Special Report of the Public Defender of Georgia

National Preventive Mechanism

Thematic report on the monitoring carried out at Acad. B. Naneishvili National Centre of Mental Health Ltd

(April 22-25, 2019)

The document was prepared in accordance with Article 21, paragraph g, of the Organic Law of Georgia on the Public Defender of Georgia

2019

Contents

1. Introduction

The Special Preventive Group[1] of the Public Defender of Georgia carried out monitoring at Acad. B. Naneishvili National Centre of Mental Health (National Centre of Mental Health/establishment) on April 22-25, 2019, in order to assess the human rights situation there. Monitoring was conducted only in the Centre's civil units and shelter, and not in the forensic psychiatric units. Monitoring was carried out thematically and covered the following issues: ill-treatment, physical/chemical restraint and isolation; psychiatric case management; somatic health care; sanitary-hygienic conditions, therapeutic and safe environment. In accordance with international human rights law, each State individually and collectively is the primary bearer and guarantor of the responsibilities of the international human rights regime. The obligations of the State also apply to the cases when the State privatizes services that affect the human rights situation. States should ensure that they can effectively oversee the enterprises' activities, including through the provision of adequate independent monitoring and accountability mechanisms.[2]

According to the General Comment of the Convention against Torture, States bear international responsibility for the acts and omissions of their officials and others, including agents, private contractors, and others acting in official capacity or acting on behalf of the State, in conjunction with the State, under its direction or control, or otherwise under colour of law. Accordingly, each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example, in prisons, hospitals, schools, establishments that engage in the care of children, the aged, the mentally ill or disabled, in military service, and other establishments as well as contexts where the failure of the State to intervene encourages and enhances the danger of privately inflicted harm.[3]

Acad. B. Naneishvili National Centre of Mental Health Ltd was privatized on the basis of the agreement of 20 January 2016 and 95% of the Centre's shares was transferred to a private investor. Following the privatization, positive changes were carried out in the Centre, mainly related to the improvement of material conditions, but the quality of patient care and treatment remains a problem. As said above, under international human rights law, regardless of privatization, the obligation to protect the rights of patients at the National Centre of Mental Health rests primarily with the State. Accordingly, it is important that the Government of Georgia, by exercising control, ensure that the investor fulfills its obligations with regard to the quality of service and, with the active involvement of public authorities, facilitate that the establishment provides quality services to patients.

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[2] The UN Guiding Principles on Business and Human Rights, I (5), page 8, available in English at: <https://www.ohchr.org/documents/publications/GuidingprinciplesBusinesshr_eN.pdf> [last accessed: 28.05.19].

[3] UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Committee against Torture, General Comment No. 2, implementation of Article 2 by States Parties, Scope of State obligations and responsibility, para. 15, January 24, 2008, available at: <https://bit.ly/2r1r0Ra> [last accessed: 27.05.19].

In the 2017-2018 monitoring report on the National Centre of Mental Health, the Public Defender of Georgia made 63 recommendations to the Minister and the Director General of the establishment.[4] It should be noted that despite several positive changes carried out in the establishment during the mentioned period, implementation of the Public Defender's substantial recommendations is unsatisfactory.

The Public Defender's Office assesses positively the commissioning of a new building in 2018 as part of the inpatient civil unit of the National Centre of Mental Health. The process of updating the old equipment of the units should be highlighted positively. The introduction of the verbal de-escalation tool is also welcome. However, **compared to the previous visit, the gravest situation in the establishment's shelter and in the men's 2nd and women's 7th civil units has not changed substantially, which according to the Special Preventive Group, should be described as a degrading and inhuman treatment.**

The Public Defender emphasizes that placement of persons with mental health problems in large establishments cannot be seen as a high level of protection of their rights. Therefore, the Public Defender calls on the agencies in charge of determining the state policy to take effective steps to facilitate the deinstitutionalization process and the development of community-based services in the shortest possible time. Inter alia, active steps should be taken to build group homes in order to facilitate the integration of beneficiaries into the community. At the same time, until the end of the deinstitutionalization process, the Government of Georgia should have immediate communication with investors, as a temporary measure, and should take active steps in the shortest possible time for providing minimal therapeutic environment in the establishment's shelter, men's 2nd and women's 7th civil units.

The European Committee for the Prevention of Torture, following a visit to Georgia in 2018, made **two urgent recommendations** in relation to B. Naneishvili's National Centre of Mental Health at the meeting with senior officials of Georgia, in accordance with Article 8, paragraph 5, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.[5]

In the **first** urgent recommendation, the Committee urged the Georgia's high officials to replace beds in general psychiatric wards, women's forensic psychiatric wards and shelter. In addition, the Committee gave three months to the State to provide information on the implementation of this recommendation. During the visit of the Special Preventive Group, the process of replacing old beds was ongoing; however, during monitoring, most of the beds in the men's 2nd and women's 7th civil units were old and in poor condition.

[4] Report on the monitoring of Acad. B. Naneishvili National Centre of Mental Health (May 22-25, 2017 and March 6-7, 2018), available at: <https://bit.ly/2EP06pB> 0.[last accessed: 30.05.19].
<https://www.ohchr.org/documents/publications/GuidingprinciplesBusinesshr_eN.pdf> [last accessed: 28.05.19].

[5] In accordance with Article 8, paragraph 5, of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the Committee may, if necessary, contact the competent authorities of the party concerned.

In the **second** urgent recommendation, the Committee requested daily access to exercises in fresh air for all patients. The Committee gave three months to the State to provide information on the implementation of this recommendation. The Committee, after receiving a reply from the State on 23 July 2019, expressed its regret at the failure of the State to implement the recommendation and again called on the authorities to ensure that all patients were able to enjoy unlimited presence in fresh air. During the visit of the Special Preventive Group, the recommendations relating to the patients of the 1st and 3rd units had been partly implemented. In particular, these units were provided with appropriate infrastructure (a well-arranged yard, volleyball and basketball courts). Nonetheless, the restrictions applied in the establishment could not allow the beneficiaries to enjoy unlimited access to fresh air. In addition, the Committee's recommendations were not implemented with respect to beneficiaries of the establishment's shelter,[6] men's 2nd and women's 7th civil units. In particular, the lack of proper infrastructure, as well as restrictions provided for in the day schedules, was problematic.

In light of the extremely difficult conditions in the Centre, the Committee urged the Government to provide quarterly detailed information on the ongoing repairs in the establishment.

The European Committee for the Prevention of Torture expressed its serious concern about the practice of placing patients with mental health problems and persons with mental retardation in one and the same unit and urged the Government to take appropriate steps to place the above-mentioned patients separately, in order to facilitate that patients of both categories receive more benefits in accordance with the individually tailored plans.[7]

The Special Preventive Group will closely monitor the implementation of the Committee's recommendations by the State and will periodically provide the Committee with updated information.

In terms of physical environment, patients, who do not require active treatment, remain in the psychiatric establishment for years despite the gravest situation in the shelter, men's 2nd and women's 7th units.[8] They cannot leave the establishment against their wish, due to the lack of services in the community.

The Public Defender is extremely concerned about the fact that the establishment does not respond to the patients' somatic health problems in a timely manner, which causes deterioration of the patients' health condition and even death in some cases. The Special Preventive Group was able to obtain and study 25 medical records of patients who died between

[6] The only exception were women placed in the shelter, who were able to enjoy longer walks in good weather. However, the facility's infrastructure was not in order and did not allow walking in rainy weather.
[7] Report of the European Committee for the Prevention of Torture on the visit to Georgia (CPT/Inf (2019) 16), para. 131, September 10-21, 2018, available in English at <https://rm.coe.int/1680945eca> [last accessed: 15.05.19].
[8] According to the management of the institution, about 60-70 patients should not be at the hospital, but they cannot be discharged due to lack of support services.

