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Report

to the Russian Government on the visit to the Russian Federation carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

from 19 to 29 October 2018

The Russian Government has requested the publication of this report and of its response. The Government's response is set out in document CPT/Inf 2019) 27.

Strasbourg, 24 September 2019

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Psychiatric establishments

The delegation visited for the first time Federal Specialised Psychiatric Hospitals with Intensive Supervision in Kazan and Volgograd, Branch No. 2 of Volgograd Regional Psychiatric Hospital No. 2, and Krasnoarmeyskaya Regional Psychiatric Hospital named after Yuriy Alekseevich Kalyamin in Saratov region.

Many of the interviewed patients spoke positively of the clinical staff, especially in the two hospitals in Volgograd region. However, the delegation received a few allegations of physical ill-treatment of patients by staff as well as of other forms of ill-treatment. Inter-patient violence did not appear to be a substantial problem in any of the hospitals visited.

Patient accommodation was generally clean, warm, well lit and ventilated, with visible evidence of completed or on-going renovation. However, with the exception of Volgograd Hospital Branch No. 2, the establishments visited were severely overcrowded, with many beds touching. This is not in compliance with the living space requirements in national legislation. Moreover, the rooms were austere, lacked personalization and offered virtually no space for keeping personal belongings.

Concerning staffing, inadequate staffing levels were found in differing degrees in all the hospitals visited. The Committee recommends that the Russian authorities take urgent measures to address the serious recruitment difficulties regarding medical, ward-based and multi-disciplinary clinical staff.

Regarding treatment, this was based predominantly on pharmacotherapy. With the exception of Volgograd Federal Hospital, opportunities for psycho-social rehabilitation were limited to a minority of patients, these deficits often arose because of totally inadequate multi-disciplinary staffing levels. Furthermore, in both civilian hospitals patients had very limited opportunities for outdoor exercise.

At Kazan Federal Hospital, the delegation noted with grave concern that electroconvulsive therapy (ECT) was being administered to patients on some wards in unmodified form, i.e. without an anaesthetic and muscle relaxants. In the CPT's view, the administration of ECT in unmodified form can raise issues under Article 3 of the European Convention on Human Rights.

Regarding means of restraint, the mechanical restraint of patients using canvas straps was practiced in all hospitals visited. However, to differing degrees, international guidelines regarding such measures were not being followed in any of the four establishments. It was particularly concerning to note that at Kazan Federal Hospital patients could be subjected to four-point fixation alone in isolation rooms for many days without any release; various patients who had been subjected to such lengthy measures told the CPT delegation that they had refused to be fed as they found it too challenging to defecate into a bedpan while being fixed horizontally. Patients explained that after a few days of not being able to defecate, their abdomens would swell and become very painful. Furthermore, one younger male patient who told the delegation he had recently been restrained for a week was found to have a number of bed sores on his sacral area.

Seclusion was used in the two federal hospitals visited by the CPT. On the intensive care wards of both hospitals, patients were sometimes spending months or even years alone in very small bare rooms as narrow as 1.1 m, with almost no daylight and artificial lighting switched on for 24 hours a day. At Kazan Federal Hospital, patients in seclusion had no access to a toilet (having instead to use a bucket placed in the corner of the room); at Volgograd Federal Hospital, there was a small unscreened floor-level toilet in the corner of the room near the barred gate door. In addition to having no or almost no access to outdoor exercise and to being prevented from any physical exercise inside the rooms, some patients in both hospitals were not even given a toothbrush or a spoon (obliging them to eat with their hands) for months or even years. In the CPT's view, such conditions do not befit a health-care institution and amount to inhuman and degrading treatment.

Regarding legal safeguards, the CPT delegation noted that many patients in Krasnoarmeyskaya Hospital and Volgograd Hospital Branch No. 2 who had signed consent to hospitalisation forms and were still deemed voluntary were nonetheless not truly consenting to their hospitalisation. Such "voluntary" patients were thus *de facto* detained. Some of these patients were not even allowed to leave the ward to exercise in the grounds, let alone exit the hospital, having, for example, been labelled as "prone to escape" in clinical records. Further, such "voluntary" patients had sometimes been given forced medication and had been mechanically restrained. The CPT reiterates its recommendation that persons admitted to psychiatric establishments be provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently.

Social care establishments

The CPT delegation carried out first-time visits to four social care establishments for adults (so-called Psycho-Neurological Internats, hereafter referred to as PNI) in three different regions of the Russian Federation: PNIs Nos. 16 and 34 in Moscow, Angarsk PNI (Irkutsk Region) and Babushkin PNI (Republic of Buryatia).

The delegation observed a generally positive interaction between residents and staff members and heard no allegations of recent physical ill-treatment of residents by staff. That said, in all the establishments visited, the delegation received allegations (and found other evidence, including in the form of lesions directly observed by the delegation's doctors) of inter-resident violence.

As regards living conditions, residential buildings were in a good state of repair and, on the whole, provided clean, well-lit and ventilated accommodation. Although the most autonomous residents usually lived in smaller rooms (for one to four residents), other residents tended to be accommodated in larger dormitories, some of which were overcrowded. The CPT is of the opinion that living in large dormitories that lack personalisation is not conducive to a therapeutic and rehabilitative approach.

The Committee considers the staff complements at the PNIs visited more or less adequate as regards doctors and ward-based care staff (feldshers, nurses and orderlies). However, steps should be taken to reinforce the resources of staff qualified to provide psycho-social rehabilitative activities (psychologists, special educators, occupational therapists, physiotherapists, social workers, etc.).

With the exception of Babushkin PNI, both psychiatric and somatic treatment was generally of a good standard. In Babushkin PNI, the delegation was especially concerned about the poor availability and deficient quality of psychiatric treatment, as the purportedly full-time psychiatrist was only actually physically present in the establishment every two to three months.

In all the establishments visited, the delegation received numerous detailed allegations of the use of means of restraint (mainly strapping patients to beds with distinctive soft bandages), including in specific seclusion rooms used for "calming-down" purposes. This unofficial practice was not recorded, nor were residents able to avail of any of the procedural safeguards that should accompany the use of restraint measures. The CPT calls upon the Russian authorities to adopt, without delay, written provisions on recourse to means of restraint and seclusion in all social care establishments.

In a number of the establishments visited, the delegation found that the blanket designation of an establishment's director as the guardian of all legally incapacitated residents placed the director in a potentially invidious position and residents under guardianship at risk of the exploitation of their personal resources. The most striking example of this was at Babushkin PNI, where there was a list of so-called "additional social services" that were charged to residents, including bathing, shampooing, use of the minibus of the establishment, drinking water from the corridor's tap, washing/repairing/ironing clothes. In the light of these findings, the Committee suggests that an independent audit be conducted into the legitimacy of the expenditure by the director/guardian of the private funds of legally incapable residents at Babushkin PNI.

Concerning legal safeguards in the context of placement in a PNI, the Committee notes that the court decision on the deprivation of legal capacity carries with it almost automatically the consequence that an initial placement will be authorised. The CPT recommends that the Russian authorities introduce an effective and automatic and periodic review by an outside authority (e.g. a court) of the need to continue each and every placement in a PNI.

I. INTRODUCTION

A. The visit, the report and follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as "the Convention"), a delegation of the CPT carried out a visit to the Russian Federation from 19 to 29 October 2018. The visit was one which appeared to the Committee "to be required in the circumstances" (see Article 7, paragraph 1, of the Convention). It was the CPT's 27th visit to the Russian Federation.[1]

2. The visit was carried out by the following members of the CPT:

- Mark Kelly, 2nd Vice-President of the CPT (Head of the delegation)
- Gergely Fliegauf
- Inga Harutyunyan
- Vytautas Raškauskas.

They were supported by Natacha De Roeck and Dalia Žukauskienė of the Committee's Secretariat, and assisted by:

- Timothy Harding, psychiatrist, former Director of the University Institute of Forensic Medicine in Geneva, Switzerland (expert)
- Clive Meux, forensic psychiatrist, Oxford, United Kingdom (expert)
- Inna Bashina (interpreter)
- Galina Ermakova (interpreter)
- Vladislav Kostiuchenko (interpreter)
- Pavel Palazhchenko (interpreter).

3. The list of psychiatric and social care establishments visited by the CPT's delegation can be found in Appendix I.

[1] See the full list of visits and their dates on the CPT's website, https://www.coe.int/en/web/cpt/russian-federation.

4. The report on the visit was adopted by the CPT at its 98th meeting, held from 4 to 8 March 2019, and transmitted to the Russian authorities on 25 March 2019. The various recommendations, comments and requests for information made by the CPT are set out in bold type in the present report. The CPT requests the Russian authorities to provide within three months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report.

As regards the recommendations in paragraphs 53 and 61 of the report, the CPT requests that an account of action taken to implement them be provided within one month.

B. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the delegation held consultations with Oleg Salagay, Deputy Minister of Healthcare, and Svetlana Petrova, Deputy Minister of Labour and Social Protection, as well as with senior officials of the aforementioned Ministries.

In addition, a meeting was held with the Independent Psychiatric Association of Russia, a non-governmental organisation active in areas of concern to the CPT.

A full list of the authorities and organisations with which the CPT's delegation held consultations is set out in Appendix II.

6. The co-operation received by the delegation throughout the visit from the federal and regional authorities and staff at the establishments visited was on the whole very good. The delegation was provided with the information necessary for carrying out its tasks[2] and was able to speak in private with psychiatric patients and residents of social care institutions. The delegation also wishes to express its appreciation for the assistance provided before and during the visit by the CPT's liaison officer, Mr Yaroslav Sakhno from the Ministry of Justice.

However, despite repeated requests made by the delegation both before and during the visit, its members were not provided with official credentials from the Ministry of Healthcare and Ministry of Labour and Social Protection nor had relevant regional ministries been informed regarding the CPT's visit in an effective manner. Consequently, when visiting Branch No. 2 of Volgograd Regional Psychiatric Hospital No. 2 and Babushkin Psycho-Neurological Boarding Home in the Republic of Buryatia, the delegation was prevented from gaining access to the areas of these establishments housing patients and residents for several hours as their managements had not been properly informed about the CPT's visit to the country or its mandate and powers. **The CPT requests that the Ministries of Healthcare and of Labour and Social Protection ensure that, in future, information on the Committee's mandate and powers is disseminated to all the relevant authorities, and that its visiting delegations are supplied with official written credentials.**

[2] Although that information was not always accurate - see paragraph 111 below.

C. Immediate observations under Article 8, paragraph 5, of the Convention

7. At the end of the visit, the CPT's delegation met deputy ministers and senior Government officials in order to acquaint them with the main facts found during the visit. On that occasion, the delegation made two immediate observations, in pursuance of Article 8, paragraph 5, of the Convention, on certain particularly urgent matters.

8. The **first immediate observation** concerned the use of electroconvulsive therapy (ECT) in the Federal Specialised Psychiatric Hospital with Intensive Supervision in Kazan, where it was being administered in an unmodified form without the presence of an anaesthetist and administration of an anaesthetic. The Russian authorities were requested to confirm, within one month, that the administration of unmodified ECT would cease in all psychiatric hospitals of the Russian Federation.

9. The **second immediate observation** concerned the unacceptable situation at Babushkin Psycho-Neurological Internat (PNI), including, *inter alia*, poor living conditions on some wards, insufficient access to psychiatric care, and lack of effective review of the need to continue placement. The Russian authorities were requested to:

- make significant improvements to living conditions on the ward for the least mobile residents;

- carry out an independent review of the availability and the quality of psychiatric care offered to residents (for instance by experts from another region);

- subject the use of *pro re nata* (PRN) medication (authorised in advance on as needed basis by the psychiatrist) to a review by an independent psychiatrist or another independent supervision entity;

- carry out an independent multi-disciplinary assessment and review of the continued need for legal incapacity of all residents;

- carry out an individual needs assessment of resident A.[3] (who lived on the ward for the least mobile residents) and transfer him to a location better adapted to his intellectual and physical skills.

The Russian authorities were requested to confirm, within two months, that steps have been taken to address these concerns.

10. The immediate observations referred to in paragraphs 8 and 9 above were subsequently confirmed in a letter of 9 November 2018 from the President of the CPT.

By letter dated 28 December 2018 the Russian authorities informed the Committee of the measures taken. Those measures will be assessed later in the report.

[3] In accordance with Article 11, paragraph 3, of the Convention establishing the CPT, the name has been deleted.

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Psychiatric establishments

1. Preliminary remarks

11. The delegation visited for the first time Federal Specialised Psychiatric Hospitals with Intensive Supervision in Kazan and Volgograd, Branch No. 2 of Volgograd Regional Psychiatric Hospital No. 2, and Krasnoarmeyskaya Regional Psychiatric Hospital named after Yuriy Alekseevich Kalyamin in Saratov region.

12. Psychiatric establishments in the Russian Federation are, as a rule, run by municipal or regional authorities. As an exception to this rule, the Federal Ministry of Healthcare is directly responsible for eight federal specialised psychiatric hospitals with intensive supervision which provide compulsory treatment to persons found to be criminally irresponsible for their acts or those who develop a mental illness in the period after committing a crime. Prior to this visit to two such hospitals, the CPT has visited other establishments of this type in the past – in St. Petersburg in 1999,[4] in Kaliningrad in 2003,[5] and in Novosibirsk in 2016.[6]

13. Federal Specialised Psychiatric Hospital with Intensive Supervision in Kazan (hereafter – Kazan Federal Hospital) is located in a suburb of the city of Kazan. It was built in 1900 as an extension to a regional psychiatric hospital built in 1869 and, in 1909, it became the first forensic psychiatric hospital in Russia. In 1939, this special block became directly subordinated to the NKVD[7] and was renamed Kazan Prison Psychiatric Hospital; in 1998, the hospital was transferred to the responsibility of the Federal Ministry of Healthcare.

Currently, the hospital accepts for compulsory treatment women from the entire Russian Federation[8] and men from ten subjects of the Russian Federation.[9] With an official capacity of 1,020 beds, at the time of the visit, Kazan Federal Hospital was accommodating 741 patients – 216 women and 525 men (one of them being a 16-year old juvenile).

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4 See paragraphs 213 to 234 of document CPT (2000) 7.

5 See paragraphs 90 to 113 of document CPT (2003) 74.

6 See paragraphs 129 – 130, 133 – 134, 137 – 138, 141, 143, 146, 150 – 151 and 158 of document CPT (2017) 33.

7 The People's Commissariat for Internal Affairs (Народный комиссариат внутренних дел).

8 Except those with tuberculosis who are treated in Federal Specialised Psychiatric Hospital with Intensive Supervision in Oriol and residents of Kaliningrad region who are treated in Federal Specialised Psychiatric Hospital with Intensive Supervision in Kaliningrad. See also paragraph 75 below.

9 Republic of Bashkortostan, Republic of Mariy El, Republic of Mordovia, Republic of Tatarstan, Republic of Udmurtia, Chuvash Republic, Nizhny Novgorod Region, Ulyanovsk Region, Kirov Region, and Perm Territory.

14. Federal Specialised Psychiatric Hospital with Intensive Supervision in Volgograd (hereafter – Volgograd Federal Hospital) is located in the countryside in Dvoryanskoye village, some 240 km from Volgograd and 20 km from the nearest town Kamyshin. The hospital was opened in 1978 on the premises of a former female correctional labour colony, and at the time of the visit received for compulsory treatment men from 20 subjects of the Russian Federation.[10] With an official capacity of 710 beds, at the time of the visit, the hospital was accommodating 723 patients (all of them adult).

15. Branch No. 2 of Volgograd Regional Psychiatric Hospital No. 2 (hereafter – Volgograd Hospital Branch No. 2), located in a suburb of the city of Volgograd, was formerly called Volgograd Regional Psychiatric Hospital No. 5 (opened in 1958), which then became a structural branch of Volgograd Regional Clinical Psychiatric Hospital No. 2 after the reorganisation of health-care establishments in Volgograd region in 2016. At the time of the visit, the hospital, with an official capacity of 195, was accommodating 165 patients – 90 men (including one 16-year old) and 75 women (including one 15-year old). There were 10 "civil" involuntary patients[11] and no forensic patients undergoing compulsory treatment.

