



Cage beds and coercion in Czech psychiatric institutions



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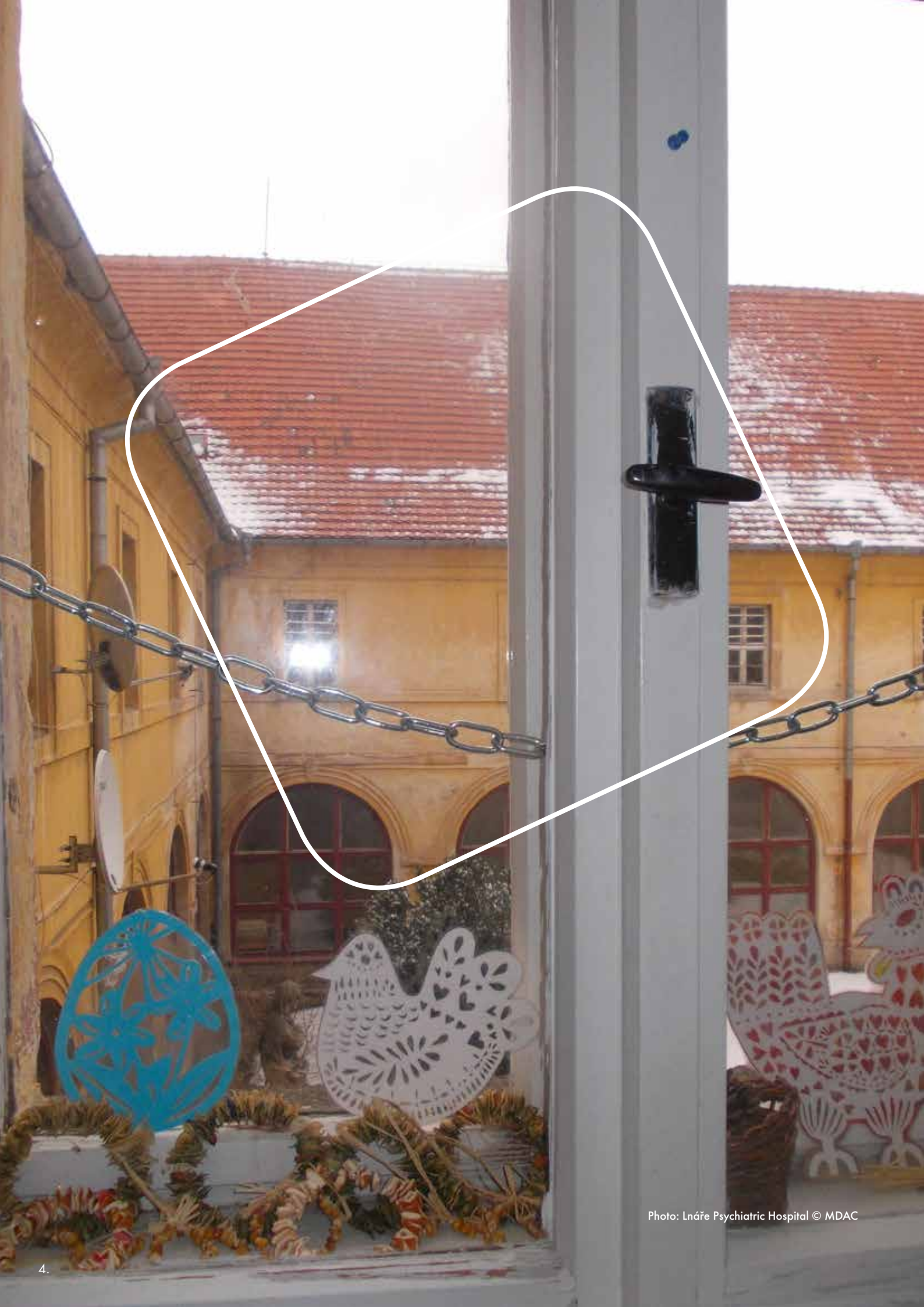


Photo: Lnáře Psychiatric Hospital © MDAC

1. Foreword

Ill-treatment is a persistent beast. Cage beds are a degrading experience for the user, and considered ill-treatment by many observers. Still, the phenomenon persists in Czech psychiatric institutions and elsewhere. It is defended by those who apply the method, with the argument that the alternatives are worse. The same argument is used by those who defend other forms of coercion in different countries. The argument is flawed. Ill-treatment cannot be justified, legally, clinically or morally. More specifically, the use of any means of mechanical restraint for days on end can have no medical justification and amounts to ill-treatment.

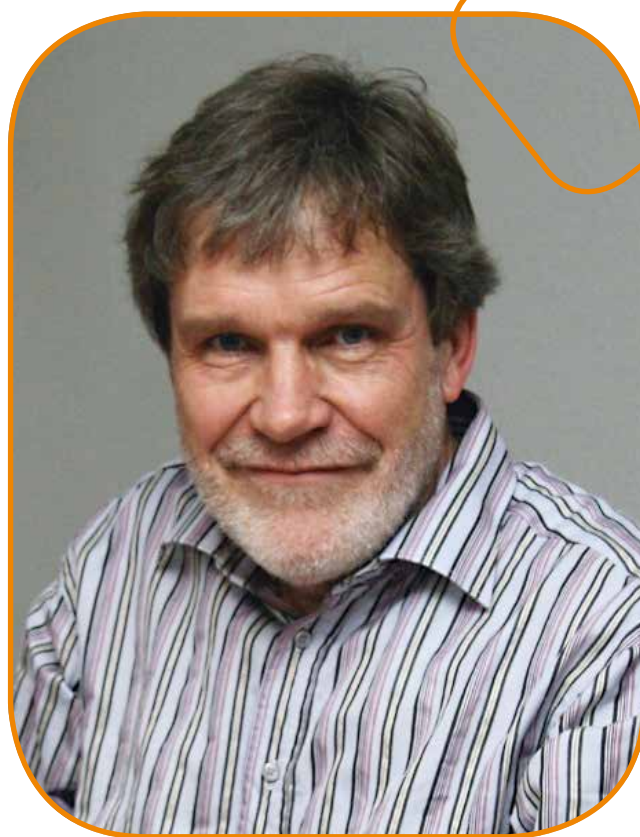
Flawed arguments alone cannot explain the persistence of different forms of coercion still prevalent in the Czech Republic and across the region. Whilst the techniques may be different, the common element is their persistence, particularly difficult to understand when they are performed by otherwise well-meaning staff in institutions. Cultural traditions in therapy can be so intractable that they seem to be built into the foundations of hospitals. In these settings, coercive practices are expected by all, even victims. These traditions remain unchanged in spite of legislative amendments, funding, training, academic research and public opinion. Often, the only solution is complete prohibition, tearing down the walls. This has been the case with various forms of coercion in psychiatry and social care in several countries.

Cage beds are degrading. Now, why is that? Is it because of some international convention, or because foreign monitors think it is? In fact, it is for neither of these reasons. Cage beds are degrading because this is what people placed in them tell us. International conventions prohibiting the use of cage beds follow from this simple fact. "It's like being a bird in a cage," a person who has been in one told me, powerfully explaining the definition of degrading treatment in a nutshell.

The prohibition of degrading treatment and punishment is a rule without exception, as is the broader prohibition of torture and all forms of ill-treatment.

A very important finding in this report is that in some institutions the removal of cage beds has led to increased use of other degrading "alternatives" such as seclusion, chemical restraint and/or immobilisation with belt straps. Some institutions removed the cage beds, only to systematically replace them with seclusion rooms.

Luckily, some of the new seclusion rooms have not been used. Even in the face of persistent support for coercion, some staff reported that less coercive methods have been developed to assist in challenging situations. The lesson to be learned is that seclusion, strapping and medication are not real alternatives to cage beds. It shows that highly coercive practices are simply unnecessary and can be done without. This practical argument against their use, in addition to the more important human rights



arguments above, fundamentally undermines those who argue in favour of high levels of coercion. The same experience was found in other countries which have successfully managed to reduce their own preferred forms of coercion in psychiatry, often to the surprise of ardent supporters of coercion.

Fighting the persistent beast of ill-treatment in psychiatry will require effort from all sides. Cage beds are still in use: that is unacceptable in the modern era. Substituting them with other coercive practices is both unacceptable and unnecessary. The future vision must be to eradicate ill-treatment from psychiatry and social care. Any means of coercion and restraint that exists, with the equipment ready and legal provisions in place, will inevitably be used, and the use will inevitably be excessive. Therefore, the only way is a total prohibition of specific forms of coercion, and a clear movement towards informed consent and user-centred approaches. Supported housing and community-based services are the "alternatives" which are now demanded by international human rights law.

MDAC has been crucial in calling for these changes, in the Czech Republic and elsewhere. It will continue to be an important voice in calling for recognition of the autonomy and dignity of all people with mental health issues, and holding to account those governments who fail to do so.

Dr. Pétur Hauksson, MD

Practicing psychiatrist, Iceland

Former Member and 1st Vice-President of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, 2000-2011

Head of Mission, MDAC monitoring team to the Czech Republic, 2013

2. This report

2(A). Mental Disability Advocacy Center (MDAC)

Mental Disability Advocacy Center (MDAC) is an international human rights organisation which uses the law to secure equality, inclusion and justice for people with mental disabilities worldwide.

Our vision is a world of equality – where emotional, mental and learning differences are valued equally; where the inherent autonomy and dignity of each person is fully respected; and where human rights are realised for all persons without discrimination of any form.

In the 2014-2020 period, MDAC is focusing on some of the most extensive human rights issues affecting people with mental disabilities globally through three international campaigns.

1. **Schools for All** – advancing inclusive education for all children with mental disabilities, and challenging segregated education.
2. **I'm a Person** – pushing for supported decision-making for all persons with mental disabilities and the abolition of systems of guardianship.
3. **My Home, My Choice** – promoting independent living and community-based services and challenging abuse in institutions.

2(B). Methodology

This report seeks to answer the question: “What forms of torture or ill-treatment exist in Czech inpatient psychiatry, and what can be done to reform the system?”

At the end of 2012, MDAC submitted official freedom of information requests to 45 inpatient psychiatric facilities in the country, requesting information on the use of cage beds. 17 institutions said that they still use a total of 120 cage beds. Eight institutions failed to respond. Kosmonosy Psychiatric Hospital reported the highest number of cage beds in use in the country, 27 in total.¹ A detailed breakdown of responses to the freedom of information request can be found in Annex 1.

In conjunction with its NGO partner the League of Human Rights in the Czech Republic, MDAC contacted the directors of 25 psychiatric facilities identified as still using cage beds or other coercive practices in early 2013 to request permission to conduct monitoring visits. Of those contacted, 12 failed to respond, and eight agreed to the proposed visit.

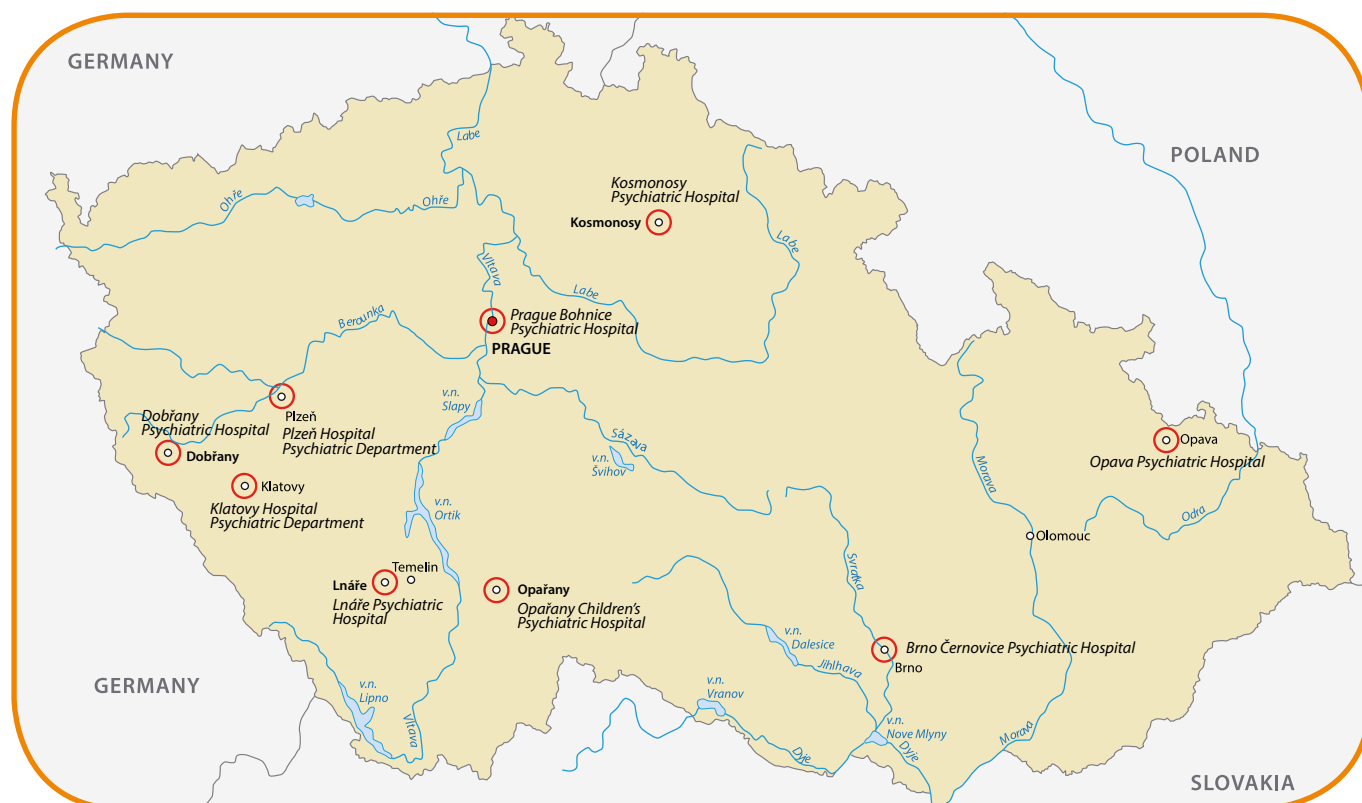
¹ Although the director of the institution reported that 29 were in use when interviewed in person by the MDAC monitoring team – see Chapter 6.

The institutions visited were:

1. **Kosmonosy Psychiatric Hospital**, with 600 beds and 15 wards including geronto-psychiatric, male and female acute and chronic, detox, rehabilitation and forensic facilities.
2. **Plzeň Hospital Psychiatric Department**, situated in a large general hospital, which has 76 beds for men, women and children and providing general psychiatric facilities.
3. **Dobřany Psychiatric Hospital**, a large institution in a rural setting with 1,250 beds including male and female acute, chronic, detox, geronto-psychiatric and forensic facilities. Some beds of the hospital have been designated 'social care' beds and are used for people with intellectual disabilities.
4. **Opařany Children's Psychiatric Hospital**, which has 150 beds and separate wards for boys and girls with mental health issues, and another ward for children with intellectual disabilities.
5. **Opava Psychiatric Hospital**, a large institution with 863 beds and numerous wards including adult male and female geronto-psychiatric, acute, chronic, detox and forensic facilities, including wards for children from the age of 5 years.
6. **Prague Bohnice Psychiatric Hospital**, the largest psychiatric facility in the country based in the capital, with 1,300 beds including adult male and female geronto-psychiatric, acute, chronic, forensic and rehabilitation facilities, and child psychiatric wards.
7. **Klatovy Hospital Psychiatric Department**, situated in a large general hospital, with 25 beds for men and women and providing general psychiatric facilities.
8. **Lnáře Psychiatric Hospital**, a rural facility with 70 beds and predominantly providing geronto-psychiatric facilities to men and women.

One further institution, **Brno Černovice Psychiatric Hospital**, was visited by the monitoring team but the director refused to grant access to them. Instead they met with patients in a café run by an NGO at the institution, and the institution ended the use of cage beds many years previously. The director of **Kosmonosy Psychiatric Hospital** allowed access to the monitoring team on a number of occasions but refused access to wards containing cage beds. A list of all institutions contacted and visited is provided in Annex 2.

Monitoring took part in early February 2013 and late March 2013. Monitoring teams comprised of a senior clinical psychiatrist and ex-member of the European Committee for the Prevention of Torture, a health care inspection professional from the Care Quality Commission in the UK, two Czech lawyers, a representative of a Czech mental health NGO, a disability studies researcher, interpreters and interns. Monitors spoke with patients, staff and directors of all institutions visited. Two interviews were held with people who have used cage beds, who were not in psychiatric hospitals at the time of being interviewed. To protect the identities of patient-informants, their personal identities have not been used in the report beyond descriptions of age and gender.



Map showing the eight psychiatric institutions MDAC visited, plus one where access was denied

2(C). Acknowledgements

MDAC is grateful to many people who made this report possible, including those who took part in the two monitoring missions in 2013, and those who contributed research, guidance and recommendations.

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The report was collated and edited by **Steven Allen**, MDAC
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Photo: Kosmonosy Psychiatric Hospital © MDAC



Photo: Klatovy Hospital Psychiatric Department © MDAC

"It is a feeling like you were closed as if you were an animal. As if you weren't a human. They treat you as someone even lower than an animal. [...] I saw the other patient across the room that was there [in the cage] for a really long time, I don't know how long. She was there all the time. She kept hanging on the cage, pulling it."

Testimony of a cage bed survivor

3. Executive summary

3(A). Exposing abuse in 2003

In 2003, the Mental Disability Advocacy Center published a report exposing how human beings were being caged in psychiatric and social care institutions in the Czech Republic, Hungary, Slovakia and Slovenia.² The report led to several European Union and United Nations bodies condemning “cage beds” as inhuman and degrading treatment which were prohibited under international human rights law.

MDAC’s report was met with fierce opposition in the Czech Republic. At the launch event at the Czech Senate, the head of the Czech Psychiatric Association denied that human rights were relevant, and suggested painting cage beds different colours to make them look better.

The report led to some significant results. In July 2004 the Hungarian government banned cage beds,³ followed soon after by Slovenia and Slovakia which banned them in social care institutions.⁴ TIME magazine named Dr. Jan Pfeiffer, then the Board Chair of MDAC (and now a member of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)) as a 2004 ‘European Hero’ for his anti-cage bed advocacy. MDAC’s cage bed work was profiled by the BBC’s Ten O’Clock News and the British Medical Journal.⁵

In the same year, the British *Sunday Times* newspaper drew on MDAC’s report and went undercover to expose cage beds in a children’s psychiatric hospital.⁶ This spurred *Harry Potter* author JK Rowling to write a letter of concern to Czech authorities, throwing the issue into even greater limelight both domestically and internationally.⁷ MDAC’s cage bed report was cited on JK Rowling’s website, and she subsequently founded a charity – originally the Children’s High Level Group and now Lumos – as a result.

