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REPORT ON FOLLOW-UP VISITS

to psychiatric clinics

I. Introduction

1. The Public Defender of Rights (hereafter simply the Defender), under the authority granted by the provisions of § 1 Paragraph 3 a 4 c) of Law No. 349/1999 Coll., Public Defender of Rights Act, as subsequently amended (hereafter simply the Public Defender of Rights Act), performed systematic visits to places which house or which could house persons deprived of their liberty by a public authority or as a result of dependence on care received, with the aim of protecting such people against torture, cruel, inhumane and degrading treatment or punishment or other forms of mistreatment.[1]

On the basis of this authority, in 2008 the staff of the Office of the Public Defender of Rights visited 8 of the 17 psychiatric clinics for adults in the Czech Republic (a total of 30 wards; hereafter simply PC or clinics). The visits focused on wards housing patients who have just entered the clinics (admission or agitation wards) and gerontopsychiatric wards. These wards contain people with very difficult conditions resulting from mental illness; the findings made in these wards cannot be applied to the clinic as a whole.

The Defender summarised his findings and recommendations in his Report on Visits to Psychiatric Clinics, published in September 2008 (hereafter simply 2008 Report on Visits to PC). For visits to be effective, they must be repeated at regular intervals. Therefore, in 2009 seven of the original clinics were revisited, on the basis of which the Defender assessed his findings.[2]

2. Follow-up visits were made to seven clinics: PC Dobřany, PC Havlíčkův Brod, PC Horní Beřkovice, PC Kosmonosy, PC Kroměříž, PC Opava and PC Šternberk.[3] The aim was to check compliance with the recommendations the Defender made to the management of the clinics in 2008 and also the recommendations addressed to the Ministry of Health (hereafter simply the Ministry) and regional authorities. The visits were always unannounced and always related to a visit to the appropriate

[1] The Czech Republic, as a state which ratified the Optional Protocol (Memo No. 78/2006 Coll. m. s.) to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (New York 1984, No. 143/1988 Coll.), pledged to set up a national body which would carry out systematic preventive visits to determine how people deprived of or restricted in their liberty are treated. The Defender has acted in the capacity of this national preventive mechanism since 2006; the results of this work can be seen at http://www.ochrance.cz/ochrana-osob-omezenych-na-svobode/.

[2] According to the provisions of § 21a Paragraph 2 of the Public Defender of Rights Act, the Defender is obliged to draw up a report on the findings made during his visits to these facilities. This report may contain recommendations or suggest remedial measures. After sending them his report, the Defender requests that facilities issue a statement on his report, recommendations, or suggestions within a certain deadline. After completing a series of visits to a certain type of facility the Defender compiles an overall report which summarises his findings from the area in question, formulates recommendations for other facilities (not visited), and also for local and state government bodies, where applicable.

[3] No follow-up visit was made to PC Lnář as in terms of its nature and size this regional clinic is very different to the others.

district court. With just one exception, all the clinics were very cooperative during the visits and the subsequent discussions.

3. The Defender considers psychiatric care, and especially psychiatric detention, to be very sensitive and specific areas. The cost and organisational difficulties involved means that an individual approach cannot be taken to the facilities visited as the issue involves a number of issues relating to central healthcare policy. On the other hand, the founding body of all the clinics investigated during follow-up visits is the Ministry of Health, which the Defender sees as another party with which to discuss his findings and recommendations.

In the interim after issuing his 2008 Report on Visits to PC, aware that this was going to be a long process, the Defender took the following steps:

- Asked all regional authorities to issue a statement on the points contained in the 2008 Report on Visits to PC relating to social services;
- Held a series of discussions with representatives of the Zlín regional authority regarding the fate of two women, since 2010 just one woman, who had long been confined in a psychiatric clinic; on 4 October 2010 she was also admitted to a social services facility in the South Moravian region;[4]
- communicated with the Personal Data Protection Office concerning the use of camera systems in psychiatric clinics;
- issued a document entitled *The Placement and Residency of Mentally Handicapped People in Psychiatric Clinics* as an appendix to the report for the Chamber of Deputies of the Parliament of the Czech Republic for the 4th quarter 2009;
- in January 2010 discussed his systematic visits to clinics with the Health Minister, after previously having written to inform her about his findings in the Kroměříž, Kosmonosy and Opava psychiatric clinics;
- issued his Summary Report on his activities in 2009 to inform the Chamber of Deputies of the Parliament of the Czech Republic and the public of his findings from the follow-up visits and formulated his requirements as regards legislation;
- exercised his authority to impose sanctions as granted by the provisions of § 21a Paragraph 3 of the Public Defender of Rights Act and in June 2010 informed the public about what he considered unsatisfactory cooperation with Šternberk Psychiatric Clinic; in August 2010 another unannounced visit (the third) was made to the clinic;
- shared in the pooling of experience with other national preventive mechanisms around Europe, in March 2010 in Padua in Italy on the topic of preventing poor treatment in psychiatric institutions.

Some of these activities are described in greater detail below.

4. In point 142 of the 2008 Report on Visits to Psychiatric Clinics the Defender recommended that the Ministry of Health focus on the conceptual aspects of psychiatry[5], with reference to the urgency of the matter resulting from the adverse

[4] A special place was created in a social services facility in the Zlín region, but the guardian did not agree with the facility on the wording of the contract.

[5] Since 2008 Czech psychiatry has been governed by the revised Psychiatry Concept, a document issued by the ČLS J. E. P. Psychiatry Association. This states that the Czech Republic is in the minority in the European Union in that it has not set up a government mental health programme. “The result of this is that the establishment of psychiatric institutions is not systematic, with lacking or unevenly distributed out-patient services, outdated bed capacities, and lack of community care facilities. The availability of psychiatric care is unsatisfactory; psychiatry in the Czech Republic has long been inadequately funded and, in comparison with most European countries, the development of psychiatric care has been neglected and left to fall behind that of other nations.”

consequences of care provided in overcrowded admissions wards coupled with a lack of staff.

The Defender regrets to say that since September 2008, when he informed the Ministry of his recommendations, no progress has been made in rectifying the shortcomings highlighted by the Defender. In 2008 the Defender received a response from the minister that was merely formal and contained nothing of substance. By June 2009 he had still not received the reply he had requested in his report. By the end of 2009 the Ministry still had not initiated any talks with representatives of psychiatric clinics concerning the future concept of psychiatric care. The Health Minister said at a meeting in 2010 that the Ministry had begun cooperating with the Czech Psychiatric Society to revise and revitalise psychiatric care in the Czech Republic. The Ministry also claimed that (for years) it had been concentrating on creating a National Action Plan for the Support of Mental Health. However, no steps have been taken to change the situations criticised by the Defender.

II. Fulfilment of the Defender's recommendations

Stigmatising and undignified clothing worn by patients

5. The Defender criticised it as stigmatising and undignified that patients in the wards visited (patients who were not somatically ill enough to remain in bed) wore mostly pyjamas or other institutional and undignified attire. This was not just in the wards, but also in the clinic grounds and nearby. Apart from for a short time after being admitted, there is no reason for patients to wear special clothes and this is an outdated rule.

