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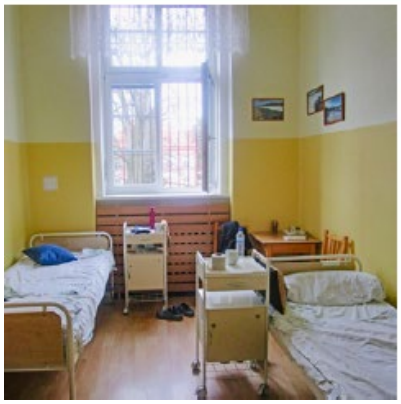
# FORENSIC TREATMENT, MEANS OF RESTRAINT AND OTHER TOPICS



## REPORT ON SYSTEMATIC VISITS 2019

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# FORENSIC TREATMENT, MEANS OF RESTRAINT AND OTHER TOPICS

## REPORT ON SYSTEMATIC VISITS 2019

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# TABLE OF CONTENTS


Mission of the Defender ..... 7

Foreword ..... 8

Summary ..... 10

Abbreviations ..... 13

Forensic treatment: brief introduction ..... 15

1) Characteristics of the visits and the hospitals visited ..... 16
2) Statutory basis for the visits and provisions on ill-treatment ..... 17
3) The concept of forensic treatment ..... 17
   a) Background ..... 17
   b) Purpose of forensic treatment ..... 18
4) Process of institutional forensic treatment ..... 20
   a) How institutional forensic treatment is arranged and provided ..... 20
   b) Concept of forensic treatment in the hospitals visited in 2017 ..... 22

Forensic treatment: systemic comments ..... 26

5) Insufficient legal framework for forensic treatment ..... 26
   a) Gaps in the legal regulation of forensic treatment ..... 26
   b) No regulation of transfers (relocation) ..... 27
   c) No regulation of suspension of forensic treatment ..... 28
   d) Involuntary hospitalisation of offenders ..... 28
6) Insufficient administrative framework of forensic treatment ..... 28
   a) The capacity and availability of beds for forensic treatment are not specified ..... 28
   b) Security issues are left up to individual hospitals ..... 29
   c) Major difficulties connected with forensic treatment of children ..... 30
   d) Lacking records of patients receiving forensic treatment ..... 30
   e) Systemic obstacles stand in the way of subsidiarity of institutional treatment ..... 30
   f) No guidance for assessing the danger posed by patients ..... 32
   g) The contents and form of the hospitals' reports and procedural proposals are not unified ..... 33
   h) Hospitals object to court experts' work and the use of expert reports ..... 34
   i) Secure preventive detention cannot resolve issues faced in forensic treatment 34
   j) Lacking forensic treatment policy ..... 35
7) Judicial decision-making ..... 35
   a) Lack of uniformity in decision-making ..... 36
   b) Imposing useless forensic treatment ..... 36
   c) Decision-making on a discharge ..... 37
8) Lacking professional standard ..... 38

9) Supervision and control ..... 38
a) Lacking supervision by the public prosecutor's office over forensic treatment ..... 39
b) No infractions defined in the Healthcare Services Act ..... 39
10) Proposed measures to resolve systemic issues ..... 40
a) Measures proposed in 2014 ..... 40
b) Systemic recommendation of the Defender ..... 41
Forensic treatment: situation in hospitals ..... 44
11) Security at a ward ..... 44
a) Managing acute aggressive behaviour ..... 44
b) Safe, secure and drug-free environment ..... 45
c) Cameras ..... 45
d) Window bars ..... 47
e) Role of the police in ensuring security in hospitals ..... 48
f) Lack of information about patients ..... 49
g) Intervention by a security service ..... 49
h) LGBTI ..... 50
12) Informed consent ..... 51
a) Legal standard ..... 51
b) Current legislation and two related issues ..... 52
c) Findings from the visits ..... 52
d) Evaluation and recommendations ..... 54
e) Possible safeguards in case of involuntary treatment ..... 56
13) Treatment ..... 57
a) Forensic treatment programmes ..... 57
b) Comprehensive treatment ..... 59
c) Specifics of juveniles ..... 60
d) Motivational system ..... 61
e) Keeping medical records ..... 61
f) Provision of somatic care ..... 62
g) Surgical castration ..... 63
h) Penile plethysmography (PPG) ..... 63
i) Reading out judgements and court expert reports ..... 64
14) Regime ..... 65
a) Legal basis for a regime ..... 65
b) Basis for a specific treatment regime ..... 66
c) Permissions to leave ..... 66
d) Confiscating ordinary items and prohibiting indulgences ..... 67
e) Compulsory wearing of pyjamas during the day ..... 69
f) Preventing access to dormitories during the day ..... 70
g) Use of mobile phones ..... 70
h) Very strict regime ..... 71

**15) Other topics related to therapy and regime ..... 72**
a) Rounds in the presence of several patients ..... 72
b) Lack of outdoor access ..... 72
c) Presence of another person in the shower ..... 73
d) Prohibition of child visitors ..... 74
**16) Environment and accommodation ..... 75**
a) Large-capacity dormitories ..... 75
b) Therapeutic environment ..... 76
c) Lockable spaces for personal belongings ..... 77
d) Sanitary conveniences and hygiene ..... 78
e) Visiting room ..... 78
f) Private room ..... 79
**17) Human resources ..... 79**
a) Sufficient personnel in care ..... 79
b) Evaluation and recommendations ..... 80
c) Professional behaviour of the staff ..... 81
**18) Information on the patient's rights and obligations ..... 82**
**General topics ..... 84**
**19) Electroconvulsive therapy (ECT) ..... 84**
a) Standard ..... 84
b) Ensuring privacy during and after the treatment ..... 85
c) Consent to treatment ..... 85
d) Restrictions and concealing information ..... 86
e) Situation at the national level ..... 87
**20) Means of restraint ..... 88**
a) Standard ..... 89
b) The concept of "imminent threat" ..... 90
c) Necessary restriction of free movement, or supervision? ..... 91
d) Unjustified duration of a restraint ..... 92
e) Privacy and safety of restrained patients ..... 94
f) Supervision by staff and providing the patient with the option to call for assistance ..... 95
g) Debriefing ..... 96
h) Enclosure beds ..... 97
i) Pharmacological restraints ..... 98
j) Additional interpretation: tranquillising medication prescribed on a pro re nata basis ..... 100
k) Patients with mental disabilities ..... 101
l) Paediatric patients ..... 102
m) Entries in medical records ..... 102
n) Staff support ..... 103

**21) Restraint as a last resort ..... 104**
a) Alternatives to restrictive management of dangerous behaviour ..... 104
b) Systematic efforts to reduce the need to apply restrictions ..... 104
c) Records of cases and evaluation of the situation in the hospital ..... 106
d) There is a risk of deterioration of the current situation in psychiatric hospitals ..... 108
**22) Complaints ..... 109**
a) Standard ..... 109
b) Complaints mechanisms in psychiatric hospitals ..... 109
c) Complaints containing an arguable claim of ill-treatment ..... 111
**23) Recording and reporting medical evidence of ill-treatment ..... 112**
a) Standard ..... 112
b) Findings from psychiatric hospitals ..... 113
**Overview of systemic recommendations ..... 116**
**References ..... 119**

# MISSION OF THE DEFENDER

Since 2001, the Defender has been defending individuals against unlawful or otherwise incorrect procedure of administrative authorities and other institutions as well as against their inactivity. The Defender may peruse administrative and court files, request explanations from the authorities and carry out unannounced inquiries on site. If the Defender finds errors in the activities of an authority and fails to achieve a remedy, the Defender may inform the superior authority or the public.

Since 2006, the Defender has acted in the capacity of the national preventive mechanism pursuant to the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. The Defender systematically visits facilities where persons are restricted in their freedom, either ex officio or as a result of dependence on the care provided. The purpose of the visits is to strengthen protection against ill-treatment. The Defender generalises his or her findings and recommendations in summary reports on visits and formulates standards of treatment on their basis. Recommendations of the Defender concerning improvement of the conditions ascertained and elimination of ill-treatment, if applicable, are directed both to the facilities themselves and their operators as well as central governmental authorities.

In 2009, the Defender assumed the role of the national equality body pursuant to the European Union legislation. The Defender thus contributes to the enforcement of the right to equal treatment of all persons regardless of their race or ethnicity, nationality, gender, sexual orientation, age, disability, religion, belief or worldview. For that purpose, the Defender provides assistance to victims of discrimination, carries out research, publishes reports and issues recommendations with respect to matters of discrimination, and ensures exchange of available information with the relevant European bodies.

Since 2011, the Defender has also been monitoring detention of foreign nationals and the performance of administrative expulsion.

In January 2018, the Defender became a monitoring body for the implementation of rights recognised in the Convention on the Rights of Persons with Disabilities, also helping European Union citizens who live and work in the Czech Republic. The Defender provides them with information on their rights and helps them in cases of suspected discrimination on grounds of their citizenship. The Defender also co-operates with foreign bodies with similar responsibilities regarding Czech citizens abroad.

The special powers of the Defender include the right to file a petition with the Constitutional Court seeking the abolishment of a secondary legal regulation, the right to become an enjoined party in Constitutional Court proceedings on annulment of a law or its part, the right to lodge an administrative action to protect a general interest or to file an application to initiate disciplinary proceedings with the president or vice-president of a court. The Defender may also recommend that a relevant public authority issue, amend or cancel a legal or internal regulation. The Defender advises the Government to amend laws.

The Defender is independent and impartial, and accountable for the discharge of his or her office to the Chamber of Deputies, by which he or she was appointed. The Defender has one elected deputy, who can be authorised to assume some of the Defender's competences. The Defender regularly informs the public of his or her findings through the media, Internet, social networks, professional workshops, roundtables and conferences. The most important findings and recommendations are summarised in the Annual Report on the Activities of the Public Defender of Rights submitted to the Chamber of Deputies.

# FOREWORD

Mgr. Anna Šabatová, Ph.D.
Public Defender of Rights

Protecting people restricted in their freedom against ill-treatment is one of the tasks entrusted to the Public Defender of Rights by law. This role of the Defender honours the Czech Republic's obligation under the Optional Protocol to the Convention against Torture. The Defender, as an ombudsperson, is not a regular supervisory body. After each visit to a facility, he/she will issue an inquiry report including a recommendation on how to improve the facility's operation. Following a whole series of visits to facilities of a certain kind, a summary report is then published as a guidance also for other facilities of the same type. Summary reports approach the issues detected in a broader context and also include recommendations to ministries and other stakeholders who, through their legislative and methodological activities, can influence the quality of life enjoyed by persons restricted in their freedom.

In recent years, we visited a total of ten psychiatric facilities, five of which provide forensic treatment. We also dealt with several individual complaints. While the present summary report attempts primarily to identify systemic problems encountered in forensic treatment, it also gives a summary of our findings regarding some general questions of psychiatric treatment. In the Czech Republic, people do not undergo forensic treatment in specialised facilities, but rather in psychiatric hospitals, and sometimes even at regular wards together with patients who undergo their treatment voluntarily.

We conducted a number of debates with experts in the field of psychiatry, and especially forensic treatment, during the preparation of this report. At the Ministry of Justice, I took part personally in several meetings of an expert committee led by MUDr. Růžena Hajnová regarding forensic treatment in both institutional and outpatient form. Despite the dedicated work of many experts, the forensic treatment system still suffers from a great many afflictions and is far from perfect.

The first part of my report (roughly one third of it) focuses on systemic issues, the legal framework and gaps in the legislation. For example, the law lacks any provisions governing the relocation of patients or suspension of forensic treatment, and it likewise fails to provide for a network of outpatient facilities that would be ready to take on the patients at the right time. But primarily, there exists no overarching legal regulation of institutional treatment, including the rights and obligations of the patients. This is why the staff at individual facilities often grope in the dark. Financing forensic treatment is also an important and yet unresolved issue. Institutional forensic treatment is paid for in the Czech Republic in the same way as

regular psychiatric care – through health insurance companies. In Germany, on the other hand, each federal State has its own forensic treatment law regulating all the aspects of this treatment, including reimbursement from the State's budget.

The second part of the present report reviews the prevailing practice and deals with common operational issues and problems related to forensic treatment, as they were manifested during our visits. This part will likely be the most useful for the staff and the patients themselves. It describes various aspects of everyday life and touches on issues of the regime imposed on people restricted in their freedom, as well as ensuring security at a hospital ward and obtaining the patient's informed consent.

The third and final part then deals with general issues related to psychiatric care. It focuses especially on the use of restraints as a measure of last resort and on electroconvulsive therapy. We also highlight the significance of recording and reporting evidence of possible ill-treatment.

I sincerely hope this text will prove to be an inspiration to you.

# SUMMARY

The report is based on my visits to 10 psychiatric facilities for adults and also on several individual inquiries. The first three parts of the text follow from 5 visits focusing on institutional forensic treatment. The part titled General topics focuses on general psychiatry issues.

*Forensic treatment: brief introduction* provides, among other things, a description of how forensic treatment is organised both in general and specifically in the hospitals we visited. It can be summarised that the **State does not specify the capacity of institutional forensic treatment or material and personnel requirements on hospitals**. The total number of patients undergoing institutional forensic treatment is unknown as there are no central records of this kind; based on a one-off census, we know that the number of patients in hospitals increased by 13% over a period of 18 months. **Many hospitals are overburdened and improvise in ensuring safety and security of the relevant wards**. The specific features of this kind of care are not compensated financially in any way. It is also alarming from the patients' point of view that their access to available beds is not equal, nor is there any guarantee of equality in treatment and the standard of care provided.

In the part *Forensic treatment: systemic comments*, I draw on my findings from the visits and also a number of discussions with experts and hospital representatives, as well as documents drafted by the ministries and other stakeholders after the "Ždár case", which shook Czech society in 2014. First, I **try and detect any gaps in the legal framework**. Especially serious gaps are those in the actual legislation on the performance of forensic treatment as there is consequently no statutory basis for certain types of interference with the patients' rights (treatment without consent; use of cameras and bars; types of treatment; transfer of patients) which can thus be questioned in terms of their conformity with the Constitution.

**The administrative framework of forensic treatment is also insufficient.** There exists no policy of forensic treatment as a whole, its concept both in hospitals and in prisons and outpatient care facilities. Not all the treatment programmes are designed in detail at the national level and there is thus no guarantee as to their contents. Many systemic issues cause patients to stay in an institution longer than absolutely necessary, which is at variance with the purpose of such treatment. Significant difficulties are linked with forensic treatment imposed on juveniles and on patients not motivated to start a therapy for alcohol or drug addiction.

In some cases, this type of court-imposed treatment is admittedly inappropriate (without there being any hope of achieving its purpose in the first place) and court experts probably somewhat misunderstand the full potential of forensic treatment. This also owes to a lack of tools for more objective evaluation of the attainment of forensic treatment's purpose and persisting danger posed by the patient. The ratio of patients discharged from an institution dropped after the media reported on several serious crimes committed by persons (formerly) undergoing forensic treatment. Due to security issues in hospitals, there have been calls for more frequent use of secure preventive detention; this, however, does not solve the problems encountered by the hospitals.

I would like to point out that it follows from systemic **evaluation of the findings from my visits that forensic treatment is partly non-functional in terms of both protection of society and proper care for the patients**. Both these areas can entail serious violations of fundamental rights. I would like to express my support for the staff of psychiatric hospitals as without guarantees of safety and quality of this specific care, they cannot be asked to assume responsibility for the patients.

From the patients' point of view, I note that a lower standard of protection is extended to their rights than those of prisoners, as there exists no regular supervision of forensic treatment by the public prosecutor's office.

In conclusion of this part, I **provide systemic recommendations**, especially for the Ministry of Health as the central governmental authority which has so far failed to ensure a quality legal regulation, adopt measures to deal with topical issues and provide the necessary budget for this area. I therefore suggest a comprehensive review of the legal regulation of forensic treatment and drafting of the necessary legislative proposals. Furthermore, it is crucial to draw up a forensic treatment policy, improve regular training of court experts, and support individual hospitals in establishing secure and sufficiently staffed wards.

In the part titled *Forensic treatment: situation in hospitals*, I present my findings from visits to 5 hospitals and also from individual inquiries. In addition, I explain the standard which I have inferred from my interpretation of the contents of a person's right not to be subjected to ill-treatment and from medical standards. **While I found no wilful ill-treatment, there were a number of very risky situations and conditions that could have reached the threshold of ill-treatment in aggregate for some individuals.** This was true, for example, of a prolonged very strict regime associated with seclusion and a lack of activities. It can be stated in general that, in a number of aspects, the Czech Republic fails to adhere to the Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder and recommendations of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT).

The material conditions are mostly good or at least decent, but the environment generally enhances the restrictive conditions entailed in the hospitalisation. Several of the wards we visited have walk-through rooms housing multiple patients, with extremely austere furnishing and sometimes even no bedside tables; the patients also have no privacy in sanitary facilities. Overall, the local environment in itself poses a significant risk of ill-treatment.

As regards the treatment as such, a lack of uniformity among forensic treatment programmes provides a substantial margin of discretion to individual therapeutic teams. I point out cases where an interference with the patients' rights (denial of permission to leave the facility, confiscating ordinary items and prohibiting indulgences) is not sufficiently anchored in an individualised treatment procedure and cannot thus be considered a legitimate treatment regime. I also criticise certain relics of the times past such as compulsory wearing of pyjamas or blocked access to the dormitories in day-time. However, many of the hospitals have already abandoned these practices. I analysed especially thoroughly the topic of informed consent as there is a predominant feeling in Czech practice that a court decision on forensic treatment replaces the patient's consent to specific treatment procedures. This follows from literal interpretation of the Specific Healthcare Services Act, which however leads to violation of the patient's fundamental rights.

Any improvement of the material conditions and loosening the restrictive nature of care are naturally conditional on the providers' budgets, as such steps require investments and better staffing. Some providers are waiting for strategic decisions to be made regarding the future of hospitals, and the situation has been unsatisfactory for years. The uncertainty surrounding the financing of psychiatric hospitals and the lack of experts on the labour market are likely to further worsen the current situation as the numbers of patients undergoing forensic treatment and patients admitted to a facility while intoxicated are growing, which in turn gives rise to specific security risks. The State should react to these trends quickly. Should the worst-case staffing scenarios come true, it will no longer be possible to meet the standards of direct human supervision over persons subjected to a means of restraint, leave dormitories unlocked during day-time, allow patients to keep their ordinary belongings including mobile phones, and use non-pharmacological components of treatment. The need to ensure elementary security will again prevail and call for highly restrictive care.

Systemic decisions are currently being adopted on the future course of the psychiatric care reform. While I generally welcome these developments, including a gradual reduction in the capacity of major psychiatric hospitals, these decisions will affect the funding of psychiatric hospitals and entail

a possible impact on the settings (capacity, target groups) of those facilities where means of restraint are already used for various reasons. Indeed, certain investments are required to overcome the existing shortcomings. I **call on the Ministry of Health, as the authority responsible for the sector of healthcare and for the psychiatric care reform, to take account of the findings described in this report and to avoid stagnation, or even deterioration, in the already inadequate situation in psychiatric hospitals.**

The last part, titled General topics, deals with electroconvulsive therapy, complaints, and means of restraint and reducing the need for their use. I offer the related recommendations to all providers of (not only) psychiatric care, as it is clear that the standard of ill-treatment prevention must also be monitored and promoted at psychiatric wards of general hospitals and any other facilities where personal freedom is restricted. The requirements for **documenting and reporting medical evidence of ill-treatment, which are partially hindered in the Czech Republic by unsuitable legislation and a lack of methodological guidance for physicians, are generally valid with regard to any healthcare services**. An inadequate medical report on injuries of a person restricted in his/her freedom can frustrate appropriate and effective investigation.

# Abbreviations

**CPT** – European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. CPT standards have the nature of international soft-law; having only informal effect, they are not binding, but can serve as guidance for interpretation. A number of CPT standards have been incorporated in national laws and binding court decisions.

**Recommendation Rec(2004)10** – Recommendation of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder.

**European Convention** – Convention for the Protection of Human Rights and Fundamental Freedoms, as promulgated in the Collection of Laws under No. 209/1992 Coll.

**Methodological Guideline of the Ministry** – Ministry of Health. Methodological guideline for providers of inpatient care on restraining the free movement of patients and the use of means of restraint in patients. Volume 4/2018 of the Official Journal of the Ministry of Health [online]. Prague: Ministry of Health, 2018 [retrieved on 19 April 2019]. Available at: https://www.mzcr.cz/legislativa/dokumenty/vestnik-c4/2018 15323 3810 11.html.

**Civil Code** – Act No. 89/2012 Coll., the Civil Code, as amended.

**1998 CPT Standard** – European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Involuntary placement in psychiatric establishments. Excerpt from the 8th CPT General Report, CPT/Inf(98)12-part [online]. Strasbourg: CPT, 1998 [retrieved on 19 April 2019]. Available at: https://rm.coe.int/16806cd43e.

**2006 CPT Standard** – European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Means of restraint in psychiatric establishments for adults, CPT/Inf(2006)35- part [online]. Strasbourg: CPT, 2006 [retrieved on 19 April 2019]. Available at: https://rm.coe.int/16806cceb6.

**2017 CPT Standard** – European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Means of restraint in psychiatric establishments for adults (Revised CPT standards), CPT/Inf(2017)6 [online]. Strasbourg: CPT, 2017 [retrieved on 19 April 2019]. Available at: https://rm.coe.int/16807001c3.

**Code of Criminal Procedure** – Act No. 141/1961 Coll., on criminal court proceedings (the Code of Criminal Procedure), as amended. Criminal Code – Act No. 40/2009 Coll., the Criminal Code, as amended.

**Convention on the Rights of Persons with Disabilities** – promulgated under No. 10/2010 Coll. of International Treaties

**Internal and office rules for district, regional and superior courts** – Instruction No. 505/2001-Org. of the Ministry of Justice, issuing the Internal and office rules for district, regional and superior courts, published in No. 1/2002 of the Instructions Register.

**Decree on the minimum requirements for personnel in healthcare services** – Decree No. 99/2012 Coll., on the minimum requirements for personnel in healthcare services.

**Decree on the requirements for minimum technical and material equipment of healthcare facilities** – Decree No. 92/2012 Coll., on the requirements for minimum technical and material equipment of healthcare facilities and home care contact offices, as amended

**Medical Records Decree** – Decree No. 98/2012 Coll., on medical records, as amended.

**Specific Healthcare Services Act** – Act No. 373/2011 Coll., on specific health care services, as amended.

**Healthcare Services Act** – Act No. 372/2011 Coll., on healthcare services and the conditions of their provision, as amended.

dormitory

shared bathroom

multi-occupancy dormitory


complaint box with instructions


notice board at the ward

smoking room

# Forensic treatment: brief introduction

## 1) Characteristics of the visits and the hospitals visited

A series of systematic visits to psychiatric hospitals took place in 2017 with an emphasis on the performance of forensic treatment. The following hospitals were visited.

| Facility | Total capacity | Type of FT | Number of patients subject to FT | Wards specialising in patients undergoing FT |
|---|---|---|---|---|
| Havlíčkův Brod Psychiatric Hospital | 710 | P, TOXI, S | 83 | 1 (S) |
| Horní Beřkovice Psychiatric Hospital | 507 | P, TOXI, S | 133 | 4 + 1 (S) |
| Kosmonosy Psychiatric Hospital | 500 | P, TOXI, S | 59 | 1 + 1 (S) |
| Kroměříž Psychiatric Hospital | 939 | P, TOXI | 47 | - |
| Opava Psychiatric Hospital | 863 | P, TOXI | 74 | - |

Key: FT = Forensic treatment P – psychiatry, TOXI – alcohol and drug addiction, pathological gambling, S – sexology.

All the visits were unannounced. They were carried out based on my authorisation by employees of the Office of the Public Defender of Rights (hereinafter the "Office"), specifically lawyers and experts in the fields of psychiatry and nursing. The inquiry comprised an inspection of selected units of the given psychiatric hospitals; observation; interviews with senior employees and regular staff, and confidential interviews with patients; examination of the facility's internal policies and documentation, including medical records.

I sent the reports on the visits, containing a description of my findings, evaluation and, in each case, a suggestion for remedial measures, to the directors of the individual hospitals. Each of them commented on the report and informed me of the measures adopted. As I explain below, not all the recommendations were put into practice. In the case of Kosmonosy Psychiatric Hospital, I also communicated with the Ministry of Health, as the hospital's founder, regarding the latter's possible contribution to the co-ordination of remedial measures.

A round table with representatives of the hospitals visited and guest experts was organised in December 2017 with a view to discussing disputable topics and obtaining further information on the systemic aspects of institutional forensic treatment. Furthermore, I draw in this report on the outputs of the Working Group on Forensic Treatment established by the Ministry of Justice, of which I am a member, and the experience of representatives of other psychiatric hospitals with whom I met several times in 2018 and 2019.

# 2) Statutory basis for the visits and provisions on ill-treatment

Based on Section 1 (3) and (4) of Act No. 349/1999 Coll., on the Public Defender of Rights, as amended, the Public Defender of Rights carries out **systematic visits** to places (facilities) where persons restricted in their freedom are or may be present. The restriction results either from a decision of a public authority or dependence of the person on the care provided. **The aim of the visits** is to strengthen the protection against all forms of ill-treatment. The **visits are preventative in nature** and aim to influence future conduct.

Once mutual communication with the facilities is complete, **the reports** on the individual visits are published, as are summary reports on my findings and recommendations. They are available online on the Defender's website[1] and in the Defender's Opinions Register (ESO).[2]

**Ill-treatment** is a broad term. Its significance as conduct or treatment that is absolutely (without any exceptions) prohibited is laid down in Art. 7 (2) of the Charter of Fundamental Rights and Freedoms and Article 3 of the European Convention. The following situations may attain the gravity of inhuman or degrading treatment:

- poor living conditions if this goes beyond the unavoidable level of suffering and humiliation associated with deprivation of liberty (such circumstances are decisive as the standards of hygiene and privacy; quality of the bed; sufficient personal space; daylight; sufficient food of appropriate quality; sufficient stimulation and access to activities; access to the open air – the cumulative effect and duration of the above are taken into consideration), failure to provide healthcare and an overly restrictive regime;
- some involuntary treatment procedures (the European Court of Human Rights dealt with this issue with regard, e.g. to anti-androgen therapy) and use of physical force that is not unavoidable in view of the patient's conduct;
- unprofessional conduct or even violence used by the caregivers; and
- failure to ensure protection against bodily harm or abuse by patients or third parties.

The monitoring carried out to date indicates that the level of care and treatment is usually satisfactory in psychiatric hospitals. Nevertheless, deprivation of liberty always entails a risk of ill-treatment, and it is thus essential that these monitoring visits are carried out.

# 3) The concept of forensic treatment

## a) Background

Forensic treatment is one of protective (forensic) measures used in criminal law[3] to deal with a criminal offence committed in a condition of diminished sanity or in a condition caused by a mental disorder, or an act that would otherwise be punishable, but is committed by a person who is not sane (lacks compos mentis). Its **purpose** is to therapeutically influence the offender with a view to eliminating or at least reducing the likelihood of jeopardising or violating the interests protected by the Criminal Code. The objective is thus to ensure rehabilitation and detention the offender, rather than retaliation or balancing out the harm inflicted on the victim.

For those persons who must or may be ordered to undergo forensic treatment, the statutory criterion is whether they are **dangerous** if not restricted in freedom. A court expert is called on in the criminal proceedings to provide an opinion on this issue and also on the person's medical condition and treatment options. Forensic treatment may also be imposed in cases where criminal prosecution has not been initiated, if the offender proves to be insane at an earlier stage.

1 Public Defender of Rights – Ombudsman [online]. Brno: © The Office of the Public Defender of Rights [retrieved on 26 July 2019]. Available at: http://www.ochrance. http://www.ochrance.cz/ochrana-osob-omezenych-na-svobode/.

2 The Defender's Opinions Register (ESO) is available at: https://eso.ochrance.cz/Vyhledavani/Search.

3 Section 96 et seq. of the Criminal Code.

Depending on the nature of the illness and the treatment options, the court will impose forensic treatment **in the form of institutional or outpatient care**, while applying the principle of subsidiarity of the institutional form to outpatient treatment – institutional treatment may only be ordered as a measure of last resort. Forensic treatment is not ordered for any fixed period of time, but **rather continues as long as its purpose so requires**; the maximum duration, however, is two years. Furthermore, the court may decide on prolongation based on a motion of the public prosecutor or medical facility, even repeatedly. There also exists another related protective measure – secure preventive detention. The court may replace forensic treatment by such detention under the statutory conditions or because the purpose of forensic treatment is not being attained.

Judges most often order institutional treatment in **psychiatric hospitals**. In the case of persons with diminished sanity, the court may also impose forensic treatment along with imprisonment, and some of the patients undergoing forensic treatment thus have recent experience with serving time in prison.

The conditions for imposing forensic treatment are laid down in the Criminal Code (Sections 96 to 99) and the procedural rules in the Code of Criminal Procedure (Sections 351 to 355). The basic legal framework for the provision of care and treatment of patients is laid down in the Healthcare Services Act and the Civil Code. Furthermore, forensic treatment is subject to a special legal regulation enshrined in the Specific Healthcare Services Act (Sections 83 to 89). However, the **legal regulation** governing forensic treatment and the rights and obligations of all the stakeholders is much more complex, being partly scattered over secondary law and organisational regulations, it is indeed fragmented.

From the patient's point of view, institutional forensic treatment represents **an interference of a similar intensity as a custodial sentence**. It involves an interference with both personal freedom and privacy (a strict regime in the hospital, compulsory treatment, loss of employment and the related financial issues). This is why both the Criminal Code and the Specific Healthcare Services Act require proportionality between the harm inflicted and the purpose of the forensic treatment in any case where this kind of treatment is imposed and administered.[4]

## b) Purpose of forensic treatment

**The purpose of forensic treatment is a key notion**: (a) it serves as the decisive criterion for court's decision on imposing this treatment while reflecting the principle of proportionality; (b) the patient is discharged from forensic treatment if its purpose has been attained; (c) patients who were ordered to undergo this treatment in view of a criminal offence committed under the influence of an addictive substance are also discharged if the purpose cannot be attained;[5] (d) if the purpose of the treatment has not been attained because of the patient's behaviour, the court may replace the forensic treatment by secure preventive detention;[6] (e) serious conduct with the aim to frustrate the performance or purpose of forensic treatment constitutes a defining element of the criminal offence of obstructing the enforcement of an official decision;[7] (f) attainment of the

4 Section 96 (2) of the Criminal Code: "Harm caused by a protective measure imposed and implemented may not exceed that what is necessary for achieving its respective purpose." Section 83 (3) of the Specific Healthcare Services Act: "Forensic treatment may only involve the restrictions on human rights laid down by the law and these may only occur to the extent necessary for attaining the purpose of the forensic treatment if the purpose cannot be attained otherwise."

5 Section 99 (6) of the Criminal Code.

6 Section 99 (5) of the Criminal Code: "The court may replace institutional forensic treatment by secure preventive detention under the conditions provided in Section 100 (1) or (2). If the conditions set out in Section 100 (1) or (2) are not met, the court may replace institutional forensic treatment by secure preventive detention if the forensic treatment imposed and performed does not serve its purpose or fails to ensure sufficient protection of society, especially if the offender absconds from the healthcare facility, uses violence against the staff of the healthcare facility or other persons in undergoing forensic treatment, or repeatedly refuses to undergo examination or treatment or otherwise shows a negative attitude towards the forensic treatment."

7 Section 337 (1)(j) of the Criminal Code: "Every one who frustrates or substantially hinders the enforcement of a court decision or decision made by another public authority by committing serious acts aimed to frustrate the performance or purpose of forensic treatment or protective education imposed by the court, or otherwise, in particular by absconding from the institution, by providing help in absconding, substantially hindering the enforcement of such decisions, or frustrating supervision imposed upon termination of the forensic treatment, is liable to imprisonment for up to two years."

purpose of forensic treatment is a legitimate objective justifying a reasonable interference with the fundamental rights of the patient during treatment.

In spite of its significance, the purpose of forensic treatment is not explicitly specified by the law, and has to be inferred by interpretation:

- The explanatory memorandum on the Specific Healthcare Services Act gives as the main objectives of institutional forensic treatment the following: treatment of a mental disorder due to which the patient has committed an unlawful act; resocialisation and return to normal life; prevention of recurrence of an act caused by a mental disorder; isolation of an individual if he/she poses danger to society in view of his/her medical condition.
- The purpose is not necessarily to achieve complete recovery, but rather to stabilise the disease: While the objective is "primarily to exert therapeutic influence on a convict, with the aim of his/her recovery or at least achieving a therapeutic effect where the offender no longer poses a danger if his/her freedom is not restricted",[8] the Constitutional Court refers to complete recovery as the "ideal outcome".[9]
- The purpose of forensic treatment has to be inferred on an individual basis as this measure is imposed in view of a specific concern and whether the purpose is attained is determined based on that concern.

Definition of the purpose of forensic treatment [with the exception of treatment imposed pursuant to Section 99 (2)(b) of the Criminal Code] also requires interpretation of the **notion of danger**. This is not a danger for society ensuing from the given act, but rather the danger associated with future freedom of the given person.[10] It is inferred based on the act committed whether the danger is restricted to a certain activity and whether there is a likelihood of recurrence. Along with the threat of recidivism, consideration is also given to the danger of escalation, which again is not assessed only generally with regard to a certain type of disorder, but rather in relation to a specific patient and his/her willingness to undergo treatment.[11] Nonetheless, the existence of danger is not derived solely from the existence of a mental disorder and lack of awareness of the disorder, but as an abstract potential danger.

This is sometimes referred to as "elimination of danger" and elsewhere as its "minimisation", which appears more realistic in view of the general unpredictability of human behaviour. "A person's freedom poses a danger if it is very likely that the person will again attack the interests protected by the Criminal Code in the future under the influence of the given mental disorder."[12] Some physicians proclaimed that they were unable to evaluate the danger posed by a patient in the future, but rather only make a situational estimation. I would say that this is an expression of their scepticism in view of the current social pressure on absolute infallibility of physicians and courts, which is however an unattainable ideal (see more in chapter 6 (f)).

In any case, the question of whether the purpose of forensic treatment is being attained and whether the patient continues to pose a danger, or whether this danger has been minimised, has to be answered by the court when it decides on continuation of the forensic treatment or its replacement by secure preventive detention. This issue must also be dealt with from time to time by the healthcare services provider in order to adapt its approach to the patient and also the

8 ŠKVAIN, Petr. § 353 [Propuštění z ochranného léčení a jeho ukončení]. (Section 353 [Discharge from forensic treatment and its termination].) In: ŠÁMAL, Pavel, GŘIVNA, Tomáš, NOVOTNÁ, Jaroslava, PÚRY, František, RŮŽIČKA, Miroslav, ŘÍHA, Jiří, ŠÁMALOVÁ, Milada, ŠKVAIN, Petr. Trestní řád I, II, III. (Code of Criminal Procedure I, II, III) 7th ed. Praha: Nakladatelství C. H. Beck, 2013, p. 3990. ISBN 978-80-7400-465-0.

9 Constitutional Court, judgement of 11 April 2017, File No. III. ÚS 3675/16 (N 58/85 SbNU 81), available at http://nalus.usoud.cz, paragraph 32.

10 "[I]n view of the link to the mental disorder of the offender of an act that would otherwise be punishable, the decisive factor is a substantiated conclusion regarding future behaviour of the person concerned." Ibid., paragraph 21.

11 Cf. ibid., paragraphs 21 to 31.

12 ŠÁMAL, Pavel. K úpravě ochranného léčení v trestním zákoníku. (On the Regulation of Forensic Treatment in the Criminal Code.) Trestněprávní revue 4/2010, p. 99. In: Beck - online [online]. Nakladatelství C. H. Beck [retrieved on 1 August 2019] ISSN 1213-5313.

contents of the **motions and reports for the court**, which the provider is required to present (see more in chapter 6 (g)).

