REPORT ON VISITS

to homes for the disabled

Contents

Appendices:

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I. General introduction

a) Legal basis for systematic visits

1. The Public Defender of Rights was appointed, on the basis of the amendment to Law No. 349/1999 Coll., Public Defender of Rights Act, as subsequently amended (hereafter simply PDRA), which entered into force as of 1. 1. 2006, with the task of the national preventive mechanism as defined by the Optional Protocol[1] on the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[2]. This task involves making systematic visits to places (facilities) which contain or could contain persons deprived of their liberty (§ 1 Paragraphs 3 and 4, § 21a PDRA).

2. The aim of these systematic visits is to determine how persons deprived of their liberty are treated and whether their basic rights and freedoms are respected, thus enhancing the prevention of all forms of mistreatment. Whether persons are deprived of their liberty de facto – as a result of their factual dependence on the care they receive (due to old age, illness, or physical or mental disability), or de iure – on the basis of a decision issued by a public authority, is irrelevant in protecting them against mistreatment.

Mistreatment

3. Mistreatment is understood to mean behaviour which fails to respect human dignity. In extreme cases it can be in the form of torture, cruel inhumane or degrading

[1] Memo No.78/2006 Coll.m.s. of the Ministry of Foreign Affairs on the 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 number 143/1988 Coll. as a directive of the Minister of Foreign Affairs

treatment or punishment. Mistreatment, however, is disrespect for a person and that person's rights, failure to respect one's social autonomy, privacy or right to participate in the process of making decisions about that person's own life, or the abuse of dependency on care or the enhancement of that dependency. In formal terms, mistreatment may consist of the violation of the rights guaranteed by the Charter of Fundamental Rights and Basic Freedoms (hereafter simply CFRBF)[3], international treaties, laws, and legislative rule, as well as failure to comply with more or less binding instruction, orders, standards of care, or the principles of good practice and good procedures.

b) Systematic visits to homes for the disabled

4. For the period of January to June 2009 the Public Defender of Rights (hereafter simply the Defender) chose to make systematic visits to homes for the disabled (hereafter simply HD), i.e. social services facilities as defined by the provisions of § 48 of Law No. 108/2006 Coll., the Social Services Act, as subsequently amended (hereafter simply SSA). The Defender's investigation focused on homes whose target group are people with mental or combined disabilities, specifically for clients under the age of 26. In addition to matters common to all clients (e.g. their right to freedom of movement, right to privacy, etc.) the Defender was also interested in the right to education, collaboration with bodies for the social and legal protection of children, and the reasons why these children had been placed in HD.

5. Appointed staff of the Office of the Public Defender of Rights (hereafter simply the Office) visited 25 such facilities. Residential social services facilities are not typical detention facilities, but places which, as defined by the provisions of § 1 Paragraph 4 c) PDRA, contain or could contain persons deprived of their liberty as a result of dependency on care provided. The Defender therefore proceeded in a logically different manner than with classic detention facilities such as prisons or police cells. He also drew on his findings from his systematic visits to institutions providing social care for physically handicapped adults made in early 2006, to homes for senior citizens in 2007, and his visits to psychiatric clinics made in 2008. The Defender also acquires information from individual claims filed by people contacting the Office.

Course of the visits

6. The systematic visits were always unannounced, although obviously with the knowledge of the site management. The course of the visits corresponded to the size and structure of the facilities. The one-day or two-day visits included an inspection of the premises, interviews with the management, social workers, healthcare staff and direct care workers, the study of clients' documentation and internal regulations of the facility and interviews with randomly selected clients. The interviews were semi-standardised. Where the clients' state of health permitted, we interviewed them without other people being present. The facilities visited provided the staff of the Office with all

[3] Resolution of the Presidency of the Czech National Council No. 2/1993 Coll., on the declaration of the Charter of Fundamental Rights and Basic Freedoms as part of the constitutional order of the Czech Republic.

the assistance they needed. The visits were generally made by 3 – 5 employees of the Office, plus one of the Defender's seven external co-workers.[4] The Defender compiled reports of his findings containing recommendations and proposals for remedial measures, which he submitted to representatives of the facilities for them to state their opinion.

c) Mentally handicapped people in our society and the care they receive

7. The provision of quality care using modern social work methods in the social services environment, which is integrated into day-to-day life and which respects the principles of normality, is a challenge for social services providers, a challenge which they try to meet with the aim of offering care for disabled people within the environment of a real home. Examples of good practice show that this is not only possible, but is also essential to assure that service users are satisfied and to achieve high standards of social services. The history of social work makes clear the pitfalls in seeking forms of care which break away from institutionalised collective oversized facilities that are closed off to the outside world, towards integrated formal and informal, laical forms of care which make up part of everyday life. The first example tends to be considered segregational, i.e. setting disabled people apart from the community into institutional ghettos. The second example from history is usually referred to as integrational, or incorporative, keeping disabled people part of the normal life of their towns and communities.

History

8. The needs for institutional care stems from the coming of the modern age as characterised by industrialisation and booming population in towns which had to deal with a rising number of social problems. The breakup of the traditional family has also ruined the environment for the natural provision of care by relatives in a person's own natural environment.[5] A wide range of organisations are springing up which have begun to provide laical and professional institutional care. The rise and gradual development of social work as a new scientific discipline have led to the somewhat naive idea that we can deal with social problems using these newly established institutions. The multidisciplinary approach focused on copying methods from other helping professions and led to uniformity, the construction of institutional complexes that are strikingly similar to hospitals and psychiatric clinics, though these work on an admission and discharge basis. Hospital patients probably had the chance to return to normal life, but users of social services had to and frequently still have to accept the idea of lifelong

[4] These are acknowledged experts on social services for the mentally handicapped in the Czech Republic and in Austria (e.g. the directors of large organisations also providing residential services, the director of a smaller organisation providing, amongst other things, sheltered housing, a quality inspector who is also academically active in the field of social services, a supervisor, special teacher, etc.).

[5] Nowadays the transferrability of the traditional concept of care is much disputed. See, for example, Kosina, K.: Four Dilemmas in Social Care, conference entitled Dilemmas of the Sexuality of Mentally Handicapped People, Olomouc, 2009: "Examples of this concept can still be seen in some rural areas today. In these we can see not only part of tradition, but mainly a great deal of humanity and respect for a person, who is not "looked after" in the sterile environment of an institution far from home. The care provided by lay people should be an inspiration and a lesson for those working in the social services."

care. In other words, we can imagine a temporary stay in an impersonal hospital facility, but not permanent confinement with no possibility of release.

The present day

9. Nowadays social services providers find themselves at the crossroads of these two approaches, in integrated form. Concepts have arisen which merge these two approaches, not always in the optimal way, or which fail to fully distinguish between these two incompatible approaches to the provision of social services. Advocates of the merging of institutional care with integrated forms of care set up sheltered housing inside the walls of institutions and thus essentially contradict the principles of integration. The development of non-governmental organisations which prefer integrated forms of sheltered housing and employment, education, and leisure time has resulted in huge differences between applied methods of working with clients and the quality of services provided. Outdated institutional complexes which mostly date back to communist times are now no longer suited to modern trends in y helping professions. To transform them is and will continue to be a costly matter.

Next year we will have the chance to assess twenty years of the provision of services in a free civil society. How will it be balanced, not only in terms of social services staff and users, but also of society as a whole? The Defender believes that this report, which is merely one tale from the lives of contemporary clients of social services, shows that social services provided not only to handicapped people is worthy of greater attention on the part of the relevant institutions and society as a whole.

d) Homes for the disabled

The law

10. The overall conditions in facilities and particularly the rights and obligations of people living in such facilities were not governed by any law until January 1 2007. This field was only partially regulated by legislative standards[6] with a few minor exceptions.[7] The legal situation changed with the issue of the SSA and Regulation No. 505/2006 Coll., which implements certain provisions of the Social Services Act (hereafter simply Regulation No. 505/2006 Coll.). The SSA now makes quality standards relating to social services (hereafter simply quality standards) binding; these are defined in more detail in Appendix 2 to Regulation No. 505/2006 Coll. Certain other regulations were amended or abolished.[8] The SSA consolidates what were previously fragmentary laws covering the provision of social services. With regard to contractual principles, however, it is also necessary to work with Law No. 40/1964 Coll., the Civil Code, as subsequently amended (hereafter simply the Civil Code), and in matters relating to legal capacity,

[6] Regulation No. 182/1991 Coll., which implements the Social Security Act and the Czech National Council Act on the competence of bodies of the Czech Republic with regard to social security, as subsequently amended,
Regulation No. 82/1993 Coll., on payments for stays in social care facilities, as subsequently amended,
Regulation No. 83/1993 Coll., on catering in social care facilities, as subsequently amended,
Regulation No. 195/2005 Coll., which amends the conditions to prevent the outbreak and spread of infectious diseases and the hygiene requirements covering the running of medical facilities and social care institutions, as subsequently amended.

[7] E.g. the provisions of § 89a of Law No. 100/1988 Coll., of the Social Security Act, as subsequently amended, which as of October 1 2005 defined the obligations of institutions in the use of measures to restrict people's movement.

[8] E.g. the amendment to Regulation No. 182/1991 Coll.

guardianship, etc., with Law No. 99/1963 Coll., the Civil Court Rules of Procedure, as subsequently amended (hereafter simply CCRP).

With regard to the target group for the Defender's visits, it is also important to comment on the law covering the protection of children's rights. The protection of children contains the guarantees provided by an extensive collection of laws and the justified interests of children and is therefore covered by various branches of the law and with varying degrees of legal force in the laws. In a broader sense the institute of social and legal protection is defined in the provisions of § 1 of Law No. 359/1999 Coll., on the social and legal protection of children, as subsequently amended (hereafter simply SLPC), which, together with Law No. 94/1963 Coll., the Families Act, as subsequently amended (hereafter simply the Families Act), is a crucial law covering the social and legal protection of children. On the question of the broader protection of the rights of children the SLPC states that the other regulations covering this area are not affected by the aforementioned law. These are particularly the Criminal Law,[9] the Penal Code,[10] the Law on Juvenile Courts,[11] Law No. 109/2002 Coll., on institutional or protective education in schools, as subsequently amended (hereafter simply LIPES), amongst others. It is also important not to overlook the international laws, as Article 10 of the Constitution of the Czech Republic states that published international contracts the ratification of which was approved by parliament and by which the Czech Republic is bound, are part of the Czech legal system. These include the Convention on the Rights of the Child,[12] which is a key international document as regards the protection of the rights of children. As a whole it is part of this country's legal system and its provisions take priority over the law. Another important international document relating to the protection of children's rights is the Declaration of the Rights of the Child,[13] which is sometimes rightly referred to as the Charter of the Rights of the Child and is the predecessor to the more modern Convention on the Rights of the Child.[14] In addition to these there is also a range of other documents at the international level, which, however, we will not list here so as not to digress from this report.[15] In general we should mention Law No. 20/1966 Coll., the Healthcare Act, as subsequently amended (hereafter simply HCA) and the Biomedicine Treaty,[16] which is later referred to in this text in relation to healthcare.

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[9] Law No. 140/1961 Coll., of the Penal Code, as subsequently amended

[10] Law No. 141/1961 Coll., of the Rules of Criminal Procedure, as subsequently amended

[11] Law No. 218/2003 Coll., on the responsibility of juveniles for illegal activities and on the juvenile court, as subsequently amended

[12] FMFA Memo No. 104/1991 Coll. on the Convention on the Rights of the Child.

[13] The Declaration of the Rights of the Child was issued on 20.11.1959 through Resolution No. 1386 (XIV) at the United Nations General Meeting in New York.

[14] Proceedings of the Public Defender of Rights, Family and Child, available on the internet http://www.ochrance.cz/documents/doc1197532465.pdf

[15] Worst Forms of Child Labour Convention, European Convention on the Exercise of Children's Rights, European Convention on Recognition and Enforcement of Decisions Concerning Custody of Children and on Restoration of Custody of Children, European Convention on the Legal Status of Children Born out of Wedlock, European Convention on the Adoption of Children, as well as the Convention on the Civil Aspects of International Child Abduction, Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption, Convention on the Recovery of Alimony Abroad, Convention on the Recognition and Enforcement of Decisions Concerning the Duty to Provide Alimony

[16] Ministry of Foreign Affairs Memo No. 96/2001 Coll. m. s., Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine.

11. More recently the position of disabled people has been covered by the approved Convention on the Rights of People with Disabilities (hereafter simply CRPD) and the attached Optional Protocol, which entered into force on 3 May 2008 and were approved by the Chamber of Deputies and the Senate (22. 7. 2009) of the Parliament of the Czech Republic and signed by the President (September 2009). The adoption of these is followed by an effort to strengthen the legal standing of disabled people in various walks of life. These include the right to work, the right to be part of society and have access to community services and the right to have their legal capacity in all aspects of life to be recognised as being equal with that of others. A major impact on the current practice of restricting or depriving people of their legal capacity will evidently result from the provisions of Article 12, which can be interpreted that it basically forbids the deprivation of anyone's legal capacity. The draft of the new Civil Code also does not allow for the complete deprivation of a person's legal capacity.[17]

Strategic documents

12. In 1999 the process began to transform the social services, the aim of which was to create and set up legislation to cover the conditions for the provision of such services. The first stage was to decentralise the funding of these services from the state budget to the level of regional and municipal budgets. Preparations also began to convert large residential facilities to other types of social services (sheltered housing, personal assistance). The transformation process was scheduled for 2007-2013 and should be governed by the principles of humanisation, individualisation and the provision of services in a natural environment. The Public Defender of Rights is aware that the changes associated with the adoption of the SSA and implementary regulations cannot be made all at once, but that this is a long-term process. The process of integration and transformation is also covered by a whole series of strategic documents, such as the National Report on Social Protection and Social Integration Strategies, the Concept for the Support of the Transformation of Residential Social Services to Other Types of Social Services Provided in Users Natural Communities and Supporting the Social Integration of Users into Society (hereafter simply Transformation Support Concept), the Criteria for the Transformation, Humanisation and Deinstitutionalisation of Selected Social Care Services, and the National Plan for the Support and Integration of Disabled Citizens for the Period 2006-2009.

13. It is expected that the development of social services facilities will focus on providing services which meet the individual needs of each user and professional

[17] A person's legal capacity may be restricted, although up to now only for serious medical reasons and only on the basis of a court ruling. It is now proposed that when deciding on someone's legal capacity, the judge must see the person in question and many only order such an infringement of human rights if no less drastic measures are possible. In addition to this, new legislation is to be introduced to help in the decision-making process, allowing a court not to restrict a person's legal capacity but to appoint someone who does not act on behalf of the person in question but who helps that person in day-to-day activities – see http://obcanskyzakonik.justice.cz/cz/obecna-cast-zakoniku/co-upravuje-obecna-cast-zakoniku.html#3

trends.[18] The SSA defines the purpose of social services as the social integration of persons in disadvantageous social situations.

The statistics as of 2003 show that of the former social care institutions, 98 are for adults and 173 for young people with 7 744 places, or 12 056 places respectively, while the number of unsuccessful applicants for places in these homes in that year totalled 3 477, or 792 respectively.[19] The National Report on Social Protection and Social Integration Strategies states that in 2007 there were 205 "homes for disabled people" with a capacity of 16 638 beds. Of these 205 facilities, 5 were state-run, 151 were regional, 32 municipal, 10 ecclesiastical and 7 classed as other.

These figures show that despite the effort to ensure that community services predominate over institutional services, extra attention must be devoted to institutional care, the improvement of such care[20] and the protection of the rights of the clients of these institutions.

Content of services in accordance with the provisions of § 48 SSA

14. The social service offered by homes for the disabled constitutes a residential service offered in return for a fee (the provisions of § 73 Paragraph 1 b/ SSA) to people who are less self-sufficient, particularly due to medical disability, whose situation requires the regular assistance of another person (the provisions of § 34 Paragraph 1 d/ together with the provisions of § 48 SSA). This residential service includes (as precisely defined by the provisions of § 48 SSA) partly accommodation and meals and partly comprehensive care consisting primarily of assistance in routine personal care, personal hygiene or the provision of conditions for personal hygiene, nurturing, education and activation, mediating contact with society, social therapy, assistance in the exercise of rights and legitimate interests, and in taking care of personal matters.

15. Homes for the disabled may provide institutional education or preliminary measures as defined by special laws.[21] The provision of institutional education or preliminary measures in homes for the disabled with regard to the specific needs of disabled people is covered to a reasonable extent by the provisions of LIPES[22] with respect to:

- the rights and obligations of children in schools providing institutional education,
- the right of the director of such a facility to allow a child to reside outside the facility; to ban or discontinue visits by persons responsible for education or other people to the facility; to be present at the opening of letters or parcels sent to children; to remove and put into temporary safekeeping any valuables, money or items which

[18] These aims are formulated, for example, in the Transformation Support Concept, see Resolution of the Government of the Czech Republic No. 127 dated 21 February 2007, available at http://www.mpsv.cz/files/clanky/3859/usneseni_vlady.pdf

[19] Transformation Support Concept, pg. 7 and following. These figures clearly show that supply is far exceeded by demand. The high demand not only shows great interest generated by the quality of the services on offer, but also the lack of any commensurate alternative services enabling people to live in a natural environment.

[20] In this respect the Transformation Support Concept describes the humanisation of services. The Criteria for Transformation, Humanisation and Deinstitutionalisation, however, now offer providers a guide as to how services should be provided in larger facilities.

[21] The provisions of § 46 of the Families Act, as subsequently amended. The provisions of §§76, 76a CCRP.

[22] The provisions of § § 20 and 23 Paragraph 1 a), e) to h) and l), § 24 Paragraph 1 a), d), g) to j) and l) and § 31 of LIPES

would impair the education or endanger the health or safety of a child; to allow children over the age of 15 to travel home unsupervised and to represent children in routine matters,

- the obligation of the director of such a facility to inform children of their rights and obligations; to apply to the appropriate court to have a person's institutional education annulled, if reasons exist for such a course of action; to apply to the appropriate court to have a person's institutional education extended, if it is in the interests of the child; to provide information about a child to its legal representatives and bodies for the social and legal protection of children upon request; to discuss matters of crucial importance with a child's legal representatives, provided that a delay would not make matters worse; to inform the relevant municipal authority with extended powers that a child is about to be discharged from the facility; to discharge children under the age of 15 only when accompanied by persons responsible for their upbringing,
- the entitlement to pocket money and the amount of money provided.[23]

The provisions of the reasonable application of LIPES also state the obligation to subordinate the decisions of directors of such facilities concerning the rights and obligations of people in state administration and listed in § 24 Paragraph 3 cit. of the law in the regimen of the administrative rules of procedure as defined by the provisions of § 36 of this law.[24] The administrative body superior to the HD director is the Regional Authority.

16. The provisions of § 36 SSA state that the provider of such a residential service is obliged to also provide clients with medical care; in the case of physiotherapeutic nursing car, this is to be provided primarily by employees with the vocational qualifications to pursue a medical career as stipulated by a special law.

II. General findings about the homes visited

a) Information about facilities

17. The sample of selected homes includes facilities set up by different bodies (regional authorities, municipal authorities, the Evangelical Church of Czech Brethren). A total of 25 facilities were chosen, covering all the regions of the Czech Republic on an equal basis.[25] These were homes for the disabled in Aš, Bystré u Poličky, Háj u Duchcova, Hodonín, Jáchymov, Jeseník, Jindřichov, Křižanov, Kutná Hora, Kvasiny,

[23] Amendment to SSA implemented by Law 206/2009 Coll. and effective as of 1 August 2009.

[24] As regards homes for the disabled, it seems that only three directorial decisions are subject to the administrative rules of procedure: 1) approval for stays outside the facility, 2) allowing children obliged to undergo institutional, having completed their compulsory school attendance, to temporarily reside outside the facility for the purposes of study or work, 3) the withdrawal of the right to stay outside the facility or to temporary accommodation outside the facility if a child behaves improperly or if no adequate care for the child is assured or if the reason that permission to stay outside the facility was granted changes.

[25] Two facilities were visited in each region, with the exception of the regions of Zlín, Central Bohemia and South Moravia, where only one facility was visited in each of these regions. As regards founding bodies, 22 facilities were set up by regional authorities, two by municipal authorities, and one by an ecclesiastical legal entity.

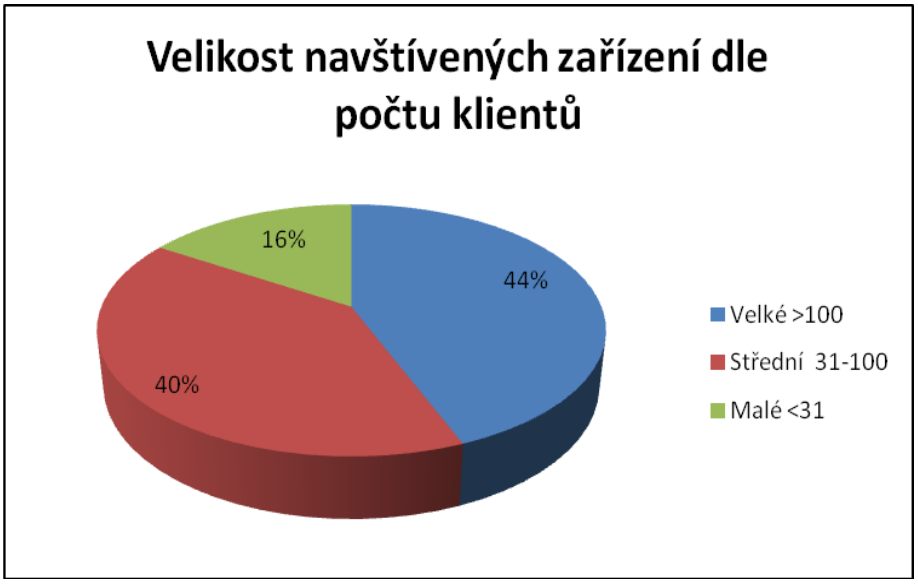
Anenská Studánka, Liberec, Litvínov, Mačkov, Nezamyslice, Nýrsko, Ostrava, Pacov, Plzeň, Prague, Psáry, Raspenava, Rychnov nad Kněžnou, Uherský Brod and Zběšičky.[26] The capacity of the individual facilities ranged from 15 places (Prague) to 205 places (Jáchymov) (see Table 1).

Of the homes visited, three were in the pilot phase of the transformation project as part of the nationwide project for the deinstitutionalisation and humanisation of selected social care facilities. These are the homes for the disabled in Jáchymov, Křižanov and Jindřichov.[27]

18. As Graph 1 shows, facilities containing more than 100 users are still no exception, and in fact these homes make up 44 % of the sample in question. As the Defender has stated several times in his reports, these homes, despite being somewhat more modern, are still no substitute for care in a natural environment. Residential services should approximate the natural environment as closely as possible. This requirement primarily involves smaller facility capacities, equipment, regimen and the lifestyle of clients (individualised regimen) as well as being situated in normal built-up areas.[28] The common denominator of higher-capacity facilities is generally that many services are provided inside the building, which deprives clients of the natural opportunity to interact with the outside world.

From a strategic point of view priority should be given to building small integrated facilities.

Graph 1



[26] Also referred to later in the text under their full names.

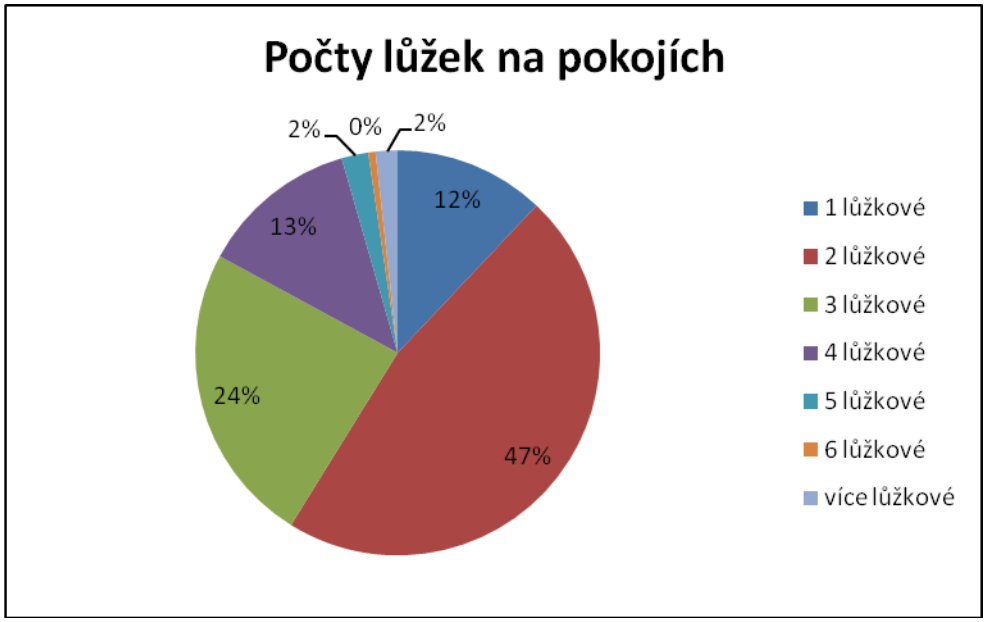
[27] Support for the transformation of residential services is based on the main priorities of the National Development Plan for 2007-2013 and the National Strategic Reference Framework 2007-2013, which are national strategic documents. In the pilot phase of the project several facilities were selected in each region (approx. 2 in each region) to enter the transformation process. For more, see http://www.mpsv.cz/cs/3857

[28] Transformation Support Concept, pg. 15 - 16

Size of facilities visited by number of clients
Large >100 Medium 31-100 Small <31

19. Two- and three-bedded rooms were the standard in the homes visited (see Graph 2, Table 2), although it was also found that some rooms contained up to eight clients (e.g. Křižanov).

Graph 2



Number of beds in rooms
1 bed 2 beds 3 beds..... more beds

With retirement homes, just like any other social services facility, it is difficult to reduce the number of beds in rooms in historical buildings such as chateaus, etc. A single or double room measuring 20 – 40 m² will be far from appealing. In these cases it seems best to "partition" the room, e.g. with carefully placed furniture, to at least assure the minimal level of privacy.
In their plans to reduce capacity, homes have the full support of the Defender.

20. In some homes the rooms (or partitioned areas) have en-suite toilets and bathrooms. Most of them, however, have shared facilities in the corridors (in exceptional cases these are even unisex). In general (with a few exceptions), the furnishings of rooms differ between rooms for clients with milder disabilities and those for clients with severe or combined disabilities, who are placed in "nursing wards" or "medical sections". In the first case, rooms are equipped with a bed, bedside tables, and shelves, some rooms have a television, and are decorated how the client wants. In the second

case, the majority of clients' rooms contain just a bed and shelves and the room does not feel "lived in" and lacks the personal touch. In some rooms the walls are painted in different colours, others have cuddly toys on the shelves (although often out of the client's reach).

All the facilities contain a dining room and a common-room. In some homes there is a smoking room, or at least an area set aside for smokers, as well as workshops and physiotherapy. Some homes offer visitors the chance to sleep over. The wards of almost all the facilities had some form of kitchenette. The opportunity for clients to use these also differs, depending on their disabilities as well as on the home rules.

21. Most of the homes have a garden or a park and are situated on the edges of villages or towns. Some homes are in the centre. In exceptional cases a home stands all on its own (e.g. HD Jáchymov), with the nearest village being several kilometres away.

In the case of homes which are situated in remote outlying areas, it is recommended that they do not invest in expanding these complexes, but give priority to building detached sites which are integrated into populated areas.

22. The facilities are unisex, with one exception[29]. In several facilities it was observed that the structure of the clientele was markedly homogeneous, both in terms of age (e.g. HD Anenská Studánka), and sex (HD Nezamyslice). Some facilities, in addition to providing residency all year round, also provide other social services (day or week wards, etc.). The homogeneity of the facilities is not considered to be a problem, in fact it could be expected that the target group would end up being changed with the agreement of the founding body, but this has not been the case in any of these facilities. Obviously, if a home for men only decides to start taking in women, it first has to prepare the necessary conditions, both in terms of structural alterations (separate toilets and bathrooms) as well as preparing the existing clients for such a major change, as apart from the nursing staff, they only see other women a few times a year. One of the facilities visited, which was occupied by men only, has admitted (although only temporarily) 4 female clients. As there are fears for their safety, they are kept locked in their room at night.[30]

Specialists, in line with research, confirm that the non-co-ed nature of facilities promotes artificial homosexuality amongst the clients. In such a case, clients have no freedom of choice as regards with whom to share their sex lives. This kind of system has nothing in common with life in normal society. See also point 118.

It is strongly recommended that "homogeneous" facilities start taking in members of the opposite sex.

23. Some of the larger homes have or are near to a special school or class, where clients attend compulsory lessons.

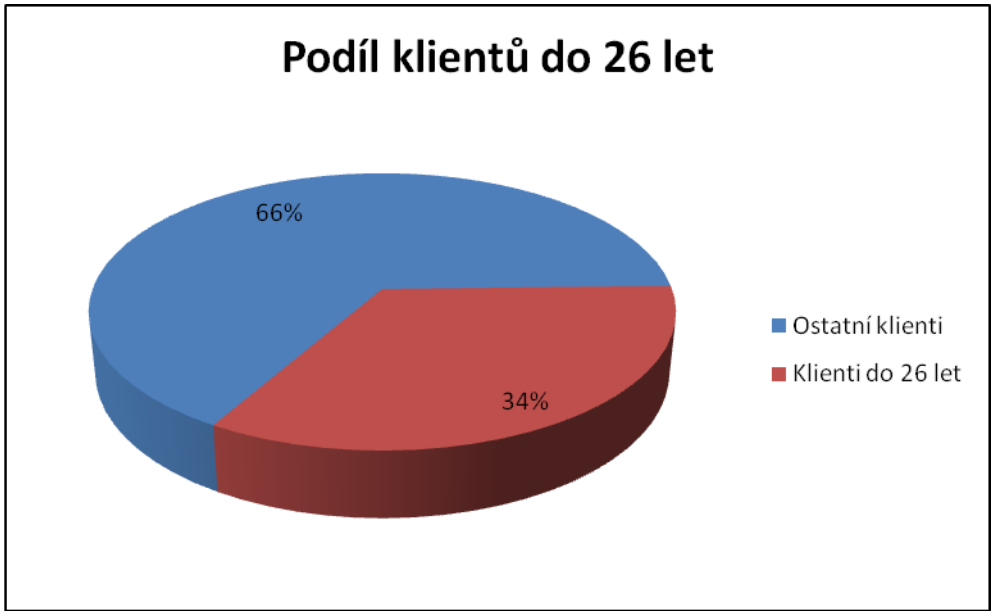
[29] Besides this one exception, another home for the disabled has a unisex medical section; otherwise it only provides services for men.

