

VISIT REPORT

TÜRKİYE

April 2018



CPT

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

AD HOC VISIT

4 - 13 April 2018

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Prevention of Torture and Inhuman
or Degrading Treatment or Punishment

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EXECUTIVE SUMMARY

The main objective of the visit was to examine the treatment and living conditions of patients in psychiatric establishments and residents in social welfare institutions. The CPT's delegation took stock of progress made in these areas since the last time the CPT visited such establishments in Turkey in 2006. It also looked into the legal safeguards related to the involuntary placement/treatment of patients/residents and their implementation in practice.

Throughout the visit, the delegation received very good co-operation in all the establishments visited.

Psychiatric establishments

The CPT welcomes the Turkish authorities' efforts to reform the mental health sector, focusing on the de-institutionalisation of long-term psychiatric patients, the creation of community mental health centres and the gradual downsizing of regional mental health hospitals. However, the Committee notes with concern that Turkey still lacks a specific mental health law; the delegation once again observed that this lacuna gave rise to a number of deficiencies in the country's mental health system, in particular as regards safeguards in the context of involuntary hospitalisation, consent to treatment and use of means of restraint. The CPT urges the Turkish authorities to enact comprehensive mental health legislation without further delay.

The delegation received virtually no allegations of ill-treatment by staff in most of the hospitals visited. On the contrary, patients generally spoke favourably of staff and many patients expressed their appreciation about the caring attitude of nursing staff. However, at Elazığ Mental Health Hospital, the delegation did receive several allegations of recent physical ill-treatment (such as pushing, punches, kicks and blows with a broomstick) by orderlies. A number of patients met in this hospital also complained about the use of disrespectful language and threats against them by orderlies. The CPT recommends that the management of the Elazığ Hospital deliver the clear message to orderlies that patients must be treated with respect, and that all forms of ill-treatment of patients (including verbal abuse) are unacceptable and will be punished.

Material conditions in the High-Security Forensic Unit at Adana City Hospital were of a very high standard and were also generally satisfactory in the other establishments visited. With some exceptions, patients' rooms were well-maintained, reasonably clean and airy and had adequate access to natural light. That said, in many wards at the Adana, Elazığ and Manisa Hospitals, patients were accommodated in six- to ten-person rooms (with beds placed close to each other), which offered limited living space and failed to provide any privacy. Further, patients' rooms in these hospitals were only equipped with beds and at best a few cupboards; the absence of other furniture or decoration contributed to the impersonal and austere atmosphere.

Whilst acknowledging that most patients' wards at Adana, Elazığ and Manisa Mental Health Hospitals had an outdoor area, in principle accessible to patients for up to four hours per day, the CPT notes with great concern that patients accommodated in the "prison ward" at the Adana and Manisa Hospitals were not offered any outdoor exercise (for weeks and occasionally even months on end). Further, in most of the other wards at the Elazığ and Manisa Hospitals, patients did not usually benefit from outdoor exercise on a daily basis, as it was often denied if the weather was inclement. Moreover, due to the lack of a designated outdoor facility in the Psychiatric Ward of Ankara University Hospital, patients had no access to the open air for several days or weeks after their admission.

As regards staff, psychiatrists at Adana, Elazığ and Manisa Mental Health Hospitals were found to be struggling to cope with a heavy workload, given that they also had to devote most of their time to consultations in the outpatient clinic attached to the hospital. The psychiatrists met by the delegation confirmed that this preponderance of outpatient work led to a relative neglect of inpatients. The Committee recommends that the presence of psychiatrists on inpatient wards at these hospitals and, as appropriate, in other psychiatric hospitals in the country be increased.

Whilst acknowledging the efforts made by the management in the mental health hospitals visited to provide patients with a range of therapeutic, rehabilitative and recreational activities, the CPT was concerned to note that the possibilities for patients to take part in such activities remained limited. For the great majority of patients in the establishments visited, psychiatric treatment was still predominantly based on pharmacotherapy (sometimes combined with electroconvulsive therapy). The Committee recommends that steps be taken at the establishments visited to further develop the provision of psychosocial rehabilitative activities based on individualised patient treatment plans.

There appeared to be no excessive resort to means of mechanical restraint (i.e. up to five-point fixation to a bed with belts) in any of the mental health hospitals visited; such means were generally applied infrequently, usually for periods not exceeding a few hours. That said, the delegation noted that no staff member was designated to stay with and observe immobilised patients in any of the hospitals visited. Further, patients usually did not benefit from a debriefing with a member of the health-care staff after having been subjected to means of restraint. Moreover, although a restraint register was kept on every ward in the hospitals visited, there was no central register at the hospital level. It is also a matter of concern that instances of chemical restraint were recorded in a restraint register only when used together with mechanical restraint, but not when administered separately.

Social welfare establishments

The delegation visited a private social care home for adult persons with psychiatric disorders in Adana (Adana Care Centre"), a public social care home for persons with an intellectual disability in Şereflikoşisar ("Ankara Care Centre") and a private social care home for adult persons with an intellectual disability in Mersin ("Mersin Care Centre").

The delegation received no allegations of ill-treatment by staff in any of the centres visited, and it observed for itself a caring and dedicated attitude of staff towards residents. Further, violence between residents did not appear to be a major problem.

Material conditions were generally satisfactory at Adana and Ankara Care Centres and very good at Mersin Care Centre, in terms of state of repair, ventilation, hygiene and living space (with usually two or three persons per room). Further, all three centres had spacious, pleasantly-decorated and well-equipped communal rooms, as well as verandas or covered outdoor lounges. That said, it is a matter of concern that several residents at the Ankara Care Centre were compelled to sleep on a mattress placed on the floor, due to overpopulation. Further, in particular at Ankara Care Centre, residents' rooms were quite austere (i.e. lacking decoration and personal belongings).

In all the care centres visited, residents were offered a range of recreational activities, and they could in principle spend several hours per day in the gardens. In addition, several occupational activities (such as painting, drawing and handicrafts) were organised in activity rooms on a daily basis. It is particularly noteworthy that, at Adana and Mersin Care Centres, around 20% of the residents attended outside rehabilitation centres or schools. That said, in practice only more autonomous residents were able to take part in the above-mentioned activities. The existing staffing levels were clearly insufficient to provide less autonomous residents with organised activities. It is also a matter of concern that, in contrast to Adana and Ankara Care Centres, Mersin Care Centre did not have any specialised staff for this purpose. The CPT recommends that more occupational and recreational activities tailored to the needs of residents be offered and that the number of specialised staff providing such activities be increased.

As regards health care, the CPT welcomes the 24-hour presence of nursing staff in all the care centres visited. In case of need, residents were usually transferred to a local hospital without delay and medical check-ups were arranged at regular intervals. Nonetheless, the CPT encourages the Turkish authorities to ensure that all care centres visited, as well as other similar institutions, are visited at least once a week by a general practitioner and at least once a month by a psychiatrist.

The delegation was not in a position to obtain a clear picture of the use of padded anger control rooms and other means of restraint, since no register was kept of such instances in any of the care centres visited. The CPT formulates a number of specific recommendations regarding the use of restraint measures, in particular as regards the involvement of a doctor, the supervision of residents under restraint and the keeping of a dedicated register.

Safeguards in the context of involuntary placement of persons in psychiatric and social welfare establishments

Overall, the visit revealed a number of striking shortcomings in law and practice. In particular, in all the psychiatric hospitals and care centres visited, many patients/residents who were classified as “voluntary” appeared to be de facto deprived of their liberty, without benefiting from the safeguards provided for by law for involuntary patients/residents. Further, involuntary placement procedures were usually carried without any involvement of the patients/residents concerned, and placement decisions which were usually indefinite were still not subject to an automatic judicial review at regular intervals. It is also a matter of concern that, in all the hospitals visited, no distinction was made in practice between the involuntary placement and involuntary treatment of a patient.

The CPT recalls that every patient capable of discernment – whether voluntary or involuntary and whether civil or forensic – should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances. The Committee formulates a number of specific recommendations aimed at reinforcing the safeguards offered to involuntary patients/residents in the context of involuntary placement/treatment.

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 Turkey from 4 to 13 April 2018. The visit was one which appeared to the Committee “to be required in the circumstances” (see Article 7, paragraph 1, of the Convention).

2. The main objective of the visit was to examine the treatment and living conditions of patients in psychiatric establishments and residents in social welfare institutions and to take stock of progress made in these areas since the last time the CPT visited such establishments in Turkey in 2006. In this connection, the CPT’s delegation also looked into the legal safeguards related to the involuntary placement/treatment of patients/residents and their implementation in practice.

3. The delegation visited the following places:

Psychiatric establishments

- Adana Mental Health Hospital
- Elazığ Mental Health Hospital
- Manisa Mental Health Hospital
- Adana City Hospital (High-Security Forensic Ward)
- Ankara Dışkapı Yıldırım Beyazıt University Hospital (Psychiatric Ward)

Social welfare establishments

- Ata Köşkü Canev Private Care Centre, Adana
- Şereflikoçhisar Care and Rehabilitation Centre, Ankara (including one detached supervised sheltered housing (so-called “Hope Home”) in Şereflikoçhisar)
- İnci Yaşam Private Care Centre for Persons with Disabilities, Mersin.

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

- Mykola Gnatovskyy, President of the CPT (Head of the delegation)
- Dagmar Breznoščáková
- Julia Kozma
- Vytautas Raškauskas.

They were supported by Michael Neurauter (Head of Division) and Elvin Aliyev of the CPT’s Secretariat and assisted by an expert, Timothy Harding, psychiatrist and former Director of the University Institute of Forensic Medicine in Geneva (Switzerland).

5. The report on the visit was adopted by the CPT at its 97th meeting, held from 5 to 9 November 2018, and transmitted to the Turkish authorities on 12 December 2018. 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 Turkish authorities to provide, within six 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.

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

6. In the course of the visit, the delegation had consultations with Ahmet Demircan, Minister of Health, Mehmet Karabay, Deputy Minister of Family and Social Policies, Bilal Uçar, Deputy Minister of Justice, and Eyüp Gümüş, Undersecretary of the Ministry of Health, as well as with senior officials from the Ministries of Health, Family and Social Policies, Justice and Foreign Affairs.

In addition, the delegation met representatives of civil society organisations active in areas of concern to the CPT.

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

7. The co-operation received by the delegation throughout the visit was very good in all the establishments visited. The delegation generally enjoyed rapid access to all the places visited as well as to the documents requested, and was able to speak in private with all the persons it wished to interview. That said, it is regrettable that the Ministry of Health had not provided relevant information about the CPT and its mandate to the management of mental health hospitals (including those which had been notified in advance), which caused delays in obtaining relevant information at the beginning of the visits to some of the hospitals.

||| The CPT trusts that the Turkish authorities will take the necessary steps to ensure that, in the future, information on the Committee's mandate and powers is disseminated to all the health-care institutions and staff concerned.

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

8. During the end-of-visit talks with the Turkish authorities on 13 April 2018, the delegation outlined the main facts found during the visit. On that occasion, the delegation made an immediate observation under Article 8, paragraph 5, of the Convention, requesting the Turkish authorities to take urgent measures to ensure that all mentally-ill prisoners held at Adana and Manisa Mental Health Hospitals are offered at least one hour of outdoor exercise every day. Further, the delegation called upon the Turkish authorities to take urgent measures to ensure that all other patients at Elazığ and Manisa Mental Health Hospitals, as well as in the Psychiatric Ward of Ankara University Hospital, are offered access to an outdoor yard on a daily basis.

9. The above-mentioned immediate observation was subsequently confirmed in a letter of 7 May 2018 from the Executive Secretary of the CPT.