# 4) Process of institutional forensic treatment

## a) How institutional forensic treatment is arranged and provided

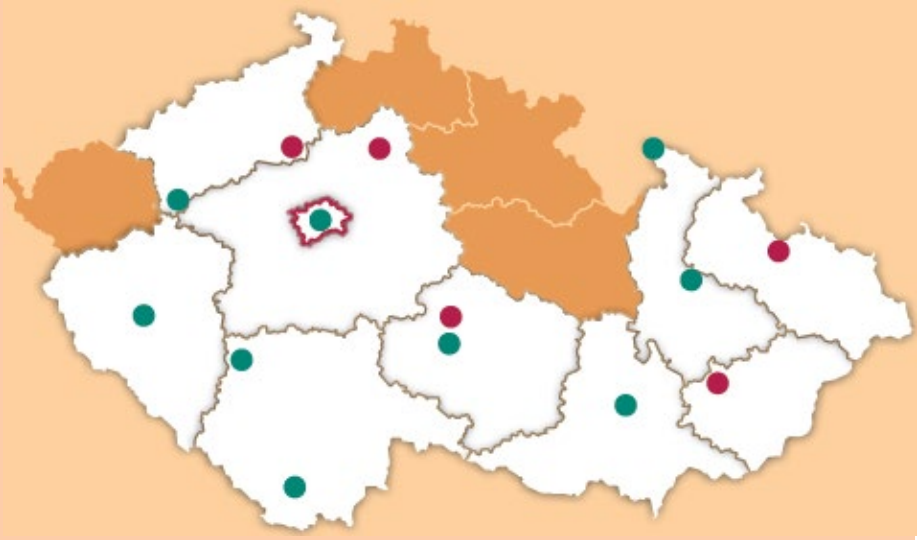
The current settings and manner of providing institutional forensic treatment are based, to a large degree, on the tradition of Czech healthcare and the professional opinion of experts specialising in treatment of mental illnesses and disorders. The legal regulation is highly fragmented and there is no established **forensic treatment policy**, including a link to other criminal, healthcare and social measures, that would shape the approach taken by the courts, court experts and care providers.

Although the law does not comprise any **typology based on indications and treatment methods** in view of which forensic treatment would be divided into psychiatric, sexological and addiction therapies (the latter covering alcohol and drug additions and pathological gambling), and also combined treatment, this classification plays a crucial role in practice. On the one hand, it is reflected in expert reports and court decisions and, on the other hand, it serves as a basis for the providers' approach.

The Internal and office rules for district, regional and superior courts comprise a list of psychiatric hospitals providing forensic treatment of any given type based on this typology and specify their respective catchment areas. **There are 14 such hospitals on the list**, where psychiatric and sexological forensic treatment is respectively provided in 13 and 7 of these hospitals (in reality, currently only in 6 of them).

Psychiatric hospitals for institutional forensic treatment with identification of the facilities visited.

Prague
Kosmonosy
Červený Dvůr
Lnáře
Dobřany
Horní Beřkovice
Petrohrad
Havlíčkův Brod
Jihlava
Brno
Bílá Voda u Javorníka
Šternberk
Kroměříž
Opava



It is unknown how many people are required to undergo forensic treatment in the Czech Republic at a certain point in time or how many persons are actually being treated in this way in psychiatric hospitals. **There are no centralised records of imposed forensic treatment** and data from judicial statistics do not cover all the cases of forensic treatment; specifically, this is true of cases of forensic treatment where criminal prosecution was discontinued in the pre-trial procedure due to a lack of sanity, i.e. cases of persons with a serious mental illness and lacking recognition and control abilities.

In 2018, the Ministry of Health issued a one-off request for data from psychiatric hospitals, and it is thus known that the **total number of patients** undergoing institutional forensic treatment in the

hospitals was 951 as of 30 June 2018 (of which 664 received psychiatric treatment, 145 treatment for addictions, and 142 sexological treatment), and that this number had increased by 13% over the previous 18 months (from the total of 847). The increase was seen in all treatment types save for sexological treatment. Patients have to register in waiting lists for addiction treatment (in one hospital, for example, the wait time was as long as until 2029) and further people join the system after serving a prison sentence; we cannot be sure what kind of pressure these future patients will exert on the hospitals.[13] It follows from the statistics that the number of patients undergoing court-ordered forensic treatment is constantly rising and one third of them remain in treatment for more than two years.

While the mentioned instruction of the Ministry of Justice defines the respective catchment areas of individual psychiatric hospitals, there is no regulation or policy to specify the capacity or form of forensic treatment, and thus also the **actual availability** of beds assigned for a certain purpose. Since the catchment areas of psychiatric hospitals are determined by historic considerations, rather than based on current objective criteria, such as temporal availability or the number of beds per 100,000 inhabitants, the territory of the Czech Republic is not covered evenly. The instruction does not reflect reality either, as it includes, for example, Opava Psychiatric Hospital among those providing sexological treatment, although this has not been the case for some time already.

Even individual hospitals frequently do not determine their respective **capacities for forensic treatment**. While some of them make at least an informed guess (hospitals that have established specialised wards infer the total capacity partly from the capacity of these wards), others remain in the dark. The mentioned method is not quite conclusive, also because there is only one specialised ward for women, and the determined capacity thus applies only to male patients, and moreover other than those placed in geriatric psychiatry wards. Some hospitals set a capacity percentage (10% or 15%), which they believe should not be exceeded by the number of patients undergoing forensic treatment.

Capacity is important because it usually serves as a basis for **material and staffing requirements**. However, it seems as if de lege lata there was no reason to distinguish whether or not, for instance, a person placed in follow-up inpatient psychiatric or sexological care is subject to the regime of forensic treatment, as the values specified in the Decree on the minimum requirements for personnel in healthcare services differ only by 2 full-time equivalents of an orderly or caregiver and 0.3 full-time equivalent of a clinical psychologist or healthcare psychologist, all that per 30 beds. The Decree on the requirements for minimum technical and material equipment of healthcare facilities does not reflect forensic treatment at all. Furthermore, capacity values can be used to determine the **provider's workload**, where any excess of acceptable workload is a reason for refusing a patient for forensic treatment. [14]

One half of the hospitals have some beds dedicated to forensic treatment, and so they actually concentrate patients in a ward where the care and security are specifically arranged in some way. However, even in these hospitals, some patients subject to this measure are treated at regular wards – both open and closed. As mentioned above, there exists only one specialised ward for women – at Horní Beřkovice Psychiatric Hospital.

Forensic treatment **may also be ordered to a child**, i.e. a person under 18 years of age. There were 4 such patients in the above census. The regulations do not envisage any special considerations or conditions to be applied in this case.

On top of that, no regulation describes the manner in which **hospitals are to be secured** against the absconding of patients, and internal security measures to be used when patients showing

13 For details and statistics on outpatient treatment, see PÁV, Marek and Jiří ŠVARC. Stávající stav a doporučení k dalšímu rozvoji sítě ochranného léčení. Analýza realizovaná v rámci projektu Deinstitucionalizace. (Existing Situation and Recommendations for Further Development of the Network of Forensic Treatment. Analysis Carried out within the "Deinstitutionalisation" Project.) Prague: Ministry of Health, 2018, 42 p.

14 Section 84 (2) of the Specific Healthcare Services Act.

dangerous behaviour or addiction to drugs are hospitalised, and there is no difference in this regard as compared to "regular" hospitalisation.

The costs associated with forensic treatment (in psychiatric hospitals and in outpatient care) are not financed from any special sources of funding, and are **covered by health insurance companies**. This is unique in the European context.[15] From a hospital's point of view, such a payment is the same as for any other patients in follow-up psychiatric care, with the only difference being that the highest nursing categories have been set down for patients in forensic treatment since 2018.

## b) Concept of forensic treatment in the hospitals visited in 2017

**Havlíčkův Brod Psychiatric Hospital** had no specialised ward for patients undergoing forensic treatment, but these occupied most of the capacity of the sexology ward (21 out of 26 beds). The hospital had 4 beds reserved for forensic treatment of unmotivated patients with addictions and this capacity was apparently booked out 8 years in advance; motivated patients were able to start treatment within weeks. There was no capacity set specifically for psychiatric forensic treatment and this kind of treatment was spread over a number of wards, with two of them treating most of the patients.

**Horní Beřkovice Psychiatric Hospital** has four wards assigned exclusively for forensic treatment: the men's admissions ward, men's alcohol and drug addictions ward, men's psychiatric ward, and one women's ward without further distinction. Patients assigned to sexological forensic treatment were placed in the sexology ward. On top of that, patients undergoing forensic treatment were also treated in eight other wards.

**Kosmonosy Psychiatric Hospital** had one closed ward reserved specifically for psychiatric forensic treatment and for forensic treatment of addictions. Patients subject to sexological forensic treatment formed a majority of the patients at the sexology ward. In addition, forensic treatment patients were also located in a number of other wards.

At **Kroměříž Psychiatric Hospital** and **Opava Psychiatric Hospital**, forensic treatment took place in 14 and 15 wards, respectively. These hospitals have no specialised wards for this kind of treatment.

Two distinct approaches to forensic treatment could thus be seen in the hospitals we visited. The first approach is to fully integrate patients undergoing forensic treatment across various wards. The second is to concentrate these patients in certain **specialised wards** where the therapy follows a specific objective and course, and where some specific tools are utilised to this end; except for one hospital, this is not true of women and also patients in acute stages of their illness, who are treated in the admissions ward or the "restlessness" wards. Experts with whom I discussed broadly this topic concurred that, for some patients, it could be beneficial to receive treatment at a general ward, while others might fare better at specialised wards.

Where a hospital lacks a closed specialised ward, some of the patients need to stay in the admissions ward, as it would be **dangerous** to move them elsewhere. Unfortunately, the therapy is scarce at these wards and the patients can pose a threat to others. It thus seems essential to have at least one specialised ward in place so that patients undergoing forensic treatment are not forced to stay in admissions wards. Similarly, unmotivated patients disturb the treatment of others.

Furthermore, even in hospitals with specialised wards, patients undergoing forensic treatment tend to "flow over" to other wards for capacity reasons. With a few exceptions, specialised wards are used for sexological forensic treatment; nonetheless, when their capacity is full, patients are placed

15 Where applicable, the State pays the costs related to forensic treatment of persons who are not covered by public health insurance in the Czech Republic. For a European comparison, see Páv a Švarc, cited above, p. 19.

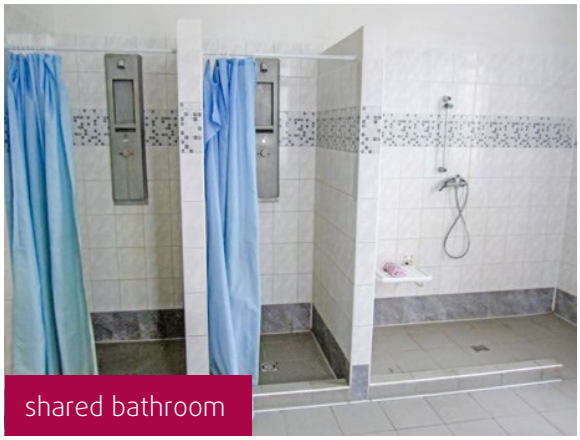
in other wards (some time ago, I received a complaint against this practice, including "integration" of sexual offenders).

Finally, the existence of a specialised ward does not necessarily entail a higher standard of care. I rather preferred to focus on a different aspect, specifically what **forensic treatment programmes** the individual hospitals had in place for their patients – whether they offered a wide range of therapeutic activities for each patient and whether certain benchmarks were set for a patient's progress, including the rules for its evaluation. In other words, whether the contents and course of the treatment and the steps taken by the hospital were predictable for the patient and the court. The inquiry revealed inconsistency within individual provider's organisations and also across the country; more details are given in chapter 13.


information for patients in the hospital ward

multi-occupancy dormitory

outdoor area with a gazebo



shared bathroom

common premises

bars installed inside the ward

# Forensic treatment: systemic comments

## 5) Insufficient legal framework for forensic treatment

In view of the prohibition of ill-treatment and the right to protection of physical and mental integrity (as enshrined in the European Convention), the State is required to introduce a legal and administrative framework for the provision of healthcare services and deprivation of liberty. Governmental authorities may only legitimately interfere with the freedom and integrity of a human being if the interference has a basis in the law. Conditions must be laid down for the provision of healthcare services so as to ensure effective protection of patients' lives and human dignity regardless of whether they are placed in a governmental or private institution.[16]

### a) Gaps in the legal regulation of forensic treatment

The legal regulation of forensic treatment is comprised in several distinct pieces of legislation. Based on systematic visits and follow-up consultations, we can pinpoint several areas where it is lacking.

Primarily, the conditions to be met by facilities providing forensic treatment are not specified. I dare say that **the quality of care is inconsistent**. The Decree on the minimum requirements for personnel in healthcare services gives only a minor consideration to forensic treatment (it adds 2 full-time equivalents for orderlies or caregivers and 0.3 full-time equivalents of clinical psychologist per 30 beds) and, moreover, **effectively fails to provide for adequate staffing**. Specifically, the prescribed numbers of nursing staff and other experts are very low (according to the hospital managers, "impracticable for psychiatric care") and, on top of that, the Decree states that "the provision of medical staff and other professionals beyond the scope of the set requirements depends on the type and volume of the healthcare provided, the field and range of the tasks performed, and the relevant activities, so as to ensure quality, safety and availability of healthcare". Thus, a regulation issued with a view to safeguarding quality, security and availability only states that these indeed should be ensured (sic!).[17] As regards the material and technical means, there is, for instance, no legal basis for the use of camera surveillance systems, bars and other security elements, and there are no requirements set for safeguarding the outdoor spaces of closed wards.

Further, the patient's rights and obligations are not covered comprehensively; some common ways of interference with the patients' rights lack any legal basis. There are ambiguities in practice relating to treatment without the patient's consent (cf. chapter 12), scope of "regime measures" (getting outside, the possibility of wearing one's own clothes and using own things, including a telephone; cf. chapters 14 and 15), and use of security equipment (cameras, bars; cf. chapter 11).

An informal typology (psychiatric and sexological forensic treatment, forensic treatment of additions) appearing in court decisions based of court experts' proposals is relevant for the identification of hospitals where individual patients will subsequently be placed, and this typology is often used by physicians to determine which kinds of treatment can be provided without consent. However, the approach taken by the courts, court experts and providers in this regard is far from uniform. While some judges believe that several types of treatment can be provided in parallel, others consider it possible to order and provide only one type at a time.

16 Cf. the rulings of the European Court of Human Rights in Calvelli and Ciglio, no. 32967/96, judgement of the Grand Chamber of 17 January 2002, paragraph 49; Storck v. Germany, no. 61603/00, judgement of 16 June 2005, Section 103; X. v Finland, no. 34806/04, judgement of 3 July 2012, paragraphs 213-220.

17 The Standard of Acute Inpatient Psychiatric Care (Official Journal of the Ministry of Health of the Czech Republic, Volume 5/2016, p. 51) provides a guidance on staffing, i.e. recommendations aimed at optimising the situation in acute care; however, no such standard exists for follow-up care.

Finally, while the duties borne by various parties involved are perhaps not exactly "chaotic", as stated by experts of the Prison Service of the Czech Republic to the Ministry of Justice in 2014, there are certainly some flaws and ambiguities in the mutual co-operation.

For comparison, while secure preventive detention, which concerns in practice about 85 inmates and several dozen employees of detention institutions, is governed by a special law, including a basis for supervision by the public prosecutor's office, forensic treatment, which applies in its institutional form alone to almost 1 000 persons and several hundreds of healthcare professionals, is completely neglected in this regard.

## b) No regulation of transfers (relocation)

During my systematic visits and also when dealing with individual complaints, I realised there was no legal basis for transferring patients from one hospital to another. A transfer is commonly requested both by the patients themselves (the family has relocated; the patient wants to prepare for a transition to outpatient care in another region; somatic problems require the care of a remote provider) and by the providers (cessation of certain type of care); the therapeutic potential may also be lost and any further progress stalled because of fatigue or disruption of mutual relations. This is not surprising as treatment may take years.

The general patient's right to choose a provider does not apply in forensic treatment. The court orders [18]forensic treatment in a specific hospital based on the catchment areas specified in the instruction of the Ministry of Justice. Transfers **are not envisaged in the law at all** and no patient is therefore entitled to one. The courts may decide on a transfer relying on an analogy with other statutory provisions, but the practice is not uniform. Before the hospitals became overcrowded with patients undergoing forensic treatment, it was quite common – either based on the patient's initiative or at the court's direct instigation – that the hospitals agreed on an exchange or simple transfer, and the court "re-ordered" the treatment. While the hospitals continue to deal with requests for the admission of "non-catchment" patients on a case-by-case basis, their motivation to satisfy these requests has decreased significantly and the **previous system of ad hoc exchanges practically ceased to function**. On top of that, some courts consider this procedure impossible – for example, one patient was advised that the hospital's competence to provide forensic treatment was laid down by the law the court could not change it. I also encountered a case where a patient was transferred between hospitals based on approval of a judicial officer, without the court actually changing its decision. The patients are then entirely justified in perceiving this as a double standard.

I have already inquired into two cases where the mutual relationships between a patient and his/her therapeutic team were so seriously disrupted, and the patient's regime consequently became so restrictive, that this amounted to ill-treatment. While I saw a possibility for an instant remedy in the patient's transfer, there was no way of forcing the court to allow this.

I consider such a situation unacceptable. The substance of the patient's right to the protection of private and family life and, in extreme cases, also the right to an effective remedy in case of ill-treatment, **depends in fact on a completely informal procedure based on a forthcoming attitude of the court and hospitals**. Moreover, it is unclear who should deal with a patient's request for a transfer (whether the court or the hospital), and there are also doubts as to court jurisdiction.

At the same time, the rigid approach requiring treatment in the catchment hospital lacks any practical justification. Catchment areas are not equally populous and they differ in size; some hospitals thus carry a greater load than others and the patients are not on equal footing in terms of the distance between the hospital and their home. We could draw a parallel with prisons, which

18 The presiding judge under Section 351 (1) of the Code of Criminal Procedure, or the court secretary or head of court office under Section 6 (1)(k) of Decree No. 37/1992 Coll., on the rules of procedure for district and regional courts.

do have a procedure in place for inmate transfers; as a matter of fact, forensic treatment ordered for an indefinite term may be much longer than a prison sentence, and denial of a transfer can thus be even more painful. The mentioned lack of equality also manifests itself in that there is nothing in theory to prevent a transfer of a patient undergoing forensic treatment during a custodial sentence, while there is simultaneously no regulation of transfers before and after their imprisonment.

### c) No regulation of suspension of forensic treatment

This is an important measure which, however, lacks any basis in the law. There are situations in practice that call for a suspension of forensic treatment, mostly due to a change in the medical condition. For example, I inquired into an individual complaint concerning a patient who was diagnosed with cancer during institutional treatment; this diagnosis required a surgery and several months of recovery. The courts cannot draw any legal guidance from the Code of Criminal Procedure as to how they should proceed in such a case. This is a notable difference as compared to custodial sentences, which can be suspended under the law.

### d) Involuntary hospitalisation of offenders

If an offender is found insane, his/her criminal prosecution is discontinued and the relevant ground for his/her remand in custody ceases to exist. If the act the offender committed has consequences comparable to a felony, the prosecuting bodies will ask a hospital to detain the offender until the court makes a decision on his/her forensic treatment. The patient is then usually hospitalised without his/her consent and civil detention proceedings are initiated; however, the patient's consent to hospitalisation might also be granted in these instances. In any case, the prosecuting bodies rely on the fact that the offender is placed in a hospital and that recidivism is thus prevented for the time being. It then takes months or even a year for the criminal court to decide. **Hospital representatives speak about outright pressure to hospitalise offenders** and, moreover, they justifiably complain that they are asked to admit patients without being offered additional information (the Code of Criminal Procedure envisages the provision of an expert report only after forensic treatment has been ordered), they lack appropriate means to ensure security in the case of dangerous offenders, and the legal framework for hospitalisation is inadequate in cases where the patient's condition is stabilised and there are no manifestations of direct and serious danger for the patient or his/her surroundings.

## 6) Insufficient administrative framework of forensic treatment

The course of forensic treatment is based not only on the applicable legal framework, but also on organisation, management and financing of healthcare services. Following the "Žďár case"[19], the forensic treatment system has been exposed to a heavy load, which has revealed its weaknesses.

### a) The capacity and availability of beds for forensic treatment are not specified

**The availability of beds for forensic treatment is imbalanced.** The State does not set the capacity and facilities for institutional forensic treatment. The capacity available in individual hospitals for forensic treatment is determined by tradition and personal commitment of individual therapeutic teams; where the provider loses experts, specialised care is no longer offered. As a result, patients from Morava can only undergo sexological forensic treatment in Havlíčkův Brod

19 On 24 October 2014, a woman who had been released from institutional forensic treatment into outpatient care eight months earlier, murdered a student and injured several other people in the town of Žďár nad Sázavou, all that while being affected by a serious mental disorder.

and Brno – the whole North Moravian administrative region has no facility of this kind. The network of facilities depends on financing, which is now, in turn, absolutely dependent on the contracting policies of health insurance companies.

**There has been an increase in the number of patients without simultaneous determination of the capacity of the current system.** As regards exact data, I refer to the analysis by Páv and Švarc,[20] documenting a sharp increase in the number of patients undergoing institutional forensic treatment. Providers and their doctors feel responsibility for providing treatment and endeavour to cover the demand following from the courts' decision-making. However, the hospitals are clearly strained. According to the law, a psychiatric hospital may refuse a patient for forensic treatment if his/her admission would increase the workload above an acceptable level. Such refusals do occur in reality and I believe that this is a reasonable step if the capacity of specialised programmes (for the treatment of sexological disorders or addictions) is full or the hospital is unable to ensure security in view of an excessive number of patients showing aggressive and criminal behaviour. For instance, we identified this problem in co-operation with the management of Kosmonosy Psychiatric Hospital – given its inadequate material background and staff, the hospital was unable to ensure security in hospitalisation of unmotivated and dangerous patients with a drug addiction. I was surprised that this issue was being addressed completely informally as the hospital informed the courts that it would not receive any further patients. The Ministry of Justice's instruction comprising a list of hospitals and their respective catchment areas was not modified accordingly. The fact that patients are not admitted forthwith, but are rather entered in some sort of waiting lists, represents a problem in terms of execution of criminal measures, and judges object to this. However, I would like to express my support to hospitals as they indeed cannot be asked to assume responsibility for treatment of the patients without having safeguards of security and quality of this specific care.

**There is no direct co-financing from other budgets** (if we disregard one-off contributions to the hospitals from their founding entities, e.g. for the installation of an elevator). Páv and Švarc conclude that building, maintaining and financing the forensic treatment system is left exclusively to health insurance companies.[21] The unsuitability of the usual system for financing forensic treatment can well be illustrated on an example of permissions to leave a facility. Since institutional treatment also includes guiding the patients in their integration into society,[22] physicians allow the patients to leave the healthcare facility for short periods of time. In the case of a whole-day leave, the psychiatric hospital loses a part of the payment for the given day (e.g. 75%), although the costs of care decrease only marginally. I have encountered a case where a patient wanted to make use of permissions to leave the facility to fulfil her study obligations at a university, and this would entail no security risks. However, it was the financial aspect that played a crucial role in this case, together with the hospital's concern that, should the patient be absent on a regular basis, the health insurance company might question the indication of the care and request a refund, along with a possible penalty.

Considering the above, it is doubtful whether this is indeed a "system". It is unclear whether even the current level of uniformity and quality could be ensured if 12 out of the 14 hospitals providing institutional treatment were not directly controlled by organisations of the Ministry of Health.

## b) Security issues are left up to individual hospitals

Some of the patients undergoing forensic treatment are aggressive people lacking motivation, or even criminals. They may pose a threat to the staff and other patients and it is crucial that they never leave the hospital without permission. Detention of such patients is impracticable in the conditions or regular psychiatry. **However, the providers are not compensated in any way for**

20 Páv and Švarc, cited above.
21 Ibid, p. 19.
22 Šámal, cited above.

**the costs of securing their premises. Moreover, there are various ways to ensure security.** The applicable regulations provide no legal basis whatsoever for construction-technical features or staffing, and describe merely the methods of performing body searches and checks of personal belongings; the providers thus follow local customs and operate within the limits of their budgets. On top of that, it may be difficult on occasions to recruit male employees and the staff might feel threatened without them. It is a question where the hospital's task to ensure the detention aspect of forensic treatment begins and where it ends. Nevertheless, this issue cannot be resolved by mere specification of a number of "bed-days" in the mutual contract between a health insurance company and the given hospital as regards the payments for general follow-up psychiatric care from health insurance.

## c) Major difficulties connected with forensic treatment of children

Children's psychiatric wards are not equipped to house dangerous patients. On the other hand, children form a vulnerable group in specialised wards for adults, and these wards also lack the necessary tools for upbringing and schooling of children. Páv and Švarc refer to unnecessary isolation without schooling and contact with peers.[23] I encountered the case of a juvenile placed in a sexology ward, and this indeed posed a specific burden on the staff (for more details, see chapter 13 (c)). Although he was hospitalised for several months, the hospital did not feel responsible for ensuring the patient's schooling.

## d) Lacking records of patients receiving forensic treatment

Forensic treatment records are still incomplete. There is no way of determining the number of patients for whom forensic treatment was imposed, ordered or terminated on a specific day, or the identity of these patients. Such data would be of use for courts (as, for example, they are unaware whether forensic treatment has already been imposed on an offender), the prison service, healthcare services providers, as well as the Ministry of Health with a view to managing the healthcare system.

## e) Systemic obstacles stand in the way of subsidiarity of institutional treatment

Institutional forensic treatment constitutes an extraordinarily serious restriction of personal freedom, which may sometimes inflict greater harm than a custodial sentence, especially due to its indefinite duration. It should only be imposed in exceptional cases where there is no other way of addressing a specific concern for which it can be ordered.[24] This principle also applies to continuation of institutional forensic treatment. Once a patient is prepared and motivated to proceed with a transition to outpatient care, this transition should commence. This, however, often does not happen in practice for reasons that have been repeatedly pointed out by courts and healthcare professionals.

First, **there is no functional network for outpatient forensic treatment**. The courts thus face difficulties in transferring patients to outpatient care. A technical problem lies in the fact that there is no transfer mechanism in place – a list of providers is lacking and so is a specification of catchment areas. The Ministry of Justice has therefore called for the creation of a special register or use of the existing register of healthcare services providers. The Ministry of Health, on the other hand, has advised the courts to contact health insurance companies.[25] However, this cannot be an effective step in a situation where there is no network of outpatient facilities for forensic treatment. There are not enough such facilities, either – within the jurisdiction of some district courts, forensic treatment is provided by only 20% outpatient psychiatric clinics, while others lack a physician with

23 Páv a Švarc, cited above, p. 29.

24 Cf. the judgement of the Constitutional Court of 3 March 2011, File No. I. ÚS 3654/10 (N 35/60 SbNU 425), available at: http://nalus.usoud.cz.

25 Based on letters exchanged between the Ministers of Health and Justice in 2017.

an appropriate expertise (sexology or addition therapy). In this situation, the burden of seeking a willing outpatient physician is borne by the court, hospital or, in some cases, the patient him/herself if he/she asks for a change in the form of treatment.

Thanks to the introduction of special codes in the reports of care for reimbursement by insurance companies, it has at least been possible since 2017 to identify providers who offered outpatient forensic treatment as of a certain date. Furthermore, since 2017, services and medicinal products provided in connection with an ordered forensic treatment have not been counted towards the maximum amount of reimbursement, which de facto limits the outpatient providers, and these are thus fully covered from health insurance. However, beyond the scope of the payment for treatment from public health insurance, no compensation is still provided for the costs of non-medical activities specific for forensic treatment. In the past, the Ministry of Justice presented some calculations of these costs, as well as a proposal for the introduction of a "risk contribution". These measures, which were suggested to the responsible ministry, i.e. the Ministry of Health, might motivate outpatient doctors to accept more patients undergoing forensic outpatient treatment.

Furthermore, experts point out that the "Žďár case" has resulted in extreme demands on the supervision over patients in forensic treatment. As **the degree of supervision is reduced in outpatient care to occasional meetings at the physician's office**, detention measures can no longer be considered compliant with the principle of subsidiarity – hospitalisation continues in many cases only because, in view of the persisting level of danger, it is necessary to provide for a higher degree of supervision than these meetings can offer, given that they take place once every several weeks or months.

My findings from the visits confirm that the **courts make a change in the form of treatment conditional not only on the medical indication, but also on social background**. If a patient has no family capable of providing supervision and material conditions, his/her discharge depends on there being a current vacancy in a social services facility. However, social service providers will not include a patient in their waiting list if he/she is yet to be discharged from the institution providing forensic treatment (a social service facility needs to know the date of his/her arrival, but the hospital cannot guess when the court will decide on its motion for the patient's discharge). Not to mention the lack capacity of specialised special-regime homes and their latent unwillingness to accept persons with a criminal history. One hospital has even established four sheltered housing beds on its premises and uses them for the transition of patients to the social system. Hospitals have great difficulties finding accommodation for some of their patients. Those who no longer have family or friends cannot be discharged as they have nowhere to go. Providers are frustrated that they are unable to hand over patients to outpatient care although they are prepared for such a step, and claim that "a hospital should not serve as an accommodation facility".

I note that there is a new institution – mental health centres – which should assist in reintegration of patients into the community after long hospitalisation and ensure functional interconnection between outpatient and inpatient care.[26] However, their target group does not include patients subject to institutional forensic treatment and their functions do not comprise co-operation with the judiciary. The centres rely on co-operation agreements with current stakeholders and on the work of regional working groups established with a view to systematically co-ordinating services for persons with a mental disorder. However, these stakeholders show little interest in taking over some of the tasks in forensic treatment and they are not bound or motivated to do so now.

My recent survey indicates that **certain social services are unavailable**, including those for stigmatised target groups such as persons with a mental illness, homeless people and convicts released from prison. Administrative regions are required, in their independent competence, to plan

26 Standard of care provided in Mental Health Centres, Official Journal of the Ministry of Health of the Czech Republic, Volume 5/2016, from p. 35.

for availability of social services and create medium-term plans for the development of social services. But as the survey showed, they approach this duty with a varying degree of specificity.[27]

**The above obstacles hindering transition of patients to outpatient treatment force hospitals to exercise some self-restraint in filing motions for such transition. A hospital will likely not propose a transfer if it suspects that the court will deny it in view of lacking follow-up outpatient care or social safety net (whether formal or informal). These facts represent a legal obstacle to a change in the form of the patient's treatment in ensuing court proceedings. Nonetheless, these are absolutely objective facts attributable to the State – in specific cases, they could justify a complaint about unauthorised deprivation of liberty.**

## f) No guidance for assessing the danger posed by patients

Assessment is made with regard to every patient as to whether the objective of forensic treatment has been attained and whether the dangers associated with his/her freedom continue to exist or have been minimised. This assessment has to be carried out by the court when it decides on continuation of the forensic treatment or its replacement by secure preventive detention, and must also be dealt with by the healthcare services provider.

Some physicians object that this is a legal question which they are not competent to resolve. I cannot fully agree because the provider is required to submit reports and motions to the competent court for the needs of assessing these very dangers, and must also adapt its own approach towards the patient to these circumstances. The danger posed by a patient serves as a reference point when the purpose of forensic treatment is being set, reflecting on the justification of interference with his/her fundamental rights in hospitalisation.

**A psychiatric hospital should therefore evaluate the risks posed by each patient – not only at the beginning of his/her hospitalisation and at times of scheduled court review of further continuation of the measure, but regularly.**

In view of the major – bordering on decisive – significance of the provider's opinion, there is a pressing need for some guidance as to the medical element of the danger assessment process. In practice, the patient's behaviour throughout the treatment is summarised to the court, and the parties seek its interpretation. Patients naturally complain that any misconduct they have committed during the treatment is being overestimated or that the doctor's assessment is downright unfounded. While every important statement (motion) for the court is discussed at a meeting of head physicians, this is always influenced by the individual physicians' experience. **The hospitals I visited did not use any standardised or structured approach to this issue.**

An improvement in this area would be desirable because motions for a change in the form of treatment or suitability of continued institutional forensic treatment should be comprehensible and comprise a reviewable substantiation. Objective characteristics of the patients in terms of the dangers they pose would also better reflect the complexity of the care ensured by the provider and better support budgetary requirements essential for good-quality and secure care.

As regards the methods of risk assessment, I refer to the work of Páv and Švarc, and strongly support the proposal to implement professional tools that help objectivise and structure the considerations in assessing the risks posed by the patients.[28]

It should be noted that criticism has also been voiced with regard to **the courts' legal assessment of the dangers posed by patients**. When Páv and Švarc try to reflect on the issue of why patients

27 See the PUBLIC DEFENDER OF RIGHTS. Availability of social services for persons with autism spectrum disorder, File No. 45/2018/OZP/VV [online]. Brno: KVOP, 2018 [retrieved on 26 June 2019]. Survey report available at: https://eso.ochrance.cz/Nalezene/Edit/6204; recommendation available at: https://eso.ochrance.cz/Nalezene/Edit/6206.

28 Cf. the overview of available tools in Páv and Švarc, cited above, p. 32. Additionally, also ZVĚŘINA, Jaroslav and Petr WEISS: Doporučené postupy v terapii parafilních sexuálních delikventů (Recommended Procedures in the Therapy of Paraphilic Sexual Offenders) [online]. Prague: Ministry of Health, 2012 [retrieved on 26 July 2019]. Available at: https://www.mzcr.cz/dokumenty/doporucene-postupy-v-terapii-parafilnich-sexualnich-delikventu_12999_3216_1.html, chapter 4.

often remain in an institution longer than absolutely necessary, they offer public opinion as one of the possible explanations. This is a hypothesis supported by current data; its verification would, however, require longer monitoring. Nonetheless, the authors present their professional belief: although there exists an intermediate step in the form of outpatient treatment for patients who are assumed by the law to still pose certain dangers for society, it seems as if these had to be absolutely eliminated for the institutional treatment to end.

## g) The contents and form of the hospitals' reports and procedural proposals are not unified

The healthcare providers' reports to courts on the progress in treatment and the procedural motions they present in certain situations carry great significance for continued forensic treatment (overall or in institutional form). With regard to their contents, the Code of Criminal Procedure merely states that the motions should describe the course and results of the forensic treatment and indicate the reasons for the proposed procedure (Section 353 (1)); **the required degree of detail is not specified**. Generally speaking, the law anticipates that such motions will be filed with regard to (non-)attainment of the forensic treatment purpose – cf. chapter 3 (b).

As regards the **uniformity of the hospitals' procedure in drafting these motions**, various opinions were expressed during the Government's "inventory" in 2014: Based on a review of court files, the Ministry of Justice concluded that the motions were sometimes very brief and their form differed significantly, while the Ministry of Health reached the conclusion that there were "uniform features" in the psychiatric hospitals' procedures. In my systematic visits, I encountered complaints from both providers (e.g. concerning a lack of adequate court response to detailed expert opinions) and patients (e.g. regarding insufficient reasoning of the hospital's statement for the court). For details on the topic of comprehensibility and reviewability of these reports and motions, see chapter 6 (f).

Certain guidance as to the structure of the proposals/reports can be derived from a document prepared by the Ministry of Health for the Government in 2014. According to it, a motion for a change in the form of forensic treatment should be conditional on:

- Elimination or at least mitigation of acute psychopathology, meaning that the patient's freedom would no longer pose a danger for society. The risk of decompensation of the mental state can never be entirely ruled out in the future, but it is not anticipated at the time when the motion is filed.
- Verification of the stability of remission and its social acceptability – open regime in the ward, outings and permissions to leave the facility.
- Continued treatment in outpatient form can be assumed.