Following this advocacy, Jozef Kubinyi, then Czech Minister of Health, issued a letter to directors of all psychiatric institutions instructing them to stop using *metal* cage beds.⁸ For taking this step he was swiftly removed from post by the President.⁹ Václav Klaus, the President of the Czech Republic, criticised Ms Rowling’s intervention on the basis of “one accidental, non-serious article in the British press”, and “refute[d] the idea that the use of [cage] beds is abusive, or worse, that mentally handicapped children are tyrannised in our country.” He went on to say that “[i]t would be likewise possible to criticize the placement of handicapped patients in special rooms or their sedation by increased doses of medicine”,¹⁰ perhaps failing to recognise that such practices were also abusive in and of themselves.

The President’s response failed to engage in a discourse about his government’s human rights obligations and reflected a majority opinion within the Czech psychiatric community that coercion – including cage beds – was a tradition, an essential and necessary aspect of the clinical toolkit and that those coming from a human rights perspective were “antipsychiatry”.¹¹



Václav Klaus, former President of the Czech Republic, and Jozef Kubinyi, former Minister of Health
Photo: ČTK/Zbyněk Stanislav

2 Mental Disability Advocacy Center, *Cage Beds: Inhuman and Degrading Treatment or Punishment in Four EU Accession Countries*, (Budapest: MDAC, 2003)

3 European Public Health Alliance, *Cage beds banned in Hungary*, (Belgium: EPHA, 2004), available online at: <http://www.epha.org/spip.php?article1361> (last accessed: 15.06.2014).

4 Act No. 576/2004 Col. on Health Care.

5 Graham Thornicroft, ‘*Mental Health in Europe*’, (British Medical Journal, 330: 613, 2005).

6 Justin Sparks, ‘*Ordeal of the caged Czech children*’, (UK: The Sunday Times, 13.06.2004), available online at: <http://www.freerepublic.com/focus/f-news/1152553/posts> (last accessed: 15.06.2014).

7 Justin Sparks, ‘*Rowling rejects caged children excuse*’, (UK: The Sunday Times, 25.07.2004), available online at: http://www.thesundaytimes.co.uk/sto/news/world_news/article114664.ece (last accessed: 15.06.2014).

8 Amnesty International and the Mental Disability Advocacy Center, *Czech Republic: JK Rowling letter prompts end of ‘cage beds’*, (UK: Amnesty International, 16.04.2014), available online at: <http://www.amnesty.org.uk/press-releases/czech-republic-jk-rowling-letter-prompts-end-cage-beds> (last accessed: 15.06.2014).

9 Nicole Paseka, ‘*Group to sue over caged patients*’, (Prague: The Prague Post, 26.04.2014), available online at: <http://www.praguepost.cz/archivescontent/1530-group-to-sue-over-caged-patients.html> (last accessed: 15.06.2014).

10 The letter is available on Mr. Klaus’s personal website: Václav Klaus, *Letter of the President to Joanne Kathleen Rowling*, (Prague: Václav Klaus, 28.07.2004), available online at: <http://www.klaus.cz/clanky/2367> (last accessed: 15.06.2014).

11 See, for example: Jiří Švarc, ‘*Omezující prostředky v psychiatrii*’, (Psychiat. Praxi, 9(5): 243-245, 2008) at p. 243.

3(B). Developments in the last decade

The government's instruction to directors of psychiatric and social care facilities in 2004 ended the use of metal cage beds in all institutions. Whilst the 2006 Social Care Act banned all cage beds from social care institutions, the 2011 Medical Services Act (No. 372/2011) continued to allow for netted cage beds to be used in psychiatric hospitals. The distinction the Czech authorities make between the metal and netted variants of cage beds is purely semantic, given that both types deprive a person of their liberty and can constitute ill-treatment.

MDAC decided to conduct a follow-up monitoring mission to psychiatric facilities in 2013, a decade after publishing its initial report on cage beds. The Czech Republic is the only country in the EU without a governmental mental health policy,¹² with the majority of mental health provision in the country provided through large, outdated psychiatric institutions. In 2012 there were 18 psychiatric hospitals for adults with 8,847 beds, of which 188 beds were set aside for child patients, and three hospitals exclusively for children with 250 beds. Another 1,260 beds were in psychiatric wards of general hospitals. Although the Ministry of Health adopted a "Strategy for Reform of Psychiatric Care" for the period 2014-2020, it has done little to reduce the high levels of mental health coercion, as documented in this report.

In a positive development, the Czech government ratified the Optional Protocol to the UN Convention against Torture in 2006, designating the Public Defender of Rights (Ombudsperson's office) as the "National Preventive Mechanism", the body responsible for visiting all facilities in which people may be deprived of their liberty. The government also ratified the UN Convention on the Rights of Persons with Disabilities in 2009, signalling its commitment to moving towards recognition of the dignity, autonomy and liberty of everyone with disabilities – including those with mental health issues, dementias and intellectual disabilities.

Ratifying these treaties, however, has not substantially reduced overall levels of coercion within psychiatric institutions, a point which has also been reported by the Public Defender of Rights. In a country which spends a mere 0.26% GDP on mental health service provision (the average in the EU is 2%),¹³ moving to community-based mental health provision remains low on the government's set of priorities, partly because of a lack of political will, and partly because of a lack of investment into the mental healthcare sector.



3(C). Findings of this investigation

MDAC visited eight psychiatric facilities across the country in 2013, interviewing patients, staff and directors in all facilities about their experiences of cage beds, restraints and seclusion.

Cage beds have been removed entirely from one children's psychiatric hospital visited (Opařany), and all but one removed from Prague Bohnice Psychiatric Hospital. But at the time of the monitoring, the majority of institutions still used cage beds in their every-day clinical practice. Kosmonosy Psychiatric Hospital reported 27 cage beds in response to MDAC's 2012 freedom of information request, although the director told the monitoring team that there was a total of 29 when he met them in person. Notably, he refused MDAC access to wards where they were kept. Detailed findings in relation to cage beds are presented in Chapter 6 of this report.

Numerous people shared with MDAC their experiences of psychological devastation from being placed in a cage bed. One 33-year-old female patient at Kosmonosy Psychiatric Hospital, interviewed at a café at the institution, told MDAC that, "I did not want to be in a cage. I was afraid I would be there forever." Monitors met a woman placed in a cage bed who shook with fear when she believed it was about to be locked by a doctor who was present. This woman had herself been a doctor at the same institution for many years previously. Other patients reported the degrading nature of being placed in cage beds, sometimes out of view of other patients, and at other times in full view of all. A recurrent theme was that placement in cage beds meant that patients would not be allowed out to go to the toilet. A 59-year-old woman at Kosmonosy Psychiatric Hospital told MDAC of a corner room at the institution which had five cage beds. She described them as being for people, "who cannot hold their urine and faeces." Placement of elderly persons in cage beds meant they would be required to wear nappies. Another patient told MDAC that when he had been placed in a cage bed he was required to urinate in a bottle.

12 Jiří Raboch and Barbora Wenigová (eds.), *Mapování stavu psychiatrické péče a jejího směřování v souladu se strategickými dokumenty České republiky (a zahraničí)* (Czech), (Prague: Česká psychiatrická společnost o.s., 2012).

13 Petr Winkler (ed.), *Reforma systému psychiatrické péče: mezinárodní politika, zkušenost a doporučení* (Czech), (Prague: Psychiatrické centrum Praha, 2013), at p. 29.

Monitors found that cage beds were disproportionately used for elderly patients, seemingly justified on safety grounds, such as the risk of them falling out of bed. Staff explained to monitors that they were also used to manage “difficult” or “agitated” patients in the context of staff shortages, and to punish bad behaviour. Overwhelmingly, psychiatrists, doctors and nursing staff expressed their preference for cage beds over other forms of restraints or seclusion. One hospital director said that “99.9%” of psychiatrists polled would choose this form of restraint over strapping.

The European Committee for the Prevention of Torture, the UN Committee against Torture, and the UN Human Rights Committee have all found that cage beds constitute ill-treatment and have called for them to be banned. Last year the UN Special Rapporteur on Torture specified that there can be, “no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions”.¹⁴

If a ban on cage beds were the only outcome of this report, it would be a Pyrrhic victory. A ban would not solve the extensive use of coercive practices in Czech psychiatric institutions. This report also presents findings on the use of chemical restraints, straps, seclusion and other coercive practices. In settings where the use of cage beds has decreased, the evidence is that staff have increased the use of these coercive “alternatives”.

Many clinical staff of the psychiatric institutions MDAC visited considered the framing of **psychotropic medication as chemical restraint**, which can lead to torture or ill-treatment, as offensive at worst and eccentric at best.¹⁵ Several doctors told MDAC monitors that medication is not a restraint, but “part of a continuous treatment of mental illness”, as one psychiatrist put it. Another said definitively that medication “is not seen as abuse in this country.” There is one issue which all clinicians can hopefully agree on, and that is preventing the death of children. MDAC heard from the director of Opařany Children’s Psychiatric Hospital that clozapine (Leponex) is sometimes used but the hospital does not carry out routine blood tests. The potential risks of using clozapine without monitoring blood include death.¹⁶ The practice can be easily changed.

Highlighting the problem of concurrent multiple forms of restraint, a male patient in his early 50s at Kosmonosy Psychiatric Hospital told MDAC that he received an injection every time he was put into straps, and that afterwards he felt sleepy, that his head spun and he had to kneel down or pass out. Multiple forms of restraint – caging, strapping and sedation – were prevalent. Sedatives were recorded as forms of restraint in non-psychiatric health care facilities, but they were not recorded when used on psychiatric patients in the same hospitals. This raises serious questions about discriminatory practice, the result of which is that fewer safeguards apply to mental health patients.

Strapping with fabric or leather straps was used in many institutions visited, often in conjunction with placement in cage beds or in seclusion rooms. As with other forms of coercion, strapping was used as a form of punishment for “troublesome” patients. A 20-year-old male patient at Opava Psychiatric Hospital told the monitoring team that he had seen people strapped down for two or three days and sometimes for up to a week. He had watched how staff fed meals to people while they were still strapped. People were strapped, he said, because, “they couldn’t adjust to life here – they couldn’t handle it”. He gave an example of a man who kept shouting. As staff couldn’t stop him from yelling they strapped him as a form of punishment.

When questioned about why straps are used, a doctor at Plzeň Hospital Psychiatric Department told the monitoring team that during the night there were only two nurses for 25 patients. Highlighting the way in which such coercive practices are associated with “managing” people rather than for any therapeutic benefit, he said that they were, “necessary for newly-admitted patients who are in acute conditions or patients who are trying to escape or attack [other] patients and nurses”. They are used for “the safety and benefit of the patients”, he argued.

In a number of institutions visited the reduction in the numbers of cage beds has led to the installation of **seclusion rooms**. In Prague Bohnice Psychiatric Hospital, staff reported that one person had been in seclusion for almost two months, notwithstanding that there are safeguards such as a doctor having to authorise the use, and nurses having to review the person every twelve hours. During their February 2013 visit to Bohnice, monitors met a young female patient in a seclusion room. She had been placed in seclusion the morning of the monitors’ visit. When asked why, she replied: “I don’t know. I wanted to go home; I wanted to light a cigarette. I don’t know what I did wrong.”

14 Juan E. Mendez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, (United Nations: UN doc A/HRC/22/53, 1 February 2013)

15 Austrian legislation, however, provides a definition of ‘chemical restraints’, including a requirement that their use be registered. See, for example: European Committee for the Prevention of Torture, *Report to the Austrian Government on the visit to Austria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 15 to 25 February 2009*, (Strasbourg: Council of Europe, CPT/Inf (2010) 5, 11 March 2010), at para. 141.

16 See, for example: J. Munro et al, ‘Active monitoring of 12,760 clozapine recipients in the UK and Ireland. Beyond pharmacovigilance’, (British Journal of Psychiatry, 175: 576-580, 1999).

3(D). Reducing coercion

The Czech authorities have voluntarily signed up to a range of human rights obligations. They must, under law, adopt a human rights approach to the mental health system. This is even more the case since ratifying the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2009. In policy terms the government must take an active approach to reducing coercion, and rolling out a system of community-based services. Ending the most egregious forms of coercion in psychiatric institutions is an immediate task.

Although the international law impetus is established, there is strong opposition on the ground. MDAC found that many mental health professionals did not believe that psychiatric care was possible without coercion. This finding signals a role for government to carry out targeted training; to convene meetings where people who take different views can discuss their standpoints and find common ground; to set specific clinical quality standards and to establish a robust enforcement mechanism for clinicians who, after training and warning, opt to abuse their patients.

The report notes several promising practices. At Prague Bohnice Psychiatric Hospital where all but one cage bed had been removed, a doctor told MDAC that he does not miss the cage beds. In a cage bed-free era, doctors pay more attention to patients, he said. They talk to them every day: “The wards are smaller and more specified, the supervision is more intensive”. His commitment to a more personal and humane way of practising psychiatry shows that change is possible.

In order to scale up such change, the report offers practical ideas for reducing coercion in psychiatric hospitals, and these flow from emerging practice internationally. A combination of the following clinical practices can lead to less reliance on coercion:

- rapid clinical assessment;
- observation procedures;
- advance directives;
- independent advocacy;
- involving people with mental health issues in their own treatment decisions.

These ideas can and should be quickly implemented. Alongside them, the more fundamental shifts required by international human rights law must also be rolled out.



Photo: Shutterstock

4. Recommendations

MDAC makes the following recommendations to the Czech government, including the Ministers of Health, Social Affairs, Justice and Finance. There are also recommendations to the Public Defender of Rights (Ombudsperson), the Czech psychiatric community, and to health insurance companies.

4(A). To the Minister of Health

1. Cage beds (including those that the Czech government refers to as 'net beds') should be immediately removed from all psychiatric institutions in the country.
2. Other forms of restraint including strapping, chemical restraints and seclusion should immediately be ended as standard practices in Czech psychiatry. The removal of one form of restraint must never be used to justify an alternative coercive measure.
3. Conduct a rapid assessment of all psychiatric medications used in hospitals, with a view to avoiding medication as punishment, and reducing preventable side effects. This includes ensuring that clozapine is never given without ongoing blood tests.
4. Issue guidance that all forms of restraint or seclusion, including chemical restraint, must be recorded and centrally monitored in all cases, whether or not 'consent' is given by patients in any psychiatric facility. This information should be made available to independent bodies, including the Public Defender of Rights (Ombudsperson) and civil society upon request.
5. Establish a programme of workforce development to train all staff of psychiatric services about human rights standards and how each person's practice needs to change as a result (from the management of mental health facilities, to clinicians, nurses, auxiliary nurses, cleaners, receptionists and anyone else who comes into contact with patients).
6. Ensure all mental health services comply with the provisions of the UN Convention on the Rights of Persons with Disabilities (CRPD), particularly in relation to informed consent.
7. Progress towards achieving the above should be submitted to the UN Committee on the Rights of Persons with Disabilities in an annex to the Czech Republic's report. This report should be made public.

4(B). To the Minister of Social Affairs

1. The deinstitutionalisation of social care institutions must never result in persons with intellectual disabilities being placed in psychiatric institutions.
2. Under no circumstances must persons with intellectual disabilities be transferred to psychiatric hospitals where they can be placed in a cage bed, as was uncovered at Klatovy Hospital Psychiatric Department.

4(C). To the Minister of Justice

1. Ensure that a robust complaints mechanism is introduced into all mental health facilities to ensure that everyone has access to free legal advice and assistance, given the allegations of ill-treatment occurring in these settings.
2. Ensure that all allegations of abusive and coercive practices in psychiatric facilities are promptly investigated by a team independent from the Ministry of Health.
3. Provide recognition, rehabilitation and compensation for harms caused by the mental health system, as detailed in this report.
4. Initiate legislative amendments creating corporate criminal liability for mental health facilities which condone violations of international human rights law binding on the Czech Republic.
5. In line with Article 33(3) of the CRPD, ensure that members of civil society, including representatives of non-governmental organisations (NGOs), disabled persons organisations (DPOs) and persons with disabilities themselves are guaranteed access to monitor human rights standards related to all mental health and social care facilities and services in the country.

4(D). To the Minister of Finance

1. Greater resources are required in the mental health sector to fund services which comply with the Czech Republic's obligations under international human rights law. The move from institutionalising people with mental health issues towards providing support and services in the community is now urgent. At a minimum, the government should invest in this transformation at the same level as the European average, being 2% of GDP.
2. Ensure that any EU funding which is used to finance any aspect of the mental health or social care system is not spent to bolster institutions, but instead funds community support services, in compliance with the CRPD.

4(E). To the Public Defender of Rights (Ombudsperson)

1. In exercising its functions as a National Preventive Mechanism under the Optional Protocol to the Convention against Torture, place a strong emphasis on monitoring psychiatric institutions.
2. Renew the call for an end to all forms of coercive practices which violate international human rights law.
3. In line with Article 33(3) of the CRPD, coordinate with representatives of non-governmental organisations (NGOs), disabled people's organisations (DPOs) and people with disabilities themselves when conducting monitoring of psychiatric institutions, social care institutions, and mental health services in the country.

4(F). To directors of psychiatric hospitals and wards

1. Clinicians should ask, "How can I and my team maximise the patient's autonomy and dignity?" They should ask a wide variety of patients how they would answer, and act on their findings.
2. Cage beds (including what the Czech government refers to as 'net beds') should be immediately withdrawn from practice.
3. Other forms of restraint including strapping, chemical restraints and seclusion should immediately be ended as standard practices. The removal of one form of restraint must never be used to justify the use of an alternative form of coercion.
4. An independent psycho-pharmacologist should be commissioned locally to review the drug charts of each inpatient, with the intention of reducing sedative and other side effects of medications.

4(G). To providers of health care insurance

1. Health care insurance schemes should never fund coercive practices or interventions given without the consent of patients, particularly in respect of cage beds, seclusion, physical and chemical restraints.