[30] Zdražilová, P.: Attitude of Social Services Facilities Towards the Sexuality of Mentally Handicapped Clients; Sexuality Dilemmas of Mentally Handicapped People, Olomouc 2009

b) Information about users

24. As described above, the Defender's visits focused primarily on clients under the age of 26. In the homes visited, these made up approximately 34 % of all the clients (see Graph 3). The majority of clients under 26 were men (56 %). The guardianship of clients who have been partially or wholly deprived of their legal capacity is shown in Table 4 (see also point 180). The Defender considers it remiss that a high percentage of clients have the facility or an employee of the facility as their guardian, or trustee (21 % of all clients under the age of 26). This high proportion persists, despite the fact that the only data monitored concerned clients under the age of 26, i.e. those whose legal status has changed in the last eight years. As regards contributions towards care, the largest group of users receiving contributions were Grade IV (66 %) and Grade III (18 %), see also point 107. For further information about the clients, see Table 3 and Table 5.

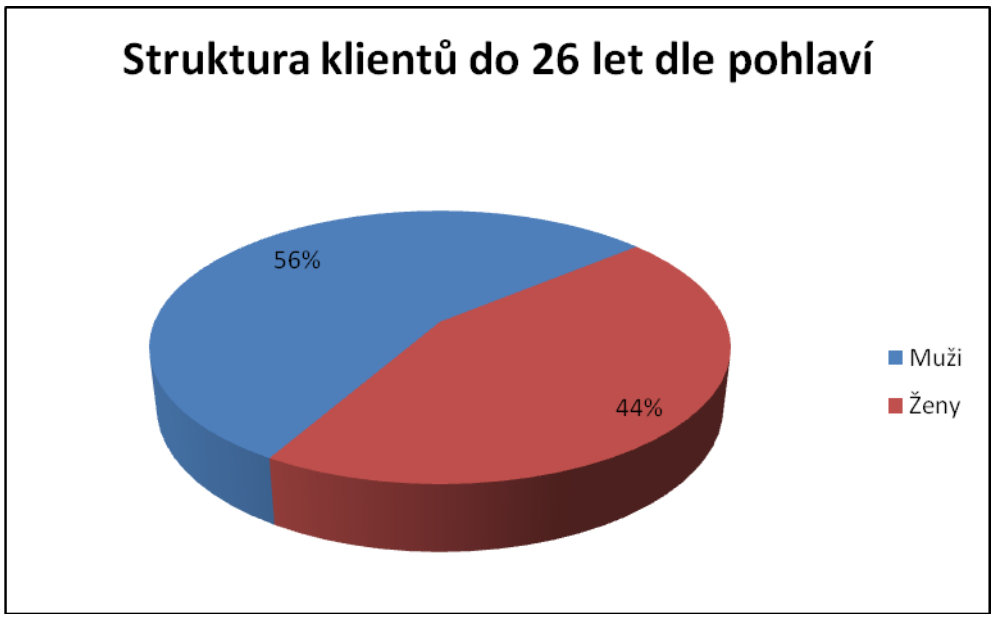
Graph 3



Proportion of clients under the age of 26

Other clients
Clients under the age of 26

Graph 4



Structure of clients under the age of 26, by sex

Men

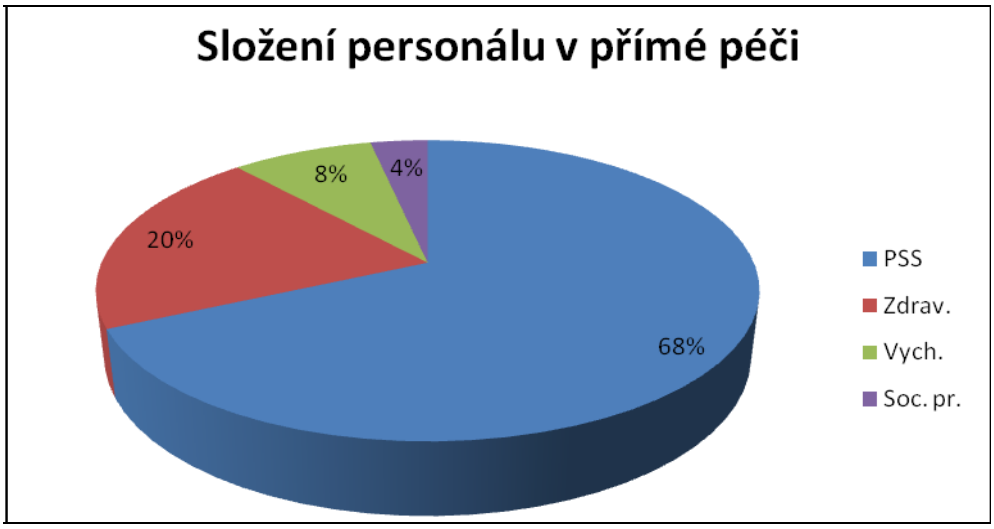
Women

c) Information about staff

25. As is the case with other facilities, there is a limited number of direct care workers to provide individual care. The direct care staff in home were social services workers (hereafter simply SSW), medical staff (nurses) and specialised staff (ergotherapists, physiotherapists); there are often tutors, although their duties are often little different from those of SSW[31]. Nursing staff alternate in two to three shifts. A more detailed look at the composition of staff can be seen in Graph 5 and Table 6.

Graph 5

[31] These are generally university-educated staff who do not work shifts and who are involved in methodical and teaching work with clients and are thus sometimes higher ranking than SSW.



Composition of direct care staff
SSW
Medical
Tutors
Social workers

26. As regards the composition of staff in terms of sex, some facilities do not have any (or practically no) male direct care workers.[32]

Lack of staff

27. The individual facilities greatly differed in terms of the number of staff providing services and staff on night shifts. In some places the Defender found that there was a major deficit of direct care workers, particularly non-medical staff (SSW). In some details the following data may diverge from the actual facts, partly due to the fact that in rare cases the source data are not wholly accurate, and particularly due to the difficulty of counting staff in cases where facilities provide multiple social services and the duties of some employees cover more than one service. However, the margin of error certainly does not exceed 5 % in each subentry[33] and is thus essentially negligible. The aim is rather to highlight the staffing situation in general.

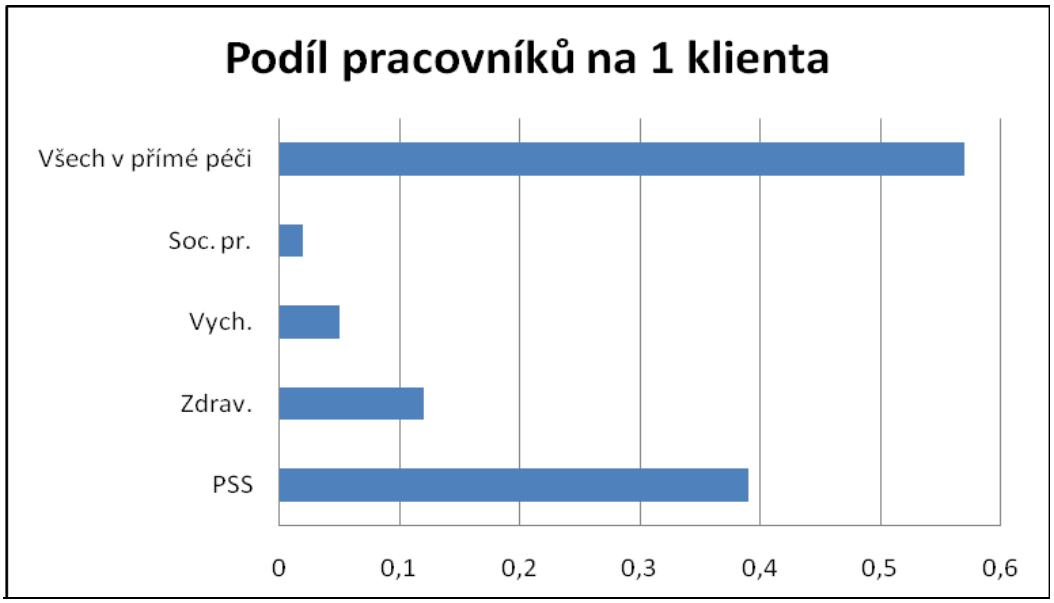
28. In terms of staff, the largest of the facilities visited is HD Jáchymov (180 contractual employees), and the smallest is Prague (8.5 contractual employees). As regards another important parameter – **the number of workers per client**[34] – the best is clearly HD Raspenava; at the opposite end of the range there are several large facilities which, if they were to achieve comparable numbers of staff and clients, would have to increase their workforce by an extra 50 %. Moreover, these HD also have an extremely low number of non-medical direct care staff per client (0.13–0.16 SSW per

[32] E.g. of the 65 direct care workers in Křižanov, only 1 is male; the situation is similar in many other facilities.
[33] E.g. in the case of social workers, which make up 4 %, so the margin for error is no more than ± 0.2 %.
[34] However, the Defender is aware that certain differences are due to the conditions of a particular facility (the composition of the clientele and the nature of their afflictions, space and equipment available, etc.).

client, which in real terms corresponds to 7 clients per SSW; when we consider that these are divided up into shifts, take sick leave, holidays, etc., there are actually more than 15 clients per SSW in terms of actual care provided).

The most important coefficient in the selected sample, **the number of direct care workers per client**, ranged from 0.44 (HD Psáry, HD Křižanov) to 0.66 (HD Raspenava); the average was 0.55 direct care workers per client. Social workers (SW) were not included in this figure; the average is more than 50 clients per social worker (0.02 SW per client).

The Office staff also came across (in at least one facility) low numbers of staff **on night shifts** (3 nurses per 145 clients), which in unexpected circumstances (such as a fire) puts the lives of immobile clients at risk[35].



Proportion of staff per 1 client
All direct care staff
Social workers
Tutors
Medical staff
SSW

29. This lack of staff may also lead to other shortcomings, from a deterioration in the quality of care and individual care to, in extreme cases, overdosing of medication and restrictive mechanical and regimen measures (see points 69, 70, 114 and 116).
The Public Defender of Rights believes that it is essential to increase the number of direct care workers in order to improve the quality of the services provided.
It is recommended more male staff be taken on to provide direct care.

[35] It is also necessary to add that in this facility severely disabled clients were locked in the rooms at night and sedated to get them to sleep. What any potential evacuation of this three-storey historical building would be like under such conditions, "doesn't bear thinking about" (the actual words of one member of staff at this facility).

30. The Defender also met with a number of other shortcomings: there are organisational deficiencies, sometimes serious, in communication and the passing on of information about clients, the scheduling of shifts and sequencing of tasks, as well as the allocation of staff to individual types of clients.

When drawing up a model of shifts, it is necessary to take account of the number of clients and the severity of their disabilities and not to insist on using one single system. It is also necessary to remember that it is very hard for workers responsible for two services to manage their care duties during "peak times" (serving meals, hygiene)[36]; at times like this there should be extra staff to look after the severely disabled (see points 109 – 111). When planning services it is necessary to include changeover times, as well as to calculate time that has to be spent outside the workplace (training sessions, meetings, etc.).

Good practice *from Jedličkův ústav in Liberec:*
The shift system for direct care workers is relatively complicated, depending on the needs of each workplace. Direct care staff work in four shifts of varying lengths, to ensure that the greatest possible number of staff are available at the most difficult times.

Also, in many facilities teamwork is inadequate. There is a lack of interdisciplinary consultation teams (see points 36, 62 and 129) and no actual team approach taken in making decisions about and caring for individual clients. Therefore the Defender recommends that efforts be made to integrate doctors (especially practitioners and psychiatrists) into an interdisciplinary team (see points 113, 129).

31. Most homes are visited by a general practitioner and a psychiatrist (the latter generally once a month). Facilities were also visited by a neurologist, dentist, and psychologist. Female clients attended a female doctor. In exceptional cases some clients were provided with speech therapy, massage, and the services of a physiotherapist. Examples of good cooperation between facilities and specialists were noted in several facilities, when homes provided clients with regular dental care.

Education

32. Some of the staff in the homes visited gained additional qualifications through extra study. More often, however, education is in the form of training courses and seminars relating to the specialised provision of care. It was found that these courses and seminars were predominantly attended by medical staff, and less by other members of staff. Seminars on more general topics are provided for a wider range of staff (e.g. typically training in standards). Education in specific forms of alternative or augmentative communication and methods and approaches relating to aggressive behaviour on the part of clients, clients with autistic tendencies, etc., unfortunately tend to be the exception in individual planning. The approach taken by homes towards contributions or to the provision of study breaks differed.

[36] In a number of cases this means that severely disabled adults are fed from a bottle to keep to the mealtime schedule (more on this later).

In general, as regards education, some homes can still be said to lack a focused staff training plan, or have no systematic approach to the process of lifelong education. The main criteria for choosing a particular course should be how it benefits the quality of services provided in a specific workplace and the credit of the organisation providing the training (there is no guarantee of quality without the latter).

It is recommended that the programme of training and seminars for employees include more topics relating to specialised care and how to deal with clients with specific types of behaviour, the rights of clients, how to approach them, and not merely in medical or nursing terms. It is recommended that facilities consider playing a financial role in education as one motivational factor. It is recommended that a systematic education plan be drawn up with relation to the facilities' target groups for all direct care workers.

33. One of the basic means of ensuring the personal development of staff and preventing burnout syndrome is supervision, i.e. support from an independent qualified specialist in order to help resolve the problems that individual employees or teams experience in the course of their work. As the Defender has stated in all his summary reports on visits to social services facilities, particularly in the helping professions supervision helps to maintain an unencumbered view of the work and to avoid recurring mistakes. This is one of the options required by Quality Standard No. 10 e). It was found that supervision only tends to be used in exceptional cases.

It is recommended that home introduce a system of staff supervision, which should be seen as part of common practice.

III. Implementing the rights of clients

a) Free movement

34. In the facilities he visited the Defender explored the question of how much free movement clients are allowed outside the ward or home, especially in the case of clients who require active assistance. It was found that clients faced obstacles to free movement, besides their actual disability, especially in the form of material obstacles, lack of staff, organisational shortcomings and the restrictive rules of the homes.

Basic requirements

35. In cases where disabled people moving around would pose a certain risk, homes must respond by drawing up a set of rules – both for clients and care workers. It is in relation to this that the Defender in his reports has repeatedly stated that he does not agree to blanket bans on the free movement of clients. Every client has different needs and desires as regards free movement and each has his or her own perspective on minimising the risks that free movement poses for that particular client. Therefore a risk assessment should be carried out for each individual client, determining what can be deemed acceptable risk and whether the support and assistance of the staff are able to cope with this risk.

Clients who have prospects of learning to move independently to some extent should be encouraged in the form of exercises. The Defender was always critical of

facilities which failed to work with clients' abilities, and the staff's only duty in relation to client's going outside, away from the home, was to either ban it or permit it. In time clients' capabilities should be overestimated. (In some facilities there was the risk that clients remain as originally classified.)

In any case the scope of support must be specified (e.g. who will accompany the client, how often, and to what extent). These steps should have a standardised procedure (Quality Standards No. 1 c) and No. 2 a) and b). Amongst other things, it must be determined what powers each individual member of staff or team has in this matter, and objectified entries should be made in the client's documentation. As regards rules, these should also be clear to users of a particular service (taking account of their level of disability), as well as when and to what extent they receive support and supervision.

Good practice *from Jedličkův ústav Liberec:*
Personal outings and stays alone outside the facility are governed by the *Rules on the Provision of Independent Outings*. These clearly describe who can make the decisions regarding independent outings. A permit is required for children (under the age of 18) so such decisions are made by their parents or the home's team in the case of children who have been ordered into institutional care. The rules define who makes up such a team. They state that decisions concerning users over the age of 18 who have been deprived of their legal capacity will also be made by the team, which in such cases also includes the user's guardian. It is in the home's interests to involve guardians in the decision-making process. As regards the weight of a guardian's vote, the majority opinion is decisive. Each user is assessed as to whether he or she can go outside the facility independently or only when accompanied. Independent movement training is common practice.

Good practice *from Domov na zámku Bystré:*
The individual plans of each client state whether or not they can leave the home independently. For patients who cannot, there is a level of support defined and individual training is provided; these clients can opt for accompanied outings, most often in the mornings. Some wards schedule outings for clients on different days (by simply marking days on a timetable). An internal regulation has been drawn up on the assessment of the level of clients' independence.

Good practice *from Domov u studánky in Anenská Studánka:*
The home has compiled a list of issues relating to general real-life situations which clients are tested on on an individual basis to determine whether they are fit to take independent outings. Independent outings do not require that clients have legal capacity.

It is recommended that individual analyses and assessments be carried out to determine the risk posed to clients who independently go outside the home complex. With clients for whom the home rates the risk as unreasonable, it is recommended that work should be done to minimise the risk and to ensure that such clients can enjoy a certain standard of accompanied outings. The possibility

of training should also be determined. Rules such be set for this assessment and clients should be reassessed at suitable intervals. It is recommended that rules and obligations for both staff and users be defined (in the form of an internal regulation) with respect to outings and time spent outside the home.

36. The Defender assumes that the provider of the service, or the specialised team, is fit to judge whether or not a disabled person may go outside the facility (near or far, alone or in a group) without such an outing posing an unreasonable risk. The Defender considers it to be a transfer of liability when, for example, it is set that situations requiring supervision should be decided upon by a psychiatrist/general practitioner/guardian. Such people may be part of the special team, although there is no reason to consider them the sole authority. There is certainly no need to doubt the competency of people such as special teachers, psychologists, "personal partners" (key staff members) or other staff that the client has come into contact with, or, in fact, the team as a whole. The team's task is to assess the risk of actions which could pose a danger to a specific client yet which the client wants to perform.

37. In relation to what is classed as legal action (see points 42, 181), the Defender does not consider it to be of crucial importance to change the competence of users to take legal action for them to go out independently. This opinion is based on the fact that an assessment should be carried out into the risk of actions which could pose a danger to a specific client yet which the client wants to perform, and the home should either support or not support this activity (outings) based on this assessment.

The situation is also sensitive in the case of children who are nearing lawful age. It can happen that the parents of a seventeen-year-old user can forbid outings, which would be a rather drastic restriction (although in practice it was not found that this had happened.) In the Defender's opinion, if the opinion of the specialised team differs from that of the parents, the child's interest in moving around freely like his or her peers outside the home should be defended, ideally through efforts to persuade the parents.

It is recommended that the same approach be taken to all clients, regardless of their legal capacity.

Free movement accompanied by a member of staff

38. Where the risk of independent movement is inacceptable, the provider should offer support in the form of an escort, for either group or individual outings. Considering the poor understanding of clients' needs and also the lack of staff, individual outings with an escort tend to be something of a luxury. Each form, however, serves a different purpose. In some situations, group outings can be stigmatising. If a client wants to go out alone, this should be permitted. The provider of the service must take account of such requests beforehand and be prepared for them. If a facility does not have enough staff to provide individual escorts, clients (it was found) do not request them.

It is recommended that the importance of an individual escort should not be underestimated. If a client desires an escort, especially to go shopping or walk around the town, one should be provided.

Restrictions on free movement

39. Mention was made of other restrictions on free movement than clients' disabilities. Wherever clients are highly dependent on the help of staff, free movement is generally not always practical when the client wishes to out. Or, depending on the number of clients and staff on the shift, facilities may provide accompaniment on a staggered. At least a balcony or terrace can help to do something to improve clients' quality of life.

***Good practice from** the home in Aš:*
Even completely immobile clients are taken out onto the covered terrace next to the common-room every day. (Sleeping bags are used for clients in winter.)

If a client cannot get an escort whenever he or she wants, it is necessary to plan when an escort can be provided. It should be made clear how often clients are to go out, how often they get support to go outside the facility. (Some "plans" were very vague and offered no specific standard of support.) The Defender was always critical when some clients did not manage to get outside the facility at all.
The provision of escorts and support for free movement is part of the basic services offered by homes for the disabled. It is recommended that each individual plan should include the provision of the service and the provision of escorts. With each client who does not leave the facility independently, it should be decided how often the client gets the change to go outside into the fresh air and how often he or she will get "into town" (i.e. outside the facility amongst other people). Depending on the age of needs of each client, it is recommended that some time outside the facility should be planned.

40. The Defender must state that in many of the facilities visited the staffing situation in this respect was poor and there was no initiative to try to improve it. Just enough staff are assigned to shifts to allow supervision of the ward, but employees cannot manage to do anything more. (The Defender found a clear lack of staff to provide escorts in five homes.) Some organisations have reserves – in one, for example, it was found that there were times during the day when clients were elsewhere (e.g. at school) and the ward staff were standing idle. In contrast, it was also discovered that some staff provided accompaniment in their free time. This accompaniment is obviously provided in the form of "kindness", and the user is obliged to the employee.
If a home has insufficient staff and cannot provide clients with an escort, the founding body of the facility should be informed. In addition to this it is recommended that staff shifts be organised so as to provide as many escorts as possible. It is recommended that advantage be taken of the potential of volunteers and non-governmental organisations and these should be actively sought out.

41. It is also worth mentioning material restrictions on free movement. For example, if the premises do not offer sufficient space to move around for clients who require accompaniment outside the complex.

***Good practice from** Jedličkův ústav Liberec:*
The clients of one ward, which contains the most able-bodied clients, have a key to the main door of the building, so they can go out unhindered. Clients inform staff when they are leaving, but no permission is required.
***Good practice from** Domov u studánky in Anenská Studánka:*
The gate in the fence around the home is closed as suspicious people have been loitering in the grounds. Clients were given electronic chips to open the gate.

Unfortunately it was found that even relatively new facilities lack a path for taking beds or wheelchairs outside. In one case it was found that immobile clients were placed on upper floors where there was no lift. Other homes have a complicated layout and clients get lost, and the gardens have dangerous concrete paving or drainage channels. The overall structural and technical design of buildings and complexes should not prevent disabled people from moving around freely.
HDs providing social services must be barrier-free as standard.

42. Internal rules in facilities may also be restrictive. These are rules of varying complexity regarding who takes change or a client, where the client will stay, how individual fact will be demonstrable, etc. The Defender has concerns about excessive formalism, which could spoil clients' chances of sometimes getting outside the facility, especially where staff do not know the limits of their responsibilities.

Responsibility
Adults, including mentally handicapped people, are responsible for their conduct (providing that common sense and volition are maintained). The legal system does not support restrictions on the personal freedom (freedom of movement) of social services users, regardless of their legal capacity. Homes may only support their procedures on the provisions of damage liability, i.e. on the basis of these provisions it is necessary to infer the obligations of individual subjects in certain specific situations and also how the service provider is to act to ensure that (in the case of any potential court proceedings) it can prove that it has not neglected its due to provide the appropriate supervision.[37] For civil responsibility what is important are the provisions of § 422 of the Civil Code, amongst others, which state that, in the case of damage caused by those who are unable to judge the consequences of their actions, "whoever is obliged to provide supervision is exempt from responsibility if it can be proven that the person in question did not neglect the appropriate supervision". The level of responsibility or the level of the required supervision is never determined on a flat-rate basis and must be inferred for

[37] Together with the authors of the treatise on responsibility in the publication entitled The Rights of Mentally-Handicapped People, we can also consider personal responsibility, in a person's conscience and experience. Every person has different ideas regarding personal responsibility, whereas legal responsibility is relatively clearly defined. Sobek, J. and Co., The Rights of Mentally-Handicapped People, Guidelines for Social Services Providers, Portus Praha, o. s., 2007, pg. 41 and following

each user and each provider.[38] If any damage is incurred (to property or health), it must first be determined whether the client is able to judge the consequences of his or her actions; if not, it must be determined whether there is someone who was obliged to supervise the disabled client. The Civil Code does not define who is responsible for providing the appropriate supervision (even with regard to guardians), and the court would judge the case based on the circumstances of the case in question. The fact that the law permits exemption from responsibility means that appropriate supervision cannot be understood to mean supervision performed constantly, over every step a client takes.

Yes, facilities should define rules so that the provision of a service does not pose any risk, and should specify who is to supervise whom and when, but it is also not permissible to restrict a person's freedom solely in the attempt to avoid a reasonable level of risk to their safety.[39]

In one facility it was found that a person who took a client out of a home was required to sign a form declaring transfer of liability. This kind of form, especially when it is individualised and contains the address of the client and a description of his or her physical and mental state, etc., can be an assurance both for the home and for the person taking charge of the client. It can also constitute evidence if liability is inferred. The Defender only wants to make certain that the obligation to provide the appropriate supervision,[40] and thus any liability, passes to the person the client is to live with, automatically, by the fact that that person has taken charge of the client.

The investigations found practices reflected in the rule that states "free movement of clients who have been deprived of or restricted in their authority to take legal action must be approved by a legal representative (guardian)". With regard to this the Defender states that such a rule is not supported by the law. He draws attention to the danger of interfering with users' rights if the provisions were to be strictly adhered to. The rights and obligations of a guardian are based merely on the decision to appoint such a guardian, and cover the guardian's representation in the taking of legal action. What constitutes legal action is discussed elsewhere (see point 37, 181). It is not necessary to modify a user's legal capacity for that person to go outside the facility, and the free movement of clients cannot be conditional upon the consent of a guardian. The consent of a guardian does not exempt a home from its obligation to provide the client with the appropriate supervision, i.e. to provide the service lege artis, nor does it exempt it from any responsibility.

It is recommended that unnecessary formal measures should not be taken to prevent clients' freedom of movement

[38] "However, it is never given beforehand that a service provider takes responsibility for all aspects of a user's life, all the time and in every situation. The service provider should always define and declare the scope of its responsibilities as precisely as possible. The boundaries between the provider's and the user's responsibilities should be completely clear: to the user and his or her relatives, as well as to the staff providing the service. The scope of responsibilities can be defined in the description of the service, in internal documents, in the contract with the client, in the individual plan, etc." Ibidem.

[39] "There is also always a certain risk and for everyone this is the other side of the freedom coin, i.e. of basic human rights and freedoms." Rights of Mentally Handicapped People, Guidelines for Social Services Providers, Portus Praha, o. s., 2007, pg. 41 and following

[40] The provisions of § 422 of Law No. 40/1964 Coll., Civil Code, as subsequently amended.

43. The Defender was also critical

- when a daily regimen which sets aside just a few hours for clients to leave the ward is taken as decisive and inflexible, thus restricting the free will and free movement of the clients;
- when outings are banned as a form of punishment (evidently seen in one facility);
- when it is not clearly defined who can decide that a client can be allowed outside unaccompanied;
- when children in institutional care as the result of a court order are not allowed to go out unaccompanied[41];

Aids

44. In isolated cases it was found that people under restrictions did not have the requisite compensatory aids to allow the client to move or be manipulated.

It is recommended that clients should be provided with compensatory aids, ideally in collaboration with doctors.

Free movement within the facility

45. With regard to the mobility abilities of some clients consideration should be given to clients' possibilities of moving around within the facility, ward, or sections of the ward. Several times the Defender had to draw attention to the undignified environment that users had to spend whole days in, and to the lack of space (see point 91). Due to staffing shortages clients are sometimes forced to be in each other's company all the time and have no chance for privacy. The Defender was also critical of when clients who are at least able to crawl spent all day in bed – with no chance of moving and no sequence to their day.

It is recommended that clients be given space to move around in, with regard to their needs and abilities.

Free movement within the room, mechanical restrictions

46. Wherever a client moving freely around a room is deemed to be a risk, most homes use a variety of mechanical precautions. The primary motive in this is not, at least Defender assumes, to restrict a person's rights or to circumvent the law. In short, in cases of users who are unable to walk, who can only crawl and could fall out of bed or crawl off somewhere, or patients who are able to walk but who have motoric problems, are not sure-footed, or have a severe mental handicap, mechanical precautions are used for when no staff member is able to individually look after the client. In isolated cases this also concerns people with problematic behavioural disorders.

[41] This kind of general approach is unlawful. For institutional care in homes for the disabled there are adequate provisions covering the rights and obligations of children placed in schools for institutional care on the basis of a special law. This law is Law No. 109/2002 Coll., on institutional care or protective care in school facilities and preventive educational care in school facilities and on the amendment to other laws. The provisions of § 20 Paragraph 1 p) of the this law state that a child who has been ordered into institutional care has the right to go for an outing alone with the consent of a teacher at the facility, provided that the child is over the age of 7 and provided that no ban or restrictions have been imposed by the provisions of this law.

Specifically the Defender found locked wards, high grilles (barriers) around beds, bars closing off certain parts of the ward, barriers to keep a person in, e.g. in a play area, clients locked in their rooms with no handles on the door or even with locked doors, bed nets and lowered bed nets, straitjackets. There is no need to go into the details of each individual case. Overall such precautions were found in more than half of the facilities visited. In general these measures are not seen as restrictive; they are used intuitively, with no rules.

47. All these measures undoubtedly have the potential to restrict a person's freedom of movement, or to restrict that person with regard to their ability to move. If a person's mobility is not restricted by a material barrier, there is no need to worry about violating the provisions of § 89 SSA through the use of such a barrier. Such a conclusion will always depend on the type of precaution and the client, and must be the result of an assessment. The Defender was critical when measures were used which have the potential to restrict a person, without the impact on that particular client having been assessed and without any rules. For clients who are capable of at least some movement, it is necessary to prepare a suitable environment for activities. This should be the aim.

48. In his summary report on psychiatric clinics the Defender drew attention to the fact that homes frequently overestimate the legal importance of distinguishing between protective measures and restrictive measures. He especially does not agree when this differentiation is on the grounds of speculation, that is, to avoid taking responsibility for the improper use of restrictions. There is undoubtedly a difference in whether a restriction is in response to agitation or aggression on the part of a patient in reaction to the potential undesirable consequences of such agitation or aggression, or is a precaution to prevent the patient falling or pulling out a drip. There must be a criterion for protection in all situations, however, otherwise the restriction is illegal.[42]

Good practice *from Domov Barevný svět in Ostrava:*
An internal regulation states that protective measures which have no restrictive potential must be subject to an inspection system to ensure that the client does not become more dependent on them. Long-term usage should be reassessed by specialised teams (as well as by doctors, heads of facilities and the heads of social medical wards).
Good practice *from Jedličkův ústav Liberec:*
The whole team is involved in decisions on the use of potentially restrictive measures and it is also defined who is competent to say that a user's opinion should not be taken into account. The team approach helps to reduce the risk non-uniformity or excesses on the part of individuals.

Restrictions on agitated clients

49. The most severe restrictions are placed on clients who show some form of agitation, such as not sleeping at night and disturbing other clients by moving around and banging into things, or constantly asking for things they cannot have.

[42] For more see the Report on Visits Made by the Public Defender of Rights to Psychiatric Clinics, available at: http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=1341.