These preconditions can be used as a basis for monitoring the attainment of the forensic treatment's purpose and the subsequent procedure by the hospital. However, they are not formally specified anywhere; the mentioned material notes without further ado that they follow from the state of the art in psychiatry. The hospitals' practices differ in terms of for how long the state of remission is verified and what the safeguards in follow-up outpatient care should look like.

It is also problematic in practice how the hospitals should approach patients refusing treatment and, in particular, pharmacotherapy, and specifically whether or not to propose a transfer from institutional treatment to secure preventive detention in such situations. Treatment is associated with ensuring the protection of society, as there is a significant threat of recidivism if certain disorders are not treated. However, this is not always true and, in my opinion, the above is not in itself a statutory ground for ordering secure preventive detention, although the Criminal Code explicitly mentions repeated refusal to undergo examination or treatment procedures or some

other expression of a negative attitude towards forensic treatment as a reason for such a court decision (cf. also chapter 12 (b)).[29]

I believe that it is clearly needed to unify the form and contents of these proposals/reports, e.g. by interpreting the provisions of the Code of Criminal Procedure or issuing certain model documents.

What has been settled (and introduced in all the facilities I visited), on the other hand, is that motions for a discharge from forensic treatment are submitted to the courts by head physicians and based on a statement drafted at a **meeting of head physicians**. The provider's motions thus do not represent merely the opinion of the examining physician, but rather a broader consensus among experts, some of whom are qualified court experts.

## h) Hospitals object to court experts' work and the use of expert reports

A court expert plays a key role in imposing and reconsidering forensic treatment. Although the final decision on the form of the measure and its duration is up to the court, a court expert is to provide a statement on the given person's medical condition, the current state of the disease or disorder, the effects of treatment so far and other treatment options, and the medical forecast in view of the dangers posed by the offender and his/her reliability, and propose measures corresponding to the above.

The same objections were repeatedly raised in my visits and follow-up debates with professionals from the field. Specifically: that the court experts' approach is inconsistent; that they propose forensic treatment even where there is no hope of attaining its purpose, or that they oppose the patients' discharge; and that without knowing the reality of institutional treatment, they base their expert assessments on "customs".[30]

It is a fact that no more detailed requirements are formally set for **expert assessment** [31] and there thus indeed is a risk of inconsistency and errors. Nonetheless, a court expert must present his/her expert statement in a qualified manner, which includes the **requirement for objectivity and reviewability**. Consequently, the court expert's conclusions must be substantiated, as required, e.g., in general terms (statistics, studies on the usual course of the disorder) and specifically (test results, evaluation of the personal history),[32] and it must be clear from the report how the expert reached his/her conclusions. What is not explained in the report is unreviewable. A conclusion that is illogical or contrary to the rules of science is naturally defective.

On the other hand, in the absence of any policy of forensic treatment or set treatment programmes, it is quite logical that the court experts' recommendations may differ from the opinions of clinical physicians.

**I definitely recommend to point out any poor expert report to the Ministry of Justice or the president of the regional court with which the court expert is registered.**

## i) Secure preventive detention cannot resolve issues faced in forensic treatment

After a student was stabbed to death in Žďár nad Sázavou in 2014, there were calls for more frequent use of the institution of secure preventive detention. Secure preventive detention is one of the elements of a system which also includes forensic treatment and where mutual links among

29 See Section 99 (5) of the Criminal Code. Section 351a (1) of the Code of Criminal Procedure indicates, however, that it is also necessary to meet the criterion of necessity of such a measure for effective protection of society, i.e. that the danger cannot be contained by simple presence in a hospital.

30 Cf. also Páv a Švarc, cited above.

31 The recommended procedures for clinical practice (of 2010) focus on expert examination concentrating on evaluation of the state of recognition and control abilities (i.e. the basis for a decision on the perpetrator's sanity).

32 Cf. judgment of the Constitutional Court File No. III. ÚS 3675/16, cited above, paragraph 24.

the individual elements are highly desirable. The number of inmates in detention has doubled since 2014 and the current capacity is fully used. As part of my systematic visits to secure preventive detention institutions, I analysed all the cases where secure preventive detention had been ordered so far,[33] and **expressed a concern about the constant increase in the number of inmates**.

It can be assumed that better equipment of psychiatric hospitals for ensuring security during the hospitalisation of violent patients and also safeguards against absconding would alleviate the pressure to use secure preventive detention. And vice versa, if hospitals are allowed to set their capacity or target groups of the individual wards (beds) reserved for forensic treatment as they wish, and continue refusing non-perspective patients with reference to full capacity, the pressure on secure preventive detention will remain.

I will illustrate another reason why the detention capacities are full on a specific example. The court ordered that a blind woman be moved from psychiatric forensic treatment to secure preventive detention, among other reasons, because living in a hospital community and in close vicinity of other patients increased the dangers she posed, and the patient herself demanded quiet and solitude. The hospital submitted a motion for such a change after two months of her presence. The court expert stated that he considered secure preventive detention appropriate because the patient would have a separate room there and would thus not be in such a close contact with patients suffering from serious mental disorders. The woman told the court that she wanted to move into a detention facility because such an environment would suit better her disability and she would be able to spend time listening to the radio and reading magazines for blind people. This example illustrates how demanding the conditions are at some wards of psychiatric hospitals. The experience of physicians working in secure preventive detention facilities also proves that psychopharmacotherapy can be paradoxically reduced there, because the danger posed by the inmates decreases on better guarded premises. **For some patients, detention thus substitutes for a suitable therapeutic environment**, which is at variance with the principle of subsidiarity.

I therefore believe that the increasing number of inmates is not an objective expression of the need to utilise secure preventive detention.

### j) Lacking forensic treatment policy

All the various issues elaborated above can be explained by a lack of nationwide forensic treatment policy. Such a policy should be prepared in close co-operation with experts in order to make it clear for whom forensic treatment is intended, what objectives it has and how this should be arranged in hospitals, and what rights and obligations are vested in the patient and in the provider in this regard. Furthermore, it is necessary to establish the concept of forensic treatment during the service of custodial sentences in prisons (currently, physicians speak of "lost time" for convicts) and in outpatient treatment. A clear forensic treatment policy would also serve as a guideline for courts and court experts, and help unify their activities, which is what healthcare professionals call for.

## 7) Judicial decision-making

Decisions on imposing and re-evaluating forensic treatment are specific in that they combine legal and medical issues. The outcome is significantly influenced by the court, public prosecutor, court expert and examining physician, while each of them pursues a somewhat different interest. The providers of healthcare also openly speak about the pressure of public opinion. The final decision is always up to the court. In the following text, I offer suggestions aimed at better procedural justice.

33 PUBLIC DEFENDER OF RIGHTS. Report on visits to secure preventive detention facilities [online]. Brno: KVOP, 2019 [retrieved on 22 June 2019]. Available at: https://eso. ochrance.cz/Nalezene/Edit/6656, p. 29 et seq.

## a) Lack of uniformity in decision-making

The analysis by Páv and Švarc provides some very interesting observations. The catchment areas of psychiatric hospitals for forensic treatment are defined in the relevant instruction of the Ministry of Justice on a territorial basis, but the numbers of patients undergoing forensic treatment in individual hospitals do not correspond to the respective populations of the areas. In some hospitals, the number is almost two- or three-fold the average. Further, based on statistical data regarding instances of forensic treatment exceeding two years, the authors inferred that forensic treatment tends to be the longest in hospitals with an above-average number of patients undergoing this treatment. At the same time, the decisions on a discharge from forensic treatment are made by the court in whose district the given hospital is located. The authors fear that this may owe to the fact that judicial and court expert activities are influenced by certain habits, which differ regionally and reflect, e.g., the number of outpatient physicians available in the given region.

The lack of uniform judicial practice was also pointed out by doctors in the facilities I visited. They mentioned cases where the court would not permit a transfer to outpatient care earlier than one year after the commencement of institutional treatment or without the application of depot medication (which has long-lasting effects and is administered by injection once every several weeks), while other courts proceeded strictly ad hoc.

The review of court files carried out by the Ministry of Justice in 2014 also indicated that individual courts would take various quantities of evidence when attempting to clarify the facts in decision-making on proposals for a change of institutional forensic treatment into outpatient care. There were marked differences in terms of whether the court commissioned an expert report in these instances. On the one hand, an expert report might have been useful in some cases, but there was none, while on the other hand, such a report was sometimes redundant and its preparation protracted the proceedings (some physicians qualified as court experts could not understand why the court commissioned an expert report although their motion for replacement of change of forensic treatment with some other form of treatment comprised extensive substantiation, or how a court could react to a motion for termination of treatment which was not serving its purpose by asking the hospital "to give it another try").

"The purpose of taking evidence in criminal proceedings is to ascertain the facts of the case beyond any justified doubts, to an extent necessary for a decision" (Section 2 (5) of the Code of Criminal Procedure). There exist no unified guidelines or templates; the procedure is strictly individualised. It is then up to the court's discretion what means of evidence it will use to clarify a certain circumstance in co-operation with the parties, which are supposed to adduce the necessary evidence.[34] However, it is desirable to minimise any unwarranted inconsistency, e.g. by offering further education to judges and public prosecutors on the specifics of forensic treatment.

## b) Imposing useless forensic treatment

Hospitals house a number of patients for whom – according to the doctors – forensic treatment is clearly useless (in the therapeutic sense). This is true especially of unmotivated alcohol and drug addicts, as the success of such treatment depends exclusively on the patient's resolution to recover and his/her willingness to co-operate in psychotherapy. These patients not only do not comply with their own treatment regime and, therefore, do not benefit from the treatment, but interfere with the treatment of other patients. Furthermore, a lack of purpose in treatment is apparent with regard to patients with more serious mental disabilities, dementia and foreign nationals who do not speak Czech. Healthcare professionals cannot understand why forensic treatment is imposed on these persons in the first place, and speak explicitly of "incorrectly imposed treatment". They regret the blocked capacities and do not feel comfortable to provide only for the patients' detention.

34 Supreme Court, resolution of 18 February 2015, File No. 3 Tz 58/2014, available at www.nsoud.cz.

Hospitalisation in cases where there is no chance of improvement is also at variance with the principles of constitutional law.

Specifically, it follows from Section 99 (2)(b) of the Criminal Code that forensic treatment shall not be imposed in cases of alcohol and drug addiction if it is clear that its purpose cannot be achieved for the offender.[35] However, based on the findings of psychiatric hospitals, the courts do not always check for this information during the proceedings or they impose forensic treatment even where it is not recommended by the court expert, or the court is in accord with the expert, but the treatment is still clearly useless.

## c) Decision-making on a discharge

I marginally addressed certain critical comments presented by some providers regarding their co-operation with courts deciding on a discharge from institutional forensic treatment. It was my objective to verify whether or not the current set-up of criminal proceedings entailed any systemic issue.

First, I analysed on my own initiative the procedures followed by one specific court to determine whether the **enforcement proceedings were smooth and rapid**, focusing specifically on the court's activities between publication of the resolution on discharge from institutional forensic treatment and the actual discharge from the hospital.[36] Based on my suggestion, the court's president carried out an inspection and found that there had been several minor delays in 2018 that postponed the patient's discharge from a psychiatric hospital by 2 to 6 days. Even without such a protraction, it usually takes 14 days (sometimes less, sometimes more) before a promulgated resolution on a discharge from forensic treatment enters into legal force and the decision becomes enforceable, and before a discharge order is made and the relevant decision with a clause of legal force is handed over to the healthcare services provider. This depends, among other things, on the service of process on persons who can file a complaint against the resolution and the associated time limits. In view of the gravity of the interference with personal freedom ensuing from institutional forensic treatment, any such delays should be avoided.

I would like to point out that, **in case of doubt, all the parties may turn to the president of the competent court, who has tools to monitor possible delays and, if need be, provide for a remedy both within general prevention and in response to a specific complaint**.

Second, it is a considerable burden for psychiatric hospitals when a public court hearing **does not take place in the hospital itself** (as is the practice, e.g., of the District Court in Litoměřice and the District Court in Plzeň-South), and all the parties involved are thus forced to travel to the court building (as is common, for example, for the Municipal Court in Brno). This is no longer a matter of court administration, but rather a decision made by the presiding judge. While a venue outside the court building is envisaged for a hearing in the case of civil proceedings on the permissibility of admission to a healthcare institution, Section 199 (2) of the Code of Criminal Procedure merely allows for a hearing to take place elsewhere in "suitable cases", in view of the principle of publicity. The situation is thus somewhat different here. On the other hand, as stated above, some courts proceed regularly in this way and allow other patients and interested public to observe the hearing of the case in a hospital, thus adhering exactly to the requirements of the mentioned provision of the Code of Criminal Procedure.

35 Šámal, cited above: "Experience shows that the patient's proper motivation to achieve a positive change and his or her co-operation in treatment is crucial for effective forensic treatment, especially in the case of alcohol and drug addicts. Therefore, when imposing forensic treatment under Section 99 (2)(b) of the Criminal Code, the court must also examine whether or not there exists any contraindication in the offender him/herself, i.e. whether or not it is clear that the purpose of forensic treatment cannot be achieved for the given offender. If the court determines that such a contraindication exists, it shall not impose forensic treatment."

36 Municipal Court in Brno, File No. 7781/2018/VOP. Pursuant to Section 1 (1) and (7) of the Public Defender of Rights Act, the Defender's competence includes the exercise of State administration of courts.

# 8) Lacking professional standard

Recommended clinical practices are important both in view of their actual impact on the provision of care and because of their legal significance. The latter is true as the legislation refers to recommended procedures as a limit or standard defining medical necessity and justification of interference with human integrity. [37]

Since 1998, the Psychiatry Society of the Czech Medical Association of J. E. Purkyně (in co-operation with the Czech Psychiatry Association) has been compiling recommended clinical procedures (five versions so far). The contents of forensic treatment have yet to be encompassed in the recommended clinical procedures. The recommended practices of psychiatric care address individual health problems (e.g. treatment of addictions, therapies for paraphilic sexual offenders, and certain topics of psychiatric treatment), rather than the topic of forensic treatment as such.

I dare say that the concept of forensic treatment follows tradition and the professional conviction of individual experts. I base this conclusion on the fact that certain phenomena were present in all the facilities visited, and they could be considered generally recognised and settled, while other tools and methods were rarely used. In some cases, this has no other explanation than practicality.

One can agree with Šámal that forensic treatment is sometimes conceived as a system based on gradual acquisition of benefits based on goals fulfilled by the patient, where the patient is motivated by the ultimate goal – discharge from the facility and smooth transition to normal life. [38] The rule is that with decreasing danger, the regime becomes gradually less restrictive and permissions to leave the facility are granted with a view to testing how the patient functions outside an institution. However, the requirements as to what the patient needs to fulfil considerably differ among therapeutic teams, including the duration of various stages of the patient's stay.

It is clear that every physician or therapist has his/her own experience and opinion, an individual "lege artis".[39] However, the system in which they operate must be unambiguous and settled in view of the requirement for transparency and fairness for the patient and also the possibility of co-operation within multidisciplinary teams.

I identified areas where, in my opinion, professional topics clearly collide with the patient's dignity and his/her right to self-determination, and it is therefore necessary to unify the approach to these topics and incorporate them in treatment programmes: motivational systems (chapter 13 (d)), assessment of danger (chapter 6 (f)); use of penile plethysmography (chapter 13 (h)); permissions to leave the facility (chapter 14 (c)); contents of the treatment regime (chapter 14).

In view of the physicians' complaints concerning misunderstanding of the potential and nature of institutional forensic treatment by the courts and some court experts, it would be best to prepare standards for the individual types of forensic treatment.

# 9) Supervision and control

The positive duties borne by the State with regard to protection of the rights of persons with a mental disorder also include supervision and control. Specifically, protection against ill-

37 "Any intervention in the health field (...) must be carried out in accordance with relevant professional obligations and standards," states Article 4 of the Convention on Human Rights and Biomedicine. According to Section 4 (5) of the Healthcare Services Act, "[p]roper professional expertise means the provision of healthcare services according to the rules of science and recognised medical procedures while respecting the patient's individuality, and taking into account the specific conditions and objective possibilities".

38 Šámal, cited above.

39 "[D]ifferent therapeutic methods are often applied at various facilities according to the therapists' field of specialisation." Zvěřina and Weiss, cited above, chapter 5. 6.

treatment thus requires effective tools to prevent continuation or recurrence of ill-treatment, investigation of suspected ill-treatment, and prosecution of offenders.[40]

## a) Lacking supervision by the public prosecutor's office over forensic treatment

While the Public Prosecutors Act[41] requires that public prosecutors supervise, under the conditions and in the manner specified by the law, compliance with the legal regulations in facilities where personal freedom is restricted, no such supervision applies to forensic treatment. The reason lies in the absence of a special law defining the subject and conditions of such supervision, analogously, for example, with the Service of Imprisonment Act or the Institutional Education Act. Consequently, while public prosecutors carry out regular inspections in prisons and children's homes, meet with the detainees face to face, may issue instructions to comply with the legal regulations, and may order that a person detained unlawfully in such a facility be released, patients in psychiatric hospitals do not benefit from any such protection.

This means, specifically, that there is no independent authority that could quickly ensure remedy in cases of ill-treatment. Patients can invoke enforceable protection of their rights in court; however, from the perspective of a person suffering from a mental disorder and deprived of liberty, this is a demanding option that also takes too long. The complaints process under the Healthcare Services Act is lengthy (the patient must first file a complaint with the provider) and a remedy is difficult to achieve. In a case where I carried out an individual inquiry and expressed my conviction that the patient had been exposed to inhuman and degrading treatment, the patient had first turned to the police. The police had contacted the hospital in response and accepted its version of the facts; while this procedure was clearly incorrect from my point of view, it corresponded to the low awareness of the issue of ill-treatment of patients.

I have already been pointing out for several years that this shortcoming can lead to violation of the patients' fundamental right to an effective remedy under Article 13 in conjunction with Article 3 of the European Convention. I discussed a possible redress with the Deputy Minister of Health and members of the lower house of the Parliament. In 2018, the lower house even asked the Government to address my proposal for legislative changes.[42]

## b) No infractions defined in the Healthcare Services Act

The Healthcare Services Act provides for administrative punishment of healthcare services providers in case of non-compliance with formalities, but defines no infraction covering often serious instances of interference with privacy, safety, integrity and dignity of patients. This makes it impossible to penalise those forms of ill-treatment that do not attain the gravity of a criminal offence, and consequently reduces the provider's respect for the rights of patients and supervisory bodies. I thus recommend to supplement the list of infractions in the Healthcare Services Act.

In my report on visits to facilities for long-term patients (2017), I recommended that the Ministry of Health add to the Act a specific infraction of non-compliance with the statutory duties associated

40 Rulings of the European Court of Human Rights in Storck v. Germany, cited above, paragraph 103; Ananyev and Others v. Russia, no. 42525/07 and no. 60800/08, judgement of 10 January 2012, paragraphs 97-98; and Bureš v. the Czech Republic, no. 37679/08, judgement of 18 October 2012, paragraphs 121-127. In Storck v. Germany, the Court inferred that the European Convention required the State to carry out preventive checks at reasonable intervals focusing on potentially serious interferences with the rights of vulnerable groups of persons. For effective protection of rights, it is necessary that the State perform, at its own initiative, regular inspections in psychiatric treatment facilities in order to ensure that the patients' rights are respected.

41 Section 4 (1)(b) of Act No. 283/1993 Coll., on public prosecutors, as amended.

42 Chamber of Deputies of the Parliament of the Czech Republic. Resolution No. 292 of 28 June 2018 adopted during the 16th session, on the Annual Report on the Activities of the Public Defender of Rights in 2017 [retrieved on 27 July 2018]. Available at: https://www.psp.cz/sqw/text/text2.sqw?idd=149943.

with the use of restraints. The Minister informed me[43] that he would include illegitimate use of restraints as an infraction among the suggestions for amendment to the Healthcare Services Act.

# 10) Proposed measures to resolve systemic issues

## a) Measures proposed in 2014

Forensic treatment has an infamous symbol in the Czech Republic – the tragic event that occurred in the town of Žďár nad Sázavou in October 2014. It appeared that this would be a tipping point for the whole concept of forensic treatment. Based on a task assigned by the Government, the Ministry of Justice prepared a Report on the results of inquiries by the competent authorities into the tragic event in Žďár nad Sázavou, and proposed individual and systemic measures to improve the situation.

However, the effects have so far been only partial, perhaps because the Government merely took the report into cognisance,[44] without assigning any tasks to the relevant ministries. Nonetheless, the Ministry of Justice has prepared a partial amendment to the Criminal Code and arranged, through the Judicial Academy, that the plan of educational events would include systematic training of judges and public prosecutors in topics of forensic treatment, also from the perspective of healthcare services providers. The Ministry of Health at least pushed for simplification of the system of prescribing depot antipsychotics.

**The findings from my visits essentially reveal that the Ministry of Justice and the Ministry of Health must tackle two issues: (i) ensuring secure and fully-fledged institutional forensic treatment for a constantly increasing number of patients; and (ii) elimination of the existing inequalities among citizens ensuing from the lack of uniformity in imposition and duration of this measure. Both these problems need to be addressed simultaneously – if they are both successfully resolved, the number of patients is likely to decrease and the pressure on secure preventive detention subside.**

These problems have been debated for some time now; the two Ministries have established working groups[45] and agreed, based on an analysis of the situation in 2014, that **forensic treatment would have to be regulated by a special law**.[46] Along with unification of terms, this would have the potential to improve the existing conditions of outpatient forensic treatment, provide a basis for financing the treatment from multiple sources, and clearly define the duties of all the affected entities. The plan has yielded no fundamental results over the last five years, however. No ideas have reached the stage of legislative proposals in the field of healthcare. A specific law governing forensic treatment would fall within the competence of the Ministry of Health, with co-responsibilities borne by the Ministry of Justice, the Ministry of the Interior and the Ministry of Labour and Social Affairs. At the time, the Ministry of Justice stated that it was ready to co-operate immediately in the preparation of a substantive intent of such a law.

There are a number of options and **measures that would contribute to improvement of the situation**. The ministries certainly have room for improvement: pressing for unification of the practice of courts and experts, introduction of tools for supervision over patients subject to outpatient treatment, and motivation of outpatient physicians. It has been proposed to update the

43 By a letter of 11 January 2018, Ref. No. MZDR 517/2018-3/OZS.

44 By virtue of Resolution No. 1015 of 8 December 2014.

45 In June 2014 (before the attack in Žďár nad Sázavou), the Ministry of Justice established an interministerial expert working group for forensic treatment, tasked with increasing the efficiency of procedures applied towards people in forensic treatment with a view to achieving both consistent protection of society and provision of highly professional healthcare. All the stakeholders are represented in the working group. A number of proposals which are still relevant have been put forward, with some of them also gaining my personal support.

46 This proposal was raised for the first time by the Government Council for Human Rights in 2005, based on which the Minister of Health, in co-operation with the Minister of Justice and the Chairman of the Government Legislative Council, was tasked with submitting the relevant bill. Cf. Government Resolution No. 1292 of 8 November 2006. The outcome was the Specific Healthcare Services Act, which concerned, however, only the medical component of forensic treatment.

concept of forensic treatment for persons treated for addictions (amend Section 99 (2) of the Criminal Code) or better prepare future patients at a time when they are still serving imprisonment. An existing proposal for establishing a forensic psychiatric facility could be put into practice – this would be a specialised secure centre outside regular psychiatry which would develop the professional aspects of forensic treatment and, where appropriate, serve as a facility for a transition between secure preventive detention and forensic treatment.

I note that if financing does not change, fundamental humanisation measures that I recommend in this report will not be feasible in hospitals (reduction of the capacity of dormitories, access to the open air); to the contrary, the situation will further deteriorate – due to increasing capacity of individual wards, which is becoming a topic again.

The Ministry of Health has assured me that forensic treatment is being addressed within the reform of psychiatric care and that the issue of forensic treatment is one of important areas the Ministry is dealing with and where it supports a comprehensive solution. As far as I am aware, however, the individual steps taken within this reform have so far failed to address directly the specific problems described above (for more details, see chapter 6 (e)). I therefore welcome that at least a partial step has been taken – a pilot project of a forensic multidisciplinary team which, if fully developed, could contribute to the prevention of hospitalisation or reduction of its duration, and help reintegrate long-term hospital patients into their own social environments.

It would certainly help reintegration of patients if a **network of follow-up social services** was established in the administrative regions, or if the capacity directly reserved for patients in forensic treatment was known.

## b) Systemic recommendation of the Defender

### Recommendations to the Ministry of Health (in co-operation with the Ministry of Justice)

- carry out comprehensive review of the legislation on forensic treatment and prepare the necessary legislative proposals (i.e., among other steps, supplement the legislation on security of the relevant facilities; set the personnel requirements on providers; provide a legal basis and safeguards for treatment without consent; establish a mechanism of relocation of patients; specify guaranteed specific conditions for children; cf. chapters 5 and 6);
- prepare a forensic treatment policy and, within its framework, improve the mechanism of its financing (cf. chapter 6 (j));
- unify the procedure of healthcare services providers in evaluating the attainment of the purpose of forensic treatment and persisting danger posed by the patient (offer guidance for the provider's structured considerations; cf. chapter 6 (f) and 6 (g));
- ensure reopening of the sexological treatment ward for the Northern Moravia catchment area (see chapter 6 (a));
- subsidise investment plans of psychiatric hospitals related to security at wards specialising in the provision of forensic treatment for dangerous patients (cf. chapter 6 (b));
- continue the development of pilot forensic multidisciplinary teams (cf. chapter 10 (a));
- guarantee further education of court experts so as to promote uniformity (cf. chapter 6 (h));
- prepare a draft amendment to the Healthcare Services Act so as to define an infraction of degrading treatment and incorrect use of restraints (cf. chapter 9 (b));
- prepare a draft amendment to the Specific Healthcare Services Act so as to define the subject and conditions of supervision by the public prosecutor's office at places where forensic treatment is provided (cf. chapter 9 (a)).

### Recommendations to the Ministry of Justice

- ensure guidance and further education of judges to promote uniformity (as regards imposing individual "types" of forensic treatment, presenting questions to experts, not making forensic treatment conditional on some traditionally perceived deadlines; cf. chapter 7);
- introduce uniform records of forensic treatment (imposed and ordered) and a central register of patients undergoing forensic treatment (cf. chapter 6 (d));
- unify the form and contents of motions/reports submitted by healthcare facilities to the courts (cf. chapter 6 (g)).

## Recommendations to the professional community

- standardise the procedures used in forensic treatment and establish forensic treatment programmes for its individual types (cf. chapter 8);
- prepare and offer to physicians a tool for evaluating the risks posed by a patient in forensic treatment (cf. chapter 6 (f)).

men's toilets

free clothing

corridor

outdoor area

toilet stall door


common premises

# Forensic treatment: situation in hospitals

## 11) Security at a ward

Hospital should provide a therapeutic environment that is safe for both patients and staff. A special challenge in forensic treatment lies in that it is necessary to prevent the patients' absconding, with some of them showing aggressive behaviour. Therefore, various measures are being taken in the hospitals I visited, such as the construction of special wards, improvement of internal security systems, and application of stricter regimes. Hospital representatives speak of a pressure to admit more patients even if this would mean getting spread too thin to ensure secure care.

The right to life and the prohibition of ill-treatment entail the duty to adopt appropriate measures to protect life and personal integrity (of both patients and the staff) against predictable sources of danger. This general prevention includes effective complaint mechanisms and programmes to avoid bullying, violence, accidents and injuries. The staff must be appropriately trained to be able to detect risks in due time and handle even restless and aggressive patients in an appropriate manner. Violence and abuse must be prevented both between the staff and patients and among the patients themselves.

If a specific person finds him/herself in a specific danger, it is the hospital's duty to take all reasonable steps that can be required of the hospital to prevent the security risk from materialising. The State has the duty to protect patients against assault by third parties provided that governmental authorities knew or should have known about the existence of the actual and imminent danger.

### a) Managing acute aggressive behaviour

Most hospitals have introduced some system of **calling other staff members for help**. This is necessary because hospitals mostly lack funds for sufficient staffing even in the most exposed wards. For example, one large hospital has established a "mobile team" whose members receive more thorough training. A smaller hospital has put a system in place where male staff can be summoned from other wards: they have a table identifying the nursing staff on duty each day and the nurse responsible for co-ordination of the staff can thus call for help in cases of reported emergency. I noticed that the staff mentioned during the interviews that they did not feel completely safe where a similar system was not in place or failed to ensure the help of more than one person. I add that where such systems operate, this is the result of constant work with the staff. It is important to also keep in mind that the possibility of calling for help has to be direct and quick – e.g. using a button carried by each staff member – and not bound on some interim steps or use of a telephone at the office.

With a few exceptions, I noticed dissatisfaction with the **lack of men** among the nursing staff in hospitals. Where male staff was present, the wards were noticeably more peaceful. Most often, there are only one to three men per shift at selected wards or in an emergency team. In one hospital, the personnel situation has already been unsatisfactory for years in view of the specifics of the given region, and the solution seems beyond the capability of the hospital management, and so I have called on the founder to help.

### RECOMMENDATIONS TO HOSPITALS

- ensure a sufficient number of staff at wards where serious behavioural disorders can be expected in the target group of patients.

## b) Safe, secure and drug-free environment

It seems that ensuring a safe (prevention of bullying, violence, suicides), secure (no absconding) and drug-free environment for forensic treatment poses one of the greatest problems in hospitals.

I encountered two problematic situations. The first entailed **the use of an extremely austere environment and regime** for some patients. Since the admissions wards are generally best secured, some patients undergoing forensic treatment stay in them due to security concerns if no other secure ward is available. In specific cases, I did not question the reasons why the hospital kept a patient in a secure environment. However, the method chosen was unsuitable both for the ward in question and the patients. Admissions wards are designed for short-term stay only and security is the highest priority there (cf. chapter 14 (h)). The second problem was the **drugs at the wards and their abuse among patients**. In one especially serious case, this problem was caused by an unsuitable construction layout of the building, a non-functioning camera surveillance system in the exterior, availability of hiding places in the interior, and a lack of male staff. Hospital representatives claim that it is impossible to eradicate drugs from parts of their facilities, but there is no hope of successful treatment without a drug-free environment. A voluntary patient is forced to leave if tested positive for drugs. However, this is not a solution for patients undergoing forensic treatment and the hospital must use increased efforts to minimise drug penetration.

It is a question where the hospital's task to ensure the aspect of forensic treatment consisting in the protection of society begins and where it ends. Indeed, the basic purpose of a hospital is to provide treatment, not detention (this is also the rationale behind reimbursement from health insurance). I present this question to the Ministry of Health (cf. chapter 10 (b)), since security at the relevant facilities must also be supported by investments and clearly set rules. Until then, I urge the hospitals to use their best efforts to ensure maximum possible security.

## c) Cameras

In a number of psychiatric hospitals, **cameras are used at individual wards**; in fact, only one out of the five psychiatric hospitals I visited did not have cameras installed inside the wards. Most frequently, they are used to monitor a room where means of restraint are used so that personal checks on the patient's condition can be combined with the option of observing the situation on a monitor in the staff room; only in some of these cases is the nursing staff required to watch the monitor at all times. Furthermore, cameras are sometimes installed in the smoking room, visiting room, terrace and courtyard. In exceptional cases, cameras are used to a much greater extent at a ward: in the corridor;[47] in selected dormitories and the common room;[48] in a major part of the ward;[49] in the entire ward for the admission to forensic treatment, including sanitary facilities.[50] During my visits to psychiatric wards of general hospitals in 2018, I also repeatedly encountered an idea that a ward could be monitored as a whole.

47 Psychiatric clinic at Olomouc University Hospital. File No. 2618/2016/VOP.

48 Bohnice Psychiatric Hospital, findings from 2018: In acute-care wards and in ward 17, cameras are installed in selected places (observation rooms and common premises), with the images displayed in the staff rooms. File No. 14/2018/NZ

49 Dobřany Psychiatric Hospital, acute-care ward 13, findings from 2016. File No. 2361/2016/VOP, https://eso.ochrance.cz/Nalezene/Edit/4382.

50 Horní Beřkovice Psychiatric Hospital. File No. 6/2017/NZ and also findings from 2018.

The use of cameras on premises where patients live and are treated may remove all intimacy and result in replacement of personal care by remote non-personal surveillance. Moreover, this does not save the staff's time, because the video has to be watched by a staff member, and since this type of work entails great demands on concentration, the staff members have to take regular turns so as to ensure proper monitoring. I therefore disagree with this practice and suggest a more thorough risk assessment; based on its results, patients should be placed in well-staffed wards ensuring increased supervision. I admit that some healthcare professionals believe that the use of cameras within a strictly defined scope is necessary to ensure practical protection of the patient's life and health in such a dangerous situation as, for example, one justifying the use of restraints. Be it as it may, this is a very serious interference with privacy which might even attain the intensity of ill-treatment. Therefore, I consider **the use of camera surveillance without a statutory basis** an unsustainable interference with the patients' fundamental rights.[51] Medical and legal arguments have to be considered and, if the established practice is to continue, it is necessary to adopt legal regulations to define its limits. For the sake of completeness, I note that it is neither appropriate nor realistic to address the problem by including the authorisation to deploy cameras in the forms used for (not) providing consent to hospitalisation.

## RECOMMENDATIONS TO THE MINISTRY OF HEALTH

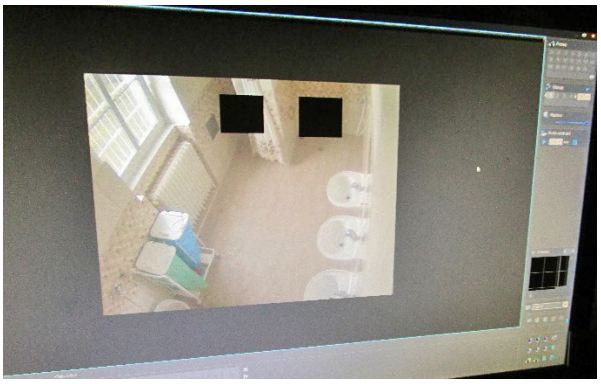
- either prepare a draft amendment to the Healthcare Services Act in order to define the conditions of permissible use of cameras in hospitals or take steps for methodological guidance with a view to terminating the use of cameras.

That is for the principal issue. I have to add that in some cases, the way cameras are used is entirely inadmissible: the camera view also includes the squat toilet in the seclusion room and is not blinded in this direction; the camera view covers the corridor in front of the dormitories and turns on at night (the staff stated this was no good anyway because they either had work to do and could not watch the monitor or they heard any movement); the camera monitors a person inside the shower or on the toilet. Such a manner of using a camera surveillance system (without purpose or indiscriminately in the case of an intervention of maximum intensity) is inadmissible.

51 "A camera surveillance system conforming to the applicable legislation" is envisaged in the Standard of Acute Inpatient Psychiatric Care (Official Journal of the Ministry of Health of the Czech Republic, Volume 5/2016, starting on p. 51), which however does not, in itself, constitute a statutory authorisation.

## RECOMMENDATIONS TO HOSPITALS

- until clear statutory rules are set, adhere to the principle of proportionality in the use of camera surveillance systems and apply these security measures only on the basis of individual risk assessment regarding a patient.




Disproportionate use of a camera surveillance system – in the bathroom and toilets. Black fields are part of the hospital settings.

