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20 November 2020

Case Document No. 3

Validity Foundation v. Czech Republic
Complaint No. 188/2019

SUBMISSIONS BY THE GOVERNMENT ON THE MERITS

Registered at the Secretariat on 16 November 2020

THE CZECH REPUBLIC

OBSERVATIONS OF THE GOVERNMENT ON THE MERITS OF THE COLLECTIVE COMPLAINT

VALIDITY FOUNDATION v. the Czech Republic
(no. 188/2019)

PRAGUE

16 NOVEMBER 2020

1. In its letter of 17 September 2020, the European Committee of Social Rights ("the Committee") notified the Government of the Czech Republic ("the Government") that on 9 September 2020, the collective complaint lodged by the Validity Foundation ("the complainant"), a non-governmental organisation, against the Czech Republic, under no. 188/2019, had been declared admissible. The Committee also invited the Government to submit their observations on the merits of this collective complaint.

THE FACTS

I. CIRCUMSTANCES OF THE CASE

2. Annex no. 1 to the collective complaint presents the data collected by the complainant on the numbers of net-beds and on the number of times that they were used in 23 psychiatric facilities in 2018.[1]

3. The Government conducted an inquiry into the current situation and gathered information on the net-beds in all 46 residential psychiatric facilities in the Czech Republic and the numbers of times they were used. The data was collected for the period from 2017 to 2020. All of this data structured by facility are attached to these observations.

4. As follows from this data, the figures provided by the complainant are in part out-of-date and in some cases inaccurate.

5. As to the number of net-beds, Annex no. 1 to the collective complaint contains the following inaccurate or outdated figures:

- Although the Psychiatric Hospital in Jihlava had four net-beds in 2018, their number was reduced to three in 2019;
- The Psychiatric Ward of the Klatovy Hospital currently has nine net-beds;
- The Psychiatric Hospital in Bohnice has not had any net-beds since 2020;
- The Psychiatric Hospital in Šternberk had two, not four, net-beds in 2018, and since 2020 it does not have any;
- The Psychiatric Hospital in Havlíčkův Brod had twelve net-beds in 2018, not eleven;
- The Psychiatric Hospital in Petrohrad had five, not four, net-beds in 2018, but their number was reduced to three in 2019.

[1] Annex No. 1 to the collective complaint refers to a total of 24 psychiatric facilities but the figures from the U Honzíčka Psychiatric Hospital, i.e. the Psychiatric Hospital in Písek, its successor, are not provided.

6. As to the number of times that these were used, Annex no. 1 to the collective complaint contains the following inaccurate or outdated figures:

- The Psychiatric Hospital in Jihlava reduced the number of uses from 305 for 62 patients in 2018 to 160 uses for 37 patients in 2019;
- The Psychiatric Clinic of the University Hospital in Plzeň reduced the number of uses from 28 in 2018 to 14 uses in 2019;
- At the Psychiatric Clinic of the University Hospital in Olomouc the number of uses went up from 98 in 2018 to 141 in 2019;
- At the Psychiatric Ward of the Regional Hospital in Liberec the number of uses rose from 95 in 2018 to 98 in 2019;
- The Psychiatric Ward of the Klatovy Hospital used the restraint 50 times in 2019 compared with 24 in 2018;
- The Psychiatric Hospital in Petrohrad restrained 25 patients 109 times in 2018, while in 2019 there were 98 uses for 20 patients;
- At the psychiatric ward of the Pardubice Region Hospital, the number of uses rose from 16 in 2018 to 22 in 2019;
- The Psychiatric Clinic of the University Hospital in Brno used net-beds 25 times in total in 2018, placing 12 patients in them, but in 2019 the number of uses dropped to two for two patients;
- At the Psychiatric Hospital in Havlíčkův Brod the number of uses rose from 71 patients restrained 148 times in 2019 compared with 72 patients restrained 128 times in 2018.

II. RELEVANT DOMESTIC LAW AND PRACTICE

A) Act no. 372/2011 on Healthcare Services and the Conditions for Their Provision (Healthcare Services Act)

7. The Government provide below the texts of the relevant provisions of this law and their evolution. The parts that were amended are italicised.

(i) Original wording of the Healthcare Services Act in force from 1 April 2012

8. The use of restraints in health care facilities was governed by section 39, which read as follows:

> "(1) The following can be used to restrict a patient's freedom of movement while providing health care:
>
> a) holding of the patient by medical staff or other persons assigned by the provider,
>
> b) restriction of the patient in movement by protective belts or straps,
>
> c) placing the patient in a netted cage-bed,

d) placing the patient in a room designed for secure movement,

e) protective jacket or vest restricting movement of the patient's upper limbs,

f) psychotropic drugs or other medicines administered parenterally, which are suitable for restricting the patient's free movement while providing health care, if it is not treatment at the patient's request or continuous treatment of a psychiatric disorder, or

g) combinations of the methods under (a) to (f),

(hereinafter referred to as "restraints").

(2) Restraints can be used

a) only if the aim is to avoid imminent danger to the life, health or safety of the patient or other persons, and

b) only for such a period of time for which the reasons for the restraints under (a) remain.

