European Committee for the Prevention of Torture
and Inhuman or Degrading Treatment or Punishment
(CPT)

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Factsheets are issued under the authority of the Executive Secretary of the CPT. They aim to present the CPT's standards on key issues. However, they do not claim to be exhaustive, in particular as regards the references to country visit reports.

Persons deprived of their liberty in social care establishments

1. Introduction

1. Pursuant to the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the Convention"), the CPT is called upon to examine the treatment of all categories of persons who are deprived of their liberty by a public authority. Such persons may also be accommodated in social care establishments which, across Europe, vary significantly in terms of legal status, ownership, profile and capacity. Many of these institutions are administered by national or local authorities, while others are owned by religious communities, charity organisations or (non-) profit-oriented private entities. Social care establishments may cater for persons with learning disabilities and/or chronic mental disorders (such as schizophrenia), for children, adolescents or elderly persons (including those suffering from dementia). Since 1990, the CPT has visited over 100 social care establishments in various Council of Europe member States.

2. The CPT wishes to stress that its mandate covers both public and private social care establishments where persons may *de jure* or *de facto* be deprived of their liberty.[1] In other words, even if under national law residents are not formally considered to be deprived of their liberty, the CPT may visit a home to examine whether residents are *de facto* deprived of their liberty. The situation of the latter category, those residents of social care institutions who are formally regarded as voluntary, but in practice are not free to leave the institution, is of particular concern to the CPT. The persons concerned are often subjected to involuntary treatment and/or means of restraint without being protected by the legal safeguards applicable to residents who are formally involuntary.

The European Court of Human Rights has concluded in several cases concerning the placement in a closed social care establishment of a legally incapacitated person under guardianship from whose conduct it was obvious that he/she did not consent to his/her her placement that the person concerned 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.[2]

When visiting social care establishments, CPT delegations on occasion concluded that residents accommodated in a particular institution were not deprived of their liberty and thus did not fall within the Committee's mandate. However, more often than not, delegations observed that residents were *de facto* deprived of their liberty. It is therefore up to the CPT, on the basis of direct observations, to establish whether a given social care establishment falls within its mandate or not.[3]

3. The CPT has long advocated that the authorities in member States visited develop a process of **de-institutionalisation,** reducing institutional capacities while increasing the possibilities for community-based care. In particular, large-capacity establishments entail major risks of institutionalisation for both residents and staff which may have adverse effects on the care provided to residents.[4]

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1 See, in this regard, paragraphs 28 and 32 of the Explanatory Report to the Convention.

2 See, for example, the Grand Chamber judgment in the case of *Stanev v. Bulgaria*, no. 36760/06, § 132, 17 January 2012, and *Červenka v. the Czech Republic*, no. 62507/12, §§ 103-104, 13 October 2016.

3 Germany: 2000 visit, paragraph 153.

4 Azerbaijan: 2016 visit, paragraph 187; Bosnia and Herzegovina: 2007 visit, paragraph 110.

2. Ill-treatment

4. In the CPT's experience, instances of deliberate **ill-treatment of residents by staff** are rather rare, but, in a number of social care establishments visited, the Committee did receive allegations of physical ill-treatment (e.g. slaps, punches or blows with wooden sticks), verbal abuse or disrespectful behaviour by staff. In such cases, the CPT has recommended that the institution's management remain vigilant and remind all staff that any form of ill-treatment (including verbal abuse) and disrespectful behaviour towards residents is unacceptable and will be sanctioned accordingly.[5] The CPT considers that in the case of more serious incidents, it would be important that concerned staff members also receive appropriate training to upgrade their professionalism and understand why their actions were completely inappropriate.[6]

5. **Inter-resident violence** appears to be a more frequent phenomenon in social care establishments and, in particular, in those with an inadequate staff presence. Such violence may take the form of verbal altercations but also of physical assaults (including sexual violence) between residents. The CPT has repeatedly emphasised that the authorities' obligation to care for residents includes responsibility for protecting them from other residents who might cause them harm. This means in particular that staff should be alert to residents' behaviour and be both resolved and properly trained to intervene when necessary. Likewise, an adequate staff presence should be ensured at all times, including at night and weekends. Further, appropriate arrangements should be made for particularly vulnerable residents, by taking care, for example, not to accommodate them or leave them alone with residents identified as behaving in an aggressive manner.[7]

6. The CPT also wishes to stress that, in social care establishments, very poor living conditions or the prolonged application of mechanical restraint may in themselves amount to **inhuman and degrading treatment** of residents (see Sections 3 and 6).

3. Living conditions

7. When examining living conditions in social care establishments, the CPT generally applies the same standards as in psychiatric establishments.[8] First and foremost, this includes the requirement that the basic needs of residents are met in terms of **living space and adequate heating, ventilation, access to natural light and artificial lighting,** as well as **hygiene**.