1 January 2018 and 24 April 2019.[9] 7 out of them died in the establishment, while 18 died after being transferred to other medical facilities, within a short period – from one day to two weeks.

In addition, amidst the chaotic environment of the establishment, inadequate supervision, lack of conflict prevention strategies, inadequate number and qualifications of staff, a significant challenge is violence among patients that endangers their lives and health.

The establishment still applies methods of physical and chemical restraints towards beneficiaries. The approaches of the State and the establishment fail to ensure reduction in the use of physical and chemical restraints or introduction of alternative de-escalation methods.

It should be noted that, like previous years, psychiatric care in the establishment is in fact limited to pharmacotherapy and the management of side effects of antipsychotic medication is problematic. Patients sign a document on informed consent so that they do not have proper information about the service and are not properly involved in the treatment process.

2. Ill-treatment

The visit to the National Centre of Mental Health made it clear that patients of the establishment are not protected from verbal, psychological or physical abuse or indifference. Cases of conflict and violence among patients are frequent in the establishment. It should be noted that the European Committee for the Prevention of Torture has also referred to this problem following its visit to the Centre in September 2018. The CPT says in the report that the duty of care which is owed by staff in a psychiatric establishment to those in their charge includes the responsibility to protect them from other patients/residents who might cause them harm. This requires not only adequate staff presence and supervision at all times, but also that staff be properly trained in handling challenging situations/behavior by patients. The Committee calls on the Georgian authorities to solve the problem.[10]

According to the Special Preventive Group, the common forms of violence among patients at the National Centre of Mental Health are: verbal and physical abuse. As a result of the latter, in some cases, patients sustain serious physical injuries. The Group found out that conflicts begin between patients mainly after they steal or grab each other's personal belongings. It was found out that most patients in the 2nd and 7th units do not have storage space for personal belongings, while the bedside tables enjoyed by certain patients cannot be locked. Therefore, there are frequent cases, when patients steal each other's personal belongings. In addition, according to the Special Preventive Group, one of the major risk factors for violence is the placement of patients with

[9] According to the N913 reply sent by the National Centre of Mental Health on April 24, 2019, 5 patients died at the Centre, namely in the establishment, from January 1, 2018 until April 24, 2019.

[10] Report of the European Committee for the Prevention of Torture on the visit to Georgia (CPT/Inf (2019) 16), para. 108, September 10-21, 2018, available in English at: <https://rm.coe.int/1680945eca> [last accessed: 15.05.19].

serious health problems[11] and long-term patients,[12] as well as patients with mental retardation and other psychiatric diagnoses, together in the 2nd and 7th units.

As for violence against patients by staff members, it should be noted that during the visit, the Group received no information about the cases of physical or verbal abuse by staff. However, we also emphasize that the administration and medical staff have indifferent attitude towards patients/beneficiaries. According to the Special Preventive Group, patients in the 2nd and 7th units, as well as beneficiaries of the shelter, are in extremely degrading situation. Their needs, including somatic health needs, are neglected. These issues are discussed in detail in the relevant chapters of the report.[13]

In addition, the Special Preventive Group found out that the staff of the National Centre of Mental Health exploits the labour of patients/beneficiaries, in exchange for cigarettes or extra food. Some patients/beneficiaries clean up toilets and yard, assist staff members in taking care of other patients or physically restraining them, bring food from the kitchen to wards. According to the Special Preventive Group, this practice represents exploitation of patients' labour,[14] as patients/beneficiaries are forced to agree to do the above work in order to satisfy their food and cigarette needs, since they have no option.

The National Centre of Mental Health does not take sufficient measures to protect patients/beneficiaries from ill-treatment. In particular, the inadequate number and qualifications of the establishment's staff are problematic, system of assessment and reduction of risks coming from patients, the existing practice of documentation of cases of violence or responses to such cases, the existing system of checking the quality of the activities of the staff and reviewing complaints, provision of information to patients about legal aid mechanisms and access to them remain problematic.

It should be noted that despite the Public Defender's recommendation, the National Centre of Mental Health has not yet developed a **strategy for conflict and violence prevention**. It has not implemented the Public Defender's recommendations to draw up detailed instructions for each employee, according to their competences, for communicating with patients, and to provide regular trainings in the direction of human rights, management of agitated patient, non-violent de-escalation and the use of the method of physical restraint.[15] During the interviews, staff members said that they had been trained several times, but they could not elaborate on the themes or period of the trainings, which refers to the ineffectiveness of the trainings.

[11] Inpatient treatment of acute cases, which implies arrest of acute psychotic symptoms or treatment of the kind of behavioral or affective symptoms that endanger the life and health of patients or their surrounding persons.

[12] Long-term inpatient care implies inpatient treatment of people with chronic mental disorders, who have severe psychosocial functioning disorders and/or prolonged psychotic symptoms (including treatment after inpatient care of acute cases).

[13] See the chapters on physical environment and somatic health.

[14] The use of the situation (vulnerability) of a person in one's own interests, UNODC, Concept of Exploitation in the Trafficking, p. 21, available at: <https://bit.ly/3118bRo> [last accessed: 30.05.19].

[15] Report of the visit of the Special Preventive Group to Acad. B. Naneishvili National Centre of Mental Health in 2017 and March 6-7, 2018; available at: <http://www.ombudsman.ge/res/docs/2019040510063472825.pdf> p. 8.

It is to be welcomed that the patient risk assessment system has been introduced in all units of the Centre since March 2019. However, it should be noted that during the psycho-diagnostic examination of patients, no risk triggers[16] are identified along with assessing risks, which would have enabled the staff to be aware of the factors provoking patients and helped them avoid potential violence from patients. It should be noted that along with the risk assessment, it is equally important to reduce the identified risks, but no multidisciplinary efforts are made, unfortunately.

The documents of the establishment show that no psycho-therapeutic efforts are made for the purpose of managing the behavior of patients with high risk of violence and that only pharmacotherapeutic means are used, in particular, no increased doses of drugs are administered. As for the assessment of risks of the shelter beneficiaries, psychologists draw up individual rehabilitation plans, which inter alia should include the assessment of risks coming from beneficiaries, but no risk factors are assessed in the individual plans.

The monitoring carried out by the Special Preventive Group showed that the cases of violence against patients are only documented in the patient's medical records and the patient observation journals. As noted above, documentation of the cases of violence, as well as the measures taken in response, is faulty. In particular, documentation of violence is not complete. Most of the above documents do not indicate the time of violence, the persons involved in the incident or the causes of violence. For example, one of the documents only provides the following information: "Beneficiary A., during a verbal conflict, punched Ch. sustained a small bruise" (punctuation preserved). As can be seen from the above case, no time, circumstances or causes of the incident or the responsive measures were indicated.

As for the response to the cases of violence, the practice of the establishment shows that victims of violence do not receive psycho-therapeutic support or legal aid. If a patient suffers physical injuries as a result of violence, only medical intervention is provided to treat bodily injuries. Information about medical interventions is mainly indicated in the medical records and patient observation journals. Interviews with the staff made it clear that in response to a conflict between patients, in some cases, patients are separated by being taken to a different ward or by placing one of the patients in an isolation room, but information on response measures is not documented. In addition, it should be noted that the legal documents of the establishment do not specify who shall send notification about violence to the investigative body or in what case, and no statistics on notifications are maintained.

