VISIT REPORT

UKRAINE

May - June 2025

CPT

EUROPEAN COMMITTEE
FOR THE PREVENTION OF
TORTURE AND INHUMAN OR
DEGRADING TREATMENT
OR PUNISHMENT

AD HOC VISIT

26 May – 6 June 2025

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COUNCIL OF EUROPE
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Council of Europe

Contents

KEY OBSERVATIONS

PRIORITY TOPICS

■ Psychiatry and Social Care

DE-INSTITUTIONALISATION – Continue the implementation of respective de-institutionalisation strategies.

LIVING CONDITIONS – Continue refurbishment of psychiatric and social care establishments

STAFF – Strive to hire more qualified socio-therapeutic staff and

TREATMENT - Increase the range of treatments other than pharmacotherapy

MEANS OF RESTRAINT – Stop using means of restraint in social care establishments

SAFEGUARDS – Ensure genuine, free and informed consent to placement and treatment for all formally voluntary patients and residents.

THE CPT AND UKRAINE

Ukraine ratified the ECPT in 1997, and the Committee's first visit took place in 1998.

Since ratification, the CPT has carried out 18 country visits to Ukraine– 8 periodic and 10 ad hoc – including 162 visits to police establishments, 64 to prisons, 12 to psychiatric institutions, 9 social welfare and educational-correctional establishments, 6 to military detention facilities, and 19 to border and immigration detention facilities.

All the visit reports have been published. Ukraine has accepted the automatic publication of the visit reports since November 2014.

EXECUTIVE SUMMARY

The aim of this visit, the CPT's second since the beginning of the full-scale military aggression by the Russian Federation in February 2022, was to examine the treatment and conditions of detention of persons hospitalised and treated against their will in psychiatric hospitals, as well as those accommodated in social care establishments for disabled and older persons. The delegation visited psychiatric hospitals in Lviv (Kulparkiv Hospital), Orlivka (Sarny) and Hlevakha (Kyiv Region), as well as Hrushkivskyi "Internat" (Lviv Region), Vinnytsia "Pensionat for the Elderly and Disabled Persons", and Baraboi "Internat" (Odesa Region).

The CPT is particularly pleased to note that, despite the extremely challenging situation prevailing in Ukraine, its delegation received excellent co-operation throughout the visit at all levels.

Psychiatric establishments

The delegation heard no allegations of physical ill-treatment by staff at any of the hospitals visited. Overall, there was a relaxed atmosphere and the delegation observed good staff-patient relations. As for inter-patient violence, conflicts did occur sometimes but they were not a serious issue at any of the hospitals, and staff intervened promptly and adequately whenever such conflicts arose.

Living conditions varied in the hospitals visited. The best (i.e. good) conditions were observed on the already refurbished wards in Lviv and Hlevakha, where patients lived in smaller, well furnished, decorated and personalised rooms. The majority of the wards in Lviv and Hlevakha, whilst not of such a high standard, offered still decent accommodation. The worst (i.e. quite poor) conditions were found on Ward 2 in Lviv, Wards 2, 3 and 4 at Orlivka Psychiatric Hospital, as well as on the forensic wards and Ward 18 in Hlevakha, with austere and cramped dormitories, and a lack of lockable space, privacy and personalisation. There was ongoing refurbishment in the three hospitals, and it was clearly both the plan and the intention of the respective managements to gradually bring the living conditions to the level found on the already refurbished wards. The CPT cannot but encourage the Ukrainian authorities to pursue these efforts which should also permit, in due course, to have more living space per patient on all the wards.

The health-care staff complements appeared to be generally sufficient. Admittedly, there were vacant posts in the three hospitals, mostly so at Orlivka and Hlevlakha; the Committee invites the Ukrainian authorities to strive to fill them. By contrast with the satisfactory staffing situation as regards doctors, nurses and orderlies, there were generally too few psychologists and other therapeutic staff, such as occupational therapists and physiotherapists. Likewise, there were not enough social workers.

In the three psychiatric hospitals visited, the treatment was essentially based on pharmacotherapy which was generally adequate although the dosage and combination of prescribed medicines was sometimes rather high in Orlivka. Other psycho-social therapeutic activities were available in Hlevakha and on most of the wards in Lviv but were in short supply in Orlivka.

The Committee invites the Ukrainian authorities to make serious efforts to further develop a range of therapeutic options and involve more patients in rehabilitative psycho-social activities; to make it possible, more qualified staff (psychologists, occupational therapists, physiotherapists, social workers, etc.) will need to be hired.

All patients at the Orlivka and Hlevakha hospitals had access to at least two hours of daily outdoor exercise in a decent environment whereas at Lviv this was not the case. The Committee recommends that urgent steps be taken to remedy this situation. More generally, the aim should be to ensure that all patients benefit from an unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward.

Seclusion was not applied at any of the psychiatric hospitals visited. As for mechanical restraint (fixation), it was not used frequently and when it was applied then as a last resort measure and always for short periods of time. However, although the use of fixation was generally well recorded, there were still no centralized registers (only ward-based ones). Further, the use of chemical restraint was not recorded in aforementioned registers at any of the hospitals. The main issue of concern at Kulparkiv and Orlivka

Psychiatric Hospitals was that, unlike at Hlevakha Psychiatric Hospital, patients were often fixated in view of other patients. Further, at Kulparkiv Psychiatric Hospital the delegation observed that police officers could sometimes be asked by health-care staff to help them restrain a patient. The CPT recommended that steps be taken to address the above lacunas.

The legislation in force concerning involuntary psychiatric hospitalisation and treatment seemed to be duly followed in practice, both as regards the "civil" and forensic patients. The delegation examined several administrative/legal patient files in the hospitals visited and concluded that there were no delays in the context of initial placements for "civil" involuntary patients (in Lviv) and for the prolongation of preventive measures (pursuant to Section 508 of the Code of Criminal Procedure) for forensic patients in Orlivka and Hlevakha. For forensic patients, at Orlivka the 6-monthly reviews by the hospital's psychiatric commission were carried out but often at the very end of the 6-month period (although the law stated "no less than every 6 months") and then there were sometimes delays (10 to 40 days) in the court issuing a decision. By contrast, in Hlevakha the hospital's psychiatric commission had the practice of sending its recommendation to the court sufficiently in advance to prevent such delays in court decisions. The Committee recommends that an analogous practice be adopted at Orlivka Psychiatric Hospital.

On the positive side, all patients – both "civil" and forensic – had access to (mostly *ex officio*) legal assistance and there was always a court hearing.

All "civil" patients were asked by the admitting doctor, upon arrival, to sign consent forms with three signatures, confirming that they agreed to be hospitalised, to undergo diagnostic procedures and to receive any treatment prescribed by the hospital's doctors. However, the CPT has misgivings as to how genuinely free and informed that consent could often be. The Committee recommends that steps be taken to ensure that "civil" patients are always able to give their free and informed consent to both hospitalisation and treatment.

Finally, it is positive that as a rule patients had good possibilities to receive visits by relatives and friends and they had access to a telephone as well as controlled access to the internet. However, although internal complaints procedures did formally exist in the three hospitals, the delegation gained the impression that these procedures were not operating very efficiently. The Committee recommends that measures be taken to improve the operation of the internal complaints systems in the three psychiatric hospitals visited.

Social care establishments

The delegation did not receive any credible allegations of deliberate physical ill-treatment of residents by staff in the social care establishments visited. The overall atmosphere and staff-resident relations appeared fairly relaxed. As for inter-resident violence, conflicts between residents did occur occasionally but were swiftly and adequately addressed by the staff. The CPT welcomes this.

Living conditions were overall good in the refurbished parts of the establishments visited. By contrast, conditions were poor in the not (yet) refurbished areas, especially floors 2 and 4 of Ward 2 of Vinnytsia "Pensionat" as well as all the resident accommodation at Baraboi "Internat", where the rooms were quite dilapidated and often austere. This was compounded by overcrowding on some of the wards. The worst conditions were observed in the rooms and dormitories accommodating bedridden residents e.g. on Ward 2 in Vinnytsia, with a lack of privacy and lockable space. In the three social care establishments visited, the managements were making intense efforts to seek funding to continue improving the living conditions. The CPT can only encourage these efforts with a view to completing as soon as possible the refurbishment of all the remaining resident accommodation.

As for outdoor exercise, most of the residents could circulate freely during the day within the establishments' extensive green areas. Access was more problematic for bedridden residents and those with reduced mobility. The Committee recommends that steps be taken to provide residents with reduced mobility with adequate staff assistance to be able to accede to the outdoor exercise areas in the three social care establishments visited.

Regarding health-care staff, the three social care establishments visited would clearly benefit from an increased presence of doctors, nurses and orderlies. However, the biggest problem was the insufficient complement of other therapeutic and rehabilitation staff. None of the social care establishments employed a psychologist or a fully trained occupational therapist; further, there were very few social workers and only Vinnytsia "Pensionat" had an in-house physiotherapist. The Committee recommends that efforts be made to improve the staffing situation in the social care establishments visited.

