A Report by the Helsinki Committee for Human Rights in Serbia

PEOPLE ON THE MARGINS (2)
Human Rights in Social Care Institutions in Serbia

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Human Rights in Social Care Institutions in Serbia – Part I

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INTRODUCTION

The report on the situation in social care institutions accommodating old people and persons with disabilities is a part of a larger project the Helsinki Committee for Human Rights in Serbia has been realizing under the common title "Social Care Institutions in Serbia: Support to the Reform-Oriented Strategy" and with the assistance of the Open Society Institute.

Fact-finding missions to social care institutions only logically followed in the footsteps of the Committee's four-year monitoring of Serbia's prisons and initial monitoring of the institutions for long-term hospitalization of psychiatric patients: they were actually yet another attempt to throw light at the position of yet another vulnerable group: institutionalized social care beneficiaries this time.

The main goal of the project is to provide objective overviews of the situation of social care institutions and – on the grounds on summarized findings and observed shortcomings – offer recommendations to individual institutions and indicate system problems and policy failures at the level of the state. In other words, the project is meant alert the general public, governmental agencies and relevant international organizations of impermissible practices – if any - raise public awareness about the problems plaguing institutionalized persons and mobilize people and major opinion-makers (the media) to raise a powerful voice of moral conscience and solidarity with vulnerable groups of the society. Last but not least, the project aims at assisting the development of a clear-cut, modern strategy for social care reform that would explore all avenues of community-based services.

Apart from children and adults with mental disabilities and psychiatric patients, social care institutions in Serbia cater for children and young adults without parental care and/or with social behavior disorders, as well as the persons with physical disabilities and old people. Since they actually accommodate the persons incapable, temporarily or permanently, to exercise their basic rights and look after their own interests, social care institutions must be under permanent control. The existing legislation just partially (moreover, loosely and generally) provides guarantees for the protection of rights of social care beneficiaries and representation of their interests. Serbia's legal system does not envisage protection mechanisms that would respond to the status and vulnerability of this category of population, whereas a number of legal shortcomings enable arbitrariness and even misuse. The social care system is still not adjusted to international standards for catering for most vulnerable groups and there are no clear-cut rules that would regulate treatment by and responsibility of the persons providing care to them. The state has not adopted yet a comprehensive approach to the development and implementation of a humane social care policy.

Social issues only logically top the list of priorities against the backdrop of Serbia's devastated society and institutions in 1990s. The reform of Serbia's social care system was announced in the wake of the ouster of the Milosevic regime. The first stage was planned to last eight years (2001-2008) after which a new law on social protection was to be enforced on January 1, 2009. However, the law has not been passed so far, not even drafted. The Ministry of Labor and Social Policy has been

repeatedly indicating the urgency of passing a new social protection law, as well as the need for a multidisciplinary approach and cooperation between different ministries in the process. The absence of any result clearly indicates the absence of a political consensus on the issue, as well as the absence of a clear-cut vision for social reforms and priorities.

In mid-2005 in municipalities all over Serbia, the Ministry presented the *Draft reform strategy for the social care system* envisaging its adjustment to international conventions and European standards, and maintenance of time-tested practices and mechanisms. The strategy introduced major changes in the existing and obsolete (established in 1970s) social care system, emphasized building up of professional capacity of social care workers (particularly those dealing with vulnerable groups), proposed partial decentralization, i.e. transfer of some responsibilities to local self-governments, and – gradual deinstitutionalization. In 2006 the government adopted the *National Strategy for Aging Population (2006-2015)* adjusted to the recommendations of the 2002 Madrid plan of action for aging population, and the regional strategy for its implementation developed by UN Economic Commission for Europe. This major governmental act set the goals, activities and the factors responsible for their implementation. However, its impact has been rather meager. The same year (2006) the National Assembly passed the Law on Prevention of Discrimination against the Persons with Disabilities, and the government adopted the Strategy for Improvement of the Position of Persons with Disabilities. It also announced a number of measures meant, in the first place, to open new avenues of education and employment for the persons with disabilities. All of a sudden the persons with disabilities were in the social limelight. Unfortunately, things have changed little in the real life. After initial enthusiasm, almost everything boiled down to adaptation of parts of pavements to facilitate to the movement of persons in wheelchairs. A most trivial examples testifies of the state's concern for improvement of the overall conditions of life of persons with disabilities: out of hundreds and hundreds so-called "housing-business" facilities that are being constructed throughout the country just few have ramps enabling access to persons in wheelchairs despite the fact that contractors are bound by law to build them and that construction itself costs almost nothing. The global economic crisis – the full impact of which is expected – diverted the focus on existentional problems, those of the state, its economy and citizens, and marginalized all other issues. So the problems of aging and old people remained on the periphery of the state's and the society's concerns, whereas the persons with disabilities were mostly subjected to occasional marketing manipulation.

In 2006, the Ministry of Labor and Social Policy developed guidelines for all types of social care institutions, stating in detail the standards related to space, equipment, management, maintenance of general and individual hygiene, etc. However, those guidelines just touched on staffs' professional capacity, while totally neglecting the aspects such as treatment of social care beneficiaries and their rights. Those aspects are now mostly regulated by the rules developed by individual institutions. The network of social care institutions catering different types of beneficiaries was also revised, whereas the Ministry of Labor and Social Policy drafted minimal standards for one group of social care beneficiaries. The standards included annexes defining inspection and control of standard implementation. The standards were piloted in the period May-December 2008. Therefore, their practical effects are still to be summed up, and the final text drawn. It's most indicative that the staffs in many institutions know nothing about those standards, the same as they are

fully unaware of other relevant both domestic and international strategies and covenants. Unfortunately, the situation in the terrain is far from the proclaimed goals although both efforts and funds have been invested in more humane conditions in the institutions catering for socially vulnerable persons, and in adoption of modern methods for meeting beneficiaries' needs.

The Helsinki Committee approached the monitoring of social care institutions from the angle of a human rights organization. We were focused on one of the modes of social care protection – institutionalization. Our research was unique in terms of different categories of beneficiaries it included – they ranged from children and adults with mental disabilities, and psychiatric patients, through children and young adults without parental care and/or with social behavior disorders, to people with disabilities and aging persons. The methods we used in the research were the following: analyses of various documents (laws, bylaws, regulation, house rules, etc.); analyses of statistics and other available data; standardized questionnaires developed for different groups of beneficiaries (including sections for institutional management and individual services); and, informal though focused interviews with beneficiaries. We have scrutinized overall conditions determining functioning of institutions and their personnel, as well as lives of social care beneficiaries, and possible incompatibilities with major domestic and international human rights standards. In our fact-finding missions concerned with old people and persons with disabilities we were particularly attentive to the principles contained in the following documents: Universal Declaration of Human Rights, UN Principles for Older Persons, Vienna International Plan of Action on Aging, Madrid International Plan of Action on Aging, European Convention on Human Rights, European Social Charter, International Covenant on Civil and Political Rights, International Covenant on Economic, Social and Cultural Rights, International Convention on the Rights of Persons with Disabilities, Law on the Prevention of Discrimination against Persons with Disabilities, Strategy for Improvement of the Position of Persons with Disabilities in the Republic of Serbia, National Strategy for Aging Population, Recommendations of the Council of Europe dealing with the Action Plan for Full Social Integration of Persons with Disabilities, Madrid Declaration against Discrimination, etc.

The analysis presented here compiles individual reports on each of the monitored institutions, wherein each mirrors specific aspects of their functioning. Though the monitored institutions were of different type, the great majority of noted shortcomings were characteristic for all. It can be said, therefore, that those shortcoming indicated system problems. This is why the summary below attempts to underscore major conclusions and put forth general recommendations.

We hope this report on the situation of social care institutions catering for old people and persons with disabilities (the same as the forthcoming reports on social care institutions catering for children and young adults without parental care and/or with social behavior disorders, and for children and adults with mental disabilities and with mental illnesses) would provide deeper insights into existing problems and contribute to the search for more effective transitional solutions and drafting of an efficient reformist strategy for social care system.

The Helsinki Committee for Human Rights in Serbia thanks employees of the Ministry of Labor and Social Policy, directors and personnel, and beneficiaries of the institutions catering for old people and persons with disabilities for their cooperativeness that made this project possible in the first place.

SUMMARY

According the decision on the network of social care institutions accommodating social care beneficiaries the Serbian government adopted in September 2008, there are 14 old people's homes, 27 gerontology centers, 2 homes for adult persons with disabilities and 1 home for those with impaired vision. Further, the said decisions legally bounds the institutions catering for old people to adjust the number and structure of their staffs and beneficiaries to the set capacity standards within six months, whereas obliging the institutions catering for persons with disabilities to perform the same task within three years from the day the decision came in force.

The Helsinki Committee opted to conduct fact-finding missions to three gerontology centers (in Sombor, Sabac and Belgrade) and one old people's home (in Dimitrovgrad), as well as to the Home for Adult Persons with Disabilities in Doljevac. The criteria by which we selected those institutions were their locations, sizes, economic development of local communities, structure of beneficiaries, etc.

The Committee's team of experts included a psychologist, a special pedagogue, a specialist in general medicine, a sociologist and a human rights lawyer. The monitoring of those four institutions was conducted in the period June – September 2008.

Speaking of the quality of accommodation provided to beneficiaries, we were specially observing architectural-technical conditions, general hygiene and equipment of the institutions. Regardless of whether the buildings are older or newer, electrical installations, plumbing and sewers, and central heating systems in all of them badly need reconstruction – which in itself implies huge investment. Given that funds for this purpose are non-existent, all the institutions have had build in electrical devices that secure the stability of electrical systems and, more importantly, figure as safeguards against fire. Along with anti-fire protection system, this is the minimum guaranteeing safety of both beneficiaries and personnel. For, bearing in mind that the great majority of beneficiaries are either with moving difficulties or cannot move at all, consequences of the worst scenarios would be fatal.

Unlike electrical installations, plumbing and sewers are old but mostly in function. The only exception is the serious problem of water supply in Doljevac that threatens the health of mostly bedridden beneficiaries. All the observed institutions have central heating systems. The quality of heating differs from institution to institution, depending on the funds available for crude oil supply, sizes of buildings, their insulation and condition of window panes. Rooms, living areas, furniture and equipment also differ from institution to institution. There is huge discrepancy between budgets of the institutions – their budgets are mostly determined by the number of institutionalized beneficiaries, but also on the avenues open to them for profit-making and performance of directors and expert

personnel. Namely, some large institutions have turned sections or wings into the so-called high-standard accommodation areas (charging double prices on average), hall that are being rented, restaurants, etc. Though legal such profit-making cannot but be questionable taking into account continuous growth in the number of older people and inadequately developed alternative, non-institutional protection system.

Institutional personnel are engaged in expert teams, as medical staff, for cleaning and maintenance, administrative jobs, etc. Apart from medical staff, the number and professional capacity of other employees are laid down in the norms developed by the Ministry of Labor and Social Policy and mostly depend on institutional capacities, i.e. number of beneficiaries. However, those strictly formal and bounding rules usually do not correspond to real-life needs of both institutions and their beneficiaries. For instance, the norms envisage one psychologist for an institution catering for 250-300 beneficiaries. This means that an institution with less than 250 beneficiaries is not entitled to engage a psychologist. Unfortunately, state of health and social life of beneficiaries are such that they require presence of a psychologist regardless of the size of any institution. The same refers to other professionals (such as social workers, jurists, work therapists, etc.) and, in particular, to nurses who are too few when compared with the age and category of beneficiaries. Understaffed institutions and inadequate professional capacity of staffs directly affect the quality of services rendered to beneficiaries, and the level of meeting their actual needs.

Instead of being on the priority agenda of the institutions catering for old people and persons with disabilities, the number of medical officers is a crying shame and as such threatening to lives of beneficiaries. In addition, cooperation between local medical centers and institutions is more or less problematic. Medical officers engaged in social care institutions are being paid from the budget of the Ministry of Healthcare that decides their number, professional capacity and paychecks. According to the interviewed medical officers, their salaries are lower than those of their colleagues in other medical institutions despite difficult conditions in which they work. Communication between the two ministries is totally inadequate, whereas that with other major factors (such as ministries of education, culture, local self-government or employment) non-existent. The outcome is more than poor situation of institutions accommodating this category of beneficiaries, let alone the incoherent and unsustainable reform of the social care system.

The quality of life of beneficiaries and the treatment provided to them are directly connected with the two aforementioned aspects of social care. Depending on overall capacities of institutions (spatial, professional or financial), beneficiaries do or do not satisfy their needs, exercise individual affinities and engage in meaningful activities. The discrepancies evident at several levels (between institutions located in different parts of the country, between different beneficiaries in the same institution, etc.) testify of a rift in the Serbian society and indicate that equal rights and equal opportunities for all citizens without exception are still far from sight.

Regular contacts with one's family and community are highly important for any individual, let alone for someone who is institutionalized. Institutionalization that dislocates an

individual from his or her natural environment is by itself an inhuman and restrictive measure that may seriously impair the individual's personal integrity and dignity. Accommodating a person in an institution that is far from that person's local community often stands for an insurmountable problem for that person's contact with his or her family and friends. However, a person rejected by his or her family (due to old age or disability) actually undergoes torture and can feel totally degraded. No doubt that this, plus local community's prevalent disinterestedness (and even overt or covert discriminatory attitude) opens the door to marginalization and exclusion of old people and persons with disabilities.

Guarantees for the rights and freedoms of beneficiaries are mostly inadequate. Though those social care institutions are open for beneficiaries, most of them are incapable of freely choosing the way of life that suits them the best. On the other hand, the great majority of the rules on institutionalization and the practice of institutionalization rely on obsolete approaches to the treatment of social care beneficiaries, whereas the whole system seems to be impermissible bureaucraticized. Inadequate legal system and huge transitional problems in the state such as Serbia result in numerous incompatibilities, legal loopholes and non-existent or deficient protection mechanisms. The same as many other areas of life, the social care system is not adequately supervised and subjected to independent control that could contribute to more efficient protection of the rights of socially vulnerable categories of population.

OLD PEOPLE'S HOME IN DIMITROVGRAD

1. Introductory Remarks

Out of three municipalities making the Pirot District, Dimitrovgrad is the smallest. And, no doubt that it is among the poorest in Serbia despite the fact that it lies along the highway to Bulgaria, in the borderline area with possibility for development of several branches of economy. Decades-long isolation of the entire Eastern Serbia has caused considerable emigration of population to foreign countries or urban centers in the country. Large areas have been left almost unpopulated or with aging population mostly in mountain villages. Though the phenomenon plagues other parts of Serbia as well, Dimitrovgrad is characteristic for its extremely low wintertime and high summertime temperatures, which, in addition to poor access to many households, makes independent living of older and aging people very difficult, often impossible.

Old People's Home in Dimitrovgrad is the only social care institution of this type in the entire Pirot District. The assessment that only one social care institution for the aging population meets the needs of the region rests on the information compiled more than thirty years ago. In the meantime, negative demographic and economic trends have changed the needs. The facts that the Old People's Home in Dimitrovgrad was allowed to expand its capacity from 80 to 90 beneficiaries, and that in 2007 it accommodated over 100 persons testify of the necessity for thorough reconsideration of realistic needs or the search for alternative solutions in social care protection of local population.

At the time we inspected the institution it catered for total 91 persons – 35 men and 56 women. By categorization criteria, the institution accommodated 30 independent, 15 semi-independent and 46 dependent beneficiaries.

2. Living Conditions

The Old People's Home in Dimitrovgrad was opened in 1985. Its interior indicates that those who had planned it in the first place failed to take into account the basic purpose it would serve, but also tells a lot about the state's decades-long attitude towards the persons that need social protection. Erected in the outskirts of the town, without a single elevator and with long, narrow hallways and tiny rooms, the building has never been adequate for accommodation of old people. This, along with the fact that it hasn't been reconstructed for 20 years, is telling enough that the Home is far from meeting both international and domestic standards for dignified life.

Actually, the Home is a single facility of some 2,300 square meters with a basement, a ground floor and one floor. It provides 14 single rooms, 16 double rooms, 4 three-bed rooms and 8 four-bed rooms for total 90 beneficiaries, which is in keeping with its capacity approved by the Ministry of Labor and Social Policy. However, it does not meet the standards for the number of square meters per beneficiary.

A SINGLE ROOM SHOULD HAVE AT LEAST 12 SQUARE METERS, A DOUBLE ROOM AT LEAST 15 SQUARE METERS AND A ROOM WITH MORE THAN TWO BEDS AT LEAST 5 SQUARE METERS OF SPACE PER A BENEFICIARY. (*ARTICLE 4, RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLD PEOPLE*.)

At referred to in the paragraphs above, the Home accommodated 91 beneficiaries at the time of the team's visit. This in itself did not exceed the proscribed capacity of the Home but raises some questions: is a capacity of an institution increased whenever necessary and how both beneficiaries and personnel function under such circumstances? In what way do local social care centers provide assistance to persons who need it when one takes into account that there is no other similar institution in the entire district? Are old, disabled and sick persons left to manage on their own?

Rooms are well-kept and tidy. However, we noted patches of humidity on some walls. Bedclothes are old but clean and kept in good condition – more precisely, general hygiene is rather adequate. There is little furniture in the rooms. Beneficiaries are allowed to keep odds and ends of their own, such as bed covers, small carpets, transistors or TV sets. All beneficiaries have their own cupboards with locks, which provide them with sense of safety and privacy. However, all those cupboards with locks and chains on them speak more of forceful detention than some new habitat providing humane conditions to an older person. Though those locks and chains have been placed as the only solution available to the management, the team takes that some other means could be found to protect beneficiaries' privacy.

Sizes of radiators are adequate to the sizes of rooms, though the radiators are rather old. The Home has its own boiler room and uses heating oil. Heating is adequate, according to the interviewed beneficiaries. The fact that old window-panes were replaced by new ones – the only investment made in the Home since its construction - certainly contributed to more adequate room temperature. On the other hand, the Home has no air-conditioning system. Therefore, room temperature in summertime is rather high and in those located in south and west wings almost unbearable. Such heat threatens lives of 46 immovable beneficiaries and 15 who move with difficulties.

All rooms have wash basins with small boilers that are properly kept. Rooms have no toilets and bathrooms – those facilities are available to beneficiaries on each floor in each wing of the building. The overall surface of the sanitary area is less than 100 square meters, which is absolutely insufficient for so many beneficiaries and personnel. The absence of private toilets and bathrooms in an institution providing permanent accommodation negatively affects beneficiaries' sense of dignity and personal integrity. For their basic physiological needs beneficiaries must leave their rooms and walk the distance of tens and tens of meters. This is a huge problem for most of them, given that they are old people most of whom have difficulty to control their bladders and bowels. One cannot but wonder how those people manage during bedtime. Do they walk the distance of tens meters from their bedrooms to toilets half-asleep or do they empty their bladders in some pots placed in their bedrooms? Be it as it may, they cannot but feel humiliated (in the event of incontinence) or stop caring

about it any longer and thus impair their own hygiene, and that of other beneficiaries and personnel.

Though the building was so constructed to allow entrance of natural light and fresh air, sizes of the rooms, threadbare mattresses and bedclothes, and dilapidated furniture create the impression of stuffiness and neglect.

> CREATING A POSITIVE THERAPEUTIC ENVIRONMENT INVOLVES, FIRST OF ALL, PROVIDING SUFFICIENT LIVING SPACE PER PATIENT AS WELL AS ADEQUATE LIGHTING, HEATING AND VENTILATION, MAINTAINING THE ESTABLISHMENT IN A SATISFACTORY STATE OF REPAIR AND MEETING HOSPITAL HYGIENE REQUIREMENTS. (*CPT/INFO (98), 34.)*

The quality of communal living area shared by all beneficiaries is also inadequate. The dinning room is large but dark and humid, with concrete floor and inadequate heating. The kitchen looks well-kept and clean but has only one usable refrigerator. Nondurables such as eggs are kept in a storage adjacent to the kitchen even in summertime. According to institutional personnel and the manager, electrical installations are old and inadequate for more sophisticated household appliances. Therefore, even the purchase of new ones would be questionable in the final analysis. Repair of the leaking roof and reconstruction of sewers are the most pressing problems for the institution. Inadequate electrical installations and humidity are actually alarming when one bears in mind the age and movability of beneficiaries.