Photo: Kosmonosy Psychiatric Hospital © MDAC

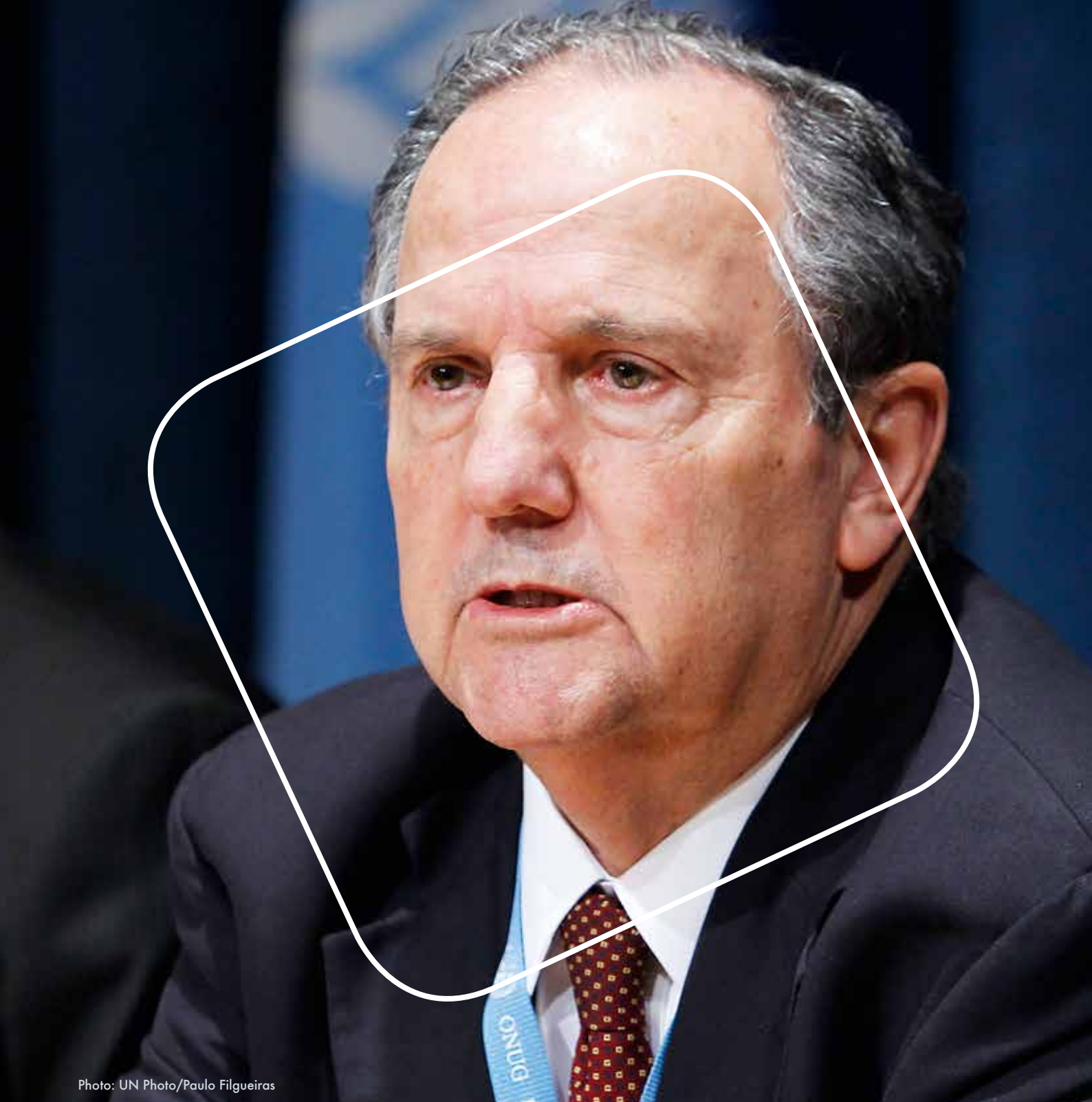


Photo: UN Photo/Paulo Filgueiras

"There can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions."

Juan E. Méndez, UN Special Rapporteur on Torture

5. Context

MDAC undertook this research in response to the failure of the Czech Government to address the serious human rights abuses that result from the use of cage beds in psychiatric institutions. In 2003, MDAC uncovered the extensive use of cage beds in the Czech Republic (and elsewhere), noting that their use violated international human rights law.¹⁷

Since then, the international community has continued to express serious concern about the extent of coercion in Czech psychiatric institutions. Both the Council of Europe's Committee for the Prevention of Torture (CPT) and the United Nations Committee against Torture (CAT) have severely criticised the ongoing use of cage beds, and the failure of the Czech Government to eradicate their use.

MDAC's 2003 Cage Beds Report

The continuing use of cage beds is, indeed, symptomatic of the wider reforms that are still required in the social care homes and psychiatric institutions of Central and Eastern Europe. These reforms will clearly not come without cost – without considerable investment in the material and human resources of mental health care services. However, the respect for the dignity and most elementary rights of persons with mental disabilities demands these reforms as an urgent priority.

Alvaro Gil-Robles, (then) Council of Europe Commissioner for Human Rights, in his Foreword to MDAC's 2003 report on the use of cage beds in four Central and Eastern European countries.

In early 2003 and in partnership with local organisations in four then-accession countries to the European Union (Czech Republic, Hungary, Slovakia and Slovenia), MDAC conducted monitoring in psychiatric and social care institutions. Framing the use of cage beds as a human rights violation, the report called for their abolition, along with action to reduce other forms of restraints and seclusion.

5(A). Key findings from 2003

- MDAC was refused access to visit Jihlava, Opava and Kosmonosy Psychiatric Hospitals, all of which had high levels of use of cage beds.
- 430 people had been placed in cage beds at Kosmonosy Psychiatric Hospital in the previous year, an institution with 500 beds.
- 10% of the 600 beds at Jihlava Psychiatric Hospital were cage beds.
- At one children's psychiatric hospital, two "small beds for very young children with nets" were in use, reportedly "to prevent these children from getting out".
- A seven-year-old boy was observed in a cage bed without any supervision.
- Other physical restraints were in common use, including straps and straightjackets. People were restrained for extended periods of time, sometimes for days.
- In 2002, a 14-year-old girl had died in a straightjacket locked in a cage bed when an iron bar from the frame of the bed fell on her. Rather than removing the cage beds, the psychiatric institution instead replaced them all.
- The director of one social care institution had already banned cage beds eight years previously: "I simply threw them away," he reported to MDAC. "Staff should know the client so well that they can predict a possible attack and prevent aggression."



Photos: © MDAC

¹⁷ Mental Disability Advocacy Center, *Cage Beds: Inhuman and Degrading Treatment or Punishment in Four EU Accession Countries*, (Budapest: MDAC, 2003), at pp. 42-6.

- Independent inspections of psychiatric facilities in the country were not compulsory. Psychiatric institutions even refused access to the then Czech Commissioner for Human Rights, Jan Jařab.

In 2013, ten years after it reported on cage beds in Czech psychiatry, MDAC organised two follow-up monitoring missions to institutions in the country to find out whether there had been any progress. A decade on there remains a troubling picture. The overall numbers of cage beds in psychiatric institutions have been significantly reduced but many are still in use. Indeed, in one children's psychiatric institution, they were reportedly only removed at the beginning of 2013. The reduced numbers of cage beds have not prompted any decrease in overall levels of coercion, which remains a hallmark of the overall psychiatric practice in the country. Other restrictive techniques including seclusion, physical and chemical restraints – all of which are abusive and amount to ill-treatment or torture – have become increasingly relied upon.

The intention of this report is call on the Czech Republic to take measurable steps to ensure that people in its mental health system are not subjected to abusive practices which are unlawful under international human rights law. To do this, the chapters are set out as follows. This chapter starts by providing the context of coercion within Czech psychiatry. It then presents the standpoints of experts in relation to torture prevention. **Chapter 6** sets out the findings on the use of cage beds in eight psychiatric hospitals visited by MDAC monitoring teams. **Chapter 7** goes on to present findings about the use of chemical restraints, straps, seclusion and other forms of coercion. It provides an overview of the perspective of staff working in Czech psychiatric institutions and their general disbelief that lower levels of coercion are either possible or desirable.

Leadership is required within governments and within the global psychiatric community to move beyond old models of managing people with mental health issues through coercive practices. To assist staff and policy-makers, **Chapter 8** outlines several evidence-based approaches to reducing coercion, many of which can be achieved without much financial investment.



Photo: © MDAC



Photos: © MDAC

5(B). Glossary

‘Cage beds’

MDAC uses the phrase ‘cage beds’ to mean to any form of enclosure around or attached to a hospital bed, irrespective of the material used to form the cage.

The Czech authorities use the term ‘cage beds’ to refer to a bed with metal bars and the term ‘net beds’ for a bed with netting (like a football net) around the sides and tops. Some mental health professionals use the euphemism ‘therapeutic bed’ to mean netted cage beds. MDAC’s term has been endorsed by the UN Committee against Torture which has noted that netted cage beds have “effects [that] are similar to those of [metal] cage-beds”.¹⁸

Metal cage beds were banned in psychiatric hospitals in 2004.¹⁹ All forms of cage beds were banned in social care institutions in 2011. Netted cage beds still exist in psychiatric institutions.

The report uses the term ‘cage bed’ consistently, because they are all designed for, and have the effect of, encaging human beings. Moreover, despite the legal label and material used, patients in Czech psychiatric hospitals themselves referred unprompted to ‘cages’ and ‘cage beds’ in interviews with MDAC. When referencing the position of the Czech government, the report uses the terms ‘metal cage bed’ and ‘netted cage bed’ simply to refer to the difference in material.



Photo: Klatovy Hospital Psychiatric Department © MDAC

‘Physical restraints’

This term refers to a variety of straps and attachments which can be applied to beds in a hospital and applied to the limbs and/or torso of a patient with the intention of attaching the patient to the bed. Physical restraints include fabric or leather straps, handcuffs, manacles, and straightjackets attached to the structure of the bed. In some cases the term includes other rudimentary forms of restraint such as the use of sheets or towels to tie people to their beds or chairs, often in combination with chemical restraints.

‘Chemical restraints’

Chemical restraints include any medication which is used with the intention of sedating a person. Examples of these include drugs such as carbamazepine and levomepromazine. There is considerable debate regarding the therapeutic effects of such drugs. They should properly be referred to as restraints when they are primarily used with the intention of restraining the behaviour or dampening the mind of patients.²⁰

‘Seclusion’ and ‘isolation’

These terms are used interchangeably throughout the report. They refer to solitary confinement, which is the placement of patients into separate, individual rooms where they are denied contact with other patients or staff.

‘Patient’

The report uses the term ‘patient’ to refer to a person placed in a psychiatric institution, whether or not they have given their consent. The term is problematic, emanating from the medical model of disability. Without accepting the medicalisation associated with the term, and after considering other options such as ‘persons with disabilities in institutions’ and ‘inmates’, MDAC determined that the term ‘patients’ has the greatest level of recognition among audiences for whom this report is written, namely policy-makers, mental healthcare professionals and civil society.

‘Psycho-social disability’

Particularly in reference to international law and standards, the report refers to people with psycho-social disabilities to mean people with a variety of mental health issues and diagnoses. The term is used by the UN Committee on the Rights of Persons with Disabilities and reflects a social model of disability, that disability is the result of the interaction of an individual’s impairment with the social environment, particularly in relation to stereotypes, prejudice and discrimination.

¹⁸ The legislation is referenced by UN Committee against Torture, see: Committee against Torture, *Concluding observations of the Committee against Torture: Czech Republic*, (United Nations: Committee against Torture, Forty-eighth session, CAT/C/CZE/CO/4-5, 7 May- 1 June 2012), at page 7.

¹⁹ Government of the Czech Republic, Follow-up response of the Government of the Czech Republic 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 21 to 30 April 2002, 14 April 2005, CPT/Inf (2005) 5, available online at <http://www.cpt.coe.int/documents/cze/2005-05-inf-eng.pdf> (last accessed: 15.06.2014), at p. 27.

²⁰ Austrian legislation provides a definition of ‘chemical restraints’, including a requirement that their use be registered. See, for example: European Committee for the Prevention of Torture, *Report to the Austrian Government on the visit to Austria carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 15 to 25 February 2009*, (Strasbourg: Council of Europe, CPT/Inf (2010) 5, 11 March 2010), at para. 141.

5(C). Mental health services and inspection in the Czech Republic

The Czech Republic is one of few countries of the European Union (EU) which does not have a mental health policy.²¹ As a result of a directionless mental health service, there is an abundance of institutional confinement and very little community mental health care.

According to official data, in 2012, there were 2,834,000 community mental healthcare examinations and 578,413 patients were treated. There were 790 psychiatrists working in outpatient facilities, funded primarily through public health insurance via payments for medical procedures.²²

The numbers of beds in inpatient psychiatry were:

- 8,847 beds in 18 adult psychiatric hospitals (including 188 beds for children);
- 250 beds in three child psychiatric hospitals; and
- 1,260 beds in psychiatric wards of general hospitals.

This amounts to a total of 10,357 psychiatric beds.

Budgetary expenditure on psychiatric service provision constitutes 2.91% of the total healthcare budget, which equates to just 0.26% GDP (the average in the EU is 2% GDP).²³

Approximately 80% of all resources for inpatient psychiatric care are allocated to psychiatric hospitals, the other 20% being allocated to psychiatric facilities housed within general hospitals. A third of the capacity of psychiatric hospitals are acute care and two thirds chronic beds. Approximately half of beds in psychiatric hospitals relate to geronto-psychiatric care, child and juvenile psychiatric care, forensic care and addictions.

Psychiatric hospitals are financially dependent upon the number of beds which are occupied at any one time. The vast majority of involuntary hospitalisations are to psychiatric hospitals as opposed to psychiatric wards in general hospitals. In 2012, **39,615 adults** and **1,040 children** were hospitalised as inpatients. The average percentage of beds in use at any one time in adult psychiatric hospitals in the Czech Republic in 2012 was 93.3% for adult psychiatric settings, and 87.7% in respect of children's psychiatric hospitals.²⁴ Psychiatric wards in general hospitals offered a total of 1,260 beds in 2012, however several of these wards do not provide care for patients with more severe mental health issues due to a lack of professional and technical capacities.

In October 2013 the Ministry of Health adopted a 'Strategy for Reform of Psychiatric Care' for the period 2014-2020. The strategy recognised that the provision of institutional psychiatric care is insufficient and committed to developing community care. It proposed the establishment of 'Centres of Mental Health' as a new form of psychiatric care and 'humanisation'²⁵ of psychiatric hospitals.²⁶

Coercion is associated with managing chronic patients, especially elderly patients. Lack of alternatives to hospitalisation, outdated hospital infrastructure and a lack of financial resources are all factors which explain the commonplace nature of restraints and seclusion within Czech psychiatry. A typical example is the use of cage beds for elderly patients with Alzheimer's disease or other forms of dementia.

21 Jiří Raboch and Barbora Wenigová (eds.), *Mapování stavu psychiatrické péče a jejího směřování v souladu se strategickými dokumenty České republiky (a zahraničí)* (Czech), (Prague: Česká psychiatrická společnost o.s., 2012), at p. 2.

22 *Ibid.* at p. 17.

23 Petr Winkler (ed.), *Reforma systému psychiatrické péče: mezinárodní politika, zkušenost a doporučení* (Czech), (Prague: Psychiatrické centrum Praha, 2013), at p. 29.

24 *Supra* note 21 at p. 23.

25 It is notable that this term is avoided by policy-makers in the context of social care institutions in the country, due to the awareness that this could sound like making 'golden cages' rather than focusing on an overall goal of deinstitutionalisation. Source: conversation with MDAC Legal Monitor in the Czech Republic.

26 Czech Ministry of Health, *Strategie reformy psychiatrické péče* (Czech), (Prague: Ministry of Health, 2013), available online at: http://www.reformapsychiatrie.cz/wp-content/uploads/2013/10/SRPP_publicace_web_9-10-2013.pdf (last accessed: 15.06.2014).

5(D). Developments in the Czech Republic since 2003

After reading MDAC's 2003 report, J.K. Rowling – author of the *Harry Potter* series – weighed in on the use of cage beds. Her criticism led to the Minister of Health banning metal cage beds. Despite good intentions, the decision was taken without proper preparation, education or training of medical personnel and led to opposition and heavy criticism from a number of influential mental health professionals. The minister paid the price by losing his job.

Although the use of cage beds in social care settings has been unlawful since adoption of the 2006 Social Care Act, the 2011 Health Code recognised netted cage beds as a form of lawful restraint in psychiatric institutions. The use of netted cage beds has been criticised by the Ombudsperson (referred to as the Public Defender of Rights in the national context) in a 2013 report on monitoring visits to children's psychiatric institutions. The Ombudsperson recommended that psychiatric hospitals find alternatives to cage beds.²⁷

The Ombudsperson acted in his monitoring capacity under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). Since being designated as the 'National Preventive Mechanism' in 2006, the Ombudsperson has carried out regular visits with the aim of strengthening the protection of persons restricted of their liberty against torture, cruel, inhuman or degrading treatment or punishment.²⁸

When performing visits the Ombudsperson and authorised employees have the statutory authority to enter all areas in facilities being visited, including the authority to inspect files (including medical records), question all persons (employees, patients, clients or imprisoned persons) and conduct interviews in private. Systematic unannounced visits are made at different times of the day and night.

Findings and recommendations are generalised in summary reports following visits by the Ombudsperson. Proposals for improvement of the ascertained conditions are directed toward individual facilities and their promoters, as well as toward central state administrative bodies. The Ombudsperson collaborates with external experts, especially doctors, nurses, and inspectors of social services.²⁹ The Ombudsperson can (and should) collaborate with non-governmental organisations in organising and conducting monitoring visits, and advocating for resultant recommendations to be implemented.

In 2008 the Ombudsperson published a report on psychiatric hospitals,³⁰ and followed this up with another report in 2010.³¹ These reports detailed how cage beds were routinely used to prevent 'unrest' in the context of low staff numbers. In 2013 he published a report on children's psychiatric hospitals,³² finding in one a boy who was placed in a cage bed twice every day.

In 2012 the Czech parliament enacted a new Civil Code, partly in response to its obligations under Article 12 of the CRPD which guarantees the right to legal capacity for all persons with disabilities. The legislation, which came into force at the beginning of 2014, abolished plenary guardianship in favour of partial guardianship arrangements, advance directives, and recognition of supported decision-making processes.³³ The recognition of legal capacity must apply in all areas of life, including for people in psychiatric institutions, as outlined in Article 12(2) of the CRPD.

27 Public Defender of Rights (Ombudsman), *Dětských psychiatrických nemocnic (Czech)*, (Brno: Public Defender of Rights (Ombudsman), 2013), available online at: http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/ZARIZENI/Zdravotnicka_zarizeni/SZ-detske-psychiatricke-lecebny.pdf (last accessed: 15.06.2014).

28 Public Defender of Rights (Ombudsman), *Protection of Persons Restricted in their Freedom: What is ill-treatment*, (undated), available online at: <http://www.ochrance.cz/en/protection-of-persons-restricted-in-their-freedom/performing-systematic-visits/what-is-ill-treatment/> (last accessed: 15.06.2014).

29 *Ibid.*

30 Public Defender of Rights (Ombudsman), *Zpráva z návštěv psychiatrických léčeben (Czech)*, (Brno: Public Defender of Rights (Ombudsman), September 2008), available online at: <http://www.ochrance.cz/ochrana-osob-omezenych-na-svobode/zarizeni/zdravotnicka-zarizeni/psychiatricke-lecebny/zprava-z-navstev-psychiatrickych-leceben/> (last accessed: 15.06.2014).

31 Public Defender of Rights (Ombudsman), *Zpráva z návštěv psychiatrických léčeben (Czech)*, (Brno: Public Defender of Rights (Ombudsman), November 2010), available online at: http://www.ochrance.cz/fileadmin/user_upload/ochrana_osob/2009/2009-PL_nasledne.pdf (last accessed: 15.06.2014).

32 *Supra* note 27.

33 Mental Disability Advocacy Center, 'Czech Republic enacts legal capacity law reform', (MDAC: 21 February 2012), available online at: <http://mdac.org/en/news/czech-republic-enacts-legal-capacity-law-reform> (last accessed: 15.06.2014).

