Public Defender of Georgia

Legal Situation of Persons with Disabilities in State Care Institutions

Short version of special report

2016

Contents

Introduction

The present document is a special report reflecting the results of the monitoring carried out by the Public Defender's Office (PDO) to study the situation with the rights of persons with disabilities (PWD) in state care institutions.

The monitoring was conducted within the scope of activities of the National Preventive Mechanism and the mechanism for the monitoring of implementation of UN Convention on the Rights of Persons with Disabilities – the two significant mandates granted by the state to the PDO under internationally recognized obligations. The group consisted of members of the Special Preventive Group,[1] members of the monitoring group for the implementation of UN Convention on the Rights of Persons with Disabilities,[2] employees of the Department of Prevention and Monitoring[3] and the Department of the Protection of Rights of Persons with Disabilities[4] of PDO.

Over the period from 14 to 21 March 2016, the monitoring group inspected the level of protection of human rights of PWD beneficiaries placed in five state residential institutions,[5] its compliance with the standards established in the UN Convention on the Rights of Persons with Disabilities, other international documents and the national legislation. A visit to each institution lasted one day.

To clarify the information obtained through the monitoring and fill in the existing gaps, additional data was requested[6] from the Ministry of Labor, Health and Social Affairs of Georgia, LEPL State Fund for Protection and Assistance of (statutory) Victims of Human Trafficking, LEPL Levan Samkharauli National Forensic Bureau, police departments of the Ministry of Internal Affairs of Georgia.

1. Providing specialized round-the-clock service to PWDs

Safety and protection of PWDs from discrimination, ill-treatment and torture, provision of PWDs with social security and ensuring their right to life comprise the spirit of many international acts. The UN Convention on the Rights of Persons with Disabilities of 13

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[3] Levan Begiashvili.
[4] Irine Oboladze, Rusudan Kokhodze.
[5] Tbilisi Infants' House – 58 beneficiaries; Kojori PWD Children's House – 28 beneficiaries; Dzevri Boarding House for PWDs – 64 beneficiaries; Dusheti Boarding House for PWDs – 43 beneficiaries; Martkopi Boarding House for PWDs – 69 beneficiaries.
[6] Correspondence N09–3/2455, 25 March 2016.

December 2006[7] is especially worth noting among these international acts. It establishes a human rights-based vision towards disabilities and aims at ensuring a full-fledged and equal exercise of all rights and fundamental freedoms by PWDs.

According to the human rights-based vision and modern international standards, the life of PWDs in large residential institutions is considered as isolation of PWDs from the society and violation of their rights.

Within the process of deinstitutionalization, large institutions were optimized and the number of PWDs living in boarding houses slightly decreased in the past few years. In particular, since 2015, Senaki institution for children with disabilities was closed down as a result of reorganization; the number of beneficiaries in other institutions has been decreased by several dozen persons (see the table) as well.[8] However, these developments are not sufficient to ensure effective implementation of deinstitutionalization and independent life of PWDs.

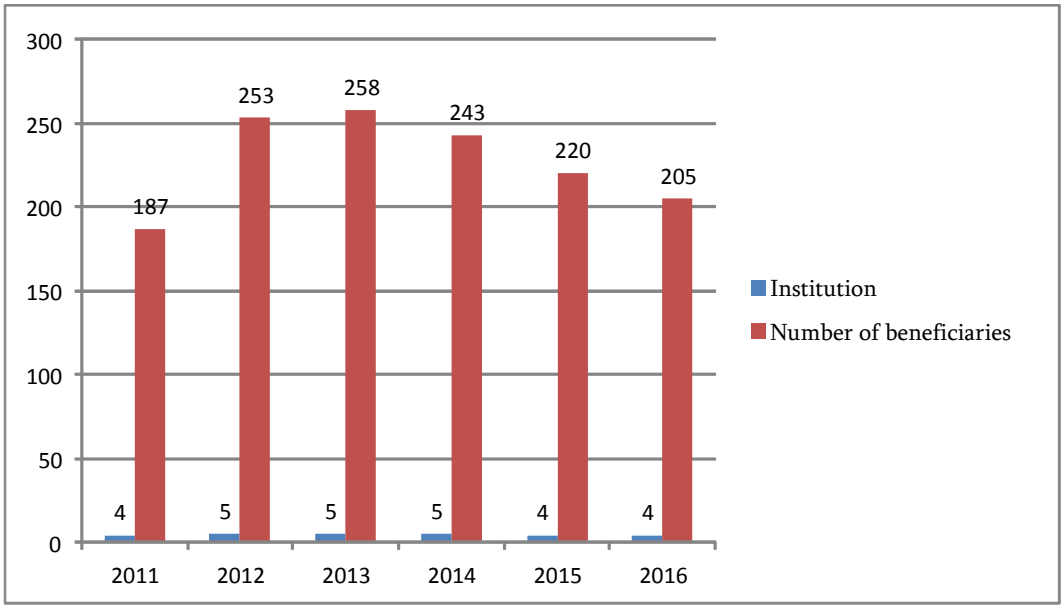
The legislation still provides the ground for the placement of PWDs in specialized institutions. Consequently, there operate three large residential institutions as well as the infants' house and Kojori boarding house for children with disabilities. For the state, placement of persons with disabilities in boarding houses is considered to be the key measure for ensuring adequate housing to them.

Table 1. Statistics on boarding houses for PWDs [9]

[7] The Convention (UN CRPD) was signed by Georgia in June 2009; the parliament of Georgia ratified it on 26 December 2013. On 12 April 2015, the document entered into force in Georgia.

[8] Information is available at http://www.atipfund.gov.ge/images/stories/pdf/statistika/2016/statistika3.pdf [last retrieved on 04.04.2016].

[9] The data do not include indicators of number of beneficiaries in the infants' house.



1.1. Administration and monitoring of service

The process of PWDs enrollment in boarding houses is coordinated by LEPL Social Service Agency which receives applications, identifies needs of PWDs and takes decision on their placement into the specific institution. This issue is regulated by the Ordinance #52/n of the Minister of Labor, Health and Social Affairs, dated back to 26 February 2010, "On Approval of Procedures and Conditions for Placing Persons in and Taking Persons out of Specialized Institutions."[10] State residential institutions represent territorial bodies (branches) of the LEPL State Fund for Protection and Assistance of (statutory) Victims of Human Trafficking (hereafter the Fund) which is subordinated to the Ministry of Labor, Health and Social Affairs of Georgia. The structure, power and rule of activity of these entities are determined by a charter which is approved by the director of the Fund.[11]

According to the charter, main issues related to the operation of branches falls within the competence of the director of the Fund. The internal regulation[12] of institutions also attribute important components of administering the service to the competence of the Fund. According to the charter, the head of the branch is responsible only for effective organization of general activity, discipline, protection of beneficiaries' rights, protection and maintenance of material-technical base of a branch. Duties of the head of the branch do not include issues related to providing supplies, employing a sufficient number of people and upgrading their qualification.

[10] Available at https://matsne.gov.ge/ka/document/view/1008810 [last retrieved on 31.03.2016].
[11] Paragraphs 2, 4 and 5 of Article 4 of the Ordinance N146 of the Government of Georgia, dated 13 February 2014, on the "Approval of Charter of LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking."
[12] Paragraph 1 of Article 2 of Internal regulation of Territorial Units (Branches) of LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking.

The analysis of the situation makes us believe that the enhancement of the role of a branch administration would ensure effective and timely identification and settlement of abovementioned issues. Moreover, there is a need to improve communication between the Fund and the territorial bodies, i.e. branches.

According to the charter of the central office[13] of the Fund , which is approved by its director, responsibility for the conduct of planned and unplanned monitoring of branches of the Fund lies with the Division of Monitoring, Evaluation and Project Design (hereinafter, the Monitoring Division). With the involvement of a special group, the Monitoring Division carries out monitoring, prepares a report on the findings and draws up corresponding recommendations.

The PDO requested information[14] about monitoring/inspection of branches conducted by the Fund in 2015 and 2016. According to received correspondence,[15] the Monitoring Division conducted 12 planned and 19 unplanned monitoring of branches during 2015, and nine unplanned monitoring as of April 2016. As explained by the director of the Fund, unplanned monitoring is conducted to double-check the information concerning individual beneficiaries and to study letters received from the PDO.

Based on the analysis of the documentation[16] received from the Fund, which reflects the results of planned and unplanned monitoring, it may be concluded that in the majority of cases monitoring was a mere formality. Although certain shortcomings related to the maintenance of documentation, treatment of beneficiaries with medication, low qualification of employees, etc. were identified, the reports, on certain occasions, do not reflect a real situation in the institutions. The format and volume of reports also make it unclear what was the instrument based on which the special group conducted monitoring.

1.2. Human Resources and requirements towards staff

Beneficiaries in specialized residential institutions should be provided with service, education and development of their skills by a sufficient number of qualified employees. The evaluation of documentation of residential institutions for PWDs, interviews with service providers and beneficiaries, conducted by the monitoring group, reveal that the employment of a sufficient number of qualified personnel represents a serious challenge.

[13] Article 10 of the Charter of the Central Office of LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking; available at http://www.atipfund.gov.ge/index.php/ka/sajaro-info/229 [last retrieved on 20.04.2016].
[14] Letter N09–3/2455 of 26 March 2016.
[15] Letter N07/554 of 13 April 2016 of the director of LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking.
[16] Letter N07/554 of 13 April 2016 of the director of LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking; attachments 1, 2, 3.