8. It has been the CPT's long-standing position that **large-capacity dormitories** have a counter-therapeutic, depersonalising effect on residents, compromise their privacy and impede the creation of a caring environment. Moreover, they may make it more difficult to control the spread of infectious diseases and thus present a higher risk for the health of residents. Residents should be accommodated in smaller rooms in a caring environment. The aim should be to ensure that no room accommodates more than four residents.[9]

9. Although **men and women** may share day areas and recreation facilities, they should have their own protected bedrooms and sanitary facilities. In the CPT's view, particular precautions are required to ensure that residents are not subjected to inappropriate interaction with other residents who threaten their privacy.[10]

10. Social care establishments should provide a homely, **individualised environment** providing some degree of privacy. Every resident should have a personal, lockable space in which to keep their personal belongings and to be able to dress and undress, wash, shower and bathe in conditions respecting their intimacy. Particular attention should be paid to the specific needs of elderly and/or physically disabled residents. Residents should be encouraged to personalise their rooms.[11]

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5 Latvia: 2016 visit, paragraph 142.
6 Ireland: 2019 visit, paragraph 138
7 Bulgaria: 2017 visit, paragraph 153; Russian Federation: 2018 visit, paragraph 84.
8 See the CPT's 8th General Report (CPT/Inf (1998) 12), paragraphs 32 to 36.
9 Moldova: 2020 visit, paragraphs 161 and 164.
10 Azerbaijan: 2013 visit, paragraph 53.
11 Moldova: 2020 visit, paragraph 164.

11. The CPT has repeatedly criticised the practice of requiring residents to wear pyjamas or uniforms during the day.[12] Similarly, practices such as having a shared pool of **clothes** which is re-distributed after each laundering does not help to generate a sense of autonomy. Clothes are a way of expressing personal choice; choosing and caring for one's own clothes enhances responsibility. Consequently, residents should be allowed and encouraged to wear their own clothes.[13]

12. **Outdoor exercise** should be available on a daily basis, regardless of weather conditions. In outdoor recreation areas, there should be a place where residents can shelter from the rain and the sun. Lack of appropriate clothing should not be used as a reason for not offering outdoor exercise.[14] The aim should be to ensure that all residents benefit from unrestricted access to outdoor exercise during the day unless scheduled activities require them to be present on the ward.[15] Staff should ensure the residents' safety when outdoors and provide the necessary assistance to all residents suffering from physical impairments.[16]

13. Accommodation should be designed or adapted to recognised standards of **accessibility** (ramps, wheelchair access, lifts). Unsuitable accommodation/infrastructure cannot be an excuse to prevent residents from accessing daily outdoor recreation areas/gardens. Residents with reduced mobility should be provided with adequate staff assistance,[17] as well as with appropriate equipment (wheelchairs, etc).

14. There should be a regular supply of **hot water**, and residents should be able to take **a shower** at least twice a week and more frequently if needed.[18] Incontinent residents should be provided with disposable pads and waterproof mattress covers.[19]

15. The CPT also has serious misgivings about the practice of **mixing mentally ill residents with learning disabled residents**. Such a shared accommodation of residents with different needs could result in the failure to provide appropriate care and develop suitable therapeutic programmes for residents The Committee is far from convinced that such a practice is beneficial for either category of resident.[20]

16. In all social care establishments, arrangements should be made to allow residents to have appropriate **contact with the outside world**, i.e. to send and receive letters, make telephone calls and receive visits. It is a praiseworthy practice to allow visitors coming from far away to stay in the establishment overnight.

5. Staff and care provided to residents

17. Given the challenging nature of their job, it is essential that **ward-based staff** (i.e. nurses and orderlies) in social care establishments be carefully selected and given suitable training on how to care for residents humanely and safely before taking up their duties, as well as on-going training later. Particular attention should be paid to the presence of sufficient numbers of ward-based staff during night shifts with a view to ensuring the provision of adequate care and a safe environment to all residents (see also paragraph 19). While carrying out their duties, such staff should be subject to regular supervision. It is important that staff be provided with the necessary support and counselling to avoid burn-out and to maintain high standards of care.[21]

18. The **care** of residents should include the drawing up of an individual care plan for each resident, indicating the goals of treatment, the therapeutic means used and the staff member responsible. These plans should be regularly reviewed and adapted according to an in-depth assessment of each resident's physical and mental state. Indeed, health care staff should participate, alongside with other categories of staff, in the drawing up and review of the care plans, to ensure a multi-disciplinary approach. To this end, social care establishments should employ sufficient numbers of specialised staff trained to carry out the rehabilitative and therapeutic activities relevant to the needs of residents, including educators, psychologists, social workers and occupational therapists. Particular attention should be given to developing programmes