16. Krasnoarmeyskaya Regional Psychiatric Hospital named after Yuriy Alekseevich Kalyamin (hereafter – Krasnoarmeyskaya Hospital), opened in 1960, is in a remote location in Kamenskiy village, some 110 km from Saratov and 40 km from the nearest town of Krasnoarmeysk. With an official capacity of 610 beds, at the time of the visit, the hospital was accommodating 577 patients (318 on male wards, 171 on female, and 88 on mixed wards). There were (officially) no "civil" involuntary patients[12] but 66 forensic patients were undergoing compulsory treatment. Of those, five women were accommodated on general wards and 61 male patients were accommodated on the forensic ward of specialised type[13] (including five on whom the court had imposed compulsory treatment in a hospital of general type).

17. It is noteworthy that the delegation was informed by the management of Krasnoarmeyskaya Hospital that there were approximately 250 patients (more than one third of the total number) who did no longer need to be hospitalised but who allegedly remained in the hospital (in many cases, according to the patients interviewed, against their will) due to the lack of adequate care/accommodation in the community. In the Committee's view, for persons to remain *de facto* deprived of their liberty as a result of the absence of appropriate community facilities is a highly regrettable state of affairs.

In order to improve the quality of life of patients and reduce the potential for ill-treatment, **the CPT recommends that the Russian authorities make every effort to further promote, as a matter of priority, de-institutionalisation and make available good care, accommodation and social support in the community; this is also relevant in the context of the country's obligations stemming from the UN Convention on the Rights of Persons with Disabilities.[14]**

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10 From the Russian Federation's southern regions and from the republics of the North Caucasus to the Far East.

11 See, however, paragraph 70 below.

12 See, however, paragraph 70 below.

13 Section 97 of the Criminal Code (CC) provides that compulsory treatment is decided by a court, which also specifies the type of regime of hospitalisation (hospital of general type or specialised type, or specialised type with intensive supervision) to which the person concerned is to be subjected.

14 Ratified by the Russian Federation in 2012.

Furthermore, steps should be taken to facilitate the movement of patients along a planned pathway of care and support, offering consistent quality, so that patients are treated in the least restrictive environment possible and therefore have their in-patient stay shortened (or even avoided altogether). Community accommodation should take the form of small living units in the community, ideally in towns, with all the relevant facilities close at hand. Placement in large social care institutions is not true de-institutionalisation or proper re-integration of patients into the community. Nor is the conversion of the psychiatric hospitals into psycho-neurological internats with the same occupants. In other words, trans-institutionalisation is no substitute for true community-based de-institutionalisation (see also paragraph 77 below). **The CPT recommends that the Ministry of Healthcare and the Ministry of Labour and Social Protection work together closely to implement these precepts.**

Progress in this direction would also address some of the serious issues found in psychiatric hospitals such as overcrowding and should improve treatment experiences and outcomes for patients.

2. Ill-treatment

18. Many of the patients interviewed by the delegation spoke positively of the clinical staff, especially in the two hospitals in Volgograd region (Volgograd Hospital Branch No. 2 and Volgograd Federal Hospital). The delegation did not receive any allegations of physical ill-treatment of patients by staff in three of the hospitals visited, but at Kazan Federal Hospital it did hear complaints regarding one particular female nurse (reportedly hitting patients on one ward) and regarding some orderlies occasionally pushing, hitting and kicking patients. The identity of the nurse was disclosed to the Director of the establishment. **The CPT requests the Russian authorities to provide information on the follow-up given to these allegations.**

Furthermore, in all the hospitals visited, the delegation received allegations that, on occasion, orderlies were verbally rude to patients. Bearing in mind the challenging nature of their work, it is of crucial importance that orderlies be carefully selected and that they receive both appropriate training before taking up their duties and in-service courses. Further, during the performance of their tasks, they should always be closely supervised by – and be subject to the authority of – qualified health-care staff.

The CPT recommends that the managements of the psychiatric hospitals visited exercise continuous vigilance and remind staff at regular and frequent intervals that patients should be treated with respect, and that any form of ill-treatment of patients, whether verbal or physical, is totally unacceptable and will be punished accordingly.

Moreover, **it is essential that ward-based staff be carefully selected and given suitable training on managing patients humanely and safely, receive regular supervision and be provided with appropriate support and counselling to avoid burn-out and ensure good quality care.**

19. Regarding other forms of ill-treatment, a significant number of male patients at Kazan Federal Hospital said that if they were seen by staff to be masturbating (privately in their beds), they would receive injectable psychotropic medication or would be mechanically restrained. **Such a response, or indeed any other punitive reaction, to patients privately masturbating would amount to degrading punishment and should never take place (see also paragraph 66 below).**

20. At Volgograd Federal Hospital, the delegation learned that three female staff members had recently breached professional boundaries and had had sexual contact with a male patient; two of the three had subsequently resigned.

In this connection, **the CPT wishes to make clear that, given the inherent vulnerability of persons deprived of their liberty, there is no scope for consent in sexual contact between staff and detainees; this applies equally to patients. Such conduct on the part of staff should always be regarded as an abuse of their authority and be dealt with as such.**

The Committee would like to be informed whether an (internal) investigation into these three cases has taken place and, if so, what was the outcome of the investigations and what measures have been taken.

21. Regarding inter-patient violence, although some disagreements and occasional fights between patients did occur, this did not appear to be a substantial problem in any of the hospitals visited.

3. Patients' living conditions

22. From the outset, the Committee wishes to stress that in all the hospitals visited, patient accommodation was generally clean, warm, well lit and ventilated, with visible evidence of completed or on-going renovation.

However, with the exception of Volgograd Hospital Branch No. 2, the establishments visited were severely overcrowded, with many beds touching. In this respect, none of them complied with the Sanitary and Epidemiological Requirements for Organisations carrying out Medical Activities (Sanitary-epidemiological Norm No. 2.1.3.2630-10) approved by the Chief State Sanitary Doctor of the Russian Federation in 2010, according to which there should be at least 7 m² of living space per patient in multiple-occupancy rooms in psychiatric hospitals.

The CPT recommends that the Russian authorities review the official capacities in all psychiatric hospitals of the Russian Federation in order to ensure that they comply with the aforesaid legislation.

a. Federal Specialised Psychiatric Hospital with Intensive Supervision in Kazan

23. Located on an extensive 2.2-hectare site, Kazan Federal Hospital comprised three blocks of patient accommodation plus some ancillary buildings, all surrounded by a secure perimeter wall topped by razor wire.

Patients were accommodated on 13 wards,[15] with 37 to 115 beds each – ten wards for male patients (an admission ward, an intensive care ward, four treatment wards, three rehabilitation wards and a somato-psychiatric ward) and three treatment wards for female patients (including one offering more intensive care and one providing some rehabilitation).

24. Patient accommodation consisted of dormitories with up to 10 beds per room; except for those on rehabilitation wards, the dormitories were locked. They did not provide patients with any personal lockable space and essentially contained only beds, and sometimes a few cupboards. Furthermore, the absence of any decoration or personal belongings on all wards except rehabilitation contributed to an impersonal and austere atmosphere. Some patients on the intensive care ward also complained of cockroaches in the dormitories.

In this regard, the CPT wishes to emphasise that it is generally considered that large-capacity dormitories are not compatible with current standards of accommodation for psychiatric in-patients. In the Committee's opinion, the provision of accommodation structures based on small groups (preferably, of not more than four patients) is a crucial factor in preserving and restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients. Structures of this type also facilitate the allocation of patients to relevant categories for therapeutic purposes.

25. As already mentioned (see paragraph 22 above), there was significant overcrowding in the hospital, especially given the fact that on the day of the delegation's visit there were some 280 patients less than the official capacity of 1,020.[16] Even with the current occupancy, the dormitories often provided less than 3 m² of living space per patient.[17]

The delegation saw a newly built unoccupied accommodation block for 100 patients (50 male and 50 female) which was supposed to become operational in 2019; once brought into service, the new block should at least partially relieve the overcrowding until appropriate long-term solutions are found.

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15 Two more wards, one containing a treatment and diagnostic polyclinic and the other for occupational therapy, were non-residential clinical units.

16 The delegation noted that, in the hospital management's opinion, the official capacity of the establishment should not be more than 500 beds.

17 E.g. some 8 m² for 3 beds, some 21 m² for 8 beds, or some 23 m² for 9 beds.

26. During interviews with patients, the delegation received complaints that, on some male wards, access to the toilet was not always guaranteed – patients were allegedly taken to the toilet twice a day (before lunch and before dinner)[18] and received a bucket in the dormitory for the night. In this context, the CPT wishes to stress that ready access to proper toilet facilities and the maintenance of good standards of hygiene are essential components of a humane environment; the practice of defecating into a bucket in one's multiple-occupancy dormitory is degrading and unhealthy.

Conditions in the communal sanitary facilities were satisfactory. However, as a general rule, patients could use the shower only once a week; this is not sufficient.

27. **The CPT recommends that the Russian authorities take the necessary measures to improve living conditions at Kazan Federal Hospital, and in particular to ensure that:**

- **occupancy levels are reduced to provide patients with a living space provided for by the national legislation;**

- **thorough and repeated disinfestation measures are carried out on Ward 2, and other wards if necessary, so as to eliminate the problem of infestation with cockroaches;**

- **conditions in the dormitories are conducive to the treatment and welfare of the patients and provide visual stimulation and personalisation, in the light of the above remarks;**

- **all patients are provided with personal lockable space in which they can keep their belongings;**

- **all patients have unimpeded access to toilet facilities without undue delay at all times (including at night);**

- **all patients have unrestricted access to a shower.**

Furthermore, **the CPT would like to receive confirmation that the aforementioned new block is now fully operational. In the long term, steps should be taken to reconstruct patient accommodation areas so as to replace large-capacity dormitories with smaller rooms (for up to four patients).**

[18] Which, in some cases, allegedly led to patients urinating or defecating in the room, in the bed or next to the door, and then being punished with injections or mechanical restraint.

b. Federal Specialised Psychiatric Hospital with Intensive Supervision in Volgograd

28. At Volgograd Federal Hospital, a range of clinical and non-clinical buildings within the secure perimeter were set in flat landscaped grounds with many pleasant garden areas. Patients were accommodated on eight wards, in rooms/dormitories containing from three to 12 beds each – an admission ward, an intensive care ward, two "minor rehabilitation" wards, three rehabilitation wards and a ward for patients with tuberculosis.

29. Living conditions in the rooms/dormitories ranged from acceptable to good, with rooms on rehabilitation wards decorated with flowers, personal items and photographs and equipped with TV sets and air conditioners.[19] The delegation noted the staff's considerable efforts to make the environment homely and welcoming.

However, as already mentioned in paragraph 22 above, the hospital was significantly overcrowded; some rooms/dormitories provided less than 2 m² of living space per patient,[20] many beds were touching and on two wards several patients had to sleep on mattresses on the floor.

30. The delegation noted the plans to complete the construction of a new three-storey block with a capacity of 180 beds; however, the management of the hospital were not in a position to say when the construction works would actually re-start (after the work had been suspended for some time) and, more importantly, when they would be completed.

31. Overcrowding was also evident in the exercise yards which, on most wards, were too small for the number of accommodated patients. Some of the exercise yards, if filled to capacity, only allowed 1.5 m² of personal space,[21] which meant that patients often just stood packed together instead of genuinely exerting themselves.

32. Conditions in the communal sanitary facilities were satisfactory. However, as a general rule, patients could use a shower only once a week; this is not sufficient.

33. **The Committee recommends that the Russian authorities take steps at Volgograd Federal Hospital to ensure that:**

- **every patient has his own bed and occupancy levels on the wards are reduced to provide patients with a living space provided for by the national legislation;**
- **patients have enough space to genuinely exert themselves physically during daily outdoor exercise;**
- **all patients have unrestricted access to a shower.**

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19 The dormitories on rehabilitation wards were not locked.

20 E.g. some 14 m² for 8 beds.

21 E.g. a yard measuring approximately 192 m² for 129 patients.

Further, **the CPT would like to receive information on steps being taken to complete the construction of the new accommodation block, including the allocated funding and intended date for its entry into service. Reference is also made to the recommendation in paragraph 27 above, which applies fully with respect to Volgograd Federal Hospital.**

c. Branch No. 2 of Volgograd Regional Psychiatric Hospital No. 2

34. At Volgograd Hospital Branch No. 2, patients were accommodated on four wards (in two two-storey buildings), with 40 to 60 beds each. The delegation was informed that renovation of two wards (i.e. Wards 1 and 2) in one of the buildings had been completed in 2018; the remaining two wards (i.e. Wards 3 and 4), though clean, bright and warm (as were the renovated wards), had run-down wooden floors, old windows and worn-out beds. The psychologist's office, attended by patients, was situated in a separate semi-abandoned building and was also in dire need of renovation.

Patient accommodation, although not overcrowded, consisted of large, rather austere and impersonal dormitories[22] without doors (for up to 13 patients) which did not provide patients with any privacy or personal lockable space and essentially contained only beds and sometimes a few cupboards per room.

35. **The Committee recommends that the Russian authorities take steps at Volgograd Hospital Branch No. 2 to ensure that:**

- **Wards 3 and 4, as well as the office of the psychologist, are fully renovated as a matter of priority;**
- **conditions in the rooms are conducive to the treatment and welfare of the patients and provide visual stimulation and personalisation;**
- **all patients are provided with personal lockable space in which they can keep their belongings.**

d. Krasnoarmeyskaya Regional Psychiatric Hospital

36. There were several multi-purpose buildings scattered around the grounds of Krasnoarmeyskaya Hospital; patients were accommodated in four of them, on eight wards with 65 to 90 beds each[23] – three wards for male patients, two for female patients, an addictions ward, a somato-psychiatric ward and a ward of specialised type, with a separate secure perimeter, for male patients receiving compulsory treatment. Two more wards were empty and undergoing renovation which was planned to be completed in the course of 2019.

Except for the addictions ward, where rooms had no more than 4 beds each, patients were accommodated in very large dormitories (containing up to 33 beds) without doors. As already

22 E.g. approximately 42 m² for 7 beds and 21 m² for 4 beds.
23 Except for the addiction rehabilitation ward which had only 30 beds.

mentioned (see paragraph 22 above), the wards were severely overcrowded, with nearly all the beds touching and sometimes with barely 2.1 m² of living space per patient, effectively the size of the bed upon which they lay. The bleak and austere dormitories with no decoration (such as photographs, pictures or plants) or personal belongings, contained only beds and sometimes a few cupboards; there was no individual lockable space.

37. Living conditions in psychiatric hospitals should be conducive to the treatment and welfare of patients; in psychiatric terms, they should provide a positive therapeutic environment. In the CPT's view, such large and overcrowded dormitories as those found in Krasnoarmeyskaya Hospital have a counter-therapeutic, institutionalising effect on patients, infringe upon their privacy and dignity and even compromise their safety. A situation where hundreds of patients live in such conditions without any privacy and personal space is unacceptable; when combined with the almost total lack of individualisation found in Krasnoarmeyskaya Hospital, where patients spend years in shared pyjamas, without personal possessions or any prospect of discharge,[24] it can only be described as dehumanising.

38. **The Committee recommends that the Russian authorities take urgent steps at Krasnoarmeyskaya Hospital to ensure that:**

- **occupancy levels are reduced to provide patients with a living space provided for by the national legislation;**

- **architectural solutions are found to split the dormitories into smaller units, which would allow for more individualised accommodation;**

- **conditions in the rooms are conducive to the treatment and welfare of the patients and provide visual stimulation and personalisation;**

- **all patients are provided with personal lockable space in which they can keep their belongings;**

- **all patients are allowed and encouraged to wear their own clothes in order to strengthen their sense of self-esteem and to benefit individualised treatment.**

Furthermore, **the CPT would like to receive confirmation that the renovation of the two wards mentioned in paragraph 36 above has now been completed; the Committee also wishes to receive detailed information about living conditions and the number of patients accommodated on these wards.**

[24] See also paragraphs 17 and 70.