As for the treatment provided to residents, it was essentially based on pharmacotherapy, with a limited range of mostly first-generation anti-psychotic drugs available. Further, the range of other psycho-social therapies and activities available appeared to be rather limited. The Committee recommends that steps be taken to develop the offer of psycho-social therapy and other activities for residents of the social care establishments visited.

The CPT is of the view that, as a matter of principle, means of restraint should not be applied in social care establishments. The policy should be to gradually phase out their use and replace them with alternatives such as de-escalation techniques, for the use of which staff working in such establishments should receive adequate training. On those rare occasions when a resident becomes agitated and has not calmed down despite the staff having applied de-escalation techniques, the normal procedure should be to call an ambulance with the view to transferring the resident without delay to a more appropriate health-care setting. The CPT recommends that the Ukrainian authorities modify their approach in respect of resort to means of restraint in social care establishments, in the light of the above remarks.

The delegation noted that the legal framework was generally duly observed in the three social care establishments visited, including the requirement to sign "contracts" between residents (or their guardians) and the establishments' Directors, and to carry out reviews by medical commissions and district medico-social expertise commissions. However, it remained the case that residents were as a rule not given a copy of the "contract" and that staff usually did little to explain the meaning and the content of the "contracts" to the residents. The CPT calls upon the Ukrainian authorities to ensure that residents in social care establishments (including those legally incapacitated) are systematically given a copy of the "contract" signed with the Director of the institution and are provided with information, in a format they can understand, about the meaning of the "contract" and their right to request discharge from the establishment.

The Committee is concerned by the fact that, despite its previous repeated recommendations, many legally incapacitated residents in the three social care establishments visited had the establishment's Director performing the functions of their guardian. The CPT again calls upon the Ukrainian authorities to search for alternative solutions which would better guarantee the independence and impartiality of guardians.

As regards complaints, residents could *inter alia* complain online and by phone to the Ombudsman. However, as far as the delegation could ascertain, there were no formal internal complaints procedures and no complaints registers. The Committee recommends that steps be taken to ensure that residents are informed of possibilities to lodge both internal and outside complaints, on a confidential basis.

Concerning contact with the outside world, residents could receive visitors without restrictions. However, residents without own mobile phones had no (or very limited) access to a telephone. The CPT reiterates its recommendation that steps be taken to facilitate access to a telephone for residents who do not possess their own mobile phones.

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 Ukraine from 26 May to 6 June 2025. It was the CPT's second visit to Ukraine since the beginning of the full-scale military aggression by the Russian Federation in February 2022. The previous visit took place in October 2023.[1]

The visit was one which appeared to the Committee "to be required in the circumstances" (see Article 7, paragraph 1, of the Convention) and its purpose was to examine the treatment and conditions of detention of persons hospitalised and treated against their will in psychiatric hospitals, as well as those accommodated in social care homes ("internats" and "pensionats") for disabled and older persons. In this context, the CPT also assessed the implementation of its previous recommendations on these issues, made in the reports on the 2017 periodic[2] and 2019 ad hoc visits.[3] It was the Committee's eighteenth visit to Ukraine.[4]

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

- Victor Zaharia, Head of delegation
- Dovilė Juodkaitė
- Alexander Minchev
- Ceyhun Qaracayev.

They were supported by Borys Wódz (Head of Division) and Monica Martinez of the CPT's Secretariat, and assisted by:

- Andres Lehtmets, Head of the Psychiatry Clinic of Tartu University Hospital, Estonia (expert)
- Dmytro Kopylov (interpreter)
- Oleksandr Martseniuk (interpreter).

3. The delegation visited psychiatric hospitals in Lviv (Kulparkiv Hospital), Orlivka (Sarny) and Hlevakha (Kyiv Region), as well as Hrushkivskyi "Internat" (Lviv Region), Vinnytsia "Pensionat for the Elderly and Disabled Persons", and Baraboi "Internat" (Odesa Region).

4. The report on the visit was adopted by the CPT at its 118th meeting, held from 3 to 7 November 2025, and transmitted to the Ukrainian authorities on 19 November 2025. The various recommendations, comments and requests for information made by the Committee are set out in bold type in the present report. The CPT requests the Ukrainian 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.

1. See https://www.coe.int/en/web/cpt/-/council-of-europe-anti-torture-committee-cpt-visits-ukraine.
2. Document CPT/Inf (2018) 41, http://rm.coe.int/16808d2c2a.
3. Document CPT/Inf (2020) 1, https://rm.coe.int/1680997b34.
4. See the full list of visits and their dates on the CPT's website, https://www.coe.int/en/web/cpt/ukraine. All the Committee's reports and responses of the Ukrainian authorities to date are in public domain, upon the authorities' request and pursuant to the automatic publication procedure introduced by the Ukrainian authorities in 2014. According to this procedure, all documents related to CPT visits shall be published automatically, unless the Ukrainian authorities submit within one month a request to postpone (for a period of up to six months) the publication of the document concerned.

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

5. In the course of the visit, the delegation had consultations with Ihor Kuzin, Deputy Minister of Health, Iryna Postolovska, Deputy Minister of Social Policy, and senior officials from the aforementioned Ministries.

In addition, talks were held with Artem Volodin, Director of the Department for the Implementation of the National Preventive Mechanism (NPM) of the Office of the Ukrainian Parliament Commissioner for Human Rights (Ombudsman). The delegation also met representatives of non-governmental organisations active in areas of concern to the CPT.

A list of the national authorities and non-governmental organisations with which the delegation held consultations is set out in the Appendix to this report.

6. The CPT is particularly pleased to note that, despite the extremely challenging situation prevailing in Ukraine, its delegation received excellent co-operation throughout the visit at all levels. It enjoyed rapid access to all the establishments it wished to visit, was provided with the information necessary for carrying out its task and was able to speak in private with persons deprived of their liberty.

In this context, the Committee would like to express its particular appreciation for the assistance provided before and during the visit by the CPT's Liaison Officer, Ms Svitlana Rohozianska from the Ministry of Justice, as well as by her Deputy, Mr Vladyslav Klysha.

II. Facts found during the visit and action proposed

A. Psychiatric establishments

1. Preliminary remarks

7. As already mentioned in paragraph 3 above, the delegation visited psychiatric hospitals in Lviv (Kulparkiv Hospital), Orlivka (Sarny) and the Kyiv Region (Hlevakha); the visit to Hlevakha Hospital was of a follow-up nature as the CPT had visited it previously, in 2017.[5]

Lviv Regional Psychiatric Hospital (hereafter Kulparkiv Psychiatric Hospital), inaugurated in 1875, was composed of several buildings spread across a 16-hectare park; both the buildings and the park were legally protected as architectural monuments. At the time of the visit, the hospital had the official capacity of 553 beds and was accommodating 490 adult patients. Approximately 330 of the patients were legally considered as "civil" patients,[6] almost all of them (except for two female patients) formally voluntary.[7] Patients were accommodated on 13 wards[8] whilst one ward (Ward 14, 30 beds) was temporarily closed and undergoing refurbishment. The average stay was said to be 18 days.[9]

Orlivka Psychiatric Hospital,[10] located near the town of Sarny (Rivne Region), was opened in 1983 and had served as a regional psychiatric hospital until March 2025 when it was reprofiled as a forensic psychiatric establishment. At the time of the visit, the hospital had the official capacity of 500 beds[11] and was accommodating 393 forensic patients[12] including some 50 women. Most of the patients had been transferred from Dnipro Psychiatric Hospital, others from Lviv and Poltava, and the majority had already been hospitalized for several years (some since 2013).

Accommodation was provided on three wards (Ward 2 with 130 patients on general regime, Ward 3 for women upstairs and 75 men on general regime downstairs, Ward 4 for 138 men including 37 on high-security regime[13]) whilst Ward 1 was temporarily closed and undergoing refurbishment.