12 Hungary: 2018 visit, paragraph 133.
13 North Macedonia: November 2002 visit, paragraph 100.
14 Ukraine : 2017 visit, paragraph 160.
15 Moldova : 2020 visit, paragraph 167.
16 Bulgaria: 2017 visit, paragraph 166.
17 Ukraine : 2019 visit, paragraph 23.
18 Ukraine : 2017 visit, paragraph 159.
19 Ukraine : 2019 visit, paragraph 21.
20 Azerbaijan: 2013 visit, paragraph 55.
21 Bulgaria: 2017 visit, paragraph 149; Moldova: 2020 visit, paragraph 170.

of rehabilitative activities with a view to improving the quality of life of residents, as well as resocialisation programmes preparing residents for more independent living and/or return to their families. Further, residents should be involved in the drafting of their individual plans and be informed of their progress.[22] As an absolute minimum, every resident should, health permitting, be offered the opportunity to participate in one organised activity every day.[23]

19. **Medical and psychiatric treatment** forms an important part of overall care. To this end, a general practitioner and a psychiatrist should be present on a regular basis according to the residents' needs and the size of the establishment, and at least one nurse should always be present, including at night.[24]

20. Every newly admitted resident should benefit from a **medical examination upon admission** and their **somatic** condition should be regularly monitored.[25] Preventive care is important in any institutional setting, including the availability of relevant vaccinations and the provision of health education.[26]

21. There should be a **personal medical file** for every resident, containing diagnostic information (including the results of any special examinations which the resident has undergone), as well as an ongoing record of the resident's mental and somatic state of health and treatment.[27]

22. Every resort to **psychotropic medication** must be specifically authorised by a doctor beforehand, and its administration properly recorded.[28]

23. **Dental care** should be part of every resident's care plan; a review of dental health should be carried out for every resident and a regular check-up should be available. Dental care should not be limited to extractions but should also include preventive and conservative treatment.[29]

24. Particular attention should be paid to the **nutritional needs** of residents. All residents and, in particular, bedridden residents should be regularly weighed with a view to monitoring and documenting their nutritional status and, where appropriate, prescribing effective nutritional intervention.[30]

25. A specific and comprehensive strategy should be developed in all social care establishments which addresses the authorities' obligations in response to the ongoing **Covid-19 pandemic**. Such a strategy should, *inter alia*, include awareness-raising on Covid-19 infection prevention in such establishments and the methods that will be used by the State to guarantee that every establishment is provided with sufficient quantities of appropriate personal protective equipment (or additional funds to obtain it). Further, it should specify how it will be ensured that rapid, easily accessible and free PCR testing is available for every resident or staff member, should they develop symptoms suggestive of Covid-19 or be exposed to others suspected of having Covid-19. Moreover, serious consideration should be given to the institution of a State-funded system of regular PCR testing of all staff (and any social care resident who enters or re-enters the establishment).[31]

26. When a **death** occurs in a social care establishment (or in a hospital to which a resident has been transferred), an autopsy should be carried out unless a clear diagnosis of a fatal disease has been established prior to death by a doctor. Further, whenever an autopsy is performed, its conclusions should be systematically communicated to the management of the social care establishment, with a view to ascertaining whether there are lessons to be learned as regards operating procedures.[32]

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22 Azerbaijan: 2013 visit, paragraph 54; Moldova: 2020 visit, paragraph 170; Russian Federation: 2018 visit, paragraph 107.
23 Moldova : 2020 visit, paragraph 172.
24 Czech Republic: 2018 visit, paragraph 126.
25 Azerbaijan: 2013 visit, paragraph 59.
26 Malta: 2015 visit, paragraph 167.
27 Azerbaijan: 2013 visit, paragraph 58.
28 Azerbaijan: 2013 visit, paragraph 56.
29 Moldova: 2015 visit, paragraph 188; North Macedonia: 2014 visit, paragraph 176.
30 North Macedonia: 2014 visit, paragraph 176.
31 Bulgaria: 2020 visit, paragraph 38.
32 Bulgaria: 2017 visit, paragraph 152.

6. Means of restraint

27. As regards the use of means of restraint, such as **physical restraint, mechanical restraint and chemical restraint** (i.e. forcible administration of medication for the purpose of controlling a resident's behaviour) and **seclusion** vis-à-vis agitated and/or violent residents in social care establishments, the CPT usually applies the same standards as in psychiatric establishments. For further details, see the CPT's standards as set out in the document "*Means of restraint in psychiatric establishments for adults*" published on 21 March 2017 (CPT/Inf (2017) 6).