By letter of 17 August 2018, the Turkish authorities provided comments on various issues raised by the delegation during the end-of-visit talks, including the immediate observation referred to above. This information will be commented upon in the relevant sections of the present report.

II. Facts found during the visit and action proposed

A. Psychiatric establishments

1. Preliminary remarks

10. At the outset of the visit, representatives of the Ministry of Health informed the CPT's delegation about ongoing reforms in the field of mental health (in line with the World Health Organization's European Mental Health Action Plan for 2013-2020), which focused on the de-institutionalisation of long-term psychiatric patients, the creation of community mental health centres and the gradual downsizing of regional mental health hospitals.¹ It was indicated that, in the framework of a national Action Plan on Mental Health Services for 2011-2023, the authorities intended to move away from the present system of large mental health hospitals² towards a system of smaller psychiatric units for civil patients at general hospitals. Work was already underway, and it was planned to open such units in a total of 29 city hospitals; the ultimate goal was to close down all regional mental health hospitals in the country by 2023.

As regards forensic psychiatric patients (i.e. those undergoing a court-imposed measure of compulsory psychiatric treatment in the context of criminal proceedings or forensic assessment) and mentally-ill prisoners, the Turkish authorities planned to set up secure psychiatric units for such persons within general hospitals in 18 provinces, with a total capacity of 2,200 beds. It was mentioned that some of these units had already entered into service (e.g. at Adana City Hospital) and that several others were under construction.

The CPT welcomes these efforts; it would like to receive further information on the implementation of the above-mentioned action plan.

In this context, the Committee trusts that, while pursuing their de-institutionalisation policy, the Turkish authorities will maintain adequate resources for the proper functioning of existing regional mental health hospitals.

11. The CPT is concerned to note that, despite the specific recommendation repeatedly made by the Committee after previous visits, Turkey still does not have a specific mental health law. The delegation once again observed that this lacuna gave rise to a number of deficiencies in the Turkish mental health system, in particular as regards safeguards in the context of involuntary hospitalisation, consent to treatment and use of means of restraint. In this regard, the delegation was told that consultations were still ongoing with regard to the adoption of a new mental health law.

The CPT urges the Turkish authorities to take appropriate measures to ensure the enactment of comprehensive mental health legislation without further delay; it trusts that the relevant recommendations made in this report will be taken into account in this context.

12. In the course of the visit, the delegation carried out first-time full visits to Adana and Manisa Mental Health Hospitals³ and a follow-up visit to Elazığ Mental Health Hospital. Further, it visited the high-security forensic unit at Adana City Hospital and the psychiatric ward at Ankara Dışkapı Yıldırım Beyazıt University Hospital (hereinafter: "Ankara University Hospital").

1. As the delegation could observe for itself when it visited Adana and Elazığ Mental Health Hospitals, long-term chronic (civil) patients were generally no longer held in hospital but were able to receive non-residential care at the affiliated community mental health centres.

2. Turkey currently has eleven regional mental hospitals located in ten cities.

3. Adana Mental Hospital was only briefly visited by the CPT in 2005, primarily with the purpose of examining the procedures for the administration of electroconvulsive therapy (see CPT/Inf (2006) 30).

Adana Mental Health Hospital was opened in 1984 and provides both in- and out-patient psychiatric services to 16 provinces. It is divided into 16 wards, including six male and three female wards for civil patients, several wards for the treatment of alcohol and substance dependence (“AMATEM”), a forensic ward and a “prison ward”.⁴ The hospital was operating above its official capacity of 450 beds,⁵ with a total of 469 patients at the time of the visit. Some 10% of the patient population were forensic patients, and a further 25 patients were being held in the “prison ward”. There was a very high turnover of inpatients, with some 10,000 admissions per year,⁶ and the average length of hospitalisation of civil patients was said to be 20 days. The hospital had seen a steady decrease in the number of in-patients over recent years, and the delegation was informed of immediate plans to further reduce that number, notably by transferring more forensic patients to the newly-opened high-security forensic unit at Adana City Hospital.⁷

The main features of *Elazığ Mental Health Hospital* were described in the report on the CPT’s 2006 visit.⁸ The hospital’s official capacity had since been reduced from 528 to 488 beds. It was accommodating 333 patients (including two juveniles) at the time of the visit, distributed among 14 wards. Some 15% of the total patient population were forensic patients. Further, the hospital’s “prison ward” was holding 13 patients at the time of the visit.

Manisa Mental Health Hospital occupies several buildings in a large park surrounded by walls, close to the town centre. The original building of the hospital, which currently serves as the administrative building, was opened in 1926. With a catchment area covering twelve provinces and an official capacity of 530 beds (including a 160-bed annexe near the town of Ahmetli⁹), the hospital was accommodating 493 patients (including 16 juveniles) at the time of the visit. The number of forensic patients stood at nearly 15% of the total number of patients. The establishment’s “prison ward” was holding 14 patients.

Adana City Hospital’s High-Security Forensic Unit was opened in January 2018 and is the first establishment of this kind in Turkey established under a “public-private partnership”. Located within the perimeter of the new general city hospital, it occupies a stand-alone building completely sealed off from the hospital. The unit’s official capacity was 100 beds (including ten beds for juveniles); however, due to a lack of staff, only two wards with a total capacity of 30 beds were operational at the time of the visit, accommodating 26 patients.

Ankara Dışkapı Yıldırım Beyazıt University Hospital’s Psychiatric Ward had an official capacity of 22 beds distributed over ten rooms and was operating at full capacity at the time of the visit. It admitted between 300 and 400 male and female civil patients every year, who were mainly referred from community mental health centres.

13. The legal framework governing the involuntary hospitalisation of civil and forensic psychiatric patients remains by and large unchanged since the 2006 visit.

The legal grounds for *involuntary placement of a civil nature* are set out in Section 432 of the Civil Code, which stipulates that “[a]ny adult who constitutes a danger to the public due to mental illness or mental retardation, alcohol or narcotic substance dependence, very dangerous contagious disease or vagrancy, shall be placed in an appropriate institution for the purpose of treatment, training or rehabilitation or be detained, if no other means of securing his personal protection is available.”

4. All major State psychiatric hospitals in Turkey have so-called “prison wards”, which are run jointly by the Ministries of Justice, Health and the Interior. Such wards accommodate remand prisoners referred by court decision for observation purposes (in order that a report on their criminal responsibility might be drawn up), as well as remand and sentenced prisoners sent for treatment by a prison doctor.

5. The hospital had 713 beds until 2017.

6. The overall number of out-patient consultations carried out by the hospital in 2017 reached approximately 230,000.

7. Over 20 forensic patients had already been transferred to this unit by the time of the visit.

8. See CPT/Inf (2009) 17, paragraph 11.

9. Situated in the countryside some 50 km from Manisa, the three-storey annexe building was mainly accommodating long-term male patients suffering from chronic psychotic disorders.

The placement procedure is regulated by Sections 432 to 437 of the Civil Code and the general provisions of the Law on Civil Procedure (for further details, see paragraphs 78 to 81).

14. As regards *forensic psychiatry*, persons with mental disorder who have committed a criminal act may be placed by a criminal court in a mental health hospital under Section 57, paragraph 1, of the Penal Code as a preventive measure on account of their criminal irresponsibility¹⁰ or diminished criminal responsibility.¹¹

Further, persons suspected of having committed a criminal act may be placed by a criminal court in a mental health hospital for assessment for an initial period of three weeks, which may be extended to a maximum of three months (Section 74, paragraph 1, of the Criminal Procedure Code – CPC).

Moreover, according to Section 16 of the Law on the Enforcement of Sentences and Preventive Measures, the enforcement of a sentence of a prisoner suffering from a mental illness may be suspended and the prisoner concerned transferred to a mental health hospital until he/she recovers. The period spent in the hospital shall be counted as having been served in a prison.

15. In the hospitals visited, only a small number of civil patients was formally classified as “involuntary”. However, as was the case during previous visits, many of the so-called “voluntary” patients were prevented from leaving the hospital premises without being accompanied by a member of staff or family member and were thus *de facto* deprived of their liberty, without benefiting from the safeguards otherwise provided for by law for involuntary patients.¹² For further details, see paragraphs 76 and 77.

2. Ill-treatment

16. The delegation received virtually no allegations of ill-treatment by staff in most of the hospitals visited. On the contrary, patients generally spoke favourably of their relations with staff; in particular, many patients expressed their appreciation about the caring attitude of nursing staff towards them.

17. However, at Elazığ Mental Health Hospital, in particular on Wards 1, 8 and 10, the delegation did receive several allegations of recent physical ill-treatment by orderlies, consisting of pushing, punches, kicks and blows with a broomstick. Further, a number of patients interviewed in this hospital complained of the use of disrespectful language and threats against them by orderlies.



The CPT recommends that the management of Elazığ Mental Health Hospital deliver the clear message to orderlies that patients must be treated with respect, and that all forms of ill-treatment of patients (including verbal abuse) are unacceptable and will be punished accordingly.

18. At Elazığ Mental Health Hospital, the delegation met a female patient who had sustained a comminuted fracture of the shaft of the right humerus in the admission ward a few days previously, while being escorted forcibly by the hospital’s security staff. It emerged from the documentation consulted by the delegation that immediately after the incident the patient concerned had been restrained to a bed (leaving her injured arm free) for almost two hours, without receiving any treatment for her fracture;¹³ nor had she received any pain relief during that period.

By letter dated 17 August 2018, the Turkish authorities informed the CPT that an internal inquiry conducted by the hospital’s management into the incident had concluded that there had not been any negligence or wrongdoing on the part of the hospital staff that would warrant the opening of disciplinary proceedings. Further, the Committee understands that the incident had been reported to the regional prosecutor’s office following the delegation’s visit to the hospital.

10. Section 32, paragraph 1, of the Penal Code.

11. Section 32, paragraph 2, of the Penal Code.

12. It is noteworthy that a number of them told the delegation that they did not wish to stay at the establishment.

13. Although the patient told the hospital’s health-care staff that she had suffered a broken arm and that she was in acute pain, she was taken to the emergency unit of the local polyclinic only after some two hours.

The CPT would like to be informed of the outcome of the investigation by the prosecutor's office.

More generally, the CPT recommends that, whenever a patient in a psychiatric establishment sustains a serious injury as a result of the use of force (including mechanical restraint) by staff, the matter be immediately brought to the attention of the competent prosecutor.

19. In most of the establishments visited, inter-patient violence did not appear to be a major problem, and staff appeared to be vigilant in this respect. That said, the CPT is concerned by the levels of tension and violence among patients, as well as of violence against staff, at Adana Mental Health Hospital. Although the scale of the problem appeared to have somewhat diminished following the recent reduction in the number of patients, the number of ward-based staff in certain wards remained insufficient to ensure proper supervision of patients (see paragraph 33).

3. Patients' living conditions

20. Material conditions in the High-Security Forensic Unit at Adana City Hospital were of a very high standard. Patients were accommodated in single-occupancy rooms which measured some 19 m² (including a sanitary annexe comprising a toilet and a shower) and were suitably equipped, including with a bed, a table, armchairs, a call bell and an air-conditioning system. The rooms also had good access to natural light, and artificial lighting was adequate.

21. Material conditions were also generally satisfactory in the other establishments visited. With some exceptions, patients' rooms were well-maintained, reasonably clean and airy and had adequate access to natural light. As regards more particularly Elazığ Hospital, this represents a marked improvement as compared to the situation observed by the CPT in 2006.

That said, in many wards at Adana, Elazığ and Manisa Mental Health Hospitals, patients were accommodated in six- to ten-person rooms (with beds placed close to each other), which offered limited living space and failed to provide for any privacy. Conditions were particularly cramped in a number of patients' rooms at the Ahmetli annexe of Manisa Mental Health Hospital (e.g. rooms of some 28 to 30 m² accommodating eight patients).