As for Hlevakha Psychiatric Hospital, it had the official capacity of 512 beds and was accommodating 397 patients (including 54 forensic, eight of whom on Section 508 measure) allocated among 13 operational wards.[14] As had been the case during the 2017 visit, the wards were surrounded by a well-kept 22-hectare

5. For a detailed (and still generally correct) description of the establishment see e.g. paragraph 191 of the report on the 2001 periodic visit (CPT/Inf (2002) 19), https://rm.coe.int/1680698393.
6. There were no more any forensic patients, since the hospital had lost this function and all its forensic patients had recently been transferred to Orlivka Hospital (see below).
7. See, however, paragraph 26 below.
8.. Admission/intensive care (10 beds, mixed-gender); first psychotic episode (Ward 25, 35 beds, mixed-gender); acute wards for men (Ward 3, 45 beds) and women (Ward 22, 40 beds); two general psychiatry wards for men (Ward 10, 50 beds, and Ward 12, 40 beds); a general psychiatry ward for women (Ward 20, 50 beds); three wards for patients with PTSD (Ward 15, men only, 50 beds; Ward 9, mixed-gender, 50 beds; Ward 7, mixed-gender, 35 beds); an addictions ward (Ward 31, 40 beds, mixed-gender); a long-term ward for chronic patients for whom no solution had so far been found to transfer them to appropriate social care establishments (Ward 2, mixed-gender, 75 beds) and a supported living (transition) ward with place for up to three patients living semi-autonomously.
9. For the "civil" patients, the National Health Service paid for a maximum of 30 days of hospitalisation; any stays longer than 30 days were to be paid from the hospitals' own resources.
10. Official name: Rivne Branch of the Institute of Forensic Psychiatry.
11. The delegation was told that it was planned to reduce the official capacity to 150 beds by the end of 2026, after transfer of forensic patients from Western Ukraine to a new forensic hospital to be opened in Ivano-Frankivsk.
12. Including 44 (38 men and 6 women) subjected to a "preventive measure" (equivalent of remand imprisonment) pursuant to Section 508 of the Code of Criminal Procedure (see paragraph 24 below).
13. Regimes for forensic patients were set by court when persons concerned were committed to undergo a compulsory measure; in practice, there was hardly any difference between the regimes other than the extent of freedom of movement within the territory of the hospital (from completely unrestricted for general regime to restricted to the territory of the ward for the high-security regime). See, on this, paragraph 8 below.
14. Admission/intensive care (12 beds, mixed-gender); first psychotic episode for men (Ward 10, 40 beds); first

park but, unlike then, two of the wards were not operational (Ward 3 awaiting the future arrival of patients with PTSD and the addictions ward which had no patients and was thus "conserved"); further, one ward was temporarily closed for refurbishment (Ward 6, general psychiatry for women, 40 beds) although the work had almost been completed and the ward was scheduled to be reopened within the next 10 days. It is noteworthy that none of the "civil" patients were formally involuntary and that there had reportedly been no such patients at the hospital for the past several months; on this, see paragraph 26 below.

8. Both in the psychiatric establishments visited and during the meeting at the Ministry of Health, the delegation was informed that the reform of the psychiatry sector (pursuant to the National Health Care Strategy until 2030) was progressing despite the ongoing war. The reform comprised *inter alia* a reduction of the sizes and capacities of existing large regional psychiatric hospitals, gradually transferring patients to smaller (30 – 40 beds) psychiatric wards of general hospitals (so as to allow patients to be closer to their homes), reducing the number of forensic hospitals (in order to have only six such hospitals in the country with forensic patients being, again, allocated as close to their homes as possible) and developing outside structures in the community (including more protected accommodation and outpatient services) in co-operation with regional and local authorities and in accordance with the de-institutionalisation objective.

The delegation was also informed that a draft new Mental Health Act, reflecting these objectives,[15] was under preparation and it was hoped that it would be examined and adopted by the Verkhovna Rada (Parliament) before the end of 2025.

The CPT would like to be provided with updated information on the draft new Mental Health Act and on the progress of the aforementioned reforms. In this context, reference is also made to the recommendation in paragraph 13 below.

2. Ill-treatment

9. The delegation heard no allegations of physical ill-treatment by staff at any of the hospitals visited. Overall, there was a relaxed atmosphere and the delegation observed good staff-patient relations in the three hospitals.

However, a few isolated complaints were received from interviewed patients regarding rude behaviour and the use of impolite language by particular members of the junior ward-based health-care staff ("sanitars" or orderlies) in Lviv and Orlivka.

The Committee recommends that the managements of both aforementioned hospitals remind all junior health-care staff that they must always treat patients politely and with respect.

10. As for inter-patient violence, conflicts did occur sometimes but they were not a serious issue at any of the hospitals, and staff intervened promptly and adequately whenever such conflicts arose.

psychotic episode for women (Ward 2, 40 beds); two general psychiatry wards for men (Wards 1 and 16, each with 60 beds); a general psychiatry ward for women (Ward 7, 40 beds); two long-term psychiatric wards accommodating patients evacuated in 2022 from a hospital near Kharkiv which had found itself in the vicinity of the front (Ward 15 for women, with 50 beds and 43 patients, and Ward 18 for men with likewise 50 beds and 45 patients); two forensic wards for men (Wards 13 and 17, each with 40 beds); a neurosis/borderline ward (Ward 5, mixed-gender, 40 beds); an epilepsy/psycho-neurology ward (Ward 11, mixed-gender, 20 beds) and a palliative care/old age psychiatry ward (Ward 4, mixed gender, 20 beds).

15. The draft new MHA would reportedly also abolish the regimes in psychiatric hospitals, leaving only the distinction between inpatients and outpatients. In addition, corresponding amendments to the Criminal Code and Criminal Procedure Code were under preparation (for the forensic patients).

3. Patients' living conditions

11. Living conditions varied in the hospitals visited. The best (i.e. good) conditions were observed on the already refurbished wards in Lviv and Hlevakha (e.g. admission/intensive care ward and Ward 25 at Kulparkiv Psychiatric Hospital and Wards 2, 4, 6 and 10 of Hlevakha Psychiatric Hospital), where patients lived in smaller, well furnished, decorated and personalised rooms measuring from 20 to 35 m^2 and accommodating from one to four patients.[16] Also the communal areas (day rooms and canteens) were pleasantly decorated and the wards were designed in such a manner that every two to three rooms shared a common fully-equipped bathroom (including a shower); that said, not all of the bathrooms were fully accessible for patients with reduced mobility.

The majority of the wards in Lviv and Hlevakha, whilst not of such a high standard, offered still decent accommodation,[17] with dormitories and communal areas (corridors, canteens and day rooms) being clean, well-lit and ventilated, and with nothing negative to report as concerns the beds and bedding, hygiene items, access to toilets and showers, patients' individualised clothing and food.

12. The worst (i.e. quite poor) conditions were found on Ward 2 in Lviv,[18] Wards 2, 3 and 4 at Orlivka Psychiatric Hospital, as well as on the forensic wards (in particular the male Ward 17[19]) and Ward 18 in Hlevakha, with austere and cramped dormitories (measuring from 25 to 115 m^2 and accommodating between five and 15 patients each) and a lack of lockable space, privacy and personalization. The lack of privacy was particularly striking in Orlivka where dormitories did not have doors and where there were no curtains in windows (not even in the toilets and shower rooms on men's wards, including those located opposite the women's accommodation on Ward 3).

13. As already mentioned in paragraph 7 above, there was ongoing refurbishment in the three hospitals and it was clearly both the plan and the intention of the respective managements to gradually bring the living conditions to the level found on the aforementioned already refurbished wards.

> **The CPT cannot but encourage the Ukrainian authorities to pursue these efforts which should also permit, in due course, to have more living space per patient on all the wards.[20] In the context of the ongoing refurbishment, particular attention should be paid to ensuring accessibility throughout the facilities, including in the bathrooms, for patients with reduced mobility.**
>
> **The Committee further recommends that, pending the completion of the comprehensive refurbishment work, urgent steps be taken to address the lack of privacy at Orlivka Psychiatric Hospital. A solution must also be found for the *de facto* social care patients accommodated on Ward 2 of Kulparkiv Psychiatric Hospital[21] and Ward 18 of Hlevakha Psychiatric Hospital.[22] As already mentioned in paragraph 7, patients had been placed in the latter ward on an emergency and in principle temporary basis, in a building originally slated for demolition. They should be transferred to social care homes (or other suitable outside structures) as soon as possible; see also the recommendation in paragraph 8 above.**

16. It is noteworthy that the ongoing reconstruction of Ward 1 at Orlivka Psychiatric Hospital was being carried out according to the same principle.
17. E.g. Wards 3 and 31 in Lviv, with dormitories measuring approximately 50 to 60 m^2 and generally accommodating four to five patients each; and Ward 7 at Hlevakha Psychiatric Hospital, with the dormitories measuring up to 80 m^2 and accommodating up to ten patients.
18. Accommodating long-term, *de facto* social care patients, many of them older and incontinent.
19. Admittedly, Ward 17 had been refurbished quite recently and would have offered decent conditions were it not for the fact that it was (temporarily) overcrowded, pending the completion of refurbishment of Ward 13, with the 30 m^2 rooms (normally supposed to accommodate four patients) being used for seven patients each.
20. As already mentioned above, at the time of the visit, conditions were rather cramped on some of the wards as other wards were temporarily closed and undergoing refurbishment.
21. See footnote 9 above.
22. See footnote 15 above.

4. Staff and treatment

14. The health-care staff complements appeared to be generally sufficient in the three psychiatric establishments visited.

Kulparkiv Psychiatric Hospital (capacity 553, population 450) had 70 psychiatrists, 290 nurses and 220 orderlies.[23]

Orlivka Psychiatric Hospital (capacity 500, population 393) employed six psychiatrists, 60 nurses and 72 orderlies,[24] whilst Hlevlakha Psychiatric Hospital (capacity 505, population 397) had 18 psychiatrists, 113 nurses and 147 orderlies.