(3) The provider must ensure that

a) the patient on whom the restraint has been used is, with regard to their state of health, understandably informed about the reasons for the use of the restraint,

b) the patient's statutory representative has been informed without undue delay about the use of the means of restraint referred to in subsection (1)(b), (c), (d) or (e); communication with the patient's statutory representative shall be entered in the patient's medical records, and the record shall be signed by the health care professional and the statutory representative,

c) during the use of a restraint the patient is under the supervision of health professionals; supervision must be consistent with the severity of the patient's health condition and, at the same time, measures must be taken to prevent damage to the patient's health,

d) the use of a restraint is always indicated by a physician; in exceptional cases requiring urgent solutions, the use of restrictive means may also be indicated by a paramedical health professional who is present; the physician must be informed of such use of the restraint without delay and must confirm the justification for the restriction,

e) any use of a restraint must be entered in the patient's medical records."

9. Section 40 provided for notifying a court of the use of restraints:

"(1) The provider shall notify the court within 24 hours (…)

b) of additional restrictions on the patient who was hospitalised on the basis of their consent, concerning their free movement or contact with the outside world applied later in the course of treatment."

10. Part eight of the law governed the lodging of complaints and proceedings thereon:

"Section 93

(1) Complaints can be lodged against the provider's procedure in the provision of health care services or against activities related to health care services by

a) the patient,

b) the patient's statutory representative,

c) a close person if the patient cannot do so due to their health condition or if they have died, or

d) a person authorised by the patient.

The complaint shall be filed with the provider against whom it is directed; this is without prejudice to the possibility of filing a complaint under other pieces of legislation. The complaint must not be prejudicial to the person who has filed it or to the patient whom the complaint concerns.

(2) If a person who has filed a complaint with the provider (hereinafter referred to as the "complainant") disagrees with the manner it was handled, they can lodge a complaint with the competent administrative authority that granted the provider the authorisation to provide health care services. Concurrently, they shall state the reasons for disagreeing with the provider's handling of the complaint.

(3) The provider must

a) suggest to the complainant a discussion in person of the complaint if this is appropriate in view of the nature of the complaint,

b) deal with the complaint within 30 days of the date of its receipt; that period may be extended by a further 30 days if justified; in the case of a complaint for which it is not competent, it must demonstrably refer the complaint to the competent authority within five days of the date of its receipt; it must inform the complainant about the extension of the time limit and the referral of the complaint,

c) keep records of complaints and of the manner they were handled,

d) allow the complainant to inspect the specific complaint file and to make copies thereof,

e) if the complaint is being investigated by the competent administrative authority, the provider must provide it with timely and necessary cooperation upon request; this also applies to the provider of related health care services.

(4) The provider of inpatient or one-day care is additionally obliged

a) to develop a complaint handling procedure,

b) to publish the procedure under (a) and information on the possibility of lodging a complaint to the entities stated in subsection (2) in a publicly accessible place in the health care facility and on its website.

(…)

Section 94

(1) The competent administrative authority must

a) handle the complaint

1. within 30 days of the date of its receipt;

2. within 90 days of the date of its receipt, if an independent expert must be appointed to handle the complaint;

3. within 120 days of the date of its receipt, if an independent expert panel must be appointed to handle the complaint;

(…)

b) develop a complaint handling procedure and to designate the offices of the regional authority for the receipt of complaints,

c) publish the procedure referred to in (b) and the address of the designated office, the office hours and contact details of that office on the official notice board,

d) keep records of complaints and the manner they were handled,

d) allow the complainant to inspect the specific complaint file and to make copies thereof.

(…)

(4) The competent administrative authority may, on the basis of a complaint, another request or of its own initiative, in particular for the purpose of assessing cases where there were doubts as to compliance with the proper procedure in the provision of health care services, or to exclude a causal link between an incorrect procedure and injury to the patient's health in the course of the provision of health care services, appoint

a) an independent expert; it shall always appoint an expert if a complaint or other request challenges the correct procedure in the course of the provision of health care services, or in the event of a claim of injury to the patient's health in the course of the provision of health care services and the complaint or request is not manifestly ill-founded,

b) an independent expert panel; it shall always appoint it if

1. the independent expert proposes the appointment thereof having reviewed the medical records, or

2. in the administrative authority's view the case is such that in terms of expertise, review by an independent expert is insufficient or there is a need for assessing whether personal injury was incurred in the provision of health care services, which has resulted in the patient's death, provided that the complaint or other request is not manifestly ill-founded.

(…)

Section 96

(1) Where the competent administrative authority finds, when investigating a complaint, a violation of rights or obligations in the course of the provision of health care services, or activities related thereto, provided for by this Act or by other regulations or other errors concerning the rights and interests of patients, it shall

a) order the provider to adopt remedial measures, including the time limit for compliance, or

b) file a report with

1. the authority competent under other pieces of legislation;

2. the competent chamber if it finds an error by a health care professional who is a member of the chamber that is competent to investigate under the law governing the activity of chambers;

the provider proceeds analogically.

(…)"

11. Part ten governed inspection activities. The relevant part thereof reads as follows:

"Section 107

(1) The inspection of providers in connection with the provision of health care services (…) is carried out by

a) the ministry,

b) the competent administrative authority,

c) the regional authority that has registered the provider of social services or the provider of health care services in the National Register of Providers under section 20,

(…)

g) chambers, to the extent laid down by another law,

(hereinafter referred to as "inspection bodies").

(…)

Section 108

(1) In carrying out the inspection activities under section 107(a), (b) or (c) the inspection bodies inspect compliance with the obligations and conditions laid down in this Act or other regulations governing health care services or activities related to health care services.

Section 109

Inspection bodies may

a) order the adoption of remedial measures to remedy the shortcomings found,

b) specify time limits within which the remedial measure must be taken,

c) check the implementation of remedial measures,

d) require written reports on the implementation of remedial measures from the inspected persons."

