Annex to the Report of the Public Defender of Rights for the Fourth Quarter of 2009

Placement and Stays of Mentally Disabled Persons in Mental Homes

I.

The Public Defender of Rights as a national preventive mechanism

1. Since January 1, 2006, the Public Defender of Rights (hereinafter also the Defender) has been performing, on the basis of the authorisation in Section 1 (3) and (4) of Act No. 349/1999 Coll., on the Public Defender of Rights, as amended (hereinafter the Public Defender of Rights Act), **systematic visits to places where persons restricted in their freedom by public authority, or as a result of their dependence on care provided, are or may be confined**, with the objective of strengthening the protection of these persons against torture, or cruel, inhuman and degrading treatment, or punishment and other maltreatment. The aforementioned obligation was imposed on the Defender in connection with ratification of the Optional Protocol[1] of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[2], where the Czech Republic agreed to establish a national body for examining, by performing systematic preventive visits, the treatment of the persons restricted in their freedom.

Since 2006, 19 police facilities, 7 prisons, 4 remand prisons, 4 facilities for the detention of foreigners, 2 asylum facilities for foreigners and 4 reformatories have been visited.

However, facilities were also visited where persons are or may be restricted in their freedom as a result of their dependence on the care provided. These included:

- 5 social care institutions for physically handicapped adults (2006),
- 2 follow-up visits to social care institutions for physically handicapped adults (2007),
- 8 mental homes including 30 psychiatric departments (2008),
- 25 homes for people with disabilities (2009),
- 7 follow-up visits to mental homes (2009).

[1] Notice No. 78/2006 Coll. of Int. Tr. of the Ministry of Foreign Affairs on conclusion of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

[2] Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, New York 1984, published in the Collection of Laws under No. 143/1988 Coll. as a decree of the Minister of Foreign Affairs

2. In Section 21a (2), the law imposes on the Defender the duty to draw up a report on his findings with recommendations for remedy after performing a visit to a facility and to send the report to the facility concerned for a statement. After completing a series of visits to a certain type of facility the Defender draws up an overall report where he summarises the findings from the given area, formulates recommendations for other (unvisited) facilities and, if applicable, for self-governing bodies and bodies of state administration. The summary reports are also published at www.ochrance.cz.

3. As a result of the aforementioned authorisation, but also obligations, and the manner of performing the visits, the Defender has the possibility of monitoring some phenomena in the long term and across several government departments. Departmentalism is a typical feature of administration in the Czech Republic in dealing with individual problems; it is an unfortunate phenomenon where borderline and overlapping issues are concerned.

The Defender therefore considers himself obliged to point out the persisting below stated cases of the maltreatment of mentally disabled persons placed in mental homes. He decided to take this step not only due to the seriousness of the findings in relation to the individual "patients", but also because he openly communicated with a majority of the institutions concerned for the whole time and, thus, the information published here is not unknown to them. If he remained silent, the Defender would also be giving up the tasks of the national preventive mechanism following from the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the requirements of the Convention as such.

4. The Defender's recommendations and findings are based on visits to mental homes in 2008, follow-up visits to the mental homes in 2009 and visits to homes for persons with disabilities in 2009. The Defender also obtained information on this issue from his other activities, as well as in co-operation with experts in the field of social services.

5. Our ability to flexibly respond to conduct that may be regarded as inhuman witnesses our human, professional and philosophical attitudes. There is no doubt that citizens, who are due to their restriction dependent on functioning protective mechanisms created by society in the protection of their rights and human dignity, deserve our increased attention.

Findings from visits to mental homes in 2008

6. In the first half of 2008, the authorised personnel of the Office of the Public Defender of Rights performed the first series of systematic visits to mental homes (hereinafter also Homes). Eight of the 17 mental homes for adults were selected;

namely the homes in Dobřany, Havlíčkův Brod, Horní Beřkovice, Kosmonosy, Kroměříž, Lnáře, Opava and Šternberk.[3] 30 departments were visited in total.[4] The summary Report from Visits to Mental Homes (hereinafter also the Report from Visits) was published in September 2008 where the Defender laid down recommendations and proposals for remedial measures addressed to the bodies of state administration and self-government. The report was sent, together with a request for a statement, to all Regional Presidents, the Mayor of the Capital City of Prague, the Minister of Health, the Minister of Labour and Social Affairs and others.

7. **Mental disabled people represent a specific group of patients in mental homes.** Mental disability itself, "mental retardation", under the International Statistical Classification of Diseases and Related Health Problems (10th revision, ICD-10), is classified as a disease (F70–F79) among mental and behavioural disorders.[5] The specifics of mentally disabled persons include a very low adaptability and poor tolerance of changes; their symptoms may worsen significantly after a change of environment accompanying hospitalisation; they tend to be more challenging in terms of nursing care; they tend to be excluded from the community at the department and communication with the personnel due to the often impaired ability of verbal communication; they become an easy target of abuse by other patients that may go undetected (impaired communication, lowered pain threshold); they tend to imitate the conduct of others, which represents a true problem among people with pathological manifestations; their response to administered psychopharmaceuticals (and combinations thereof) are difficult to predict.

8. Focusing on this group of patients of mental homes, the Defender made the following findings:

- people in mental homes include those with disability and other psychiatric diagnoses and those without psychiatric diagnoses, only based on the symptoms given by the disability (see the example of J. J. in the case report in the conclusion to this document);
- if there is no specialised department in the home, mentally disabled people are hospitalised together with patients without a handicap and it can be demonstrated with specific examples that the cohabitation harms patients with disabilities;
- means of restraint are used on many mentally disabled patients, including long-term use;
- mentally disabled people stay in the homes also because they are not provided with proper social services.