5(E). Developments internationally since 2003

In August 2003 the UN Human Rights Committee (the monitoring body of the International Covenant on Civil and Political Rights) reviewed Slovakia, which had very similar cage bed prevalence and laws as the Czech Republic. In its concluding observations, the Committee said that it was “concerned at the continuing use of cage-beds as a measure of restraint in social care homes or psychiatric institutions” and recommended that “[c]age-beds should cease to be used”.³⁴

In its report to the Czech government in 2004, the European Committee for the Prevention of Torture (CPT) noted that both netted and metal cage beds were frequently used in two psychiatric hospitals it visited,³⁵ finding that they, “are not an appropriate means of dealing with patients/residents in a state of agitation”. The CPT’s inspection standards clarify that restraints including handcuffs and cage beds are “totally unsuitable” for dealing with agitated people, and “could well be considered as degrading”, breaching Article 3 of the European Convention on Human Rights (the right to freedom from torture and inhuman or degrading treatment or punishment). The CPT has unequivocally called for all such forms of restraint to be immediately withdrawn.³⁶

In its response to the CPT’s 2004 report the Czech Government stated that all directors of health care facilities had been told to withdraw the use of metal cage beds.³⁷ The subsequent Medical Services Act (No. 372/2011) did not ban, but actually legalised the use of restraints, including netted cage beds. It was silent on the topic of metal cage beds. In 2012, the UN Committee against Torture recommended that the Czech government prohibit the use of cage beds (whether metal or netted, noting that netted cage beds have “effects [that] are similar to those of [metal] cage-beds”).³⁸

In 2012, the UN Committee against Torture noted that the high level of psychiatric coercion reflected a failure by the Czech government to adopt mental health reforms, expressing concern at “reports of frequent placement of persons with intellectual or psychosocial disabilities in social, medical and psychiatric institutions without their informed and free consent”. Reforms had been slow and piecemeal, the Committee found, causing concern to be raised about “the continued use of cage-beds, despite the prohibition in law, and of net-beds as well as the use of other restraint measures such as bed strapping, manacles, and solitary confinement, often in unhygienic conditions and with physical neglect”. “In addition, the “absence of investigations into the ill-treatment and deaths of institutionalized persons confined to cage and net-beds, including suicides” was a matter of particular concern highlighted by the Committee.³⁹



34 UN Human Rights Committee, Concluding Observations with regard to Slovakia (CCPR/CO/78/SVK), 22 August 2003, para. 13.

35 European Committee for the Prevention of Torture, *Report to the Czech Government on the visit to the Czech Republic carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 21 to 30 April 2002*, (Strasbourg: Council of Europe, CPT/Inf (2004) 4, 12 March 2004), at p. 51.

36 European Committee for the Prevention of Torture, *Committee for the Prevention of Torture Standards* (Strasbourg: Council of Europe, CPT/Inf/E (2002), Rev. 2013), at p. 59.

37 Government of the Czech Republic, *Follow-up response of the Government of the Czech Republic 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 21 to 30 April 2002*, (Strasbourg: Council of Europe, CPT/Inf (2005) 5, 14 April 2005), at p. 27.

38 Committee against Torture, *Concluding observations of the Committee against Torture: Czech Republic*, (CAT/C/CZE/CO/4-5, 7 May-1 June 2012), p. 7.

39 *Ibid.*

5(F). International human rights standards

The four human rights treaties most relevant to this report are:

- **The European Convention on Human Rights (ECHR).** Adopted in 1950. Ratified by the Czech Republic in 1992.
- **The UN Convention against Torture (CAT).** Adopted in 1984. Ratified by the Czech Republic in 1993.
- **The Optional Protocol to the UN Convention against Torture (OPCAT).** Adopted in 2002. Ratified by the Czech Republic in 2006.
- **The UN Convention on the Rights of Persons with Disabilities (CRPD).** Adopted in 2006. Ratified by the Czech Republic in 2009. People with mental health issues are considered to be “persons with disabilities” for the purposes of the Convention.⁴⁰

5(F)(i). Torture and ill-treatment

The ECHR and the CAT prohibit torture and other forms of ill-treatment.⁴¹ Of particular relevance is that the European Court of Human Rights has found the Czech Republic to be in breach of the prohibition of inhuman and degrading treatment in a case about a man who spent at least three hours needlessly restrained with leather straps because of his perceived mental health issue.⁴²

The CAT defines ill-treatment as “other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture [...], when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.”⁴³

The CRPD reflects a global movement away from the medical model of managing and warehousing people with disabilities and requires governments to enact legislation to secure a range of human rights, including the right to health and the right to autonomy and recognition before the law. The CRPD repeats CAT’s absolute prohibition of torture or cruel, inhuman or degrading treatment or punishment against all persons with disabilities.⁴⁴

⁴⁰ CRPD, Article 1.

⁴¹ The ECHR prohibits torture and inhuman or degrading treatment or punishment in Art. 3. Article 1 of CAT defines torture as “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.”

⁴² Bureš v. Czech Republic, Application no. 37679/08, judgment 18 October 2012.

⁴³ CAT, Article 16.

⁴⁴ CRPD, Article 15.



Lukáš Bureš
Photo: © MDAC

Lukáš Bureš was 22 years old in February 2007 when he accidentally overdosed on medication prescribed by a psychiatrist.

He was brought by the police to a sobering-up centre, where he was immediately strapped with restraining belts to a bed, although he was not presenting a danger of any kind. How long he remained in the restraints was disputed between Mr Bureš and the Czech government but what is not disputed is that he spent at least three hours during the night in restraints, resulting in physical injuries. This was particularly traumatic for him, as Mr Bureš was a cellist.

Once he was out of the hospital, Mr Bureš brought criminal charges for the ill-treatment he had suffered. Despite clear evidence that there was no justification for the use of restraints, the public prosecutor decided not to prosecute and no one was held accountable.

The European Court of Human Rights unanimously held that both the application of restraints and the Czech Republic’s failure to take measures to prevent ill-treatment violated Article 3 of the European Convention on Human Rights. In a strongly-worded rebuke to the government, the Court stated that it, “considers that using restraints is a serious measure which must always be justified by preventing imminent harm to the patient or the surroundings and must be proportionate to such an aim. Mere restlessness cannot therefore justify strapping a person to a bed for almost two hours.” The Court further observed that no alternatives to restraint had even been attempted, and that “[s]trapping was applied as a matter of routine.”

The Court had equally strong criticism for the prosecutor’s decision to end the criminal investigation on the basis that no crime had been committed, holding that this violated the Czech Republic’s obligation to provide practical and effective protection of the rights guaranteed under Article 3 of the European Convention on Human Rights, particularly in light of its finding that “the application of restraining belts on the applicant was a willful act constituting inhuman and degrading treatment.”

The Court awarded Mr. Bureš 20,000 euros for the violations of his rights and the psychological and physical pain he suffered.



Juan E. Méndez
UN Special Rapporteur on Torture
Photo: UN Photo/Jean-Marc Ferre

The UN **Special Rapporteur** lays down a requirement on governments to prohibit restraints and seclusion.

"The mandate has previously declared that there can be no therapeutic justification for the use of solitary confinement and prolonged restraint of persons with disabilities in psychiatric institutions; both prolonged seclusion and restraint may constitute torture and ill-treatment... The Special Rapporteur has addressed the issue of solitary confinement and stated that its imposition, of any duration, on persons with mental disabilities is cruel, inhuman or degrading treatment... Moreover, any restraint on people with mental disabilities for even a short period of time may constitute torture and ill-treatment. It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions. The environment of patient powerlessness and abusive treatment of persons with disabilities in which restraint and seclusion is used can lead to other non-consensual treatment, such as forced medication and electro-shock procedures."

Juan E. Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, (United Nations: UN doc A/HRC/22/53, 1 February 2013)

The CRPD has inspired the UN Special Rapporteur on Torture to re-examine the torture framework as applied to people with disabilities. He has expressed concerns about the notion of consent to treatment of people with mental health issues.⁴⁵ He has found that poor physical conditions and solitary confinement can amount to cruel, inhuman or degrading treatment or punishment and even torture.⁴⁶ In 2013 he voiced his opinion that it is unacceptable for laws to permit doctors to force mental health treatment when the patient refuses to consent to such treatment.

The CRPD sets out a number of specific requirements, all of which are relevant to this report.

5(F)(ii). Liberty

The ECHR sets out criteria whereby people of "unsound mind" may lawfully be detained. The CRPD adopts a different approach, with Article 14 of the Convention stating that disability shall "in no case justify deprivation of liberty". A report of the Office of the High Commissioner for Human Rights has interpreted this to mean that involuntary detention and/or treatment based the presence of a mental disability or a mental disorder is not permitted.⁴⁷

In 2010, the "World Report on Disability", drawing on a variety of sources, reported that persons with disabilities are at greater risk of violence than those without disabilities and that abuse against persons with disabilities has been reported to be 4–10 times greater than that against people without disabilities.⁴⁸ The prevalence of sexual abuse against people with disabilities has also been shown to be higher, especially for institutionalised men and women with intellectual disabilities, intimate partners and teenagers.⁴⁹

5(F)(iii). Exploitation, violence and abuse

Article 16 of the CRPD sets out the right to be free from all forms of exploitation, violence and abuse. It recognises the particular prevalence of these violations against people with disabilities due to social discrimination, particularly in institutional settings. Governments must provide information, assistance and support to report allegations of exploitation, violence and abuse. It requires governments to roll out effective recovery and rehabilitation programmes in cases where these have taken place. It further requires robust investigation and prosecution.

45 Juan E. Méndez, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment* (A/66/268, 5 August 2011), and Juan E. Méndez, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, (United Nations: UN doc A/HRC/22/53, 1 February 2013).

46 Juan E. Méndez, *Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, (A/66/268, 5 August 2011). He also found that the use of solitary confinement increases the risk that acts of torture and other cruel, inhuman or degrading treatment or punishment will go undetected and unchallenged.

47 UN High Commissioner for Human Rights, "Thematic Study on Enhancing Awareness and Understanding of the Convention on the Rights of Persons with Disabilities", (A/HRC/10/48) 26 January 2009, para. 48.

48 World Health Organization and the World Bank, "World Report on Disability", 2011, p. 59.

49 *Ibid.*

As a supplement, Article 17 of the CRPD states that everyone has the right to physical and mental integrity on an equal basis with others. Article 25 of the CRPD sets out the right to health, and requires governments to ensure that clinicians provide healthcare on the basis of free and informed consent.

5(F)(iv). Regular and independent monitoring

Article 16(3) of the CRPD requires that all facilities and services designed to serve people with disabilities (such as psychiatric hospitals) be monitored by a body independent from government.⁵⁰ This is a similar obligation to that set out in the OPCAT, under which the government has designated the Public Defender of Rights (Ombudsperson's office) as the "National Preventive Mechanism" to carry out preventive monitoring of all places in which a person can be denied their liberty. This includes psychiatric hospitals, psychiatric wards and social care institutions.

5(F)(v). Training

Restraints and seclusion are used as a response to inadequate staffing levels and training of staff.⁵¹ The CRPD sets out the obligation on governments to "promote the training of professionals and staff working with persons with disabilities in the rights recognized in [the CRPD] so as to better provide the assistance and services guaranteed by those rights."⁵²

The European Committee for the Prevention of Torture (CPT) has found that use of restraints "appears to be substantially influenced by non-clinical factors such as staff perceptions of their role and patients' awareness of their rights".⁵³ Indeed the CPT acknowledge that the frequency and use of restraints such as cage beds relates not only to staffing levels but also to the material conditions in the setting and to the "culture and attitudes of hospital staff".⁵⁴ In order to effectively combat the use of restraints and other forms of coercion, a transformation in the culture of Czech psychiatry is required, led by management.⁵⁵

5(F)(vi). Community living

The CRPD sets out in Article 19 the right for people with disabilities to live independently and to be included in the community. Institutionalising people constitutes a "pervasive violation" of Article 19 of the CRPD.⁵⁶ Monitoring teams at Dobřany Psychiatric Hospital found that a number of patients in the institution had recently been trans-institutionalised – that is, moved out of a social care institution and into a psychiatric institution. This raises significant questions about the Czech government's commitment to ensuring the right to live in the community.

The Council of Europe's Commissioner for Human Rights has considered the institutionalisation of people with disabilities as "one of the most egregious forms of isolation".⁵⁷ High levels of institutionalisation are a direct result of a failure to develop community-based services, he has found. People with mental health issues have "no viable choice other than living in an institution".⁵⁸

The CPT has noted that the international trend is to reduce the number of beds in psychiatric establishments and to develop community-based mental health services.⁵⁹ As such the CPT states that "large psychiatric establishments pose a significant risk of institutionalisation for both patients and staff" and have a "detrimental effect on patient treatment".⁶⁰

5(F)(vii). Reporting

A requirement of the CRPD is that two years after the date of ratification, each State Party must submit a report on how well it is implementing it.⁶¹ The Czech Republic ratified the CRPD in 2009 and therefore its report was due in 2011. It sent its report in on 28th October 2011.⁶² One might reasonably expect the report to set out the steps which the government is taking with regard to cage beds and other restraints, considering the international attention this issue has now had for over a decade. Despite these expectations, not once does the report mention cage beds or other restraints in psychiatry. Concerns have, however, continued to be voiced by Czech civil society, including in a shadow report made to the CRPD Committee.⁶³

50 The ITHACA Toolkit is an example of a clear and practical way to monitor human rights and health care provision in European mental health facilities and it places a premium on the importance of involving service users in human rights monitoring. See ITHACA Toolkit: For Monitoring Human Rights and General Health Care in Mental Health and Social Care Institutions (Institutional Treatment, Human Rights and Care Assessment (ITHACA), 2010), available online at: <http://www.ithaca-study.eu/toolkits/english/2.4%20Ithaca%20Toolkit%20English.pdf> (last accessed: 15.06.2014).

51 World Health Organization, *Investing in Mental Health* (Geneva: World Health Organization, 2003).

52 CRPD, Article 4(1)(i).

53 European Committee for the Prevention of Torture, *Committee in the Prevention of Torture Standards*, *supra* note 36, at p. 63.

54 *Ibid.*

55 *Ibid.*

56 Council of European Commissioner of Human Rights, *The Right of People with Disabilities to Live Independently and Be Included in the Community* (Strasbourg: Council of Europe, Issue Paper, 13 March 2012, CommDH/IssuePaper(2012)3), at p. 5.

57 *Ibid.* at p. 35.

58 *Ibid.*

59 European Committee for the Prevention of Torture, *Committee in the Prevention of Torture Standards*, *supra* note 36, at p. 57.

60 *Ibid.*

61 CRPD, Article 35(1).

62 Government of the Czech Republic, *Initial reports submitted by States parties under article 35 of the Convention: Czech Republic*, (United Nations: Committee on the Rights of Persons with Disabilities, CRPD/C/CZE/1, 27 June 2013).

63 Alternative Report for the UN Committee on the Rights of Persons with Disabilities: Czech Republic, (Liga lidských práv and others: 2011), available online at: http://tbinternet.ohchr.org/Treaties/CRPD/Shared%20Documents/CZE/INT_CRPD_NGO_CZE_15594_E.pdf (last accessed: 15.06.2014), at para. 67.



Photo: Klatovy Hospital Psychiatric Department © MDAC

Cage beds “are great for geriatric patients and the mentally retarded: isolation or straps are much worse.”

Director of Kosmonosy Psychiatric Hospital

“Don’t even ask me what I can feel, we have to shut out our emotions. It doesn’t help our health – it’s not therapeutic. We feel like we are free when we can walk.”

Woman restrained in a cage bed
at Klatovy Hospital when monitors visited

6. Cage beds

This chapter sets out how cage beds are used in eight psychiatric hospitals. It starts with the experiences of patients and ex-patients, highlighting the restriction, lack of dignity and misuse of caging on the premise of 'protection'. Following this, key observations made by the monitoring teams on the basis of on-site visits are presented. The chapter concludes by assessing the views of staff encountered during the monitoring missions.

6(A). Testimonies

Most people interviewed told MDAC of their feelings of degradation and humiliation associated with being caged.

6(A)(i). *Danger and safety*

Some patients interviewed were sympathetic with the perspectives of nursing staff. Two female patients at Kosmonosy Psychiatric Hospital told monitors that cage beds were often the effect of understaffing. In a particularly troubling finding, some patients interviewed reported feeling safer in cage beds due to high levels of violence in psychiatric institutions.

One male patient at Kosmonosy Psychiatric Hospital said that the reason he felt safe in a cage bed was because he felt scared on the ward. At the same institution, a 40-year-old female patient said that she had been placed in a cage bed because she could not protect herself from other patients.

A 40-year-old female patient interviewed at Klatovy Hospital described her shock at seeing a cage bed for the first time. She was so frightened she may be placed in one that she discharged herself from the hospital within a day.

At Kosmonosy Psychiatric Hospital, a 33-year old woman told the monitoring team, "I did not want to be in a cage. I was afraid I would be there forever." She recalled how four nurses had grabbed her, gave her a tranquilising drug and placed her in a cage bed. Once inside, she had no way to contact the nurses. She subsequently learned that the hospital routinely placed newly-admitted patients into cage beds. She explained: "It is part of the treatment, the patients there realised why they were put there and they don't do the same thing afterwards." Asked whether she would have preferred to be treated differently, she said: "It would be better if they had given me something to calm down, rather than the cage." She explained how later during her hospitalisation she saw another woman who was in a cage bed for a month. When MDAC asked whether she had ever complained about her or the other woman's treatment, her answer was: "There is nobody to complain to".

6(A)(ii). *Cage beds and bodily functions*

A male patient at Kosmonosy Psychiatric Hospital said he had been in a cage bed six or seven times, always during the night, and released at approximately 6am the next day. He recalled how two other patients helped staff to place him in the cage bed. He said was given an injection against his will, which made him fall asleep. He explained how he wanted to go to the toilet, to which the staff responded: "hold it". He said he felt bad about being in a cage bed and that he should not have been put in one.



Photo: Shutterstock

Forced to urinate in a bottle

Many patients raised the issue of urination and defecation in a cage bed.⁶⁴

A 36-year old male patient at Kosmonosy Psychiatric Hospital explained how he had been strapped into a cage bed on two occasions, for approximately three days each time. Patients were routinely strapped on admission, he said, and other residents helped staff to do this. "You become an animal in there," he said, explaining how patients were not allowed to go to the toilet while strapped in a cage bed: they were given a bottle to use.



Photo: Shutterstock

"In the cage bed it's really unpleasant that you can't go to the bathroom, you can't brush your teeth", said one female patient at Kosmonosy Psychiatric Hospital. A 59-year-old woman at the same institution told MDAC about a corner room which had five cage beds. They were for people "who cannot hold their urine and faeces," she said, adding that that patients went in at 7pm and were let out at 7am.

A 60-year old male patient from the elderly ward at Kosmonosy Psychiatric Hospital told MDAC that cage beds were used for "naughty" patients, and those who became aggressive, often following arguments about cigarettes. He told MDAC about a patient on his ward who was in a cage bed all the time. Patients have no chance to go to the toilet in cage beds: he sometimes had to change the bed linen in the mornings, and he reported seeing urine and faeces on the sheets, despite the fact that many caged patients were required to wear nappies. He said that nurses brought meals and tea for patients to eat in their cage beds.