4. Staff and treatment

39. Kazan Federal Hospital[25] employed 30 psychiatrists (among them, 14 heads of wards), two GPs, two neurologists, a physiotherapist, a radiologist, a laboratory doctor, and a chief nurse. The ward-based staff included 287 nurses (14 senior nurses plus 273 nurses of other grades) and 130 orderlies. As regards multi-disciplinary clinical staff, there were four psychologists, 18 social workers and 18 occupational therapy instructors.

The Director informed the delegation that many more staff posts were vacant – some 20% of doctors' posts (mostly for psychiatrists), about 30% of nurses' posts and more than 50% of orderlies' posts – and stated that such a staffing deficit was a major problem. The delegation noted that most of the staff worked on 12-hour shifts and that there would usually be two or three nurses and one orderly per shift,[26] which is grossly insufficient to provide adequate care, assistance and supervision and to ensure a safe environment on wards with an average of 60 patients.

40. Volgograd Federal Hospital[27] employed 19 psychiatrists, four other medical doctors (a radiologist, a pulmonologist and two laboratory doctors), 193 nurses (a small number of whom were also working as occupational therapists) and 209 orderlies; the establishment did not have a dedicated GP, that role was covered by the psychiatrists. Multi-disciplinary clinical staff included a psychotherapist, four psychologists and 15 social workers.

As at Kazan Federal Hospital, many more posts were vacant[28] and a number of staff worked on 2 or 3 posts. The 12-hour shifts on the wards comprised insufficient numbers of staff, e.g. four nurses and four orderlies on a ward with 129 patients.[29]

41. Volgograd Hospital Branch No. 2[30] employed 11 psychiatrists, a GP, a laboratory doctor, a physiotherapist, 85 nurses (with 51 more posts vacant) and 34 orderlies; further, there were two psychologists and a social worker but no occupational therapists.

The ward-based staff worked mostly 12-hour shifts (on some wards orderlies worked 24-hour shifts) and there would generally be two or three nurses and three or four orderlies per shift on a ward with approximately 50 patients.[31]

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25 With an official capacity of 1,020 beds.

26 From 9 a.m. to 5 p.m. on working days there was also a head nurse, a housekeeping nurse, and a procedure nurse.

27 With an official capacity of 710 beds.

28 For 19 psychiatrists, some 100 nurses, some 100 orderlies, 11 psychotherapists and 9 psychologists.

29 From 8 a.m. to 3 p.m. on weekdays they would also be supported by a head nurse, a housekeeping nurse and a procedure nurse.

30 With an official capacity of 195 beds.

31 From 8 a.m. to 3 p.m. on weekdays they would also be supported by a head nurse, a housekeeping nurse and a procedure nurse.

42. Krasnoarmeyskaya Hospital[32] employed seven psychiatrists, a half-time GP, a half-time neurologist, a half-time pulmonologist, 63 nurses and 119 orderlies (a number of posts were vacant, including for eight psychiatrists, some 40 nurses and 30 orderlies). Ward-based staff included two nurses and three orderlies working on 24-hour shifts on each ward (with approximately 90 patients), plus a head nurse and procedural nurse on working days. Other multidisciplinary clinical staff included a psychologist (working almost exclusively on the addictions ward) and 11 social workers.

43. The Committee has repeatedly stated in its reports on previous visits to the Russian Federation that staff resources in psychiatric hospitals should be adequate in terms of numbers and categories of staff (psychiatrists, general practitioners, nurses, psychologists, occupational therapists, social workers, etc.). Deficiencies in staff resources can seriously undermine attempts to offer rehabilitative and therapeutic activities; further, they can lead to high-risk situations for patients, notwithstanding the good intentions and genuine efforts of the staff in service.

Furthermore, the CPT considers it inappropriate for ward-based clinical staff to work on 24-hour shifts, as was the case at Volgograd Hospital Branch No. 2 and at Krasnoarmeyskaya Hospital.[33] Apart from being detrimental for the staff's own health, this does not allow staff to optimally perform their duties vis-à-vis patients and will inevitably have a negative effect on professional standards.

44. In the light of the above remarks, **the Committee recommends that the Russian authorities take urgent measures to address the serious recruitment difficulties regarding medical, ward-based and multi-disciplinary clinical staff at the hospitals visited (and, as applicable, in other psychiatric hospitals in the Russian Federation). This may well require a review of the salaries and terms and conditions offered to such personnel to ensure that the necessary numbers of staff of appropriate quality are deployed to properly care for patients and thus offer the necessary full range of modern psychiatric therapies.**

Further, **steps should be taken to put an end to the practice of ward-based clinical staff working 24-hour shifts in psychiatric hospitals.**

Finally, **the management of Volgograd Federal Hospital should take urgent measures to fill the vacant post of a general practitioner.**

45. The delegation noted that security staff at Kazan and Volgograd Federal Hospitals were provided by the Federal Penitentiary Service (FSIN); there would usually be one guard present on each ward.[34] Although the guards wore white coats over their uniforms (and were only visibly carrying truncheons in Volgograd Federal Hospital), patients were well aware of the presence of the FSIN staff.

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32 With an official capacity of 610 beds.

33 It was not the practice at federal specialised psychiatric hospitals with intensive supervision.

34 Krasnoarmeyskaya Hospital employed two guards from a private company, one based at the entrance of the forensic ward for male patients and another covering the entire outside territory; they had no access to patient accommodation areas and had no "special means".

Whilst recognising that adequate security must be maintained when caring for potentially dangerous psychiatric patients and realising that clinical staff may need to call upon nearby FSIN staff in the case of an untoward incident (and that FSIN staff might then intervene, in the presence of and in consultation with qualified clinical staff), the core security in clinical areas of a health-care facility should be provided by clinical staff, utilising appropriate environmental and dynamic security means. The routine presence of FSIN guards, not just on the perimeters but actually within the clinical areas of a health-care facility, is unnecessarily intimidating to patients and not conducive to the establishment of a therapeutic environment.

The CPT recommends that the visible carrying of truncheons by FSIN guards be stopped immediately within the clinical areas of Volgograd Federal Hospital and, as applicable, in other federal specialised psychiatric hospitals with intensive supervision.

More generally, **the Committee recommends that the practice of having FSIN guards routinely present in clinical areas of federal specialised psychiatric hospitals with intensive supervision be phased out; this may require amendment of relevant provisions of the Federal Law on Ensuring Security of Psychiatric Hospitals of Specialized Type with Intensive Supervision and/or development of new inter-ministerial protocols on the subject.**

46. Turning to treatment, in all the hospitals visited it was predominantly based on pharmacotherapy and was not patient-centred. Newer generation psychotropic medication was unfortunately not widely available in any of the hospitals and was completely absent at Krasnoarmeyskaya Hospital, due to financial constraints. **The CPT encourages the Russian authorities to strive to provide an adequate supply and range of newer generation psychotropic medication for patients at Krasnoarmeyskaya Hospital and, as applicable, in other psychiatric establishments in the Russian Federation.**

47. The delegation was concerned to note that there was no systematic monitoring of the white blood cell count of patients treated with Clozapine, which can have as a side-effect a potentially lethal reduction of white blood cells (granulocytopenia). Therefore, **the Committee recommends that the Russian authorities take urgent steps to ensure that a protocol on the mandatory monitoring system of the white blood cell count of patients treated with Clozapine be drawn up at the national level. Further, health-care staff should be alert to the early signs of the potentially lethal side effects of Clozapine.**

48. Regarding psychosocial treatment, with the exception of Volgograd Federal Hospital[35] it was offered to a small minority of patients or was even completely absent; this was linked with totally inadequate multi-disciplinary clinical staffing levels.[36] As a result, many patients were seen lying idly, some in locked and overcrowded dormitories, or wandering around with no rehabilitative input and no meaningful activity. Such an approach to psychosocial interventions is neglectful and does not reflect modern psychiatric practice.

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35 Where a number of activities were on offer (e.g. a karaoke club on the admission ward, an art studio on Ward 2, a folklore group on Ward 3, a humour and satire studio on Ward 4, a circus studio on Ward 5, a theatre studio on Ward 6, a music studio on Ward 7, and a dance-musical studio on Ward 8). During the winter, competitions of board games and table tennis were organised. Further, in the spring and in the summer, patients could participate in volleyball, basketball and mini-football competitions.

36 See paragraphs 39 to 42 above.

Furthermore, there were only very limited recreational opportunities, for example at Kazan Federal Hospital and in parts of Volgograd Federal Hospital there were no radio or TV sets in many of the locked dormitories; as for Krasnoarmeyskaya Hospital, there was only a seating area for 10 patients to watch a single TV set on a ward with over 90 patients.[37]

The situation was made even more unacceptable at Volgograd Hospital Branch No. 2 and Krasnoarmeyskaya Hospital by the fact that patients had no access to outdoor exercise for more than six months of the year (approximately from September to May).[38] A female patient under compulsory treatment at Krasnoarmeyskaya Hospital had not been allowed to go outside since her arrival at the hospital some 19 months earlier, allegedly due to the risk of escape.[39]

49. **The CPT recommends that the Russian authorities take the necessary steps to:**

- **ensure that all patients, including involuntary and forensic patients, at Volgograd Hospital Branch No. 2 and Krasnoarmeyskaya Hospital (and, as appropriate, in other psychiatric hospitals in the Russian Federation) have daily access to meaningful outdoor exercise (unless there are clear medical contraindications). To this end, appropriate clothing and footwear should be made available to patients who wish to take outdoor exercise in inclement weather;**

- **develop, at Kazan Federal Hospital, Volgograd Hospital Branch No. 2 and Krasnoarmeyskaya Hospital, a range of therapeutic options (including group therapy, individual psychotherapy, art, drama, music and sports) and involve patients in clinically appropriate rehabilitative psychosocial activities, in order to prepare them for more independent living and/or return to their families; occupational therapy should be an important part of the long-term treatment programme, providing for motivation, development of learning and relationship skills, acquisition of specific competences and improvement of self-image.**

  It is axiomatic that this will require the recruitment of specialists qualified to provide therapeutic and rehabilitation activities (psychologists, occupational therapists, and social workers);[40]

- **ensure that all patients are offered a range of recreational activities suited to their needs; moreover, patients should have regular access to suitably-equipped recreation rooms.**

50. In all hospitals visited (with the exception of a very small number of re-hospitalised patients in Volgograd Federal Hospital) individual treatment plans contained only biological components of therapy (e.g. pharmacotherapy and/or electroconvulsive therapy).

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37 On some wards, patients were seated on a bench in the corridor, watching TV through the glass side of the nurses' room.

38 By contrast, access to outdoor exercise was guaranteed at Kazan and Volgograd Federal Hospitals throughout the year, except on extremely cold days. See, however, paragraph 31 above as regards exercise yards at Volgograd Federal Hospital.

39 Male patients under compulsory treatment were placed on a dedicated ward, which had its own secure exercise yard.

40 See the recommendation in paragraph 44 above.

In the Committee's view, psychiatric treatment should be based on an individualised approach which would cover both pharmacotherapy and psychosocial activities. An individual treatment plan should be drawn up for each patient (taking into account the special needs of acute, long-term and forensic patients including, with respect to the last-mentioned, the need to reduce any risk they may pose), indicating the diagnosis, the goals of treatment, the therapeutic means used and the staff member responsible, with timescales. The treatment plan should also ensure regular review of the patient's mental health condition and a review of the patient's medication. Patients should be informed of their individual treatment plans and progress; further, they should be involved in the drafting and implementation of these plans.

For patients accommodated in acute wards, the plans should clearly address the patient's immediate needs and identify any risk factors, as well as focus on treatment objectives and how in broad terms these will be achieved. For patients placed in the rehabilitation wards, the plans should identify early warning signs of relapse and any known triggers, and an action plan that a patient and family members should take in response to relapse. The plan should also specify the follow-up care.

The CPT recommends that the Russian authorities take urgent measures to ensure that the aforementioned precepts are effectively followed in practice as regards patients in all psychiatric hospitals in the Russian Federation where this is not yet the case.

51. At Kazan Federal Hospital, the delegation noted that courses of bilateral electroconvulsive therapy (hereafter – ECT) were being administered to patients on some wards to treat "acute schizophrenia". ECT was administered out of sight of other patients in a separate room. However, the delegation was extremely concerned to learn that the ECT was being administered in an unmodified form, without the presence of an anaesthesiologist and administration of anaesthetic, despite the CPT's recommendation to the Russian authorities to cease this practice made almost 20 years ago.[41] The medical staff interviewed by the delegation acknowledged that the ECT thus administered was very painful for the patients concerned.

52. As already mentioned in paragraph 8 above, at the end of the visit the delegation invoked Article 8, paragraph 5, of the Convention and requested the Russian authorities to confirm, within one month, that the administration of unmodified ECT has ceased in all psychiatric hospitals of the Russian Federation.

[41] See paragraph 212 of the report on the 1999 visit (CPT (2000)7).

Unfortunately, in their letter dated 28 December 2018, the Russian authorities have not provided such a confirmation. That said, the authorities informed the CPT that in the Russian Federation, administration of ECT was regulated by two orders of the Minister of Healthcare both of which provide for administration of ECT with anaesthesia.[42] Furthermore, according to the Russian authorities, the Russian Society of Psychiatrists also recommends administration of ECT with anaesthesia.[43] However, the authorities went on to state that ECT without anaesthesia can be administered in extraordinary cases when there are urgent indications and other methods of treatment are ineffective. The Committee was also informed that the Ministry of Healthcare would carry out an inspection at Kazan Federal Hospital regarding the use of unmodified ECT.

53. In the light of the above-mentioned response by the Russian authorities, the CPT must stress once again that – while ECT is a recognised form of treatment for psychiatric patients suffering from some particular disorders – care must always be taken that it fits into the patient's treatment plan and its administration must be accompanied by appropriate safeguards. In particular, the administration of ECT in its unmodified form (i.e. without anaesthetic and muscle relaxants) can no longer be considered as acceptable in modern psychiatric practice. The use of this out-dated method entails a heightened risk of emotional distress for the patient, the unnecessary infliction of pain and undesirable medical complications. In the CPT's view, the administration of ECT in unmodified form can raise issues under Article 3 of the European Convention on Human Rights.

The Committee calls upon the Russian authorities immediately to discontinue the practice of unmodified ECT (i.e. without an anaesthetic and muscle relaxants) at Kazan Federal Hospital as well as in any other psychiatric establishment in the Russian Federation where this method is still employed. It requests that the Russian authorities confirm <u>within one month</u> that, in accordance with the relevant regulations of the Ministry of Healthcare, this recommendation has been implemented.

More generally, **the CPT recommends that the Russian authorities accord a high priority to ensuring that all psychiatric establishments in which ECT is used are provided with the necessary staff, equipment and facilities so that this treatment can be administered in its modified form (i.e. with both an anaesthetic and muscle relaxants) and in an effective and dignified manner.**

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42 Order No. 1233 of 20 December 2012 and Order No. 1400 of 24 December 2012.

43 The Russian authorities also informed the CPT about the methodological recommendations "Electroconvulsive therapy in modern treatment of psychiatric disorders in the Russian Federation: indications and safety" that are currently being drafted by the Bekhterev Psychoneurological Research Institute and the Sechenov Institute of Evolutionary Physiology and Biochemistry of the Russian Academy of Sciences.

