's aides); Principles developed should be regularly reviewed / updated. It is very important that both staff and administration officials are involved and support the creation of the guidelines. The hospital's management must exercise regular supervision of the systematic implementation of these principles into practice. In this part, the breaches by the staff shall be followed by an appropriate response.

The Special Preventive Group also believes that patients shall be informed on a regular basis in the language they understand (written as well as oral form) about the appeal structure of physical and chemical restraint procedures applicable in the establishment. Such information will help patients (and their representatives) to understand the justification of physical restraint measures. This is important in so far as the physical restrictions are currently perceived by patients as a form of punishment. Awareness shall be increased to promote the change of this perception. Also, it is important that the staff talk to the patients who were subject the physical restrictions and / or those who have witnessed the use of physical restraint at the end of the procedure. This will help the doctor-nurse-patient relationship and therapeutic action, and also, presumably, will allow the patient to articulate their feelings and emotions which led to the physical restraint, which could lead to a better understanding of the behaviour of the patient by the staff.

RECOMMENDATIONS

RECOMMENDATIONS TO THE MINISTER OF LABOUR, HEALTH AND SOCIAL AFFAIRS

- Amend the "Instruction for application of physical restriction methods on mental patients" established by Order #92/n of the Ministry of Labour, Health and Social Affairs, dated 20 March 2007 to include the following: the maximum length of application of physical restriction; recording obligation regarding physical restraint, injuries suffered by including the patient and / or staff of in the process on a special register (special register); Special Registry (special journal) form; Detailed instructions for the implementation of physical restraint; the specific characteristics of the means to be used for Physical restraints; regulation of the place and who may be present during the process of the physical restrictions; requirements towards the isolation room; the video surveillance system-related issues during the process of physical restriction; the obligation to inform the patient by the hospital's staff on the right to appeal

- take all necessary measures not to use the isolation rooms before the proper infrastructure and special equipment to ensure the protection of the patient from self-harm and compliance with the legal requirements is not ensured

- the creation of system of adequate supervision and response to breaches of the rules of physical restraints, isolation and chemical restrictions
- to define the list of mandatory training, for the personnel involved in physical restriction procedure
- Organize trainings on the issue of physical and chemical restraints and develop instructions on chemical restriction

PROPOSAL TO THE PARLIAMENT OF GEORGIA

- Amend the Law of Georgia on Psychiatric Care and provide the definition chemical restrictions, and the rules and procedures of its use as the, as well as determine that the Ministry of Labour, Health and Social Affairs adopt the detailed instruction on the use of chemical restrictions
- Amend the Article 16 of the Law of Georgia on Psychiatric Care and to determine the maximum duration of physical restraint and the obligation to record the information in a special register and obligation to apply the special requirements for isolation, physical restraint of the video surveillance system-related issues and disabilities after the hospital's staff and patients of the right to appeal, the obligation to inform the interview, the video surveillance system-related issues during the process of physical restriction and the obligation to inform the patient by the hospital's staff on the right to appeal
- Amend the Article 16 of the Law of Georgia on Psychiatric Care and determine that patients formally on voluntary treatment should not be subject to restraint. If physical restraint is necessary, the legal procedure of the review of the patient's status (voluntary / involuntary) the must be immediately initiated

TO THE DIRECTORS OF THE MENTAL HEALTH INSTITUTIONS

- Take all necessary measures to ensure that the physical restraint, isolation and chemical are used only as a last resort, when all other reasonable means prove ineffective and in any case will not be used to compensate for the lack of qualified personnel and for the comfort of the staff, or as a punishment
- Take all necessary measures not to use the isolation rooms before the proper infrastructure and special equipment to ensure the protection of the patient from self-harm and compliance with the legal requirements is not ensured; Also ensure that the patient does not occur in isolation for the failure of the staff to perform their duties, or to relieve the staff from performance of their obligations

- Ensure that physical restraint measures are used for as short period of time as possible
- Take all necessary measures to ensure that patients formally on voluntary treatment are not subject to restraint. If physical restraint is necessary, the legal procedure of the review of the patient's status (voluntary / involuntary) the must be immediately initiated
- Ensure that the relevant personnel undergo regular training in physical and chemical restraint procedure and de-escalation techniques and use strict control over the fulfilment of the requirements of the instruction and the practical implementation of the knowledge gained by the staff
- Ensure that the patient's physical restrictions do not occur in the presence of other patients, except in cases when the patient requires the presence of another patient
- Ensure that the patient, who was subject to the physical restriction is under constant supervision of the qualified employees who help them satisfy their physiological needs and control water and food intake
- Take all necessary measures to ensure that physical and chemical restraints and isolation are comprehensively recorded and documented in the patient's medical record and the special register (special register), as well as a doctor and/or nurse blogs by the appropriate personnel
- Ensure provision of the information on the possibility of appeal and interviewing of the patient after physical restraint is applied
- Undertake strict control on the due fulfilment of the duties by the staff in order to prevent inhuman and degrading treatment of the patients; in cases of the breach of the rules applicable to physical restraint procedure and ill-treatment of patients, react accordingly; in case of commission of actions containing a crime by personnel, duly refer to the relevant investigating authorities.

6. MATERIAL CONDITIONS – SANITARY-HYGIENIC CONDITIONS, THERAPEUTIC AND SAFE ENVIRONMENT

The European Committee for the Prevention of Torture emphasizes the need for securing adequate living conditions for patients and treating them with respect and dignity. Inadequacies in these areas can lead to situations falling within the scope of the term "inhuman and degrading treatment". It is necessary to create material conditions for patients that are conducive to their recovery and well-being, in psychiatric terms, a positive therapeutic environment. This is important not only for patients, but also for the personnel of psychiatric institutions. Besides, adequate treatment and care, both psychiatric and somatic, must be provided to patients, having regard to the principle of the equivalence of care.[73] Living conditions in mental health facilities should be as close as possible to normal living conditions of persons of similar age.[74]

Living conditions and quality of treatment is dependent on available resources. The European Committee for the Prevention of Torture emphasizes that the provision of certain basic necessities must always be guaranteed in institutions where the state has persons under its care and/or custody. This includes adequate food, heating and clothing as well as – in health establishments – appropriate medication.[75]

In order to evaluate the existence of positive therapeutic environment in mental health institutionsof Georgia, members of the Special Prevention Group checked 12 mental health institutionsin Tbilisi, Rustavi, Imereti, Samegrelo, Samtskhe-Javakheti and Adjara.

BEDIANI MENTAL HOSPITAL

73 Standards of the European Committee for the Prevention of Torture, p. 80, para 32, Georgian version available at http://www.cpt.coe.int/lang/geo/geo-standards.pdf [last visited 03 March 2016].

74 Resolution of the UN General Assembly on the Protection of Psychiatric Patients and Improvement of Mental Health, 17 December 1991, available at http://www.un.org/documents/ga/res/46/a46r119.htm [last visited on 3 March 2016].

75 Standards of the European Committee for the Prevention of Torture, p. 80, para 33, Georgian version available at http://www.cpt.coe.int/lang/geo/geo-standards.pdf (last visited 03.03.2016)

As a result of external and internal examination of the building of this institution, it may be concluded the entire infrastructure is old and dysfunctional. Material conditions are not conducive to health and well-building of patients.

The use of wood furnaces and coverage of windows with cellophane to keep the building warm is insufficient. Patients have individual beds, but the space allocated to each patient is less than standard 8 square meters.[76] Multi-patient units are overcrowded, with 4, 5 square meters per patient and sometimes even less.[77] There is limited free space in each unit. The distance between the beds is sometimes even less than a meter.

In the Unit for Male Patients, there are two rooms (No. 4 and 5) that are connected and are not isolated. No separate heating device is secured for these rooms. They are heated indirectly with heating devices installed in other rooms.

The conditions in units for male patients and in units for female patients do not correspond to the standards established by the Decree on Issuing Licenses for Medical Activities and Permissions for Opening Hospitals.[78]

76 Decree of the Government of Georgia of 17 December 2010 No. 385 about the Rules an Conditions of Issuing Licenses for Medical Activity and Giving Permissions for Opening Hospitals" Appendix no. 2.

77 For example, the unit for male patients includes 8 rooms (there are 2 patients in a 9,3 sq.m. room, 4 patients in a 15,7 sq. m. room; 11 patients in a 48, 16 sq. m. Room); In the unit for female patients, there are 5 rooms, (with 7 patients in a 24, 2 sq. m. Room; 8 patients in a 24 sq. m. room; 3 patients in a 17,5 sq. m. room, etc).

78 Decree of the Government of Georgia of 17 December 2010 No. 385 about the Rules an Conditions of Issuing Licenses for Medical Activity and Giving Permissions for Opening Hospitals".

The sanitary facilities in these units need to be repaired. In the unit for male patients, the sanitary-hygienic conditions are inadequate. In the units for female patients, the situation is better in this regard, but some repair and renovation needs to be done. Inviolability of personal space is not secured at sanitary facilities. The needs of the elderly patients and those with mobility restrictions are not properly taken into account.

Sanitary-hygienic conditions are satisfactory in the dining room and living room for male patients. However, it is still advisable to renovate these rooms. The infrastructure of the kitchen area needs to be repaired. The cooking equipment is old and sanitary-hygienic condition is far from being satisfactory.

Sanitary-hygienic conditions are not satisfactory in staff rooms. The room needs to be repaired. Sanitary hygienic conditions are inadequate in all storage rooms of the institution. Food is not properly stored. Laundry rooms are old and need to be renovated.

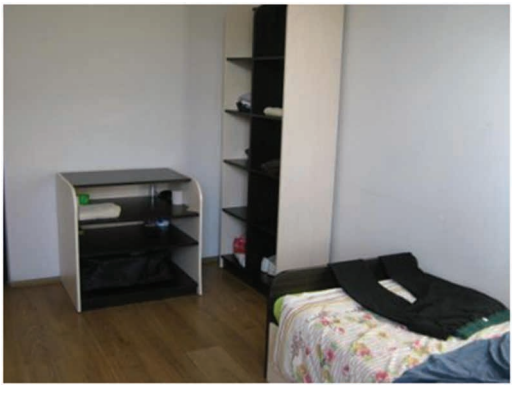
Sanitary-hygienic conditions are satisfactory in the room for art therapy. The environment necessary for art therapy is secured.

The hospital has a sufficiently large yard, with green spaces, but the problem lies in the small size of the living room and the absence of necessary equipment.

CLINICAL PSYCHONEUROLOGICAL HOSPITAL (KHELVACHAURI)

The infrastructure and sanitary-hygienic conditions of the first and the second buildings of the Clinical Psychoneurological Hospital considerably differ. The infrastructure of the first building is adequate. All the units are properly lit and ventilated. Sanitary-hygienic conditions are satisfactory. The infrastructure of the second building is in a deplorable state. It is not conducive to the health and well-being of the patients on an equal basis.

The third unit in the first, main building has been repaired. Patients accommodated in private rooms are allocated space in accordance with the standard.[79] The infrastructure of the second building is in a deplorable state. The walls are dirty. The interior is damaged due to moisture and needs to be repaired. Furniture is old and few. There is a bad smell in rooms. There are insects. Overcrowding is a problem.[80] There are extra beds in some of the rooms.



79 9,9 sq. meters per patient. Two-patient rooms are 14.24 sq. meters, three-patient rooms are 18, 75 sq. meters.

80 The unit for male patients has 9 units for acute care and 9 units for long-term stay (3 patients – 19 square meters; 4 patients – 21,59 square meters). In some rooms there are extra beds. For example, in one room (21,24 square meters), there are 2 patients and 3 beds. In another room (41,24 square meters, there are 6 beds and 5 patients).

The sanitary facilities are in a relatively better state in the first building than in the second building. In the second building, walls are damaged and repairs are needed. Walls and floors are damp and damaged in bathrooms.

The laundry room for the second building is in a separate building that is old and needs to be repaired. As regards the laundry room of the first building, washing machines installed there are in good shape. The common kitchen is also in a good shape. The music room is also satisfactory. Patients from the first, second and third units come to this room. They can watch movies and play the piano. There is a table. There are also some chairs and decorative flowers.

After rain, the personnel do not let patients go to the yard, since the holes in the ground are filled with water.

TBILISI CENTRE OF MENTAL HEALTH

As a result of external and internal examination of the building, it can be concluded that the entire infrastructure of the building needs to be repaired. The environment is such that it is not conducive to health and well-being of patients. All the rooms, bathrooms and toilets need to be repaired. The furniture is insufficient and most of it is damaged. There is no ventilation in the rooms. On a positive note, a central heating system works. The units for male[81] and female[82] patients are equipped with individual beds for each patient, but there is less than the required 8 square meters of living space per patient, with the exception of a few rooms.[83]

81 There are two rooms, with four beds each (one is 17,57 square meters and the other one is 23,24 square meters).

82 3 beds – 3 rooms – 17,00 square meters, 4 beds – 2 rooms – 34,00 square meters, 5 beds – 3 rooms – 32,690m^2, 7 beds – 1 room – 41,645 square meters, 6 beds – 2 rooms – 35,885 square meters).

83 The unit for male patients (7 rooms with 3 beds 24,760 square meters), the unit for female patients (2 beds, 4 rooms, 17,87square meters and 4 beds in 2 rooms 34,00square meters).

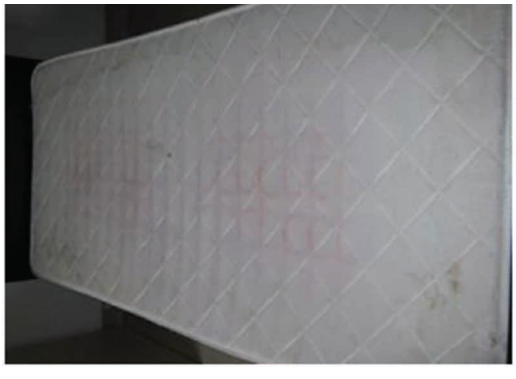
There is a shortage of sanitary facilities in units for male and female patients. Sanitary-hygienic conditions are not satisfactory. The sanitary facilities need to be repaired. There is a common bathroom for all units. There is a schedule for its use for different units. Toilets in mixed units for male and female patients work properly. The state of the common dining-room and storage rooms is satisfactory.

The institution has a good size yard that can be used for the purpose of recreational activities. The sports room is out of order and is not used.

GHUDUSHAURI NATIONAL MEDICAL CENTRE

The external and internal examination of the building allows concluding that its entire infrastructure needs to be repaired. The central heating is secured only in the corridors. Air conditioning devices are used for heating patient rooms. As water pipes get frequently damaged, the corridors get flooded.

It is to be pointed out that in units for male and female patients a standard 8 square meters per patient is secured. Sanitary-hygienic conditions in patient rooms are satisfactory, but the mattresses of some beds are dirty and damaged. Furniture needs to be repaired. The building needs to be renovated.



In sanitary facilities for men and women, ceiling and walls are damp and moldy. Floors are wet and dirty. There is air pump and natural ventilation in sanitary facilities. Flash toilets have no plastic seats, making it impossible to sit. The condiiton of the kitchen is normal overall, but walls are damp and in need for renovation.

The institution has a yard, with artificial ground cover. A table and chairs are under the roof. Patients can play table tennis in one of the rooms. They can also watch TV in a specially designated area, with couch and armchairs.

KUTAISI MENTAL HEALTH CENTRE

The examination of the building reveals that the environment and sanitary hygienic conditions are satisfactory. The building was repaired//renovated four years ago. The entrance to the building was adapted to meet the needs of persons with disabilities. There is a central heating system in the building. The yard is surrounded by a metal fence and is in good condition.

The overall condition of patient rooms is satisfactory. On a positive note, patients in units for male and female patients have individual beds and a standard living space of

8 square meters.[84] Conditions of shower facility and toilets are generally satisfactory. Shower facility for male patients and toilet of female patients need minor repairs. The kitchen is clean.

The Centre has a yard and a room for various activities to secure recreation.