At present the only lawful measures limiting people's movements are concentrated in the provisions of § 89 SSA. One general provision states that "the provision of social services does not permit the use of measures restricting people's movement" (first sentence of Paragraph 1). This means that the use of bed nets and high side-bars, etc., is illegal. The Defender considers it to be a difficult situation in facilities which do not ignore this problem but which do not have the means to lifting the restrictions. Obviously, if the solution would involve the use of a single room or a change in regimen or the organisation of staff, it should be insisted that the restrictions are impermissible.[43] Lack of staff cannot constitute grounds for the regular use of restrictions, especially then the situation can demonstrably be resolved in a different manner. With reference to the exemption provisions of § 108 Paragraph 1 SSA, the temporary use of restrictions is permissible as long as plans are made to switch over to the use of legal means of restraint.

It is recommended that homes begin the process of removing mechanical restrictions which have been in use for a long time. Cases should be resolved with the assistance of a supervisor with experience with problematic behaviour and all possible steps should be taken to resolve the situation without the use of restrictions.

50. It is useful to rise above the consideration of which measures are permissible and which are not. When we take a broader view of the fate of very demanding clients who are classed as "agitated" due to their disability and behaviour, we see an interesting sequentiality. They live in facilities where there are only adequate numbers of staff to provide supervision, but not for individualised care. They gradually become accustomed to life in gloomy surroundings, without standard furnishings and fittings, decor, or equipment. Their living space is closed off and there are few opportunities to leave it.

Good practice *from Diaconia of the Evangelical Church of Czech Brethren – Zvonek Centre in Prague 4:*
One boy diagnosed with child autism found it difficult to adapt to the needs of the group and agitation and aggression made him a risk. His condition is compensated for with regular medication, and the facility works with the school to prepare the introduction of visual aids and an image communication system as part of the daily programme. For a client in the therapeutic workshop who sometimes becomes agitated, the facilities managed to set up a quiet corner to which she could retire alone without the situation becoming worse.

In relation to the recommendations contained in points 113 and 116, it is recommended that the service's founding body be informed that under the

[43] To put a client to bed when he or she shows signs of being tired and it is likely that sleep will keep the client in bed. To assign the client a separate room where he or she will not disturb the others, or in part of the facility where the other clients can lock themselves in. Another solution is if the client wakes up during the night, the staff on duty should take him into the common-room and engage him in some form of soothing activity. To find out whether the client compensates for being awake at night by sleeping during the day. To consult a doctor to see whether the client suffers from a sleeping disorder. To not insist that the client spends 10 hours in bed.

current conditions the provider cannot assure the service without the use of illegal restrictions.

Immobile clients who remain in bed

51. In several homes the Defender found that clients with severe disabilities, who, although "immobile", could at least crawl or roll over, were kept in bed for most of the day. In such cases the beds understandably are fitted with barriers, high wooden bars like on a cage bed, nets (lowered net bed) or normal side-bars, where these suffice. Some clients do not lie in their bed, but are in different positions. Thus clients have no chance to move, as they would, for example, on a mat in the play area. The mechanical barriers on their beds are not to prevent them from *going* anywhere. This is evidently a restriction on movement compared to situations where people are allowed to move, such as crawl, as clients are confined to their beds almost all day.

One sign of respect for the freedom of movement of a person with such a disability could be precautions such as a lowered bed or allowing clients with severe mobility difficulties to crawl in their rooms.

It is recommended that each bedridden client should be assessed as to whether he or she could benefit from time spent out of bed, and to enable this time to be spent (in accordance with the principle of normality, see points 109, 110).

Side-bars

52. The Defender considers side-bars, of whatever type (lowered, separate or forming part of the bed) as restrictive only where the user's free movement is restricted by the bars (i.e. cannot remove the side-bars himself or does not have shortened side-bars). It is then necessary to work together with the client to assess the risk of the client falling (and this should be filed in the client's documentation). If it is deemed that the risk justifies the restrictions, it is necessary to determine the purpose and extent to which the restrictions will be used (times and type of side-bars). It must be clearly defined which staff member is qualified to make this decision. Facilities are not allowed to act against the will of their clients, even if their opinions differ from those of the professional staff. (If a user does not want side-bars even though there is a risk of falling, other precautions should be taken, such as lowering the bed or using another mattress to cushion any potential falls.) Possible exceptions are cases where clients have been confirmed by a doctor as being unfit to make a judgement.

Even if restrictions are applied with the user's consent, these restrictions must be as minor as possible. In general terms, any developments must focus on ensuring that the client can remove the side-bars himself, depending on the design of the bed, or to get out of bed where shortened side-bars are used. It is also necessary to check that such measures are justified at regular intervals, and to overestimate (which should also be entered in the documentation).

All these rules must be clear to all members of the care team. If a client is unable to judge the level of risk or express himself on the use of side-bars, the risk must be assessed and decisions taken by the specialised team. (The responsibility for the use of these measures is part of the service provider's responsibilities.)

In his Report on Visits to Psychiatric Clinics[44] the Defender stated that **movement-restricting measures must always serve to protect and may only be used in situations where the required level of safety cannot be assured through the use of other non-restrictive measures (particularly by increasing the number of staff who could devote more attention to clients). The criterion of protection, whether it be against agitation or aggression or a fall or accidental removal of a drip, must be present in all situations, otherwise the restrictions are illegal.**

Good practice *from Jedličkův ústav Liberec:*
Only a few beds are fitted with fixed side-bars. With a number of clients alternative measures have been introduced to prevent them from falling: the beds are low, surrounded by mattresses or special cushions, or a wide and designed in a special way. It was found that several clients had been relieved from years spent in beds with high bars (grilles). (The record clearly shows that clients do sometimes fall out of bed at night.)

Dangerous forms of restraint*? rezidua*

53. The Defender considers it a risk and unsustainable in the long term when net beds and cage beds are used without being closed off normally like a standard bed. This was found to be the case in just two of the facilities visited. In one case the facility stated that it was because that was what the client was used to and the client was unable to switch to a normal bed, which was also available. In the second case the bed was only closed sometimes, when the client's condition deteriorated at night. The facility removed the net beds immediately upon receiving the Defender's report.

b) Measures restricting people's movement

54. "The provision of a social service may not include the use of measures restricting the movement of people receiving the social service, with the exception of cases where there is a direct risk to their health and life or to the health and life of other persons; in such cases measures must be applied under set conditions and only for the minimum amount of time necessary to remove the direct risk to their health and life or to the health and life of others." (provisions of § 89 Paragraph 1 SSA)

A situation which endangers health and life may result from a number of circumstances.[45] It is necessary to anticipate that only a small proportion of people with mental disabilities can be deemed aggressive as the result of hostility or through premeditation. In most cases aggression is caused by inner tension. Around a third of the facilities visited did not contain users who showed signs of aggression and in others such people were isolated cases. There is therefore no reason to make generalisations about symptoms shown by people with disabilities. Agitation is obviously more widespread. Such clients pose a risk due to the possible escalation of their agitation and being a source of irritation to other clients. These aspects place great demands on the mental state and professionalism of staff.

[44] See the Public Defender of Rights' Report on Visits to Psychiatric Clinics, available at: http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=1341, pg. 30 and following
[45] Dysfunction of a certain part of the brain; frustration or stress; partial result of mental illness.

In three of the facilities visited the staff declared that no restrictions were used. Paradoxically, one facility was very generous in its use of sedatives, while another used extensive mechanical restrictions on free movement (see above). It is therefore necessary to differentiate very precisely and to investigate the nature of and reason for each of the individual measures.

Means of restriction

55. "Providers of social services are obliged, when using restrictions on free movement, to always opt for the least severe measures. Firstly physical restraint may be attempted, then placing the person in a safe-room, or, where necessary, medication may be administered in the presence of the doctor who has prescribed the medication" (provisions of § 89 Paragraph 3 SSA).

These provisions must be interpreted that other restrictive measures than those specified in the first paragraph cannot be used. The text also later makes clear the need for a sequence, from physical restraint, to a safe-room, and to medication, where absolutely necessary. In the course of his work the Defender has never come across a clear justification for this rule.[46] Only eight of the facilities visited had a safe-room, three of which did not use it, and one only minimally. Some of the carers questioned said they had an internal block preventing them from placing clients in "isolation".

Physical restraints, which the law (and the Recommended Procedure of the Ministry of Employment and Social Affairs Concerning the Use of Measures Restricting People's Movement[47]) prioritises, are included in facilities' internal regulations, although they are only professionally used in isolated cases. The staff do not rely on them.

The most common means of restriction permitted by the law is thus the use of sedatives (for details see point 64 and following).

56. In isolated cases it was found that measures were used to restrict people's movement other than those stipulated by the law. In one a net bed was used, when the client's agitation took the form of shouting and banging around in the night; in another case a straitjacket was used as the client showed signs of self-aggression.

Measures which may be used in situations which are potentially harmful or life-threatening are listed at the end of in the provisions of § 89 SSA. Apart from these three, there is no other legal option. Although staff may see the use of physical restraints as unsuitable or unacceptable with specific clients, the law must be interpreted properly and must form the basis for any potential solution.[48]

In both these cases the use of restriction could be minimised through the use of methods which would avoid situations where restrictions are essential (compare the provisions of § 89 Paragraph 4 SSA).

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[46] The explanatory report on the draft SSA does not provide any information on this matter. The Defender contacted a variety of specialists but they were unable to explain this sequentiality. Light is shed on the matter by the Recommended Procedure of the Ministry of Employment and Social Affairs Concerning the Use of Measures Restricting People's Movement, which, in describing when movement-restricting measures should be used, states that the qualified use of physical restraint should come first, and the safe-room only if the situation continues to pose a risk. The use of medication is permissible where necessary.

[47] http://www.mpsv.cz/files/clanky/5532/doporuceny_postup.pdf

[48] In certain circumstances, like binding restraints, net beds are not illegal in medical facilities. The situation in the social services differs from the Social Services Act in this respect.

It is recommended that illegal means of resolving situations as specified in the provisions of § 89 SSA should not be used.

57. Self-harming by certain clients may pose such a risk as to justify the use of restraints, although the least severe measures should be adopted. Options include, for example, a cushioned helmet, restraining the elbows so that the person cannot reach his or her head yet is still able to take hold of things, gloves, etc. These precautions should improve the lives of clients without the need for more drastic measures.

Safe-room

58. The Defender was critical with regard to safe-rooms. In one case the room was undignified – there was a grille over the door enabling anyone passing by to see who was inside. Another facility did not have a safe-room, but instead used a cubby-hole whenever necessary, even though it was not secure at all and there were no rules permitting this. The room itself should not be a danger (just the opposite); these rooms must be carefully thought out, safe and secure.[49]

It is recommended that careful attention be given to rooms which are used as a form of restriction.

Preparation of staff

59. The Defender considers it highly negligent toward both staff and clients when employees are not trained in how to react when clients behave in a dangerous manner. In the majority of the facilities visited the staff did not have (unless on their own initiative) any chance for this kind of training – the rules of prudent self-defence, how to manage client aggression, etc., so they act on intuition and could cause injury both to themselves and to clients, as well as damaging the staff-client rapport. In isolated cases interviews showed that staff members were afraid of clients, and injuries to social workers were not unusual (large bruises, weals, etc.). It is particularly absurd if staff are expected to use physical restraints when they have not been properly trained in them.[50] Some facilities erroneously consider it sufficient when only one team member has been trained.

***Good practice** from Domov na zámku Bystré:*
The staff were trained and practised in the use of physical restraints. When necessary they could be called within a few minutes using the electronic communication system.

It is recommended that staff be properly trained in the use of physical restraints so they can react in a professional manner to agitation or aggression on the part of clients, and this training should be repeated regularly (at least once a year).

Described and defined procedures

[49] The Recommended Procedure of the Ministry of Employment and Social Affairs Concerning the Use of Measures Restricting People's Movement states that "Safe-rooms should not be locked when not in use, to allow users to enter whenever they wish. This also constitutes a significant preventive measure. A safe-room is a dignified environment and its furnishings should calm, not harm, the user. The environment of a safe-room should provide users, with warmth, light and comfort."

[50] "Physical restraints may only be applied by specially-trained staff." Ibidem, pg. 8

60. Considering the severe infringement of the rights of users as permitted in certain situations by the law in the provisions of § 89 SSA, facilities should comply with Quality Standard No. 2 (protection of people's rights) and ensure that the use of movement-restricting measures are covered by internal rules.[51] To ensure that this requirement is met in material terms, these rules should be practical and specific. The Defender noted that these internal rules were impractical and vague in five facilities, and one facility did not even have any internal rules.

It is recommended that rules be drawn up for staff using movement-restricting measures. The procedure must not be too general, but specific and based on the conditions of the site in question.

Documentation and assessment of the situation

61. The provisions of the law (amended as of 1 August 2009) oblige service providers to keep records and also to report to the registering body the number of cases in which restrictions were used, on a twice-yearly basis. These are the formal requirements.

Restrictions must be assessed in terms of expediency and risk at intervals in line with the nature of the restrictions. Well-kept documentation is essential for feedback. The law stipulates that records must be kept and some records are kept in all the facilities visited, although only is some cases are used for some purpose.[52] The Defender was critical when records of the use of movement-restricting measures were only kept as evidence and not used for further assessment and training. This often meant that the causes of incidents were not investigated, and only restrictions applied. Even the one-off and exceptional use of restrictions must be properly assessed. Assessments should be carried out in all situations where a client's behaviour poses a threat. The results of inspections and assessments provide a basis for fresh work on plans for the use of restrictive measures and overall comply with the legal requirements covering prevention (the provisions of § 89 Paragraph 4 SSA).

The Defender notes that central records (central for the site in question) can be more useful than individual documentation. To some extent central records are kept in four facilities. Without central records the management has nothing to help in answering the questions of how often, why and at whose instigation restrictions (or, for example, sleeping pills) are used, and in which ward, whether or not someone is at a disadvantage, and whether the actions taken by staff are consistent. Assessments should be based on records describing the situation before the client became agitated, to try to find a possible "trigger".[53]

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[51] This is also an obligation stipulated by Quality Standard No. 1 c).

[52] Only one case was found where restrictions were used without any documentation. Otherwise the Defender generally found impractical or incomplete documentation.

[53] With mentally-disabled people the causes of aggressive behaviour may stem from something other than a "mere" dysfunction of a certain part of the brain. They could be a learned reaction resulting from adverse social circumstances (violence, etc.), frustration, or a reaction to stressful situations. It can also be affected by mental disorders or illnesses (neuroses, psychosis, depression). It can greatly benefit the home to determine the triggers of aggressive behaviour, which could be, besides poor communication, a lack of understanding of the client's values, excessive delineation of social boundaries (strict rules, bans of all kinds), excessive care or the opposite, denial of care, the aloofness of staff, living conditions (lack of space, provocation from other clients), staffing fluctuations, changes in the weather, lack of sleep, pain, a change of medication, sexual desires, the scarcity or lack of activities the client is interested in, or even too many activities, fear of change, impatience on the part of staff, private problems (divorce or death of parents, empty promises), etc. Finding what triggers aggressive behaviour many help to greatly reduce the number of such situations in the facility.

It is recommended that the law be respected when documenting situations resulting in the use of movement-restricting measures. It is recommended that central records be kept for each site. It is recommended that situations where measures were not used but the client's behaviour was a threat be documented. It is recommended that situations be assessed by the team.

Inspections and teamwork

62. All organisational measures must focus on ensuring that the staff proceed towards clients in risk situation in a consistent manner; not based on intuition but only on the basis individual experience. It should also be said that there is the need for a very active approach on the part of managerial staff and teamwork on the part of carers. If well kept, client records can help to share experience and good practices.

It is recommended that inspections be carried out, management take an active approach, and staff work as a team.

Individual plan

63. If there is a risk of the need for measures restricting people's movement, in order to ensure that services remain individualised it is necessary to draw up plans for coping with risk situations. It is always necessary to analyse and assess situations involving behaviour which threatens the life or health of the user or of others, with the aim of minimising the likelihood that such dangerous behaviour will be repeated.[54]

It is recommended that these individual plans should describe risk situations and define preventative measures and solution procedures.

Good practice:

In the *HD in Jindřichov* the individual plan of each client known to have aggressive tendencies defines a risk procedure for such situations. This characterises the risk, sets measures to prevent the occurrence of the risk, and detailed procedures to be taken if it does occur. The client is informed of the procedure, if able to understand it, and the client's signature is requested.

In *Domov na zámku Bystré* the repeated use of movement-restricting measures is accompanied by an investigation to determine the cause of the problem. This facility also works together with a doctor.

Medication

64. The law permits the use of medication as a possible measure in situations posing a risk to people's lives or health.[55] The Defender in no way judges the propriety of medication as his task was to investigate the systematic measures and safeguards in the facilities he visited, not to judge whether doctors' actions are appropriate.

Sedatives as movement-restricting measures were not used in five of the facilities visited. They were used minimally in another two.

[54] For more, see the Recommended Procedure of the Ministry of Employment and Social Affairs Concerning the Use of Measures Restricting People's Movement, available on the internet at http://www.mpsv.cz/files/clanky/5532/doporuceny_postup.pdf

[55] Now after the amendment by Law No. 206/2009 Coll.: "during the surgery of a called-out doctor and in that doctor's presence".

65. Most of the visits were made before the amended SSA came into force, which was effectively implemented on 1 August 2009 by Law No. 206/2009 Coll. None of the facilities where medication is used as a form of restriction complied with the explicit requirement that a doctor be present when the medication is administered. Medication was administered by nurses from the facilities after prior consultation with a doctor, or even subsequent consultation, on the basis of a session set up by the doctors beforehand for risk clients.

It is recommended that the valid laws be respected and that sedatives only be used in the presence of a doctor.

66. The Defender is considering the impact of the new legislation (the stipulation that a doctor be present when medication is administered). This means that in cases when a doctor will not or cannot come out to a facility, the staff are forced to call the emergency services. The experiences of providers vary: in Prague and other cities the problem is to persuade the emergency services to come, and the approach taken by doctors is a routine one; in rural areas, however, the doctors generally already know the home's clients. In any case, medical workers (doctors other than psychiatrists) generally use a surgery set up beforehand by an attending doctor, so the client is given sedatives anyway, assuming, of course, that the client is not taken to a psychiatric clinic.

Those who have bad experience of the abuse of power, which the application of sedatives undoubtedly is, will appreciate this amendment as a way of reducing its overuse. The goal of the new amendment is to urge providers to refrain from using restrictions in the form of medication outside the scope of home care, which is certainly a laudable aim. Opponents of the amendment may justifiably argue that overburdening the emergency services will have a series of negative consequences (including lack of sympathy on the part of majority society towards the needs of people in homes when the emergency services become less available). There is also the fact that more people with mental disabilities will be hospitalised in psychiatric clinics, while a stay in a psychiatric clinic can be highly dangerous for a disabled person.

In the Defender's opinion additional checks should be made as to who is authorised to use sedatives. For clients there is no difference as to whether medication is administered by a nurse intending to abuse it or whether it is administered by an unknown doctor in the emergency service (who does not dare not to intervene and admit a predicated danger). Not even doctors are checked. It is also appropriate to consider whether nurses, many of which are university educated, do not merit greater trust, obviously with the due inspections and rules.

Formal matters regarding medication

67. If medication is used which has a sedative effect which could restrict a person, outside regular consultation sessions extra care must be taken to avoid the ever-present risk of the abuse of such medication (to facilitate care) or overuse. Some of the requirements covering staff procedure are stipulated by the law.[56] If medication is administered in a situation when a client's life and health are not in danger (as part of

[56] The provisions of § 89 SSA: these should only be cases which pose a direct risk to life and health; medication should only be administered after other measures to mitigate a person's behaviour have been tried and failed; a doctor should always be present when medication is administered.

the routine administration of medication), it is necessary to ensure that the doctor's consultation session is exactly right, as regards the type and quantity of medication and any repeated dose, as well as the exact details of the type of behaviour which would merit the administration of medication. Facilities should work very closely with the client's doctor.

In practice, however, doctors' surgeries were found to be brief and vague; the doctors transfer all responsibility for the administration of medication to the nurse. This was criticised in eight facilities. In their difficult work nurses deserve clear consultation, not merely recommendations, and the user deserves consultation based on a set of rules which preclude arbitrariness and the potential overuse of the medication.[57] In relation to this homes should assess their collaboration with doctors as to whether their consultation sessions are sufficiently explicit as regards conditions which merit the administration of medication.

In three homes this topic also related to ambiguities found in the consultation sessions. Entries in the medical documentation were transcribed or crossed out, or had other entries glued over the top. Elsewhere medication was issued based on the home' own lists (transcription increases the risk of errors!) or from lists written in pencil. Medication must be issued following the original documentation.

It is recommended that doctors be required to provide precise consultation sessions, especially as regards medication with a sedative effect. It is recommended that medication be administered on the basis of clients' documentation, not lists.

Prevention of errors and abuse of medication

68. With regard to the use of medication with a sedative effect and other measures which have the potential to restrict a person's movement, the Defender always focused on systematic guarantees set up to prevent possible abuse. It constitutes good practice

- when the head of staff always investigates the circumstances of every additional dose;
- when managerial staff carry out spot checks;
- when staff access to such medication in the workplace is restricted;
- when users are constantly monitored to ensure they are not excessively sedated;
- when users wake up in the night, the staff try to use a different way of soothing them, or move the beds around so that nobody is disturbed;
- when every brief outburst of anger, such as when something gets broken, does not result in immediate sedation or the transfer of the client to psychiatric care, but rather to efforts to find the cause or trigger of such reactions.

Dangers of over-medication

69. Several cases in which the Defender subjectively (after a general consultation with a psychiatrist) found very high – regular – medication with a sedative effect led him to challenge whether the level of such medication had been critically assessed by the care staff. There is no room for generalisation here. Over-medication undoubtedly reduces a

[57] For a more detailed argument, see point 87 of the Public Defender of Rights' Report on Visits to Psychiatric Clinics, available on the internet at http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=1341

person's quality of life, from rendering them unable to concentrate to artificial incontinence. It is a good idea to contact an unbiased psychiatrist, or carefully investigate the possible causes of the client's agitation.

***Good practice from** Domov u studánky in Anenská Studánka:*
The staff of the home work with a psychiatrist to try to reduce the long-term medication of new clients, as clients transferred from other facilities are generally more heavily medicated than necessary.

It is recommended that the possible causes of clients' agitation be analysed, steps should be taken to minimise such causes, and a procedure adopted aimed at reducing medication.

70. A number of such cases of high medication, or a blanket approach to medication, was found in one facility. By this, the Defender does not mean an ad hoc reaction to a danger, but the wide-scale application of diazepam before sleep in several ("medical") wards. There were many related deficiencies as regards care on the ward – clients had no space to move around, there were very few staff, and sedating clients was seen as a normal procedure. The Defender highlighted these errors and is still discussing them with the facility.

71. In some cases the Defender found that consent was requested from legal representatives, either for the use of long-term restraints or restrictions in situations described in § 89 SSA. The law does not associate any special consequences with such consent.[58] Consent does not exempt the home from its responsibility to proceed lege artis and in compliance with the conditions required by SSA.

c) Autonomy of will

General introduction

72. In terms of the modern-day concept of social services it is not permissible for clients to be mere passive recipients of care; they must be active partners able to express their will. The Defender focused on how facilities proceed towards disabled people to ensure that, despite their circumstances, they are given the chance to make decisions on matters concerning their own lives.

In all the facilities visited this procedure was covered in internal documents. Specific features were guarantees of the autonomy of users in choosing forms of address, shopping, decorating their rooms, choosing activities, therapy, meals, the times they get up and go to bed, times for hygiene routines, or recreation. However, the day-to-day reality was often different. In their relations to staff clients tend to play a passive role,[59] or the authority to make decisions (or grant approval) varied widely

[58] The consent of users is covered by the Recommended Procedure of the Ministry of Employment and Social Affairs, available on the internet:
http://www.mpsv.cz/files/clanky/5532/doporuceny_postup.pdf

[59] E.g. as regards activities, if a client wants to do something other than a social activity and the home has the staff available, and this activity requires the supervision of a member of staff, it is not permitted. If a client wants to go for a walk, there is often a lack of staff; there is nobody to accompany the client.

amongst the staff.[60] In general it can be said that the least attention is given to the autonomy of clients with severe mental disabilities, or with combined disabilities. One reason is the lack of understanding, as described later; the staff of some facilities assume that these people have no more than the very basic needs. The lack of staff on these wards is also a major factor.

It is recommended that greater attention be given to the autonomy of clients with severe forms of mental disability. Direct care staff should be able to tell the difference when clients manifest signs of pleasure or displeasure and care should be provided accordingly.

Communication

73. For clients to be able to exert their will, they must be able to express themselves so that the staff understand them. If a person cannot speak, the most suitable alternative form of communication must be used. Visual communication is more demonstrative. Many facilities contain a number of users who are unable to speak.

In general it must be said that facilities do not take a systematic approach to nonverbal communication, or are only just beginning to do so. Staff training tends to be unsystematic in this respect. Ideally, communication with individual clients provides concise information about their abilities (states the status quo, without further predicting developments). Some homes have dealt with this matter, although often incompletely, by modifying their work procedures; in some homes staff use their own initiative (for example creating home rules or other documents that are important to clients, in the form of images or pictograms). Good practice was also found, however: practising communication using pictograms, Makaton testing.

The intuition of staff really cannot be relied upon ("we can sense what the client wants"); it is also necessary to communicate with clients and find suitable ways of doing so. It was also found that staff used one client to communicate with the others, as she was better able to communicate with them than the staff themselves. Although this is certainly practical, it does not exempt the staff from their responsibilities. Alternative or augmentative communication should be – where appropriate – part of the individual plan, though this was only found to be the case in isolated cases. Homes should also ensure that skills which clients acquire are maintained (there was one case where two clients learned how to communicate using Makaton at school, but nobody at the facility knew how to use this system, so it was not used and the clients forgot how to do it).

Good practice:

The head of one ward in the *HD in Jeseník* said she was interested in using an alternative form of communication. Pictures and pictograms are used, but also an EICS system (exchangeable image communication system) or "simplified communication"[61]. Each SSW creates their own "picture book", something like a communication chart, which clients use to communicate.

[60] Permission or approval mechanisms were found, e.g. in cases where clients wanted to meet friends outside the home, pocket money, free movement outside the facility, preparing refreshments in kitchenettes, etc.

[61] A member of staff supports the client's hand, enabling them to write or draw, or points to a sign on which are written the words YES/NO. According to the staff, this form of communication has surprising results. It was found, for example, that one client was able to write.

In the *HD in Jindřichov* the internal rules state that each client has an alternative form of communication customised to their needs in their individual plan. Clients should be constantly maintained and supported in "their" system of communication; notebooks can be used, or a communication chart.[62]

If a client is unable to speak, it is recommended that they be given the opportunity to use an alternative form of communication, whatever is most suitable for them. The Defender calls upon homes to intensify their efforts to provide greater options for alternative and augmentative forms of communication both amongst staff and amongst clients.

74. The role of users in a facility, their rights, and their obligations towards others are specified in the form of a home rules document. The Defender noted that if this is a complicated text, a mentally disabled person will find it hard to understand, assuming that they can even read. Facilities must remember that without making things clearer, users will not have enough information about what is and is not permitted, what options they have, etc. Therefore an active approach is required on the part of staff, as well as alternative means of conveying the most important information (where to file complaints, when outings are scheduled, who is available to offer advice, etc.).[63]
It is recommended that alternative ways be sought of ensuring that clients are kept as fully informed as possible regarding the home's internal rules covering aspects of client's everyday life or ways in which they can express themselves.

Conflict of interests and protection of clients' rights

75. The law[64] requires that providers compile internal rules to avoid situations where the provision of a social service could infringe upon a person's basic human rights and lead to a conflict of interests. Merely differentiating between these terms can be a problem for service providers, management, and ordinary members of staff. There is generally a fear of admitting conflicts of interests, or the staff are familiar with a few cases but fail to "look beyond" those.

[62] Communication charts contain frequently used terms/symbols arranged by theme, and enable people to get their message across. Symbols can be placed in groups to make them more easily accessible. Symbols must be arranged schematically (in a lifelike manner), taxonomically (by category) or grammatically (based on the laws of grammar). Organisation charts can be created for each client individually to suit their needs, abilities, and skills. It is important that the client learns the meaning of the different symbols and how they (or others) use them in specific situations. Clients should always have access to the communication chart they use, and it should become a regular aid to help them in all imaginable situations. Charts should also be constantly added to and updated. They should not only work with symbols, but can also use keyboards with letters, numbers, punctuation signs, etc., all depending on the communication skills of that particular client.

[63] Images, photos, pictograms. These can be used to explain the community rules of cohabitation to clients with less severe disabilities, something the Defender came across in his earlier visits to homes. This is not a particularly long document, which comprehensibly and clearly (for example in the form of principles or points) formulates the rules covering everyday life in the facility. It does not have to go into detail on all aspects; in the case of community rules it should explain the main points and state who is able to provide any additional information required. The Defender sees this as a great opportunity for self-reflection on the part of clients and getting them actively involved if they can work with the staff on the wording of these rules. This would provide the staff with a means of obtaining interesting information about how the clients see their role and mutual relations in the home, as well as whether they know all the rules and what they are there for.

[64] Quality Standard No. 2

It is especially important to anticipate that in reality the everyday provision of social services necessarily results in conflicts of interests.[65] The question is how these interests are balanced. Internal rules should be there to aid the staff, to help them to act in conflict situations. It is the management's responsibility that these rules are compiled properly, ideally in collaboration with direct care workers.

76. In his visits the Defender found that the standard of internal rules varied fairly widely (it was only in exceptional cases that homes did not have any at all). Unfortunately these were often merely to formally comply with the stipulations of the Quality Standard. It is not sufficient to have a merely ideological document, with no specific casuistry or relation to the actual situation in the home. Interviews with the staff of such facilities clearly showed that this document did not help in resolving day-to-day conflicts of interests. All it did was increase distrust in "new" formalities.

Good practice:

In Jedličkův ústav *in Liberec* there are possible conflicts of interests arising from specific, day-to-day situations which are described in each user's individual plan, including a description of measures for avoiding such situations. Procedures are based on rules drawn up by the teams in each individual workplace. The rules were extremely clear as regards each situation.

The internal rules in Domov Petra Mačkov are also conditional upon the monitoring and recording of conflict situations for each client. *Ústav sociální péče Litvínov-Janov* implemented a questionnaire for staff focusing on conflicts of interests and the potential infringement of clients' rights.

It is recommended that conflicts of interests and the potential infringement of clients' rights be precisely defined in homes' internal rules, including specific procedures and casuistry.

77. One specific conflict of interests the Defender would like to draw attention to is the conflict of interests between parents and adult children (including those outside social services facilities). In formal terms a parent has no means of governing the life of an adult child. Even when appointed guardian, for example, that person's authority only extends to legal action. In practical terms, of course, parents are still very important to clients and clients are in many respects dependent on them, despite the fact that they live in a home. The staff of the home have to cope with these complicated relationships.[66] From the Defender's point of view it is important what stance should be adopted in similar cases, and how the care team feels as a whole. As mentally handicapped people are easily manipulated, their family can, for various reasons, prove

[65] The only thing that is not a conflict of interests is that the child has to get up in the morning to go to school and cannot sleep until 9 o'clock whenever he or she wants.