In this respect many sites had made positive progress. Clinics allow patients to wear civilian clothes and provide facilities for washing and drying them. They have also installed cupboards for patients to put personal items in.

The clothing worn by patients who require extra care is another matter. In his report on follow-up visits the Defender criticised two clinics where women in gerontopsychiatric wards (who evidently did not spend time in bed or in their rooms) wore institutional attire which revealed intimate parts of the body (referred to as the "angel"). This situation is highly undignified.

Privacy

6. The Defender was supported by doctors in his recommendation that more privacy should be provided during visiting times. When visitors are received in common areas or in workrooms in the presence of people who should not be there, this is an infringement on patients' right to the protection of sensitive personal data.

The Defender's recommendations that inmates should not bathe (shower) together and that shower curtains should be fitted were also accepted, as was the recommendation to improve procedures in wards as regards the provision of information about patients only to those people who have the right to the information (people designated by the patient). Despite the cost, the beds in one room in the psychiatric clinic in Havlíčkův Brod were fitted with screens where ECT is applied, albeit to more than one patient, thus ensuring their privacy.

House rules

7. The Defender criticised a number of sites for not having written house rules or for having rules that were not updated, were inadequate, or not properly displayed. In all cases the Defender pointed out that the lack of rules can lead to uncertainty

amongst patients and others and can result in arbitrary behaviour. Some progress was seen in the course of follow-up visits.

Monitoring the permissible duration of involuntary hospitalisation

8. Proceedings concerning the permissibility of admitting and holding patients without their consent are governed by strict deadlines to ensure compliance with patients' basic right to personal freedom as granted by Article 8 of the Charter of Fundamental Rights and Freedoms. It was found that courts do issue rulings by the designated deadlines, although clinics are not necessarily informed of the outcome of the proceedings in time (no written ruling is available; only some clinics can rely on the fact that the court will notify them of the decision). Therefore, owing to this potential "technical" infringement of human rights, the Defender recommended that clinics find out how the court has decided in each particular case.

In the majority of cases the clinics liaised with the appropriate courts (telephone checks, sending information by fax, etc.) to agree how to avoid situations which would result in patients being held even though the court failed to decide by the given deadline or would have decided that the patient should be discharged.

IIII. Partial fulfilment of the Defender's recommendations

Combination of consent to hospitalisation with consent to treatment

9. The Defender was critical of clinics which, when admitting patients and giving them a "consent to hospitalisation" form[6], also asked them to sign a form granting consent to unspecified examinations and treatment procedures,[7] or to "all" hospitalisation-related procedures. Any healthcare procedure may only be performed with the consent of the patient (Convention on Biomedicine[8]) and, in the Defender's opinion, it is not right to ask for prior consent to all procedures. Neither the Convention on Biomedicine or the national law require written consent to a procedure (in the healthcare sector the written form is used for uncommon or potentially risky procedures, while consent is usually implied in the case of routine procedures such as taking a blood sample.)

The Defender recommended that when patients are admitted to a clinic, they are only asked to grant consent to procedures which may be assumed to be necessary in the near future. Consent to further treatment should only be requested once the patient is stabilised and better able to understand the information provided. The use of these initial forms could lead to a situation where both forms end up combined, which would make the provision of valid consent a travesty. Regardless of the fact that some wards were found to follow the correct procedure, whereby the doctors consulted any further treatment with the patients, the Defender insisted that these controversial forms be abolished.

With just one exception, all the clinics changed their forms.

[6] A patient may be admitted to a clinic either with his consent or with or without the permission of the court. Voluntary admission to a clinic means that upon admission the patient is able and willing to give written confirmation that he consents to hospitalisation (if not, the clinic informs the court of the patient's admission.)

[7] These are forms of the type: "I declare that I voluntarily consent to (…), and undertake to abide by the home rules and to undergo all medical procedures which the attending doctor deems suitable."

[8] sdělení Of the Ministry of Foreign Affairs č. 96/2001 Coll. m. s., Convention on 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

10. Also in 2008 the Defender drew attention to the example of gerontopsychiatric patients, in that it is not proper to accept consent to hospitalisation from patients who are (as evident from their medical documentation) in factual terms ineligible to provide consent at the time they are admitted. Considering the fact that doctors alternate shifts and patients are not always admitted to a gerontopsychiatric ward by a specialist, the Defender requested that a uniform procedure be drawn up.

Both of these aspects require methodical steps to be taken by the by the Ministry of Health, which in this respect has taken no action and left the initiative wholly down to the individual clinics. In most cases clinics have begun to deal with the problem by organising training sessions for doctors.

Mixed, high-capacity wards

11. In his 2008 Report on Visits to Psychiatric Clinics (points 30, 33, 34) the Defender discussed in detail the negative impact that the current structural, technical and organisational design of (acute) admission wards in clinics has on the health and dignity of patients. From the viewpoint of patients' conditions and diagnosis, admission wards are mixed, busy and noisy (11 from the wards visited in 2008 contained more than 40 beds) and the residential and social areas are often poorly designed. The environment in itself is stressful. (In one clinic the agitation ward is so crowded that when at full capacity two people have to be housed in rooms that are at other times used as isolation wards. Some sites still have high-capacity bedrooms. Also in one case part of the clinic's bed capacity includes net beds.)

First of all the Defender highlighted the shortcomings found to the directors of the clinics in his report. Follow-up visits found that remedial measures had been adopted, although only where possible and on a very small scale (changes in the right direction had been made in a total of 10 wards; e.g. reducing the capacity of the ward in PC Havlíčkův Brod from 40 to 30, reducing the capacity of the women's admission ward by setting up another ward in PC Opava, greatly reducing the capacity of the men's agitation ward in PC Horní Beřkovice and separating patients there for protective treatment, moving the men's admission ward in PC Kosmonosy and reducing the capacity from 55 beds to 39). Clinics are attempting to avoid the negative impact by considering how patients should be allocated to bedrooms, focusing on any socially pathological behaviour, marking out potential subjects of abuse, etc.; in some cases renovations are being paid for out of the clinics' budgets (PC Horní Beřkovice, PC Kosmonosy). However, no significant change is possible without further investment into the reconstruction and alteration of wards. It was also found that none of the clinics had received any funding from their founding bodies to reconstruct the wards visited. Therefore the Defender wrote to rebuke the Ministry of Health as the founding body of these clinics for its inactivity (in the case of PC Kroměříž and PC Kosmonosy; also, in PC Opava there is still a room with seven beds and one with nine beds in the gerontopsychiatric ward).

The Ministry of Health keeps records of how much it invests in psychiatric clinics every year, yet the system remains unchanged. Wards are not really getting any smaller.

Patient access to rooms during the day

12. Another aspect of the regimen in the clinics which the Defender was critical of was that patients are restricted from going into their bedrooms during the day for organisational (not therapeutic) reasons. This means that all the patients gather in busy walk-through common areas where there is no privacy and lie around in armchairs and on the floor.