Heads and personnel of institutions had not undertaken a professional training in the field of PWD care and protection of their rights. Stuff responsible for medical service and rehabilitation lack competence; their personal files often miss documents certifying their qualification (Dzevri boarding house for PWDs, Dusheti boarding house for PWDs, Tbilisi Infants' House).

Social workers[17] rarely visit boarding houses – only upon the request of administration. Consequently, they are not involved in evaluating individual needs of beneficiaries, designing individual development plans and psycho-social rehabilitation programs and meeting their various needs.

According to the acting director of Tbilisi Infants' House, an acute shortage of stuff prevents the institution from creating an effective and caring working environment. Considering the needs of beneficiaries of this institution, a short-term leave of employees as well as a paid leave of any employee often results in only two caregivers being left in a group of children with grave health conditions.

A shortage of stuff is also observed in the Kojori house for children with disabilities. The institution lacks a psychologist, an occupational therapist, masseur and a sufficient number of caregivers (especially during non-working days and hours or in cases when a caregiver has to attend a beneficiary in hospital). The administration of Dzevri boarding house for PWDs also complains about the lack of sufficient stuffpersonnel. There are four nurses and seven caregivers working around the clock in this institution. One caregiver has to simultaneously supervise 11 beneficiaries with at least 10 amongst incapable to take care of themselves.

A gender balance among the institution staff is a serious problem as well. Medical personnel and caregivers in PWD boarding houses (except for Martkopi and Dzevri boarding houses) are only women and any care – be it personal hygiene or bathing, change of clothes and linen - is provided only by women caregivers. Heads of boarding houses view the gender imbalance as a serious problem though explain it with the difficulty in finding sufficient stuff.

Personal files of employees are also maintained poorly. The majority of them miss documents certifying their qualification/retraining and appointment to a position. Heads of branches explain this shortcoming with the fact that employees are selected by the Fund. The documentation of employees is in a relatively better condition in Dusheti and Dzevri branches and the Infants' House. Personal files of Martkopi boarding house staff, according to the head of boarding house, is kept in the Fund and only copies of incomplete documentation are available on the site.

[17] Employees of territorial units of the LEPL Social Service Agency.

The lack of care for the professional development of employees, which has an extremely adverse effect on the quality of service, was observed in all inspected residential institutions for PWDs. According to the administration of several branches (Martkopi boarding house for PWDs, Kojori PWD Children's House), they often approach the Fund with the request to retrain the personnel but without result. The inspection of documentation revealed that personal files of the staff working on bio-psycho-social aspects of beneficiaries (psychiatrist, therapist, nurses, psychologist, occupational therapists and caregivers) lack documents certifying trainings for upgrading the qualification and the professional development. The last training conducted for a segment of personnel took place at the end of 2012, and that training was not distinguished for a variety of topics. Administrations of several institutions (Martkopi boarding house) name a poor qualification of caregivers in providing first aid to beneficiaries as a serious problem.

It is worth noting that based on the findings of internal monitoring, the Monitoring Division of the Fund underlined the problem of qualification among personnel of branches and issued a recommendation to develop a plan of necessary measures for retraining employees of the Fund, especially, in issues of confidentiality, protection against violence and exploitation and prevention of ill treatment. However, the information provided by the Fund[18] shows that no trainings were conducted for the personnel of branches on the mentioned topics.

Physical and mental state of beneficiaries in the boarding houses is diverse. A day-long observation during the monitoring showed the difficulties in working with them. Nurses and caregivers work round the clock in difficult, emotionally unbearable conditions, which undermines their productivity and adversely affects the quality of service. It is recommended to ease the working schedule, to ensure the supervision of the personnel by an invited specialist (a consultant or a psychotherapist), and in order to maintain their mental health, to conduct a team work on emotional ventilation (venting negative emotions) at least once a quarter.

The legislation and practice must ensure social guarantees of personnel working in residential institutions for PWDs; this implies the adequate working schedule and labor remuneration, addition of needed specialists, the protection of the right to paid leave, et cetera.

1.3. Feedback and complaints procedures

The monitoring has revealed the incompliance of the majority of institutions with the standards of feedback and complaints procedures. Moreover, beneficiaries are not aware of feedback and complaints procedures at all.

[18] Letter N07/554 of 13 April 2016 of the director of LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking; attachment 5.

Every boarding house has an internal regulation either posted on the board or placed in the form of a bound document; however, reading it is a serious challenge as it hangs at a significant height and is printed in a hardly readable font. According to service providers, the internal regulation, together with a special anonymous box, is deliberately placed at an unreachable height for fears of being "torn or damaged."

A special anonymous box, the so-called "complaints box" is placed in every boarding house. According to the internal regulation, the box is opened by a representative of Monitoring Division of the Fund while the protocols on the study/consideration of the content of the box are maintained in the Fund. As the heads of boarding houses said, this procedure was carried out several times, but the boxes were mainly empty and therefore, the opening procedure is rarely performed.

The institutions do not practice feedback procedure by means of anonymous questionnaires. Every boarding house has a feedback and complaints registration log, but as a formality with no incidents registered in it. Nor are measures undertaken in response to expressed opinions recorded in it. Feedback and complaints registration logs do not contain even a single entry which would indicate about problems emerging in the service, expressed opinions or interactive discussion and resolution of issues. Service providers do not record instances of expressing positive or/and negative opinions by beneficiaries.

Interviews of the monitoring group members with beneficiaries of boarding houses revealed that due to the reading, writing and vision impairments , beneficiaries mainly approach the administrations of boarding houses with oral opinions and complaints, but they are not considered and registered. For example, according to beneficiaries of the **Dusheti boarding house for PWDs**, they, either individually or as a group, used to appeal to the management of boarding house about unsolved problems and violation of their rights occurring for years (the problems related to clothing, food, special assistive devices and orthopedic shoes; violence among beneficiaries; inhumane treatment by service providers; denial of support in exercising the rights), but instead of problems being solved they got negative assessments and reprimands from the management. Employees scolded beneficiaries for being "ungrateful" for living in the boarding house and receiving "so much care;" as a result, beneficiaries regularly apply extreme forms of protest (hunger strike, self-injury, blocking of the road, calling in police) or apply to nongovernmental organizations and the PDO.

Beneficiaries of **Martkopi PWD boarding house** were mainly grateful to the head of the branch for providing support and assistance in contacting the social service and nongovernmental organizations, dealing with health issues, though they complained about pension issues, violence

among beneficiaries, separation from their children, fail to obtain necessary support in the issue of placement in geographically remote Child Care Institutions.

In **Kojori PWD children's boarding house**, only one beneficiary seems to take efforts to realize his own rights. He repeatedly asked the administration to allow him to use a personal computer (due to sharp impairment of vision), also, in order to avoid deterioration of mental health and prevent conflict, he regularly demanded that to be isolated from aggressive beneficiaries. With this request, he also addressed the PDO by phone. The administration failed to provide him with a personal computer and protect him from violence. As a compromise, he is allowed to use the office computer only during working hours.

2. Challenges in protecting the right to life of beneficiaries with disabilities in state care institutions

A high number of deaths of beneficiaries is an unfortunate trend observed in territorial units (branches) of LEPL State Fund. Relevant services of the Ministry of Internal Affairs launched investigation into several cases under Articles 115 and 116 of the Criminal Code of Georgia; in particular, on 28 November 2015, investigation began on the fact of death of M.K. in Tbilisi Infants' House (criminal case N007281115002); on 22 December 2015, investigation began on the fact of death of G.M. in Martkopi boarding house for PWDs (criminal case N021221215001); and on 4 February 2016, investigation began into the death of I.G.in Dusheti boarding house for PWDs (criminal case N025040216002).

Within the mandate granted under Article 12 of the Organic Law of Georgia on Public Defender of Georgia, the Public Defender, on his own initiative, started the study into the facts of the above mentioned facts. Representatives of the Department of the Protecting Rights of Persons with Disabilities of PDO instantly paid visits to the above listed institutions. Through official correspondence, information was also requested from LEPL State Fund for Protection and Support of Victims of and Persons Affected by Human Trafficking, Prosecutor's Office of Georgia, LEPL Levan Samkharauli National Forensic Bureau, relevant police departments and divisions of the Ministry of Internal Affairs of Georgia.

The analysis of the received information prove that the investigations into the above mentioned cases are carried out in an ineffective and procrastinated manner. The investigation into the death of M.K. in the Tbilisi Infants' House, launched on 28 November 2015, and into the death of G.M. in Martkopi boarding house for PWDs, which started on 22 December 2015 (criminal case N021221215001), are still under way and no criminal proceedings has been instituted against

any concrete person.[19] The investigation into the death of I.G. in Dusheti boarding house for PWDs, which started on 4 February 2016 (criminal case N025040216002), **was terminated due to absence of criminal signs envisaged in the Criminal Code**.[20]

Case of I.G.

On 4 February 2016, the beneficiary I.G. of Dusheti branch was served dinner into his living room by S.T., another beneficiary and I.G.'s roommate. As S.T. recounted, when eating I.G. "choked with" a piece of meat; the service personnel tried to help him, but without result. A medical crew of ambulance, which was called in, took the beneficiary to the hospital where, despite undertaken reanimation measures, the biological death of I.G. was stated.

According to the conclusion N000592116 of LEPL Levan Samkharauli National Forensic Bureau, "the death of I.G. was caused by mechanical asphyxia resulting from a foreign body (foreign microelements in bronchial lumen; according to medical documentation, food masses) having entered respiratory passages."