Further, patients' rooms in these hospitals were only equipped with beds and at best a few cupboards; the absence of other pieces of furniture, such as personal lockers, tables and chairs, or of any decoration contributed to an impersonal and austere atmosphere. On the positive side, patients' rooms typically opened onto a corridor with an adjacent area for watching television, which was equipped with tables, chairs and sofas.

22. The CPT must reiterate its view that large-capacity dormitories are scarcely compatible with the norms of modern psychiatry; indeed, they may have a counter-therapeutic, depersonalising effect on patients and compromise their privacy and safety. The Committee considers that, as the number of patients needing hospitalisation appears to be falling throughout the country, the opportunity should be seized to carry out a wholesale redesign of patients' accommodation in psychiatric hospitals. Provision of accommodation structures based on small groups is a crucial factor in preserving/restoring patients' dignity, and also a key element of any policy for the psychological and social rehabilitation of patients.

The CPT recommends that steps be taken at Adana, Elazığ and Manisa Mental Health Hospitals to improve patients' living conditions, in the light of the preceding remarks. In particular, occupancy levels in patients' rooms should be reduced to provide for increased living space per patient. Further, patients' living areas should be suitably furnished and efforts should be made to personalise them, *inter alia* by providing patients with individual lockers and allowing them to decorate their rooms.

||| The Committee also urges the Turkish authorities to transform the large-capacity rooms into accommodation structures based on smaller groups (i.e. no more than four beds in one room).

23. In the “prison wards” of Adana and Manisa Mental Health Hospitals, in addition to being poorly ventilated, cells were fitted with small windows covered with metal shutters, which reduced access to natural light to a minimum. Access to natural light was also poor in some of the patients’ rooms (including a room for disabled patients) in Ward 5 of the Adana Hospital.

||| The CPT recommends that steps be taken to remedy these shortcomings.

Similarly, patients’ rooms in the semi-basement-level Ward 10 of Elazığ Mental Health Hospital had limited access to natural light. The delegation was told that the ward in question would soon be taken out of service once the hospital’s forensic patients had been transferred to the high-security forensic unit in the new city hospital at Elazığ.

||| The CPT would like to receive confirmation that this has indeed happened.

24. In all the establishments visited, patients could take a shower at least twice a week or more frequently if needed. However, some of the communal showers at Adana Mental Health Hospital were dilapidated and dirty. Further, most of the communal sanitary facilities at the Ahmetli annexe of Manisa Mental Health Hospital were in a state of disrepair, also resulting in problems of humidity in adjacent rooms.

||| Steps should be taken to remedy these deficiencies.

25. The delegation noted that in all the establishments visited most, if not all, of the patients were wearing pyjamas or uniform tracksuits (marked with the hospital name) all day long.¹⁴ The CPT wishes to stress that, together with the lack of personal items, such a practice contributes to a loss of identity and is not conducive to strengthening the patients’ sense of self-esteem and to individualised treatment.

||| The Committee recommends that steps be taken in the establishments visited and, where appropriate, in other psychiatric establishments in Turkey to ensure that patients are allowed and encouraged to wear their own clothes. If necessary, patients should be provided with appropriate non-uniform clothing.

26. It is noteworthy that nearly all patients in the establishments visited benefited from an open-door regime within their respective wards throughout the day. As regards outdoor exercise, most wards at Adana, Elazığ and Manisa Mental Health Hospitals had a fenced outdoor area or garden attached to them, which was in principle accessible to patients for 1½ to 4 hours per day, and in some wards (e.g. Ward 6 at the Adana Hospital, Ward F at the Manisa Hospital) for even longer. Moreover, some patients also had the possibility of access to the hospitals’ park-like compounds. The delegation gained a particularly positive impression of the spacious grounds (with extensive flower gardens and trees) of the Ahmetli annexe of the Manisa Hospital, where patients seemed to be spending a large part of the day. At the High-Security Forensic Unit at Adana City Hospital, patients had access for several hours per day to a large yard equipped for basketball.

27. However, it is a matter of serious concern that, at Adana and Manisa Mental Health Hospitals, patients accommodated in the “prison ward” were not offered any outdoor exercise, and that for weeks and occasionally even months on end.¹⁵ At Adana, the management tried to alleviate the adverse effects of this state of affairs by applying an open-door policy within the ward; patients from different cells were generally allowed to associate and watch television in the corridor. In contrast, at Manisa, patients were confined to their cells for the entire day, with hardly anything to occupy themselves.

14. The delegation was told that patients could keep their own clothes if they had family who came and took their laundry for washing.

15. It is noteworthy that mentally-ill prisoners held at Elazığ Mental Health Hospital had free access to an outdoor yard for most of the day.

Further, in most of the other wards at the Elazığ and Manisa Hospitals, patients did not usually benefit from outdoor exercise on a daily basis, as it was often denied due to inclement weather (in particular during winter months). As a result, patients remained locked up in their wards, passing their time in their rooms or corridors, often under cramped conditions. By way of example, the examination of relevant records on (female) Ward 5 and (male) Ward 10 of the Elazığ Hospital revealed that no outdoor exercise had been provided during the entire months of January and February 2018, while in March, access to outdoor exercise had been irregular.¹⁶ Further, many patients on (male) Ward D-2 at the Manisa Hospital did not benefit from outdoor exercise for the whole of their stay (i.e. up to several weeks).

It should also be added that, due to the lack of a designated outdoor facility, patients held in the Psychiatric Ward of Ankara University Hospital had no access to the open air for several days or weeks after their admission. The delegation was told by staff that patients would be allowed to take a stroll around the hospital grounds if accompanied by their visitors.

28. As already mentioned in paragraph 8, at the end of the visit the delegation invoked Article 8, paragraph 5, of the Convention and requested the Turkish authorities to take urgent measures to ensure that all mentally-ill prisoners held at Adana and Manisa Mental Health Hospitals are offered at least one hour of outdoor exercise every day. Further, the delegation called upon the Turkish authorities to take urgent measures to ensure that all other patients at Elazığ and Manisa Mental Health Hospitals, as well as in the Psychiatric Ward of Ankara University Hospital, are offered access to an outdoor yard on a daily basis.

29. In their letter dated 17 August 2018, the Turkish authorities informed the CPT that the Ministry of Justice had issued a circular on 1 August 2018, requesting the relevant Prosecutor's Offices "to take required actions to ensure that mentally-ill detainees and convicts benefit from at least one hour of outdoor activity per day, if needed with the assistance from security officers against the security and escape risks".

The CPT would like to be updated on the concrete action taken at Adana and Manisa Mental Health Hospitals following this circular letter.

In their letter, the Turkish authorities also indicated that patients held at Elazığ and Manisa Mental Health Hospitals were offered two hours of outdoor activities every day. The CPT would like to receive confirmation that this will also be the case in the cold or rainy/snowy season. To this end, appropriate clothing and footwear should be made available to patients who wish to take outdoor exercise in inclement weather.

As regards the Psychiatric Ward of Ankara University Hospital, the CPT recommends that the Turkish authorities take steps to ensure that all patients held in this establishment have the possibility to take outdoor exercise on a daily basis (unless there are clear medical contraindications); if necessary, the establishment should be equipped with a secure outdoor exercise yard.

16. Staff explained this by the fact that patients did not have coats and shoes appropriate for the winter season.

30. At Manisa Mental Health Hospital, the delegation saw three male forensic patients who had been held, for between two and four years, in individual cell-type rooms in a distinct section of Block E.¹⁷ In view of past incidents of violence against other patients, the patients concerned were deemed to be especially unpredictable in behaviour and were deprived of any contact with each other or other patients. As a result, they were held under conditions akin to solitary confinement. Their only human contact (other than infrequent family visits) was when meals were delivered or when staff members spoke to them. Further, it appeared that these patients remained locked up in their rooms (which were equipped with a television set) all day long, only being allowed to go outside once or at most twice a week, in the presence of staff. As far as the delegation could ascertain, the patients concerned had no legal possibility to challenge the imposition of the solitary confinement-type regime before an independent authority.

Similarly, a female patient met by the delegation in the “prison ward” of Elazığ Mental Health Hospital had already been held on her own for over a year, without being allowed to associate with other patients.¹⁸ The delegation was told that the patient concerned received weekly visits from a psychologist. Further, she had ready access during the day to a small exercise area within the ward (which she chose not to use most of the time).

Whilst acknowledging that special precautions may have to be taken vis-à-vis the above-mentioned patients, the CPT recommends that urgent steps be taken to ensure that they are offered adequate psychological support and meaningful human contact (including with properly trained staff). Further, the management of both hospitals should explore possibilities to provide these patients with small group activities with selected patients under close supervision. It should also be ensured that they are offered daily access to outdoor exercise.

Further, the Committee recommends that the Turkish authorities take steps to ensure that, whenever a psychiatric patient is subjected to a solitary confinement-type regime for security reasons, the measure is reviewed on a regular basis by a multidisciplinary team and the patient concerned has the possibility to appeal against the imposition/prolongation of the measure to an independent authority.

31. As regards patients’ contact with the outside world, the situation in all the psychiatric hospitals visited was generally satisfactory. They were able to send and receive correspondence, to have access to the telephone, and to receive visits from their families.

4. Staff

32. Staffing levels at Elazığ Mental Health Hospital (488 beds) had improved since the CPT’s 2006 visit, notably as regards nursing staff.¹⁹ The hospital now employed 19 psychiatrists (including three specialists in adolescent psychiatry), 201 nurses,²⁰ 105 orderlies/cleaners (“temizlik personeli”) and 28 security staff.²¹

At Adana Mental Health Hospital (450 beds), the staff complement comprised 28 psychiatrists (including four specialists in adolescent psychiatry), 144 nurses, 148 orderlies and 50 security staff.

Manisa Mental Health Hospital (530 beds) had 31 psychiatrists (including four specialists in adolescent psychiatry), 162 nurses, 106 orderlies and 57 security staff.

17. All three of them were subject to a court-ordered mandatory psychiatric treatment in the context of criminal proceedings involving serious violent offences.

18. She had been referred to the “prison ward” after killing a fellow patient in another ward of Elazığ Hospital.

19. The hospital had 12 psychiatrists and 70 nurses at that time (with an official bed capacity of 528).

20. This number included 13 midwives who had been employed – after having received additional training – to perform nursing duties. They did not practice midwifery in any form.

21. Security staff are responsible for ensuring general security of the hospital premises. They are also regularly involved in escorting patients between different wards and for various activities.

The three hospitals also employed a range of other somatic health-care personnel, notably neurologists, general practitioners, internists, anaesthesiologists, dieticians and X-ray technicians. With very few exceptions, all medical doctors (including psychiatrists) worked from 8 a.m. to 4.30 p.m. on weekdays; outside these working hours, there were usually one or two psychiatrists on duty for each establishment. Further, each ward was generally staffed by two to six nurses during the day and by two nurses at night and weekends, assisted by a few orderlies and security staff.

As regards Adana City Hospital's High-Security Forensic Unit (30 beds), the full-time presence of two psychiatrists was ensured from a pool of twelve psychiatrists employed by the general hospital, on a rota basis. The unit was also staffed by 12 nurses and a number of orderlies and security staff.

The staff of Ankara University Hospital's Psychiatric Ward (22 beds) consisted of one psychiatrist, three nurses, two orderlies and one member of the security staff.

33. As concerns more specifically Adana Mental Health Hospital, while the ratio of one nurse per three beds could be considered as generally adequate, in some wards the presence of nursing staff at night and on weekends is, in the CPT's view, insufficient, given the number and the profile of patients held (e.g. two nurses and one orderly having to supervise over 40 acute patients).