The establishment has an internal complaints mechanism - the complaint review commission - to protect patients' rights and provide them with quality care. Complaints boxes are placed/hung on walls in all units. According to the work principles of the commission, it studies patients' oral and

[16] "Triggers are situations or stimuli that make a person feel distressed, frustrated, angry, and agitated which in turn can lead to a potentially tense and challenging situation"; for details, see the Guideline of the World Health Organization: "Creating mental health and related services free from coercion, violence and abuse" p. 34, information is available on the following website: <https://bit.ly/2QEHzAL> [last accessed 27.05.2019].

written applications and complaints, regularly talks to patients, prepares an annual recommendation for the administration of the establishment and a special report for the Director General at the end of the year. Clearly, it is welcomed that the establishment has an internal control mechanism for the protection of patients' rights in the form of a complaints review commission, although the Special Preventive Group considers that the work of this commission is faulty and needs to be improved. In particular, the documents of the commission do not include information on how many complaints were taken out of the complaint boxes; they only indicate which unit's patients expressed complaints. Members of the commission inform the administration of the establishment about the patients' complaints and wishes discussed at the meeting, but the practice of submitting a recommendation in writing to the director/administration regarding the patients' complaints could not be confirmed by the commission members. In addition, the commission has not drawn up an annual recommendation document as required by its own statute. In addition, contrary to the regulations, at the time of the visit, the complaints review commission had not prepared a report of 2018.

Monitoring showed that patients/beneficiaries do not have information about their rights or external complaints mechanisms. Information leaflets about their rights or information about the complaints procedures, including the Public Defender's hotline, are not provided in the 2nd and 7th units. Specifically, this information is available outside the units, in corridors, where patients/beneficiaries cannot move independently. It should be noted that during monitoring, some patients were interested in receiving legal aid, although they did not have information about the state agencies or non-governmental organizations providing such assistance. Most of the interviewed patients know that they can cast complaints in the box, but they rarely use this mechanism, as they have no hope that their problem will be solved.

Recommendations

To the Minister of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- Develop a legal act determining the rule of documenting the cases of conflict and violence and the measures taken in response, as well as the obligation of the inpatient psychiatric establishment to apply this rule.

To the Director General of Acad. B. Naneishvili National Centre of Mental Health:

- Ensure in 2019 that all patients are provided with personal bedside tables that can be locked and unlocked by the owner
- Ensure in 2019 the systemic recording of the cases of conflicts, violence, patients' injuries and response measures, including the time of incidents, identities of those involved in the conflict, causes of conflicts, injuries sustained and measures taken in response
- Take all measures in 2019 to carry out active recruitment policy for attracting new staff, including sanitarians, caregivers, psychologists, etc. To achieve this:

    - Actively inform the public about the employment opportunities and working conditions of the establishment
    - Increase the remuneration of the staff to make the working conditions favorable and provide adequate remuneration for the difficult and time-consuming work
    - Train staff in the direction of job burnout and stress management
    - Provide transportation of staff to the establishment
- In 2019, develop detailed instructions for communication with patients, including the standards of ethics, care and protection of psychiatric patient's rights;
- In 2019, develop a conflict and violence prevention strategy, which, among other important components, should include:
    - Examination of causes and risk factors for violence against patients and conflict among patients;
    - Measures to be taken to reduce violence and risks of conflict;
    - A list of actions to be taken in case of conflicts and violence.
- In 2019, ensure that the beneficiaries' individual rehabilitation plans include assessment of risks coming from beneficiaries and a list of actions to be taken to reduce these risks
- In 2019, develop an individual legal act that would determine that a notification shall be sent to the Ministry of Internal Affairs regarding all cases of violence against patients and that relevant document shall be drawn up if the above is done by telephone, and also maintain the registry of notifications
- In 2019, provide patients with information about their rights, including by putting information leaflets in accessible locations and explaining this information to beneficiaries/patients in an understandable language
- In 2019, provide contact details of NGOs working on human rights, rights of persons disabilities, in the units of the establishment
- Ensure that the minutes of the meetings of the complaints commission include: 1) information about the number of complaints taken out of complaints boxes, by indicating the units; 2) information about which units' patients expressed complaints; 3) identity of the staff member, who was the addressee of the patient's complaint; 4) information about the measures taken to eliminate the problems identified at previous meetings of the commission.

3. Physical and chemical restraint

Taking into account the spirit of the Convention on the Rights of Persons with Disabilities[17] and the approach of the World Health Organization towards the mental health rights, which is rights-based and recovery-oriented,[18] the Public Defender considers that the State should facilitate

[17] Guidelines on the interpretation of Article 14 of the Convention on the Rights of Persons with Disabilities, available in English at: <https://www.ohchr.org/.../GC/GuidelinesArticle14.doc> [last accessed: 17.05.19].

[18] World Health Organization (WHO), WHO Initiative, Quality and Rights, implying improvement of access to quality mental health services and protection of the human rights of people with psychosocial disabilities, 2017, available at < http://www.who.int/mental_health/policy/quality_rights/en/ > [last accessed: 17.05.19].

reduction of the use of physical and chemical restraints towards inpatients and the use of alternative de-escalation methods.

It is worth mentioning that no alternative methods of physical or chemical restraint (de-escalation[19]) have been determined at the legislative level. The Public Defender welcomes the introduction of verbal de-escalation methods by the National Centre of Mental Health.[20] However, the establishment does not apply verbal de-escalation methods in practice. In particular, the staff interviewed by the Special Preventive Group lacked information and training regarding the verbal de-escalation method. As in previous years, the establishment uses **the methods of physical and chemical restraints against the will of formally voluntary patients.** Specifically, from April 2018 to 24 April 2019, in the absolute majority of cases, the methods of physical and chemical restraints were applied in relation to formally voluntary patients. The above vicious practice was also underlined in the report prepared by the European Committee for the Prevention of Torture after paying a visit to Georgia in 2018.[21] The Committee emphasizes in its report to Georgia that **no physical restraint should be used towards formally voluntary patients. If it is deemed necessary to restrain a voluntary patient, the procedure for re-examination of his/her legal status should be initiated immediately.[22]**

The establishment continues the practice of involving the supervision service in the process of the use of physical and chemical restraints towards patients, which is against the instruction approved by the order on the use of physical restraint methods,[23] according to which, physical restraint should be carried out by the relevant staff assigned under internal regulations, who should have proper qualifications and expertise in using this method. **Patients' involvement in the process of the use of chemical and physical restraints, as well as the vicious practice of the use of physical restraint in the presence of other patients, continues in the establishment**.[24] **The staff of the supervision service are still involved in the process of physical and chemical restraints. In addition, the use of physical restraint is not sufficiently justified (no causes or circumstances are fully described in the documentation),** which violates the instruction approved by the order on the use of physical restraint methods, according

[19] The de-escalation techniques may include: immediate assessment of potential crisis and rapid intervention; orientation to problem solving; empathy and persuasion; stress management or relaxation techniques, such as breathing exercises; allocation of personal space; variety of options; time to think.

[20] Order N058/2 of the Director General of Academician B. Naneishvili National Centre of Mental Health, March 3, 2019, Approval of Methods of Verbal De-escalation.

[21] According to the report of the European Committee for the Prevention of Torture, "As a result of the information provided to the delegation by doctors, it has become clear that patients undergoing voluntary treatment at the establishment are subject to physical restraint."

[22] Report of the European Committee for the Prevention of Torture to the Government of Georgia following a visit paid to the country on 1-11 December 2014, para. 151.