Follow-up visits found that the situation had somewhat improved. In three clinics the bedrooms were accessible all day; two clinics had made bedrooms freely accessible for part of the day and one clinic had allowed patients to go into their bedrooms on request. In Kroměříž Psychiatric Clinic this step had been taken in just one ward, so the Defender again asked the management to change the situation and they promised to do so. Also, in Šternberk Psychiatric Clinic the Defender's recommendations had only been implemented in certain wards so the clinic was again prompted to make changes. During the third visit it was found that patients were permitted to go and lie down after lunch.

Use of restraints[9]

13. The practice of using restraints varied from clinic to clinic and the Defender made a series of recommendations in this respect. As he stressed in his 2008 Report on Visits to Psychiatric Clinics, facilities must ensure that, on the one hand, they only use restraints that are legal and do not infringe upon human dignity and on the other they take precautions to minimise the risk of abuse.

Follow-up visits found that a number of recommendations had been implemented, for example to differentiate between situations where a patient is placed in a room used as an isolation room and the doors are kept locked or unlocked; increasing privacy during confinement (getting rid of peepholes from freely accessible places); treating medication administered as a means of quickly calming agitated patients as a form of restraint; clarifying forms to prevent the arbitrary use of restraints, and setting time limits on the validity of consultation sessions; keeping central records to ensure that the use of restraints can be properly checked; modifying and defining procedures within the clinics' internal regulations to prevent arbitrary action. The willingness shown by the doctors is highly commendable in this respect, as this matter encroaches on the field of medical treatment more than any other the Defender dealt with on his visits.

The Defender's recommendations can only be considered to have been partially complied with as shortcomings at certain workplaces persisted. For example, where net beds remain in rooms, the people living in those rooms have to move elsewhere; where net beds are part of the ward's bedding system; when the use of restraints is not assessed.

One clinic saw the Defender's recommendations relating to how net beds are used, recorded and assessed as a request to remove the beds. This clinic replaced the net beds in its gerontopsychiatric wards with binding straps, which, however, was not what the Defender recommended.

14. In determining whether a specific measure can be classed as a restraint, the Defender partly based his consideration on the methodical measure of the ministry and partly on a simple assessment of whether the measure has the potential to restrict the patient's free movement. This logically conflicted with what medical staff

[9] Procedures which infringe upon a person's liberty to move around freely are, in a certain form and under certain circumstances, part of modern psychiatric care. This primarily concerns action in response to agitation or aggression on the part of patients which poses such a danger as to merit such an infringment of human rights. Restraints sometimes tend to be divided up into physical, mechanical and chemical restraints. The only law which explicitly covers the medical use of restraints is methodological measure of the Ministry of Health No. 37800/2009. This methodological measure allow the use (or combination) of the following restraints (and attempts to define the term): grasping a person, protective belts or straps, ned beds, isolation rooms, acute parenteral administration of medication. At the legal level the "law" covering the use of restraints allows it to be classed as a therapeutic procedure which does not require the consent of the patient if the person shows symptoms of mental illness or intoxication and puts himself and those around him at risk (the provisions of § 23 Paragraph 4 b) of Law No. 20/1966 Coll., of the Public Healthcare Act, as subsequently amended).

consider to be measures that are in fact restraints but which also serve as a significant means of protection.[10] Gerontopsychiatric wards use restrains that cannot be overcome (side-bars, nets, straps) to protect patients from falling or other potential accidental harm (falling out of bed), or in cases of agitation. The confused wanderings and uncertain movement of old, sick patients poses certain risks and so restraints are commonly used in terms of how rooms are laid out, furnishings and fittings, and staffing. However, the use of these restraints can present a risk where patients suffer from incontinence or loss of mobility.

In relation to this the Defender was critical when other precautions were not taken first (partial side-bars; barriers which can be taken down); when the procedures used by the nursing staff were in no way regulated (by internal regulations, by a doctor); when the use of restraints was not specifically documented and thus open to checks; when there was no form of signalling system by the beds of restrained patients. The Defender's recommendations were respected where they did not involve any extra expense to the clinic. However, it was again found that mechanical restraints are seen as normal regimen-based measures which required no special checks or guarantees that they would not be abused.

In his 2008 Report on Visits to Psychiatric Clinics (point 78) the Defender asked the Ministry of Health to issue a statement on the fact that its facilities contain elderly people who are being restrained because there is nobody to supervise them. No satisfactory response has yet been received.

15. In one case there remained a difference in opinion between the Defender and the clinic as to whether the additional administration of psychopharmaceuticals (in this case parenterally) can be classed as a restraint. Undoubtedly clear differentiation is required in this case, as the administration of psychopharmaceuticals is a basic medical procedure in psychiatry. What is important here is that the psychopharmaceuticals are administered not as part of a therapy plan but in response to an acute situation involving some sort of threat or risk.

Possibly this dispute is more about terminology, or perhaps reflects the clinic's unwillingness to take the matter of medication to court and initiate detention proceedings. (The law obliges clinics to notify the court of all cases where restrictions are imposed on patients hospitalised with their consent.)

The Defender agrees that for many situations involving the use of measures restricting free movement the provisions of § 191a Paragraph 2 of the Civil Court Rules of Procedure[11] are not particularly practical. Detention proceedings themselves are not a fitting response in many situations, as they do not include any ruling on the use of restraints. The Defender also noted that it was hard to come to an agreement as regards terminology (which is essential for any kind of discussion). It is obviously a fact that medication is also often used to restrict freedom of movement, and all that remains is to differentiate between the different situations. A good guideline is to

[10] Point 77 of the 2008 Report on Visits to Psychiatric Clinics: "In the course of his visits to medical facilities the Defender often found that clinics were overestimating the legal significance of classing a certain measure as protective or restrictive. In particular, he does not agree with the practice where this differentiation is made on a a speculative basis, or when clinics overlook factors which must be considered when using restraints (special indications, records, notifying the court). There is undoubtedly a difference in whether restraining measures are in response to agitation or agression on the part of a patient, i.e. a reaction to undersirable circumstances, or are to protect a patient from falling or pulling out a drip. However, the criterion of protection must always exist, otherwise such restraints are illegal."

[11] Law No. 99/1963 Coll., Civil Court Rules of Procedure, as subsequently amended. "If a person admitted into medical care with their written consent is restricted in their free movement or in their contact with the outside world during the course of treatment, the relevant institution is obliged to notify the court of the matter in accordance with Paragraph 1 within 24 hours of the imposition of the restriction."

differentiate between cases where the (parenteral) administration of sedative medication is part of the procedure planned by the doctor (and also reflects the effort to not overmedicate the patient with preventive doses but to wait to see if any reaction to the patient's condition is called for) and where medication is administered as the staff's response to threatening or unpleasant behaviour and the therapy plan is contained in the medical files. Unfortunately, very few clinics actually write up their therapy plans (such as PC Horní Beřkovice).

The Defender insists that restraints should not be termed therapy. He again emphasises that certain "restrictions" must be combined with additional checks and policies to prevent abuse, such as special documentation, consultations, staff training, etc.

Privacy in toilets

16. In the wards he visited the Defender found a number of infringements of patients' privacy on the toilet, as if they were unavoidable. These included (although not in all the wards) the use of room toilets without screens and nappy-changing in front of other people and with the doors left open. Some toilets had no doors, or in isolated cases even no cubicles. In quite a lot of cases it was not possible to close the toilets or there was nothing to show that the cubicle was occupied. In the Defender's opinion these invasions of privacy can be moderated or eliminated completely and are not justified, or justified only on the grounds of lack of staff.