III The Committee recommends that the Turkish authorities review the presence of nursing staff at Adana Mental Health Hospital, in the light of these remarks.

Further, the existing arrangement at Adana City Hospital's High-Security Forensic Unit whereby psychiatrists worked on rotation could compromise continuity of care and the implementation of long-term treatment and rehabilitation plans.

III Steps should be taken to address this problem.

34. That said, the CPT's main concern relates to the fact that psychiatrists at Adana, Elazığ and Manisa Mental Health Hospitals were struggling to cope with a heavy workload, given that they also had to devote most of their time to consultations in the outpatient clinic attached to each hospital. The psychiatrists met by the delegation confirmed that the preponderance of their work was seeing outpatients and that this led to a relative neglect of inpatients. For example, one of these psychiatrists, who was responsible for 28 hospitalised patients spread over seven different wards, spent about one hour in the morning and one hour in the afternoon seeing patients on the inpatient wards. The rest of the working time was devoted to consultations at the polyclinic, as well as to certain administrative duties and weekly medical board meetings.²² The psychiatrists with whom the delegation spoke indicated that they tried to see patients during their first two weeks of hospitalisation at least three times a week.²³ However, the duration of such consultations was by all accounts brief; according to patients, they lasted less than five minutes, while psychiatrists themselves acknowledged the short duration of such interviews (see also paragraph 46).

III The CPT recommends that the Turkish authorities take steps to ensure that the presence of psychiatrists on inpatient wards is increased, in the light of the above remarks, at Adana, Elazığ and Manisa Mental Health Hospitals and, where appropriate, in other psychiatric hospitals.

22. During the polyclinic hours, psychiatrists would normally only go on the wards in the case of an emergency, for example, a patient needing restraint.

23. Individual patients' files examined by the delegation showed that, during the early stages of hospitalisation, patients were seen in most cases three times per week.

35. Each of the mental health hospitals visited also employed a number of other professional staff, such as psychologists,²⁴ occupational therapists, social workers and teachers. As regards more specifically psychologists, the delegation gained the impression that they concentrated on forensic patients, taking part in assessments for the court, as well as on patients in the outpatient clinic, with little time left for therapeutic work. Almost none of the civil patients interviewed by the delegation at the Elazığ and Manisa Hospitals described having had sessions with a psychologist and, in the patients' files which were reviewed, no records of interviews or therapy sessions with a psychologist were found. At Adana City Hospital's High-Security Forensic Unit, a psychologist organised group therapy meetings twice a week, but hardly any individual therapy was offered to patients. In this regard, **reference is made to the relevant recommendation in paragraph 39.**

36. The delegation learned that as of April 2018 orderlies and security staff working in psychiatric hospitals were no longer contracted through an external company but were directly employed by the Ministry of Health and were subordinated to the hospital's director.

The CPT considers it essential that orderlies, as well as security staff working within the hospital premises, be carefully selected and given appropriate training before taking up their duties, and that afterwards they receive ongoing training. Particular attention should be given to training in the prevention and management of aggressive behaviour in psychiatric patients, including verbal de-escalation skills. Further, while carrying out their duties, orderlies should be closely supervised by health-care staff.

||| The CPT would like to receive more detailed information on the (initial and continuous) training provided to orderlies and security staff in psychiatric hospitals.

5. Treatment

37. The CPT acknowledges the efforts made by the management in the mental health hospitals visited to provide patients with a range of therapeutic, rehabilitative and recreational activities. In this regard, it is noteworthy that each hospital possessed a dedicated unit for therapeutic activities. Further, the delegation gained a favourable impression of the facilities for patients' association/recreation (including a fitness room and a number of table games) at Adana City Hospital's High-Security Forensic Unit, which were accessible throughout the day.

At Elazığ Mental Health Hospital, diverse activities, such as painting, sewing, handicrafts and music therapy, were offered to patients at the establishment's rehabilitation centre. The centre also had a well-equipped sports room and an outdoor football field. The activities were organised by an occupational therapist (who visited the centre twice a week), a number of teachers and three nurses. According to staff, while over half of the patient population showed an interest in taking part in these activities, the centre could only service up to 30% of patients, and others could be involved in certain activities (such as music therapy and folk dance) on their wards. However, many patients indicated that ward-based activities were extremely limited.

The main premises of Manisa Mental Health Hospital had a rehabilitation centre with an occupational therapy room where some 50 to 70 patients benefited from various workshops (such as felt, leather, ceramics, sewing, wood, and baking) on a daily basis. In addition, many patients had access to an outdoor sports area equipped with diverse workout appliances and a small field for ball sports. There were also opportunities for therapeutic activities (crafts, music, etc.) at the hospital's Ahmetli annexe, including, in the spring and summer months, for horticulture.

At Adana Mental Health Hospital, some occupational therapy (such as painting and handicrafts) and sports activities were on offer. By way of illustration, 13 of the 42 patients in (female) Ward 2, nine of the 30 patients in (female) Ward 3 and five out of 32 patients in (male) Ward 6 were involved in workshops and/or sports facilities every weekday.

24. Adana, Elazığ and Manisa Mental Health Hospitals employed respectively 20, 10 and 22 psychologists.

38. That said, the CPT was concerned to note that the possibilities for patients to take part in the above-mentioned activities remained limited. Many patients met by the delegation, including at Ankara University Hospital's Psychiatric Ward, complained of a complete lack of activities apart from watching television in the ward corridors, especially during the early stages of hospitalisation.

It is also a matter of concern that in none of the mental health hospitals visited were mentally-ill prisoners allowed to visit the rehabilitation centre. The same was true for male forensic patients at Adana and Elazığ Mental Health Hospitals.²⁵

39. To sum up, for the great majority of patients in the establishments visited, psychiatric treatment was still predominantly based on pharmacotherapy (in some cases combined with electroconvulsive therapy). Further, any individual treatment plans usually contained only a pharmacological component and there appeared to be no multidisciplinary team approach to enable staff to meet regularly in order to share information and discuss patients' progress.

The CPT recommends that steps be taken at the establishments visited to further develop the provision of psychosocial rehabilitative activities, preparing patients for a more autonomous life or return to their families; occupational therapy should be an important part of a patient's treatment programme, providing for motivation, development of learning and relational skills, acquisition of specific competences and an improved self-image. To this end, the staffing levels of psychologists, occupational therapists and other professionals should be increased accordingly. Further, steps should be taken at the mental health hospitals visited to ensure that therapeutic and rehabilitation activities are also available to mentally-ill prisoners and forensic patients.

Further, the Committee recommends that an individual treatment plan be drawn up for every patient shortly after admission (taking into account the special needs of acute, long-term and forensic patients including, with respect to the latter, the need to reduce any risk they may pose), comprising the goals of the treatment, the therapeutic means used and the staff members responsible. Patients should be informed of their individual treatment plan and their therapeutic progress; further, they should be involved in the drafting of these plans and their subsequent modifications.

40. There were generally no problems in the establishments visited with the supply of psychoactive medication (including newer-generation drugs). That said, at Elazığ Mental Health Hospital, the delegation was informed that there were certain restrictions on prescribing more expensive psychotropic medication, in particular atypical antipsychotics, within the hospital for budgetary reasons.²⁶

III The CPT would like to receive the Turkish authorities' comments on this matter.

41. The delegation observed some signs of overmedication at Elazığ and Manisa Mental Health Hospitals. At Elazığ, the administration of haloperidol (by injection) in high doses during the first days of hospitalisation appeared to be a frequent practice: patients often received three injections of 5 mg of haloperidol by intra-muscular route every day for the first week of hospitalisation. At Manisa, psychiatrists frequently resorted to polypharmacy, such as a combination of antipsychotics, a mood stabiliser and anxiolytic medication.²⁷

25. At Adana, the Forensic Ward had its own handicraft workshop; however, patients claimed that it was not easily accessible. Similarly, the Forensic Ward of the Elazığ Hospital had an activity area equipped with various table games, which, according to patients, was accessible at best once a week.

26. These restrictions did not apply to outpatient care.

27. E.g. risperidone 6 mg, olanzapine 20 mg, quetiapine 300 mg, biperiden 2 mg, lorazepam 5 mg, valproate 3x500 mg.

Psycho-pharmacological medication often forms a necessary part of the treatment given to patients with mental disorders. However, the CPT has misgivings about the use of high-potency anti-psychotic medication in large doses for prolonged periods and the resort to polypharmacy, as observed by its delegation at Elazığ and Manisa Hospitals.

||| The Committee recommends that a review be carried out of the above-described practices at Elazığ and Manisa Mental Health Hospitals and that a more individualised approach be adopted in prescribing psychotropic medication.

42. Electroconvulsive therapy (ECT) is a recognised form of treatment for psychiatric patients suffering from some particular disorders. However, care should be taken that ECT is being used for the proper indications and that it fits into the patient's treatment plan. Further, its administration must be accompanied by appropriate safeguards, in particular as regards the procedure for obtaining consent to this treatment (see, in this regard, paragraph 90).

43. In all the establishments visited,²⁸ ECT was administered to patients exclusively in its modified form (i.e. under anaesthesia and muscle relaxation), in well-equipped, dedicated units by appropriately trained staff.²⁹ Prior to every ECT session, an electrocardiogram and a physical examination were performed by a doctor, and, during the treatment session, a psychiatrist and a fully-qualified anaesthesiologist were always present. Further, the use of ECT was regulated by a detailed written policy and all applications of ECT were recorded in a central register³⁰ as well as in the patients' files.

||| That said, with the exception of Ankara University Hospital's Psychiatric Ward, in none of the establishments visited was electroencephalography (EEG) monitoring of the treatment session carried out. The CPT recommends that steps be taken at Adana, Elazığ and Manisa Mental Health Hospitals and, where appropriate, in other psychiatric establishments in Turkey to ensure that ECT is always performed with EEG monitoring.³¹

44. Furthermore, the information gathered by the delegation suggested that ECT was being used more frequently at Manisa Mental Health Hospital than in the other establishments visited. For example, from January to March 2018, between 250 and 300 patients had received such therapy in this hospital, totalling 1,707 ECT sessions. By comparison, at the Elazığ Hospital, only about 40 patients underwent this treatment in the same period, with a total of 227 sessions.

In this connection, the Committee has noted that the Manisa Hospital's guidelines on the use of ECT (revised in January 2016) contain an extremely wide and inclusive list of conditions for which ECT can be considered an appropriate therapeutic choice. For example, under major depressive disorders, specific indications for ECT treatment include high risk of suicide, homicidal risk, depression with physical consequences, catatonia (stupor), psychotic symptoms, weak response or lack of response to medication, high risk of anti-depressant medication for the patient, good response to previous ECT treatment, and maintenance treatment for depression resistant to drug treatment.

28. At Adana City Hospital's High-Security Forensic Unit, there was a fully-equipped ECT unit but no such treatment had yet been administered.

29. ECT was applied with bitemporal electrode placement using a Thymatron IV machine, on which the dose can be varied from 5% to 200%. The treating psychiatrist usually started with a low dose of about 20% and increased it until a convulsion was obtained.

30. The register included the name of the patient, the ward in which he/she was hospitalised, the protocol number, the indication for ECT treatment, the anaesthetic drug used, the ECT dose and the number of ECT treatments in sequence. Further, the names of the anaesthetist, the psychiatrist and the nurse present were recorded.

31. Without EEG monitoring it can occasionally be impossible to determine whether any seizure activity has been induced in the patient's brain and what its duration has been. As a consequence, it cannot be ensured, on the one hand, that an adequate seizure is induced and, on the other hand, that a potentially dangerous prolonged seizure activity will be detected.