## d) Window bars

In almost all the facilities I visited, window bars were used to some extent. Two facilities also used bars in the interior – to secure the entrance area (this is also true, for example, of one ward in Bohnice Psychiatric Hospital) or to separate the operational premises from the areas used by patients. Bars installed at the entrance to a seclusion room were noticed in Petrohrad Psychiatric Treatment Facility.[52]

I understand that there are two noteworthy reasons for using bars in the windows – to prevent the patients from absconding and also from jumping out of the window. Bars are also relatively cheap to install. Nonetheless, I still call for seeking and using alternative security features such as safety glass windows with small ventilation windows, etc. The reason is simple: while patients undergoing forensic treatment are subject to a penal measure, they are not prisoners, but patients, and the psychiatry staff must not be put into the roles of prison guards and those who punish. Bars evoke a prison environment. They also make a very bad impression on "civilian" patients and, as a matter of fact, are one of the reasons for stigmatisation of psychiatry.

As far as bars in the interior are concerned, I questioned the justification of their use at certain places as most providers could do without them. Bars at the entrance illustrate the issue with securing areas where dangerous patients are to be treated (cf. chapter 6 (b)). The law does not permit the use of any security construction-technical elements, which however clearly does not dissuade some of the providers from using bars.

52 Individual inquiry in case File No. 4174/2016/VOP.

### RECOMMENDATIONS TO HOSPITALS

- do not use window bars, but rather neutral security elements.

## e) Role of the police in ensuring security in hospitals

**Police officers intervene** in all the facilities I visited **on certain occasions**. They carry out investigation (typically with regard to drugs), guard persons of interest or accompany certain patients during their admission to the facility. The municipal police also assist in some cases. In one psychiatric hospital, I noticed a completely disproportionate number of interventions by the police on the hospital premises, based on the staff's requests for assistance in managing aggressive patients. The police recorded a total 100 interventions in different wards of the hospital over a period of 17 months, in addition to cases where they accompanied a patient during admission. Coercive means under the Police Act were not used during these interventions; the mere presence of police officers often forced the patient to co-operate with the medical staff or they assisted in applying means of restraint (the police officers were present in a whole quarter of cases where safety straps were applied). I drew these findings from an analysis of the official police records because the hospital itself did not keep records of the interventions. The inquiry in the hospital showed that the medical staff felt unable to handle aggressive patients themselves, and some of them viewed the patients primarily as aggressors. At the same time, it was found that there was a lack of male staff, there was no effective system of calling colleagues for help and the internal environment of some wards was dangerous. In other hospitals, police interventions inside the facility were rare.

I criticised the above situation as posing a very strong risk of ill-treatment in the form of excessive use of force and emphasised that the healthcare staff were also unacceptably threatened by injury if adequate staffing is not ensured for an intervention. Patients have the right to healthcare, rather than to be handled as potential offenders against whom a police intervention is directed. **The hospital should be staffed so as to be able to manage aggressive patients** if such a behaviour is a manifestation of their disorder (rather than criminally punishable behaviour). Unfortunately, these episodes can be anticipated in the target group of certain wards, and the hospital should therefore be prepared to handle them primarily through its own resources. I am not criticising the very fact that police officers help apply certain means of restraint if they are present, for example, when delivering a patient to the hospital. However, I consider it important that healthcare not be replaced by coercive elements: he patient's behaviour must be assessed by a professional in the field of psychiatry, who must also communicate with the patient and generally play the leading role in the intervention.

I note that it is in no way guaranteed that a police intervention in a hospital will be proportionate. I dedicated a special inquiry[53] to this question and concluded that police officers were not adequately trained in handling psychiatric patients, and they thus constituted an element of pure force. As part of my inquiry, I recommended that the Ministry of Health provide professional support to the Police Presidium in the preparation of a **training programme for police officers** covering the issues of intervention on request of psychiatric staff, assistance in treating a person suffering from a mental disorder, de-escalation and alternative means of handling by force problematic behaviour of a person suffering from a mental disorder. I am not aware of any such programme having been prepared yet. Therefore, I suggest that the providers establish close co-operation with the police bodies (nationwide or municipal police) where appropriate in view of the local conditions, and agree on specific procedures to ensure compliance with the above principles.

53 Individual inquiry in case File No. 2618/2016/VOP.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- inquire into and analyse cases where the police interfere on request of the staff of psychiatric wards and hospitals; regularly reflect the results in the methodological guidance and education;
- prepare, in co-operation with the Police Presidium, a procedure for situations where healthcare professionals summon the police to handle an aggressive patient and where the police operate on the premises of a healthcare facility, in order to ensure their co-ordination and procedure based on the principle of the least possible restriction and minimisation of the use of force.

## f) Lack of information about patients

The psychiatrists and managers of the hospitals I visited were sometimes dissatisfied with the fact that the police failed to provide information regarding the behaviour and history of a patient who was brought to an outpatient department or for admission to the hospital. For example, a patient is escorted by a police officer who is unaware of the circumstances of his/her detention or criminal prosecution, or the police officers do not wait for the doctor's arrival and leave the hospital.

However, the doctor needs all the relevant information to be able to legitimately decide on whether the patient should be admitted to the facility without his/her consent. I believe that it is appropriate to lay down – either by law or by an internal police regulation – the duty of the police to ensure that information on the circumstances of patient's detention and escort will always be provided to the healthcare workers. This should be taken care of by the Ministry of Health so as to fully reflect the purpose of this communication of information (i.e. activities subject to the Healthcare Services Act).

Another problem arising at a later stage is that the caregivers are not always provided with the expert report drawn up for the purposes of the criminal proceedings, or at least with its part concerning assessment of the danger posed by the patient.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- ensure, possibly in co-operation with the Ministry of the Interior, that a regulation is issued requiring the police to ensure that healthcare professionals are provided with information on the circumstances of detention and escort of a patient where the police has provided assistance.

## g) Intervention by a security service

I encountered two instances where a private security service operated in a psychiatric hospital, but the tasks of the guards did not include any intervention against the patients. The general hospitals I visited used security services, but these intervened only exceptionally in psychiatric wards; they were used more often to ensure peace and quiet in the waiting room in front of the outpatient office. However, one of the hospitals lacked sufficiently detailed records of interventions in the individual wards. No special training of the security guards was ensured in any of the hospitals for the purposes of intervening at the psychiatry ward.

It again holds in this regard that **the provider has to ensure that, as a rule, any manifestations of the patients' mental disorder are handled by the medical staff**. If security guards are allowed to intervene inside the individual wards, the provider has to ensure that such persons have **clearly set responsibilities, are chosen from among suitable persons and are sufficiently trained** for dealing with a patient suffering from a mental disorder (in communication, use of verbal and manual techniques of handling restless or violent patients) and assistance to medical staff. This is a prerequisite for managing potential conflicts without using force (the principle of the least possible restriction) and efficiency, consideration and safety of the procedures chosen (the principle of minimising the use of force). The objective is good co-ordination with the medical staff. A member of the medical staff must always be the one to decide on the course of the intervention. The provider has to ensure that this is the case regardless of whether the security guard is part of the internal team or supplied by a contractor. However, in view of the above risks (chapter 11 (f)), it is certainly preferable to establish internal crisis teams consisting of healthcare professionals.

### RECOMMENDATIONS TO HOSPITALS

- ensure management of aggressive behaviour that is a manifestation of the patient's disease primarily by efforts of the medical staff;
- ensure that security guards that might potentially be asked to intervene at the psychiatric ward have clearly defined responsibilities, are chosen from among suitable persons and are sufficiently trained to handle patients with a mental disorder and to provide assistance to healthcare professionals.

## h) LGBTI

LGBTI patients,[54] i.e. patients with a minority sexual orientation and transgender people, are a vulnerable group in closed communities. The staff of a psychiatric hospital must know the related specific requirements for protection against discrimination and ill-treatment and ensure such protection. Transsexual patients should be placed in a ward on the basis of individual assessment and based on agreement with the patients themselves.[55] I commented on this topic in three hospitals, but exclusively on a positive note.

54 Lesbian – gay – bisexual – transsexual – intersexual.

55 The Committee against Torture. Ninth annual report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment CAT/OP/C/57/4 [online]. Published on 22 March 2016. United Nations. Available at: https://documents-dds-ny.

# 12) Informed consent

## a) Legal standard

It holds as a principle in the provision of healthcare services that any intervention in the health field may only be performed if the person concerned has given free and informed consent to it provided that he/she is capable of giving such consent; if not, the consent is to be granted by his/her guardian or, in cases of a major interference with integrity, the court. There are exceptions to the above, such as handling urgent cases and treatment of a serious mental disorder; nevertheless, **the procedure in such exceptional situations must be laid down by the law and there must exist instruments of control and appeal (remedy) for the protection of patients**. This is laid down in both the Convention on Biomedicine[56] and the European Convention,[57] which have priority over statutory law and serve for its interpretation conforming to the Constitution.[58]

Further details follow from the decisions of the European Court of Human Rights regarding consent. Consent to treatment is not provided (or replaced) by consent to hospitalisation or a court decision on the admissibility of hospitalisation.[59] On top of that, depending on the circumstances, treating a patient without consent in the regime of forensic treatment can amount to inhuman and degrading treatment.[60] Nonetheless, no interference with the right to be provided with care principally on the basis of free and informed consent follows from the fact that a patient is under the pressure of circumstances when asked to make a decision – i.e. when the patient has to choose between taking medication and earlier discharge from the hospital, on the one hand, therapeutic procedures reducing the danger he/she poses at a slower pace, which mean a longer restriction of his/her freedom.[61]

It is up to each country to determine what instruments of control and appeal it will lay down. As regards the form of consent to treatment, neither the international commitments nor the Civil Code indicate that written form is compulsory; however, it is recommended in Recommendation Rec(2004)10 of the Council of Europe's Committee of Ministers. This form helps ensure that the given act will indeed take place, excludes later ambiguities and improves the evidence in case of a dispute. Specifically, with regard to the consent to anti-androgen hormonal treatment, the European Court of Human Rights reproached the Czech Republic in 2014 for not requiring written consent.[62]

56 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, promulgated under No. 96/2001 Coll. of International Treaties; Articles 5 and 7 (protection of persons with mental disorders).

57 Article 8 (Right to respect for family and private life). Any interference with the integrity of a person, such as medical procedures carried out against the patient's will, is a violation of the fundamental right to protection of private life unless it is in accordance with the law, pursues a legitimate objective and is necessary in democratic society. The condition of legality requires, inter alia, that the law on which the provision of care without consent is based contain safeguards of protection of an individual against arbitrariness. Cf. Judgement of the European Court of Human Rights in X. v. Finland, cited above, paragraphs 212-217.

58 The Convention on the Rights of Persons with Disabilities, promulgated under No. 10/2010 Coll. of International Treaties, also has priority over national law. The Convention's interpretation by the UN Committee on the Rights of Persons with Disabilities is quite radical and implies a strict prohibition of any involuntary medical interventions; an intervention substantiated by a mental disorder or disability represents inadmissible differentiation among people based on this criterion, and thus discrimination. Forced treatment is interpreted by the Committee as violation of several articles of the Convention. Cf. Committee on the Rights of Persons with Disabilities. General comment No. 1 (2014). CPRD/C/GC/1 [online]. New York: United Nations, 2014 [retrieved on 1 November 2017]. Available at: https:// documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?0penElement; paragraph 42. The Convention's interpretation in the context of protection of human rights within the Council of Europe system has yet to be clarified; nevertheless, one certainly cannot expect any decrease in the level of protection of the patient's rights already laid down by the European Convention.

59 The fact that a decision on involuntary stay in a hospital cannot comprise the option to subject the patient to medical procedures even against his/her will, without thus violating his/her fundamental rights, is expressly stated in the decision X. v. Finland, cited above, paragraph 220.

60 The European Court of Human Rights dealt with this issue with regard to an anti-androgen therapy in forensic treatment in the case of Dvořáček v. the Czech Republic (judgement of the European Court of Human Rights of 6 November 2014, Dvořáček v. the Czech Republic, no. 12927/13). In that case, the Court arrived at the conclusion that treatment had been provided with the patient's informed consent and thus did not deal with the question of whether there existed procedural safeguards for adopting decisions on treatment without consent (cf. paragraph 90 of the judgement).

61 Ibid, paragraphs 102 and 104. The Constitutional Court took a similar approach in its ruling File No. I. ÚS 3654/10, o cited above.

62 Dvořáček v. the Czech Republic, cited above, paragraph 104.

## b) Current legislation and two related issues

Section 88 (1)(a) of the Specific Healthcare Services Act lays down an exemption from the rule of treatment with consent with regard to forensic treatment as follows: "In forensic treatment, the patient is (...) required to undergo an individual treatment procedure specified for forensic treatment, including all the medical interventions that form a part of the individual treatment procedure; this shall in no way prejudice the patient's right to choose from among possible treatment alternatives or their right to give consent under the Healthcare Services Act for individual medical interventions that are not directly related to attaining the purpose of the forensic treatment."

**The law thus goes beyond what can be interpreted in a manner compatible with the European Convention.** Firstly, the chosen phrasing is general as if a procedure without the patient's consent was not an exception and as if the patient had no right to express his/her consent to the individual medical interventions or the related right to information, as well as the right to refuse certain interventions. Moreover, Section 99 (5) of the Criminal Code explicitly states that repeated rejection of examination or treatment interventions or other manifestation of a negative attitude towards forensic treatment can be a ground for subsequent change of forensic treatment into secure preventive detention. The second problem entailed in the legislation is that there is no special provision on how a patient can object to the physician's considerations and the specific treatment chosen by the physician, or how a decision to commence a certain treatment is taken.

These inadequacies have been known to the responsible authorities for several years, but no action has been taken to remedy the situation; quite the contrary, the Ministry of Health seems to be postponing it. As early as in 2015, the Government promised[63] to clarify the legislation and issue a guideline to eliminate any doubts as to the need for the patient's consent to treatment with anti-androgens. Further, in 2016, the Government tasked[64] the Ministry of Health with drafting a methodology of application of the cited provision, evaluating its effectiveness from time to time, and presenting to the Government an analysis of conformity of the state of affairs with the European Convention by 31 March 2018. The Ministry failed to fulfil the task and actually achieved its cancellation shortly before the deadline.

## c) Findings from the visits

Findings from my systematic visits confirm that **Section 88 (1)(a) of the Specific Healthcare Services Act is interpreted literally**. Psychiatric hospitals usually quote the provision in their internal rules or modify it along the following lines: "the patient has the right to agree or disagree only with those medical interventions that are not connected with the forensic treatment imposed". It clearly follows from the statements made by hospital representatives during our joint debate that they consider the (lack of) patient's consent decisive only in treatment of problems that are not covered by the court decision on forensic treatment; **in the case of forensic treatment, the patient may only choose among the options available**.[65] With regard to psychiatric forensic treatment, these mean pharmacotherapy options; psychotherapy is not considered to fall within these by physicians.[66]

63 CZECH REPUBLIC, Government of the Czech Republic. Response of the Czech Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the Czech Republic from 1 to 10 April 2014. CPT/Inf (2015) 29 [online]. Strasbourg: CPT, 2015 [retrieved on 3 September 2018]. Available at: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168069568f, bod 158.

64 Government of the Czech Republic. Resolution No. 609 of 7 July 2016 on the draft Act amending Act No. 373/2011 Coll., on specific healthcare services, as amended, and certain other laws [retrieved on 3 September 2018]. Available at: https://apps.odok.cz/attachment/ydown/ RCIAABTGY91A.

65 Cf. also Páv a Švarc, cited above, p. 9.

66 I provided a detailed analysis of pharmacotherapy administered against the patient's will within psychiatric forensic treatment (imposed on the patient for the offence of defamation) in case File No. 5091/2017/VOP. Not quite voluntary acceptance of treatment is a rule in treatment of psychoses and affective disorders.

Hospitals consider the contents of forensic treatment a purely medical issue and consent replaced by a court decision on a penal measure. In practice, medication is forced in some cases; in others, the patient has time to adapt and is gradually convinced. The patient's examining physician is responsible for setting the treatment. The patient does not receive a written version of the physician's decision; he/she may only request a copy of his/her medical records.

**Patients are informed of the proposed treatment** informally. While a treatment plan is usually prepared and can sometimes be found in the documentation (in the epicrisis or records made by the physician from time to time) and the doctors claim that the patient is informed about the plan, it is not a custom for the patient to be asked to attach his/her signature to the record or receive the information in writing. Only highly general advice on the rights and obligations in forensic treatment is provided in writing at the beginning of hospitalisation. The Kosmonosy hospital went one step further and individualised the initial advice. The initial advice for patients subject to psychiatric forensic treatment summarises the diagnosis and goals of the forensic treatment as follows, for example: "a psychotic disease; introduction of regular antipsychotic therapy; dosage setting; obtaining adequate overview of the matter and a positive approach towards therapeutic procedures", and describes the contents of the forensic treatment: "regime treatment; psychotherapy; administration of medication as indicated by the examining doctor"; the patient further declares: "I acknowledge that some of the medication administered may have side effects and these questions will be discussed with me individually in each case, if relevant". While this is a positive step towards involving the patient in the decision-making, it is nevertheless not sufficiently specific for the needs of an informed consent to concrete medication; the contents of the information provided would thus have to be demonstrated by witness testimonies.

The situation is different with regard to **electroconvulsive therapy**, where consent forms are presented together with detailed written information; without the patient's consent, this therapy is administered only based on "vital indications" (for details, see chapter 19).

Express consent is required in practice with regard to **anti-androgen treatment**, also for patients undergoing forensic treatment. Anti-androgens form a part of biological treatment methods with regard to paraphilics, where they are further combined with psychotherapy. This is a hormonal treatment causing a reduction of men's sexual activity (and thus also the dangers posed by offenders). If there is no contraindication for the use of hormonal treatment, the patient can be discharged relatively soon. The treatment has side effects, mostly reversible, but partly irreversible. According to professional standards, this treatment is conditional on free informed consent of the patient.[67] This was confirmed during the visits; if a patient refused, the physician waited for him to change his mind and motivated him to do so. It is a fact that paraphilic sexual offenders are mostly referred to treatment involuntarily and overcoming their resistance is usually considered a part of the psychotherapeutic effort. [68] Save for one exception, the consent was provided in writing; in the hospital where this way not so, I recommended a change and the hospital complied. The hospital in Havlíčkův Brod also used detailed written information materials on the individual hormones. The consent and information should be provided in writing as rule.[69]

**In practice, there are no safeguards applicable in case the patient actively rejects** the proposed treatment. If a patient disagrees with the presented plan, some physicians refer to his/her right to file a complaint against the provision of healthcare services under Section 93 et seq. of the Healthcare Services Act; such a complaint is then addressed by the provider during the next 30 or 60 days, and later by the regional authority, which, however, lacks the competence to give any

67 Cf. ZVĚŘINA, Jaroslav: Terapie sexuálních delikventů – mezinárodní standardy (Therapy for Sexual Offenders – International Standards). Prague: Čes a slov Psychiatr, 2012; 108(1): 35-40. ISSN 12120383. Further, Zvěřina and Weiss, cited above, chapter 5.3.3.

68 Cf. ibid., chapters 5.2.2.2 and 5.6.1.

69 Cf. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Report to the Czech Government on the visit to the Czech Republic carried out in 2014. CPT/Inf(2015)18 [online]. Strasbourg: CPT, 2014 [retrieved on 26 July 2019]. Available at: https://www.coe. int/en/web/cpt/czech-republic, paragraph 158.

order to the provider. Moreover, it is not customary to delay the commencement of treatment because of a complaint filed by the patient. Otherwise, the representatives of hospitals suggest that a dissatisfied patient turn to the competent criminal court with a motion to change the decision on the forensic treatment; this option is both lengthy and ineffective as the criminal court lacks any basis for ruling on a specific proposed treatment. The head physicians did rounds at all the wards and this served as de facto supervision. However, treatment is fully within the competence of the examining doctor and his/her decisions are not regularly reviewed by the head physician in any way, and certainly not in the sense of a patient's right to independent review.

Consequently, apart from the fact that it is not customary to apply safeguards, **I doubt that any effective safeguards are available**. This situation is similar to the one where psychiatric patients are subjected to involuntary regular treatment;[70] they too lack an effective tool to achieve a review the hospital's opinion that their situation justifies involuntary provision of care, or rather which care specifically (cf. the case of involuntary electroconvulsive therapy described in chapter 19 (c)). I am aware that, relying on Section 101 of the Civil Code, one psychiatric hospital has been testing, on a pilot basis, a model of presenting to a court for approval cases where a patient considered incapable of own judgement actively protests against treatment. However, the court usually remains silent for weeks and this unacceptable for clinical practice and ineffective from the patient's perspective. Pursuant to Section 101 of the Civil Code, the court's approval is required for any intervention that will have "permanent, unavoidable and serious consequences"; the hospital representatives with whom I discussed the problem at a round table could not see any of these aspects in psychiatric treatment. Furthermore, pursuant to Section 82 of the Civil Code, a patient has the theoretical option to ask the court to prohibit any further unauthorised interference with the patient's personal rights, but as far as I am aware, no one has ever used this option in practice to prevent the start of treatment, not to mention the absence of any system of legal advice for hospitalised patients. In my opinion, it is also necessary to take into consideration the public-law nature of forensic treatment, where healthcare professionals play a dual role vis-à-vis the patients, and a number of steps taken by a psychiatric hospital can represent the exercise of a public authority against a patient. A certain element of public authority, and thus also a basis for the jurisdiction of courts in administrative justice, can be seen in the use of restraints, restriction of a patient's contact with the outside world or commencement of treatment without consent. However, I again doubt that this type of protection is effective without further considerations (problems associated with advice provided to patients; exemption from the judicial fee; availability of legal aid; speed of the decision-making).

## d) Evaluation and recommendations

Decisions on treatment are thus made in practice by the examining doctor as he/she is the one to set the individual treatment procedure. In addition to the lege artis requirement, the doctor is limited by the law only in terms of the general concept of purpose of forensic treatment. A patient may choose among various options provided that any are presented to him/her by the doctor. I explained above that without the possibility of effective control and appeal, such a model is at variance with the European Convention. It is also not beneficial in terms of the long-term therapeutic effects if the physician is expected to de facto force the patient to undergo treatment.

**In my opinion, the best solution to this unsatisfactory state of affairs would be to amend the Specific Healthcare Services Act** so that the two above shortcomings are remedied. It is therefore necessary to further specify Section 88 (1)(a) of the Act, incorporate in the Act the principle of the least restriction or nuisance (in treatment) and the principle of provisional validity of the decision on treatment, and provide safeguards against an abuse of power (rules for adopting decisions on involuntary treatment and the process of appeal and review).

70 Pursuant to Section 38 (3) of the Healthcare Services Act.

When I refer to a "**decision on involuntary treatment**", I follow the current approach used across the Member States of the Council of Europe, as expressed in Recommendation Rec(2004)10 of the Committee of Ministers and the corresponding draft Additional Protocol to the Convention on Human Rights and Biomedicine.[71] Recommendation Rec(2004)10, which is also binding on the Government of the Czech Republic, expressly recommends certain procedures for adopting decisions on involuntary treatment (Art. 20) and the manner of exercising the right to information (Art. 22). The patient has the right to a review of the decision and appeal. Several recommendations can be inferred from an analysis of these documents and also from the opinions presented by the CPT to date as regards decisions on involuntary treatment in Czech practice:

- First provide the patient with information on the proposed treatment (purpose, duration and effects).
- When setting up the individual treatment procedure, justify any decision on treatment without consent – i.e. state why the given treatment is necessary to achieve a certain specific objective and why a less restrictive (more acceptable for the patient) option was not preferred.
- Address the patient's wishes and opinions – they must always be at least taken into consideration.
- Specify when the decision will be renewed – i.e., as a rule, it must be issued for a fixed term. Be prepared to change the treatment regime into treatment with consent if the patient changes his/her mind and wishes to give consent.
- Inform the patient of the option to request a review of the decision – internal, if introduced in the hospital (e.g. review by the head physician or a physician not connected with the relevant medical staff in any way), and external, i.e. by a court.
- Make a record of the decision comprising all these items and submit a copy to the patient and, if appropriate, to his/her guardian.

I believe that if this concept is adopted, the situation will become clearer for each patient, it will be easier to strike a balance between the patient's interest and that of society, and any potential review will be facilitated.

## RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- prepare a draft amendment to Section 88 (1)(a) of the Specific Healthcare Services Act so as to include the principle of free and informed consent also in case of forensic treatment, and phrase any exemptions in clear terms, require a justified decision on involuntary treatment if such an exemption is applied, and provide for an appeal with an independent body;
- analyse the availability and effectiveness of existing tools for protection (in civil or administrative courts) for patients who disagree with a decision made by the guardian or provider/physician on their psychiatric treatment; based on the results of the analysis, prepare methodological and information materials for the providers and patients as to how these tools should be used effectively in clinical practice, or prepare a draft amendment to the Healthcare Services Act and introduce a new tool;
- summarise the legal rules for treatment of mental disorders without consent in a methodological material for healthcare services providers.

71 Committee on Bioethics (DH-BIO). Draft Additional Protocol concerning the protection of human rights and dignity of persons with mental disorder with regard to involuntary placement and involuntary treatment, as revised by the 13th DH-BIO (Strasbourg, 23 - 25 May 2018). DH-BIO/INF (2018) 7 [online]. Strasbourg: Council of Europe, 2018 [retrieved on 3 September 2018]. Available at: https://rm.coe.int/inf-2018-7-psy-draft-prot-e/16808c58a3.

### RECOMMENDATIONS TO HOSPITALS

- proceed in accordance with the European Convention until the legislative changes are implemented, i.e. (i) request informed consent to the proposed individual treatment procedure from patients undergoing forensic treatment and attempt to persuade them to grant such consent; if the patient refuses the proposed treatment, or if it is at variance with consent granted by the guardian, and the treatment is necessary in the physician's view, then (ii) make a detailed substantiated record of the decision to commence treatment without consent and submit a copy to the patient or his/her representative, and (iii) inform the patient of the option to apply to the court for the protection of his/her personal rights under Section 82 of the Civil Code;
- administer anti-androgen treatment on the basis of written consent and provide patients with written information on the effects and the course of the treatment.

## e) Possible safeguards in case of involuntary treatment

Along with my interpretation, I present several references to relevant sources from which Czech legislation can draw inspiration in setting up the system of control and appeal in case of involuntary treatment.

Primarily, there is Recommendation Rec(2004)10 of the Committee of Ministers to member states, where Articles 16 to 25 comprise the basic principles and framework for decisions on involuntary treatment and the parameters of patient protection.

An informal measure to protect a patient may consist in the duty to submit a treatment plan questioned by the patient to the head physician or a psychiatrist independent of the provider for confirmation, as required in some countries. (The option of asking for an external opinion on the proposed treatment is already envisaged by Section 109 of the Civil Code, but it is not clear who should bear the costs.) Another measure may be compulsory reporting of each case of involuntary treatment to the supervisory body and limited period of validity of the physician's decision on a certain treatment, implying the need to make a new decision. A formal measure then consists in the patient's right to appeal against a physician's decision to an external authority.

The CPT report on the visit to Norway in 2018 describes the local rules, which can be expressed in simple terms as follows: The law specifies cases where involuntary treatment is exceptionally permissible. It then describes the following procedure: (i) test/exclude voluntary options; (ii) seek the patient's opinion; (iii) seek the opinion of another psychiatrist; (iv) be convinced that there is a great likelihood that involuntary treatment will lead to the cure or significant improvement of the patient's medical condition, or avoid significant deterioration of the illness; (v) observe the patient for at least five days, except for cases where delayed commencement of treatment would entail significant damage or where the patient is well-known to the facility; (vi) issue a decision on involuntary treatment and set a deadline of 48 hours for the patient or his/her next-of-kin to appeal. The decision is valid for no more than three months.[72]

72 Cf. the CPT report on the visit to Norway in 2018, CPT/Inf (2019) 1 [online]. Strasbourg: CPT, 2019 [retrieved on 18 June 2019]. Available at: https://rm.coe.int/1680909713, paragraph 132.

# 13) Treatment

Treatment is the core of the very purpose of forensic treatment. A patient undergoing forensic treatment has the right to a programme enabling him/her to achieve the purpose of forensic treatment. At the same time, a great many aspects of treatment represent a substantial interference with human integrity. If they are particularly burdensome or humiliating and occur without the patient's consent or without meeting the condition of medical necessity in view of lege artis, can amount to ill-treatment, either in themselves or as a sum of several interferences, also in view of their duration and consequences for the individual.

Of course, the prism of ill-treatment prevention is very narrowing and the following chapters have no ambition to cover the whole area of care in psychiatric hospitals.

The situation in the facilities I visited can be characterised in that the patients receive different levels of care. Only some of them are treated as part of a clearly established plans indicating the contents and course of the stay in hospital and the conditions for the patient's possible discharge. The treatment provided at some of the wards I visited is not comprehensive. I point out phenomena which are especially sensitive in terms of an abuse of power (the motivational system, treatment regime, permissions to leave the facility), which are not always sufficiently anchored in the treatment programme. The following text presents and summarises these topics and I refer the reader directly to the visit reports regarding the situation in the individual hospitals.

Treatment should be based on an individualised approach. The treatment plan should include a wide range of therapeutic activities and patients should, in principle, have daily access to the open air. It is also desirable that they be offered education and suitable work.[73]

## a) Forensic treatment programmes

Forensic treatment is a very demanding task. The circle of patients undergoing forensic treatment comprises individual subgroups that have very different needs and options as regards security, work with the volitional component of personality, inducing the patient's full awareness of the disease and the act he/she committed, the need for a set regime, benefits from group psychotherapy, and the ability to work. Some patients are unmotivated and aggressive. The programmes thus need to be varied. At the same time, even though every patient is different, everyone has the right to be provided with care that will enable him/her to achieve the purpose of forensic treatment.

In this sense, I examined the forensic treatment programmes offered: whether there was clear content and course of the treatment for the individual subgroups of patients undergoing forensic treatment; whether the stages of treatment and the rules for evaluating the patient's progress were clearly specified; whether the group and regime elements, and if appropriate, also the motivational system, had a professional framework and set rules.

Each sexology department had its own treatment programme. In the treatment of addictions, this generally depended on whether the patient was placed in a ward with a psychotherapeutic programme, which is usually elaborated in detail. In view of the capacity of these wards and the demands on motivation, this level of care was accessible only to some of the patients. An elaborate programme of psychiatric forensic treatment was also available only in some of the facilities. It is true that psychiatric treatment is more individual, but e.g. in Horní Beřkovice, the forensic treatment programme was set and the patients knew what was expected of them and how much they have progressed.

I voiced criticism in several cases. For example, in a ward designated for patients undergoing psychiatric, alcohol or drug addiction forensic treatment, patients were merely required, along with

73 CPT Standard of 1998, paragraph 37.

taking medication, to participate in approximately 2 hours of therapeutic activities a day, and once every two weeks, they had group psychotherapy. The treatment programme was not elaborated in any further detail. Although the treatment was presented to patients as comprising several steps, progress was based only on the time spent in the ward and the degree of co-operation provided by the patient, which the staff defined as an absence of problematic behaviour. In practice, the patient's progress as reflected in the degree of permitted outings and permissions to leave the facility, which did motivate some of the patients, but the programme was too easy on some of them and their presence in the facility was not meaningful enough. The problem, caused by a lack of professional staff and elaborated programme, was further aggravated by tensions in the cohabitation of patients with psychosis or a mental disability and drug addicts. The programme was thus partly non-existent and partly not put into practice.

There exists **inequality in the conditions for patients** as regards the variety of treatment activities, the restrictive nature of the regime, and the period of time following which a hospital actually contemplates filing a proposal for moving the patient to outpatient care. The conditions are also unequal within the individual hospitals, among departments and therapeutic teams (cf. the description of the concept of treatment, chapter 14 (b)). The programmes are mostly bound to individual wards. So, if sexological patients "overflow" into other wards, they also receive different treatment. Separate issues are the treatment of women, who are most often scattered across many wards, and patients held in admissions wards for security reasons (cf. chapters 11 (b) and 13 (b)). I refer to individual reports for details.

Whatever the organisation of care, **forensic treatment programmes should be defined**. As far as the scope and level of detail are concerned, they should reflect the individual stages of the hospitalisation and treatment, and no patients should be excluded. As to their concept, they should aim to end the forensic treatment or discharge the patient from an institution to outpatient care. I believe that establishing such programmes would facilitate the work in setting the individualised treatment plans as well as greater certainty on the part of patients and medical staff. Indeed, it would be clear to the patients what is expected of them and how the hospital reports to the court on their treatment. Finally, the room for unofficial procedures would be reduced.

In chapter 10 (b), I formulated my recommendations to **standardise** nationwide procedures used in forensic treatment and establish forensic treatment programmes for its individual types. The aim of preparing such general programmes would be primarily to guarantee the minimum contents of forensic treatment. Furthermore, I believe that if greater attention was paid to forensic treatment programmes and they were better elaborated, this would not only eliminate inequality, but also unify interpretation of the patient's rights and obligations (the current problems in practice include a variety of regimes, rules of separation and security; doubts, e.g. as to the possibilities of training financial literacy, saving money and the content of work therapy).

### RECOMMENDATIONS TO HOSPITALS

- have forensic treatment programmes in place in writing in the sense described in chapter 13 (a) of the report, and reflect in these programmes the local method of ensuring treatment for women and juveniles;
- in the framework of the care provided, ensure sufficient separation of psychotic patients from drug addicts.

## b) Comprehensive treatment

There exists a broad consensus that a treatment programme should be comprehensive, where pharmacotherapy should only form one of its components, and should be accompanied by psychotherapy, education, rehabilitation and resocialisation, along with the ward regime. In addition, opportunities should also be provided for meaningful spending of leisure time and physical activity.

Considering the (lack of) availability of nursing staff and staff educated in therapeutic methods at the individual facilities, it is not surprising that **pharmacotherapy considerably prevailed in many facilities**. For example, a psychologist was present in a number of wards only for diagnostic purposes, but not for therapy. The programme was most diverse at sexology wards, always providing group psychotherapy, education, individual sessions and a motivational programme. I similarly appreciated the conditions at some wards specialising in treatment of addictions or and post-treatment wards. I my reports, I also described examples of good practice, such as a well-equipped multifunctional room for leisure and sports activities in a closed forensic treatment ward in Kosmonosy; in Havlíčkův Brod, I noted the illustrative catalogues informing the patients about the activities offered and a "group to gain awareness of the disorder" for patients undergoing psychiatric forensic treatment.

I recommended to four hospitals that they expand the range of therapeutic and leisure-time activities as they were insufficient at some wards. I noted a **poor offer of therapeutic activities** in several cases. First, this was true of patients placed in admissions wards for a long period of time. These are closed wards intended for patients shortly after admission, usually with a need for acute care, high degree of supervision and handling restlessness. It follows from the nature of the conditions treated in these wards that they do not provide psychotherapy and often even any organised leisure-time activities or activity therapy. I criticised the fact that no individual measures were adopted to supplement pharmacotherapy with other treatment elements for patients detained in such wards for security reasons (I encountered cases where this continued for weeks, months and even a year). The consequences are similar if therapeutic activities and options of spending meaningfully leisure time are available only in central workshops or clubs, and patients held in a closed ward regime lose the opportunity to participate in them for various reasons. Second, I encountered an unsatisfactory range of therapeutic activities for individuals (women and senior citizens) and groups of patients undergoing forensic treatment at wards specialising in treatment of chronic diseases and geriatric psychiatry wards. It was apparent that the patients felt isolated and lacked any purpose and hope.

### RECOMMENDATIONS TO HOSPITALS

- in terms of an individualised approach, provide access to leisure-time activities and activity therapies to all patients whose current medical condition allows this, including those in closed wards;
- organise meaningful spending of leisure time even at admissions wards and for chronic patients.

## c) Specifics of juveniles

In chapter 6 (c), I identified some major difficulties connected with forensic treatment of children. In the systemic recommendations, I suggest to also provide safeguards for the treatment of children within the relevant legislative proposals. Until the systemic environment is improved, I urge the providers to adopt a proactive approach to children.