28. The CPT wishes to emphasise that the **administration of rapid tranquillisers** requires close medical supervision and adherence to strict protocols by all staff involved, as well as the necessary skills, medication and equipment.

The use of a PRN (*pro re nata)* prescription for rapid tranquillisers must be accompanied by specific safeguards: as a minimum, any such PRN prescription should be drawn up by an experienced doctor after having thoroughly assessed the resident's physical status, should only be valid for a limited time (i.e. weeks rather than months) and should be re-assessed each time it is used or where there is a change in the resident's medication. The application of rapid tranquillisers on the basis of a PRN prescription without the explicit re-confirmation of a doctor may place too much responsibility on nurses as regards the assessment of the resident's mental state and the provision of an adequate response, in the absence of a medical doctor, to potential complications. In the Committee's opinion, in the event of a resident presenting with a state of agitation which cannot be dealt with by the nursing staff, the resident's psychiatrist (or the duty psychiatrist) should be called immediately and intervene promptly to assess the state of the resident and issue instructions on the action to be taken. Only in exceptional situations, when a resident's agitation cannot be controlled by nursing staff and the intervention of a psychiatrist is not possible within minutes, may the administration by nursing staff of rapid tranquillisers under a "conditional" PRN prescription be justified, meaning that a medical doctor must be contacted (e.g. by phone) and must confirm the prescription prior to its use. Further, a doctor must arrive without delay to monitor the resident's response and deal with any complications.[33]

7. Safeguards

29. The CPT considers that **involuntary placement** and stay of residents in social care establishments (including situations in which the restrictions imposed amount to *de facto* deprivation of liberty) should be regulated by law and accompanied by appropriate safeguards. In particular, placement must be made in the light of an objective medical assessment, including of a psychiatric nature.

Further, all residents who are involuntarily placed in a social care establishment (including situations in which the restrictions imposed amount to *de facto* deprivation of liberty), whether or not they have a legal guardian, must enjoy an effective right to bring proceedings to have the lawfulness of their placement and stay decided speedily and **reviewed regularly by a court** and, in this context, must be given the opportunity to be heard in person by the judge and to be represented by a lawyer. The Committee also wishes to underline that, if it is considered that a given resident, who has been voluntarily admitted and who expresses a wish to leave the establishment, still requires care to be provided in the establishment, then the involuntary placement procedure provided by the law should be fully applied.[34] In the absence of involuntary placement procedures, a clear and comprehensive legal framework should be put in place which allows residents who have been admitted voluntarily to challenge the imposition of any subsequent restrictions amounting to deprivation of liberty before a court as set out above.[35]

30. In the context of involuntary placement procedures, the residents concerned, as well as their guardians, should be notified in writing of the placement decision and informed, in writing and verbally, of the reasons for the decision and the avenues/deadlines for lodging an **appeal** against that decision.[36]

31. An **introductory leaflet** setting out the establishments' routine and residents' rights – including information about complaints bodies and procedures – should be drawn up and systematically provided to residents (and their guardian/families) on admission. Any residents unable to understand this leaflet should receive appropriate assistance.[37]

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33 Russian Federation: 2018 visit, paragraph 113.
34 Hungary: 2018 visit, paragraph 152.
35 Latvia: 2016 visit, paragraph 156.
36 Poland: 2009 visit, paragraph 164.
37 Russian Federation: 2018 visit, paragraph 123.

32. The CPT has serious misgivings about the practice observed in various countries of entrusting **guardianship** to staff of the very same establishment in which an incapacitated person is placed, as this may easily lead to a conflict of interest and compromise the independence and impartiality of the guardian. Alternative solutions should be found which better guarantee the independence and impartiality of guardians.[38]

33. The CPT wishes to stress the importance of effective **complaints and inspection procedures**; they are basic safeguards against ill-treatment of residents.

34. In all social care establishments, there should be an effective internal complaints mechanism, and residents should also have the possibility to lodge complaints to an independent outside body, authorised to directly receive confidential complaints and make any necessary recommendations. Complaints addressed to the establishment's administration should be recorded in a specific register.[39]

35. Further, all social care establishments should be visited on a regular basis by an independent outside body. This body should be authorised, in particular, to talk with residents in private and make recommendations to improve the care and conditions afforded to residents. In addition to national preventive mechanisms and Ombudsperson institutions, civil society actors can also play an important role in this regard.[40]

38 Ukraine: 2019 visit, paragraph 44.
39 For further details, see the CPT's 27th General Report (CPT/Inf (2018) 4), paragraphs 68 to 91.
40 Bosnia and Herzegovina: 2007, paragraph 132; Slovak Republic: 2005 visit, paragraph 113.