54. Moreover, with a view to ensuring that ECT is only used for the proper indications and is carried out in an appropriate manner**, the Committee recommends that clear, detailed and binding written rules on recourse to ECT be elaborated and distributed to each establishment where this treatment is used and that they include the following safeguards:**

- **ECT is administered only by staff who have been specifically trained to provide it;**

- **a fully qualified anaesthesiologist, appropriate physical monitoring (including electroencephalography and electrocardiography), and resuscitation equipment is present throughout;**

- **the written informed consent of the patient (or of the guardian, if the person concerned is deprived of legal capacity by a court) to the use of ECT and the associated anaesthesia, based on full and comprehensible information, is sought and kept in the patient's file and, save for exceptional circumstances clearly and strictly defined by law, the treatment is not administered until such consent has been obtained on the occasion of each treatment in the course;**

- **ECT is administered out of the view of other patients (preferably in a room which has been set aside and equipped for this purpose);**

- **recourse to ECT is recorded in detail in a specific register and is a part of a written individual treatment plan included in the patient's medical record.**

Furthermore, **the CPT would like to be informed of which legal act of the Russian Federation provides for administration of unmodified ECT in extraordinary cases.**

Finally, **the Committee would like to receive the results of the inspection at Kazan Federal Hospital, including the names of the patients who were administered unmodified ECT and, as regards each individual patient, the number and frequency of treatments administered and what other treatments had been tried in these patients and what were the indications for ECT to be applied urgently as a result of previous treatment failure.**

55. Regarding the somatic care of psychiatric patients, the CPT was particularly concerned to learn that patients with HIV infection at Kazan Federal Hospital had not been provided with anti-retroviral medication since 2016, allegedly due to a miscommunication between the relevant federal and regional authorities. **The CPT recommends that urgent measures be taken to ensure that adequate somatic care is provided to these patients.**

56. The delegation also noted that deaths occurring at Krasnoarmeyskaya Hospital[44] were not subjected to any post-mortem examination if the family objected to this. In the Committee's opinion, an autopsy should be carried out in all cases where a patient dies in a psychiatric hospital, unless a clear diagnosis of a fatal disease has been established prior to death.

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44 34 deaths in 2017 and 25 in 2018.

The CPT recommends that the Russian authorities take measures to ensure that the aforementioned principles are effectively implemented in practice in all psychiatric hospitals. More generally, **the Committee recommends that the Russian authorities institute a practice of carrying out a thorough and independent inquiry into every death of a patient, in particular with a view to ascertaining whether there are lessons to be learned as regards care quality and operational procedures.**

57. The CPT has a number of concerns regarding the allocation of psychiatric patients in the hospitals visited.

At Krasnoarmeyskaya Hospital, in one dormitory of a mixed-sex ward for somato-psychiatric patients, a small number of male patients were being accommodated with a majority of female patients. In the Committee's view, the clear benefits of a mixed-sex ward should not be to the detriment of privacy. Special precautions are required to ensure that patients are not subjected to inappropriate interaction with other patients which threaten their privacy; in order to maintain their dignity, male and female patients should be accommodated in gender-specific dormitories.

At Kazan Federal Hospital there was one patient aged 16 and at Volgograd Hospital Branch No. 2 two patients aged 15 and 16, all three accommodated with adult patients. It is noteworthy that the CPT repeatedly expressed its concerns regarding this practice, for the first time as early as almost 20 years ago.[45] The Committee must reiterate once again that in view of their vulnerability and special needs, juveniles requiring psychiatric care should be accommodated separately in establishments with facilities suited to their age, which have staff especially trained to cope with the psychiatric needs of young persons.

Lastly, in all the hospitals visited, patients with a learning disability were accommodated together on the same wards or even in the same dormitories with mentally ill patients. The CPT has on many occasions expressed its serious misgivings about this practice. There should be stratification of patients separating those suffering from mental illnesses from those suffering from learning disabilities, accommodating them on different wards, so that both categories benefit from tailored individualised treatment.

The Committee calls upon the Russian authorities to take urgent measures to ensure that the aforementioned precepts are effectively implemented in practice as regards patients in all psychiatric hospitals in the Russian Federation where this is not yet the case; the relevant legal provisions should be amended as necessary.

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[45] See paragraph 142 of the report on the 2000 visit (CPT (2001) 2) and paragraph 136 of the report on the 2001 visit (CPT/Inf (2003) 30).

5. Seclusion and other means of restraint

58. Seclusion was used in the two federal hospitals visited by the CPT. On the intensive care wards of both hospitals, patients were sometimes spending months or even years[46] alone in very small bare rooms as narrow as 1.1 m (at Kazan Federal Hospital) and 1.3 m (at Volgograd Federal Hospital), with the total floor space of 3.7 – 4.7 m² (making it impossible to even pace around inside), with almost no daylight and the artificial lighting switched on 24 hours a day (which some found disorientating). Some patients in seclusion with whom the delegation spoke were visibly distressed and asked the delegation to help them leave, saying they could not bear the solitude any longer. Patients were also sometimes mechanically restrained (with 4- or 5-point fixation) to the beds in these rooms.

At Kazan Federal Hospital, patients in seclusion had no access to a toilet (having instead to use a bucket placed in the corner of the room[47]); at Volgograd Federal Hospital, there was a small unscreened floor-level toilet in the corner of the room near the barred gate door. In addition to having no or almost no access to outdoor exercise and to being prevented from any physical exercise inside the rooms, some patients in both hospitals were not even given a toothbrush or a spoon (thus being forced to eat with their hands) for months or even years.

In short, the conditions in which patients were placed in seclusion at Kazan and Volgograd Federal Hospitals did not befit a health-care institution and amount, in the CPT's view, to inhuman and degrading treatment.

59. The Committee has stressed many times in the past that placement in a seclusion room without appropriate accompanying safeguards may have an adverse result.[48] Seclusion must be very carefully applied and should only be a measure of last resort and for the shortest possible period; it should not be resorted to because there is a lack of alternative strategies, staff and regime provision.

The CPT is also of the view that, although resort to seclusion in high security hospitals may well be required for safety reasons (and the two federal hospitals visited had seemingly no immediate alternative), the use of the current seclusion rooms must be phased out and replaced with humane and adequate conditions for seclusion as soon as possible. Further, patients should not be prevented from using toothbrushes, cutlery or outdoor/indoor exercise, other than for short periods if required by their mental or physical state. At other times such basic amenities should be permitted, with additional staff supervision if indicated.

60. It was apparent from discussion with clinical staff in the intensive care wards of the two federal hospitals visited, that the reason a small number of patients[49] were being held there in seclusion rooms for very long periods was because they were deemed to be highly treatment resistant and were presenting a long-term, immediate and very serious danger to others in their vicinity.

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46 One of the patients interviewed by the delegation said that he had been in seclusion for the past two and a half years; this was later confirmed by the Head doctor of the ward.

47 A bucket with faeces was allegedly taken out quickly; a bucket with urine would apparently only be changed when full.

48 See also the recommendations in paragraph 64 below.

49 Less than five in each hospital.

In the Committee's view, although resort to long-term preventative individual segregation of such patients in high security hospitals may exceptionally be required for safety reasons after a period of seclusion, such an intervention must only be initiated for clinically sound reasons, based on clear risk-based criteria, rigorously monitored and reviewed and have in place special arrangements to compensate for the detrimental long-term isolating effects on patients undergoing such a measure.

61. **The Committee recommends that the Russian authorities take urgent measures to guarantee humane and dignified conditions for seclusion and long-term preventative individual segregation at Kazan and Volgograd Federal Hospitals, including steps to ensure that every patient thus held:**

- **has unimpeded access to toilet facilities without undue delay at all times (including at night);**

- **is offered daily outdoor exercise (unless there are clear medical contraindications);**

- **is provided with cutlery and a toothbrush, with additional staff supervision if indicated.**

Further, **the CPT recommends that the Russian authorities take out of service the current totally inappropriate seclusion rooms and replace them with specially designed rooms for seclusion and long-term preventative individual segregation which would provide a safe and calming environment for the patient as well as a living space provided by the national legislation. The Committee would like to be informed about the timeline of the aforementioned taking out of service within one month.**

Finally, **the CPT requests the Russian authorities to ensure that greater efforts are made to limit the use of seclusion to a matter of hours while a patient's acute disturbance settles and that if a patient, very exceptionally, has still not sufficiently improved after a period of some days in seclusion and requires long-term preventative individual segregation in order to manage treatment resistant, long-term, immediate and very serious risks to others in the vicinity, steps are taken to ensure that:**

- **the reasons for initiating and continuing the long-term segregation are medically authorised and justified, involve multi-disciplinary clinical input, are risk-based and are fully recorded in the patient's personal file as part of the individual care plan, which should also include, in addition to medication, the psychosocial therapies that will be offered to the patient;**

- **there is a clearly described planned pathway, formulated in consultation with the patient, which defines how attempts will be rigorously made to re-integrate the patient back into full association with others in a less restrictive environment, as soon as possible;**

- **the patient has regular, meaningful, daily, face-to-face human contact, opportunities to participate in meaningful activities, (including recreational, with access to reading material and radio or TV) and possibilities to maintain contact with the outside world via visits or telephone;**

- **staff monitor and record the patient's state on a daily basis and continuation of the long-term segregation is reviewed and justified by a multi-disciplinary team and recorded on at least a weekly basis;**

- **should the period of preventative individual segregation still be occurring after some months, there is a formal independent, external clinical review of the patient's case to consider possible alternative approaches;**

- **the patient concerned has the possibility to appeal against the imposition/prolongation of the measure to an independent authority;**

- **a separate register is established to record all instances of long-term preventative individual segregation. The entries in the register should include the time at which the measure began and ended; the reasons for resorting to the measure; daily entries by the staff on the clinical review of the patient's state, time out of the room, activities offered and taken; weekly entries on the review by a multi-disciplinary team.**

Additionally, every psychiatric establishment concerned should have a comprehensive, carefully developed written policy on the use of long-term preventative individual segregation.

62. Mechanical restraint of patients (using canvas straps) was practised in all the hospitals visited. However, despite written guidelines on the use of means of restraint in these hospitals, internationally accepted proper practice regarding mechanical restraint was not followed, to differing degrees, in all four establishments. Sometimes at Volgograd Federal Hospital and in all cases in the two "civilian" hospitals, patients were restrained in dormitories or corridors in front of other patients, and, apart from Volgograd Hospital Branch No. 2, did not benefit from continuous personal supervision by staff to respond to any immediate needs of the patient.

The Committee wishes to reiterate its view that restraint should not occur in view of other patients (which is undignified, potentially unsafe and may be threatening to other patients) or without continuous personal supervision by a member of staff. Locking a restrained and agitated fixated patient alone in a room, as practised at Kazan Federal Hospital, is not acceptable.

At Krasnoarmeyskaya Hospital, there were not even any registers recording the use of mechanical restraint; such restraint could, at times, be applied at a nurse's discretion without immediate prior authorisation by a doctor and might only be recorded very superficially in the nurse's book or patient's clinical file, if at all.

63. Although in three of the four hospitals visited mechanical restraint was generally not applied for unduly long periods, it was of particular concern that, at Kazan Federal Hospital, patients were subjected to four/five-point fixation for days on end without any release, alone in seclusion rooms.[50] Several patients with whom the delegation spoke, and who had been subjected to such lengthy measures, told the delegation that they had refused to be fed as they found it too challenging to defecate into a bedpan while being fixed horizontally. Patients explained that after a few days of not being able to defecate, their abdomens would swell and become very painful.

One younger male patient who told the delegation he had recently been restrained for a week was found, on medical examination by one of the delegation's doctors, to have a number of bed sores on his sacral area.

In the light of the above findings, the CPT must emphasise that applying means of restraint for days on end endangers the patient and cannot have any medical justification, and amounts, in its view, to ill-treatment. Furthermore, patients under mechanical restraint should, as far as possible, be enabled to eat and drink autonomously and to comply with the needs of nature with dignity in a sanitary facility.

64. The restraint[51] of violent psychiatric patients who represent a danger to themselves or others may exceptionally be necessary. However, it should always be applied in accordance with the principles of legality, necessity, proportionality and accountability.[52]

The Committee recommends that the Russian authorities take urgent steps to modify the current practice of the use of means of restraint at the psychiatric hospitals visited and, as applicable, in all other psychiatric establishments in the Russian Federation so as to ensure that:

- **patients are only restrained as a measure of last resort, to prevent imminent harm to themselves or others, and restraints are always used for the shortest possible time (usually minutes to a few hours). When the emergency situation resulting in the application of restraint ceases to exist, the patient should be released immediately;**

- **if it is deemed necessary to restrain a voluntary patient and the patient disagrees, the legal status of the patient is reviewed;[53]**

- **means of restraint are never used as punishment, for convenience, because of staff shortages or to replace proper care or treatment;[54]**

- **every resort to means of restraint is always expressly ordered by a doctor after an individual assessment, or immediately brought to the attention of a doctor with a view to seeking his/her approval. To this end, the doctor should examine the patient concerned as soon as possible. No blanket authorisation should be accepted;**

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50 See paragraph 58 above. According to the dedicated register on Ward 2, there had been 22 episodes of restraint in the period between 1 January and 1 September 2018, some of them lasting 44, 46 or even 67 hours.

51 I.e. seclusion, physical and mechanical restraint; for chemical restraint, see paragraph 65 below.

52 See also "Means of restraint in psychiatric establishments for adults (Revised CPT standards)", document CPT/Inf (2017) 6, https://www.coe.int/en/web/cpt/means-of-restraint-psychiatry.

53 See paragraph 70 below.

54 See paragraphs 19 and 66.

- **patients are not subjected to mechanical restraint in view of other patients (unless the patient explicitly expresses a wish to remain in the company of a certain fellow patient); visits by other patients should only take place with the express consent of the restrained patient;**

- **every patient who is subjected to mechanical restraint or seclusion is subjected to continuous supervision. In the case of mechanical restraint, a qualified member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide him/her with assistance. If patients are held in seclusion, the staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous staff presence;**

- **once means of restraint have been removed, a debriefing of the patient takes place, both to explain to the patient why they have been subjected to restraint and to offer the patient an opportunity to explain his/her emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of his/her behaviour;**

- **a specific central register is established to record all instances of recourse to means of restraint in order for the management to be able to monitor their use. This is in addition to the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this entitlement; at their request, they should receive a copy of the full entry.**

Furthermore, **steps should be taken to ensure that existing written guidelines on the use of means of restraint in the hospitals visited by the CPT are amended to include the requirements listed above. Such guidelines should be aimed at preventing as far as possible the resort to means of restraint and should make clear which means of restraint may be used, under what circumstances they may be applied, the practical means of their application, the supervision required and the action to be taken once the measure is terminated. The guidelines should also contain sections on other important issues such as staff training, complaints policy, internal and external reporting mechanisms, and debriefing. Patients should be provided with relevant information on the establishment's restraint policy.**

The frequency and duration of instances of restraint should be reported on a regular basis to a supervisory authority and/or a designated outside monitoring body. This will facilitate a national overview of existing restraint practices, with a view to implementing a strategy of limiting the frequency and duration of the use of means of restraint.

65. The delegation noted that chemical restraint[55] was used in all the hospitals visited, often in combination with other restraint measures. Although at Volgograd Hospital Branch No. 2, resort to chemical restraint was recorded in the restraint register when it was used in combination with mechanical restraint, appropriate safeguards (see paragraph 64 above) were not fully followed in any of the hospitals. Indeed, at Krasnoarmeyskaya Hospital the delegation observed the use of PRN prescriptions of identical doses of injectable Aminazine;[56] on one ward this was authorised by the doctor, by means of a list, to be given to 75 out of the 96 patients solely at the nurses' discretion. Needless to say, such a practice is totally unacceptable.

The Committee wishes to emphasise once again that if recourse is had to chemical restraint such as sedatives, antipsychotics, hypnotics and tranquillisers, it should be subject to appropriate safeguards. Only approved, well-established and short-acting drugs should be used. Most importantly, chemical restraint should never be applied without the prior authorisation of a doctor who has assessed the patient immediately before the medication is administered.

The side-effects that such medication may have on a particular patient need to be constantly borne in mind, particularly when medication is used in combination with mechanical restraint or seclusion. Further, patients subjected to mechanical restraint should never be medicated without consent, except in situations where they may be in danger of suffering serious health consequences if medication is not administered and then only with appropriate safeguards.

The CPT reiterates its recommendation that the Russian authorities take the necessary measures to ensure that the above-mentioned principles are respected in all psychiatric establishments; the relevant legal provisions should be amended as necessary.

66. At Kazan Federal Hospital, the delegation gained the impression that many patients did not regard the use of seclusion or mechanical/chemical restraint as a short-term, last-resort intervention to necessarily and safely manage an acute episode of a disturbed mental state and related behaviour within an overall therapeutic context, but as a potential and threatening punishment for infringement of their ward's formal rules and informal codes of approved behaviour.[57] It appeared that staff were not working to dispel such a belief, thus perhaps perpetuating the threat of restraint as a means of controlling the behaviour of patients in their charge and thereby reinforcing its perception as a punitive measure. The same situation appeared to prevail on the ward for compulsory treatment at Krasnoarmeyskaya Hospital.