The living room is spacious and has been redecorated recently. It has a TV set and a DVD set. However, it's rather dark and inadequately heated. What leaps to the eye in this room are armchairs with perfectly clean and totally unruffled covers – and with not a single person sitting in them. Everything looked so well-polished and strangely orderly, whereas the movable beneficiaries were all grouped in the communal living area – dark, chilly and with concrete floor covered with patches of rugs and carpets here and there – sitting either in dilapidated armchairs or in plastic chairs. Of course, the management's intention to keep up appearances is not wrong in itself nor should be criticized. The Helsinki Committee's teams on fact-finding missions to all institutions in the past several years have witnessed such practices. The question is whether the institutions look after beneficiaries and are concerned with their living conditions in normal times, i.e. when no visits are announced in advance. And the question is to what degree institutional personnel are professionally capacitated for their jobs. Resulting from inadequate investment, inadequate living conditions mark, as a rule, almost all types of facilities for long-term institutionalization. More funds, therefore, would hardly change the situation for the better. What can make the difference is a change in the attitude of policymakers, who must be dedicated to overall reform of the society and to the establishment of a socially responsible, efficient and modern state. On the other hand, a positive change in policies depends, in many respects, on institutional personnel that are, more often than not, unmotivated and even overtly hostile to any new practice and standard.

The Home does not have communal recreational areas or rooms that could be used for work therapy, barber or hairdressing services, there are no kiosks, postal services, etc. A shop the movable beneficiaries usually go to buy this or that for themselves or others is located in the vicinity of the Home. However, they are all

dependent on institutional personnel when it comes to goods not available in the shop or various services that can be provided downtown only.

> AN INSTITUTION SHOULD HAVE SEPARATE ROOMS TO BE USED AS LIVING AREAS, FOR WORK THERAPY, COMMUNAL RECREATIONAL ACTIVITIES, BARBER AND HAIRDRESSING SERVICES…(*ARTICLE 3, PARA 1, RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLD PEOPLE*.)

Yet, the most serious problem of all is that the Home has no elevator – an insurmountable obstacle for two-thirds of semi-dependent and dependent beneficiaries. Some of them, therefore, never leave their rooms and adjacent halls. Others can leave their rooms just occasionally as they are dependent on orthopedic aids and personnel, both of which are few. The use of stairs cannot but be stressing experience to aging beneficiaries. To avoid it, they stay in their rooms and logically turn apathetic.

A young woman of 26 is also a resident of the Home. She walks on clutches and with much difficulty. Until the age of 20 she was hospitalized in the Institute for Cerebral Palsy in Belgrade. Then a social care center placed her temporarily to the Old People's Home in Dimitrovgrad. Now she doesn't want to leave the Home – she has adapted herself and appreciates the personnel's care and attention. She has been given a single bedroom she likes very much. However, the room is on the first floor. Always someone strong and reliable enough – which means someone from the staff – has to help her to take stairs. Whenever she needs to go to the dinning room or the communal living room, or wants to step outside the building, she has to ask an employee for assistance and often waits long before that person can attend her. "Taking the stairs is my only physical therapy," she says amiably. And yet, this 26-year-old is doomed to hours of meaningless sitting since the Home cannot provide her with an adequate wheelchair. Though the emotional ties between her and the personnel are obvious and mutual, being accommodated in this specific institution is a negative solution for her in many respects: no physical therapy can be provided to her, the possibilities for development of her mental capacities are rather meager, no cultural or educational contents are available to her, she has no peer to socialize with. Therefore, one cannot but feel that professionals from both the Home and the social care center have not tried hard enough to accommodate this young woman in a less restrictive institution or to create for her more humane living conditions in this Home. So far, no one has even given thought to some form of community-based for her.

The Home itself is surrounded by some 2 hectares of nicely kept park with orchard within it. The fruits picked in the orchard are served to beneficiaries. Those among them who are capable and movable enough help in keeping the orchard, picking up the fruits and conserving them. That's certainly a meaningful activity that gives them the sense of usefulness. However, the park itself could be put to better use than it is. It has only one bench and a table, accommodating 3-4 persons at the most

and no other facility for beneficiaries to feel more comfortable in the open air. Placing more benches and tables would be a small investment providing by far more possibilities for recreation and therapy.

Last but not least, it should be noted that the offices used by employees somehow fit into the general, somber picture: they are barely furnished, and the furniture itself is pretty dilapidated. There is just couple of PCs available to the staff.

Generally speaking, monitoring of the institution and interviews conducted with both the personnel and beneficiaries suggest that the latter are basically catered for. The team did not observe any signs of dissatisfaction or revolt – on the contrary, beneficiaries looked calm but apathetic. Despite many shortcomings noted in the institution, none of them complained about living conditions. Actually, their behavior was uniform – as if all of them have accepted those elementary standards of living. Among other things, their apathy is a natural result of the totally passive and outdated approach to institutionalized social care: this is the approach whereby beneficiaries are provided minimal living conditions, which implies accommodation, food and medical care. Beneficiaries – older people in particular – have no other choice but to accept what is being offered to them and forget about their individual needs and wishes. For them, that's the only way to feel welcome in their new surrounding.

Recommendations

- Investment in total reconstruction of the facility is urgent – this particularly refers to electrical installations and humidity, as well as to building in an elevator;
- Funds should also be secured for adding the rooms for work therapy and recreational activities, as well as for more toilets and bathrooms;
- A hospital signalization system and air-conditioning should be installed, the same as handrails to all staircases;
- Old mattresses and bedclothes should be replaced, new pieces of furniture added, the same as kitchen utilities, all of which would improve living conditions for the beneficiaries;
- The exterior of the Home should be suited to recreational and therapeutically needs of the beneficiaries.

3. Institutional Personnel

Generally speaking, the Home is understaffed in terms of professional staff. Out of 33 employees only one is a social worker and she is in charge of all the beneficiaries. The medical staff that is of vital importance to the beneficiaries includes one doctor, a head nurse and 9 nurses. The rest of the staff works in administration, kitchen and on maintenance. There are no psychologists, physiotherapists or social work therapist on the staff. Only three employees are with university diploma, four have graduated from high schools, 12 from secondary, whereas the rest are either qualified workers or with elementary school. Personnel's age structure is even more inadequate: only two employees have under 2-year professional career, 3 are with careers of 5-10 years, and the rest over 10. Actually, 23 employees have been working for more than 23 years.

The number of the employees making the professional staff has remained the same since the institution's establishment – which means that the quality of the servi-

ces provided has not changed. Paradoxically, nowadays when deinstitutionalization is being propagated, the main criterion for professionals is the number of beneficiaries they caters for rather than their professional capacity or multidisciplinary approach. When asked the need for in-service courses of training and problems they face in their professional work, the members of the professional staff provided just general responses. Except for the workload, everything else functions smoothly, according to them.

They said repeatedly they were expecting an occupational therapist on the staff but none of them had any idea what that professional would be tasked with and what difference it would make for the beneficiaries. The records the team inspected were kept in detail. However, the team was told that such model of keeping the records was a novelty the staff was still mastering including its adequate implementation in everyday life. On the other hand, since only one member of the staff is in charge of keeping the records, it would be quite unrealistic to expect this single person to be competent enough to properly organize all the aspects of professional work with the beneficiaries, i.e. to implement the strategy for aging persons.

The interviews conducted with the beneficiaries and the general atmosphere observed clearly indicate that the personnel treat the beneficiaries correctly. The interviewed beneficiaries praised their good communication with nurses and the social worker and spoke about their exceptional dedication to work. Given that none of the personnel has undergone in-service courses of training in his or her specific field, their overall positive attitude towards professional services and treatment of the beneficiaries is rather telling of those people's personal qualities and true dedication to their work. Unfortunately, this is not enough to secure high-quality work with specific groups of population such as aging persons. Indicatatively, several employees said that the beneficiaries with senile dementia were actually retarded. Offhanded and unqualified qualification of social care beneficiaries is a worrisome and, moreover, a widespread phenomenon in many institutions.

The problem of institutions understaffed in terms of professional personnel is more plaguing in small communities such as Dimitrovgrad. Apart from poor educational structure of such communities, assignment of managerial posts by partisan criteria additionally burdens and often threatens the very functioning of the anyway problematic and inadequate systems. It is absolutely imperative to introduce in-service courses of training and licensing for all the employees in the social care system, and a strategy to be urgently put in practice.

The problem that notably plagues the Home – and is characteristic for all other social care institutions as well – is the problem of inadequate medical care. Actually, everything boils down to undefined (or poorly defined) relations between ministries of labor and social care, and healthcare and the Republican Health Security Fund. Their divided jurisdictions and financing result in poor medical care in almost all social care institutions. Taking into account the profile of social care beneficiaries and socially vulnerable groups, the government's and ministries' indifference in the search for a system solution that would provide quality medical services to those categories is not only hard to justify but impermissible. Regardless of the age of the persons it has to cater for, and the number of semi-dependent and dependent beneficiaries, the Old People's Home in Dimitrovgrad is understaffed in terms of medical officers and thus incapacitated to look after the beneficiaries in a proper way. And all this despite the fact that nurses work hard and are highly dedicated to their job. Moreover, their job as such threatens their health as well.

The Home is definitely understaffed and cannot provide adequate services to the beneficiaries, and the more so since the institution does not have an elevator, has shared bathrooms and toilets, large areas covered with glass, concrete floors, etc. Therefore, the staff has to work by far harder to have the Home function and by far more than planned by the established professional norms. This primarily refers to nurses and charwomen. It is hardly possible for them to keep all the rooms perfectly clean and pay due attention to all the beneficiaries day in day out, all the year long.

As referred to in the paragraphs above, there is no occupational therapist on the staff. Such situation deprives all the beneficiaries of the much needed occupational and social activism. This is why they are all notably lethargic. It goes without saying that daily psycho-physical activities are vital for old people. Otherwise, the process of their bodily and mental deterioration is guaranteed.

The beneficiaries are also deprived of adequate physiotherapy, which makes the old people feel better and is often medically imperative. In addition, physiotherapy encourages old people to try by their own to stay in as good shape as possible.

Those old people also badly need psychological support. They need a professional they can trust to listen to their personal problems and provide them encouragement in surmounting them. In this sense, reliance on understanding and good will of someone from the staff is not enough and may often be counterproductive.

Recommendations

- The Ministry of Labor and Social Policy and the Ministry of Healthcare should reconsider and review the requirements for engagement of professionals and other employees so as to make it possible for all institutions to recruit sufficient number of various professionals;
- The personnel should be encouraged to attend courses of in-service training and follow contemporary trends in treatment of old persons;
- Living and working conditions of the entire staff should be improved through increased salaries and bonuses for dedicated and conscientious work.

4. Medical Care

The medical staff includes one general practitioner (with professional experience of couple of months only), a head nurse and nine nurses not specifically trained to cater for old people. There are no nurse's aids on the staff though such professionals are more than necessary for this category of beneficiaries. The doctor and the head nurse are present on the premises in daily hours only. Just two nurses work nightshifts.

A social care center evaluates a beneficiary before admission and, among other things, forwards his or her medical file. The social worker, the doctor and the head nurse are on the admission team. Beneficiaries are once again medically examined upon admission and are given a period of 3-6 months to adapt themselves. According to the social worker who has been there for already 22 years, only two beneficiaries failed to adapt. This piece of information in itself could be highly recommendable for both the institution and the personnel. On the other hand, one always has to take into account that potential beneficiaries in this region practically have no other choice.

Independent beneficiaries are given elementary medical care (regular medical examinations and therapies for those with chronic illnesses, whereas specialist examine them either in the local medical center or in the Home). Semi-dependent and dependent beneficiaries are supervised by the medical staff round the clock. A plan for individual medical treatment of beneficiaries is underway.

The Home has an in-patient ward attended by a specialist in internal medicine. Whenever called in (usually once a month) he comes to examine all the beneficiaries. Those who need to be seen by some other specialists are taken to Pirot in an ambulance. There have been no systematic medical examinations so far since the institution did not have a full-time doctor on the staff. Laboratory tests are conducted by the local medical center on weekly basis given that the institution does not have a laboratory for basic blood or urine tests of its own. The Home has only one glucometer for determining the approximate concentration of glucose in the blood. Some kind of mini-lab would surely facilitate the doctor's work and make it possible for him to a better insight into beneficiaries' state of health and promptly diagnose deceases.

Beneficiaries can require to be medically examined by specialists. The doctor decides whether or not such requests are justified on the grounds of their medical files (that are kept conscientiously and contain information about earlier specialist examinations, lab tests, etc.) The institution arranges for an examination and provides an ambulance. Any hospitalization is also recorded in a beneficiary's medical file. A beneficiary has the right to refuse therapy. In such case a nurse informs the doctor who has the final say. Bearing in mind that aging people are among the most vulnerable categories of the poor and that they rarely have access to costly medical examinations even in the outside community, it is only logical to presume that all medical services are not available to the Home's beneficiaries. In addition, no brochures that would instruct them how and where to lodge their complaints are being distributed to them.

The Home does not have written rules on procedures in cases of emergency treatment. When the doctor is not present on the premises (in the afternoons, at night or during weekends) a nurse calls in doctors from the local medical center. Nurses are allowed to provide emergency treatment in the presence of a doctor only.

Medicaments in ampoules are kept in a locked cabinet in the doctor's office. The head nurse keeps tablets in her room, whereas independent beneficiaries have their tablets with them. A nurse supervises regular administration of therapies. Medicaments that are mostly prescribed to beneficiaries are antihypertensives and sedatives. The Home has never been out of medicaments.

Beneficiaries take tranquillizers only if they are prescribed to them by neurologists or psychiatrists, and under the control of the doctor. All prescriptions for tranquillizers are documented in medical files. In doctor's absence a nurse can give a beneficiary this medicament only if his or her medical file says so – which is certainly a good practice to prevent misuse of sedatives. In some cases for safe intravenous therapies beneficiaries have to be tied to their beds to prevent self-mutilation. The team did not observe any visible traces of instruments of restraint on beneficiaries' skin. However, the Home does not keep records on the use of instruments of restraint and has no written rules on their usage. It also caters for some persons with mild mental disabilities. Medical officers have not undergone courses of training in treatment of such beneficiaries or those who are agitated. Emergency treatments are

usually provided by the team that includes the doctor (during working hours), nurses and nurse's aids.

OLDER PERSONS SHOULD BE ABLE TO UTILIZE APPROPRIATE LEVELS OF INSTITUTIONAL CARE PROVIDING PROTECTION, REHABILITATION AND SOCIAL AND MENTAL STIMULATION IN A HUMANE AND SECURE ENVIRONMENT *(ARTICLE 13, UN PRINCIPLES FOR OLDER PERSONS)*

Dependent and semi-dependent beneficiaries are accommodated in dormitories (usually with four beds) that are in the basement and on the first floor. Those dormitories are sunny with floors covered with linoleum that makes maintenance of hygiene easier. The beds the beneficiaries are sleeping in are not hospital beds though they can be approached on both sides. Unavoidable plastic covers are placed on all mattresses. Though few, medical officers change and move bedridden beneficiaries three times a day (and more often if necessary). The team did not observe any trace of bedsores on them. All the other beneficiaries must take baths once a week. Toiletries are provided to them or they buy them if they can afford it. Given that bathrooms are shared and located at the end of halls one cannot but question regular maintenance of personal hygiene by the beneficiaries who move with difficulty. Under such circumstances 10 nurses must exert themselves to cater of 61 dependent beneficiaries, apart from 30 who can walk by themselves. The beneficiaries are, therefore, subjected to neglect despite the fact that nurses and nurse's aids perform their duties professionally and conscientiously.

Once a week beneficiaries can have their clothes washed for them. The Home provides clothes to the beneficiaries who cannot afford them. Despite many shortcomings in terms of space and personnel, personal hygiene of beneficiaries is properly maintained, which is of major importance to their health.

Weekly menus are decided by a chef, the head nurse, the social worker and one beneficiary. Fruits are served twice a week, whereas sweets only once. No food (not even fruits) is available to beneficiaries outside regular meals. Therefore, many beneficiaries who can walk keep electric rings in their rooms. Only the patients with diabetes mellitus are regularly served snacks twice a day.

Statistics on suicides are not kept in writing. According to interviewed employees, one person committed suicide last year. Cases of suicides are rare and mostly relate to psychiatric patients, say the staff. Such a statement is rather questionable since no serious psychiatric cases are being accommodated in the Home or belong there. The fact that some beneficiaries, no matter how few, have suicidal behavior indicates a serious failure of the part of the institution to timely detect such cases and administer medicaments to them or provide some other form of treatment. Heavy workload among professionals is never an excuse when it comes to human lives. Justifying a person's suicide by his or her mental disorder that has not been professionally diagnosed borders on crime that is legally punishable.

Recommendations

- Adequate number of medical officers, including nurse's aids, should be engaged on full-time basis;
- Beneficiaries should be medically examined upon admission and systematic examinations should be organized at least once a year;

- A small lab for basic test should be set in;
- A room for physiotherapy should be set aside and properly equipped for that purpose;
- Food and drinks should be provided between meals, notably to semi-dependent and dependent beneficiaries;
- Written rules specifying the cases when instruments of restraint are allowed should be developed and all such cases should be recorded in a special register;
- A sufficient number of hospital beds should be secured the same as walking aids for semi-dependent and dependent beneficiaries;
- Medical control and treatment of depressive beneficiaries and those showing signs of suicidal behavior should be intensified; legal procedure for the cases of suicide should be set in.

5. Patients' Living Conditions and Treatment

At the time of the team's visit the Home accommodated 6 beneficiaries under 50, 10 between 50-60, 26 between 60-70, 24 between 70-80, 21 between 80-90 and 4 beneficiaries over 90 years old. The beneficiaries' educational structure is rather poor – most of them have finished neither elementary school. The quality of the work with beneficiaries is rather poor – the personnel ascribes this to various reasons ranging from the lack of adequate space and technical conditions to unmotivated beneficiaries. Organized activities are rarely organized (e.g., one excursion in the past year). Except from occasional shows staged by elementary school students, no occupational or recreational activities are available to beneficiaries. However, beneficiaries are satisfied with that minimum they get the more so since the great majority of them have been socially neglected before admission to the Home. The absence of those crucial activities is evident in beneficiaries' psychosocial functioning. Depressive atmosphere and apathetic beneficiaries – that's the impression the Home leaves on observers. Such climate could be ascribed to the lack of professional cadre but certainly to the existing personnel's passivity and the longstanding approach to older people that rests on their deficits rather than on their capacities and potentials. The absence of physiotherapy, any kind of occupational therapy and adequate recreational activity mostly affects dependent beneficiaries. The situation of beneficiaries could be treated as inhuman and degrading were it not for the exertion and conscientious work of the handful of medical officers.

WITH A VIEW TO ENSURING THE EFFECTIVE EXERCISE OF THE RIGHT OF ELDERLY PERSONS TO SOCIAL PROTECTION, THE PARTIES UNDERTAKE TO ADOPT OR ENCOURAGE, EITHER DIRECTLY OR IN CO-OPERATION WITH PUBLIC OR PRIVATE ORGANIZATIONS, APPROPRIATE MEASURES DESIGNED IN PARTICULAR:

- TO ENABLE ELDERLY PERSONS TO REMAIN FULL MEMBERS OF SOCIETY FOR AS LONG AS POSSIBLE…

- TO GUARANTEE ELDERLY PERSONS LIVING IN INSTITUTIONS APPROPRIATE SUPPORT, WHILE RESPECTING THEIR PRIVACY, AND PARTICIPATION IN DECISIONS CONCERNING LIVING CONDITIONS IN THE INSTITUTION. *(ARTICLE 23, EUROPEAN SOCIAL CHARTER - REVISED)*

Out of 30 beneficiaries who can walk and 15 who walk with difficulty only four are engaged in some meaningful activity. A 93-year-old lady knits in her room and another tends her plants and the rosebushes in the front of the building. An elderly gentleman makes collages in his room (and some of them are exhibited in the several places in the Home), whereas a young man (accommodated here impaired mental abilities) assists the janitor.

The lack of occupational therapies impairs beneficiaries' sense of self-respect and meaning of life. Only the activities that are continued and productive, and appreciated by others boost people's motivation and activism. Otherwise, they turn apathetic, inert and see themselves as useless.