[66] For example the staff of a home which actively cooperates with parents knows that the mother of a client with severe epilepsy has decided to stop buying special medication for the client (with his own money) – the client felt obliged to agree with his mother, that they would stop buying the expensive medicine. As the director of the home discusses the medical needs of the client with a doctor, he knows that the mother's decision will not necessarily reduce the client's quality of life. Therefore, and rightly so in the Defender's opinion, the director does not interfere between the mother and her son.

to be a harmful influence (selfishness, excessively strong ties which enhance the feeling of dependence) and the service provider should be prepared to act in a professional manner, possibly with the client's help, to defend the client's interests.

Self-governing body of clients

78. In relation to the change in the approach towards people with mental disabilities (from the concept of a recipient of care to an active partner), the question arises as to how much opportunity clients have to influence the running of the homes they live in. It should be said that in this respect the Defender found that homes were obliging, especially towards people with less severe disabilities: in many homes clients come into contact with staff in a variety of situations (meetings, community, advice) and have the chance to express their thoughts on aspects of life in the home (type of activities, recreation, choice of meals, regimen, etc.). The Defender considers this commendable.

Choice of clothing

79. The Defender considers that clients can receive a boost to their independence as regards the choice of clothing and how they are dressed. It was found that for organisational reasons, to save time, a unified approach to clothing is taken (clothes are chosen and prepared by the staff, who help clients to get dressed); in certain cases this constitutes excessive care. The reason for this is that the staff assume that clients would start to pull clothes out of cupboards and make an unnecessary mess. It is obviously hard to keep things tidy around clients, but this system does not help clients to become more independent and does not constitute an individual approach.

The clothes and hairstyles of the female clients of some homes are virtually identical to those of the men. This blurs their identity, and it is only because it takes more time to wash and brush long hair; nobody had noticed that the women were wearing men's clothes.

Clothing that is appropriate for the environment and situation and care for clothes is a basic social skill, which must be supported in mentally handicapped people.

It is recommended that homes plan exercises to try to develop clients' abilities as regards clothes and care for clothing. In this respect the individuality of clients should be supported. Where clothes are chosen and provided by the home, there should be a difference between men's and women's attire.

Daily regimen

80. The Defender also investigated the conditions under which clients exercised their will as regards the course of their day, including whether their daily regimen was based on their biorhythms (the times they get up, go to sleep, eat meals) and whether they could influence the timing and nature of hygiene routines and other activities. The Defender is aware that there are logical limits inherent in collective cohabitation. (This is one reason why the transformation process was initiated.) Despite this, it is extremely important to take a critical approach to established systems; to ask, for example, whether it is normal for an adult to go to bed at 6 p.m. Whether that person really does need so much sleep and whether or not he or she is hungry when there are 14 hours between dinner and breakfast.

81. As regards the daily regimen, in formal terms clients have autonomy of will in many of the facilities. Formal restrictions were only found in isolated cases.[67] In practice, however, the facilities visited featured a number of restrictions:

- The wishes and habits of clients are subordinate to the running of the home and to making the work of staff easier (especially as regards getting up and going to bed, mealtimes, the timing of hygiene routines, etc.); in more than one facility clients are put to bed as early as 6 p.m. basically right after dinner (forcing them to spend more than 12 hours in bed, even though not all of them wanted to)
- There are limits due to the number and organisation of staff[68]
- The regimen is more relaxed at weekends, yet fewer staff are on duty to provide for activities
- In one facility the daily regimen was adjusted more to the needs of the children than the adults (as clients got older, life in the home ceased to change).

In addition the Defender states that, like people outside the facility, some users also have obligations, such as attending school, sheltered workshops. It is not the home that hampers their free will, and so there is no infringement of autonomy.

It is recommended that the biorhythms of all clients be respected. It is recommended that staff be provided and organised so as to assure conditions in which clients' wishes as respected within the daily regimen.

82. Besides the information in the previous paragraph the Defender states that on his visits he also found cases where homes did not insist on clients' participation in therapeutic and work activities, the reason being that "clients cannot be forced to do anything". This practice was introduced after completion of the "initial training for guides in the introduction of social services quality standards" as part of a Ministry of Employment and Social Affairs project, which stated several times that clients pay for the services and it is therefore entirely up to them which activities and other options they take advantage of. This is, to a great extent, true, although on the other hand it is necessary to remember that the social services provider is obliged to provide the service user with nurturing, education, activities and social therapy, the provision of which helps to develop or maintain personal and social skills and abilities which assist in social integration (§ 14 Paragraph 1 e/ and g/ of Regulation No. 505/2006 Coll.). The statutory regulations state that this (while respecting users' dignity) should help people in difficult social situations (the provisions of § 2 SSA). In a number of places in this report the Defender has referred to the principles of normality, which stipulate that the day must be clearly structured and include a time for work (or some alternative activity). Work has always been one of the fundamental aspects of human existence, and creative work helps people to develop. Although in "normal" life it is true that a person can decide not to work, this generally does not happen for reasons of common sense.

The Defender considers that the SSA does not merely grant clients rights, but also the law explicitly requires clients to play an active role when using services funded

[67] It was only in exceptional cases that wake-up times and dinner times were definitively set. Rough daily schedules exist and are used to organise the duties of staff.

[68] The times that clients with severe disabilities are put to bed or woken up may obviously differ from the set daily regimen, although only within reason. One example of good practice was to overlap staff shifts at care-intensive times (Jedličkův ústav in Liberec, Domov Laguna Psáry, Domov Petra Mačkov).

from public resources. This should also be reflected in contracts for the provision of a social service.

Right to choose a doctor

83. The internal rules of only one of the homes visited did not give clients the chance to choose their doctor. The Defender draws attention to the fact that clients' right to choose their doctor is guaranteed by the provisions of § 9 Paragraph 2 HCA and cannot be restricted as such. One problem could be unwillingness on the part of the doctor, or distance from the home. In the first case, the status of a disabled person is equal to that of any other insurance policy holder.[69] As regards distance, the Defender calls upon providers to accompany clients to a doctor outside the facility, wherever possible. It is also good when the client leaves the home, as this prevents the provider from having too great an influence on the client's healthcare.

It is recommended that clients' right to choose (any) medical care be respected. Homes, despite the general lack of direct care staff, should not avoid their obligation to accompany clients who have their own doctor.

Autonomy and medical care

84. Only one home was found to have rules which stated that the doctor "may limit or prohibit outings for medical reasons", and also that "the director does not recommend outings if clients' health or safety were to be put at risk, e.g. during epidemics, bad weather, or icy conditions. For these reasons users may be restricted or forbidden from going into the garden".

The Defender draws attention to the fact that personal freedom may only be restricted in accordance with the law and under the conditions defined by the law. So far (in addition to cases of involuntary admission to a medical facility) there has only been one case of *persons with an infectious disease*, or cases of *measures adopted by public health bodies as the result of an epidemic* in accordance with Law No. 258/2000 Coll., on the Protection of Public Health and on the amendment to certain related laws, as subsequently amended. For other reasons, however, the doctor (or any other person, for that matter) does not have the right to forbid clients from leaving the home. The doctor may make certain recommendations, or recommend that certain activities be stopped, although it is purely down to the individual client whether he or she follows these recommendations or not. The possible interruption of the therapy regimen is, according to the Public Health Insurance Act, a matter between the doctor and the patient; thus it is again at the discretion of the client/patient whether these doctor's recommendations are followed or not.

One practical limit on such a decision is obviously clients' ability to judge the consequences of their actions. This is the degree of autonomy. The home must respond to such requests by performing a risk analysis (see points 88, 131).

The same applies for the typical example of an outing in bad weather (clients can only be warned of the possible consequences, or recommended to wear suitable clothes, but nobody else can decide whether the client is permitted to go on the outing;

[69] The provisions of § 11 of Law No. 48/1997 Coll., Public Health Insurance Act and on the amendment and supplementation of certain related laws, state that a doctor may only reject a policy holder in cases where the acceptance of the policy holder would exceed the doctor's sustainable workload in a qualified manner.

also see point 35, 36), but also for very sensitive matters such as the right to refuse an examination, treatment or doctor's orders (e.g. diet, taking tablets). These are typical conflicts of interests. The Defender understands that the provision of the service can be affected if a client fails to take medication or does not abide by a regimen set by a doctor. It is, however, important to point out that these questions relate to the user's free will as a patient and this is a matter between the patient and the doctor.

It is recommended that doctors retain their competency as regards doctor-patient relations but should refrain from interfering in the home.

85. Considering the fact that most clients have been deprived of their legal capacity as regards the provision of informed consent, the question of informed consent to an operation or possible reverse falls within the authority of the guardian. The will of the guardian with respect to the client is not limitless in this sense, as the Czech legal system has now adopted the Convention on Biomedicine, which introduces new forms of protection for people unable to grant their consent to an operation.[70] This convention distinguishes between two groups of such people – underage and adults. In the first case, the opinion of an underage child "… should be considered a decisive factor, the weight of which increases with age and the degree of maturity"[71] (Article 6 Paragraph 2). In the case of an adult, that person "… should participate in the granting of consent by proxy" (Article 6 Paragraph 3). This text, according to the Explanatory Report on the convention, implies the obligation to involve adults in the procedure by which consent is granted by a legal representative, wherever possible. It will be essential to explain the meaning and circumstances of the operation to the patient and to find out that person's opinion on the matter.

The Defender calls upon providers to create the appropriate conditions to ensure that persons who are not deemed as having legal capacity yet are able to grant informed consent (or reverse) have the chance to express their opinions and to have those opinions heard.

Alcohol and tobacco

86. Most of the facilities visited had very different standpoints as regards smoking and the consumption of alcohol. Homes often forbid the keeping and consumption of alcohol, limit the number of cigarettes smoked, impose compulsory orientation tests, or allow staff to intervene in a number of ways; they do not set aside smoking areas.

Smoking and the consumption of alcohol are regulated by the law,[72] although obviously adults cannot be forbidden (by a blanket ban) from doing so. It is not possible to penalise adults for the mere consumption or keeping of alcohol, provided that this does not involve, for example, the harassment of others or giving alcohol to a child. This is partly because alcohol is legal, and partly because drinking alcohol on the part of adults is seen as normal in Czech society. Adults, albeit with a mental disability, have

[70] Operation in the broader sense, i.e. involving "… all procedures carried out on the patient for medical reasons, including preventive care, diagnosis, treatment, rehabilitation and research." (Explanatory Report on the convention, Article 5, point 34).

[71] The wording of the convention is basically the same as the wording of the United Nations Convention on the Rights of the Child (Article 12).

[72] Law No. 379/2005 Coll., on measures to prevent damage caused by tobacco products, alcohol and other addictive substances and on the amendment to related laws, as subsequently amended

the right to act like the majority of society. It is just a question of setting conditions which are also acceptable to the home (clients drinking in the privacy of their rooms or at parties, an agreement to allow staff to monitor consumption, etc.) and which would not put clients' health at risk (e.g. alcohol in combination with medication). The Defender does not want to support smoking or the consumption of alcohol, and understands the fears that a bad example could be set for children, but draws attention to the fact that adults should be able to make their own decisions. Smoking or the consumption of alcohol certainly cannot be taken as grounds for sanctions or termination of contracts (the formulation of some homes' contracts on the provision of social services in combination with internal rules do allow this type of sanction).

It is recommended that clients should not be forbidden a priori from the consumption of alcoholic drinks or smoking. If there is a risk involved, the matter should be resolved for each client individually (see point 131).

Ventilation and heating adjustment

87. Clients should have, after individual consideration and risk assessment, a free hand as regards ventilation or adjusting the heating in their rooms. It is considered bad practice when locks are installed on all windows or none of the radiator valves are accessible.

It is recommended that clients be allowed to ventilate their rooms and adjust the heating as they desire. Proper assessment of the risks for each client prevents the occurrence of unpleasant or dangerous situations.

Reasonable level of risk

88. Earlier in the text frequent use has been made of the term "risk" or "consideration of risk". These terms can be said to reflect the reality of our day-to-day lives. In the case of disabled people this involves special risks, although obviously for such people risks can only be minimised. Any effort to completely eliminate risks would result in total sterility, and as regards autonomy, would result in an unreasonable restriction of the will of clients with mental disabilities.[73] A good provider should assure clients the greatest degree of safety while allowing them to enjoy standard situations of day-to-day life. It is essential to work with risks in a systematic manner. The process of working with a risk should begin with the identification of the risk, followed by an assessment of the severity of the risk and suggestions for solutions, through to the compilation of a risk plan, which must be revised on a regular basis.[74] In relation to this, there is a reasonable level of risk which is permissible. The assessment of a risk must lead to a decision as to where the risk ceases to be reasonable and where a certain activity should no longer be supported.

Homes work with risks on a variety of levels. Some facilities are just starting to clarify the term in their internal rules, while others are only fragmentarily working on the issue at the individual planning level. As this shows, in the name of risk many facilities place blanket bans on a number of activities and client decisions without assessing the

[73] We should also consider that risks are not merely something negative and undesirable, as they also have positive aspects in our lives (success, the attainment of goals, development, experience). Mentally disabled people stagnate like anyone else, if they do not have the chance to acquire experience and make mistakes.

[74] For more, see Sobek, J.: Working with Risks in Social Services, Social Services 2/2009, pg. 20 - 21.

risk on an individual basis. This results in the illegal imposition of restrictions on clients. One example of good practice is Jedličkův ústav in Liberec, which works with risks on a systematic and specific basis.

It is recommended that work be stepped up to identify and assess risk situations with individual clients (describe potential risks, compile prevention plans and procedures to resolve risk situations), instead of automatically refusing activities which could potentially involve a risk.

d) Privacy

Multi-bed rooms

89. The right to privacy is infringed by multi-bed rooms, which in some facilities contain as many as eight beds (see point 19). Examples of good practice could be facilities which have no more than three beds per room (Anenská Studánka, Háj u Duchcova, Liberec, Prague), while the client can lock the room and there are lockable cupboards. In some buildings rooms have their own toilet and bathroom (Kvasiny, Háj u Duchcova), which is excellent where clients are able to use them by themselves. In these cases the accommodation is of a high standard, comparable with a normal household.

It is recommended that room capacity be reduced and one- or two-bedded rooms be set up wherever possible. It is recommended that walk-through rooms be abolished.

Occupation of rooms

90. There is a risk when children and adults live together in the same room (different interests, potential for manipulation or abuse). The Defender, for example, came across a case where a 13-year-old boy occupied a room together with several 40-year-old adults. This is neither suitable nor natural, regardless of the risks described above. In some facilities boys and girls continue to live together in one room. The Defender is aware that this question can be viewed in different lights, depending on the age of the clients or the severity of their disability; nevertheless, he assumes that at a certain age, like in the rest of society, it is not “normal” for one room to be shared by people of the opposite sex who are de facto “strangers” to one another.

It is recommended that the age of clients be taken into account when placing them in rooms. It is recommended that people of the opposite sex should not be placed together in the same room, unless they explicitly request it.

Private and shared space

91. In certain cases the structural design of some rooms did not allow privacy in the bedroom on the one hand, while on the other it was not possible to make good use of the shared space.

In one facility clients practically live in one large room divided up by a glass partition wall into two bedrooms and a hall, which serves as a day-room. In another facility rooms are separated by just a glass (i.e. transparent) wall; curtains are fitted on these glass walls and should be drawn in accordance with the director’s instructions, but were not at the time of the visit. In another facility a peephole from the nurse’s room

allowed staff to watch what was happening in clients' rooms. Viewing apertures or peepholes from the corridor are also an infringement of privacy.

In some facilities the rooms for daytime activities are too small, or even part of the bedrooms. In some cases the corridor is used as the day-room. If work activities (work, education, therapy, etc.) take place in the facility (and not at school, in a workshop, at an employer's premises, etc.), the necessary space must be provided. This also applies to clients with the most severe disabilities, who also deserve a degree of normality as regards some change to their environment. As the Defender also states, he considers clients with severe disabilities to be a priority, that they must receive adequate stimulation, activation, etc., so therefore recommends activities which take place outside the bed and logically not in privacy, but in the company of others. Nevertheless the Defender is convinced that these clients also need their own "little corner" where they can find privacy, i.e. naturally in their bedrooms.

It is recommended that wherever possible clients' rooms be designed to feel as closely as possible like a normal household environment. It is recommended that peepholes and viewing-slots be removed and privacy be assured in clients' rooms. Space should be provided for activities, sleeping, and leisure time.

92. In some facilities dimmed lighting is continually on in the bedrooms.
It is recommended that dimmed lighting not be used at night.[75]

93. In one facility the windows are fitted with bars on the inside, together with wire mesh in some rooms. If the reason for this is to prevent the glass from being broken, this can be resolved by installing unbreakable glass. If it is to stop clients falling out of the window, stops and safety devices can be installed.
It is recommended that the bars be removed from the windows.[76]

Privacy on the toilet and in the bathroom

94. As regards toilets and bathrooms, it is also necessary to insist that privacy standards be improved, as it proved to be inadequate in some facilities. The inability to lock the toilet or bathroom door is sadly commonplace, as this was discovered to be the case in 13 facilities. (In one facility the staff get by this by placing a chair in front of the door when someone is in the bathroom to indicate that others should not enter. There were two boys and nine girls in that particular ward.) The Defender therefore recommends the use of keys or, ideally, secure locks. In cases where the staff need to be able to get into a locked room, special fixed locks which turn on the inside to lock should be used; these can easily be opened from the outside, for example with a coin or screwdriver.

More serious infringements of privacy were noted. The use of toilet cubicle doors which are cut off at the bottom to a height of 3/4 of a metre. Elsewhere doors were missing completely, as were toilet seats. In one case the bowls were next to one another, with no dividing partition, let alone doors. In one facility the toilets and

[75] Dimmed night lighting is used in remand prisons, which is a wholly different type of facility. It can also be found in hospitals, for example, which are also very different.
[76] Rules are defined for school facilities by the provisions of § 15 of LIPES. The use of special technical measures to prevent children from escaping, such as bars on windows, are only permitted in facilities housing children who have been ordered into care.

bathrooms were not even separated off, but were just divided from the living quarters by a wooden partition wall with no door, allowing anyone to see into the toilet. What is more, there was also a bath in this exposed area. In another case the bath was in the main room and so all hygiene care was in full view of all the other clients. These examples are infringements of privacy which violate the principles of human dignity. The majority population would not tolerate such a system.
It is recommended that privacy be assured in toilets and bathrooms. Water closets should be partitioned, cubicles fitted with doors, and also locks where the clients are able to learn how to use them.

95. It was also found that there were cases where toilets or bathrooms had windows or peepholes which were not fitted with blinds or curtains on the inside. In one facility the bathrooms have windows opening into the adjacent rooms. There are curtains on the windows, but on the outside, so anyone can look in and violate the person's privacy. Such a case constitutes an infringement of privacy. Showers often have no shower curtains.
It is recommended that clients be assured privacy (e.g. using self-adhesive paper on glass, etc.) both in bathrooms and toilets. Showers should be fitted with shower curtains.

Privacy during hygiene routines

96. Many facilities do not respect clients' privacy during hygiene routines. Users tend to their personal hygiene in a public area. It was found that when assistance or support was provided, doors were left open allowing anyone in the corridor to see. (This happened to the Office's team several times on their visits.) Some facilities have screens, but the staff do not use them. This results in the degradation of the right to privacy and does not respect human decency or the need to tend to personal hygiene individually and away from others.

***Good practice** in Jedličkův ústav in Liberec:*
Hygiene routines (including nappy-changing) are only performed in the bathroom, behind closed doors. The rules also stipulate that users may only be assisted in their hygiene routines by a staff member of the same sex, where conditions permit.[77]

It is recommended that bathroom and toilet doors be closed when clients are tending to their personal hygiene routines and that screens be used.

97. It was also found that mobile toilets are used in many wards, even with clients who are capable of using a standard WC. If it is necessary to use a mobile WC, screens should always be used to assure privacy.
It is recommended that mobile toilets be used only in essential cases, while respecting the privacy of the client.

[77] The Defender sympathises with the approach characterised by the term dignitogenesis. This is the active development and reinforcement of the dignity of invalid, disadvantaged clients of medical and social services, as a further step following the elimination of neglect and abuse. See Kalvach, Z.: Geriatric Challenge: Supporting the Dignity of Senior Citizens (from the European conference 2009); collective volume of the 13th Gerontological Days Congress in Ostrava, September 2009

98. Involving clients to provide assistance or support in the intimate hygiene routines of another client must be considered a wholly inadmissible infringement of privacy. This residuum of the past, sometimes in the guise of work-educational therapy as a substitute for lack of direct care workers, is absolutely inappropriate and unacceptable.
It is recommended that steps be taken to ensure that clients are not involved in helping other clients perform their hygiene routines.

Room keys

99. In many facilities clients cannot lock their rooms, even though the most self-sufficient of them would be capable of doing so. In many cases clients expressed the desire to lock their rooms, but their request was refused. Facilities should not take a general approach to the option of locking rooms, and each client should be individually assessed as to whether he or she is capable of doing so. The provision of keys should never be ruled out beforehand. In fact this is a chance to develop clients' skills in this area through the use of training plans. Some facilities (for example in Jeseník, Bystré) do now provide keys to the more self-sufficient clients. According to the staff, around half of them keep a key on them, while with the other clients the use of keys had been included in training plans.
It is recommended that the use of room keys be included in training plans is clients so wish.

Items in a special, lockable place

100. Another aspect of the right to privacy is the ability to lock cupboards (as places to store personal items). In the majority of facilities, however, clients do not have a lockable cupboard. In one facility clients do not have their own cupboard at all and their personal belongings are stored with everybody else's in the shared lockers in the corridors. In other facilities clients have their own cupboard, but these are not in their rooms but in the corridors and only the staff have access to them.

Good practice:
In *Ústav sociální péče pro mládež Jeseník* the cupboards in clients' rooms are lockable. The use of keys is also part of clients' training plans. In *Domov na zámku Bystré* a differential approach is taken to the allocation of keys.

The Defender is aware that not all clients are able to use the keys to their cupboards. This ability should be developed individually through clients' training plans. Where a client is unable to use a key, the key should obviously be kept by the staff. What is important is that each client must have their own separate and secure space for storing their personal items.
It is recommended that clients have a cupboard in their rooms and should be instructed through training plans in how to use it.

Own clothing

101. In one facility it was found that clients wore institutional clothing. These clothes were kept together in shared wardrobes. The Defender considers it inappropriate that clients do not have their own clothes (everything is shared).
It is recommended that each client should have "their own" (albeit government-issue) clothing.

Personal papers

102. Three homes took charge of all the clients' personal papers, without assessing whether clients are capable of keeping them in a lockable cupboard. Training plans could also be used here to develop clients' abilities.
It is recommended that consideration be given to allowing clients to retain their personal papers on the basis of individual planning.

Handling of personal data

103. With regard to the rules and authority to handle the personal data of clients, providers must look to the SSA , which stipulates a series of obligations, for example the keeping of records, and the general law, i.e. Law No. 101/2000 Coll., on the protection of personal data and on the amendment to certain laws, as subsequently amended (hereafter simply Personal Data Protection Act).[78] The Public Defender of Rights believes that the topic of the protection of personal data does not generally fall into the category of potential mistreatment. Therefore the Defender only looked at those aspects which struck him as being unusual or dubious.

Both of the aforementioned regulations (as well as Regulation No. 505/2006 Coll.) imply the following principles. Providers may only process users' personal data to the extent necessary to provide an effective and high-quality social service (the principle of appropriacy). They should not collate data that are surplus and unnecessary. They should also provide users with adequate information about the data they process (the principle of awareness). Internal rules on the processing of data should be drawn up and complied with; the application of these rules should be checked on a continual basis. Providers should be governed by the principles of truth, consideration, responsibility, transparency, and discretion. The purpose of the law is not to minimise the amount of data, but to acquire and use only such data which help to maximise the quality of the service provided.

Methods used to store personal data

104. In one facility it was found that clients' cards (personal items) were kept in the games room without any form of security. Anybody had access to them (visitors, technical staff, etc.). This prompts the Defender to give the following instructions.

It is not practical to adopt a single, ideal method for storing data, yet it is extremely important that providers take precautions to ensure that data cannot get lost, be abused, or put at risk in any way.[79] For example it is not a good idea to keep all data in one place, with one person, but the processing of individual groups of information (depending on their nature) should be assigned to multiple employees according to their specialisation. Obviously, it is possible that some information about a user will need to

[78] A wealth of useful information can be found at www.uoou.cz.
[79] See the provisions of § 13 of Law No. 101/2000 Coll.

be shared. The aim of this "specialisation tendency" is to try to ensure that staff members only have access to the data they need for their job. For example, a social worker does not need to know the temperature or blood pressure of client Y on that particular day. The protection of data against random access by unauthorised people must be a matter of course.

It is recommended that client documentation containing personal data be properly secured as required by law.

Consent of data subjects

105. It was found that some facilities published personal data without the required consent. For example on notice boards in the common-room there were photographs of the users with their date of birth and details of their weight; the client documentation did not contain any explicit consent to the handling of these data. Another facility used photographs depicting clients as part of their promotional materials, without having the clients' explicit consent to the publication of these pictures.[80]

In general, to legally process personal data the administrator of the data must have the consent of the subject of the data (in this case the user or his or her legal representative).

It is recommended that users' personal data not be processed – or published – without their consent.

The use of video cameras

106. Four of the facilities visited use video cameras. In two of these the cameras are placed in a public area (they cover the main entrance, the corridor by the main doors, and the outside of the building); in the other two the cameras monitor areas frequented by clients are which are of a private nature (the corridor in the ward). In some places the cameras are only used at night, to allow the staff to see those parts of the facility where they cannot be present in person. No recordings were made in these cases.

As regards video equipment which records images of areas and allows the identification of people shown in the images, the provider-administrator is subject to the obligation of notification as defined by § 16 of Law No. 101/2000 Coll.; this obligation must be met before starting to process data. This type of camera system may only be used with the explicit consent of the subjects of the data (informed consent may, for example, form part of the contract between the provider and the user). Cameras may only be used without the consent of the user in cases explicitly stipulated by the law.[81] Even so, such processing (i.e. without the consent of the user) must not violate the rights of the subject of the data concerning the protection of his or her private and personal life as guaranteed by the Charter of Fundamental Rights and Basic Freedoms. It is therefore inadmissible for cameras to be placed in showers, toilets, or users' rooms. They can be used by the entrance to the building. For more, see Office Statement No.

[80] In the Contract on the Provision of Social Services the client only agrees *"… that the Service Provider… collate and process personal and sensitive data for the internal records of the facility and in order to keep the appropriate staff informed…"*

[81] Most often the purpose is to protect the property of the administrator or specific people (e.g. staff or clients) in accordance with § 5 Paragraph 2 e) of the law.

1/2006, on the operation of camera systems from the viewpoint of the Personal Data Protection Act[82].

In relation to these cases the Defender states that clients in facilities have the same right to privacy in the premises they reside in as people in a normal household do. It is the corridors that are a contentious issue here. In the Defender's opinion it is necessary to consider whether this space as like part of the household (clients go down it from their bedrooms to the living room or the toilet). It is also necessary to consider the possible misuse of the images, such as for spying. The image is displayed on a monitor in the workroom (in the ward or at the reception area for the facility as a whole) and the inspections found that no attention was paid to who had access to these images. It was also found that the residents of the facilities were not informed about where and how the cameras worked.

It is recommended that the degree to which privacy is infringed by the use of interior cameras which show recognisable images of people be assessed, together with whether such cameras are necessary. Cameras could, for example, be turned on at night in parts of the complex where no staff member is present. Rules must be set for the use of cameras, and switching devices installed where necessary. In all circumstances there must be notices in the rooms monitored by cameras and clients must be informed of the use of cameras wherever they are able to understand the concept.

e) Care

General introduction

107. All the facilities were found to offer professional nursing care, which should be highlighted and commended, considering how difficult it can be. Clients were clean and the rooms they lived in did not smell;[83] Bedridden clients did not have bedsores, or any sores were treated immediately. Careful attention was given to the nutrition of those users which had a drip feed.

In many cases the facilities were found to be very well equipped, such as with a lifting system and a suspended sliding harness, allowing staff to easily move immobile clients around the ward, as well as physiotherapy equipment, chip devices for calling for assistance for certain clients, or bed mats enabling the monitoring of epileptic fits and life functions. In many facilities keep detailed nursing plans, which focus on improving the quality of life of clients with more severe physical disabilities, and enuretic programs were also a good feature (taking incontinent clients to the toilet), or the popular concept of basal stimulation. Most homes also provide a physiotherapy clinic.

The make-up of clients in the wards visited in terms of the degree of their dependence on the assistance of another person is shown in the following graph and Table 5:

[82] http://www.uoou.cz/files/stanovisko_2006_1.pdf

[83] The smell of urine was sporadically apparent in bathrooms and toilets; in rare cases, also in the ward.

Contribution towards care for clients under the age of 16

It is recommended that self-critical consideration be given to the number of clients in wards requiring extra nursing care and, according to the ratio of available staff, reduce the capacity of these wards or increase the number of direct care workers. The obligation to provide not merely nursing care to the severely disabled, but also education, stimulation, etc., must be emphasised.

Therapy

108. With just a few exceptions homes see it as their role to provide an abundance of activities which are often referred to as "therapeutic". These range from a wide variety of exercises, music therapy, bibliotherapy, snoezelen, ergotherapy, and all kinds of workshops, to the use of animals (hippotherapy or canistherapy). Although the Defender praises this effort as a way of developing skills and brightening up clients' lives, he would like to draw attention to a few controversial issues presented by "therapeutic" activities in homes:

- There are very few therapists (if a therapist is on holiday or on sick leave, the activity is cancelled). If an individual plan is focused on planning participation in activities, this suddenly breaks down. It is worth mentioning what we found in a facility which had room which was set up perfectly for music therapy. As the facility had no music therapist when we visited, the room was mothballed, yet it could have been put to good use by clients in the presence of another member of staff.
- Basically, any activity organised by the home tends to be referred to as "therapy", although no effort is made to help clients resolve their problems or to achieve some sort of specific, quantifiable result.
- Activities rarely improve clients' skills in a way which would help them to live a more normal life. Activities bear no relation to the personal goals of clients.
- The great majority of activities take place inside the facilities, or even in the ward itself. For the sake of the principles of normality clients should be taken outside as

much as possible so as to avoid the "slippers syndrome" (a situation where clients have everything within reach under one roof).

Experts claim that a good basis for therapy in homes should be physiotherapy, ergotherapy and speech therapy (there is a general lack of speech therapy in homes). Animals are generally not used very much, even though this has been shown to produce good results (nevertheless some facilities do now keep animals – e.g. Domov Laguna Psáry, or the care for animals at the farm at Zelený dům pohody in Hodonín); the same applies to therapy involving time spent in water.