The Defender recommended that toilet cubicles be fitted with lockable doors (fit locks which can easily be unlocked from outside, for example using a screwdriver or a coin) and to install doors and cubicles to screen toilets that currently do not have them. Screens should be set up to protect the privacy of patients that require more sensitive nursing care.

One example of what can be done is PC Šternberk, where they have increased patients' privacy on the toilet by installing lights to show when cubicles are occupied; PC Dobřany has done the same. Other clinics accepted the Defender's recommendations that peepholes in cubicle doors be covered up. Vacant/occupied signs were fitted. Clinics promised to start using screens, but the Defender still comes across situations which are undignified for patients and for visitors. It should be mentioned that in one case the Defender had to repeat his recommendations and it was not until after the follow-up visit that the clinic promised to rectify the situation.

17. A conflict of interests concerning at least the basic minimum of privacy and the protection of patients' safety in relation to the use of toilets led to a lengthy exchange of opinions with one clinic. The Defender was critical when in a men's agitation ward (for patients with unquestionably difficult conditions) the toilet cubicle doors (which were, moreover, monitored by cameras) were replaced with transparent plastic curtains. The clinic claimed that this reflected the high standard of care, as the main priority was patient safety. The Defender, however, did not consider this invasion of privacy as being proportionate to the risk of suicide when doors are fitted to toilets instead of curtains.[12] As this difference in opinion persisted, the Defender contacted the Ministry of Health as the founding body of the clinic, which eventually gave in and fitted the doors.

[12] "Despite having no studies to back up my convictions, I do not suppose that patiens from region of the clinic are more prone to suicide that those in other regions. Therefore, in my opinion the measures adopted by the clinic are not proportionate to the invasion of patient's privacy and dignity. The director speaks about risk assessment; however, in my opinion this is irrelevant as this measure, which is intended to prevent suicide, is applied to all patients regardless of their risk level." (Excerpt from the Defender's letter to the Minister of Health.)

18. A separate question in itself is the use of camera systems in toilets. These are cameras in toilet vestibules and also cameras directed towards cubicles. In one follow-up visit it was found that there was a camera which clearly showed a man sitting on the toilet. The justification behind the use of cameras in toilets is that they are there to observe any possible suicide attempt or assaults amongst patients; the cameras are also intended as a deterrent (to discourage such activity by making it obvious that the area is under surveillance). This transgresses general considerations of how cameras should be used in psychiatry, the duty to register, etc.

In the Defender's opinion, the reason why cameras should not be permitted in toilets is that the matter is out of all proportion. It is an invasion of the privacy of patients whose condition and behaviour do not merit surveillance in the toilet. The staff must be able to recognise who is a possible suicide risk and such patients should be given extra supervision. Cameras should only be used once all other options have been exhausted, yet in practice no other alternatives are used.

In this matter, as with other aspects relating to the use of cameras, no clear procedure was adopted. In three clinics the Defender observed the procedure of the Personal Data Protection Office, which also carried out an inspection at the site. In PC Kroměříž the cameras had been moved so they only showed the upper part of the body. The Defender, however, remains of the opinion that cameras do not belong in toilets and that they constitute an unreasonable invasion of privacy and an infringement upon human dignity.

19. Another related question concerning the use of camera systems to record people on the toilet is how cameras are set up in isolation rooms. In two clinics, where the isolation rooms contains a Turkish-style toilet, cameras are set up to film the person using the toilet. PC Kroměříž and PC Havlíčkův Brod have screened (adjusted) these cameras so that they no longer cover the toilet.

IV. Failure to fulfil the Defender's recommendations

20. Despite the unquestionable personal efforts made by many professional doctors, nurses and managers, and despite the respect he has for the difficult work they do, the Defender feels obliged to state that many psychiatric clinics still fail to respect patients' rights and some clinics are still guilty of mistreatment (point 22).

Barriers

21. Only some clinic wards are completely barrier-free. However, the Defender found there was a serious barrier problem in two clinics, and recommended that they rectify the situation on their gerontopsychiatric wards. He also pointed out that it was not suitable when wards for patients with mobility problems were situated on upper floors.

Follow-up visits found that the gerontopsychiatric ward in Kroměříž Psychiatric Clinic is on an upper floor without a lift. The Defender rebuked the Ministry of Health for failing to take action in this matter. The clinic helped to improve the situation by installing fire-signalling equipment. In other clinics (PC Opava), elderly sick patients are housed upstairs (there is now a lift) – a fire evacuation drill showed that if there were an emergency, this could have fatal consequences.

This situation will remain unsatisfactory until a conceptual decision has been taken.

Patients with mental disabilities

22. One specific group of patients in psychiatric clinics is mentally handicapped people.[13] The Defender discussed their situation in his 2008 Report on Visits to Psychiatric Clinics (points 34, 38 and 79). He also focused on their conditions in psychiatric clinics in three individual cases. His findings from systematic visits to various types of facilities (also to homes for the disabled in 2009) indicate that some mentally handicapped people slip through the system, as it were, and that there is a lack of places able to care for people with behavioural problems.[14]

The Defender discussed his findings and conclusions at great length in the document entitled *The Placement and Housing of Mentally Handicapped People in Psychiatric Clinics*, which is the appendix to his report for the Chamber of Deputies of the Czech Parliament for the 4th quarter of 2009 and to which he makes full reference.[15] His findings can be summarised as follows:

- Psychiatric clinics also contain people with disabilities and with or without other psychiatric diagnoses, purely on the grounds of these disabilities;
- In clinics which do not have a specialised ward,[16] mentally handicapped people are hospitalised together with patients with no handicap; placing them amongst patients in the acute stages of a mental illness or amongst patients undergoing protective treatment exposes them to a high risk of abuse and harm;
- Restraints and used more often on patients with mental disabilities, frequently in the long term;
- Mentally handicapped people are also placed in clinics because they are not provided with the appropriate social service.

Mentally handicapped people in psychiatric clinics are especially at risk from mistreatment, something the Defender found in several cases.

23. At present, the system of institutional psychiatric care is poorly set up with regard to the needs of people with mental disabilities. Care provided on normal wards poses an extra risk for the patient, including the potential use of restraints. (They are an easy target for bullying and abuse by other patients. If they disturb the regimen on the ward, they face massive restrictions. If their condition destabilises, they face many months of hospitalisation.) Care provided on specialised wards means a long time spent living in conditions which are merely provisional compared to the standard of care provided in social services facilities.

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[13] Specific characteristics of mentally disabled people are that they are mush less able to adapt and find it hard to tolerate change; a changed environment combined with hospitalisation can cause their condition to seriously deteriorate; they tend to be more demanding in terms of nursing care; often less able to communicate verbally they tend to be excluded from the community of the ward and from communication with staff; they become easy targets for abuse by other patients, and such abuse is often not discovered (communication problems, lower pain threshold); they tend to imitate the behaviour of others, which amongst people with pathological conditions can be a major problem; their reaction to psychopharmaceuticals (and combinations of such drugs) are hard to predict.