Whilst acknowledging that order must be maintained on wards accommodating large numbers of potentially dangerous forensic psychiatric patients, the Committee wishes to stress that a fuller range of more therapeutic non-punitive approaches should be employed to achieve this (as was indeed attempted at Volgograd Federal Hospital), such as offering psychosocial interventions, rewards and counselling to patients, in a co-productive spirit, to help them understand the benefits and consequences to themselves and others of prosocial behaviour when feeling challenged and assisting them psychosocially to learn alternative strategies to achieve that.

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55 I.e. forcible administration of medication for the purpose of controlling a patient's behaviour.

56 A sedative anti-psychotic medication.

57 For example, for having a fight with another patient, for not taking the medication, for masturbating in private.

The CPT recommends that the managements of Kazan Federal Hospital and Krasnoarmeyskaya Hospital develop the clinical practice in their forensic psychiatric environments and employ a wider range of more psychosocial methods to positively influence patients' behaviour, so that the punitive threat of means of restraint is no longer necessary and restraint is only used clinically appropriately and in strict and transparent compliance with the national legislation.[58]

6. Safeguards

67. The legal framework governing compulsory psychiatric treatment (for forensic patients) and involuntary "civil" hospitalisation has remained basically unchanged since the 2016 periodic visit.[59]

It should be recalled that the procedures for the compulsory treatment[60] of persons found to be criminally irresponsible for their acts or who develop a mental illness in the period after committing a crime (i.e. forensic patients) are regulated by Sections 433 to 446 of the CCP as well as the Law on Psychiatric Care (LPC). Compulsory treatment is applied when a person's mental disorder is associated with a danger to him/her or others or a possibility of causing other significant harm.

Section 97 of the Criminal Code (CC) provides that the placement of such persons in a psychiatric establishment is decided by a court, which also specifies the type of regime (hospital of general type or specialised type, or specialised type with intensive supervision) to which the person concerned is to be subjected (Section 99 of the CC).

The prolongation, modification or termination of compulsory treatment is decided by a court at the request of the hospital administration based on the recommendation made by a commission of psychiatrists, or at the request of the patient, his/her lawyer or legal representative (Section 445 of the CCP). During hospitalisation, the examination by a commission of psychiatrists should be performed not less than once every 6 months (when initiated by a treating doctor); further, the patient him/herself, his/her relatives or legal representative may request it at any time.

68. On the basis of interviews with patients and staff and the examination of patients' files in the three hospitals accommodating patients under compulsory treatment,[61] the delegation gained the impression that patients did attend the hearings of hospital commissions every 6 months and – at Kazan Federal Hospital – could attend the court hearings (held on the hospital's premises) and were then represented by *ex officio* lawyers. By contrast, at Volgograd Federal Hospital and at Krasnoarmeyskaya Hospital, patients' appearance before the court seemed to be discouraged by staff and occurred only extremely rarely; furthermore, patients were not allowed to see the psychiatric commissions' reports.

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58 According to Section 30 of the Law on Psychiatric Care, physical restraint and seclusion should be applied only in those cases, forms and for such a duration when, in the psychiatrist's opinion, it would be otherwise impossible to prevent actions by a patient which pose immediate danger to him/herself or others.

59 See paragraphs 150 to 152 of document CPT (2017) 33.

60 "Принудительное лечение" (*prinuditelnoye lecheniye*) in Russian.

61 Kazan Federal Hospital, Volgograd Federal Hospital and Krasnoarmeyskaya Hospital (the latter with a dedicated secure ward for male patients under compulsory treatment).

In the Committee's view, a patient's appearance before the court (with the presence of a legal representative and family if requested) so that the hospital commission's view can be explored and potentially challenged is an important safeguard enshrined in the law; it should be easily accessible to patients. Patients should also be able to access medical information (such as their medical notes) and clinical reports written about them.[62] **The CPT recommends that the Russian authorities take the necessary measures to ensure that the above-mentioned principles are respected when reviewing the further necessity of compulsory treatment.**

69. Pursuant to Section 29 of the LPC, a "civil" patient may be involuntarily admitted[63] to a psychiatric hospital if his/her assessment or treatment is only possible in hospital conditions and he/she is suffering from a serious psychiatric disorder, and when one of the following conditions is met: a) the person represents an immediate danger to him/herself or others; b) the person is helpless, i.e. not in a position to satisfy independently his/her basic needs; c) failure to hospitalise the person would be detrimental to his/her health.

Within 48 hours of admission the patient must be examined by a commission of psychiatrists (Section 32 of the LPC). If the commission decides that there are grounds for hospitalisation, the commission's conclusion must be referred to a competent court within a further 24 hours by the administration of the hospital or by the prosecutor (upon receiving the request for involuntary hospitalisation, the court sanctions the hospitalisation until such a request is considered). Pursuant to Section 34 of the LPC, the court must be convened within 5 days following the request for involuntary hospitalisation. The patient has the right to appear at the court hearing (in court or in the hospital), the presence of a representative of a hospital, a prosecutor and a representative of a patient is mandatory. Further, the court's decision may be appealed against within 10 days of its notification.

Under Section 36 of the LPC, involuntary hospitalisation must end as soon as the circumstances which prompted it cease to apply. During the first six months in hospital, the patient must be examined at least once a month by a commission of psychiatrists which decides whether to extend the hospitalisation. Extension of a patient's hospitalisation beyond the six-month limit requires a new court hearing. Subsequently, the commission of psychiatrists reviews the patient's condition at least once every 6 months, and the court convenes once a year in order to decide whether to extend hospitalisation.

70. It became clear during the visits to Krasnoarmeyskaya Hospital and Volgograd Hospital Branch No. 2 that many patients who had signed consent to the hospitalisation forms and were still deemed voluntary were nevertheless not truly consenting to their hospitalisation. Indeed, it was remarkable that only 1.5% of the patients accommodated in these two hospitals (10 of the 165 at Volgograd Hospital Branch No. 2 and none of the 527 at Krasnoarmeyskaya Hospital) were *de jure* involuntarily hospitalised under the LPC. However, many of those so-called "voluntary" patients clearly stated to the delegation that they were not giving informed consent to their continuing hospitalisation and treatment.[64]

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62 With third party information redacted as appropriate.

63 "Недобровольная госпитализация" (*nedobrovolnaya gospitalizatsiya*) in Russian.

64 Numerous "voluntary" patients approached the delegation's members in tears, asking to be released or at least be allowed to have a "holiday" outside the hospital; others were grimly stating that they were "life-sentenced" and would not be allowed to leave the hospital until their death.

Such "voluntary" patients were thus *de facto* detained and some were often not even allowed to leave the ward to exercise in the grounds, let alone exit the hospital, having, for example, been labelled as "prone to escape" in clinical records. Further, such "voluntary" patients had sometimes been given forced medication and had been mechanically restrained.[65] Many patients had seemingly succumbed to paternalistic control by staff.[66]

Further, for the small number of formally involuntary patients at Volgograd Hospital Branch No. 2 there were significant delays in the court providing the hospital with its written decisions confirming involuntary hospitalisation (e.g. over one month).

71. **The Committee reiterates its recommendation that the Russian authorities take effective steps to ensure that the provisions of the LPC concerning "civil" involuntary psychiatric hospitalisation are fully implemented in practice. The Russian authorities must also ensure that proper information and relevant training on this subject is given, as a matter of priority, to all structures and persons involved (in particular, psychiatrists, hospital management and judges) in the Russian Federation.**

Further, **the CPT reiterates its recommendation that persons admitted to psychiatric establishments be provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation, and on the possibility to withdraw their consent subsequently. Moreover, patients deemed to be voluntary and legally competent should be informed of their right to leave the wards whenever they want, including departing the institution without delay should they wish to discharge themselves. When involuntary hospitalisation is confirmed by the court, the patient and hospital should receive the decision speedily and in writing.**

As regards more specifically Krasnoarmeyskaya Hospital and Volgograd Hospital Branch No. 2, the Committee recommends that the legal status of all patients currently considered as "voluntary" be urgently reviewed by an independent external authority which ensures that consent to hospitalisation is a fully informed decision, including providing the patients with information on safeguards guaranteed to involuntary patients by the law.

72. Pursuant to Section 11 of the LPC, the treatment of a person suffering from a psychiatric disorder is carried out when there is free and informed consent to such treatment. However, paragraph 4 of this Section provides that consent is not required for the treatment of forensic or "civil" involuntary patients. The treatment of such patients is provided based on the decision of a commission of psychiatrists.

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65 On this latter aspect, see the recommendation in paragraph 64 above.

66 When asked when they thought they could leave the hospital, "voluntary" patients provided replies such as "when my mother and doctor decide", "when my brother takes me", "when doctors will say I do not need treatment anymore", etc.

The CPT wishes to stress once again that every patient, whether voluntary or involuntary, should, as a matter of principle, be placed in a position to give their free and informed consent to treatment as well as to withdraw it at any time. The admission of a person to a psychiatric establishment on an involuntary basis – whether in the context of civil or criminal proceedings - should not preclude seeking informed consent to treatment. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances.

Moreover, the relevant legislation should require an external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the establishment's doctors; further, patients should be able to appeal against a compulsory treatment decision to an independent outside authority and should be informed in writing of this right.

The Committee reiterates its recommendation that the Russian authorities amend the relevant legal provisions to ensure that the above-mentioned precepts are effectively implemented in practice.

73. As regards patients' contact with the outside world, they were not allowed to keep their mobile phones with them and access to a telephone was very limited or even not possible at all in the hospitals visited.[67]

The CPT considers that allowing patients to retain their mobile phones is a good practice given how much a phone is often an integral part of a person's daily life, used to keep not only contacts and personal information but to manage day to day activities. However, the Committee acknowledges that in forensic psychiatric hospitals there are likely to be clear security restrictions in this regard. Nevertheless, **such restrictions should be clearly regulated by hospitals, explained to patients, and effective alternatives should be provided.**

74. The delegation noted the absence of consistency regarding possibilities to receive visits – from daily at Krasnoarmeyskaya Hospital and Volgograd Federal Hospital to twice a week at Volgograd Hospital Branch No. 2 and to an unduly restrictive once a month at Kazan Federal Hospital. **The Committee recommends that the frequency of visits be significantly increased at Volgograd Hospital Branch No. 2 and (in particular) Kazan Federal Hospital.**

75. Further, **the CPT invites the Russian authorities to reconsider the current arrangement under which female forensic patients under the regime of specialised type with intensive supervision are sent to Kazan Federal Hospital from the entire Russian Federation.**[68] As observed during the visit, not accommodating such female patients closer to their homes impacted negatively on them maintaining contacts with their families.

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67 The practice varied – some patients were allowed to use their mobile phone once a week, some patients were allowed to receive occasional calls on the hospital's phone number from family members, some could ask their treating doctor to call their families, etc.

68 Except for those with tuberculosis who are treated at Federal Specialised Psychiatric Hospital with Intensive Supervision in Oriol and residents of Kaliningrad Region who are treated at Federal Specialised Psychiatric Hospital with Intensive Supervision in Kaliningrad.

76. The delegation noted that there was considerable scope for improving accessible formal complaints mechanisms for patients in the hospitals visited, especially at Kazan Federal Hospital. There, very few patients believed they could safely and confidentially complain to the hospital authorities or other bodies and perceived that they were punished if they complained.[69] In all the hospitals, patients were not actively encouraged to voice their concerns.

In the Committee's view, there should be a more trusted and effective, formalised complaints system, with a central register of complaints that records complaints/themes, responses within agreed timescales and actions taken. There should also be clear access for patients to external and independent bodies who also have the power to investigate complaints. Psychiatric hospitals should have systems, using clinical governance principles that demonstrate multi-disciplinary learning from complaints and investigations, so as to then improve the quality of patient care. Further, patients should be provided with information brochures regarding the hospital's routine, patients' rights, legal assistance, review of placement (and the patient's right to challenge this), consent to treatment and complaints procedures. **The CPT recommends that the Russian authorities take urgent measures to ensure that the aforementioned requirements are effectively implemented as regards all the patients in all psychiatric hospitals in the Russian Federation where this is not yet the case.**

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The Committee notes, as a general comment, that many clinical areas of practice and living conditions varied greatly between the hospitals visited, with examples of good, acceptable and poor practice. In the CPT's view, there is considerable scope for greater consistency in the quality of care provision across the psychiatric system that would allow good practice and improvements to be widely disseminated and instituted, and at least acceptable standards to be achieved throughout. This could dramatically improve conditions and treatment for many patients. **The Committee encourages the Russian authorities to implement systems to allow greater consistency of good care and the dissemination and implementation of examples of good practice throughout the psychiatric hospital system.**

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69 Many patients interviewed by the delegation stated that letters containing any criticism of the hospital and/or its staff, even letters to the families, were returned and patients were told to rewrite them.

B. Social care establishments

1. Preliminary remarks

77. The CPT's delegation carried out first-time visits to four social care establishments for adults (so-called Psycho-Neurological Internats (*психоневрологические интернаты*), hereafter referred to as PNI) in three different regions of the Russian Federation: PNIs Nos. 16 and 34 in Moscow, Angarsk PNI (Irkutsk Region) and Babushkin PNI (Republic of Buryatia).

PNI No. 16 is located in the Moskvorechye-Saburovo District of Moscow. The establishment was opened in 1964 and was officially designated a PNI in 1967. The overall capacity was 710, with 715 residents at the time of the visit: 320 women and 395 men. 75% of the residents were aged under 55. The majority (80%) of residents were said to have various degrees of learning disability, but due to psychiatric co-morbidity, many residents required psychiatric treatment. The majority of residents were accommodated on general wards and there were also two so-called "mercy"[70] wards for residents with the most severe disabilities[71].

PNI No. 34 is located in the same district of Moscow as PNI No. 16. It comprises eight buildings, six constructed in 1965 with additional buildings constructed in 1968 and 1972. The establishment had functioned as a psychiatric hospital[72] (under the authority of the Ministry of Healthcare) until 2017 when it was transferred to the Ministry of Labour and Social Protection and became a social care establishment. 700 existing patients of the psychiatric hospital became residents of the new social care establishment. The first new residents were admitted to PNI No. 34 in October 2017 and, by 1 July 2018, the number of residents had reached 900, with an official capacity of 901. At the time of the visit, the official number of residents was 919 (including 483 men and 436 women); however, 19 residents were hospitalised elsewhere, mainly for somatic problems, so the number of residents actually present on site was 900. Four hundred of them were referred to by the staff as "charity" residents and accommodated on "mercy" wards[73] and 501 as "general" residents, accommodated on so-called "medico-social wards". Residents ranged in age from 18 to 101.

Angarsk PNI is situated in a residential area of the town of Angarsk, some 45 km from Irkutsk. It was built in 1957 and used to be a social care home for veteran soldiers. In 1995, it was re-designated as a PNI. At the time of the visit, there were 365 residents, including 176 women (for an overall capacity of 405), among whom some 200 had severe mobility problems. Residents were aged between 18 and 103.

Babushkin PNI is situated in a hamlet of the same name in the Republic of Buryatia (Kabanskyi District), on the shores of Lake Baikal directly adjacent to the Trans-Siberian railway line. At the time of the visit, 201 residents (equivalent to the official capacity), almost exactly divided equally between men and women, were accommodated in the establishment. Residents ranged in age from 18 to 90 plus, with an average age of 64.

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70 All social care homes are divided into two types of wards: the so-called general or "medico-social" wards where residents have a certain degree of autonomy; and the so-called "mercy" wards (from the Russian милосердие = misericordia/charity) where residents have less autonomy due to motor disabilities/more severe mental disorders than in the general wards.

71 One in building 1, second floor, for women with 43 residents and one in building 3, second floor, for men with 32 residents.

72 At the time, it was called Psychiatric Hospital No. 15.

73 "Mercy" wards were located in Blocks 1 ("mercy" Ward 2) and 6 ("mercy" Wards 5 and 6).