To study the case, the Public Defender sent a letter to the Internal Audit Department of the Ministry of Labor, Health and Social Affairs of Georgia.[21] In response, a report was provided with a correspondence N01/43414 of 6 June 2016, according to which the Internal Audit Department found out that the beneficiary I.G. had his meals mainly in his living room (without a caregiver's supervision), though no such medical indication was given by a doctor.

The Internal Audit Department established that the head, the deputy head, the doctor therapist, the psychologist and caregivers of Dusheti boarding house failed to properly fulfill the obligations set forth in the charter and internal regulation of the institution and issued the following recommendations:

- […] Discipline must be reinstated in the boarding house and the catering process be placed within the limits of regulations in order to avoid it directly or indirectly contributing to lethal outcome;
- The management of the Fund must evaluate facts specified in the conclusion and within the limits of its discretionary powers, apply measures of disciplinary liability against concrete individual stuff members, including their dismissal from jobs.

[19] Letter NMIA316017174774, dated 11 July 2016, of the Kvemo Kartli Department of the Ministry of Internal Affairs of Georgia; Letter NMIA41601846427, dated 27 July 2016, of Bake-Saburtalo Division of Tbilisi Police Department of the Ministry of Internal Affairs of Georgia.
[20] Letter N1170898, dated 13 May 2016, of the Dusheti District Division of the Ministry of Internal Affairs of Georgia.
[21] Letter N 09/5619 dated 1 June 2016.

The PDO found out that in order to fulfill the recommendation issued by the Internal Audit Department concerning the death of I.G., the LEPL State Fund had dismissed the head of Dusheti branch on the basis of the latter's personal letter of resignation; applied a disciplinary sanction - "reprimand" towards a psychologist and a caregiver of the boarding house for the failure to properly perform their duties; also, the catering process of the institution was placed within strict limits of the regulation.[22] As noted already, the Dusheti district division of the Ministry of Internal Affairs terminated the investigation into the death of I.G. (criminal case N025040216002) because of absence of criminal signs envisaged in the Criminal Code.

The monitoring group believes that none of the state entities responded to the death of beneficiary I.G. in the Dusheti boarding house for PWDs in an effective and adequate manner; this may be evaluated as the violation of the right to life.

3. Treatment of PWDs in the state care institutions

Beneficiaries of specialized residential institutions for PWDs shall receive service based on their individual needs and capabilities. This service shall be delivered to service recipients without discrimination on any ground, biased attitude or negative treatment on the part of service providers, other beneficiaries or any other person. All beneficiaries of the institutions shall be protected from any form of violence (physical, psychological, sexual, economic) and compulsion. They shall be ensured with equal opportunity of using services.[23]

Based on the results of the monitoring of residential institutions for PWDs, the Public Defender believes that the institutional arrangement of specialized residential institutions, unadjusted infrastructure, shortage of specialist and supportive staff and their poor professionalism, lack of psycho-social services and contact with outer world and families cannot ensure the delivery of services tailored to individual needs of PWDs, thereby provoking gross violations of rights and unequal and degrading treatment of beneficiaries.

3.1. Protection against discrimination

[22] Letter N 07/877 dated 4 July 2016.

[23] Order N01–54/n, dated 23 July 2014, of Minister of Labor, Health and Social Affairs of Georgia "On Approval of Minimum Standards of Service to PWDs and Elderly Placed in Specialized Residential Institutions," Annex N1, Article 10. Available at https://matsne.gov.ge/ka/document/view/1008810 [last retrieved on 31.03.2016]; Order N66 of the Government of Georgia, dated 15 January 2014, "On Technical Regulation on Approval of Childcare Standards," Annex N1, Article 11; available at https://matsne.gov.ge/ka/document/view/2198153 [last retrieved on 31.03.2016];

The institutions inspected by the Public Defender, regardless of their size, the number and age of beneficiaries, represent a typical example of an institution[24] where persons with disability status due to mental retardation and mental disorders stay for long periods of time and often, till the end of their lives. Being isolated from a society, they lose personality, private space and initiative, become accustomed to routine life and form an institutional subculture.

The results of the monitoring show a high risk of unequal treatment of beneficiaries on various grounds in the institutions for PWDs.

Several beneficiaries of Dusheti boarding house, who are distinguished for their aggressive, manipulative or querulant behavior, seem to enjoy certain privileges. Compared with others, they have relatively better refurbished and equipped rooms and enjoy a higher degree of independence and possibility to disobey established rules. They have the right to use individual lavatory, satellite broadcasting, the Internet, also, to receive a member of family overnight, to have dinner in their living rooms, to enjoy service of other beneficiaries or have caregiver make them coffee in their rooms. All this develops a sense of inequality among other beneficiaries based on different treatment and it is not clear whether all this have an objective reason.

The monitoring process revealed yet another problem questioning the issue of equality of PWDs in the residential institutions. In the past, the majority of beneficiaries were declared legally incapable[25] and as a result, they were not regarded as subjects of law. The beneficiaries are not informed about implemented legal procedures and identities of their trustees. According to effective legal regulations, beneficiaries declared legally incapable by a court, cannot receive social package (pension) personally and this amount is monthly accumulated on their bank accounts.[26] However, they were not properly informed about these procedures. They thought they were deprived of pension without any reason and asked members of the special preventive group to help in reinstating it. According to beneficiaries, the lack of money poses serious

[24] THE ITHAKA TOOLKIT defines an institution as "any place in which people who have been labelled as having a disability
are isolated, segregated and/or compelled to live together. An institution is any place in which people do not have, or are not allowed to exercise control over their lives and their day-to-day decisions."

[25] Court recognized eight out of 44 beneficiaries in Dusheti branch, 39 out of 68 beneficiaries in Martkopi branch, and 60 of 64 beneficiaries in Dzevri branch as incapable. According to administrations of Dusheti and Martkopi branches, the documentation on the beneficiaries who were declared incapable are now at the stage of preliminary preparation and they have not yet addressed the court to be recognized as their supporters. According to the head of Dzevri branch, personal files of all beneficiaries who were declared incapable had been sent to a court by 1 March.

[26] Ordinance №279 of the Government of Georgia, dated 23 July 2012, on "Determining Social Package." Paragraph 9 of Article 16: "A person who was declared incapable before 1 April 2015, does not have a representative (guardian) and becomes eligible for, or already obtained the right to, a social package, the Agency, before individual assessment, opens a current (deposit) account on the name of this person in a banking institution issuing a social package, onto which an amount of social package is transferred monthly, while after an individual assessment, the receipt of social package shall be carried out in accordance with paragraph 2 of article 10 of this Rule." Available at https://matsne.gov.ge/ka/document/view/1707671 [last retrieved on 14.04.2016].

problems to them – they cannot buy needed items to arrange their private space, to visit their children in other institution, to replenish their clothes and footwear, et cetera.

Despite crucial positive changes introduced to the Georgian legislation in 2015,[27] the evaluation of the degree of legal capability of beneficiaries in residential institutions and the identification of a supporter still remain a problem, therewith violating the rights of beneficiaries who were declared incapable by a court due to their mental disorders and retardation.

Proceeding from the above said, the monitoring group believes that due to ignorance of corresponding legal guarantees, the beneficiaries of boarding houses for PWDs do not have a possibility to enjoy a number of rights on equal footing with others and represent a risk group of unequal treatment.

3.2. Protection against violence

Based on the analysis of documentation, interviews with beneficiaries and stuff members conducted by the representative of the Public Defender, the monitoring group arrived at a conclusion that the state care system fails to ensure the protection of PWDs from violence, to manage their difficult behavior and to prevent them from abusing alcohol. Nor does it ensure the safety of beneficiaries and stuff.

The main form of violence in the inspected residential institutions is the violence among beneficiaries, conditioned by the lack of professionalism of institution stuff in preventing from as well as dealing with difficult and violent behavior, psychomotor agitation of beneficiaries. Responsible personnel is ignorant of verbal and non-verbal de-escalation technique. They often refer to facts of violence as physical and verbal offense; are not able to give medical and legal assessment to facts and to protocol incidents. Employees are mainly in the position of observers and sometimes even become victims of violence. Medical and supporting personnel are not trained in the issues of managing violence, auto- and hetero-aggression or agitation.

Service providers are unable to manage violent and aggressive behavior caused by abuse of alcohol and to protect beneficiaries from violence and exploitation.

Internal regulation of boarding houses (which fully reflect the requirements of minimal standards of servicing PWDs and older persons in specialized residential institutions) regulate the issue of **Protecting Beneficiaries from Violence, Discrimination and Neglect**. In accordance

[27] With the mentioned changes the mechanisms of support and in exceptional cases, replacement were introduced instead of the system of entire neglect. Such a large-scale legislative amendment was prompted by a decision of the Constitutional Court of 8 October 2014, by which effective legislative regulations on the restriction of capability of persons with disabilities were declared unconstitutional.

with these very standards, the institutions have "the log for the registration of measures undertaken in response to violence;" however, this log, in the majority of cases, does not contain comprehensive entries. Nor does it contain the information about measures undertaken in response to violence. **Although all units of service providers are highly motivated to undertake training/retraining, the Fund do not organize for them any.**

The beneficiaries interviewed by an expert-psychiatrist from the special prevention group did not state openly about physical violence applied by service providers against them.

Within the limits of their cognitive and sensory capabilities, beneficiaries talked openly and freely about their problems. In case if the difficulties emerged in clarifying the facts, they asked other beneficiaries whom they trusted to get involved in the conversation. Only one beneficiary (in Dzevri boarding house for PWDs) expressed fear and concern saying that if in a conversation with the expert he discloses any information that is unfavorable for the service provider, he may get a corporal punishment – be "beaten" or given "injections." Other beneficiaries did not confirm such facts.