[14] In 2009 visits were made to a total of 25 homes for disabled people specialising in children and young people with learning difficulties. As regards psychiatric hospitalisation as a means of resolving uncontrollable agitation in the conditions of social services facilities, the Defender summarised his findings as follows (point 115 of his Report on Visits to Homes for the Disabled): *"In cases of uncontrollable agitation 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 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."*

[15] http://www.ochrance.cz/zpravy-pro-poslaneckou-snemovnu/

[16] Out of the eight clinics visited, only three have set up specialised wards to treat mentally disabled people: PC Dobřany, Havlíčkův Brod and Horní Beřkovice; however, mentally disabled people are hospitalised in all eight clinics.

The Defender supports a radical change as regards the placement of people with mental disabilities in normal psychiatric wards. On the one hand he recommends reducing the need for long-term psychiatric hospitalisation by careful improvement of social services for mentally handicapped people, while on the other hand psychiatric care should be provided at special sites in the Czech Republic, the capacity and distribution of which should correspond to the current level of need.

The use of restraints not covered by the law

24. There is no law covering the use of restraints in medical facilities – there is nothing to define general authority to use restraints or the conditions under which they should be used. The legal framework is based solely on the general provisions covering involuntary examinations and treatment procedures, which are obviously not particularly fitting in this case.[17] Staff may draw on methodical measure of the Ministry of Health No. 37800/2009. Yet these are common procedures in psychiatry and are also applied in non-psychiatric facilities. **In the Defender's opinion this situation violates the constitutional requirement that lawful authority is necessary if a person's freedom is to be restricted, and the matter must therefore be rectified.** There is nothing more than the provisions of the Civil Code[18] on personal protection and damage compensation and criminal provisions to force facilities to respect principles. Patients' equality of rights is not guaranteed (practices vary from facility to facility). There is no system of external inspections set up as regards the use of restraints. (In detention proceedings, even those initiated due to the use of restraints, courts do not deal with restraint-related conditions. In fact the court does not have the means of doing do, and inspections would be very time consuming.) So clinics setting up their internal rules covering the use of restraints are also waiting for a change in the law.

The Defender formulated his legislative recommendations in point 148 of the 2008 Report on Visits to Psychiatric Clinics. He asked for specification of the conditions under which restraints may be used and requested that guarantees be defined. He then had the opportunity to remark on the draft amendment to the Medical Services Act. This draft was a major step forward in that it was the first time that the use of measures to restrict free movement in healthcare had been covered by the law. The Defender felt it necessary to draw attention to the lack of any effective guarantee that such restraints will be lawful due to the fact that the draft amendment unjustifiably introduced a regimen which is different to that set by the laws on social services.

After the draft amendments to the healthcare laws were not passed in 2009, the Defender repeated his legislative recommendations in a brief report for the Chamber of Deputies. He especially recommended that the Chamber ask the government to present an amendment to the Public Health Act (or completely new laws) which would cover the use of restraints and generally treat the living conditions of patients in psychiatric clinics.

In August 2010 the Defender was informed by the Ministry of Health that is not acceptable from a legal and material point of view that the issue of restraints be dealt

[17] The provisions of § 23 Paragraph 4 of Law No. 20/1966 Coll., of the Public Healthcare Act, as subsequently amended: "Examinations and treatment procedures may be carried out and, if the patient's condition so requires, the patient may be taken into institutional care without the patient's consent

a) if the illness is one specified by a particular law allowing the enforcement of compulsory treatment;
b) if a person showing signs of mental illness or intoxication poses a threat to himself or those around him;
c) if the patient's consent cannot be obtained as result of his condition and the treatment is urgently required to save the patient's life or health,
d) if the patient is a carrier.

[18] Law No. 40/1964 Coll., as subsequently amended

with in a partial amendment to Law No. 20/1966 Coll., the Public Health Act, as it only covers one aspect of healthcare. Likewise, in the Ministry's opinion, inspections and sanctions cannot be amended in this area as under the current law this would result in unjustified equality in relation to the exercising of the other rights and obligations of staff and patients. Such definitions must be formulated as part of the preparation of a comprehensive system of laws covering the provision of medical care. The Defender does not concur with this opinion, and especially not with the approach taken by the Ministry. A law covering rights and obligations in at least one area is better than no law at all, especially for an issue as sensitive as the restriction of patients' personal freedom.

The Defender again warns the Ministry of Health that under the current legislation this practice, which is common in all sites of this type all over the Czech Republic, is in contravention of the Constitution of the Czech Republic and the international treaties by which the country is bound.

25. One of the legislative recommendations made by the Defender was to set the maximum length of time that a restraining order could last. This was in reaction to the fact that in some clinics staff treated doctors' restraining orders entered into the medical files as a permit to apply future restrictions, without the need for any further confirmation from the doctor. In a meeting with ministerial representatives the Defender was informed that the duration of restraints could not be limited in advance, as they depended on the condition of the patient at the time. This was a misunderstanding – confusing the terms length of use of restraints and length of restraining orders.

Long-term use of restraints

26. Restraints may only be used for the minimum length of time necessary, i.e. for as short a time as possible.[19] It was found that patients who needed restraining due to a condition such as psychosis, for example, mechanical restraints (including isolation) are only used for a matter of hours, in exceptional cases a few days. Doctors give medication to calm the patient and the need for restraints no longer applies. Restraints are, however, also used in situations where patients cannot be given adequate supervision (for example while unattended the patient could swallow something or wander off somewhere). According to what the Defender found, this applies to patients with mental disabilities and in many cases it was found that mechanical restraints were used for days, weeks, or even months. These restraints including binding straps, net beds, straitjackets, and the acute administration of psychopharmaceuticals.

There is no generally binding law which specifies the maximum length of time for which restraints can be applied or how often they can be used consecutively. It is, however, obvious that restricting a person's freedom of movement is an extreme and acute measure and that the use of restraints in the long term, with no ease from restraint, can be considered abuse. Even after the Defender had drawn the attention of the Ministry of Health and regional authorities to the long-term use of restrictions on free movement in his 2008 Report on Visits to Psychiatric Clinics (points 79,[20]

[19] The Ministry's methodological measure states "for the amount of time the reason for the restraint applies".

[20] "Net beds and other restrictions are, in these cases, to compensate for lack of staff and the lack of any specialised workplace for these types of disabilities. They are not used in extreme cases to safeguard patients, but as a long-term solution. The Defender feels that it is not his place to comment on the specialised aspects of these cases. (It must be said that the staff devoted a great deal of attention to these patients; the doctors regularly assessed the restraints and checked up on the health of the patients.) In the environment of a social services facility this sort of treatment would be illegal. In a medical facility this is inhumane treatment. Restraints are used in a manner which is out of all proportion to the purpose of the restraint as defined by the methodological measure, and can therefore be considered an unreasonable infringement on patients' freedome and dignity. In a

100, 103, 142), this did not resolve the situation (which, by the way, was described very specifically).[21] Follow-up visits confirmed that the long-term use of restrictions on free movement continues. It is again necessary to stress that this problem is out of the hands of the individual clinics.[22]

Excerpt from the appendix to the report for the Chamber of Deputies of the Parliament of the Czech Republic for the 4th quarter 2009:
It is recommended that the Ministry of Health, as representing state administration, and regional authorities, as representing local government, resolve the problem of patients whose free movement is restricted in the long term, for example by setting up and funding special workplaces, either as part of the healthcare system or social affairs, equipped in such a manner as to ensure high-quality specialised care.