CENTRE FOR MENTAL HEALTH AND PREVENTION OF DRUG DEPENDENCE

The external and inernal examination of the building showed that its entire infrastructure is in need for additional reparational works. In rooms for long-term stay, patients have individual beds, but they are not secured with the standard living space of 8 square meters.[85] Mattresses for beds are stained. Air conditioning devices are installed in all rooms, but most of them are out of order.

There is a rehabilitation room in the unit for a long-term stay. Due to a small size of the room, there is a lack of air if the number of patients in the room is large. The requirements related to living space are generally observed in acute care units, except for several three-patient units that are 15 square meters.

84 Two-patient rooms are 16, 27 square meters and 17.86 square meters.

85 Two-patient rooms are 14 square meters, three-patient rooms are 17, 88 square meters or 16,64 square meters.

The state of sanitary facilities is satisfactory, but repairs are still needed. Corners of the bathroom are covered with mold, due to moisture. Flash toilets have no plastic seats. As shower cabins are only half-isolated and are in the same space as toilets. This undermines inviolability of personal space of patients. The situation in the kitchen (sanitary-hygienic conditions) is satisfactory.

The conditions are inadequate in the storage room for medications. The refrigerator for storing medications did not work. There was no air conditioning and the temperature regime necessary for storing medications could not be secured.

There are rooms for joint activities. In the yard, there are volleyball net and basketball courts. There are also armchairs. The walls are decorated with paintings. Since the yard is between two buildings, it is not properly ventilated and does not get any sunshine.

N5 CLINICAL HOSPITAL

It may be concluded, based on external and internal examination of the building, that its entire infrastructure is in need for additional repairs. The existing environment is not conducive to the health and well-being of patients. The second unit of the hospital is divided into sub-units for adults and children.

The unit for adults is not properly ventilated. The rooms are properly lit. Heating of rooms is secured through air source heat pumps. In contrast to rooms, central heating is installed in corridors. The smoking room does not get properly ventilated. Not all rooms correspond to the living space standards.[86] The Unit for Children fulfills this standard.[87] It is also satisfactory in terms of securing lights and ventilation. There is a small playground. Food is delivered with plastic containers and vacuum flasks. The dining room is in good shape.

The Adult Unit has sanitary facilities separately for men and women. There is no natural ventilation in the sanitary facilities for female patients. In sanitary facilities for male patients, a few toilet seats are damaged. The walls are covered with mold. The sanitary facilities are in order in the unit for children. Sanitary-hygienic conditions are adequate.

Patients do not have an access to the yard of the institution. There is no special room for joint activities, except for the Unit for Children.

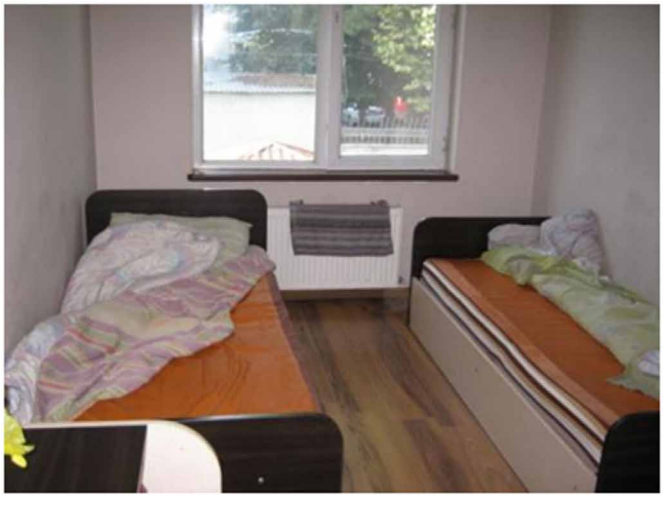
86 Rooms are between 12, 5 and 17 square meters. There are two beds in each room.
87 Each room is 17 square meters, with two beds.

RUSTAVI MENTAL HEALTH CENTRE

The external and internal examination of the building of this institution allows making a conclusion that the entire infrastructure is satisfactory. The entrances to the yard and to the ambulatory care unit are equipped with wheelchair ramps. Central heating system works in the corridors and in the sanitary facilities. Air-conditioning devices are available in all patient rooms. The living space per patient corresponds to the standard.[88] Sanitary-hygienic conditions are generally satisfactory in patient rooms.

Sanitary-hygienic conditions in bathrooms and toilets are satisfactory, but the toilet on the first floor is not properly ventilated. The flush toilet in the sanitary facility for female patients does not have a plastic cover.

The Centre has a common dining room in a good condition.



88 The room that is 10,63 square meters is for 2 patients.

Recreation room is organized in the corridor of the second floor. The Centre also has internal yard for patients.

"UNIMED KAKHETI" TBILISI REFERRAL HOSPITAL

The entire infrastructure is old and in disrepair. It is not conducive to health and well-being of patients. There is a moisture problem in most rooms in the northern part of the building. The mirrors are missing from the doors of some patient rooms. All door locks are broken. Windows are closed at all times and hence there is no natural ventilation. Artificial ventilation is not secured. There is no sufficient artificial light in patient rooms. Most of the light bulbs do not work. They can be turned on and off only from outside the room.

Living space for each patient is 8 square meters as required. Even though mattresses of beds are stained and damaged. Sanitary facilities need to be repaired. In bathrooms, inviolability of personal space is not secured.

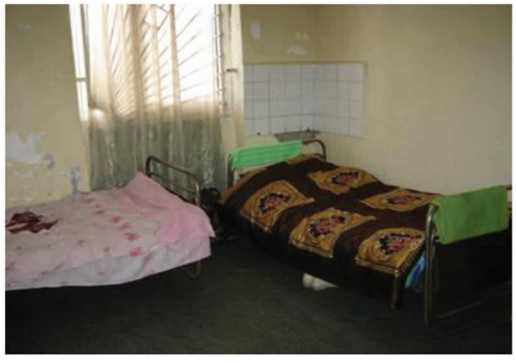
The hospital has a yard, with some greenery. However, there are no chairs and other equipment to secure adequate recreational environment.

SENAKI INTER-DISTRICT PSYCHONEUROLOGICAL DISPENSARY

The entire infrastructure of the building is old and in disrepair. This does not facilitate health and well-being of patients. The building was repaired in 2002, but moisture damage can be observed on the walls inside and outside. The sewerage pipe is damaged and leakage causes a contamination of the yard. Medical and other remains are thrown out into the yard.

The walls of patient rooms are damaged. There are holes at the edges of floors. Living space per patient is inadequate,[89] except for a few rooms.[90] Light switchers areoutside patient rooms and are controlled by the personnel.

89 E.g. 3 patients in a 20 sq. m. room, five patients in a 26 sq.m. room, etc.
90 One patient in a 16 sq. m. room, three patients in a 32 sq. m. room, etc.



The main storage room for medications is at the pharmacy on the first floor, but the Monitoring Group found expired medications in the room of the nurse. The walls in the lab for conducting tests (full blood exam, glucose test, syphilis test) are damp. At the time of monitoring, there was no sterilizer in the lab.

There are sanitary facilities on both floors, but hot water is available only on the first floor. Walls are damaged with mold. Only cold water is available for washing hands. Both toilets are ventilated with small windows. Water basin for flushing water is out of order.

The laundry room is next to toilets. Moisture damage can be observed on the walls. There is no hot water in the kitchen and dishes are washed with water warmed up with the gas stove. This does not allow having adequate sanitary-hygienic conditions. The situation in the kitchen and dining room is generally satisfactory.

The hospital has a yard, with inadequate sanitary-hygienic conditions. It is not equipped with armchairs and other furniture. This hinders creating recreational environment.

The entire infrastructure of the building is old and in a state of disrepair. This does not help secure health and well-being of patients. The buildings were last repaired approximately twenty years ago. Coal is used for heating. At the time of monitoring, none of the buildings were heated.

Patient rooms are not artificially lit and heated. Due to the absence of thermal insulation, cold gets into the rooms. There is moisture damage on the walls. Furniture is old. Sanitary-hygienic conditions are not satisfactory. Smell in the rooms is unpleasant. The unit for male patients is overcrowded. Living space per patient does not correspond to the standard.[91] Furniture and generally the environment is the same in all rooms.

Sanitary facilities are in bad conditions. The infrastructure is in a state of disrepair. Sanitary-hygienic conditions are inadequate, except for one toilet for male patients that was renovated a year ago but still does not function.

91 For example, eight patients are located in a 35, 74 sq. m. room; 9 patients in a 35, 26 sq. m. room


The laundry room is old and in a state of disrepair. Walls and ceiling of the dining room are dampened. The floor is dirty. Sanitary- hygienic conditions are not adequate.


Taking into account inadequacy of sanitary-hygienic conditions in the buildings, the yard is the only place for rest and recreation.

ACADEMIC B. NANEISHVILI NATIONAL CENTRE FOR MENTAL HEALTH

The infrastructure of most buildings of the Centre is old and in a state of disrepairs. This does not help secure health and well-building of patients. They are kept under conditions violating their dignity.

Living space per patient is insufficient[92] except for a few rooms.[93] (The standard requirement is 8 square meters per person). Rooms for multiple patients are overcrowded. The actual living space per person is 4 square meters or even less.[94] The beds are made of metal and in some instances, patients have no mattresses. One may notice moisture damage on the walls of most rooms and corridors. These need to be repaired.

When it rains, the ceiling leaks. Doors are damaged. Central heating system is installed, but does not work in most units. Centralized ventilation is not also secured. Sanitary-hygienic conditions are not adequate in patient rooms.

The interior and equipment is old and needs to be repaired. The walls and ceilings are dirty. Sanitary-hygienic conditions are unsatisfactory. Ceilings leak. Walls are covered with mold. Hold water is available only in bathrooms.

92 10 patients in a 25, 27 sq. m. room, 10 patients in a 33.19 sq. m. room.

93 4 patients in a 52, 8 sq. m. room, 4 patients in a 51, 9 sq. m. room.

94 In the Unit for Male Patients, there are 8 rooms (2 patients in a 9,3 sq. m. room, 4 patients in a 15, 7 sq.m. room, 11 patients in a 48,16 sq. meters room). In the Unit for Female Patients, there are 5 rooms (7 patients in a 24,2 sq.m. room, 8 patients in a 24 sq. m. room, 3 patients in a 17,5 sq. m. room).

The situation in the kitchen is satisfactory, but it is difficult to keep kitchen clean. Part of cooking equipment is old.

The units for patients undergoing forcible treatment and patients transferred from penitentiary institutions for involuntary psychiatric care are isolated from the rest of the hospital. Such patients have a separate yard surrounded with a metal bar fence and roofed with metal bars.

As regards the rest of the hospital territory, the buildings are located in the yard with the greenery and environment appropriate for the recreational activities. As found out as a result of the visit, only the patients that clean the yard are allowed in. Other patients spend most of the time the buildings and in the small area surrounded with a metal net.

RECOMMENDATIONS TO THE MINISTER OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Take all necessary measures to repair the buildings of Bediani Mental Health Hospital, Adjara Clinical Psychoneurological Hospital (the second building), Senaki Inter-district Psychoneurological Dispensary, "Unimed Kakheti" Tbilisi Referral Hospital, Al. Kajaia Surami Psychiatric Hospital, Naneishvili National Centre for Mental Health; to secure necessary therapeutic environment.
- Take all the necessary measures to ensure that infrastructure is renovated and positive therapeutic environment is created at Gldani Mental Health Centre, Ghudushauri Mental Health Hospital, Centre for Mental Health and Prevention of Drug Dependence, N5 Clinical Hospital, Rustavi Mental Health Centre.
- Take all measures necessary to secure psychiatric care for all patients on an equal basis.
- Take all measures to control compliance of conditions at mental health institutions with the standards established by the Decree about Issuance of Licenses for Medical Activities and Permissions for Opening a Hospital.

- Take all measures to ensure that each patient of a mental health institution is secured with sufficient living space, in accordance with the standards.
- Take all measures to equip all institutions with necessary furniture, including bedside tables and closets to ensure that patients have the possibility to store personal items.
- Take all necessary measures get rid of common rooms with multiple patients.
- Take all measures to secure necessary lighting, heating and ventilation for patients in all mental health institutions.
- Take all measures to secure adequate sanitary-hygienic conditions.
- Secure taking into account needs of the elderly patients and patients with disabilities.
- Take all measures to secure provision of necessary facilities in patient rooms and recreational areas in all mental health institutions in order to stimulate patients.
- Take all measures to guarantee proper sanitary facilities and secure inviolability of personal space.
- Take all necessary measures to provide food to patients in satisfactory sanitary-hygienic conditions.

7. LEGAL GUARANTEES FOR PROTECTION

7.1. HOSPITALIZATION AND INFORMED CONSENT

The State Parties to the UN Convention on the Rights of Persons with Disabilities undertake to require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent, by raising awareness of the human rights, autonomy and needs of persons with disabilities, through training and the promulgation of ethical standards for public and private health care.[95]

The UN Special Rapporteurs on the Rights of Persons with Disabilities and on the Right to Health called on states to eradicate any form of non-consensual psychiatric treatment, to put an end to arbitrary detention, forced institutionalization and forced medication, in order to ensure that persons with developmental and psychosocial disabilities have their human rights respected. According to the Rapporteurs, the concept of 'medical necessity' behind non-consensual placement and treatment falls short of scientific evidence and sound criteria. Non-consensual interventions are very often misused and overused, turning exceptions into rule. The legacy of excessive use of force in psychiatry is against the '*do no harm*' principle ('*primum non nocere*') and should not be accepted.[96]

In a system of psychiatric care that is based on personal dignity and inviolability, informed consent of patients must be a precondition for providing treatment. According to the European Committee for the Prevention of Torture, consent to treatment can be regarded as free and informed only if it is based on full, accurate and detailed information about the patient's condition and the treatment proposed.[97]

According to the decicion of the Constitutional Court of Georgia, 'modern international law requires taking into account the will of patients with cognitive or other disabilities to a maximum extent possible and establishes a range of mechanisms to minimize interference with their personal autonomy. National legislation of a large number of states shares this approach and envisages an obligation to take into account the views of the person regarding the questions of placement in a medical establishment and even more frequently, medical treatment. Mental disorders may influence ability to give consent to medical treatment. At early stages of treatment of grave forms of diseases, a patient may not be able to give an informed consent, but subsequently it may get that ability back. Whenever an adult is able to give free and informed consent regarding interference with his/her health, such interference should be carried out only with his or her consent. In case of grave form of illness, when an adult is unable to give free and conscious consent,

95 Article 25 (1) (d), Convention on the Rights of Persons with Disabilities.

96 Dignity must prevail" – An appeal to do away with non-consensual psychiatric treatment World Mental Health Day – Saturday 10 October 2015, United Nations Special Rapporteurs on the rights of persons with disabilities, Catalina Devandas-Aguilar, and on the right to health, Dainius Pûras.

97 Standards of the European Committee for the Prevention of Torture, para 41.

interference may still be carried out, if it is in the best interest of this person.[98]

Under Georgian Law on 'Psychiatric Care' (Article 4 (j)), informed consent is consent of a person or his or her legal representative to psychiatric treatment, given on the basis of full, objective and comprehensible information about illness and medical intervention, provided in a timely manner. Under Article 15 (1) of the same law, hospitalization is voluntary, except for cases envisaged by Articles 16 (methods of physical restraint), Article 18 (Involuntary inpatient Psychiatric Help) and Article 22^1 (forcible psychiatric treatment). A patient is placed in an adequately licensed mental health institution, if warranted by his or her medical condition. Under Article 5 (c), a patient has the right to get full, objective and comprehensible information about the illness and planned treatment in a timely manner. If a patient is unable to make a decision, information will be given to his/her legal representative and in the absence of the latter, to his/her relative.

The Monitoring Group found that in practice, patients give consent without first getting adequate explanation, full, objective, comprehensible information in a timely manner. Informed consent[99] is essential to avoid involuntary placement of a patient in a mental health institution. This entire procedure is directed at having a consent form with a signature included in medical files to meet this formal requirement.