[23] Order #92/N of the Minister of Labour, Health and Social Affairs of Georgia on Approval of Instructions on the Rules and Procedures for the Use of Methods of Physical Restraint in relation to Patients with Mental Disorders.

[24] The European Committee for the Prevention of Torture (CPT) states that patients should not be physically restrained in the presence of other patients.

to which, the staff are obliged to indicate the cause and essence of application of physical restraint in the patient's medical record.[25]

The cases of isolation are not documented either. During the visit, the isolation wards in the 1st and the 3rd units were in good condition, while situation in the isolation wards in the 2nd and the 7th units was grave.[26] One patient was placed in each of the two isolation wards of the men's 2nd unit. According to the Special Preventive Group, the placement of patients in the isolation wards of the 2nd and 7th units represents ill-treatment. The Group believes that it is important to create relaxation rooms instead of the isolation rooms, where a therapeutic environment would be provided and patients would be allowed to spend some time alone.

Examination of medical documentation showed inaccuracies in the records of chemical restraint. **In particular, in some cases, the information in the patient's medical record about the drugs taken by the patient differs from the same information in the nurse's journal.** Just like previous visits, the process of physical and/or chemical restraint is not observed dynamically.

No conversation is held with the patient after the use of physical restraint in order to inform him/her about the right to appeal against the use of this method.

Recommendations

To the Minister of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- In 2019, in order to amend the rules and procedures for the use of physical restraint towards patients with mental disorders, determine the obligation of the use of alternative methods in case of critical intervention and documentation of the use of such methods, as well as provision of explanations of why these methods were not effective and why it became necessary to use physical restraint;
- In 2019, ensure that the State Regulation Agency for Medical Activities[27] examines the justifiability and legality of the use of restraint.

To the Minister of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia and to the Director General of Acad. B. Naneishvili National Centre of Mental Health:

[25] Order #92/N of the Minister of Labour, Health and Social Affairs of Georgia on Approval of Instructions on the Rules and Procedures for the Use of Methods of Physical Restraint in relation to Patients with Mental Disorders, para. 6, Tbilisi, March 20, 2007, available at: <https://matsne.gov.ge/ka/document/view/69838?publication=0> [last accessed: 30.04.19].

[26] The isolation ward has poor sanitary-hygienic conditions, has no bathroom and is narrow. If necessary, the patient placed in the isolation room should request the staff to take him/her out of the room.

[27] Subparagraph 33^1 of paragraph 3 of article 2 of the provisions of State Regulation Agency of Medical Activities – legal entity of public law approved by Decree N01-64/N of the Minister of Labour, Health and Social Affairs of Georgia, December 28, 2011.

- In 2019, develop binding guidelines and approve them by order, in accordance with the document developed by the World Health Organization – "Creating mental health and related services free from coercion, violence and abuse"[28], which should provide the following strategies for eliminating coercion, violence and restraints:
    - Identification of triggers and warning signs, and making adequate response;
    - Comfortable rooms and sensory approaches;
    - Establishment of the culture of saying 'yes' and 'I can do it';
    - Development of individual plans for the prevention and management of tense situations;
    - Communication techniques;
    - Formation of response groups;
- In 2019, create relaxation rooms instead of isolation rooms, where a therapeutic environment would be provided and patients would be allowed to spend some time alone
- In 2019, train the staff in: verbal and non-verbal de-escalation, prevention and management of aggression
- Ensure that a complete description of the reasons and circumstances of the use of physical and chemical restraints, as well as isolation, is immediately provided in the medical documentation
- Immediately eliminate the practice of the use of physical restraint in common space, in the presence of other patients
- Immediately eliminate the involvement of the establishment's supervision service in the processes of physical and chemical restraint of patients
- Ensure that each case of the use of chemical restraint is documented immediately and eliminate inaccuracies in the documents

4. Medical services

4.1 Psychiatric case management

During the visit made by the Special Preventive Group on April 22-24, 2019, one of the key issues to study was how the establishment managed a psychiatric case under extremely limited scope of psychosocial rehabilitation. [29] [30] The monitoring identified several key issues that will be briefly discussed below.

[28] World Health Organization (WHO), Quality and Rights, "Creating mental health and related services free from coercion, violence and abuse", available at: <https://bit.ly/2XhF0qZ> [last accessed 21.05.19].

[29] Report of the National Preventive Mechanism on the visits paid to the National Centre of Mental Health on May 22-25, 2017 and March 6-7, 2018, p. 34-38; available at: <http://www.ombudsman.ge/res/docs/2019040510063472825.pdf> [last accessed 21.05.2019]

[30] The serious problems of psychosocial rehabilitation are also highlighted in the report of the European Committee for the Prevention of Torture on the visit paid to Georgia on 10-21 September 2018, para. 122, 125, available at: <https://rm.coe.int/1680945eca> [last accessed 21.05.2019].

4.1.1 Adequate number of qualified staff as a prerequisite for the provision of adequate psychiatric care

There is still apparent shortage of professional and support staff[31] at the National Centre of Mental Health, which negatively impacts the quality of psychiatric care.[32] Specifically, psychiatric care is provided by 8 psychiatrists, who are assisted by 3 residents. Consequently, one psychiatrist has to deal with approximately 75 chronic and severe psychiatric cases; in addition, once in 8 days they have to work round the clock. The staff of the establishment work overtime, which can lead to "job burnout". According to the information received by the management of the establishment, positions of 3 psychiatrists, 3 psychologists, specialists of the psycho-social rehabilitation team, 5 caregivers and 4 members of the kitchen staff are vacant and they cannot attract staff despite efforts.

In addition, no proper training-retraining of the staff is provided. The monitoring showed that no certified training had been provided for the staff of the establishment in psychiatric case management, crisis intervention, including verbal de-escalation or human rights, throughout the previous year.

4.1.2 Informed consent of the patient and involvement in the process of the service

Like previous years, formally voluntary patients[33] still cannot leave the establishment voluntarily.[34] Patients sign a document on informed consent so that they do not have proper information about the service.[35]

The monitoring showed that a significant number of patients were brought to the establishment with the assistance of the emergency brigade, police officers or family members, against their wish. This circumstance, and in particular the acute mental condition described by a doctor in a specific case, make us think that the patient probably found it difficult to make an informed decision or realize the essence of the service offered.[36]

[31] The shortage of staff is emphasized by the European Committee for the Prevention of Torture in its report on the visit paid to Georgia on 10-21 September 2018, para. 19.
[32] These issues are also mentioned in the report of the National Preventive Mechanism on visits to the National Centre of Mental Health on May 22-25, 2017 and March 6-7, p. 41.
[33] It should be noted that during the visit of the Special Preventive Group, only 3 patients were involuntarily placed in four units of the institution.
[34] Ibid. p. 18-20.
[35] For example, the informed consent document has a signature of a patient, who is not able to read or write, and who says that he is against the inpatient treatment, as he was at the time of admission.
[36] For example, according to the diagnostic evaluation of one of the patients upon admission, the patient was in a severe psychotic state, refusing to receive food and water, and also had difficulty in communication, he/she hardly answered any question; however, the patient was admitted formally voluntarily.

In some cases, psychological pressure[37] was used to persuade the patient to sign the document and therefore, the signature on the informed consent form cannot be considered as a free expression of the patient's will.