(ii) Wording in force between 14 March and 31 December 2013

12. The wording of section 39 of the Healthcare Services Act remained unchanged.

13. Section 40 of the Healthcare Services Act read as follows:

"(1) The provider shall notify the court within 24 hours

(…)

b) of additional restrictions on the patient who was hospitalised on the basis of their consent, concerning their free movement *under section 39(1)(b) to (g)* or contact with the outside world applied later in the course of treatment.

(2) The patient's hospitalisation *and additional restrictions* shall not be notified to the court if *consent was* demonstrably additionally expressed within 24 hours."

14. The wording of sections 93 to 96 and the relevant part of sections 107 to 109 remained unchanged.

(iii) Wording in force between 1 January 2014 and 30 May 2017

15. Effective from the beginning of 2014, section 39(3)(b) was amended as follows:

"(3) The provider must ensure that

(…)

b) the patient's statutory representative *or legal guardian* has been informed without undue delay about the use of the means of restraint referred to in subsection (1)(b), (c), (d) or (e); communication with the patient's statutory representative shall be entered in the patient's medical records, and the record shall be signed by the health care professional and the statutory representative *or legal guardian*, (…)."

16. The wording of section 40(1)(a) was amended accordingly:

"(1) The provider shall notify the court within 24 hours

a) of the hospitalisation of the patient under section 43(1)(b) and (c); it shall proceed analogically if *the patient, the patient's statutory representative or the patient's legal guardian* has revoked their consent while reasons for hospitalisation without consent remain, (…)."

17. As to the provisions governing complaints, section 93(1)(b) and section 94(2) were amended:

"Section 93

(1) Complaints may be lodged against the provider's procedure in the provision of health care services or against activities related to health care services by (…)

b) the patient's statutory representative *or legal guardian*, (…).

Section 94

(…)

The competent administrative authority may terminate the investigation of a complaint if it is necessary to review the patient's medical records or to make copies or excerpts from these records in order to handle the complaint if *the patient or the patient's statutory representative or legal guardian* has not given their consent to the inspection of the medical records or to making copies or excerpts from the records. (…)"

18. The wording the relevant part of sections 107 to 109 remained unchanged.

(iv) Current wording in force since 31 May 2017

19. At the end of May 2017 the law has been extensively amended, including, *inter alia*, changes to section 39:

> "(1) The following can be used to restrict the patient's freedom of movement while providing health care
>
> (…)
>
> c) placing the patient in a netted cage-bed*; that is not the case for alcohol recovery units,*
>
> (…).
>
> (2) Restraints can be used
>
> (…) b) only for such a period of time for which the reasons for the restraints *under (a)* remain *and*
>
> *c) after more moderate action than restrains has been used unsuccessfully, except in cases where the use of more moderate action would have obviously not achieved the purpose under (a), in which case the least restraining means proportionate to the purpose of its use must be chosen.*
>
> (3) The provider must ensure that
>
> (…)
>
> e) any use of a restraint, *including the reason for its use,* must be entered in the patient's medical records.
>
> *(4) The provider must keep a central register of the use of restraints, which contains summary data on the numbers of uses of the restraints for each calendar year for each type of restraint separately; the identification data of the patients on whom they were used shall not be recorded in the central register. Any use of a restraint shall be entered in the central records within 60 days of the date of its use."*

20. The wording of sections 40 and 93 to 96 and the relevant part of sections 107 to 109 have not been amended.

B) Act no. 100/1988 on Social Security, as in force between 31 September 2005 and 31 December 2006

21. In 2005, section 89a was added to the Social Security Act; it read as follows:

> "(1) Measures restraining the movement of persons being provided with institutional social care may not be used in the provision of institutional social care (...), except in cases of imminent danger for the health or life of such persons or the health or life of other persons, when restraints may only be used for the time strictly necessary."

C) Act no. 108/2006 on Social Services, As amended

22. The use of measures restricting the movement of persons is provided for in section 89:

"(1) Measures restricting the movement of persons being provided with social services may not be used in the provision of social services, except in cases of imminent danger for their own health or life or the health or life of other individuals, under the following conditions and only for the time strictly necessary and sufficient to avert the imminent danger for their own health or life or the life of other individuals.

(2) Measures restricting the movement of persons may only be used after other measures were unsuccessfully used to prevent such conduct of the person that presents a danger for their own health and life or the health and life of other individuals. Depending on the situation, the provider of social services must first try to calm down the situation verbally and use other methods to calm down the situation, e.g. divert their attention, distract them, or actively listen to them. The person must be informed in an appropriate manner that restraints may be used against them.

(3) The provider of social services must use the least restrictive measure when resorting to measures restricting a person's movement. Intervention can take place first by physical holds, then by placing the person in room designed for secure stay, or, upon the decision of a physician and in the physician's presence, by administering medicines.

(4) The provider of social services must provide social services in such a manner that the methods of providing them prevent situations in which it might be necessary to use measures restricting a person's movement.

(5) The provider of social services must inform the statutory representative or the legal guardian of the person being provided with social services, or the person who has custody of the minor if social services are being provided to a minor who has been placed in the custody of another person by the decision of a competent authority, or the individual designated by the person being provided with social services, subject to such individual's prior consent, without undue delay as soon as a measure restricting the person's movement has been used.

(6) The provider of social services must keep records of uses of measures restricting a person's movement (…)."