The survey of patients conducted by the Centre for Mental Health and Prevention of Drug Dependence revealed that informed consent is given on paper, but not in practice. Particularly, patients are not informed about their rights, essence, methods and duration of treatment. No explanation is given about the function of informed consent to treatment and factual/legal consequences of giving consent or refusing treatment. As reported by one patient, at the time of arrival at the institution, he was told that he had to sign papers to agree to a ten-day stay. It was not clear to the patient why he was not allowed to leave the hospital after the indicated term expired.

Another patient indicated that he wanted to be discharged. He had not given consent to voluntary treatment. There was no judicial order imposing involuntary psychiatric treatment. The medical files of the patient were checked to verify this information. The patient was hospitalized on 15 September 2015 by emergency medical personnel and underground patrol police. He was diagnosed with mild mental retardation, with impairment of behavior and psychotic tendencies (F70.1). Informed consent form included in the medical files was not signed. There was no court authorization for hospitalization to undergo involuntary psychiatric treatment. Accordingly, there was no legal basis for keeping this patient in the mental health institution.

Under Article 17 (3) (b) of Georgian Law on Psychiatric Care, a patient placed in a medical establishment for voluntary treatment is to be discharged at his/her request at any stage of treatment. However, the survey revealed that wishes of patients are systematically disregarded and they are kept in mental health institutions forcibly.

98 *Irakli Kemoklidze and David Kharadze v. Parliament of Georgia*, the Decision of the Constitutional Court, 2nd collegium, №2/4/532,533, 8 October 2014, para. 50.

99 Medical Documentation Approved by the Order No.108/N of 19 March 2009 of the Minister of Labor, Health and Social Protection of Georgia – Form NIV-300-12/a – Informed consent of a patient on medical care.

In a psychiatric division of the 5th Clinical hospital, one patient, undergoing voluntary psychiatric treatment according to medical records, wanted to leave the hospital due to improvement of conditions. When interviewed, he declared that the doctor neither lets him leave the hospital nor explains how long he will remain hospitalized.

In the **National Centre of Mental Health (Qutiri),** in a civil psychiatric division, absolute majority of patients with severe psychosis and with chronic mental disorder are hospitalized on a voluntary basis (medical files of each includes an informed consent form), but according to the interviews, patients are not allowed to leave the Centre, notwithstanding their demands.

In **Surami Psychiatric Hospital**, most patients either do not know what they signed or assert that they had to sign an informed consent form, because doctors threatened them with a court-imposed six-month medical treatment if they refused. A number of patients could not clearly understand the essence of informed consent to treatment when interviewed, due to their own mental state. Some of them were fully aware of their state, wanted to be discharged to continue treatment on an outpatient basis and did not understand the reasons for the refusal. One patient that has been hospitalized since July 2015 said that he wanted to go home, but did not know why he was not allowed to, did not know "what he was treated for and what medicine he got", did not know his rights.

In the **Clinical Psychoneurological Hospital (Khelvachauri),** all medical cards include an informed consent form, but medical documentation frequently shows that patients are brought by the medical emergency units or patrol police. It is unclear why patrol police or medical emergency unit was needed if the patient gave consent to hospitalization. The doctors explained to the Monitoring Group that they 'convince patients to agree to treatment.'

It is worth noting that based on medical records, no patient was hospitalized involuntarily. This was notwithstanding the fact that a few patients requested to be discharged. According to the Special Prevention Group, in such cases, a patient should either be discharged from a hospital immediately or if health state warrants involuntary hospitalization for psychiatric treatment, a court should be requested to authorize such hospitalization.[100]

The representatives of the hospital Administration explained to the Monitoring Group that 'they could not let the patient leave if there was no one to accompany them' or 'the patient had nowhere to go'. According to the Special Prevention Group, a timely and adequate intervention is necessary in such instances in order to avoid keeping a patient hospitalized without any medical necessity[101] and without any legal basis.[102]

100 Articles 17 (4) and 18 of Georgian Law on Psychiatric Care

101 The UN Committee on the Rights of Persons with Disabilities recommends the state party to review its laws that allow for the deprivation of liberty on the basis of disability, including mental, psychosocial or intellectual disabilities […] to adopt measures to ensure that healthcare services, including mental healthcare services are based on the informed consent of the person concerned. Concluding Observations on Spain (2011), CRPD/C/ESP/CO/1, para. 36, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fESP%2fCO%2f1&Lang=en [last visited on 5 March 2016].

102 UN Committee against Torture recommends that the State party "take measures to ensure that no one is involuntarily placed in mental health institutionsfor reasons other than medical […] ensuring

The Monitoring Group expresses concern that voluntarily hospitalized patients report about not being allowed to take walks in the yard or leave the territory of the medical establishment temporarily.

According to Article 18 (1) of the Georgian Law on Psychiatric Care, involuntary hospitalization for psychiatric treatment is appropriate when a patient is unable to make a conscious decision because of mental disorder and it is impossible to treat him/her without hospitalization, and also if the delay in providing treatment creates a threat to life and/or health of this patient or other person; the patient must suffer considerable property damage as a result of his/her own action or inflict such damage on others.

The necessity for involuntary hospitalization for psychiatric care is determined by a doctor of emergency medical service or other adequately certified doctor. Law-enforcement authorities are obliged to place the patient in a psychiatric institution if requested. A doctor on duty makes a preliminary decision about involuntary hospitalization. Involuntary hospitalization starts from the moment of placing the patient in a hospital. Within 48 hours from that moment, the Committee of Psychiatrists must examine a mental state of the patient and decide on appropriateness of involuntary hospitalization. For the decision regarding involuntary hospitalization to be reached, majority of members of this Committee should regard it necessary. If the votes are divided, the decision is made by a clinical director of a psychiatric institution. If the latter is not present, the decision should instead be made by a properly authorized person that replaces him. Dissenting views of psychiatrists will be attached to the decision of the Committee.

If the Committee of Psychiatrists concludes that the requirements envisaged by Article 18 (1) are fulfilled and involuntary hospitalization is necessary, management of the mental health institution addresses a court with the request for authorizing such hospitalization within 48 hours from the moment of placing the patient in that institution. The patient, his/her legal representative and in the absence of such, his/her relative will be informed about the Committee's decision. If the patient is a foreign citizen, the respective diplomatic representation will be informed. The court is obliged to examine this request within 24 hours of its receipt, in accordance with the Code of Administrative Procedure and decide on involuntary hospitalization. It is essential to secure participation of the patient in the hearing. The legal representative of the patient or his/her relative and a lawyer represent him/her before the Court. If the patient does not have a lawyer, a public counsel is appointed.

Judicially authorized involuntary hospitalization is warranted as long as the relevant criteria remain fulfilled, but it cannot be extended beyond a six-month term. The Committee of Psychiatrists is obliged to review the appropriateness of continued hospitalization for psychiatric treatment every month.

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that hospitalization for medical reasons is decided only upon the advice of independent psychiatric experts and that such decisions can be appealed; UN Committee against Torture, Concluding Observations about Turkmenistan (2011) CAT/C/TKM/CO/1, para. 17, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CAT%2fC%2fTKM%2fCO%2f1&Lang=en [last visited on 5 March 2016]

The results of monitoring reveal that staff of mental health institutions prefer to obtain consent of patients at the early stage of hospitalization and subsequently, neglects their right and wish to leave the hospital. Importantly, consent to hospitalization is obtained by unethical means, specifically, with the 'threat' of requesting a court order that authorizing involuntary hospitalization for six months.

In the spirit of the UN Convention on the Rights of Persons with Disabilities, the Special Prevention Group calls for taking measures to ensure that psychiatric treatment is primarily provided based on informed, conscious consent of patients and the practice of involuntary hospitalization is finally, gradually eradicated. At the same time, the Special Prevention Group is worried about the vulnerable legal position of individuals that are hospitalized voluntarily according to medical records, but in practice, their hospitalization is involuntary. These patients remain beyond judicial control. They cannot protect their own rights and are subjected to medical interventions and physical restraint contrary to their will. The rights of these patients to personal liberty and inviolability are breached and under the conditions of arbitrary restrictions, they are frequently victims of inhuman and degrading treatment.

The Special Prevention Group considers that in a short-term perspective, in order to avoid the above described state of vulnerability of patients, it is necessary for the mental health institutions to address the court immediately if a patient undergoing treatment on a voluntary basis requests to be discharged from the hospital, but at that point, the criteria for involuntary hospitalization for psychiatric care are fulfilled. The Special Prevention Group also underlines that the risk of hospitalization without any grounds and/or the risk of long- term hospitalization exists even under judicial control. Accordingly, in a short-term perspective, until full eradication of the concept of involuntary psychiatric care, solid guarantees of protection must be created in this regard as well.

The Recommendation 2004 (10) of the Committee of Ministers of the Council of Europe to member states concerning the protection of human rights and dignity of persons with mental disorder lists the following conditions for involuntary placement in a mental health institution: a) the person has a mental disorder; b) the person's condition represents a significant risk of serious harm to his or her health or to other persons; c) the placement has a therapeutic purpose; d) no less restrictive means of providing appropriate care are available; e) the opinion of the person concerned has been taken into consideration.[103]

Article 18 of the Georgian Law on Psychiatric Care is reflective of the above listed conditions, but the Special Prevention Group regards the inclusion of the risk of infliction by the patient of substantial property damage to himself/herself or to other person among the criteria impermissible.[104] It is also important to take into account the opinion of the patient in deciding on his or her involuntary hospitalization in a mental health institution.

103 Recommendation 2004 (10) of the Committee of Ministers of the Council of Europe to member states concerning the protection of human rights and dignity of persons with mental disorder, Article 17(1).

104 Article 18 (1) (b) of Georgian Law on Psychiatric Care.

The monitoring revealed a range of problems related to the practice of involuntary hospitalization for psychiatric care. In a few instances, the requests to courts referred only to one criterion, while at least two criteria need to be fulfilled. Requests substantiating the necessity for involuntary hospitalization as well as court orders authorizing involuntary hospitalization are formulated identically, following the same pattern. Besides, prior hospitalization experience is frequently decisive in authorizing involuntary placement in a psychiatric institution. Some kind of 'presumption of illness' applies. The monitoring revealed that judges fulfill requests of mental health institutionsand authorize involuntary hospitalization. They readily accept opinions of doctors and take little interest in opinions of patients. Psychiatrists think that they are in a better position to determine what patients need and judges with no medical education should not rule contrary to their opinions. Under such conditions, especially if court proceedings involve assessment of appropriateness of prolonging involuntary psychiatric care, it is important to hear the views of an independent psychiatrist. According to the standards of European Committee for the Prevention of Torture, judicial decision regarding involuntary hospitalization is to be made taking into consideration a psychiatric opinion independent of the hospital in which the patient is placed.[105] The absence of this requirement in the Georgian legislation constitutes a significant shortcoming from the perspective of protecting the rights of patients and should immediately be corrected.

RECOMMENDATIONS

RECOMMENDATIONS TO THE MINISTER OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Examine cases of patients that according to medical files are undergoing psychiatric treatment on a voluntary basis, but in practice, are hospitalized against their will; take all the necessary measures to secure immediate discharge of patients, if a legal basis for involuntary psychiatric care is lacking.
- Take consistent steps to intensively develop services outside hospitals in order to reduce hospitalizations.
- Take all necessary measures to gradually introduce an exclusively consent-based model of psychiatric care.

RECOMMENDATIONS TO THE HIGH SCHOOL OF JUSTICE OF GEORGIA

- Provide training to judges regarding the issues of mental health and relevant international human rights standards.

105 The European Committee for the Prevention of Torture, Report on Finland, CPT/Inf (2009) 5, paras. 138-139, available at http://www.cpt.coe.int/documents/fin/2009-05-inf-eng.pdf [last visited on 20 March 2016].

RECOMMENDATIONS TO THE DIRECTOR OF THE SERVICE OF LEGAL AID

- Secure training of public counsels on issues of mental health and relevant international human rights standards.
- Amend Article 18 of Georgian Law on Psychiatric Care to introduce the obligation to obtain an opinion of a psychiatrist independent of the hospital in which the patient is placed when deciding on involuntary hospitalization for psychiatric care or extension of the hospitalization term.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Take all necessary measures to discharge patients undergoing treatment on a voluntary basis from the hospital at their request immediately, if there is no legal basis for involuntary placement for psychiatric care.
- Take all necessary measures to ensure that patients are given full, precise and detailed information in an understandable form about planned psychiatric care and consequences of refusing such care, at the time of hospitalization as well as subsequently, on a regular basis.
- Reinforce activities of social workers to facilitate discharges of patients from hospitals.
- Revise excessively restrictive conditions and regime of stay of patients undergoing voluntary treatment; Taking into account safety risks, secure their free movement inside the institution and also let them leave the institution for a short period of time.

PROPOSAL TO THE PARLIAMENT OF GEORGIA

- Remove Article 18 (1) (b) of the Georgian Law on Psychiatric Care, listing the likelihood of infliction of significant property damage by a patient upon himself or herself or upon another person as one of the criteria for imposing involuntary care.

7.2. THE PROBLEM OF LONG-TERM HOSPITALIZATION

The UN Committee on the Rights of Persons with Disabilities expresses concern about institutionalization of persons with disabilities and lack of community-based support services. It recommends states introduce support services and implement effective deinstitutionalization strategy, as a result of consultations with organizations of persons with disabilities.[106]

106 The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Spain (2011) CRPD/C/ESP/CO/1, paras. 35-36, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fESP%2fCO%2f1&Lang=en [last visited on 12.03.2016];

In addition, the Committee asks states to allocate more financial resources to secure community-based support to persons with disabilities.[107] Monitoring revealed significant problems and challenges in terms of fulfilling this request.

According to the Special Prevention Group, there are patients in mental health institutions that do not need intensive treatment, but do not leave because they either 'have nowhere to go' or their families are reluctant to take them home. Importantly, administrations of all institutions with units for prolonged stay[108] declare that such patients constitute 30-40 % of overall number of patients in such units.

Discharge is delayed even if according to medical files patients are treated on a voluntary basis and want to leave the hospital. It is clear that delays in discharging patients are not always due to their state of mental health. The problem of prolonged stay is es-

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on China (2012), para. 26, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/CHN/CO/1&Lang=En [last visited on 12.03.2016]; The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Argentina, (2012), para. 24, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/ARG/CO/1&Lang=En [last visited on 12.03.2016]

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Paraguay (2013), para. 36, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/PRY/CO/1&Lang=En [last visited on 12.03.2016]

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Austria (2013), para. 30, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fAUT%2fCO%2f1&Lang=en [last visited 12.03.2016]

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Sweden (2014), para. 34, available http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/SWE/CO/1&Lang=En [last visited 12.03.2016]

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Costa-Rica (2014), para. 30, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/CRI/CO/1&Lang=Sp [last visited 12.03.2016]

The UN Committee on the Rights of Persons wsith Disabilities, Concluding Observations on Azerbaijan (2014), para. 29, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/AZE/CO/1&Lang=En [last visited on 12.03.2016].

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Ecuador (2014), para. 29, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/ECU/CO/1&Lang=En [last visited on 12.03.2016].

The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Mexico (2014), para. 30, available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/MEX/CO/1&Lang=En [last visited on 12.03.2016].

107 The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on China (2012), para 26; The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Austria (2013), para. 31; The UN Committee on the Rights of Persons with Disabilities, Concluding Observations on Sweden (2014), para 36.

108 The European Committee for the Prevention of Torture voices the view that it is better not to have sections for prolonged stay in psychiatric institutions, since long-term treatment should be associated with psycho-social rehabilitation, to be secured in the institutions for social care. Only patients with acute psychotic conditions should be treated in psychiatric hospitals. Others should benefit from community-based services. ("Institutionalisation Versus Timely Discharge from a Psychiatric Institution (Factors that impede timely discharge)", document prepared by Mr Vladimir Ortakov, 2005, European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), available in English at http://www.cpt.coe.int/en/working-documents/cpt-2005-91-eng.pdf [last visited 13.03.2016]).

pecially acute in Bediani and Surami psychiatric hospitals and National Centre for Mental Health (Qutiri).