As for the patient's involvement in the process of psychiatric care, the monitoring results show that patients of the establishment are not properly involved in this process, which was confirmed by the fact that some of the interviewed patients were not even aware of their diagnoses or the names of the prescribed drugs. Some of them did not have information about the main and side effects of the prescribed drugs. According to the Special Preventive Group, it is virtually impossible under similar conditions to create a therapeutic alliance between the staff and patients and to substantially improve the patient's condition.[38]

4.1.3 Use of antipsychotic medication

The overuse of medicines represents a problem in the establishment, both at the time of admission of the patient to the establishment, for rapid tranquillization and sedation (non-therapeutic purposes), and during later treatment. Like previous years, psychiatric care is virtually reduced to pharmacotherapy, which is not enough to improve the patient's mental health.

The monitoring showed that sometimes, especially on non-working days, doctors use injectable forms of antipsychotic drugs without relevant prescription, in order to manage the critical situation and quickly tranquillize formally voluntary patients, without offering pills to them, which contradicts the clinical practice guidelines applied in the country.[39] In addition, the need for rapid tranquillization is not properly justified or documented in accordance with the mentioned guidelines.[40]

The monitoring also showed that there had been cases of overdose in the establishment. According to the Special Preventive Group, a case, when a maximum therapeutic dose of one antipsychotic drug is used in combination with a medium or even a minimum therapeutic dose of another antipsychotic drug, can be regarded as an overdose.[41]

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[37] For example, during the interview, one of the patients confirmed that he had signed an informed consent document, but he did it because of fear, as doctors told him they would apply to court and leave him in the establishment for 6 months.

[38] The European Committee for the Prevention of Torture, in its report on the visit paid to Georgia on September 10-21, 2018, draws attention to the vulnerability of formally voluntary inpatients and the problems of patients' involvement in treatment, p. 62-65 and p. 56-58.

[39] Clinical practice guideline - Treatment and Management of Schizophrenia in Adults - Para. 4.8.2 (Treatment of an acute episode): "Offer oral antipsychotic medication in the event of a severe attack or relapse of schizophrenia." Para 4.8.2.2. (Rapid tranquilization): "Use rapid tranquilization when other strategies fail to sedate the patient; Rapid tranquillization is an emergency treatment, not a primary therapy strategy." Para. 4.8.2.2.2. (Carrying out rapid tranquilization): "Offer oral medication first, if possible." Available at: <https://bit.ly/2XmJH2P> [last accessed 22.05.2019].

[40] Ibid, para. 4.8.2.2.3 - "Physical monitoring of rapid tranquillization".

[41] The following combinations are worth paying attention in terms of overdosage: 1) injection of Triptazine (2 mg/ml) and Tisercin (25 mg ml) in combination with Cordyamine (2.0 ml); 2) Speridol 5/mg twice daily, Tisercin 25 mg/ml twice

Such a combination of medications is dangerous and can have a fatal outcome.[42]

The Special Preventive Group considers that, in most cases, the doses used at the beginning of treatment do not comply with the national clinical practice guidelines. According to the latter, antipsychotic medications shall be prescribed in the lowest possible dose. The dose for each patient shall be selected within the least known effective dose. The dose can be increased only after 2 weeks of treatment - after the dose turns out to be ineffective.[43]

The practice of the use of Zopin without proper monitoring of the patient's somatic (physical) health is particularly concerning. The European Committee for the Prevention of Torture also refers to this problem in its report following a visit paid to Georgia in 2018. In particular, patients were prescribed Clozapine (Zopin) without providing blood tests on a regular/systematic basis. The CPT believes[44] that Clozapine can have as a side-effect a potentially lethal reduction of white blood cells (granulocytopenia). **Therefore, the CPT recommends that the Georgian authorities take urgent steps to render regular blood tests mandatory.[45]**

The Special Preventive Group is concerned about the fact that patients,[46] who do not need active treatment, remain in the establishment for years; they cannot leave the establishment against their wish, because of the lack of services in the community.[47] The Special Preventive Group stresses that the de facto deprivation of liberty of a patient in a mental establishment, in the absence of medical necessity, on the ground of lack of community-based services, is contrary to Article 14, paragraph 1, subparagraph b, of the United Nations Convention on the Rights of Persons with Disabilities, which prohibits the deprivation of liberty of a person on the ground of disability. Accordingly, the Special Preventive Group believes that in the short run, it is important to thoroughly study the needs of such patients in order to discharge them from the establishment and refer them to outpatient services.[48] Community-based services, including a shelter component, should be developed as soon as possible and various ways of strengthening of social support should be considered,[49] in order to end the continuous violation of the rights of persons with disabilities, namely their rights to freedom and security.

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daily, Diazepam 10 mg/2 ml twice daily and Cordyamine 2.0 ml twice daily; 3) Haloperidol (30 mg/maximum therapeutic dose - three times daily), Zopin (300 mg/medium therapeutic dose of pills) and pills of Benzhexol (6 mg/day).

[42] See analysis of death cases in the chapter on cases of death.

[43] Clinical practice guideline - Treatment and Management of Schizophrenia in Adults, p. 46.

[44] Report of the European Committee for the Prevention of Torture on the visit paid to Georgia (CPT/Inf (2019) 16), para. 124, September 10-21, 2018, available in English at: <https://rm.coe.int/1680945eca> [last accessed: 15.05.19].

[45] Monitoring indicators generally for antipsychotic medications, including Zopin (Table 4.8). See the Clinical practice guideline - Treatment and Management of Schizophrenia in Adults, p. 66.

[46] According to the management of the institution, about 60-70 patients should not be at the hospital, but cannot be discharged due to lack of support services.

[47] Report of the National Preventive Mechanism on the visits paid to the National Centre of Mental Health on May 22-25, 2017 and March 6-7, 2018, p. 21.

[48] A comprehensive study of patients' needs is mentioned in the Georgian Public Defender's Report on the Situation of Human Rights and Freedoms in Georgia 2018, pages 75-76.

[49] This issue was mentioned in the 2018 Parliamentary Report of the Public Defender of Georgia, p. 75, available at:

In view of the above, the Special Preventive Group concludes that the establishment fails to adequately manage psychiatric cases. The services provided are not focused on recovery or based on respect for personal autonomy. Moreover, in some cases, interventions cause significant harm to the patients.

Recommendations

To the Minister of IPDs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- Instruct the State Regulation Agency for Medical Activities to study the cases of formal voluntary psychiatric care of patients, when they are actually hospitalized against their will, and take all necessary measures in order to ensure that patients are immediately discharged, if there is no legal basis for their involuntary psychiatric care;
- Amend the Minister's Order[50] so that to ensure that filling in the №IV-300-12/a form, approved by Appendix 13 of Order #108/N of the Minister of Labour, Health and Social Affairs of Georgia, is mandatory at all stages of initiation, continuation or modification of patient's treatment
- Assign the State Agency for Medical Practice to study the use of antipsychotic medication and its associated side effects at the National Centre of Mental Health

To the Director General Acad. B. Naneishvili National Centre of Mental Health:

- Ensure the needs assessment of patients who have spent more than 6 months in the establishment, in order to facilitate the process of discharging and referring them to the community services
- Immediately discharge formally voluntary patients, who request the above, if there is no legal basis for the use of the procedure of involuntary psychiatric care
- As a result of multidisciplinary work, develop and implement an individualized plan of psychiatric care for each patient, with the patient's involvement
- To better inform patients about psychiatric care, provide all patients with information in accordance with the clinical practice guidelines[51]
- Train staff in psychiatric case management, by using the WHO national guidelines and the clinical practice guidelines applied in the country
- Introduce the practice of holding doctors' council, which would discuss the adequacy of the use of antipsychotic medication and management of their side effects, in order to prevent overdose or the use of a drug dose that is clearly inadequate with the clinical practice guidelines

<http://www.ombudsman.ge/res/docs/2019042620571319466.pdf> [last accessed 22.05.2019].