Similar indications are listed under mania³² and schizophrenia,³³ along with other psychotic and neuropsychiatric conditions, such as acute paranoid syndromes, schizophreniform conditions, malignant neuroleptic syndrome, difficult-to-control epilepsy, delirium, and mood disorders due to physical state. This perhaps explains the existing practice of frequent use of ECT at Manisa Hospital.

In the CPT's view, another factor contributing to the above-described practice at Manisa Hospital is related to the lack of meaningful individual contact between psychiatrists and patients, as well as the very limited rehabilitation services for patients in acute admission wards. The delegation found that many ECT treatment decisions had in fact been taken during the first week of hospitalisation, before the full therapeutic effect of pharmacotherapy could possibly be assessed. This reflects a perceived need in the hospital to shorten the duration of hospitalisation as far as possible and to seek a rapid clinical response.

45. The CPT encourages the Turkish authorities to review and monitor the use of ECT at Manisa Mental Health Hospital, in the light of the above remarks. This may require reviewing prescribing practices by psychiatrists working in this hospital and encouraging more interaction between psychiatrists in order to reach a more consensual approach to prescribing ECT. The aim should be to reduce resort to ECT by providing more direct, therapeutic contact between the treating psychiatrist and the patient, with recourse to a wider range of pharmacotherapy on an individualised basis, as well as other individual therapies in the acute stages of mental disorder.

46. Records entered in patients' medical files by treating psychiatrists in the three mental health hospitals visited were far too succinct, often being limited to prescriptions without any further assessments. These files usually contained very little or no information about the patient's medical history, extremely brief description of the patient's current mental state and therapeutic progress, no substantiation of diagnosis and no records in the medical diary (see paragraph 34).³⁴

Steps should be taken to remedy this shortcoming.

47. It is also a matter of concern that most wards at Elazığ and Manisa Hospitals did not possess a dedicated consultation room in which psychiatrists could undertake individual assessment and therapy. Psychiatrists were, in most cases, restricted to the use of the nurses' station or to seeing patients in a communal area. A number of such encounters were witnessed during the visit, for example, on Ward 10 at Elazığ and Wards D-2 and F at Manisa Hospital.

The CPT recommends that steps be taken at Elazığ and Manisa Mental Health Hospitals to ensure that each ward is equipped with a suitable facility in which psychiatrists can carry out private interviews without interruption.

6. Means of restraint

48. In the course of the visit, the delegation examined the use of means of restraint at Adana, Elazığ and Manisa Mental Health Hospitals. Due to the lack of mental health law, the use of means of restraint was only regulated in the form of internal instructions at the hospital level. These instructions refer to mechanical restraint, chemical restraint and seclusion.

49. It should be underlined at the outset that there appeared to be no excessive resort to means of mechanical restraint (i.e. up to five-point fixation to a bed with belts) in any of these hospitals; such means were generally applied infrequently and usually for periods not exceeding a few hours.³⁵

32. With the limitation that ECT should be used in manic syndromes only in limited circumstances, provided that it is not first-line therapy.

33. According to the guidelines, under schizophrenia, ECT can be considered a first-line therapy in patients with acutely suicidal thoughts with high risk of suicide, a rapidly deteriorating physical state, the need for rapid symptomatic response, associated affective symptoms, anti-social behaviour and weak response to medication.

34. On a positive note, daily records made by nurses were quite detailed.

35. For instance, at Elazığ Mental Health Hospital, in those wards where the use of mechanical restraint was reviewed

50. The internal instructions on the use of means of mechanical restraint of each of the hospitals visited contain several important safeguards. In particular, they stipulate that means of restraint may only be used as a last resort, with the purpose of preventing patients from harming themselves or others. Further, means of restraint must always be ordered by a doctor or, when ordered by a nurse in the case of an emergency, must be approved by a doctor within 15 minutes (who must see the patient concerned). The initial period of mechanical restraint must not exceed two hours, following which there should be an assessment of whether restraint can be discontinued. It is also required that all instances of restraint be recorded in a specific register.

51. That said, some shortcomings were identified in the mental health hospitals visited regarding the practice of resorting to mechanical restraint.

First of all, no staff member was designated to stay with and observe the immobilised patient in any of the hospitals visited. Instead, such patients were checked by a nurse every 15 to 30 minutes and were monitored with video surveillance (CCTV) or through a small window from an adjacent nurses' office. As the CPT has stressed in the past, such practices cannot be considered as a substitute for a continuous staff presence.

Secondly, patients usually did not benefit from a debriefing with a member of the health-care staff after having been subjected to means of restraint.³⁶ In the Committee's view, such a debriefing is an occasion for the patient concerned 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. For the doctor, this will provide an opportunity to explain the rationale behind the measure, and thus reduce the psychological stress of the experience, as well as restore the doctor-patient relationship.

Thirdly, whilst acknowledging that a restraint register (indicating, *inter alia*, the patient's name, the time at which the restraint measure began and ended, and the name of the doctor who ordered it) was kept on every ward in the hospitals visited, there was no central register at the hospital level. Further, ward registers often lacked important data, such as the time of release from restraint and/or the doctor's name. Moreover, at Manisa Hospital, individual restraint forms, which were kept in the patients' files, were on occasion incomplete, notably as to the circumstances of the case and the reasons for resorting to the measure as well as the sedative given. It would also appear that nurses working at Manisa Hospital were generally unaware of the existence of the hospital's internal instructions on the use of restraint.

52. At Elazığ Mental Health Hospital, the delegation learned that, shortly before the visit, two patients had been mechanically restrained at the same time for a period of two hours following an attempt to escape. It transpired from the examination of relevant documentation that the escape attempt had been the only reason for the application of restraint; no symptoms or abnormal behaviour that would justify the measure had been noted.

The CPT must stress that it is unacceptable to use means of restraint as a punishment; patients should only be restrained as a measure of last resort to prevent imminent harm to themselves or others.

53. In all the establishments visited, wards generally had dedicated rooms for applying mechanical restraint, which offered adequate privacy to restrained patients, in accordance with the hospitals' internal guidelines. However, there was no such room in the "prison ward" of Manisa Mental Health Hospital, where the restraint bed was located at the end of the ward's corridor, next to a cell door. Further, at Adana Mental Health Hospital, one of the restraint rooms in the "prison ward" had a grille gate instead of a door, which would equally allow other patients to see the immobilised patient. It is also a matter of concern that, in ward B-1 of Manisa Hospital, the restraint room was situated in front of a so-called "observation room" with four beds, which was used for patients in preparation for or after an ECT session; in order to enter the corridor, patients held in that room would have to cross the restraint room.

by the delegation, the maximum duration of restraint was four hours, with an average duration ranging between 30 minutes (Ward 1) and 1½ hours (Ward 10). At Manisa, in the three wards reviewed, the maximum duration of mechanical restraint was 3½ hours, with an average duration varying between 45 minutes (Ward F) and 1½ hours (Ward D-2).

36. It is noteworthy that some of the patients interviewed perceived means of restraint as punishment.

54. In all three hospitals, mechanical restraint was almost always applied in combination with chemical restraint, in the form of an intra-muscular injection of a combination of haloperidol and biperiden. In most cases, haloperidol was injected at the outset of the restraint episode.

It is a matter of concern that, in the mental health hospitals visited, instances of chemical restraint were recorded in a restraint register only when used together with mechanical restraint, but not when administered separately.

On a more positive note, the delegation received assurances from both medical and nursing staff to the effect that every resort to chemical restraint was ordered by a doctor.

55. Each of the mental health hospitals visited had seclusion rooms ("padded rooms"); as far as the delegation could ascertain, these rooms were hardly ever used.

56. In the light of the above, the CPT recommends that the Turkish authorities take steps – including by issuing instructions by the Ministry of Health and providing training to relevant staff – to ensure that the CPT's standards on means of restraint in psychiatric establishments as set out in document CPT/Inf (2017) 6³⁷ are effectively implemented at Adana, Elazığ and Manisa Mental Health Hospitals as well as in all other psychiatric establishments in the country.

In particular, steps should be taken to ensure that:

- **means of restraint are never used as punishment;**
- **whenever a patient is subjected to mechanical restraint, he/she always benefits from continuous, direct and personal supervision by a qualified member of staff who maintains the therapeutic alliance with the patient and may provide prompt assistance. A written running record should be kept by the supervising staff member and included in the patient's medical file;**
- **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);**
- **once means of restraint have been removed, a debriefing of the patient takes place;**
- **a dedicated register is established – and properly maintained – to record all instances of recourse to means of restraint (including chemical restraint). This should supplement 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, the time at which the patient had a debriefing, and an account of any injuries sustained by patients or staff. The keeping of such a register will allow hospital management to monitor the extent of recourse to means of restraint and enable measures to be taken, where appropriate, to reduce their incidence.**

Further, the Committee recommends that all types of restraint and the criteria for their use in psychiatric establishments be regulated by law.³⁸

37. Available at <https://rm.coe.int/16807001c3> (in English) and <https://rm.coe.int/16808e4a4e> (in Turkish).

38. See, in this regard, paragraph 11.

57. Finally, the CPT would like to express its misgivings about the practice observed in most of the establishments visited of security staff being called upon to assist nurses in restraining agitated and/or violent patients.

In this connection, the CPT wishes to stress that the application of means of restraint on psychiatric patients should always be performed by adequately trained health-care staff. Security staff may only intervene in exceptional cases where health-care staff are not able to control the situation themselves (e.g. in the case of particularly violent and/or agitated patients) and at the express request of the latter. In such cases, security staff must act strictly upon the instructions of health-care staff.

 **The CPT recommends that these precepts be duly taken into account in the context of the initial and ongoing training programmes referred to in paragraph 36.**

B. Social welfare establishments

1. Preliminary remarks

58. The delegation visited Ata Köşkü Canev Private Care Centre in Adana (“Adana Care Centre”), Şereflikoçhisar Care and Rehabilitation Centre in the Ankara Province (“Ankara Care Centre”) and İnci Yaşam Private Care Centre for Persons with Disabilities in Mersin (“Mersin Care Centre”). In addition, the delegation paid a brief visit to one of two sheltered housings (so-called “Hope Homes”) in Şereflikoçhisar, which were affiliated to the Ankara Care Centre.

Adana Care Centre was opened in 2009 as a private social care home catering for female and male adults with psychiatric disorders (mostly schizophrenia). With an official capacity of 107 beds, at the time of the visit, the care home was accommodating 107 residents (44 women and 63 men). According to the management, it was planned to transfer all residents with an intellectual disability (25 at the time of the visit) to another care centre of the same care-providing enterprise, which was catering exclusively for residents with an intellectual disability.

Ankara Care Centre is a public social care home for persons with an intellectual disability, located on the outskirts of the town of Şereflikoçhisar. The care home is administered by the district health administration (under the Ministry of Family and Social Policies). With an official capacity of 50 beds, it was accommodating at the time of the visit a total of 57 male residents with a learning disability (many of them were also suffering from epilepsy). In addition, 12 residents were being accommodated in sheltered housing in two six-bed “Hope Homes” in the town centre of Şereflikoçhisar.³⁹

Mersin Care Centre was opened in 2015 as a private social care home for adult persons with an intellectual disability. At the time of the visit, it was accommodating 59 residents (23 women and 36 men, many of whom were also suffering from epilepsy). The construction of an annexe of the building was in its final stages. With the opening of these additional premises (planned in the weeks following the visit), the official capacity was planned to be increased from 60 to 96 beds.

59. Persons may be placed in a social welfare establishment by a court on the basis of Section 432 of the Civil Code or by a court-appointed guardian (for further details, see paragraphs 13 and 92).

2. Ill-treatment

60. At Adana, Ankara and Mersin Care Centres, the delegation received no allegations of ill-treatment by staff. On the contrary, all residents interviewed by the delegation spoke positively about staff, and the delegation observed for itself the staff’s caring and dedicated attitude towards residents.