PROFESSIONAL SOCIAL WORK PARTICULARLY REFERS TO:

- DEVELOPMENT AND IMPLEMENTATION OF THE PROGRAMS FOR PROFESSIONAL AND OTHER WORK WITH BENEFICIARIES, WHICH HELPS THEM TO ADAPT THEMSELVES TO LIVING CONDITIONS IN INSTITUTIONS AND ENGAGE IN ACTIVITIES THAT CONTRIBUTE BOTH TO THEIR MENTAL AND PHYSICAL HEALTH AND LIVING CONDITIONS IN INSTITUTIONS;
- DEVELOPMENT AND IMPLEMENTATION OF THE PROGRAMS FOR DAILY ENGAGEMENT OF BENEFICIARIES IN MANDATORY AND FACULTATIVE ACTIVITIES IN KEEPING WITH THEIR ABILITIES, MENTAL AND PHYSICAL STATUS, INTERESTS, HABITS, HOBBIES AND EDUCATION;
- ORGANIZATION OF VARIOUS CULTURAL AND RECREATIONAL CLUBS IN KEEPING WITH INSTITUTIONS' CAPACITIES AND BENEFICIARIES' INTERESTS;
- ORGANIZATION OF COMMUNAL AND INDIVIDUAL, MEANINGFUL TASKS.

(*ARTICLE 45, PARA 2,7,8,9, RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLD PEOPLE*.)

Recommendations

- Psychosocial components of the treatment should be in the focus of attention;
- Rooms should be set aside and professionals engaged for the purpose of quality treatment;
- Educative programs should be developed and implemented in keeping with beneficiaries' levels of education and interests;
- Suitable programs should be developed for semi-dependent and dependent beneficiaries.

6. Contact with the Outside World

Beneficiaries' contact with the outside world is almost negligible – actually, corresponds the institution's overall capacities. Over the past 12 months only one excursion to the outside community was organized for beneficiaries, whereas those who are capable enough (independent) can get self-organized and thus be in contact with the local community. In real life this means that the great majority of them communicate with passersby while sitting on the benches outside the Home or with salespersons while doing their shopping at the nearby retailer's. Phone booths are not available to beneficiaries on the premises. Those who need to make phone calls must

go to the offices used by the staff. This means that they cannot make phone calls at any time or when they wish so but have to turn to the personnel. This also means that they do not enjoy privacy and that they cannot make any phone call in afternoon or evening when the offices are closed. In brief, they are deprived of the right to communicate by phone with their families and friends, as well as of the right to privacy of communication. It is only logical that under such conditions beneficiaries often give up any idea about making a phone call. All this additionally impairs their communication with families and friends and adds to their sense of loneliness and isolation.

However, none of the interviewed beneficiaries complained about anything doing with phone calls. Those with families receive visits though such visits are really rare. Asked whether or what is being done to encourage beneficiaries' better communication with the outside world and to have them enjoy a less restrictive regime, the interviewed members of the staff say that initiatives in this direction are few but they do keeps records on family visits. Speaking of their cooperation with social care centers they refer to it as good. On the other hand, the team left under a different impression as it was provided with not a single evidence about some positive effects this cooperation has on beneficiaries. Beneficiaries themselves say that social care centers from the communities they come from have never been exactly interested in their fate.

The Home is located in the periphery of the town, close to a residential area. Apart from the above-mentioned retailer's that is at walking distance from the Home, no other public facility is available to beneficiaries.

PROFESSIONAL SOCIAL WORK PARTICULARLY REFERS TO:

- MAINTAINANCE OF BENEFICIARIES' CONTACTS WITH THEIR FAMILIES, CLOSE FRIENDS AND RELATIVES, WHO USED TO MAKE THEIR NATURAL ENVIRONMENT;
- ORGANIZED VISITS TO AN INSTITUTION – BOTH INDIVIDUAL BY FAMILIES AND FRIENDS, AND COLLECTIVE BY VARIOUS CONCERNED INDIVIDUALS AND INSTITUTIONS;
- RECREATIONAL AND CULTURAL PROGRAMS ARRANGED FOR BENEFICIARIES, SUCH AS EXCURSIONS TO NEARBY TOWNS, NATIONAL PARKS AND THE LIKE, AS WELL AS VISITS TO THEATER, MOVIES, CONCERTS, ETC.;
- CONTINUED COOPERATION WITH SOCIAL CARE CENTERS, HUMANITARIAN ORGANIZATIONS, ETC. (*ARTICLE 45, PARA 3,10,11,12 RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLD PEOPLE*.)

Recommendations

- Cooperation with families, relatives and friends should be encouraged; working together with them should be perceived as a most welcome form of treatment in the best interest of beneficiaries;
- Inventive and regular cooperation with local community, schools, humanitarian and non-governmental organizations should be established;
- Adequate measures should be taken to encourage communication between beneficiaries and their local social care centers;
- Beneficiaries should be motivated to engage in meaningful activities, develop friendships and maintain in contact with the outside world.

7. Guarantees for Beneficiaries' Rights and Freedoms

Paradoxically vis-à-vis the situation described in the section above, two persons much younger than the rest of beneficiaries have been accommodated here for rather long time. This refers to the afore-mentioned 26-year-old girl with cerebral palsy and a 33-year-old man categorized (long ago) as mildly retarded person. Social care centers have allocated them both to the Home since they became too "old" for the institutions for children and the young that had catered for them. Their allocation to the Home was supposed to be a provisional solution at the time. Ever since, neither social care centers of the institution have taken any significant step towards finding more adequate accommodation for them, let alone explored all avenues for their community-based care. Their further education and possible employment were totally neglected.

- PUBLIC AUTHORITIES SHALL MAKE IT POSSIBLE FOR PERSONS WITH DISABILITIES TO EXERCIZE THEIR RIGHTS AND FREEDOMS WITHOUT DISCRIMINATION.
- DIRECT DISCRIMINATION EXISTS WHEN PERSONS OR GROUPS – THE SITUATIONS OF WHICH ARE SAME OR SIMILAR – ARE BY ANY ACT OR ACTION DISCRIMINATED AND COULD BE DISCRIMINATED DUE TO THEIR DISABILITIES. INDIRECT DISCRIMINATION EXISTS WHEN A PERSON WITH DISABILITY IS DISCRIMINATED THROUGH ACTS OR ACTIONS TAKEN UNDER THE PRETEXT OF EQUALITY AND NON-DISCRIMINATION, UNLESS THOSE ACTS OR ACTIONS ARE JUSTIFIED BY LEGAL GOALS AND THE MEANS FOR ATTAINMENT THOSE GOALS ARE APPROPRIATE AND NECESSARY.
- THE PRINCIPLE OF EQUAL RIGHTS AND DUTIES IS BREACHED IF THE GOAL OR CONSEQUENCES OF THE STEPS TAKEN ARE UNJUSTIFIED, AND IF THE STEPS TAKEN AND THE GOAL TO BE ACHIEVED BY TAKING THOSE STEPS ARE DISPROPORTIONATE. *(ARTICLES 4, 6, 7, LAW ON PREVENTION OF DISCRIMINATION AGAINST PERSONS WITH DISABILITIES)*

The 33-year-old man is presently very unhappy. He has broken up with a woman he loved when he found out, after talking to the personnel, that he could not have a life together with her in the Home and that even she disliked the idea. "I haven't finished any school and no one would give me a job…so, I broke up with her," he says.

In the context of psychosocial functioning of this beneficiary there are institutions and solutions that would by far better meet his needs and those of his girlfriend. On the other hand, the personnel are not even aware of how grossly the rights of such persons are being violated and that they are actually discriminated. On the contrary, they take that they are protecting them by keeping them in the institution and doing nothing about their needs.

Inadequate architectural conditions, understaffed institution particularly in terms of specialists and insufficient professional capacity of the existing personnel result in involuntary neglect of beneficiaries, of which employees are not fully aware. Physiotherapeutic, psychological and social needs of the beneficiaries are not being met. This creates a climate conducive to intolerance and occasional conflicts between beneficiaries – the problem many of them underlined over interviews.

A young and recently recruited jurist is mostly engaged in secretarial duties. The Home has adopted all the rules it is legally bound to have, including house rules, rules on services provided to beneficiaries, rules on pocket money, etc. The Home

itself is not a party in any legal procedure (either as suer or defendant) and not a single employee has ever been suspected or accused of ill-treatment or torture.

The jurist usually does not communicate with beneficiaries. None of them has ever turned to her for legal advice. Generally, when they have some complaints they turn to the social worker. The jurist says that her cooperation with social care centers is correct and boils down to formal issues.

Recommendations

- The interests of the beneficiaries whose age and needs make them unfit for accommodation in the Home should be met in cooperation with the relevant social care center; Other beneficiaries should also be provided assistance for the exercise of their rights;
- As an expert in legal issues, the jurist should communicate more frequently with beneficiaries to provide them legal guidance or counsel;
- Beneficiaries should be informed about their rights and the mechanisms for the protection of their rights via brochures, posters, etc.
- The Home should establish a clear-cut and efficient grievance system.

GERONTHOLOGY CENTRE – SOMBOR

1. Introductory Remarks

Two physically separate wholes make the Gerontology Center in Sombor. The first is located downtown and formally categorized as a high-standard Home for Pensioners and Older People, whereas the second functions as an in-patient ward called the Nursing Home for Old People. The downtown facility was constructed in 1984 and has 95 one-bedroom and 25 two-bedroom apartments. The Home was built in 1987 and consists of a central facility accommodating semi-dependent and dependent beneficiaries and two smaller facilities for independent beneficiaries. Overall accommodation capacity of the institution is 310 persons. At the time of the team's fact-finding mission it catered for 257 beneficiaries (59 independent, 89 semi-dependent and 109 dependent) out of which 95 were men and 162 women.

Speaking of other forms of social care for older people, "Food Service" and "Laundering Service" have been operating since mid-1980s, while "Home Help" was organized sometime later. Two years ago, "Meals on Wheels" service was set up. It is financed (with many problems, delayed payments, etc.) by the local self-government.

2. Living Conditions

Since the high-standard facility does not fulfill the requirements for accommodation of beneficiaries, it mostly houses those who are independent, whereas the in-patient facility caters for semi-dependent and dependent one. On the other hand, the main criterion for accommodation in the high-standard facility is a beneficiary's financial capacity – a legal possibility available to all social care institutions that meet prescribed preconditions. In other words, apart from a beneficiary's state of health and psychophysical abilities, his or her financial status stands for a major precondition for his or her accommodation: only the beneficiaries who can afford costlier accommodation – and they are few among the overall population of beneficiaries – can secure for themselves better living conditions. This is probably why the high-standard facility operates at some 50% of its overall accommodation capacity (caters for only 71 beneficiaries), while the Nursing Home is overcrowded – with the accommodation capacity for 169 persons it caters for 198 beneficiaries. According to the management, the problem will be solved through reconstruction of the high-standard facility and its adaptation to the needs of dependent beneficiaries as well. Such a solution, however, will certainly not solve the problem of accommodation prices, on the contrary. Financial capacity – that cannot be ignored in the context of accommodation – raises the question of the right to quality nursing care and living conditions for the majority of the population of older people, i.e. to what extent such a concept for functioning of social care institutions for older people is corresponds to its basic purpose. It is beyond dispute that the state (in addition to private businesses and private persons) may legally earn money by providing high-standard services if there is extra space for such services. However, in

setting its priorities in this domain the state must first improve conditions in all other facilities that cater for vulnerable categories of population. The question is whether the state should deal in such business in the first place. The duty of a state is to cater for the population that needs social protection and to ensure fulfillment of standards and control over privately-owned institutions providing social care services. Serbia is too poor to afford the luxury of turning its existing, low-quality and insufficient accommodation capacities into high-standard ones and renting them to the citizens who are better off.

The fact that the Commissariat for Refugees has invested some 50 percent of overall funds in the construction of the downtown facility now poses additional problem. Namely, due to the investment some 50 percent of accommodation capacity still has to be set aside for the persons with refugee status. Given that nowadays such persons are few, the management compensates the cost of unoccupied capacities through services provided to third parties and uses the money to pay running costs, improve services for beneficiaries and to add some extra money to employee's paychecks. Unoccupied rooms are rented to elementary school students or workers on excursions, whereas larger halls are rented for weddings, wakes, seminars, etc. Though the institution has all the premises laid down by the standards for catering for older people, one cannot but be under the impression that those premises are more at the disposal of third parties than of the beneficiaries. High costs of accommodation in this facility – when compared with those in the Nursing Home – imply higher costs of maintenance and services. In such a situation the institution practically has no choice the more so since the Ministry and the Executive Council (the government) of Vojvodina fund only the accommodation of beneficiaries in the Nursing Home. Half-empty accommodation capacities of one facility and overcrowding of the other testify of that authorities have poorly assessed accommodation needs and failed to do the right thing to improve the situation of a socially vulnerable group of population. Impermissibly bad treatment of socially vulnerable beneficiaries is just a natural outcome of such a gross failure. A socially responsible state is the one that caters for this category of population through humane treatment and living conditions that safeguard their human dignity. The rooms in this facility are in keeping with the standards for space and equipment. Here, beneficiaries live in one-bedroom apartments of some 26 square meters. One apartment usually houses a single beneficiary despite the fact most bedrooms have two beds. All apartments have bathrooms with tubs (though showers would better suit aging beneficiaries).

Though considered luxurious, the building as a whole and, in particular, the wing housing the beneficiaries looks so uncomfortable and gloomy as if no one lives in it. Communal areas where beneficiaries spend most of their time are scarcely furnished, while halls are dilapidated, dark and creepy. The dinning room – a decent and tidy one – has no ventilation and not a single radiator. Built-in electric stoves have never been operable. The beneficiaries say that the room is unbearably chilly in wintertime and like a furnace in summertime regardless of two air-conditioners. This is probably so because the entire building has a Plexiglas roof. The facility has two elevators that are always in order thanks to a janitor whose lives on the premises. Functioning elevators are crucial for the beneficiaries. The facility also has a poorly furnished recreation hall (just one table for table tennis and a couple of gym pads). Physiotherapists are available to the beneficiaries in mornings.

The downtown facility is surrounded by a small park that needs to be better tended and adjusted to the beneficiaries. The roof and halls also need repair the

kitchen and the laundry need new utilities and furniture. By comparison with the Nursing Home living conditions in the high-standard facility are by far better – but not because they really meet some high living standards but because the conditions in the former are by far worse.

The Nursing Home, located in the outskirts of the town, houses mostly dependent and semi-dependent beneficiaries, who make two-thirds of the total number of beneficiaries. It goes without saying that the needs of the beneficiaries in the two facilities differ. The Nursing Home should, only naturally, focus nursing care of its beneficiaries. However, what the team saw were inadequate architectural, technical, hygienic, medical and other preconditions for such a focus. Rooms have no bed alarms, basic equipment and walking aids are not available to the beneficiaries, the facility is overcrowded and does not provide sufficient living space per beneficiary, there are no single or double bedrooms, bathrooms and toilets are inadequate…True, there are rooms for recreational activities and occupational therapy but they are too small and poorly equipped. The in-patient ward consists of three 6-bed rooms on each of the three floors. Actually all dependent and semi-dependent beneficiaries' sleep in dormitories.

CREATING A POSITIVE THERAPEUTIC ENVIRONMENT INVOLVES, FIRST OF ALL, PROVIDING SUFFICIENT LIVING SPACE PER PATIENT AS WELL AS ADEQUATE LIGHTING, HEATING AND VENTILATION, MAINTAINING THE ESTABLISHMENT IN A SATISFACTORY STATE OF REPAIR AND MEETING HOSPITAL HYGIENE REQUIREMENTS. (*CPT/INFO (98), 34.)*

The management has obviously done all in its power to renovate the facility: new windows with shades and air-conditioners were installed in all rooms, while the rooms themselves are freshly painted. However, the furniture is old and dilapidated. Hospital beds are accessible on both sides. Floors in the rooms and the halls are covered with linoleum – a solution that is good from the angle of maintenance but risky from that of walking difficulties of semi-dependent beneficiaries.

THE STANDARDS AN INSTITUTION HAS TO MEET IN TERMS OF EQUIPMENT – AND DEPENDING ON THE TYPES OF SERVICES IT PROVIDES – ARE AS FOLLOWS:

- A DORMITORY FOR BEDRIDDEN PERSONS SHOULD HAVE AN ALARM SYSTEM AND ALARM CONNECTION WITH AN EMPLOYEE. ALL DORMITORIES SHOULD BE EQUIPPED WITH OVER-THE-BED TABLES AND SPECIAL HANDLES SHOULD BE INSTALLED OVER EACH BED. (*ARTICLE 5, PARA 2 RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLD PEOPLE*.)

Some independent beneficiaries are accommodated in two small pavilions – one for men and the other for women. Living conditions in those two pavilions are about the same as in the main building. The team found the façade of the main building in the process of renovation: asbestos insulation was being removed. Bearing in mind the detrimental effect of asbestos fibers on people's health, it is rather strange that renovation has not seen earlier as a priority.

The facility has a large terrace that might be most welcome for those people walking with difficulty. Unfortunately, it has been totally neglected. All beneficiaries can do there is sit on old and uncomfortable chairs.

A big and nicely kept park surrounds the Nursing Home. However, though well-tended such an exterior can be put to by far better use.

Recommendations

- The problem of accommodation capacity of the downtown facility should be solved and its premises used rationally;
- Funds should be secured for reconstruction of the roof and halls, as well as for the purchase of new equipment (for laundry and kitchen) and furniture for communal rooms;
- Ventilation and lighting should be improved, particularly in the halls;
- Extra radiators should be installed, as well as air-conditioners in the critical rooms;
- Funds should also be secured for improvement the overall living conditions – for renovation of the rooms and purchase of new equipment in the Nursing Home;
- Hospital alarm system should be installed in the Nursing Home, as well as video surveillance system for the rooms accommodating bedridden beneficiaries;
- Wheelchairs, walking and other aids should be secured in adequate number and type, and rails should be installed throughout the facility; bed handles for dependent beneficiaries should also be mounted;
- Both the terrace and the park should be better adjusted to the needs of the beneficiaries who cannot walk by themselves.

3. Institutional Personnel

The institution is adequately staffed with professional and other officers. Since the number of beneficiaries exceeds 250, the institution, in keeping with norms, recruits 116 full-timers. The so-called professional service includes 9 employees: one psychologist, three social workers, two occupational therapists, one jurist, one manager of the in-patient ward (economist by vocation) and a director (andragogist by vocation). The employees are proportionally engaged in the two separate units taking into consideration the number of beneficiaries accommodated in both. Since the institution makes extra profit all the employees are entitled to bonuses ranging between 10 to 30 percent of their salaries. The percentages are decided by heads of services. Judging by interviews conducted with the employees they seem to be somewhat dissatisfied – more precisely, their perceptions of each other's conscientiousness and quality of work differ, which cannot but affect inter-staff relations. The same as other social care institutions, this one also suffers from inappropriately regulated relations with the Ministry of Healthcare and the Republican Fund for Healthcare. Medical officers have a lower salary coefficient and are not entitled to paid night shifts, paid work on weekends, etc. Employees are also dissatisfied with the Ministry's decree on salary coefficients, which have been changed several times but always to the advantage of the officers with university diploma. According to the interviewed employees, such a policy has a negative effect on their motivation and quality of work. Bearing in mind considerable subsidies the Center gets (over 115 million RSD in 2007), extra profits it makes and the bonuses to which the employees are entitled, one cannot but leave under the impression that the institution can better distribute available funds among employees, regardless of the set salary coefficients. It goes without saying that such redistribution should not be at the

detriment of beneficiaries, the more so since the actual structure of expenditures is not to their benefit – salaries for the employees make 51.3% percent of overall expenses, whereas 15.6% is spent on food for beneficiaries, only 1.5% on medicaments, 2.4% percent on clothes and footwear, 4.3% on toiletries, etc. Situation is about the same in other social care institutions. That indicates that the budget for social protection of the population is inadequate. The costly and inefficient state that squanders at many levels of governance is extremely restrictive when it comes to the needs of the most vulnerable strata of population. Such state is not socially responsible and violates fundamental human rights of its citizens, the same as its own and international obligations it is bound to respect.