[50] Order # 87/N of the Minister of Labour, Health and Social Affairs of Georgia on Approval of the Rules of Placement of Patients in Psychiatric Hospital, March 20, 2007, Tbilisi.

[51] Available at: < https://bit.ly/2MnSUH5 > [last accessed: 25.05.2019].

- By developing internal regulations, ensure that the necessity of the use of rapid tranquilization is justified in each case; the patient's consent to tranquilization is documented in writing; physical monitoring is carried out in accordance with the clinical practice guidelines and the monitoring results are recorded in the medical documents.

4.2 Somatic (physical) health

4.2.1 Death cases

During the visit, the Special Preventive Group examined the medical records of the patients who died both in the establishment and other medical facilities. It should be noted that the establishment does not have death statistics, which proved to be a hindrance for the Special Preventive Group. Despite difficulty, the Group managed to obtain and examine 25 medical records of the patients who died from January 1, 2018 through April 24, 2019.[52] 7 of them died in the establishment, while 18 others died shortly after being transferred to other medical establishments, within a period from one day to two weeks.

Managing somatic (physical) health problems and access to medical care remain problematic at the National Centre of Mental Health. The mental health programme[53] does not provide for the monitoring and treatment of somatic (physical) health problems of persons with mental health problems placed in a psychiatric hospital, which may lead to the deterioration of their health or death in some cases.

In most cases, the cause of death indicated in the medical records of the patients who died at the National Centre of Mental Health is sudden death, severe cardiovascular failure. The cause of the above might be incomplete monitoring of patients' somatic condition and lack of consideration of risk factors. The lack of access to medical care and management of physical health problems is proved by the fact that the patients' inpatient medical records include information only about patients' mental health, while nothing is indicated about their somatic health before the complication of their condition or death. Examination of the deceased patients' medical documents (form N100/a) issued by the referral clinics shows that the patients' condition had deteriorated a few days before being admitted to a general profile hospital, while the medical records of the National Centre of Mental Health indicate that the patients' health deteriorated only on the day of their transfer to a general profile hospital.

In several cases of death, complication of somatic health problems might be caused by the antipsychotic drug overdose[54] or risky combination of drugs, such as prescription of Zopin (Clozapine) together with

[52] According to reply N913 sent by the National Centre of Mental Health on April 24, 2019, 5 patients died in the Centre, namely in the establishment, from January 1, 2018 to April 24, 2019.

[53] Resolution N693 of the Government of Georgia "On Approval of State Health Programmes for 2019", Annex M11 Mental Health (programme code 27 03 03 01)

[54] According to one of the deceased patient's medical record, maximum therapeutic dose of one drug was prescribed in combination with a medium or even a minimal therapeutic dose of another antipsychotic drug, and sometimes with third antipsychotic drug, including Zopin.

other antipsychotic drugs.[55] The medical records do not include information about the somatic health screening or management of side effects of drugs; it is indicated that shortly before death, or on the day of death, the patient had hypotension, was provided first aid, but died of severe cardiovascular failure.

The state tuberculosis programme is being implemented at the National Centre of Mental Health. A consultant-phthisiologist provides outpatient service for patients. If needed, patients are taken to a general profile hospital for radiography.[56] Nevertheless, there are substantial gaps in terms of timely detection of tuberculosis in the Centre. In three cases of death, patients were diagnosed with tuberculosis in a general profile hospital, while no suspicion of tuberculosis is indicated in the medical records of the Centre and the phthisiologist of the Centre has not heard of the case. The Ministry organizes screening for the prevention of tuberculosis.[57] It is important that they introduce and regularly carry out screening for tuberculosis in the Centre.

It should be noted that the management of somatic (physical) health problems also involves treatment with therapeutic medicines. Patients placed in the establishment have to purchase therapeutic medicines at their own expense. Patients often cannot afford to purchase medicines or undergo treatment.[58] For example, one of the patients diagnosed with pneumonia was admitted to a general profile clinic in July 2018; antibiotic therapy was recommended to the patient when discharged from the clinic. However, nothing is indicated about antibiotic therapy in the medical records or prescription papers of the Centre. The patient was hospitalized again to the inpatient medical facility two months later, where he died.

4.2.2 Management of somatic (physical) health

Medical service is reimbursed for the patients enjoying the universal health care programme only in urgent cases, while regular health care service is only co-financed, and patients often cannot afford it. Transportation from the National Centre of Mental Health to another medical establishment, which is associated with additional costs, is also problematic. The establishment does not have a therapist or a family doctor who would monitor patients' health, timely respond to problems and refer patients to relevant specialists. Although the Centre has contracts with various doctors, their services are related to finances. The European Committee for the Prevention of Torture also mentioned this problem in its report after paying a visit to Georgia on 10-21 September 2018. The Committee disapproves the fact that mentally disordered inpatients, who have financial problems, are expected to fund their own somatic health care. The Committee recommends the State that urgent action be taken to remedy this.[59]

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[55] One of the patients was prescribed tablet treatment: Haloperidol (maximal therapeutic dose) - 30 mg three times a day, Zopin (Clozapine) 300 mg and Benzhexol 6 mg a day.
[56] From January 1 to April 24, 2019, 76 patients were transferred to a general profile hospital for radiography.
[57] Law of Georgia on Tuberculosis Control, Article 9, part 5.
[58] Report of the European Committee for the Prevention of Torture on the visit to Georgia (CPT/Inf (2019) 16), para. 128, September 10-21, 2018, available in English at < https://rm.coe.int/1680945eca > [last accessed: 28.05.19].
[59] Ibid, para 128.

Like previous years, reimbursement for the treatment of foreign nationals' somatic health remains problematic. According to the reply received from the Ministry, all the patients receiving involuntary inpatient psychiatric treatment, who are beneficiaries of the universal health care programme or other state programmes, can use the mentioned programmes for the treatment of somatic diseases.[60] In addition, funding for the service, which is not covered by the above-mentioned state programmes or insurance package, can be considered within the framework of the referral service programme, regardless of the nationality of the patient. At later stages, along with budget increases and design improvement, it will be possible to review the funding methodology for the treatment of somatic diseases of involuntary patients (regardless of nationality). Article 2 of the referral service programme determines the programme beneficiaries. It should be noted that foreign nationals are not beneficiaries of this programme, however, under Article 2 (21) of the same law, exceptions may be allowed by the commission. It is important that the government programmes take into account the medical needs of foreign patients, who are involuntarily placed in a mental establishment, and to reimburse for the treatment of somatic (physical) health of such patients on the basis of relevant changes.

According to the clinical manager of the establishment, they need to call an ambulance every second day. In case of emergency, patients are taken from the establishment to a general profile hospital by ambulance/emergency centre brigades.[61] Patients are mainly taken to other facilities due to aggravation of their health condition, under emergency rules, which is also caused by the lack of timely detection of disease and regular treatment.

The state mental health programme only provides for urgent therapeutic and surgical dental services. The establishment has a dentist's room that does not meet the standards applied in the country.[62] The room is not repaired and it is impossible to protect sanitary-hygienic norms there. The equipment is old. The sterilizer is also old and is placed directly in the dentist's room.[63] It is not possible to manage clean and dirty flows during sterilization. The quality of sterilization is not controlled. The dental equipment cannot provide all the services under the programme and dental care is limited to tooth extraction only.[64] Other dental procedures require that patients be taken to a dental clinic, which may result in additional costs.