When visiting groups of beneficiaries in Kojori boarding house for PWDs, experts observed a fact which smacked of violence. In particular, a caregiver had her hand laid on the face of a girl in a wheelchair with speech impairment and was expressing "caress and affection" towards her with a sharp pressing gesture on her mouth. At the same time, the caregiver was claiming that the girl liked that gesture. However, one could read an unpleasant emotion on the beneficiary's face. A member of the special prevention group got an impression that the caregiver did not even realize that she was handling the beneficiary violently and that the beneficiary did not like her behavior. This is yet another indication of low qualification of the caregiver.

However, in the post-monitoring period, the Public Defender of Georgia learned about an alleged violence against a beneficiary in Dzevri boarding house by a caregiver R.V. According to the information, the incident took place outside the institution, in Terjola, on 29 July 2016, when the beneficiary was being taken to a hospital for a medical service and the caregiver, accompanying the beneficiary for the latter's difficult behavior, applied violent methods. The PDO started the inquiry into the case (N981316) and will inform the interested public society about its results. At the same time, representatives of the Public Defender carry on a systematic monitoring of such types of institutions to identify violence or other facts of human rights violation and to react to them.

The evaluation of interview with service providers and beneficiaries, entries in the log for registering measures undertaken in response to violence, also, the observation of environment and behavior of beneficiaries during the monitoring period provides us with the ground to

assume that violence among beneficiaries occurs daily in Dusheti, Martkopi and Dzevri boarding houses. Separate incidents of violence among beneficiaries are observed in Kojori PWD children's house whereas facts of violence are not timely identified and evaluated by the personnel, nor are they properly managed and registered in the log for measures undertaken in response to violence.

A disagreement which starts over a trivial matter in the institutions often degrades into a verbal and physical offense, auto- and hetero-aggressive behavior, and ends up in calling police by a beneficiary involved in the conflict, taking beneficiaries into mental clinics or staging protest actions by beneficiaries.

A fact of physical violence between beneficiaries was observed in Dusheti boarding house for PWDs and a criminal proceeding was instituted against one of the beneficiaries. After conducting a forensic mental health examination, the beneficiary was placed under a compulsory treatment.

Incidents recorded in the log for registering measures undertaken in response to violence are, as a rule, assessed as "conflicts." The log does not contain a description of measures undertaken by the administration in response to mentioned facts.

On 22 April 2015, during violence among four beneficiaries, one of the beneficiaries called the police. This fact is assessed as a "conflict" and the log does not indicate the measures undertaken by the administration to settle it. According to the records, the abovementioned fact took on a broader scale; it involved other beneficiaries and a segment of them blocked the road in protest. The records do not explain the reason and results of the protest. On the same day, a fact of violence between two beneficiaries took place: "a conflict occurred involving wheelchair crashes." Similar facts were recorded in the following days too and police was called on each occasion.

On 16 August 2015, a beneficiary verbally and physically offended a cleaner which resulted in the cleaner requiring medical assistance (because of high blood pressure).

Opposition between separate groups of beneficiaries is observed in Dusheti branch. In their interviews with a member of the monitoring group, they referred to each other using offensive and threatening words; they recounted incidents of violence by using phrases such as: "beat up each other," "threatened each other with cutting off their heads," "was squeezing his throat but others managed to stop him," et cetera. Beneficiaries do not hide their aggressive nature and consequently, do not rule out using all means (including knives) available to them in a yet another conflict.

Interviews with beneficiaries revealed incidents of economic and psychological violence in Dusheti boarding house for PWDs, which might be of systemic nature; in particular, a beneficiary who deems himself intellectually superior to others and human rights defender of those "who are illiterate and cannot even make simple math," said that he went on "hunger strike naked," sewed up his mouth, "ripped his own belly," etc. to defend their rights; he went on to say that he does not ask for his share in exchange for his efforts but if anyone gives him a certain sum from their pensions, he will not refuse taking it. This beneficiary is indignant about being branded a "sexual offender," though he does not deny having sexual intercourse with beneficiaries. Although the interviews with beneficiaries and the personnel during the monitoring did not reveal concrete facts of sexual exploitation,[28] this issue requires additional study and monitoring by responsible persons.

Records in a log of nurses for daily shift and shift handover prove that conflict and violence among beneficiaries happens daily. The violence is mostly verbal, sometimes degrading into physical offense. Reasons of violence, alongside daily, trivial ones, include inebriation, swearing, irregular behavior of beneficiaries, psychomotor agitation and insomnia.

One of the beneficiaries leaves the boarding house every day and returns inebriated. His behavior, cursive and offensive expressions provoke others towards aggressive actions and he also easily responds to provocation. Alcohol is also easily available for other beneficiaries of violent and aggressive behavior. Yet another beneficiary, in a state of agitation, smashed a glass of picture frame hanging on the wall with his fist and threatened to harm himself (gouge his eyes out), kill himself, harm others unless he was added psychotropic medication. The record of the nurse does not describe measures undertaken to deescalate aggressive behavior, nor does it provide an assessment of the medical personnel of circumstances having provoked the behavior.

The shortage of medical and educational stuff is apparent in **Kojori PWD children's house** as well as the lack of their practical skills of verbal and non-verbal management of aggressive behavior of children. They are unable to ensure protection of beneficiaries from violence. One of the institution's beneficiaries is distinguished for his aggressive/difficult behavior and often applies violence against other beneficiaries – harms others as well as harms himself and a need arises to take him to hospital by ambulance for medical assistance.

One should mention a positive practice in Kojori PWD children's house – violence or tragic accidents are recorded as extreme incidents, detailing all components of difficult behavior.

[28] **Sexual exploitation** – involvement of a person in prostitution, other sexual services or production of pornographic materials by using threat, violence, coercion, blackmail against him/her or abusing his/her helpless state; by using official status, or through providing false information about the nature and conditions of the job offered. Article 3 of Law of Georgia on Combatting Human Trafficking.

3.3. Mechanical/chemical restraint and isolation

Service providers and beneficiaries in the boarding houses for PWDs, Kojori PWD children's house and the Infants' House, which were inspected by the monitoring group, deny instances of mechanical restraint[29] and isolation;[30] the institutions do not have a room for isolation and special means of Physical/mechanical restraint. Every institution has a log for registration of mechanical or/and chemical restraint[31] though not a single fact of undertaking this procedure has been entered in it.

Article 12 of the internal regulation of branches specifies verbal and non-verbal procedures of managing difficult behavior. To manage difficult situation, paragraph 7 of the article, in acute situations, allows; (a) physical interference, (b) mechanical restraint and (c) chemical restraint, as well as isolation and obligates the service providers to register instances of mechanical or/and chemical restraint.

In the opinion of expert psychiatrist of the monitoring group, the methods of managing difficult behavior, set out in the internal regulation (article 12), are ambiguous; **they do not consider requirements of the Georgian legislation and international standards of mechanical or/and chemical restraint and isolation procedures**. In addition being an indication of lack of training of the stuff in managing difficult behavior, this **contains a threat of violating the PWDs' rights and violent and inhumane treatment against them**:

- Paragraph 10: "Mechanical restraint is applied towards a beneficiary upon the decision or consent of a psychiatrist who writes the information about the use of mechanical restraint in a medical documentation of beneficiary, included in the log for registering instances of mechanical restraint" – **this paragraph does not contain accurate procedures and mechanisms for the monitoring of mechanical restraint**;

- Paragraph 11: "Mechanical restraint shall last until a beneficiary with difficult behavior poses a threat to himself/herself or/and others" – **this paragraph does not specify strict terms of length of mechanical restraint;**

[29] Ordinance №92/n of Minister of Labor, Health and Social Affairs of Georgia, dated 20 March 2007, on "Approval of Instruction on the Rule and Procedures of Applying Methods of Mechanical restraint of Patients with mental Disorders."

[30] **Seclusion** - involuntary placement of a patient alone in a locked room. Means of Restraint in Psychiatric Establishments for Adults. Excerpts from 16th General Report of the European Committee for the Prevention of Torture [CPT/Inf (2006) 35].

[31] **Chemical restraint** - medicating a patient against his/her will for the purpose of controlling behavior. Means of Restraint in Psychiatric Establishments for Adults. Excerpts from 16th General Report of the European Committee for the Prevention of Torture [CPT/Inf (2006) 35].

- Article 12 **does not specify by whom and where may the mechanical restraint or isolation be performed and what particular means can be used** for the aim of the mechanical restraint;

- The definition of chemical restraint provided in the internal regulation "chemical restraint – the use of medication" (paragraph 7, "c") does not reflect the essence of the procedure and does not meet the definition of chemical restraint provided by international organizations.

The institutions lack a protocol of mechanical and chemical restraint or isolation. The personnel of the boarding houses are ignorant of the instruction on the rule and procedures of applying methods of mechanical restraint.[32] The branches are not equipped with special means of mechanical restraint. Beneficiaries are not informed about the legitimacy, or medical indication of immediate need for isolation, mechanical and chemical or manual restraint procedures.

4. Beneficiary-oriented environment, safety and sanitary conditions

The monitoring revealed problems in terms of infrastructure, physical environment and sanitary-hygienic conditions in all inspected institutions. At the same time, the number of beneficiaries in boarding houses well exceed the maximum number[33] established by the standard (the number of beneficiaries shall not exceed 24), which is not conducive to creating a family type environment. Requirements of the universal design were not taken into account in arranging a physical environment of boarding houses and therefore, there is a need for a special design – adjustment to the needs of PWDs. Infrastructure of none of the institutions meets accessibility standards for PWDs. The needs of persons with hearing and vision impairments are totally ignored. Serious problems were also observed in ensuring supporting equipment.