D) ACT NO. 349/1999 ON THE PUBLIC DEFENDER OF RIGHTS, AS AMENDED

23. The competence of the public defender of rights [= ombudsperson] are set out in section 1:

"(…)

(3) The Defender shall systematically visit places where persons restricted in their freedom by public authority, or as a result of their dependence on care provided, are or may be confined, with the objective of strengthening the protection of these persons against torture, or cruel, inhuman and degrading treatment, or punishment and other forms of ill-treatment.

(4) The competence of the Defender under subsection (3) above applies to

(…)

c) places where persons restricted in their freedom are or may be confined as a result of dependence on the care provided, in particular (…) health care facilities (…)"

24. The course of visits is provided for as follows:

"Section 15

(1) The Defender is authorised, with the authorities' heads being aware, to enter all of the authorities' premises even without prior notice in order to carry out an inquiry consisting of:

a) inspecting files,

b) interviewing the authorities' employees,

c) interviewing persons placed in the facilities, also without the presence of other persons.

(2) At the Defender's request, the authorities shall carry out the following within the time limit set by the Defender:

a) provide information and explanations,

b) submit files and other written materials,

c) provide their opinion in writing on the case as to the facts and as to the law,

d) take the evidence proposed by the Defender,

e) perform such supervisory actions to which they are authorised by the law and which the Defender suggests.

(3) The Defender is authorised to be present at meetings in person and during evidence taking by the authorities and to ask questions of the persons present.

(4) For the purposes of inquiry under the subsection above, a person authorised to this effect under a separate law shall, at the Defender's request, relieve the authority's individual employees of confidentiality obligation (…).

Section 16

All governmental bodies and persons exercising public administration are obliged, within their competence, to provide any assistance requested by the Defender during the Defender's inquiry.

(…)

Section 20

(…)

(2) If the authority fails to comply with the duty (…), or if the remedial measures are insufficient in the Defender's opinion, the Defender

a) shall inform the superior authority, or, if there is no such authority, the Government;

b) may inform the public of his or her findings, including disclosure of the first names and surnames of persons authorised to act on behalf of the authority.

(…)

Section 21a

(1) Sections 15 and 16 apply analogously to visits to facilities (...).

(…)

(3) After visiting a facility, after any associated visits to several facilities (…) the Defender shall draw up a report on their findings. The report may include recommendations and/or suggestions for remedial measures.

(4) The Defender shall request the facility to respond to the Defender's report, recommendations or suggestions for remedial measures within the time limit set by the Defender. The Defender may also request the same from the founder of the facility or the competent authorities. If the Defender finds their statements satisfactory, the Defender shall inform the facility or its founder, or the competent authorities accordingly. Otherwise, following receipt of the statement or expiry of the time limit to no effect, the Defender may proceed under section 20 (2) *mutatis mutandis*.

(5) In case of failure to comply with the co-operation duty under sections 15 and 16, the Defender may proceed under section 20(2)."

E) ACT NO. 89/2012, THE CIVIL CODE

25. The Civil Code provides for the protection of personal rights in the following provisions:

"Section 19

(1) Every individual has innate natural rights knowable by the very reason and feelings, and therefore is considered to be a person. A statute only provides for the limits of the application and the manner of the protection of the natural rights of individuals.

(2) Natural rights associated with the personality of an individual cannot be alienated and cannot be waived; should this occur, it is disregarded. The limitation of these rights to an extent contrary to the law, good morals or public order is also disregarded.

(…)

Section 81

(1) The personal rights of the individual, including all their natural rights are protected. Everybody is obliged to respect the free choice of an individual to live as they please

(2) Life and dignity of an individual, their health and their right to live in a favourable environment, esteem for them, and their honour, privacy and expressions of a personal nature shall enjoy particular protection.

Section 82

(1) An individual whose personal rights have been affected has the right to demand that the unlawful interference be ceased or its consequence remedied.

(2) After the death of an individual, the protection of their personal rights may be sought by any of their kith and kin.

(…)

Section 2951

(…)

(2) Non-pecuniary damage shall be redressed by just satisfaction. Satisfaction must be provided in money unless real and sufficiently effective redress for the damage incurred can be provided otherwise.

(…)

Section 2958

In the case of damage to health, the wrongdoer shall compensate the victim for such damage in money, fully compensating for the pain and other non-pecuniary damage suffered; if the damage to health resulted in an impediment to a better future for the victim, the wrongdoer shall also compensate the victim for the reduction in the amenities of life. Where the amount of compensation cannot be determined in this manner, it shall be determined under the principles of decency.

Section 2959

In the case of killing or particularly serious damage to health, the wrongdoer shall compensate the spouse, parent, child or other person of kith and kin for their mental suffering in money, fully compensating for their suffering. Where the amount of compensation cannot be determined in this manner, it shall be determined under the principles of decency.

Section 2960

The wrongdoer shall also reimburse the costs reasonably incurred in the care for the health of the victim and the care for the victim and their household to the person who incurred these costs; if such a person so requests, the wrongdoer shall provide them with an appropriate advance payment for these costs."

F) REGULATION NO. 99/2012 ON REQUIREMENTS FOR THE MINIMUM STAFFING OF HEALTH CARE SERVICES

26. On 22 March 2012, the Ministry of Health issued a regulation setting out the requirements for the minimum staffing of health care services. Annex 3 to that regulation lays down the staffing requirements for inpatient care. For psychiatry, it makes a distinction between standard acute inpatient care, follow-up inpatient care, and long-term inpatient care. The requirements are set for a 30-bed ward. Any staffing with health care and other professionals beyond these set requirements depends on the type and volume of health care provided, along with the field and range of procedures and activities carried out, so as to guarantee the quality, safety and availability of such care. This statutory instrument also establishes how staff numbers are to be adjusted if there are more or fewer than 30 beds.