Three years in a cage bed due to 'restlessness'

A 70-year old woman who had lived at Kosmonosy Psychiatric Hospital for three years told MDAC that she wanted to get out.

She recounted how she had spent each night for the previous three years in a cage bed. She said she did not understand why she was put inside the cage bed. She reported feeling degraded. Inside the cage bed she had no visual or other contact with patients or staff. She told MDAC how she often called for help, but that "nobody shows up". She therefore stopped calling for help.

⁶⁴ Although later standards have called for a ban on cage beds, even the CPT in 2007 said it was "unacceptable" to give a person in a cage bed a urination bottle, rather than let them go to the toilet. CPT Report to the Czech Government on the visit to the Czech Republic carried out by the CPT from 27 March to 7 April 2006 and from 21 to 24 June 2006, (CPT/Inf (2007) 32, 12 July 2007), para. 114.

6(A)(iii). Cage beds and restlessness

The use of cage beds to deal with agitated patients was another key theme addressed by patients. MDAC spoke with several elderly patients who had been labelled as 'restless' and for this reason had been placed in cage beds.

A 65-year-old female patient at Kosmonosy Psychiatric Hospital told MDAC that she had been in a cage bed every night for a year. She disliked how cage beds could be seen by other people through the windows. A recurring theme from cage bed victims was that "everybody can see you", as a 30-year old male patient at the same hospital put it, highlighting the degrading experience of being on show in a cage.

6(A)(iv). Cage beds in place of therapy

At Klatovy Hospital Psychiatric Department, monitors spoke to a woman in a cage bed. She said:

"Don't even ask me what I can feel, we have to shut out our emotions. It doesn't help our health – it's not therapeutic. We feel like we are free when we can walk [outside the cage bed]. It doesn't help to call for staff, they won't come. Maybe if I scream they would, but night staff would never come."

At Plzeň Hospital Psychiatric Department, a male patient told monitors how he had seen someone "in the cage" in room 12, although the door is normally closed. He explained how he was worried that he "could be put in the cage, you never know what could happen". He speculated that "it must be terrible, what can I say, it's horrible, scary".

Long-lasting impact of being caged

MDAC also conducted an interview via Skype with a person who had been detained in a psychiatric hospital in 1993. Although her experience is two decades ago, her description of being inside a cage bed illustrates the long-lasting effects of the trauma:

It is a feeling like you were closed as if you were an animal. As if you weren't a human. They treat you as someone even lower than an animal. You feel like a monkey in a zoo. You feel humiliated. The space of the cage is really small.

I saw the other patient across the room that was there for a really long time, I don't know how long. She was there all the time. She kept hanging on the cage, pulling it. The aggressive one did it as well. It was a habit on this department, when they were unable to handle any of the aggressive patients; they locked them down into this cage. [...]

The worst thing is that they just lock you there and they do not pay attention to you anymore. They just sit, smoke and drink coffee and don't care [about] the people there and if someone starts to scream really loud, they lock them, or strap them.

Alone in a cage bed

At Opava Psychiatric Hospital, MDAC monitors met a 68-year old woman who described the previous night she had spent in a cage bed. "It's stupid" ("je to blbý") she said of the cage bed, adding that she did not know why she was placed there. No one had given her any reasons.

She reported that it was a degrading experience. She did not call for help as, "nobody will come anyways". She said that nobody came to check up on her during the night. She was alone in the cage bed, and there was no one else in the room.

6(B). Observations

6(B)(i). Kosmonosy Psychiatric Hospital

At the time of the monitoring visit, Kosmonosy Psychiatric Hospital had 29 cage beds in use,⁶⁵ the highest number of any institution visited. Management denied access to the rooms in which the cage beds were located, purportedly because it was impossible to “receive relevant consent from the patients” placed in cage beds. Instead, the monitoring team met with staff and patients in the cafeteria. Staff emphasised that they did not use the term “cage” or “net beds”, but referred to them as “protective beds”, and that they are used mostly for women. They would be “insufficient” for men, said one staff member, as they could too easily damage the netting. Instead they were restrained with straps, she explained. Another staff member explained that cage beds were used for “delirious grandmas”. The director of the institution said that 90% of the use of cage beds occurs on ward B1 (a female admission ward) and on ward B3 (a female elderly admission ward). In elderly wards, four or five women were placed in cage beds during the night, he said, due to “nocturnal confusion or delirium”. Cage beds “are great for geriatric patients and the mentally retarded: isolation or straps are much worse,” he explained. In the elderly psychiatric wards, foam side boards were reportedly used, or the beds are lowered. He reported that the admissions ward (B1) had two cage beds in one room with a glass window to the nursing station. In another ward there were six cage beds in one room. The room had a window and heating, but no means of monitoring patients from outside the room. Staff asserted that cage beds were used for agitated or distressed patients and each use is documented, giving the duration of and the reason for use. Because MDAC was denied access to any of the areas containing cage beds in the hospital, none of these assertions could be verified.



Photo: Klatovy Hospital Psychiatric Department © MDAC

6(B)(ii). Plzeň Hospital Psychiatric Department

Hospital staff said that one “restrictive bed” (meaning cage bed) was used for “aggressive patients”. MDAC monitors were formally refused access to the room in which the bed was located. However, because there was someone in the cage bed at the time of the visit, a monitoring team member managed to look into the room. The frame construction of the bed was similar to those seen elsewhere, but had a thick wire mesh instead of a cotton net, similar to a strong garden fence. The whole construction was painted yellow. The front of the bed was closed. Inside the room, a doctor was discussing something with the patient in the cage bed. A psychiatrist told MDAC that, “when a patient is placed in the restrictive bed and we give them medication, then the doctor can talk to him”.

In another room there were three cage beds. Staff said that sometimes they were occupied at the same time. The monitoring team saw three sets of straps in this room, which were used to tie the patients’ wrists and ankles to the beds. If a patient was “very aggressive”, nurses said, they would strap a sheet over the patient’s body and tuck it into the sides of the bed.

Another room contained one cage bed and two ordinary beds. Staff said that the cage bed was sometimes used as a normal bed with the net open. It was in a corner of the room, and could not be observed from the corridor. If all cage beds were occupied, staff use straps, they said. There were no formal criteria for the use of any of these restraints. A patient could be caged for “five to ten hours”, said staff, explaining that two hours was “too short” to see how the person reacted to medication. Cage beds were used at night only for “aggressive patients”, staff explained.

The director of this hospital referred to cage beds as “therapeutic beds”. He told MDAC that there had been a poll among 400 psychiatrists at a conference four years ago. The attending psychiatrists were asked to vote which restraint they would prefer to be placed in themselves. The choices given were a “therapeutic bed”, an isolation room, a “therapeutic jacket” (straightjacket) or strapping. He said that “ninety nine percent chose the therapeutic bed”, because the psychiatrists thought it was “good for them”.

The director reassured MDAC monitors that although cage beds “might look like medieval torture”, they were more comfortable than straps and the patient could have eye contact with staff, something which was not possible in a seclusion room. During the conversation, a psychiatrist concurred: “I really prefer using net beds. In my opinion it is the best type of restraint.”

⁶⁵ As verbally reported by the Director of the institution, although this differs from the number declared in response to MDAC’s freedom of information request to the same institution at the end of 2012 where 27 were declared – see Annex 1.

International focus on Dobřany

As noted above, the European Committee for the Prevention of Torture (CPT) carried out a visit to the Czech Republic in mid-2006. During its visit, the CPT delegation found fifteen cage beds, which were used often.⁶⁶

In early 2012 a woman was found dead in a cage bed at this hospital,⁶⁷ but no investigation was carried out. Cage beds were removed at the end of that year, following this death. Non-governmental organisations including MDAC raised this case to the Committee against Torture. As a direct result, the Committee expressed concerns about “the absence of investigations into the ill-treatment and deaths of institutionalized persons confined to cage and net-beds, including suicides”.⁶⁸

6(B)(iii). Dobřany Psychiatric Hospital

The director told MDAC that at one time the hospital had 140 cage beds,⁶⁹ a claim MDAC was unable to verify. The director went on to say that they had been replaced with increased usage of isolation rooms and straps. A psychiatrist told MDAC that cage beds were better than isolation rooms, because patients could not fall out of them. He explained how elderly patients were placed in seclusion rooms if they were agitated at night, compared to a year previously when no-one over the age of 60 was secluded. MDAC was shown no documentation confirming this assertion. It seems that after the removal of cage beds, the seclusion rooms in unit 13B (an acute ward) were used for patients from all other units of the hospital, including the units for women. Staff said that seclusion rooms were used, “to protect the patients from other patients.” Another psychiatrist confirmed that using restraints was “a necessary evil” following the removal of cage beds.

6(B)(iv). Opařany Children’s Psychiatric Hospital

The last remaining cage bed was reportedly removed from this children’s hospital at the end of February 2013. According to staff it had not been used much, and when it had, it was used for children with intellectual disabilities. The director explained how cage beds “would be dangerous for children without intellectual disabilities [...] because they would move”.

The director was dismissive of cage beds for any children, saying that staff prefer talking to patients or using seclusion rooms and in “extreme cases” using straps, although this was said to be rare. For upset children, “most doctors prefer medication,” she explained. Her view was that more staff were needed to take better care of the children, and more psychologists to help calm them down.

Staff told the monitoring team that some of the new seclusion rooms had not been used and others were used infrequently. To their surprise, staff had managed to handle children who would previously have been placed in cage beds without resorting to any form of restraint. There seemed to be other reasons for the shift in staff attitudes. A change in staff shift times had reportedly had a beneficial effect on staff behaviour. Staff gradually considered it too early to put children in cage beds at the end of the afternoon shift when it ended at 7pm. After the shift times were changed to end at 9pm, it became too late to put them in cage beds because they were all asleep anyway.

6(B)(v). Opava Psychiatric Hospital

At the time of the visit, Opava Psychiatric Hospital had 22 cage beds. The management reported their desire to have more, but they lacked the space. Staff told the monitoring team that cage beds were sometimes used as regular beds: the bars were pulled down and staff expected the patient to ignore the netting around the bed. From the perspective of staff this may seem like an ordinary bed, but any occupant is likely to see things differently: at any moment staff could pull up the side of the bed and encage the person.

Staff showed the monitoring team a room containing three cage beds. Each had a metal frame and a sliding bar that could be raised upwards and locked, enclosing a patient inside a net consisting of cord approximately 5mm thick. The monitoring team were told that one or two of these cage beds were in use at any one time. When questioned about the sparseness of the rooms, and whether patients had anywhere to store their possessions, staff said, “such patients hardly have anything” but they could store their possessions elsewhere on the ward.

In this hospital, cage beds were mainly used at night to prevent people with dementia or delirium from getting out of bed, but were used at other times in response to behaviour that staff perceived to be “dangerous” (for these people straps were also used). A nurse told MDAC that a person can be in a cage bed from one to twelve hours, and a cage is usually used for people with delirium, people who self-harm or are “aggressive”. Staff reported that before they place someone into a cage bed, they try to calm the person down, or use medication.

66 European Committee for the Prevention of Torture, *Report to the Czech Government on the visit to the Czech Republic carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 27 March to 7 April 2006 and from 21 to 24 June 2006*

67 ‘Právo: Mental hospital patient strangles herself in caged bed’, (Prague: Prague Daily Monitor, 26 January 2012), available online at: <http://praguemonitor.com/2012/01/26/pr%C3%A1vo-mental-hospital-patient-strangles-herself-caged-bed> (last accessed: 15.06.2014).

68 Committee against Torture, *Concluding Observations: Czech Republic*, (UN: Committee against Torture, CAT/C/CZE/CO/405, 13 July 2012), at para. 21.

69 A BBC article from 2004 states that the hospital had 1,300 beds, ten percent of which were caged: Rosie Goldsmith, ‘Czech man’s week in a cage’, (BBC News Online, 7 July 2004), available online at: http://news.bbc.co.uk/2/hi/programmes/crossing_continents/3873123.stm (last accessed: 15.06.2014).

A side room had three beds, one of which was a cage bed, empty at the time of MDAC's visit. The monitoring team tracked down a patient who had slept in this cage bed. She reported feeling degraded by the experience and did not understand the reason she had to sleep there. A nurse said that patients who are confused and mobile could stand on their beds, or climb over horizontal bedrails and fall badly. Cage beds were, therefore, "effective". The monitoring team suggested having lower beds to shorten a potential fall distance, but the nurse dismissed this suggestion.

At the time of the visit, there were two doctors for 830 patients in the hospital. Cage beds were particularly used, said staff, for "confused patients that have a tendency to get up and leave during the night." The doctors tried to reduce the amount of medication to patients but they believed the use of cage beds was "more humane." Getting rid of cage beds would result in increasing the dose of medication, which can lead to the death of older patients, said one doctor.

A person in a cage bed was observed every three hours, staff told MDAC. One nurse explained that "patients are not able to ask for their needs," implying that cage beds were best for them. Patients in cage beds wore adult nappies, and the team was told that this was the case for most patients anyway.

MDAC monitors went into a further two rooms with three cage beds in each. In the first room, one of the beds was painted yellow, with a vertical bar mechanism that closed the structure by being slid shut from left to right. In the second room, there were three beds that closed by sliding a bar from the bottom of the bed to the top. There was no material difference in the different designs. All of these cage beds could be locked shut with an Allen key. None of the rooms had curtains or other coverings on the windows: all had two wall lights (at least one of which was suitable to be left on at night) and an overhead bulb. Lights were controlled from outside the room. The rooms were bare except for the beds. In a women's room there were three beds, of which one was a cage bed. Staff told the monitoring team that if a person was restrained in this cage bed, the other two beds may continue to be used for other patients if the hospital was at full capacity.

Some cage beds in the elderly ward had clean nappies on top of them, prepared for new entrants. At the time of the visit, the room smelled of urine and disinfectant. The nurses told MDAC that caring for these patients is "like caring for 25 children, it is impossible to maintain all of them" (*"je to jako 25 dětí, není možné je udržet"*). Again likening patients to children, another nurse said that cage beds were "like cots for infants", explaining that she might put an agitated person into a cage bed for one or two hours, sometimes after giving medication. Some of the nurses presented cage beds in part as alternatives to medication.

6(B)(vi). Prague Bohnice Psychiatric Hospital

The monitoring team was informed that there was one remaining cage bed in the female long-term care unit (Ward 16) for a specific patient: a woman with an intellectual disability for whom the hospital is her (completely inappropriate) home. The woman's parents had lobbied the hospital to retain "her" cage bed because they feared she would otherwise be strapped. Staff told MDAC that the woman had lived in the hospital for several years and had "behavioural problems," was often "restless" and "attacks other patients." She was put in the cage bed every day, but the netting of the bed was not closed the whole time.

The cage bed was situated in a regular room with three normal hospital beds and was used by the woman as a regular, everyday bed. Staff said she was not chemically restrained, but was sometimes given sleeping pills. The room was not locked from the outside and there was a window in the door to enable staff to monitor her when in the cage bed (also other patients could see her). Staff told the monitoring team that she just played with her toys in the cage bed. Every two hours, a nurse took her out to the toilet. Food was brought to her in the room when she was locked in the cage bed.

The monitoring team were told that the woman was not in the cage bed at the time of their visit, but rather in the nurses' room, because nurses had informed her about their arrival in advance and she had, apparently, become agitated. Nurses asked the monitoring team to leave the ward so that they could place the woman back in the cage bed. The monitoring team learned that the woman was under the guardianship of one of her parents, so the hospital was acceding to a legal guardian's request to use a cage bed. Her case makes clear the causal link between deprivation of legal capacity and further abuses such as institutionalisation and caging, a point which has also been made by the UN Special Rapporteur on Torture: "Fully respecting each person's legal capacity is a first step in the prevention of torture and ill-treatment".⁷⁰

6(B)(vii). Klatovy Hospital Psychiatric Department

At the time of MDAC's visit, Klatovy Hospital Psychiatric Department had nine cage beds. "We have some internal regulation but not in detail. We have no information about how long, in what situation, etc." said the director openly, noting that since cage beds had been banned in social care institutions, some former social care institution residents had been transferred to his hospital where cage beds were still allowed.

When MDAC asked the director about informed consent, he laughed: "No, confused patients are not able to give consent, they are not logical because they are delusional." Staff said that there were usually four people in cage beds at any one time in the hospital, often two patients placed in them each day. They pointed out that on the day of the MDAC's visit only one cage bed was in use. However, the monitoring team witnessed several cage beds occupied, albeit with the sides open and unlocked. Upon clarification, it transpired that "placement in a cage bed" in this institution meant only cases where the netting is up and the cage is locked.

⁷⁰ Juan E. Méndez, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, supra note 14 at p. 15.

A doctor told MDAC that the only person in a locked cage bed at the time of the monitoring team's visit would be discharged the next day because the family wanted to take care of him at home. It was not clear to the monitoring team why a person who was deemed so "agitated"/"aggressive"/"ill" to require a cage bed would be discharged the very next day to someone's home, which presumably did not have a cage bed.

Seemingly contradicting the director, a psychiatrist told the monitoring team that a doctor must prescribe every the use of cage beds, and (in common with other forms of restraint) was required to record in the patient's medical records the type of restraint, when it was initiated, the period of time used, the reason for its use and the frequency of observation. The doctor informed the team that the hospital informed the court by post once a week about the use of restraints. The director said that there was a "brief" internal registry, but the monitoring team was not shown any evidence of this.

When a patient was in a cage bed, the nurse checked on them at intervals of up to an hour, staff said. The patient was not given food, and only a drink if they requested. Patients could be taken to the toilet, but given that the cage beds are used mostly for elderly patients who wear nappies, staff did not feel that this was necessary. Staff said that sometimes a patient was locked into a cage bed at 8pm and released at 6am. Alternatively if a patient was found wandering around at 1am, staff said they would be placed in a cage bed. Patients were chemically restrained before being placed in cage beds, and "aggressive patients" were always chemically restrained without being put in a cage bed, with straps being used if patients were "really aggressive".

MDAC monitors went into another room containing four cage beds, each of which was open and occupied by an elderly person. A male doctor walked over to an elderly woman in one of the cage beds. He pulled up the netting on the side of the cage bed as an unrequested demonstration of how the cage



Photo: Klatovy Hospital Psychiatric Department © MDAC

An isolation room contained two cage beds stood side by side length-ways. The bed frames had been attached to the wall in order to prevent the inhabitant from toppling from the bed to the floor, which had reportedly happened in the past. Across from each bed was a commode chair-toilet-pan. MDAC was permitted to take photographs. Staff told the monitoring team that the beds were old and strong and cannot be broken easily, and that they were used for isolating "problematic" patients.

Both cage beds had old leather straps with a belt buckle attached to them. Staff explained that the straps were permanently attached to the beds for cases when there "may not be enough time" to attach them. Staff said that a patient had once "escaped" from the cage bed by lifting up the mattress and the underlying boards. He had been "caught" in the corridor. A nurse told MDAC that it was easy for a patient to damage the netting, and it was observed that the nets had been visibly repaired in several places. It was clear that leather belts were used to restrain people damaging the netting.