According to the director, 37 employees have attended various courses of in-service training. This mostly refers to medical officers. In-service course of training for occupational therapists has been organized only once. For their part, the interviewed employees did not manifest any interest in such courses. Moreover, most of the officers while interviewed in the Nursing Home were openly referring to beneficiaries as "knows nothing," "retarded" or "no one cares about him" in their presence. Such language has nothing to do with professional approach and may hurt people's feelings. It also shows that they are not properly professionally capacitated and fully unaware of contemporary trends in the treatment of social care beneficiaries.

Beneficiaries' files are kept meticulously. On the other hand, all the files inspected seemed somehow uniform in terms of generalized assessments and loose findings. As it seems, some employees who should be in constant and direct communication with beneficiaries are not sufficiently motivated for continued, individual approach to them.

Generally speaking, the interviewed beneficiaries seem to be satisfied with the staff's attitude. However, one lady in the room for bedridden beneficiaries complained, "This woman next to me emptied her bowels in her bed last night. I was calling them repeatedly to open the window at least…The stench was unbearable, it made me sick. It was only in the morning that they cleaned her up."

Recommendations

- The staff should be encouraged to improve their professional capacity by attending courses of in-service training, through exchange of experience and models of positive approach to beneficiaries;
- Mechanisms that would buffer dissatisfaction among different categories of the staff should be established, and all the employees, without exception, should be motivated to work conscientiously.

4. Medical Care

Medical services in the Sombor gerontology center are well-organized. Once a beneficiary's medical file is forwarded by a relevant social care center, a team composed of a social worker, a physician, a head nurse, an occupational therapist, a jurist and the director admits him or her into the institution. Upon admission all beneficiaries undergo sanitary-hygienic procedure.

The medical team in the downtown facility includes one general practitioner, a head nurse, 2 nurses (who work in shifts), one physiatrist and 5 nurse's aids (working in 3 shifts).

The institution provides elementary healthcare. Systematic medical examinations are not organized though they should at least once a year. The institution has both space and the number of staff necessary for such preventive protection.

The downtown facility accommodates some ten semi-dependent and dependent beneficiaries who have turned dependent since arrival. They are provided nursing care round the clock, including regular change of diapers. Medical treatments are individualized – a physician makes a plan of treatment with a beneficiary's consent and includes it in his or her medical file. It is most important to keep beneficiaries informed about the treatment provided to them – not only because institutions are legally bound to do so but also because such approach makes beneficiaries trust the staff and provides them with a sense of safety, which is vital for older people.

Beneficiaries are entitled to ask to be medically examined by specialists. If in a doctor's opinion such a request is medically justified, the institution makes all necessary arrangements for such examinations and pays for them. Whenever a beneficiary is hospitalized such information is registered in his or her medical file, along with hospital release papers, which makes the medical documentation complete.

In the event of an emergency situation while the physician and the head nurse are not on premises, a nurse must immediately contact them. However, though the physician is not present the nurse regularly provides therapy to the beneficiary needing first aid – something that should be practicized only if his or her state of health demands urgent action. According to medical officers, cooperation with the local ambulance service is not satisfactory. Their colleagues in the other facility, the Nursing Home, did not complain of the ambulance service. So different assessments may indicate that the ambulance service does not treat all the beneficiaries in the same way. If that is true, that would be impermissible discrimination (either by the criteria of beneficiaries' solvency or on the grounds of an arbitrary assessment that the beneficiaries accommodated in the Nursing Home are is worse condition than those in the downtown facility). On the other hand, the Gerontology Center has three ambulances of its own and a mini van with 9 seats. Therefore, one cannot but wonder about the institution's capacity to get well organized for emergency situations.

The institution is well supplied with medicaments. Shortages are rare, according to the interviewed medical officers. The institution's agility in getting donations must be commended. The use and storage of medicaments and ampoules are kept under proper control. The medicaments that are mostly prescribed to the beneficiaries are antihypersensitives, aminophilins, Ranisan, etc., which corresponds with the symptoms found with older persons. A nurse takes care of regular administration of therapies.

The institution has physiotherapy ward providing paraffin and chine therapies necessary for this category of beneficiaries. The institution plans to acquire new equipment to improve this type of treatment. Beneficiaries are satisfied with both therapies they are getting and their frequency.

A beneficiary may refuse a therapy but has to put it in writing in his or her medical file. A physician in such case notes down that the beneficiary was informed

about possible consequences, which is in accordance with the Law on Healthcare. However, such cases are rare in the institution. Beneficiaries said they were always getting reasonable explanations about the therapies prescribed to them.

Sedatives are administered to almost all the beneficiaries (those aggressive, depressive, agitated, suffering from insomnia, etc.). When necessary, nurses administer sedatives parenterally. Though sedatives have to be prescribed by a physician, nurses "occasionally," as they put it, administer them on their own (usually during weekends or nights) if some beneficiaries are too agitated or suffer from insomnia. Such practice is not allowed – the use of sedatives needs to be strictly controlled to avoid misuse (e.g. when sedatives are given to beneficiaries just to lessen their activity or keep them tight asleep at night). A neuropsychiatrist evaluates the state of mental health of beneficiaries. The head nurse instructs the others on her staff how to treat agitated or aggressive beneficiaries and there are no written procedures. Though institutions of this type do not generally cater for beneficiaries with mental problems, the team takes that the Ministry of Labor and Social Policy should pass some regulation on the treatment of such beneficiaries the more so since states of agitation or aggressive behavior may be caused by beneficiaries' inability to adjust themselves to institutional care and not solely by mental illnesses. Therefore, it is most important that the staff of social care institutions undergo courses of training in treatment of mentally agitated patients. According to the interviewed medical officers, they rarely attend courses of in-service training and when they do they pay them from their own pockets. In cooperation with republican and provincial ministries, social care institutions need to find some modes of financing in-service courses of training for all types of staff, since this is about a serious problem plaguing all social care institutions.

Suicide attempts are rare (employees recalled one case, which fortunately did not result in death). The criteria by which suicide cases in state institutions are judged by public opinion and courts of law, notably international, are most strict. The Ministry of Labor and Social Policy and social care institutions, therefore, should be particularly concerned with prevention of suicides and regularity of the procedures they do result in death.

Daily menus are made by the head nurse and, if necessary, the physician. The must always know the exact number of beneficiaries with special diets (those with diabetes, gastrointestinal diseases, etc.). The institution is not entitled to engage a nutritionist on a full-time basis. It used to have one on staff for the period of six months thanks to the program of subsidies for public institutions. That period was used for setting the menus by nutritive standards and those menus are most in use to this very day. The overview of weekly menus showed that fruits were not served regularly enough. However, this may be ascribed to a short-term deficit in supply of sufficient quantify of various fruits. Bearing in mind that the main supplier has influence on the menus, the quality of meals served to beneficiaries do depend on his (cost-benefit) assessment as well. Under the rules on beneficiaries the Center adopted on April 17, 2006, only the Board of Beneficiaries is entitled to make complaints or suggestions about menus. One beneficiary was subsequently included in the team composing the menus, which is certainly a small step in the right direction. Even was it not for their costly accommodation, beneficiaries should be included in deciding the menus as they are in some other social care institutions with by far smaller budgets.

OLDER PERSONS SHOULD BE TREATED FAIRLY REGARDLESS OF AGE, GENDER, RACIAL OR ETHNIC BACKGROUND, DISABILITY OR OTHER STATUS, AND BE VALUED INDEPENDENTLY OF THEIR ECONOMIC CONTRIBUTION. *(UN PRINCIPLES FOR OLDER PERSONS, ARTICLE 18)*

The medical staff of the other facility, the Nursing Home, is bigger and bigger it has to be due to the overall state of health of its beneficiaries. Here the medical staff includes a head nurse (with secondary rather than with high school), 10 nurses, 20 nurse's aids and one physiotherapist. However, the number of staff is insufficient bearing in mind the number and pathology of beneficiaries. A physician engaged on full-time basis is not on the staff. Instead, four doctors from the local medical center are available for 3-4 hours on the premises each and come in on call whenever necessary. Doctors have been engaged on contractual basis ever since the institution was established due to the fact that one of the buildings within compound of the downtown facility has been lent to the local medical center. This is why one physician is always present on the premises of the old people's home, and is practically available round the clock since the facility is at walking distance. But the Nursing Home should have a doctor present on premises at all times as well. It is impermissible and unjustifiable to deprive beneficiaries with serious health problems, but with little money, of continued medical supervision, whereas those who are located downtown (and are generally in better health) are provided by far better medical care just because they pay for their accommodation from their own pockets. It is the state's duty to make medical services available to all citizens without exception and there is no excuse for discrimination, particularly in the institutions in its ownership.

The medical staff works in three shifts. One nurse and 3 nurse's aids are present on each floor in afternoon shifts, while one nurse and one nurse's aid at night. As noted above, the Nursing Home is understaffed taking into account the workload. Once a month, a neuropsychiatrist, a specialist in internal medicine, a physiatrist, a dentist and a surgeon come in for consultative examinations and are paid honoraria for their services. Systematic medical examinations are not conducted (under the pretext that there is not full-time doctor on the staff).

Regardless of prior medical examinations conducted in social care centers, beneficiaries are once again medically examined and tests are run for them upon admission. This is necessary bearing in mind their general state of health and a long waiting list for admission. In addition, beneficiaries undergo hygienic and sanitary examinations.

The procedure for examinations by specialists and hospitalization, and the method for keeping medical files are the same as in the downtown facility. In emergency cases when a doctor is not present on the premises a nurse calls in ambulance service. The fact that the facility does not have one ambulance at least at its disposal is hard to understand the more so since the Gerontology Center as a whole has several such vehicles.

A doctor prescribes all therapies and makes entries in beneficiaries' medical files. The medicaments that are usually prescribed are antihypertensitives, sedatives, antipsychotics, etc. The cooperation with local and hospital pharmacies (for therapies

given in ampoules) is good and the facility is properly stocked with medicaments. Nurses are in charge of regular administration of therapies.

Medicaments are given to agitated and aggressive beneficiaries beyond usual hours only if a doctor has allowed it in writing in their medical files. Notwithstanding, a nurse once again informs a doctor that such medicaments have been administered. If some beneficiaries need to be frequently sedated, a neuropsychiatrist is being consulted for a possible change of therapy.

A beneficiary who refuses a therapy must sign his or her refusal in his/her medical file. Beneficiaries with mental disorders may end their therapies only with a doctor's consent. Otherwise, they are administered their therapies under nurses' intensive control. In such cases beneficiaries must be ensured the right to lodge a complaint before a commission, and the institution must make sure that those beneficiaries are aware of that right. The fact that the psychologist and the social worker keep eye on the beneficiaries refusing medical care, particularly on those who are incapable to comprehend the necessity of such care, is not a sufficient guarantee against possible misuse.

A psychiatrist evaluates beneficiaries' state of mental health once a month, which may be inadequate bearing in mind the number of beneficiaries and their pathologies. The team did not observe signs of physical restraint or bedsores on beneficiaries (dependent beneficiaries wear diapers and nurses take care of their daily hygiene).

Bearing in mind that it makes some extra profit, the institution should consider the possibility of establishing a lab for elementary tests, purchasing yet another ECG (there is only one for both facilities) and an oxygen tank, and engaging more medical officers. However, those are activities that have to be realized in tandem with the Ministry of Healthcare that, unfortunately, seems to be not interested and cooperative enough when it comes to social care institutions.

Recommendations

- Systematic medical examinations should be organized once a year at least for beneficiaries in both facilities;
- A clear-cut and legal procedure for emergency situations should be established;
- The use of sedatives should under strict control and guided by detailed written rules;
- A physician should be always present at the premises of the Nursing Home, the same as an adequate number of nurses;
- All beneficiaries should be informed about the types of medical services and their right to lodge complaints.

5. Quality of Life and Treatment of Beneficiaries

Since the occupational therapist was not present on the premises of the high-standard facility at the time of the team's visit, he could not been interviewed about the type of activities organized for beneficiaries. The facility has a reading room and a library attended by a beneficiary. According to him, other beneficiaries are not much interested in reading or have some literary preferences. The facility has enough space and number of rooms for a variety of activities. However, the team saw hardly anyone

in those scarcely furnished rooms leaving no impression about some meaningful and continued activities – occupational therapies or any form of rehabilitation - taking place in them. As referred to in the sections above, the facility has a large hall that is being rented to third persons. There is a table for table tennis in this hall. Though the team was told that a pensioner club and a chess club were organized in the institutions, all it saw while touring it were empty halls, smaller or bigger, that could be used for rent. Beneficiaries were mostly sitting in their own rooms. Those interviewed, confirmed that occasional entertainment programs were being organized for them and said they had plenty of time and opportunity for knitting, painting, etc. However, none of them look exactly motivated for any of those activities. The management should obviously give a thought to beneficiaries' individual needs and try to engage them in stimulating activities. It could even organize some activities outside the facility the more so since most beneficiaries can walk and the institution itself is located in the town's center.

PROFESSIONAL SOCIAL WORK INCLUDES THE FOLLOWING SERVICES IN PARTICULAR:

- DEVELOPMENT AND IMPLEMENTATION OF THE PROGRAMS THAT HELP BENEFICIARIES TO ADAPT THEMSELVES TO LIVING CONDITIONS IN AN INSTITUTION, AND CONTRIBUTE TO THEIR MENTAL AND PHYSICAL HEALTH;
- DEVELOPMENT AND IMPLEMENTATION OF THE PROGRAMS OF DAILY – MANDATORY AND FACULTATIVE - ACTIVITIES FOR BENEFICIARIES THAT ARE ADJUSTED TO INDIVIDUAL PSYCHOPHYSICAL STATUSES, INTERESTS, HABIT OR LEVELS OF EDUCATION;
- ORGANIZATION OF VARIOUS CULTURAL AND RECREATIONAL CLUBS IN KEEPING WITH AN INSTITUTION'S CAPACITIES AND BENEFICIARIES' INTERESTS;

(*ARTICLE 45, PARA 2,7,8,9 RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLDER PEOPLE*.)

It this context the other facility is another story. The overcrowded facility can hardly set aside an adequate spare room for quality occupational or other therapy. Besides, it lacks the equipment necessary to semi-dependent and dependent beneficiaries. The room that is being used for occupational therapy cannot accommodate more than 10 people. The people using it usually knit, tend flowers, play chess, etc. An elderly lady cares after the animals in the mini-zoo within the compound. Though all this may give one the impression that the activities the beneficiaries are engaged in are many and diverse, the interviews conducted with both the staff and the beneficiaries showed that those activities were not available to all. All dependent and most semi-dependent beneficiaries do not partake in any organized activity at all. The staff explains this by their bad psychophysical states and disinterestedness. "He is retarded," "He suffers from dementia," "We have consulted a doctor and he said he is incapable of making any progress at all," "He would not cooperate," were the usual answers the team got. "Only movable and mentally capable" beneficiaries partake in the manifestation called "Sunny Autumn" the institution has been organizing for some time now. To say the least, such exclusive approach to categorization of the beneficiaries – the categorization resulting from evaluation by either external or internal commissions - leaves plenty of room for neglect. Beneficiaries' pathetically empty lives become even emptier with nothing to

fill them. Unfortunately, neglect of this type is not identified as such since it is veiled by experts' indisputable opinions. Such approach to persons with any type of disability, including mental, was abandoned long ago in the civilized world. This is why various courses of in-service trainings and overcoming bias about older people even among professionals should be placed on priority lists of healthcare, social care and education ministries.

In addition, the large and nicely kept park offers plenty of opportunity for beneficiaries' recreational and therapeutic activities. However, those opportunities are not sufficiently used. On a nice and sunny day the team saw just a handful of beneficiaries seated on the terrace. When asked why they were not outside, sitting on benches in the park, they said they could not reach the park on their own. Understaffed social care institutions (particularly those catering for persons who need physical assistance) obviously result in neglect. However, bureaucratic attitude by some employees (staying in their offices most of the time) is the problem the institution must solve by itself through precise distribution of duties and tasks for the personnel. Apart from medical treatments, almost all other can take place in the open air when the weather is fine. All it takes is little good will from the staff and a more positive attitude towards their jobs.

Recommendations

- The number and types of activities should be adjusted to each beneficiary's individual needs and abilities;
- Preconditions for quality professional work with the beneficiaries – in terms of space and the staff – should be secured.

6. Contact with the Outside World

Most of the beneficiaries presently accommodated in the institution are in contact with their families. The staff just registers visits to beneficiaries and is not concerned with the quality of family communication. Bearing in mind that older people are most sensitive about whether or not their families care about them and that any breaks of family contacts may leave them seriously depressed, the fact that the staff has distanced themselves from this aspect of beneficiaries' lives is surprising to put it mildly. Though touching on delicate and intimate subjects while being interviewed by the team, the beneficiaries only welcomed the opportunity to speak about their families. This indicates that the institution needs to pay by far more attention to their emotional needs.

As for other contacts with the outside community, they are realized through visits by various cultural or folk dance troupes, groups of elementary school students, etc. as well as organization of painting colonies. Excursions and outings for beneficiaries themselves are rarely organized mainly because the institution has no adequate vehicle for their transportation, said the interviewed staff. It was only recently that the institution acquired a mini van with nine seats. Be it as it may, transportation arrangements for the beneficiaries are too much complicated and sometimes impossible to make. Independent beneficiaries keep contact with the local community on their own.

PROFESSIONAL SOCIAL WORK INCLUDES THE FOLLOWING SERVICES IN PARTICULAR:

- ESTABLISHMENT OR MAINTENANCE OF BENEFICIARIES' CONTACT WITH THEIR FAMILIES, CLOSE FRIENDS AND RELATIVES THEY USED TO LIVE WITH IN THEIR NATURAL ENVIRONMENTS;
- ORGANIZATION AND REALIZATION OF RECREATIONAL, ARTISTIC AND ENTERTAINMENT PROGRAMS FOR BENEFICIARIES SUCH AS EXCURSIONS IN THE OPEN AIR, TO NEARBY TOWNS AND THE LIKE, VISITS TO THEATER, MOVIES, CONCERTS, ETC. (*ARTICLE 45, PARA 3,11 RULES ON DETAILED CONDITIONS FOR BEGINNING OF WORK AND FUNCTIONING, AND NORMS AND STANDARDS FOR FUNCTIONING OF SOCIAL CARE INSTITUTIONS FOR PENSIONERS AND OTHER OLDER PEOPLE*.)

The beneficiaries accommodated in the downtown facility have phone in their rooms, whereas those in the Nursing Home do not even have a phone booth available to them. They can make calls only by mobile phones that are being brought to them, said the interviewed members of the staff and beneficiaries. The cooperation with relevant social care centers is considered good. The institution also actively cooperates with other similar old people's homes, notably with the one in Hungary (in Baja). Exchange of experience with their Hungarian colleagues, say the interviewed employees, is most beneficial in terms of introduction of new and different methods of work with beneficiaries, underline the staff. This form of cooperation is highly commendable and should be maintained and extended. Besides, all members of the staff should partake in it rather than just a small circle of them.

Contacts with priests are organized at beneficiaries' request. Eastern Orthodox and Catholic priests often visit the institution on their own. The management boasted of having prohibited Jehovah's witnesses from the promises. "We didn't want them to mingle around here," said the director. It goes without saying that this stands for violation of religious rights. However, the management actually had no choice in this matter as its attitude towards Jehovah's witnesses rests on official stance by which they are treated as a "dangerous sect." By the way, neither the Serb Orthodox Church nor the Catholic Church has ever given any donation to the institution or at least to its poorest beneficiaries.

EVERYONE SHALL HAVE THE RIGHT TO FREEDOM OF THOUGHT, CONSCIENCE AND RELIGION. THIS RIGHT SHALL INCLUDE FREEDOM TO HAVE OR TO ADOPT A RELIGION OR BELIEF OF HIS CHOICE, AND FREEDOM, EITHER INDIVIDUALLY OR IN COMMUNITY WITH OTHERS AND IN PUBLIC OR PRIVATE, TO MANIFEST HIS RELIGION OR BELIEF IN WORSHIP, OBSERVANCE, PRACTICE AND TEACHING. *(ARTICLE 18, PARA 1, INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS)*

Recommendations

- Adequate steps should be taken to ensure maintenance of beneficiaries' more frequent and better contacts with their families;
- At least one phone booth should be installed in the Nursing Home;
- Adequate number of vehicles should be secured to enable beneficiaries' contact with the outside community.