[3] The Ministry of Health of the Czech Republic is the founder of all the visited homes except for Lnáře.
[4] 11 of them provide more than 40 beds.

[5] Mental retardation: A condition of arrested or incomplete development of the mind, which is especially characterised by impairment of skills manifested during the developmental period, skills which contribute to the overall level of intelligence, i.e. cognitive, language, motor, and social abilities. Retardation can occur with or without any other mental or physical condition.

9. **A specialised department for the treatment of mentally disabled persons exists in three of the eight mental homes visited** (in the Dobřany, Havlíčkův Brod and Horní Beřkovice mental homes). Other homes place these people among patients without a handicap, depending on their symptoms and need for care. This means that if a mentally disabled person fails to adapt in the after-treatment department, he/she is placed in the so-called agitation control (or admission) department which, however, is primarily designed to manage acute conditions manifesting themselves in agitation. In the Report from Visits, the Defender described the environment as follows:

"The common characteristics of patients of agitation departments are agitation and age, rather than diagnosis. A very challenging environment is generated where patients with a diverse range of psychiatric diagnoses are treated together, moreover in various phases of diseases, seriousness, chronicity, personality traits, etc.[6] *Patients with sometimes contradictory psychological conditions must get along with each other; it is very difficult if not impossible to maintain a comprehensible order at the departments; the environment cannot be used therapeutically. Consequently, according to the invited expert, attempts at understanding interactions between the patients and between the patients and the personnel, using them for a more thorough understanding of the patients' problems and modifying them therapeutically are given up*[7]*. (…) According to the doctors, patients are transferred to a more comfortable department immediately after they have calmed down and provided with initial treatment; in fact however, patients can be encountered who have been hospitalised in the agitation department for several years."*

The medical personnel indicate in interviews that they are aware of the unsuitable conditions but have no means of remedying them. They may objectively perceive patients with a disability as a burden on the personnel of the department, notwithstanding the impossibility of providing for individualised care at the department or rehabilitation.[8]

Mentally disabled people placed among patients in an acute phase of a mental disease and among patients subject to the regime of protective treatment are exposed to a high risk of abuse and damage.

---

[6] Psychopaths of various types, pyromaniacs, patients with schizophrenia, bipolar disorder, sexual sadists, patients with a dual diagnosis (psychosis plus polymorphous addiction), paedophiles, people with mental retardation of various degrees and people with various behavioural disorders are placed in the admission department. Thus, perpetrators of crimes, i.e. persons with a serious psychopathology, are placed at the same departments as psychologically and socially fragile persons, who often manifest their psychopathology in self-destruction. Here, detention issues blend together with therapeutic issues and not a single group of patients receives anything they could benefit from. Cohabitation of these persons unavoidably results in the generation of pathological bonds (abuse of the weak by the stronger, bullying, etc.), deepening psychopathology and hopelessness. See on that point the CPT requirements for prevention, CPT standards, paragraph 30, p. 52.

[7] A deaf patient with schizophrenia and mental retardation can be presented as an example: psychopharmacoceuticals were administered after he was "aggressive without any external causes" (entry in the case notes) – he kicked a patient known to be psychopathic and sexually harassed his fellow patients.

[8] "There is no capacity for individualised approach in excess of basic care, for accompanying patients to deal with their private matters, for activating mentally retarded and elderly patients". Report from Visits to Mental Homes, paragraph 38.

The Defender pointed out in the Report from Visits how negatively the quality of care of mentally disabled people is affected by their placement together with patients with a wide range of diagnoses and staying in agitation control departments. The same is true about the lack of non-medical personnel. **The Defender recommended that the Ministry of Health deal with psychiatry in a conceptual manner and resolve both problems.**

10. It was also ascertained that **many mentally disabled patients are subject to the use of means of restraint.**[9] This involves means such as straps, netted beds, jackets preventing the movement of upper limbs, and the acute administration of psychopharmaceuticals.

Although no generally binding regulation stipulates the maximum duration of the use of means of restraint or repeated use, it is expected to be used for several hours on other patients. (The Methodological Instructions of the Ministry of Health stipulate that means of restraint may be used only during the period when the reasons for their use continue). On the other hand, the use of mechanical restraints on movement for days, weeks and months was repeatedly ascertained with respect to mentally disabled persons. It was ascertained during a systematic visit in 2008 to the Dobřany Home that six patients with the most severe degree of disability were constantly placed in netted beds at the department for patients with mental disabilities. The personnel attempts to serve them meals outside the netted bed and take them into the open air from time to time; otherwise they stay in bed under constant supervision of a worker. Furthermore, a woman with a mental disability of medium severity who had been immobilised by the restraint jacket and tied to the bed for six months for most of the day, when the nurse was unable to attend to her, was encountered in the Kroměříž Home in 2008 (see the case report in the conclusion of this document).

This represents a long-term use of means of restraint in spite of the fact that the legal regulation provides for short-term use only. The Defender drew the attention of the regional self-governments and the Ministry of Health to the long-term restraint in 2008.

[9] Means of restraint are a procedure used by the medical personnel to calm down a patient. Methodological Instructions of the Ministry of Health of the Czech Republic Ref. 37800/2009 is the only legal regulation which expressly stipulates the use of means of restraint in healthcare. In legislative terms, the use of means of restraint is "stipulated" to the extent that it may be included in the use of therapeutic operations without the consent of the patient if the latter shows signs of a mental disease or intoxication and endangers him/herself or third parties (Section 23 (4) (b) of Act No. 20/1966 Coll., on care of people's health, as amended).