In this hospital, patients could be simultaneously placed in a seclusion room, put into a cage bed, strapped down by leather belts, and sedated with neuroleptics. This amounts to quadruple means of restraint applied simultaneously to the same patient.

bed can be closed. As he did this, the woman became visibly frightened and repeatedly said, "please don't do that". He stopped, letting go of the netting.

According to the director, the hospital had plans to upgrade its facilities. Under the new structure the same number of cage beds would exist, but in a different configuration of rooms. The hospital planned to "upgrade" the cage beds: some new cage beds would apparently be sourced from a nearby social care institution (where cage beds were previously banned). The director stated that others would come from a neurology ward where they were replacing their beds.

6(B)(viii). Lnáře Psychiatric Hospital

The director of Lnáře Psychiatric Hospital told the monitoring team that staff rarely use restraints, and that only "in extreme cases" is one of the hospital's four cage beds, straps or a straightjacket used. Cage beds are the "most humane form of restraint", he said, because, "a person is free to move there." Patients who are "acute psychotic patients, who attack other patients or harm themselves" could be placed in a cage bed for up to 24 hours. If the aggression persists the patient was transferred to Dobřany Psychiatric Hospital.

The other group of cage bed occupants were patients with dementia who were caged during the night if they were restless. The director told MDAC that elderly women could “weave themselves out” of the netted cage. Doctors reportedly always authorised the use of cage beds, and any use by a voluntary patient would be reported to the court under provisions of the Civil Procedure Code. A nurse on duty said cage beds are usually used as ordinary beds and are unlocked, adding that having been a nurse for 30 years, she considered cage beds “a bit dated”.

In an older patients’ ward, MDAC monitors saw a room with six beds, one of which – a cage bed – was not currently in use. Other beds on this ward had rails to stop patients falling out. Some of these beds had hoists (like the hanging strap used in a tram) to help patients sit up and/or get out of bed. The team were also shown a room with 4 beds – one of which was a cage bed, which had its front open. The room was fully occupied by elderly male patients, sleeping after lunch, including in the open cage bed.

6(C). Staff views

One of the reasons for MDAC’s reassessment of Czech cage beds a decade after its 2003 report was to establish the reasons that they were still in use. MDAC wanted to ascertain who healthcare staff (psychiatrists and nurses) and directors of psychiatric hospitals continue to justify the use of cage beds, in order to offer suggestions for change.

The following four reasons were given to monitoring teams:

- I. Cage beds are part of the admissions procedure,
- II. Cage beds are used to deal with aggression,
- III. Cage beds are used to deal with restlessness, and
- IV. Cage beds are used to punish bad behaviour.

6(C)(i). Cage beds are part of the admissions procedure

In one hospital, a patient told the monitoring team that she had been in a cage bed for the previous two weeks, since the time of her admission. She said that newly-admitted patients were placed in cage beds, but the cage bed was not always locked. This happens to all new admissions for the first one or two weeks, until a “proper bed” is found, she said. Staff members confirmed that cage beds were used on admission, but for patients who were in a state of “acute restlessness”.

In another hospital the cage bed was located in the “admissions room” with other regular beds; this cage bed was sometimes left unlocked and “used as a regular bed”. In this hospital, newly-admitted patients spent the first two days in the admissions room, and if they calmed down they would be transferred to a regular room. The person in the cage bed was checked every half an hour, the staff reported.

The use of cage beds as an overflow control mechanism in this way becomes inevitable when a hospital operates at or near capacity; so long as the cage beds remain in operation, that is. The cage beds are likely to be the last available beds on any admission wards. According to hospital staff, patients on such wards are only placed in them in response to what

staff perceive to be “difficult behaviour”: a label which is undoubtedly given to *all* newly-admitted patients. Patients who are admitted at times when all normal beds are occupied are therefore likely to be assigned to a cage bed. Even when the front panel of the bed is left open, so that such patients are not actually locked into the cage, it is clear that this constitutes an degrading and intimidating start to any hospital experience.

6(C)(ii). Cage beds are used to deal with aggression

MDAC’s 2003 cage bed report laid out staff views on aggressive behaviour. Overall they said it was rare. This is not a finding which was repeated in 2013; on the contrary, MDAC monitors found that staff frequently spoke about their difficulties in dealing with situations which they perceived as “dangerous”. Staff in several hospitals told MDAC that cage beds were used for patients who they judged to be “aggressive”, although staff rarely defined what this actually meant, and how it differed from “anger”, a perfectly natural response to being detained and injected with medication against one’s will, and without much legal remedy.

A doctor in one hospital shared her observation that in recent years intoxication had resulted in more aggression, and cage beds, “are the best way to help the patient, not isolation,” adding that “there is this public pressure to ban net beds and we are planning to build an isolation room but this is not a good idea.” Staff in many hospitals told MDAC they used cage beds to constrain patients they considered “dangerous”. In other places it seemed that cage beds were used as a way for a predominantly female workforce to contain patients: it was difficult to recruit men, especially in psychiatry, MDAC was told, because of pay and status.

The length of time a person was placed in a cage bed seemed to depend on their perceived level of aggression at the time of placement. A psychiatrist told MDAC that in cases where patients “are in delirium or more aggressive” they were placed in a cage bed for three days.

A female patient in one hospital had worked at the hospital previously, so she was used to seeing the cage beds and was not shocked when she saw them upon arrival as a patient. This person had become accustomed to their use for agitated patients, describing one person's placement into a cage bed simply "because she was moving too much". This patient explained that, "we cannot have dangerous objects such as [phone] chargers, because we could hang ourselves." Her perception of dangerousness included pre-empting any outward signs of aggression. A belief in the inevitability of cage bed use was held by a majority of patients with whom MDAC spoke, and was likely held because these patients (like the majority of people in the Czech Republic) had not had access to more humane alternatives.

The mother of a young patient told MDAC that cage beds were used because staff lacked skills to protect patients from violence. Her son had been given new medication that made him distressed. He had been screaming for three days which in turn caused other patients to become agitated and they beat him up, so the staff "isolated him in a net bed to protect him".

6(C)(iii). Cage beds are used to deal with restlessness

In most hospitals agitation was the reason staff gave for using cage beds. At Opařany Children's Psychiatric Hospital where cage beds have been withdrawn, staff said that the cage beds were "never used for children with normal intelligence", but they were used to constrain children during the night, instead of allowing them to run around. On elderly wards cage beds were purportedly effective in constraining elderly patients who would otherwise fall out of bed. Staff at Kosmonosy Psychiatric Hospital told MDAC that they could not imagine using straps for elderly patients during the night, and side-boards on normal hospital beds were dangerous for the "grandmas," as they could fall from the bed and hurt themselves.

A psychiatrist in a different hospital said that cage beds are better than seclusion rooms, because there is no danger of the patient falling out of a cage bed. This does not make much sense, since most isolation rooms have at most a mattress on the floor. In another hospital, cage beds were reportedly used primarily for elderly patients who may otherwise fall from ordinary beds at night: staff prefer cage beds over sedatives. Some patients go into a cage bed every night, while others only when staff deem it necessary. If a patient has "delirium", the cage bed is used for three or four hours or the whole night. It seemed that this was the case for women in one particular hospital, while the men who became restless are strapped to the bed and/or chemically restrained.

At Kosmonosy Psychiatric Hospital, a nurse told MDAC about a woman who could not walk and had been in a cage bed for three-and-a-half years. Sometimes the staff took the woman out in a wheelchair, said one staff member, recalling that this had only happened five times during placement in the cage bed. She would visitors in the cage bed, eat in the cage bed, and drink in the cage bed. When she wanted to use the toilet, the nurses would take her out. Apparently, she recovered her walking and when she started to walk again she was finally released.

At Opava Psychiatric Hospital, staff said that they use cage beds for "confused patients", especially those with dementia, who might hurt themselves. "Sundown syndrome" was used by staff members to describe the phenomena where patients would try to walk around in the late afternoon and evening, and they would fall. These people did not present a danger to others but to themselves. Staff said that some patients would get confused and wander somewhere, then urinate on the floor, and slip on their urine and break a bone. Thus were the justifications for using cage beds to prevent restlessness.

6(C)(iv). Cage beds are used to punish bad behaviour

In 2003 MDAC reported the use of cage beds as a particularly cruel form of punishment in violation of international human rights law. Since then, the UN Special Rapporteur on Torture has called for a ban on all forms of restraint, seclusion and coercion in healthcare settings, including psychiatric hospitals.⁷¹ The CPT standards are clear that physical restraints, "should never be applied, or their application prolonged, for punishment".⁷²

When asked why people are placed in cage beds, a nurse said it happened "when people get naughty, break stuff, make stuff dirty." Many patients said that, "people are put in the beds as a punishment". Two female patients at Kosmonosy Psychiatric Hospital said that that nurses put people into "cages" when they were "naughty",⁷³ for example when they were screaming or fighting. A 21-year old female patient at Klatovy Hospital Psychiatric Department explained that staff first sedated and then caged patients who attacked them. Another patient at the same hospital recalled how nurses broke up fights between patients and then "nurses grab patients by the collar and put them in net beds".

Another female patient at Klatovy Hospital Psychiatric Department told MDAC that cage beds were used as punishment throughout Czech psychiatric hospitals. She explained that some years ago when she had been at a different hospital, she and other patients had complained to the chief nurse about the attitudes of some of the nursing staff. Upon hearing this, the chief nurse put all the complainants in cage beds, she reported.

⁷¹ Juan E. Méndez, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, *supra* note 14 at pp. 14-15.

⁷² European Committee for the Prevention of Torture, *CPT Standards*, *supra* note 36 at p. 31.

⁷³ In Czech the word is "zlobit", a word which is used to describe children who are misbehaving or irritating their parents.



Photo: Shutterstock

Physical restraints “should never be applied, or their application prolonged, for punishment”.

European Committee for the Prevention of Torture

7. Other restraints and seclusion

Banning cage beds is necessary but not sufficient in eradicating coercion in Czech psychiatry. This chapter documents the use of forms of coercion other than cage beds: chemical restraints, leather and fabric straps and then seclusion. The chapter also outlines other dehumanising and coercive practices observed by monitors.

The effects of restraint

Restraints, including strapping, can have serious direct and indirect effects.⁷⁴ Some of the **direct physical impacts** of restraint can be asphyxia, aspiration, blunt trauma to the chest, catecholamine rush (massive release of adrenaline which can affect the heart rhythm), rhabdomyolysis (breakdown of skeletal muscle tissue), leg vein thrombosis, muscular atrophy (muscle wastage), decubitus ulcers (pressure sores), pneumonia, cutaneous abrasions (cuts to the skin), bruises, soft tissue compression, neural lesions (damage to the spinal cord), fractures and death.⁷⁵

Indirect injuries from restraints are also serious for the health and wellbeing of patients. These can include an increased mortality rate, pressure sores, bladder and bowel incontinence, mobility problems, nosocomial infections (hospital-contracted infections), more agitated behaviour, greater cognitive decline, declining socialisation, and increased disorientation.⁷⁶

The use of restraints also has **psychological effects**. These include, but are not limited to, feelings of anger, sadness, fear, abandonment, anxiety, frustration, boredom, confusion, disgust, entrapment, punishment, resentment, degradation, dehumanisation and guilt, as reported by people who have experienced restraint.⁷⁷



74 David Evans, 'Patient injury and physical restraint devices', (Journal of Advanced Nursing, 41: 274-282, 2003).

75 Stacey A. Tovino, 'Psychiatric restraint and seclusion: Resisting legislative solution' (Stanta Clara L. Rev., 47: 511, 2007); AM Berzlanovich, 'Deaths due to physical restraint', (Dtsch Arztebl Int., 109(3): 27-32, Jan 2012).

76 Supra note 74, at p. 278.

77 Dave Holmes, 'The Mentally Ill and Social Exclusion: A critical examination of the use of seclusion from the patient's perspective' (Issues in Mental Health Nursing, 25(6): 559-578, 2004), at p. 566.

7(A). Chemical restraints

Old drugs such as Chlorpromazine and Carbamazepine were widely used as sedatives for dealing with agitation displayed by patients. These drugs should be considered as restraints. In emergency situations when an agitated person is given sedative medication in order to calm him or her down the intention is to restrain their behaviour. Medication is used to manage chronic patients deemed “bothersome”, for example, those who take other patients’ cigarettes, or who are otherwise agitated or restless. In these cases sedatives are frequently applied for extended periods of time, with staff sometimes relying on the justification of protecting other patients. Using chemical restraints also conveniently relieves staff of the burden of monitoring people placed in cage beds, straps or seclusion rooms.

Directors of several of the psychiatric institutions visited, supported by the psychiatrists who work in them, considered MDAC’s framing of medication as restraint as offensive or at least eccentric.⁷⁸ Several doctors told us that drugs used for chemical restraint are “part of continuous treatment for mental illness”. Medication “is not seen as abuse in this country,” asserted one psychiatrist.

Klatovy Hospital has a policy on sedatives. If sedation is used in the non-psychiatric parts of the hospital, it is recorded as a restraint. If used on the psychiatric ward it does not need to be recorded as a restraint, as it is considered regular “treatment”. A doctor at Dobřany Psychiatric Hospital suggested that chemical restraints are not recorded as such because they help the person “to calm down, and the doses are not that high, and medication is often given at the same time as [other] restrictions, which are registered.” MDAC observed that sedatives are frequently used in combination with strapping and/or cage beds. The majority of patients, however, are medicated without being strapped or placed in a cage bed. Medications are often the first-line restraint/treatment option.

A particularly alarming practice was observed at Opařany Children’s Psychiatric Hospital. There, the director told MDAC that clozapine (Leponex) is sometimes used (two or three times during 2012), but the hospital does not carry out routine blood tests – essential as clozapine can cause neutropenia which is potentially fatal.⁷⁹ The director said that bloods were screened on arrival, but subsequent testing depended on the initial results. This made no sense as it is widely accepted medical practice that there should be routine blood tests at least monthly, if not more frequently, where clozapine is in use.



Photo: tajpharmaceuticals.com

MDAC heard many examples of sedatives being injected into patients following “incidents” on the wards. A female patient at Opava Psychiatric Hospital recalled a fight between two patients. As the nurses stopped them they “used an injection and put the patients in a room on their own.” Sometimes nurses strapped patients to make it easier for them to administer an injection. A nurse told MDAC that the strapping remained in place “just for an hour”, which means that straps are not just used to hold the person down in order to administer an injection, but that patients remain needlessly strapped even after this has been given.

Patients complained about a variety of medication-related topics. Several said that sedatives were often unnecessary. A female patient at Kosmonosy Psychiatric Hospital told MDAC that police officers had watched her being injected on admission to the hospital. She felt the injection was unnecessary as she was not distressed. A young man, no more than 20 years of age at Opava Psychiatric Hospital, told MDAC that he had been given an injection on admission, and other medications since then (he did not know what they were or – even more worryingly – what they were for). Another young man on the same ward said that he too did not know what medications he was taking. He described being forced to sit down in a chair and being made to swallow pills. A male patient in his early 50s at Kosmonosy Psychiatric Hospital said that he was injected every time he was put into straps, and that afterwards he feels sleepy and then his head spins and he has to kneel down before passing out.

⁷⁸ However, note that neighbouring Austria has legislation outlining the definition and registration requirement for chemical restraints – see *supra* note 15.

⁷⁹ ‘Neutropenia’ is the medical term describing a significant depletion of white blood cells which can result from usage of Clozapine. It damages the ability of the immune system to respond to bacterial or fungal infection and, in serious cases, can be fatal.

7(B). Leather and fabric straps

7(B)(i). Testimonies

A female patient in her 50s at Kosmonosy Psychiatric Hospital recalled a woman who was paralysed and who was always trying to stand up. Staff would strap the woman to a chair for most of the day, and then strap her to a bed at night.

Patients also reported that toileting in straps was also an issue: at Opařany Children's Psychiatric Hospital, patients in straps were taken to the toilet "when possible", but staff also used a box which they put under patients.

A 20-year-old male patient at Opava Psychiatric Hospital reported seeing people strapped for two or three days and sometimes for up to a week. He had seen staff feed people who were strapped. He said that people were strapped because "they couldn't adjust to life here – they couldn't handle it", and gave an example of a man who kept yelling. As staff couldn't stop him from yelling they strapped him. Another young man at Opava Psychiatric Hospital said that he had been strapped because he refused to take his pills: he was strapped by his wrists (until they hurt, he reported) and across his chest. This happened all day. He felt "like a dog".

A 21-year-old man at the same hospital said that he had been strapped twice: once after he had made a "stupid remark". That time he was strapped for almost two days, on his arms, legs and waist. He was released when he "got better" ("až se polepšil"). This demonstrates the arbitrariness of when a person is strapped, and when the straps are removed within a punitive context. He reported that the only attention he received from staff when strapped was food and medication. Of particular concern is that he had wanted to complain, but could not.⁸⁰



Photos: Klatovy Hospital Psychiatric Department © MDAC

Strapping at Kosmonosy Psychiatric Hospital

A man in his 50s with alcoholism explained that he prefers cage beds to straps because he could move more in a cage bed. He said that he has experienced being in straps for two days but if he is very aggressive then he is put in for four days.

During the period of strapping, he said that staff fed him meals, and when he needed to urinate they gave him a bottle. When he needed to defecate they accompanied him to the toilet. After he was released from the straps there was a rule that he was not allowed outside for a week. He said that he hates it because he could not smoke in straps, and that he felt like killing himself because he was so restrained, and that could not move because of the straps across his neck, arms, legs and they also crisscrossed his chest.

He reported that the straps were made from the same material as a fire-hose. "They pull it very tight, as tight as possible", he said, recounting a time when a policeman tied the straps so tight that his hand turned blue. After they released him from the straps he felt stiff and said he was "not right" for about 2 days after.



⁸⁰ He asked MDAC to complain on his behalf to the Czech Ombudsperson and gave his name and address. After the monitoring visit, MDAC duly passed on his complaint.

7(B)(ii). Observations

MDAC found that leather straps and other physical restraints are commonly used in many psychiatric institutions, sometimes in combination with cage beds and very often with chemical restraints.

In 2006, registration of the use of restraints in psychiatry became compulsory in a computer system, and also in a register held by each hospital. Despite this, no national statistics are available to the public. Hospitals have their own guidelines on the use of restraints (MDAC was shown these at Prague Bohnice, Kosmonosy, Opařany, Opava and Dobřany hospitals). The guidelines regulate clinical and related practices inside psychiatric settings and are required by law. Some specify that a record must be made of a patient's behaviour before the use of restraints, that restraints must have prior authorisation by a doctor (apart from "in exceptional cases", a phrase which is undefined), and some also outlined the maximum time period that straps could be applied.

At Prague Bohnice Psychiatric Hospital the maximum time allowed for the application of straps was three hours, but a staff member told MDAC that in the previous year a patient had been strapped for nine hours. At Opava Psychiatric Hospital the maximum period was 12 hours, and at Kosmonosy Psychiatric Hospital there was no limit and decisions on length of time for strapping were entirely at the doctor's discretion.