7. Guarantees for Beneficiaries' Rights and Freedoms

A young man lies in a bed with protective rails in the room with six bedridden men. He looks lonely but tense at the same time. Obviously no one has spoken to him for hours. He doesn't look at as we move towards his bed and evidently ignores the nurses in our company. He is lying in a weird position that must be uncomfortable for him. We stood by his bed and begun conversation. All of a sudden he is interested in us and starts talking. He talks with difficulty but seems never to want stop talking. The nurse in our company said for him to hear, "He has a genetic disorder and no chances for getting better." "Do you ever take him out to the terrace," we asked. "No, he refuses to cooperate," she said.

OLDER PERSONS SHOULD HAVE ACCESS TO HEALTH CARE TO HELP THEM TO MAINTAIN OR REGAIN THE OPTIMUM LEVEL OF PHYSICAL, MENTAL AND EMOTIONAL WELL- BEING AND TO PREVENT OR DELAY THE ONSET OF ILLNESS. *(UN PRINCIPLES FOR OLDER PEOPLE, ARTICLE 11)*

An elderly lady with absent-minded look, lying in a corner bed, attracted our attention. The nurses accompanying us said she wouldn't talk to anyone except for an employee who spoke Hungarian. Nevertheless, we addressed her in Serbian, slowly and understandably. She looked us attentively and tenderly, and then started speaking in Hungarian.

The above two sketches cannot but leave a bad feeling in one's stomach and make member of the team wonder about the number of beneficiaries whose needs are so ignored that such attitude can be treated as torture. "Refusal of cooperation" is the term that, as a rule, reveals unprofessional approach – for a human being had an inherent need to communicate with other humans. On the other hand, a person who obviously wants to communicate cannot do so because she has found herself in the environment where her mother tongue is not spoken. The question is, "Why this lady has been allocated to this institution in the first place, and why the institution, in tandem with a social care center and her family, does nothing to reallocate her?" It is also strange to found no one among the employees speaking Hungarian in the town with some 13,000 citizens of Hungarian origin (the second biggest town with Hungarian population).

When it comes to regulations and control by relevant state authorities, the situation in the Gerontology Center in Sombor is about the same as in other similar institutions. Institutional regulations are standardized and in keeping with the law. The control over the institution is regular (financial controls, sanitary inspections, food control, inspection of anti-fire equipment, etc.). The rule on beneficiaries is generalized and loosely defines beneficiaries' rights.

It goes without saying that the institution needs to develop additional mechanisms for the protection of beneficiaries' rights: a clear-cut grievance procedure, circulation of brochures on those rights to all beneficiaries, and the like. Just telling older people that they can "turn to employees at all times" is not enough even when effective. Brochures or leaflets will not undermine direct communication, on the contrary. They will make it easier for the staff to perform their jobs and make the beneficiaries feel safe about their rights and dignity. It is most important that the

staff is kept posted about new trends in their respective professions, and that they include beneficiaries in planning their own activities aimed at improving their living conditions and quality of life. Such a practice imbues them with the sense of being equal and stimulates their overall capacities.

Like in other social care institutions, the institution's legal service is mostly concerned with legality of various activities (such as tenders, contracts, staff issues, etc.). Jurists engaged by the institution are usually not interested in dealing with beneficiaries' individual legal cases. The interviews conducted with the beneficiaries accommodated in the Nursing Home (who cannot afford to pay for their stays and are, therefore, completely or partially subsidized by the state) showed that there had been cases of fraud (and, probably, even more serious crimes) which left them without any property at all. Since potential perpetrators are usually families or relatives, the damaged parties (now social care beneficiaries) could not accept the truth for long nor had no money to pay lawyers to protect their rights. Some of them have been turning in vain to their social care centers. Some say that people working for those centers were involved in criminal activities against them. Given that social care centers are the ones that assess the need for institutionalization and prepare necessary documentation for each individual case, old people's homes actually know nothing about the circumstances under which older persons were placed under social protection. The director of the Gerontology Center says his institution never signs contracts on life-long care in return for property with beneficiaries. However, he said, there was a case of a lady who had signed such contract with her social care center. Since the property in question was considerable, it was only logical for her to expect to be accommodated in the downtown, high-standard facility. For its part, the social care center insisted on paying for her accommodation only in the Nursing Home. The lady, therefore, broke the contract, sold all her property and herself paid for her accommodation in the downtown facility. Unfortunately, this is not an isolated case the team learned about in the course of its fact-finding missions. There are eleven beneficiaries in the Gerontology Center in Sombor, who have been deprived of legal capacity – and six of them are placed under the custody of their local social care centers. Except for photocopies of court decisions whereby those beneficiaries have been deprived of legal capacities, the staff has no other information about those cases and, after all, is not at all interested in learning more about those persons' fate.

Social care centers' custody over the persons unable to look after themselves and protect their interests is among major aims of any social policy. However, deficient legal system and other huge transitional problems of the states such as Serbia give rise to a number of inconsequencies, legal holes and inadequate protection mechanisms. This is why any case indicating a possible misuse or crime calls for prompt reaction.

The Helsinki Committee is most concerned with any attempt of manipulation the victims of which would be older, half-educated and vulnerable persons. Therefore, the organization appeals to the Ministry of Labor and Social Policy to intensify the control over social care centers, particularly when it comes to their bargains over people's property. Since potential perpetrators are usually individual persons (children, close relatives, etc.) the Ministry should develop an efficient mechanism for the protection of older people and investigation of all suspicious cases. It goes without saying that other institutions, such as ministries of the interior, judiciary and healthcare, should actively participate in the process. There are too many alarming cases of persons deprived of legal capacity and placed under the custody of social care

centers all over Serbia. The Helsinki Committee has found tens and tens of such cases that have never been reviewed, whereas the persons placed under custody have ended up in various institutions.

Recommendations

- Clear-cut and precise regulations on treatment of beneficiaries with disabilities should be developed, the same as those against unprofessional attitudes that undermine beneficiaries' dignity and personal integrity;
- All beneficiaries must be informed about their rights and guarantees for the respect of those rights should be in place;
- Jurists should communicate more with beneficiaries and provide them legal assistance whenever necessary;
- Whenever justifiable, the cases of deprived legal capacity should be reviewed;
- The institution should cooperate more closely with social care centers, particularly when there is a reasonable doubt that a beneficiary has been deprived of some rights.

GERONTOLOGY CENTER - SABAC

1. Introductory Remarks

The social institution for residential care of the retired and elderly in Šabac dates back to the early 20th century. It was expanded in 1984, by the construction of another building. At present, this institution called Gerontology Center, has two in-patient wards with 65 and 170 beds respectively. The projected capacity of the institution is 230 elderly persons.

At the time of the visit the institution had 15 independent, 18 semi-dependent and as many as 202 dependent beneficiaries, 39 of whom were refugees.

2. Living Conditions

Patients in the wards are generally demented and disoriented, as well as dependent and mostly bed-ridden. Living conditions in the old building are unsatisfactory: washrooms are in a poor state of repair (two toilets and a bathroom with three open shower stalls per floor), premises for leisure activities, entertainment and work therapy are practically non-existent, all beneficiaries are in three or five-bed rooms, while unpleasant smells and the obvious dilapidation of the building create the impression of neglected and cramped space. Once the renovation works, currently under way, are completed, living conditions in the ward will probably become more tolerable.

> CREATING A POSITIVE THERAPEUTIC ENVIRONMENT INVOLVES, FIRST OF ALL, PROVIDING SUFFICIENT LIVING SPACE PER PATIENT AS WELL AS ADEQUATE LIGHTING, HEATING AND VENTILATION, MAINTAINING THE ESTABLISHMENT IN A SATISFACTORY STATE OF REPAIR AND MEETING HOSPITAL HYGIENE REQUIREMENTS. (*CPT 9TH GENERAL REPORT, CPTT/INF (98) 12, PARA 34)*

The second building, where living conditions are generally far better, reveals certain shortcomings in project design, reflected in the shortage of space for work-occupational and physiotherapy, insufficient number of single bedrooms, uneven distribution, i.e. accessibility of toilets and bathrooms per number of beneficiaries, a lift that does not reach the basement where the dining room is located, absence of alarm systems and basic technical equipment in rooms.

> OUT OF THE TOTAL NUMBER OF ANTICIPATED SLEEPING ROOMS, THE INSTITUTION MUST HAVE AT LEAST 10% OF SINGLE AND DOUBLE BEDROOMS EACH;
>
> CONDITIONS, AN INSTITUTION SHOULD FULFILL WITH RESPECT TO EQUIPMENT DEPENDING ON THE TYPE OF SERVICE IT PROVIDES INCLUDE: AN ALARM SYSTEM LINKING THE ROOMS OF IMMOBILE PERSONS WITH THE DUTY STAFF MEMBER (*ART. 3, PARA 2 AND ART. 5, PARA 2, OF THE RULES SPECIFYING THE CONDITIONS FOR THE START UP AND OPERATION OF SOCIAL INSTITUTIONS FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER OLD PERSONS).*

In this situation the staff tries to overcome these problems in different ways: small investments were provided to renovate the kitchenette and terrace for work therapy, and living rooms double as dining rooms or physiotherapy rooms as required... Leaving aside the problems of inferior construction and design solutions, hygienic-medical and other conditions in this building are satisfactory. The institution's independent residents are on the ground floor, and the dependent beneficiaries, who account for the majority, on the first and second floors. All floors have two wings (30-35 residents) with kitchenettes and „living rooms" (part of the first floor living room has been adapted for physiotherapy, and part of the second floor living room is used for dining). There is also a library, a kitchen with a dining room in the basement and a dispensary on the second floor. Residents are housed in double or treble bedrooms. Some of the rooms have their own bathrooms with a shower stall or a bath, while joint bathrooms cater for about 30 residents. The staff and management have clearly invested a lot of efforts to overcome the concrete problems and the absence of appropriate conditions, and make the entire space more pleasant and functional. The building has only one single apartment that meets high standards criteria, but the question is if even that one apartment was necessary in view of the lack of space for many important functions (moreover, it was empty at the time of the HC visit). In any case the Center needs urgent investments into reconstruction of the old in-patient ward and possible expansion of the more recently constructed building and purchase of new equipment (to replace the old and worn-out equipment in sleeping and community rooms, and especially the kitchen).

This Center has its own boiler room using heating oil. Since it is a costly system connection to the gas pipeline is planned when it becomes technical feasible. The electrical installation is old, and electricity supply insufficient, which is why the complete network has to be reconstructed. The management has taken the necessary measures for fire prevention and protection (including safety switches and fire-fighting protective devices), but the in-patients ward and its residents are not safe. The problem of faulty installations is generally shared by all social care establishments.

Professional staff has appropriately equipped premises and the managements' offices are in a separate building attached to the laundry, storehouse and the Center's own bakery. The Center is located in a Šabac residential suburb, alongside the main road. For security purposes paths and a special entrance for its residents from a small side street were constructed. The buildings are surrounded by a garden with well kept paths, benches, trees and flowers, all of which creates a very pleasant ambience.

Recommendations

- Financing of urgent reconstruction of the old in-patients ward and creation of more humane conditions for medical care and life of the Center's beneficiaries should be ensured;
- Funds should be provided to improve the quality of the beneficiaries' accommodation, both space and equipment wise.

3. Institutional Personnel

Bearing in mind that employment of professional personnel depends exclusively on the number of beneficiaries, the Center employs two social workers, two work therapists, a legal officer and a manager. The management and personnel

stress the need for a psychologist, in view of the structure of their wards, but the Center does not have 250 beneficiaries, which is a state-imposed precondition for employment of a professional of this kind. That is why they use the services of the local social work center's psychologist, as required, but he is often unavailable when urgently needed and moreover cannot continuously monitor specific beneficiaries.

STAFF RESOURCES SHOULD BE ADEQUATE IN TERMS OF NUMBERS, CATEGORIES OF STAFF (PSYCHIATRISTS, GENERAL PRACTITIONERS, NURSES, PSYCHOLOGISTS, OCCUPATIONAL THERAPISTS, SOCIAL WORKERS, ETC.), AND EXPERIENCE AND TRAINING. (*CPT 9TH GENERAL REPORT, CPTT/INF (98) 12, PARA 42)*

The professional team meets on daily basis, while the Center's collegium is convened three times a week and is attended by the physician and the matron. There is also a special multidisciplinary commission for the admission of beneficiaries. Cooperation with the management is correct. Talks with the staff suggest a positive atmosphere and team approach to the Center's work.

The Center has a full-time staff of 80 and 16 part-timers. Employee age structure is well balanced; almost all services in addition to experienced, mostly middle age, personnel, have a number of younger staff, which is a condition for efficient functioning of this institution.

As for advanced professional education, in addition to the fact that not one of the Center's professional staff had additional education, or attended a seminar for that purpose – the employees are fairly unenterprising in this respect and say that "no one informs us on education possibilities, especially in relation to care for old people", while the competent ministry has failed to "come up with an education program for professional staff."

Additional education is usually sought by the medical staff. The management and employees with higher education should make some effort to devise and find the ways for advanced training so as to increase their professional competence.

Files kept on all beneficiaries individually offer comprehensive and continuous data. However, the most recent monitoring commission of the ministry suggested several changes in the structure of the relevant documentation and its keeping. The staff has proposed the relevant changes and still awaits the response of the competent bodies, or more precisely their confirmation of the new way of keeping the files.

Recommendations

- Possibility to employ a psychologist should be examined with the competent institutions; the Ministry of Social Policy should reexamine the conditions for employment of professional and other staff;
- Personnel should be continuously encouraged to engage in advanced professional training and to keep abreast of modern trends in care for the elderly.

4. Medical Care

The medical team comprises one general practitioner (11-year experience), one physician beginner engaged on contract (3-month experience), a matron, 14 nurses, 17 nursing assistants and 1 physiotherapist. Doctors work in two and nursing staff in three shifts. Admission procedure starts by a hygienic-sanitary procedure.

Evaluation of the professional team (social worker, resident physician, work therapist, matron) is decisive for admission of beneficiaries, who are often inappropriately evaluated by the social work center (especially in terms of their psychical state and degree of mobility). Physicians believe that a Rtg of lungs should be mandatory, due to numerous cases of TB diagnosed among the beneficiaries immediately following their admission. However, health institutions have not (yet) agreed to these requests, despite the awareness of existence of TB in the region to which most of beneficiaries belong.

The Center provides primary health care to independent beneficiaries, and functions as an in-patient clinic for the semi dependent and dependent. The dispensary of the local health center is practically next door, and the two institutions have good cooperation (physicians from the health center come on call). The Gerontology Center has a laboratory measuring erythrocyte sedimentation rate (CBC and urine test would be of great help to the physicians, and the financial costs involved are low). Other laboratory analyses are done in the local hospital, and the lab technician comes once a week to collect the samples. The Center is equipped with an electrocardiograph, otoscope (to look into the ears), and ophthalmoscope (to examine fundus oculi), and an oxygen bottle. Beneficiaries whose health condition is considered fairly good, undergo complete medical checks once a year. Aside from the specific diseases of individual beneficiaries, they mostly suffer from anemia. In view of the low personal standard and poor mobility of the majority of beneficiaries the Center should make additional efforts to eliminate this condition (by means of improved diet and medicaments) in cases when it is due to the inferior material status of residents. The Center employs a nutrition service officer (food technology engineer), who makes the menu in consultation with the physician, main cook and a representative of beneficiaries; medical staff advises on specific diet for certain groups of patients (e.g. diabetics, or those with digestion or swallowing problems).

The Gerontology Center has no signed cooperation protocols with health institutions, which is absolutely necessary in view of the large number of its dependent residents. The social work center has, on several occasions, tried to establish closer relations with these institutions, based on the specific nature of the Centre and its beneficiaries, but to no avail. Cooperation with first aid services does exist, but the medical staff believes that it should be improved. Namely, 90 per cent of calls from the Center result in medical advice over the phone, which is absolutely unacceptable, as well as contemptuous and discriminating. In such cases nurses, in addition to the instructions for therapy, invariably enter the name of the physician who gave them and thus, essentially, free themselves of the responsibility for its outcome. However, this kind of treatment of beneficiaries of social care (who are also seriously ill) is bound to backfire, and it is only a question of when this will happen and how serious the consequences will be. Cooperation with the general hospital is also inadequate and the Center's employees claim that they and their wards are treated as the "necessary evil".

PROVIDE PERSONS WITH DISABILITIES WITH THE SAME RANGE, QUALITY AND STANDARD OF FREE OR AFFORDABLE HEALTH CARE AND PROGRAMS AS PROVIDED TO OTHER PERSONS, INCLUDING IN THE AREA OF SEXUAL AND REPRODUCTIVE HEALTH AND POPULATION-BASED PUBLIC HEALTH PROGRAMS;

PREVENT DISCRIMINATORY DENIAL OF HEALTH CARE OR HEALTH SERVICES OR FOOD AND FLUIDS ON THE BASIS OF DISABILITY.

(CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES, ART. 25)

A physiatrists comes to the Center once, and a neuropsychiatrist and an internist twice a month. The need for specialist examinations outside the Center is established by the resident physician, and the Center arranges the visit to the specialist and transport of the beneficiary. The physiotherapist applies electro or kinesi therapy suggested by the physiatrist. The therapist keeps the protocol of each therapy and treats 15 to 20 residents a day. The physiotherapist also instructs the beneficiaries to use orthopedic aids (canes, crutches, walkers), which, too, are scarce. The new building has a well equipped therapy room, and the physiotherapists says that most of the beneficiaries receive therapy; still, an institution with so large a number of dependent beneficiaries requires more physiotherapists and additional, mobile equipment, to make therapy available to all beneficiaries, as necessary.

The pharmacy of the Center includes all medicaments obtained for its beneficiaries on prescription. The medicaments are kept by nurses and every beneficiary has its daily therapy dispenser box. Outside the prescribed therapy tranquillizers are administered only in agreement with the neuropsychiatrist (over the phone) and the resident physician, while the nurse is obliged to make a record of it. This reduces the risk of unjustified use of sedatives and their potential abuse.

Beneficiaries are entitled to refuse therapy, but that has not been the case so far. If they doubt, or establish that a beneficiary throws his oral therapy away, the physician and nurses deal with this problem by closer monitoring, which is usually enough. If a beneficiary refuses medical help, the staff is often assisted by his/her family.

Some beneficiaries tend towards excessive use of alcohol, but the staff and their peers say that they are not violent and create no problems. They are mostly people without any family or anywhere to go, and the personnel uses talk therapy to help them.

Contrary to many other institutions, the centre has a defined procedure for physical restraint of beneficiaries and a fixation protocol, which states the full name of the beneficiary, the reason, time of beginning and end of fixation, and the name of the physician.

Medical personnel believe that opportunities for education and rare and would welcome more such possibilities. They also point out that they have, so far, applied for education on their own initiative. This fact illustrates both the inferior attitude of the ministry of health towards social protection institutions and the unequal treatment of their medical employees.

Gerontology Center used its own funds to purchase 17 PCs, which form a network and include all data on the Center's beneficiaries. Medical documentation is also kept in electronic form (with internally developed software); the physician enters the relevant data and sends the nurses therapy for all beneficiaries through the network. Access to the physician's part of the medical file is protected by a password, while the plan of medical treatment of a beneficiary may be accessed with the physician's agreement. This is a very good advance solution, indicating that medical care is rightly considered a priority, in view of the structure of the Center's beneficiaries.

Several suicide attempts have been registered, especially among the refugees. In these cases a psychiatrist was consulted, and while some of the beneficiaries were

hospitalized, all of them were subject to increased monitoring of the staff. This additionally reinforces the Center's need to employ a psychologist.

According to the law, the Center's resident physician establishes death and informs the coroner and the family of the deceased. The Center has two chapels.

Recommendations

- Appropriate protocols on cooperation with health institutions should be signed, to ensure appropriate and tamely medical care for the beneficiaries;
- The number of analyses done in the Center's laboratory should be increased;
- Physiotherapy should be improved and made accessible to all beneficiaries (especially the dependent) to the required degree, bearing in mind their specific health requirements;
- Education of professional staff should be encouraged and supported;
- Control and monitoring of the use of sedatives should be increased.