I encountered a juvenile patient undergoing forensic treatment only in a single hospital, and the primary problem there was **schooling**. The patient was hospitalised in a sexology ward and was offered the same range of activities as others. The hospital neither provides nor mediates any schooling (secondary or vocational courses). It considers this to be a private matter of the patient, or rather his statutory representatives, and would merely allow or prevent any educational activities depending on the current medical condition and individual treatment procedure.

I can understand the hospital's approach, as it lacks any special legal basis and financial resources for ensuring the patient's education. On the other hand, this element must also be reflected in the forensic treatment programme for juveniles given their lack of maturity and special need for activities aimed at physical, intellectual and social development.[74] I believe that, while using standard tools such as social work and holistic approach to patients, including rehabilitation and resocialisation, the hospital should seek information on the education attained by the patient or his/her previous studies, and as soon as possible after the patient's admission, discuss with him/her and the persons responsible for his/her upbringing the possibility of continuing current schooling or providing new educational activities. If this task appears to be impracticable using the hospital's own resources, the hospital should ask a body for social and legal protection of children for help.

It is also important **to ensure increased protection of juveniles against all forms of violence and manipulation** by other patients if juveniles need to cohabitate with adult patients.

I believe that juveniles should normally have a separate dormitory unless it would be especially suitable for them to share sleeping accommodation. The special vulnerability of juveniles must also be reflected in special supervision by the staff, even during the night.[75]

74 With regard to special needs of children and juveniles, cf. Recommendation CM/Rec(2008)11 of the Committee of Ministers to member states on the European Rules for juvenile offenders subject to sanctions or measures of 5 November 2008 [online]. Strasbourg: Council of Europe, 2008. [retrieved on 24 June 2019]. Available at: https://www.vscr.cz/wp-content/uploads/2017/03/Kompendium2009_final.pdf.

Detained juveniles should be provided with the widest possible access to outdoor activities. As far as possible, it is necessary to ensure continuation of the juvenile's schooling. Resocialisation efforts, which should start as soon as possible in order to commence systematic preparation of the juvenile for life after being discharged (including seeking suitable employment, housing, establishing contact with suitable social services, etc.), should be an important part of this. Paragraphs 77-79.

75 Cf. ibid, paragraphs 63.2 and 64.

**RECOMMENDATIONS TO HOSPITALS**

- arrange for educational activities within the treatment programme for juvenile patients;
- within protection against violence in an adult ward, provide a juvenile with a separate dormitory and increased supervision.

## d) Motivational system

Therapies for drug and alcohol addictions and sexological therapies usually include a motivational system. The aim is to reinforce compliance with the set rules. Violations result in demotion and compliance in promotion within the set treatment programme.

I have not encountered any explicit punishment, but some of the consequences of a patient's failure could be perceived in this way. Nonetheless, save for certain exceptions (cf. chapter 14 (e)), this was never humiliating. On two occasions, I expressed in my reports a reservation or warning regarding the scoring system used in a hospital. First, I would like to stress that scoring can be permitted as a tool for illustrating the patient's progress in treatment if it serves only as a basis for verbal evaluation by a professional, which is decisive and linked to the values pursued by the treatment. The purpose of treatment is only achieved if the patient learns from the evaluation he/she receives not to do something because it is wrong, rather than because it entails a negative score. Second, a scoring system places increased demands on the staff – uniformity within the team and the existence of safeguards against an abuse of power, in order to avoid unfair or disproportionate evaluation of patients, which could disrupt the therapeutic alliance and be counterproductive.

There have yet to be issued any official guidelines for the use of motivational systems (cf. chapter 8). I have noted the intention of some experts to harmonise their procedure with their colleagues in other hospitals, which I appreciate.

**RECOMMENDATIONS TO HOSPITALS**

- set the rules of the motivational system in writing.

## e) Keeping medical records

The manner in which medical records are kept generally did not call for any remarks. I occasionally appreciated thoroughness of the records. My only critical remark is directed towards the (lack of) conclusiveness of records on the reasons for use of restraints (chapter 20 (m)) and the (in-)completeness of records on signs of ill-treatment (chapter 23 (b)).

I also call for improved **documentation of the (non-)attainment of the purpose of forensic treatment**. The patient's attitude towards treatment, his/her behaviour in the hospital, compliance with the regime and treatment recommendations, overall attainment of the purpose of forensic treatment, danger posed by the patient – all this is important for the patient's future fate and court's decision-making. The court is not competent to evaluate the patient's medical condition, but must sufficiently verify the above facts; in doing so, it relies on the provider's reports. The latter must then be based on specific entries in the medical records. I consider it insufficient, for example, to merely note violation of the applicable regime. In contrast, it is necessary to describe the substance

of the violation, as the gravity of the failure can be assessed in different ways, for example, by a nurse and by the court. The records also serve as a basis for the work of court experts.

Similarly, if a hospital is supposed to proceed legitimately in **decision-making on the patient's rights** within the treatment regime (cf. chapter 14 (a)), it must be credibly substantiated why this is required by the purpose of the forensic treatment or individual treatment procedure.

Therefore, it is necessary to insist that the provider keep medical records in detail with an emphasis on important aspects, and that the patient's evaluation is not merely about impressions and general summaries.

### RECOMMENDATIONS TO HOSPITALS

- record facts important for the patient's assessment by the court (documenting the patient's attitude towards the treatment, his/her behaviour in the hospital and compliance with the regime) in detail and conclusively; the records should not be limited to mere general evaluation.

## f) Provision of somatic care

As far as somatic care is concerned, **I noticed a problem only in relation to dental care**. Some psychiatric hospitals do not provide dental services and there is no dentist nearby. Patients with acute problems are therefore transported to emergency facilities, often even to distant cities, which is a burden for everyone involved. What is a serious problem, however, is that preventive and standard treatment is not available to patients at all unless they are permitted to leave the facility. Some of them last visited a dentist in prison and the regular dentist they went to years ago may no longer be in business. The problem becomes crucial in case of long-term hospitalisation, which is often the case in forensic treatment.

In terms of human rights, a patient subject to institutional forensic treatment is deprived of liberty and the **State is responsible for ensuring healthcare (including somatic)** based on the principle of equivalence with care ensured in the community. The hospitals responded to my criticism of their passivity by arguing quite logically that they do not provide this type of care. From the patient's point of view, however, it is irrelevant what organisational arrangement the State opts for. Nonetheless, if the patient requires a permission to leave the facility or has to be accompanied to visit a dentist, this must be provided.

It is beyond the abilities of certain patients to take care of dental prevention or register with a new dentist on their own. I consider it justified to request that psychiatric hospitals include preventive dental care in the programme of care for patients hospitalised in the long term who are not able to regularly visit a dentist themselves in view of their mental disorder. What I mean is that the hospital should ensure that such patients get regular appointments with a dentist with whom they are registered and that they be chaperoned if they are unable to visit the dentist on their own for security reasons. Indeed, in some hospitals, a note regarding dental care is a standard component of the daily records. If the patient is not registered with a dentist, it is an option to ask his/her health insurance company to provide one.

### RECOMMENDATIONS TO HOSPITALS

- make appointments for the patients and accompany them to a dentist if they cannot manage themselves and a next-of-kin is not available.

## g) Surgical castration

During the systematic visits, we did not encounter any patient indicated for surgical castration[76] within sexological treatment. The Ministry of Health informed me that in the period from 1 April 2012 to 31 October 2017, when stricter statutory rules for castration applied, the Ministry's expert committee discussed three such applications and provided an affirmative opinion on two of them. After the effective date of Act No. 202/2017 Coll., which modified the rules, i.e. from 1 November 2017 to 30 June 2018, the committee discussed and approved one application. **The Ministry does not know the number of castrations carried out.**

## h) Penile plethysmography (PPG)

Three of the hospitals I visited had a programme in place for the treatment of sexual deviations, and one of them used a penile plethysmograph. It was used as part of the diagnostic phase, usually after a patient was admitted to a specialised ward.[77] The physician recorded the informed consent granted in this regard by the patient, his guardian or a legal representative, in the case of juvenile patients.

The specific Czech diagnostic method using PPG can also be encountered in the Czech Republic in other fields, including court expert activities, probably based on the experience of the given sexologist or a tradition maintained at the given facility. Use of PPG – indications, circumstances and manner of performance, incentives used for the patient, the manner of interpreting the results, training of the assessing medical professional – is not standardised. The only regulation I encountered had the form of an internal policy (at Brno University Hospital). However, the **success of this examination depends on the quality and skills of the examining person**. Furthermore, this examination can only be considered lege artis if used as an **auxiliary, rather than an independent method**.

There are strong reasons for a **cautious approach towards this diagnostic method**. It is ethically questionable to work in this manner with images depicting children and violence, or use these methods on juveniles. In view of these considerations and of the actual nature of this examination, it would be degrading to use it without the patient's consent, which has to be truly voluntary and informed. I also received a complaint from a patient in this sense, as he did not feel that he could refuse the procedure in the hospital.

### RECOMMENDATIONS TO PROFESSIONAL PUBLIC

- issue a lege artis standard for the use of penile plethysmography.

76 I use the CPT terminology here when I deal with the concept denoted by the Specific Healthcare Services Act as "therapeutic castration" or "testicular pulpectomy".

77 Penile plethysmography, or phaloplethysmography, is an auxiliary diagnostic method. It uses a device that measures and records the reaction of a man's penis when the patient is presented with a set of visual stimuli. The result of the examination is an expert's report interpreting the data obtained.

## i) Reading out judgements and court expert reports

It was established within group psychotherapy in one of the hospitals I visited that, at a certain stage, a patient had to read out to the whole group his/her own convicting judgement and parts of the court expert report on which the judgement relied. Some patients complained about this because they did not want to open in this way to others. This is a serious interference with privacy – while judgements are public instruments, expert reports may contain very private information. Their publication, even within such an enclosed group, may be inappropriate. I therefore requested an explanation of the purpose and meaning of this requirement.

The group psychotherapy in the hospital is elaborated, profound in professional terms and functioning. Reading out such documents is one of the means of confronting the patient with objective facts and shaping his/her view of the acts he/she committed. Before this stage is reached, the patient has become accustomed to the group and built his/her awareness of his/her disorder in one-on-one sessions. The patient is also prepared for this on one-on-one basis and is provided with subsequent support. Only the description of the act and the conclusion are read from the expert report. If the patient refuses, he/she is not punished, but further therapeutic procedure is delayed.

I accept such an approach as justified and appropriate, since this exercise forms a part of systematic work, the patient is not punished in any way for refusal and only the conclusions are read out from the expert reports. At the same time, I believe that if a patient is unable to accomplish this task because of insurmountable timidity or other personal reasons, he/she should not be viewed as refusing therapy.

# 14) Regime

Forensic treatment entails significant interference with one's fundamental rights, at a scale that sometimes exceeds the effects of imprisonment.[78] If carried out in an institution, the treatment affects not only the individual's liberty, but also his/her private and family life. This manifests itself very clearly in the set of measures that are often understood under the general term "regime". These measures determine where the patient is allowed and expected to stay, with whom he/she can meet, what he/she is allowed to eat, drink and wear, what belongings he/she can have access to, how he/she can spend his/her time, when he/she has to get up in the morning and when go to sleep at night. In legal terms, these measures can be either part of an individual's treatment regime, or they can follow from the legislation or operational reasons, but there are also interferences that lack any basis in law.

The topic of regimes is rather sensitive, given that a regime may include subjectively very demanding requirements on the patients or their limitations. The requirements therefore must not be arbitrary, random or unreasonable. Rather, unless they are necessary to ensure security, a therapeutic environment and respect for the rights of others, they should stem from an individualised treatment procedure. Illegitimate interferences with a patient's personal integrity can amount to ill-treatment, either in themselves or in aggregate of several interferences, possibly also in view of their duration and consequences for the individual. While a measure used as a therapeutic necessity generally cannot be regarded as inhuman or degrading, the above measures are not always required from the medical point of view.

The following text covers topics which could be seen as part of treatment (a treatment regime), but also measures whose sole purpose was to streamline the operation of the ward or that followed from certain habits persisting at the facility. For the situation in the individual hospitals, the reader is kindly referred to the visit reports.

## a) Legal basis for a regime

When assessing an interference with fundamental rights, one should examine whether the interference complied with legal regulations,[79] whether it pursued a legitimate objective and whether it was proportionate. The Specific Healthcare Services Act paraphrases this constitutional rule and provides that "Forensic treatment may only involve restrictions on human rights laid down by the law and these may only occur to the extent necessary for attaining the purpose of the forensic treatment if the purpose cannot be attained otherwise" (Section 83 (3)).

Measures of various nature are subsumed under the term "regime", relying on three types of statutory authorisation, which further define the nature and limits of these measures.

Firstly, a regime can be imposed **as part of an individualised treatment procedure**, where "treatment regime" means a "set of measures supporting treatment and minimising its potential risks, including recommendations for lifestyle changes". [80] Regime is an important part of the treatment plan in respect of e.g. addictions and sexual deviations. Similar to treatment as a whole, a treatment regime is individualised, follows the rules of medical science and is generally subject to informed consent, unless requisites have been met that allow non-consensual treatment.

Secondly, the Act allows healthcare facilities to restrict a patient's rights with a view to ensuring proper operation and respecting the rights of other patients. Such restrictions take the form of internal policies, i.e. general rules for the provision of healthcare services at the given facility. Patients are obliged to comply with the internal policies.[81] The law does not expressly indicate

78 Cf. judgment of the Constitutional Court File No. III. ÚS 3675/16, cited above, paragraph 21.
79 Any limits on fundamental rights may only be imposed by the law. Article 4 (2) of the Charter of Fundamental Rights and Freedoms.
80 Section 3 (3) of the Healthcare Services Act.
81 Cf. Section 46 (1)(a) and Section 41 (1)(b) of the Healthcare Services Act.

what matters can be regulated in internal policies (it only mentions this possibility in relation to visits, spiritual care and presence of an assistance dog) and, for this reason, the permitted scope of measures governed by internal policies must be construed based the purpose of such policies, specifically providing for a therapeutic environment, which includes safety of the patients and staff. They encompass general rules that, under the law, may not interfere with the patients' rights beyond what is absolutely necessary.

Measures described as a "regime" may also take the legal form of restrictions that patients must tolerate in forensic treatment on the basis of **special provisions of the Specific Healthcare Services Act**, either in connection with their individual treatment procedure and the purpose of their forensic treatment, or with a view to ensuring proper operation of the facility and the rights of others.[82]

As regards the legal limits for various restrictive measures and rules, it should be noted that patients have the right to be provided with healthcare services in the least restrictive environment available that still ensures that the healthcare services provided are of high quality and secure.[83] This reflects one of the basic principles of care for persons with mental disorders, i.e. the principle of the lowest restriction possible: "Persons with mental disorders should have the right to be cared for in the least restrictive environment available and with the least restrictive or intrusive treatment available, taking into account their heath needs and the need to protect the safety of others."[84]

## b) Basis for a specific treatment regime

Where treatment was based directly on a certain regime, the regime was usually introduced in a uniform way. However, the rules were very vague at times, without clearly defining the competences of the individual members of the therapeutic team or even communities, and without determining what was considered an infraction and who was competent to decide on this. At one facility, I also noticed that compliance with the regime was monitored and evaluated only by nurses; it was as if the physicians operated independently of the nurses, which gave rise to concerns as to whether the regime measures were really necessary for the given patients from the medical point of view.

**The more demanding and more restrictive regime for patients, the better it must be defined – either in the treatment programme or in the individualised treatment procedures.** However, the above was sometimes not documented with the required level of evidence. The quality of the documentation of the individualised treatment plans varied. While in some hospitals, physicians draw up highly informative epicrises, including plans, or provide detailed accounts of their considerations whenever they change the existing procedure, the situation was less satisfactory in other facilities, where there were no identifiable plans. **The therapeutic plan (general when the treatment starts, and more elaborated after the patient's adaptation) should always be included in the medical records.**

## c) Permissions to leave

A short-term leave or outing (i.e. when the patient is allowed to temporarily leave the ward) has dual nature: first, it is therapeutic (part of resocialisation and verification of the treatment progress) and second, the patient can use it for his/her private and family life (contact with children, participation in a university admission procedure). I dealt with this issue extensively in my inquiry into an individual case.[85] The relevant hospital had a **tradition of issuing leave permits only before a planned discharge of the patient and with a fixed frequency** (no further, more frequent leaves were granted). In my opinion, this practice cannot withstand the legal test of

82 This includes an exceptional prohibition of a specific visit, use of a telephone and transmission of correspondence, denial of short-term leave from the healthcare facility (Section 85 (1)), body search and inspection of personal belongings (Section 88 (1)).

83 Section 28 (3)(k) of the Healthcare Services Act.

84 Article 8 of Recommendation Rec(2004)10 of the Committee of Ministers.

85 Final opinion including proposed remedial measures in a forensic treatment case, File No. 5091/2017/VOP.

legitimacy of the interference with the patients' rights: every interference with a fundamental right must meet the requirement of lawfulness, pursuit of a legitimate objective and proportionality.

The Specific Healthcare Services Act merely refers to the purpose of forensic treatment and the individual treatment procedure in respect of the physicians' decision-making on leave permits. While these are general notions, they take on specific shapes in the context of individual cases and thus provide a sufficient legal basis if the physician decides not to permit a leave. However, the physician must rely on the patient's individualised treatment procedure or the danger entailed in the patient moving about freely, rather than on habits, which are significantly influenced in Czech reality e.g. by attempts not to lose entitlement to public health insurance reimbursement (cf. the explanation of reducing the "bed-day" indicator when a patient is on a leave in chapter 6 (a)). I believe that a very individual approach and frequent all-day leaves aiming to ensure resocialisation are justifiable based the individualised treatment procedure.

The criterion of proportionality that is part of the above legal test must therefore be assessed very strictly, as the law lays down the explicit principle of subsidiarity specifically for forensic treatment: "Forensic treatment may only involve restrictions on human rights laid down by the law and these may only occur to the extent necessary for attaining the purpose of the forensic treatment if the purpose cannot be attained otherwise."[86]

In another hospital, granting a permission to leave was **conditional on the consent of the patient's guardian**. Such an approach, however, lacks any legal basis – first, leaving the hospital is not a legal act and there is therefore no room for the guardian's role, and second, the law does not require the consent of a third party for issuing leave permits. The provider may at most take into account the guardian's opinion when assessing the risk, provided that the guardian knows the patient or the guardian may take on the role of the patient's chaperone while on leave.

## d) Confiscating ordinary items and prohibiting indulgences

I have encountered various attempts to influence the patients' behaviour by confiscating their belongings or by limiting them in their simple indulgences, or by making these conditional on the preferred behaviour. Such attempts were always disguised as part of treatment (the regime) with the hospitals rejecting any criticism in this respect, referring to their effectiveness. This certainly is the case in some sense, just as one can generally motivate a person by depriving them of something.

In one hospital, I found it illegitimate **that there existed a limitation on what goods forensic patients could have purchased for them in a closed ward** and brought in from the canteen. The patients could buy coffee, cigarettes, press, hygiene and postal items, but not sweets, snacks, milk, dairy products or fruit. The hospital stated a number of reasons (diet, treatment regime, money management training), but I believe that, in actual fact, the patients had a lower motivation to progress in treatment and move to other wards when allowed to purchase goods from the entire range of products. However, this actual purpose was illegitimate in my opinion because the law[87] does not permit the use of sweeping measures to achieve the purpose of forensic treatment. There could be no doubt about the sweeping nature of the measure in the case at hand, as there was a mixture of patients undergoing various types of forensic treatment in the ward, and the patients did not stay there merely during some individual phase of a structured treatment programme; rather, some of them had been there for many weeks or months.

In one hospital, they **issued a general ban on laptops with an Internet connection** and access to the Internet was only allowed on the institution's computers. The stated purpose was to prevent online gambling and gaming, drug dealing and stalking. These are lawful reasons based on which internal rules of a facility or limitations within an individual treatment procedure can indeed be set.

86 Section 83 (3) of the Specific Healthcare Services Act.

87 Section 83 (3) of the Specific Healthcare Services Act.

However, since the prohibition collides with the patient's right to private and family life (correspondence, studies, online banking) and to receive information, it must withstand the proportionality test. In the case at hand, the measure was neither suitable (i.e. capable of resolving the problem because the patients still had their mobile phones with Internet connection) nor proportionate (less severe measures such as individualisation and regulation of access to laptops) would suffice. Consequently, the measure was illegitimate.[88]

On the other hand, I did not question that Internet access was included into the motivational system in one ward (sexology ward in Kosmonosy) where it formed a part of a sophisticated treatment programme. I applauded the acquisition of institutional computers blocking inappropriate websites, on which each patient had his/her personal account.

In three hospitals, I commented on the **regulation of drinking coffee**, which differs in various hospitals as well as their individual wards. Most frequently, a daily schedule defines times when the personnel at the ward will handle hot water. This measure is motivated by safety and security reasons and means that there are two or three time slots during the day when fresh coffee is brewed. There was a minimum of one and a maximum of six slots in one hospital. In some places, a patient could also be accommodated at other times, but there usually was a fixed limit. Patients felt aggrieved by these restrictions and complained about them.

A very long debate can be held on this topic. The argument that coffee distorts the effect of psychopharmaceuticals can be countered by the fact that, after moving to an open ward or after discharge, the patient starts drinking coffee again and, therefore, it would be more advisable to adjust the medication and ensure that it is compatible. Some opine that consumption of coffee is generally undesirable in the use of psychopharmaceuticals. However, the manner of treatment is governed by the patient's will and nobody generally regulates the patient's coffee consumption in an open ward, unless the patient overindulges. Coffee mitigates the effect of hypnotics, but those are by far not prescribed to all the patients. It is certainly true that some states of serious mental disorders deprive patients of the ability to deal with ordinary matters, including coffee consumption management; on the other hand, the aforementioned rules are usually sweeping, regardless of the medical condition of the individual patients. The facilities tend to argue that, without supervision, the patient would drink 20 cups of coffee per day; however, this argument cannot proportionately justify that not even three cups are allowed at the ward.

In my view, the strongest argument for setting these rules is that making coffee blocks the staff's capacity, and the capacity is indeed very insufficient at some wards. The approach should be individualised in relation to the patients. However, if the ward management considers an individual approach unfeasible for operational reasons, the matter should be tackled reasonably, but without overlooking its potential for expressing power and escalating tension. It is clear from our comparison of the hospitals visited that one or two cups of coffee a day is too strict a measure. Furthermore, hospitals should not make patients feel treated unfairly by allowing different wards within one hospital to apply different limits (why should women have a limit of two and men of three cups?).

Secondly, coffee works as the only means of motivation for some patients with disrupted motivational systems, while others must be supervised even when enjoying their coffee. The regulation must then be based on the physician's decision and recorded in the documentation.

88 For more detailed arguments, see case File No. 8135/2018/VOP.

### RECOMMENDATIONS TO HOSPITALS

- strive for an individualised solution for the patients' access to coffee, respecting their wishes and habits; if operational reasons make it necessary to determine fixed time slots for brewing fresh coffee, then allow a generous number of these, if possible, uniformly across the hospital;
- if limiting coffee intake is motivated by the patient's medical condition, this fact should be included in the individualised treatment plan documentation.

Regulation of the **number of cigarettes per day** or access to the smoking room is similarly controversial. I acknowledge that local conditions may require certain measures to ensure proper operation of the ward and, for example, the patients' attendance of treatment programmes. However, the rules must always be set as leniently as possible, especially at wards with patients in unstable condition so as not to fuel their tension. In one hospital, for example, there is no smoking room in the admissions (restlessness) ward for men, and the staff must accompany the patients to the yard. I criticised the fact that for the first two days after admission, no patient was allowed to smoke because risk assessment was being performed; this was very harsh and stressful and not compensated for by substitute therapy. If regulation of smoking is part of the motivational system, it is subject to the patient's consent.

## e) Compulsory wearing of pyjamas during the day

The duty to wear pyjamas during the day in cases where the patient is not ordered by a physician to stay in bed reduces the patient's dignity. Compared to former times, this practice is not so widespread; nevertheless, during my visits in 2017, I encountered an instance in one hospital where this was used as punishment for thefts at the ward; in two hospitals, this was associated with a specific regime at some wards (newly admitted patients were asked not to leave their dormitories and this was supported by removal of their civilian clothing; in other cases, this applied indiscriminately the first 21 days or first month of stay). In another hospital, pyjamas were no longer worn, but the practice continued to be included in the scoring system. During an exchange of arguments with one hospital, I strongly objected to the hospital's claim that there was a consensus among experts that this was a common practice.[89]

### RECOMMENDATIONS TO HOSPITALS

- allow the patients to wear their own clothes unless these are inappropriate, and never use pyjamas as tools (to punish, motivate or restrict movement).

89 My colleagues in Slovenia exerted considerable efforts to refute these practices. The local Ombudperson, who also acts as the national preventive mechanism, was supported by an expert psychiatric panel at the Ministry of Health in combating the wearing of pyjamas during the day in closed wards of psychiatric hospitals. They had to argue, for example, against the opinion that wearing pyjamas was important because it helped the patient acknowledge and accept his/her illness. The official attitude of experts, which the Ministry introduced to all hospitals, is that patients should be encouraged to wear civilian clothes, including in secured wards and during forensic treatment. Furthermore, specific exceptions were defined, such as contagious diseases, patients needing surgeries and diaper changing. (From the European NPM Newsletter 84-85 for January and February 2016.)

## f) Preventing access to dormitories during the day

In three of the facilities visited, I criticised locking of the patients' dormitories during the day, which occurs at some wards indiscriminately, unless certain patients have been ordered by a physician to stay in bed. Thus, the patients were able to stay in their dormitories and use them as a quiet place or to rest in bed only during the siesta. At different times, the staff would only allow them to pick up their belongings at request.

Locking dormitories is a traditional approach aimed at ensuring supervision; activation of patients during the day is also stated as a reason for this practice. But locking the rooms in itself does not result in activation. Rather, it leads to accumulation of patients in common areas and may cause escalation of conflicts. The primary activation measure should consists in offering suitable therapy and leisure activities. If this offer covers less than several hours a day, activation cannot be achieved by sitting and walking about the corridor and common rooms. In wards like these, there is a larger number of patients nodding off in armchairs. Supervision is indeed easier in a corridor; however, it is feasible even if the patients are free to move around. The negatives following from being surrounded by other people, the absence of peace and privacy and complete dependence on favours from the staff outweigh the positives – facilitating the staff's work.

I consider it justified to prevent patients from staying in their dormitories during the (therapeutic) activities or, at most, as an individualised measure. Locking the dormitories is unnecessary in this respect. In other cases, preventing access to the dormitories falls short of the proportionality standard. It is worth noting that although a number of hospitals already abandoned the practice of locking the dormitories years ago and adapted the care accordingly, the practice still persists and is defended by the same arguments in others. However, this is clearly not a matter of scholarly debate, but rather an organisational issue directly related to the number of staff and the entire therapeutic programme and regime. Therefore, the change must be made in a sophisticated manner, cautiously, but consistently.

### RECOMMENDATIONS TO HOSPITALS

- avoid indiscriminately preventing access to the dormitories during the day and adjust the manner of providing care at the ward accordingly.

## g) Use of mobile phones

Patients in forensic treatment had very different access to their own phones in the hospitals visited. In one hospital, mobile phones were completely prohibited at the admissions (restlessness) ward (the stay lasted for 18 days on average, but it took months for some patients); in psychiatric wards, the use of a mobile phone was allowed only during unsupervised outings. In another hospital, mobile phones were limited only by the day regime at the admissions ward and their use was further restricted in individual cases based on risk assessment. In other hospitals, the conditions varied greatly across their closed wards (an hour or two per day). Sometimes, limited access to the phone is part of the treatment programme (e.g. access on one day a week in the first stage lasting 4 to 6 weeks), but the patient's consent to this programme is not always sought.

The variety of measures and their restrictiveness described above are unjustified. As a rule, patients should be allowed to have mobile phones and use them from the beginning of their hospitalisation. Exceptions may be justified by a **specific risk in individual cases** (e.g. in case of suspected criminal activities over the telephone or in self-inflicted harm). Restriction of the use of mobile phones at certain times of day may be justified by the **daily schedule** (it is certainly undesirable for the patients to use their phones during therapy). However, if that is the case, account must be taken

of any possible time constraints on the other side, so that the patient does not lose the only option of contacting a close person or dealing with the authorities. Finally, the restriction may be based on **therapeutic reasons** (as part of the motivational system) and then, in principle, it is subject to the patient's consent. The manner of using phones can naturally be regulated by internal policies with a view to protecting the rights of others (e.g. defining premises that one can or cannot enter with a mobile phone).

**RECOMMENDATIONS TO HOSPITALS**

- allow patients to use their mobile phones from the beginning of their hospitalisation; exceptions to the rule may be justified by an individual risk assessment, daily schedule or therapeutic reasons.

## h) Very strict regime

A patient may be subject to a very strict regime in individual cases and this may occur for a host of reasons. These are cases of patients held in admissions wards for security reasons (chapter 11 (b)). Chapter 20 (c) describes a situation where a patient is permanently held in a room to ensure supervision, his/her regime only occasionally allows him/her to leave the room, or is otherwise secluded from the ward; I encountered cases where this measure lasted for days and weeks on end, without any compensation. This is a general topic, but I also encountered it in cases of patients undergoing forensic treatment.

Social deprivation, poor programme and restriction of autonomy and freedom of movement may amount to ill-treatment, depending on how long they last. I would like to draw attention to this problem, which is not always clear in the eyes of medical professionals as they focus primarily on the aspects of supervision and security. A patient may be isolated from certain stimuli or substances or other patients if a physician considers it necessary from the viewpoint of the treatment regime, but this measure must be strictly individual and proportionate, temporary and accompanied by safeguards against misuse.

I recommend specific safeguards in chapter 20 (c). Among other things, it is necessary to determine how the measure will be compensated for – how the facility will provide for the non-pharmacological part of the therapy, leisure activities, contact with other people, spending time in fresh air and smoking. If the personnel of the ward is not able to provide for such measures, additional staff must be brought on.

**RECOMMENDATIONS TO HOSPITALS**

- if a stricter regime is applied, take compensatory measures, including those based on individual care, where applicable.

# 15) Other topics related to therapy and regime

## a) Rounds in the presence of several patients

In three hospitals, both daily rounds and rounds taken by the head physician were held in some wards in the presence of several patients at a time. For example, a physician passed through a common room and dealt with the individual patients one by one, or a physician took the round room by room. This does not mean that the physicians do not meet the patients on a one-on-one basis as well; such meetings usually did take place, but the rounds were public in nature.

Confidential communication between the patient and the therapeutic team may not take place in the presence of undesirable witnesses (other patients, cleaners) nor can it be left it to the patient to insist on a greater degree of privacy. Anything beyond the scope of regular social contact must remain private.

**RECOMMENDATIONS TO HOSPITALS**

- ensure that rounds are carried out in privacy.

## b) Lack of outdoor access

**A great many patients in psychiatric care do not have day-to-day access to open air.** This occurs at wards that do not have any outdoor premises and where some patients are ordered not to leave the ward for some reason. Other patients are allowed to participate only in group outings with the staff, which, however, do not take place every day. This practice has been repeatedly confirmed in the reality of psychiatric hospitals (and also psychiatric wards of general hospitals) and it thus also affects patents in forensic treatment.

**The facilities visited offer various standards** – several wards had the advantage of secured gardens or terraces. Nevertheless, I recommended four hospitals to adopt remedial measures because they did not have any secured spaces or did not employ enough staff to provide time in open air, did not provide for outings in wintertime or applied a strict regime not allowing a patient to leave the ward at all for a certain period of time. In two hospitals, there were regimes that, as a rule, did not allow the patients outside for two weeks after their admission or after being transferred from a stricter stage of treatment. It is not an exception for patients in forensic treatment to be kept indoors for three months, ten months[90] or longer because they cannot be included in a regime entailing outings.

The Defender has been pointing out the failure to ensure daily outdoor access for more than 10 years and the CPT has been drawing attention to the matter since 2002. There has been some improvement over that time, but, for example, **all the hospitals visited have already been called on by the Defender or even the CPT to remedy the situation and the progress is only insubstantial**, and we still face arguments such as "it has always been this way" and "outdoor access must be prescribed by a physician". It is really time to stop the discussion of "whether" and look for ways "how". A minimum of one hour of outdoor access every day has been guaranteed in prison since time immemorial. The current European standard for psychiatric and social care, including care for forensic patients, is daily outdoor access with a requirement for ensuring supervision and security, if necessary, and a change of clothes and footwear, if the patient does not have his/her own; the minimum number of one hour per day has already been abandoned as

90 Cf. the case from Dobřany Psychiatric Hospital, File No. 2361/2016/VOP.

an uncalled for parallel to prisons and the recommendation now does not have a time limit, but only refers to accommodating for the prescribed procedures and activities.[91]

In conclusion, it is not possible to provide for access to the open air only through group outings, because some of the patients cannot attend them during certain time spells for security or health reasons. Moreover, it is not possible to only administratively order the staff to ensure this higher standard without implementing the necessary construction or organisational measures.

**RECOMMENDATIONS TO HOSPITALS**

- provide patients with daily access to the open air in order to ensure that they are not limited in time other than by participation in the prescribed procedures and activities.

Until this standard is ensured, providers should **at least strive for partial improvement**. I. e., ensure going outside based on an individual approach and in co-operation with relatives of patients who cannot take part in group outings, even if not on a daily basis, but at least to some guaranteed degree. Chaperoning in individual outings should be part of the staff's duties and the frequency of such outings should then be determined by the employee in charge of the shift.

## c) Presence of another person in the shower

In most of the facilities visited, the staff supervised personal hygiene in some way and the **practice was very inconsistent**, even within a single hospital. In three hospitals, an indiscriminate approach was employed at some of the wards where a member of the staff was present during showering of each of the patients without distinction, which I criticised as disproportionate. In another hospital, it was found in two wards that a bathroom would be simultaneously used by several patients; the staff justified this by temporal and capacity reasons. Good practice has also been observed where the staff approached the patients' needs and made showers accessible to them even outside the defined time slots.

We need not analyse how easy it is to humiliate people when they are undressed or why privacy is important in personal hygiene; loss of the intimate sphere is a strong mark of institutional treatment. It is equally important to provide the necessary assistance in the bathroom and protect patients against assault and those with impaired sense of balance or mobility against slipping. It is proportionate to create suitable conditions to ensure that showering is generally safe (e.g. at a ward where there was a danger of harassment, the staff would draw up a schedule so that the patients could not meet in the bathroom) and **perform direct supervision only for selected patients, i.e. based on an individual risk assessment, and only to the extent necessary**. The approach of the staff should correspond to the level of the prescribed supervision, which is noted in the patient's records.

Let me note that some of the interferences with privacy are caused by the spatial design of bathrooms, as the patient undresses and dresses in places where others wait their turn in the shower or use washbasins. Unsuitably designed bathrooms and the need to organise the course of personal hygiene complicate the staff's work. The aim should be to establish bathrooms for private, rather than collective showering.

Finally, I would like to point out that it is inappropriate to wait until the patients object to something they find unpleasant. Every person has different boundaries and, moreover, the subordination of

91 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Report to the Czech Government on the visit to the Czech Republic carried out in 2018. CPT/Inf(2019)23 [online]. Strasbourg: CPT, 2019 [retrieved on 26 July 2019]. Available at: https://www.coe.int/en/ web/cpt/czech-republic, paragraph 94.

the patient weakens his/her freedom of expression. Respect and individual approach must therefore be a standard and it is also necessary to ensure supervision by a person of the same sex to the greatest degree possible.

**RECOMMENDATIONS TO HOSPITALS**

- ensure that patients can shower in private;
- ensure supervision in showers within a scope following from an individual risk assessment.