In some of the institutions, internal policies specified the situations when the court must be notified of the use of straps. At Opava Psychiatric Hospital, if a person is an involuntary patient then the court is notified about the use of restraint. Court notification is not required, however, if the patient gives his or her "consent" to the restriction within the 24 hour period following removal of the restraints. This creates an obvious way to avoid the notification requirement, allowing hospital staff to exert pressure to obtain retrospective consent. It is a nonsensical provision.

Seven point restraint for children

Seclusion rooms were used in Opařany Children's Psychiatric Hospital where they are known as "rooms of individual surveillance". They were in both the boys' and girls' wards. In the boys' ward, the room was quite small with a bed on the right-hand side of the room and a soft green mattress next to the bed. The room was light green and white with tiles on the floor.

The one bed in the room had seven-point straps attached (the seven points of attachment are to the left and right ankles, left and right wrists, chest, and left and right shoulders), ready for use. The straps were not hidden from view as the director had told the monitoring team they would be. The monitoring team also ascertained that the children knew of the existence of the straps which they viewed with fear, illustrating that mere knowledge of their existence had a coercive effect.

The official line of most psychiatric hospital directors interviewed was that restraints are only used as a "last resort". They told MDAC that nurses are trained to deal with "difficult" patients, and the first line approach is manual holding, although no evidence of this was provided. Injections and straps are the most common restraints, according to one hospital director, but no data is available.

Straightjackets – euphemistically referred to as "protective jackets" by some senior staff at Opařany Children's Psychiatric Hospital – are used rarely, but again no data was available to verify this assertion, and they were not shown to the monitoring team. At Opava Psychiatric Hospital the deputy director said that a straightjacket had been used once in the previous year, though again no data was available.

Many types of straps

The monitoring team found that leather and fabric straps are prevalent across Czech psychiatric institutions.

1. Some **leather straps** have a layer of fleece on the side of the strap which touches the skin of the patient so that it feels soft.
2. Other hospitals use **white canvas straps**, with buckle fastenings or magnetic locks.
3. In wards for elderly people **abdominal straps** are used, as well as boards on the sides of hospital beds, and sometimes one limb of a patient is strapped to prevent them from falling.
4. A special **jacket attached to the sheet of a bed** is used in some institutions. Once a patient is inside one of these jackets, the jacket "brings him back to the bed" if they try to get up, according to staff at Prague Bohnice Psychiatric Hospital.



Photo: © MDAC

At Plzeň Hospital Psychiatric Department, a psychiatrist told MDAC that they used straps to restrain a patient's wrists and ankles, and if they were "very aggressive" the staff would tie a bed-sheet over the patient's chest. At Opava Psychiatric Hospital staff said that straps were usually used on patients' wrists and legs and only "in exceptional cases" on the chest. Straps were used for "patients that are restless and have a tendency to stand up". Chemical restrictions are always used in conjunction with straps, "to treat the source of the restlessness." According to staff, they monitored strapped patients every 20 minutes. Elsewhere, such as at Lnáře Psychiatric Hospital, strapping seemed to occur less frequently.

7(B)(iii). Staff views

The reasons that straps are used appear to be similar to the justifications given to cage beds, with two subtleties. First, straps are used more on men as some are seen to be too strong for cage beds. Second, straps are apparently more treatment-focused because strapping a person allows medical staff to render the patient's body (or at least an arm) nearly motionless so that an injection can be given.

A doctor at Plzeň Hospital Psychiatric Department told the monitoring team that during the night there were two nurses for 25 patients, so restraints were "necessary for newly-admitted patients who are in acute conditions or patients who are trying to escape or attack [other] patients and nurses". Straps are necessary due to, "the safety and benefit of the patients", he explained. A 36-year-old patient at Kosmonosy Psychiatric Hospital said that "everyone is who is admitted is put in straps for prevention, whether they come by ambulance or police". A 30-year-old patient explained how, "they usually strap newly-admitted patients, just for one-two days. There is a special room with beds which have straps."

A doctor at Kosmonosy Psychiatric Hospital said that she could not imagine treating a patient in a seclusion room. "On the other hand", she added, "everything is possible in straps."

Prolonged strapping at Lnáře Psychiatric Hospital

A nurse told the monitoring team that a male patient's hands were strapped because "he was aggressive and didn't want his injection". The medical records stated that he had been strapped from 5.30pm to 10pm, although the reason given for the straps by staff was to give him an injection. It is clear that he must have remained strapped for several hours after the injection.

At Klatovy Hospital Psychiatric Department, MDAC monitors were told that people with alcoholism were strapped if staff had to give infusions for which they needed access to the patient's arm. Straps were used for patients having hallucinations and those who harmed themselves, other people, or had destroyed cage beds.

At Opava Psychiatric Hospital, a nurse confirmed that patients could be strapped "just for an hour" to receive injections. This means that the straps were used not only at the time of the injection, but for an extended period of time thereafter.

Similar to the use of cage beds, straps were used to prevent patients from falling, according to some staff. At Dobřany Psychiatric Hospital, where cage beds have been removed, staff instead used small round straps which were placed on a patient's wrist and affixed to the side of the hospital bed with a Velcro fastener. In the detox unit of Prague Bohnice Psychiatric Hospital, straps were used for situations of "restlessness" according to the director, or when staff consider patients to be "dangerous" to themselves or others. There is no assessment tool to evaluate perceived dangerousness.

7(C). Seclusion

Most hospitals which MDAC visited had seclusion rooms, the exceptions being at Klatovy Hospital Psychiatric Department and at Lnáře Psychiatric Hospital. The director at Plzeň Hospital Psychiatric Department said that there were no seclusion rooms, although rooms with cage beds were sometimes used for seclusion. Klatovy, Opařany, Dobřany and Kosmonosy hospitals all had seclusion rooms, most with physical restraints at the ready.

At Dobřany Psychiatric Hospital the seclusion room was located at the end of the hallway. It contained a mattress and a "Turkish toilet" (a hole in the ground above which the person must crouch). The window could be opened from outside the room and the heating controls were also external. The seclusion room was, according to the staff "very hot", because "some of the patients in seclusion are naked, because they could harm themselves with their clothes."

Unit 13 of Dobřany Psychiatric Hospital had five seclusion rooms. Two contained a bed and were padded. Three were without a bed and had a slanted floor. Seclusion rooms such as these were described in a report by the European Committee for the Prevention of Torture in their 2006 report after visiting the institution: “[T]he floors of these tiled cells were uneven, with an incline down towards the floor level toilet; several patients complained that their mattresses would slide towards the toilet during the night”.⁸¹ At Prague Bohnice Psychiatric Hospital seclusion rooms are frequently used. According to staff, some patients are medicated too and most are strapped.

An isolation room for girls

On the girls’ ward at Opařany Children’s Psychiatric Hospital, the seclusion room had blinds that could be opened. At the time of the monitoring team’s visit, the straps had been sent to wash (indicating their recent use) and there were two more primitive sets in storage. There was a light switch inside the room, and an electrical box on the wall which presented an additional risk, although it was high enough on the wall to be out of reach.

The window could be opened fully, which also seemed to be a risk. The seclusion room could not safely be used for secluding an agitated child without the additional use of physical restraints, otherwise the person may jump out of the window. On this basis, the monitoring team concluded that the seclusion room was most likely only used in combination with physical restraints.

There was some minor material damage to the walls, repaired and painted over. There was a smoke detector. The staff said that there were no legal provisions regulating the interior of seclusion rooms or the equipment which one should contain. It appeared that the room was used often, and sometimes children asked the staff to go there because they wanted to be left alone. The director of the institution told the monitoring team that, “if a child is in fear then seclusion rooms are good”.

MDAC monitors were told that the two seclusion rooms for girls age 13 to 18 had been used eight times in February 2013. The last child had been placed in straps for 40 minutes, according to the director. A nurse wanted to respond to a monitor’s question about how often a child in the seclusion room was checked, but the director jumped in and said monitoring was “continuous, or every five minutes, or according to the internal rules”, then “according to the level of agitation” and finally clarified that the minimum interval for checking was 30 minutes. After repeated questioning she said that, “a nurse monitors all the time, every 5 minutes, but it is a demanding job”. The monitoring team were left wondering which of the variety of answers most closely resembled the reality.

Staff at Prague Bohnice Psychiatric Hospital told MDAC monitors that a doctor always reviewed the necessity of seclusion before the event, and every 12 hours once the placement in seclusion had begun. The longest stay in seclusion reported by staff was almost two months. The seclusion room had one bed and a window with unbreakable glass, and a toilet was located outside the room. At Dobřany Psychiatric Hospital, staff told MDAC monitors that patients could be placed in seclusion for a maximum of three days, and were checked every three hours. Overall, there seemed to be wide variety of practice across the country, with no national policy or discussion as to minimum standards. The result is inevitably that many people are placed needlessly in seclusion, for too long, without regular enough review, and placing them at substantial risk.



Photo: Dobřany Psychiatric Hospital, Ludvik Hradilek – Aktuálně.cz

81 European Committee for the Prevention of Torture, *Report to the Czech Government on the visit to the Czech Republic carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 27 March to 7 April 2006 and from 21 to 24 June 2006*, supra note 35, at para. 115.

7(D). Dehumanisation and coercion

Physical restraints like cage beds and straps are really only the most visible forms of coercion and control in Czech psychiatric institutions. MDAC learned that subtler forms of dehumanisation and coercion are also widely in use. An example is that in all adult hospitals visited, many of the patients were recorded as being “voluntary” patients. In law this means that they could leave any time. The reality was that staff had to agree if someone wanted to leave: people were in fact deprived of their liberty. Another example is that monitors observed how patients were forced to do chores, and that sanctions were imposed if these were done unsatisfactorily.

A system of coercion and punishments

A 50-year old male patient at Kosmonosy Psychiatric Hospital talked about punishments for infraction of rules.

- Failure to complete cleaning duties to a satisfactory standard
- Smoking in the hallway
- Coming back late from day-leave

Punishment: Three days not allowed to leave the ward

A 40-year-old male patient at Klatovy Hospital Psychiatric Department explained that if a patient on Ward 8 (the “chronic ward”) got drunk, they would be prohibited from leaving the ward for two months. Another voluntary male patient there said that he wasn’t allowed to leave the ward on his own, only in a group. To go home for the weekend, he had to apply for “special permission”.

Also at Klatovy, the monitoring team asked staff whether patients classified as “voluntary” could leave the ward as they wish. The doctor explained that the ward was locked (the monitors had all noticed) and patients needed special permission to get out. He said that this was discussed every morning, and the doctors recorded in each patient’s medical records whether or not they could go out that day.

In many of the hospitals visited, monitoring teams observed that patients who were less mobile were taken outside less frequently.

Other dehumanising practices were also observed. At Kosmonosy Psychiatric Hospital, the monitoring team spoke to a female patient who had had long hair, which was shaved off against her will when she was admitted to hospital. The reason for this? For “retaliation”, she said. “They had not done it to everyone but to around three people, and as they were doing it they were making joking comments.”

At the same hospital another female patient told the monitoring team that residents do not have personal lockers and their belongings got lost all the time. Their clothes (even if they had names sewn on them) were collected and washed together and then handed out randomly to patients. She recalled that she once saw an elderly patient going out into the freezing cold wearing trousers in which he had recently urinated. The nurse shrugged her shoulders when it was brought to her attention. Dehumanisation was a daily occurrence according to this patient: there are no towels, she said, and patients had to use bed sheets to dry themselves after showering.

Hygiene and privacy are other areas where control is exerted. At Dobřany Psychiatric Hospital, staff informed the monitoring team that patients could take a shower every day, but only under supervision. At Kosmonosy Psychiatric Hospital, the mother of one resident told the monitoring team that, “the hygiene is generally bad, some patients do not shower at all, when the nurses are asked about it, they only say, ‘they can shower whenever they want.’” She went on to say:

The staff don’t let the patients do anything for themselves, like shaving or getting their hair cut; a mother tries to make her son do all these when at home, so he does not lose the ability.

There was a general lack of showers and toilets. At Kosmonosy Psychiatric Hospital a female patient told MDAC that on her 40-person ward, there were only three showers and three toilets. She reported that the toilets were often clogged, and that it was difficult to keep clean; she worried about getting sick. Highlighting the irony of the position, she told MDAC that she attended a group run by a psychologist in the library, where patients lie on the floor and listen to a tape that tells them to imagine running water and that they are being cleansed – this in a hospital where cleanliness was impossible.

Similarly at Opařany Children’s Psychiatric Hospital, MDAC monitors were shown to the bathroom where there were only five toilets for twenty children. In the same area there was a shower and a bathtub, which could both be used simultaneously with the assistance of nursing staff. The bathtub was in the same room as the toilets and was not concealed in any way. In the ward for children with intellectual disabilities there was a smell of urine. Nurses said this was difficult to eradicate as the building was old.

Uniforms

At Opava Psychiatric Hospital the monitoring team was told that staff take patients’ clothes and personal belongings from them. Each patient had to wear institutional uniforms. Hospital clothes were communal and washed together. Some of the nurses complained about this, so they or their friends sometimes brought old clothes for patients to wear when they went out.



Photo: The Human Side of Hospitals blog

"...everything is possible in straps."

Doctor interviewed at Kosmonosy Psychiatric Hospital

8. Reducing coercion

This chapter provides information to Czech policy-makers and clinicians regarding steps they can take to improve the human rights of people in the mental health system.

8(A). Workforce perspectives

MDAC investigated coercion in Czech psychiatry a decade after producing its first report because it wanted to find out whether the views of healthcare providers about reducing coercion in psychiatry had shifted during that time.

The director of Plzeň Hospital Psychiatric Department told MDAC monitors that there was a push across all psychiatric hospitals to get rid of cage beds. He referred to a report of the Ombudsperson where the use of cage beds was considered negative. In his view, media attention had influenced psychiatric hospitals and he thought that cage beds had been removed “to escape the negative attention, not because the experience of using the beds has been bad”. He was adamant that cage beds (“therapeutic beds” as he called them) were helpful: “they make sense”. Directors of psychiatric hospitals want “peace from these attacks”, so they have decided to get rid of cage beds, he

said. Although two people had reportedly died in cage beds in recent years, his view was that this did not decrease their necessity. Every therapeutic procedure could have fatal complications, he explained. “The fact that an operation can be fatal does not stop the surgeons from carrying out the operation”.

Doctors at Klatovy Hospital Psychiatric Department told MDAC monitors how they had new long-term patients who were formally residents of social care institutions as a result of the 2006 ban on cage beds in these establishments.⁸² The hospital had two new cage beds from the local social care institution where their use had been banned.

Overall, the prevailing views of directors, clinicians and staff was that coercive practices were still necessary.

8(B). Eating slippers and other risks

Many psychiatrists were adamant that cage beds represented an indispensable part of their clinical practice. Explaining their position, they often invoked the horrors of other forms of physical restraint. A psychiatrist at Plzeň Hospital Psychiatric Department told monitors that patients calmed down quicker in a cage bed than in straps. She regretted plans to remove cage beds: according to her, this would result in patients being strapped for longer periods. “We cannot survive without restraints”, she said, because “there are only two nurses and one doctor [at night]. Patients are even brought in by six police officers.” Another doctor in the same hospital predicted that people would look back and realise that cage beds were “the

most helpful [means of restraint] for the patients”. She conceded that there was growing public pressure to stop cage beds. Her response to this? “We are planning to build a seclusion room.”

Another psychiatrist at Plzeň Hospital Psychiatric Department explained that the public looked at cage beds as if they are medieval torture instruments. His view was that a patient in a cage bed could be given lower doses of medication, and that caging someone was better than placing them in a seclusion room as staff could observe them. He said that patients had told him that in a cage bed they can itch a scratch, but in straps they couldn’t. “That must be torture,” he argued.

⁸² Social Services Act, Law no. 180/2006.

In Kosmonosy Psychiatric Hospital a doctor explained that cage beds existed for “historic and architectural reasons.” If they had to go, he suggested that on the elderly ward they be replaced with “belly straps”. A doctor at Klatovy Hospital Psychiatric Department was of the view that the demand for cage beds would decrease only if more staff were recruited. This was unlikely, he continued, as staff numbers had already been reduced and a minimum staffing level had now become the norm. A doctor in the same hospital thought it would be “stupid” to get rid of cage beds, adding that he could not imagine what he would do with “geriatric patients”. Thanks to cage beds, he said, patients did not need to be chemically restrained. Furthermore, cage beds had prevented broken limbs as they constrained patients who might otherwise have slipped on the floor. He said that there had been no leg fractures for 14 years in his hospital (a statement which the monitoring team were unable to verify). The correlation between the use of cage beds and the lack of leg fractures had, according to him, become a simple matter of cause and effect. Without cage beds, “we would have to use straps”, pointing out that in England there are no cage beds but that staff “lie on patients” there. Monitors asked where he had heard this, to which he replied, “probably on the internet”.

At Plzeň Hospital Psychiatric Department, a psychiatrist seemed rather relieved that he did not have to treat elderly patients, as he did not know “what to do with patients with dementia when the therapeutic beds are outlawed”. At Kosmonosy Psychiatric Hospital staff explained that increased staffing levels would enable the hospital to reduce the prevalence of strapping and the length of time a person is strapped, but more staff would not diminish the use of cage beds. In the same hospital, another doctor explained that a new seclusion room would replace the cage bed on her unit. The seclusion room would have straps: “It would be dangerous for staff to enter so there will always be need for straps,” she said, noting that the staff were planning to use more strapping if cage beds are removed.

Dobřany Psychiatric Hospital had removed cage beds following a death of a patient in 2012. The monitoring team were particularly alarmed at the perspectives of staff. A senior psychiatrist expressed some frustration when asked about the removal of the cage beds, complaining that he had been asked the question numerous times previously. According to him there had been no benefit in removing cage beds, meaning that patients were placed in two new seclusion rooms instead. The hospital director told monitors that removing cage beds was a bad idea. The European Committee for the Prevention of Torture (CPT) had visited the hospital in 2006 and asked the director to release a male patient from a cage bed. The director told MDAC monitors that when staff complied with the request, “before they could get him back in, he ate another patient’s slippers.”



8(C). Removal of cage beds at Opařany Children’s Psychiatric Hospital

With the exception of the director at Opařany Children’s Psychiatric Hospital, few clinicians engaged with the possibility of a coercion-free environment in psychiatric institutions. She spoke about how JK Rowling had criticised cage beds and had caused perspectives on the use of cage beds to change. She said that she had always been opposed to cage beds, but had not known how to deal with “difficult cases”. Seclusion rooms had been installed when the cage beds were taken out of use, and had apparently been inspired by a visit to the UK and a discussion of employee injuries.

To the surprise of medical and nursing staff at the institution, there had been a reduction in incidents which previously would have justified the use of cage beds. It should be noted that this supports global evidence of how alternatives to coercion are intuitively sought by staff when coercive measures are removed, as discussed in the next section.