It is recommended that the Ministry of Health, in collaboration with the Ministry of Employment and Social Affairs and local governments, accept responsibility for resolving cases of patients who are (currently) permanently confined in psychiatric clinics.

The Ministry of Health, as the founding body of the facility in which long-term restrictions were placed on freedom of movement, is recommended to react flexibly, for example by increasing staff numbers in the individual wards and by pressing for specific cases in the region to be resolved.

It is recommended that social services facilities strive to take a special approach to clients with specific requirements as regards care and support. In cases where a facility is unable to provide the appropriate care and thus risks harming the client (long-term hospitalisation, restrictions on free movement), it is recommended that the body which set up the service be informed. The Defender also recommends that homes contact their regional authorities and ask them to resolve the situation of these clients.

People forced to stay in psychiatric clinics due to the lack of social services

27. In his 2008 report on visits to psychiatric clinics the Defender stated (point 19) that due to the lack of related social services psychiatric clinics housed a relatively high number of patients for whom, under certain circumstances, out-patient psychiatric care would be sufficient. This is the case with elderly patients (one hospitalised for two and a half years in a gerontopsychiatric ward) and many patients with mental disabilities. Mental illness or just a case history of psychiatric

positive legal sense it could be argued that patients show signs of mental illness and regularly pose a risk in the open ward; however the use of isolation and mechanical restraints in this way is unreasonable and in practice the ward is not in compliance with the internal regulations."

[21] The Minister of Health's reply to the Defender in November 2008: "It is unclear as to what your claim in point 79 is based on, stating that the use of restraints in medical facilities is inhumane treatment." "The Ministry of Health does not plan to build or fund specialised workplaces designed only for patients who require longer-term restrictions on their freedom of movement as the result of their illness."

[22] In the document entitled *The Placement and Residency of Mentally-Handicapped People in Psychiatric Clinics*, which forms the appendix to the report for the Chamber of Deputies of the Parliament of the Czech Republic for the 4th quarter of 2009, the Defender draws attention to the danger that the Czech Republic could violate Article 3 of the European Convention on Human Rights by the fact that it tolerates long-term restrictions on free movement. The Ministry of Health, as the founding body of the psychiatric clinic, could contribute towards the violation of the procedural obligations imposed by Article 3 of the Convention by failing to take action, if it were aware of the restriction but did not investigate complaints of excessive restriction imposed on patients.

hospitalisation prevents many people from being admitted to existing facilities,[23] and there is a lack of social services institutions with the facilities to cater to the specific needs of such people. In fact some doctors in the clinics visited said that they had found that social services providers defer admitting difficult clients into their clinics without taking active steps to adapt the services to their specific needs.

The Defender found specific cases where it had long been impossible to find a suitable social service for patients with mental disabilities in PC Kosmonosy, PC Opava and PC Kroměříž. The Defender's recommended that the clinics provide support in finding a suitable social services, although without further action there is little home of success. PC Horní Beřkovice has a specialised ward with around twenty patients who have been living there for a long time, years in fact. The situation was similar in PC Dobřany, where there is no chance of transferring patients to other facilities.

The Ministry of Health initially distanced itself from the problem, though in 2010 it stated that it was also convinced of the situation.[24] In his 2008 Report on Visits to Psychiatric Clinics the Defender formulated recommendations especially for regional authorities, stating that they should take steps to resolve the situation of mentally ill people in their locality. Partly because regional authorities are the providers of a range of social services and partly that the Social Services Act obliges them to provide the necessary social services in their locality and also to compile a medium-term social services development plan.

28. Psychiatric clinics have a lack of social workers (in practice these are generally women) able to provide real social work that benefits patients, i.e. to find patients suitable social services and get more subjects involved in dealing with what happens to patients after they are discharged from clinics. Social workers are burdened with dealing with pensions, handling clients' financial affairs and sorting out various other matters for them. Subsequent visits found that no additional staff had been taken on since 2008. Health insurance companies do not want to pay for the work done by social workers. There are no standards of social work in psychiatric clinics, which is a challenge, obviously one not yet met, for the methodical agenda of the Ministry of Health.

Activity of regional local governments

29. In his 2008 report on visits to psychiatric clinics the Defender also contacted regional authorities with his recommendations.[25] He urgently recommended that they

[23] A social services provider may refuse to conclude a contract on the provision of social services with someone whose state of health precludes them from receiving such social services (the provisions of § 91 Paragraph 3 of Law No. 108/2006 Coll., Social Services Act, as subsequently amended); such medical conditions are defined by Executive Regulation No. 505/2006 Coll., as subsequently amended, as follows: the person's condition requires institutional care in a medical facility, or the persons behaviour as a result of a mental disorder could seriously impair collective cohabitation. Facilities should not just look at the fact that a person's case history includes a stay in a psychiatric clinic; they should also review the applicant's actual condition – whether there really is a reason for refusing to conclude a contract. Also, the notice periods on social services contracts tend to make it easy for facilities to terminate contracts with people showing signs of mental illness.

[24] "Following our meetings we have assessed the most serious shortcomings in the individual psychiatric clinics as found in your inspections of psychiatric clinics. Our investigations found one fundamental problem which is faced by all psychiatric clinics. It has long been a problem to place patients in social services facilities. (…) The capacity of newly-built social facilities designed for chronic psychiatric patients is sadly inadequate." Letter to the Public Defender of Rights dated 13. 4. 2010

[25] Regional authorities have a number of obligations as regards social services stipulated by the provisions of § 95 of the Social Services Act. They are obliged

- to work with municipalities, other regional authorities and with social services providers to provide people with assistance;

take steps to resolve the situation of mentally ill people within the region, to determine the adverse effects of long-term hospitalisation on patients with mental disabilities and other groups of patients who spend longer periods of time in clinics than is strictly necessary to compensate for their psychiatric disorder. One reason for this is that the network of related social services is inadequate. Considering the fact that the Defender described his findings in detail in his report, he was expecting that regional authorities would respond to his recommendations by, for example, contacting the relevant psychiatric clinics and urging them to work more closely together and obtain the appropriate data to allow them to update their medium-term social services development plans. He requested that regional authorities inform him of any steps they took.

The Defender received a response from the regional authorities, although some responses were very vague. Although the Defender emphasised that there was a real need for interrelated social services facilities, with the exception of the regions of Moravia and Silesia, Ústí, Plzeň and Hradec Králové, regional authorities had not begun to cooperate with psychiatric clinics. It was only the Region of Hradec Králové, as far as the Defender is aware, that supported the establishment of a specific social services facility. Hradec Králové also began a needs-mapping project in the region.