## d) Prohibition of child visitors

In two facilities, child visitors (up to 10 and 14 years of age, respectively) were generally banned due to concerns about their safety in the ward, but there was no possibility of an alternative visit site (cf. chapter 16 (e)). In one case, the staff made an exception and allowed a patient to meet a child visitor elsewhere, but this was an extraordinary favour. I would like to add that I encounter prohibitions of child visitors up to a certain age in the internal policies also during systematic visits to other psychiatric facilities.

I acknowledge that being present at the ward may pose a risk for some child visitors. However, an absolute ban of child visitors can hardly be considered proportionate as the risk can be minimised by using a separate visiting rooms. The ban is usually not needed in any case, as even without visiting rooms, some other solution can generally be improvised. I consider it suitable to proceed on a case-by-case basis and set the rule, for example, that the time and conditions of the visit will be decided by the competent staff.

**RECOMMENDATIONS TO HOSPITALS**

- refrain from prohibiting child visitors and ensure their safe visits within the meaning of the remarks contained in chapter 15 (d).

# 16) Environment and accommodation

Inadequate material conditions can, in an extreme case or in combination with other problems, result in violation of the patient's right not to be subjected to ill-treatment. The material conditions in the facilities visited can be characterised as mostly good or at least decent, but the environment generally increases the restrictive conditions entailed in the hospitalisation. Several of the wards we visited have walk-through rooms housing multiple patients, with extremely austere furnishing and sometimes even no bedside tables; the patients also have no privacy in sanitary facilities. Overall, the local environment in itself poses a significant risk of ill-treatment. The following text presents this topic and I refer the reader to the visit reports regarding the situation in the individual hospitals.

Even in forensic treatment, patients have the right to privacy and provision of services in the least restrictive environment possible that allows for proper operation of the facility.[92] The environment where the care is provided can support the treatment and promote the objective of the hospitalisation, which is why it should be therapeutic and should not enhance the institutionalisation of patients. Moreover, in forensic treatment, the considerable duration of hospitalisation increases the effect of any unsuitable environment.

## a) Large-capacity dormitories

| equipment | maximum number of beds in a dormitory |
|---|---|
| Havlíčkův Brod | 7 |
| Horní Beřkovice | 12 |
| Kosmonosy | 7 |
| Kroměříž | 15 |
| Opava | 9 |

The highest number of beds in dormitories in the visited wards in 2017.

Almost all the facilities mostly accommodated patients undergoing forensic treatment in large-capacity dormitories, in some cases even consisting of walk-through rooms; dormitories with the capacity of four beds or fewer were seldom.

Indeed, even fifteen-bed dormitories were used in one of the facilities. I note that this is not only a problem related to the aforementioned hospitals, as I found the same situation in the recent years at the Dobřany and Petrohrad hospitals as well.

**The inconvenience of accommodation in large-capacity dormitories is far beyond an acceptable standard**; in the CPT's opinion, "such facilities are scarcely compatible with the norms of modern psychiatry". [93] This is not a matter of the floor area attributable to one bed; indeed, some large-capacity dormitories are relatively spacious. Large-capacity dormitories are problematic because they do not afford patients any privacy and the patients are being disturbed or upset by others. The lack of a private space and the related impossibility to manage one's social interactions, among other things, increases the frequency of use of restrictive measures[94] and may be counterproductive in terms of the treatment process. Moreover, it becomes almost impossible to

92 Section 28 (3)(a) and (k) in conjunction with Section 46 (1)(a) of the Healthcare Services Act.

93 1998 CPT Standard, paragraph 36.

94 Cf. SCHAAF, P. S., DUSSELDORP, E. et al. Impact of the physical environment of psychiatric wards on the use of seclusion. The British Journal of Psychiatry [online]. 2013, no. 202, p. 142-149. Available at: http://bjp.rcpsych.org/content/202/2/142.

assign patients to suitable dormitories on the basis of individual risk assessment and needs in this arrangement. In my opinion, the mental state or specific vulnerability of some patients even requires accommodation in one-bed rooms if the risk of interference with their or other patient's rights is to be contained.

I recommended that the providers reduce the capacity of rooms to 4 beds of fewer.[95] The **improvement is, of course, conditional on there being any funds earmarked for this in the providers' budgets** and some of them are already working on a step-by-step improvement. Others are however waiting for strategic decisions to be made regarding the future of hospitals, and the situation has been unsatisfactory for years. I note that this is, of course, not exclusively a problem of the facilities visited, but also of a number of other psychiatric hospitals.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- ensure that patients in forensic treatment are accommodated in dormitories with a maximum capacity of 4 beds;
- consider laying down this standard in a decree (the Decree on requirements for minimum technical and material equipment of healthcare facilities).

## b) Therapeutic environment

As regards **dormitories**, at least one ward was found unsatisfactory in each hospital; in some hospitals, this was true of most of the wards: dormitories are still often austere rooms filled with beds, with bare walls, central artificial lighting, where other equipment consists merely of bedside tables and sometimes an armchair. In some cases, patients are moved after several weeks, but many of them live in such an environment for months and years. I appreciated the individual efforts in some wards to make the dormitories cosier: equipping them with wooden beds, paintings and curtains, allowing the patients to adapt their rooms and playing down the hospital-like features, reducing the number of beds and equipping the rooms using every-day furniture for storing personal belongings and clothes. It appears that the situation reflects, inter alia, whether the wards are specifically reserved for patients in forensic treatment (and long-term patients). All the rooms visited were maintained, clean and bright, with adequate ventilation and heating.

The patients spend the biggest parts of their days on the **common premises**. Their unwelcoming and unstimulating interiors drew criticism in a number of cases; I had to draw attention to dirt and excessive wear and tear in one instance.

I admit that security is a concern when such spaces are designed, and I would be the last to object to humbleness. But the conditions ascertained are inadequate. There is plenty room for improvement: using alternative materials, involving patients in the decision-making and production of decorations and brightening elements and their regular renewal. However, individual efforts appear to be in vain in rooms so full of beds they even cannot take up standard furniture.

95 The number used by the CPT in its recommendations.

### RECOMMENDATIONS TO HOSPITALS

- ensure that dormitories for patients in forensic treatment are equipped, as far as possible, in a manner that does not evoke a hospital environment, in accordance with the principle of the least restrictive environment in the provision of healthcare services.

## c) Lockable spaces for personal belongings

In almost all the facilities visited, I criticised the impossibility of using a lockable cabinet or bedside table for safe storage of usual valuables or items that have a special meaning for the patients. Moreover, I must say that there are still wards with beds lacking bedside tables, dormitories where the patients do not have wardrobes to hold their clothes, and in two cases, we saw patients wearing their personal belongings in plastic bags with them along the corridors.

**I consider it a standard that the patient should be provided with a bedside table, a wardrobe and a lockable space**; this would correspond to the modern cultural conditions and, what is more, the patients cannot feel safe and autonomous without such background.[96] Exemptions are possible in individual cases and must be constitute proportionate measures aimed at attaining a therapeutic or security objective. Situations where the locker or key re available only at request thus also fall short of this standard.

### RECOMMENDATIONS TO HOSPITALS

- as a rule, provide each patient with a bedside table, wardrobe and lockable space; exemptions may be permitted on the basis of properly performed individual assessment.

96 1998 CPT Standard, paragraph 34.

## d) Sanitary conveniences and hygiene

In most of the facilities visited, I found certain privacy-related shortcomings in the area of hygiene. There were often no curtains in the showers and, in some wards, the showering stalls were not separated on the side and not even from the washbasin areas. In two facilities, the individual toilet cabins were fitted with only "swing" doors that did not cover the full length of the door and so the legs and head of the patient were visible, and from close-up even the whole figure. In one of the facilities, the doors to the men's toilet stalls had glazed windows so that anyone walking in the adjacent room to use the urinal could see the people sitting in the stalls. The toilet door often would not lock. At times, we had to point out the missing seats and toilet paper. While in some facilities the patients had to bring their own toilet paper, they could not have it with them in another facility and they always had to pick up their rations at the nurses' station. Both approaches are humiliating as, in the first case, the patients had to keep the paper with them at all times, because the rooms where they had their belongings had to be locked during various programmes.

Supervision of a specific patient may be necessary even in personal hygiene in certain situations during psychiatric hospitalisation. **Conditions must be created in the hospitals to ensure that such a regime does not affect all the patients indiscriminately and that security measures do not interfere with the patients' privacy beyond the necessary degree.** The standard must be that the patient carries out personal hygiene and uses the toilet peacefully without being subjected to sudden intrusions. It should be noted in this respect that, in view of the lack of privacy elsewhere, this is also an appropriate environment for autoerotic practices, which should not be a taboo either. All this requires modified toilet stall doors (equipped with a lock allowing the staff to open the door from the outside[97]) sufficiently large to cover the whole figure from sight, as well as shower stalls that do not expose the persons showering and getting ready for the shower. Nowadays, modern safety features are available, such as shower curtains and door handles specially secured against the patients hanging themselves, which provide patients with both privacy and safety.

### RECOMMENDATIONS TO HOSPITALS

- equip the showers with blinds and the toilet stall doors with locks that the staff can open from the outside if necessary.

## e) Visiting room

In most cases, there were no rooms set aside for visits. Patients who could not leave the ward had visitors in dining rooms, multi-bed dormitories or corridors, i.e. often in walkways or spaces used simultaneously for different purposes. This is problematic because the visit then does not take place in peace and at least in basic privacy and makes it difficult to welcome child visitors for whom it may be inadvisable to visit the ward in specific cases. In two facilities, child visitors (up to 10 and 15 years of age, respectively) were indeed generally banned due to concerns about their safety in the ward, but there was no possibility of an alternative visit site (cf. chapter 15 (d)). Last but not least, the absence of suitable visiting rooms is difficult on the staff, who, for example, had to leave their office and make it available for a visiting lawyer.

The situation found is unsatisfactory because visits – which are in themselves emotionally and organisationally challenging for all the people involved – cannot run smoothly and with a maximum benefit for maintaining and strengthening the patients' social ties if the premises are inadequate.

97 Cf. the "key & thumb turn cylinder" in Recommendations for Safe Practice 2015/02 - Locking dormitories at healthcare service providers, Official Journal of the Ministry of Health of the Czech Republic, Issue 2, from p. 13.

As regards child visitors, the aim should be to ensure that the hospital has premises adapted, in terms of both the overall atmosphere and equipment, for parent-children meetings and make them available to patients in forensic and other treatment. This would provide privacy and prevent potential traumatisation of young children by the institutional environment. I would like to point out that the contact of children with their parents cannot be limited to meetings during outings on the premises or to leaves; indeed, some patients are waiting to be included in a regime allowing this for a long time, not to mention the need for shelter in case of inclement weather.

**RECOMMENDATIONS TO HOSPITALS**

- ensure suitable visiting rooms and, in particular, environment for child visitors.

### f) Private room

Most wards fail to provide suitable conditions for dignified intimate contacts between the patients and their partners[98]. This is not a problem for patients who can get leave permits. However, we consider that in the case of patients in forensic sexological treatment, the therapy includes adaptation of their sexual behaviour so as not to violate social norms and, if possible, establishing of quality romantic relationships. Achieving this goal by rendez-vous in hospital parks is humiliating for the patients and embarrassing for any people around.

**RECOMMENDATIONS TO HOSPITALS**

- provide a room for intimate contacts within the premises.

## 17) Human resources

### a) Sufficient personnel in care

During my visits, I examined the levels of staffing as this is a **key aspect determining the quality and security of psychiatric care**. It is difficult to provide a detailed statement in this respect, as we do not have a good national standard (I explain in chapter 5 (a) that the Decree on minimum requirements for staffing of healthcare services does not, in principle, deal with sufficient staffing; in chapter 10 (b), I propose that the Ministry set the adequate staffing standards). Therefore, I considered the Decree only an auxiliary criterion and rather examined whether the given ward seemed secure and non-restrictive.

As regards the staff numbers, I only found non-compliance with the minimum requirements laid down in the Decree in a single ward. However, I must note that **at some wards, I noticed the staffing was inadequate to ensure a rich forensic treatment programme and secure care for patients with behavioural risks** (cf. chapters 13 (b) and 11 (a)). This conclusion is difficult to quantify, but can be well documented for Kosmonosy Psychiatric Hospital and the extraordinary frequency of police interventions there as well as the duration of the use of restraints. In my reports on three other hospitals, I pointed out that especially the nursing staff had to be reinforced so that the patients could enjoy a meaningful leisure time and get out in the open air, and so that the necessary supervision could be ensured without restrictive measures (locking the dormitories in daytime; holding certain patients in the dormitories; removing mobile phones, broad use of camera

98 In the broadest sense of the word, including spouses.

surveillance systems). In my reports, I applauded the availability of psychologists in Kroměříž, continuous support and training of the nursing staff in Havlíčkův Brod and supervision in Kosmonosy.

As regards the **lack of physicians** reported by the hospital directors, I did not find any violation of regulations in this respect and the availability of physicians was generally good. However, a shortcoming is apparent in that elaborated forensic treatment programmes are sometimes lacking (cf. chapter 13 (a)); the problem of **narrowing down treatment to pharmacotherapy**, supervision and occasional activation applies to at least one ward in almost every hospital.

The hospitals' responses to their respective reports were similar to one another. **Mid-level medical staff and male staff is scarce on the labour market.** Moreover, physicians will likewise be lacking in the future. Forensic treatment in a hospital relies on one or two experts who cannot be substituted and the population of these experts is aging. Psychiatry is not attractive for young physicians (approx. 800 are lacking) and not everyone can work with the specific forensic treatment target group.

It should be added that according to experts, it takes three to four years to create a forensic treatment team. Páv and Švarc reflect on this when they note that education in the area of forensic psychiatry should be borne in mind in the transformation of hospitals and planning of their personnel (i.e. the long-term care standard) and focus should be put on building up teams so as to cover all the areas of forensic treatment.

## b) Evaluation and recommendations

An ideological conflict arises from the tense staffing situation: while I recommend measures requiring a larger staff to reduce the restrictive nature of the care provided, the managers of psychiatric hospitals consider these unrealistic measures aimed to further the quality of care, which, according to them, is already good in view of the humanisation of psychiatric hospitals that has taken place in the past 10 years.

I partially reject these arguments – for example, I disagree with the statement that secure preventive detention is suitable for a number of patients (cf. chapter 6 (j)). The fact that the staff levels are lower in a hospital than in a secure preventive detention facility is not a reason to give up on providing good care in hospitals. At the same time, I have a great understanding for the managers' warnings because it is true that **if the dark scenarios on the labour market and future financing of psychiatric hospitals come true, it will not be possible to meet the human standard** of directly supervising persons subject to restraints, eliminating enclosure beds, moving away from seclusion of the patients and opting for supervision instead, refraining from locking dormitories over the day, letting the patients keep their belongings, including mobile phones, activation, etc. The need to ensure elementary security will again prevail and call for highly restrictive care.

As part of communication over the Kosmonosy Psychiatric Hospital case, the Minister of Health admitted that the lack of staff in healthcare was a fundamental problem that **could not possibly be tackled by the individual healthcare services providers themselves**. He noted that it was being dealt with comprehensively by his Ministry at a systemic level. One of the measures was to increase the premiums for working in shifts for selected healthcare staff. [99]

Further measures of both organisational and budgetary nature must follow. Both the Ministry and health insurance companies should promote better staffing in psychiatric care in general.

Finally, we should appreciate that the hospitals manage normal operation of the wards with the current staff levels without any serious problems. This involves working with patients who often lack motivation and require a lot of time and patience, and whose treatment calls for a high level

99 See the letter of Minister Mgr. et Mgr. Adam Vojtěch, MHA of 24 January 2018, regarding systematic visit File No. 20/2014/NZ.

of knowledge and experience in therapeutic management and also in managing behavioural disorders, not to mention a certain level of risk for the personal safety of the staff, which is increasing with their insufficient numbers. However, these are still not the only sources of stress for the staff, as they are also affected by the pressure exerted by society and expectations regarding complete success of any treatment.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- prepare a specific plan with temporal milestones to improve the staffing in follow-up psychiatric care in general and in facilities providing forensic treatment in particular.

## c) Professional behaviour of the staff

I consider it a good sign that I only rarely noticed complaints about the behaviour of the staff in the above-mentioned five hospitals: one case involved a physician abusing his power (he allegedly threatened to influence the proceedings on the patient's legal capacity so that the patient would tell him about the contents of his interview with an employee of the Office) and, in one hospital, there were complaints about harshness of the staff at two wards.

### RECOMMENDATIONS TO HOSPITALS

- strive to ensure a high level of organisational culture; managerial staff should monitor the attitude of the medical staff towards the patients and respond appropriately to any imperfections.

## 18) Information on the patient's rights and obligations

The Specific Healthcare Services Act explicitly defines in Section 85 (3) information that the provider must communicate to the patients upon their admission for forensic treatment. Specifically, this includes (i) the rights and obligations related to the provision of healthcare services in the performance of forensic treatment at a healthcare facility; (ii) the anticipated period of therapy and the possibility of changing its form; (iii) individualised treatment procedure; (iv) internal rules. Further information should be provided pursuant to the Healthcare Services Act, including information on the medical condition and proposed healthcare services. The law places a considerable emphasis on the necessity of documenting that the information has indeed been communicated, requiring even a signature of a witness present to the communication.

Hospitals use written advice forms signed by the patient for this purpose. This is good practice; nevertheless, I found it problematic that the texts used by the hospitals were mostly **written using legal language** (without an easy-to-understand summary), which was used even in their complaint policies and house rules. Examples of good practice in this respect include, for example, the advice on the conditions of forensic sexological treatment in Horní Beřkovice or the information leaflet used in Opava; the nurses there used education sheets including questions to verify that the patient has understood the information.

In general, the CPT recommends that psychiatric hospitals should use **information leaflets** that the patient can keep and refer to later, as they may have trouble focusing on all the details or asking questions when being admitted to the hospital.[100] I recommended to three hospitals to draw up and issue brochures because they did not offer anything of this nature to the patients.

As regards the contents, I often recommended **to supplement information** on other rights and circumstances concerning forensic treatment (the right to necessary defence in court when a decision is made on a change or prolongation of the forensic treatment; two-year period during which the court is required to review the continuation of treatment; the patient's right to apply with the court for review of further treatment before expiry of the two-year period). The patient should also receive information on the possibility of replacing institutional forensic treatment with outpatient care subject to certain conditions.

### RECOMMENDATIONS TO HOSPITALS

- draw up and issue to patients upon admission for forensic treatment an information brochure formulated using easy-to-understand language to ensure that the advice meets its purpose.

100 See paragraph 117 of the Report on Visit to the Czech Republic in 2018, paragraph 117: "The CPT considers that an information brochure, setting out the hospital's routine and patients' rights – including information on legal assistance, review of placement (and the patient's right to challenge this), consent to treatment and complaints procedures (including with clearly designated outside bodies) – should be drawn up and issued to all patients on admission to a psychiatric establishment, as well as to their families. Patients unable to understand this brochure should receive appropriate assistance."

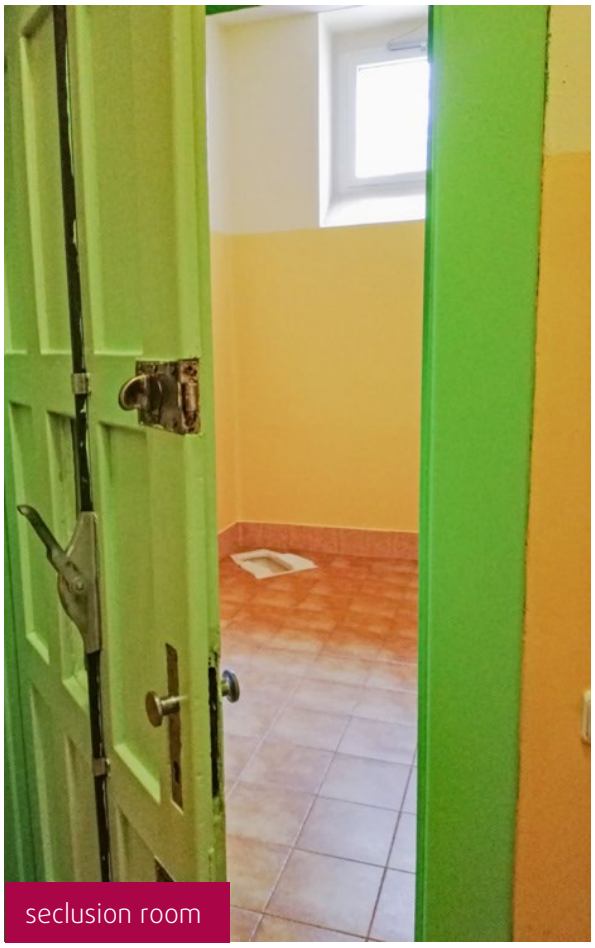
dormitory with regular and enclosure beds

camera surveillance system at the "restlessness" ward

room reserved for ECT

geriatric psychiatry ward dormitory

seclusion room



seclusion room

# General topics

## 19) Electroconvulsive therapy (ECT)

Beyond forensic treatment, I inquired into the use of electroconvulsive therapy in each of the hospitals visited. ECT was administered in four of the hospitals and is also common in other facilities, including psychiatric wards of hospitals, where "modified" ECT, i.e. using general anaesthesia and muscle relaxants, was applied in all cases. A special form is always prepared to document consent to this therapy. In some cases, a specific central overview of the individual applications is kept. An exemption to this rule was found in one facility, which often used ECT in non-consenting patients. This method is perceived as sensitive and stigmatised by both the professional and lay public, and yet there are no mechanisms in place to monitor or harmonise the practice across the country.

### a) Standard

Electroconvulsive therapy (ECT) is a recognised form of treatment of some severe mental illnesses and disorders resistant to therapy. It has a limited indication spectrum, but the treatment can prove life-saving depending on the circumstances of the case. In the Czech Republic, ECT is used annually in about 1,000 patients, both hospitalised and those receiving outpatient care, at 26 healthcare services providers.[101]

The sensitive nature of the method follows, firstly, from the risk of adverse side effects which it carries (ensuing from anaesthesia, and also temporary undesirable effect on cognitive functions and muscle pain); however, compared to massive pharmacotherapy, these can be more moderate and the method is in fact advantageous for a number of patients. Secondly, some patients are anxious about ECT – for a host of reasons, including a clear stigma. I have indeed been witness to this fear for a long time. If, under such circumstances, the therapy is performed without the patient's consent, this causes great humiliation for the patient, who may actually feel broken or perceive the treatment as punishment, depending on the circumstances. Therefore, I am convinced that although a number of psychiatrists recommend electroconvulsive therapy and consider the benefit for the patient's health to be the most important point of view, ECT must be used in a manner that minimises the patient's concerns as much as possible. If ECT is one of the options for treating a patient, it must be determined whether or not the patient prefers it.

101 In 2014, the number was 10 (of 12) psychiatric hospitals, 6 psychiatric clinics (i.e. all of them) and 10 (of 18) psychiatric wards of other hospitals. Cf. KALIŠOVÁ, Lucie, et al. Electroconvulsive Therapy in the Czech Republic. J ECT. 2018 Jun;34(2): 108-112. ISSN 1095-0680.

Furthermore, I fully adopt the CPT standard[102] on the manner of performing ECT and the related safeguards:

- It is necessary to ensure that the application of ECT is aligned with the patient's treatment plan.
- ECT must be administered out of the sight of other patients (if possible in a room designated and equipped for this purpose) by specially-trained staff.
- The use of ECT should be recorded in a specific register. Only in this way can the hospital management unambiguously identify any undesirable practices and discuss them with the staff.
- As a rule, patients should be in a position which allows them to grant (or withhold) their free and informed consent; exemptions for clearly and narrowly defined exceptional cases may be laid down by the law.
- Naturally, consent to treatment can only be considered free and informed if it is based on complete, accurate and comprehensible information on the patient's condition and the proposed treatment; describing ECT as "sleep therapy" should be considered as providing incomplete and inaccurate information on this treatment.

## b) Ensuring privacy during and after the treatment

In one hospital, I criticised the environment where the therapy was performed – it was administered in a multi-bed dormitory on a set day in the morning with the patients brought in one-by-one with the room also serving as a recovery room. The individual beds were not separated from one another, not even by screens, so that the patient coming in the saw patients resting in beds after receiving the treatment; the patients had no privacy.

### RECOMMENDATIONS TO HOSPITALS

- ensure privacy during ECT and rest after the treatment, at least using screens.

## c) Consent to treatment

I had no reason to criticise the quality of the forms used for the provision of consent and, apart from one hospital, not even the manner of discussing the treatment with the patient. I appreciated that a positive attitude was required even for patients whose legal capacity had been limited in the area of decision-making on healthcare and that any administration based on vital indications (i.e. without consent, as a life-saving operation) was properly documented.

Several disputable cases were documented in one hospital; however, they did not keep central records of cases, and it was thus difficult to obtain an overall picture of their approach. In randomly studied cases, it was found that ECT was used on the basis of the patient's consent but also without the patient's consent and even despite his/her disagreement. For example, there was a patient for whom a series of ECT was initiated based on vital indications and whose condition and communication later improved; when he then expressed disagreement with the continuation of the ECT, this was not taken into account because the series was already considered as decided. However, I believe that where a reason for treatment without consent ceases to exist during a series of ECT, it is necessary to follow the patient's decision.

102 1998 CPT Standard, paragraphs 39 and 41. Recommendation Rec(2004)10 in Art. 28 (1) (cf. the explanatory memorandum, paragraphs 206-208) likewise provides a clear indication anchor, requiring safeguards for this kind of therapy.

Even stricter requirements have been laid down in the WHO standards, where no exemption is permitted from the rule that ECT can only be used on the basis of the patient's free and informed consent. Cf. WORLD HEALTH ORGANISATION. Resource book on mental health, human rights and legislation [online]. WHO, 2005 [retrieved on 26 July 2019]. Available at: https://ec.europa.eu/health/sites/health/files/mental_health/docs/ who_resource_book_en.pdf, paragraph 10. 3.

In another case, the patient's (public) guardian approved ECT. The patient had been treated for several months with medication with a view to switching to a depot medicinal product. Electroconvulsive therapy was commenced one week after the patient absconded from the hospital and was found at the guardian's office; he no longer wanted to be in the hospital and requested that he be discharged. Following several instances when this treatment was administered, the patient clearly rejected the ECT and repeatedly complained in writing to the director of the hospital about the negative effects, but the treatment continued. In view of the patient's persisting and comprehensible resistance, I recommended that the hospital submit this and similar cases to the court to resolve the dispute between the guardian and the person under guardianship pursuant to Section 100 (1) of the Civil Code.[103] However, according to the hospital, this constituted urgent care[104] related to psychotically motivated dangerous behaviour of a patient whose medication failed to achieve the expected effect, and therefore [in the sense of Section 38 (4)(a) of the Healthcare Services Act] the consent of the guardian was likewise not required; it was thus not appropriate to contact the court on the grounds of the conflict of opinions with the person under guardianship.

Putting aside the fact that I did not agree with the hospital as to whether the documentation showed any sudden episodes or changes in behaviour or the likelihood that the patient's medical condition would deteriorate without the ECT (i.e. whether urgent care in the form of ECT was required), the example nonetheless shows two model problems. In this hospital, there is a different approach to ECT in non-consenting patients as compared to the other hospitals visited – there, the use of ECT without consent was de facto limited only to vital indications, which corresponds to the recommended psychiatric care procedures.[105] Secondly, this is a specific example of the absence of safeguards for a psychiatric patient's active rejection of involuntary treatment: the patient has no option to achieve review the hospital's opinion that the situation justifies urgent care (cf. chapter 12).

### RECOMMENDATIONS TO HOSPITALS

- use ECT in non-consenting patients only based on vital indications.

## d) Restrictions and concealing information

Beyond the scope of the findings from 2017, I will provide further insights based on a systematic visit to one hospital in 2014. I found the practice where some patients were placed in enclosure beds or locked in personal safety rooms for the night before the ECT application to prevent the patient from avoiding the morning treatment by eating or drinking. The hospital's internal policy allowed this with the proviso that this was "not classified as the use of means of restraint, but as part of comprehensive care for patients with serious mental alteration before short-term anaesthesia", and it also "classified" any subsequent use of an enclosure bed or room in case of impaired consciousness or disorientation after the ECT. I strongly objected to such preventive use

103 "If the integrity of a minor who has reached at least the age of fourteen years and has not acquired full legal capacity, and who seriously objects to an intervention although his legal representative consents to it, is to be interfered with, such an intervention may not be performed without court approval. This also applies where an intervention is carried out on an adult person without full legal capacity."

104 Urgent care is "care that is aimed at preventing or limiting the occurrence of sudden episodes that directly endanger life or could lead to sudden death or serious danger to health, cause sudden or intensive pain or sudden changes in the behaviour of a patient who poses a danger to him/herself or the people around him/herself" (Section 5 (1)(a) of the Healthcare Services Act).

105 "ECT may be administered without the patient's consent only in cases where serious mental disorder episodes are present and the patient is unable to make a decision (e.g. lethal catatonia, severe depressive episodes with psychotic symptoms, suicidal or food rejecting patients) and ECT is applied based on vital indications; in those situations, the valid legal framework must be observed." ANDERS, Martin. Biologická léčba - elektrokonvulzivní léčba (Biological treatment – electroconvulsive treatment). In: RABOCH, Jiří, et al., ed. Psychiatrie: Doporučené postupy psychiatrické péče IV. (Psychiatry: Recommended psychiatric care procedures IV), 2014, pages 185-190. ISBN 978-80-260-5792-5, p. 187.

of restraints and the internal rule that clearly violates the statutes on means of restraint; the hospital subsequently remedied the shortcoming.

I also found that, in some cases, the staff had concealed from the patient the intention to initiate ECT so that the patient would not avoid the treatment if he/she wanted to. Of course, this also meant that the patient could not have been informed about the nature of the treatment (despite having a right to this). It is difficult to fully appreciate the negative impact of this secrecy on the part of the therapeutic team – on the trust of the patient and others, increasing the feeling that ECT is a somewhat obscure tool used by power. I would like to add that ECT was commonly used at the given facility as treatment in non-consenting patients, with the staff recording in the documentation why ECT was suitable, rather than why it was necessary. And where the physician came to the conclusion that the patient was unable to make decisions on the treatment, no efforts were made to ascertain his/her attitude.

These practices are against the law and, in the long run, also hamper the success of psychiatric treatment rather than benefit the patient. To prevent this, **the management of each provider should systematically monitor the use of ECT**.

## e) Situation at the national level

My findings on the failure to keep central records of the use of ECT by certain providers merely confirm the conclusions of the survey carried out by Czech psychiatrists in 2015.[106] This means that there **is no national database or other aggregate source of knowledge on the use of ECT, and individual providers usually do not have information about the physicians' practices** (even if, for example, there is a notebook with central records, it does not contain the details that are recorded in individual patient's documentation only). The researchers also found that the practice at individual facilities differed in terms of the scope of care (somatic examinations) before the procedure, the method of application of electroconvulsive therapy and monitoring of its effects. Although they assessed it as harmonised and generally in line with national best practices, they also found that latest scientific knowledge was not being followed. Experts also point out that there exists no training programme for psychiatrists focused on the use of the ECT, with training provided only by dealers of the devices used and doctors sharing experience within individual facilities.

Considering that the stigma carried along with this method persists and the practice is not unified among the providers, there is a significant lack of data – nationally and at the level of the providers – on the extent to which ECT is used, based on which indications, whether the patient's consent is obtained and what are the effects and complications (side effects) of the treatment. National co-ordination also has room for improvement with regard to the consent forms and written information materials for patients, which are now being prepared by the individual providers.

106 Kališová et al., cited above.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- prepare a training programme for psychiatrists on the use of ECT and act as an supervisor for the programme;
- determine the parameters of the records on the use of the ECT in the form of methodological guidance and keep a national overview on the basis of these data.

### RECOMMENDATIONS TO HOSPITALS

- keep and regularly evaluate the records of ECT administration in order to verify compliance with the legal standards in cases where the physicians act without the patient's consent.

## 20) Means of restraint

Under means of restraint, I understand the use of physical force, mechanical means, medication, or seclusion to restrict or prevent the patient's movement. The permitted types of such means are listed in legislation, which also lays down that these may only be used to avert an imminent threat to life, health or safety of the patient or other persons and if this purpose cannot be achieved in a less severe manner.

Visits to almost half of the hospitals[107] revealed unauthorised and prolonged use of restraints – in part due to the staff confusing permanent supervision with confinement in a locked room, but also for other reasons due to which healthcare professionals are reluctant to release the patient from restraints until he/she is completely calm. In two hospitals, I urged the management to seek an alternative option to the use of straps for stretches of several days on end. Very often, the patient is exposed to further hardships due to the use of the restraints: he/she is not in private or cannot summon the staff who are not always nearby. There is a serious lack of single-bed dormitories, which would have prevented some instances where the restraints were used or at least ensured the patient's privacy. Instead of debriefing, patients are only being informed of the reasons why the restraints were used, which jeopardises their therapeutic alliance with the staff. Providers are not informed as to the approach to the ever-criticised enclosure beds and how to deal with pharmacological restrains. In several hospitals, there are patients with mental disabilities with severe behavioural disorders, who tend to be subjected to restraints on a regular and long-term basis. On a positive note, the quality of record keeping is improving[108] and so is supervision over the patient – it is accepted everywhere that restraints should only be used as a last resort.

Different types of restraints have different impacts on the patient and there are varying opinions on them. Their use differs across Europe, the Czech Republic, and even within individual hospitals. In any case, those used in the Czech Republic represent an interference with the integrity of

107 In addition to the five hospitals mentioned, I add to this chapter, where appropriate, also findings from the facilities visited in 2018 to 2019, i.e. three other psychiatric hospitals and two psychiatric clinics of teaching hospitals.

108 In addition to the five hospitals mentioned, I add to this chapter, where appropriate, also findings from the facilities visited in 2018 to 2019, i.e. three other psychiatric hospitals and two psychiatric clinics of teaching hospitals.

a person which may constitute a serious violation of the person's fundamental rights or ill-treatment in the event of unauthorised or incorrect use.

I note that free movement is restricted not only in the field of psychiatry, but also in the provision of healthcare in other medical disciplines. A number of general remarks must therefore also be taken into account by providers of these healthcare services.

## a) Standard

**The law[109] recognises as a means of restraint**: (a) a grip by the medical staff or other persons designated by the provider; (b) restricting the patient's movement by protective belts or straps; (c) placement in an enclosure bed; this does not apply to sobering-up cells; (d) confinement in personal safety rooms; (e) safety jackets or vests preventing the movement of the upper limbs; (f) psychopharmaceuticals, or other medicinal products administered parenterally, which are suitable for restricting free movement in the provision of healthcare services, other than at the patient's request or in systematic treatment of a psychiatric disorder; and (g) a combination of the above.

In addition to achieving the primary purpose, which is to avert serious danger, means of restraint often also have **adverse effects** (pain and humiliation, injuries, including mental trauma, of both the patient and staff, disruption of the therapeutic alliance and even sudden deaths). The purpose of the concept of restraints in legislation is to ensure through strict rules that these particularly sensitive interventions **are only used as a last resort** in ensuring the safety of patients and others, and are used carefully, safely and with utmost respect for the patient's dignity.

The following **principles** follow from Section 39 of the Healthcare Services Act and the European Convention[110]:

- The use of restraints must be necessary in light of the circumstances and must be aimed at preventing imminent or threatening harm and must be proportionate to its aim (the necessity principle). The use of restraints cannot be justified by a person's objection to their use and is unacceptable as a punishment or educational measure.
- For a restraint to be a matter of last resort, its use must be preceded by attempts at milder alternatives unless this would clearly not avert the danger (the subsidiarity principle). The most moderate restraint must be chosen from among the alternatives available.
- Once personal freedom has been restricted, every use of force that is not absolutely necessary due to the person's previous conduct is an interference with human dignity and constitutes, in principle, degrading treatment. It is up to the facility to justify the use of a restraint by the existence of threats and ineffectiveness of milder measures.