In Prague Bohnice Psychiatric Hospital, where all but one cage bed had been removed, a doctor told the monitoring team that he did not miss the cage beds. They “could be used for patients that are strapped now, but there is a greater risk of excessive use [when compared to other restraints].” He explained that without the possibility of resorting to cage beds, doctors paid more attention to the residents: “The wards are smaller and more specified, the supervision is more intensive”, he said.

In general, however, MDAC monitors found little empathy amongst professionals for patients subjected to coercive practices.

8(D). Practical measures to reduce coercion

When Philippe Pinel threw open the doors at the Salpêtrière and the York Retreat,⁸³ it became apparent that even those with significant levels of distress and agitated behaviour could be effectively cared for without recourse to physical restraint or restriction of liberty. Coercion has long been associated with psychiatric practice, particularly in institutional settings. Reports on the earliest facilities often revealed shocking practices. At the same time, it has been demonstrated over many years that mental health care can be humane, person-centred and cost-effective. Taking action in this respect is not only desirable but is now required under international human rights law.



Philippe Pinel
Image by: Julien Léopold Boilly

At the end of the 17th century, the Salpêtrière in Paris was used to house four categories of women: 'bad' adolescents, prostitutes, criminals and the 'insane'. By the early 19th century it had become an asylum used to warehouse people with mental health issues, the vast majority kept in chains. When social reformer Philippe Pinel (1745-1826) visited, he was reportedly so shocked at the scene that he called for the women to be unchained and released. Along with other reformers including Jean-Baptiste Pussin (1745-1811), Pinel is seen as one of first who attempted to humanise psychiatry in Europe.

At the same period, William Tuke (1732-1819), founded the York Retreat in northern England for 30 patients. At this new institution, he believed that the focus must be on developing the 'morality' of patients, placing an emphasis on the minimisation of restraints.

Adapted, in part, from: Ivan Berlin, *'The Salpêtrière Hospital: From Confining the Poor to Freeing the Insane'*, (American Journal of Psychiatry, 2003, 160:1579-1579).

There has been a steady move towards community support services and the closure of large psychiatric and social care institutions in many countries over the last sixty years. This has meant that hospital stays have shortened and become more 'acute' in many countries, and units have become smaller and more focused on the goal of getting people back into their own homes, with support, as quickly as possible. This move into the community has occurred at different rates. Many countries still concentrate their mental health services in large institutions with little community services.⁸⁴

Research in the field is challenging and robust evidence hard to come by. However, a growing evidence base exists suggesting that coercion itself is not associated with improved clinical outcomes and negatively impacts upon the individual's experience of care,⁸⁵ perspectives which were also repeatedly stated by patients in those institutions visited. Reflecting the move towards a more human rights-compliant approach to psychiatry, a growing medical consensus exists that treatment within institutions must be carried out in the least restrictive manner possible.

International practice varies significantly and there is no single measure which can fully minimise coercion. This is the case in all countries. For example, there have recently been concerns regarding the use of "face down restraint" in UK National Health Service (NHS) hospitals and injuries and fatalities associated with this.⁸⁶ In the USA and some Scandinavian countries practices such as strapping continue to be used and in low-income countries people in distress may simply be chained to a tree.⁸⁷

The evidence on reducing coercion in psychiatric settings points to a number of interventions which may reduce coercion. If applied in a systemic manner, they can reduce overall levels of abuse and ill-treatment associated with cage beds, restraints and seclusion. These interventions are summarised briefly below. It must also be noted that such interventions cannot replace broader structural changes required, including securing the right to community living for everyone with mental health issues, as required by international law.

83 D.H. Tuke, 'Retrospective glance at the early history of the retreat, York; its origins and influence', (British Journal of Psychiatry 38: 1892, 333-359).

84 World Health Organization, *Mental Health Atlas 2005*, (Geneva: World Health Organization, 2005).

85 Tulla Wallsten, Lars Kjellin and Leif Lindström, 'Short-term outcome of inpatient psychiatric care - impact of coercion and treatment characteristics', (Social psychiatry and psychiatric epidemiology, 2006, Vol.41(12), pp.975-80).

86 Mark Easton, 'Excessive' use of face-down restraint in mental health hospitals, (BBC, 10 June 2013), available online at: <http://www.bbc.co.uk/news/uk-22955917> (last accessed: 15.06.2014).

87 Mental Disability Advocacy Center, *Human rights and mental health services in Zambia*, (Budapest: MDAC, 2014).

8(E). Rapid clinical and risk assessment on admission

When a person is admitted to hospital the process is often bureaucratic, unnerving and overwhelming for the person concerned, particularly where admissions are involuntary. Established institutional cultures may lead to the use of coercion early on admission with people initially being admitted to locked and/or highly staffed units with greater restrictions pending assessment. Front loading the assessment process with senior clinical involvement at an early stage should allow for a triage system upon admission. The intention of this is to prevent the need for restrictive or coercive practices. It also allows for the timely management and support of people presenting with high levels of behavioural disturbance, removing the requirement for implementing coercive measures in place of providing individualised support.

Front loading is already common in mental health care systems where inpatient beds are a precious and expensive resource.⁸⁸ It has a beneficial effect for people admitted to institutions and lowers overall costs. It has the additional benefit of ensuring that treatment and support can be started quickly in order to minimise the length of admission. Whilst ensuring senior clinical involvement may require making changes to the overall staffing arrangements at hospitals, improved clinical outcomes, a focus on establishing community transition, and shorter admissions are likely to lead to a reduction in overall resources required.

8(F). Observation procedures

As noted above, the UN Special Rapporteur on Torture has called for an absolute ban on restraints and seclusions. This follows a trend in global psychiatry to reduce seclusion and restraint down to an absolute minimum. When the American Psychiatric Association introduced guidelines that all patients in seclusion had to be reviewed by senior psychiatrists at regular intervals, including through the night, the use of this restrictive measure decreased rapidly and significantly.⁸⁹ Similar guidelines exist in the UK and other countries and, while designed to increase safety, they undoubtedly contribute to the reduction in the use of coercive interventions and greater respect for the dignity and autonomy of patients.

In large hospitals resident doctors should be on call at all times, and should be required to frequently review all those subjected to any coercive measures, their physical condition and safety. A requirement could also be made that the senior psychiatrist in charge of patient care be required to conduct additional reviews at regular intervals. The burden of assessment and administration would likely lead to a reduction in use and change the default options considered by clinical staff. In addition, guidance could stipulate that records be kept, automatically forwarded to independent monitoring bodies such as the Ombudsperson and made available to inspectors including NGOs upon request to ensure compliance.



Photo: Shutterstock

88 Michael I. Harrison, *Implementing Change in Health Systems: Market Reforms in the United Kingdom, Sweden, and the Netherlands*, (UK: Sage, 2004).

89 K.A. Huckshorn KA, 'Redesigning State mental health policy to prevent the use of seclusion and restraint', (Administration and Policy in Mental Health and Mental Health Services Research, July 2006, Volume 33, Issue 4, pp. 482-491).

8(G). Advance directives

Advance directives are mechanisms whereby an individual can articulate and formally record their wishes regarding treatment in advance. They are often completed between periods of crisis when the person is supported to reflect on their choices regarding treatment. In some countries, such as Switzerland, they are legally binding and can offer clear information to treatment teams regarding the will and preferences of the person, recognising the importance of informed consent and supported decision-making.

Advance directives are most useful when they provide options for treatment as well as practices to be avoided. Although uptake can be slow, they can prove to be beneficial in reducing coercion in individual cases and form part of an overall package to increase autonomy.⁹⁰

8(H). Lay and legal advocacy

There is evidence that the provision of independent lay (non-legal) advocacy, often through independent non-governmental organisations part-funded by the state can lead to greater empowerment of patients including those in community settings. It can allow people to become more involved in their care and treatment decisions.⁹¹ The beneficial effect of advocacy goes beyond positive clinical outcomes, and includes reductions in frustration and fear which are often used to justify coercive measures. Numerous models have been developed internationally, including services which can be provided at a relatively low cost.

Under Czech law, the possibility for informal advocacy through a representative or 'confidante' is possible.⁹² The confidante can receive information about the person being supported, and can exercise all of the rights connected to the hospitalisation of the person concerned, including the right to appeal against particular decisions. The Code also provides that the patient can meet with their representative or confidante in private.

It is advisable for patients in psychiatric hospitals to have the opportunity to seek legal representation in proceedings to challenge their detention and treatment. Without a system where lawyers are involved, abusive practices continue to be carried out with impunity: clinical standards do not get developed, victims are not provided with legal remedies, and perpetrators go unpunished.

90 JQ La Fond JQ and D. Srebnik, 'The impact of mental health advance directives on patient perceptions of coercion in civil commitment and treatment decisions'. (International journal of law and psychiatry, 2002, 25(6), pp. 537-55); Susanne Brauer, Prof. Nicola Biller-Adorno and Dr. Roberto Adorno, *Country Reports on Advance Directives*, (Zurich: Institute of Biomedical Ethics, University of Zurich, 2008)

91 H. P. Lefley, H. P., *Advocacy, Self-Help, and Consumer-Operated Services, in Psychiatry* (3rd edn.), (Chichester, UK: John Wiley & Sons, Ltd.)

92 Article 106 of the Civil Code, Law No. 89/2012 Coll.

8(I). Involvement of patients and families

In places where there is relatively limited visiting from families and others, and where healthcare decisions are made by clinicians alone (and in many large institutions doctors alone), there is an obvious potential for higher levels of coercive measures in terms of both intensity and time. This is particularly the case where such practices are part of the history and culture of the institution.⁹³ From the findings of the monitoring, this is undoubtedly the case in many psychiatric institutions in the Czech Republic.

The simple step of inviting families to be as fully involved as possible in their relative's care in hospital bears no cost implications and should automatically lead to a more person-centred and holistic approach. At the hospital level, a 'patients and carers group' could be established to work with senior clinicians and managers. Giving those directly affected a voice in the organisation of services is also vital as governments make progress on the process of deinstitutionalisation, as required by international law.⁹⁴

8(J). Visiting

In the UK there was a highly critical inquiry into abuse and conditions in a hospital.⁹⁵ This highlighted sustained mistreatment and neglect of patients. One of the most important recommendations was simple: allowing for routine extended visiting hours. This has been pointed out in other similar inquiries, highlighting the importance of opening up otherwise closed institutional cultures as a method for reducing coercive and abusive practices. Inviting the public into psychiatric hospitals means that the system usefully opens itself up to external scrutiny: transparency can only be a good thing for clinicians and patients alike.



Photo: iStock

93 A. Fiorillo et al, 'How to improve clinical practice on involuntary hospital admissions of psychiatric patients: Suggestions from the EUNOMIA study', (Journal of the Association of European Psychiatrists, May 2011, 26(4), pp. 201-7).

94 See Article 4(3) of the CRPD, which reads: "In the development and implementation of legislation and policies to implement the present Convention, and in other decision-making processes concerning issues relating to persons with disabilities, States Parties shall closely consult with and actively involve persons with disabilities, including children with disabilities, through their representative organizations."

95 Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, (London: The Stationery Office, 2013). The report and associated materials can be found online at: <http://www.midstaffpublicinquiry.com> (last accessed: 15.06.2014).



Photo: Opava Psychiatric Hospital © MDAC

"Before they could get him back in, he ate another patient's slippers."

The 'risks' of removing cage beds, according to one the director of one institution visited.

9. Conclusion

MDAC first called for the prohibition of cage beds in Czech psychiatric hospitals in 2003. Despite continuing international attention, the response of the government and the Czech psychiatric community has been insufficient. The retention of netted cage beds and supplementing them with straps, restraints and seclusion is indicative of the failure to reduce overall levels of coercion in Czech psychiatry, despite the removal of metal cage beds. All of these practices constitute ill-treatment prohibited by international law.

The outdated and indefensible practices observed by MDAC monitors overwhelmingly reflect the archaic institutional nature of psychiatric service provision in the country, predominantly provided at large and dilapidated institutions where coercive practices are literally built into the fabric of the buildings. Without doubt, this points to a failure to invest in community-based mental health services, as well as a broader attitudinal problem whereby decision-makers and service providers continue to revert to a medicalised model of disability rather than engaging with a human rights approach which places dignity, autonomy and consent at the centre.

As has been highlighted in this report, not only is it possible to drastically reduce coercive practices inside institutions, but this is now a requirement under international law. However, reducing coercion cannot be an end in itself. The UN Convention on the Rights of Persons with Disabilities requires that institutions

which segregate people with disabilities from society are eventually closed, with investment instead being focused in the communities where we all belong. Whilst social prejudices and discrimination may make such a transformation difficult to imagine it has been shown to be possible where there is strong leadership and a reallocation of resources.

MDAC hopes that the Czech government will now show this leadership, proving to people with mental health issues and the international community that they will take real, concrete steps to bring Czech psychiatry into the twenty-first century. An obvious first step would be to immediately ban cage beds – something that could have been achieved a decade ago. It is also hoped that new generations of medical professionals operating in the field will contribute to the broader changes required, supporting the autonomy and dignity of the people that they have committed to serve.

The fundamental changes required mean that the voices of people placed in psychiatric institutions should now take centre stage. MDAC will continue to monitor the human rights of people with mental disabilities in the Czech Republic and elsewhere. It is hoped that the recommendations provided in this report will contribute to the push to ensure that all people with mental disabilities are included and supported to be equal members of our societies.



Annex 1.

Numbers of cage beds self-reported by directors of psychiatric facilities

The following figures were elicited from directors of 45 psychiatric facilities across the Czech Republic following official freedom of information requests on the basis of Act 106/1999 (free access to information) submitted in December 2012.

Institution	Cage beds	Notes
Psychiatrická léčebna Kosmonosy	27	
Psychiatrická léčebna Opava	24	
Psychiatrická léčebna Havlíčkův Brod	19	
Psychiatrická léčebna Jihlava	11	Used 818 times in 2012
Psychiatrické oddělení nemocnice Klatovy	9	
Psychiatrická léčebna, Petrohrad, p.o.	6	
Psychiatrická léčebna Dobřany	4	Plan to remove all in 2013
Psychiatrické oddělení nemocnice Pardubice	4	
Psychiatrická léčebna Lnáře	4	
Dětská psychiatrická léčebna Opařany	2	
Psychiatrická klinika 1.lékařské fakulty UK a VFN v Praze	2	
Psychiatrická klinika FN Brno Bohunice a LF MUNI	2	
Psychiatrické oddělení Vojenské nemocnice Olomouc	2	Not used in previous 2 years
Psychiatrické oddělení Fakultní nemocnice Plzeň	1	Above 50 uses per year
Psychiatrické oddělení nemocnice České Budějovice	1	
Oddělení psychiatrie a psychoterapie Svitavské nemocnice	1	
Psychiatrická léčebna Praha - Bohnice	1	
Dětská psychiatrická léčebna Velká Bíteš		No response
Psychiatrická léčebna Bílá Voda		No response
Psychiatrická léčebna Šternberk		No response
Psychiatrická léčebna U Honzíčka		No response
Psychiatrická klinika nemocnice Olomouc		No response
Psychiatrické oddělení Městské nemocnice Ostrava		No response
Psychiatrické oddělení nemocnice Liberec		No response
Soukromé psychiatrické oddělení CNS		No response
Dětská psychiatrická klinika UK 2. LF a FN Motol	None	
Dětská psychiatrická léčebna Louny	None	
Oddělení dětské psychiatrie Thomayerovy nemocnice	None	
Psychiatrická léčebna Brno - Černovice	None	
Psychiatrická léčebna Horní Beřkovice	None	
Psychiatrická léčebna Kroměříž	None	
Psychiatrická léčebna Sadská – dislokované pracoviště Psychiatrické léčebny Kosmonosy	None	
Psychiatrické centrum Praha	None	
Psychiatrická klinika lékařské fakulty a FN v Hradci Králové	None	
Psychiatrické oddělení fakultní nemocnice v Ostravě	None	
Psychiatrické oddělení Masarykovy nemocnice v Ústí nad Labem	None	
Psychiatrické oddělení nemocnice Jičín	None	
Psychiatrické oddělení nemocnice Most	None	
Psychiatrické oddělení nemocnice Ostrov	None	
Psychiatrické oddělení Nemocnice s poliklinikou Havířov	None	

Institution	Cage beds	Notes
Psychiatrické oddělení nemocnice Tábor	None	
Psychiatrické oddělení nemocnice v Novém Městě nad Metují	None	
Psychiatrické oddělení nemocnice Znojmo	None	
Psychiatrické oddělení Ústřední vojenské nemocnice	None	
Psychiatrické oddělení Vojenské nemocnice Brno	None	

Annex 2.

List of psychiatric facilities contacted and visited

Name of institution	Type	Permission to visit	Dates of monitoring visits
Dobřany Psychiatric Hospital	Adult psychiatric hospital	Yes	7 February and 27 March
Klatovy Hospital	Adult psychiatric department of hospital	Yes	24 and 25 March 2013
Kosmonosy Psychiatric Hospital	Adult psychiatric hospital	Yes	4, 6 and 8 February, and 24 March 2013
Opava Psychiatric Hospital	Adult psychiatric hospital	Yes	27 March 2013
Prague Bohnice Psychiatric Hospital	Adult psychiatric hospital	Yes	7 February 2013
lnáře Psychiatric Hospital	Adult psychiatric hospital	Yes	27 March 2013
Opařany Children's Psychiatric Hospital	Children's psychiatric hospital	Yes	26 March 2013
Plzeň Hospital	Adult psychiatric department of hospital	Yes	25 March 2013
Jihlava Psychiatric Hospital	Adult psychiatric hospital	Yes	Monitoring teams unable to visit
Brno Černovice Psychiatric Hospital	Adult psychiatric hospital	Refused	27 March 2013 (external café only)
VFN v Praze Psychiatric Clinic	Adult psychiatric department of hospital	Refused	
Bílá Vode Psychiatric Hospital	Adult psychiatric hospital	No response	
České Budějovice Psychiatric Department	Adult psychiatric department of hospital	No response	
CNS Psychiatric Department, Trinec	Adult psychiatric department of hospital	No response	
Havlíčkův Psychiatric Hospital	Adult psychiatric hospital	No response	
Honzička Psychiatric Hospital	Adult psychiatric hospital	No response	
LF MUNI Psychiatric Clinic, Brno	Adult psychiatric department of hospital	No response	
liberec Psychiatric Department	Adult psychiatric department of hospital	No response	
Olomouc Psychiatric Clinic	Adult psychiatric clinic of hospital	No response	
Olomouc Psychiatric Hospital	Adult psychiatric hospital	No response	
Ostrava Psychiatric Department	Adult psychiatric department of hospital	Yes	
Pardubice Psychiatric Department	Adult psychiatric department of hospital	No response	
Petrohrad Psychiatric Hospital	Adult psychiatric hospital	No response	
Šternberk Psychiatric Hospital	Adult psychiatric hospital	No response	
Svitavské Psychiatric and Psychotherapy Department	Adult psychiatric department of hospital	No response	
Velká Bíteš Children's Psychiatric Clinic	Children's psychiatric hospital	No response	



Notes