The Defender pointed out the problem of long-term to permanent use of means of restrain in the Report from Visits.[10] Since the problem exceeds the possibilities of the individual mental homes[11], the Defender formulated the following recommendations:

It is recommended that the Ministry of Health, as a representative of state administration and regions as self-government representatives, resolve the problem of patients restrained from free movement in the long term, for example by establishing and funding specialised sites, whether within the healthcare sector or under the sector of social affairs, that would be equipped for providing high-quality specialised care.

It is recommended that the Ministry of Health assume responsibility in co-operation with the Ministry of Labour and Social Affairs and local self-governments for resolving the cases of patients who are (currently) restrained in free movement in mental homes on a permanent basis.

11. The Defender's general finding, i.e. that relatively many patients **remain in the visited homes due to the inadequate network of follow-up social services** in spite of the fact that out-patient psychiatric care would be sufficient for them under certain circumstances, applies particularly to **many mentally disabled patients**. Their disease, or simply the psychiatric hospitalisation indicated in their anamnesis, in fact excludes them from admission to existing facilities[12] and there are not enough vacant places in social service facilities that would be prepared for their specific needs. Some doctors in the visited Homes even stated that **social service providers deposit awkward clients in mental homes** without actively adapting the content of the service to the specific needs of the clients.

[10] "In these cases, netted beds and other restraints substitute for the lack of personnel and absence of a specialised site for the described types of disability. Instead of serving as an extreme means of ensuring the safety of patients, they are a long-term solution. The Defender is not competent to comment on the professional aspect of these cases. (It should be noted that the personnel paid considerable attention to these patients; the doctors regularly prescribed the restraints and cared about the patients' health condition.) The aforementioned treatment would be illegal in a social service facility. It is inhuman treatment in a medical facility. The restraints are used in a manner which is incompatible with the purpose of means of restraint as defined by the Methodological Instructions and can be considered to be a measure which disproportionately restrains the personal freedom and dignity of patients. It may be objected in the sense of legal positivism that the patients show signs of mental diseases and regularly endanger one another at the department; in spite of this, the use of isolation and mechanical restraints in the aforementioned manner is disproportionate and does not comply with the internal regulations of the department." Paragraph 79 of the Report from the Visits to Mental Homes

[11] There were many more netted beds in the Dobřany Home before (over one hundred); according to the management, they were reduced to the lowest sustainable number within efforts to humanise care. It is not likely that humanisation would continue without external intervention. The experience from the Kroměříž Mental Home (see the Annex) also suggest that the Home itself is unable to remedy the defective state of affairs independently.

[12] A provider of social services may refuse to conclude a social service contract with a person whose health condition precludes provision of that social service (Section 91 (3) of Act No. 108/2006 Coll., on social services, as amended); such health conditions are stipulated as follows by implementing decree No. 505/2006 Coll., as amended: the condition of the person requires provision of institutional care in a medical facility or the behaviour of the person would materially disrupt collective cohabitation due to a mental disorder. **The correct approach of the facility would be not to merely accept that the interested party has to stay in a mental home based on his/her anamnesis**, but instead to examine his/her actual symptoms - whether there are actual grounds for refusing to conclude the contract. The reasons for termination in social service contracts are also set so that it is easy to terminate the contract with respect to persons with the symptoms of a mental disease.

Specifically, the Defender encountered patients with a mental disease for whom it was impossible to find a suitable social service in the Kosmonosy, Opava and Kroměříž mental homes. The Defender's recommendation for the mental homes was to provide support in looking for a suitable social service, but there is little hope of success without further steps.

About twenty patients have stayed long term, i.e. for years, at the specialised department of the Horní Beřkovice mental home. The same holds true for the Dobřany mental home.

The Defender pointed out the poor provision of social services and the consequent prolonging of psychiatric hospitalisations in the Report from Visits. The Defender formulated the following recommendations for administrative bodies:

It is recommended that the Regions begin to deal specifically with the situation of mentally ill people in their territory, for example by negotiating a public obligation to ensure the provision of individual types of social services between the parties concerned (Region, municipality, non-profit organisations, the Ministry of Health).

It is recommended that the Ministry of Health and the Ministry of Labour and Social Affairs actively co-operate with the Regions in supplementing the network of social services.

12. Given that the Defender considered the situation of the patients ascertained by the visits (not only those with a mental disability) to amount to maltreatment, the Defender also formulated a recommendation in the Report from Visits that the **Ministry of Health and the Regions inform him by the end of June 2009 of the steps that have been taken for fulfilment of the above-specified recommendations.**

13. Furthermore, **the Defender informed the Chamber of Deputies of Parliament of his recommendations** in the *2008 Annual Report on the Activities of the Public Defender of Rights*, including the finding concerning permanent restraint of some mentally disabled patients and long-term hospitalisations as well as hospitalisations necessitated by the lack of specialised social service facilities.

Findings from follow-up visits to mental homes in 2009

14. The Defender performed follow-up visits in seven mental homes (the mental homes in Dobřany, Havlíčkův Brod, Horní Beřkovice, Kosmonosy, Kroměříž, Opava and Šternberk) in order to verify fulfilment of the recommendations he had addressed to the management of the mental homes after visits in 2008, as well as the recommendations published by the Defender in the Report from Visits that were also intended for the Ministry of Health and the representatives of regional self-governments.