61. Violence between residents did not appear to be a major problem in any of the care centres visited. The delegation gained the impression that, when such incidents occasionally occurred, staff usually intervened promptly and in an appropriate manner.

3. Living conditions

62. Material conditions were generally satisfactory at Adana and Ankara Care Centres and very good at Mersin Care Centre and the “Hope Home”⁴⁰ in Ankara/Şereflikoçhisar, in terms of state of repair, ventilation and living space (with usually two or three persons per room), and, in each care centre, the entire premises were impeccably clean. Further, all three centres comprised spacious and pleasantly-decorated communal rooms with tables, chairs, sofas and a television set, as well as verandas or covered outdoor lounges; in addition, there were various kinds of domestic animals.

39. The “Hope Home” is an apartment located on the ground floor of a two-storey building owned by the municipality.

40. The “Hope Home” comprised three rooms with twin beds and a pleasantly decorated living room (equipped with sofas and a television set), as well as a kitchen and a room for staff.

That said, it is a matter of concern, that, due to overpopulation, several residents at the Ankara Care Centre were compelled to sleep on a mattress placed on the floor. Further, in particular at Ankara Care Centre (including in the detached “Hope Home”), residents’ rooms were quite austere (i.e. lack of decoration and personal belongings).

III The CPT recommends that steps be taken by the management of Ankara Care Centre to ensure that every resident has his own bed and that residents are provided with a more personalised environment (including in the “Hope Home”).

63. In all the care centres visited, residents were offered a range of recreational activities (including sports), and they could in principle spend several hours per day in the garden.⁴¹ In addition, several occupational activities (such as painting, drawing and handicrafts) were organised in an activity room on a daily basis. It is particularly noteworthy that, at Adana and Mersin Care Centres, around 20% of the residents attended outside rehabilitation centres or schools (five days a week for six hours at Adana and twice a week for three hours in Mersin).

That said, in practice only more autonomous residents were able to take part in the above-mentioned activities. The existing staffing levels were clearly insufficient to provide less autonomous residents with organised activities. It is also a matter of concern that, in contrast to Adana and Ankara Care Centres,⁴² Mersin Care Centre did not have any specialised staff for this purpose.

III The CPT recommends that the Turkish authorities take steps to ensure that in all three care centres visited, more occupational and recreational activities are offered which are tailored to the needs of residents. To this end, the number of specialised staff should be increased accordingly.

64. In all three care centres, efforts were being made to prepare individual care/activity plans for residents. However, at Ankara Care Centre, the delegation was informed that no such plans were being prepared, due to the prolonged sick leave of the staff member concerned.

III The CPT would like to receive confirmation that this shortcoming has in the meantime been remedied.

65. Finally, in all three care centres, the arrangements for allowing residents to maintain contact with the outside world were satisfactory. In particular, residents could receive visits every day.

4. Health care

66. The CPT welcomes the 24-hour presence of nursing staff in all three care centres visited, with a second nurse usually being present during day shifts.⁴³ In addition, there were 39 caretakers at Adana, 43 at Ankara and 21 at Mersin.

67. That said, whilst acknowledging the fact that in case of need residents were usually transferred to a local hospital without delay and that medical check-ups were being arranged at regular intervals (see, however, the remarks in paragraph 71 regarding Mersin Care Centre), the CPT has misgivings about the current arrangements regarding the presence of doctors in the care centres visited.

At Adana and Ankara Care Centres, a general practitioner was present for only a few hours per month, and Mersin Care Centre was not regularly visited by a doctor.

41. In the “Hope Home”, a member of staff (educator/social worker), who was present around the clock, organised some basic activities, and residents were provided with board games. In addition, they had free access to the adjacent yard.

42. Both centres had four educators.

43. There were a total of six nurses at Adana and five in Ankara and Mersin.

Further, despite the fact that around 30% of the residents received psychotropic medication on an ongoing basis, Ankara and Mersin Care Centres were hardly ever visited by a psychiatrist.⁴⁴ Instead, residents were usually taken to the hospital every six months in order to have their prescriptions renewed. Occasionally, residents were also brought to the local hospital for outpatient psychiatric consultations, with frequently changing psychiatrists; such a practice could easily compromise continuity of care. The situation was more favourable at Adana Care Centre with one psychiatrist visiting the centre twice a month for one hour and with up to 50 residents per month being taken to the outpatient service of the psychiatric hospital, although they often saw a different psychiatrist from one consultation to another.

III The CPT encourages the Turkish authorities to take the necessary steps to ensure that Adana, Ankara and Mersin Care Centres, as well as any other care centres of a similar profile, are visited at least once a week by a general practitioner and at least once a month by a psychiatrist (preferably the same doctor each time).

68. The CPT is pleased to note that Adana Care Centre employed one psychologist (in addition to the Director who was a psychologist himself). That said, it is a matter of concern that no psychologist was present on a regular basis in either of the other two care centres visited.

III The CPT recommends that this deficiency be remedied at Ankara and Mersin Care Centres.

69. At Ankara Care Centre, the delegation was informed that the post of physiotherapist had been vacant for quite some time, despite the fact that a significant number of residents were physically disabled.

III The CPT trusts that the Turkish authorities will take the necessary steps to fill that post without further delay.

70. Regrettably, the delegation was not in the position to consult medical files in the care centres visited, as all the doctors' records were stored externally (at a hospital and/or the doctor's office), as well as in the health database of the Ministry of Health to which only doctors had access.

On a positive note, the CPT would like to stress that, in all the care centres visited, nursing records were found to be very detailed and well-kept (with personal care forms being prepared for every resident).

71. In all three care centres, newly-admitted residents were physically examined by a doctor outside the centre. Further, at Adana and Ankara Care Centres, residents underwent a medical check-up, which included *inter alia* screening for hepatitis B and C and the measuring of the body mass index) every six months as well as an X-ray once a year.

That said, it is a matter of concern that no regular medical check-ups were performed at Mersin Care Centre.

III The CPT recommends that the Turkish authorities take the necessary steps to ensure that residents at Mersin Care Centre, as well as in other care centres in Turkey, benefit from medical check-ups (including screening for chronic and transmissible diseases) on a regular basis.

5. Means of restraint

72. The use of means of restraint in social care establishments is regulated by Circular No. 2010/15, issued on 14 December 2010 by the Ministry of Family and Social Policies. This circular distinguishes between two types of restraint measures, namely the fixation of an agitated/violent resident to a chair or bed (mechanical restraint) and the placement of a resident in an 'anger control room' (seclusion). Among other things, the circular stipulates the following:

44. In 2018 (until April), Ankara Care Centre was visited by a psychiatrist once and Mersin Care Centre three times.

- all staff dealing with residents shall receive continuous training on how to handle difficult situations;
- means of restraint must not be used as a punishment;
- a resident under restraint must be checked by a member of staff every 15 minutes;
- a resident shall not be subjected to fixation/seclusion for more than three hours;
- if there is no prior "medical report", the resident concerned shall be transferred rapidly to a health institution and further action shall be taken as recommended by a doctor;
- if a prior medical report exists, staff are obliged to report the use of means of restraint without delay to the establishment's Director;
- every anger control room must be padded and equipped with a hatch.

73. All three care centres visited had a padded anger control room which, except at Adana, was also equipped with video surveillance (CCTV). In addition, a restraint bed was available at Adana and Mersin Care Centres and a straightjacket at Ankara Care Centre.

74. Regrettably, the delegation was not in a position to obtain a clear picture of the use of restraint measures in practice, since no register was kept of such instances in any of the three care centres visited. The delegation was told by staff that mechanical restraint had hardly ever been used, that residents had been placed in an anger control room very infrequently and for short periods only (i.e. not more than 15 minutes) and that, when a resident had not calmed down after a short time, s/he was transferred by ambulance to the local hospital. Chemical restraint was reportedly never applied in the care centres visited.

That said, the CPT notes with concern that, at Ankara Care Centre, the decision to resort to means of restraint was usually taken by non-health-care staff (a social worker) and that a doctor was apparently not always informed of such instances. Moreover, it remained somewhat unclear to what extent residents subjected to mechanical restraint or placed in an anger control room were monitored by a member of staff. Notwithstanding that, the CPT wishes to stress that the requirement set out in the above-mentioned Circular of the Ministry of Family and Social Policies to perform visual checks every 15 minutes is not sufficient.

75. The CPT recommends that the Turkish authorities take the necessary steps, including by amending the above-mentioned Circular, to ensure that in all social care establishments in Turkey:

- **resort to mechanical restraint and/or seclusion (placement of a resident in an anger control room) is always either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his/her approval;**
- **every resident who is subjected to mechanical restraint or seclusion (placement in an anger control room) benefits from 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 resident and provide him/her with assistance. If a resident is placed in an anger control room, the staff member may be outside the room (within hearing so that personal contact can be established immediately). Video surveillance should not replace continuous staff presence.**
- **every instance of restraint of a resident should be recorded in a dedicated register established for this purpose (as well as in the resident's file);**
- **whenever a resident is subjected to mechanical restraint and/or seclusion, the nurse who supervises the resident maintains a log or journal, in which the condition of the resident is noted down at regular intervals (e.g. every 30 minutes).**

Further, the CPT recommends that all types of restraint and the criteria for their use in social care establishments be regulated by law.

Finally, the Committee would like to receive detailed information on the training which has been provided to staff working in the three care centres visited on the management of agitated/violent residents (including on the use of de-escalation techniques and means of restraint).

C. Safeguards

1. Safeguards in the context of involuntary hospitalisation

a. legal status of patients

76. As already mentioned, in each of the three regional mental health hospitals visited, as well as at Ankara University Hospital's Psychiatric Ward, only a small number of civil patients were formally classified as "involuntary" (i.e. had been subjected to an involuntary placement order under Section 432 of the Civil Code). However, most wards in these establishments were closed, and many "voluntary" patients were generally only allowed to leave the premises when accompanied by a member of staff or family member.⁴⁵ Thus, many of the patients classified as "voluntary" appeared to be *de facto* deprived of their liberty, without benefiting from the safeguards provided for by law for involuntary patients.

Further, it remained the case that civil psychiatric patients were frequently hospitalised on the basis of the consent given by a family member who was not a court-appointed guardian and that the patients concerned were classified as "voluntary". Indeed, quite a number of the patients concerned affirmed to the delegation that they had objected to their placement ever since their admission and that they wished to leave the hospital. Moreover, the CPT is puzzled by the fact that, in some cases, the "voluntary" admission form had been signed by ambulance staff or an escorting law enforcement official.

In the CPT's view, consent to hospitalisation should always be sought from the patient him/herself and if the latter does not give his/her consent (or withdraws his/her consent), the criteria for involuntary placement should be assessed and, where appropriate, the case should be reported to the competent court.

The CPT recommends that the Turkish authorities take steps to ensure that, in all the psychiatric hospitals visited, and, where appropriate, in other psychiatric establishments in Turkey, the legal status of all patients who are classified as "voluntary" is reviewed, in the light of the preceding remarks.

77. As regards the situation of patients who were admitted to any of the hospitals visited with the sole consent of their court-appointed guardian, reference is made to the remarks and recommendations in paragraph 81.

b. involuntary hospitalisation of a civil nature

78. According to the relevant provisions of the Civil Code,⁴⁶ psychiatric hospitals are under a legal obligation to notify involuntary admissions "immediately" to the competent court,⁴⁷ and judges are required to hear the patients concerned before taking a decision on the placement on the basis of the report of the Medical Board of the Hospital. Patients must be informed in writing of the reasons for the decision, as well as of the right to challenge before the appeal court the court decision on involuntary hospitalisation within ten days of notification of the latter decision.