Each hospital also had a number of other (somatic) doctors of different specialities, either resident or visiting.[25]

In the three hospitals, each ward (usually 40 to 60 patients) had at least one to three psychiatrists (including a chief doctor of the ward),[26] at least two to three nurses and at least two to four orderlies present during each working day (between 9 a.m. and 4.30 p.m.); at night and on weekends and public holidays, each ward had at least a nurse and at least two – three orderlies, whilst there usually were two psychiatrists present at the establishment (a duty doctor and another doctor working on the admissions/intensive care ward) and a duty anaesthesiologist.

Admittedly, there were vacant posts in the three hospitals, mostly so at Orlivka[27] and Hlevlakha;[28] the Committee invites the Ukrainian authorities to strive to fill them. Further, the Ukrainian authorities should take steps in anticipation of the likely departure of more doctors from Hlevakha Psychiatric Hospital in the near future, given that approximately half of the currently employed doctors are about to reach (or have already reached) their retirement age.

15. By contrast with the aforementioned generally satisfactory staffing situation as regards doctors, nurses and orderlies, there were generally too few psychologists[29] and other therapeutic staff (such as occupational therapists[30] and physiotherapists[31]). Likewise, there were not enough social workers.[32]

In this context, reference is made to the recommendation in paragraph 17 below.

23. Not all of those psychiatrists, nurses and orderlies were employed on a full-time basis.
24. In addition, Orlivka Psychiatric hospital employed 52 security staff who were essentially former (retrained) orderlies. Usually one or two security staff (guards) were present on each ward (exclusively female guards on the women's floor of Ward 3); they were not uniformed and were not issued with any "special means". Their main task was to assist the health-care staff and help prevent conflicts between patients, always upon doctor's instructions and under the supervision of nurses.
25. General practitioners, infectious diseases specialists, internal diseases specialists, neurologists and neuropathologists, surgeons, anaesthesiologists, dermatologists, gynaecologists, ophthalmologists, dentists, radiologists, laboratory specialists, etc.
26. Plus sometimes two – three trainee doctors.
27. 54 vacant doctor's posts, 40 vacant nurses' posts and 30 vacant orderlies' posts; it is noteworthy, however, that many of the nurses and orderlies worked on more than one post (and were paid accordingly).
28. According to the Head doctor, only 53% of doctors' posts were filled (and approximately 70% of the posts of nurses and orderlies).
29. There were eight psychologists at Kulparkiv Psychiatric Hospital, two at Orlivka Psychiatric Hospital and eight at Hlevlakha Psychiatric Hospital.
30. There were eight occupational therapists at Kulparkiv Psychiatric Hospital, one at Orlivka Psychiatric Hospital and six at Hlevakha Psychiatric Hospital.
31. There was one physiotherapist at Kulparkiv Psychiatric Hospital, none at Orlivka Psychiatric Hospital and one at Hlevakha Psychiatric Hospital.
32. There were three social workers at Kulparkiv Psychiatric Hospital, two at Orlivka Psychiatric Hospital and two at Hlevakha Psychiatric Hospital.

16. In the three psychiatric hospitals visited, the treatment was essentially based on pharmacotherapy which was generally adequate although the dosage and combination of prescribed medicines was sometimes rather high in Orlivka (especially shortly after admission).[33]

The CPT recommends that a review be carried out of the dosage and combination of medication prescribed to patients at Orlivka Psychiatric Hospital, especially during the initial period of hospitalisation.

17. Other psycho-social therapeutic activities were available in Hlevakha[34] and on most of the wards in Lviv[35] but were in short supply in Orlivka,[36] which was reportedly due to the fact that the hospital had only recently started operating as a forensic establishment and the relevant department was still at the setting up stage.

The delegation also observed that there were no proper detailed individual treatment plans[37] and no genuine multi-disciplinary teamwork by staff[38] at any of the hospitals visited.

The Committee reiterates its recommendation to take the necessary measures to draw up and regularly revise/update an individual written treatment plan for each patient (taking into account the special needs of acute, long-term and forensic patients and, with respect to the last-mentioned, the need to reduce any risk they may pose), including the diagnosis, the goals of treatment, the therapeutic means used and the staff members responsible. Patients should be effectively involved in the drafting and revision of their individual treatment plans and be informed of their progress.

The CPT also invites the Ukrainian authorities to make serious efforts in all the psychiatric establishments visited to further develop a range of therapeutic options and involve more patients in rehabilitative psycho-social activities, in order to prepare them for more independent living and/or return to their families and (in the case of forensic patients) also reduce the risk of re-offending.

Psychological and 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 improving self-image. It is axiomatic that this will require the recruitment of more specialists qualified to provide therapeutic and rehabilitation activities (psychologists, occupational therapists, and social workers); further, there needs to be a much fuller and more multi-disciplinary clinical team treatment approach, including multi-disciplinary clinical meetings where patients' cases can be regularly discussed.

33. For example, a young female patient interviewed by the delegation, who displayed typical symptoms of overmedication (expressionless face, tremor in hands, slow speech and gait), was receiving Clozapine 25 x 3, Haloperidol 0,5% 1.0, Quetiapine 200 mg x 2, Carbamazepine 100 mg + 200 mg and Clopixol depot 1/month.
34. Individual and group psychotherapy, arts, crafts and sports, involving approximately 100 patients per day. In addition, several patients helped, on a voluntary basis, maintain the hospital's grounds (especially the garden).
35. Individual and group psychotherapy, arts and crafts, sports, yoga, a small farm, cooking, carpentry, blacksmith workshop, movie club, etc. Those activities (apart from psychotherapy) were mostly available to patients (118 of them on the first day of the delegation's visit) who were allowed to leave their wards and could come on their own to the activity centre. In addition, some on-site activities were available to approximately 70 patients not allowed to leave their ward.
36. Some individual and group psychotherapy, music, arts and sports but only involving a few patients in total. In addition, eleven patients were gainfully employed (maximum 2 hours per day), helping distribute the food, washing the dishes, cleaning and gardening.
37. The ones the delegation saw in patients' files were mostly quite succinct and stereotypical, and drafted without the involvement of the patient.
38. Doctors and nurses did meet every day to discuss the situation of each patient on the ward, but there was no participation of other therapeutic staff (especially psychologists) who were not working on the wards but in separate departments. Interestingly, since 2024 multi-disciplinary teams had been set up (approximately 200 of them already operational throughout the country) but only for the work with outpatients.

18. All patients at the Orlivka and Hlevakha hospitals had access to at least two hours of daily outdoor exercise in (at the very least) a decent environment (with means of rest, shelter against inclement weather, grass and plants, fitness equipment, etc.) whereas at Lviv this was not the case.[39]

The Committee recommends that urgent steps be taken to remedy this situation.

More generally, the aim should be to ensure that all patients (in all psychiatric hospitals) benefit from an unrestricted access to outdoor exercise during the day unless treatment activities require them to be present on the ward.

5. Means of restraint

19. Seclusion was not applied at any of the psychiatric hospitals visited. As for mechanical restraint (fixation), it was not used frequently[40] and when it was applied then as a last resort measure, always for short periods of time (maximum three hours in total). Fixation was always ordered by a psychiatrist (for 30 minutes at a time) and its continuation required another decision by a doctor who had to see the patient prior to such prolongation. Further, whilst fixated, patients were under direct and permanent supervision by the nurses who were required to make written observations on the patients' condition (in the nurses' daily (shift) log) at least every 15 minutes. However, although the use of fixation was generally well recorded,[41] there were still no centralized registers (only ward-based ones).[42] Further, the use of chemical restraint was not recorded in aforementioned registers at any of the hospitals.[43]

The main issue of concern at Kulparkiv and Orlivka Psychiatric Hospitals was that, unlike at Hlevakha Psychiatric Hospital, patients were often fixated in view of other patients (in Lviv because of the absence of dedicated rooms and in Orlivka because of the absence of doors in such rooms[44]). Further, at Kulparkiv Psychiatric Hospital the delegation observed that police officers could sometimes be asked by health-care staff to help them restrain a patient.