15. The follow-up visits **did not ascertain any progress as regards the placement of mentally disabled persons in agitation control departments together with other patients as well as the long-term use of means of restraint** (the Dobřany and Kroměříž Homes): rather the opposite, with another case of a permanently restrained sixteen-year-old mentally disabled girl who had been hospitalised because the social services in the original facility were unable to accommodate her needs due to a lack of personnel (see the case report in the conclusion of this document).

The findings regarding the activities of the responsible bodies are also unsatisfactory. Given that the Defender described his findings in detail in the Report from Visits, he expected that in response to his notice, the Regions would for example contact the nearby mental homes in order to strengthen co-operation and obtain information relevant for implementation of medium-term plans of development of social services. Although the Defender emphasised the need to address the issue immediately, the regional self-governments, with two exceptions (the Moravian and Silesian Region and the Hradec Králové Region), did not respond in accordance with his specific expectations.

The Ministry of Health of the Czech Republic did not inform the Defender by the end of June 2009 on the steps taken to implement his recommendations as he requested in the Report.

Mentally disabled people in mental homes

16. Several comments follow on the position of mentally disabled persons in excess of what is specified above under paragraph 7.

Even if means of restraint are not used on a patient in a specific case, it should be noted that the living conditions in a mental home are worse than in social service facilities. In spite of this fact, hospitalisations of people with a disability lasting several months were ascertained in five of the eight mental homes visited.

17. The Defender gained extensive experience during evaluation of the systematic **visits to homes for persons with a disability**; the authorised personnel of the Office of the Public Defender of Rights performed 25 such visits in 2009, with an emphasis on children and mentally disabled juveniles. For example, as regards psychiatric hospitalisation as a means of addressing agitation unmanaged in a social services facility, the Defender summarised his findings in the Report from Visits to the Homes for People with a Disability as follows: *“In case of unmanaged agitation, clients are transported to the catchment mental home. The personnel of some homes are aware of the unsuitability of this measure (since the clients always return strongly medicated and working with them is substantially more difficult; even some “home” psychiatrists perceive this as a negative step) and of the need to create specialised sites for providing care to users with conditions unmanageable in usual conditions. (…) The Defender is aware that the homes provide the service also to clients with agitation and aggression. At present, there is no other suitable social service for most of them; the only alternative is to keep them in a mental home in the long term or permanently.”*

18. A number of patients now in Czech mental homes could not be hospitalised at all under the laws of some countries, for example Austria, the reason being that the law, or interpretation of Art. 3 of Act No. 155/1990 BGBI ("Unterbringungsgesetz", Act on Detention in Institutions), admits hospitalisation only in case that the mental disability is combined with some other psychiatric diagnosis that can be treated by hospitalisation.

II.

Position and roles of the individual authorities and institutions

19. Current institutional psychiatric care is not adjusted to suit mentally disabled people. This clearly follows from the Defender's findings made in the systematic visits as described above. The care provided at standard departments involves an increased risk for the patient, including the risk of use of means of restraint. The care provided at specialised departments is characterised by long-term stays in conditions that are improvised compared to the standard of care provided in social service facilities. How, in the Defender's opinion, should the individual institutions and authorities proceed?

The Ministry of Health

20. The Ministry of Health of the Czech Republic is the central state administrative body in the healthcare sector. It has not responded with any specific steps to the Defender's appeals and recommendations since September 2008. The concept of psychiatry has not changed in the Czech Republic and no discussion on it has been initiated. More details on the November 2009 statement of the Minister on the Report from Visits to Mental Homes:

- As regards co-operation with the Regions on supplementing the network of social services, "this issue does not fall within the competence of the Ministry".
- Concerning the concept of psychiatry, "the Ministry anticipates establishment of an Interdepartmental Workgroup for the preparation of a National Strategy and National Action Plan for the Support of Mental Health".
- Concerning the assumption of responsibility for patients subject to permanent restraint: *"It is not clear what your affirmation is based on that inhuman treatment occurs in medical facilities in the use of means of restraint." "The Ministry of Health does not plan to build and finance specialised sites intended only for patients who require long-term restraint on their movement due to their disease."*
- Regarding the conditions of use of means of restraint, *"the Health Services Act will define the conditions of use of means of restraint. These must not be used as a means of convenience facilitating care for the patient."*

21. The Defender insists on his recommendations formulated in the Report from Visits to Mental Homes:

- **pursue psychiatry in a conceptual manner;**
- **deal with the problem of the departments (admission, agitation departments) where patients with a wide range of diagnoses and mentalities are placed;**
- **deal with the problem of ill people on whom means of restraint are used long term, for example by establishing and funding specialised sites that would be equipped for providing high-quality specialised care;**
- **introduce legislative changes, among other things with the objective of stipulating the conditions for the use of means capable of restraining a patient.**

22. **With respect to specific cases**, such as the cases of J. J. and M. Š. described in detail in the conclusion to this document or patients placed long term in netted beds in the Dobřany Mental Home,

the Ministry, as the founder of the facilities where free movement is restricted in the long term, should flexibly respond, for example by reinforcing the personnel of the individual departments (such as the 5A department in the Kroměříž Mental Home) and urging solution of the individual cases in the region.

The Regions

23. The Regions are the founders of many social service facilities. As such, they are the ultimate guarantors that services are provided on a truly individual basis in the facilities established by them. Where specific needs arise with respect to individual clients, an adequate response must follow.