4.2.3 Other screening and diagnostic examinations

The laboratory of the establishment is renovated and equipped with modern devices. When admitted to the National Centre of Mental Health, the following diagnostic services are provided

[60] Beneficiaries of state health care programmes are persons with Georgian citizenship document, neutral ID cards, neutral travel documents, stateless persons that have a status in Georgia, persons seeking asylum in Georgia, persons with refugee or humanitarian status (unless other terms are determined by a certain programme)
[61] Ambulance documents are kept in the medical records.
[62] Sanitary rules for dental outpatient-polyclinic institutions, approved by Order N309/N of the Minister of Labour, Health and Social Affairs of Georgia of 5 November 2002.
[63] Ibid, Article 22, part 3.
[64] Tooth extraction.

for patients: urinalysis, measurement of blood glucose level, screening for viral hepatitis C and syphilis. Some patients' rapid test for hepatitis C virus are positive, however, they cannot get medical service as the establishment is not involved in the state programme for the elimination of hepatitis C. If the patient cannot enroll in the programme, examinations are useless.

Patients taking long-term antipsychotic medications should undergo regular physical health examinations.[65] The regular medical examination at the Centre involves only urinalysis once a year. This creates the problem of managing the side effects of antipsychotic medication and increases the risk of late diagnosis of somatic diseases.

Adequate management of psychotropic medicines according to domestic[66] and international guidelines,[67] without taking into account the electrocardiogram dynamics, is risky. It is unclear why it is not mandatory for a psychiatric establishment to have an electrocardiogram device.[68] Although electrocardiographic examination is provided, the Centre has no specialist able to read the electrocardiogram and the examination is formal in nature.

4.2.4 Management of side effects of drugs

The psychiatrist's monitoring results only reflect the patient's mental state and the dynamics of antipsychotic medication in the medical records. It does not include the side effects of treatment with drugs or a list of clinical-laboratory examinations or doctors' consultations aimed at managing comorbid[69] somatic diseases, nor does it include activities designed to raise patient's psycho education or awareness of mental health. Most of the interviewed patients were not aware of their own diagnoses, did not understand their mental health problems, could not name the drugs prescribed for them, had no information about the main and expected side effects of drugs, or alternative treatment options.

Nurses often indicate the alleged side effects of drugs in the records. For example, severe hypotonia,[70] shortness of breath, coordination impairment or loss of consciousness, which require intervention for maintaining tone and blood circulation dynamics under the doctor's administration, or assistance of an ambulance brigade and hospitalization of the patient to a general profile clinic.

According to the Special Preventive Group, the frequent use of Zopin (active ingredient Clozapine),[71] both along with other antipsychotic medications and psychotropic medications of a

[65] Treatment and Management of Schizophrenia in Adults, clinical practice guideline, chapter 4.7.
[66] Treatment and Management of Schizophrenia in Adults, clinical practice guideline,
[67] Handbook on the Use of Antipsychotic Drugs, see the link <https://bit.ly/31doY3U> [last accessed 20.05.2019]
[68] Decree N385 of the Government of Georgia (17 December 2010) on Approval of Provisions on the Rules and Terms for Granting Medical Activity Licence and Inpatient Facility Permit, Annex N21.
[69] Concomitant diseases.
[70] Lower than normal blood pressure.
[71] Treatment with Clozapine requires adherence to the medication prescription procedure and management of side effects. During treatment with Clozapine, no initial dose of 12.5 mg is used. The medication is prescribed in the doses

different group, as well as in the form of monotherapy, needs to be paid due attention. It should be noted that no international or national standards[72] for the management of side effects of Clozapine[73] are taken into account during the use of this drug. For example, examination of medical records of 10 beneficiaries of the women's shelter and doctor's prescription papers of 22 beneficiaries showed that Zopin (active ingredient Clozapine) was prescribed for 16 out of 22 beneficiaries; in 9 cases, the drug was prescribed together with anticonvulsant or other antipsychotic medications.[74] Beneficiaries had not had blood test, electrocardiogram or liver examination before the prescription of Zopin (Clozapine) or later dynamically.[75] Although blood pressure and pulse are monitored daily, this alone cannot provide adequate management of side effects. The European Committee for the Prevention of Torture refers to the need for regular blood tests during the prescription of Clozapine[76]. The CPT recommends that the Georgian authorities take urgent steps to render regular blood tests mandatory in all psychiatric establishments whenever Clozapine is used; staff should be trained to recognize the early signs of the potentially lethal[77] side effects of Clozapine.

Recommendations:

To the Director General of Acad B. Naneishvili National Centre of Mental Health:

- Provide adequate treatment of patients' somatic health problems by providing access to family doctors and timely diagnosis
- In order to manage the side effects of drugs, ensure clinical-laboratory, dynamic assessment of risk factors of agranulocytosis,[78] metabolic processes and especially hyperglycemia,[79] as well as control of leukocytes[80]
- Provide qualified electrocardiographic examination and a cardiogram specialist in the establishment to manage the side effects of psychotropic medications

of 50, 100 or 300 mg from the very beginning of treatment. For example, one of the patients was prescribed 50 mg of Zopin (Clozapine) twice a day together with Psyzine (Trifluoperazine). Another patient was prescribed Zopin - 0.3 mg three times a day together with Hoperoperidol - 30 mg.

[72] Management of Schizophrenia in Adults - Clinical practice guideline, chapter 4.7.

[73] During the Clozapine monotherapy and combination with other psychotropic medications, orthostatic hypotension, bradycardia, syncope and cardiac arrest, or fatal myocarditis and cardiomyopathy may develop, <https://ecitydoc.com/download/dosing-switching-and-other-practical-information_pdf >

[74] Convulsion medications.

[75] Treatment and Management of Schizophrenia in Adults - clinical practice guideline, chapter 4.8.

[76] Report of the European Committee for the Prevention of Torture on the visit paid to Georgia on 10-21 September 2018; see the link: https://rm.coe.int/1680945eca [last viewed 23.05.2019]

[77] Causing death.

[78] Decrease in the number of leukocytes (white blood cells) in the blood, see the link: <http://www.medgeo.net/2009/06/30/agranulocytosis/> [last accessed 27.03. 2019].

[79] High sugar level in blood, see the link: http://gh.ge/ka/disease/900/> [last accessed 23.03.2018].

[80] White blood cells, see the link: <http://www.nplg.gov.ge/gwdict/index.php?a=term&d=13&t=7368> [last accessed 23.08.2018].

- Bring the infrastructure and equipment of the dentist's room in compliance with relevant standards[81] and provide patients with urgent therapeutic and surgical dental services as defined in the State Mental Health Programme

To the Director General of Acad. B. Naneishvili National Centre of Mental Health and to the Minister of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- In case of somatic health problems, ensure that patients are timely referred, through co-operation, including by providing access to a family doctor and allocating finances for transportation to the medical establishment
- Ensure screening of all patients within the state tuberculosis programme
- Introduce the state programme for the elimination of hepatitis C in the establishment

To the Minister of IPDs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- Amend the Mental Health Programme and the management of side effects of drugs be provided through appropriate examinations and consultations, in accordance with the guidelines applied in the country
- Ensure management of somatic health problems of foreign nationals at the expense of the State.