78. The PNIs visited were accommodating several categories of residents: those transferred from psychiatric hospitals with long-term psychosocial disabilities related to their underlying mental disorder; persons transferred directly from orphanages when they reached the age of 18 (many of them suffering from learning disabilities from birth or early childhood, such as genetic and chromosomal disorders, including Down syndrome), some having associated physical disorders and problems with mobility; elderly persons suffering from dementia and neurodegenerative disorders; and persons who did not correspond to the former three categories but who were placed in PNIs because of the lack of any alternative care in the community. This latter group included individuals with severe motor disabilities, earlier periods of mental disorder without any on-going symptoms and persons facing complex social problems of unemployment, poverty and lack of family support. It also included persons suffering from epilepsy, who could easily live more autonomously with the appropriate support.

79. At the end of the visit, the Deputy Minister for Labour and Social Protection told the delegation that current PNIs were inadequate and required rebuilding or refurbishment to improve access, capacity and life environment. To this end, sanitary and epidemiological guidelines and rules have been drawn up to end overcrowding on "mercy" wards with new guidelines on dormitory accommodation and the introduction of kitchens to which residents will have access.

The delegation was also informed about "stipulated demographic criteria and sanitary projects", apparently recently approved by the Prime Minister of the Russian Federation. The Deputy Minister also expressed the view that many people living in PNIs were there because of incorrect initial assessments, resulting in their continued placement. She spoke of the need to establish multi-disciplinary panels for decision making in all regions. She also underlined a need to focus on the evolution of home-care as an alternative. She identified some of the remaining obstacles to be surmounted in order to achieve a comprehensive multi-disciplinary approach.

The CPT would like to receive further information about the new "stipulated demographic criteria and sanitary projects" to which the Deputy Minister referred.

80. In the light of the situation observed by its delegation in the PNIs visited, the Committee can also only agree with the Deputy Minister that there is an urgent need to develop a genuine de-institutionalisation policy[74] with respect to PNI residents. This policy should be co-ordinated with the Ministry of Healthcare, with the objective of providing meaningful community care for residents with psycho-social disabilities and mental disorders.

Indeed, many residents were found by the delegation to remain in the PNIs visited because of failures in their psycho-social rehabilitation during earlier periods of psychiatric hospitalisation and the lack of an adequate infrastructure for community mental health care, particularly for those with long term serious mental disorders of a psychotic nature. Further, the presence of some residents in the PNIs bore witness to the lack of social services and care for persons facing homelessness due to social problems or with severe motor disabilities. This conclusion was also confirmed by representatives of the regional Ministries of Labour and Social Protection, as well as by some of the Directors of the PNIs visited.

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[74] This stems also from the State's obligations under the UN Convention on the Rights of Persons with Disabilities, ratified by the Russian Federation in 2012.

81. **The CPT recommends that the Russian authorities continue to pursue their efforts towards the development of community social care options, when necessary associated with mental health care, as this can not only shorten or avoid institutional stays and reduce the potential for ill-treatment/violence between residents, but also improve experiences and proper re-integration into the community and outcomes for service users. Such community accommodation should consist of small group home living units in the community, ideally in towns, with all the relevant facilities close at hand and not larger units situated on the grounds of long-standing social care establishments (which do not allow genuine de-institutionalisation and proper re-integration into the community).**

In this regard, the Committee would also like to receive more detailed information from the Russian authorities about their plans to provide enhanced care in the community for this cohort of current PNI residents.

2. Ill-treatment

82. The delegation observed a generally positive interaction between residents and staff members in most of the PNIs visited. Many residents spoke highly of the work of the staff. Further, the delegation heard no allegations of recent physical ill-treatment of residents by staff.

That said, at PNI No. 34 in Moscow, the delegation witnessed an orderly punch a severely disabled resident[75] on the head, apparently to keep her quiet. **The Committee recommends that the management of PNI No. 34 in Moscow give a clear message to the staff that any form of ill-treatment of residents is unacceptable and will be punished accordingly.**

83. Moreover, in all the establishments visited, the delegation received allegations (and found other evidence, including in the form of lesions directly observed by the delegation's doctors) of physical violence between residents.

For example, at PNI No. 34 in Moscow, the delegation saw three residents from the "mercy" Ward 6 displaying lesions on their arms highly suggestive of recent bite marks, dating back to three or four days prior to the delegation's visit. The location of these lesions was suggestive of a protective posture at the moment of the bite, indicating that the bite was caused by another resident or residents.

At PNI No. 16 in Moscow, the delegation's doctor observed an extensive haematoma on the external surface of a female resident's upper arm. In addition to a central area of bluish discoloration, surrounded by yellowish colouration, there were several small round areas of haematoma of about 1 cm diameter. The overall dimensions of the bruising measured 15 cm x 9 cm.

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[75] Who, at the time, was lying on her bed and required permanent supervision due to self-harming/scratching her face.

Further, at Babuskin PNI, a resident of a "mercy" ward was found to have a recent lesion, namely a three and a half cm long gash above the right eyebrow at its outer limit. The gash was gaping at its centre by between one and two mm. The edge of the gash had a crust of dark red blood. The congealed blood was seen on his right eyebrow and at the hairline. According to the nurses, he had had a fight at breakfast time two days previously with a very aggressive and unpredictable fellow resident.

The delegation was very concerned to note that none of the above-mentioned lesions had been recorded in residents' files or in any other journal, logbook or report.

84. In the light of the above remarks, **the CPT calls upon the Russian authorities to take steps to ensure that residents in the PNIs visited (and, as applicable, in all other PNIs in the Russian Federation) are effectively protected from other residents who might cause them harm. This requires not only an adequate staff presence and supervision at all times, but also that staff be properly trained in handling challenging situations/behaviour by residents. Further, appropriate arrangements should be made for particularly vulnerable residents, such as those who have motor disabilities or are bedridden, by ensuring, for example, that they are not placed or left alone with residents identified as behaving in an aggressive manner. This should also apply *mutatis mutandis* with respect to residents prone to committing acts of self-harm.**[76]

85. The Committee also wishes to stress that ward-based staff in all PNIs must receive clear instructions that any traumatic lesions observed on residents should be immediately reported to the most senior nurse or a doctor working on the ward. The resident should be carefully examined by the doctor and, when possible, a full history taken of the circumstances in which the trauma occurred. The doctor should draw a tentative conclusion as to the origin of the lesion or lesions observed: an accidental fall, self-harm, violence by other residents, or ill-treatment by staff members. The quality of medical notes concerning lesions can be enhanced by using "body charts" and, when appropriate, photographs. Accounts of any incident should be sought from other residents, in a tactful manner, avoiding the impression that a disciplinary enquiry is being carried out. The results of the medical examination and any relevant accounts should be noted in the medical file and in a centralised register of traumatic lesions, and reported to the Director of the PNI. **The CPT recommends that the Russian authorities issue instructions to all PNIs on the recording and reporting of injuries in the PNIs, in accordance with the above precepts. Further, existing procedures should be reviewed in order to ensure that, whenever injuries are recorded by a doctor which are consistent with allegations of ill-treatment of a resident, the record is systematically brought to the attention of the competent judicial authorities.**

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[76] The delegation saw several residents with sometimes fresh (and not always properly treated) injuries resulting from self-harm, e.g. at PNI No. 34 in Moscow.

3. Residents' living conditions

a. Psycho-Neurological Internat No. 16 in Moscow

86. The residential buildings were in a good state of repair and, on the whole, provided clean, well-lit and ventilated accommodation. Although the living conditions were excellent in some areas, it was striking that there were much less pleasant, overcrowded and less equipped rooms, sometimes in the close vicinity.[77] Overall, only 13% of residents were accommodated in single or double rooms, with over half the residents accommodated in rooms for six persons or more, including some dormitories for ten residents.

87. The fourth floor of Male General Ward 3 had been fully renovated in 2017.

The result was good, although it was somewhat disappointing that the renovation had not altered the original configuration of the floor, which consisted of 12 single/double rooms, and four larger rooms, one accommodating eight, one seven, one six and one four residents, in respectively, 44, 41, 29 and 24 m². Even if these larger rooms offered sufficient living space per resident, it would have been preferable for them to have been converted to smaller rooms, which can offer a quieter and more therapeutic environment.

The bathroom and lavatories had also been renovated and were spotlessly clean. However, in common with lavatory facilities in other parts of the establishment, there were no doors on the cubicles of the four lavatories. Moreover, although the bathroom area was fairly large (some 13 m²) it had been fitted with only one shower (to serve 37 residents) in a space that could easily have fitted three.

The CPT recommends that these considerations be borne in mind during the planned renovation of the equivalent spaces on the lower floors of the building.

b. Psycho-Neurological Internat No. 34 in Moscow

88. The residential areas of PNI No. 34 were warm, with adequate access to natural light, artificial lighting and ventilation. Further, in a few of the dormitories the delegation saw mechanical hoist systems fixed to the ceiling to aid in moving bedridden residents.

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[77] A few residents (those who had volunteered to work at the establishment) were accommodated in single rooms, which were furnished and equipped in a personalised manner, with a wooden desk, a locked cupboard, a TV set, personal items (including photographs) and some decoration. On the male general Ward 4, three rooms measuring just over 10 sq. metres were each accommodating three residents. Another room accommodating seven residents offered barely 3.7 m² per resident.

The overall living space available was adequate but some dormitories were too big (e.g. on Ward 6, where they accommodated up to ten residents). There were virtually no personal belongings or decoration in the rooms, and residents did not have any lockable space. Moreover, on some of the "mercy" wards nearly all residents were seen wearing standard hospital gowns of coloured, patterned, cotton material. Although the colours and patterns varied, the overall "uniform" effect and lack of identity was striking.

The delegation also noted on the "mercy" wards (in particular, in Ward 6), that the communal sanitary facilities consisted of unscreened toilets and therefore no privacy at all (and sometimes with unscreened bathtubs with shower heads).

89. The delegation was informed of a plan to complete, by the end of 2019, a major renovation of one of the buildings at PNI No. 34, which was not in use at the time of the visit and which would in the future accommodate some 180 residents in single and double rooms. **The Committee would like to receive updated information on these plans including on the total capacity of PNI No. 34 after the renovation is completed.**

c. Angarsk Psycho-Neurological Internat

90. Accommodation for residents at Angarsk PNI was in two 4-storey over ground floor V-shaped blocks (A & B), connected by a triple height space housing administration facilities, the canteen, a conference hall and a "conservatory" in the form of an interior winter garden.

Many residents lived in bedrooms for two people, with a few having single occupancy rooms. Most of these provided reasonably pleasant accommodation with sufficient light, ventilation and space and access to a balcony.

A minority of residents (approximately 50) were accommodated in rooms for more than two persons (some accommodating three to five residents each, with beds touching) with less natural light and ventilation than in the other rooms. **The CPT recommends that the occupancy levels in these rooms be reduced.**

91. The worst conditions seen were on the first and second floors of Block B, which housed residents with dementia, severe mental retardation and bedridden people.

On the first floor, men and women were confined to their beds and it was unclear if they ever left them.

On the second floor, the entrances to the two wings housing men and women were kept locked and entry/exit was closely supervised by staff. This meant that residents were effectively confined to their rooms and the corridor. In the wing for women, the dining room was locked and a group of women was observed sitting upright on two wooden benches placed against the corridor walls, below a wall-mounted television. One woman was sitting on the floor beneath the television, rocking and keening. Conditions were similar in the wing for men, where residents were found wandering around aimlessly in the corridor.

The CPT recommends that a concerted effort be made to improve conditions on the second floor (in particular, by providing better association space) and to explore opportunities for bedridden residents on the first floor to be taken out of their rooms on a regular basis.

92. At the time of the visit, a new accommodation block was nearing completion and was due to be fully commissioned at the beginning of December 2018. A single-storey structure, it is envisaged that it will house 50 residents, in six six-bedded, two four-bedded and three two-bedded rooms.

Although it is clear that each of the rooms in the new building will offer sufficient space per resident, it is unfortunate that the majority of rooms are planned as six-bedded dormitories rather than smaller bedrooms. Another shortcoming observed during the visit was that there was no association room included in the plan. Apparently, it was intended to mount a television to the wall just inside the entrance to the building, thereby replicating the undesirable arrangement seen on the second floor in Block B.

The CPT recommends that consideration be given to reducing the capacity of the new building, in order to allow a reconfiguration of the premises to include smaller rooms and a dedicated association space.

d. Babushkin Psycho-Neurological Internat

93. Founded in 1939 as an "invalid home", from 2005 to 2008 a new "dormitory building" was constructed at what is now Babushkin PNI. It consists of a two-storey H-shaped structure, with women being housed in one wing, and men in the other, these two wings being connected by a block containing a canteen on the ground floor. A further residential "isolator"[78] unit housing both men and women residents with the most severe mental disorders and/or mobility issues is located on the lower ground floor of the men's wing.

Rooms in the general wards were quite basic, with very little personalisation, some of them being very overcrowded (e.g. in room 7 on the female general ward, the four residents had just over two m² of living space per person).

94. At the time of the visit, the "isolator" unit was holding 48 people - 25 men and 23 women.

Conditions were much poorer than in the general wards. Male and female residents were held on either side of a central corridor and neither their rooms, nor the lavatories had doors, so they had virtually no privacy. Living conditions were cramped and depersonalised. For example, on the male side of the corridor, room 6 contained only five beds and one table. There were no bedside cabinets, nor was there any form of decoration.

78 The "isolator" unit served a purpose similar to the "mercy" wards seen in the other PNIs visited.

The only association space was a television room, located in a kind of alcove off the main corridor and furnished with wooden benches. At the time of the visit, a mass of physically disabled residents with severe mental retardation and/or learning disabilities were crammed into this space (41 persons in a room measuring 34 m²). It was a miserable sight, representing the very antithesis of a positive therapeutic environment.

95. As already mentioned, at the end of the visit, the delegation made an immediate observation concerning Babushkin PNI.

In their response (dated 28 December 2018), the Russian authorities informed the Committee that additional financial resources had been provided to improve the general living conditions at the establishment. In particular, doors and TV sets were added in the rooms, screening was installed in the sanitary facilities to ensure more privacy to residents, visuals and decorations were added on the walls, and wheelchairs, walking tools and bedside tables were added on the wards. In the dayroom area, sofas had been added and new seats and tables ordered. More equipment for the sanitary facilities had been ordered, as well as for the bedrooms. In the "isolator" unit, an additional dayroom area had been arranged with sofas and TVs.

96. It should also be recalled (see paragraph 9 above) that the CPT's delegation invoked Article 8, paragraph 5, of the Convention and made an immediate observation regarding the manifest inappropriateness of the living conditions of A.

A. is a quadruple amputee (a consequence of severe frostbite previously sustained while indigent and homeless), with average intellectual capacity who, at the time of the visit, was being held in the "isolator" unit at Babushkin together with people with severe mental retardation/learning disabilities. He was found sitting alone, in a damaged wheelchair, quietly reading a book.

In their response to this immediate observation, the Russian authorities indicated that he has been transferred to a two-bed room on the ground floor at the establishment which, according to the authorities, better matches his intellectual and physical capacities. He has apparently also been provided with a fully-functioning wheelchair and a computer. The Committee welcomes this modest improvement in the living conditions of the resident concerned. However, on the basis of its delegation's findings, it continues to entertain serious doubts about the appropriateness of A.'s continued detention at Babushkin PNI. **The Committee invites the relevant authorities to conduct a further review of the current living circumstances of the resident concerned, with a view to identifying a fully accessible living environment in another establishment better equipped to support his physical disability and intellectual needs.**

97. More generally, in the light of the remarks in paragraphs 86 to 95 above, **the CPT recommends that the Russian authorities review conditions in all PNIs in the Russian Federation in order to ensure that all residents (including bedridden or least mobile ones) have:**

- **sufficient living space in their bedrooms (i.e. at least as much as is formally provided for in the relevant regulations for psychiatric patients – i.e., 7 m^2 per person)[79] and day association areas and, wherever possible, are accommodated in smaller (single or double) rooms, especially after premises have been refurbished;**

- **congenial and personalised surroundings, in particular by providing them with lockable space and allowing a reasonable number of personal belongings (including their own clothing) in their rooms;**

- **access to a pleasant common dayroom area, which allows for contact between residents and association activities in general.**

4. Staff and treatment

98. As regards the staff complement at PNI No. 16[80] in Moscow, there were six psychiatrists (and four more vacant posts) of whom two were allocated to the "mercy" wards. In addition, a neurologist was employed as a Head of a ward and there were two general practitioners working as consultants, part time, making one full time equivalent. There were 65 nurses (out of 94 posts) and five orderlies employed at the time of the visit on the "general" wards, as well as 18 nurses (with six additional vacant posts) and 21 orderlies (with six and a half additional vacant posts) on the "mercy" wards.