This means taking into account the needs of the given facility and its clients – for example by increasing the number of personnel or negotiating provision of the service by some other facility with a higher degree of specialisation.

Psychiatric hospitalisation must be an ultimate, exceptional solution rather than standard as now the case.

24. Furthermore, the Regions as territorial self-governing units are the obliged parties in the sector of social services under Section 95 of the Social Services Act[13] . Thus, they are obliged to

[13] Act No. 108/2006 Coll., on Social Services, as amended

- co-operate with municipalities, other Regions and providers of social services in arranging assistance;
- draw up a medium-term plan for development of social services in co-operation with the municipalities in the territory of the Region, representatives of social service providers and representatives of those to whom social services are provided;
- ensure availability of the provision of social services in their territory in accordance with the medium-term plan.

25. As the Defender noted above, he considers it suitable that the issue of mentally disabled persons that is challenging in terms of care and support be dealt with at the level of the Regions (e.g. cities or municipalities).

This is already in progress in some places as the Defender is aware not only based on his other activities, but also from the meeting of the Social Committee of the Association of Regions of the Czech Republic (November 3–4, 2009), with participation of several workers of the Office of the Public Defender of Rights. The representatives of the individual Regions confirmed at the meeting of the Committee that they encounter the problem of placement of clients that are challenging in terms of care and support; nevertheless, they also added that they are building for these persons either small independent facilities or specialised departments within the existing facilities. For example, a project is in progress in the Hradec Králové Region with the participation of representatives of the Havlíčkův Brod Mental Home and the personnel of the Regional Authority, external personnel, etc. The objective of the project is to adjust rules and conditions for facilities specially intended for persons with a mental disease. A councillor of the Zlín Region for social affairs also participated in the meeting of the Committee; it therefore seems that the situation will also begin to develop there, although so far the Region has repeatedly transferred responsibility to the Ministry of Labour and Social Affairs in its correspondence with the Defender.

26. The recommendations formulated by the Defender in the Report from Visits to Mental Homes fully correspond to the obligations stipulated in the Social Services Act.

- **deal with the problem of patients in mental homes on whom means of restraint are used long term, for example by establishing and funding specialised sites that would be equipped for providing high-quality specialised care;**
- **begin to deal specifically with the situation of mentally disabled people placed long-term in mental homes in their territory, for example by negotiating a public obligation to ensure the individual types of social services between the parties concerned (Region, municipality, non-profit organisations, the Ministry of Health); the aforementioned target group is statistically traceable; it is not a vague task.**

Mental Homes

27. The Defender recommends that mental homes

- **actively co-operate with the providers of social services to patients subject to long-term hospitalisation or long-term use of means of restraint, with the objective of helping them ensure a follow-up service;**
- **if the negotiations with the provider have little future, alert the provider's founder;**
- **actively co-operate with the guardians or family of the patients;**
- **address the Region as the party responsible for community planning of the provision of social services and ensuring their availability;**
- **take the fact of long-term hospitalisation into account by adjusting the living conditions of the specific patient towards more comfort than is sufficient for stays that last a few weeks;**
- **address their founder requesting a temporary increase in the number of personnel or adoption of some other measure so as to avoid the use of long-term measures restraining movement.**

The mental home would bear responsibility for potential consequences of long-term restraint; it should therefore use all means available to it and make every effort to ensure that it is not held accountable for the illegal state of affairs which has its root cause in the inactivity of quite different bodies (whereby the mental home obviously does not rid itself of liability for its potential shortcomings). The paradoxical conclusion is that whether it likes it or not, the mental home must assume responsibility for persons into whose fate neither of the above institutions is willing to invest anything at all because being "merely" disabled, they do not belong to the hospital.

Social Services Facilities

28. **It is recommended to work towards a special approach to clients with specific demands for support and care. If the facility is unable to provide the care and there is a threat of harm to the client (through long-term hospitalisation, restraint of free movement), it is recommended that the founder of the service be informed in writing. The Defender also recommends that the Homes directly address the Regions and request resolution of the situation of these clients.**

III.

Obligation of the state, but also "local authorities" not to tolerate maltreatment

29. The Public Defender of Rights ascertained during the systematic visits that means of restraint were used long-term on individual mentally disabled patients, either in the form of placement in a netted bed or by tying to bed. It is one of the forms of restricting the personal freedom of an individual that are justified to a certain degree in medical facilities insofar as they are used for a legal purpose and proportionately to the purpose. However, precise rules for using means of restraint in healthcare in the form of generally binding regulations do not exist or have not been adopted. It is therefore necessary to refer to general rules and the case-law following from them.

30. The use of means of restraint affects personal freedom of an individual and, in a disproportionate manner and intensity of use, it may also represent maltreatment, or inhuman and degrading treatment which is absolutely prohibited in the sense of Art. 3 of the Convention for the protection of Human Rights and Fundamental Freedoms published through Communication of the Federal Ministry of Foreign Affairs No. 209/1992 Coll. (hereinafter the Convention). Thus, the use of means of restraint falls under the jurisdiction of the Council of Europe's European Court of Human Rights (hereinafter also the ECHR). Article 3 of the Convention reads as follows: *"No one shall be subjected to torture or to inhuman or degrading treatment or punishment"* and, as the ECHR has already stated in the judgment in *Airey v. Ireland*, *"the Convention is intended to guarantee not rights that are theoretical or illusory but rights that are practical and effective"*[14].