5. Physical environment

Following the visit paid to the establishment on March 6-7, 2018, the Special Preventive Group notes positively the commissioning of a new building in the civil inpatient unit of the National Centre of Mental Health in 2018, where the 1st and 3rd units were located and 78 patients were placed during the visit. However, compared to the previous visit,[82] the gravest situation in the establishment's shelter, men's 2nd and women's 7th civil units (where 213 patients were placed during the visit) has not changed substantially, which according to the Special Preventive Group, represents **degrading and inhuman treatment.**

The European Committee for the Prevention of Torture says in its report of 10 May 2019 that during the visit of the delegation,[83] the men's ward was in a worse state. There was significant water damage to the ceilings, walls and floors. The conditions on the remaining wards were basically unchanged. Dormitories were overcrowded (with some beds in the corridors),

[81] Sanitary rules for dental outpatient-polyclinic institutions, approved by Order N309/N of the Minister of Labour, Health and Social Affairs of Georgia of 5 November 2002.
[82] Public Defender's Office, National Preventive Mechanism, Report on the monitoring of Acad. B. Naneishvili National Centre of Mental Health (May 22-25, 2017 and March 6-7, 2018), p.22, available at: http://www.ombudsman.ge/res/docs/2019040510063472825.pdf > [last accessed: 23.05.19].
[83] The European Committee for the Prevention of Torture paid a visit to Georgia on 10-21 September 2018.

dilapidated, dirty and infested with flies, with no privacy and no furniture except for damaged beds with thin mattresses and threadbare blankets and bed sheets. According to the Committee, the living conditions at the hospital could well be described as inhuman and degrading.[84]

New building (I and III units)

Old building

Men's 2nd and women's 7th civil units

The building's infrastructure is old, walls are damp and some wards have no doors. Some of the beds are wooden, but most of them are made of iron and are old. The rooms are not provided with artificial lighting, artificial ventilation or heating. No sanitary-hygienic conditions are protected in the building. The wards are overcrowded.[85] There is a heavy and bad smell everywhere. The environment is not safe for patients. During the visit of the Special Preventive Group, beneficiaries placed in the establishment's shelter, men's 2nd and women's 7th civil units were allowed to stay in fresh air for an hour a day. It should be noted that women in the shelter were the only exception, who were able to enjoy longer walks during good weather. The infrastructure of the establishment is not arranged for a walk during rainy weather.

Shelter

The bathroom of the shelter was renovated, but people with mobility disability still cannot move independently.[86] The shelter has 6 wheelchair users, who satisfy their physiological needs in wards. Other beneficiaries assist them in removing the fecal matter. The shower room is locked. The door is opened only when requested by beneficiaries/patients.

Patients do not have clean sheets, clothes or bedside tables for keeping personal belongings.

[84] The report is available at: <https://rm.coe.int/1680945eca> [last accessed: 17.05.2019]

[85] The average area of a room is 30-52 square meter and it accommodates 10-13 patients.

[86] The door size is not complaint with standards.

1st and 3rd units

The infrastructure in the new building of the National Centre of Mental Health should be praised. 2 units are located in the building.[87] The units have uninterruptible power and water supply, as well as proper natural and artificial lighting. The temperature in the building was satisfactory during the visit. However, the building was overcrowded. The permit[88] requirements[89] were not fulfilled. The shelves for storing items were placed in a common space,
but were not sufficient for all patients. In addition, the building partially meets the needs of persons with disabilities.[90] Bathrooms in several wards are partly adapted to the needs of persons with disabilities.[91]

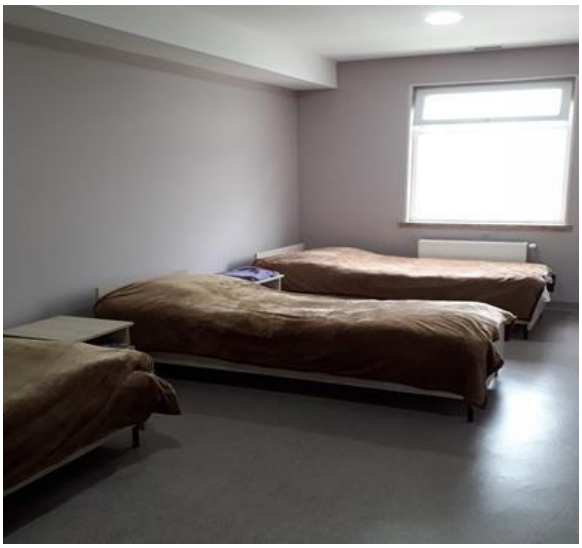
[87] 1st unit - 18 wards, 45 patients; 3rd unit - 18 wards, 32 patients, including 14 women.

[88] Decree N385 of the Government of Georgia (17 December 2010) on Approval of Provisions on the Rules and Terms for Granting Medical Activity Licence and Inpatient Facility Permit.

[89] 8 square meters per patient. The area of the wards in the units is 15-16 square meters on average, with three beds in each. The area of some wards is 27 square meters (4 beds).

[90] The buildings have a two-side ramp, with slope of 5.86% and 5.94% (according to the Government's Decree No. 41 (January 6, 2014) on Space Arrangement and Technical Regulations for Architectural and Planning Elements, the slope of a ramp shall not exceed 6% (8% in an extraordinary case), so this requirement is not fully observed in the given case. The length is 9.92 sm. The height of railings is 0.59 m (instead of required 0.90 m). The surface of the ramp is smooth, the ramp is not protected from atmospheric precipitation, which is a violation of the requirements set forth in the regulation. The building is not accessible by people with visual impairment. In particular, there is no tactile paving.

[91] The basin/toilet in the bathroom has auxiliary handrails. The width of a bathroom door is 1.03 m (according to the regulations, the width of a door should be at least 0.90m; so, this requirement is observed), but the door threshold creates an obstacle for wheelchair uses to move freely.




The establishment does not have sufficient staff (both medical personnel and support staff). They do not have information about the rights of persons with various disabilities (sensory, physical), as well as the skills needed to communicate with them and assist them. They have not been trained in this direction.

Food is served three times a day, but patients are not provided with fruit. Some patients noted that food was not enough or delicious. Patients can walk in the yard for an hour a day, but allocation of extra time is also considered. They cannot walk in rainy weather, as only part of the yard is covered.


The building is equipped with fire extinguishers; evacuation plans are posted on all floors and wards are equipped with smoke detectors. There is an emergency exit on the second floor of the building, though patients and some staff members were not aware of this. In addition, patients and staff are not informed about safety rules or how they should behave in case of fire.

The building is equipped with a video control system (covering external and internal perimeters). The respective warning sign (sticker) is placed at the entrance of the building, but there is no such a sign inside the units. Consequently, most patients are not informed about the video control.

Recommendations

To the Minister of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- Control the fulfilment of inpatient permit requirements by the establishment through systematic monitoring

To the Director General of Acad. B. Naneishvili National Centre of Mental Health and to the Minister of IDPs from the Occupied Territories, Labour, Health and Social Affairs of Georgia:

- Ensure that the capital repairs are launched in the shelter and women's and men's units of Academician Bidzina Naneishvili National Centre of Mental Health in the shortest possible time
- Take into account the standards of access to physical environment for persons with disabilities when conducting infrastructural work
- Provide all the wards of the establishment with necessary furniture (bed, bedside table, closet)
- Ensure adequate sanitary-hygienic conditions in all units of the establishment
- Take necessary steps to ensure that all patients are provided with food in adequate sanitary-hygienic conditions
- Train/provide information to the staff/patients about safety rules and behavior in case of fire. At the same time, information should be provided to patients in a simple and understandable language
- Train the staff with regard to the rights of persons with disabilities, their needs and the rules of communicating with them.