In the Defender's opinion "therapy" should be seen and understood as an alternative occupation for users who do not go to work or to school. Not as the only aspect of care. Activities should take place as much as possible outside the facilities and should aim at helping clients attain new skills, which would help them to live a more normal lifestyle, and also be related to their personal goals.

Immobile clients with serious disabilities

109. During his visits the Defender paid special attention to care for clients with more serious, often combined forms of disability, who are cared for in nursing wards. He looked at how often these clients get out of bed or out of the ward, what activities they have on offer, what forms of stimulation, etc., i.e. whether the aim is not just to cater to clients' physiological needs. The established trend nowadays is that severely disabled people – provided that they are not ill – should not spend all day in bed. There should be some change of activities and environment to promote their ability to enjoy daily rituals, provided that they are capable of doing so (the principle of normality).[84]

110. One thing the Defender was pleased to see was that in many of the facilities visited clients did not spend all their time in bed. They had the chance of a change of environment – to be in the common-room, games room, in a wheelchair, on a beanbag or in inflatable paddling pools during the day. It was found that several homes have good experience with sensory stimulation and are building rooms for multisensory therapy, known as snoezelen.[85] It can be cheap and easy to stimulate an immobile

[84] These are the fundamental rules of the principle of normality. These principles, generally acknowledged in Europe, have their roots in Scandinavia, state that when creating a living environment and caring for mentally handicapped people, it is necessary to focus on the norms of society and on a day-to-day routine. The basic idea behind these principles is that disabled people should move in three separate spheres, like anyone else, these being: the sphere of living and sleep, the education or employment sphere, or therapeutic-medical assurance and care, and the leisure time sphere. The principle of normality consists of the following three elements:

- *normal rhythm of life* – this includes the normal daily rhythm (to school or work in the morning, afternoon activities, evening relaxation), normal weekly rhythm (working days and weekends, public holidays), normal yearly rhythm (holidays, breaks, seasons), normal life in the world of men and women, a normal home life surrounded by other people;
- *normal environment* – a change of place is normal, desirable, so that not all day is spent in one environment; normally people live, go to school or work and enjoy their hobbies in different places;
- *socially valuable means of meeting needs* – it is necessary to meet the needs of mentally handicapped people in the same ways commonly used for others, to offer socially valuable activities (to use subjects to suit people's age, to create an environment appropriate to people's age, and to offer meaningful activities).

See, for example, Šelner, I. (1999): Mentally Handicapped Citizens – Parallels and Contrasts, III. Gerontological Days, Collected Lectures, pg. 37.

[85] The main principle of this method is to create an environment which offers a pleasant atmosphere, sensory stimuli and which stimulates people. What is essential is contact between two or more people who enter a room together (child, therapist, or parent), mutual understanding and acceptance. The basis purposes of snoezelen are – restful (relaxation, peace, "nothing needs doing", "anything goes", feeling of well-being), cognitive (sensory stimulation,

person – e.g. by decorating the ceiling and parts of the room in his or her line of view, using aromas to stimulate sense of smell (incense sticks, oil lamps), etc.

Therefore, the Defender was surprised that these techniques were not used more.[86] Sometimes clients did not even have at least the minimal sensory stimulation which is so important for that particular type of disability (visual stimuli, more frequent interaction with staff). There were cases where toys were out of clients' reach – they were unable to grasp or even touch them. With the staff of wards for clients with severe disabilities emphasis is placed on the nursing aspects of care; knowledge of the potential of stimulation and activation tends to lie with specialised staff who just visit and are relied upon for these things. (These findings are referred to in the part of the report dealing with education.)

Unfortunately it was found that there was minimal activation and change of environment in several facilities. On the one hand the Defender did not hesitate to draw attention to the deprivations faced by the users of such facilities, except for regular nursing care and brief intervals of planned activation with a therapist, in beds with high bars and just two solitary clients in the bedrooms. On the other hand he also criticised the nursing department, where although beds were placed in rooms with half-glazed walls, users remained in their beds all the time except for certain activities.

It is recommended that clients with more severe forms of mental disability, or combined physical disabilities, should be provided with as much sensory stimulation and a natural change of environment as possible.

111. In general it is necessary to add that care in wards requiring extra nursing supervision, although focused on the individual through other plans, tends to be collective, apart from a few short periods of time. The total number of users tends to be too high and does not permit a real individual approach, which is especially important considering the severity of users' disabilities. Some bedridden clients only receive attention for very short lengths of time during the day. Even meals tend to be very quick. Excessive numbers of users make it harder to resolve certain problem situations, ensuring that clients can move freely, etc. Experience also shows that many people with severe disabilities prefer peace and quiet, privacy, and a smaller group, which in this case is not possible. It would be necessary to reduce the number of users in individual wards to a level which allows for the provision of a high-quality individualised service.

It is recommended that staff numbers be increased.

***Good practice from** Jedličkův ústav in Liberec:*

motivation to move and exercise, relocation, discovery) and interactive (the desire to influence events, to turn something off, to change things). The main benefits of the snoezelen method are relaxation, relief from stress and tension, calming unrest, aggressive tendencies and hyperactivity, discovering new things, developing sensory perception, establishing and strengthening relationships between children and professionals, or parents, and raising interest in one's surroundings. A snoezelen room must be specially modified with special equipment and aids – most often: heated waterbed, special coloured lights, fluorescent lamps, balls, lava lamps, illuminated fountain, flexible tube lights, waterfalls, UV lamp, mirrored wall, projectors, scans, stereo system, aroma-lamp + fragrant oils, therapeutic sacks, items to develop the sense of touch, etc.

[86] Abroad it is commonplace for seriously handicapped clients to be taken out for short drives in the car. Watching what goes on outside the car window provides a range of new visual stimuli, while most clients also enjoy the ride. This is, of course, a most expensive activity.

At peak times (from 10:00 a.m. to 3:30 p.m.) the ward for users with the most severe disabilities had 12 members of staff for thirteen clients. The care provided respects the individual needs of the clients and their tempo. The staff claimed that the introduction of this system greatly reduced the number of cases of aggressive and problematic behaviour on the part of certain users. Clients have individualised bedrooms (for one or two people), spend time in the kitchen, the living room, the games room, and in the classroom in the mornings (this is on another floor and was available for those who had already completed their compulsory school attendance). Hygiene and nappy-changing take place in the bathroom, while meals are served in the ward's small canteen, where each client has their own place where they usually sit. Time spent outside is seen as a priority (and records of this are kept to ensure that it is not just some clients who get this chance). The staffing numbers and the care system allow clients to go outside almost every day during summer. The prenatal room or snoezelen are regular supplementary activities during which clients are accompanied outside the ward.

Emergencies

112. The problem of emergencies includes not only health-related aspects (falls, injuries), but also social factors (bullying or aggression which are not resolved using restriction so are not documented, etc.). All these situations are part of normal life in such facilities, nevertheless few facilities work with them systematically to reduce the incidence rate. If they are recorded, it is only randomly and most often as part of daily reports. Such cases are not assessed retrospectively and are not reflected in clients' individual plans. However, good practices were found, e.g. Domov Petra-Mačkov, which exposed bullying amongst clients through the use of documentation and assessment of problematic situations.

Psychiatric care, cases of uncontrollable restlessness

113. Clients of homes for the disabled are very often patients of psychiatrists,[87] who regularly visit homes (most often at monthly intervals). Although basal psychiatric care is always provided, doctors take very differing approaches to clients. Some psychiatrists personally examine their clients on a regular basis, while others merely prescribe medication and, in better cases, have sporadic personal contact with their clients (it is not unusual for doctor's prescriptions to be issued two months in advance; this is essentially nothing more than a formality; the doctor does not see the patient in natura). The consequences of insufficient contact with a psychiatrist are obvious, and the Defender came across them: higher doses of medication are given (evident over-medication was found in isolated cases, in one case on a large scale, see points 69, 70); the staff lack support and the feeling that there is someone to help them cope with demanding conditions, and have nobody to consult clients' symptoms with; conditions become acute and lead to hospitalisation in a clinic.

It is not only homes which often have huge problems providing any psychiatric care for their clients (especially in more remote areas) that suffer these drawbacks. It is necessary to insist that the doctor form part of the team that cares for the users. If the doctor is unwilling to see to the patient more often or no doctor can be found, the

[87] It is very difficult to determine the percentage; it ranges from 20 % to 100 %. However, it is generally around half of all the clients in a particular facility.

Defender recommends that homes do not give up and, for example, draw the attention of the health insurance company to the matter, or help users to exercise their right as policy holders to turn to the insurance company if they believe that they are not being provided with proper medical care.[88]

It is recommended that a psychiatrist be included in the care team and that efforts should be made to provide care where it is currently inadequate. It is recommended that the attention of founding bodies also be drawn to unsatisfactory situations.

114. It has been mentioned that there were problems with medication in terms of the high doses and combination of psychopharmaceuticals in the case of several individuals[89] and in the large-scale use of sedatives in one case. The Defender's special recommendations partly concern movement-restricting measures (points 54 and following). The topic of reducing the psychiatric medication of mentally handicapped people in social services facilities is not a new one and sobering experiences have already been published in the Czech Republic. As part of an extensive project carried out in 2007 the use of psychiatric medication was monitored in 13 social services facilities in the region of Central Bohemia.[90] Amongst other things, this survey confirmed that there is a fundamental link between the amount of medication and the number of staff in the facilities on the one hand, and the nature of the care provided by a specific psychiatrist on the other. The authors of this research conclude that "with the current state of social services facilities the use of psychiatric medication cannot be reduced as part of a blanket process or particularly dynamically; instead, individual cases should be resolved on a gradual basis".[91] They state that "the system of contact with a psychiatrist in some institutions must be changed", and that in isolated cases a change of doctor is also necessary.

If a doctor acts inappropriately, it is important to stand up for the client and assist him or her in filing a complaint against the doctor, as described in the previous point (to contact the health insurance company or the registration body, which is the regional authority in the case of private doctors).

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[88] In such situations clients also have the right to contact the Czech Medical Chamber, their superior doctor (where applicable), or the registration body. This right is stipulated by the provisions of § 11 Paragraph 2 of Law No. 48/1997 Coll., Public Health Insurance Act and on the amendment and supplementation of certain related laws, as subsequently amended.

[89] This involved the conversion of multiple recommended doses of haloperidol.

[90] Stuchlík, J., Petišková, M.: Psychiatric Medication in Social Care Institutions, available on the internet at http://www.kvalitavpraxi.cz/psychiatricka-medikace-v-ustavech.html.

[91] Reasons stated include the following:

"a) It is simply not possible in such great numbers – pharmacotherapy is a sophisticated and responsible process and cannot be changed for 20 clients at once, especially in situations when a doctor has another 30 people to tend to and only visits once a month.

b) When elderly people are given high doses of neuroleptic medication, this can result in the phenomenon known as *"emotional unblocking"* and the deterioration of the client's overall mental state, including behavioural disorders. In some cases this is a wholly natural process, but for the client to adapt to new conditions requires extra assistance and patience on the part of staff, who should not be in charge of large numbers of other residents.

c) Clients may experience the current process of change in facilities as a major upheaval. It is therefore not a good idea to change clients' personal assistants, the play where they live, and their medication all at once. This obviously requires more awareness of clients' situations on the part of doctors and teamwork with the facility staff. Under the present conditions this does not always happen."

If there is any doubt, homes should consider whether the case should be examined by another psychiatrist or whether the client should have a change of doctor.

115. In cases of uncontrollable restlessness clients are taken to the regional psychiatric clinic. The staff of some homes see this is being disadvantageous (as clients always return heavily medicated, making it more difficult to work with them); this is also viewed in a negative light by certain "home" psychiatrists) and believe that there is the need to create specialised workplaces for the provision of care to users in the standard conditions associated with uncontrollable conditions. The Defender draws attention to the fact that many clinics do not have a specialised ward for people with mental disabilities, so such people are placed in normal wards (which are most often closed wards offering no peace and quiet) amidst psychotics and people with behavioural disorders, where the staff sometimes have little knowledge of the problem of mental disability and sometimes do not have the room or time to provide special care. Clinics often do not have an aftercare ward specially for the mentally handicapped. The situation in wards with psychiatric patients is wholly unsuitable for mentally handicapped people.[92] If they disturb the regimen on the ward, they face serious restrictions. Destabilisation of their condition results in many months of hospital care.

The Defender sees that homes provide a service also to clients who are agitated or aggressive. For most of such people there is currently no more suitable form of social service; the only alternative is long-term or permanent confinement in a psychiatric clinic.

Special care, autism

116. A special approach is required with clients with Alzheimer's Disease (or another cause of dementia syndrome)[93] as well as with clients who find it hard to tolerate collective cohabitation and the way in which care is provided. In the facilities visited the Defender found that there were difficulties especially with the provision of care to people with autistic spectrum disorders (hereafter simply ASD). The specific manifestations of their disorder place them at a great disadvantage[94], as does the fact that they are relatively often socially naive (can become targets of bullying).[95] Homes are not prepared to provide such clients with good care.

We must be aware that a certain percentage of disabled people cannot get by without an individual assistant. The fact that people with such disabilities spend long periods in psychiatric clinics (as the Defender found during his systematic visits to

[92] For more details see Point 34 of the Public Defender of Rights' report on visits made to psychiatric clinics, http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=134

[93] The Defender met very few clients suffering from dementia syndrome in homes for the disabled, although with the ageing rate of home residents, this number will increase. The Defender referred to the special needs of people suffering from dementia syndrome in his Report on Visits to Social Services Facilities for Senior Citizens dated August 2007, point 91; http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=780

[94] "It has been found that unlike mentally retarded people, those with autistic spectrum disorders have greater difficulty understanding and expressing a wide range of emotions, understanding and using non-verbal and verbal communication, and adequately responding in a variety of social situations. Problematic behaviour such as aggression, destructiveness, obsessive tendencies and self-harming occur more frequently." Thorová, K.: School Pass for Children with ASD, APLA Praha a Střední Čechy, o. s., 2008, pg. 18.

[95] Thorová, K.: School Pass for Children with ASD, APLA Praha a Střední Čechy, o. s., 2008, pg. 44.

clinics) proves that social services providers are unable to assure professional and individual care for this type of disability. Users are in a trap due to the current system of psychiatric care and the absence of a specific social service.

One possible solution is qualified individual care either in specially-designed facilities or in specialised sections of normal homes for the disabled. Integration is also more convenient for assistants – so that their overall workload is lighter as part of a team than in a specialised facility.

Staff should take a different approach to clients with autism; like with clients suffering from dementia syndrome, completely individual care is required.[96] The Defender believes that crucial factors for the systematic improvement of the situation of clients with autism in residential facilities are as follows:

1) Rediagnosis of clients – according to the information available, the number of clients with autism in social services facilities is negligible (the Defender often came across cases where the staff just used guesswork in these diagnoses, based on the behaviour of the client). This, however, is far from accurate. In other words this means that people with this type of disability are not provided with adequate support. Better awareness greatly improves the quality of the diagnosis of clients with autism, particularly in children of pre-school and school age, which obviously plays a major role in improving their quality of life. The diagnosis of adult clients reflects the situation five, ten or even more years ago (before they were admitted to a residential facility), when ASD was virtually not diagnosed at all. Therefore, in many cases their problematic behaviour is not explained as an inevitable desperate reaction to their current condition, but is dealt with as an irrational manifestation of a mental disorder (using medication or various restrictions).

2) Continual consultancy support for staff – staff are trained relatively well, yet without continual consultancy support they cannot put their skills into practice. Experience from European projects shows that training accompanied by subsequent support for staff makes the integration of the skills they acquire far more effective. Courses in methodical support for clients without follow-up support for staff do not have the intended effect.

3) Compulsory training in support methodology at least for key staff members who work with clients with autism.

4) Meaningful increase or restructuring of the number of direct care staff to ensure that clients receive individualised support. This is directly related to dealing with potential risks posed by the behaviour of clients with autism.

It is recommended that homes try to take a special approach to clients with autism or dementia. If a home is unable to provide care, thus putting a client at risk (long-term hospitalisation, restrictions on movement), the founding body of the service should be informed. The Defender also recommends that homes contact their regional authorities and request that they resolve the situation of these clients. If there are multiple cases in the region, the regional authority should respond by setting up a social service designed especially for these clients.[97]

[96] In any case, both groups of clients require suitable expert assistance, something homes should strive to provide if they have such a client in their facility. In the case of Alzheimer's dementia, professional help is available, e.g. www.alzheimer.cz; in the case of ASD, www.apla.cz., www.autismus.cz.

[97] For more see point 79 of the Public Defender of Rights' Report on Visits to Psychiatric Clinics: http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=134

Assessment and regulation of clients

117. In the facilities he visited the Defender was interested to see what approach was taken with clients whose behaviour is seen as undesirable, and what rewards or sanctions were used. Clients with difficult behaviour are dealt with on an individual basis. The staff said that they especially use positive motivation, or by forbidding things that a particular client likes. The use of unreasonable or degrading punishments was not found in any of the homes, although clients did describe consequences of undesirable behaviour which in pedagogic terms are highly controversial. Punishments ranged from bans (on outings, TV, making coffee), to orders (go to bed early, kneel down), through to the use of cold showers or even, in one case, slaps.

The Defender agrees with the general approach, i.e. that the primary means of dealing with undesirable behaviour should be positive motivation. Clients can also be shown the consequences of their own poor behaviour. Homes should not be afraid to do this, as people without disabilities are also liable for their conduct (in civil law or criminal terms). The important question homes should be able to answer is this: What is behind a client's undesirable behaviour? If it is the fact that the client deliberately intends to break the rules, then the use of sanctions is appropriate. However, there should be a rule that the same "offence" receives the same response from all members of staff.

It is recommended that clients should be made to feel responsible for their behaviour, or should be shown the negative consequences of their own behaviour, and positive motivation should be used. Staff should take a uniform approach to correcting behavioural problems.

Sexuality of mentally handicapped people

118. In general the question of the sexuality of mentally handicapped people is burdened by a number of prejudices from the past, on the part of both laymen and specialists[98]. It has proven to be essential that facilities begin to pay attention to this aspects of their clients' lives, while extremes must be avoided, i.e. on the one hand making it a taboo subject, and on the other a kind of "uninhibited openness", which is merely a token of irreverence and lack of respect for people's right to enjoy an intimate sex life[99].

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[98] Some of the most common prejudices are the idea that mentally handicapped people have greater/lesser sexual urges; that the sexual needs of mentally handicapped people can be suppressed by hard physical work (that with a lot of work they stop thinking about their sexual needs); we avoid sexual problems by separating the two sexes; a mentally handicapped people is still a child; sex education unnecessarily incites sexual desire; mentally handicapped people have a sexual handicap, etc. Kozáková, Z.: Sexuality and Sex Education of Mentally Disabled People in the Conditions of Social Care Facilities. In Collective Volume of Materials from the Nationwide Conference *Sexuality of the Mentally Handicapped.* Praha: Centrum denních služeb o.s. Orfeus, 2004.

[99] This means, for example, that the intimate lives of clients are discussed publicly or information is made available to a wider group of staff that is necessary. In one facility, for example, there is a female client who has a boyfriend in the home. Once a week they are given privacy, although the entire ward must be empty (the other clients have things to do outside the ward, or had previously been frightened by the unfamiliar noise). Sometimes the other clients do not want to leave, which complicates matters. The situation was extremely undignified for all concerned. A client of another facility who likes to satisfy herself anally is stigmatised because the other clients, who know about her situation, talk about her to others, even to strangers. One client in another facility suffered from such an excessive desire to masturbate that he injured himself. This client had sheets of paper stuck up in his room on which he described his situation in large letters and in great detail. Moreover, after this experience he has a very negative view of masturbation, almost repulsion. All these examples were found in homes which do not work with sexuality at all, or if they do, it is very unsystematic and intuitive.

It was found that systematic work on this topic was lacking in almost all the homes.[100] Staff are dependent on their own intuition and experience, which is inadequate and may lead to different approaches being taken. Moreover, this can result in the projection of the staff's attitude to the clients' situation, so this is not recommended.

The only examples of **good practice**, i.e. practice based on a systematic approach, were *Domov pro osoby se zdravotním postižením Zběšičky* and *Domov Barevný svět* in Ostrava. The first of these had compiled a sexuality protocol, while the second worked systematically and in detail with sexuality as part of the individual planning process; in both cases the matter is dealt with by a specially appointed female member of staff, and staff members have the proper training.

The Defender made the following findings:

- The homogeneity of the facility (albeit one) is not seen as a problem (see point 22).
- Homes do provide some more or less elementary sex education for clients, but this begins and ends with the need for privacy and hygiene.
- The only work that some homes do on the topic of clients' sexuality is to set conditions for masturbation.
- The sexuality of clients with more severe forms of mental disability is often ruled out completely. (Despite the inconsistency of expert opinions on this issue, there is the general conviction that this situation cannot be underestimated and ignored.[101])
- Homes should be prepared for partners to cohabit.[102] Positive practice was often found in this respect.

119. In the Defender's opinion, based on the available literature and specialised articles, homes should meet the following requirements:

- Primarily facilities should open up this topic for discussion by the staff to enable them to share their opinions, prejudices, attitudes, etc. on the matter[103].
- The greatest possible degree of professionalism is required and homes should try to find out as much as possible about this topic from the information published in recent years (e.g. collected volumes of papers from conferences on this theme). A specific member of staff should be appointed to collate and share these findings and supervise the home's approach to this matter; this was found to be the case in some homes.
- The obligation stipulated by Quality Standard No. 1, i.e. that work procedures in facilities must be changed, is particularly essential as regards this sensitive topic.

[100] A good example is the female client of one home who reacts boisterously in the presence of men (although she does not have this reaction in the few male staff or male clients in the home). This client was frequently agitated. The home, however, never considered sexuality as being a possible cause.

[101] Uzel, R. (2005): Which Form of Anti-conception?: "Sexual motivation is conditioned by the automatic mechanism of survival and every person is hardwired with this biological attribute regardless of their mental state." http://www.dobromysl.cz/scripts/detail.php?id=615

[102] In one home a client was in love with a girl from another ward, although the staff would not let him go and see her. They would only let him take clean clothes to the entrance to the ward.

[103] Exploring this topic should primarily reflect staff members' own opinions on sexuality and their openness to other viewpoints." Mairhofer, H.: Sexuality of Disabled People, conference entitled Dilemmas in the Sexuality of Mentally Handicapped People, Olomouc, 2009.

A document should be compiled which details this theme[104,105]; such documents are generally referred to as sexuality protocols. This document should not merely constitute an ideological bases, but should describe specific situations (provide staff with support in resolving day-to-day situations), define different approaches to clients with differing degrees of mental disability, clients of different ages, etc.

- All the staff will be familiarised with the document. Staff will also be trained (externally) on the topic; supervision or another opportunity for self-reflection should be assured.
- The Defender agrees with the opinion that human sexuality cannot be reduced to the level of merely satisfying a sexual urge, but must be approached from a much broader viewpoint (particularly in the cases of disabled people, this is the satisfying of one of their fundamental needs – to have someone close to them, to have a partner, to be caressed and to touch someone, etc.). Before getting onto the actual topic of sex, it is necessary to start educating boys and girls about the differences between the male and female body and about reasonable and socially acceptable day-to-day behaviour, etc. This step cannot be skipped before starting to educate clients about how and where to have a sex life, and who with.
- What should be the result of work with clients, as regards the matter of their own sexuality? Obviously, they should know how to avoid possible abuse and how to stay healthy. The aim should then be to help them to lead responsible and dignified sex lives[106], to treat others with respect and to accept their attitudes on sexuality (e.g. possible rejection). The next step is to provide specific support, the extent, nature and form of which should be defined by the facility in question. It is should be pointed out that the form of support is a very controversial topic and is still not

[104] The term currently being used is "sexuality protocol"; some experts refer to is as "sexuality and sexual abuse protocol" (this is the Dutch model). In contrast, the Austrian-German school uses the term "sexual concept of the facility". However homes refer to their conceptual approach to sexuality, such approaches should always contain the facility's attitude to sexuality and the education of clients (philosophy and attitude towards sexuality, the values and norms which the facility will abide by), educational topics, including specific information for clients (the different forms of relationships and sexuality – what clients imagine by this, what the current scientific findings are, what the home will provide for its clients in this respect, what cannot be tolerated), means of dealing with the possible consequences of sexuality (questions of anti-conception, the possible consequences of sexuality, pregnancy and parenthood), admissible and inadmissible forms of contact, care and support provided (permissible forms of contact and dignified treatment, bodily care, options and limits), education and prevention (prevention of sexually transmitted diseases, boosting immunity), staff responsibilities regarding sexuality (general, responsibility for upbringing and sex education, collaboration with experts), parents and legal representatives (mutual cooperation), attitude to sexual abuse, procedures to be adopted in cases of sexual abuse (abuse indicators, suspicion of and reporting abuse, examination, help and support for victims, approach to offenders), preventive policy inside the facility (training for staff and clients). (Kozáková, Z.: Sexuality and Sex Education of Mentally Disabled People in the Conditions of Social Care Facilities. Collective Volume of Materials from the Nationwide Conference *Sexuality of the Mentally Handicapped.* Praha: Centrum denních služeb o.s. Orfeus, 2004; Šelner, I.: Sex Education and Psychosexual Consultancy for Mentally Handicapped People, working texts for seminar, Olomouc, 2009).

[105] One other possible definition: The sexuality protocol summarises the attitudes, knowledge, responsibilities and standards supported and espoused by the facility. It is binding for all members of staff and should be drawn up by the staff and management of the facility. The sexuality protocol should allow all members of staff to act quickly and properly in a variety of difficult situations, including possible sexual abuse. The sexuality protocol should rule out situations where a certain situation passes one member of staff by while causes an uproar with another (after which it is the client that is left most confused). Therefore a consistent approach must be taken by all staff (not that everyone should act in exactly the same way, but that they should share the same ideas as to what is good and what is bad). Bednář M.: Introductory Course for Staff of ÚSP Na výsluní Bilsko, Olomouc, 1994, pg. 28.

[106] In one facility, for example, it was found that a client did not want to talk about sexuality, "*because he is not a pervert*".

resolved even abroad, where the sexuality of clients with mental disabilities has been the topic of discussion for far longer and, in a more open manner [107].

- Sexuality will be included in individual planning.
- The Defender is aware that this is a very sensitive matter and is new (or at least unresolved) for almost all the facilities. Considering the demands of maintaining the dignity and the privacy of the client, this question can only be properly dealt with by a forward-thinking team sharing a common view of the matter, which is not always possible or acceptable for each member of the team. Individual staff members cannot inquire into the wishes and desires of clients according to their own preferences, opinions or convictions. If the wishes of a client do not constitute a breach of the rights of other clients, staff members must be able to support the client in satisfying his or her needs. If staff are unable to respect clients' rights to privacy and dignity in less delicate situations (hygiene, nappy-changing, privacy in rooms, autonomy)[108], how will they be able to cope with the topic of sexuality? The working team must be as sophisticated as possible.

It is recommended that these criteria be extended to include a good approach to the issue of sexuality.

Sexual abuse

120. The Defender does not assume that it would be possible for his visits to uncover all cases of abuse amongst clients. Often not even the staff who spend all day with clients are able to do this. If, however, a situation arises where the staff suspect that a client has been abused, there should be clear-cut rules on how to proceed, and these must be strictly observed. A medical examination is crucial in cases of suspected abuse (to objectivise the victim and acquire biological material); also the situation must be appropriately recorded (describing any signs of violence, sexual intercourse, self-defence, conditions causing vulnerability), proof must be found (determine whether clothing is torn, whether it is stained by any fluids and, if so, arrange for DNA tests, which often tend to be the only form of evidence).[109]

The Defender found one specific case which unfortunately provides a good illustration of the need for the aforementioned requirements. In one of the facilities visited it was found that once a member of staff had seen a 13-year-old boy (verbally

[107] Assistance can be passive or active. Passive sexual assistance means supporting clients in the sense of allowing them to live their own form of sexuality (consultancy in personal development and clients' sex lives, providing a consulting room and accompaniment in consultation sessions, assistance in obtaining sex aids, etc.). This support is understood in the sense of "help towards self-help". In contrast, active sexual assistance means any form of direct assistance in relation to the intimate lives of clients and helping them to realise and satisfy their sexual desires, in which the staff member plays a direct role. "This form of sexual assistance, however, cannot be provided by staff and is strictly forbidden. The reason is that active sexual assistance is not compatible with their role in this matter, especially as it can blur the boundaries between active sexual assistance and the "abuse of dependent people". Mairhofer H.: Sexuality of disabled people (from the Principles for Staff of ASSISTA Altenhof), conference entitled Dilemmas in the Sexuality of Mentally Handicapped People, Olomouc, 2009.

[108] If a member of staff wants to establish a good rapport with a client and is able to act appropriately in aggressive situations, it should not be difficult to provide him or her with support in matters of sexuality. In particular the staff member should find out what clients know about their bodies and sexuality, how they see their bodies and sexuality, how they rate sexuality around them, in their family, what experiences they have, whether there are signs of sexual harassment, etc. Mairhofer, H.: Sexuality of Disabled People, conference entitled Dilemmas in the Sexuality of Mentally Handicapped People, Olomouc, 2009.

[109] Zdražilová, P.: Attitude of Social Services Facilities to the Sexuality of Mentally Disabled Clients, conference entitled Dilemmas in the Sexuality of Mentally Handicapped People, Olomouc, 2009

uncommunicative, ordered into institutional care) come out of the toilet with his trousers and sweatshirt in disarray. Nearby was another client (30 years old, with a mild disability). When the member of staff adjusted the boy's clothes she found that the sweatshirt was stained at the back, as was the his back and bottom. The logbook states: "Underage boy came, was crying, complaining about pain in rectum, which was slightly ruptured. Evidently spattered with ejaculate." What action did the facility take? First of all, the stained clothes were immediately washed. The boy was put into the shower, as he was crying and kept wanting to wash himself. The facility management were not informed until the following day and it was not until two days later that a medical examination was performed, which found no injuries. It is not clear when the police were informed, but it was not immediately. It was three months before the Police of the Czech Republic interviewed the boy (although he unable to communicate verbally, he can make himself understood using shrieks), who apparently stated that nobody in the home had hurt him and that client X. Y., who was seen in the corridor by the toilets, had also not harmed him. No child protection body was contacted. The Police of the Czech Republic deferred the case. The Defender severely reprimanded the home for this malpractice, which was made even worse by the fact that the director of the home was the legal representative of both clients.

Staff must clearly know how to proceed in exceptional cases, such as the suspicion of sexual abuse. It is recommended that internal procedures be changed to ensure that they respect the aforementioned requirements.