5. Quality of Life and Treatment of Beneficiaries

Organization of the activities and leisure is fairly good, bearing in mind the large number of beneficiaries and the fact that the Center has only two work therapists (one is a teacher and the other has 2 years at agricultural faculty) and two social workers.

The personnel try to meet the needs of the beneficiaries to the extent possible, depending on their psycho-physical abilities and capacity. It is important to note that the approach to beneficiaries in the in-patients ward and the new building is more or less the same, i.e. that there is no substantial difference in the treatment of dependent and independent beneficiaries. Contents of work-occupational therapy are diverse and beneficiaries like to take part in them: there is an art and a music group, as well as groups for handicrafts, knitting and crocheting, and a "mixed bag" of activities like paper cutting, arranging of cubes, etc. intended for bed-ridden dependent patients. The personnel has come up with a synergy of activities, which means that the work therapy of dependent beneficiaries is mostly reduced to partial completion of various items, while a smaller number of independent beneficiaries and work therapists "put" the final product together. The results of such joint efforts are presented at exhibitions of e.g. knitted products, Easter eggs, New Year cards made of dried flowers, etc. Furthermore, sales of such products as jerseys, vests and socks so produced are organized in the Center or the town, although such items are sometimes produced for a specific client. The money thus obtained is reinvested into whatever is required for work therapy. The beneficiaries are, their state notwithstanding, clearly in a mood to talk and associate, which is indicative of a generally positive and stimulative atmosphere and good communication with the Center's staff.

We have already mentioned that rooms for rehabilitation and work with beneficiaries in a makeshift form exist only in the new building. That is certainly one of the reasons why a lot of activities, weather permitting, take part outdoors. However, the staff believes that it is important for the beneficiaries to spend some time in the fresh air, and therefore enlist the mobile beneficiaries to help them work the garden. In some cases the living room, which receives about 20 people, is used for work therapy and often also the corridor linking the two wings of the building. The

lack of space intended specifically for work therapy is a major problem, and doubtlessly reduces the scope of possible activities, or else denies the rights of some beneficiaries in favor of others. An additional problem is the absence of a storeroom for the material and equipment used in work therapy and finalized "products" of beneficiaries. The available space, obtained from a kitchenette and a terrace is very small, and attempts to establish some order in it is close to impossible.

> THE INSTITUTION SHOULD HAVE SEPARATE LIVING ROOM, WORK THERAPY ROOM AND ROOM FOR JOINT CULTURAL ACTIVITIES AND ENTERTAINMENT… (*ART. 3, PARA 1 OF THE RULES SPECIFYING THE CONDITIONS FOR THE START UP AND OPERATION OF SOCIAL INSTITUTIONS FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER OLD PERSONS*).

The personnel also points to the lack of appropriate space where the beneficiaries' products could be exhibited, as that would increase their motivation and sense of purpose. We believe that beneficial and stimulative effect could be achieved by several movable boards; it is a cheaper solution, which could enrich both indoor and outdoor space, and most importantly, could be moved from one part of the institution to another, including the rooms of immobile beneficiaries.

Leisure activities include various party games, cultural events and forms of entertainment (birthday celebrations, patron saints day celebrations, fancy dress parties, literary evenings....).

> WITH A VIEW TO ENSURING TO PERSONS WITH DISABILITIES, IRRESPECTIVE OF AGE AND THE NATURE AND ORIGIN OF THEIR DISABILITIES, THE EFFECTIVE EXERCISE OF THE RIGHT TO INDEPENDENCE, SOCIAL INTEGRATION AND PARTICIPATION IN THE LIFE OF THE COMMUNITY, THE PARTIES UNDERTAKE, IN PARTICULAR:
>
> - TO PROMOTE THEIR FULL SOCIAL INTEGRATION AND PARTICIPATION IN THE LIFE OF THE COMMUNITY IN PARTICULAR THROUGH MEASURES, INCLUDING TECHNICAL AIDS, AIMING TO OVERCOME BARRIERS TO COMMUNICATION AND MOBILITY AND ENABLING ACCESS TO TRANSPORT, HOUSING, CULTURAL ACTIVITIES AND LEISURE *(ART. 15, PARA 3, PART II, EUROPEAN SOCIAL CHARTER REVISED)*

The Center's personnel encourage the beneficiaries participation in decision-making on issues of importance for the functioning and organization of the Center. Thus housing units organize their own meetings and there is also a Council of Beneficiaries of the Center. Once a month, they meet to discus the current issues and problems important for the life of beneficiaries, such as the prices of accommodation, health services, quality of food, pocket money, adjustment of new beneficiaries. Meetings of housing units are chaired by a social worker, and other staff is invited to attend, if so required. The beneficiaries are satisfied with the functioning of the Council and the treatment of its members and proposals by the staff, and substantiate this claim with several examples of the Center's management and employees' efforts to meet their justified requests (concerning e.g. health care, food, etc.). The importance of the beneficiaries' participation is confirmed by the fact that the Council has decided to form a Commission for interpersonal relations, which has been doing quite well in mediating between the beneficiaries, or between beneficiaries and the staff. This is a good example that shows how personal engagement and participation of beneficiaries in the formulation of house rules and decisions on the functioning of

the Center substantially contribute to the observance of these rules and decisions and create a positive psychological and social climate.

Recommendations

- Conditions and funds should be provided in order to deal with the problem of cramped space and improve the quality and scope of rehabilitation and therapeutical activities, including work therapy, group therapy, artistic, drama, music, cultural-entertainment and other activities of the beneficiaries;
- The obviously successful practice of beneficiaries' participation in the formulation of house rules and decision-making on living conditions in the Center should be continued and they should be encouraged to expand the range of their participation.

6. Contact with the Outside World

The existing structure of beneficiaries comprises almost equal parts of those who have families and maintain contacts with them, and those who have no family or relations of any kind. The personnel react to that with different measures and activities. Beneficiaries with families are encouraged to maintain contacts, which are monitored by the staff, in order to help them have frequent and good communication. In addition to possibilities to receive visits and go to their families over the weekend, beneficiaries in the new building can also use two telephone booths, or telephone lines in their rooms to contact their kin. Those in the in-patients ward have the use of cordless phones. Beneficiaries without family relations, or wards of the social work center, are encouraged to maintain regular contacts with it. Unfortunately, the social work center rarely visits its wards, if at all.

Other forms of contact with the outside world are related to work therapy or other organized activities such as cultural or literary evenings, shows, parties… The Center has long standing cooperation with the local cultural and artistic society, Šabac town theatre, certain schools…

However, contacts with these institutions are generally reduced to visits of certain guests, while outings and outside visits of the beneficiaries are rarely organized. That is primarily due to the problem of transportation of immobile or handicapped beneficiaries who are in the majority. Although a large number of beneficiaries are psychically fit and interested in visiting cultural events, going to various shows or excursions, in the absence of appropriate means of transportation the staff is hardly in a position to meet their wishes.

TO ENABLE PERSONS WITH DISABILITIES TO LIVE INDEPENDENTLY AND PARTICIPATE FULLY IN ALL ASPECTS OF LIFE, STATES PARTIES SHALL TAKE APPROPRIATE MEASURES TO ENSURE TO PERSONS WITH DISABILITIES ACCESS, ON AN EQUAL BASIS WITH OTHERS, TO THE PHYSICAL ENVIRONMENT, TO TRANSPORTATION, TO INFORMATION AND COMMUNICATIONS, INCLUDING INFORMATION AND COMMUNICATIONS TECHNOLOGIES AND SYSTEMS, AND TO OTHER FACILITIES AND SERVICES OPEN OR PROVIDED TO THE PUBLIC, BOTH IN URBAN AND IN RURAL AREAS (*ARTICLE 9, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES*).

On the other hand, even the mobile, independent beneficiaries are not motivated to engage in such activities due to inadequate public transportation and peripheral location of the centre, which poses a problem of going to town and back.

A SOCIAL CARE INSTITUTION FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER OLD PERSONS SHOULD FULFILL THE FOLLOWING GENERAL CONSTRUCTION AND TECHNICAL CONDITIONS:

- IT SHOULD BE LOCATED IN A SETTLEMENT WITH DEVELOPED TRANSPORT AND OTHER COMMUNICATIONS…

SERVICES OF PROFESSIONAL SOCIAL WORK, IN PARTICULAR, INCLUDE:

- ORGANIZATION AND IMPLEMENTATION OF RECREATIONAL AND CULTURAL-ENTERTAINMENT PROGRAMS WITH BENEFICIARIES SUCH AS NATURE OUTINGS, EXCURSIONS TO NEIGHBORING TOWNS, ETC., VISITS TO THEATRES, CINEMAS, SHOWS AND CONCERTS (*ART. 2, PARA 1, ARTICLE 45, PARA 11 OF THE RULES SPECIFYING THE CONDITIONS FOR THE START UP AND OPERATION OF SOCIAL INSTITUTIONS FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER OLD PERSONS*).

Although excursions and other forms of visits outside the institution are rarely organized due to above-mentioned reasons, they are occasionally arranged with a smaller number of beneficiaries. Thus, e.g. the beneficiaries participated in the „Night for Museums“, a city-level event, and even had their stand with folk costumes. A pensioners club, as a non-institutional form of protection of the elderly also exists in the town, but the beneficiaries rarely go there, again due to its distance from their Centre.

Recommendation

- Appropriate solution for the transport of beneficiaries should be found in cooperation with local self-administration bodies, or at least on appropriate vehicle for their use should be provided.

7. Guarantees for Beneficiaries' Rights and Freedoms

In view of the structure and, especially, destitution of the majority of beneficiaries, the Center's employees make major efforts to increase the level of services and observe their interests in the best possible manner. Despite the modest conditions and a series of deficiencies, the institution and its personnel doubtlessly operate in the best interest of their beneficiaries, which is not always the case with institutional care. The general impression is that the relations in the Center are sound, both between the employees and beneficiaries, and the beneficiaries themselves.

Naturally, there are occasional incidents and dissatisfied individuals, but the staff is open and ready to discuss the problems. Beneficiaries confirmed that they were informed about the HC visit, but without any suggestions. One of them expressly demanded to talk with someone from the team without the presence of the Center's employees. We were notified on this request immediately upon our arrival, but received some information about that person, only after the interview. The staff kept its distance even during our talks with other beneficiaries, and even in cases when they were present they refrained from making any comments. Their professional and caring relation towards the beneficiaries was also revealed in the fact that they made

no mention of their health condition and obvious disadvantages, but instead spoke of their progress and plans for further improvement, even in cases when that could hardly be expected.

Beneficiaries made few objections, mainly in relation to interpersonal relations and inappropriate behavior of some of their peers. Some among them indulge in alcohol and may be rather intolerant in moments of psychical crises (especially the refugees). Beneficiaries try to overcome these problems by themselves, but often turn to the Center's staff for help. Disciplinary measures are taken in cases of gross violations of house rules, or when the rights of other beneficiaries are seriously endangered. This behavior is sanctioned by a warning, last warning and expulsion. In most cases the personnel tries to resolve the conflict and remove the tensions in communication with the offenders and in other ways. Bearing in mind that such beneficiaries actually have no where else to go, efforts are made for their socialization and adjustment. If that fails, the staff tries to move the beneficiary concerned into another institution, in cooperation with his/her social work center. Only one beneficiary has been expulsed so far, for assaulting a nurse under the influence of alcohol, and more over that was not the first incident caused by that person.

We have already noted that the Center's professional team pays great attention to the contacts between beneficiaries and their families, as well as competent social work centers. Same as in other institutions of this kind, cooperation with the referring centers differs; some are in continuing communication with the Gerontology Center and the beneficiary, while others show no interest whatsoever and do not inquire about them even by phone. The Gerontology Center has 16 legally incompetent beneficiaries; seven of them have relatives as guardians, while in the case of others the guardian is their social work center. The Gerontology Center and its legal officer have no knowledge why these persons were declared legally incompetent, and have never suggested that the relevant decisions be reviewed. It has become a common practice to bury in archives any procedure that has been „successfully" completed in court.

Helsinki Committee has inquired into a court ruling of over 50 years ago depriving a beneficiary of the Gerontology Center, now demented and in advanced old age, of legal competence. This person, a young teacher at that time, was committed to a mental institution by her father, who only a month after that started a procedure to take her legal competence away. A year later, a hearing was held, and when the father confirmed that her condition was unchanged, the court ruled to deprive the girl of her legal competence in only two days. She had that status throughout her life, despite the fact that she was not treated in an institution ever again, and the fact that the documentation of the social work center includes no documents referring to lasting incompetence or a serious psychiatric disorder. Once taken, the court decision has never been revised.

This kind of behavior of social work centers suggests the need to seriously reconsider their concept and manner of work. Bearing in mind that they are the key institutions in the system of social protection, it would be only logical that they appear as proponents of a new, reformist approach, which they usually are not. There is no doubt that the difficult and thankless job, which has never been properly appreciated in Serbia, as well as the lack of selectivity in employment, have caused the apathy and

insensitivity of many who work in this sector. Too many cases reveal an inadmissible practice to consider their job finished once a beneficiary is placed in an institution, or a decision taken to approve or deny assistance, or transfer the case to another institution. Not infrequently initiatives by institutions caring for beneficiaries forwarded to such centers are dismissed or neglected; bearing in mind that the institution caring for beneficiaries cannot initiate procedures for the protection of their rights, the system is actually based on voluntarism and does not offer sufficient guaranties that things are done in the best interests of its wards. That makes the very concept of social policy untenable.

Recommendations

- Beneficiaries should be informed of their rights by means of a printed brochure, and kept continuously informed on the possibilities to exercise these rights;
- Efficient mechanisms to protect the rights of beneficiaries should be established, along with a system dealing with grievances and responsibility;
- Legal assistance and provision of professional advice to beneficiaries who need them should be ensured;
- Beneficiaries should be continuously observed and offered support in all aspects of their lives; in agreement with the beneficiaries relevant procedures for the achievement and protection of their rights should be initiated.

GERONTOLOGY CENTER "BEŽANIJSKA KOSA" – BELGRADE

1. Introductory remarks

Gerontology Center in Belgrade is the largest in Serbia and comprises retirement homes for senior citizens on three locations in Belgrade (Bežanijska kosa, Karaburma and Voždovac), and an in-patients ward for immobile beneficiaries.

Ever since it has been opened (1983) the retirement home at Bežanijska kosa has been considered as one that offers best living conditions to its residents. Judging by its present situation its reputation of high standard accommodation facility remains intact. Accordingly, the prices of accommodation in this home are the highest. In addition to beneficiaries who can personally afford more expensive accommodation, the home also have residents whose expenses are fully, or in part, covered by the state. Still, it must be noted that the institution and its personnel make a lot of effort to provide all beneficiaries equal treatment and access to services, the differences in their quarters notwithstanding.

According to a new Decision on the network of social care institutions, the capacity of this huge complex on Bežanijska kosa has been reduced from 631 to 550 beneficiaries. At the time of our visit the retirement home had 572 beneficiaries, 183 of whom were independent, 60 semi-dependent and even 320 dependent, including two adult but no elderly residents.

2. Living Conditions

The complex comprises the administration building and buildings in the so-called blocs A (A1, A2, A3) and B (B1, B2). The administration building and bloc A units are interconnected by heated passages, which are fitted with handrails and rest stops, and are generally comfortable and nice looking (with lots of flowers and pictures or paintings). These passages enable the beneficiaries to freely circulate and visit one another even in cold weather, and to use all amenities and services offered by the home. The majority of residents in Bloc A are independent and accommodated in 192 apartments (171 single bedrooms, triple bedrooms, 10 double rooms and 8 apartments of high standard for in-patient care around the clock). The rooms, with their own bathrooms, are equipped well and in good taste, and are kept tidy and clean. Each of the units in Block A has its own dining room, living room and rooms for different activities, and telephone sets and notice boards placed in all corridors.

Bloc B houses semi-dependent and dependent residents, definitely less well-off. However their accommodation is far better than that provided to this category of beneficiaries in other institutions. This is the only retirement home where temperature in the rooms is more pleasant than in the offices. Although the rooms have several beds and are certainly less comfortable than apartments, they are well equipped and

maintained; depending on the health needs of the beneficiaries they have beds with height-adjustable mechanism and other necessary aids (hand grips, bed trays, etc.). There is a toilet shared by two rooms, while joint bathrooms (one bathroom for 20 beneficiaries) are placed in the middle part of the corridor and have two entrances, equidistant from rooms on both sides of the corridor. The bathrooms are equipped with several lifting devices, which facilitate the work of nursing assistants and the beneficiaries, and also help them keep their dignity. It is obvious that a lot of funds have been invested into this facility and that the hygiene and general state of the premises are given a lot of attention. The home purchases sufficient quantity of bed linen, blankets and mattresses, as well as washing agents. In addition to the chief laundress, there are 12 more laundresses and a tailor who take care of the bedding and clothing of the beneficiaries. However, the laundry room requires urgent investments, to improve the working conditions and substitute the obsolete and inadequate equipment.

The part related to food is also well organized and functional. Food is prepared in the kitchen and then sent by kitchen lifts to dining rooms each of which has a sufficient quantity of tableware for the beneficiaries who use it. We must note that the kitchen in this institution is the only one where entry is allowed only to those who work in it, and moreover only if they are wearing the appropriate sanitary outfit, which is a commendable practice. Judging by a glance from the entry to the kitchen and the words of the chief nutritionist and cook, the kitchen has state-of-the-art equipment and lacks nothing.

Another specificity is that the menu is the responsibility of a professional nutritionist, who cooperates with the physicians, and a sufficient number of cooks, kitchen assistants, pastry-cooks and serving staff. The available space and personnel enable preparation of diverse food, as well as hot meals outside the normal schedule (for beneficiaries on a special diet, or those who were absent at the usual time, etc.) Another commendable practice in the kitchen is the willingness of cooks to experiment with beneficiaries' recipes, since it does not imply any additional costs and has a highly stimulative effect on the beneficiaries, introducing competitiveness and increasing their self-respect and the sense of purpose.

The home also has a restaurant intended for the beneficiaries and their guests and other visitors. The administration building houses a cinema, a shop, a tobacconists, hairdresser and a post office, while the opening of a pharmacy is in the offing. Creative workshops and a mini garden with greenery and birds are located in the basement.

The institution's compound includes a large garden which is well kept and planted with different trees, grasses and flowers. Park benches are distributed evenly and easily accessible by all beneficiaries. There is also an outdoor amphitheatre, a vine covered terrace, etc.

In addition to clearly better conditions for work and accommodation, which makes this institution impossible to compare with others, the element that makes the most important difference is the obvious effort of the employed to create a more humane ambience and an atmosphere favoring the individual personalities of beneficiaries and their needs, as opposed to impersonal collective accommodation facilities.

Recommendations

- Additional efforts and funds should be invested to improve the living conditions in the bloc housing semi-dependent and dependent beneficiaries, in order to enable them equal access to services and amenities offered by this institution;
- Reconstruction and provision of equipment for the laundry are necessary, to ensure appropriate conditions for the work of personnel and the beneficiaries' hygiene;
- Additional equipment and aids should be purchased to facilitate the life and movement of beneficiaries (especially the semi-dependent and dependent ones) and the work of the personnel.

3. Institutional Personnel

This institution employs a staff of 281, 246 of whom are women and 35 men. The professional staff meets the anticipated criteria. At this point of time there are 5 social workers, 1 psychologist, 1 legal officer, 1 entertainment organizer, 1 work therapist and 1 clerk for the work with beneficiaries. Except for the clerk who has secondary professional education, all other above mentioned professionals have high education.

Despite their multidisciplinary orientation, the personnel generally believe that in view of the number of beneficiaries, a larger number of teams would certainly contribute to their still more efficient work. They speak of good mutual relations, and cooperation within and between services. The structure of the personnel in terms of their age and length of experience reveals the predominance of younger people. It seems that the enthusiasm and energy of the young and the experience of more seasoned personnel combine to ensure the quality and efficiency of their work with the beneficiaries and the generally positive climate and relations in this institution. Work meetings are held on daily basis and once a week with the manager, while the meetings of the institution's collegium are held twice a month and are attended by the director. Staff members are highly motivated for additional education, but stress the lack of funds for that purpose, especially for international seminars, or exchange of experiences with colleagues from similar institutions abroad.