The special preventive group believes that all the above mentioned might create the ground for degrading and humiliating life of PWDs in the Institutions.

Dusheti boarding house for PWDs

[32] Law of Georgia on Psychiatric Care, Article 16, Methods of mechanical restraint of patients.
[33] Order N01–54/n, dated 23 July 2014, of Minister of Labor, Health and Social Affairs of Georgia "On Approval of Minimum Standards of Service to PWDs and Elderly Placed in Specialized Residential Institutions," Annex N1, Article 2, paragraph 2. Available at https://matsne.gov.ge/ka/document/view/2391345 [last retrieved on 31.03.2016].


The entry to the residential building is adjusted. There are two wheelchair ramps on the front side of the building; one of them is installed at the central entrance though it is impossible to use it due to its steep falling surface, while another, an operative ramp, is installed at the end section of the façade. Therefore, when coming out into the yard by the ramp, beneficiaries have to take quite a long distance and they expressed their dissatisfaction about that in their interviews with the monitoring group members. The building lacks a balcony. The staircase does not have a handrail, thus posing a problem to people with restricted mobility. An elevator in the building operates with difficulties due to low voltage. It cannot be called to the ground floor.

There is an isolator on the ground floor of the main building, with satisfactory sanitary-hygienic conditions. The lavatory in the isolator is not adapted. Beneficiaries are placed here upon the decision of a doctor when various risk-factors occur.


A kitchen/dining room is located in a separate building which is connected to the main building by a corridor with a falling surface. It is noteworthy that due to the angle of steep falling surface, this corridor can only be used by beneficiaries in electric wheelchairs.

A microbus of the boarding house is not adjusted to the needs of PWDs, Beneficiaries use this transportation means by using a manually produced device while the wheelchairs inside the microbus are fixed only with the use of wheelchair wheel locks which do not ensure proper safety.

Kojori boarding house for Children with DIsabilities


The boarding house has an uninterrupted water, natural gas and electricity supply. The temperature in the building is satisfactory. There is a wheelchair ramp at the central entrance with 6% slope, and two ramps in the back yard with 20% slope which does not meet the standard determined by the Technical Regulations on the Space Design and Architectural and Planning Elements for Persons with Disabilities approved by the resolution No 41 of the government of Georgia on 6 January 2016.[34]

There is an isolator consisting of two rooms on the ground floor of the main building and its sanitary-hygienic condition is satisfactory. The isolator has a lavatory adjusted to the needs of Persons with Disabilities.


Cleanliness is observed in the kitchen and the dining room and they are properly ventilated.

[34] According to Paragraph 4 of Article 3 of the Technical Statute for Setting up Areas and Architectural and Planning Elements for Persons with Disabilities, approved under the Ordinance No 41 of the Government of Georgia on 6 January 2014, "the slope of the wheelchair ramp must be 6% of its length (in special cases, 8% of the length)."


A microbus of the boarding house is not adjusted and beneficiaries in wheelchairs get on it with the assistance of personnel, which creates a threat of injuring beneficiaries.

Tbilisi Infants' House

The Tbilisi Infant's House has two two-story residential and dining buildings. The entrance of the residential building is not adjusted to the needs of PWDs and the stuff has to carry beneficiaries with wheelchairs in their hands. The territory of the boarding house is hedged.


The ground floor of the main building houses the administration, a warehouse for medications, a warehouse for hygienic supplies; toys are also kept here. The building has an elevator. The institution is fit with sensory and rehabilitation room. It does not have a physiotherapy cabinet.

The sanitary-hygienic condition of the main kitchen and warehouse is not satisfactory.


Martkopi boarding house for PWDs

The number of beneficiaries in Martkopi boarding house is almost three times as many (67 beneficiaries) as the established standard[35], making it impossible to create family-type conditions. The territory of the boarding house is hedged and it has a yard which is not used for therapeutic purposes or for the development of everyday skills.


None of the wheelchair ramps installed at the building has handrails.[36] The institution lacks fully adjusted lavatory, furniture (beds, chairs, tables, etc.). The environment is completely inaccessible for persons with vision and hearing impairments.

Beds of beneficiaries in wheelchairs are not adjusted and they find it difficult moving from the wheelchair into the bed due to small space in the room.

[35] According to Paragraph 2 of Article 2 of Minimum Standards of Service to PWDs and Elderly Placed in Specialized Residential Institutions approved under Order N01–54/n, dated 23 July 2014, of Minister of Labor, Health and Social Affairs of Georgia, the maximum number of beneficiaries shall not exceed 24.

[36] According to Paragraph 6 of Article 5 of the Technical Statute for Setting up Areas and Architectural and Planning Elements for Persons with Disabilities, approved under the Ordinance No 41 of the Government of Georgia on 6 January 2014, the height of the handrail shall be 0,9 meters, made of rods at the height of 0,5 meters and 0,7 meters.

The residential building is equipped with the elevator. Responsibility for assisting in opening and using the elevator lies with the watchman. A person in wheelchair must approach him in order to move up to a corresponding floor. The elevator is not adapted, especially, for people with visual impairments.

None of the rooms in the institution have identifying inscription. The administration justifies it with the illiteracy of beneficiaries.

The monitoring group observed certain shortcomings in the supply of supportive items. In particular, none of 12 beneficiaries in wheelchairs have special cushions or electrical wheelchairs. The warehouse missed the supply of other supportive items too. The boarding house has beneficiaries with impaired mobility, who have only walking sticks.

One of the beneficiaries of the institution, whom the personnel refer to as a "bedridden glass child" is taken into the yard in an obsolete pram. They lack a special supportive item by which they would be able to move the child and provide hygienic procedure to this him/her.

The microbus of the boarding house is not adapted for PWDs; it is not fit with identification/information sign, the only sign the microbus has is an inscription which says "children."

<u>Dzevri boarding house for PWDs</u>

Dzevri boarding house for PWDs shelters three times as many beneficiaries (64 beneficiaries) as the established standard, making it impossible to create family-type environment. The physical environment does not meet a broad spectrum of individual requirements. The requirements of universal design were not observed in constructing and refurbishing the building and therefore, the physical environment requires adjustment.


The power distribution substation is in the yard, making it impossible to observe minimal safety standards as the source of power is not properly protected. There is a fire fighting pool between the residential building and the dining building, in which household waste is placed. Containers for such waste lack lids, creating a problem in terms of sanitary-hygienic condition.


The absolute majority of sleeping rooms in the boarding house do not meet established standards. The size of a room for four beneficiaries comprises 4.4 X 3.7 = 16.3 instead of minimum 24 square meters. They are not equipped with proper inventory, curtains and mosquito nets. Beds are not adjusted to the needs of PWDs. Some of them are damaged.

Lavatories of shared use need repair and are not adjusted to PWD needs; they are not supplied with hot water. Lavatories lack artificial ventilation systems, which results in a very unpleasant smell.




Electrical wiring in the bathroom is short of minimal safety standards and is dangerous for people there.


The slope of wheelchair ramp of the dining building (21%) and the handrail do not meet established standards.[37] Another entrance is fit with a ramp (with 18.5% slope) which has a handrail and a slip-resistant surface.[38]

The monitoring group detected certain shortcomings in the supply of beneficiaries with supportive items. In particular, beneficiaries in wheelchairs do not have special cushions or electrical wheelchairs. The warehouse missed the supply of other supportive items too. The beneficiaries with impaired mobility are supplied with only walking sticks.

There are problems in terms of such support materials that would contribute to cognitive development of beneficiaries (visual aids, a clock with a large face, etc.), physical activity (walking frames, adjusted exercise equipment, etc.) or would ensure minimal comfort (for example, a shower wheelchair, chiming clock, etc.).

The boarding house has an adjusted bus (however, a person in wheelchair cannot use an electrical ramp without assistance) which has 14 seats and can additionally serve three persons in wheelchairs.

[37] According to Paragraph 4 of Article 3 of the Technical Statute for Setting up Areas and Architectural and Planning Elements for Persons with Disabilities, approved under the Ordinance No 41 of the Government of Georgia on 6 January 2014, "the slope of the wheelchair ramp must be 6% of its length (in special cases, 8% of the length)."

[38] According to Paragraph 6 of Article 5 of the same Statute, the height of the handrail shall be 0,9 meters, made of rods at the height of 0,5 meters and 0,7 meters

A power generator available in the boarding house is only fit for a water boiler. The building does not have any other alternative source of power and in case of power interruption they use candles.

5. Catering

The full observance of the standard of catering of beneficiaries remains a challenge in the residential institutions for PWDs which were inspected by the monitoring group of the Public Defender. Although food products are supplied to the institutions by the Fund in a centralized manner, under the state procurement regulations, certain shortcomings are observed in the quality of food products as well as storage and preparation thereof. A segment of beneficiaries believe that their individual needs are not considered in the catering process. A problem in several institutions is the observance of catering regime and the use of the dining room by beneficiaries (Dusheti boarding house for PWDs). The majority of beneficiaries in this institution prefer to have food in their living rooms, which is associated with certain risks and fall short of requirements of established standard.

It is worth noting that two recent facts of deaths of beneficiaries in specialized residential institutions for PWDs were related precisely to catering process, which strengthens doubts about the quality and safety of catering. Since the mentioned cases are still under investigation, the Public Defender refrains from preliminary assessments.