31. According to the ECHR, conduct falls under the scope of Art. 3 if it attains a minimum level of "severity", where the level of severity is relative in individual cases, it depends on all circumstances of individual cases, such as the duration of the ill-treatment, its physical and mental effects, and, in some instances, the age, sex and state of health of the person (victim). To assess whether conduct is degrading under Art. 3 of the Convention, the Court examines whether the purpose of the conduct was to humiliate and debase the person concerned and the applied measure affected the person concerned in a manner incompatible with Art. 3 of the Convention. Yet the absence of any such purpose could not rule out a finding of violation of Article 3 of the Convention.[15] In addition, compared to the assessment of a treatment as "torture" or "inhuman" treatment, relative factors such as age or sex may play a greater role in "degrading" treatment, since assessing a treatment as "degrading" is more subjective. In addition to the foregoing, according to the case-law of the ECHR, it may suffice that the person is humiliated in his own eyes, even if not in the eyes of others.

[14] Judgment of October 9, 1979, Ref. No. 6289/73 26

[15] Cf. *Peers v. Greece,* judgment of April 19, 2001, Ref. No. 28524/95, §§ 67 – 68 and 74, and *Valašinas v. Lithuania*, judgment of June 24, 2001, Ref. No. 44558/98, § 101

According to the judgment in *Soering v. the United Kingdom*, the "method of execution" of the measure restraining movement is also relevant.[16]

In general, an inverse proportional relationship may be formulated between the intensity of the suffering inflicted and the severity of effects on the one hand and the duration of the treatment causing the suffering on the other hand. The longer the treatment, the less the intensity and severity of consequences required for it to qualify as "ill-treatment" (cruel, inhuman, degrading or torturing). This could also be called a cumulative or holistic approach or, most comprehensibly, the "last straw phenomenon": The individual aspects of treatment in themselves need not reach the required minimum intensity of harm inflicted, but together they may substantially exceed this limit.[17]

32. In several judgments, the ECHR has dealt directly with the conditions and means of restraint in psychiatric facilities; the case-law of the ECHR is still developing in this respect. The ECHR explicitly admitted general oversight over psychiatric facilities in *Herczegfalvy v. Austria*, since *"while it is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are responsible, such patients nevertheless remain under the protection of Art. 3, whose requirements permit of no derogation".* The case involved a mentally ill patient of a mental home who had been force fed, had means of restraint applied (hand tying, attachment to bed, therapeutic isolation) and had sedatives administered; the ECHR stated that Art. 3 of the Convention had not been breached since this had been "necessary for therapeutic reasons". The ECHR stated that this conduct was justified by the "psychiatric principles generally accepted at the time and medical necessity".[18] The Court also stated that "a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading", but the Court must satisfy itself that the medical necessity has been convincingly shown.

33. The ECHR stated in *Hénaf v. France* with reference to *Tyrer v. the United Kingdom* and *Soering v. the United Kingdom* that the Convention is a "living instrument" which must be interpreted in the light of the present-day conditions, and certain acts that were classified in the past "only" as inhuman or degrading treatment as opposed to torture could be classified differently in future.[19] In the aforementioned judgment, the court found inhuman treatment towards a 75-year-old prisoner who had been transferred to hospital for surgery and spent the night before the operation attached to the bedpost by one of his ankles in spite of the fact that he was simultaneously physically guarded.

---

[16] *Soering v. the United Kingdom*, judgment of July 7, 1989 , Ref. No. 14038/88, §100

[17] Langášek, T., Ochrana před mučením a špatným zacházením [Protection Against Torture and Maltreatment]. In Pospíšil, I., Kokeš, M.: In dubio pro libertate. Contemplations on constitutional values and the law. Honour to Eliška Wágnerová on the occasion of her jubilee, 2009, pp. 121 - 134

[18] "According to the psychiatric principles generally accepted at the time, medical necessity justified the treatment at issue…" *Herczegfalvy v. Austria*, judgment of September 24, 1992, Ref. No. 10533/83; § 82.

[19] *Hénaf v. France*, judgment of November 27, 2003, Ref. No. 65436/01, § 55; *Tyrer v. the United Kingdom*, judgment of April 25, 1978, Ref. No. 5856/72

34. In *Nevmerhitsky v. the Ukraine*, the ECHR changed its assessment of the practice in *Herczegfalvy v. Austria* when it concluded that the force-feeding of a mentally sane convict on hunger strike amounted to "torture" under Art. 3 of the Convention and reiterated that a measure which is a therapeutic necessity from the point of view of *established* (de lege artis) principles of medicine cannot in principle be regarded as inhuman and degrading (and the same can be said about force-feeding that is aimed at saving life); nevertheless, the medical necessity was not shown to exist in this particular case and the decision to force-feed was assumed to be arbitrary.[20]

35. As regards the situation (material/regime/personnel) in individual facilities that may be one of the reasons for maltreatment, the ECHR refers with increasing frequency to the findings of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter the CPT) with respect to the facts and the standards and recommendations formulated by the Committee for standardised assessment (cf. e.g. § 65 of the Nevmerzhitsky case).