Deadline for court rulings on protective treatment

30. During his systematic visits to psychiatric clinics in 2008 the Public Defender of Rights heard from doctors about their thoughts on the deadlines for court rulings on protective treatment. While the law states that clinics providing protective treatment must notify the court "without delay" if there is no further reason for a patient to receive protective treatment, the Criminal Procedure[26] does not set any deadline for court rulings on the continuation or termination of protective treatment. In practice this means that when clinics apply to cease protective treatment for people who no longer need it, such people remain in the clinics for longer than necessary. The Public Defender of Rights recommended that the Chamber of Deputies request that the government draft an amendment to the Criminal Procedure which would oblige the courts to issue a ruling in such cases by a certain deadline. No such amendment has yet been passed; nevertheless Criminal Procedure has been changed in the sense that the need for institutional protective treatment is now reviewed every two years.

V. General notes

Regimen of psychiatric hospitalisation not governed by law

31. In general the first visits found the environment on wards to be very restricting and an infringement on personal rights (clothing, access to rooms, access to coffee, using the telephone, the granting of permission, the level of privacy). In some respects the clinics did accede to the Defender's recommendations, although it is impossible to say whether the facilities that were not visited did the same. Inequality rules in one clinic, all the more so in comparison to other clinics. Anyone who wants

- to compile a medium-term social services development plan in collaboration with municipalities in the region, with representatives of social services providers and with the representatives of the people who receive the social services;
- to make social services provision available in their locaility in line with the medium-term plan.

[26] Law No. 141/1961 Coll., on Criminal Judicial Procedure (Rules of Criminal Procedure), as subsequently amended

to be treated in a psychiatric clinic must be subject to the regimen and the limits to what such a person must undergo are not defined.

One thing the Defender would like to stress is that while the Czech law is very inadequate as regards involuntary treatment and legal proceedings concerning mentally ill people, this is doubly true of the overall regimen involving staying in a clinic. There is absolutely nothing in the law stating what should go on behind the walls of a clinic in other respects, too. The criterion of voluntary or involuntary hospitalisation resolves nothing, as in detention proceedings courts only consider the question of restrictions on personal freedom. In addition, the two regimens (voluntary/involuntary hospitalisation) cannot encompass the wide variety of situations that exist in psychiatric care. There are no laws which stipulate that patients may only face regimen-based restrictions where absolutely necessary.

Also, as regards time spent outside, the position of patients in psychiatric clinics is much less clear-cut than in prisons, for example. The law guarantees prisoners an hour in the fresh air every day. Although the situation is more complicated with patients (some can leave the ward, some can only do so when accompanied, while others cannot go out at all), there are also staffing and structural considerations which prevent patients from going outside often. One some of the clinics (PC Havlíčkův Brod, PC Horní Beřkovice[27]) have taken active steps to adapt the areas around the clinic to provide a place for patients who cannot go into the grounds alone to get some air. This is obviously down to the goodwill of the clinics, however, and the patient has no guaranteed entitlement. The Defender found that in one clinic patients spent week, even as long as six months, without going outside.

Therefore, the Defender, in his Summary Report on the Activities of the Public Defender of Rights for 2009, recommended that the Chamber of Deputies request that the government draft an amendment to the Public Health Act (or completely new laws) which would cover the use of restraints and generally deal with the living conditions of patients in psychiatric clinics.

According to the information available to the Defender, a comprehensive draft healthcare bill will be presented in 2012, which he considers unacceptable. For a number of years now the Defender has been highlighting the fact that there is a legal vacuum affecting patients as well as the staff of hospitals, psychiatric clinics, hospices and other institutional medical facilities. There are no regulations covering the use of movement-restricting measures, nor anything to prevent the abuse of such measures, and some of the important articles of the Convention on Biomedicine have not been implemented. As regards the ministerial statement, the Defender does not believe it deserves any comment, as all it does it once again demonstrate the Ministry's unwillingness to take any steps to deal with the Defender's comments and recommendations. **The Defender once again draws the Ministry of Health's attention to the fact that under the current legislation the regimen-based restrictions imposed on patients in psychiatric clinics, commonplace in all such institutions throughout the country, is a violation of the Constitution of the Czech Republic.**

<u>The use of camera systems</u>

32. The inadequacy of the law covering the provision of psychiatric care means, amongst other things, that there is no legal basis for the use of camera systems. Most clinics use camera systems to some extent (see the analysis in points 114 and following of the 2008 Report on Visits to Psychiatric Clinics). It is important to point out that at the time of the follow-up visits, despite the Defender's recommendations,

[27] In a closed ward PC Horní Beřkovice set patients' participation in outings as an indicator of quality.

some clinics had not given the situation consideration; in three cases the recommendations had to be repeated and it was not until the subsequent visits that the clinics promised to rectify the matter. One clinic asked to be registered with the Personal Data Protection Office, while others were willing to stop making recordings.

Regardless of whether a recording is taken or not, the situation is still unsatisfactory as far as the positioning of the cameras is concerned. In the name of security, cameras are freely used, as it were, with no rules and no consideration of when (in what situations and where) this invasion of privacy is reasonable. A number of questions are raised and at a meeting with representatives of European national preventive mechanisms the Defender had the opportunity to also hear the opinions of lawyers and psychiatrists from abroad. For example, there is the danger that camera surveillance of isolation rooms means that staff carry out physical checks less frequently. There is also the problem of infringement on the rights of patients whose condition does not justify the use of cameras, yet they have to put up with them because of the other patients. The use of cameras in toilets is also a problematic issue.

In individual cases the Defender informed the Personal Data Protection Office, but its investigations and conclusions only relate to Law No. 101/2000 Coll., the Personal Data Protection Act, as subsequently amended, or the duties of administrators of personal data, i.e. the specific aspects of making video recordings.

The Defender also pointed out that the placement of camera system monitoring screens in staff workrooms was a sensitive issue. The images should not be visible to anyone who enters the room (PC Havlíčkův Brod, for example, complied with the Defender's wishes and turned the monitors around.)

Conditions for the treatment of patients with mental disorders are not covered by the law

33. In his 2008 Report on Visits to Psychiatric Clinics the Defender formulated specific legislative recommendations for the Ministry of Health., i.e. that it enable consent by proxy in accordance with Article 6 Paragraph 3 of the Convention on Biomedicine, that it enable people with mental illnesses to be treated without their consent in accordance with Article 7 of the Convention on Biomedicine, and also that it alter the conditions concerning the protection of such people's rights and the conditions covering supervision, inspection and appeals.

After the new comprehensive healthcare bill was not passed in 2009, the Public Defender of Rights repeated his legislative recommendations in the form of a summary report for the Chamber of Deputies. He especially recommended that the Chamber request that the government submit an amendment to the Public Health Act (eventually a completely new system of laws) which would enforce the provisions of Article 6 Paragraph 3 and Article 7 of the Charter of Human Rights and Biomedicine. Although the Defender keeps repeating these recommendations, the Ministry of Health refuses to make any partial amendment to the Public Health Act (see points 4, 24 and 31). The Ministry is thus doing nothing to improve the situation.