Employees leave the impression of professionals interested in their work, who are well-versed in modern approach to caring for the elderly, as well as enterprising and innovative. Most of them are satisfied with their working conditions and assets, and speak less of problems and more of current actions and plans. It is important to note that all of them have undergone training for work with the elderly and have authored an accredited program of training for housekeepers for older persons and gerontological nurses. However, the insufficient number of certain professionals (only one psychologist, work therapist and entertainment organizer) necessarily reflects on the approach to beneficiaries and their everyday needs and activities. One could realistically expect that in a situation of this kind semi-dependent and dependent beneficiaries in Bloc B will be most often neglected.

STAFF RESOURCES SHOULD BE ADEQUATE IN TERMS OF NUMBERS, CATEGORIES OF STAFF (PSYCHIATRISTS, GENERAL PRACTITIONERS, NURSES, PSYCHOLOGISTS, OCCUPATIONAL THERAPISTS, SOCIAL WORKERS, ETC.), AND EXPERIENCE AND TRAINING. (*CPT 9TH GENERAL REPORT, CPTT/INF (98) 12, PARA 42)*

The beneficiaries, on their part, say they have open and normal communication with the personnel; they also stress that the understanding and devotion of the staff exceed their expectations, which is certainly one of the reasons for the popularity of this home.

Recommendations

- The number of professional teams should be increased in line with the number and categories of beneficiaries;
- Funds for further professional training should be secured and the personnel encouraged to advance their education and monitor modern trends in caring for the elderly.

4. Medical Care

The medical team comprises: 4 general practitioners, specialists in internal medicine, psychiatry and physical therapy, a matron, 6 senior nurses (technicians), 32 nurses (technicians), the chief physiotherapist, 5 physiotherapists, and 80 nursing assistants. This apparently numerous medical staff is absolutely necessary in view of the large number of beneficiaries, and especially their health.

Independent beneficiaries who live in apartments (of 36 square meters) can see the resident doctor if they so wish every day until 3 p.m. Each beneficiary has his/her health file with data on the therapy he/she takes, and record of medical consultations and hospitalizations. If specialist examinations are considered required these are organized by the staff who take the beneficiaries to Zemun hospital, where laboratory analyses are also made. This institution also cooperates with the Medical Center Bežanijska kosa. The physician judges if the beneficiary is capable of taking his oral therapy by him/herself or needs the assistance of a nurse. Regular medical checks of these beneficiaries are scheduled once a year. They most frequently suffer from cardio-vascular and gastro-intestinal disorders and diseases of the locomotor systems and most medicaments are prescribed for their treatment. Physical therapy (kinesi, electro, paraffin) is applied in a well equipped dispensary, as required. Some beneficiaries who tend to consume alcohol extensively are specially monitored by the medical staff and social workers. During the past 15 years, three beneficiaries were expelled. Attempted suicides are rare; in the past two years one beneficiary tried to kill herself twice attempting to attract her daughter's attention. Such cases are registered and entered in the health files of beneficiaries, so that competent professional services can undertake appropriate measures and pay the required attention to the persons concerned. Beneficiaries are satisfied with the medical care and social life and claim their institution is the best in the country.

Bloc B has two physicians (one in each of two shifts), while nurses and nursing assistants work in three shifts. Patients suffering from psycho-organic syndrome, Alzheimer's disease and dementia are on the ground floor. They are cared for by experienced medical staff; in the first two shifts there are 3-4 nurses on duty, and 2 in the night shift. There are 54 such beneficiaries and they are ambulatory and semi-mobile. Their rooms have several beds, and are spacious and airy, but sparsely equipped (they seem empty and „cold"). The psychiatrist says that is necessary to prevent self-inflicted injuries of patients, and also makes the work of the medical staff easier. However, a space deprived of private items belonging to patients, and those they consider important, is not a stimulative environment and may adversely affect their

health condition. This approach to people with psychiatric difficulties is problematic and the shortage of staff cannot excuse the absence of a more humane treatment.

> PARTICULAR ATTENTION SHOULD BE GIVEN TO THE DECORATION OF BOTH PATIENTS' ROOMS AND RECREATION AREAS, IN ORDER TO GIVE PATIENTS VISUAL STIMULATION. THE PROVISION OF BEDSIDE TABLES AND WARDROBES IS HIGHLY DESIRABLE, AND PATIENTS SHOULD BE ALLOWED TO KEEP CERTAIN PERSONAL BELONGINGS (PHOTOGRAPHS, BOOKS, ETC). THE IMPORTANCE OF PROVIDING PATIENTS WITH LOCKABLE SPACE IN WHICH THEY CAN KEEP THEIR BELONGINGS SHOULD ALSO BE UNDERLINED; THE FAILURE TO PROVIDE SUCH A FACILITY CAN IMPINGE UPON A PATIENT'S SENSE OF SECURITY AND AUTONOMY. (*CPT 9TH GENERAL REPORT, CPTT/INF (98) 12, PARA 34)*

An example of a completely opposite approach is found barely ten meters away: the corridor opens on a spacious terrace with a nice view, and a brick fence only a meter high; since the beneficiaries often use the terrace it has wooden benches and chairs, a wall painted with various scenes, while a wire fence placed for security reasons is almost invisible and covered with greenery. Moreover, at least one nurse stays on the terrace with the beneficiaries at all times.

Beneficiaries who move with great difficulty are on the first floor (mostly partially paralyzed due to disease or trauma) in rooms with four or six beds (all beds are adjustable, mattresses are well preserved with oilcloths under the linen, which is necessary). Dependent beneficiaries are on the second floor. They are completely paralyzed due to an illness or injury, although there are some with congenital paralysis. In addition to a physician, they are cared for by one senior nurse, 2 nurses and 3-4 nursing assistants. All beneficiaries have health files and therapy boxes. Most of them use adult diapers (provided to patients with these diagnoses by the Health Care Fund), which facilitates care for their hygiene. Bearing in mind that the institution has a psychiatrist on its regular staff, physical restraint is not used to control agitated beneficiaries or prevent self-inflicted injuries in administration of intravenous therapy. The beneficiaries show no signs of neglect, physical restraint or injury. Medical personnel have a glass-walled cubicles at the centre of both of the floors, which is a very functional solution enabling them a good view of the beneficiaries and allowing for speedy reaction. Daily presence of a physiatrist and several physiotherapists yields important results, especially with hemiplelgic beneficiaries. The beneficiaries say they are satisfied with medic treatment and even speak of the physician's excessive care.

Recommendation

- The level of health care services should be maintained and improved, especially with respect to a positive approach to the treatment of persons with different types of disabilities.

5. Quality of Life and Treatment of Beneficiaries

The personnel devote great attention to the work with beneficiaries, from the moment of their admission. In addition to the Admission Commission at the level of the Gerontology Center (comprising a legal officer, work therapist, physician, psychologist and social work coordinator) which in agreement with the beneficiary decides where to place him/her, the assessment of what is in the best interest of a

particular beneficiary is also done by a commission in a specific facility he/she has been sent to. The period of adaptation, which takes up to three months, in addition to the social worker, physician and psychologist also involves the Council of Beneficiaries (which has its own commission for food and admission of new residents), which is a very good practice. This reduces the negative effects of changing the living environment, common with elderly people, while peer solidarity and understanding encourage the person concerned and facilitate him/her to adjust to the new environment and overcome any problems. The period of the beneficiary's adaptation is very important and substantially influences his/her motivation and active relation towards his/her own life.

The current age structure of the beneficiaries reveals the predominance of people between 70 and 80 years of age, with mostly secondary (about 220) and high education (about 150). Qualification structure of this kind requires an appropriate treatment in terms of rehabilitation, work-occupational therapy and all other activities that should contribute to the preservation of the beneficiaries' personal capacities.

OLDER PERSONS SHOULD HAVE ACCESS TO APPROPRIATE EDUCATIONAL AND TRAINING PROGRAMS. *(ARTICLE 4, UN PRINCIPLES FOR OLDER PERSONS)*

As already mentioned a favorable situation with respect to available space and personnel, their skills and modern approach to the problems of the elderly are clearly visible and distinguish this Center from similar other institutions. The quality and contents of work with the beneficiaries reflect their interests and needs. Activities are continuous and range from cultural events and entertainment to those of work-occupational therapy. At least twice a week the beneficiaries have organized visits to a cinema, ballet, theatre, or participate in literary evenings, internal contests and tea parties. Within their work therapy the beneficiaries knit, crochet, paint, sew, make models in clay and other materials. In addition to physiotherapy, beneficiaries, depending on the weather and their health, go on organized excursions and walks, and have regular PT in the morning. This approach to the elderly stimulates their energy and help them retain the feeling of purpose and pleasure in life, which doubtlessly contributes to their overall and especially mental health.

All beneficiaries are involved and active in line with their psychophysical abilities. Work with dependable beneficiaries mostly focuses on manual activities aimed at improving orientation in time and space, while those of independent beneficiaries are far more diverse. Bearing in mind the number of beneficiaries, this segment of the institution's work should be promoted still further, in the first place by employing at least one more work therapist and psychologist. Some thought should also be given to the ways for more creative involvement of the Council of Beneficiaries, and especially more active participation of semi-dependent and dependent beneficiaries. Namely, some of them believe that the Council has little importance, while others are not certain that it actually exist. Bearing in mind that the council meets in the cinema, one gets the impression that it is not always available to all beneficiaries and ways have to be found for a different operation of the Council. As for important problems in this institution, in addition to several residents who complained about food, a number of beneficiaries pointed to excessive consumption of alcohol by some of their peers. Since the management has also mentioned this problem it is clear that control should be increased and new mechanisms devised to react in such cases and protect other beneficiaries.

Recommendations

- Appropriate social-medical measures should be taken to deal with the problem of alcohol abuse by some beneficiaries;
- Additional efforts should be made to devise the solutions for more active participation of semi-dependent and dependent beneficiaries in the work of the Council of Beneficiaries;
- The quality of life should be improved by arranging appropriate educational programs and courses, depending on the beneficiaries' interests.

6. Contact with the Outside World

Beneficiaries have contacts with the outside world through visits of their family or relations, organized excursions, cultural events, visits of artists, school children, etc. In addition, the facility also houses a Daily Center and a Club for the elderly (as part of extrainstitutional services) where its beneficiaries can meet nonresident pensioners. The staff confirms that the development and expansion of extrainstitutional protection has relieved the pressure on institutional care, which is why the time of waiting for accommodation has been reduced. Regardless of the fact that Belgrade has a fairly well developed system of household help to senior citizens and pensioners, no beneficiary has ever left the retirement home, despite the possibility to function outside of it. The reason for that should be sought primarily in the inferior organization of health institutions and isolation of old people, both on the part of their kin and the community in general.

The personnel encourage the beneficiaries to have contacts with their families and closely monitor this aspect of their life, and in that context, take specific measures to increase the frequency of these contacts or improve the relations between the beneficiaries and their families and friends. Most beneficiaries have families or relatives, but many of them live abroad, which is why contacts with them are less frequent and possibilities of the staff to do something about that fewer. However, what matters is that the staff is sensitized to the private relations and communication of the beneficiaries and aware of their importance.

In case of organized visits outside the institution, the beneficiaries use a van with seven seats and room for two wheelchairs. This kind of vehicle is really necessary, but one is insufficient for the institution’s requirements.

STATES PARTIES RECOGNIZE THE RIGHT OF PERSONS WITH DISABILITIES TO TAKE PART ON AN EQUAL BASIS WITH OTHERS IN CULTURAL LIFE, AND SHALL TAKE ALL APPROPRIATE MEASURES TO ENSURE THAT PERSONS WITH DISABILITIES:

- ENJOY ACCESS TO CULTURAL MATERIALS IN ACCESSIBLE FORMATS;
- ENJOY ACCESS TO TELEVISION PROGRAMS, FILMS, THEATRE AND OTHER CULTURAL ACTIVITIES, IN ACCESSIBLE FORMATS;
- ENJOY ACCESS TO PLACES FOR CULTURAL PERFORMANCES OR SERVICES, SUCH AS THEATRES, MUSEUMS, CINEMAS, LIBRARIES AND TOURISM SERVICES, AND, AS FAR AS POSSIBLE, ENJOY ACCESS TO MONUMENTS AND SITES OF NATIONAL CULTURAL IMPORTANCE *(ART. 30, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES)*

Recommendation

- Alternative possibilities for transportation of beneficiaries should be provided in line with their needs and health condition, in order to enable all to use the services arranged outside the institution.

6. Guarantees for Beneficiaries' Rights and Freedoms

Although this institution (like others) has only one legal officer, his job implies work with the beneficiaries. In most cases he mediates in securing a certain right for one of the beneficiaries (collecting the necessary documentation, formulating the request, informing the family or social work center, communicating with competent state bodies, etc.). Quite often only his legal advice is sought, but it is highly important that beneficiaries are in the position to obtain a legal opinion or assistance of this kind. A professional who takes interest in his work is important not only for the attainment of the guaranteed rights of beneficiaries, but also for the prevention of their abuse. Since the legal officer is only one of several experts dealing with the problems of beneficiaries, it is not surprising that there is no formal record of a case where a beneficiary was damaged because he/she was unaware of his/her rights or incapable of timely reaction.

Overall potentials of this institution (living conditions, medical care, therapeutical activities) serve the best interests of the beneficiaries and minimize the possibilities for their abuse or neglect. Bearing in mind that professional staff in institutions of this kind is in most cases, and to a highest degree, responsible for inappropriate, inhuman and degrading treatment of beneficiaries, they must be continuously scrutinized, on the one hand, but on the other must also be given proper conditions for work and possibilities for further education.

The impression is that this institution derives a lot of benefits from the fact that the director of the Gerontology Center is a member of the Executive Committee of the International Association for the Aging and that her institution is one of two from Serbia (the other is Gerontology Center Subotica) with the status of a member in the European social network and association of old people's homes. Management's awareness of modern trends is essential for the creation of a sustainable and socially acceptable model of social protection. That has, in this institution, resulted in an innovative approach to fund raising and employment of authors of several accredited programs and donations projects.

Cooperation with social work centers is correct, and the existing problems are objective. Namely, due to the complex procedure and slow processing of the beneficiaries cases on the part of the social work centers (even a year) there is often a difference between the centers' evaluation of the beneficiary's psychophysical condition and the actual situation at the time of his/her admission to the home. That is why professional services of this institution have their own evaluations and medical checks, but rarely refuse to admit a beneficiary (with the only exception of people with grave psychiatric diseases and alcoholics).

If the total number of beneficiaries in this institution 15 have been deprived of legal competence, and 53 have temporary guardians (mainly relatives and only rarely social work center) for the purpose of admission to the institution. The employees are

not aware of the reasons for denying these beneficiaries legal competence, since they were admitted to the institution with court rulings issued long time ago.

Recommendations

- Beneficiaries should be informed of their rights and the institution's possibilities to help in their protection, by means of continuing printed and other information;
- Cases of beneficiaries deprived of legal competence should be analyzed and contacts established with relevant social work centers for possible institution of proceedings to reverse the initial rulings.

HOME FOR DISABLED ADULTS IN DOLJEVAC

1. Introductory remarks

The home for residential care of physically disabled adults is a relatively new institution. Built by the Commissioner for Refugees and completed in 2003, it was subsequently given to the Ministry for Social Policy. The first residents moved into it in September 2004. According to the most recent decision of the relevant bodies, the Home is intended for accommodation of disabled adults and has the capacity of 100 persons. Its previous name also referred to old people, because of the dual purpose of this institution in the previous period. At the time of the HC visit, it housed the total of 64 beneficiaries: 44 disabled and 20 old persons (25 women and 39 men). Only 3 beneficiaries were independent, and 9 semi-dependent while 52 were dependent (8 old people and 44 disabled).

2. Living Conditions

Despite the fact that this is a new facility, there are important problems which affect the living conditions of its beneficiaries. Namely, the building was not initially intended for the disabled and old people, which means that its architectural design does not take into account the relevant accessibility requirements. Another important problem is the non-existent connection to a water supply, which makes the supply of hygienically sound water difficult and seriously endangers the work of this institution. The fact is that Doljevac does not have a town water supply network, and the institution uses artesian wells which often dry up, especially in summer, when drinking water has to be brought in water tankers from Niš. Water, even when there is some in the wells, is often bacteriologically and chemically undrinkable. Frequent disruptions in water supply make the beneficiaries (both old and disabled) feel degraded and dependent on others. That is why most of them are withdrawn, passive and uninterested in personal hygiene, while others who cannot accept this situation and the feeling of impotence, neglect and humiliation, are dissatisfied, quarrelsome and rebellious. Poor quality of drinking water endangers the hygiene of premises and food provisions, increasing the risk of various infections and requires great efforts of the staff to prevent that.

AN INSTITUTION FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER AGING PERSONS SHOULD FULFILL THE FOLLOWING CONSTRUCTION AND TECHNICAL CONDITIONS:

- IT SHOULD BE CONNECTED TO A PUBLIC WATER SUPPLY NETWORK AND IF IT DOES NOT EXIST, MUST HAVE APPROPRIATE SUPPLY OF HYGIENICALLY SOUND RUNNING HOT AND COLD WATER FROM AIR COMPRESSED WATER TANKS (ART.*2, PARA 4, OF THE RULES SPECIFYING THE CONDITIONS FOR THE START UP AND OPERATION OF SOCIAL INSTITUTIONS FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER OLD PERSONS).*

The institution has undertaken to resolve this problem by digging a new artesian well in its vicinity, but cannot go ahead in the absence of agreement of the Commissioner for Refugees. Namely, according to the law permissions for any major work on a facility require submission of urban and construction projects, which is impossible in this case because the formal and legal user of the facility is still the Commissioner for Refugees and this institution shows no interest to transfer that right to the ministry. The indolence of the state administration and the Directorate for Property who have failed (or refused) to regulate the relations between these two institutions for four years now, is both incomprehensible and inadmissible, all the more so because the property concerned will in any case remain in the hands of the state. The fact that Doljevac home is one of only two existing institutions for residential care of disabled adults in Serbia (and additionally cares for some old persons) speaks volumes of the government's attitude towards this population, regardless of all its promises, laws and strategies.

Furthermore, the building has problems with hydro-insulation of foundations, the roof, etc. However, efforts of the staff and assistance of the Ministry for Social Policy have enabled the overcoming of at least some problems and finding alternative solutions for others that cannot be dealt with at present.

The building itself has three floors and 24 rooms (with two, four and five beds), each with a toilet and a bathroom with protective rails. The fact that the home has fewer than anticipated number of beneficiaries allows for better accommodation and greater comfort, but the home's operation with full capacity would be problematic since almost all of its beneficiaries seem to be there for good. The space is reduced still more with the use of "orthopedic" beds which are larger, but necessary for persons with bodily disabilities. The number of available beds of this kind is smaller than required. The home also lacks the so-called trapeze handles which increase the degree of independence of persons trying to change their (e.g. to sit up, turn or move from the bed to a wheelchair or vice versa). This aid also helps the staff, which is important in view of the small number of personnel and the difficult job they do on daily basis.

> STATES PARTIES SHALL TAKE EFFECTIVE MEASURES TO ENSURE PERSONAL MOBILITY WITH THE GREATEST POSSIBLE INDEPENDENCE FOR PERSONS WITH DISABILITIES, INCLUDING BY:
>
> FACILITATING ACCESS BY PERSONS WITH DISABILITIES TO QUALITY MOBILITY AIDS, DEVICES, ASSISTIVE TECHNOLOGIES AND FORMS OF LIVE ASSISTANCE AND INTERMEDIARIES, INCLUDING BY MAKING THEM AVAILABLE AT AFFORDABLE COST (*ART. 20, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES*).

The rooms are sufficiently spacious, light and airy, and the mattresses, blankets and bed linen are satisfactory. In addition to central lighting, there are individual neon bulbs above beds.

Windows were replaced in all rooms and new protective blinds installed, which although transparent, offer protection from external heat. However, due to poor thermal insulation and the heat which bothers the disabled, the management has started to install air conditioning devices in the entire building and has also secured the funds for thermal insulation of the roof and works on the foundations. The

building has its own boiler room and uses coal for heating. Hygiene is on a high level and the only objection of the beneficiaries is insufficient closet space. Each of them has a night table and a part of a clothes closet which can be locked.