Regulations and professional standards provide **specific safeguards** to ensure that these principles are applied in practice: the use of a restraint must, in principle, be decided by a doctor, unless there is a risk of delay; the provider must ensure proper supervision of the patient subjected to the restraint; there is a strict documentation duty; the use should also be recorded centrally; the patient should be debriefed once the restraint is released to reflect his/her feelings and reduce the need for the restraint in the future.

The legal regulation governing the criteria for the use of restraints is not in conformity with the European human-rights standard. In other respects, there is room for improvement that I will point out below. In addition to Section 39 of the Healthcare Services Act, the rules for use of restraints are specified in the Medical Records Decree and the Methodological Guideline of the Ministry of 2018. The international standard of prevention of ill-treatment is contained in CPT documents, specifically in the 2017 CPT Standard and partially also in the 2006 CPT Standard. The relevant

109 Section 39 (1) of the Healthcare Services Act.

110 Interpreted in the light of the ruling of the European Court of Human Rights in Bureš v. the Czech Republic, cited above, and in M. S. v. Croatia (no. 2), no. 75450/12, judgement of 19 February 2015.

chapters of the Recommended Practices of Psychiatric Care II[111] and Recommended Practices of Psychiatric Care III[112] serve as sources of recognised medical procedures in the use of restraints.

## b) The concept of "imminent threat"

The law specifies that restraints may only be used if they are aimed at "averting an imminent threat" to life, health or safety of a patient or other persons. [113] I repeatedly encounter voices that consider **the indeterminate legal notion** of "imminent threat" unsuitable for application in practice because of its ambiguity, and I take this opportunity to express my opinion on the matter.

The use of general terms, which are construed using legal interpretation methods, **is typical of legal regulation and should not pose a problem in itself** just because the addressees of the legislation are mostly non-lawyers. For their needs, the normative text can be followed by a commentary, instructions for interpretation, a set of case studies or similar literature.

In this case, the statutory phrase "averting an imminent threat" corresponds exactly to the formulations of international legal standards[114] and should not be changed. Rather, the application uncertainty and the respective interpretative guidelines should be tackled by scholarly literature and the Ministry of Health, as the body responsible for the Healthcare Services Act. Unfortunately, this has not yet happened, not even with the new methodological recommendation of the Ministry.

It is clear from the linguistic expression "imminent" that the use of restraints should not be postponed until an actual harm to the life, health or safety of the patient or other persons is already being sustained; it rather **expresses that an expert should realistically predict this consequence**. Recommended Practices of Psychiatric Care II refer to "conditions that are most likely to result" in threatening manifestations.[115] In doing so, the healthcare professional works with the information available to him/her. Recommended Practices of Psychiatric Care III state that "it is also appropriate to take into account the development of the disorder over time and the nature of the disease, reflecting the necessity and indication of medical care. We tend to opine that it is not always medically justified to wait until the patient actually becomes dangerous to him/herself or others".[116]

While there is thus some discretion available, this cannot be understood as **room for clinical assessment according to the rules of medicine**, not for a general preventive approach. In assessing the patient's condition, the physician takes account of circumstances, such as the patient's current condition and previous behaviour, or the failure of a less restrictive procedure, to justify his/her judgment that a threatening behaviour will occur soon. One psychiatrist stated in a discussion on this topic that he evaluated the patient's behaviour "within the given episode". One additional limit based on the principle of proportionality should also be considered – not just any threat to health or safety is sufficient.

The law therefore leaves space for **discretion of the healthcare professional, who is to make a professional decision in a specific situation on the basis of the information currently available to him/her**, as is usual in the provision of care.

During our meeting in February 2019, representatives of psychiatric hospitals said that hospital staff were afraid of the consequences (legal, media, moral) of any mistakes or injuries sustained by the

111 BAUDIŠ, Pavel et al. Omezovací prostředky (Means of Restraint). In: RABOCH, Jiří et al., ed. Psychiatrie: doporučené postupy psychiatrické péče II (Psychiatry: Recommended psychiatric care procedures II). Prague: Infopharm, 2006, pages 152-162. ISBN 80-239-8501-9.

112 BAUDIŠ, Pavel et al. Omezovací prostředky (Means of Restraint). In: RABOCH, Jiří et al., ed. Psychiatrie: doporučené postupy psychiatrické péče III (Psychiatry: Recommended psychiatric care procedures III). Brno: Tribun EU, 2010, pages 213-221. ISBN 978-80-7399-984-1.

113 Section 39 (2)(a) of the Healthcare Services Act.

114 Cf. the term "to prevent imminent harm" – Art. 27 (1) of Recommendation Rec(2004)10, paragraph 1.4 of the 2017 CPT Standard and paragraph 96 of the Bureš v. the Czech Republic judgement (cited above).

115 Baudiš et al., 2006, cited above, p. 155.

116 Baudiš et al., 2010, cited above, p. 217.

patient, which caused pressure to use means of restraint rather than allow, for example, an injury. Scholarly literature also thematises pressure of the nursing staff on physicians to order restraints if the team is overburdened.[117] This is a serious concern that may have implications for the way care is provided and needs to be addressed. However, this is not a problem caused by the use of a general term in the law.

## c) Necessary restriction of free movement, or supervision?

**As an example of unauthorised use of a restraint**, we could mention the placement of a patient in a locked room (seclusion room or increased-care room) not because there is an imminent threat to be averted, but **as a measure to ensure an appropriate degree of supervision**. We found this in two of the five psychiatric hospitals visited in the series of forensic treatment visits, and we also ascertained the same during visits elsewhere, in 2018 and 2019 and earlier. The patient is usually completely dependent on the staff for access to the toilet, is forced to tolerate the proximity of another patient or patients (a six-bed dormitory was found, where newly admitted and restless patients were locked together), it is not customary to compensate for the austere regime by controlled access to public spaces, individual therapeutic activities and outings. I would add that perhaps because the patient has the opportunity to move freely within the room, these measures remain in force for many hours and whole days, and rarely even months.[118] Given the duration, the threshold of ill-treatment was exceeded in many cases, in my opinion.

It was difficult to formulate concrete remedial measures so that their effects would not be even more restrictive (the dormitory would open, but some patients have to be fixated by straps). However, it is indisputable that the conditions for the provision of (acute) psychiatric care must be set so **that permanent supervision does not mean locking the patient in a room**. With sufficient staff, permanent supervision can be ensured even without restrictions – in the day room, the corridor, the garden and so on.

In this context, I would like to point out that the risk of ill-treatment is high even if the doctor "redefines" a restraint as strict regime with occasional leaving of the dormitory. If a physician considers it necessary to isolate the patient from certain stimuli or substances or other patients in view of the treatment regime, he/she may introduce this measure, but it must be proportionate, temporary and accompanied by safeguards against misuse. As soon as it is clear that isolation from the ward or an otherwise stricter regime will take longer, (i) the case should be brought to the attention of the hospital management; (ii) the patient (or his/her representative) should receive a written decision on the regime and be instructed on the possibility of lodging a complaint against it; (iii) it must be determined how the measure will be compensated for – how the non-pharmacological part of the therapy, leisure activities, contact with other people, outings will take place; (iv) a plan of steps should be determined immediately that will allow the patient to move freely about the ward again; (v) it should be regularly assessed whether all the restrictive elements of such a regime are absolutely necessary, and the longer the patient follows the regime, the more thorough the assessment must be.[119]

117 A French detention inspector sees a vicious circle here: Teams who do not receive sufficient training or support pressure physicians to order seclusion to relieve them. But this is only effective in the initial phase, because this way of working with restlessness and aggression will have a negative impact on the way the entire team works. These methods also deepen the feeling of guilt in the nursing staff and the impression that they are involved in the punishment. Contróleur général des lieux de privation de liberté. Isolation and restraint in mental health institutions [online]. Paris: Contróleur général des lieux de privation de liberté, 2016, 126 p. [retrieved on 24 April 2019]. Available at: http://www.cglpl.fr/wp-content/uploads/2012/12/CGLPL_ReportJsolation-and-restraint- in-mental-health-institutions.pdf, p. 86.

118 I refer to individual case File No. 2361/2016/VOP and systematic visit File No. 14/2018/NZ.

119 I follow here from the CPT standard for solitary confinement of prisoners; in prison, this sometimes occurs to protect others from a dangerous prisoner, or to protect a vulnerable prisoner from others. Solitary confinement carries high risks in relation to the prohibition of ill-treatment. This is why strict standards are laid down for its conditions, the decision-making process on placement and review of these decisions. CPT. Solitary confinement. Excerpt from the 21st General Report of the CPT published in 2011. CPT/Inf(2011)28-part2 [online]. Strasbourg: CPT, 2011 [retrieved on 26 April 2019]. Available at: https://rm.coe.int/16808ef5b7.

### RECOMMENDATIONS TO HOSPITALS

- resort to locking patients in rooms only in situations where they immediately endanger themselves of their surroundings; in other situations, if necessary with regard to the provision of treatment, treatment regime as well as the operation of the ward and respect for the rights of other patients, use an appropriate level of supervision and tailor-made regime and clearly determine the time that the patients can spend in the common part of the ward, their participation in therapeutic activities, outings and smoking;
- when applying a stricter regime associated with some degree of restriction of the patient's free movement within the ward, ensure that the measure is proportionate, temporary and accompanied by safeguards against abuse.

## d) Unjustified duration of a restraint

A serious shortcoming also lies in **continued restraining of the patient even after the imminent threat has ceased to exist**. I noted this in several cases studied in two hospitals visited in 2017 and also in three facilities visited in 2018 and 2019. Typically, I relied on the contents of medical records describing the patient's calmness accompanied by continuing "unpredictability", tension, or negativity. This was not just a mistake of the nursing staff involved, or clumsiness in drawing up the documents, as each patient was visited during the time he/she was restrained by several physicians who approved repeatedly further use of the restraint and also made this kind of records. In the two hospitals mentioned, I also found cases of **excessive duration of fixation** – i.e. use of straps lasting a day or longer; a duration of up to three days was commonly found, and there were cases of even longer fixation. These also included cases without proper justification. A physician's statement was also recorded that patients were being released from straps primarily in the morning because the ward had the greatest number of staff then, including medical staff.

Restraining a patient when this is not absolutely necessary constitutes ill-treatment. It also follows from the principle of necessity that **the longer the duration of the restraint, the more convincingly its reason must be documented and the more intensive the effort to create the conditions for its termination must be**. As for the use of a mechanical restraint lasting for days, this can be justified only in absolutely exceptional cases, as shown by the practice in most of the facilities visited.

The provider is obliged to take measures to protect patients from ill-treatment, including unjustified restrains. Depending on the circumstances, the measures have a general or individual nature. If nursing staff are concerned that, after releasing the patient, they will not be able to provide the necessary supervision or restore the restraint in the event of another danger, this is a **clear reflection of the overall care conditions and staff must be reinforced**. In specific cases, if it is not possible to release the restrains even after a few hours, **individual measures** must be taken **to speed up the release**. In addition to striving for therapeutic effect on the patient, this also means the creation of a safe environment for the patient and ensuring permanent supervision, possibly in one-on-one context. Frequent visits by a doctor must be a matter of course. Individual measures are foreseen in the Recommended Practices of Psychiatric Care II: "An individualised care plan should, inter alia, determine how the patient can most effectively manage the loss of self-control and subsequent dangerous behaviour."[120] In Art. 1 (1), the Ministry also recommends to

120 Baudiš et al., 2006, cited above, p. 153.

prepare a risk management plan for high-risk patients in order to prevent life-threatening situations, where this plan should be part of an individualised treatment procedure.

I recommended that the management of one of the above hospitals, where long-term use of mechanical restraints was found, perform an **internal audit**, i.e. retroactively evaluate for 6 months all the cases where restraints had been used for periods exceeding 12 hours (continuous or with interruptions to use the toilet). In the second hospital, this was part of a bigger problem of lacking nursing staff in general, and men in particular. This was evidenced by the fact that in a quarter of the cases, the nurses summoned the police to help apply the straps and the hospital management was aware of the problem. I also called on the founder, the Ministry of Health, to help with the remedy.

## RECOMMENDATIONS TO HOSPITALS

- ensure that the use of restraints without a proper reason is not tolerated;
- actively address cases where the use of restraints lasts more than several hours: adopt measures to accelerate release and, if appropriate, initiate audits of the overall situation in the given ward;
- on the basis of continuous monitoring of the situation in busy wards as well as analysis of individual non-standard cases, make appropriate adjustments in the organisation as well as material and personnel available in these wards in order to significantly reduce the duration of use of the restraints.

## e) Privacy and safety of restrained patients

In three hospitals, I criticised the **use of straps in multiple-bed dormitories** (general or increased care rooms), where the beds could be occupied by other patients depending on the number of patients in the given ward. At the same time, restraints should not be used in sight of other patients (unless the patient expressly states his/her wish to remain in the company of a fellow patient); this should serve to ensure privacy and safety of the patient, as well as peace and safety of others. This standard is relatively frequently not met – I regularly find this also during other visits, even in the form of confinement in an enclosure bed in a multi-bed dormitory. The problem also applies to wards specialised in managing dangerous episodes where they lack single-bed dormitories. I have occasionally encountered cases where patients had to help apply restraints due to a lack of medical staff, which is unacceptable as such.

It is also an intrusion on the patient's privacy if he/she is **exposed to the eyes of unwanted witnesses** when being confined in a locked room. This typically occurs when the doors of the rooms have windows leading to corridors accessible to others. This was the case of one of the visited hospitals and psychiatric wards of two hospitals visited in 2018 and 2019.

Furthermore, intrusions can occur **with the camera surveillance system**. In one hospital, the camera was not blinded, so it captured the entire seclusion room, including the squat toilet. In addition, in this hospital in particular, they routinely removed all clothing from patients for safety reasons prior to their placement in the room. I criticised this fact because such an intrusion in a person's intimacy can only be justified by an extraordinary and, most importantly, individually-assessed risk.

### RECOMMENDATIONS TO HOSPITALS

- observe the privacy of patients who are being restrained and, above all, not allow the patient to be restrained in the presence of other patients or other patients to assist in the application of restraints.

## f) Supervision by staff and providing the patient with the option to call for assistance

The CPT promotes as a standard that any patient who is subjected to a mechanical restraint or seclusion should be supervised in person by a staff member.[121] In addition to ensuring safety, the need for reducing the patient's distress and preventing the feeling of abandonment should also be primary concerns. A camera cannot replace supervision on this level. The national standard is less demanding as it requires **continuous supervision** in general.[122] The national standard was met in one psychiatric hospital of the five facilities visited in 2017 and even later visits to other facilities showed that the standard was not commonly complied with in practice, probably due to a lack of nursing staff. Supervision is most often a combination of personal checks and surveillance through a window leading to the staff's office or using a camera.

In four hospitals, I noticed that, to some extent, a restrained patient (typically in a locked room or enclosure bed) **had no way of summoning the staff**. This is thus a common problem which I encounter at other places as well. The patient is thus exposed to the risk of undignified situations if he/she needs help or use the toilet, and this increases the patient's feeling of helplessness and frustration. Continuous surveillance by watching the feed from cameras that cover the space with the patient mitigates the impact, but it is not an ideal solution, as it relies on the often strained staff. A better solution would be to keep in mind the need for a signalling device when designing the equipment of the rooms (in another hospital, some patients were provided with a portable button at least).

### RECOMMENDATIONS TO HOSPITALS

- strive to ensure continuous supervision over restrained patients, preferably in the form of a carer's presence;
- provide patients with signalling equipment to call in the staff.

121 2017 CPT Standard, paragraph 7: "Every patient who is subjected to mechanical restraint or seclusion should be subjected to continuous supervision. In the case of mechanical restraint, a qualified member of staff should be permanently present in the room in order to maintain a therapeutic alliance with the patient and provide him/her with assistance. If patients are held in seclusion, the staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous staff presence."

122 Cf. Art. 1 (11) of the methodological guideline of the Ministry.

## g) Debriefing

Patients were not debriefed after restraint episodes in any of the hospitals except one. All the providers deal in some way with the statutory duty to inform the patients of the reasons for using the restraints.[123] The medical staff stated that they were always trying to explain to the patient what was happening and why. That is certainly good practice. **However, it is not customary to return to the incident later.** The CPT recommends this as a step towards restoring trust between the patient and the staff and towards finding preventive measures for the future:

"Once means of restraint have been removed, it is essential that a debriefing of the patient take place. For the doctor, this will provide an opportunity to explain the rationale behind the measure, and thus reduce the psychological trauma of the experience as well as restore the doctor-patient relationship. For the patient, such a debriefing is an occasion to explain his/her emotions prior to the restraint, which may improve both the patient's own and the staff's understanding of his/her behaviour The patient and staff together can try to find alternative means for the patient to maintain control over himself/herself, thereby possibly preventing future eruptions of violence and subsequent restraint." (2006 CPT Standard, paragraph 46).

Also in view of the controversy inherently raised by using means of restraint and the persisting feeling of unfair treatment in some former and current users of psychiatric care, **I recommend to devote more attention to communication than has been customary to date**. It should be realistically considered when, given the operation of a particular facility, an employee will have time to talk with the patient after using the restraints. A summary of the medical staff's views communicated in the next round cannot pass for debriefing. The Ministry's methodological guideline (cf. Art. 1 (5)) recommends a therapeutic interview, except for cases where the patient has been urgently transferred from the ward. However, I repeat communicating one-sided information is not sufficient.[124]

### RECOMMENDATIONS TO HOSPITALS

- debrief the patient at a suitable time after releasing the restraint with the aim not only to inform him/her why it was necessary to use the restraint from the medical staff's point of view, but also to hear the patient's view and to jointly seek alternative measures for the future.

123 Section 39 (3)(a) of the Healthcare Services Act.

124 Other arguments: "Attempts on the part of the staff to only justify a decision to apply a restraint can be counterproductive; the aim is to examine, in the framework of an empathic therapeutic alliance, in which respects the procedure helped, in which it did not, and what should therefore be different in the future." Mental Health Act 1983: Code of Practice, paragraph 26.167. Department of Health 2015, available at https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983; ISBN 978-0-11-323006-9, wording effective from 1 April 2015.

The International Society of Psychiatric-Mental Health Nurses explicitly calls for a restraint be followed by debriefing carried out by the primary carers and the patient. International Society of Psychiatric-Mental Health Nurses (ISPN). ISPN Position Statement on the Use of Restraint and Seclusion, 2001. JCAPN Volume 14, Number 3, July-September, 2001.

"The basic golden rule for all procedures performed against or beyond the patient's will, possibly also procedures with which the patient agrees passively but without confidence, is that they must be discussed with the patient in a suitable form before and during the application. Subsequently, it is necessary to evaluate, explain and 'destigmatise' these by repeated explanations and discussions with the improved patient. The memory of the application must not create an emotional scar, even if a dissimulated one, which would disrupt the relationship between the patient and the doctor in the future." BAUDIŠ, Pavel and Jan LIBIGER. Psychiatry and Ethics. Prague: Galén, c2002. ISBN 80-7262-104-1, p. 149.

## h) Enclosure beds

**I am not aware how many enclosure beds**[125] are used in the Czech Republic – at psychiatry wards or other healthcare facilities. Of the psychiatric hospitals visited in 2017, enclosure beds were used in Havlíčkův Brod, Kosmonosy (later all eliminated) and Opava (at that time, a decision on whether to eliminate them was pending). I found their use by other providers in the period from 2018 to 2019: at Bohnice Psychiatric Hospital (1 bed), Petrohrad Psychiatric Hospital (4) and Psychiatric Clinics in Plzeň and Brno (2 and 1 bed, respectively). All conceivable variants of the restraint have occurred: for a specific patient with a mental disability suffering from behavioural disorders, in geriatric psychiatry wards to manage night-time restlessness and the risk of falling, in the male and female admission wards.

Enclosure beds have their advantages and disadvantages compared to other means of restraint. The advantage is that the bed allows the patient to move freely within the given area and thus eliminate health risks and pain resulting from immobilisation or sedation. The disadvantage is that the patient is dependent on help in using the toilet (and diapers are sometimes used preventively for this reason) and that the beds are commonly used for long periods of time (dozens of hours, as follows from the inspected records), perhaps due to the lower risk of complications. Considering that usually the nursing staff is not required to be with the patient (a check interval may be set every 2 hours, for example) and the patient has no signalling equipment, there is an **important element of abandonment and helplessness**. In addition, there have been cases of lethal accidents in the bed and tipping the bed over by a restless patient. While healthcare professionals sometimes use the milder term "safety bed", patients do not feel easy about enclosure beds and commonly refer to them as "cages".

The use of enclosure beds is probably motivated by tradition in the region of former Austria-Hungary. The CPT has long criticised this practice, and it is currently used only in Slovakia, apart from the Czech Republic. In Austria, the use of enclosure beds ended in July 2015. The Czech Republic is also facing criticism for the use of enclosure beds, and the **government has not yet taken a position on this issue**. Although, after the visit in 2014, it informed the CPT that the beds were generally being eliminated and ways would be sought to replace them, the governments is, in fact, not taking any action.

**Some physicians are concerned that enclosure beds will simply be replaced by other means of restraint, which is realistic if the removal is not accompanied by investments in staffing and development of alternative procedures.** When the Austrian Federal Ministry of Health banned enclosure beds, it provided for a one-year transition period for their removal and the development of alternative procedures (expansion of de-escalation techniques, definition of broader nursing staff responsibilities, more flexible support from physicians, introduction of lower beds and sensors monitoring movement on the floor).[126] I believe that also in the Czech Republic, the removal of enclosure beds should be not only a legislative measure (amendment to Section 39 (1) of the Healthcare Services Act), but also a sophisticated and financially substantiated effort to provide safe care at the facilities affected.

125 An enclosure bed is a bed that is enclosed on all sides by a metal structure that is filled with a net. It is possible to open or close the barrier and lock it from one side.

126 According to the information provided to me by the Austrian National Prevention Mechanism, a monitoring series was carried out over six randomly selected months from February 2014 to September 2016 to analyse the impacts the ban had on the use of other means of restraint. Analysis of the data thus obtained showed that the instances where restraints had been used had increased (by 9%), but their overall duration had decreased significantly. A further decrease is expected once the planned construction modifications of selected hospitals are completed.

### RECOMMENDATIONS TO HOSPITALS

- strive to eliminate the use of enclosure beds as part of the adopted personnel, organisational and construction-technical measures.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- adopt a strategic approach on the ban of enclosure beds that includes a search for and promotion of effective alternatives to the use of not only enclosure beds, but means of restraint in general.

## i) Pharmacological restraints

In two of the hospitals visited in 2017, they failed to acknowledge the notion of pharmacological (or chemical) restraint,[127] although it is one of the types of restraints listed by the law. During visits to other facilities (in 2018 and 2019), I came across situations where the provider's internal policies would use the notion, but it would not appear in the records, although cases of use would be found in the individual documentation. Or it would be reported only by some wards of a psychiatric hospital, which indicates the ignorance or internal reservation of some healthcare staff towards the concept of pharmacological restraints. Clearly, **ambiguities and non-acceptance persist**, which may lead to circumventing the law. Sedatives affect the very core of one's personality, i.e. consciousness and will, and any incorrect use cannot be subsequently cancelled as is the case with mechanical restraints. In combination with another health problem, some medication may, in extreme situations, cause unexpected reactions such as life-threatening cardiac arrhythmia, reduction in blood pressure and respiratory depression (although in a very small proportion of cases statistically).

The reason may also lie in the fact that the **definition of a pharmacological means of restraint** is a matter of debate. The statutory definition[128] is unfortunately unclear and the methodological guideline of the Ministry is not helpful either [129] Given the nature of a restraint that is imposed by force or power over the patient, for which special rules and safeguards are laid down, **I favour the CPT interpretation, where a pharmacological restraint is considered to refer to the administration of medication by force in order to control the patient's behaviour**. I believe that it is precisely the administration by force or under threat of coercion that the provider should understand as means of restraint, regardless of whether the aim is also to treat the patient's illness (which is usually the case in psychiatry).[130] In my opinion, the form of administration of the

127 The term "chemical restraint" is most common in legal and medical literature. However, some physicians consider it pejorative and prefer the term "pharmacological".

128 Section 39 (1)(b) of the Healthcare Services Act. "A patient's free movement may be restricted in the provision of healthcare services by psychoactive drugs or other parenterally administered medicinal products suitable to restrain the patient within provision of healthcare services, unless the patient is treated on his/her own request or in the case of long-term treatment of a psychiatric disorder".

129 However, in 2015, the Government promised the CPT to clarify the rules of application practice. Cf. Response of the Czech Government to the report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the Czech Republic from 1 to 10 April 2014, cited above, response to paragraph 166.

130 The situation is obscured by the fact that, in general, administration of medicines against a person's will and excessive medication is also a major threat to human dignity and integrity, and this is sometimes mixed up with restraints in the debate. Excessive sedation has much in common with restraints: it is very difficult to prove and disclose it convincingly; it carries similar risk factors, i.e. a lack of carers, unsuitable material conditions for the provision of care and unavailability of the complete range of treatment interventions. In both cases, medicines can also be misused to punish and "decommission" a difficult patient, which can amount to ill-treatment from a legal point of view. However, the situations differ in the core of the problem and also in the appropriate argumentation. While in the case of restraints, it is primarily in the interest of patients to enforce preventive measures and insist

medication should not be decisive, although injection is the typical way in cases where the patient refuses to co-operate or directly opposes this measure.

A pharmacological restraint either consists in isolated administration of medication or fits into the context of restlessness treatment (for more details, see the following chapter). Because the line between the treatment of mental illness and pharmacological restraint is sometimes blurred in practice, there will probably always be situations where the distinction will be debatable. However, treatment does not preclude the use of a restraint.

In summary, it will certainly help to adhere to the purpose of the legislation governing restraints, which is to protect the patient from arbitrariness, and not to disable treatment or cause preventive overmedication. In practice, I recommend **using the CPT definition in doubt** and considering the use of medication as a means of restraint if the use of force is made or threatened (for example, when a patient does not actively resist an injection due to the presence of a male nurse, guard or the police).

## RECOMMENDATIONS TO HOSPITALS

- in internal policies and in providing guidance to healthcare professionals, use the term "pharmacological restraint" [i.e. administration of sedatives using force (or its threat) in order to control the patient's behaviour], and ensure that this means is used in compliance with the principles of necessity and subsidiarity, as a rule at the discretion of the physician and with proper documentation, including central records.

## RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- either improve the definition of a pharmacological restraint in the Healthcare Services Act, or shape the interpretation of the Act through a methodological guidance to include the CPT definition.

on the criterion of necessity, in the case of overmedication the main topic is correctness of the treatment procedure and the patient's informed consent.

## j) Additional interpretation: tranquillising medication prescribed on a pro re nata basis

One measure that can generally prevent the use of restraints is timely treatment of restlessness. In addition to drugs prescribed for regular administration, ***pro re nata*** **medication (medication prescribed "as needed")** is used, i.e. there is a prescription that entitles the nurse to administer the medication if a foreseen event occurs (deterioration, aggression, restlessness; in one hospital, the staff explicitly refers to this as the "restlessness injection"). Depending on the circumstances, the administration may constitute a restraint, but it is not the same thing in principle.

A good reason for this type of prescription is to avoid regular doses higher than necessary and to have at the ready a prescription thought out by a doctor in advance and with regard to the individuality of the patient. **There are at least two risk aspects.** Firstly, if certain regulations are inadequately applied, decisions on pharmacotherapy and resolution of possible complications are passed on to the nurse. Secondly, if the nurse fails to negotiate the administration with the patient and the patient opposes, the administration of fast-acting tranquillising medication should be considered a pharmacological restraint; otherwise, procedures reliant on force and power are "concealed" as therapy which is not further recorded and evaluated in terms of necessity and subsidiarity. Because some medication prescribed pro re nata has serious side effects and is potentially dangerous, its use against the patient's will can amount to ill-treatment.

**Different approaches can be found** to the use of as-needed prescriptions for tranquillising medication, and very often this is not explicitly enshrined in the provider's internal policy, but rather follows customs or approaches of the particular doctors or nurses. In some facilities, it is entirely up to the nurse to use the prescription; in others, nurses feel obliged to call the doctor first, but they do not always note down that the consultation took place; it is no exception that it is not clear from the records what behaviour on the part of the patient led the nurse to use the prescription and what effect the administration of the medication had; vague rules such as "in case of restlessness" are common. Very often, this administration of medication is considered as following a prescription, which supposedly means that the situation cannot be regarded as the use of a restraint, as the circumstances would suggest.

I draw inspiration from the CPT standard, which is well expressed in the report on the visit to the Netherlands in 2016 [131] and the report on the visit to the Czech Republic in 2018.[132] According to the CPT, given the significant dangers posed to the patient's health by the use of fast-acting tranquillising medication (albeit in a statistically small percentage of cases), their use requires medical supervision, strict procedures by all healthcare staff concerned and the necessary skills, medicines and equipment. Medical supervision will also reduce any motivation of the nursing staff to attempt to de-escalate the situation by other means.

The **procedure presented by the Committee as a standard is** that nurses must call a doctor if the patient is restless and they cannot handle the situation, and the attending physician (or the physician on duty) must act immediately to assess the patient's condition and order further steps, if necessary. Only in exceptional cases where the doctor is not available within minutes and the situation is not otherwise manageable, can the nurse administer a fast-acting sedative on the basis of a pro re nata prescription (PRN). Even so, the nurse should try to get the doctor's approval at least by telephone before administering the medicine, and the doctor must arrive immediately and monitor the patient's response and deal with any complications. **In addition, the Committee also formulated specific safeguards**, namely that such pro re nata prescriptions can only be made by experienced physicians based on comprehensive assessment of the patient's physical condition,

131 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Report to the Government of the Netherlands on the visit to the Netherlands carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 2 to 13 May 2016, CPT/Inf(2017)1 [online]. Strasbourg: CPT, 2017 [retrieved on 23 April 2019]. Available at: https://rm.coe. int/16806ebb7c, paragraph 112.

132 CPT, cited above, paragraph 101.

their validity must be limited (weeks rather than months) and they must be reviewed after each use or change in the medication prescribed to the patient. In the 2018 Report on Visit to the Czech Republic, CPT recommends that each administration of psychotropic drugs based on a PRN prescription be recorded in special PRN records along with the patient's documentation.

### RECOMMENDATIONS TO HOSPITALS

- establish clear rules in internal policies for the use of PRN medication with a sedative effect, using the standard described in chapter 20 (j), and ensure that any change in the patient's condition can be, as a rule, addressed by a physician (attending, or on duty).

## k) Patients with mental disabilities

People with mental disabilities are a vulnerable group in a psychiatric context, as they require a higher level of support and care to ensure that their stay at the ward is safe and they are not subject to restrictions. We repeatedly encounter the use of restraints to ensure supervision and in response to behavioural disorders, even as a long-term measure.

I also have recent reports from three psychiatric hospitals regarding inability to discharge certain patients into home care or social service care because of behavioural disorders, so they remain in a hospital for years without any prospects of a change (for example, these concern a patient who are regularly strapped in the long term, another patient placed in an enclosure bed on a similar basis and a patient who is, with some breaks, permanently fixated in the chair or in the bed using an abdominal safety belt [133]). I absolutely agree with the director's opinion that the psychiatric hospital cannot resolve this on its own. It is necessary to create a transition plan for each patient, and above all provide for individualised follow-up care.

I reacted to these findings differently depending on the purpose and circumstances of the use of restraints. Where the staff try to ensure supervision by confinement to dormitories, I recalled the general recommendation not to replace permanent supervision with restrictions and not to allow patients to suffer from a poor regime, but rather to provide them with sufficient social and sensory stimulation, switching environments, activities, exercise and outings. With regard to long-term limitations, I pointed out that it seems disproportionate that, on the one hand, nursing and medical staff made a number of regular records and, at the same time, there was no well-thought-out plan of how to approach the patient in terms of safety, which primary and secondary prevention measures did not work and what they planned to test, how the restrictive regime would be compensated for and gradually relaxed. The legal regulations do not stipulate the frequency of regular records, so nothing prevents the hospital from setting up their own documentation rules and directing the efforts of the staff elsewhere than towards dealing with red tape.

133 Cf. case File No. 14/2018/NZ.

## l) Paediatric patients

**The specifics of paediatric patients are not explicitly noted in any standard** – in the law, the methodological guideline of the Ministry, the CPT standard, and, as far as I am aware, even the recommended procedures of psychiatric care. We must therefore follow from the fact that a child is more sensitive and vulnerable and thus should not be subject to restraints as a matter of principle. The clinical evaluation of the situation is certainly decisive, and there is generally a much greater difference between a sixteen-year-old and a ten-year-old than between a sixteen-year-old and a twenty-year-old, who is already an adult. Where restraint is necessary to prevent injury to the patient or others, utmost care should be taken to avoid feelings of abandonment and trauma. In legal terms, children are a vulnerable group, which means that the threshold for the severity of treatment that can be considered inhuman and degrading is lower, and appropriate adjustments must be made to the service provided compared to the standard for adults.

I had the opportunity to comment on the use of restraints in paediatric patients only sporadically, during visits in 2018 and 2019.[134] It certainly occurs much less often than for adults, but I am unable to characterise the overall situation due to the incompleteness of the central records at some providers. I can also neither confirm nor refute the serious statement of one provider that there is no network of facilities capable of providing adequate care to adolescents who act violently, so that when they need to be hospitalised, they concentrate in a handful facilities, and this has a negative effect on their care.

In my reports, I adopt the CPT's recent position, i.e., **save for exceptions, I recommend not to use any means of restraint other than grips for children under 16 years of age**[135] and strive to ensure supervision in that someone accompanies the child throughout the time he/she is subjected to the restraint.

## m) Entries in medical records

The use of means of restraint always represents a considerable documentation burden as it is necessary to record all **circumstances important for the decision on use of the particular restraint as well as its duration** and the care provided during the time when the patient was subjected to the restraint, including any complications. Specific requirements are set out in the Medical Records Decree.

Each hospital has its own rules for the frequency of regular entries, which I had no reason to comment on if the records contained the above circumstances. It is also possible to use various time saving abbreviations, provided that these are properly defined. **However, the records not always contain the important information.** For example, thus is true where a description of the risk is missing ("reasons for restraint last" as justification for keeping the means of restraint in place after two days, or "interruption of restraint cannot be continued" without further explanation), or if the description is vague ("hetero-aggression, psychotic"). I admit that a talented medical professional must not necessarily be a talented writer; however, the ability to comment concisely on one's decisions can be improved. As a matter of fact, healthcare professionals are dependent on the accuracy of the records to ensure continuity of care.

134 Moreover, I can refer to later visits that focused on paediatric psychiatry facilities, cf. File Nos. 16/2018/NZ and 2/2019/NZ. I do not include the findings from these in the present report.

135 "Juveniles below 16 years of age should in principle never be subjected to means of restraint. The risks and consequences are indeed more serious taking into account the young persons' vulnerability. In extreme cases where it is deemed necessary to intervene physically to avoid harm to self or others, the only acceptable intervention is the use of physical (manual) restraint, that is, staff holding the juvenile until he/she calms down." CPT. Report to the Finnish Government on the visit to Finland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 22 September to 2 October 2014, CPT/Inf (2015) 25 [online]. Strasbourg: CPT, 2018 [retrieved on 24 April 2019]. Available at: https://rm.coe.int/1680695f70.

I would point out that, as of November 2018, it is also required that the reason given for any use of restraints must also indicate why it was not sufficient to use a more moderate procedure.[136]

### RECOMMENDATIONS TO HOSPITALS

- as part of internal control, ensure that records of any use of restraints are complete and concise.