20. In the light of the above remarks, the CPT recommends that the Ukrainian authorities take measures to modify the current practice of the use of means of restraint at Kulparkiv, Orlivka and (as applicable) Hlevakha Psychiatric Hospitals, so as to ensure that:

- **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);**

- **mechanical restraint is only applied by properly trained health-care staff; police officers should never be asked to assist health-care staff in restraining a patient;**

39. For example, ten out of the 45 patients on Ward 3 and likewise ten out of the 35 patients on Ward 25 of Kulparkiv Psychiatric Hospital were prohibited to go outdoors, reportedly because of a combination of the absence of a secure outdoor yard and the lack of staff capacity to escort them during outdoor walks.
40. For example, in Lviv and Hlevakha, depending on the profile of the ward, there had been between two and six instances of fixation per ward in the year 2024. In Orlivka, fixation had been used five times since the hospital's opening (including three times in respect of one and the same patient).
41. With *inter alia* a mention of the time of the start and end of the measure, the identity of the doctor who ordered its start and possible prolongation, and the name of the health-care staff members actually implementing the decision.
42. In addition to the aforementioned ward-based registers, instances of fixation were recorded in patients' medical files (both on paper and in a scanned form saved in the nationwide electronic database) and in nurses' daily (shift) logs.
43. The administration of chemical restraint (usually chlorpromazine (Aminazin), sometimes benzodiazepines or haloperidol) was recorded in the patients' medical files and in nurses' daily (shift) logs.
44. In addition, fixated patients were sometimes (rarely, only if the dedicated room was already in use) placed on the ward's corridor, close to the nurses' desk.

- **a specific central register is established to record all instances of recourse to means of restraint (including chemical restraint) in order for the management to be able to monitor the frequency and duration of their use. This is in addition to the records contained within the patient's personal medical file. 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.**

21. As far as the delegation could ascertain in the three psychiatric hospitals visited, there was a practice of staff debriefing patients after the end of the restraint measure, both to explain to the patients why they had been subjected to restraint (and, in particular, that it was not a punishment measure) and to offer the patients an opportunity to explain their emotions prior to the restraint; this is positive. However, the fact of such debriefing having taken place was as a rule not recorded in writing.

The CPT recommends that this lacuna be eliminated.

22. The delegation also noted that (formally) voluntary "civil" patients could sometimes be subjected to a fixation measure, without any change in their formal legal status (from voluntary to involuntary). The managements and doctors in the three psychiatric hospitals interpreted patients' initial consent to hospitalisation and treatment (see paragraph 26 below) as implying also consent to being restrained whenever the doctors deemed it necessary.

The Committee is of the view that this is not a correct approach and that, as a matter of principle, voluntary patients should not be restrained unless they specifically consent to a restraint measure; if such consent is not given (and recorded) and the doctors still think applying restraint is necessary, the involuntary hospitalisation (and treatment) procedure should be initiated without delay.[45]

The CPT recommends that the current practice be modified accordingly.

6. Safeguards

23. The legislation in force concerning involuntary psychiatric hospitalisation and treatment seemed to be duly followed in practice, both as regards the "civil" and forensic patients.

The rules applicable had remained essentially the same as during the 2017 periodic visit.[46] For a brief reminder, in the case of *"civil" patients* the initial decision (valid 24 hours maximum) was taken by the head doctor of the admission ward (or the duty doctor, if admission occurred at night or on weekends).

Immediately upon arrival, provided the admitting doctor considered hospitalisation necessary, patients were requested to give their consent to hospitalisation and treatment (see paragraph 26 below). If a patient refused, the hospital's medical (psychiatric) commission (usually composed of at least two, sometimes three psychiatrists including the Head doctor) had to examine the patient and – if the commission agreed with the admitting doctor that hospitalisation and treatment were necessary – send (within 24 hours from admission) a reasoned request to the competent court which had another 24 hours to confirm the measure. The court's decision was usually valid for 30 days, sometimes less but never more. Any continuation of involuntary "civil" hospitalisation required another request by the hospital's medical commission and another court decision.[47]

45.. See also point 10 of document CPT/Inf (2017) 6, "Means of restraint in psychiatric establishments for adults (Revised CPT standards)", https://rm.coe.int/16807001c3.

46. See paragraphs 140 and 145 of document CPT/Inf (2018) 41.

47. That said, involuntary "civil" hospitalisations almost never lasted more than 30 days due to the already mentioned (see paragraph 7 above) fact that the National Health Service would not pay for any longer stays.

As for *forensic patients*, the placement (which implied compulsory treatment) was always by a court decision and was valid for up to 6 months at a time. Prior to the expiry of the (up to) 6-month period, the patient had to be examined by the hospital's psychiatric commission which could recommend a continuation, a modification (to outpatient treatment) or a termination of the measure. The decision then again rested with the court which had to review the measure in maximum 6-monthly intervals.[48]

Both in the case of "civil" and forensic patients, all court decisions could be appealed by the patients, their lawyers and legal representatives.

24. The delegation examined several administrative/legal patient files in the hospitals visited and concluded that there were no delays in the context of initial placements for "civil" involuntary patients (in Lviv)[49] and for the prolongation of preventive measures (pursuant to Section 508 of the Code of Criminal Procedure)[50] for forensic patients in Orlivka and Hlevakha.

For forensic patients, at Orlivka the 6-monthly reviews by the hospital's psychiatric commission were carried out but often at the very end of the 6-month period (although the law stated "no less than every 6 months") and then there were sometimes delays (10 to 40 days) in the court issuing a decision. By contrast, in Hlevakha the hospital's psychiatric commission had the practice of sending its recommendation to the court sufficiently in advance to prevent such delays in court decisions.

The Committee recommends that an analogous practice be adopted at Orlivka Psychiatric Hospital.

In this context, senior officials from the Ministry of Health told the delegation that the draft new Mental Health Act (see paragraph 8 above) would contain a provision requiring hospitals' psychiatric commissions to submit their recommendations to courts no later than before the expiry of the period of 5 months since the last compulsory measure.

The CPT would like to be informed, in due course, whether the aforementioned provision has been adopted.

25. On the positive side, all patients – both "civil" and forensic – had access to (mostly *ex officio*) legal assistance and there was always a court hearing (though usually online). In the CPT's view, it would be a good practice if the competent judges came to the hospitals for the hearings.

Such a practice would enable the judge not only to hear any explanations that the patient and doctor might have, but also to convey his or her decision personally and directly to the patient (with the assistance of the doctor if necessary).

26. All "civil" patients were asked by the admitting doctor, upon arrival, to sign consent forms with three signatures, confirming that they agreed to be hospitalised, to undergo diagnostic procedures and to receive any treatment prescribed by the hospital's doctors.[51]

48 . I.e. intervals could theoretically be shorter though they rarely were.

49. By contrast, appeals courts sometimes took up to 2 months to decide, so that on not infrequent occasions patients were released by the hospital (or consented to stay on a voluntary basis) before the court had issued a decision.

50. Preventive measures were a sort of equivalent of remand in custody but with respect to forensic patients; they were imposed by courts pending the outcome of psychiatric forensic assessment of persons who had been detained in connection with a punishable act (and pending the adoption of the compulsory measure). Such preventive measures were valid for 2 months at a time but could be prolonged an unlimited number of times, which sometimes resulted in preventive placements lasting many months.

51. The delegation also observed the practice of asking newly-arrived patients hospitalised pursuant to Section 508 to sign the form of consent to treatment, in order to fill a legal loophole (Section 508 permitting involuntary hospitalisation but not involuntary treatment).

However, the CPT has misgivings as to how genuinely free and informed that consent could often be. As already mentioned in paragraph 7 above, there were very few "civil" patients in Lviv who remained formally involuntary after the first 24 hours. As for Hlevakha, there were no formally involuntary "civil" patients at all during the visit, something that is highly unusual in a psychiatric establishment of this size.

The delegation spoke with a few patients who said that upon their arrival at the hospital they had been in such a condition that they could not fully (if at all) understand the meaning of their signature; there was also at least one case where a patient had signed the consent forms but immediately after this his condition had worsened so much that the doctor ordered to fixate him (which did not prompt any re-evaluation of the consent issue). At Hlevakha Psychiatric Hospital in particular, it transpired that only patients actively resisting hospitalization (who would write and sign a clear statement to this effect) would be considered as involuntary.

It is also an issue of concern that formally "voluntary" patients were often in fact unable to leave their ward (without the doctor's permission) – or at least leave it unescorted – and could be subjected to a measure of fixation.[52]

In the light of the above remarks, the CPT recommends that steps be taken (in the form of instructions and training for doctors) to ensure that "civil" patients are always in a position to give their free and informed consent to both hospitalisation and treatment.

In particular, upon their admission into psychiatric establishments, patients should be provided with full, clear and accurate information, including on their right to consent or not to consent to hospitalisation and treatment. Patients should also be provided with support to understand the treatment proposed and its implications, as opposed to doctors "convincing" patients to sign the consent forms. Further, it is essential that all patients who have given their consent to treatment are continuously informed about their condition and the treatment applied to them, and that they are placed in a position to withdraw their consent at any time. In addition, every patient capable of discernment should be entitled to refuse a particular treatment or any other medical intervention. Reference is also made here to the recommendation in paragraph 22 above.

27. Another issue of concern was that the psychiatric hospitals visited had no access to information on whether newly-admitted patients had a legal guardian. The Committee recommends that steps be taken to ensure that psychiatric hospitals have access to the relevant nationwide database kept by the guardianship authorities.