45. In addition, several "voluntary" patients were repeatedly subjected to means of mechanical restraint.

46. Sections 432 to 437.

47. See also Ministry of Health Circular No. 14160 (2005/155) dated 13 October 2005 which instructs the Directors of all psychiatric hospitals to immediately inform the magistrate's court of any involuntary admission.

79. From the consultation of numerous patients' files in all the psychiatric hospitals visited, it transpired that involuntary admissions were usually notified to the court within 24 hours at Adana Mental Health Hospital and within 72 hours in the other hospitals visited. Notifications always contained a report and recommendation by the hospital's Medical Board, which was composed of three doctors at Adana Mental Health Hospital and Ankara University Hospital and five doctors in the other psychiatric hospitals visited.

That said, the delegation observed a number of blatant shortcomings. First of all, despite the legal requirement set out in the Civil Code, patients were usually not seen by the judge, but the latter routinely approved in a stereotyped manner the hospitals' requests for involuntary hospitalisation on the basis of the report of the Medical Board, without any court hearing. Several doctors interviewed by the delegation indicated that during their entire professional career they had never come across a case in which a judge had rejected the hospital's request for involuntary hospitalisation. Moreover, one doctor stated that, throughout the year, all court decisions on involuntary placement (including the reasoning) were virtually identical, apart from changes in the name of the patient and the dates of admission to the hospital and the court decision. In practice, court decisions were often sent to the hospital by fax the same day as the involuntary admission was notified to the court. Another shortcoming lies in the fact that, in particular at Elazığ Hospital, court decisions on involuntary placement were frequently transmitted to the hospital after a considerable delay (often more than ten days after the decision had been taken).

Further, it is a matter of concern that court decisions, which contained relevant information on appeal procedures, were often not delivered in writing to the patient concerned, but placed in his/her individual file. The delegation was told by various members of the medical and nursing staff that patients would be informed orally of the court decision.⁴⁸ However, a number of patients met by the delegation appeared to be unaware of the court decision on their hospitalisation, let alone of the possibility to challenge the latter before the appeal court.

80. In the light of the above, the CPT cannot but conclude that the judicial placement procedures as carried out in practice in all the hospitals visited were by and large meaningless as legal safeguards, since judges appeared to simply "rubber stamp" recommendations made by the hospitals' Medical Board and, in many cases, court decisions were not even notified to the patient concerned. Thus, the right of appeal against a placement order was often rendered ineffective.

The CPT reiterates its recommendation that the Turkish authorities take the necessary steps, through appropriate channels, to ensure that:

- **every patient who is admitted to a psychiatric hospital in Turkey on an involuntary basis is heard in person by the judge (at the court house or on the premises of the hospital) before a decision on placement is taken;**
- **the patients concerned receive a copy of the court decision expeditiously and are informed, verbally and in writing, about the reasons for the decision and the avenues/deadlines for lodging an appeal. To this end, the patients concerned should be asked to sign a statement attesting that they have received the court decision.**

Further, the Committee encourages the Turkish authorities to provide specialised training on relevant mental health issues to judges who are dealing with involuntary placement/review procedures.

48. At Adana Mental Health Hospital, the delegation was told by staff in several wards that the practice of delivering court decisions to the patient concerned had been discontinued about one year earlier, while at least in one ward that practice was apparently still maintained and patients signed an attestation that they had received the court decision.

81. Particular mention should also be made of legally incapacitated patients who were considered “voluntary” on the basis of the consent to the hospitalisation given on their behalf by their court-appointed guardian. However, when they expressed a wish to leave the hospital they were usually not allowed to do so. Thus, many of them appeared to be *de facto* deprived of their liberty.⁴⁹

The CPT notes that the relevant legislation contains important safeguards for the patients concerned. In particular, Section 462 of the Civil Code stipulates that the placement of legally incapacitated patients by their guardian must be approved by the competent guardianship court. Further, according to the Ministry of Health Circular No. 141160 (2005/155) dated 13 October 2005, the management of all psychiatric hospitals is instructed to verify whether guardians had obtained court approval before giving their consent to the placement of the patient concerned and, in the case of emergency, to ensure that the admission is notified to the competent court.

At Ankara Psychiatric Hospital, the delegation was informed by medical staff that, whenever legally incapacitated patients were opposed to the placement by their court-appointed guardian, their hospitalisation was routinely communicated for approval to the court. That said, it is a matter of concern that the above-mentioned legal provisions remained by and large a dead letter in all the other psychiatric hospitals visited.

In this regard, the specific recommendations made in paragraph 98 concerning the admission of legally incapacitated persons to social welfare establishments with the consent of their guardian equally apply to all psychiatric establishments where civil inpatients are held. In particular, steps should be taken to ensure that all admissions of legally incapacitated persons by their guardian are subjected to approval by the competent guardianship court.

c. review and discharge procedures

82. In accordance with the relevant legislation, involuntary hospitalisation of a civil nature was usually indefinite and was only terminated with the approval of the hospital's Medical Board (upon the recommendation of the treating doctor or at the request of the patient concerned).

According to Article 435 of the Civil Code, patients could in principle challenge before the court the hospital's decision to reject a request for discharge. However, patients were usually not informed of such a possibility.

Moreover, despite the specific recommendation made by the Committee after previous visits, there is still no automatic judicial review procedure in place.

83. The placement of forensic patients in a mental health hospital by a criminal court as a protective measure under Section 57 of the Penal Code on account of their criminal irresponsibility⁵⁰ was usually also ordered for an indefinite period of time.

In this connection it is regrettable that, despite the specific recommendation made by the CPT after previous visits, Turkish criminal legislation still does not provide for an automatic judicial review procedure in such cases. Further, it would appear that the patients concerned still do not have a formal right to request for themselves (or through a lawyer) a judicial review of their placement.⁵¹

49. See, in this regard, the Grand Chamber judgment of the European Court of Human Rights in *Stanev v. Bulgaria* (no. 36760/06, § 132, 17 January 2012) and the judgment *Červenka v. the Czech Republic* (no. 62507/12, §§ 103-104, 13 October 2016), in which the Court concluded that in the case of placement in a closed establishment of a legally incapacitated person from whose conduct it was obvious that he/she did not consent to his/her placement, the person concerned must be regarded as being “deprived of his/her liberty” within the meaning of Article 5, paragraph 1, of the European Convention on Human Rights, despite the approval of the guardian.

50. Section 32, paragraph 1, of the Penal Code.

51. Patients (or their relatives) could address themselves to the Medical Board (directly or through the hospital management), and it remained at the discretion of the Medical Board to recommend to the Court that the patient be discharged.

84. On the basis of interviews with patients and staff and the examination of numerous patients' files, the delegation observed significant differences in practice in the hospitals visited. At Elazığ Hospital, it appeared to be the routine practice of judges to indicate in the placement order the period (usually one year) after which the need for placement had to be reviewed by the court (on the basis of a report of the Medical Board of the hospital), and in the event of a negative assessment of the court, a new court decision was taken to prolong the placement for another year.

That said, the Committee notes with concern that, in the context of review procedures, court decisions were usually taken without the patients having been heard in person by the judge.

At Adana Hospital, it transpired that the placement of patients declared criminally irresponsible was usually reviewed by the Medical Board of the hospital following requests by the competent Execution of Sentences Department of the public prosecutor's office. Such requests were made on a regular basis (usually, every six to twelve months⁵²), while in some cases, the prosecutor indicated as the deadline for the next review a much longer period (in one case, 2½ years). Only if the Board considered that the patient should be released, did it transmit a report to the public prosecutor's office, which subsequently forwarded the report to the competent court.⁵³ If the Board considered that inpatient treatment should be continued, the correspondence to the prosecutor only contained statements like "no plan to release", sometimes with the last page of the patient's medical file being enclosed. It is a matter of particular concern that, according to the information contained in the files, a number of forensic patients had been held in the hospitals visited for years (and sometimes for even more than ten years) without their placement having ever been reviewed by the court.

85. **The CPT reiterates its recommendation that the Turkish authorities take steps – including at the legislative level – to ensure that in all psychiatric hospitals in Turkey:**

- **involuntary placements of a civil nature, as well as placements of forensic patients under Article 57 of the Penal Code, are subjected to an automatic court review at regular intervals;**
- **forensic patients hospitalised under Section 57 of the Penal Code have a formal right to request at reasonable intervals that the necessity for their placement be reviewed by a court;**
- **in the context of the above-mentioned judicial review procedures, the patients concerned are heard in person by the judge;**
- **newly-admitted involuntary civil patients are informed of the right to request a review of their placement and to challenge before the court any decision of the hospital's Medical Board to reject a request for discharge.**

86. In particular at Elazığ Mental Health Hospital, the delegation observed that in cases where forensic patients had been held in the hospital for a prolonged period (five years or more), an expert opinion was sought from a psychiatrist of the Institute of Forensic Medicine in the context of the review procedure. The CPT welcomes this practice.

In the CPT's view, commissioning, at reasonable intervals, in the context of the review of the measure of compulsory hospitalisation in a psychiatric establishment, a psychiatric expert opinion which is independent of the hospital in which the patient is held would offer an important additional safeguard.

52. In the case of placements under Section 57 of the Penal Code of persons who had been declared to have diminished criminal responsibility (Section 32, paragraph 2, of the Penal Code), reviews were usually carried out at shorter intervals.

53. A discharge procedure may also be opened at the initiative and request of the hospital's Medical Board, the public prosecutor or the judge for the execution of sentences.



The Committee invites the Turkish authorities to consider introducing such an external psychiatric input in the context of judicial review procedures in all psychiatric establishments in which forensic patients are hospitalised.

d. consent to treatment

87. The CPT wishes to stress that consent to hospitalisation and consent to treatment are two separate issues. Every psychiatric patient should, as a matter of principle, be placed in a position to give his/her free and informed consent to treatment. The admission of a person to a psychiatric establishment on an involuntary basis – be it in the context of civil or criminal proceedings – should not preclude seeking informed consent to treatment. Of course, consent to treatment can only be qualified as free and informed if it is based on full and accurate information about the patient's condition, the intended treatment and possible side effects. In this connection, it is also 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.

Further, every patient capable of discernment – whether voluntary or involuntary and whether civil or forensic – should be given the opportunity to refuse treatment or any other medical intervention. Any derogation from this fundamental principle should be based upon law and only relate to clearly and strictly defined exceptional circumstances. A decision to administer medical treatment against the patient's will should require the approval of at least one more doctor who is not involved in the treatment process. Moreover, patients should be able to appeal against an involuntary treatment decision (or the consent to treatment provided by the guardian) to an independent outside authority and should be informed in writing of this right.

88. The CPT notes that the Ministry of Health Regulation on the Rights of Patients No. 23420 (as amended in 2014)⁵⁴ contains important safeguards in this respect. According to Section 22, “no person may be subjected to a medical procedure without his/her consent or in a manner that is not in keeping with the consent that s/he has given, subject to exceptions laid down by law”. Further, Section 24 stipulates that “[i]n cases when the patient's consent cannot be obtained and an emergency situation occurs where there is a danger to life and his/her consciousness is impaired as well as when s/he has a condition which may result in the loss of an organ or failure to perform its function, a medical intervention on the patient shall not be subject to his/her consent. (...) If possible a relative or legal representative shall be notified.”

89. That said, the Committee is very concerned that, in all the hospitals visited, it remained the case that no distinction was made in practice between the involuntary placement and involuntary treatment of a patient. Medical staff met by the delegation expressed the view that patients who were hospitalised against their will were not able to give valid consent to any subsequent treatment on account of their illness. Court decisions to place civil and/or forensic patients “for treatment” in a psychiatric hospital were regarded by doctors as blanket authorisation to administer any medical treatment without the consent of the patients concerned. Similarly, mentally-ill prisoners who had been transferred to a prison ward of a psychiatric hospital were as a matter of routine subjected to pharmacological treatment without their consent, and they were not in a position to refuse any treatment.