It is also worth noting that the state has not yet developed - and consequently, not approved by a relevant legislative act - the minimum standard of catering in specialized residential institution. Local legislative regulations only stipulate an obligation to provide four meals a day and good food products; any other standard such as calorie intake, periodicity of meals, etc., are not clearly specified.

Meals in institutions are provided four times a day. Beneficiaries have general and dietary menus. The Tbilisi Infants' House and the Kojori PWD children's house separately prepare a

special food menu for beneficiaries suffering from phenylketonuria (an inborn error of metabolism that leads to grave mental retardation).

The institutions are supplied with drinking water mainly from the central water supply system. Although the Kojori PWD children's house receives water from central water supply system and interruptions are very rare, the branch also has a five-ton tank for drinking water; however, the rules of cleaning the tank are not observed (according to the administration of the branch, the tank is not treated with chlorine and only once a year, a watchman scrubs the inside of the tank with a piece of cloth).

Representatives of the Public Defender detected certain problems in relation to existing food supplies. In particular, in Martkopi boarding house for PWDs, the supply of perishable food products (meat, fish, eggs, dairy products) were completely exhausted by the time of monitoring; the warehouse of Dzevri institution lacked dairy products and fruit. According to the heads of these branches, perishable food products are delivered by companies twice a week and supplies will be replenished in the next few days.

Tbilisi Infants' House had only frozen herbs stored. Although according to the agreement on the supply of food products, signed between the Fund and the supplier, herbs must be delivered once a week, the inspection of documentation proved that Tbilisi Infants' House was not delivered herbs during a month and it used frozen product in catering beneficiaries.

Shortcomings were detected in the areas of food quality control and food storage. According to an employee of Kojori institution, for the time of the monitoring the food was not inspected by anyone because the pediatrician responsible for controlling the food products was on a paid vacation. Nevertheless, corresponding columns in the log for food quality control were filled in. In Martkopi institution, bucks of industrial paint were kept alongside the vegetables in the food storage.

One should also note the practice of keeping food samples. For example, Dzevri branch does not keep food samples at all. According to the head of the branch, such a requirement was not set to them by the internal monitoring service of the Fund. At Martkopi branch, they said that samples are kept for 24 hours. Nor did Kojori children's house have samples of previous day food. According to a cook at Tbilisi Infants' House, food samples are kept only until next morning. Only Dusheti branch keeps samples for the period of three days.

6. Protection of the right to health

Problems with regard to the protection of health of beneficiaries were revealed in almost all inspected institutions. The majority of institutions maintain medical documentation and registration logs improperly.

The branches do not use logs for registering physical/mechanical and/or chemical restraint and isolation and do not make entries in it. The log for registering prophylactic vaccinations also lack records.

The personnel does not have a clear understanding of the purpose of the log for registering accidents. In some branches the deaths of beneficiaries are registered in this log although there is a separate log for registering deaths of beneficiaries.

Several institutions maintain separate logs for registering injuries or traumatization; but they are also maintained improperly as they do not indicate the reasons of injuries.

Disinfection of institutions takes place once a month, according to the plan. To this end, the Fund, in March 2016, signed contracts with various disinfection service providers which will probably start fulfilling their obligation after a month. This means that in the first quarter of 2016, the institutions operated without disinfection.

Medicines to institutions are supplied in a centralized way, by a company that won the tender in accordance with the public procurement regulations. In the opinion of members of the monitoring group, the system of accounting for the use of medications in the boarding houses is rather complicated and unjustified.

A problem was observed in terms of sorting and storage of expired medications at Tbilisi Infants' House. They were placed unorderly in a cardboard box thereby making it difficult to accurately check and control expired medications.

Significant shortcomings were detected in the provision of qualified medical service to several beneficiaries.

During the monitoring, the problem was observed in providing planned medical examinations to beneficiaries (in Martkopi boarding house for PWDs). According to the head of the branch, the medical insurance of beneficiaries does not cover many planned examinations while the financial capacity of the Fund does not often allow to cover the costs of such examinations. This institution also lacks a storage of medications/drugstore.

When the service of family doctor is needed, the branches approach outpatient or inpatient medical institutions. Tbilisi Infants' House has one of city policlinics designated to it.

There is a need of increasing number of medical personnel in several institutions. The entire Dzevri boarding house for PWDs, which shelters mainly legally incapable beneficiaries (60), is served by only one nurse a night; according to the head of the branch, considering the health condition of beneficiaries, there is a need of adding one doctor for a night shift.

The stuff of inspected institutions lack adequate knowledge and relevant attitude in the area of reproductive and sexual health. The beneficiaries also lack information about this issue; this poses risks of sexual harassment and sexual exploitation. The institutions do not have adequate skills of managing such risks. This problem is of systemic nature and requires a clear legislative regulation.

There were also facts of alcohol abuse observed, which led to conflict among beneficiaries. The institutions lack a scheme of managing such events.

6.1. Psychiatric assistance

In the opinion of the monitoring group, material and technical resources of the boarding houses do not allow to implement the guidelines for mental disorders and provide adequate mental assistance, to apply internationally recognized, human rights-oriented attitudes. Resources of psychosocial rehabilitation are very limited and the motivation of beneficiaries to get involved in it is low.

The monitoring revealed that the number of medical personnel, specified in the charter of the boarding houses, is insufficient to provide adequate psychiatric assistance; this has an adverse effect on the mental health and life of beneficiaries.

Both legally capable and incapable beneficiaries of boarding houses for PWDs get psychiatric assistance and in general, medical assistance without an **informed consent**; nor is a procedure applied for obtaining consent from a legal representative of a beneficiary declared legally incapable. The internal regulation does not specify the need to obtain an informed consent when providing medical assistance. A medical file does not contain a form of informed consent[39] and it is therefore not clear whether the psychiatric assistance is rendered upon beneficiaries' free will. According to doctors of boarding houses, beneficiaries often refuse to undertake a

[39] Order N108/n, dated 19 March 2009, of Minister of Labor, Health and Social Affairs of Georgia, "On Approval of Rule of Maintaining Medical Documentation in Medical Institution," Annex N13, medical documentation form NIV-200-12/a, a patient's informed written consent on the delivery of medical service.

medication treatment administered by psychiatrist and this leads to the aggravation of their condition; however, the denial of treatment is not confirmed in the medical documentation by signatures of beneficiaries.

The treatment of beneficiaries in boarding houses is mainly limited to medication treatment. Each institution has a space allocated for psychosocial rehabilitation, though material and professional resources for psychological intervention and psychosocial rehabilitation are very limited, as well as the involvement of beneficiaries in rehabilitation activities. The majority of interviewed beneficiaries did not confirm their participation in psychosocial activities.

Psychiatric cases are not managed in accordance with the international standards, national clinical practice recommendations (guidelines) and state standards of disease management (protocols). In Dzevri and Dusheti boarding houses for PWDs, the treatment is basically conducted with psychotropic medication of previous generation while antipsychotic and antidepressant medicines are either applied in a very few cases (in Dusheti branch) or not applied at all (Dzevri branch). The exception is Martkopi boarding house for PWDs and the Kojori boarding house for Children with Disabilities which have quite a supply and choice of psychotropic medications, including those of new generation.

According to the monitoring group, Tbilisi Infants' House is, in separate cases, not supplied with needed medications in the dose and form appropriate for the age group. For example, the institution purchases Clonazepam in the form of pills containing 2mg active substance; this poses problems in giving corresponding treatment dose to beneficiaries. A pill is not scored with a groove and it is difficult to split it into a needed dose. Therefore, pursuant to a decision by the administration of the branch, medications falling under a class of benzodiazepines (pharmaceutical group I, prescription F. N2) and included in the list of medications under a special control, are taken, in the amount of 3-4 pills at a time, to a drugstore to powder them and divide into appropriate doses and be given to children in the form of suspension.

The frequency of aggravation of mental state of beneficiaries in the boarding house, psychomotor agitation and aggressive behavior increases in evenings and at night, which, in an expert's opinion, may be explained by the shortage of medical and care giving stuff during night hours. A psychiatrist is unavailable at night, nor is a doctor for a night shift; this limits the possibilities of medical management of psychiatric cases. A nurse working for a shift mainly limits herself to giving valeriana pills or calls in an ambulance to move a beneficiary to a mental hospital. The frequency of taking beneficiaries to hospital is especially high in Martkopi and Dusheti boarding houses for PWDs.

Based on the monitoring results, the monitoring group of the Public Defender believes that beneficiaries in the boarding houses for PWDs do not receive adequate psychiatric assistance, the psychiatric assistance is not of multidisciplinary nature, no balance is achieved among the methods of prevention, treatment and rehabilitation, and the management of psychiatric cases does not meet standards specified in the guidelines.

The frequency of intellectual, behavioral and emotional disorders is high among beneficiaries of the infants' house; the medical staff fail to accurately identify the problem and involve a specialist of mental health. Beneficiaries do not receive adequate psychiatric assistance and in separate cases, necessary medication is not supplied in the doses and in the form appropriate for the age group.

9. Individual approach in servicing

The examination of documentation of residential institutions for PWDs, also interviews with the beneficiaries and service providers reveal that the majority of the institutions do not fulfill the requirements established under the standard of individual approach in providing services. Personal files of beneficiaries lack complete information about their individual needs.

Individual plans are basically limited to learning everyday (self-care, assistance in the kitchen, cleaning, etcetera), creative and communication skills, which does not meet the requirements established under the standards. Set goals are uniform and cannot ensure a complex support to PWD beneficiaries and their preparation for an independent life.