Anti-conception

121. In all the facilities visited it was found that most or at least some girls/women use anti-conception. In the case of medication this is an aspect of healthcare in which the principle of informed consent applies (see points 84 and 85). Although in most cases a legal representative has the authority to grant informed consent, it is unquestionable that all the use of all anti-conception medication must be voluntary and it must only given with the explicit consent of the user. Examples of bad practice included situations where one client (assumed to be poorly educated) did not know why she was taking the tablets, or facilities in which partner cohabitation is conditional upon the use of anti-conception.

In the Defender's opinion the blanket use of anti-conception, even where users do not come into contact with men, is highly questionable. When he asked for reasons, he was told, for example, that anti-conception reduces aggression and agitation on the part of clients; clients do not menstruate, meaning there is less hygiene work, and the preventive effect of anti-conception was raised, e.g. against tumours. To assess whether this is always a procedure lege artis from a medicinal viewpoint is not within the Defender's sphere of authority.

It is recommended that facilities help to provide the appropriate education for women and do not administer anti-conception without the consent of the client.

Medicaments

122. Where there are nurses working in homes, they are mostly entrusted with preparing medicaments. Medicaments are also administered by social services staff. In any case a system of administering medicaments must be introduced so as to minimise

the risk of incorrect administration,[110] especially as regards certain groups of medicaments (typically psychiatric medication) and some groups of clients (children, clients who have difficulty swallowing, clients who refuse their medication, etc.). The system should also take account of the specifics of the facility in question – the risk involved in administering medication to 20 clients is very different to that posed by 300 clients. As regards the standard of prescriptions, this varied – see above for more on this topic (point 67). Considering that this is a normal act of self-service, the aim of the care provided should be to improve or maintain clients' capabilities. Provided that there is no unreasonable risk of error, clients should take their medication themselves.

The secret addition of medicaments to food (covered medication) is a separate issue. If a client refuses to take his or her medication, the doctor should be informed, who will decide on the next course of action. There is no room for creativity on the part of staff (it is even dangerous to crush certain tablets).

It is recommended that a controlled system for the administration of medication be introduced. It is also recommended that medication only be administered on the basis of legible and clear prescriptions (details should not be transcribed with a pencil and all amendments should be dated and signed). If a client refuses to take his or her medication, the causes of such behaviour must be dealt with; solutions should be proposed by doctors.

Sharing information about clients

123. In one facility the Defender found that the protection of personal data was so diligent as to prevent nurses and social services staff from continually working together. Non-medical staff were refused information about the medical condition of their clients, so in some cases they did not know that a client suffered from mental illness, that he or she had been diagnosed as autistic, etc. They did not know what medication clients were using, and especially what effect this medication had. In interviews staff naturally complained that they were lacking this information in their work, as if they had access to it, they could better describe their effect on clients (staff do not find out if there has been a change to medication until they notice a change in the client – be it positive or negative; they are not officially informed that the client's medication has been changed)[111].

In relation to this medical staff spoke of their obligation to maintain confidentiality. When providing other care workers with access to a client's sensitive personal data (about their medical condition), it is necessary to take into account the viewpoint of the law, i.e. the Personal Data Protection Act.

From the Personal Data Protection Act:

Providing access to data is one of the many possible ways in which personal data can be processed. However, access to sensitive personal data (e.g. one-off access) is not necessarily provided for the purposes of perusing medical documentation. Verbal

[110] The system should clearly guarantee that the right person gets the right medication, at the right dose, at the right time, and in the right way.

[111] Another example is the case of a client who drags his foot behind him as he walks. As he cannot walk very well as there is the risk of his falling, he cannot go off the ward unaccompanied. Social services staff suggested therapy for this client, but do not know what the outcome of this suggestion was.

information, for example, may be provided in specific and justified cases as required by a SSW[112]. The provisions of § 9 f) of the law explicitly state that sensitive personal data may be processed (i.e. made accessible) without the consent of the subject of the data if such data are classed by a special law as being necessary for the provision of social services, provided that the data are protected accordingly in compliance with the law. This degree of necessity (for the provision of social services) must be properly assessed by the person in possession of the data, who may thus make the data accessible to others (in this case a medical worker). It is important to remember that both people (the nurse and the SSW) are employees of the same administrator (a social services facility). This means that sensitive personal data is not provided to a third party (i.e. someone other than the administrator). It is therefore at the administrator's discretion as to what rules are set within the facility for the handling of sensitive personal data and who can reasonably be given access to such data.

We can therefore conclude that it is not possible to a priori refuse to provide information about a client's medical condition to another employee of the administrator of the data merely by referring to the provisions of § 67b HCA. One-off access to sensitive data (which does not involve perusal of medical documentation) may be corroborated with reference to the provisions of § 9 f) of the Personal Data Protection Act, i.e. the provision of access to data necessary for the provision of social services. This procedure is wholly legitimate and may greatly help to improve the quality of the social service as such.

Facilities (as the administrators of personal data) are recommended to introduce a working system for passing on information about individual clients to social services employees and medical staff.

Meals

124. During his visits the Defender also looked at the question of clients' meals. Again, here are some observations which could be put into practice to increase the quality of clients' everyday lives:

- In the majority of facilities clients can choose from different meals and can express their opinion on the quality of meals and their ingredients. Most facilities use a picture menu. In most cases, however, it is only clients who do not have serious communication problems who are able to express themselves, even though more severely disabled clients can be seen to like or dislike certain meals.
- Good practice (e.g. Jindřichov, Raspenava, Liberec) can be seen where immobile clients are moved to the table to eat together. In the Defender's opinion it is not good to provide all clients with their meals in bed. Once again, this is one of the principles of normality.
- In only very few facilities was it found that clients eat together with staff (e.g. Psáry, Raspenava), yet staff should eat with clients as often as possible, so as to set a good example.

[112] E.g. an SSW is to accompany a client to an all-day sports event outside the home and knows that the client has some minor health problems, which she reports to a member of the medical staff. This member of staff arranges for the client to be examined by a doctor, who prescribes medication which could have relatively serious effects; the SSW should be aware of this to enable her to provide the appropriate supervision of the client.

- When feeding less self-sufficient clients some homes do not use head-rests because, according to the staff, some clients find it hard to swallow and otherwise would not be able to get their food down. Meals are served very quickly. Yet generally, for people who have limited opportunities for interaction with the world around them, mealtimes are a big event, and are also a chance to communicate, or at least make eye contact. When this opportunity is cut down to the minimal time necessary, the user's position and environment does not change at all, they have no chance to experience variation, which impoverishes their day. It is good practice when a member of staff sits down with a client and maintains eye contact.
- The mixing of different courses should also be criticised. This is common in large facilities, yet people generally eat their soup and main course separately.
- Facilities should assess whether some clients are able to eat, for example, minced food instead of mixed meals. This information should be part of the client's documentation.
- It is also worth rethinking the age-old habit of serving dinner at 5 p.m. (one home served it as early as 4.45 p.m.).
- As regards what meals consist of, or variety, fruit, vegetables and a variety of side dishes were seen almost everywhere. However, white and wholemeal bread should be alternated more often, breakfasts were often stereotypes, or tea is served all day (instead of other liquids, such as water).

People-focused individual planning

125. The provisions of § 88 f) SSA stipulate that the planning of social services according to people's personal goals, needs and abilities, the keeping of individual written records on the provision of the service and the process of assessing the service should, where possible, involve the people receiving the service, or their legal representatives. Quality Standard No. 5 requires that providers have a set of written internal rules covering the planning and reassessment of the service provision process.

All the facilities visited, apart from one, had commenced individual planning and drawing up individual written plans. In some facilities planning can be described as good practice (Těchobuz, Anenská Studánka Liberec). Many facilities began planning before the SSA came into force, and have managed to get a lot done. In the majority of facilities, however, individual planning is still a major problem, as a result of which plans are merely formal. In addition to the recommendation that facilities respect the provisions of the law, where there was a clear difference between theory and practice, the Defender also gave facilities suggestions as to how they could improve.

It is recommended that homes act in accordance with the law, i.e. plan services for individual clients individually and regularly assess the provision of these services.[113]

Merely formal planning

[113] The methodology of individual planning, or targeted planning, is compiled in the professional literature and is widely available, e.g. Quality Standards for Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 76 – 96; remotely accessible at: http://www.mpsv.cz/files/clanky/5966/4_vykladovy_sbornik.pdf

126. In facilities where individual plans were merely formal, it turned out that the staff responsible for the planning process had not even been trained in the methodology of individual planning, yet this is not a simple matter where “mere” intuition can suffice. It is not enough just to start using a new computer program. Lack of knowledge and merely formal plan management can result in staff not identifying with the plans and seeing them as unwanted extra paperwork, which distracts them from their work with the clients. Some facilities really do have excessive amounts of paperwork; each member of staff compiles various files and documents, so these documents often overlap and repeat themselves (e.g. logbook, client’s personal profile, daily records of what goes on on the ward, what the client does, social records, therapeutic records, educational records).

It is recommended that staff responsible for individual planning familiarise themselves with the proper methods and thus avoid formal planning which is of no benefit to the client and which staff see as unnecessary administration. Individual planning should focus on creating a plan which will be a practical and useful working tool. Quality Standard No. 5 a) recommends that facilities describe the individual planning process in internal rules, which must obviously reflect the situation in the facility.

Personal goal

127. In many facilities the goals specified in plans were inadequate: they were too general or were meaningless (“greater self-sufficiency”, “reinforcing psycho-social skills”, “gradual improvement of physical condition”, etc.); these are unrealistic or not dependent on the client for fulfilment (“my family visits me”, “we’ll buy him a CD for Christmas”); they described single actions (“buying a toy or soft drink”). In many cases they were not the goals of the client, but reflected the interests of the home of family/guardian (“does not resist nursing care”, “the client’s family is informed about all regimen-related measures”). However, the goal should be about developing the abilities or skills of the user so as to improve that person’s difficult social situation. It is also a mistake when plans do not describe how goals are to be achieved (no specific procedures are set as to how the client will learn the skill, how often practice is given, the length of the time spent practising the skill) or methods are too general (“this goal will be achieved through support in hobby activities”). Documents often labelled as “plans” show what the staff did with the client, but do not help to plan the service. It is also wrong when plans do not specify the criteria by which the achievement of the goal will be assessed.

It is recommended that the bad practices described above be avoided when formulating personal goals.

128. In practically none of the facilities visited were direct care staff appointed as planners systematically trained in understanding users with communication difficulties (alternative or augmentative communication). Likewise, they do not have any information about alternative methods enabling them to identify the needs or personal goals of these users (empathic fantasies, for example).

Teamwork

129. The service is not provided to clients by just one individual but an entire team made up of people from various professions; staff must also take a teamwork approach to planning the provision of services. This does not alter the fact that it is necessary to assign a specific member of staff to each client to implement these plans. Teamwork is a major problem in the majority of the facilities visited.

As the Defender found from practice and from discussing with professionals and watching them work, there are a number of pitfalls inherent in the individual planning process, especially that it takes a long time before the staff are able to work as a team. Amongst other things, there is the risk of a conflict of interests for a key member of staff, when on the one hand that person helps the client to formulate his or her goals and how to achieve them, while on the other hand this adds to the workload of that same staff member. If the system is set up so that a key member of staff draws up the plan and then informs the rest of the staff, that person must be under natural pressure to ensure that the team's work is not "unnecessarily" complicated.

The role of the key worker varies greatly in the facilities visited. One example of bad practice (seen in several cases) is when the plan is a key staff member's private project; the same person compiles the plan and then puts it into practice alone. His client's plan has nothing to do with the other care staff. If a key member of staff has to do something defined in a plan, this must be part of his duties and time has to be set aside for it during his working day.

Individual planning must relate to the team as a whole.

130. The role of the client's guardian in individual planning varies and is also determined by the guardian's approach to the task he or she has been entrusted with. An example of good practice may be a facility where the guardian regularly participates in the planning process (see frame). In most cases, however, key workers *"have not met the guardian and in the best cases it is the social worker that deals with him".* The opposite extreme was a case where a guardian interfered too much in the planning process, asking that the facility not support the client in going out alone, or to forbid such outings completely.

It is recommended that staff communicate with the guardians of clients and that homes change how they work with guardians as part of their planning methodology.

Good practice from *Těchobuz Institute of Social Care for the Mentally Disabled:*
This home has compiled rules covering the planning and reassessment of the scope of the services and how they are provided, including work procedures to achieve individual goals. Individual planning involves a key member of staff, the head nurse, social workers, the head teacher, therapists, a psychologist, leisure activities staff, and also the guardian (the municipal mayor), and, if he wants and his state of health permits, the client himself. If any more serious problems occur in the implementation of the individual plan, these problems are resolved in the form of case supervision.[114]

[114] Note from a social services expert: "In planning there is a clear partnership between the staff and the user. Plan records are practical and concise. The client I spoke to remembered his personal goal. The plan has a real tie in with the client's life. I particularly appreciate the fact that when compiling a plan for a severely disabled client, the team members took great care to ensure that the client was not forced into anything." His recommendations: "The planning process does not clearly distinguish between goals set by the actual client and goals suggested by the staff from their

Risk planning

131. Mental disability puts people at a disadvantage and presents new risks in many aspects of such people's lives. These are risks involved in using electrical appliances, keys, privacy, money management, moving around unaccompanied, self-harming, risk behaviour, etc. Individual planning is also part of work with risks. The risk needs to be identified and assessed in terms of its severity, and a solution is required to minimise the risk. See also points 35, 36 and 88).

It is recommended that an individual plan be used when working with risks.

f) Education

132. In accordance with the provisions of § 42 of Law No. 561/2004 Coll., on pre-school, basic, secondary, higher vocational and other forms of education (hereafter simply the Schools Act), it is the regional authority (appropriate to where the pupil lives), with the consent of the pupil's legal representative, that assigns pupils with severe mental disabilities to a form of education which is suited to the mental and physical abilities of the pupil in question, on the basis of a professional doctor's recommendations and a school consultancy body. This means that the children in the facilities visited to which these provisions apply are taught either by the staff of the home or by an external teacher who comes into the facility to teach them.

Supervision of this form of education is generally provided by a specialised member of staff of special teaching centre. The Defender expected that there would be a specific link between the social services and teaching/education, or that teaching staff in the home would be aware of the school syllabus for children. The great majority of the facilities visited, however, did not cooperate with the school or school consultants, let alone work closely with them.

It is recommended that homes cooperate with school facilities that provide education for children. It is recommended that staff duties be reworked so as to include the active preparation of children for school and to find out what children's education involves.

133. The coordination of school systems and social services systems assumes that the staff of the home will have individual school education plans for children (or at least the "practical" part of such plans, not including the conclusions of psychological and other such tests[115]), which could be part of the documentation the home keeps on the child. In the majority of the facilities visited the staff planning the provision of social services did not have these plans at their disposal. In such cases the Defender generally proposed that homes consider requesting individual education plans and using them to plan their services (e.g. repeating lesson topics and routines during activities in the home, as one

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own point of view (these goals, for example, tend to relate to improving hygiene, etc.). I would recommend that this difference be noted and that staff check to ensure that plans always include a goal which the client sees as important and would like to attain. In the case of severely disabled clients with communication problems, this goal may be substituted by a goal set after thorough observation of the client, his behaviour and reactions to various stimuli, activities and situations."

[115] See § 6 Paragraph 4 of Regulation No. 73/2005 Coll., on the education of children, pupils and students with special educational needs and extraordinarily gifted children, pupils and students, as subsequently amended.

of the features of mental disability is that people more quickly forget what they have learned and experienced, so these things need to be reinstilled and maintained more often). The Defender considers it good practice when a member of staff from the school is actively involved in planning services in facilities. He is, of course, aware that this collaboration relies on the willingness of the school employee, just as the provision of part of the individual education plan also depends on the goodwill of the school or of the pupil's legal representative.

It is recommended that homes request schools to provide at least parts of individual education plans so these can be filed with clients' records in the home, allowing the home to work with them. It is recommended that training activities be provided which take account of the individual education plans and of the individual plan for the provision of services.

Good practice:

In Jedličkův ústav in Liberec users with the most severe mental disabilities are taught by the staff of the home under the regular guidance of an external teacher, while the duties of the staff also include assistance in preparing for lessons. This is done in active cooperation with a school. A school employee regularly participates in meetings held in the home to plan for a certain child in the home's care. Education for users with severe mental disabilities is provided in a different part of the home to that in which they spend the rest of the day.

Also, the staff of *Diakonia ČCE – střediska Zvonek in Prague*, for example, actively work with the children's school as part of their duties.

School staff and employees of the home discussed education plans together in the case of *Domov Raspenava*.

134. With the adoption of the new Schools Act (effective as of 17 February 2005) the previous practice of exempting clients with severe mental disabilities from compulsory schooling was dropped; now they may only be exempted from the obligation to actually go to school. This is in compliance with the constitution, as according to Article 33 Paragraph 1 CFRBF, each person has the right to education and school attendance is compulsory. Education cannot offset the deficit caused by mental disability, although it can partially alleviate it and can undoubtedly help, for example, to develop a person's emotional intelligence.

The visits found cases where homes decided, just before the new Schools Act came into force, to exempt clients from compulsory school attendance. In these cases, considering the provisions of § 48 Paragraph 2 h) SSA[116], it would have been better if the homes had reassessed this decision to exempt clients to allow the clients to receive an education (as was the case with, for example, Ústav sociální péče pro mládež Jeseník). Social services providers should try to ensure that these clients can go to school, even if their legal representatives do not agree, as if they fail to grant consent to

[116] One of a home's fundamental duties is to assist clients in exercising their rights and legitimate interests and in dealing with personal matters; Regulation No. 505/2006 Coll. mentions help "in communication leading to the exercising of rights and legitimate interests".

education, this results in a clear conflict of interests. The decision should then be left to the guardian ad litem[117] (for other related matters see points 188 and following).

Likewise, homes should reassess courses of education which seem inadequate or unsuitable (such a case, and the home's efforts, was documented in the home for the disabled in Aš). Here the Defender refers to the *Criteria for the Transformation, Humanisation and Deinstitutionalisation of Selected Social Care Services,*[118] which state that institutions should consider "the creation of opportunities for integrating users into systematic school education as an important task, and therefore this opportunity should be explored for each individual user and users should be helped to achieve this aim."[119]

It is recommended that the situation of clients who were previously exempt from compulsory school attendance be reassessed. It is recommended that in the case of clients attending compulsory lessons that are inadequate, the scope or form of the education should be reassessed.

g) Social integration

Definition of terms

135. The SSA defines the term of social exclusion from the perspective of participation.[120] Social exclusion is understood to mean "the exclusion of a person from the normal life of society and the inability to integrate such a person into society due to their disadvantaged social situation" (the provisions of § 3 f/ SSA). According to the National Report on Social Protection and Social Integration Strategies, the people most at risk of social exclusion in the Czech Republic include disabled people. The way to support social cohesion and equal opportunities for all is particularly to intensify the integration of socially excluded people or people at risk of social exclusion. Emphasis is especially placed on the empowerment of socially disadvantaged people, particularly by improving and maintaining their social skills as job-seekers and removing the obstacles they face on the labour market. Also, as in the Lisbon Strategy, eliminating inequality in access to education.

Integration is defined by Janoušek as the integration of an individual into a group and the acceptance of that person by the other members of the group. In the narrower sense of the word it means the incorporation of disabled people into majority society, reducing their handicap, i.e. the impact that disability has on the person with the disability (mainstreaming). Janoušek defines inclusion as the greater integration of disabled or disadvantaged individuals into society and its institutions. He also states that a change of attitude is required, from the idea that "we are obliged to accept people who are different" to the new tenet which is that "each of us is in some way different and each person needs and has the right to an individual approach".

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[117] Guardianship ad litem in cases of conflicts of interests is defined by § 30 of the Civil Code.

[118] Recommended Procedure of the Ministry of Employment and Social Affairs No. 3 dated May 2009; available at: www.mpsv.cz/files/clanky/7059/Doporuceny_postup_3_2009.pdf

[119] pg. 24 ibidem

[120] Social exclusion is defined as a situation where an individual or group does not participate fully in the economic, political and social life of society, or where their access to income and other resources does not permit them to attain a standard of living considered acceptable by the society they live in or to participate in the life of society to a level which full-pledged members of society consider desirable.

Situation in the homes visited

136. Improving the social integration of clients is, by law (§ 2 Paragraph 2 SSA), one of the main aims of social services. The Defender looked at the actual situation as regards integration (in other words, the effect that services have on the level of integration) in the homes visited, and feels obliged to state some reservations.

137. The Defender was most often critical:

- when the only efforts to support the social integration of clients involve creating opportunities for them to go outside the home, such for rare sports or cultural events. There is the risk that activities will repeatedly focus on more able clients. However, users live their day-to-day lives inside the home.
- when clients only come into contact with the outside world (village, nearby town) in groups; this actually prevents any real contact. Some users with more severe disabilities do not leave the home at all.
- when services such as the hairdresser, pedicurist, doctor, etc., are provided within the facility.
- when clothes and shoes are bought for clients by the staff without the client's involvement, or these things are only bought on group outings. This gives clients no chance to enjoy natural parts of normal life, such as shopping.

138. The Defender was especially critical (and often) when it was found that homes do not try to take clients (with mild disabilities) out of the home for field-based and out-patient services, i.e. to see life outside the walls of the home.[121] Regardless of the actual possibility of passing clients on to other, related services, placing people with mild disabilities into a natural environment should be the long-term goal. Homes should also prepare selected clients for a more independent life (looking after themselves, cooking, handling their own affairs, etc.). The Defender considers it a mistake when training in normal household routines is not given priority. In the case of severely handicapped clients, the home should try to build on their skills, at least as regards the clients looking after themselves (using the toilet, feeding themselves, cooperation getting dressed).

It is recommended that services to build on clients' abilities be given priority, even just in the minor details of self-care, and that clients with mild disabilities be prepared to be eventually transferred to a related follow-up service

Good practice from** Domov Raspenava**:
The effort to enable clients to be more self-sufficient in the training flat is not merely formal. They have their lunch together only on weekdays, when they go to work in the workshop. Otherwise they are urged to be independent. The system of payments for this housing ensures that self-catering does not work out more expensive for the clients. There is a cooking group that meets in the home every week. Clients' clothes were

[121] Found in one facility: One female client participates on a weekly basis in a programme organised and funded by an external body which provides training in activities the client will need when she goes to live in sheltered housing run by this organisation. The Defender was surprised by the claim that other clients were not involved in this scheme to move on to sheltered housing, apparently because "they don't want to".

reasonable, the girls dress up and go to the hairdresser. The home uses a kind of lonely-hearts system to help boys and girls in the home to make friends. As regards clients in the ground floor, although they have a severe combined handicap, the staff strive to at least improve their skills in looking after themselves and give them practice (using the toilet, feeding themselves, cooperation getting dressed).

Excessive care

139. It is also important to mention the problem of excessive care for clients; this was not found to be widespread, but nevertheless there is a fairly major risk that clients could become dependent on the service they receive. (Able clients have their oranges squeezed for them, their bread buttered; the staff put their pots into the dishwasher and do the clients' work for them in creative activities. Facilities manage the finances of all their clients, without exception.) These situations can result in what was found in one home: in recent years clients have become lazy and do not want to do anything as they were spoiled by a former member of staff; now the staff have problems motivating them to do anything.

When clients "grow out of" an existing service

140. It was apparent that some of the facilities visited contain users who, with the proper preparation, would be capable of using a social service with a lower level of support. (One extreme case was that of a user who received no contribution towards her care.[122]) Homes react to this by setting up special, more independent housing, often within the complex, or they want to register a new service. Unfortunately, in doing so they do not realise that disabled people will continue to be concentrated in one place, remaining in an institutionalised environment with little opportunity for contact with the normal world.[123] For example the sheltered housing is linked to the rest of the facility via corridors, and is not part of a normal housing estate. Other facilities tend to rely on external organisations for the provision of related services.

It is recommended that in relation to this municipalities (the provisions of § 94 e/ SSA) and regional authorities (the provisions of § 95 d/ SSA) be informed of the specific needs of the residents of the home for related services.

[122] In regard to this it is necessary to draw attention to the case of the client M. J. This is a young adult woman, with legal capacity, who receives no contribution towards her care. She uses the services of the home because she is an orphan, is still studying, and has nowhere else to go. At the time of the visit she had spent the week at boarding school and was studying. The home was not found to have prepared or even considered her future, such as creating an individual plan to prepare her for independence, a life outside the sheltered environment of the home, or helping her to find a service with a lower level of support or a place to live outside the facility. All that the staff of the home knew was that she might want to live with her boyfriend. That is not enough.

[123] According to the Glossary of Social Work (2003, pg. 37), sheltered housing is defined as "living in a flat which is part of a normal housing estate and which belongs to a social services provider. It houses one or more clients who, as far as they are able, participate in the running of the household. Clients are in regular contact with the staff of the social agency. Services are provided to clients by a social worker, carer or assistant according to their individual needs. Sheltered housing is suitable for clients with permanent disabilities or long-term illnesses who require therapeutic support but whose condition does not require institutional care with full board and lodging." Matoušek, O. Glossary of Social Work. Praha: Portál, 2003. ISBN 80-7178-549-0.
"Sheltered housing is a comprehensive residential service which provides clients with support according to their needs so as to enable them as far as possible to lead a normal lifestyle. Clients of sheltered housing may be people who are at a permanent or long-term disadvantage due to illness or disability." Pipeková, J. Mentally Disabled People in the Light of Contemporary Educational Trends. Brno: MSD, 2006. ISBN 80-86633-40-3, p. 115.

It is recommended that homes practically and more intensively prepare certain clients for life outside the facility.

"Sheltered housing"

141. Sheltered housing as a service defined in accordance with the provisions of § 51 SSA were provided in very few of the homes visited. Many facilities have, however, especially in the last few decades, built special departments or flats which are referred to in this simplified manner. This is with the aim of providing users who are capable of a greater degree of autonomy with privacy and space. This effort is commendable in itself, though the Defender came across a number of aspects which prevented any major progress in the social integration of these people.

- The clients' daily programme is organised by the staff, their money is managed by the staff, and they only play a small role in work relating to the running of the household. Even the sheltered housing, which was registered as a separate service, functioned more as housing with a greater degree of privacy that other types of service, yet it was not found that the clients there led independent, or more independent, lives.
- For example residents in sheltered housing go to the main building to eat; they have no facilities to cook for themselves.
- "Protected" regime in one facility meant that there were fewer staff on duty than elsewhere – clients may be unsupervised during the day. No efforts are made to develop these people's ability to look after themselves. All their meals are provided and they do not cook for themselves at all. It is not possible to cook during the day as no staff are on duty to provide supervision. There is even no practice of cooking meals in the residents' equipped kitchenette. (Their fridge is almost empty.) They are completely provided for.
- In another facility which had independent housing, the clients tried to cook their own dinners. Nevertheless, as there were arguments, this was stopped and the clients continue to receive all their meals from the home. It is a pity that the home could not manage to motivate the clients to take advantage of the chance to improve their own level of self-sufficiency.

142. The Defender appreciates the efforts made by some homes, even though clients can only be partially integrated into a normal environment as the location and layout of a number of facilities are unsuitable for natural social integration. Homes are typically situated on the edge of a small village and there are too many users concentrated within the complex, meaning that to a certain extent clients will always be socially isolated. Therefore it seems a bad idea for homes to invest large sums of money into existing buildings or erecting groups of small houses near the facility. The mass provision of social services always has a markedly adverse effect on the rights and autonomy of clients (in comparison with other citizens), even though homes try to minimise this impact.

It is recommended that facilities focus their development plans on building small residential units or renting suitable premises (flats, houses) in a variety of different places so as to form a natural part of a normal built-up area. It is

unsuitable to invest a lot into existing buildings or the construction of small groups of houses near the facility.

Employment for clients

143. Work is one of the prerequisites of social integration. Mentally handicapped people are obviously fit to work from the legal point of view under an employment contract. However, for many reasons there is little chance to find work on the free labour market and in a sheltered environment.

144. Some facilities had no labour-law contract with clients. In interviews clients said they would like to work, and not just for financial reasons. Work leads a person to develop and boosts self-confidence. Not all the facilities were found to systematically help their clients to find employment. In homes the exercising of the right to work can be a major. The Defender considered it very good that several facilities run therapeutic workshops on their own initiative – either as a social service as defined by the provisions of § 67 SSA, or as an activity offered within the home.
It is recommended that that an active approach be taken to boosting client employment.

145. It is arranged that some clients work to help with the running of the home. It was found that users help with a variety of tasks within the home, while some even work completely independently (shopping, cleaning, laundry work, gardening, on reception, at the main gate, etc.). The Defender appreciates the attempt to provide clients with the chance to work. He was only critical when the work of one client was used to provide a social service to another. Clients perform other duties outside the scope of an employment contract, to help out.
It is recommended that homes define the exact number of working hours and duties for individual clients and abide by them strictly as would be the case with a normal employment contract. The Defender also urges homes to pay the same remuneration that they would have to pay if they were to contract out for the work in question on the free labour market.

Good practice from *Domov pro osoby se zdravotním postižením Zběšičky:*
26 clients perform ancillary work in the facility (on the basis of a work contract) for approximately 1 – 2 hours per week (they are paid 49 CZK/hour).

146. In several facilities some users regularly work for the service provider without being entitled to any pay. This is work that an employee would be paid for and which the facility would most likely have to hire someone to do, for example mopping floors, washing up, clearing snow, working in the garden, guarding the building at the main gate, etc.[124] Clients are "expected" to do this work.

The Defender considers this practice to be unjust and that labour-law relations with clients who work regularly should be modified. For example, some homes sell

[124] In one facility clients sorted plastic for recycling for a private entrepreneur with no remuneration (in return this entrepreneur provided a "donation" to the facility). This is evidently circumvention of the labour-law and tax regulations and is harmful to clients' interests.

products made by clients, such as from pottery or therapeutic workshops. It is not clear whether the revenues from these sales merely cover the costs or exceed them. If the revenues exceed the costs, then it would only be fair if clients were paid the difference.
It is recommended that in the aforementioned cases employment contracts be concluded with clients and remuneration be provided.[125]

h) Contract for the provision of a social service

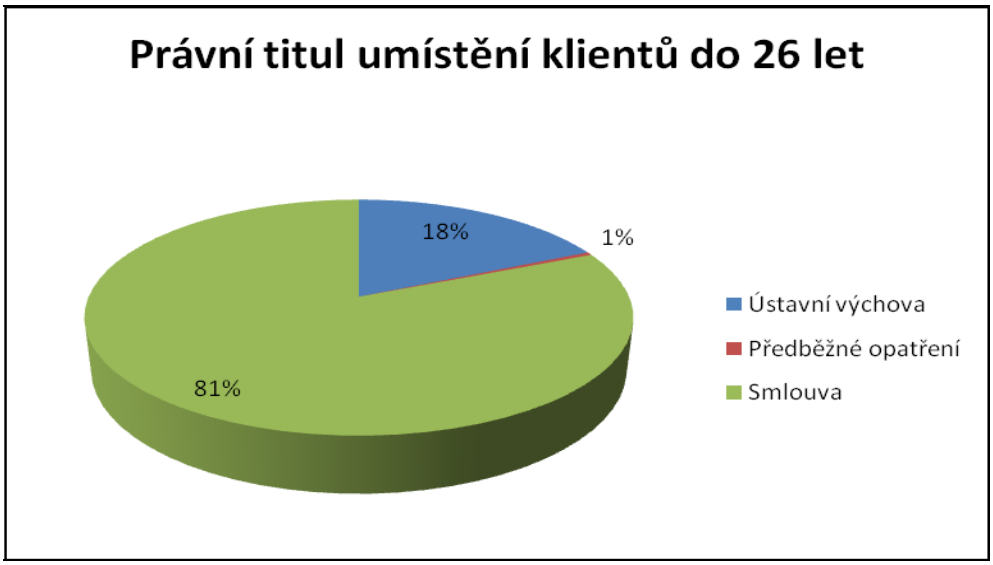
147. The Social Services Act states that social services in homes for the disabled are provided on the basis of a contract for the provision of a social service, the main appurtenances of which are defined in the provisions of § 91 Paragraph 2 SSA. The law also states that the negotiation of such contracts, as well as the legal relations associated with such a contract, are governed by the appropriate provisions of the Civil Code. Contracts must be in writing, otherwise they are invalid. The law states that the obligatory details of such a contract include the names of the contracting parties, definition of the nature and extent of the social service, service is to be provided, the fees as defined by the law, provisions concerning compliance with the service provider's internal rules, grounds for the termination of the contract, termination notice periods, and the length of time for which the service is to be provided.