28. Finally, it is positive that as a rule patients had good possibilities to receive visits by relatives and friends and they had access to a telephone (office phones or private mobiles, laptops and tablets[53]) as well as controlled access to the internet (mainly to consult official websites and perform any administrative and official actions – including contacting external complaints bodies[54] such as the Ombudsman –, study and shop online, but also for video calls with families and friends).

However, although internal complaints procedures did formally exist in the three hospitals (there were complaint boxes on the wards, as well as dedicated complaint registers), the delegation gained the impression that these procedures were not operating very efficiently; among others, the complaints registers consulted by the delegation were all virtually empty.

52. See paragraphs 18 and 22 above.
53. Depending on the ward and the patient's condition, access could be either unlimited or restricted with the mobile, tablet or laptop being kept in storage and given to the patient upon request (e.g. for up to 30 min every second day in Orlivka and up to an hour daily on "civil" wards and three times per week on the forensic wards in Hlevakha).
54. Information on the right to complain externally and the identity and contact details of external complaint bodies was available to patients in the form of notices and posters placed in ward corridors.

In this context, the CPT wishes to reiterate that, in its view, an internal complaints system should ensure that patients are effectively enabled to make confidential written internal complaints at any moment. Patients should receive, within a reasonable time, written acknowledgement of every internal complaint they make and reasoned answers in writing to written complaints (feedback on the outcome of their complaints) in a timely manner. Further, a proper record should be maintained of every complaint and the hospital authorities should use complaints to help improve their practice within a clinical governance framework.

The Committee recommends that measures be taken to improve the operation of the internal complaints systems in the three psychiatric hospitals visited, taking into account the above-mentioned remarks.

Further, patients should be systematically provided with the necessary information, in a language and manner they understand, on the existing internal complaints mechanisms.

B. Social care establishments

1. Preliminary remarks

29. As already mentioned in paragraph 3 above, the delegation carried out first-time visits to Hrushkivskyi Psycho-Neurological "Internat" (hereafter Hrushkivskyi Internat) and Vinnytsia Regional "Pensionat for Disabled and Elderly Persons" (hereafter Vinnytsia Pensionat). Further, a follow-up visit was carried out to Baraboi Psycho-Neurological "Internat" (hereafter Baraboi Internat), previously visited by the CPT in 2019.[55]

Hrushkivskyi Internat was located in the village of Yakitoriv, 45 km from Lviv. Built in 1951 (originally as a hospital) and later enlarged, it had the official capacity of 110 and was, at the time of the visit, accommodating 104 adult female residents,[56] out of whom approximately 20 were bedridden. 59 of the residents had been evacuated from an "internat" in the east of Ukraine (Slovyansk) after the beginning of the full-scale military aggression by the Russian Federation. All residents had mixed diagnoses (psychiatric disorders, mostly schizophrenia and organic disorders, and various degrees of learning disability or dementia). Approximately a quarter of the residents were legally incompetent.

Vinnytsia Pensionat, located in a green area on the town's outskirts, had the capacity of 250 and was accommodating 160 adult residents (91 women and 69 men), including 32 bedridden persons. 66 of the residents had been evacuated from the East of Ukraine after the start of the Russian full-scale military aggression. Approximately 80% of the residents were older persons with dementia but there were also some younger persons (including five aged between 18 and 35) diagnosed with a mental health condition and/or learning disability.[57] Three of the residents were legally incompetent.

The general description of Baraboi Internat, made in the report on the 2019 ad hoc visit,[58] remains accurate. At the time of the 2025 ad hoc visit, the establishment had the official capacity of 140 and was accommodating 133 adult residents including 17 men.[59] Approximately twenty of the residents had been diagnosed with schizophrenia and all residents had a degree of learning and/or physical disability. Nearly all the residents (130) were legally incompetent.

30. In the course of her meeting with the delegation in Kyiv on 6 June 2025, the Deputy Minister of Social Policy referred to ongoing reforms of the social care sector, including the December 2024 National Strategy for Psycho-Neurological Institutions;[60] she also mentioned ongoing initiatives to improve internal monitoring mechanisms and review the requirements for social care providers, including in terms of the number of staff and their qualifications. The Deputy Minister acknowledged the need to further develop social care support services in order to step up de-institutionalisation. A number of pilot programmes to set up alternative community-based accommodation were reportedly underway.

In this context (as well as in the light of the findings of its delegation during the 2025 ad hoc visit), the CPT cannot but stress the importance of promoting alternatives to placement in social care institutions through the development of community-based services and support. Indeed, in the two "internats" and in the "pensionat" visited, the delegation met several residents whose condition would have allowed them to leave the establishments provided appropriate structures existed in the outside community.

55. See document CPT/Inf (2020) 1, https://rm.coe.int/1680997b34.
56. There was also a recently opened branch in the village of Zaklad, accommodating adult men, which was not visited by the delegation.
57. However, as a rule residents with such a profile would be accommodated in one of the two remote branches of Vinnytsia Pensionat located in the small town of Voronovytsia and in the village of Plyskiv. These two branches were not visited by the delegation.
58. See paragraph 9 of document CPT/Int (2020) 1.
59. In addition, ten residents were temporarily hospitalised at a nearby psychiatric establishment.
60. Strategy for the Reform of Psycho-Neurological and Other Residential Institutions and for the Deinstitutionalisation of Care for Adults with Disabilities and Elderly Persons until 2034.

The Committee calls upon the Ukrainian authorities to step up their efforts towards the development of social care in the community,[61] as this can not only shorten or avoid institutional stay and reduce the potential for ill-treatment, but also improve experiences and outcomes for service users.[62] Such community accommodation should ideally consist of small independent though supported living units located 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).

2. Ill-treatment

31. The delegation did not receive any credible allegations of deliberate physical ill-treatment of residents by staff in the social care establishments visited. The overall atmosphere and staff-resident relations appeared fairly relaxed.

As for inter-resident violence, conflicts between residents did occur occasionally but were swiftly and adequately addressed by the staff. The CPT welcomes this.

3. Residents' living conditions

32. Living conditions were on the whole good in the refurbished parts of the establishments visited such as most of the accommodation at Hrushkivskyi Internat and Ward 1 and floors 3 and 5 of Ward 2 in Vinnytsia (with bright, airy and personalised rooms measuring 10 to 20 m^2, furnished with beds with full bedding, bedside lockers, chairs, wardrobes, occasional table, fridge and TV set, and accommodating between one and four residents each).[63] The only real issue of concern at Hrushkivskyi Internat was the relatively low temperature in the rooms and other accommodation areas (approximately 17°C).

The Committee invites the Ukrainian authorities to seek ways to address this problem.

By contrast, conditions were poor in the not (yet) refurbished areas, especially floors 2 and 4 of Ward 2 in Vinnytsia as well as all the resident accommodation in Baraboi, where the rooms were quite dilapidated (damaged floors and walls, broken lamps, etc.) and often austere and furnished with nothing but beds and shared bedside lockers.[64] This was compounded by overcrowding on some of the wards such as parts of Ward 2 in Vinnytsia and the closed-regime Ward 4 in Baraboi (accommodating 64 residents sharing five rooms measuring between 10 and 20 m^2) where the rooms were still – despite a recommendation made by the CPT in the report on the 2019 ad hoc visit – fitted with bunk beds.[65] The delegation was also concerned by conditions in the "quarantine" rooms at Hrushkivskyi Internat,[66] which were fitted with beds which had sharp corners not adapted to the needs of persons with reduced mobility and older persons.

61. See also the recommendation in paragraph 156 of the report on the 2017 periodic visit (CPT/Inf (2018) 41), https://rm.coe.int/16808d2c2a.
62. This should also be seen in the context of the State's obligations stemming from the UN Convention on the Rights of Persons with Disabilities (CRPD), ratified by Ukraine in 2009. See e.g. the Concluding observations on the combined second and third periodic CRPD reports on Ukraine, https://digitallibrary.un.org/record/4063153/files/CRPD_C_UKR_CO_2-3-EN.pdf.
63. The delegation was told by the Director of Vinnytsia Pensionat that once the rest of Ward 2 was refurbished, there would be no more than two residents in each room.
64. Some redecoration had taken place at Baraboi Internat in recent years but the overall impression of a dilapidated facility remained.
65. There were also some bunk beds on the other wards of Baraboi Internat.
66. Where newly-arrived residents would spend the first two weeks in the establishment, before moving to a room on one of the wards.

The worst conditions were observed in the rooms and dormitories accommodating bedridden residents e.g. on Ward 2 in Vinnytsia, with a lack of privacy and lockable space, as well as the absence of a call system. The relative exiguity of living space (for example, two bedridden residents sharing a room measuring some 13 m^2 or four sharing a room of 20 m^2) was exacerbated by the need to store wheelchairs and walking aids. In the three social care establishments visited, the managements were making intense efforts to seek funding (from the State but also from institutional and private donors) to continue improving the living conditions.