Planning activities tailored to interests of beneficiaries represents a problem. As interviews with the personnel reveal, activities are divided by gender roles. The stufffind it easy to plan activities for female beneficiaries (needlework, art and occupational therapy, music) though they encounter difficulties in planning activities for the development of male beneficiaries due to lack of resources. Male beneficiaries would like to have a workshop operating in the boarding house, where they would be able to master crafts (for example, woodwork), manufacture products and sell them; however, the institution fails to provide this (Martkopi boarding house for PWDs). Main male activities are limited to board games, especially in wintertime.

The majority of beneficiaries are not involved in the process of developing individual plans; consequently, the degree of awareness of objectives set in the plan is low. A low involvement of beneficiaries in the development of plans is conditioned by several factors: limited psychosomatic capacities of beneficiaries, lack of resources matching their desires, shortage of qualified cadres. It was also revealed that several beneficiaries do not want to get involved in the

development and fulfillment of plans because they believe that the development of certain skills would lead to their removal into a community service and/or suspension of pension, like it happened in the past.

As a result of interviewing beneficiaries, a member of the monitoring group came at the conclusion that abilities of some of them are not accurately evaluated and they are much higher that the objectives set in the individual plans.

8. Promoting social activity and education

Inspected specialized residential institutions for PWDs do not properly promote social activity and organize targeted events and occupational activities. Yet another problem is an issue of equipment of institutions with resources and inventory for physical, social, intellectual and creative activities, as well as the shortage and low qualification of staff. The involvement of Social Service[40] in the area of strengthening social relations of beneficiaries is minimal. Lack of relations with family members, especially, with children and parents is painful for the majority of beneficiaries

There are challenges in the field of access to information by the beneficiaries. All boarding houses have a TV set which is in a reception room. The institutions also have computers, but beneficiaries do not have access to the Internet in some of them (Martkopi and Dzevri branches). Moreover, despite the availability of the computer and the Internet, beneficiaries have not undertaken special courses how to use them and have to develop relevant skills by themselves. Problems were observed in terms of delivery of print media in Dzevri branch. This institution received only a local paper, "Terjola", which is delivered only biweekly.

Libraries have not been replenished with new books for years now (Dzevri, Dusheti, Martkopi branches) and consequently, no one visits them.

The branches have occupational therapy rooms with two occupational therapy instructors employed there. However, the monitoring showed that the occupational therapy is carried out in a sporadic and unsystematic manner.

Interviews with beneficiaries showed that they do not have a clear understanding of the purpose of occupational therapy room and often refer to it as a drawing room. One cannot also identify how long each of the beneficiaries spend their time in that room.

[40] Meaning, representatives of territorial services of the LEPL Social Service Agency.

It should be noted that crafts (knitting, embroidery, needlework), cooking, assistance in the kitchen and cleaning are viewed as key means of occupational therapy. Organizing occupational activities that are oriented on the interests of beneficiaries is problematic due to lack of equipment and resources.

Adult, legally capable beneficiaries would like to have a possibility to perform paid jobs inside or outside the institution. During the monitoring, Martkopi boarding house for PWDs had three beneficiaries employed. Two of them worked as caregivers (1 woman and 1 man) while the third worked as a watchman. According to the administration, two persons undertake temporary jobs outside the institution, working in farms of local population and getting remuneration. The administration also said that the personnel controls labor safety of these persons, however it failed to name a concrete person responsible for that.

The institutions fail to effectively manage free time and involve beneficiaries in intellectual games. They name listening to music as the most common method of therapy.

Beneficiaries of children's' houses are divided into groups during the day and they are supervised by caregivers, which makes the implementation of individual approach impossible. Daytime activities are less oriented on the development of children but rather serve the aim of "killing time." Day schedules are not developed for the groups. Kojori PWD children's house has three such groups, though the principle of distributing children among them is ambiguous; children are distributed at random which excludes inclusiveness. Beneficiaries of the Tbilisi Infants' House are distributed in five groups by their age and health condition.

Beneficiaries are rarely taken out of institutions for sightseeing or other social activities.

Serious shortcomings are observed in the exercise of the right to education by PWDs placed in the state care. Among inspected institutions only there beneficiaries of Tbilisi Infants' House receive preschool education and three beneficiaries of Kojori Boarding House for Children with Disabilities attend public school.

The institutions do not carry out sport and rehabilitation measures properly.

Beneficiaries of Kojori Boarding House for Children with Disabilities participate in the state subprogram[41] for children's rehabilitation/habilitation. Under this program, they periodically take a 10-day rehabilitation course. Moreover, the institution has a relaxation room for

[41] Ordinance N102 of the Government of Georgia, dated 26 February 2016, "On Approval of 2016 State Program for Social rehabilitation and Child Care," Annex 1.3. "Children's Rehabilitation/Habilitation Subprogram."

children's rehabilitation, located on the second floor. The building is not equipped with an elevator which provides the ground to assume that it is difficult to use the mentioned room.

9. Exercising the right to private and family life

The analysis of the monitoring results showed that the right of beneficiaries of residential institutions to private and personal life is restricted which leads to unequal treatment on the ground of residence in the institution. PWDs cannot maintain ties with their children and other family members. The right to private and family life is especially restricted in case of women and children beneficiaries.

Female beneficiaries of institutions are not able to maintain contact with their children. Their children are often placed in geographically distant educational institutions and due to financial (unavailability of social allowance) and transportation problems they have either a rare chance or no chance at all to see their children. For example, children of Dusheti, Martkopi and Dzevri beneficiaries grow up in the Orthodox Christian boarding house for children in Ninotsminda. Mothers suffer severely from being separated from their children and in interviews with members of special preventive group, they talked, in tears and agitated manner, how much they missed their children. They realize that they lack resources to live and bring up children independently; they also take into account that the law prohibits the placement of small children with their parents in the brooding houses for PWDs. There were instances of parents asking assistance, for four years, in moving their children to a territorially closer boarding institution so that to enable them see children frequently and avoid estrangement between a mother and a child.

It is important that the majority of such beneficiaries have not only maintained social and self-care skills, but can also take care of other beneficiaries and were they provided an adequate assistance they would be able to participate in the process of upbringing of their children.

Children of single mother beneficiaries of Dzevri branch (including two children of one of such beneficiaries) were placed in the Orthodox Christian boarding house for children in Zestaponi in 2011; however, the boarding house changed the location and now children live in the not-for-profit (non-commercial) legal entity "St. Nino Boarding House for Orphans, Waifs and Children in Need of Care" of the Patriarchate of Georgia, in Javakheti. According to the head of Dzevri boarding house, before the children's boarding house was relocated to Ninotsminda in 2014, Dzevri beneficiaries were taken to their children at least once a week; however, after the relocation of the institution, such visits were no longer carried out and consequently,

beneficiaries have not seen their children for four years now. Now the work on organizational issues is under way for a planned visit in the near future.

In confidential conversations with a member of the special prevention group, separate employees of Dzevri branch said that for some reason unknown to them, the head of Ninotsminda boarding school was against PWD parents to visit their children. Because of this resistance children were not placed in small family-type houses located near the boarding house in 2014; now negotiations with him are underway to get his consent on the visit of parents to children.

The monitoring group believes that all the above said leads to gross violations of the right to private and family life, recognized by Georgian legislation and International law.

10. Preparing for an independent life

Conversations with beneficiaries showed that beneficiaries see an independent life as a threat. This is mainly caused by the fact that upon reaching a full legal age, the PWDs, placed in the institutions of state care since their childhood, have to leave the institution unprepared for an independent life. The state does not provide them adequate assistance in that and apart from social and economic problems encounter after leaving the institutions, they are left without a living space and corresponding services.

The residential institutions lack sufficient resources to ensure inclusive education of PWD children left outside the deinstitutionalization process and to help them develop social skills; this impedes their personal development and deprives them of a possibility to lead an independent life after they rich the full legal age. Chances of reintegration into biological families and placement in foster care are slim; consequently, the only prospect is their removal into boarding houses for adult PWDs.

The majority of beneficiaries of boarding houses for adult PWDs have a long institutional experience and no ties with their biological families. The institutional upbringing, the lack of inclusive care and education as well as social and occupational skills resulted in the formation of institution-dependency syndrome and deepened their disabilities, thereby significantly lowering their possibilities to reintegrate into society and lead an independent life.

The study of this issue by the PDO showed that the state does not have a strategy and action plan according to which institutions would prepare children for independent life – give them education, help them develop occupational and everyday skills and provide them with adequate

assistance after leaving the institution. As a result, the majority of such persons fail to integrate into society, to get jobs; they become socially vulnerable and often even homeless and have no other option but to stay in a boarding house for the rest of their lives.

In the majority of cases, public officials and personnel of boarding houses, despite a number of problems, do not see the need to enhance the activity towards preparation of beneficiaries for an independent life and improvement of social activities and labor skills.

11. Providing information about services and confidentiality.

11.1. Informing beneficiaries about services and maintaining documentation

Main documentation[42] established under the standard is kept in the institutions in a systematized manner. The charter and the internal regulation of boarding houses are approved by the ordinance of the director of the Fund. Internal regulation regulates issues that are important for the operation of institutions; however, familiarizing oneself with the situation on the site gives rise to doubts that this document is a mere formality and provisions in the internal regulation are disregarded in the institutions.

Information leaflet and service program are available in boarding houses for interested persons; however, it is a challenge for PWD beneficiaries to read them because of difficult text, almost unreadable font and the height at which they are placed. Moreover, beneficiaries' individual capabilities (impaired hearing, vision, cognition, mobility, et cetera) are not taken into consideration.