All the facilities visited negotiated terms and prepared proposals which were presented to the potential users of the service. The Defender studied the contracts and gave the facilities suggestions as to what could be improved.[126] Most of his recommendations, however, were only for consideration as in private law contractual relationships are governed by the principle of the autonomy of the contracting parties. Where the law does not explicitly stipulate otherwise, the contracting parties can agree on whatever mutual rights and obligations they like.

148. A contract is not the only reason that people live in a home for the disabled. The following graph shows (in the facilities visited) the ratio of users under the age of 26 who have been ordered into institutional care, those subject to preliminary measures, and those with a contract.

[125] "In facilities providing social services it is common practice for some clients to work to help with the running of the facility. Such work cannot be considered work therapy or training if tasks are performed on a long-term basis, and therefore a normal employment contract is required, including financial remuneration. Otherwise it would constitute the exploitation of clients." Quality Standards for Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 33; http://www.mpsv.cz/files/clanky/5966/4_vykladovy_sbornik.pdf

[126] A number of the Defender's opinions are also given in the appropriate part of the Report on Visits to Social Services Facilities for Senior Citizens, issued in August 2007 http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=780



Legal reasons for the placement of clients under the age of 26

- Institutional care
- Preliminary measures
- Contract

Reason for refusing to conclude a contract

149. In several facilities it was found that mental illness or a mental disorder in general was considered grounds for refusing to admit a person into a home. This was part of the homes' internal rules. The Defender feels obliged to object, as the case histories of a number of people with mental disabilities involve such facts, including those who currently reside in homes.

What is important is that the circumstances under which a service provider can reject an applicant are defined by the law. These include situations when the applicant's medical condition "precludes the provision of such a social service".[127] The provisions of § 36 c) of Regulation No. 505/2006 Coll. of the law are more specific, stating that "the behaviour of a person with a mental disorder would be seriously detrimental to collective cohabitation". What is important here is not the history of mental illness itself, but how it manifests itself, which narrows down this group of people.

It is recommended that homes do not take a mental disorder or previous psychiatric hospitalisation in an applicant's case history as grounds for refusing to admit the applicant into the facility. It is recommended that applicants be assessed not merely on a formal basis, but on their actual condition and behaviour wherever possible.

150. In one case it was found that in its internal rules a provider stated that it constituted grounds for not concluding a contract if "the applicant has limited funds; the applicant draws a partial invalidity pension which is not enough to pay for the service". A social service provider cannot define such a contraindication to admission, as the law (the

[127] The provisions of § 91 Paragraph 3 c) SSA

provisions of § 91 Paragraph 3 SSA) is taxative,[128] and if it does not recognise low income as a reason to reject the provision of a service, this law cannot be used as grounds to reject an applicant. In fact, if an applicant really does need the service and there are no other legal impediments, the home is bound by the provisions of § 88 i) SSA, i.e. is obliged to conclude a contract.

Drafting contracts and key documents in advance

151. Before an applicant is admitted to a home there are usually several meetings between the candidate and his or her legal representative and the service provider, as well as an inspection of the applicant's current abode. This provides homes with a chance, and the Defender found that many of the facilities visited did this, to present the applicant with a draft of the contract and other applicable documents (e.g. the home's internal rules). The applicant must be familiarised with these documents, which is feasible (and demonstrable) especially when the applicant, alone or with his or her legal representative can study these documents in advance before signing them.
It is recommended that documents be provided for perusal in advance as part of pre-contractual negotiations with applicants.

Countersigning

152. The Defender considers it commendable when clients who are not competent to sign a contract are present when it is signed, or actually countersign the contract, especially when this is not a mere formality. This allows the client to at least confirm that he or she was present when the contract was concluded.[129]

Content of contracts

153. One essential point of the contract is the client's declaration that he or she has been acquainted with the rules of the home and the duty to abide by them (the provisions of § 91 Paragraph 2 f/ SSA). As clients in homes for the disabled often have difficulties understanding these rules, this declaration tends to be somewhat formal in many cases (the declaration is confirmed by the guardian, but it is the client who has to abide by the rules). Good practice towards clients with more severe forms of mental disability was found in one facility the Defender visited, which declares that "the client has been informed about the internal rules of the facility, although his medical condition renders him unable to fully understand the verbal explanation of these rules". This approach is considered to be fairer and more truthful.

154. As regards the individualisation of the contracts studied, the content and scope of the service were most often copies of the wording of § 48 Paragraph 2 SSA and the corresponding provisions of Regulation No. 505/2006 Coll. If, however, a contract is to

[128] This means that the particulars it contains are conclusive and no "similar" eventualities may be added later.
[129] "Applicants must always be familiarised with the content of the contract. If the applicant's mental health renders them unable to understand the legal wording of the contract, it is necessary to try to explain it in a more comprehensible manner." "Also, it is recommended that applicants who are not competent to conclude a contract be given the chance to countersign the contract. This "countersigning" does not render the contract invalid, but gives the applicant the sense that he has been involved in arranging the service he is to receive. For the applicant, the countersignature is testimony to the fact that the contract has been discussed with him." Quality Standards in Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 68 a 69; remotely accessible at http://www.mpsv.cz/files/clanky/5966/4_vykladovy_sbornik.pdf.

be specific, it should respond to the individual needs of the client as regards the provider's specific execution of its legal obligations (§ 48 Paragraph 2 c/ - h/ SSA) and should define the extent of the care.[130] It cannot be assumed that clients with varying degrees of dependence on care will be provided with the same degree of care and support; on the contrary, this is a form contract, similar to the trading conditions used in large corporations. In technical terms it is possible, in the Defender's opinion, to refer to another document which contains details of the extent of care on the basis of a standardised procedure, such as an individual plan which would then become part of the contractual negotiations between the user and the provider.

It was found that the contracts of Jedličkův ústav in Liberec, for example, drew on previous social inspections to specify the details of the frequency and conditions of the individual points as stipulated by § 14 of Regulation No. 505/2006 Coll. (e.g. washing a client in the manner he has been accustomed to since childhood) and of other activities offered by the home. The contract of Domov na zámku Bystré differentiates the assistance/support provided to the client on a graded scale: slight – partial – prevalent – complete.

Contracts should also contain the personal goal of the client. The primary goal should be evident in the course of proper pre-contractual negotiations. The Defender considers it good practice when a contract grants the client the right to request that a change be made to his individual plan and when the provider is contractually obliged to provide the service in line with the individual plan and to reassess it on a regular basis.

It is recommended that contracts for the provision of social services be individualised as regards the extent of the services to be provided. Contracts should include clients' personal goals.

155. If a contract states that the fee for housing and meals may be changed "as a result of changes to the generally binding laws, price trends, the circumstances in which the services are provided or criteria-related changes" or contains similar provisions, the provider should be obliged to inform the user of any such change in writing as soon as the provider becomes aware of the need to change the fees. However, as regards the wording of the contract it is important to remember that the contracting parties are equal in formal terms and therefore one party may not accede to any such change to the contractual terms. If a contract states that fees may be increased unilaterally by the provider (most often as a result of an amendment to § 14 Paragraph 2 of Regulation No. 505/2006 Coll.; i.e. the maximum fee for a service), the Defender considers it good practice when the user is informed in writing of the reasons for the increased fee.

Contractual penalty

156. Some contracts contained a contractual penalty as a sanction in cases where users do not state their actual income. The Defender draws attention to the fact that it is always necessary to consider whether the user really has any influence in this matter, or who will be charged the contractual penalty in cases where it is the guardian who does not state the client's actual income yet the penalty will be paid from the ward's assets.

[130] Quality Standard No. 4 criterion c) of the regulation states that "the provider must negotiate with the client as to the extent to which the social service will be provided with respect to the client's personal goal and taking account of his abilities and wishes".

Likewise, it is necessary to point out that it is unlawful to request proof of income if the client does not take advantage of the 15 % protective limit in accordance with § 73 Paragraph SSA, as in such a case there is no reason to ask about the client's income.

Notice and notice periods

157. The notice period granted by providers was often one month and the reason was the regular non-payment of fees. As regards notice issued by the provider, this notice period should be long enough to allow other accommodation and care to be found for the user without possibly worsening the client's social exclusion (the Defender bases this opinion on the provisions of § 2 SSA). With this in mind, the notice period seems unreasonably short.[131] A common reason for notice issued by providers is also "non-payment of fees", in some cases after just one monthly payment has been missed. The Defender draws attention to the fact that according to the Civil Code – if we compare the contract for the provision of social services with a leasing contract – tenants are not considered to be non-payers until they have failed to pay three instalments of the lease.[132] Moreover, it is also always necessary to consider whether the user really has any influence in this matter, or that it is the client who will be charged if the non-payment of the fee is the fault of the guardian. The Defender saw it commendable when providers included provisions in the contract obliging them to help users find other services if there are grounds for issuing a user with notice.

The Defender suggests that providers consider extending their notice periods. In cases where notice is issued to terminate a contract for the provision of social services on the grounds of non-payment, the Defender recommends that providers always investigate the matter to determine to what extent the user could influence the situation.

158. Contracts generally state that it constitutes grounds for withdrawing from a contract if "the user commits a gross violation of the obligations stipulated by the contract", where such a gross violation is also understood to mean "violation of the obligations defined by the provider's internal rules". The Defender draws attention to the fact that the term "internal rules" is very general constitutes a degree of uncertainty by which the client is bound. Generally internal rules are not referred to as such, yet documents which could be classed as internal rules tend to be more common in facilities. Contractual provisions must state the specific name of the documents or internal rules which define obligations which the user is bound to abide by.

It is recommended that contracts specify the meaning of the term "internal rules of the home" by listing and precisely defining such rules.

Court supervision of guardianship

159. It was found that the practice of the general courts differs as regards interference in the negotiations of contracts for the provision of social services and potential amendments to such contracts between providers and guardians of users. The Defender merely points this out. This practice is probably caused by different ways of

[131] Taking as an analogy a leasing contract in accordance with the provisions of § 710 Paragraph 2 of the Civil Code, the notice period may not be less than three months.
[132] The provisions of § 711 Paragraph 2 b) of the Civil Code

interpreting the term “routine matter” as contained in the provisions of § 28 of the Civil Code, which state that “if legal representatives are also obliged to manage the assets of those they represent and it is not a routine matter, court approval is required to handle their wards’ assets.”[133] This is what is required by the District Court of Ústí nad Orlicí, for example, for the approval of new contracts for the provision of social services or amendments to such contracts. Other courts, e.g. the District Court in Hradec Králové or the District Court in Šumperk, do not do this.

i) Finances

160. There were also cases of poor treatment in the handling of clients’ finances. Therefore the Defender focused on this matter, especially with regard to the extensive powers which are, in practice, transferred to home staff.

Users generally make use of the chance to have their pensions paid through a bulk payroll list into the home’s account, while the appropriate consents signed by the client or guardian are filed in the client’s documentation or contained directly in the social service contract. Another option is that the pension is paid to a separate recipient, who pays the users fees either by bank transfer or in cash. In one facility pensions are paid to the home’s account and after deduction of the contractual fee for the service, the remainder is kept as the client’s personal deposit.

Debts and “arrears”

161. All the homes visited respect the stipulations of § 73 Paragraph 3 SSA and, taking account of the user’s income, the fee for accommodation and meals is set so that the user retains at least 15 % of the remainder of the income. Some homes account for the difference between the ideal fee (as set by the price list) and the actual fee paid as “arrears”. The Defender looked at the question of what impact this accounting “implication” of the lawful minimal remainder of the income has on the clients’ situation.

Homes are generally interested in what this difference amounts to every year, for example for negotiations with the founding body. They stated that “arrears” are not accounted for as clients’ personal debts. In one facility, however, it was found that “arrears” do play a role. Any refunds were credited to this arrears account. Also, if at some point in the future more than 15 % of a client’s income remains (for example after staying outside the facility for part of the month), the home requests the amortization of the “arrears” account (the money is deducted). The Defender does not agree with this on principle; he interprets the provisions of § 73 Paragraph 3 SSA as meaning that the 15% limit is definitive for each individual, and homes cannot retrospectively take account of past months.[134]

It is recommended that homes do not claim or accept money from users to reduce “arrears” or other similar accounts which express the difference between the ideal fee required and the actual “reduced” fee paid in previous months.

[133] On this topic see also Michalík, J.: Contractual Relations in Social Services, VCIZP, Olomouc 2008, NRZP, Praha 2008, pg. 78 and following

[134] For the Defender’s detailed legal reasoning, see The Public Defender of Rights’ Report on Visits to Social Services Facilities for Senior Citizens, August 2007, point 144, available on the internet: http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=780

Management of users' money

162. All the homes manage the money of either all or some of their clients, usually through social workers. The Defender would like to draw attention to the fact that if a home deems it suitable to manage money on behalf of a client, it must have the appropriate authorisation to do so. This authorisation may be included in the social service contract or a mandate contract may be concluded in accordance with the provisions of § 724 and following of the Civil Code. A power of attorney may also be used. This system was only used in some homes; in the others social workers, obviously ipso jure, managed clients' money deposited in the home. In better cases there were rules as to what could be purchased and whose consent was required.
It is recommended that clients' money only be managed with their explicit authorisation. It is recommended that written rules be drawn up covering the management of clients' finances.[135]

163. Clients in many facilities do not receive any form of account statement. If their pension is remitted through bulk a payroll list or transferred to the home's account, in many cases they are not informed of the balance of their deposit account, etc. The Defender sees this is a chance to boost clients' social autonomy and believes that clients, if they are assessed as being capable of understanding, should be given an account statement – this can serve to teach them and get them involved in managing their affairs. If clients do some work for the facility, not only should they get paid for it, but they should also regularly be given pay slips.
It is recommended that users be supported in developing their ability to manage money.

164. Clients' money is generally held in a deposit account or transferred to their savings book or a bank account set up specially for the purpose. Facilities should consider whether a specific account with a specific bank is the most suitable place to keep the client's money, considering the bank fees.[136] As there are now a number of schemes on the market, clients should be helped to find the most effective way of looking after their savings.
The Defender suggests that this be considered and discussed with clients.

Having money available

165. The Defender was interested in the question of whether users can have their own money on them (all of it or at least part of it – pocket money), and, if so, under what conditions and to what extent. Practices varied from home to home. In six of the facilities visited, clients do not get their hands on their money at all, not even those with legal capacity. The reason for this was generally that "it is better for the users, as they don't have to worry about it and won't lose their money", or that "guardians are not interested in whether their wards receive pocket money" and that "users do not know the value of money". This is also a form of insurance, as social workers frequently said

[135] Quality Standards No. 1 c) and No. 2
[136] For example in one facility all the users have an account and the monthly account administration fee is approximately 65 CZK. If a client had an income balance of 1000 CZK, the bank fees would be more than 5 % of this sum.

that courts allegedly insist on detailed statements of account "down to the last crown" and it is practically impossible to get all the receipts from clients.[137] Some homes also only issued money to clients for a specific purpose (spending money on a trip, to buy something).

The Defender, however, does not agree with this practice and considers this blanket approach to be unusual and generally detrimental, as it makes clients more dependent on the service they receive and goes against the need to boost their level of social autonomy. Ultimately every client, regardless of their ability to manage or play a part in managing their own finances, becomes completely dependent (yet this pocket money amounts to just tens or hundreds of crowns a month). Homes should avoid practices which result in clients having the impression that they "receive" they own money from the home (from "the social"), especially in the case of clients who have some understanding of the concept of money. Clients, especially fully competent clients, but all other clients too, should be motivated to learn how to manage their money. It is only when a client is unable to manage his or her own money that the facility should manage it for them.

It is recommended that clients be supported in how to manage their own money. It is recommended that so as to boost their social autonomy each client should be assessed individually as to their ability to manage or participate in the management of their financial affairs and that they should be paid pocket money. Training activities should include practice for clients in handling money.

166. As regards pocket money for clients who have been ordered into institutional care, prior to 1. 8. 2009 neither facilities nor founding bodies were obliged to pay pocket money. In some facilities it was provided as a sort of "social pocket money". The Defender draws attention to the fact that now the provisions of § 48 SSA explicitly state that "the specific needs of disabled people" are appropriately governed by the provisions of LIPES, including their entitlement to pocket money at a graded rate.

It is recommended that homes respect the applicable law.

167. Depositing cash – pocket money - with social workers (by pocket money ceases to be pocket money) is a practical problem, particularly at weekends, as direct care staff often do not have access to this money. At the weekend the situation is generally resolved by the staff buying things such as light refreshments and then charge it to the social worker. If a home deems it necessary that clients' "pocket money" be deposited, it should find a way of making this money accessible at weekends.

Good practice:

In *Domov Raspenava* each client is paid pocket money, and the clients manage this money together with their key member of staff depending on the clients' ability to look after their money themselves. Clients who have been deprived of legal capacity receive 50 CZK a week as pocket money. The facility also provided children with pocket

[137] Why is it necessary to account for every item an adult with his own income buys with his pocket money? The court obliges guardians to submit regular activity reports and to duly manage their wards' assets. Pocket money is a legitimate expense in itself. Guardians should present their plea to the court without having to provide receipts for every soft drink purchased.

money if their parents did not give them any, regardless of whether or not they had been ordered into institutional care. This gave them the chance to learn the value of small sums of money.

In *Domov u studánky* the mandate contract specifies how money is paid to the client, partly depending on the client's financial situation and the amount of money on the account, and also based on the client's ability to manage that sum of money as described in the client's individual plan. It was found that clients who were able to do so (including clients deprived of legal capacity) regularly receive a certain amount of pocket money which they can use as they need and which enables them to learn to manage money.

In *Domov na zámku Bystré* every month clients are paid 200 CZK in pocket money and do not need to show receipts for purchases made with this money. Purchases costing more than 200 CZK must be accompanied by a proper receipt signed either by the client or by the member of staff who purchased the item.

Shopping

168. Another problem is clients' involvement in decisions concerning purchases using their money which is not pocket money. Generally these are purchases are for clothes, shoes, CD players, CDs or videos, holidays, but they can also be for medicaments or better-quality aids. Not all homes specify which member of staff is involved in this process or what the actual procedure is. Or, for that matter, what influence the client's wishes have in such decisions. Sometimes it is merely at the discretion of the social workers; in other cases the social workers discuss the matter with key members of staff, while elsewhere it is the management that decides. There is too much room for these considerations/decisions, which is wrong as there is the potential for arbitrary decisions or decisions based on what the staff want, rather than what the client wants. (No cases of theft were found anywhere.) Users should be shown how to recognise when to buy something and when not to.[138]

It is recommended that homes include shopping in their rules and get clients involved in handling their money.

Basic versus facultative services

169. In homes for the disabled, like in facilities for senior citizens, the Defender also found that there were problems relating to charges for facultative services. Facultative services include labelling clothes, shaving, shopping for groceries, goods from the chemist's or clothes, picking up prescriptions and medication, accompanying clients to the doctor or driving them somewhere, and managing their money.

The Defender draws attention to the fact that the management of money or assets, obtaining medication or the purchase of normal items can be classed under the general term of "assistance in tending to personal matters", and so charging for such services in addition to contributions towards care is against the law. Likewise, the same approach must be taken with all tasks that can to some extent be classed as "personal care

[138] "Good practice in the provision of social services includes allowing these people to learn to manage their money and make minor purchases as part of their social rehabilitation under the supervision of assistants." Quality Standards in Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 33;
http://www.mpsv.cz/files/clanky/5966/4_vykladovy_sbornik.pdf

routines" (shaving). Therefore, a client who pays a contribution towards his or her care is entitled to the free provision of services defined by the law as basic, to the extent to which the client is dependent on the care provided (or to the extent agreed in the contract).[139] If a specific client pays a contribution towards his or her care owing to a disability which prevents the client from managing his or her money without assistance, buying things, or shaving, for example, this client should receive support as part of the basic service without any additional fees being charged. If, however, the client is able to manage these things unassisted, then he or she should be permitted to do so and not be burdened by excessive care. If, for whatever reason, the client insists on receiving these services, the Defender sees no reason why such services should not be contracted as facultative.

It is recommended that no charge be made for tasks which can be classed by law as basic services and which a particular client would be unable to perform without the assistance of another person.

170. Opinions differ widely on charges for electricity as a facultative service, as neither the SSA nor Regulation No. 505/2006 Coll. cover payments for electricity, unlike cleaning and laundry. The Defender has long been of the opinion[140] that as accommodation fees are nowadays understood to include lighting and heating, they should also include power for standard appliances. Some facilities, however, charge clients from 5 CZK to 15 CZK a month for using their own electrical appliances, as a "contribution towards energy costs". By standard appliances the Defender also means radios and televisions. Here too, there is scope for consideration.

Facilities should consider whether certain facultative services do not just lead to additional unprofitable administration (inspection charges of 2 CZK per appliance, monthly fee for charging a wheelchair 5 to 10 CZK per month).

171. Facilities should seriously think what they can do to improve the quality of their clients' lives when they know that a particular client is relatively wealthy. In several cases it was found that some clients possessed hundreds of thousands of crowns.[141] If a home is to defend the interests of its clients, it should ask how this money can be used to improve the quality of their lives (by providing a personal assistant, physiotherapist, better-quality aids, etc.). Obviously in such cases it is essential to work with a guardian, whether it is a member of the client's family or the municipal authority. If any conflict of interests arises between the client and the guardian, the case should be taken to the guardianship court.

Refunds

[139] All clients are entitled to receive care to the extent necessary to allow them to retain their human dignity (according to the provisions of § 2 Paragraph 2 SSA).

[140] See, for example, point 164 of the Public Defender of Rights' Report on Visits to Social Services Facilities for Senior Citizens, available on the internet at http://www.ochrance.cz/dokumenty/dokument.php?back=/cinnost/ochrana.php&doc=780

[141] The Defender merely points out that a client who has been deprived of legal capacity cannot make a will, therefore all that person's assets pass to his or her family, even though they might not show the slightest interest in the client. It is absurd that a person who has money and who would benefit from personal assistance due to disability has to spend his life as one of a group of clients in a short-staffed ward just because his own money is not used. In a case like this, it is certainly desirable that this client be able to benefit from his money.

172. In relation to the stipulations of § 91 Paragraph 2 e) SSA, which states that contracts for the provision of a social service must define the fee and the means of paying the fee,[142] in the Defender's opinion it is essential that contracts also cover the issue of excess payments for unused services, i.e. refunds. The parties mutual rights and obligations may be defined either in the contract itself or in an internal rule to which the contract explicitly refers. If the service is paid for in the form of deposits, there must be a system for refunding part of these payments, where applicable. Or, if a service is paid for after the fact, facilities should not charge for a service which has not been provided. If the cost of residential services includes payment for accommodation, meals and care, the refunds system should take account of these three payments.

The practice varied in the facilities visited. Only some of the contracts studied dealt with the issue of excess payments. Although the Defender sees that in the case of social services there is a contractual principle in place which is governed by contractual liberty, facilities are recommended to add refund clauses to their contracts. The Defender not only considers that this would ensure greater legal certainty on the part of both contractual parties, but also draws attention to the fact that the rules on refunds relate to users' liberty to spend some time outside the facilities. If some money is not refunded to a user, that person can then not afford to take a short break away from the home.

It is recommended that contracts for the provision of social services include rules covering refunds for unused services.

173. All the facilities provide an "all-day" refund for meals if a user is away, having first notified the facility; this refund consists of the cost of the food for that day. The amount of time in advance that users have to inform the facilities of their planned absence should be reasonable, for example 24 hours taking account of the conditions within the facility; some facilities require a 24-hour notice period. The Defender believes that by facilities should also refund the cost of the food for individual meals that are not taken, which some facilities do. With respect to the principle of autonomy the Defender believes that refunds for individual untaken meals should not be conditional on the user leaving the facility; this would allow clients to choose an alternative way of taking their meals. The Defender has no objections to the practice by which clients who will be absent for a particular meal are offered the choice between a refund or a food package; however, facilities should not just offer the food package without giving the client the chance to choose. Some facilities, in addition to the cost of the food, also refund overhead costs, e.g. 20 % or 50 % of the overheads, and the Defender recommends that other facilities consider adopting this system.

Good practice *from Domov Raspenava:*
It was found that in this home it was standard practice that clients could cancel individual meals without having to be absent from the home. The system of payments is

[142] "The contract contains the following details: (…) fee for social service as agreed within the framework of the fee stipulated by § 73 to 77 and the means of paying this fee (…)."

set up to ensure that clients practising independent household skills do not pay any more for self-catering in the home's kitchenette.
Good practice *from Ústav sociální péče pro mládež Kvasiny:*
The home provides clients with refunds for individual meals at the rate of 100 % of the value of the food and 50 % of the overhead costs for each different type of meal.

It is recommended that facilities provide refunds for individual untaken meals (after prior notification).

174. In the majority of the facilities no refund is provided for accommodation in cases where clients give prior notification that they will be away from the facility for more than 24 hours. In exceptional cases, for example, 20 % or 30 % of the cost of the accommodation is refunded. The Defender recommends that facilities consider paying refunds for accommodation.[143]

175. The refunds system should also cover contributions towards care. Contributions are provided to people who are dependent on the assistance of others, in this case to social service users, to secure them the necessary assistance. Recipients of contributions are always a beneficiary, or a legal representative or physical entity who has been put in charge of an underage beneficiary. Users of residential services who are the recipients of contributions, or the legal representatives of such users, pay the facility a fee for an agreed amount of care (§ 73 Paragraph 1 SSA) at the amount of the contribution (§ 73 Paragraph 4 a/ SSA). If a user is away, having notified the facility beforehand, the necessary assistance (or the "agreed amount of care") is not provided, so users cannot be asked to pay the full amount of their contribution towards the care. A proportion of the contribution equivalent to the amount of time the user spent away from the facility should be refunded to the user or the user's legal representative to allow them to secure the assistance they need when away from the facility.
The Defender also found that some facilities refunded users a proportionate part of the contribution, but not in full, for example 50 % or 80 %. The Defender does not agree with this practice and insists that the proportionate part of the contribution towards care should be paid in full. Of course, facilities may contractually limit the amount of time users voluntarily spend away from the home during the course of the year (it was found, for example, that some facilities limit this to a maximum of 90 days).
It is recommended that in cases where users inform the facility in advance that they will be away, they should be refunded the proportionate part of the contribution towards care.

j) Legal capacity, guardianship and the legal status of children

Legal capacity

176. Legal capacity should be a working legal instrument, as assumed by the Civil Code[144] (although in practice the situation tends to be different). In cases where a good

[143] Michalík, J.: Contractual Relations in Social Services, VCIZP, Olomouc 2008, NRZP, Praha 2008, p. 104
[144] According to the provisions of § 10 courts change or annul the full or partial deprivation of legal capacity if the reasons which justified the initial full or partial deprivation of legal capacity change or are no longer applicable. Obviously disabilities do not just disappear, but with an individual approach clients do develop and can become "more

social service provider sees that there is a fundamental difference between a client's competence as determined by a court and actual competence, that provider should take active steps to help return at least part of the client's true competence. The Defender has also come across the attitude that it is better to provide more "protection" for disabled people. Restricting competence more than is strictly necessary with regard to a person's mental disability is, however, seriously detrimental. Under the current legal system, deprivation of legal capacity means, for example, that a person is unable to legally buy anything.[145] The right degree of legal capacity is related to the potential for ensuring that clients are able to play a part in normal life.

Good practice was seen in a number of facilities, where it was evident that many social workers or directors take an active interest in this matter.

Good practice:
Jedličkův ústav in Liberec employs a very good practice, as the home plays an active role together with the family in finding the optimum balance as regards legal capacity. In *DZOP Litvínov-Janov*, if a client's guardian fails to meet his or her commitments in a responsible manner (e.g. keeps the client's pocket money), the social workers immediately inform the court of the situation.
Several homes, for example *Háj u Duchcova* and *Rychnov nad Kněžnou*, help clients in appealing to the court to have some degree of their legal capacity restored.

It is recommended that homes make a critical assessment of their adult clients' legal capacity and take active steps to assist them in restoring their legal capacity (or changing their status from being deprived of legal capacity to being merely limited in their legal capacity), wherever applicable.

177. With respect to the restoration of clients' legal capacity the Defender considers it essential to draw attention to the latest breakthrough Constitutional Court ruling (File Ref. No. I. US 557/09) relating to people who have been deprived of legal capacity. Constitutional Court supported a woman after the courts had refused to restore her legal capacity, despite the fact that she only suffered a very mild mental disorder and was able to leave a full and normal life in society. The Constitutional Court particularly criticised the formalistic appraisals made by the court-appointed experts and the court's inability to consider all the evidence and the circumstances of the case in question. As the Defender considers this ruling to be a major step forward in the judicature of the courts and believes that it will affect the decision-making process of lesser degree

able". If a client is deprived of legal capacity, it can happen that he or she later "matures" into a situation which merits mere restrictions on his or her legal capacity. Homes should be able to react to these cases and propose that clients' status be changed.

[145] It is very important for non-lawyers who look after disabled people understand what the restriction means, what actions it covers, and who has what obligations and authority. For general information see, for example, Quality Standards in Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 49 and following;
http://www.mpsv.cz/files/clanky/5966/4_vykladovy_sbornik.pdf; Also, when filing an application for the restoration of at least some degree of legal capacity, it is possible to refer, for example, to the Czech Constitutional Court ruling II. ÚS 2630/07, dated 13 December 2007, where the subject of the constitutional complaint was that the claimant did not agree with the procedure adopted by the general courts, which repeatedly ruled to reject her application for the restoration of her legal capacity.

courts in similar proceedings, he would like to present an excerpt from the justification of the ruling.