The doctors interviewed name a few reasons for prolonged stay: absence of support system for discharged patients, financial insecurity, and absence of institutions for prolonged care, geographic inaccessibility of outpatient care, inadequacy of community-based psychiatric services as well as lack of abilities to live independently.

Importantly, prolonged-stay patients (the ones that do not leave because 'they have nowhere to go' or the ones whose families do not want them back) manifest the so called institutional/hospitalism syndrome[109] and learnt helplessness. [110] In some instances, prolonged hospitalization deprives such patients of life skills and causes disabilities that make their rehabilitation into the society a long and difficult process.

Article 19 of the UN Convention on the Rights of Persons with Disabilities establishes the right of these persons to live independently and be integrated in the society. Their prolonged segregation constitutes a human rights violation, depriving them of the right to live independently in a society. The two biggest groups staying in mental health institutionsare individuals with mental disorders and intellectual/cognitive deficits.[111] Institution is not defined only by its size.[112] Institution is any place for isolation, segregation and/or concentration of persons with disabilities. The terms such as 'institutionalization' and 'institutionalized' are used to characterize persons that are placed in such institutions, often involuntarily and that are deprived of the possibility to make decisions about their own lives. Institutionalization reinforces stigma and prejudice that persons with disabilities cannot or should not participate in social life.[113]

Article 19 of the UN Convention on the Rights of Persons with Disabilities obliges the states to secure the equal rights of persons with disabilities and 'prevent their isolation or segregation from the society.'[114]

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109 Wright, E. R., Gronfein, W. P., & Owens, T. J.. (2000). Deinstitutionalization, Social Rejection, and the Self-Esteem of Former Mental Patients. *Journal of Health and Social Behavior*, *41*(1), 68–90. Retrieved from http://www.jstor.org/stable/2676361 [last visited on 13 March 2016].

110 Leite, L. C., & Schmid, P. C. (2004). Institutionalization and psychological suffering: notes on the mental health of institutionalized adolescents in Brazil. *Transcultural psychiatry*, *41*(2), 281-293.

111 Mansell J *et al*, Deinstitutionalization and Community Living – Results and Costs, Report, 2nd ed. (Canterbury: Tizard Centre, University of Kent, 2007) http://www.kent.ac.uk/tizard/research/DECL_network/documents/ [last visited on 13 March 2016].

112 Parker C. and Clements L, The European Union and the Right to Community Living: Structural Funds and the European Union's Obligations under the Convention on the Rights of Persons with Disabilities (Open Society Foundations 2012), http://www.opensocietyfoundations.org/sites/default/files/,europe-community-living-20120507.pdf; European Coalition for Community Living: Lost time, Lost Money, Lost Life, Lost Possibilities? (2010) 78, http://community-living.info/documents/ECCL; International Organization of Inclusion, campaign about Article 19 of the Convention on Rights of Persons with Disabilities, www.inclusion-international.org/home/inclusion-international-campaign-on-article-19/.

113 United States Supreme Court, *Olmstead v. L.C.,* 527 US 581 (1999).

114 Report of the UN Special Rapporteur on Torture, available at http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/ [last visited on 4 March 2016].

The National Preventive Mechanism envisages the norm according to which patients whose mental state no longer requires hospitalization in a mental health institution, but who remain hospitalized due to absence of conditions of care outside hospitals, should be assessed and de-institutionalized. National Preventive Mechanism calls the state for taking all necessary measures to change large mental health institutions with smaller, modernized institutions gradually, which necessitates developing community-based services of long-term care.[115]

RECOMMENDATIONS

RECOMMENDATIONS TO THE MINISTER OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Take all necessary measures to establish specific, differentiated programs of care and rehabilitation for prolonged-stay patients to gradually restore their life skills.
- Take all necessary measures to start the process of consistent assessment of medical needs and social conditions of prolonged-stay patients, especially the ones neglected by their families and gradually transfer them to protected residences for re-socialization.
- Work out deinstitutionalization strategy, with a special emphasis on securing long-term community-based residential care.
- Secure development of community-based services in order to reduce the need for hospitalization and create the network of services of care focused on patients.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Take all necessary measures to establish specific, differentiated programs for care and rehabilitation of prolonged-stay patients to gradually restore their life skills.

7.3. COMPLAINTS PROCEDURE AND INSPECTION

The existence of effective procedures for filing complaints and for inspection is particularly important in mental health institutions, because in such institutions the risk of violence and violations of fundamental human rights is high. According to the United Nations Committee Against Torture, each state party is obliged to prohibit and prevent

115 Shepherd G, MacPherson R. Residential care. In: Thornicroft G, Szmukler G, Mueser K, Drake RE, editors. *Oxford Textbook of Community Psychiatry*. Oxford: Oxford University Press; 2011. p. 178-187.

torture and other ill-treatment in all contexts of deprivation/restriction of liberty or control, such as prisons, hospitals, institutions that engage in the care of children, the aged, the mentally ill or the disabled. The obligation also extends to institutions and contexts where the failure of the state to intervene enhances the danger of privately inflicted harm.[116]

The obligation to prevent torture and ill-treatment extends not only to public servants but also medical personnel and social workers. The state must exercise due diligence and prevent human rights violations and if such violations are committed, must secure investigation, prosecution and punishments.[117]

According to Article 15(2) of the UN Convention on the Rights of Persons with Disabilities, the state parties must take effective legislative, administrative, judicial or other measures, to prevent persons with disabilities, on equal basis with others, from being subjected to torture or crucial, inhuman or degrading treatment or punishment. Under Article 16 (2) of the same Convention, the state parties must secure effective monitoring of all programs and arrangements created for persons with disabilities by independent bodies, in order to avoid exploitation, violence and abuse.

The UN Convention on the Rights of Persons with Disabilities recognizes the significance of access to justice. Article 13 of the Convention specifies the obligation of the state parties to ensure effective access to justice for persons with disabilities, through procedural and age-appropriate accommodations, facilitating their effective role as direct or indirect participants, including as witnesses, in all legal proceedings, including at investigative and other preliminary stages. The state parties should secure training for those working in the sphere of administration of justice, including police and prison personnel, to secure effective access to justice for persons with disabilities.

Under Article 5 (1) (g) of the Georgian Law on Psychiatric Care, a patient has the right to file a complaint/an application to the court and other state institutions. Article 5 (1) (f) envisages the right of a patient to a lawyer. The Administration of the psychiatric institution is obliged to guarantee that the patient meets his/her lawyer without presence of a third party, if mental state of the patient allows. The Law on Psychiatric Care envisages the right of the patient, his/her legal representative or in the absence of latter, a relative to appeal against a judicial order about involuntary hospitalization[118] as well as to challenge the appropriateness of resort to physical restraint before the court.[119]

Importantly, Georgian Law on Psychiatric Care does not regulate the procedure for examining complaints and exercising monitoring.[120] However, the State Agency for Regulating Medical Activities, a legal entity of public law which is a part of the Ministry of

116 General Comment no. 2 of the Committee against Torture (2007), para 15.

117 General comment No. 2, paras. 15, 17 and 18; See also Committee against Torture, communication No. 161/2000, *Dzemajl et al. v. Serbia and Montenegro*, para. 9.2; Human Rights Committee, general comment No. 20 (1992), para. 2.

118 Article 18 (14) of Georgian Law on Psychiatric Care.

119 Article 16 (6) of Georgian Law on Psychiatric Care.

120 In contrast, Prison Code of Georgia includes separate chapters on monitoring of execution of prison sentences (Chapter IV) and procedures for examining complaints (Chapter XVI).

Labor, Health and Social Affairs of Georgia, among other activities, controls the quality of medical care provided to patients by natural and legal persons, including care provided within the framework of state healthcare programs[121] and examines complaints filed by citizens. [122] The Agency of Social Services, a legal entity of public law, controlled by the Ministry of Labor, Health and Social Affairs also examines applications, complaints and proposals of citizens.

The monitoring revealed the problem of state supervision over provision of psychiatric care and protection of the rights of patients. The National Preventive Mechanism has a decisive role in this regard. However, according to the Special Prevention Group, taking into account the specific character of the mandate of the National Preventive Mechanism, it is essential to secure effectiveness of other state mechanisms of control.

The procedure for internal complaint and feedback is available in mental health institutions. There are also boxes for complaints. However, patients do not use this procedure and boxes. Patients interviewed do not know their rights. They also do not know whom to address with their complaints. According to the Special Prevention Group, measures must be taken to a) inform patients about their rights in an understandable language; b) create simple and effective procedure for examining complaints, taking into account special needs of patients; c) secure proactive monitoring over inpatient and outpatient care (within the framework of sectoral state control). The National Preventive Mechanism suggests that in determining the terms and other procedural questions within the framework of the procedure for examining complaints, it is necessary to take into account special needs of patients in mental health institutions and practical difficulties that they may encounter in implementing their right to complain.[123]

RECOMMENDATIONS

RECOMMENDATIONS TO THE MINISTER OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Secure the review of the existing system of state supervision over provision of psychiatric care and monitoring of protection of the rights of patients; to introduce a simple and effective procedure for examining complaints and an effective mechanism of state supervision over provision of psychiatric care and monitoring of protection of the rights of patients.

121 Under Article 7, Appendix no.11 (Mental Health) of the Decree no. 308 of 30 July 2015 of the Government of Georgia (State Program of Healthcare for 2015) (program code 35 03 03 01), the organ responsible for the implementation of the program is the Agency of Social Services, a legal entity of public law under the state control of the Ministry of Labor, Health and Social Protection.

122 Article 2 (3) (b) (c) of the Statute of the Agency of State Regulation of Medical Activity – a public law entity, approved by the Order of the Minister of Labor, Health and Social Protection of 28 December 2011 No. 01-64/N

123 Problems related to giving effect to the right to complain are examined in the Report of Public Defender of Georgia to the Parliament, pp. 188-190, available at http://www.ombudsman.ge/uploads/other/0/86.pdf [last visited on 13 March 2016].

- Regulate common intra-hospital procedure for the examination of complaints and feedback.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Inform patients about their rights, including through reinforcement of social services of mental health institutionsand through securing increased accessibility of information about the rights of patients and about services.
- Inform patients about internal and external procedures of complaint and feedback, including about the addressees of complaints, legal aid and also about sectoral monitoring organs outside hospitals.

PROPOSAL TO THE PARLIAMENT OF GEORGIA

- Amend Georgian Law on Psychiatric Care to regulate the procedure for examining complaints in clear terms and the foundations of supervision over provision of psychiatric care, monitoring of protection of the rights of patients, carrying out supervision/monitoring by sectoral bodies outside hospitals.

8. PSYCHIATRIC CARE

Under Article 4 (c) of the Georgian Law on Psychiatric Care, 'psychiatric care' involves a set of measures aimed at the examination of a person with mental disorder, treatment, prevention of aggravation of the illness, facilitation of social adaptation and integration into the society.

Under the State Program of Mental Health[124] (program code 35 03 03 01), hospitalization in mental health institutions for minors and adults covers hospitalization of patients with mental disorders, particularly when conditions are acute. This includes treating acute psychotic conditions or behavioral or affective symptoms that threaten life and health of patients or others; long-term treatment of patients with chronic mental disorders that suffer from serious impairments of psychosocial functioning and/or prolonged psychotic symptoms (including continued treatment of patients that were previously hospitalized due to acute conditions); securing medical treatment and additional services (protection and safety) for patients with respect to which a judicial decision about hospitalization for provision of forcible psychiatric care was made, in accordance with Article 191 of the Code of Criminal Procedure of Georgia. Additional services include supply of food, products of personal hygiene and urgent surgical and therapeutic dental services as well as psychosocial rehabilitation in cases of long-term hospitalization.

The mentioned program also envisages shelters for persons with mental disorders. This includes three meals a day, one of which is a three-course dinner, introducing and implementing programs of care and individual rehabilitation for beneficiaries, teaching life skills, providing adequate medical aid and psychological services, securing participation of beneficiaries in cultural events, depending on their abilities, including outside specialized institutions.

8.1. TREATMENT

8.1.1. DURATION OF TREATMENT AND THE PROBLEM OF RE-HOSPITALIZATION

When examining the standards of treatment of persons with mental disorders, the Special Prevention Group established that in most institutions, managers as well as personnel reduce 'treatment' to pharmacological therapy. This is inconsistent with the principles of modern healthcare that is based on biopsychosocial approach and on evidence.

The management of mental disorders in mental health institutionsis still based on pharmacotherapy, notwithstanding the recommendations of the National Preventive Mechanism,[125] those of the European Committee for the Prevention of Torture[126] as well as

124 Decree no 308 of 30 June 2015 of the Government of Georgia about the Approval of State Programs on Health for 2015.

125 Public Defender's Report for the Parliament (2012) available at http://www.ombudsman.ge/uploads/other/0/86.pdf [last visited on 17 March 2016].

126 Report of the European Committee for the Prevention of Torture, based on the visit of 1-11 December 2014, para 144.

the Guidelines for the Effective Management of Mental Disorders. There is no therapeutic environment in the buildings and care for recovery of patients. The medical model is pathology-oriented.

The intensive method of pharmacotherapy is probably related to the practice established in acute care units to discharge patients as soon as possible. According to a few doctors of such units, prompt discharge of patients is based less on medical conditions and more on financial resources allocated for managing such cases as well as the period of time optimal for spending these resources (value of each case – 840 GEL). The average time for stay in such units is between 10 and 21 days.

In the room of the Head of the Unit at the Centre for Mental Health and Prevention of Drug Dependence, the Monitoring Group found a board with names of patients, indicating the dates of admission and probable dates of discharge, with 10 days between the two dates. It is clear that within this period, in order to stabilize a patient's condition, medical personnel apply intensive medication-based treatment. However, it is questionable whether this 'pre-determined' timeframe is sufficient for managing acute phases. It is also unclear whether the treatment will be adequate after discharge from acute care units or transfer to the units for prolonged stay, since funds allocated for this type of treatment is almost two times less and amounts to 15 GEL a day per patient (450 GEL monthly).

At the **Centre for Mental Health and Prevention of Drug Dependence**, after undergoing a ten-day treatment at the acute care unit, patients are transferred to the unit of prolonged stay. Most patients interviewed at the unit for prolonged stay were still unstable and with acute conditions (rambling, auditory hallucinations, etc.). This allows questioning the appropriateness of limiting the stay of patients at the acute care unit to ten days. At the same time, the use of some psychotropic medications (e.g. Tisercin) does not substantially differ in acute care and prolonged stay units, showing that the scheme of medication-based treatment of patients does not substantially change with the transfer from one unit to the other.

Most patients interviewed at **Rustavi Mental Health Centre** declare that 'they will stay for 2 or 3 weeks and then be discharged'. This approach is probably also due to the funding scheme. This affects not only this institution, but also to all other institutions.

Based on the results of monitoring, the Special Prevention Group expresses concern about the practice of keeping patients with acute psychotic conditions in acute care units only for short terms. Quick discharge of patients from acute care units increases risks of re-hospitalization and negatively affects overall adequacy of psychiatric care. The risk of re-hospitalization exists because of low funding for long-term treatment (450 GEL a month) and deficit of adequate support services. According to the information provided by the Ministry of Labor, Health and Social Affairs of Georgia, there were 31 cases of readmission to hospitals in 2014[127] and 25 cases in 2015.[128]

127 This is used in a sense defined by the State Program on Mental Health.

128 Letter N01/1222 of 9 January 2016 of the Ministry of Labor, Health and Social Protection of Georgia

Re-hospitalization is generally recognized as an indicator of quality of services in a hospital sector.[129] For the purposes of mental health program, re-hospitalization can be defined as a placement of a patient in a hospital for the second time within seven days after discharge, with the diagnosis of the illness from the same nosologic category, except for the cases provided by Georgian Law on Psychiatric Care. This indicator of quality of service provided is calculated as follows: The total number of cases of re-hospitalization (during a. 7 days or b. 30 days) should be divided by the number of patients discharged from the hospital within the past 12 months.[130]

Readmission rate is an important indicator for assessing the system of integrated care in general. Research shows that better continuity of care is secured through good planning of discharge (with timely intervention of services outside hospitals), which significantly reduces readmission and improves subjectability to treatment after discharge.[131]

In fact, hospital readmission index shows whether treatment was adequate, whether problematic symptoms were eliminated and whether the state of the patient got stabilized so that he does not need to be hospitalized and also whether the patient is managed effectively after discharge.