Registration logs required under the law are not properly maintained; the majority of them lack entries. Shortcomings were observed in filling in special feedback logs (a written description of measures undertaken in response to expressed opinions, which is required under the standard) in almost every institution. Such documents are mainly empty or contain only positive feedback of visitors to beneficiaries (Dzevri boarding house for PWDs). The log to register measures undertaken in response to violence is also maintained improperly. They mainly describe conflicts among beneficiaries, which are not evaluated as facts of violence and there are no entries about concrete measures undertaken by the administration in response since no such measures have been undertaken (Dusheti and Martkopi boarding houses for PWDs). The log on

[42] Order N01–54/n, dated 23 July 2014, of Minister of Labor, Health and Social Affairs of Georgia "On Approval of Minimum Standards of Service to PWDs and Elderly Placed in Specialized Residential Institutions," Annex N1, Article 1. Available at https://matsne.gov.ge/ka/document/view/2391345 [last retrieved on 31.03.2016]; Ordinance N 66 of the Government of Georgia, dated 15 January 2-14, On Technical Regulation on Approval of Childcare Standards; Annex 1, Article 1; available at https://matsne.gov.ge/ka/document/view/2198153 [last retrieved on 31.03.2016].

accidents is also not properly maintained. The majority of institutions declare that no accident has happened in their institutions. The stuff finds it difficult to identify which incident may be considered an accident (Dzevri boarding house for PWDs).

Personal files of beneficiaries are largely maintained in accordance with the standard. In most cases, they contain documentation required by the standard.

Interviews with the beneficiaries and personnel of the boarding houses showed that the administrations did not actually inform beneficiaries and their legal representatives about the purpose of service, undertaken measures and the rights and obligations of the parties. As a representative of Martkopi boarding house for PWDs said in an interview, a large segment of beneficiaries do not have legal representatives. The majority of them have been in state care institutions since their childhood.

11.2. Confidentiality in providing service

The legislation ensures the confidentiality of personal information concerning PWDs placed in specialized residential institutions.

Although the issues of confidentiality are regulated by the standard and internal regulation of boarding houses, the majority of beneficiaries declare that they were not informed about services and confidentiality of their documentation or about alleged violations of confidentiality. According to administration of Martkopi boarding house, a psychologist talked with beneficiaries about confidentiality, though interviews showed that the majority of them had not heard this term.

In one of the institutions, there was a possibility for anyone to access personal files of beneficiaries. Dusheti boarding house for PWDs keeps personal files of beneficiaries in a cabinet without a locket in the office of manager. During the monitoring, a member of the monitoring group spotted that the door of this office was open when no one was there and any person could easily step into it.

Representatives of administrations of boarding houses explained to members of the monitoring group that they had never faced in their practice a need to disclose confidential information on beneficiaries and consequently, do not have written consents of beneficiaries or their legal representatives on the disclosure of confidential information.

Each inspected institution uses a room of psychologist for individual consultations (in case of the Kojori PWD children's house, the so-called room for circle). The administration claims that thus the confidentiality of interviews with beneficiaries is ensured.

It is worth noting that there is an entry in a special feedback log in Dzevri boarding house for PWDs, made by one of the visitors (M.K.) on 17 August 2014, requesting a possibility to see a beneficiary, who is the visitor's relative, in a separate room. According to this entry, a visitor's appearance in a common room causes irritation in other beneficiaries and adversely affects them because the beneficiaries also want to see their relatives. The administration of the institution explained to a representative of the Public Defender that the above mentioned problem has already been resolved and beneficiaries may see their visitors in a room allocated for this purpose in an administrative building standing separately in the yard.

According to the head of Kojori PWD Boarding House for Children with DIsabilities, persons who want to pay a visit to the institution as a guest, apply for consent in writing to the LEPL Social Service Agency as the guardianship and custodianship body. The Agency informs such visitors that they are obliged to protect personal data and use any received information about the children in state care for its intended purpose.

Recommendations

To the Government of Georgia:

- To ensure a legislative regulation of measures supporting an independent life of the PWDs having left the state care institutions and to develop a state strategy and action plan in accordance with obligations assumed under the UN Convention on the Rights of Persons with Disabilities with the involvement of all the relevant ministries,;

- To specify measures in the action plan, which include the components of preparing PWDs in state care for an independent life, vocational education and employment, developing everyday skills.

To the Ministry of Internal Affair of Georgia:

To ensure a timely, effective and due investigation into the facts of death of beneficiaries in territorial units (branches) of the LEPL State Fund for Protection and Assistance of (statutory) Victims of Human Trafficking .

To the Ministry of Labor, Health and Social Affairs of Georgia:

- To ensure planning and regular implementation of relevant measures to upgrade qualification of the stiff of residential institutions for PWDs;

- To facilitate the increase of the number of institutions' stuff, including the availability of service of a social worker, a psychologist, an occupational therapist in all institutions;

- To develop minimum standard of catering for specialized residential institutions and approve it by a corresponding normative act;

- To ensure the realization of human rights-based approach within the limits of state care of PWDs through developing community-oriented social and psychiatric services;

- To support the management of psychiatric cases in accordance with the international standards, national clinical practice recommendations (guidelines) and state standards of disease management (protocols) through ensuring financial resources and professional personnel.

To the LEPL Social Service Agency:

- To observe the established standard of maximum number of beneficiaries in a specialized residential Institutions, in the process of making decision on the placement of PWD in such institutions;

- To ensure the introduction of mechanisms of active involvement, supervision and control of social services in the process of care;

- To step up activities for ensuring a close contact of beneficiaries with their families and children.

To the State Fund for Protection and Assistance of (statutory) Victims of Human Trafficking:

- To ensure a proper functioning of feedback and complaints mechanism and a possibility of anonymous feedback in the branches of the Fund;

- To ensure the improvement of internal monitoring instrument and a regular monitoring of the delivery of services to PWDs by specialized residential institutions;

- To ensure the planning and regular implementation of relevant measures to upgrade qualification of the stuff of residential institutions for PWDs;

- To direct all efforts towards providing services that are safe for the life and health of beneficiaries and minimizing any risks in this process;

- To ensure the prevention of any form of discrimination on the ground of disability in the institutions for PWDs through creating adequate forms and conditions of care;

- To evaluate risk factors of violence and ill-treatment in institutions and prevent such facts;

- To support creation of accessible, safe and hygienic environment for PWD beneficiaries in specialized residential institutions and houses for Children with Disabilities;

- To timely ensure the elimination of infrastructure problems by undertaking relevant measures;

- To ensure the supply of corresponding assistive devices to PWD beneficiaries;

- To carry out a regular control on a timely delivery of full supply of food products to institutions by the companies having won tenders;

- To give administrations of branches and employees of catering units clear instructions about standards of control, sampling and keeping of prepared food;

- To revise forms for maintaining medical documentation and improve their informative capacity;

- To revise the composition of medical stuff of the branches and correct them as needed;

- To ensure training/retraining of medical and supportive staff of the branches in the area of psychiatric assistance;

- To ensure the availability of general practitioner and a psychiatrist round the clock every day in accordance with the specifics of an institution,

- To ensure the supply of medications in accordance with the age of a target group and modern standards of treatment;

- To ensure training/retraining of personnel by means of developing skills needed for proper maintenance of individual plans;

- To ensure the branches with a position of occupational therapist for the aim of planning effective and targeted work with PWDs;

- To ensure the involvement of a social worker in the process of developing individual plans;

- To involve beneficiaries in the process of developing individual plans taking into consideration their functional and intellectual abilities;

- To support the realization of the right of beneficiaries to private and family life, the maintenance of ties with their families, including children, and their participation in the process of upbringing children;

- To plan and implement measures necessary for the preparation of beneficiaries for an independent life;

- To support the raising of awareness among the branches' stuff on the importance/need of preparing PWD beneficiaries for an independent life.

To the administration of specialized residential institutions for Persons and Children with Disabilities:

- To timely identify shortcomings in the administration of services and establish regular and effective communication for their elimination;

- To ensure the protection of beneficiaries from discrimination as well as biased or negative attitudes or actions in providing services;

- To timely ensure the submission of cases of beneficiaries declared legally incapable to courts in order to have them recognized as persons with psycho-social needs and support recipient;

- To ensure the creation of safe environment for free orientation and movement of beneficiaries;

- To ensure the adjustment of micro buses owned by institutions to the needs of beneficiaries;

- To take into account beneficiaries' desires in providing meals;

- To strictly control the quality of food supplied to the institutions and conditions of safe catering;

- To give the personnel of institutions clear explanations and instructions regarding the norms of food safety control;

- To strictly control the completeness and accuracy of medical documentation; adequate and safe storage of expired medications and their registration;

- To fully maintain the documentation related to individual attitudes in beneficiaries' personal files;

- To seek internal and external resources to teach beneficiaries how to read and write;

- To ensure employment of professional responsible for the development of skills of beneficiaries, organizing cultural, sport and labor activities;

- To ensure the development of a plan of cultural, entertainment and other events and a regular conduct of cultural and entertainment activities (discussions of films, books; sightseeing) with the active involvement of beneficiaries;

- To step up the activity for ensuring contact of beneficiaries with their families and children;

- To support the development of skills necessary for an independent life through trainings;

- To raise awareness about the requirements of confidentiality among representatives of administrations of residential institutions for PWD through conducting special training programs;

- To observe requirements for maintaining documentation, including registration logs, in accordance with the rule established under minimum standards of service;

- To have data envisaged by the standard available for any interested person; to place general information about an institution in such a manner as to enable any interested person to become familiar with it without difficulties.