Constitutional Court ruling I. US 557/09[146]

It is recommended that people applying for the restoration or reassessment of legal capacity point out the ruling of the Constitutional Court, or at least make reference to its verdict.

In its ruling the Constitutional Court stated, amongst other things, (as in previous rulings): *"The state and all its bodies are constitutionally obliged to protect and preserve the rights of the individual. In this our constitutionality is not limited to the mere protection of people's basic rights (such as their right to life, guaranteed legal subjectivity), but in compliance with the post-war shift in attitudes towards human rights (as expressed, for example, in the UN Charter or in the General Declaration of Human Rights) has become the basis on which all human dignity and fundamental human rights are interpreted, which forbids, amongst other things, the treatment of a person as a thing or an object. In this sense matters of human dignity are understood to be part of a person's qualities, an aspect of their humanity. Guaranteeing the inviolability of a person's human dignity allows them to fully enjoy their personality."*

The Constitutional Court considers the civil status of the free individual and the guarantee that such a person has the right to exercise this status as extremely important constitutional values which are a crucial aspect of constitutional order. The Constitutional Court has a duty to protect these aspects of a person's dignity – see ruling File Ref. No. IV. ÚS 412/04. This ruling stated, amongst other things: *"The concept of human dignity as described above needs to be projected into the sphere of legal competence and has strong implications as regards legal capacity as it is through a person's legal capacity and procedural competence that their legal subjectivity is constitutionally guaranteed."*

In its ruling I. US 557/09 the Constitutional Court particularly referred to two important principles for the appraisal of proposals to deprive a person of their legal capacity. Firstly, it regards it essential to always consider whether interfering with a person's fundamental rights in order to protect another important value is unavoidable. *"The fact that a person suffers from a mental disorder (…) does not in itself constitute grounds for restricting that person's legal capacity (…) but it must always be specified who or what jeopardizes the full legal capacity (…) of the person so restricted."*

The second principle highlighted by the Constitutional Court in its ruling is the need to *"consider all less drastic alternatives (…) which could still achieve the aim of protecting specific competing rights or public interests educible from constitutional order, while restricting legal capacity must always be considered an extreme measure."* This principle is rounded off by the fact that for many years now discussions have been under way at the international level to find other ways of helping people whose problems are resolved merely by restricting their legal capacity. One good way is an alternative to guardianship, where an advisor provides a disabled person with assistance and makes decisions with him, not instead of him. It must be emphasised that people who are unable to decide for themselves are extreme and minority cases.

[146] Constitutional Court ruling – File Ref. No. I. US 557/09 http://www.concourt.cz/scripts/detail.php?id=741

Likewise, the CRPD, which came into effect in the Czech Republic at the end of 2009, states that people with impaired ability to make decisions have the right to autonomy, the right to make their own decisions as far as they are able, and to take the appropriate consequences. It is assumed that the ratification of the treaty will enforce more fundamental changes to the current laws (also promised by the upcoming wording of the new Civil Code).

Guardianship

178. The Civil Code states that: "If a relative or other person who complies with the conditions of guardianship cannot be appointed guardian, the court will appoint as guardian the local government or a local government facility, provided that it is authorised to act on the local government's behalf."[147]

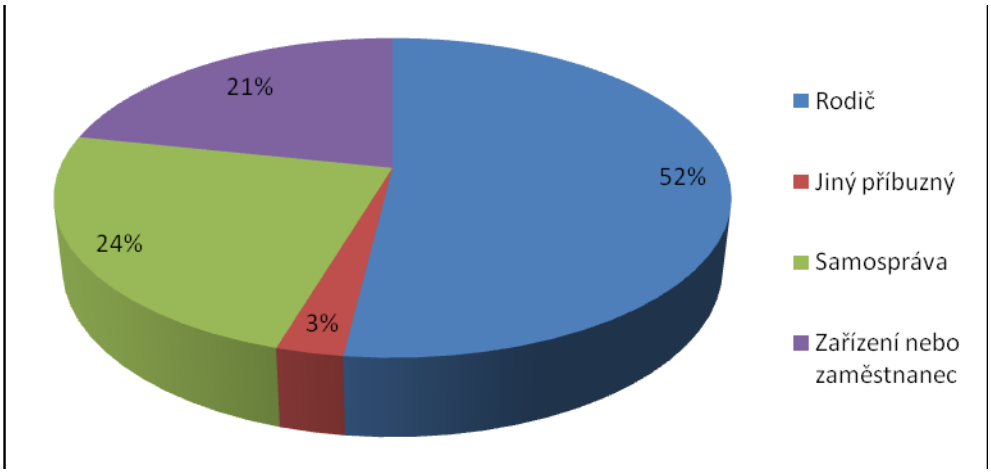
179. This implies that the court appoints a local government body as guardian without determining that body's stance on the matter or acquiring its consent. Guardianship is the exercising of the independent authority of the municipality. If a municipal authority is to act as guardian, the appropriate conditions for this specialised role should be created. The issue of public guardians is related to this.

However, no adequate network of qualified and available public guardians has ever been set up in the Czech Republic. In many cases those appointed as public guardians have no experience of guardianship, nor do they understand what the role of guardian involves or the specific needs of the various groups of people with mental disorders (mental disabilities, mental illnesses, various types of dementia, senior citizens, conditions resulting from injuries, etc.). The result of this is that such people either refuse the guardianship or merely carry out the role formally and attempt to avoid mistakes due to their lack of knowledge and experience. Inadequate and poor representation restricts the rights of the person who is represented. Social services providers are then forced to deal with problems similar those posed by poor guardianship on the part of users' relatives. Due to the lack of suitable guardians, the role of guardian is often passed on to social services providers (former social care institutions, their directors of employees).[148]

180. Information about the legal representatives of clients under the age of 26 is given in the following graph.

[147] The provisions of § 27 Paragraph 3 of Law No. 40/1964 Coll., of the Civil Code, as subsequently amended

[148] Kořínková D., Protecting the Rights and Integration of Users of Social Services Institutions and Associated Restrictions, p. 3 http://www.kvalitavpraxi.cz/res/data/001/000249.pdf



- Parent
- Other relative
- Local government
- Facility or employee

Legal action and cases of guardians exceeding their authority

181. During the visits it was found that there was ambiguity and poor understanding of the term "legal action"[149], which is a key factor in considering the role of the guardian. A number of articles[150] have been published on this topic, especially with the aim of freeing disabled people from the excessively broad perception of the concept of guardianship, which ends up giving them less chance to make decisions for themselves. What is certain is that a guardian is not a parent who the ward should honour and respect,[151] and the guardian's rights and obligations are not the same as those inherent in parental responsibility,[152] but are defined, often much more narrowly, on the basis of a court resolution.

The Defender focused on the status of people deprived of legal capacity in the facilities, or what approach providers take to such people. The rules of social services facilities are often ambiguous on the matter of whether the relationship between the guardian and the ward are perceived correctly. Examples include whether the ward should have his or her own personal property, consume alcohol, accept or refuse food, go for outings or events outside the home, or have a life in a partner relationship. These examples are not legal acts but are the execution of the client's rights. If the client is an adult, it is not the legal representative's business to decide on

[149] The provisions of § 34 of the Civil Code state: "A legal act is an expression of will leading primarily to the establishment, amendment or forfeiture of the rights and obligations related to this expression of will as defined by the law."
[150] E.g. Quality Standards in Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 54 and following
[151] "Children are obliged to honour and respect their parents." The provisions of § 35 of the Families Act.
[152] "Parental responsibility is the aggregate of the rights and obligations relating to (a) caring for an underage child, particularly looking after that child's health and his or her emotional physical, emotional, intellectual and moral development, (b) representing an underage child, (c) administering that child's assets." The provisions of § 31 Paragraph 1 of the Families Act.

these matters; the legal representative should only be involved in matters relating to legal acts.

Conflicts of interests

182. Common and ubiquitous conflicts of interests are situations where a client's guardian is the home, or an employee of the home (the director, a social worker, or even a technician). This kind of setup can be beneficial in the sense that the staff of the home have special knowledge of the problems relating to the lives and rights of people with mental disabilities and are very well acquainted with "their" clients' situation (and, importantly, are much more accessible that an official or distant family). However, the situation is not a good one as there is a constant conflict of interests between the client and the service provider, which is also the client's guardian.[153] Some homes have dealt with this by appointing a guardian ad litem for certain acts (e.g. signing the social services contract), which at least temporarily avoids the most serious conflicts of interests.

It is recommended that situations where the staff of homes act as the guardians of their client should be incorporated into an internal regulation relating to conflicts of interests and the potential violation of clients' rights. Homes should surrender the guardianship of their clients as soon as possible as such guardianship represents a permanent conflict of interests.

183. It is also a conflict of interests where an employee of a home is granted general power of attorney by a court-appointed guardian (town office) to represent a ward in all forms of legal action, with the exception of concluding a social services contract (explicitly e.g. management of that person's assets). This is a violation of the provisions of § 88 c) SSA. In this specific case it was not found that there were any means of regulating the actions of the home employee (internal rule, inspection, co-determination, consultation). It would be admissible if the employee of the home accepted power of attorney to represent the ward only in certain legal acts necessary for day-to-day life; these steps would have to be clearly assigned and managed by the guardian and checked. With reference to careful analysis of the situation[154] **the Defender recommends that in such cases facilities or their members of staff work with the public guardian to modify their sphere of authority in accordance with the above statement.**

Courts

184. Decisions concerning legal capacity, the restriction, deprivation or restoration of legal capacity and matters relating to guardianship are the responsibility of the District Courts. During his visits the Defender noted the courts' approach to certain matters relating to the status of clients. The Defender presents his findings below; in most cases these are nothing new, as similar malpractices can obviously be found in court proceedings involving people living outside facilities.

[153] Quality Standards in Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pp. 54 and 55.

[154] Quality Standards in Social Services, Interpretative Proceedings for Providers, Ministry of Employment and Social Affairs 2008, pg. 54, http://www.mpsv.cz/files/clanky/5966/4_vykladovy_sbornik.pdf;

In one case it was found that no guardian had been appointed for a client deprived of legal capacity. In several other cases the courts took a long time changing guardians, sometimes more than a year. Although the court is not bound by law to provide a guardian for a person deprived of legal capacity within a certain length of time, it must not be idle and must make its decision within a reasonable period of time.[155] With regard to Constitutional Court ruling File Ref. No.: IV. ÚS 412/04, dated December 7 2005, this practice can be considered as unconstitutional: "*Article 5 of the Charter states that every person is competent to have rights, which obliges general courts involved in guardianship proceedings not to issue rulings restricting legal capacity before appointing a person through whom the person restricted in their legal capacity may continue to exercise their rights*." The new Civil Code responds to this shortcoming by obliging courts to appoint a guardian as part of the process of deciding on legal competence.

Delays in court proceedings

If a court procrastinates in its ruling, or is completely inactive, this can constitute a delay in court proceedings. In such a case, if a client's interests or rights are at risk, homes must help their clients to file a complaint with the Chief Justice of the court in question (not the presiding judge). The complaint should be investigated within one month of its receipt by the court and the client should be informed of the result of this investigation.[156] It can happen that the Chief Justice of the court does not oblige or pursue the complaint, or the home may be in some way dissatisfied with how it is handled. In such a case the client, with the support of the home, may contact the Public Defender of Rights, who is authorised to investigate the court procedure and, if any discrepancies are found, order the court to take remedial measures.

In addition to the complaint procedure described above, the party may also file a proposal to set a deadline for a particular procedure in which proceedings are delayed. It is not necessary for the party to have filed a prior complaint concerning the delay in the proceedings. This proposal is filed with the court whose proceedings are delayed. The proposal must make it clear who the proposal is filed by, for which case, what specific procedure it concerns (e.g. the scheduling of a hearing), what aspects of the proceedings the party believes are delayed, and what remedial measures are requested. The court against which the complaint is filed must, within 5 working days of receiving the proposal to set the deadline, present a statement to the superior court so that the superior court can decide on the matter without convening a hearing within 20 working days of the date on which the case was filed or the date on which the case was duly amended. The court may, however, respond to such a proposal by going ahead with all the procedures which are allegedly delayed, within 30 days of receiving the proposal. In such a case the proposal is dropped (with the exception of situations where

[155] What is classed as a reasonable period of time for court proceedings depends on the specific circumstances of the case. In accordance with the practice of the European Court of Human Rights in Strasbourg the main decisive criteria are as follows: the complexity of the case (volume of paperwork, the need for witness statements and expert appraisals, external elements, etc.), the conduct of the parties to the proceedings (failure to attend sessions, avoidance of service, abuse of appeals and procedural proposals), the actions of the court (inactivity, ineffective organisation and coordination of work) and the significance of the subject of the dispute to the claimant.

[156] The court investigates whether the case has actually been delayed and, if so, adopts remedial measures and informs the claimant of such.

the party who filed the proposal, within 3 days of learning that the procedures have gone ahead, explicitly states that the proposal should remain in force).

It is necessary to consider that for such a proposal to be dealt with, the court against whom the complaint has been filed is obliged to send the superior court the appropriate complaint and procedural file. Therefore, despite the relatively short deadline, it is worth considering whether this procedure may actually be beneficial in the case in question (or whether, paradoxically, it will prolong the proceedings even further).

As homes are obliged to support and assist their clients in exercising their rights and legitimate interests and in tending to their personal affairs, facilities should keep these means of preventing judicial delays in mind, as such delays can be damaging to clients.

Underage clients in homes

185. First of all it is necessary to say once again that a person becomes of legal capacity when they reach 18 years of age (overlooking the fact that it may be acquired earlier through marriage, with the approval of the court). Nevertheless become competent gradually. Unlike people deprived of legal capacity, minors are, according to the Civil Code, deemed capable of taking legal action commensurate to their age. Until a child comes of age, that child's legal representatives are its parents, who bear parental responsibility – this is the sum total of the rights and also the obligations inherent in caring for an underage child.

It is important to draw attention to the right of a child who is able to formulate his or her own opinions to freely express these opinions on all matters affecting the child, while the child's opinions must be given the appropriate amount of attention commensurate to that child's age and status. A similar stipulation can be found in the Convention on Biomedicine, which states that the opinion of a minor "… *should be considered a decisive factor, the weight of which increases proportionately to the child's age and level of maturity.*"

Children ordered into institutional care

186. The facilities visited contained 140 children who have been ordered into institutional care and 3 children placed in homes on the basis of preliminary measures. From our visits it was apparent that in the great majority of cases the children had been placed into care due to a mental disorder, frequently complicated by an associated physical disability. Children come to homes from nursing institutions,[157] from children's homes for children aged between one and three[158], or from their families, where the legal representatives are unable or unwilling to take on the demanding work of caring for a mentally handicapped child. Unfortunately there are also cases where children are neglected or even abused.

[157] The provisions of § 38 of Law No. 20/1966 Coll., of the Public Healthcare Act, as subsequently amended, state that therapeutic preventive care facilities include nursing institutions, children's homes and crèches which provide all-round developmental care for children under the age of three.

[158] It does happen that mentally disabled children over the age of three are placed in children's homes for children aged between one and three if not suitable home for the disabled can be found for them.

187. The Defender was interested to know what chances these children had of being placed into foster care. He therefore approached the Ministry of Employment and Social Affairs[159] and regional authorities requesting that they provide data on the number of children in homes for the disabled who are listed as being suitable for foster care.

The foster care records of the Regional Authority of Moravia and Silesia do not contain any such children; there is 1 child in the mediation records. The records of the Olomouc Regional Authority do not contain any children, nor do those of the Regional Authority of South Moravia. The Ústí region has 3 children in its foster care records, the Liberec Regional Authority has 5 children, the Pardubice Regional Authority lists 7 children, the Regional Authority of South Bohemia lists 3 children, the records of the Zlín Regional Authority contain 3 children, Vysočina 1 child, the Regional Authority of Central Bohemia lists 22 children, while the Capital City of Prague has 5 children in its foster care records. The Regional Authority of Hradec Králové currently has not children on its books. The records of the Ministry of Employment and Social Affairs list 40 who are suitable for foster care.

Regional authorities agree that it is very difficult to find a foster family for a child with mental disabilities. If such a child is listed in foster care records, most of the time it is for foster care, not adoption.

It is also rare to find cases of host care, where children go to visit or stay with a family for the weekend, holidays, etc. These visits allow children who for some reason are not registered for foster care (these are mostly older children, children who are not legally free and maintain contact with their biological parents) to make new friends and experience family life.[160]

Parents as the legal representatives of underage clients

188. In the case of many of the children living in homes, their parents have long shown no interest in them, are of no fixed abode, do not pay care fees (for children ordered into institutional care), etc.; the Defender believes it is necessary to draw attention to the discharge of parental responsibility.

There are situations where a home needs the consent of a child's legal representative, even though that person has not been seen for years and nobody knows where he or she lives. Such situations include, for example, consent to hospitalisation, to an operation, for registration with a school, for obtaining a passport, etc. In one case, in the absence of any legal representative, a facility tried to compensate by obtaining the director's consent for the client to be hospitalised. The Defender warns against such a step, however understandable it might be. The director acted beyond the scope of the law and exceeded his authority.

One option is obviously to request that the court provide a guardian ad hoc. If, however, it is evident that this will not change the situation and lead the parents to start meeting their commitments, either the home itself or the appropriate child protection body at the home's request should take the matter to court to request that the parents

[159] According to the provisions of § 22 Paragraph 8 of Law No. 359/1999 Coll., on the social and legal protection of children, as subsequently amended, children are listed with the Ministry of Employment and Social Affairs if the regional authority does not arrange for adoption or foster care within three months of registering the child.
[160] Proceedings of the Public Defender of Rights, Family and Child, pg. 86;
http://www.ochrance.cz/documents/doc1197532465.pdf

be deprived of their parental responsibility. The child is then appointed a trustee, who may be another relative, a child protection body, or another person. It should be noted here that this could result in a conflict of interests if the trustee is, for example, the director or a member of staff of the facility.

Conflict of interests between parents and children

189. The Defender draws attention to the fact that conflicts of interests can arise between the parents of an underage child and the child itself. Parents can harm their children through their actions or lack of action – they fail to deal with official matters, refuse to allow the child to go to school, etc. Homes should pick up on these situations and defend the interests of their clients. Homes can of course first try to persuade the parents together with a child protection body. However, even in these cases the court may appoint a guardian ad hoc (the provisions of § 83 of the Families Act). Depending on the specifics of the situation, a proposal can also be filed to have the parents deprived of their parental responsibilities (see above).

Cooperation with the parents of underage children

190. Cooperation with the parents of clients varies greatly depending on their level of interest in the child, which is generally very low. If staff receive conflicting instructions from parents (e.g. those who are divorced or in the process of getting divorced), they should take the matter to court to have the situation addressed; in practical terms, what the client wants should be considered in the interim. The Defender draws attention to the fact that there are essentially three situations that could arise (assuming that neither parent has been deprived of or restricted in their parental responsibility or forbidden from contacting the child):

- Parents are not in the course of divorce proceedings (both share the same status);
- Parents are in the course of divorce proceedings, although their contact with the child has not yet changed (both still have the same status);
- Parents are in the course of divorce proceedings and an agreement has been reached and approved or a ruling has been issued on their situation prior to and after the divorce; however, the parents do not respect this ruling.

It is recommended that if parents are unable to reach an agreement concerning their child, a child protection body should be informed without delay.[161]

Collaboration with bodies involved in the social and legal protection of children

191. According to the staff in the great majority of facilities visited, children who have been ordered into institutional care are visited every three months by a social worker from a child protection body, as stipulated by SLPC. According to the staff this collaboration is beneficial and the social worker takes an active interest in the clients.

It is recommended that homes actively collaborate with the appropriate child protection body and, if these three-monthly visits are not kept up, the head of the child protection office should be informed immediately.

[161] Further information is also available from the Public Defender of Rights' Collected Volume on the Family and Child, available on the internethttp://www.ochrance.cz/documents/doc1197532465.pdf

192. If a child been ordered into institutional care, there are certain rules for when they are outside the facility. If a child who has been ordered into institutional care or placed in a home on the basis of preliminary measures is to leave the facility for no longer than 14 days (holidays or weekends with parents, visits to friends, etc.), the prior consent of the relevant child protection body is required.[162] This 14-day period may be extended with the written consent of this body. The child protection body or the director of the facility refuse to allow the child to stay with his or her parents or other people if such a stay is not in the child's interests, or if the family environment in which the child is to stay is inappropriate for the child. The director may only forbid such visits in exceptional situations where there is a real risk that the child's stay with the family poses a real risk to that child's upbringing. If a child had been placed in a facility at the request of the parents or other legal representatives, the child may only stay with other people with the prior written consent of the parents or other legal representatives, provided that there are no serious factors preventing the acquisition of this consent. Directorial decisions concerning the granting or refusal of permission to stay outside the facility are governed by the administrative rules of procedure.[163]

193. Another area in which homes and bodies involved in the social and legal protection of children must work together involves situations envisaged by the provisions of § 10 SLPC. According to Paragraph 4 of these provisions, state bodies, agents, schools, school facilities, and medical facilities and all other facilities for children are obliged to inform the municipal office of a municipality with extended powers of any facts which imply that the child is one of the cases specified in § 6 Paragraph 1,[164] without undue delay after learning of such a fact.

k) Complaints

[162] The provisions of § 30 SLPC
[163] The provisions of § 24 Paragraph 3 together with the provisions of § 36 LIPES
[164] According to the provisions of § 6 Paragraph 1, social and legal protection should focus primarily on children
a) whose parents
1. are deceased,
2. do not comply with their parental obligations, or
3. abuse or do not exercise their rights granted by their parental obligations;
b) who have been placed into the care of a person other than the child's parents, if such a person fails to comply with their obligations concerning the child in their care;
c) who lead an idle or immoral lifestyle, particularly by neglecting to attend school, not working, even though they do not have sufficient funds to live on, consuming alcohol or other addictive substances, making a living through prostitution, committing crimes or, in the case of children under the age of fifteen, committing an act which would otherwise constitute a crime, repeatedly or systematically committing misdemeanours or otherwise posing a threat to civil coexistence;
d) who repeatedly run away from their parents or other persons responsible for their upbringing;
e) against whom a crime has been committed which endangers their life, health, liberty, human dignity, moral development or property, or where there is the suspicion that such a crime has been committed;
f) who are, at the request of their parents or other persons responsible for their upbringing, repeatedly placed in a facility which provides constant care for children or who are placed in such a facility for more than 6 months;
g) who are at risk as a result of violence between their parents or other persons responsible for their upbringing, or violence between other persons;
h) who are asylum-seekers separated from their parents or from other persons responsible for their upbringing;
where such a situation persists for such a time or is of such severity as to have an adverse effect on the child's development or could be the cause of the child's adverse development.

194. The right to file complaints, suggestions and comments is the indispensable right of clients in homes as granted by the provisions of § 88 e) SSA, as well as by Quality Standard No. 7. It should also serve as an indicator of the quality of social services allowing providers themselves certain room for reflection (Quality Standard No. 15 d). None of the homes visited were found to deny this right, although it was found that several fail to comply with all the requirements stipulated by Quality Standard No. 7.

All the facilities visited had set up basic mechanisms to allow clients to file complaints; in one of the facilities the complaint procedure was unclear. In a number of the facilities staff are willing to offer advice about complaints using alternative means of communication, such as pictograms.

Good practice:
In some facilities, for example in *Domov na zámku Bystré*, clients are regularly taught how complaints can be made.

195. The complaints filing process should not be hampered by formalities and the rules covering the filing of complaints should be as simple as possible. For example, one facility has a good system where each member of staff is obliged to transcribe and place in the mailbox any verbal complaints made by clients who are unable to file them in person. This mailbox should be clearly labelled and in a place that is easily accessible but not too busy, so that complaints can be posted when there are no other clients around.

An anonymous complaint should not be rejected, as such complaints may be fully justified; these should be treated as suggestions for improvement. A response may be issued to an anonymous complaint, where appropriate, for example by posting a response in the ward or by discussing the matter in sit-down sessions with clients.

Complaints by severely disabled people

196. Severely disabled clients are unable to file a formal complaint. However, they can express satisfaction or displeasure. It is the duty of a good service provider to pay attention to these signs, as long-term systematic observation can show what activities or events make a client feel content or discontent (this practice was found, for example, in Ústav sociální péče pro mládež Jeseník). Ideally, a special tailor-made “complaint process” would be prepared for each severely disabled client as part of individual planning, which would be conveyed using an alternative form of communication. It should be a rule that any display of displeasure should be seen as a comment on the current perception of the needs of a severely disabled client and this should be taken into account when providing care.

It is recommended that displays of negative emotion by severely disabled clients should be treated as an indicator of dissatisfaction and utilized in the course of individual planning.

IV. Concluding recommendations

197. The above recommendations are addressed to all homes for the disabled (not just the ones visited by the Defender). Obviously, the implementation of some of these recommendations requires close collaboration with founding bodies.

Founding bodies and regional and municipal local governments

198. Founding bodies are strongly recommended to respond actively to requests by services they have set up concerning the provision of extra staffing so that clients with specific needs do not have to be hospitalised for long periods in psychiatric clinics and so they may continue to receive a social service which caters to their individuality and needs (see points 111, 113, 115, 116). In this respect the Defender states that if a client is hospitalised in a psychiatric clinic and often faces huge restrictions merely due to the lack of staff in the social services facility where the client previously resided, it is not just the psychiatric clinic that is responsible for such a situation, not being designed to provide long-term accommodation for mentally handicapped people. The primary responsibility is borne by the founding bodies which allow and overlook this mistreatment on the grounds of "lack of money". The conditions which mentally handicapped people live in in clinics were described by the Defender a year ago in his Report on Visits to Psychiatric Clinics (see point 118).

199. The follow-up visits made to psychiatric clinics have shown that all the regional local governments, with the exception of two, have not responded as specifically as expected to the findings and recommendations the Defender formulated in his summary report on visits to psychiatric clinics. In this summary report the Defender stated that the poor situation of patients who require both medical care and the care of social services is a very topical problem as regards both senior citizens and younger patients, where there is a lack of residential and field social services staff who are able to adequately respond to their mental state and specific social needs. The Defender emphasised that there is a real need for such staff now, and therefore this situation must be resolved immediately. It is necessary to support the establishment of these kinds of services for clients with specific needs. To be more specific – general goals must be set as regards the needs of the region in question. The Defender assumed that regions responsible for community planning have little contact with psychiatric clinics, which often contain departments for mentally handicapped people or where mentally handicapped people are housed in wards where there is no peace and quiet, to determine the number of patients who are able to be transferred to social services and which social services they could move to. Unfortunately, with the exception of two regions, this was not the case. In fact, just the opposite. During his follow-up visits to clinics the Defender came across another case of major restrictions on a girl who was just 16 years old, who was in the clinic purely due to the lack of staff in the facility she came to the clinic from.

It is again strongly recommended that regional authorities stake active steps to resolve the situation of clients/patients with specific needs. As mentioned earlier (see point 116), in our society there will always be a certain percentage of people who need specific, highly individualised and constant assistance and support. If failure to provide this assistance and support results in permanent and massive restrictions, this will constitute poor and undignified treatment which may in certain cases even harm the patient/client.

200. Municipal authorities, with regard to the amendment of the provisions of § 94 e) SSA, are recommended to actively map out the needs of their inhabitants and seek to meet these needs as part of medium-term development plans. It is also recommended that municipal authorities work together to meet the needs of the people living in the region and not rely on the fact that a neighbouring municipal authority will also look after inhabitants of another municipality free of charge.

Ministry of Justice

201. The Defender is aware that guardianship and the deprivation or restoration of legal capacity are not issues which only affect clients in homes for the disabled; nevertheless, with regard to the adoption of the CRPD and the preparations for the new Civil Code, it is recommended that the Ministry of Justice initiate special discussion and conceptual work on preparing a system of guardianship or a system of supported decision-making as introduced by the new Civil Code.

202. The Defender also draws the Ministry's attention to the abuses described in point 184, i.e. the length of time taken for any decisions concerning the deprivation or restoration of legal capacity and situations where courts decide on matters concerning the restriction/deprivation of legal capacity without having appointed a guardian. The Defender also assumes that although the laws relating to these institutions is not ideal, as things stand it is also possible for decisions to be made without excessive infringement of capacity and also to ensure that proceedings are not purely formalistic but take account of the actual situation.

Ministry of Employment and Social Affairs

203. The Ministry of Employment and Social Affairs is again specifically recommended to resolve the ambiguity of representation by municipalities with extended authority as construed by § 91 Paragraph 6 of the Social Services Act. The Defender also refers to the imprecise nature of the legislation, as representation may only be provided by a subject with its own legal subjectivity, which in this case is the municipality, not the municipal office.[165]

204. As the transitional period is coming to an end in accordance with the provisions of § 120 Paragraph 6 SSA, the Ministry of Employment and Social Affairs, founding bodies and providers are recommended to find a suitable means of informing the public, particularly clients of social services, about the upcoming changes.

V. Conclusion

[165] (Rc) 25 Co 531/97: "Public guardian is defined as a local administrative body or a facility run by such a body. However, according to the provisions of § 27 Paragraph 3 of the Civil Code, the local administrative body is not the municipal (town) office, but is the municipality (town) as a legal entity. The guardian must be granted legal capacity, which the municipal (town) office lacks. A list of legal entities is given in the provisions of § 18 Paragraph 2 of the Civil Code, which does not include municipal (town) offices.

205. In my Report on Visits to Homes for the Disabled I have tried to give as truthful and accurate a description as possible of the situation in the sample of social services facilities in the Czech Republic which I designated for my systematic visits. The situation described was as of September 2009, while appointed staff of the Office of the Public Defender of Rights carried out the visits in the first half of 2009.

My report contains a series of recommendations, both for social services providers, their founding bodies, and for local government and state administration bodies. It is my duty to describe and draw attention to the shortcomings found, despite the fact that I also saw many examples of good practice and an admirably unselfish approach to disabled people. I personally have great respect for anyone who has found their calling in such a difficult service (including the organisational and other aspects) and who can manage to carry out their duties while respecting the person placed into their charge.

In making my concluding assessment I fear that the current lack of funds in private and public budgets evident throughout our society could lead to the mothballing of existing residential social services which, as evident from the above, I consider far from satisfactory. I see it as essential to comply with the legitimate and legally defined requirement that services be provided with respect to people's needs as determined on an individual basis. This can be done by increasing the number of staff to better equate with the number of service users; by improving material conditions, including the removal of barriers and the assurance of greater privacy; by reducing the number of users receiving care in each facility. The aim of our current efforts as well as the recommendations I have formulated in this report must be to transform large facilities and move residential social services into the community.

Brno, 14 October 2009

JUDr. Otakar M o t e j l
Public Defender of Rights

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