According to the Special Prevention Group, time allocated for managing acute conditions of the patient (10-14 days average) is mostly insufficient to secure relatively stable improvement. Probably, conditions improved as a result of intensive treatment will quickly deteriorate, since stable remission is not achieved and after discharge, there is either no supervision at all or only low-intensity treatment, due to the lack of funds. Services outside the hospital setting are fragmented and under-developed and consequently, insufficient to maintain the improvement achieved. Consequently, there is a high risk of aggravation of conditions and of re-hospitalization.

The personnel of acute care units declares that the problem lies in inadequacy of services for persons discharged from hospitals, shortage of beds in units of prolonged stay and limited funds allocated for long-term services.

According to the Special Prevention Group, the funding methodology negatively influences treatment of patients placed in acute care units and prolonged stay units. This has bearing on the duration of treatment and its quality. Accordingly, the Ministry of Labor, Health and Social Affairs of Georgia should study the existing practice; strictly supervise the correlation between the length of stay and the degree of stabilization of acute conditions; increase funding for long-term treatment and revise models of financing, taking into account what kind of treatment is a priority.

129 Is the Readmission Rate a Valid Quality Indicator? A Review of the Evidence, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4224424/

130 Hermann RC, Mattke S, Somekh D, Silfverhielm H, Goldner E, Glover G, Pirkis J, Mainz J, Chan JA. Quality indicators for international benchmarking of mental health care. *Int J Qual Health Care*. 2006;18(Suppl 1):31–38. doi: 10.1093/intqhc/mzl025.

131 Steffen S, Kosters M, Becker T, Puschner B. Discharge planning in mental health care: a systematic review of the recent literature. *Acta Psychiatr Scand*. 2009;120:1–9. doi: 10.1111/j.1600-0447.2009.01373.x.

8.1.2. TREATMENT WITH MEDICATIONS

Monitoring reveals that in almost all institutions, when prescribing treatment for patients placed in those institutions voluntarily and involuntarily, medical personnel prefers to apply older generation anti-psychotic medications through administering injections (rather than giving pills) in large amounts and over extended periods of time, following the same pattern in all cases, notwithstanding the clinical picture. [132] At the same time, it is worth noting that there is no problem in terms of supplying these institutions with basic psychotropic medications. The only exception is **A. Kajaia Surami Psychiatric Hospital**.

The Special Prevention Group got an impression that 'pharmacological overload' of patients constitutes the main means of managing them. Cases are managed without any complex therapeutic structure. Involvement of patients in meaningful activities is not secured.

In the **National Centre for Mental Health (Qutiri),** the treatment is mostly medication-based, using old-generation neuroleptic medications (Haloperidol, Tisercin, etc). Second or third generation antipsychotic medications and new generation antidepressants are rarely used, especially in cases of long-term treatment.

Absolute majority of newly hospitalized patients get "Tisercin" together "cordiamin" as a rule and sometimes in combination with "dimedrol," through an injection. Medical records do not indicate reasons for administering medication by giving injections rather than by giving pills and for adding "cordiamin" and "dimedrol".

Subsequently (for 10-20 days on average) neuroleptic medications are administered by giving injections. Patients get about 2-7 injections a day. They do not know what medication they get. They are not informed by doctors about basic and side effects of the medications administered. Despite this, they describe the side effects of medications as followed: 'Medications were administered for 20 days and I was asleep all the time.' 'I could not stand up, sit or lay down, I could not sleep. I was like that.' 'You do not walk and you sleep and sleep'. 'I was asleep all the time and could not refuse injections, as I was afraid that the personnel would do worse.' 'I sleep day and night, I ask that they stop injections, but they do not do that.' The cases of medication overdose are frequent among the interviewed patients.

One of the patients (23 years old, Ds. F21) was given "tisercin" and "cordiamin" injections twice a day (4 injections) in the first two days after being hospitalized. For the following 17 days, all medications were administered as injections in muscles, 6-7 injections a day overall ("Haloperidol" 1 ml twice, then three times, "Aminazin" 2 ml twice and "Cordiamin" 2 ml twice). At the same time, he was not given medication for side effects of "haloperidol" (e.g. "cyclodol")

132 Standards of the European Committee for the Prevention of Torture, para. 40 (Regular reviews of a patient's state of health and of any medication prescribed is another basic requirement. This will inter alia enable informed decisions to be taken as regards a possible dehospitalisation or transfer to a less restrictive environment).

Another patient (29 years old, Ds. F71) was given "Aminazin" injection in the very evening of hospitalization. For the following 20 days, "tisercin" was administered through intramuscular injection (1 ml twice a day). He was simultaneously given average therapeutic dose of neuroleptic medication and corrector.

One of patients (41 years old, Ds. F20.0) was given "tisercin" (2 ml, twice a day) when hospitalized and subsequently, 4 injections were administered a day, for 7 days overall. In addition, "speridol" ("haloperidol") was administered (1ml twice), "tisercin" (1ml) and "cordiamin" (2ml).

One patient (36 years old, F20.0) got "haloperidol" injection (1 ml) three times a day, first together with "tisercin" and "cordyamin" injections and then in combination with "zopin" ("Clozapine") 100 mg pills.

After "tisercin-codyamin" injection, "haloperidol" was administered to a patient (28 years old, F 22.0) - 1 ml three times a day for ten days (together with corrector and 200 mg pills of "Zopin").

One patient (49 years old, F 20.0) was getting two neuroleptic medications, one of which is the first-generation neuroleptic ("psyzin", 30 mg a day) without corrector and 100 mg "clozapine" a day. There were side effects of medication-based treatment (extrapyramidal side effects, excessive sleepiness). The patient declared that these side effects were greatly disturbing, but doctors disregarded requests about changing the medications. No blood tests necessary for monitoring the side effects of "clozapine" (agranulocytosis) were carried out.

There have been isolated instances of combined treatment with 3-4 neuroleptic medications. The following are the examples:

One patient was given the pills of "Trifluoperazine" 30 mg, "Zopin" ("Clozapine") 300 mg, "thioridazine" 100 mg. In combination with these medications, 4, 0 ml "Aminazin" injections were administered for a month.

One patient (37 years old, Ds. F32.3) "tisercin" and "cordiamin" were administered parenterally when hospitalized. In months that followed, four different psychotropic medications were administered a day, also two neuroleptics with different chemical structure ("haloperidol" 20-30 mg, "zopin" 200 mg or "tisercin injection" 1 ml three times), tranquilizer ("diazepam" 20 mg), anticonvulsant ("neurolepsin" 600 mg), antidepressant (Amitriptyline, 50 mg) and antiparkinson medication ("benzhexol" 6 mg a day).

One of the patients (35 years old, F60.3) got the following injections in a muscle - "tisercin" 1,0 ml, "cordiamin" 2,0 ml, "dimetrol" 1,0 ml and "haloperidol" 1,0 ml twice a day - when hospitalized. Subsequently, for 20 days, "haloperidol" 1 ml and "diasepam" 2,0 ml were administered in a muscle twice a day.

Such heavy combinations of medications were applied also at the **Centre for Mental Health and Prevention of Drug Dependence**. The medical personnel prescribed "haloperidol" liquid (twice a day), "haloperidol" pills (at 10 am and 8 pm), "azaleptin" (0,5

mg) and "tisercin" (25 mg at 10 pm). Similar schemes are frequently applied in these institutions.

An acute shortage of medication has been observed at **Surami Psychiatric hospital**. There is a permanent deficit of medication recommended for managing mental disorders. This generates the problem of the lack of continuity of medication-based treatment and adequate management of psychiatric cases. The monitoring group found that majority of patients in an agitated state and revealed the symptoms of acute psychotic condition.

There was no supply of "cyclodol", the medication necessary for managing side effects of old generation neuroleptics. Majority of patients were transferred to minimal therapeutic doses of new generation medications, but the hospital would still run out of supplies in 2-3 days. The same was the situation with anticonvulsants. No new generation antidepressants were available. Old generation antidepressants were prescribed rarely and in small doses. The medical personnel noted that they had no supply of medications. The director of the hospital explained this deficit with financial problems at the end of the month.

It is also worth noting that shortage of personnel may cause disruptions in the treatment regime. It is difficult for the personnel to control how patients take medications. Some of the interviewed patients admitted that due to the negative influence of the prescribed medications, they do not take these medications, hide them and throw them away later. If this gets revealed, the personnel use manual restraint and administer injections, instead of giving pills.

In **Kutaisi Mental Health Centre**, all services (inpatient and outpatient, crisis intervention) are unified and located in the vicinity of the general hospital. This secures continuity of psychiatric treatment, prevention of aggravation of conditions, intervention of general doctors, where necessary, diagnostics of comorbid somatic problems and multi-profile management of cases.

Beneficiaries of inpatient treatment are also the beneficiaries of ambulatory care unit at the same centre. They are treated by the same psychiatrist. This, in addition to community-based services and positive therapeutic environment, reduces stigma and increases trust towards medical personnel, helps formation of positive therapeutic relationships between doctors and patients.

Some patients are attracted to a comfortable environment and feeling of protection at this Centre, aside from medical conditions that warrant their stay. They themselves address the Centre with requests for hospitalization, wait for vacant beds and get placed repeatedly. This creates risks of dependency on the service and requires undertaking preventive measures by the service providers.

The Special Prevention Group points out that unfortunately, none of the mental health institutions have introduced the so called "case management method" under which doctors with various specializations plan the process of intervention together, adjusting it to the needs of beneficiaries. In the absence of such a method, the treatment is mainly

focused on the excessive use of medications, in many instances, contrary to the will of patients.

The Special Prevention Group underlines that voluntary consent of the patient to hospitalization or involuntary placement in a psychiatric institution based on a judicial order should not be understood as precluding the patient to refuse treatment subsequently and also does not mean that there is no need for informed consent of the patient for specific medical interventions.

In this connection, the European Committee for the Prevention of Torture indicates that patients should be placed in a position to give free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis should not be construed as authorising treatment without his consent. It follows that every competent patient, whether voluntary or involuntary, should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.[133]

In its report on the visit to Georgia from 1 to 11 December 2014, the European Committee for the Prevention of Torture pointed out in psychiatric hospitals they visited, consent to treatment was assimilated to consent to placement.[134]

According to Article 5 (1) (e) of Georgian Law on Psychiatric Care, a patient has the right to refuse treatment. This right is limited in cases provided by Articles 16 (methods of physical restraint), 18 (involuntary hospitalization for psychiatric care) and 22^1 (forced psychiatric treatment). If the patient is not yet 16 years old, the decision about treatment is made by his or her legal representative or if the latter is absent, by his or her relative. It is still essential to allow participation of patients in the process of decision-making, taking into account their age and mental health state.

According to Article 10 of Georgian Law on Psychiatric Care, the treatment is carried out with the informed consent of the patient or if the latter is not yet 16 years old, with the consent of his or her legal representative. The consent form with a signature is to be included in medical files. The refusal to be subjected to treatment is also recorded in medical files. Treatment with biological therapy (shocks, seizures, etc) is only permissible if warranted by medical conditions, with an informed consent of the patient or his or her legal representative, based on the decision of the Committee of Psychiatrists.

The Special Prevention Group believes that patients should regularly be informed about the treatment in an understandable language and this should be an integral part of the therapeutic process. Medical personnel of mental health institutions must respect the patient's refusal and obtain consent by providing detailed information about the function of treatment and results expected. This will allow respecting personal autonomy of patients.

The Special Preventive Group asserts that Article 5 (1) (e) of Georgian Law on Psychiatric

133 Standards of the European Committee for the Prevention of Torture, para 41.
134 Para. 156.

Care contradicts the principle of personal autonomy as it allows restriction of the right of a patient to refuse treatment in cases provided by Articles 18 (involuntary hospitalization for psychiatric care) and 22[1] (forcible psychiatric treatment) of the same law. In order to reinforce legislative foundations for the system of mental healthcare that is based on human dignity and personal inviolability, this restriction should be removed from the mentioned provision. At the same time, the term "forcible psychiatric treatment" [135] should be changed with "forcible hospital-based psychiatric care" [136] as it is not limited to treatment and envisages complex set of measures.

At the end of review of the practice of medication-based treatment, the Special Prevention group underlines the importance of quality of medications. It has been established as a result of monitoring that insufficiency of funding as well as legal regulation of public procurement hinder purchase of high quality medications. In particular, mental health institutions purchase medications [137] through simplified electronic tendering. [138] Whoever offers the lowest price wins the tender. This negatively influences quality of medications purchased, since there are medications that contain similar substances, but are produced by different pharmaceutical companies and are of different quality. The price is directly connected with the quality. According to the Special Prevention Group, in order to secure effectiveness of treatment, it is reasonable to prepare the list of basic medications for mental health institutions, including new generation, high quality medications. Accessibility of these medications should be secured for all mental health institutions. At the same time, funding should be increased and a more convenient, favorable regime for purchasing medications should be introduced.

8.1.3. SIDE EFFECTS OF MEDICATIONS AND LAB RESEARCH

All antipsychotic medications have side-effects the signs and clinical significance of which are changing and depend on individual characteristics of medications and patients. The side effects may have the following clinical signs:

- Extrapyramidal syndrome (parkinsonism, acute dystonia, akathisia and tardive dyskinesia);
- Autonomous effects (reduced eyesight, increase in intraocular pressure, dry mouth and eyes, constipation and urinary retention);

135 Article 4 (n) of Georgian Law on Psychiatric Care defines forcible psychiatric treatment as a special type of psychiatric care that envisages measures directed at reducing risk of damage, threat or violence inflicted by the person with a mental disorder upon himself or herself or upon other persons, securing their resocialization and improvement of mental health.

136 Under Article 4 (c) of Georgian Law on Psychiatric Care, 'psychiatric care' envisages a set of measures aimed at the examination of a person with mental disorder, treatment and prevention of acute phases, social adaptation and facilitation of reintegration into the society. It is clear that treatment is only one element of psychiatric care.

137 Article 3 (1) (q) of Georgian Law on Government Procurement.

138 Tender documentation of Rustavi Mental Health Centre Ltd is available at https://tenders.procurement.gov.ge/public/lib/files.php?mode=app&file=1020606&code=1421248491 [last visited on 18 March 2016]

- Increase in prolactin levels;
- Seizures;
- Sedation;
- Weight gain.

The signs of extrapyramidal complications are easily recognized, but difficult to predict. Since they are bases for troubling prognosis, psychiatrists try to avoid such complications. Tardive dyskinesia (involuntary face and body movements) is a subject of special concern, since it has a slow or belated onset and is resistant to treatment.

"Clozapine" (50-300 mg a day) is one of the elements of combined medication-based treatment in mental health institutions. When using this medication, there is no dynamic assessment of risks of changes in blood (agranulocytosis). The blood is not controlled according to guidelines. Also, when administering second generation neuroleptic medications, no clinical lab tests of metabolical changes and risks of hyperglycemia are carried out.[139]

In **the Centre for Mental Health and Prevention of Drug Dependence**, majority of patients have the so called extrapyramidal syndrome, which is one of the results of medication overdose. There is no control over leucocytes and granulocytes in blood, when "Azaleptin" ("Leponex") is administered, since these tests are not free of charge and not all patients can afford the payment. Prescribing this medication without control of blood is dangerous for patients.