36. In the 16th General Report on the CPT's activities, the Committee deals with the use of means of restraint in psychiatric establishments for adults on agitated and/or violent patients. It emphasises that creating proper living conditions and a therapeutic climate is a prerequisite for reducing recourse to the use of restraint. If the need arises to restrain a patient in movement, it is a general rule that the method chosen should be the most proportionate to the situation encountered (paragraph 37 and 39 of the CPT Report). CPT stresses that a patient should be restrained as a measure of last resort applied in order to prevent imminent injury or to reduce acute agitation and/or violence (paragraph 43 of the CPT Report) and it should be brought to an end immediately when the need ceases to exist. According to the CPT the use of mechanical restraints for days on end amounts to "ill-treatment" (paragraph 45 of the CPT Report; in *Kucheruk v. the Ukraine*[21], the ECHR assessed the handcuffing of a prisoner with a psychiatric diagnosis for a period of seven days without being visited by a psychiatrist, as inhuman and degrading treatment). As CPT also notes, means of restraint are used in some facilities due to a lack of personnel which cannot fully attend to clients. However, this practice is fundamentally wrong as the application of means of restraint requires more – not fewer personnel as the latter should be continuously present with the patient e.g. when straps are applied (cf. paragraph 50 of the CPT Report).[22]

---

[20] Cf. § 53 of *Hénaf v. France* and *Nevmerzhitsky v. the Ukraine* judgment of April 5, 2005, Ref. No. 54825/00, § 94 – 96.

[21] *Kucheruk v. the Ukraine*, judgment of December 6, 2007, Ref. No. 2570/04

[22] Based on the general duty to prevent damage, a so-called protective measure is present in the medical practice, most often in the form of patient fixing. It is aimed at protecting the patient, most often against falling from a bed or chair or (self-) harm caused by the patient's movement during an intravenous entry. Fixing is distinguished from restraints based on the reason for indication, which means that they cannot be used to manage patient agitation, as this would *de facto* represent a measure restraining movement; as Tomáš Petr stated, psychomotor agitation, active negativism, self-harm tendencies and similar are a contraindication to the use of fixing and measures restraining movement are used to manage them. Petr T.: ***Restriktivní postupy** [Restrictive Procedures]*, In.: Psychiatrická ošetřovatelská péče *[Psychiatric Nursing Care]*, Grada, 2006, pp. 113–125.

37. **The patients discussed in the case report in the conclusion of this document were tied to bed usually when no member of the personnel was able to attend to them individually. The tying lasted several hours for a period of several weeks and, in the case of J.J., for many months.** The restraining of the patients was a response to their symptoms stemming from the type of their mental disability and diagnosis. Mental disability as such is classified as a psychiatric diagnosis; in fact it is a permanent condition which cannot be altered by pharmacological treatment. However, it is submitted in *Herczegfalfy v. Austria* that the use of means of restraint can be justified by "generally accepted psychiatric principles (at the time) and medical necessity". The girls were in fact "preventively" restrained also at times when restraint was accepted neither by the CPT nor the methodological standards of the Ministry of Health.

38. In addition, the patients whose case report is presented in the conclusion of this document were placed at the busiest department of the mental home intended for the conditions of acute agitation regardless of their accompanying diagnoses that make staying in a large department very unsuitable and risky. It can be deduced from the ECHR judgment in *Aerts v. Belgium*[23] that there must be a link between the reason for holding a person in a detention facility and the therapeutic regime established in the facility. The mental home was unable to offer therapeutic possibilities given its primary mission. In particular therapeutic interventions by teaching personnel and social workers would be appropriate, but the mental home, as a primarily therapeutic institution, does not have these personnel.[24]

A social service consisting of individual personal assistance ensuring increased oversight would be most appropriate for both patients. Using means restraining movement in such a "massive" extent as was the case in the mental home would not be possible if a suitable social service were provided in the sense of Act No. 108/2006 Coll., on social services, as amended, since it is stipulated more strictly by the law. However, such a service was not provided to them.

39. The State's Parties are obliged to ensure under the individual rights guaranteed by the Convention that the rights are fully respected in any territory under their jurisdiction, i.e. **to ensure that no individuals within such jurisdiction are subject to any form of maltreatment. A state is in breach of this obligation not only by failing to act to prevent maltreatment, but also if it acts but fails to take all necessary measures. The case-law of the ECHR imposes a similar obligation on the Regions ("local authority)** if the latter are entrusted with responsibility for such individuals. Violation of Article 3 of the Convention was found in *Z. v. the United Kingdom*[25] on the part of a municipality that had been aware of the poor social situation of children; it failed to intervene and did not ensure social service for a period of four and a half years in spite of the fact that it had the means suitable

[23] Judgment of July 30, 1998, Ref. No. 61/1997/845/1051, § 46
[24] Cf. Section 36 of Act No. 20/1966 Coll., on care of people's health, as amended. Mental homes provide "therapeutic preventative care to persons with health disorders that have a chronic course and need special professional care with a strong rehabilitative emphasis".
[25] *Z v. the United Kingdom*, judgment of May 10, 2001, Ref. No. 29392/95, § 69-75

for this purpose. In the case of patients J. J. and M. Š., whose case report is enclosed in the conclusion to this document, the women were clients of social service facilities established by the Zlín Region: the latter is the founder of many in-patient social service facilities and has the means to directly influence their personnel and investment policies.

40. The Defender does not accept a potential objection pointing out that in fact a reference is made in this case to an “economic” obligation to ensure fundamental rights, since according to the ECHR, the Convention requires ensuring real and specific protection of the fundamental rights of an individual, where the ensuring of such “civil and political" rights has economic and social implications that the Convention does not separate from the rights themselves.[26]

41. The Ministry of Health as the founder of the mental home could contribute to the violation of the procedural obligation following from Art. 3 of the Convention by its inactivity should it fail to properly deal with a complaint about excessive restraining of the patients while being aware of the above facts.