G) Regulation no. 92/2012 on Requirements for the Minimum Technology and Equipment of Health Care Facilities and Home Care Contact Centres

27. On 15 March 2012, the Ministry of Health adopted a regulation setting out the minimum technology and equipment required at health care facilities. Inpatient care requirements are covered by Annex 4 to this statutory instrument. Patients' rooms must allow for at least 5 m^2 per bed, and the minimum area of a room itself must be 8 m^2. Each bed must have its own electricity supply and local lighting, and there must be a patient-nurse communication device in the room. The room must have direct daylight. Each room must have a washbasin, unless it is connected to a bathroom, shower or toilet equipped with a washbasin, and a dedicated area where ambulatory patients can eat their meals, unless there is a separate dining room. There must be sufficient space between the beds for staff to carry out their duties, for the patients to move, and for instruments, materials and the bed itself to be handled.

H) Methodological Measure of the Ministry of Health No. 31829/2004/OZP

28. This 2004 measure, regulating the use of patient restraints at psychiatric facilities in the Czech Republic, included, *inter alia*, the following:

> "The use of restraints must be treated as a last resort in cases where this is clearly necessary to protect the patient, other patients, objects around the patient, and the staff of psychiatric facilities. Recourse to restraints is only possible after the alternatives have been exhausted. Staff need to define why they are deciding to restrain the patient. Patients must not be restrained to make caring for them easier or simply because they are restless. In all cases, it is necessary to look for causes of problem behaviour, pain, discomfort, the side effects of medication, stress, a poor relationship between the caregivers and the patient, other illness, etc. The use of restraints may be warranted only if no remediable cause of the patient's behaviour can be identified or if the patient's behaviour is excessively risky. The benefit of using restraints must outweigh the risks they pose.
>
> 1. Means of restraint include holding patients in a closed unit, placing them in a safety bed (netted cage-bed), placing them in seclusion in a locked room, restricting their movement (with protective belts or straps), using protective equipment (straitjackets), tying them to their beds and other apt furniture (prams, pushchairs, or stretchers), and parenterally administering psychotropic drugs.
>
> 2. Restraints must be used sparingly and only if patients are a danger to themselves or their surroundings, not to discipline or reprimand them. The mildest possible restraint that is best suited to the particular patient must be used.
>
> 3. The use of restraints on voluntary patients is a reason to initiate the procedure under sections 23 and 24 of Act No. 20/1966 on Public Health Care, as amended, i.e. this is reported to a court within 24 hours, unless

the patient subsequently consents to such restrictions. If anyone is deprived of (or restricted in) legal capacity, consent is instead provided by their legal guardian within a reasonable time frame. If restraints are used on patients who are under the age of 18, the attending physician subsequently informs a parent or another statutory representative of this and solicits their consent.

4. As a matter of principle, it is a physician who decides that a patient is to be restrained. Only health professionals may use restraints. Health professionals who come into contact with restraints shall attend periodic training, which includes analyses of critical and model situations.

5. Patients who are being restrained must be checked regularly at defined intervals, care must be taken to avoid injury, dehydration, malnutrition, hypothermia and pressure ulcers, and they must be given the opportunity to attend to their personal hygiene and toiletry needs.

Use of restraints must be kept to as short a time as possible. Whenever checks are carried out, the need to keep using the restraints must be reassessed and, where appropriate, they should be replaced with less restrictive measures. The use of restraints is not, in itself, a reason to limit visits of the patient.

6. Restraints may be used for various types of patient restlessness (catathymic, predominantly psychogenic, states; for child psychiatry patients in cases of severe behavioural disorders associated with aggression towards themselves or others), including delirious (psychotic, toxic) and organic (ageing disorders, mental retardation) states. A physician decides on the use of restraints and is required to draw up a record that, in all cases, indicates: who took the decision to use restraints, the type of restraint, the reason for restraint, the time the patient was restrained, the time the restraint ended, how frequently health professionals and a physician checked up on the restrained patient, a description of the patient's physical and mental condition, and checks on the functions that need to be monitored. Health professionals are required to report any change in the patient's symptoms to a physician. Records of the use of restraints are subsequently checked and approved by chief physicians on their ward rounds.

7. Restrained patients are placed out of direct contact with other patients who have not been restrained.

8. If patients, once they have calmed down, are able to understand the purpose and reasons for their restraint, the attending physician shall discuss with them why they have been restrained, what made this necessary, and circumstances that may come before or lead to mechanical restraint in the future.

9. The patients at a facility are appropriately informed that restraints may be used.

10. In line with these principles, inpatient psychiatric facilities are recommended to draw up their own internal restraint rules that reflect their specific conditions."