The building has a lift and health signals, while joint premises and corridors are monitored by video cameras, which enables the staff to follow the movements of the beneficiaries and react in case of need, and at the same time gives the beneficiaries their privacy. The corridors and staircases are spacious and have rails on both sides. The lift is also spacious enough to take a bed. Rooms for joint activities are insufficient and the existing ones are used as the living room, for dining, entertainment and work therapy. The living room is fairly large and a third of it is partitioned off for physical therapy. The living room is inadequately equipped with three office tables (discarded furniture), a table for table tennis, a TV set and a small library. Office tables with their sides and drawers cannot comfortably seat several persons, and the problem is all the more serious for people in wheelchairs.

THE INSTITUTION SHOULD HAVE A LIVING ROOM, WORK THERAPY ROOM, ROOM FOR JOINT CULTURAL ACTIVITIES AND ENTERTAINMENT, HAIRDRESSING AND BARBER SERVICES.... (*ART. 3, PARA 1 OF THE RULES SPECIFYING THE CONDITIONS FOR THE START UP AND OPERATION OF SOCIAL INSTITUTIONS FOR RESIDENTIAL CARE OF THE RETIRED AND OTHER OLD PERSONS*).

The cramped space limits the repertoire of activities and frustrates the beneficiaries interests. Conditions of that kind cause indifference and inertia, which should be a matter of special concern since the Home has a lot of young residents who have already been deprived of possibilities to develop their potentials and interest.

The kitchen is small and inadequate and lack part of cooking equipment. The dining room is spacious and airy, and enables easy movement of the disabled. It opens on a large and very nice terrace the beneficiaries can use at will. The space around the building is sufficiently large, with well kept grass, but otherwise unattended. The management and employees see that it offers numerous advantages and work to improve it for the benefit of their beneficiaries.

Recommendations

- The Ministry of Social Policy and the Commissioner for Refugees should regulate the right of use of the Home and enable this institution to operate with full legal capacity in order to provide better services to its beneficiaries;
- Funds for normal supply of running water should be urgently provided;
- Efforts should be made to provide all conditions related to the space and technical requirements for good quality accommodation of the beneficiaries.

3. Institutional Personnel

Professional service includes professionals of different profiles who, on the whole, work in the best interest of the beneficiaries. These include a social worker, a psychologies, a defectologist and a legal officer. The problem is an insufficient number of medical staff, and especially a physiotherapist. Professional staff is satisfied with their jobs as well as with the administration and cooperation with other services. Its members are motivated for additional education and professional advancement in their respective fields, and some of them, have already had such

trainings. It seems that members of the professional team seek to adjust and implement their new knowledge in their work with the residents. The work of this service is considered the most important and enjoys full support of the institution's director (a sociologist). Insight into documentation and talks with the staff suggest that the beneficiaries' files are detailed and complete, including multidisciplinary evaluation of their needs and overall state of health, a precise plan of activities in line with their needs, as well as the expected outcomes within the specified time limits and subsequent revisions depending on the results achieved. Team meetings are held on daily basis and meetings at the level of the whole institution, once a week. Bearing in mind that the budget of this institution is insufficient, the staff is given free days to compensate for overtime work. The professional service staff have organized training for the institution's employees (nursing assistants, auxiliary and technical personnel…) in order to increase the awareness of the problem of disability in general and the rights and needs of the disabled, so as to promote a positive and non-discriminatory approach to their treatment. Transfer of knowledge and skills between the institution's employees have certainly contributed to the overall atmosphere and the staff's relations with the beneficiaries. Despite serious problems and a difficult job, not one of the employees complained about working conditions, and all spoke of their beneficiaries with understanding and respect. The obvious motivation and ambitions of young personnel is clearly a great potential of this institution and guarantees that the best interests of its beneficiaries will be observed. The beneficiaries are aware of that and highly appreciate the efforts of the staff, which help them cope with the deficiencies of the institution and their everyday problems.

Recommendations

- The personnel should be encouraged to take up professional advancement and appropriate funds for this purpose should be provided;
- Living and working conditions of the entire staff should be improved, by increasing their earnings and taking of other incentive measures for their engaged, conscientious and extremely difficult work.

4. Medical Care

The medical team comprises a general practitioner (employed in the local Health Centre, but spends half his work time in the Home), a matron, 10 medical technicians, 2 nursing assistants and consulting physicians: internist, orthopedist, neurpsychiatrist, gynecologist and physiatrist, who call on the Home's residents as required (most often once a week). The physician works 4 hours in the morning, as does the matron, while other nurses work in three shifts (to per each floor in the second and third shift). Bearing in mind that most beneficiaries move with great difficulty or are bed-ridden, we think that permanent presence of a physician and a far more numerous medical staff in the institution is absolutely necessary. The beneficiaries are also dissatisfied because they do not have their permanent doctor, i.e. the fact that physicians often change. In addition, the complete medical staff (the matron with higher medical education and 10 nurses with secondary medical training) do the work of nursing assistants; despite the fact that the Ministry of Health has four years ago approved the employment of five nurses and a physiotherapist, the Health Care Fund has not yet provided the money for their salaries.

STATES PARTIES RECOGNIZE THAT PERSONS WITH DISABILITIES HAVE THE RIGHT TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH WITHOUT DISCRIMINATION ON THE BASIS OF DISABILITY. STATES PARTIES SHALL TAKE ALL APPROPRIATE MEASURES TO ENSURE ACCESS FOR PERSONS WITH DISABILITIES TO HEALTH SERVICES THAT ARE GENDER-SENSITIVE, INCLUDING HEALTH-RELATED REHABILITATION. IN PARTICULAR, STATES PARTIES SHALL:

- PROVIDE THOSE HEALTH SERVICES NEEDED BY PERSONS WITH DISABILITIES SPECIFICALLY BECAUSE OF THEIR DISABILITIES, INCLUDING EARLY IDENTIFICATION AND INTERVENTION AS APPROPRIATE, AND SERVICES DESIGNED TO MINIMIZE AND PREVENT FURTHER DISABILITIES, INCLUDING AMONG CHILDREN AND OLDER PERSONS *(ART. 25 B, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES)*

Procedures for the provision of health services unavailable in the Home (laboratory analyses, Rtg. and ECHO examinations) are well established and performed by Doljevac Health Center. For other specialist examinations the beneficiaries are taken to Niš, most often to the physical medicine or orthopedic hospitals. For these purposes the Home uses an appropriate ambulance with stretchers. If medically indicated, specialist exterminations are also carried out upon the request of beneficiaries, and the staff schedule the examination and take care of the patient's transport. There are no regular, e.g. annual, medical checks of beneficiaries, in view of the fact that they are constantly under medical supervision. Written procedure for emergency interventions does not exist, but cooperation with the local Health Center has so far been very good in cases of this kind.

Most frequently prescribed medications are analgetics (non-steroidal antirheumatics – Diclophenac, Brufen and opioid-Trodon) and sedatives (Bensedin). The institution does not have its pharmacy. Tablets are obtained on the basis of the beneficiaries' prescriptions, and ampoules through the Health Center. Therapy placed on the so-called negative list is provided by beneficiaries themselves. Nurses working in shifts control the regular use of medicaments. They say that all beneficiaries accept and take their therapy on regular basis.

Evaluation of the beneficiaries' mental health is done by a neuropsychiatrist who visits the home once a week. There is no physical restraining, except for protective belts used to protect beneficiaries who experience strong convulsions from falling out of wheelchairs. Sedatives are prescribed by the resident physician or a specialist. The medical staff does not have special training in dealing with agitated or aggressive beneficiaries, but treats them with a lot of tolerance and have the required sensibility for work with the disabled.

Each of the beneficiaries has his/her medical file with data on all changes in his/her health, therapy, laboratory analysis, and specialist examinations. The medical file contains the data on both medical and physical treatment. Most beneficiaries would like to have more frequent physical therapy but are aware of shortage of space and professional staff.

As many as 51 beneficiaries request assistance with bathing; 20 beneficiaries cannot take food by themselves, and 7 use assistance in taking liquid foods; five beneficiaries are bed-ridden and cannot sit up, and there are 17 of them who move about in wheelchairs but must be assisted. All these requirements of the beneficiaries,

including hygiene and nursing, cannot be met by the small medical staff, and other employees regularly provide addition help, e.g. in moving about or feeding the beneficiaries. Personal hygiene of immobile beneficiaries is taken care of in their beds, and they are changed at least three times a day, or more if necessary, and their position in bed is changed at least in two hour intervals; bed linen is changed as required and bathing in the bathroom is arranged once a week. Beneficiaries show no signs of decubitus which appears in consequence of inferior medical care. The beneficiaries are aware of the scarcity of medical staff and nursing assistants and appreciate their efforts, although they sometimes have to wit until noon for their morning hygiene. This situation is insupportable in the long run. It is bound to lead to inadvertent neglect of beneficiaries who are gravely ill, despite the incredible engagement and well organized work of the employees; on the other hand, the personnel is, on its part, exposed to daily efforts which doubtlessly endanger their own health.

There is no written record of suicide, although the nurses mention two or three such cases. Death is established by the physician and the family or guardian of the beneficiary concerned is duly informed.

Recommendations

- An appropriate number of properly trained personnel, should be engaged, primarily physiotherapists and nursing assistants, and a full-time resident physician;
- The institution should be supplied with additional medical equipment and apparatuses (mini-laboratory, mobile facilities for physical therapy, etc).

5. Quality of Life and Treatment of Beneficiaries

It is important to note that the heterogeneous group of beneficiaries of different age and health conditions, means that the personnel must apply diverse methods in their work. This objective cannot be fully met by the current number and structure of personnel. Bearing primarily in mind the heterogeneousness of the population and insufficient space, rehabilitation and work with the beneficiaries are on a very high level. The institution has only one room for the so-called joint activities and the staff tries to use it for multiple purposes. That is where everyday activities of either creative or educational nature take place. From 10.m. until noon beneficiaries engage in different cultural, spots or other activities (including drawing, painting, work with modeling clay, etc.) The staff sometimes arrange these activities as work-occupational therapy. As for educational activities particularly prominent are those focused on inter-personal relations, hygiene, increased awareness of the need for self-servicing, rights of the disabled, etc. Interested beneficiaries are also taught to use the computers, i.e. Internet, and the training is organized in the office of one of the staff. In view of the multidisciplinary structure of the professional team, the contents of activities they plan are diverse and adjusted to different categories of beneficiaries, or more precisely to their needs. We were told that participation in these activities is voluntary, and that the diverse nature of the activities offered encourages the beneficiaries to join in. Still, observing the beneficiaries engage in these activities and judging by the way they behaved, we did not get the impression that that was really what they needed, but that their interest was superficial and that they were absent-mindedly passing the time. The problem of the lack of motivation of the disabled is

complex and quite specific. The professional team must address it with greater attention and invest additional efforts to encourage the beneficiaries to come up with their own initiatives and suggest the activities they would like to join.

> THE BEST INTEREST OF THE BENEFICIARIES SHOULD BE BASED ON AN INDIVIDUALIZED APPROACH, WHICH IMPLIES THE DRAWING UP OF A TREATMENT PLAN FOR EACH PATIENT…. IT SHOULD INVOLVE A WIDE RANGE OF REHABILITATIVE AND THERAPEUTIC ACTIVITIES, INCLUDING ACCESS TO OCCUPATIONAL THERAPY, GROUP THERAPY, INDIVIDUAL PSYCHOTHERAPY, ART, DRAMA, MUSIC AND SPORTS... IT IS ALSO DESIRABLE FOR THEM TO BE OFFERED EDUCATION AND SUITABLE WORK (*CPT 9TH GENERAL REPORT, CPTT/INF (98) 12, PARA 37).*

The staff has the idea to partition part of the room for joint activities and equip it with relevant gymnastic apparatuses and other equipment (mats, cones, bowling pins, hoops, rollers, etc.) to enable the beneficiaries to exercise with the professional assistance of the physiotherapist or other competent persons. This idea should certainly be realized, as it enables the beneficiaries to practice numerous movements, to communicate and devise diverse games, and thereby maintain the vitality of their movements and enrich their daily routine.

The general impression is that the staff with its professional abilities, as well as good will and creative approach, manages to overcome numerous problems deriving from the lack of space and shortage of professional personnel. What the institution doubtlessly lacks is professional education of the disabled who do have the potential for appropriate active work. However, that is the problem of the entire society and remains outstanding outside institutions of this kind, which is why one could hardly expect the Home to resolve it on its own. Still, something should be done to promote the educational possibilities especially of younger persons with only bodily disabilities.

> STATES PARTIES RECOGNIZE THE RIGHT OF PERSONS WITH DISABILITIES TO EDUCATION. WITH A VIEW TO REALIZING THIS RIGHT WITHOUT DISCRIMINATION AND ON THE BASIS OF EQUAL OPPORTUNITY, STATES PARTIES SHALL ENSURE AN INCLUSIVE EDUCATION SYSTEM AT ALL LEVELS AND LIFE LONG LEARNING DIRECTED TO:
>
> - THE FULL DEVELOPMENT OF HUMAN POTENTIAL AND SENSE OF DIGNITY AND SELF-WORTH, AND THE STRENGTHENING OF RESPECT FOR HUMAN RIGHTS, FUNDAMENTAL FREEDOMS AND HUMAN DIVERSITY;
> - THE DEVELOPMENT BY PERSONS WITH DISABILITIES OF THEIR PERSONALITY, TALENTS AND CREATIVITY, AS WELL AS THEIR MENTAL AND PHYSICAL ABILITIES, TO THEIR FULLEST POTENTIAL *(ART. 24, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES).*

Speaking of the old population, its interest is predominantly aimed at entertainment which is why various parties are often organized in the dining room. In any case, the staff is aware of its tasks and the importance of the professional service for the psychosocial functioning and integration of the beneficiaries. Both the staff and residents point to the problem of separation of certain beneficiaries into informal groups, pursuant to the type of their disability, which adversely affects their mutual relations. Possible reasons for that should be found in the existence of different deprivations (as an inevitable consequence of institutional life and psychological effects of the awareness of disability) that are overcome by the beneficiaries in

various constructive or destructive ways. Prevention of conflicts, or more precisely their constructive resolution requires certain skills of the staff and clear recognition of their causes.

Three married couples living in the Home are given separate double bedrooms. The attitude and support of the management and the staff to this group of beneficiaries are commendable, despite the difficulties in communication and additional work due to special conditions provided for married couples or requested by them. The feeling of belonging to one another and mutual support gives strength to these beneficiaries to put forward and persist in their requests, and their motivation for life is stronger, as are their integrity and self-confidence.

Recommendations

- The lacking space and personnel should be provided, to ensure the quality of professional services and their adjustment to the different needs and possibilities of people with disabilities;
- Education in the fields of communication, team work and participation in decision-making should be organized;
- Efforts should be made to increased the beneficiaries' awareness of the importance of professional and work engagement and create the conditions for relevant activities as part of their rehabilitation;
- Motivation of beneficiaries to take part in various activities should be increased.

6. Contact with the Outside World

Engagement of the staff in this respect is very important on several levels and in different relations. All beneficiaries have access to telephone lines, either by using a booth in the Home or by using mobile phones. Various excursions, visit to different institutions, discussions, other cities, etc. are frequently organized. The problem is that the Home has only one vehicle, a van with only two places for wheelchairs and six seats, which limits the possibility for simultaneous transportation of larger groups of beneficiaries.

> TO ENABLE PERSONS WITH DISABILITIES TO LIVE INDEPENDENTLY AND PARTICIPATE FULLY IN ALL ASPECTS OF LIFE, STATES PARTIES SHALL TAKE APPROPRIATE MEASURES TO ENSURE TO PERSONS WITH DISABILITIES ACCESS, ON AN EQUAL BASIS WITH OTHERS, TO THE PHYSICAL ENVIRONMENT, TO TRANSPORTATION... *(ART. 9, PARA 1, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES)*

The staff works to encourage communication with the beneficiaries' social environment, including both their family and relations and the social work center, friends, and local community. In cooperation with the social work center, contacts with families are continuously encouraged and monitored. Unfortunately many families cannot make frequent visits to the Home mostly for financial reasons. Bearing in mind that Doljevac home is one of two existing institutions for residential care of the disabled, its beneficiaries come from all parts of Serbia. The distance of the Home from the place of origin of the beneficiary and his/her family is a major

problem for frequent contacts. However, many beneficiaries could have a far higher quality and more humane life outside the institution, if they received appropriate assistance of the state.

> ... SUPPORT PARTICIPATION AND INCLUSION IN THE COMMUNITY AND ALL ASPECTS OF SOCIETY, ARE VOLUNTARY, AND ARE AVAILABLE TO PERSONS WITH DISABILITIES AS CLOSE AS POSSIBLE TO THEIR OWN COMMUNITIES, INCLUDING IN RURAL AREAS. (ART. 26, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES)

The institution has cooperation with two local associations of the disabled, organizes visits of primary school children (usually the children arrange a show and gifts for the home's residents each October). Professional staff also tries to raise the awareness of the local population about the rights and needs of the disabled, through organized campaigns and distribution of promotional material, to eliminate the stereotypes and prejudices and ensure a higher degree of acceptance of the Home by the local community and citizens. Namely, the beneficiaries, although they are not distant from the settlement are still isolated. Without open contacts with the environment, which does not notice certain individuals and groups and does not give them the opportunity to join its life, these individuals and groups feel worthless and second-rate citizens. That segregates the Home's beneficiaries and denies them the fulfillment of many social needs. That is why it is necessary to continue working on the relations with the local community. That is the obligation of the home's personnel, as well as the competent people in the local administration.

> STATES PARTIES UNDERTAKE TO ADOPT IMMEDIATE, EFFECTIVE AND APPROPRIATE MEASURES:
> - TO RAISE AWARENESS THROUGHOUT SOCIETY, INCLUDING AT THE FAMILY LEVEL, REGARDING PERSONS WITH DISABILITIES, AND TO FOSTER RESPECT FOR THE RIGHTS AND DIGNITY OF PERSONS WITH DISABILITIES;
> - TO COMBAT STEREOTYPES, PREJUDICES AND HARMFUL PRACTICES RELATING TO PERSONS WITH DISABILITIES, INCLUDING THOSE BASED ON SEX AND AGE, IN ALL AREAS OF LIFE;
> - TO PROMOTE AWARENESS OF THE CAPABILITIES AND CONTRIBUTIONS OF PERSONS WITH DISABILITIES. *(ART. 8, PARAS A, B, C, CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES).*

Recommendations

- Efforts should be made to provide a sufficient number of vehicles for transportation of the disabled, either independently or jointly with associations of the disabled;
- Work too establish closer contacts with local administration, cultural, sports and other institutions, schools, the media, etc, should be intensified, including joint manifestations and activities ensuring equal participation of beneficiaries in the life of the local community.

7. Guarantees for Beneficiaries' Rights and Freedoms

Interviews with the beneficiaries and insight into the diverse aspects of the Home's operations revealed no indication of either overt or concealed abuse of

beneficiaries by the personnel. As already mentioned, there is some inadvertent neglect due primarily to the insufficient number of the employed and absence of appropriate therapy and activities that would satisfy the beneficiaries needs to a higher degree.

Some beneficiaries did complain about other residents, which places the personnel in a thankless situation to arbitrate, and they are sometimes out of their depth to do that. These problems could be resolved with additional education of the staff in the skills of communication, conflict management, etc. Furthermore, the experience reveals that participation of beneficiaries in the taking of important decisions and resolution of problems decreases violence and increases responsibility, cooperation and satisfaction.

The beneficiaries have their Council, and can use it to voice their grievances and proposals, discuss internal problems, etc. and inform the institution's manager on their decisions. As in other social care institution, the beneficiaries have their representatives on the Managing Board. In addition, internal rules anticipate the possibility for the beneficiaries to send their complaints related to the conduct of the staff, in writing to the institution's manager, who is obliged to take them into consideration and inform the beneficiary concerned on the measures taken in that respect.

Independent and semi-dependent beneficiary may leave the institution of his/her one volition, with a written statement to that effect or agreement of his/her guardian. Dependent beneficiaries must prove the social work center that they will have appropriate care around the clock.

The institution does not have beneficiaries deprived of legal competence. The institution's legal officer does his best to deal with other matters related to the exercise of the beneficiaries' rights.

Recommendation

- Cooperation with social work centers should be intensified (whenever possible) to create the conditions for the life of beneficiaries outside the institution.


ЦРКВА
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