In Surami Psychiatric Hospital, no clinical laboratory and instrumental monitoring of the side effects of psychotropic medications (agranulocytosis, hyperglycemia, arrhythmia) is carried out. According to the director of the hospital, this is due to the lack of technical and professional resources.

8.1.4. MEDICAL RECORDS

Admission, allocation of beds, discharge, observation and organization of medical records must comply with the relevant legislation and normative acts of the Ministry of Labor, Health and Social Affairs.[140] For the purpose of clinical diagnostics, it is necessary to use the international classification of diseases ICD-10, prepared by the World Health Organization and recommended by the mentioned Ministry.[141]

139 Treatment and Management of Schizophrenia in Adult Patients (Guidelines), available at http://www.moh.gov.ge/files/01_GEO/jann_sistema/gaidlaini/gaidlain-protokol/125.1.pdf [last visited on 6 March 2016] Treatment and Management of Depression in Adults, National Recommendations (Guidelines) for Clinical Practice, available at http://www.moh.gov.ge/files/01_GEO/jann_sistema/gaidlaini/gaidlain-protokol/126.1.pdf [last visited on 6 March 2016].

140 Order no. 108/N of 19 March 2009 of the Minister of Labor, Health and Social Protection of Georgia about the Rules about Preparing Medical Documents in Medical Institutions

141 International Classification of Diseases of the World Health Organization ICD-10 (1994). http://www.who.int/classifications/icd/en/ [last visited on 18 March 2016]

Deficiencies in medical documents have been revealed as a result of monitoring. In some institutions, psychiatrists visit patients irregularly. The results of these visits are included in medical files irregularly as well. Medical cards did not include information about individual plans of treatment. Most entries were not legible due to doctors' handwriting. In most institutions, entries about the conditions of patients (the so called cursuses) are irregular and mostly based on a template.

8.1.5. TREATMENT OF SOMATIC DISEASES

Persons with mental disorders frequently suffer from physical/somatic complications as well. Even though a connection between metabolic problems and antipsychotic medications is not entirely clear, everyone agrees that patients getting antipsychotic medications for a long time must do regular health checkups.[142]

National Guidelines for Managing Schizophrenia[143] emphasize the importance of monitoring the use of antipsychotic medications for the purpose of early detection of somatic problems, assessment of gravity and choice of a correct strategy of antipsychotic treatment. It also contains suggested table for frequency of examination of physical and biochemical parameters of patients.

It has been established through interviews and examination of individual medical cards that **at Surami Psychiatric Hospital**, while psychiatric state is assessed, somatic health state is not evaluated, either at the time of admission or during treatment. If the situation is critical, the nurse checks pressure and pulse and if hypertension and bradycardia[144] are revealed, an injection of "caffeine" or "cordiamin" is administered or the problem is solved with "Valerian" or "Validol" pills. In case of urgency, emergency medical services are engaged. The institution does not have a therapist and a dentist. As regards clinical analyses, only blood and urine tests are done, once a year.

One patient that was diagnosed with lung tuberculosis and underwent anti-tuberculosis treatment while hospitalized at the National Mental Health Centre (Qutiri) has been placed in Surami Psychiatric Hospital since 4 March 2011. His somatic health state has not been assessed and no monitoring has been done to prevent recurrence of tuberculosis.

At the time of admission at **the National Centre of Mental Health (Qutiri),** a list of necessary lab tests and medical consultations is drawn up: blood and urine tests, Wassermann reaction, blood sugar test, electrocardiography (EKG), consultations with a psychologist, therapist and neurologist, and if needed, dermatovenerologist, dentist, gynecologist and phthisiatrist, roentgenologic examination, sputum test. If tuberculosis is diagnosed, the patients undergo treatment.

142 Barnes et al., 2007; Newcomer, 2007; Suvisaari et al., 2007.

143 Treatment and Management of Schizophrenia in Adult Patients, National Recommendations (Guidelines) for Clinical Practice, Chapter 4.7.

144 Low arterial pressure and slow heart rate.

Despite the above said, the majority of interviewed patients complained about somatic problems and adequacy of medical treatment. A few patients declared that they had Hepatitis C virus and gastrointestinal problems, but no tests were administered. They did not have a possibility to consult a doctor.

For example, a metal implant in the knee of the patient subjected to involuntary treatment (50 years old, Ds. F20.0) restricts his movement. He needs another surgery. His psychiatrist is aware of this condition. The patient did not get consulted by a surgeon or a traumatologist. Additional tests were not administered and the operation was not planned. This patient also displays side effects of treatment with neuroleptic medications (extrapyramidal symptoms, tremor), aggravating his state and further restricting his movement.

Dental care is limited to teeth extractions. Therapeutic treatment is not available. This problem together with orthopedic problems especially affects the beneficiaries of shelters for persons with mental disorders of the National Centre of Mental Health.

Monitoring revealed some problems with accessibility of medications. Particularly, the Monitoring group found expired medications ("paracetamol", "papaverine", "dimedrol", "digoxin") at the **Clinical Psychoneurological Hospital in Khelvachauri.** Expired medications were also found at **Senaki Psychoneurological Dispensary** ("triptazine"[145], "tisercin", "dexdun", "clopheline", B1 and B6 vitamins). There was a shortage of medications at **Surami Psychiatric Hospital**.

The personnel of **Bediani Psychiatric Hospital** report insufficiency of funds for examining and treating somatic diseases. They acknowledge that the beneficiaries of the institution have acute somatic needs. The location of the hospital, considerable distance to the nearest medical institution and damaged roads also pose problems. The personnel indicate that there has not been a single transfer of patients to medical institutions for treating somatic diseases in 2015.

The Monitoring Group examined medical cards of patients and came to the conclusion that many patients require somatic health checkup and treatment. There are references to recommendations about consultations and checkups by various doctors, but there is no information about measures taken in response to these recommendations. For example, one patient was complaining about pain in lower back for three months. Medical documentation indicates a preliminary diagnosis: nephritis. There is one more entry according to which the patient has kidney failure and requires a nephrologist. "Ibuprofen" was prescribed. Nothing confirms that this patient was consulted by a nephrologist. The medical card also includes entry by a surgeon that patient had chronic nephritis, "nitroxolin" was prescribed for three days and ultrasound of urinary tract was recommended. There is no document in the medical card confirming that ultrasound was actually done.

By the time of monitoring, throughout 2015 deaths of five patients were registered at Bediani Psychiatric Hospital, 7 at Surami Psychiatric Hospital, 1 at Kutaisi Mental Health Centre, 11 at the National Centre of Mental Health, 4 at Tbilisi Mental Health Centre and

145 Triptazine was actively used in this establishment.

1 at Senaki Inter-District Psychoneurological Dispensary. The Prevention and Monitoring Department of the Public Defender's Office requested the Ministry of Labor, Health and Social Affairs to provide information about deaths of patients in mental health institutions in 2014-2015.[146] Unfortunately, the information was not received in due time to be included in this Report.

Having examined medical cards of the deceased patients, the Special Prevention Group indicates that these cards do not provide information as to whether these patients benefited from medical care. A few examples may be listed:

Case of Ts. A.

This patient was placed in the Naneishvili National Centre of Mental Health on 15 May 2015. According to the medical files, at the time of admission the patient was cachexic. He also had pressure ulcers (bedsores). The entry of 28 May 2015 in medical records made by the doctor on duty indicates that the patient was not responsive. He was in a state of coma. Khoni emergency medical unit transferred that patient to O. Chkhobadze Treatment and Rehabilitation Centre for the Elderly and the Disabled in Kutaisi. The patient died on 29 May 2015 at that Centre.

Medical history of this patient indicates that the cause of death is cardiac arrest (I46); somnolence, stupor and coma (R40), stroke not specified as hemorrhage or infarction (I64), bronchopneumonia (J18.0). Medical card indicates that the patient got cardiography once, blood and urine tests. It does not indicate how pneumonia was treated in this case.

Conducting additional consultations and checkups in connection with somatic diseases is a problem at Surami Mental Health Institution.

The Case of N.Kh.

The patient (born on 18 February 1960) was placed in Surami Psychiatric Hospital on 9 June 2014 with a diagnosis of paranoid schizophrenia (F20.0). The patient suffered from enlarged veins and chronic venous insufficiency. He was admitted to the hospital, following the left hip endoprosthesis surgery, due to the fracture of the left femur neck (S72.0).

According to medical records, due to the bed rest, the patient had bedsores that were treated with hydrogen peroxide and Turmanidze ointment. According to the entry of 10 March 2015, the patient died at 10 a.m., when doctors were making hospital rounds. Medical records do not indicate cause of death or reanimation measures undertaken, if any. The entries made by medical personnel show that despite the patient's general weakness throughout the week preceding his death, no additional tests were carried

146 Letter no. 03-1/9906 of the Head of the Department of Prevention and Monitoring of the Public Defender's Office of Georgia dated 4 December 2015.

out and no treatment was applied. Only blood and urine test results were found in the medical card of the patient.

The Case of A.M.

The patient (born on 12 January 1941) was placed in Surami Psychiatric Hospital on 19 June 2015 with the diagnosis of paranoid schizophrenia (F20.0). He also suffered from heart failure, cerebral hemorrhage and also hypertonia. Notwithstanding hypertonia, it is not entirely clear from the medical card whether arterial hypertension was regularly controlled and whether the patient was treated for somatic diseases. The patient stayed in bed. He was irresponsive the day before death. His face was swollen and heavy breathing was noticeable. On 14 October 2015, the patient died.

The Special Prevention Group reached the conclusion that there are serious problems in mental health institutionsin terms of treating somatic diseases. The situation is better in psychiatric departments/units of general hospitals (e.g. psychiatric department of the Ghudushauri National Medical Centre). Such psychiatric departments have access to services in other departments of the same hospital. The problem of diagnostics and treatment of somatic diseases arises especially acutely in the state-established limited liability companies, such as Surami Psychiatric Hospital, Senaki Psychoneurological Dispensary, Clinical Psychoneurological Hospital, Bediani Psychiatric Hospital, Naneishvili Mental Health Centre.[147] The Special Prevention Group advises taking substantial steps to allocate more beds for psychiatric patients in general hospitals and gradually move to the model of providing psychiatric care within general hospitals.[148]

According to the Special Prevention Group, it is necessary to review funding methodology and increase the amount of funds allocated for psychiatric care, so that every patient in mental health institutionshas access to timely and adequate medical service.

147 On 22 October 2015, 95 % of shares of the State owned Ltd. Naneishvili National Centre of Mental Health was sold to B & N Ltd. No. 2248 Decree of the Government of Georgia of 22 October 2015, available at https://matsne.gov.ge/ka/document/view/3034586 [last visited on 18 March 2016].

148 According to the World Health Organization, it is desirable to provide psychiatric care to patients in general hospitals. Nevertheless, many countries predominantly rely on psychiatric hospitals. In Georgia, in 2014 the number of beds allocated to psychiatric patients in general hospitals was 2, 31 for every 100 000 residents. The number of beds in psychiatric hospitals was 32, 32 for every 100 000 residents. The number of beds in psychiatric hospitals for 100 000 residents is above the world average (which is 17, 5 for 100 000 residents). However, it is three times less than the number in Latvia (105, 09). It is worth noting that the number of beds for psychiatric patients in general hospitals is 20 times less than the number in Estonia (47,05). Estonia moved to the model of providing psychiatric care in general hospitals. Consequently, the number of beds in psychiatric hospitals for 100 000 residents is only 7,71.

RECOMMENDATIONS

RECOMMENDATIONS TO THE GOVERNMENT OF GEORGIA

- Review funding methodology and increase funds allocated for psychiatric care, so that each patient has access to timely and adequate checkup and treatment for somatic diseases.
- Review funding models, keeping in mind the priority of the quality of treatment, so as to increase the amount of funds allocated for long-term treatment.
- Review funding methodology for psychiatric care to secure purchasing high quality medications.
- Introduce the most convenient, favorable regime for purchasing medications, keeping in mind quality of medications as a priority.

RECOMMENDATIONS TO THE MINISTER OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Take all the necessary measures to gather statistical data accurately, in order to ensure adequate psychiatric care in hospitals, better describe rehospitalization indicator and define standards for treatment outcomes.
- Strictly supervise correspondence of the length of stay with the degree of stabilization of acute conditions; revise models of funding, so as to increase the amount of funds allocated for long-term treatment.
- Take all the necessary measures to introduce a multidisciplinary approach in psychiatric institutions, expand the use of therapeutic methods and means and introduce a method of individual management of cases.
- Prepare additional guidelines and supervise doctors as regards doses of prescribed medications in order to reduce cases of overdose and unreasonable use of chemical restraint.
- Draw up a list of basic medications that will include new generation, high quality medications; secure accessibility of these mediations in all psychiatric institutions.
- Exercise strict supervision in mental health institutionsto ensure that somatic diseases are detected in a timely manner and adequately treated.
- Take measures to allocate more beds to psychiatric patients in general hospitals and gradually move to the model of providing psychiatric care in general hospitals.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Work out individualized plans for treatment, specifying its goals, therapeutic means used and personnel responsible for treatment; engage patients in planning the treatment and in assessing dynamics of mental health conditions.
- Take all the necessary measures to introduce a multidisciplinary approach, expand a range of therapeutic means and methods and introduce the method of individual management of cases.
- Take all the necessary measures to regularly provide information about treatment to patients in an understandable language and regard this as part of therapeutic process; ensure that medical personnel respect the patient's refusal to be treated and seek to obtain consent to treatment by providing detailed information to the patient about the role of treatment and its consequences.
- In order to manage side effects of medications, ensure conducting tests to assess the risks of agranulocytosis, metabolical changes and especially hyperglycemia and to control leukocytes.
- Include full information in medical records.
- Take all the necessary measures to ensure timely diagnostics and adequate treatment of somatic diseases.
- Secure timely and adequate dental care for patients.
- Ensure constant control of expiration dates of medications, remove expired medications as required and prevent their use.

PROPOSAL TO THE PARLIAMENT OF GEORGIA

- In order to reinforce legislative foundations for the system of mental healthcare that is based on human dignity and personal inviolability, amend Article 5 (1) (e) of the Georgian Law on Psychiatric Care and remove the phrase: "This right can be restricted in cases envisaged by Articles 18 and 22^1 of this law."
- Change the term "forcible psychiatric treatment" with the term "forcible hospital-based psychiatric care" in the Georgian Law on Psychiatric care.

8.2. PSYCHOSOCIAL REHABILITATION, PSYCHOLOGICAL AND SOCIAL SERVICES.

Under Georgian Law on Psychiatric Care, a set of measures aimed at improving mental health includes medical and psychosocial interventions. The purpose of measures

planned as part of psychosocial intervention is to help patients maintain social and work contacts and develop skills for their independent existence in a society.[149]

The Decree of the Government of 2014, adopted based on the mentioned law, introduced standards of psychosocial rehabilitation.[150] According to these standards, psychosocial rehabilitation is to be carried out in special centres for psychosocial rehabilitation as well as multi-profile psychiatric institutions, institutions of long-term psychiatric care (shelters), psychoneurogical dispensaries.

According to the Decree of the Government of Georgia of 2015 Approving State Programs of Healthcare,[151] psychosocial rehabilitation covers teaching of basic skills to patients to make sure that they adapt socially, get integrated into the society and are able to live independently. This includes identifying the needs of patients, drawing up individualized and specific rehabilitation plans, applying methods of psychosocial rehabilitation, in accordance with the established standards.

Monitoring of mental health institutionsshowed that the scope of psychosocial rehabilitation is limited at all these institutions. This is due to the shortage of means, equipment, materials and specially trained personnel. Most institutions have psychologists, but they rarely resort to therapeutic interventions for individuals and groups, as required by regulations. Work therapy is weakly developed. Most patients do cleaning and provide some other services, but this cannot be considered as work therapy.