IV. Conclusion

42. The Defender advocates a radical change as regards the placement of mentally disabled persons in standard psychiatric departments given the fundamental negative features accompanying such placement, as he intended to document by this text and support with foreign and other domestic experience. The Defender recommends, on the one hand, that the need for long-term psychiatric hospitalisation be reduced through a well-considered improvement of the social services for mentally disabled persons and, on the other hand, that psychiatric care at specialised sites be ensured with the capacity and distribution throughout the Czech Republic as required by current needs.

[26] *Airey v. Ireland,* Judgment of October 9, 1979, Ref. No. 6289/73 § 26

Case Reports of Long-term Restraint of Free Movement

As regards mentally disabled people placing particular demands on care and support who are at present threatened by long-term psychiatric hospitalisation and inhuman restraint of free movement, they represent a group which is statistically relevant already at the level of regions. Independent small facilities or special departments within existing social service facilities in individual Regions should be built for them.

A. The case o J. J. (31 years)

A woman with a light to medium mental disability who has lived in the Kroměříž Mental Home since 2005. Before hospitalisation in the Home, she was most of the time placed in the personal care of her foster mother (later guardian), most recently in a home for persons with a disability. Means of restraint (jacket and straps) have been applied to her extensively over the long term. She is staying in the Home because the Zlín Region has not provided for any other service.

Background:

- hospitalised in the Kroměříž Mental Home (hereinafter the Kroměříž Home) due to swallowing inedible objects;
- placed at the agitation control department in the Kroměříž Home, restrained in jacket and strapped almost all day;
- the Kroměříž Home did not respond to the special needs of the mentally disabled patient;
- the home for persons with a disability where she was placed through a decision of the Regional Authority, of which the Region is a founder, has not prepared conditions for her return since 2005;
- the relevant Region was advised of the case by the guardian in 2005; it refused to perform any fundamental organisational changes in social service facilities to ensure a social service and a personal assistant for J. J.;
- all attempts of the guardian to improve care and gain placement in a suitable facility remained without response in spite of the fact that she had addressed a number of institutions and exhausted all means.

The Defender's procedure:

- during the systematic visit to the Kroměříž Home in February 2008, the Defender met J. J. at the agitation control department, restrained in a jacket and strapped by her waist and legs for most of the day;
- a doctor at the Kroměříž Home also considered that staying in the department was not appropriate for the patient, but there were not enough personnel that would attend to her further;
- the Defender communicated with the guardian from the very beginning;
- he informed the head of the Kroměříž Home of his findings in the report from the systematic visit, and pointed out the unsatisfactory conditions at agitation control departments for long-term hospitalisation of mentally disabled patients;
- a professional diagnosis of the patient initiated by the Defender concluded that J. J. should be in a social service facility rather than a medical facility and a personal assistant should be provided in the Kroměříž Home;
- the Defender repeatedly addressed the Regional President of the Zlín Region as the representative of the Region (founder of the patient's original social service facility and,

at the same time, the obliged party under the Social Services Act in ensuring availability of social services in the Region). He has done so seven times since July 2008.

- in September 2008 the Defender informed the Ministry of Health with a recommendation that the problem of long-term restrained patients in mental homes should be resolved; he repeated this step in October 2009;
- the guardian has provided for personal assistants for J. J. since the beginning of 2009; they visit her in the Home several times every week;
- J. J. remains in the Home in spite of the activities of the Defender and the guardian and restraint measures are applied to her.

B. The case of M. Š. (17 years)

A woman with a severe mental retardation with erethism, atypical autism and foetal alcohol syndrome. She has spent all her life in institutional facilities, from 1997 in a home for persons with a disability established by the Zlín Region, and from 2007 staying long term in mental homes. From June 2009 in the Kroměříž Home at the agitation control department for adults. She was restrained using measures of restraint (jacket and straps) and tranquilised for two months on end. In December 2009 she was released back to the social service facility whose personnel had been reinforced by the founder - the Zlín Region.

Background:

- hospitalised in the Kroměříž Home after showing violent aggression towards herself and others;
- The home for persons with a disability actively attempted to ensure the most individualised care for her which was shown to eliminate most reliably her aggressive manifestations. The individualised care was at the expense of other clients or inadequate due to a lack of personnel. She never obtained a personal assistant. Atypical autism implies that the affected person is most likely not to respond to collective care.
- the Home repeatedly requested the founder, i.e. the Zlín Region, to increase the number of personnel, but to no avail;
- it is documented how the long-term hospitalisations in mental homes degraded M. Š. both physically and in terms of her abilities.

The Defender's procedure:

- the Defender met the patient in July 2009 during the follow-up systematic visit to the Kroměříž Home at the agitation control department; she was permanently restrained;
- the Defender described the treatment of the patient in the Kroměříž Home in August 2009 as inhuman; the patient had been considered to be bed-ridden from the outset and treated accordingly, although she had always been very mobile. By August 2009 she was unable to walk without support.
- The Defender contacted without delay the Regional President of the Zlín Region to implement the Defender's recommendations laid down already in the Summary Report from Visits to Mental Homes and respond to the case of M. Š. by reinforcing the personnel in the home for persons with a disability established by the Zlín Region, thereby contributing to her immediate return.
- The Defender addressed the Ministry of Health in October 2009. The Ministry had not intervened in any manner by January 2010.

- The representatives of the Zlín Region and the Kroměříž Mental Home met for the fist time in September 2009. The Region pledged to reinforce the personnel of the home for persons with a disability.

In Brno, on January 15, 2010

JUDr. Otakar Motejl
Public Defender of Rights