The CPT can only encourage these efforts with a view to completing as soon as possible the refurbishment of all the remaining resident accommodation. This should also include the refurbishment of the "quarantine" rooms at Hrushkivskyi Internat and the kitchen at Baraboi Internat (closed after a fire and temporarily relocated to the establishment's former "quarantine" area). Further, the Committee recommends that efforts be intensified to address the overcrowding issue, especially on Ward 2 at Vinnytsia Pensionat and Ward 4 at Baraboi Internat.

33. In the three social care establishments visited residents had unrestricted access to communal toilets and bathrooms (which were generally in a decent condition). They could use ward-based showers at least three times a week (usually more often). However, the lack of privacy and wheelchair accessibility was an issue.

The Committee recommends that efforts be made to remedy this lack of privacy and wheelchair accessibility in the social care establishments visited.

34. The supply of personal hygiene items, disposable pads for incontinent residents and waterproof mattress covers was said to be usually sufficient, although (especially in Vinnytsia) there were occasional interruptions due to intermittent financing, which sometimes obliged staff to purchase any missing items using the money from residents' pensions[67] or to rely on humanitarian help.

The CPT recommends that the Ukrainian authorities take the necessary measures to ensure adequate and uninterrupted supply of hygiene items, disposable pads and waterproof mattress covers in the three social care establishments visited and, as applicable, in all social care establishments in Ukraine.

35. As regards the food, based on its own observations and on what it was told by residents, the delegation gained the impression that it was generally sufficient in quality and quantity, which is positive.[68]

36. As for outdoor exercise, most of the residents could circulate freely during the day within the establishments' extensive, green areas which were equipped with some seating and shelters against inclement weather. Access was more problematic for bedridden residents and those with reduced mobility, as it depended on the availability of the staff.

The Committee recommends that steps be taken to provide residents with reduced mobility with adequate staff assistance to be able to accede to the outdoor exercise areas in the three social care establishments visited.

The worst situation in this respect was again observed on Ward 4 in Baraboi,[69] where residents continued to be *de facto* confined to a smaller and bare area within their ward's secure perimeter.

67. 75% of residents' pensions was transferred on the establishments' accounts; residents could use the remaining 25% to buy food, cigarettes and other items in local stores.
68. At Hrushkivskyi and Baraboi Internats some part of the food items (especially milk, vegetable and fruit) was produced in the farms administratively attached to those establishments (see also paragraph 40 below).
69. Used to accommodate residents who were more agitated and likely to physically attack residents from other wards.

The CPT calls upon the Ukrainian authorities to ensure that all residents from Ward 4 of Baraboi Internat benefit from unrestricted access to sufficiently spacious outdoor areas during the day unless treatment activities require them to be present inside the buildings. Pending this, the most autonomous residents of Ward 4 should be allowed access to the establishment's general area, under appropriate staff supervision as required.

4. Staff and treatment

37. Regarding health-care staff, the three social care establishments visited would clearly benefit from an increased presence of doctors,[70] nurses[71] and orderlies,[72] in particular with respect to the many needy bedridden and incontinent residents and persons with first grade disabilities.

However, the biggest problem was the insufficient complement of other therapeutic and rehabilitation staff. None of the social care establishments employed a psychologist[73] or a fully trained occupational therapist; further, there were very few social workers[74] and only Vinnytsia Pensionat had an in-house physiotherapist.

The Committee recommends that efforts be made to improve the staffing situation at Hrushkivskyi and Baraboi Internats and at Vinnytsia Pensionat, including by increasing substantially the numbers of ward-based staff (nurses and orderlies), recruiting psychologists, occupational therapists and physiotherapists, and hiring additional social workers. More generally, the current staff-resident ratio in social care establishments,[75] as set out in the relevant Ministry of Social Policy order, is too low and should be increased.

38. As for the treatment provided to residents, it was essentially based on pharmacotherapy, with a limited range of mostly first-generation anti-psychotic drugs available. In this context, the delegation was concerned to note that some residents at Hrushkivskyi Internat were receiving Clozapine (Azaleptol) without the necessary regular blood tests (reportedly due to budgetary constraints and the fact that the cost of blood tests was not covered by the public budget).

As stressed by the CPT many times in the past, Clozapine can have as a side-effect a potentially lethal reduction of white blood cells (granulocytopenia).

Therefore, the Committee calls upon the Ukrainian authorities to take urgent steps to render regular blood tests mandatory in all social care establishments whenever Clozapine is used. The CPT also recommends that efforts be made to ensure the supply of newer generation psychiatric medication to social care establishments.

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70. Each of the establishments employed a psychiatrist on a 0.25 FTE (full-time equivalent) basis; the psychiatrists usually came 2 – 3 times per week, each time for a few hours. In addition, each social care establishment visited employed a full-time somatic doctor (GP) and had contracts with visiting specialists (gynaecologists, surgeons, cardiologists, radiologists, dentists, etc.) who could be called as needed.
71. Hrushkivskyi Internat (104 residents) employed 9 full-time nurses, Vinnytsia Pensionat (160 residents) had 12 full-time nurses and Baraboi Internat (123 residents) had 14 full-time nurses. There were between one and two nurses present on each ward (each floor in Vinnytsia) at any given shift.
72. There were two orderlies on each ward (each floor in Vinnytsia) at any given shift.
73. Although there was a visiting psychologist in Vinnytsia, working for an NGO and coming twice a week.
74. One at Hrushkivskyi Internat, seven at Vinnytsia Pensionat and two at Baraboi Internat.
75 . E.g. one nurse per 40 residents.

39. Further, the range of other psycho-social therapies and activities available appeared to be rather limited.[76] Individual rehabilitation plans (drafted and reviewed once a year by multidisciplinary teams involving at least the psychiatrists, the GPs and the social workers) were indeed found in the residents' files but tended to be quite stereotyped; it is also noteworthy that residents were not involved in drawing up and reviewing the plans.

The Committee recommends that steps be taken to develop the offer of psycho-social therapy and other activities for residents of the social care establishments visited.[77] Further, genuine individual treatment and rehabilitation plans must be drawn up for each resident (indicating the goals of treatment and rehabilitation, the therapeutic means used and the staff members responsible) and reviewed on regular intervals according to an in-depth assessment of each resident's physical and mental state. Residents should be effectively involved in the drafting, evaluation and review of their individual plans, and be informed of their progress. In addition, the plans should be more focused on gradually empowering the residents and increasing their autonomy, thereby improving their de-institutionalisation prospects.

40. At Hrushkivskyi and Baraboi Internats, the delegation (again) observed the practice of some residents (e.g. 17 in Baraboi) performing work – such as cleaning, small repairs and helping with gardening or farm work[78] – on an unpaid voluntary basis.

While the CPT acknowledges that work can play an important positive role in the psycho-social functioning of residents, the Committee wishes to reiterate its view that any kind of such work should be remunerated, at least symbolically.

5. Means of restraint

41. The Committee is of the view that, as a matter of principle, means of restraint should not be applied in social care establishments. The policy should be to gradually phase out their use and replace them with alternatives such as de-escalation techniques, for the use of which staff working in such establishments should receive adequate training. On those rare occasions when a resident becomes agitated and has not calmed down despite the staff having applied de-escalation techniques, the normal procedure should be to call an ambulance with the view to transferring the resident without delay to a more appropriate health-care setting.

The CPT recommends that the Ukrainian authorities modify their approach in respect of resort to means of restraint in social care establishments, in the light of the above remarks.

42. As the three social care establishments visited had a Ministry of Health licence for the provision of psychiatric care, they were legally authorised to use means of restraint on the same basis and following the same procedures as in psychiatric hospitals.[79]

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76. Painting, sewing, handicraft, music, reading, excursions, concerts, etc. At Hrushkivskyi Internat and Vinnytsia Pensionat approximately a half of the residents were reportedly involved in some form of organised activity, whilst at Baraboi Internat the problem was that very few residents from the closed Ward 4 had access to such activities (6 out of 64).

77. See also paragraph 186 of the report on the 2009 visit to Ukraine (CPT/Inf (2011) 29, https://rm.coe.int/1680698430) which states as follows: "The treatment of mentally disabled persons should involve a wide range of therapeutic, rehabilitative and recreational activities, such as access to appropriate medication and medical care, occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Residents should have regular access to suitably-equipped recreation rooms; it is also desirable for them to be offered education and suitable work, the aim being to prepare residents for independent or at least more autonomous living."

78. Both internats had farms (cattle, vegetable and fruit) attached to them. Persons employed on those farms were among the (administrative) staff of the two establishments. Most of the farms' production was used to prepare the residents' food, the surplus being sold and money thus gained spent on repairs and purchasing equipment and materials.

79. See paragraph 19 above.

As far as the delegation could ascertain, there was no practice of resorting to seclusion and fixation at Hrushkivskyi Internat and Vinnytsia Pensionat. As for Baraboi Internat, the delegation heard about an isolated recent case of fixation in respect of a resident who had been transferred to a psychiatric hospital shortly after the restraint episode (he was still hospitalised at the time of the visit). However, the delegation could not verify this information in the absence of a dedicated register.[80]

For as long as means of restraint may (at least in principle) be applied in social care establishments (see paragraph 41 above), the CPT recommends that such dedicated registers be set up.