At PNI No. 34[81] in Moscow, there were 38 physicians, of whom 12 were psychiatrists, and the remainder specialists in various medical specialities, including surgery, ophthalmology and radiology. There were also three general practitioners and five psychologists. There were 147 trained nurses and 257 "lower level medical staff" who functioned as orderlies or "care givers". Staff members were allocated to wards on the basis of the residents' age and the severity of psychiatric disorders or learning disabilities. Overall on the "medico-social" wards with residents having less severe disabilities, the staff ratio was one staff member to 15 residents. On the "mercy" wards accommodating more severely disabled residents, the size of the wards was limited to 50 residents, with the presence of one psychiatrist, two nurses and three orderlies. The overall ratio was one staff member to five residents. At night time, in a ward of 50 residents, there was one nurse and three orderlies on duty. In addition, the PNI employed masseurs, physiotherapists and staff organising social activities at ward level, with an overall ratio of one staff member for 100 residents (in the general wards).

At Angarsk PNI,[82] there were three psychiatrists (including one in the mercy wards[83]), three GPs (including two in the "mercy" wards), three psychologists, four social workers and two labour therapy instructors. In the "mercy" wards there were 28 trained nurses, 75 orderlies and six "junior medical staff". In the "medico-social" wards,[84] there were nine trained nurses and 12 orderlies. In total there were two and a half vacancies, including a half-time post for a dentist. As an example, at the time of the visit, there were nine staff members in charge of a ward of 86 residents.

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79 See also paragraph 22 about the "Sanitary-epidemiological Norm No. 2.1.3.2630-10" regulating living space per psychiatric patient in multiple-occupancy rooms.

80 Capacity at the time of the visit: 715.

81 Capacity at the time of the visit: 900.

82 Capacity at the time of the visit: 365.

83 200 residents were accommodated in the "mercy wards" at the time of the visit.

84 165 residents were accommodated in the "medico-social" wards at the time of the visit.

At Babushkin PNI[85], there was a pharmacist, a feldsher, a head nurse, a procedure nurse, seven other qualified nurses and 30 "junior medical staff", variously described as care givers or orderlies. Notionally, there was also a "full-time" psychiatrist (see however paragraph 101 below concerning the actual presence of the psychiatrist in the establishment). Further, there were five staff members concerned with social care and rehabilitation including a psychologist, two social workers and staff dealing with "cultural activities".

99. Overall, the staff complements at the PNIs visited could be considered as more or less adequate as regards doctors and ward-based care staff (feldshers, nurses and orderlies). That said, **the Committee recommends that efforts be made to fill all the vacant posts for health-care staff, especially as regards psychiatrists at PNI No. 16 in Moscow. As concerns Babushkin PNI, see paragraph 102 below.**

Further, **steps should be taken to reinforce the resources of staff qualified to provide psycho-social rehabilitative activities (psychologists, special educators, occupational therapists, physiotherapists, social workers, etc.) in all the PNIs visited; see also the recommendation in paragraph 103 below.**

100. With the exception of Babushkin PNI, both psychiatric and somatic treatments were generally of a good standard in the PNIs visited. In particular, residents of the two PNIs located in Moscow had quick and effective access to various kinds of treatments, which were organised on-site or in nearby facilities.

That said, the delegation was concerned about the evident lack of access to adequate conservative or restorative dental health care in all the establishments visited. **The CPT recommends that steps be taken to ensure that residents have access to adequate conservative/restorative dental health care in all the establishments visited and, as necessary and applicable, in all PNIs in the Russian Federation.**

101. By contrast with the above-mentioned generally positive impression of the three other PNIs visited, the delegation found both the somatic and psychiatric care at Babushkin PNI to be grossly inadequate.

The delegation came across cases of several residents who had clearly not received appropriate and timely somatic care. For instance, a resident with an inguinal hernia had been waiting six months to be seen by a surgeon; a resident with bronchial asthma had been waiting for more than two months for an appointment with a pulmonologist; and a resident with rectal bleeding, diagnosed some six months before, had not yet been seen by a gastroenterologist or a surgeon.

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[85] Capacity at the time of the visit: 201.

The delegation was especially concerned about the availability and quality of psychiatric treatment at Babushkin PNI.[86] In direct contradiction to the claims of the establishment's Director and those of the psychiatrist himself, several elements emerged during the visit[87] that led the delegation unequivocally to conclude that the psychiatrist concerned was only physically present in the establishment every two to three *months*. On those occasions, he appeared to see a large number of residents for extremely brief assessments, carried out while on a "walk around" in the three wards, in presence of other residents. His notes were stereotyped and brief. Further, more than half the residents were receiving long-term medication with a combination of haloperidol and phenazepam; this is a cause for concern, especially in view of the dependence liability of the latter medication.

102. Responding to the delegation's immediate observation concerning Babushkin PNI (by letter dated 28 December 2018, see paragraph 9 above), the Russian authorities informed the Committee that a joint working group had been set up between the Regional Ministry of Social Protection of the Republic of Buryatia and the Ministry of Healthcare of Irkutsk Region to assess the way treatment and diagnoses were carried out at Babushkin PNI. As a result, a decision was taken to conclude a contract with local health care establishments for the provision of both somatic and psychiatric care to residents. A commission (including a psychiatrist) was reportedly set up to review the legal status of residents; to replace the available medicines for the treatment of mental disorders by newer generation antipsychotics; and to guarantee the access for residents to adequate somatic care.

The CPT would like to obtain clarification from the Russian authorities as to the precise mandate and composition of this newly established commission, as well as to be informed of any concrete steps that have been taken to improve somatic care for residents at Babushkin in the light of its review.

As regards psychiatric care, the CPT was informed that the psychiatrist's presence at Babushkin PNI is now based on 50% of a full-time post; if this is accurate, it would represent a significant increase in the real level of psychiatric presence at the establishment (even if, at least theoretically, it would represent a reduction in the notional time of presence of a psychiatrist).[88] **The Committee would like to obtain clarification of this point from the Russian authorities and, in particular, to be informed of how many hours per week are actually spent in Babushkin PNI by a psychiatrist and by whom that service is being provided.**

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86 See paragraph 9 above on the second immediate observation sent to the authorities at the end of the visit.

87 Based on interviews with residents, on dates/entries recorded by the psychiatrist in residents' medical files, and on the fact that the room in which the delegation's psychiatric expert held his discussion with the psychiatrist in late October 2018 (which was purportedly his office), had a door sealed with a signature and a date of 26 August 2018. That room was bare, with a desk and chair devoid of any notes, reference books or other equipment; it appeared that it had not been used for many weeks. It might be added that the psychiatrist who was supposedly working full-time in the establishment, by his own admission, lived and held another full-time position in Ulan-Ude, a city located more than two and a half hours drive away from Babushkin (in good driving conditions).

88 As already mentioned, during the visit, the Director of Babushkin PNI repeatedly told the delegation that the psychiatrist's post was "full-time", although the psychiatrist himself contented himself with the assertion that he visited the establishment "regularly".

103. In all of the establishments visited, psychological assistance seemed to be of a higher quality and frequency in the general wards than in the "mercy" wards/"isolator" unit (at Babushkin).

At PNI No. 34, five psychologists were involved mainly in assessing residents upon their admission and then engaged in sporadic activities with them, principally in the form of individual consultations on their wards. Unfortunately, there was no record of organised psychological activities and no dedicated space for bilateral or group discussions.

At PNI No. 16, the only psychologist (two posts were vacant), was away during the delegation's visit. A review of the ward journals indicated that the psychologist had made only two visits to the wards during the preceding three months. Residents confirmed that the psychologist's visits were rare and very short. No individual or group discussions were taking place.

At Angarsk, three psychologists were involved in the assessment of residents, cognitive tests, individual consultations and group work such as art-therapy. They appeared to involve themselves in the lives of residents in the general wards but much less so with those living in the "mercy" wards.

On a positive note, residents of Babushkin PNI all spoke highly of the only psychologist who seemed to actively work with the majority of them (at least in the general wards), mainly through bilateral discussions.

As it has already highlighted in the report on its 2016 periodic visit,[89] the CPT considers that the proper care of residents in PNIs must include a psychological assistance programme, included in the individual care and rehabilitation plan for each resident, with a view to offering them adapted psycho-social rehabilitative activities and improving their quality of life, as well as offering re-socialisation programmes designed to prepare residents to live in the community. Individual psychological interventions should take place in a dedicated space to ensure that confidentiality is observed.

It invites the Russian authorities to review the provision of psychological support to residents in the PNIs visited and, in particular, in the "mercy" wards/"isolator" unit at Babushkin in the light of these remarks.

104. As regards psycho-social rehabilitation, at PNI No. 16 in Moscow a new type of multi-disciplinary commission had been set up and was going through a pilot phase, with the involvement of rehabilitation/labour specialists. Health care staff were being retrained in principles of rehabilitation and improving social skills. The Director stressed that he strongly believed in a social rehabilitation approach, emphasising sports and work activities. He was attempting to lead a process of structural change to move towards a more integrated approach to social and medical rehabilitation, involving outside consultants and NGOs. However, it appeared to the delegation that progress was being hampered by the fact that the post of Deputy Director for Social Affairs at PNI No. 16 had been vacant for some time.

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89 See paragraph 175 of CPT (2017) 33, in the report on the 2016 periodic visit to the Russian Federation.

The new multi-disciplinary rehabilitation commission chaired by the Director[90] had been tasked with carrying out annual reviews of all residents and drawing up a comprehensive and individualised plan of psycho-social rehabilitation but, at the time of the visit, it had carried out only two such reviews.[91]

The CPT would like to be informed of the deadline set for completing reviews and drawing up comprehensive and individualised psycho-social rehabilitation plans of all residents at PNI No. 16 in Moscow. It would also like to be informed of whether the long-vacant post of Deputy Director for Social Affairs has now been filled.

105. PNI No. 34 in Moscow had a social rehabilitation department, housed on the first floor of a separate building to which patients could go on a daily basis.[92] There was also a pottery workshop. The department was organised in 14 "interest groups".[93] Instructors also visited the wards and organised activities for residents who were unable to visit the social rehabilitation department. Some residents could take part in visits outside the hospital to attend football matches or to visit museums.[94] Psychologists completed a "rehabilitation outlook card" which was updated every six months after consultation between psychologists and social workers. Psychiatrists and nurses did not apparently contribute to this assessment. These cards were, for nearly all residents, static in nature and did not involve a multi-disciplinary approach. This state of affairs naturally limited the potential to develop multi-disciplinary individualised care plans for all residents.

106. Psycho-social rehabilitation was also offered at Angarsk and Babushkin PNIs, but the programmes were far less developed.

In both establishments, there was very little collaboration between psychiatrists and psychologists, social workers or other rehabilitation professionals. Rehabilitation activities were patchy and inconsistent. The psychiatrists apparently did not see the need to strengthen collaboration with psychologists, social workers and others involved in rehabilitation to produce a multi-disciplinary approach to the social and rehabilitative care of all patients.

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90 The commission included all senior medical staff and also social workers, educators, representatives of NGOs, volunteers, psychologists and a lawyer.

91 In the six medical files of residents examined by the delegation's doctors, the most recent annual reviews had been carried out exclusively by medical staff and signed by three doctors (the Head of the Ward – a psychiatrist or a neurologist, the Deputy Director for Medical Affairs and a third psychiatrist). Furthermore, two medical files concerning recently admitted residents did not include a multi-disciplinary social rehabilitation plan.

92 Reportedly from 60 to 120 residents attended each day. The rehabilitation unit employed a psychiatrist, five psychologists, a person in charge of organising "cultural events", a music therapist, two rehabilitation experts, five occupational therapists and one specialist in pottery.

93 Including work therapy, sand therapy, drawing, sewing, social skills, drama and clay modelling.

94 There was approximately one such excursion each week, involving each time 15 residents and two staff members.

107. In the light of the remarks in paragraphs 103 to 106 above, **the Committee recommends that further efforts be made to develop meaningful psycho-social rehabilitation programmes in the PNIs visited (as well as, as applicable, in all other PNIs in the Russian Federation). The Russian authorities should encourage PNIs to move towards a multi-disciplinary approach, based on individual care and rehabilitation plans, involving not only psychiatrists but also other categories of professionals (e.g. psychologists, occupational therapists, social workers, special educators, physiotherapists, etc.). In this context, the pilot project initiated at PNI No. 16 in Moscow (see paragraph 104 above) should be fully implemented and consideration be given to extending it to other PNIs.**

Individual care and rehabilitation plans should be drawn up for all residents and should include goals of treatment, psychological counselling and social interventions, to achieve the greatest degree of autonomy possible. Such a multi-disciplinary approach should contribute to an annual holistic assessment of residents. There should also be additional safeguards for those residents with the most severe disabilities and/or mental disorders and those for whom there is no real prospect of legal capacity restoration; such residents should be provided with an individual treatment plan – drawn up with their participation – even if it involves more limited rehabilitative goals.[95]

108. In all PNIs visited, there was a dedicated outdoor exercise area. However, not all the residents, especially those with the more severe disabilities, had regular and effective access to these facilities.

The CPT recommends that steps be taken to ensure that all residents – whatever their degree of autonomy/level of disability – of the PNIs visited benefit from unrestricted access to outdoor exercise during the day, unless treatment activities require them to be present inside the building. In this respect, residents should be provided with appropriate clothes and shoes, and with staff assistance in the event of reduced mobility.

5. Means of restraint / seclusion

109. Certain legal rules on the use of means of restraint and seclusion are to be found in Section 30 of the LPC; however, these apparently only concern psychiatric hospitals which have a license to provide patients with psychiatric care. Although persons residing in PNIs enjoy certain rights provided for in Section 37 of the LPC, they are apparently not covered by the procedure for restricting these rights provided for in the same Section, given that in the event of forced medical treatment, they have to be immediately transferred to a psychiatric hospital. Management and staff in the establishments visited considered that this created a legal vacuum in which there was no legal basis for the application of means of restraint / seclusion to PNI residents. **The CPT would like to ask the Russian authorities to provide confirmation of whether there is indeed any basis in the law of the Russian Federation for the application of means of restraint to residents in PNIs.**

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95 Such as enhancing their capacity to feed or to dress themselves, to achieve basic language skills, etc.

That said, in all the PNIs visited, the delegation heard numerous credible and detailed allegations of the use of mechanical restraint, mainly strapping residents to beds with distinctive soft bandages, from periods of a few hours to more extended times and sometimes overnight. It is also noteworthy that the delegation found specific equipment for five-point mechanical restraint in the nursing room at Babushkin PNI. Seclusion rooms, officially used in cases of infectious diseases,[96] were also in use for "calming-down" purposes at all of the PNIs concerned.

110. As regards chemical restraint, it was resorted to in all the PNIs visited. At PNI No. 16 in Moscow, chemical restraint[97] was used together with a transfer to an "observation room" where, according to credible allegations, residents could be mechanically restrained.

At PNI No. 34 in Moscow, residents were given injections of antipsychotics and were held until the sedative effect took place. The same was true of Angarsk PNI,[98] where residents undergoing chemical restraint were sometimes transferred to seclusion rooms, for up to 3 days. The delegation heard credible accounts that residents could also be restrained mechanically by being tied with bandages to the beds in the seclusion rooms for limited periods.