Detention proceedings

34. During this follow-up visits the Defender took a deeper interest in the rights of patients in proceedings on the permissibility of admission to or confinement in medical institutions (§ 191a to 191g of the Civil Court Rules of Procedure). The staff of the Office therefore visited seven of the appropriate district courts.

The Defender found that these proceedings were very formal. Interviews with court staff about the normal procedure showed that assessment of the legal reasons

for admission (§ 23 Paragraph 4 of the Public Health Act) was not de facto made by the court, but by a doctor, sometimes the same doctor who had already decided that the patient should be admitted. The court itself does not review specific behavioural symptoms resulting from mental illness or the risk involved (witnesses are heard or proof in the form of medical documentation is presented only in exceptional cases).

35. In proceedings on the permissibility of admission to a medical institution the court is obliged, amongst other things, to hear the patient. It was found that patients were not always heard and that courts tend to be satisfied with the information provided by the attending doctor that the patient's medical condition renders any such hearing impossible. This means that the only evidence available in these proceedings is that given by the doctor. Some courts, however, do insist on hearing patients, and check for themselves when the patient is deemed unable to provide testimony.

In one case the Defender contacted the presiding judge of the district court and asked that the court staff be told that they should always meet with patients in cases of involuntary hospitalisation (including cases where the patient does not communicate). It was promised that in future staff would always have personal contact, with the exception of aggressive patients or those with infectious diseases. The Defender also recommended that clinic doctors support contact between court officials and involuntarily hospitalised patients in all forms of proceedings on the permissibility of involuntary admission for treatment, not just in marginal cases.

36. It was found that the number of patients admitted to clinics without their consent who appointed their own representative for detention proceedings was negligible. For patients who do not appoint their own representative, the court is obliged to appoint a lawyer as guardian. Interviews with clinic and court staff confirmed that lawyers acting as guardians often fail to comply with their duties as guardians and do not properly defend the interests of their wards, as generally they never visit them, play no part in proceedings that concern them, and do not read their wards' files. They only perform formal tasks, such as taking delivery of correspondence. In these cases patients' rights are not properly protected and patients have no guaranteed right to legal aid. Considering the fact that representation is generally a purely formal matter, the Defender assumes that courts should act as guardians; if they fail to comply with their obligations, they should be relieved of the role and further lack of action should not be tolerated (see also the Constitutional Court ruling dated 11 January 2007, File Ref. No.: IV. ÚS 273/2005).

37. It was found that after a clinic informs the court within 24 hours, in accordance with the provisions of § 191a Paragraph 2 of the Civil Court Rules of Procedure, that a patient who gave consent to their admission to a clinic subsequently had their free movement restricted during the course of the therapy (generally in the form of a restraint), in some cases the courts do not initiate proceedings as they do not consider such restraints as actual restrictions on free movement. General courts consider restrictions to mean just confinement in a closed ward. The existing practice, where there is no uniform idea of what constitutes restrictions on free movement in the case of voluntarily hospitalised patients, means that clinics renege on their obligation to inform the court of such restrictions.

Besides the fact that this practice contravenes the Civil Court Rules of Procedure, it also highlights a certain paradox. The law states that the specific act of restricting someone should instigate detention proceedings, although such

proceedings do not look at whether such restrictions are justifiable or reasonable, nor do they consider the specific conditions under which the patient is hospitalised or the legitimacy of the regimen the patient is subjected to. Such proceedings are definitely no guarantee that the specific use of restraints is lawful.

Protection of mentally ill people

38. Not even the best psychiatric care provided by a clinic can in itself guarantee that a mentally ill person can lead a dignified life. The applicable laws[28] state that a patient must be discharged "as soon as the requisite examinations and treatment have been carried out or if the patient's condition improves to the extent where further care can be provided on an out-patient basis or in other medical facilities or social care facilities". Many psychiatric patients, however, have no accommodation to go to or the social services they need when they are discharged. As it was stressed at the meeting with representatives of European national preventive mechanisms and psychiatrists, is some cases an early discharge from a clinic can prove very harmful to the patient.

None of the provisions of the law satisfactorily stipulate that a particular subject should be obliged to care for someone who is to be discharged from a medical facility. The most specific in terms of such an obligation are the provisions of § 92 of the Social Services Act,[29] which state: "The municipal office of a municipality with extended authority must ensure that people who do not receive a social service and are in a situation where the lack of immediate care poses a risk to their life or health are provided with social services or other forms of assistance to the extent necessary; the responsibility for this lies with the municipality in which the person in question has their permanent or registered address." The same paragraph states: "The municipal office of a municipality with extended authority, when notified by a medical facility in accordance with a special law, must determine whether a person in that medical facility need to be provided with social care services, and must facilitate such services where necessary; if the person cannot be provided with social care services, the municipal office must inform the relevant medical facility of the fact immediately." This last clause only stipulates the duty to cooperate, not to provide the service.

There are no bodies which are to some extent responsible for the fate of mentally ill people after they are discharged from a period of hospitalisation. There are, for example, no deadlines by which a review should be carried out as to whether certain social situations really are ineffective (see point 28 on social work in psychiatric clinics).

39. There is still a lack of support for patients in exercising their rights in court (the situation is such that after a court ruling in detention proceedings it is practically impossible for the patient to secure a discharge even if further confinement in the clinic cannot be justified; if a patient does not have the support of family and friends, there is no help available from the clinic to win a court case or even to have a case heard by the court). The same was found to apply with legal aid to initiate proceedings for the restoration of legal capacity. Clinics are unable to provide consultancy and assistance.

The Defender therefore recommended that that the Ministry of Justice present draft legislation covering the protection of the rights of people with mental disorders.

[28] The provisions of § 27 Paragraph 1 of Law No. 48/1997 Coll., Public Health Insurance Act, as subsequently amended

[29] Law No. 108/2006 Coll., Social Services Act, as subsequently amended

No such draft had been presented by the end of 2009. The Convention on the Rights of Disabled People (No. 10/2010 Coll. m. s.) was adopted and ratified, the provisions of which are stringent as regards equality and the autonomy of disabled people.

VI. Conclusion

40. The follow-up visits were not just quick checks to see whether clinics had kept their promises to adopt the necessary measures. Unfortunately in several cases new, detailed reports had to be drawn up, as measures had not been adopted and were not promised until later. Apart from PC Šternberk, where the fact that the clinic refused to promise to take remedial measures even after the Defender had again highlighted shortcomings led to media coverage of the issue, the cooperation shown by the clinics was good.

41. As the situation was deemed so urgent in that the Defender considered the conditions experienced by patients (those undergoing long-term hospitalisation or long-term restrictions on freedom of movement, patients with mental disabilities) to constitute mistreatment, in his 2008 Report on Visits to Psychiatric Clinics the Defender formulated recommendations and requested that the Ministry of Health and regional authorities inform him by the end of June 2009 as to what steps had been taken to comply with these recommendations. The Ministry failed to respond; regional authorities responded, with one exception.

As is evident from the above, the Ministry of Health, as the central state administrative body for healthcare, has done little to improve the situation. Since September 2008 it has not taken any specific steps in response to the Defender's appeals and recommendations.

JUDr. Pavel V a r v a ř o v s k ý v. r.
Public Defender of Rights
(report accompanied by electronic signature)