I) METHODOLOGICAL MEASURE OF THE MINISTRY OF HEALTH NO. 37800/2009

29. A new measure issued in 2009 regulated the use of restraints at all types of health care facilities:

> "Article 1
>
> (1) The following means of restraint may be used to restrict the free movement of a patient in the provision of health care:
>
> (…)
>
> (c) the placing of the patient in a netted cage-bed;
>
> (…)
>
> (2) In the provision of health care, restraints may be used only if the purpose is to avert danger to the life, health or safety of the patient or others. The restraint applied must always be consistent with the purpose for using it, while posing the least possible risk to the patient.
>
> (3) Restraints may be applied only for as long as there is reason to use them.
>
> (4) Decisions on the use and type of restraints under paragraph (1) are taken by the attending physician or by the physician from the health care facility's emergency service who is present when a situation arises where restraint may be used under paragraph (2). In the absence of a physician, decisions on the use and type of a restraint may be taken by another qualified health professional who is present and who shall report the use of a restraint promptly to a physician, who shall immediately decide whether to keep the restraint in place or remove it.
>
> (5) If the patient is a minor or is deprived of legal capacity, it is recommended:
>
> (a) to notify the statutory representative of the use of a restraint under paragraph 1 (b) to (g);
>
> (b) for the purposes of making the notification under subparagraph (a), to obtain the statutory representative's position on whether they wish to be notified of such use;
>
> (c) to enter the statutory representative's position in the patient's medical records; this entry is signed by the health professional who made it and by the statutory representative.
>
> (6) Over the time that restraints are in place, health professionals must provide the necessary supervision consistent with the seriousness of the patient's medical condition, and measures must be taken to prevent damage to the patient's health.
>
> (7) If restraints are used for an extended period, patients – as far as their health allows – must be given the opportunity to attend to their personal hygiene and other personal needs (complying with the needs of nature, taking meals) without being impeded by restraints.
>
> (8) Any restraint (the reason for using it, the type of restraint, the start date and time and end date and time of use) and information on the pa-

tient's health during supervision is entered in the patient's medical records. Physicians must always record their decisions to use restraints, or on whether to continue or stop the use of restraints in instances where they are not informed of such use until after they have been applied.

Article 2

(1) It is recommended that records be kept of the use of restraints in the provision of health care (...).

(…)

Article 3

The directors of health care facilities providing inpatient care are recommended, in furtherance of the principles referred to in Articles 1 and 2, to draw up their own internal restraint rules that reflect the local conditions at their facility."

J) METHODOLOGICAL RECOMMENDATION OF THE MINISTRY OF HEALTH (PUBLISHED IN THE BULLETIN OF THE MINISTRY OF HEALTH NO. 11/2018)

30. On 20 April 2018, the Ministry of Health adopted a new methodological recommendation for inpatient care providers on the restriction of patients' free movement and the use of patient restraints:

"Article 1

(1) Restricting patients' free movement with the use of restraints in the provision of health care ("patient restraint") in order to avert a risk of imminent danger to the life, health or safety of the patient or others must be treated as a last resort and used only for as long as the reasons warranting such patient restraint persist. It is recommended that inpatient care providers ('providers') draw up a risk management plan for high-risk patients to prevent life-threatening situations as part of their individual treatment.

(2) It is inadmissible to use restraints as a means of prevention or punishment, nor as a measure to cope with operational inadequacies (e.g. if there is a lack of staff or if the camera system is not working).

(3) The selected type and scope of patient restraint must be consistent with the threat of injury.

(4) A restraint may be used in the provision of health care service if patients' behaviour is a direct danger to themselves or others.

(5) Patients may be restrained after a more moderate action – such as verbal intervention (de-escalation), an adjustment to the patient's surroundings, or the offer to administer a psychotropic drug or other medication to pacify the patient, and the actual administration thereof if the patient so consents – has proved unsuccessful. An exception is a situation where the application of more moderate actions would evidently not achieve the purpose set out in paragraph (1), in which case the next step must be to use the least restrictive restraint relative to the purpose thereof.

(6) A patient may be restrained by:

(…)

(c) placing the patient in a netted cage-bed; this restraint cannot be used at an alcohol recovery unit;

(…)

(7) Physicians deciding to restrain a patient under paragraph (6) must always opt for a restraint corresponding to the patient's behaviour that has prompted the restraint. In exceptional circumstances requiring urgent action, in the absence of a physician, decisions on the use and type of a restraint may be taken by a paramedical health professional who is qualified for that and is present; use of a restraint must be reported without undue delay to a physician, who will confirm the justifiability of the restraint and immediately decide whether to keep the restraint in place or remove it.

(8) The patient shall be informed of the reasons for the restraint and of the action that will be taken. It is recommended that the patient be kept informed on an ongoing basis of the reasons for the restraint and of the action that will be taken. If this is not possible, in particular in view of the patient's state of health, it is recommended that the patient be provided with this information in a therapy session immediately after the restraint is removed; an exception to this is when the patient is urgently transferred to another health care facility and a therapy session cannot be conducted.

(9) The provider notifies, without undue delay, the use of patient restraint under paragraph (6) (b), (c), (d) or (e) to the patient's legal guardian or statutory representative, and, where appropriate, a person referred to in section 42 of the Healthcare Services Act if the patient is a minor who has been placed in the care of a person or facility referred to in section 42 of the Act. If, under section 33 of the Healthcare Services Act, a patient who does not have a statutory representative or legal guardian designates a person to receive information about the patient's state of health, the health care service provider is recommended to include details on the use of a restraint, as referred to in the first sentence, when providing patient health information to the designated person. If explicitly requested by a patient upon being admitted to care or at any time during hospitalisation, the health care service provider shall inform the person designated under section 33 of the Healthcare Services Act about any use of a restraint referred to in the first sentence at all times. This request for the patient's designated person to be informed of the use of a restraint is entered in the patient's medical records.