As for Babushkin PNI, a considerable proportion of residents had a PRN prescription for medication by intra-muscular injection, which could be considered as a form of chemical restraint.[99] However, there was no written protocol concerning PRN medication; it could be administered by a nurse who might call the psychiatrist if she considered it necessary. The psychiatrist himself was unable to indicate any recent incidents when he had expressly authorised the administration of intra-muscular injections, nor could he describe the monitoring and follow-up provided after the administration of medication in this manner.

111. It should be added that resort to means of restraint was not recorded anywhere at any of the PNIs visited,[100] and there were no written guidelines or a policy on the use of means of restraint, including on how to document, report and monitor it. This was hardly surprising given that, officially at least, means of restraint were not applied at PNIs, as was repeatedly (and inaccurately) claimed by the management and some of the staff in the establishments visited.

112. In the light of its delegation's findings, **the Committee calls upon the Russian authorities to adopt, without delay, written provisions on recourse to means of restraint and seclusion in all social care establishments, including in PNIs. The adoption of a policy on the use of restraints should be accompanied by practical training, involving all staff concerned (doctors, nurses, orderlies, etc.) and be regularly updated. Residents should also be duly informed of the establishment's restraint policy as well as the existing complaint mechanisms in this respect. In this context, reference is made to the recommendations in paragraphs 64 and 65.**

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96 Seclusion rooms seen by the delegation were equipped with beds, unscreened toilets and sometimes a bath.

97 Promazine sometimes together with benzodiazepines.

98 One of the psychiatrists there explained how she coped with agitation and potential self-harm or acts of violence by residents: she said she would "rush to the resident and prescribe an injection by intra-muscular route of a combination of phenazepam and either haloperidol or promazine. The resident has to be held for up to 15 minutes to receive the injection and for the medication to take effect."

99 Of the 48 residents' individual medical files checked by the delegation, 22 residents had PRN prescriptions of major antipsychotics by intra-muscular injection. In nearly every case, the drugs to be injected were promazine and haloperidol.

100 PRN injections were recorded, but not as a chemical restraint.

113. Further, as regards more specifically the use of PRN, the CPT must underline that the administration of rapid tranquillisers requires close medical supervision and adherence to strict protocols by all staff involved, as well as the necessary skills, medication and equipment. The application of rapid tranquillisers on the basis of a PRN prescription without the explicit re-confirmation of a medical doctor may place too much responsibility on nurses as regards the assessment of the resident's mental state and the provision of an adequate response, in the absence of a medical doctor, to potential complications. It may also reduce the nursing team's motivation to attempt de-escalation of the situation by other means and consequently open the door to abuse.

In the Committee's opinion, in the event of a resident presenting a state of agitation which cannot be dealt with by the nursing staff, the resident's psychiatrist (or the duty psychiatrist) should be called immediately and intervene promptly to assess the state of the resident and issue instructions on the action to be taken.

Only in exceptional situations, when a resident's agitation cannot be controlled by nursing staff and the intervention of a psychiatrist is not possible within minutes, may the administration by nursing staff of rapid tranquillisers under a "conditional" PRN prescription be justified, meaning that a medical doctor must be contacted (e.g. by phone) and must confirm the prescription prior to its use. Further, a medical doctor must arrive without delay to monitor the resident's response and deal with any complications.

Moreover, the use of a PRN prescription for rapid tranquillisers must be accompanied by specific safeguards: as a minimum, any such PRN prescription should be drawn up by an experienced doctor after having thoroughly assessed the resident's physical status, should only be valid for a limited time (i.e. weeks rather than months) and should be re-assessed each time it is used or where there is a change in the resident's medication. Indeed, other more general safeguards accompanying any use of means of restraint (such as the existence of a comprehensive policy on restraint, the use of restraint as a measure of last resort and the choice of the most proportionate method, as well as the recording of the event in the resident's medical file and in a central register of restraint measures and a debriefing of those involved) should also apply when rapid tranquillisers are administered on the basis of a PRN prescription.

The Committee recommends that instructions be sent to all PNIs in the Russian Federation to make sure that the above-mentioned precepts are duly respected in practice.

6. Safeguards

114. The basic legal framework for PNIs is set out in the Law "On the Foundation of the Provision of Social Service to the Citizens in the Russian Federation".[101] Officially, PNIs are not places of deprivation of liberty and, at the outset of the visit, the Ministry of Labour and Social Protection disputed that they fell within the CPT's mandate.

Indeed, persons over the age of 18 who had legal capacity and were admitted to PNIs on a voluntary basis were free to come and go from the establishment. For example, at PNI No. 34 in Moscow, the delegation saw that residents from this category enjoyed a high degree of autonomy, including the possibility to leave the establishment unsupervised during the day (including to shop, work, visit friends etc.).

That said, residents over the age of 18 who did not have legal capacity were in a quite different position. Persons in this category could only leave the establishment with the express permission of their official guardian (i.e. the Director of the establishment) which was rarely, if ever, granted. In consequence, these residents were *de facto* deprived of their liberty, which was acknowledged by the Russian authorities at the end of the visit.

115. Pursuant to Section 29 of the Civil Code, courts could declare persons who could not understand the implications of their actions to be legally incapable.[102] Once persons had been incapacitated, the courts appointed guardians or trustees[103] to protect their rights and interests. However, other legal provisions[104] stipulated that guardians or trustees should not be appointed for legally incapacitated persons placed under the supervision of educational, medical or social care establishments, including PNIs.

Instead, the guardianship function was vested in the establishment itself, invariably in the person of the Director.[105] Guardians took decisions about everything from pension allocation to treatment,[106] including medication, for all residents deprived of their legal capacity.

116. In a number of the establishments visited, the delegation found that the blanket designation of an establishment's director as the guardian of all legally incapacitated residents placed the director in a potentially invidious position and residents under guardianship at risk of the exploitation of their personal resources.

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101 Federal Law No. 442FZ of 28 December 2013.

102 The legal procedures concerned are set out in the LPC.

103 Based on the Federal Law No. 48-FZ of 24 April 2008 "On Guardianship and Trusteeship" and on the Civil Code.

104 Section 11 (5) of the LPC and Section 35 (4) of the Civil Code.

105 The rate of legally incapacitated residents for whom the establishment's Director had been appointed as guardian varied from 46% at Angarsk PNI to 100% at Babushkin PNI.

106 Directors (or deputies), who assumed the role of guardians, could effectively dispose of the 25% of the disability pension received by the residents to spend as they saw fit, purportedly in the interests of the residents concerned. In some cases, this power was used to pay for equipment or services which were not provided free of charge by the PNI concerned (or in excess of what was covered by the health insurance) e.g. certain medication at Angarsk PNI, as well as special electrically powered beds for bedridden residents.

The most striking example of this was at Babushkin PNI, where the delegation was shown a list of "guaranteed services" that should be made available to all residents. Basic services (such as catering, basic furniture for instance), were to be funded from the establishment's core budget, which included a mandatory contribution of 75% of the value of residents' pensions, deducted at source. However, there were also so-called "additional social services" which were charged to residents, including bathing, shampooing, use of the minibus of the establishment, drinking water from the corridor's tap, washing/repairing/ironing clothes. The cost of such additional services was to be clawed back from the remaining proportion (25%) of a resident's pension income which could not legitimately be deducted at source by the institution. While analysing individual residents' files for the years 2017-2018, the delegation found out that such services were charged to residents from 1270 RUB to 8443 RUB[107] on a monthly basis. The delegation was concerned about the fact that residents were charged for such basic services which should be covered by the mandatory contribution of 75% of the value of their pensions.

Another list of "additional social services by a *physio-cabinet*" analysed by the delegation that had been deducted from the personal resources of residents included such services as "ultraviolet physiotherapy", "electro-stimulation", "magnetic therapy", "electrophoresis" and "inhalation". The delegation found no evidence to suggest that any such "therapies" (if they exist) had actually been provided to residents at Babushkin PNI. Even basic activities, such as an "additional walk of 15 minutes" were apparently chargeable (at a rate of RUB 59 per walk) to legally incapable residents, many of whom were completely unaware of the existence of their personal monetary resources, let alone that these were being steadily depleted in this manner. A significant number of "acts of delivered additional social services by a *physio-cabinet*" were analysed by the delegation and the monthly amounts charged to residents varied from 1800 RUB to 4960 RUB[108].

The delegation's concerns about the potential conflicts of interest inherent in this situation were only heightened by the fact that it emerged that the legal basis for the provision of such "additional" services was a contract between the establishment's Director (in her capacity as the guardian of the interests of legally incapable residents) and the establishment's absentee (see paragraph 101) psychiatrist, representing the Babushkin PNI.

117. In principle, under the provisions of Law No. 48-03 of 24/4/05, a "guardianship authority" should oversee guardianship expenditure of this nature by an establishment's director; however, at Babushkin PNI, it appeared that the authority concerned issued individualised annual letters, each of which granted a general authority to the director to disburse personal funds to "meet the needs" of an individual resident. Consequently, from year-to-year, the director/guardian effectively enjoyed *carte blanche* in relation to such expenditure.

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107 From approximately 17 EUR to 112 EUR.

108 From approximately 24 EUR to 66 EUR.

118. By a letter of 9 November 2018, the CPT requested further and better particulars regarding the expenditure of the personal pension funds of legally incapable residents at Babushkin PNI. From the information transmitted by the Russian authorities in response to this request, it emerges that a significant proportion of the personal resources of the 201 legally incapable residents held at Babushkin PNI (i.e. the 25% of the pension that cannot be legitimately deducted at source) was being spent by the director/guardian purportedly to "meet their needs". As an example, one resident was charged 12 577 RUB[109] between 21 November and 31 December 2017, including 2380 RUB for 40 extra accompanied walks of 15 minutes.

In the light of its delegation's findings, **the Committee would suggest that an independent audit be conducted into the legitimacy of the expenditure by the director/guardian of the private funds of legally incapable residents at Babushkin PNI.**

119. More generally, the Committee considers that the current guardianship provisions with respect to PNI residents create a clear potential for conflict of interest and fail to maximise the protection and care of the residents. **The CPT reiterates its recommendation that alternative solutions be found which would better protect the legitimate interests of legally incapable residents held in PNIs in the Russian Federation.**

120. The initial placement procedure for a prospective resident who lacks legal capacity requires a court decision on legal capacity and a formal request by a guardianship and care authority, itself based on the resolution of a "medical commission", which shall include a psychiatrist. At each of the PNIs visited, the delegation reviewed the initial admission documentation in relation to numerous legally incapable residents and found that the admission process had been carried out in accordance with law, and was well-reasoned and documented.[110]

As regards the review of the need for continued placement, the existing practice was for an annual review to be carried out by a committee of three psychiatrists drawn from the institution in which the resident was living. No automatic court review was laid down for residents of PNIs. At PNI no. 16, a new pilot procedure has recently been introduced requiring that each placement be reviewed annually by a multi-disciplinary commission; however, only a few residents had had their placement reviewed so far (see also paragraph 104 above).

In relation to discharge procedures, discharge from a PNI of a person declared legally incapable is only likely to take place if the person concerned is successful in having his/her legal capacity restored as a result of court proceedings. In certain of the establishments visited,[111] the delegation found that staff had identified – and were working intensively with – a small number of residents whom they considered might be supported through legal proceedings to regain their legal capacity and eventually to leave the establishments; the Committee welcomes these efforts. However, in other places, notably at Babushkin PNI, it appeared to be the case that residents who had been declared as lacking legal capacity had no realistic prospects of discharge.

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109 About 166 EUR.

110 Most of the court incapacity decisions seen were drafted in a relatively precise fashion, reasoned and supported by psychiatric opinion. In many cases, the person declared incapacitated had been physically present at the incapacity hearing and/or had been seen and spoken with by the court. Following the incapacity decision by the court, subsequent transfer decisions were made by the relevant social welfare authorities.

111 In particular at Angarsk PNI.

121. The delegation understood that medical staff in all PNIs visited assumed that informed consent to treatment was not required for any residents who had been deprived of their legal capacity. As a result, treatments, often powerful neuroleptic medication, were prescribed, with little or no information provided to the resident. In the case of residents with severe learning disabilities and the absence of any language, this presents evident difficulties. The best practice would be to identify a person, independent of the establishment, who would effectively defend the interests of the resident and ensure his/her participation in the process of granting consent. However, in interviews with residents with whom a meaningful conversation could be held, it was evident that no information had been effectively communicated about the nature of their psychotropic medication and, with one exception at PNI No. 16 in Moscow, none of the residents with whom the delegation spoke were aware of the name of the medication they were taking, nor of the desired effect or possible side effects.

122. According to Section 8 of the Law on Guardianship, guardianship and trustee supervisory authorities should regularly carry out inspections of living conditions in PNIs, as well as monitor respect by guardians and trustees of the rights and interests of residents, including the safety of their property.

Residents in the PNIs visited could in theory lodge a formal complaint. However, most of the residents interviewed by the delegation appeared to be unaware of the existence of such a possibility. Additionally there was no central register of complaints in any of the PNIs visited.

123. In the light of the remarks in paragraphs 114 to 122 above, **the Committee recommends that the Russian authorities take steps (including, if necessary, legislative amendments) to ensure that:**

- **residents of social care establishments have the effective right to bring proceedings to have the lawfulness of their placement decided by a court, that they are duly informed of this right, and that in this context, they enjoy the rights to a lawyer and to be heard by the judge concerned;**

- **the decision by a court on deprivation of a person's legal capacity does not automatically carry with it the consequence that the person's initial placement in a PNI will be authorised;**

- **an effective and automatic review by an outside authority (e.g. a court) of the need to continue the placement in all PNIs is introduced and carried out at regular intervals;**

- **the discharge procedure is modified so as to allow residents in PNIs (and their guardians/trustees) to request discharge at reasonable intervals;**

- **the decision on deprivation of legal capacity does not automatically lead to the assumption that the person concerned should not and cannot give informed consent to treatment; the capacity to give informed consent should therefore be assessed on an individual basis and, even for persons from whom fully informed consent cannot be ensured, attempts should be made to provide some understanding of the treatment they are receiving, including the name of the medication, its purpose and possible side effects;**

- **in all PNIs in the Russian Federation, an introductory leaflet setting out the establishments' routine and residents' rights – including information about complaints bodies and procedures – is drawn up and systematically provided to residents (and their guardian/families) on admission. Any residents unable to understand this leaflet should receive appropriate assistance;**

- **residents in all PNIs are effectively enabled to make both internal and external complaints.**

124. As regards inspection procedures, **the CPT would like to receive more detailed information on the practical operation of the system referred to in paragraph 122 above (especially, whether inspectors are allowed to speak in private with residents, receive directly their complaints and make any recommendations). The Committee also wishes to be informed whether PNIs are regularly and frequently monitored by any other outside bodies (e.g. the federal and regional Plenipotentiaries for Human Rights).**

APPENDIX I:

List of the establishments visited by the CPT's delegation

Psychiatric establishments

- Federal Specialised Psychiatric Hospitals with Intensive Supervision in Kazan
- Federal Specialised Psychiatric Hospitals with Intensive Supervision in Volgograd
- Branch No. 2 of Volgograd Regional Psychiatric Hospital No. 2
- Krasnoarmeyskaya Regional Psychiatric Hospital named after Yuriy Alekseevich Kalyamin in Saratov Region

Social care establishments

- Psycho-Neurological Internat No. 16 in Moscow
- Psycho-Neurological Internat No. 34 in Moscow
- Angarsk Psycho-Neurological Internat in Irkutsk Region
- Babushkin Psycho-Neurological Internat in the Republic of Buryatia

APPENDIX II:

List of the national authorities, other bodies and non-governmental organisations with which the CPT's delegation held consultations

Federal authorities

Ministry of Healthcare

Oleg Salagay	Deputy Minister
Andrey Gaiderov	Deputy Director, Department of International Cooperation and Public Relations
Darya Pekova	Head of Research Department, Serbsky State Research Centre for Psychiatry and Narcology
Natalya Demcheva	Epidemiological psychiatrist, Serbsky State Research Centre for Psychiatry and Narcology

Ministry of Labour and Social Protection

Svetlana Petrova	Deputy Minister
Maria Antonova	Director, Department of Demography Policy and Social Protection
Igor Zemlyansky	Head, International Cooperation Division

Non-governmental organisations

Independent Psychiatric Association of Russia