## n) Staff support

Each hospital has a system of internal training for healthcare professionals. However, only in some hospitals is it ensured that all healthcare professionals concerned are **trained at least once a year in careful use of restraints and alternative risk management**. Regular training with a maximum interval of one year is suggested by the Ministry's methodological instructions as well as recommended psychiatric care procedures. I appreciated that in one hospital, they set up their own training program adapted to their local conditions. In another facility, they consider an external multi-day course to be very effective, but it was so expensive that it could only be provided to a few employees and only once every few years. That is why they wanted to use it to train their own staff who would subsequently work as teachers in the hospital. This was a good plan, but at the same time, I was concerned about the fact that the management of a large psychiatric hospital felt substantially financially limited in purchasing training.

### RECOMMENDATIONS TO HOSPITALS

- plan and carry out staff training so that staff at the acute care ward and other wards where restraints are often used receive effective training in alternative risk management and safe application of restraints – when they join the hospital and at an annual renewal interval.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- support quality education in a safe use of restraints and de-escalation methods, e.g. by preparing their programmes and training supervisors as part of the reform of psychiatric care.

136 This is terminology from the decision-making work of the European Court of Human Rights, which requires a state (its body) to take such action in a situation where it knows or ought to know that mistreatment is imminent. In the context of the difficulties involved in the political management of modern societies, unpredictable human behaviour and the fact that the choice of operational steps must be made according to priorities and resources, there should not be a disproportionate or intolerable burden on the authorities. Cf. the judgment of the Grand Chamber of the European Court of Human Rights in Osman v United Kingdom of 28 October 1998. The Convention on the Rights of Persons with Disabilities refers to "reasonable accommodation" which are "necessary and appropriate amendments and arrangements which do not impose a disproportionate or excessive burden and which are carried out, where the specific case so requires, in order to guarantee to persons with disabilities the exercise or enjoyment of all human rights and fundamental freedoms on an equal basis with others" (Article 2).

# 21) Restraint as a last resort

In different conditions of care provision, the threshold above which it is already necessary from the carers' point of view to use restraints is different. It fundamentally depends on the material and staffing conditions and the expertise with which the relevant procedures have been introduced. In other words, it is "necessary" to use restraints if suitable conditions are not ensured otherwise, while the same would not be necessary under different conditions.

## a) Alternatives to restrictive management of dangerous behaviour

The rule that it is only possible to resort to a restraint as a last resort is deprived of its meaning if there are no procedures in place to minimise risky situations and caregivers realistically have no alternatives to manage them once they occur.

This is not a strictly defined set of measures. For example, they can be as follows: flexibility in adapting the environment in which care is provided; the possibility of single-bed accommodation and separation of dangerous patients from others; effective and timely treatment of restlessness; determining crisis-management plans for selected patients; de-escalation techniques and non-conflict communication; staffing for increased supervision; good availability of doctors even outside working hours to support nursing staff. Research and practice show their effectiveness.

## b) Systematic efforts to reduce the need to apply restrictions

The principle of necessity is important not only for a specific team of carers when considering the use of restraints in a specific situation, but also for the requirement that hospital management and the State **minimise the need to use restraints through reasonable measures in the area of provision of care**.

This is a **requirement following from the prohibition of ill-treatment embodied in the Constitution**. The State is obliged to protect persons deprived of their liberty against ill-treatment by adopting general and individual measures. For example, in the case of violence, it is the provider's duty to protect the patient from the aggression of others and auto-aggression, for example by using a means of restraint. At the same time, however, the provider must not ill-treat the patient by applying such restraints where a less strict approach would suffice. Also, the conditions required to deprive a person of his/her liberty must be in accordance with respect for human dignity and the inevitable degree of suffering and humiliation must not be exceeded. The provider succeeds in this dilemmatic situation if all available measures that can reasonably be expected[137] to prevent violence and achieve alternative solutions have demonstrably been taken. **The Healthcare Services Act requires the provider** "to guarantee a proper standard of health care services, create conditions and measures for ensuring the exercise of the rights and duties of patients and other authorised persons, health care personnel and other professionals in providing health care services." (Section 45 (1)) Reference can also be made to the **requirements of professional standards**.[138]

137 This terminology is used in the decision-making of the European Court of Human Rights, which requires that a State (or its body) take such steps in a situation where it knows or should know that a risk of ill-treatment is imminent. In the context of the difficulties associated with political governance of modern societies, unpredictable human behaviour and the fact that the choice of steps to be taken must reflect certain priorities and resources, the burden placed on the authorities should not be disproportionate or unbearable. Cf. the judgement of the Grand Chamber of the European Court of Human Rights in case Osman v. the United Kingdom of 28 October 1998. The Convention on the Rights of Persons with Disabilities uses the term "reasonable accommodation" which means "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms" (Article 2).

138 Position of International Society of Psychiatric-Mental Health Nurses: Following the principle of the lowest possible restriction in the provision of care, they only accept seclusion and restraint as an emergency intervention employed only as a last effort. They support systematic search for and use of alternatives to restraints and consider flexibility to be necessary in adapting the environment in which care is provided to allow for safe and effective care where restraints are used for as short a time as possible. Seclusion and restraint are an emergency intervention that requires fast and co-ordinated attention. Their opinion requires that any restraint be followed by debriefing with the primary caregivers and the patient and that data be collected on individual cases

**Restrictions on patients' freedom of movement** are also related to the topics of ward security, the environment and rules of the ward, sources of frustration and tension, including inability to move and privacy, adequate staffing, patient-staff relationships, prevention of violence and aggression in the hospital, availability of milder alternatives to risk behaviour management and staff training and support. That is why I propose to work systematically in precisely these ways for this purpose.

Experts from the psychiatric hospitals visited are aware of these connections and understand them as part of care, but, with few exceptions, there is a lack of systematic efforts to reduce the need for restraint and to comply with the principle of the least restriction possible through measures in the areas indicated. In standard operation, other topics are prioritised. It may also be that the effort to use less severe measures is clearly declared in internal regulations, but this is not fundamentally reflected in practice due to the lack of training and conditions for implementation of the measures. For example, there is a lack of space for de-escalation interviews or other forms of calming down the patient.

I consider it a mistake that neither the law nor the methodological guidelines of the Ministry require **providers to regularly evaluate clinical practice and take targeted preventive measures**. It is no wonder, then, that providers only respond to adverse events and have no specific vision. The use of restraints would in fact be a suitable indicator of the quality of psychiatric care. It is advisable to target staff training according to their frequency and manner of use, pay increased attention to selected risk groups of patients, adjust the conditions and personnel for the provision of care, and **design new wards that are currently being built in general hospitals within the reform**. Finally, if the hospital were to publish information about its efforts on an ongoing basis, the resulting transparency would increase public confidence and improve the hospital's organisational culture.

## RECOMMENDATIONS TO HOSPITALS

- consider the use of restraints as part of quality and safety of the healthcare services provided;
- evaluate the records on the use of restraints at the level of the hospital management within regular audits and take measures to reduce the need for their use.

## RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- deal conceptually with the topic of restraints: systematic methodological support for providers and control bodies, support for specific projects aimed to eliminate long-term restraints, guaranteeing a special training program, etc.

and evaluated in order to improve best practice outcomes for the particular populations at risk. International Society of Psychiatric-Mental Health Nurses (ISPN). ISPN Position Statement on the Use of Restraint and Seclusion. JCAPN Volume 14, Number 3, July-September, 2001.

Introduction to the 2017 CPT Standard: "[T]he ultimate goal should always be to prevent the use of means of restraint by limiting as far as possible their frequency and duration. To this end, it is of paramount importance that the relevant health authorities and the management of psychiatric establishments develop a strategy and take a panoply of proactive steps, which should inter alia include the provision of a safe and secure material environment (including in the open air), the employment of a sufficient number of health-care staff, adequate initial and ongoing training of the staff involved in the restraint of patients, and the promotion of the development of alternative measures (including de-escalation techniques)."

## c) Records of cases and evaluation of the situation in the hospital

**In all five psychiatric hospitals** visited in 2017, it was possible to obtain from the hospital information system an overview of cases where restraints had been used, together with some other important information (patient identification, date of use, type of restraint, hospital ward). In two of them, they did not work with the records themselves at all and in another two, they only inspected the numbers once or twice. On the other hand, in one hospital (Kosmonosy), they also studied case reports of long-term use and dealt with the documentation on restraints in all closed medical files during the audit of medical records, which took place twice annually, in addition to simply comparing the numbers; the results were continuously available to healthcare staff via the intranet. This is good practice, as is the thorough audit planned at another hospital visited in 2018 (Bohnice).

In contrast, in the three **psychiatric wards of the teaching hospitals** visited so far (2018 and 2019), **they were not able to generate an overview of cases for any kind of comparison**. Without information on the duration of the use of restraints and without the possibility of finding individual cases, it is entirely impossible to gain an objective picture of the provider's practice in using restraints. For example, paediatric patients are transferred to an adult ward to deal with restlessness, but without the possibility of identifying them in the presented statistics, it was it impossible to assess how children are treated when restraints are used.

Following the example of the CPT, I have placed a great emphasis for years now on keeping a central register of restraints, the items of which would make it possible **to obtain an overview of the situation and carry out effective control in selected cases**.[139] Information systems of psychiatric hospitals generate records, but in view of the fragmented practice of other providers, I recommended a systemic measure requiring that record-keeping be regulated not only by a methodological measure, but also by a binding legal regulation. **I am therefore dissatisfied with the legislative provisions regarding the central register, as enacted on the basis of the Government's proposal for amending Healthcare Services Act.**[140] I consider it unnecessary red tape.

The current provision of Section 39 (4) of the Healthcare Services Act is inadequate as it does not fulfil any of the currently required goals, i.e. to reduce the use of restraints and ensure security and safety of the care provided. The provision introduced the duty to keep statistics on the number of instances where the individual types of restraint were used during a calendar year. Such "records" do not allow for qualitative assessment of the provider's practice, nor national benchmarking in view of the non-specificity of the data obtained. There is no requirement for the records to include e.g. information about the ward (for example the psychiatry / geriatrics / neurology ward), the means of restraint used, how long the restraint lasted and what circumstances surrounded the case (repeatedly the same patient, paediatric patient, injury, etc.). On the contrary, according to the law, patient identification data should not be entered in the records, which makes it impossible to trace and analyse the circumstances of individual cases. Of course, such records cannot be used to facilitate control either.

139 "Experience has shown that detailed and accurate recording of instances of restraint can provide hospital management with an oversight of the extent of their occurrence and enable measures to be taken, where appropriate, to reduce their incidence. To this end, a specific register should be established to record all instances of recourse to means of restraint (including chemical restraint). This should supplement the records contained within the patient's personal medical file. The entries in the register should include the time at which the measure began and ended; the circumstances of the case; the reasons for resorting to the measure; the name of the doctor who ordered or approved it; and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this entitlement; at their request, they should receive a copy of the full entry." Paragraph 11.1 of the 2017 CPT Standard.

140 Passed as Act No. 65/2017 Coll., on protection of health against harmful effects of dependency producing substances, effective from 31 May 2017.

## RECOMMENDATIONS TO HOSPITALS

- within the efforts aimed at quality and safety of the health services provided, keep records beyond those prescribed in Section 39 (4) of the Healthcare Services Act, i.e. keep an overview of cases with key circumstances (ward, type of restraint, date and duration of use, whether the patient was a minor child, injuries or complications and the patient's medical record identifier).

## RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- prepare a draft amendment to Section 39 (4) of the Healthcare Services Act so as to require that records be kept of instances where restraints were used in the true sense of the word;
- identify and analyse cases where an injury or death of a person occurs in connection with the use of a restraint; the results should be reflected in methodological direction and training.

## d) There is a risk of deterioration of the current situation in psychiatric hospitals

The discussion with representatives of psychiatric hospitals has revealed **factors that currently increase the frequency of using restraints**. These include an increasing share of patients admitted in the state of acute intoxication, fears of the staff regarding legal liability in case of injuries suffered by patients who have not been restrained and a lack of psychiatrists. There are still cases of patients with mental disabilities showing severe behavioural disorders who require completely individualised care built around personal care, and whose discharged is postponed indefinitely due to the unavailability of adequate social services (see chapter 20 (k)).

Systemic decisions are currently being adopted on the future course of the psychiatric care reform. While I generally welcome these developments, including a gradual reduction in the capacity of major psychiatric hospitals, these decisions will affect the funding of psychiatric hospitals and entail a possible impact on the settings (capacity, target groups) of those facilities where means of restraint are already used for various reasons. **Indeed, certain investments are required to overcome the existing shortcomings.** I call on the Ministry of Health, as the authority responsible for the sector of healthcare and for the psychiatric care reform, to take account of the findings described in this report and to avoid stagnation, or even deterioration, in the already inadequate situation in psychiatric hospitals.

At the governmental level, I also welcome the support of the Ministry of Health for **research into the use of restraints**, which took place in 2018 and 2019 and which can serve as a useful tool for providers to improve the quality of care and working conditions for their staff. [141] I also welcome the fact that the Ministry of Health has developed and issued a methodology for regional authorities to control the use of restraints by providers, which was one of my previous recommendations.

In conclusion, I note that nothing has changed so far in the fact that the Healthcare Services Act does not define an infraction that could serve as a basis for an administrative penalty for violating the duties under Section 39 of the same Act.

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- as the authority responsible for healthcare and guarantor of the reform of psychiatric care, ensure that the progress in the reform of psychiatric care in 2019 and 2020 will not result in deterioration of the conditions under which care is provided in psychiatric hospitals;

141 ŘÍČAN, Pavel et al. Omezovací prostředky v psychiatrii. Souhrnná zpráva (Means of Restraint in Psychiatry. Summary Report) [online]. Prague: Ministry of Health, 2019 [retrieved on 26 July 2019]. Available at: http://www.reformapsychiatrie.cz/2019/07/15/souhrnna-zprava-k-pouzivani-omezovacich-prostredku-v-psychiatrii-prvni-mapovani-situace/

# 22) Complaints

## a) Standard

A complaints mechanism is **one of the safeguards against ill-treatment** of persons deprived of their liberty. If the mechanism is taken seriously and it is indeed available to the patients, it also supports good relationships with the staff.

The Healthcare Services Act lays down the patient's right to lodge a complaint against the provider's procedure in the provision of healthcare services; initially, the complaint is to be addressed to the provider and, as a second step, to the competent administrative authority.[142] The law does not describe the manner in which the provider should set up the complaints mechanism. Hospitals are thus free to establish their own mechanisms, provided that they adhere to the **basic principles**. In addition to the principle explicitly mentioned by the law that lodging a complaint must not be detrimental to the person who filed it or the patient concerned, we should highlight the principles of preventing ill-treatment as defined by the CPT: availability, accessibility, confidentiality and safety, effectiveness and verifiability. [143] Furthermore, it is necessary to take into account the specifics arising from the fact that patients of psychiatric hospitals suffer from mental disorders.

## b) Complaints mechanisms in psychiatric hospitals

Hospitals always accept complaints delivered by regular mail or by e-mail with an electronic signature. Mailboxes were available at the wards of all five hospitals. In four of them, mail was collected every working day by the station nurse and the content was discussed at a ward (community) meeting. If there was a letter addressed to the management in the mailbox, the nurse would not open it. The mailboxes were sometimes labelled "suggestions" or "questionnaires". In one case, the mailboxes at the ward were left opened; a closed mailbox was only located in the management building. In the remaining hospital, these mailboxes were intended only for satisfaction questionnaires, which is a different topic. Station nurses and ward physicians are commonly available to patients to resolve dissatisfaction and complaints. Most often, complaints take the form of dissatisfaction informally expressed at the community meeting or in regular interpersonal contact.

I commented on whether these forms of complaints offer the **opportunity to safely file a complaint about the conditions in the ward even to patients not allowed to leave the ward**. If the healthcare professionals entrusted with care for a patient are involved in the process of receiving complaints, then there must be an alternative way of contacting the management directly, confidentially and excluding even the hypothetical possibility that any complaints will be filtered out. A written complaints box can provide such an option and I often recommend it to the facilities visited, but the complaints must be collected by a person without any links to the provision of care at the ward, such as a hospital clerk. In any case, the complaints box must be locked, located at a place freely accessible to patients and equipped with information on who collects its contents and how often. However, there are other ways to ensure that patients who, for some reason, do not want their complaint to go through the hands of the ward staff, can contact the management. For example, there could be an internal telephone for the patients to call a specific number and request an appointment with a complaints officer, or the hospital may rely on the patients' own phones, but in that case those who do not have one must be able to file a complaint otherwise. It is up to the hospital to choose the best solution in view of the local conditions. For patients who can come to the management building on their own and submit a complaint there, such measures are of course superfluous.

142 Section 93 et seq. of the Healthcare Services Act.

143 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Complaints mechanisms. Extract from the 27th General Report of the CPT, CPT/Inf(2018)4-part [online]. Strasbourg: CPT, 2018 [retrieved on 11 May 2019]. Available at: https://rm.coe.int/16807bc668.

As regards **availability of information on the complaints procedure** for patients, it is often included in the materials published on the notice boards. In one hospital, however, the information was missing at some wards, and in one I pointed out the complexity of the wording chosen. I have adopted the CPT standard that persons deprived of liberty should receive information on the internal and external complaints mechanism, both orally and in written form for later reference. This information should not be missing in the basic patient brochure (see chapter 18).

I would also like to point out the rule applied by some hospitals that a **complaint filed electronically without an electronic signature** must be subsequently confirmed by the complainant by regular mail. If it is also applied to hospitalised patients, this may constitute an obstacle to using the internal complaints mechanism (imagine a patient in a closed ward, without financial resources, who is unable to comply with these formalities). I discussed this with a hospital, which acknowledged that it had the means to verify the identity of a hospitalised complainant.

**I call for a forthcoming attitude of the hospitals towards these standards.** One provider claimed that there was no need for special considerations beyond the wording of the Healthcare Services Act, which is however not true. On the one hand, it is necessary to pay attention to the purpose of the law, which is to provide patients with a fully working complaints mechanism, not just a theoretical one. Furthermore, State authorities must take into account the extraordinary vulnerability of victims of ill-treatment and the fact that they are also often less able and willing to complain, a principle of the European Convention particularly emphasised in the context of psychiatric hospitalisation, although ill-treatment is not commonplace in this context.[144] In the case of patients deprived of their liberty, the acts of the hospital are imputable to the State.

## RECOMMENDATIONS TO HOSPITALS

- introduce a safe complaints mechanism at closed wards, i.e. a way to file a complaint with the management without it going through the hands of ward staff;
- provide patients with written information on the complaints mechanism in a comprehensible and easy-to-understand language;
- do not make the submission of a complaint conditional on the use of an electronic signature for currently hospitalised patients, but rather use alternative procedures for verifying the complaint.

144 Cf. the judgement of the European Court of Human Rights in case M. S. v. Croatia (no. 2), cited above, paragraph 76.

## c) Complaints containing an arguable claim of ill-treatment

I take this opportunity to summarise the standard following from the prohibition of ill-treatment, which is mostly unknown to healthcare services providers.

If an individual credibly claims to have been ill-treated (in the legal sense of torture and inhuman or degrading treatment), the State must ensure an official investigation that meets the parameters of effectiveness, i.e. independence and impartiality, promptness and public nature (**effective investigation**).[145] A provider cannot perform for such an investigation in the case of complaints concerning treatment of patients in its own hospital, as this would not meet the criterion of independence. Depending on the gravity of the problem, the investigation should be performed by the prosecuting bodies (intentional interference of a greater intensity) or an administrative authority (interference of a lesser intensity).

This is not meant to concern ordinary complaints, but rather an **arguable claim of ill-treatment**. A claim is "arguable" if "unless it entirely lacks credibility and unless the events described in it are unlikely, if the events described are possible in terms of their time sequence, and if it is sufficiently specific and unchanged over time".[146] Ill-treatment also includes the category of degrading treatment, which means conduct that grossly humiliates an individual in the eyes of others or in his/her own eyes, abets him/her against his will or conscience, debases or humiliates him/her, shows a lack of respect for his/her human dignity or diminishes it, or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance.[147] The intention to humiliate is a circumstance which is taken into consideration, but degrading treatment can also be unintentional. Degrading treatment may thus include, for example, unauthorised use of force by the staff (including means of restraint) or attack among patients if these exceed the minimum severity level.

It would be a mistake to apply the standard complaints procedure to complaints or notifications of this level of gravity, as it cannot lead to adequate redress or may even cause a delay in, or frustration of, the redress. **The provider should advise the complainant of the possibility to file a criminal complaint and, if the patient is unable to deal with the matter (given his/her medical condition or lack of self-reliance), also of the possibility to request that the provider be released from the duty to maintain confidentiality and report the information.** The provider can and should report any facts indicating the occurrence criminal offenses with regard to which a failure to report is a criminal act in itself;[148] otherwise, the provider is obliged to maintain the confidentiality of all the facts which learned in connection with the provision of health services[149] (cf. chapter (23a)). **At the same time, if it is possible for the provider take any step to terminate or change the given treatment, the provider has the duty to do so if the provider itself finds the given situation incorrect.**

Although this standard does not cover a large number of cases in the context of healthcare, it must be applied in view of its seriousness, both in cases where the alleged ill-treatment is caused by a member of the hospital staff and in cases where it results from acts of other individuals.

145 Cf. the judgement of the European Court of Human Rights in case Bureš v. the Czech Republic, cited above, paragraphs 122-127, and M. S. v. Croatia (no. 2), cited above, paragraphs 74 to 77.

146 "The purpose of the requirement for arguability of claims is to filter out only clearly nonsensical criminal complaints." Judgement of the Constitutional Court of 2 March 2015, File No. I. ÚS 1565/14, available at: http://nalus.usoud.cz, paragraphs 55 and 61.

147 Judgement of the Grand Chamber of the European Court of Human Rights in case M. S. S. v. Belgium and Greece of 21 January 2011, application no. 30696/09, paragraph 220.

148 Section 368 of the Criminal Code.

149 Cf. Section 51 (1) of the Healthcare Services Act.

# 23) Recording and reporting medical evidence of ill-treatment

## a) Standard

Physicians, and healthcare services in general, can and should significantly contribute to combating ill-treatment at places of detention by **methodically recording injuries and reporting to the competent authorities**. Accurate and timely documenting and reporting of such medical evidence significantly facilitates the investigation of possible ill-treatment and brings perpetrators to justice. As early as 1999, the United Nations issued the Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, and the CPT then reflected these principles in its 2013 Standard.[150] This standard consists of two components.

First, any **report on the treatment of injuries** sustained by a person deprived of his/her liberty must contain **further information**, in addition to the requirements set out in the medical standards. It must include (i) description of events, treatment and subsequent physical and mental manifestations, as stated by the patient, where this description must be provided with the greatest possible level of accuracy; (ii) a record of medical and psychological findings, including colour photographs of injuries; (iii) a physician's opinion as to the likely connection of the findings and possible ill-treatment, and any recommendations for further care.

Second, if a healthcare professional detects injuries that align with detainee's allegations of ill-treatment, or even in the absence of such an allegation, he/she should **systematically and promptly inform the competent authority**, regardless of the person's wishes. The "competent authority" to which the report of the health professional should be submitted is, in the first instance, an independent body competent to investigate the matter or, where appropriate, to issue an indictment (the Public Prosecutor's Office). The CPT does not require doctors to assess whether a criminal offense may have occurred; they are only required to present their evidence of signs of ill-treatment. The report should also be available to the detained person and his/her legal counsel.

Systematic visits continuously show that **this standard is not and, in part, even cannot be met in the Czech Republic**. Physicians are not aware that reports of examinations or treatment should comprise the first and third items listed above, and reporting on any evidence of ill-treatment is limited by the legal confidentiality of the provider and the healthcare professional. [151] A lack of information in a report can cause problems during the investigation. Indeed, in cases where an individual proves that he/she suffered an injury at a time when he/she was subjected to the State's power and complains that this was a consequence of ill-treatment, there is a rebuttable presumption that this indeed was the case. It is up to the State to provide a satisfactory and convincing explanation of the deterioration of the person's medical condition.[152] Inadequacy of the medical report on injuries of a person deprived of liberty could result in violation of the State's duty to carry out adequate and effective investigation.[153] As far as reporting cases is concerned, this is not possible without the patient's waiver of confidentiality. However, some of the victims need not be willing or able to declare the waiver, which is why the prevention standard requires systematic

150 European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Documenting and reporting medical evidence of ill-treatment. Extract from the 23rd General Report of the CPT, published in 2013. CPT/Inf(2013)29-part [online]. Strasbourg: CPT, 2013 [retrieved on 3 May 2019]. Available at: https://rm.coe.int/16806ccc4d. For a summary of these standards, cf. Istanbul Protocol on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and LUKASOVÁ, Marie. Istanbulský protokol k účinnému vyšetřování mučení a špatného zacházení (Istanbul Protocol on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment). Public Prosecutor's Office. Prague: Wolters Kluwer ČR, 2019, 3, 56-63. ISSN 1214-3758.

151 Section 51 (1) of the Healthcare Services Act.

152 Cf. the ruling of the European Court of Human Rights in Bouyid v. Belgium, no. 23380/09, judgement of the Grand Chamber of 28 September 2015, paragraph 83.

153 The European Court of Human Rights stated this, for example, with respect to a complaint concerning alleged police beatings, Dilek Aslan v. Turkey, no. 34364/08, judgement of 20 October 2015. Referring to the CPT standards and UN principles, the Court expressly criticised the State concerned that the medical report prepared by the police doctor examining the detainee contained only a description of his injuries.

reporting. It also follows from the Convention that effective investigation is likewise required in case of absence of a complaint if there are clear explicit or implicit signs of ill-treatment[154]

These weaknesses have been pointed out to the Government of the Czech Republic by the CPT for years; the above standard was also considered pressing by the UN Committee Against Torture in 2018. In 2015, the Government tasked the Minister of Health **to carry out the necessary amendment to the Healthcare Services Act**, but the task[155] was later cancelled without a relevant reason. It is high time to take the necessary steps.

It might seem that this is a topic related only to medical professionals working in the prison system, but this is not so. This also applies to treatment of persons detained by the police. Such treatment is provided by various civilian providers of healthcare services, who also provide services to those who seek treatment after release. Even psychiatric hospitals admit occasionally people who have previously spent some time in police detention. Traces of ill-treatment can also be borne by a user of social services admitted to a hospital, and a case of ill-treatment during hospitalisation in (any) hospital cannot be ruled out either. For this reason, the above-mentioned standard needs to be laid down in general regulations and methodical aids (similar e.g. to those available for domestic violence cases[156]), rather than just those related to prisons.

Given that this is an additional obligation for providers and healthcare staff already strained by administrative tasks, I propose to make the situation easier for them as much as possible. Simple forms (with a human body diagram, prepared items, instructions) and cameras should be available for recording injuries. Furthermore, I consider it important to recall the importance of this standard for ensuring the well-being and safety of patients and the conditions under which it complies with the principles of medical ethics; the CPT has elaborated on this subject.[157]

### RECOMMENDATIONS TO THE MINISTRY OF HEALTH

- prepare a draft amendment to the Healthcare Services Act so as to provide an exemption from the duty to maintain confidentiality in cases of reporting and disclosing information on ill-treatment, and also lay down the provider's duty to report signs of ill-treatment;
- issue recommendations for healthcare services providers in treatment of persons restricted in their freedom and publish them in the Official Journal of the Ministry of Health (explain the emphasis on confidentiality of the examination and the parameters of the report and the possibility to report cases to the public prosecutor).

## b) Findings from psychiatric hospitals

Since healthcare services providers do not record cases where persons showing signs of ill-treatment are admitted, I commented on only a few cases found randomly in the reports. I thus rather tried to raise awareness of the standard of documenting signs of ill-treatment, which the psychiatric hospitals tended not to accept in their statements, arguing that the law did not impose any special duties.

154 Cf. ruling of the European Court of Human Rights in case Gjini v. Serbia, no. 1128/16, judgement of 15 January 2019, paragraph 93.
155 Task of the Minister of Health No. 654/12, based on Government Resolution No. 609 of 29 July 2015.
156 Cf. Methodical instruction of the Minister of Health for the physicians' procedure in the provision of healthcare to persons threatened by domestic violence, Official Journal of the Ministry of Health of the Czech Republic, Volume 6/2008.
157 Cf. Lukasová, op. cit.

Much more often, I encountered cases of injuries that patients suffered during hospitalisation: common injuries, but also the consequences of the use of restraints, auto-aggression or attacks by other patients. I feel compelled to note that hospitalisation in some cases (and always in the case of forensic treatment) amounts to deprivation of human liberty. In such cases, the hospital's acts are attributable to the State **and any injuries and deterioration of the medical condition occurring during hospitalisation must be documented**. Otherwise, if the patient complains that the injury is a consequence of ill-treatment, there is a rebuttable presumption that this indeed is the case.

## RECOMMENDATIONS TO HOSPITALS

- consistently keep detailed records of injuries found during the admission of patients or suffered during hospitalisation; record all the aspects: patient's statements on the origin of the injury, findings of the physician and his/her opinion on alignment of the findings with the patient's statement.

very small dormitory

seclusion room

common premises

details of outdoor smoking premises

small gym in the ward

common premises

# Overview of systemic recommendations

## Recommendations to the Ministry of Health (in co-operation with the Ministry of Justice)

1. carry out comprehensive review of the legislation on forensic treatment and prepare the necessary legislative proposals (i.e., among other steps, supplement the legislation on security of the relevant facilities; set the personnel requirements on providers; provide a legal basis and safeguards for treatment without consent; establish a mechanism of relocation of patients; specify guaranteed specific conditions for children; cf. chapters 5 and 6);
2. prepare a forensic treatment policy and, within its framework, improve the mechanism of its financing (cf. chapter 6 (j));
3. unify the procedure of healthcare services providers in evaluating the attainment of the purpose of forensic treatment and persisting danger posed by the patient (offer guidance for the provider's structured considerations; cf. chapter 6 (f) and 6 (g));
4. ensure reopening of the sexological treatment ward for the Northern Moravia catchment area (see chapter 6 (a));
5. subsidise investment plans of psychiatric hospitals related to security at wards specialising in the provision of forensic treatment for dangerous patients (cf. chapter 6 (b));
6. continue the development of pilot forensic multidisciplinary teams (cf. chapter 10 (a));
7. guarantee further education of court experts so as to promote uniformity (cf. chapter 6 (h));
8. prepare a draft amendment to the Healthcare Services Act so as to define an infraction of degrading treatment and incorrect use of restraints (cf. chapter 9 (b));
9. prepare a draft amendment to the Specific Healthcare Services Act so as to define the subject and conditions of supervision by the public prosecutor's office at places where forensic treatment is provided (cf. chapter 9 (a)).

## Further recommendations to the Ministry of Health

10. either prepare a draft amendment to the Healthcare Services Act in order to define the conditions of permissible use of cameras in hospitals or take steps for methodological guidance with a view to terminating the use of cameras (cf. chapter 11 (d));
11. inquire into and analyse cases where the police interfere on request of the staff of psychiatric wards and hospitals; regularly reflect the results in the methodological guidance and education (cf. chapter 11 (e));
12. prepare, in co-operation with the Police Presidium, a procedure for situations where healthcare professionals summon the police to handle an aggressive patient and where the police operate on the premises of a healthcare facility, in order to ensure their co-ordination and procedure based on the principle of the least possible restriction and minimisation of the use of force (cf. chapter 11 (e));
13. ensure, possibly in co-operation with the Ministry of the Interior, that a regulation is issued requiring the police to ensure that healthcare professionals are provided with information on the circumstances of detention and escort of a patient where the police has provided assistance (cf. chapter 11 (f));

14. prepare a draft amendment to Section 88 (1)(a) of the Specific Healthcare Services Act so as to include the principle of free and informed consent also in case of forensic treatment, and phrase any exemptions in clear terms, require a justified decision on involuntary treatment if such an exemption is applied, and provide for an appeal with an independent body (cf. chapter 12 (d));
15. analyse the availability and effectiveness of existing tools for protection (in civil or administrative courts) for patients who disagree with a decision made by the guardian or provider/physician on their psychiatric treatment; based on the results of the analysis, prepare methodological and information materials for the providers and patients as to how these tools should be used effectively in clinical practice, or prepare a draft amendment to the Healthcare Services Act and introduce a new tool (cf. chapter 12 (d)).
16. summarise the legal rules for treatment of mental disorders without consent in a methodological material for healthcare services providers (cf. chapter 12 (d));
17. ensure that patients in forensic treatment are accommodated in dormitories with a maximum capacity of 4 beds;
18. consider laying down this standard in a decree (the Decree on requirements for minimum technical and material equipment of healthcare facilities, cf. chapter 16 (a));
19. prepare a specific plan with temporal milestones to improve the staffing in follow-up psychiatric care in general and in facilities providing forensic treatment in particular (cf. chapter 17 (b));
20. prepare a training programme for psychiatrists on the use of ECT and act as an supervisor for the programme (cf. chapter 19 (e));
21. determine the parameters of the records on the use of the ECT in the form of methodological guidance and keep a national overview on the basis of these data (cf. chapter 19 (e));
22. adopt a strategic approach on the ban of enclosure beds that includes a search for and promotion of effective alternatives to the use of not only enclosure beds, but means of restraint in general (cf. chapter 20 (h));
23. either improve the definition of a pharmacological restraint in the Healthcare Services Act, or shape the interpretation of the Act through a methodological guidance to include the CPT definition (cf. chapter 20 (i));
24. support quality education in a safe use of restraints and de-escalation methods, e.g. by preparing their programmes and training supervisors as part of the reform of psychiatric care (cf. chapter 20 (n));
25. deal conceptually with the topic of restraints: systematic methodological support for providers and control bodies, support for specific projects aimed to eliminate long-term restraints, guaranteeing a special training program, etc. (cf. chapter 21 (b));
26. prepare a draft amendment to Section 39 (4) of the Healthcare Services Act so as to require that records be kept of instances where restraints were used in the true sense of the word (cf. chapter 21 (c));
27. identify and analyse cases where an injury or death of a person occurs in connection with the use of a restraint; the results should be reflected in methodological direction and training (cf. chapter 21 (c));
28. as the authority responsible for healthcare and guarantor of the reform of psychiatric care, ensure that the progress in the reform of psychiatric care in 2019 and 2020 will not result in

deterioration of the conditions under which care is provided in psychiatric hospitals (cf. chapter 21 (d));

29. prepare a draft amendment to the Healthcare Services Act laying down the provider's liability for breach of duties pursuant to Section 39 of the Act in the form of an infraction (cf. chapter 21 (d));

30. prepare a draft amendment to the Healthcare Services Act so as to provide an exemption from the duty to maintain confidentiality in cases of reporting and disclosing information on ill-treatment, and also lay down the provider's duty to report signs of ill-treatment (cf. chapter 23 (a));

31. issue recommendations for healthcare services providers in treatment of persons restricted in their freedom and publish them in the Official Journal of the Ministry of Health (explain the emphasis on confidentiality of the examination and the parameters of the report and the possibility to report cases to the public prosecutor) (cf. chapter 23 (a)).

## Recommendations to the Ministry of Justice

1. ensure guidance and further education of judges to promote uniformity (as regards imposing individual "types" of forensic treatment, presenting questions to experts, not making forensic treatment conditional on some traditionally perceived deadlines; cf. chapter 7);

2. introduce uniform records of forensic treatment (imposed and ordered) and a central register of patients undergoing forensic treatment (cf. chapter 6 (d));

3. unify the form and contents of motions/reports submitted by healthcare facilities to the courts (cf. chapter 6 (g)).

## Recommendations to the professional community

1. standardise the procedures used in forensic treatment and establish forensic treatment programmes for its individual types (cf. chapter 8);

2. prepare and offer to physicians a tool for evaluating the risks posed by a patient in forensic treatment (cf. chapter 6 (f));

3. issue a lege artis standard for the use of penile plethysmography (cf. chapter 13 (h)).

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