It is recommended that these entries state: the date on which information is provided, how it is provided (by telephone, email, in person, etc.), the name of the person to whom the information is provided, that person's relationship with the patient (legal guardian, statutory representative, designated person, etc.), and the restraint that has been used. The entry is signed by a health professional and the legal guardian or statutory representative. It is recommended that the entry be presented to the legal guardian or statutory representative for signature the next time they visit the patient. When information is provided to a designated person or a person referred to in section 42 of the Healthcare Services Act, it is also recommended that the entry be presented to these persons for signature in the manner set out in the preceding sentence.

(10) The patient's free movement is restricted (a restraint is used) only for as long as the reason for such restriction (the reason for using the restraint) remains in place. Providers are recommended to have a physician reassess whether the grounds for using restraint remain in place after a maximum of:

(a) 3 hours if patients are restrained by protective belts or straps or if a protective jacket or vest preventing them from moving their upper limbs is used;

(b) 12 hours if patients are put in a safe room; and

(c) 12 hours if patients are placed in a netted cage-bed.

A slight departure from these time limits due to the way the ward is run or on account of specific circumstances is permissible. When the reasons for patient restraint no longer prevail, it is brought to an end by a physician or, in exceptional circumstances where unnecessary delay is best avoided, by a paramedical health professional who is qualified to do so. The physician subsequently confirms the restraint.

(11) For as long as they are restrained, patients shall be under the supervision of the provider's health professionals. The extent of this supervision depends on how serious the patient's health condition is. Patients put in a safe room, restrained by a protective jacket or vest preventing them from moving their upper limbs or by protective belts or straps, or placed in a netted cage-bed are under the continuous supervision of health professionals.

(12) Over the duration of their restraint, patients' hydration, meals, complying with the needs of nature, and hygiene are seen to, it is ensured that they are in conditions with a comfortable temperature and lighting, and measures are in place to prevent any complications arising from the restraint. Patients' health permitting, they should be allowed to attend to their personal hygiene and other personal needs unrestrained.

(13) While patients are restrained, no painful holds and no other inhumane procedure are permitted; patients' dignity and privacy must be respected. These patients are visually separated from, and must be protected from unwanted contact by, other patients. The mere fact that a patient has been restrained does not mean that they cannot have visitors.

Article 2

(1) The use of a restraint and the reasons for such restraint must be entered in the patient's medical records without undue delay.

(2) Regulation No. 98/2012 on medical records, as amended, provides that a record must contain:

(a) a record that restraint has been indicated, including a specification of the type, reason and purpose of the restraint, the intervals at which checks are to be conducted, and the scope of these checks;

(b) the times when the use of the restraint is started and ended;

(c) records of ongoing assessments as to whether the reasons for the use of the restraint remain in place;

(d) records of ongoing assessments of the patient's health while they are restrained;

(e) a description of any complications that arise;

(f) the full name of the health professional who indicated the use of the restraint and, if this health professional is not a physician, the full name of the physician who was subsequently informed of the use of the restraint;

(g) if the use of the restraint has not been indicated by a physician, a physician's record of the evaluation of the reasons for the restraint, including the time the physician confirmed this;

(h) information that the statutory representative of a minor patient or the legal guardian of a patient with restricted legal capacity has been notified of the use of a restraint.

(3) It is recommended that, in addition to the requirements set out in the regulation on medical records, any record of the use of a restraint that is entered in a patient's medical records include:

(a) a list of the more moderate actions taken before resorting to restraint, including the reasons why more moderate action could not be used;

(b) an indication of the sequence of the use of the restraints and justification if multiple forms of restraints are combined;

(c) the frequency of checks of the patient's blood pressure, pulse, state of consciousness, behaviour and complications arising from the restraint;

(d) a record that the patient has been informed of the need to apply the procedure;

(e) information that the person designated by the patient under section 33 of the Healthcare Services Act or the person referred to in section 42 of the Healthcare Services Act has been notified of the use of the restraint (see Article 1(9)).

(4) The use of restraints is also recorded, within 60 calendar days thereof, in a central register of the use of restraints kept by the provider in compliance with the Healthcare Services Act. Summary data on the number of cases in which restraints were used over the calendar year, broken down by the means of restraint, are maintained in the central register. Information identifying patients on whom restraints have been used is not entered in the central register.

Article 3

Providers of inpatient care are recommended to:

(a) draw up their own internal restraint rules that reflect the local conditions at their facility under sections 1 and 2;

(b) hold periodic training for the medical staff of workplaces where restraints are used; the provider devises training that reflects the nature of the work with, and the potential risks of, using restraints; health professionals must receive induction training when they are recruited, after which refresher training is provided at least once a year; the subjects recommended for the training of psychiatric health professionals are de-

escalation techniques, procedures ensuring that restraints are applied considerately, and basic self-defence."

K) Methodology of the Ministry of Health for Inspections on the Use of Restraints

31. On 1 July 2016, the Ministry of Health issued methodology for inspections on the use of restraints. According to that methodology:

"(…) regional authorities that have granted authorisation to provide health care services are entitled to inspect health care service providers in their administrative district in connection with the provision of health care services. (…)

Inspections may be initiated on the basis of a specific (albeit anonymous) complaint submitted to the regional authority under section 42 of the Code of Administrative Procedure or on the basis of an inspection plan drawn up under section 27 of the Code of Inspection Procedure. (…) The subject of an inspection is therefore compliance with conditions for the provision of health care services. (…) The absence of an administrative offence on the part of those involved in the use of restraints cannot be a reason to stop inspecting such use (…).