There is a social rehabilitation unit at **the Centre for Mental Health and Prevention of Drug Dependence.** It employs social workers (including the head of the unit), a psychologist, a peer recovery support specialist and an ergotherapist. There is an art therapy group. The functions of an art therapist are performed by a social worker. Psychologists use methods of individual and group therapy. The groups integrate patients that undergo acute and long-term treatment. Social workers assist patients in sports activities, walking, implementing various rights. Each patient engages in various activities only if permitted by a psychiatrist. The patients are not aware of the criteria used by the psychiatrist in making decisions. The interviews showed that such decisions are often biased. The patients point out that there is a basketball court, but engagement in sports activities is selective, based on subjective considerations and not the health state of patients. One patient asserted that he wanted to participate in sports activities, but was not given such a possibility.

Plans of treatment of patients do not include psychosocial rehabilitation. They do not mention what kind of therapeutic activities are necessary for patients. This is due to the lack of engagement of social workers in preparing these plans. Social workers assess

149 Georgian Law on Psychiatric Care, Article 21, available at https://matsne.gov.ge/ka/document/view/24178 [last visited on 21 March 2016].

150 Decree No. 68 of 15 January 2014 of the Government of Georgia, Technical Regulations – Standards of Psychosocial Rehabilitation, available at https://matsne.gov.ge/ka/document/view/2198173 [last visited 21 March 2016].

151 Decree no. 308 of 30 June 2015 of the Government of Georgia about Approval of State Programs of Healthcare for 2015, available at https://matsne.gov.ge/ka/document/view/2891068 [last visited on 21 March 2016].

each patient individually. Short evaluation forms are filled in for patients from acute care units, but these forms remain with social workers and are not included in medical cards. According to social workers, after consultations, only some patients used to undergo full evaluation. Recently, based on the court request, full evaluation of all patients has been introduced. The forms are included in medical cards of patients only after they are discharged, because according to the personnel, it is a dynamic process and these forms need to be updated periodically. This cannot be viewed as a valid defense, since the concluding part of the evaluation given by the social worker refers to the needs of the patient and the areas in which care and supervision is needed. Such information should be included in medical cards. Otherwise, it will be impossible to find and identify information about the measures taken to address the needs of the patient. Besides, this practice contradicts development of a complex, unified approach and facilitates separation and fragmentation of medical and social spheres.

The monitoring shows that it is difficult for social workers to identify the needs of persons undergoing short-term treatment. They have been able to obtain more exhaustive information about the patients undergoing long-term treatment. The Social Rehabilitation Unit does not have statistical data about the patients that get a social assistance package. The Monitoring Group was unable to obtain this information. One of the social workers told the Monitoring Group that in 2015 October, 10 persons received social assistance at the Centre for Mental Health and Prevention of Drug Dependence.

The information about the measures taken to assist patients is included in the questionnaires. There is no special registry for such information. According to the files, social workers are mainly engaged in solving the questions of social assistance, helping patients to contact their relatives and getting identification cards. They engage patients in rehabilitation programs and provide information about such programs. They also assist patients in withdrawing money with bank cards and buying the items they need.

According to the information provided by social workers, for the period of monitoring, three patients of the unit for long-term care were declared incompetent and had guardians appointed. As for the referrals to competent organs to have persons recognized as recipients of support, seven applications were filed to the court between July and October. One of the patients had been declared incompetent up to 1 April 2015. Judicial decisions were not made in any of these cases by the time of completion of monitoring (October 2015).

There were cases of long-term stay at the institution because of social problems. One of the patients was registered in order to be placed at the shelter. The patient L.A. needed to be recognized as a beneficiary of support and have a supporter designated to assist him in implementing his rights. Social services already addressed the court concerning this patient. The Head of the Social Rehabilitation Unit of this institution expressed willingness to be appointed as a supporter.

The patient A.A needed to have a supporter appointed and the social worker filed the respective request to the court. It was explained that the problem related to residence would be solved afterwards.

In case of the patient D.S. the local organs of self-governance were informed. The social worker of the institution contacted the social worker of the territorial unit of the Agency, but no written application to the Agency or Trafficking Fund was filed.

The monitoring revealed cases of neglect of the patients' rights and interests by their family members. In one case, the Monitoring group found that family members did not spend targeted social assistance allocated to the beneficiary to meet his/her needs.

There was one patient with movement restrictions that did not have a wheelchair. It was established through interviews that wheelchairs are only available at psychoneurological dispensary and social workers did not address the Agency of Social Services to secure the device for the patient.

At Bediani Psychiatric Hospital, most patients undergo long-term treatment. The institution does not have a psychologist, a specialist responsible for rehabilitation, a qualified social worker. There is no multidisciplinary team that works out individualized plans of development of beneficiaries and secures its implementation. Individual consultations with a psychologist and rehabilitative services are not accessible to the beneficiaries.

30 patients undergo rehabilitation at the unit of the art therapy at the institution. The unit is led by the person with musical education. The beneficiaries paint, sculpt, knit and embroider. Their work is on display in the rehabilitation unit.

The unit is not equipped with furniture. There is a library, but availability of books is limited. The institution has facilities for labor/physical activities, but there is no competent staff to facilitate rehabilitation. The hospital does not have a qualified social worker to solve problems for patients, to provide assistance to the elderly patients in obtaining pensions from the state or getting the status of a disabled person, to explain the procedures for getting a social assistance package, to facilitate communications with legal representatives. In many instances, social benefits to which the patients are entitled are used by their family members and/or guardians and the patients themselves have no say in managing their funds. In such cases, they need competent legal advice.

In the course of interviews at Bediani Psychiatric hospital, two patients touched upon the problem of the failure of guardians to discharge their responsibilities adequately. Specifically, these persons cannot use their social assistance packages because their plastic cards expired, but guardians do not help them solve this problem. Besides, as a result of a two-year treatment their health state considerably improved and they should no longer stay at the hospital, as concluded by their doctors. However, the guardians do not want to take them home, do not visit them. They are not interested with conditions of persons under their guardianship.

At **Kutaisi Mental Health Centre**, a psychosocial rehabilitation service is provided. It works as required by the program of psychiatric care, ensures engagement of patients to the maximum extent. The creations of patients are on display in the recreational areas of the unit.

THE ROLE OF PSYCHOLOGISTS IN MENTAL HEALTH INSTITUTIONS

Some deficiencies have been observed in the activities of psychologists at **the Centre for Mental Health and Prevention of Drug Dependence**. Majority of patients point out that despite their willingness, their communication with a psychologist is rare.

The rights and responsibilities of the psychologist in the unit of long-term psychiatric care include choosing a rehabilitation activity for the patient (social therapy, ergotherapy, art therapy, cinema therapy) and engagement of patients in individual or group psychotherapy. At the same time, a psychologist is obliged to enter the information about his/her activities in a special journal and also in medical cards, as required. No such information could be found in the medical documentation of patients.

At the acute care unit of **Tbilisi Referral Hospital ("Unimed Khakheti" Ltd)**, the role of a psychologist is limited to making a diagnosis. He/she does not have to work with beneficiaries and their family members. According to formal instructions for this position, in some instances, a psychologist may make a diagnosis for persons with mental disorders and/or engage patients in psychotherapy and should include the information in the medical documentation, as required by internal regulations of the hospital. These questions were not covered by the internal regulations provided to the members of the Monitoring Group. The beneficiaries also did not confirm engagement in activities/therapeutic measures. The list of the employees does not include a psychotherapist and an art therapist. Accordingly, patients do not have the possibility to benefit from therapeutic and rehabilitative services. Even though the function of this institution is to provide care in acute cases and not long-term treatment, further interventions need to be planned. This is especially warranted taking into account that in some instances, patients remain at the institution for over a month. According to a psychologist, they are forwarded to various centres afterwards, for the purpose of psychosocial rehabilitation.

It is worth noting that only some patients confirmed participation in rehabilitation programs. None of the medical cards specify rehabilitation as part of the treatment scheme and integrate it in the process of therapy.

Rustavi Mental Health Centre has a few psychologists (including an art-therapist) that provide services to patients three times a week. Unfortunately, plans for treatment of individual patients do not contain information about services provided by psychologists or art therapists. Such services are not integrated in the scheme of care. It is worth noting that results of psychological examination are not included in all medical cards, but the medical personnel asserts that all patients are examined to confirm diagnoses and this information is saved by psychologists.

At **Kajaia Surami Psychiatric Hospital,** medical documentation for all patients includes an entry by the psychologist that is identical in form and substance. However, none of the patients has been able to recall having a conversation with the psychologist. At the time of monitoring, the psychologist was not at the hospital. In general, activities directed at securing psychosocial rehabilitation have not been introduced at Surami Psychiatric Hospital. There is no adequate infrastructure and trained personnel.

Surami Psychiatric Hospital provides no social services to assist patients in solving a range of problems. Many of the patients do not have a status of a disabled person and therefore, cannot benefit from a social assistance package. They do not know whom to address to solve these problems. Some patients are not informed about the reasons for not getting a social assistance package. Family members and legal representatives often neglect the needs of these persons.

Naneishvili National Centre for Mental Health (Qutiri) allocates space for psychosocial rehabilitation, but the administration of the Centre claims that they do not have sufficient funds and personnel to provide adequate services to patients fulfilling the standards of the sub-program of psychiatric care at hospitals. Only a limited number of patients declared about participation in psychosocial activities.

According to the information received through monitoring, patients get a psychological evaluation once a year. When interviewed, a psychologist pointed out that he is actively engaged in the process of psychosocial rehabilitation and carries out psychological interventions. However, medical cards of patients do not contain any reference to such services. According to the psychologist, he saves relevant information, but this information is confidential. It is worth noting that norms of professional ethics require non-disclosure of information obtained through sessions of psychotherapy. However, this should not exclude giving access to the members of the Monitoring Group to some basic, non-sensitive information for the purpose of assessing the process of psychosocial rehabilitation. Social services of the institution are actively involved in solving social problems of patients. They take measures to prepare patients to be discharged and help restore family relations. There is also positive dynamics in terms of initiating medical-social expertise, determining the status of a person with a disability and granting the benefits. Despite these efforts, it was revealed through interviews that these questions remain unresolved and require urgent action.

In the psychosocial rehabilitation unit **at Khelvachauri Clinical Psychoneurological Hospital,** rehabilitation activities are carried out in the first half of the day for the patients from all three units. They have an art therapist and a work therapist. The art instructor is responsible for musical therapy which is carried out in a specially furnished room in the unit for long-term stay for women. The patients have the possibility to watch movies, listen to the music and dance. A few patients from acute care unit were attending this therapy at the time of monitoring.

Group rehabilitation exercises are carried out by a psychologist twice a week, but there are individual sessions as well. In the rehabilitation unit, the Monitoring Group members reviewed tests and questionnaires filled in by patients as well as assessments of art therapists and others. The psychologist that works with a certain patient looks into these materials and writes a conclusion about the treatment. According to him, these conclusions are included in the patient's history upon his/her discharge, but until then, they remain with the psychologist.

The program of psychosocial rehabilitation envisages taking patients on excursions. Different groups of patients were taken four times to visit the Gonio Fortress, Batumi Bou-

levard and the Zoo. Patients take walks in the yard of the establishment, but as reported by some of them, this is impossible when it rains since they do not have adequate clothing and shoes.

When visiting mental health institutionsand interviewing personnel and patients, the members of the Monitoring Group paid attention to the legislative changes carried out within the framework of reform related to legal capacity. It has been established that majority of the interviewees is not informed about new legislative regulations. At the time of monitoring (9 October – 6 November 2015), not a single person placed in these institutions was recognized as a recipient of support.

The conversations with patients revealed the need for legal consultation and assistance in resolving legal disputes. Some of them have property disputes with family members or relatives. A few patients placed in Surami Psychiatric Hospital pointed out their property remained without supervision and as a consequence, they suffered damage. One patient of the same institution underlined the problem of communication with her underage son. As she pointed out, her son was with a caretaker, she had not seen him for a few years and did not know whom to address to solve this problem. The same problem was raised by a patient of **the National Centre of Mental Health (Qutiri).** She asserted that her son was also probably with a caretaker but she did not have exact information.

According to the information provided by the lawyer of **Kutaisi Mental Health Centre, a few** patients of this institution needed to have disputes related to immovable property solved.

It may be concluded that despite efforts of personnel of mental health institutionsto help beneficiaries in solving social problems, services of psychosocial assistance, rehabilitation and reintegration are weakly developed at hospitals. In some instances, they exist only on paper and can be regarded as merely a daily activity.

RECOMMENDATIONS

RECOMMENDATIONS TO THE MINISTRY OF LABOUR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Review funding methodology in order to secure the implementation of psychosocial rehabilitation programs at psychiatric institutions, taking into account biopsychosocial aspects of recovery; to secure regular monitoring of implementation of various programs for rehabilitation of patients at such institutions.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Take into account biopsychosocial aspects of recovery and develop psychosocial interventions, secure intervention of specialists in the schemes of treatment.

- Pay special attention to the development of psychosocial rehabilitation services, to secure compliance with existing standards; to secure improvement of abilities of patients and development of skills to live independently.
- Hire qualified personnel to provide psychosocial rehabilitation services, to train personnel.
- Offer a broad range of recreational activities to patients, let them spend considerable time outdoors, to secure accessibility of books, journals and newspapers.
- Inform/train personnel about legislative changes introduced within the framework of the legal reform on legal capacity.
- Secure timely performance of obligations imposed upon them within the framework of the legal reform on legal capacity; to accelerate relevant procedures.
- Secure closer and more coordinated cooperation with the Agency of Social Services, in order to solve social problems of patients.
- Cooperate with relevant services in order to protect parental rights of patients.

9. PERSONNEL

The existing human resources must be adequate in terms of numbers, categories (psychiatrist, therapist, nurse, psychologist, occupational therapist, social worker, etc) and their professional experience and training.[152] Modern services of mental health unify healthcare managers, psychiatrists, psychologists, psychotherapists, social workers, nurses, occupational therapists and all other specialists that are necessary to provide necessary care effectively (for example, a neurologist or pediatrician, special needs education specialist or speech therapist, etc).[153]

Multidisciplinarity constitutes the basis for modern approach.[154] Unfortunately, in psychiatric institutions, multidisciplinary approach is lacking, in relation to competence of personnel and more importantly, in relation to management of mental disorders. There is a shortage of psychiatrists and other personnel (social workers, psychotherapists, nurses, etc). For example, at **the National Centre of Mental Health,** only one doctor is on duty at night (with over 650 patients). During the daytime, the monitors also communicated with one and the same doctor in the majority of units to verify the information.

Surami Psychiatric Hospital employs only three psychiatrists. They have to be on duty frequently, but have very low salaries. This causes occupational burnouts and development of a nihilistic attitude towards treatment of patients. Only one nurse is on duty in each unit and due to the workload, managing mental disorders and filling in the documentation correctly becomes impossible. The Director General of Surami Psychiatric Hospital told the members of the Monitoring Group that salaries and living conditions are not attractive for specialists.

As regards working schedule and conditions, Article 27 (1) of the Georgian Law on Psychiatric Care envisages the following benefits for those employed in the field of psychiatry, taking into account specificity of their work environment: a) reduced, 30-hour work week; B) increased 42-day holiday time. The monitoring revealed that these benefits are rarely used. The personnel have to work under difficult conditions. This has a negative impact on the quality of psychiatric care, attitude towards patients, supervision, prevention of violence and incidents between patients, etc.

According to the Special Prevention Group, the problem lies also in the absence of occupational therapists in mental health institutionsand the fact that the management of such institutions does not understand the function of this specialist and the importance of his/her activities.

152 Standards of the European Committee for the Prevention of Torture, para. 42.

153 Miller G. Mental, health in developing countries. The unseen: mental illness's global toll. *Science* 2006 January 27;311(5760):458-61.

154 Raine R, Wallace I, Nic a' Bháird C, Xanthopoulou P, Lanceley A, Clarke A, et al. Improving the effectiveness of multidisciplinary team meetings for patients with chronic diseases: a prospective observational study. *Health Serv Deliv Res* 2014;2(37).