6. Safeguards

43. The legal framework for placement in social care establishments has remained essentially the same as that described in the report on the 2019 ad hoc visit.[81] For a brief reminder, the placement requires a personal request on the part of the prospective resident (or, in the case of legally incompetent persons, their guardians), conclusions of a medical commission (composed of doctors representing various specialties including obligatorily a psychiatrist) and signing a "contract" (*договір*) between the resident (or the guardian, if the resident is legally incompetent) and the social care establishment. Once admitted to a social care establishment, the resident must be examined at least once a year by the aforementioned medical commission and – at least every two years – the resident's situation must be reviewed by a district "medico-social expertise commission" which should as a minimum comprise a psychiatrist, a psychologist and an educator to determine whether the resident should continue to be held in the establishment.

Residents may be discharged at their request if the medical commission concludes that they are able to support themselves; residents may also be discharged by a court decision if the court finds that the resident in question was placed in the social case establishment illegally. Further, courts automatically review the condition of legally incapacitated residents every two years. However, despite the CPT's long-standing recommendation, it remains the case that legally incompetent residents are not able to directly apply to a court with a view to terminating their placement.

The Committee calls upon the Ukrainian authorities to introduce the aforementioned amendment without further delay. The CPT also recommends that the current legislation be amended so as to ensure that residents are always offered the possibility to explain their situation in person before the district medico-social expertise commission; this is still usually not the case at present.

44. The delegation observed that the aforementioned legal framework was generally duly observed in the three social care establishments visited, including the requirement to sign "contracts" between residents (or their guardians) and the establishments' Directors,[82] and to carry out reviews by medical commissions and district medico-social expertise commissions.

However, it remained the case that residents were as a rule not given a copy of the "contract" and that staff usually did little to explain the meaning and the content of the "contracts" to the residents. Several residents with whom the delegation spoke appeared to have an only vague idea of what they had signed (some could not even remember having signed a "contract"). Further, a few residents told the delegation, spontaneously and insistently, that they did not wish to remain in the establishment, but at the same were not aware of what steps they could take to request discharge.

80. The instance of fixation had not been recorded in the person's individual file either.
81. See paragraph 40 of document CPT/Inf (2020) 1.
82. Such "contracts" usually included information on residents' daily routines, activities they could enrol to, as well as on their individual treatment plans; in case the residents were legally incapacitated, their guardians signed on their behalf. The establishment's social worker filed the original of the "contracts" in the residents' personal files and copies were transmitted to incapacitated residents' guardians.

The CPT calls upon the Ukrainian authorities to ensure that residents in social care establishments (including those legally incapacitated) are systematically given a copy of the "contract" signed with the Director of the institution and are provided with information, in a format they can understand, about the meaning of the "contract" and their right to request discharge from the establishment. See also the recommendation in paragraph 47 below.

45. The Committee is concerned by the fact that, despite its previous repeated recommendations, many legally incapacitated residents in the three social care establishments visited had the establishment's Director performing the functions of their guardian.[83] The CPT must once again stress that entrusting guardianship to the very same establishment in which an incapacitated person is placed may easily lead to a conflict of interest and compromise the independence and impartiality of the guardian.

The Committee again calls upon the Ukrainian authorities to search for alternative solutions which would better guarantee the independence and impartiality of guardians.

46. On a positive note, the delegation observed that Directors of the three social care establishments visited proactively brought cases to competent courts in order to reinstate residents' legal capacity;[84] the CPT encourages the Directors of the three establishments to continue this good practice.

It would alas appear that courts hardly ever followed the Directors' recommendations, generally referring to residents' original medical diagnoses as grounds justifying refusal to reinstate their capacity.

This is indeed regrettable and seemingly at odds with the principles and objectives set out in the CRPD.[85]

47. As regards complaints, residents could *inter alia* complain online and by phone to the Ombudsman. However, as far as the delegation could ascertain, there were no formal internal complaints procedures and no complaints registers. Even though there were complaint boxes available (at Baraboi Internat and Vinnytsia Pensionat), the boxes were not easily accessible and did not enable residents to make complaints effectively and anonymously. Furthermore, residents were not informed, in a format and language they understood, of their rights including on the right to complain confidentially both internally and to an outside authority.

The Committee recommends that steps be taken to ensure that residents are informed of possibilities to lodge both internal and outside complaints, on a confidential basis. This should be done in the form of a brochure drawn up in a manner easily understandable to residents and handed out to them as well as their legal representatives/guardians. In addition to information on avenues of complaint, the brochure should contain details of the establishments' daily routine and residents' rights (including the right to request discharge from the establishments, see paragraph 43 above). The aforementioned information should also be set out in the "contracts" signed by residents and (if the residents are legally incapacitated) their guardians. Reference is also made to the recommendation in paragraph 28 above, which applies *mutatis mutandis* to social care establishments.

83. This was the case with 28 residents at Hrushkivskyi Internat, two at Vynnytsia Pensionat and 110 at Baraboi Internat.
84. For example, in the period between 1 January 2025 and the date of the delegation's visit, such requests had been sent with respect to 22 residents at Hrushkivskyi Internat and six at Baraboi Internat.
85. See e.g. the Concluding observations on the combined second and third periodic CRPD reports on Ukraine, https://digitallibrary.un.org/record/4063153/files/CRPD_C_UKR_CO_2-3-EN.pdf.

48. Concerning contact with the outside world, residents could receive visitors without restrictions. Further, some residents were taken out by their families for weekends, holidays or longer periods, following prior approval by the Director. A few residents were also allowed to leave the establishment's grounds without supervision.

Free wi-fi was available throughout each social care establishment. However, residents without own mobile phones had no (or very limited) access to a telephone.[86]

The Committee reiterates its recommendation that steps be taken to facilitate access to a telephone for residents who do not possess their own mobile phones.

86. They could request to use an establishment's fixed line or one of staff's personal mobiles but generally only in exceptional situations (family related emergencies, etc.); or they relied on the generosity of other residents who might allow them to make a call using their personal mobile.

APPENDIX I – LIST OF THE NATIONAL AUTHORITIES, OTHER BODIES AND NON-GOVERNMENTAL ORGANISATIONS WITH WHICH THE CPT'S DELEGATION HELD CONSULTATIONS

A. National authorities

Ministry of Health

Mr Ihor Kuzin	Deputy Minister, Chief State Sanitary Doctor
Mr Serhii Shum	Director, Institute of Forensic Psychiatry
Ms Olena Harmata	Chief Mental Health Care Specialist

Ministry of Social Policy

Ms Iryna Postolovska	Deputy Minister
Ms Oksana Sulima	Deputy Director General, Directorate for Social Services
Ms Olena Fartushna	Head of the Expert Group on Protection of Rights of Certain Social Groups and Elderly People, Directorate for Social Services
Ms Iryna Shurpyak	Advisor to the Minister
Ms Sofia Nekrutenko	Project Office Expert

B. Other bodies

Office of the Ukrainian Parliament Commissioner for Human Rights (Ombudsman)

Mr Artem Volodin	Director, Department for the Implementation of the National Preventive Mechanism
Mr Ruslan Morozov	Head of the Division for the Implementation of the National Preventive Mechanism in the Healthcare Sector
Ms Iryna Tsykalenko	Head of the Division for the Implementation of the National Preventive Mechanism in Social Security and Education Institutions

C. Non-governmental organisations

Fight For Right

International Renaissance Foundation

Ukrainian Psychiatric Association

"NO ONE SHALL BE SUBJECTED TO TORTURE OR TO INHUMAN OR DEGRADING TREATMENT OR PUNISHMENT"

Article 3 of the European Convention on Human Rights

Established in 1989 by the Council of Europe Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, the CPT's aim is to strengthen the protection of persons deprived of their liberty through the organisation of regular visits to places of detention.

The Committee is an independent, non-judicial preventive mechanism, complementing the work of the European Court of Human Rights. It monitors the treatment of persons deprived of their liberty by visiting places such as prisons, juvenile detention centres, police stations, immigration detention facilities, psychiatric hospitals and social care homes. CPT delegations have unrestricted access to places of detention, and the right to interview, in private, persons deprived of their liberty. They may access all the information necessary to carry out their work, including any administrative and medical documents.

The CPT plays an essential role in promoting decency in detention, through the development of minimum standards and good practice for states parties, as well as through coordination with other international bodies. The implementation of its recommendations has a significant impact on the development of human rights in Council of Europe member states and influences the policies, legislation and practices of national authorities regarding detention.

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The Council of Europe is the continent's leading human rights organisation. It comprises 46 member states, including all members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law. The European Court of Human Rights oversees the implementation of the Convention in the member states.

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