Secondly, in the case of voluntary admissions, the patient's consent to treatment was usually sought upon admission to the hospital at the time when the patient gave his/her consent to the placement. To this end, patients (and any accompanying family member) were required to sign a clause on the admission form according to which they agreed to the “admission to the hospital and treatment”. In many cases, no documentation could be found which would indicate that the patient concerned had received detailed information on the diagnosis, the treatment proposed and the possible side effects. Thus, it is clear that the consent given at the moment of admission cannot be considered to be “informed consent”.

Moreover, it is regrettable that Turkish legislation does not provide for any legal remedy to challenge a decision to administer treatment against the patient's will before an independent outside authority.

54. This regulation was issued by the Minister of Health on the basis of the Law on Health-Care Services.

90. Overall, the situation appeared to be more favourable in the psychiatric hospitals visited, when it comes to the issue of consent to ECT. As recommended by the CPT after previous visits, written consent was usually sought from patients (including those who had been admitted to the hospital on an involuntary basis; except patients in the prison wards). For this purpose, a special treatment consent form was in use in all the hospitals visited. This form contained detailed information on various treatment-related issues and also mentioned the fact that additional and more specific information had been provided to the patient verbally. The information gathered during the visit suggests that the patients concerned were usually informed about the contents of the special consent form and the latter was usually signed by the patient him/herself and a family member.

91. The CPT reiterates its recommendation that the Turkish authorities take steps including at the legislative level – to ensure that the precepts set out in paragraph 87 are effectively implemented in every civil and forensic psychiatric establishment in Turkey, in respect of all categories of patient (i.e. civil and forensic patients as well as mentally-ill prisoners).

2. Safeguards in the context of admissions to social welfare establishments

92. The involuntary placement procedure provided for in Sections 432 to 437 of the Civil Code in principle also applies to the admission of persons to a care centre. However, at Adana, Ankara and Mersin Care Centres, not a single resident had undergone this type of placement procedure.

Instead, all admissions had been carried out in the context of or as a result of guardianship procedures. In every care centre, the delegation was told that all admissions were administered by the competent Governorship Office,⁵⁵ that only persons under guardianship would be accommodated in the centre and that if a resident did not have a guardian at the time of admission, the court procedure for deprivation of legal capacity and appointment of a guardian would be initiated automatically.⁵⁶ Consent to the admission was usually given by the court-appointed guardian on behalf of the person concerned. As a result, the persons concerned were not considered by the management and staff to be deprived of their liberty.

On the other hand, the delegation observed that all three care centres visited (including the Hope Home) operated as closed institutions. When residents expressed a wish to leave the establishment on their own they were usually not allowed to do so. As a rule, they were only allowed to leave the premises when being accompanied by a member of the family or staff. In the event that residents left the centre without permission, the police were called to search for them and to bring them back to the centre. Therefore, many of the residents in the care centres visited appeared to be *de facto* deprived of their liberty.⁵⁷

93. In this regard, the CPT notes that the Civil Code provides for a number of safeguards in cases where a person is placed in a closed care centre with the consent of the person's court-appointed guardian. In particular, the approval of the guardianship court is required in such cases (Section 462 of the Civil Code), and the appointment of a guardian is only valid for two years and may only be prolonged by decision of the court, for renewable periods of two years (Section 456 of the Civil Code).

55. In all three provinces visited, applications for admission to a care centre were filed by a family member to the Governorship Office and the latter decided on the allocation of free places on the basis of an evaluation of personal situation of the person concerned.

56. See Sections 405 and 419 of the Civil Code.

57. As indicated in footnote 49, the European Court of Human Rights has concluded in several cases concerning the placement in a closed establishment of a legally incapacitated person under guardianship from whose conduct it was obvious that he or she did not consent to his or her placement that he/she must be regarded as being "deprived of his or her liberty" within the meaning of Article 5, paragraph 1, of the European Convention on Human Rights, despite the approval of the guardian.

94. From the examination of numerous individual files as well as from consultations with the management and staff, it transpired that, in a number of cases, a decision had been taken by the competent guardianship court on the placement of the resident concerned by his/her guardian in the care centre (either as part of the decision on the deprivation of legal capacity and appointment of the guardian or as a separate decision taken at a later stage⁵⁸).

That said, in a considerable number of cases, courts had not been involved at all in the admission of a person to the care centre. For instance, at Adana Care Centre, the delegation was told that it was not uncommon for psychiatric patients to be transferred to the Centre from a psychiatric hospital under a “simplified” procedure, namely by arranging the admission through telephone calls between the hospital and the Governorship Office and between the latter and the Centre. The patients’ guardians were reportedly contacted thereafter in order to inform them of the whereabouts of the patient, but no such cases were notified to the court.

Another fundamental flaw lies in the fact that in practice judges usually did not hear the residents concerned before taking a decision on their deprivation of legal capacity, the appointment of the guardian and their placement in a care centre.⁵⁹ Moreover, the residents concerned were often not informed of the court decisions and the possibilities to lodge an appeal against them.

95. As already mentioned, Section 456 of the Civil Code stipulates that guardians shall be appointed by the guardianship court for a (renewable) period of two years and that for every prolongation a new court decision is required. That said, it is regrettable that, in the context of the bi-annual judicial review of the appointment of the guardian, judges are not required to hear the legally incapacitated person concerned, nor are they required to review the need for his/her placement in a closed care centre.

96. The delegation observed that, in many cases, the appointments of guardians were reviewed by the competent guardianship court every two years. However, in a significant number of cases, courts had apparently not reviewed the guardianship at all or the last review had taken place more than five years earlier.

97. Moreover, apart from the possibility to appeal against the court approval of the initial placement, residents who were placed in a closed care centre by the guardian were not entitled to request at regular intervals that the necessity for their placement be reviewed by the court, without challenging the guardianship itself.

98. The CPT recommends that the Turkish authorities take the necessary steps – including at the legislative level and through appropriate channels – to ensure that, in the three care centres visited, as well as in all the other closed social care establishments in Turkey:

- **all admissions of legally incapacitated persons by their guardian are subjected to approval by the competent guardianship court;**
- **all admissions of legally incapacitated persons by their guardian are subjected to an automatic court review at regular intervals (for instance, in the context of the bi-annual review of the appointment of guardians);**
- **residents who have been admitted by decision of their guardian and/or a court are entitled to request at reasonable intervals that the necessity for their placement be reviewed by the court;**

58. Some court decisions were formulated as placement orders while others authorised the guardian to give consent to the admission on behalf of the person concerned.

59. According to Section 409 of the Civil Code, the judge must hear a person whose legal capacity was in the process of being restricted only in cases of “alcohol or substance addiction”, whereas in cases of “mental illness or retardation”, the judge “may” hear the person concerned.

- all residents are heard in person by the judge during the procedures for their deprivation of legal capacity and the initial placement in the establishment as well as during every subsequent judicial review of their placement (whether initiated *ex officio* or at the request of the person concerned).

99. Finally, in all three care centres visited, the delegation was informed that several residents had a member of staff (usually a social worker) as court-appointed guardian. In this regard, the CPT wishes to stress that one aspect of the role of a guardian is to defend, if necessary, the rights of legally incapacitated persons vis-à-vis the hosting institution. Obviously, granting guardianship to a member of staff of the very same institution may easily lead to a conflict of interest and compromise the independence and impartiality of the guardian.

The Committee recommends that the Turkish authorities strive to find alternative solutions which would better guarantee the independence and impartiality of guardians for legally incapacitated residents placed in social care establishments.

3. Complaints and inspection procedures

100. In all the psychiatric hospitals visited, patients and their family members were able to lodge complaints (both verbally and in writing) to the establishment's Patients' Communications Unit (formerly "Patients' Rights Board"), whose main tasks were to process requests and complaints and make recommendations to the hospital management. As far as the delegation could ascertain, newly-admitted patients were usually informed orally about the internal rules of the hospital as well as of their right to lodge a complaint to the Patients' Communications Unit.

Further, in the care centres visited, residents, as well as their guardians and family members, could lodge complaints to the management and the Governorship Office.

Moreover, in all psychiatric/social welfare establishments visited, patients/residents could in principle lodge a complaint with the Ombudsman Institution. However, none of the patients/ residents interviewed by the delegation appeared to be aware of the existence of such a possibility.

The CPT reiterates its recommendation that steps be taken at all hospitals/care centres visited, as well as in all other psychiatric/social welfare establishments in Turkey, to ensure that an introductory leaflet setting out the establishments' routine and patients'/residents' rights – including information about complaints bodies and procedures – is drawn up and systematically provided to patients (and their guardian/families) on admission. Any patients/residents unable to understand this leaflet should receive appropriate assistance.

101. All psychiatric hospitals/care centres visited received regular inspections from the Ministry of Health (usually once a year).⁶⁰

The CPT would like to receive copies of the reports on the most recent ministerial inspections of Adana, Elazığ and Manisa Mental Health Hospitals as well as of Ankara, Adana and Mersin Care Centres.

60. In addition, the care centres visited were visited at least once a year by the Governorship Office and the city administration.

102. The CPT also attaches great importance to psychiatric/social welfare establishments being visited on a regular basis by an independent outside body.

In this regard, the Turkish authorities indicated in their response to the May 2017 visit, that, following a process of restructuring, the Human Rights and Equality Institution of Turkey became fully operational (again) in October 2017 as National Preventive Mechanism (NPM) under the Optional Protocol to the United Nations Convention against Torture (OPCAT).⁶¹



The CPT would like to receive further information on the visits carried out so far by the NPM, in particular as regards mental health institutions.

61. The Human Rights and Equality Institution also acts as monitoring body under Article 33 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

APPENDIX I: List of the national authorities and organisations with which the CPT's delegation held consultations

A. National authorities

Ministry of Health

Ahmet DEMİRCAN	Minister of Health
Eyüp GÜMÜŞ	Undersecretary
Elif Güler KAZANCI	Deputy Undersecretary
Alper CİHAN	Director General of Health Services
Selami KILIÇ	Director General of EU and Foreign Affairs
Muhammed Ertuğrul EĞİN	Deputy Director General of Health Services
Nuhi ÇELİKKAYA	Head of Department, Directorate General of Health Services
Yusuf IRMAK	Head of Department, Directorate General of EU and Foreign Affairs
Pınar KOÇATAKAN	Head of Department, Directorate General of Public Hospitals
Esra ALATAŞ	Head of Department, Directorate General of Public Health

Ministry of Family and Social Policies

Mehmet KARABAY	Deputy Minister
Mustafa KARAMAN	Deputy Undersecretary
Hakki ÖZTÜRK	Deputy Undersecretary
Gülser USTAOĞLU	Director General on the Status of Women
Nuray HATIRNAZ	Head of Department of EU and Foreign Relations
Hulusi Armağan YILDIRIM	Head of Department for Care Services for Persons with Disabilities
Bayram İNCE	Head of Department of Research/Development, Directorate General of Child Services

Ministry of Justice

Bilal UÇAR	Deputy Minister
Mehmet Fatih BELVİRANLI	Deputy Director General for Prisons and Detention Houses
Hüseyin ŞIK	Rapporteur Judge

Ministry of Foreign Affairs

Yonca GÜNDÜZ ÖZÇERİ	Deputy Director General for the Council of Europe and Human Rights
Çiğdem PATTABAN	Head of Department for the Council of Europe
Mehmet Zahit UZUN	Chief of Section
Zeynep MUSA	Attaché

B. Non-governmental organisations

Human Rights in Mental Health Initiative (RUSIHAK)

“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.