It has been established as a result of monitoring that apart from insufficiency of personnel, there is a problem of continuous professional education. The topics covered by the trainings as well as their frequency and actual engagement of personnel are unsatisfactory. Majority of personnel has not been trained for many years.

According to the information provided by the Ministry of Labour, Health and Social Affairs, the Council of Europe will provide funds to conduct 6 cycles of trainings throughout Georgia for doctors, nurses and social workers of institutions of psychiatric care in the area of human rights, ethics and patient care. The initiative to conduct such trainings is worth welcoming, but the Special Prevention Group considers that in-depth training is needed at least in the following areas: management of agitated patients,[155] methods of physical restraint, multidisciplinary focus, prevention of violence and incidents among patients, de-escalation techniques, the Convention on the Rights of Persons with Disabilities and modern psychiatry. The trainings about various important questions of modern psychiatry should regularly be conducted. Special attention needs to be paid to the understanding by the personnel of importance of biopsychosocial model of psychiatric care and development of skills for implementing this model in practice.

According to the Special Prevention Group, it is important to develop a strategy for supplying the system of psychiatric care with competent personnel. It is also necessary to provide adequate salaries and create additional guarantees for social protection.

RECOMMENDATIONS

RECOMMENDATIONS TO THE GOVERNMENT

- Review the methodology of financing the system of psychiatric care in order to allocate sufficient funds to secure personnel and adequate payment for the work done by the personnel.

RECOMMENDATIONS TO THE MINISTRY OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Develop the strategy for supplying the system of psychiatric care with competent personnel.
- Introduce additional guarantees for social protection of personnel of psychiatric institutions.
- Determine minimum number of personnel per a certain number of patients.
- Take all the necessary measures to train the personnel of mental health institutionsin at least the following areas: management of agitated patients, methods of physical restraint, multidisciplinary focus, prevention of violence

155 Trainings on this topic were conducted in 2011.

and incidents among patients, de-escalation techniques, the Convention on the Rights of Persons with Disabilities and modern psychiatry; to regularly conduct trainings about various important questions of modern psychiatry; to pay special attention to the understanding by the personnel of importance of biopsychosocial model of psychiatric care and development of skills for implementing this model in practice.

RECOMMENDATIONS TO THE DIRECTORS OF MENTAL HEALTH INSTITUTIONS

- Notwithstanding the limited funding, reconsider and try to increase salaries of personnel.
- Secure institutions with sufficient qualified personnel.
- Take all the necessary measures to train personnel of mental health institutionsin at least the following areas: management of agitated patients, methods of physical restraint, multidisciplinary focus, prevention of violence and incidents among patients, de-escalation techniques, the Convention on the Rights of Persons with Disabilities and modern psychiatry; to regularly conduct trainings about various important questions of modern psychiatry; to pay special attention to the understanding by the personnel of importance of biopsychosocial model of psychiatric care and development of skills for implementing this model in practice.

THE PROPOSAL TO THE PARLIAMENT OF GEORGIA

- Amend the Law on Psychiatric Care to introduce additional guarantees of social protection for the personnel of psychiatric institutions.

10. SPECIFICITY OF PSYCHIATRIC UNIT FOR CHILDREN

10 patients can be placed in the Children's Unit of Tbilisi 5th Clinical Hospital. At the time of monitoring there were 8 patients, between 1 and 16 years old. They were mainly referred from orphanages of family type. There are four doctors (child psychiatrists), psychologist, psychotherapist, 4 nurses and 4 assistant nurses in the unit.

The monitoring revealed cases of delayed discharge of children from the hospital. The Special Prevention Group suggests that this is due to the failure of social workers to perform their functions effectively. According to the personnel, some patients have to stay at the hospital even for a month and a half because social workers from the Agency of Social Services rarely visit beneficiaries and take them away from the hospital.

It is worth noting that due to their stay at the hospital, the children fail to attend school. The establishment has no invited teachers. As regards communication with parents, the doctor decides when the patients can make phone calls. Children do not have phone conversations with their parents as frequently as they want to.

Treatment of patients is not multidisciplinary. Plans of individual development do not envisage working on psychological and behavioral problems, in addition to pharmacological treatment of mental disorders. There are no individual plans for each beneficiary so that the person responsible for their implementation followed the dynamics and made sure that the patient gets a full package of services.

The examination of documents and the interviews with a 16 year old patient revealed that her views were not taken into account when making decisions about treatment. Particularly, she refused to be hospitalized. Her informed consent form is signed by a social worker. She managed to escape the hospital on the third day of hospitalization. It turned out that she wanted to attend the meeting at which the question of changing her place of residence was discussed and which the social worker did not allow her to attend. After police intervention, she was returned to the hospital and was placed in the unit for adults. The patient said that she did not feel safe with adults. Besides, her communications with outside world were limited. Her mobile phone was taken away when she was hospitalized and was kept in the safe at the reception. She was also not allowed to make calls from the hospital phone. The Monitoring group had the impression that these measures were taken to punish her. This is clearly unacceptable. It constitutes the violation of Article 12 of the Convention on the Right of the Child, according to which state parties shall assure to the child that is capable of forming his or her own views the right to freely express those views in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity. For this purpose, the child is to be given the possibility to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law. It is unacceptable to neglect the views of the child in deciding questions and making decisions that influence the life of the child. Taking into account this right, it is advisable to introduce prac-

tice of getting an informed consent from the child. This respect and recognition could help prevent escape of children from the unit (there were 2 cases in 2015).

The unit has a procedure for the temporary discharge of the child from the hospital. The person that accompanies the child files an application to the Head of the Department, indicating the time of taking away the child and the time of bringing the child back. If the Head of the Department agrees, this information is inserted into the medical card of the patient. The time of taking away the child, the reason and the time of bringing the child back is included in the special journal for temporary discharges of patients.

According to the staff of the Unit for Children, there has not been a single case of applying physical restraint. There have not been cases of suicide and self-injury. The doctor inserts information about the conditions of each of the patients in their medical cards every day.

It is a recognized approach in area of psychiatric care that children need stability and continuity of care. Apart from pharmacotherapy, the unit is unable to provide patients with other type of care, even though the absence of psychosocial interventions, correction and habilitation-rehabilitation prolongs and complicates the process of recovery and increases the risks of long-term stay.

The room allocated for rehabilitation (called a play room) does not fulfill the requirements of habilitation-correction-rehabilitation. There are no tables and chairs in the room. There are a plastic slide, a small house, a foldout couch and round poofs, only appropriate for children of pre-school age. There is no library in the unit. There are no conditions for simple physical activities. There is no infrastructure for watching movies. There are no corrective programs and treatment is limited to pharmacotherapy. Examination of medical cards of beneficiaries at the unit for children showed that none of these medical cards included information about consultations with a psychologist.

The Special Prevention Group concludes that therapeutic processes at the Unit for Children do not correspond to modern standards and international guidelines for intervention.[156] The strategies for intervention and competences of the personnel need to be improved. The Special Prevention Group is concerned about placement of a minor in the unit for adults and urges the personnel of the hospital not to allow such practice in the future.

RECOMMENDATIONS

RECOMMENDATIONS TO THE DIRECTOR OF N5 CLINICAL HOSPITAL

- Take all the necessary measures to give the child the possibility to freely express views and be carefully listened to about a range of questions, including those related to hospitalization and psychiatric care, at the time of admission

156 See e.g. https://www.nice.org.uk/guidance/cg158 [last visited on 20 March 2016].

and at any stage of psychiatric care, with due regard to the age and maturity of the child.

- Reinforce the strategy of multidisciplinarity, so that the patient benefits from an adequate, full package of services.
- Introduce the practice of evaluating the process of treatment; for example, to guarantee at least two consultations with a psychologist; the first one at the time of admission to check psychical functions and emotional state of beneficiaries and the second one at the time of discharge from hospital to assess the dynamics after pharmacological, psychological and other interventions that will reveal the effectiveness of treatment.
- Avoid keeping patients hospitalized beyond what is necessary for treatment and for that purpose reinforce communication with social workers, guardians and educational institutions.
- Secure psychological interventions to facilitate development; to develop programs that teach the child anger management, strategies for correcting antisocial behavior, improve social competences and functioning of children and positively influence their self-esteem.
- Develop infrastructure in order to create therapeutic environment.

TO THE MINISTER OF LABOR, HEALTHCARE AND SOCIAL AFFAIRS OF GEORGIA

- Take all the necessary measures to create small units of psychiatric care for adolescents (16-18 year olds) in general hospitals, taking into account geographic accessibility, in order to manage mental disorders of adolescents effectively.
- Take all the necessary measures so that social workers pay more attention to minor patients and communicate with them more frequently, to secure protection of their best interests.

11. SPECIFICITY OF THE FORENSIC PSYCHIATRIC UNIT OF B. NANEISHVILI NATIONAL CENTRE OF MENTAL HEALTH

Forensic psychiatric care at hospitals includes treatment and management of mental disorders and assessment of risks of committing crimes by the patient. The risk of violence is assessed by a recognized instrument, such as HCR-20 - The Historical Clinical Risk Management-20, Version 3 (Douglas, Hart, Webster, & Belfrage, 2013)[157].

On 26 July 2014, the Parliament of Georgia adopted the amendment[158] to the Georgian Law on Psychiatric Care which differentiated 'involuntary psychiatric care' from 'forcible psychiatric treatment.'[159]

Forensic Psychiatric Care Unit of the National Centre for Mental Health accommodates patients undergoing forcible psychiatric treatment, based on a court order[160] and also patients transferred from penitentiary institutions for involuntary psychiatric care.[161]

Under Article 22^1 (2) of Georgian Law on Psychiatric Care, the person may be placed in a hospital for forcible psychiatric treatment only if special protection is guaranteed and measures are taken to reduce risks, secure resocialization and improvement of mental health, in accordance with the order of the Minister of Labor, Health and Social Affairs of Georgia.[162]

The results of monitoring showed that conditions at the forensic medical unit are inadequate. Therapeutic environment is not secured. During the day, patients are locked up in the rooms resembling prison cells, without any privacy, with bad sanitary conditions and ventilation. They are taken for a walk in the yard that looks like a cage. [163] The Special Prevention Group concluded that the conditions in this unit and the care provided do not correspond to the goals of hospitalization. The unit is in fact merely a facility for isolation of patients with mental disorders.

A patient placed in the unit for forcible psychiatric treatment is visited by a psychologist a day after admission. The psychologist fills in the questionnaire for risk assessment and

157 The Historical Clinical Risk Management-20, Version 3. Available at http://hcr-20.com [last visited on 20 March 2016].

158 Amendments to the Law on Psychiatric Care, 26 July 2014, available at https://matsne.gov.ge/ka/document/view/2434712 [last visited on 20 March 2016].

159 Article 4 (n) of Georgian Law on Psychiatric Care defines forcible psychiatric treatment as a special type of psychiatric care that envisages measures directed at reducing risk of damage, threat or violence inflicted by the person with a mental disorder upon himself or herself or upon other persons, securing their resocialization and improvement of mental health.

160 Based on Article 22^1 of Georgian Law on Psychiatric Care.

161 Based on Article 22^1 of Georgian Law on Psychiatric Care.

162 Order No. 01-70/N of 1 October 2014 of the Minister of Labor, Health and Social Protection of Georgia approving standards for assessing risks for patients undergoing forcible psychiatric treatment and list of measures aimed at reducing risks, securing resocialization and improving mental health, necessary for carrying out forcible psychiatric treatment in a psychiatric institution, available at https://matsne.gov.ge/ka/document/view/2515573#DOCUMENT:1; [last visited on 20 March 2016]

163 Problems including those related to the conditions of stay, treatment of somatic diseases etc. are examined in chapters above.

develops a plan for individual development, which is signed by a psychiatrist, psychotherapist, social worker and psychologist. The plan is initially developed for six months and is later reconsidered. If the patient has been sentenced to forcible psychiatric treatment for less than a year, then a three-month plan is prepared, but these plans are only on paper. None of the interviewed patients undergoing forcible psychiatric treatment knew about the plan or engagement in the process of resocialization. A few patients remembered the conversation with a psychologist. The Monitoring Group had the impression that no psychosocial rehabilitation of patients takes place. The involvement of the psychologist is limited. No meaningful activities are planned and each day is similar. The conflicts among patients are frequent.

The patients undergoing forcible psychiatric treatment, based on a court order and patients transferred from penitentiary institutions for involuntary psychiatric care are under similar, strict conditions. There is no differentiated treatment. Contacts between patients are restricted. In case of both categories of patients, psychiatric care is limited to pharmacotherapy. Patients do not participate in rehabilitation-resocialization programs, sports and other activities.

There is no individualized approach to treatment. Individual needs of patients are not figured out, so that they could be fulfilled through multidisciplinary team work.[164] Patients are not engaged in the process of treatment, do not know terms of treatment and 'what to expect in the future'. They are not informed about the complaint procedures established by law. Foreign-language speaking patients are not explained their rights in an understandable language.

Aggression is managed through frightening patients or through injections. The procedure for assessing risks does not correspond to international standards. It is unclear how trustworthy this instrument can be and how the level of risk is integrated in the scheme of treatment, since all the patients are treated following the same standard scheme.

The personnel of the institution told the members of the Monitoring Group that only 15 GEL is allocated for the treatment of patients with acute conditions as well as long-term patients. This does not correspond to the needs of patients and creates a heavy financial burden for the institution. According to the representatives of administration of this institution, another problem lies in the engagement of invited specialists in the activities of the special commission[165] created to assess mental health state of patients undergoing forcible psychiatric treatment. They explained that the institution cannot attract qualified personnel due to geographic inaccessibility and limited funds. Under such conditions, it is impossible to provide full and high quality services to patients.

164 For example, special needs of patients with cognitive disabilities are not taken into account.

165 Order N01-69/N of the Minister of Labor, Health and Social Protection of Georgia, dated 1 October 2014 about composition and activities of the Special Committee created in mental health institutions- to assess mental health state of patients subjected to forcible psychiatric treatment states that according to Article 22^1 of Georgian Law on Psychiatric Care, administration of an institution responsible for forcible psychiatric treatment creates the Special Commission that is chaired by the clinical manager of that institution and consists of at least 5 members. If necessary, the administration of the institution may be expanded by inviting other specialists. This rule is available at https://matsne.gov.ge/ka/document/view/2515601 [last visited on 20 March 2016].

RECOMMENDATIONS

RECOMMENDATIONS TO THE GOVERNMENT OF GEORGIA

- Revisit the methodology of financing cases of forcible psychiatric treatment and involuntary psychiatric care under Article 22 of the Georgian Law on Psychiatric Care; study the existing needs in terms of managing such cases; secure allocation of adequate funds.

RECOMMENDATIONS TO THE MINISTRY OF LABOR, HEALTH AND SOCIAL AFFAIRS OF GEORGIA

- Introduce the system (relevant instruments) for assessing risks that is workable and based on international experience.
- Develop and approve psychosocial rehabilitation standards facilitating resocialization and reintegration.
- Consider appropriateness of introducing differentiated regimes of psychiatric care at the Unit of Forensic Psychiatric Care at the National Centre of Mental Health based on the best international practices.

RECOMMENDATIONS TO THE NATIONAL CENTRE FOR MENTAL HEALTH

- Improve conditions of stay at the Forensic Psychiatric Unit, create a therapeutic environment, organize a walking area, ensure that patients spend considerable time outdoors and are engaged in the activities that are interesting and valuable for them.
- Develop the program for psychosocial rehabilitation to facilitate resocialization-reintegration.
- Adjust individual development plans with the real needs of patients and secure actual implementation of these plans.
- Take all the necessary measures to actually engage patients in the process of providing psychiatric care, give them sufficient information about ongoing and planned interventions as well as about the rights of patients, including the right to file complaints.
- Ensure that personnel work in multidisciplinary teams.