Although the regional authority will not always be able to inspect *ex ante* whether the use of restraints is legitimate, in its inspections it can (and should) verify and check the reasons for the continued use of a restraint and the supervision over a patient for whom the use of the restraint has been indicated. This should be based on its own observations, targeted interviews with staff, the patient concerned and other patients, and a check of the relevant medical records. To this end, it would be appropriate for the inspection team to include a physician who is competent to assess whether the use of a restraint is legitimate (see section 39(3)(d) of the Healthcare Services Act).

The regional authority should request the relevant written documents and use these as an initial basis to find out how the rules on the internal running of the health care facility are set in connection with the use of restraints. Although health care service providers are not required by the law to draw up internal rules on the use of restraints, they may have introduced them (it would be desirable for them to have done so, and the regional authority should make recommendations to this effect to health care service providers). If these rules do exist, they should be inspected to determine whether their content is consistent with the applicable legislation (especially section 39 of the Healthcare Services Act and the regulation on medical records) and with the methodological instructions and recommendations of the Ministry of Health.

For the inspection to proceed properly, a necessary sample of complete and original medical records should to be solicited. In order for the inspection to serve its purpose, there is no need to consult the medical records of all patients. If a health care service provider does not voluntarily keep its own central register of the use of restraints, the regional authority will have no choice but to select a controlled sample at random or on the basis of a selected criterion, e.g. patients born within a certain

> time span (such as seniors) or patients with a certain diagnosis, or according to a time-based criterion (patients treated during a particular period). In this respect, the use of restraints would be inspected on an *ad hoc* basis, i.e. in response to the chance finding of such an entry in the medical records. The frequency of the use of restraints will undoubtedly be influenced by the target group of patients (clients) of the health care facility, e.g. it will depend on whether this is an alcohol or drug recovery unit, a psychiatric hospital, etc. (…)
>
> An inspection always turns up findings that must be sufficiently described in an inspection report, with an indication of whether they have been found to be in breach of legal obligations and, if so, which legal provisions have been violated. The inspection report does not contain a holding on liability for any administrative offence because an inspection is not a vehicle for passing judgment on rights and obligations. A standard part of the inspection report is appendices documenting the inspection findings (e.g. copies of medical records, photographs from the place of the inspection, copies of employment contracts or job descriptions, copies of staff training documents, copies of internal rules or other internal guidelines relevant to the subject of inspection, copies of complaints, or data from the register of complaints lodged against and handled by the health care service provider, etc.). Besides identifying the inspectors and the representative acting on behalf of the inspected entity, the inspection report also lists the 'liable persons' (see also the inspectors' authorisation to establish the identity of persons at the inspection site under section 8(a) of the Code of Inspection Procedure)."

L) METHODOLOGICAL MEASURE OF THE MINISTRY OF LABOUR, SOCIAL AFFAIRS AND FAMILY ON THE PROCEDURE FOR THE USE, IN EXCEPTIONAL CASES, OF NET-BEDS AT SOCIAL SERVICE FACILITIES

32. On 28 June 2004, the Ministry of Labour, Social Affairs and Family issued a methodological measure to unify the procedure for the use, in exceptional cases, of net-beds at social service facilities and to protect human rights and freedoms. The provisions laid down by the methodological measure included:

> "(…)
>
> II The use of metal-bar cage-beds is not permitted at social service facilities.
>
> III Net-beds may be used only in exceptional circumstances where the health and life of the client or another person is in danger, and only for as long as is strictly necessary and in strict compliance with the registration rules set out in points V and VI of this methodological measure.
>
> IV These beds must not be used for behavioural training, to change a client's behaviour, or to make the work of the staff easier."

M) METHODOLOGICAL OPINION OF THE MINISTRY OF HEALTH FOR THE INVESTIGATION OF COMPLAINTS AGAINST THE PROVIDER'S PROCEDURE IN THE PROVISION OF HEALTH CARE SERVICES OR AGAINST ACTIVITIES RELATED TO HEALTH CARE SERVICES (REF. NO. MZDR 4610/2020-1/PRO)

33. On 21 October 2020, the Ministry of Health issued a methodological opinion providing a legal interpretation for the investigation of complaints against the provider's procedure in the provision of health care services or against activities related to health care services. The opinion is based, inter alia, on the official activities and opinions of the Public Defender of Rights and on the case law of national courts. Its objectives are to acquaint the relevant administrative authorities with the legal interpretation of the Ministry of Health of the relevant legislation and to prevent possible shortcomings in the procedure of administrative authorities in resolving such complaints.

THE LAW

34. The complainant claims that using net-beds at psychiatric facilities amounts to a violation of the right to protection of health protected under Article 11 § 1 of the European Social Charter ("the Charter") and the right of elderly persons to social protection under Article 4 § 3 of the 1988 Additional Protocol ("the Protocol").

35. Article 11 § 1 of the Charter reads as follows:

> "With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:
>
> 1. to remove as far as possible the causes of ill health, (…)."

36. Article 4 § 3 of the Protocol reads as follows:

> "With a view to ensuring the effective exercise of the right of elderly persons to social protection, the Parties undertake to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed in particular:
>
> (…)
>
> 3. to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution."

ALLEGED VIOLATION OF ARTICLE 11 § 1 OF THE CHARTER AND ARTICLE 4 § 3 OF THE PROTOCOL

37. The complainant claims that although net-beds constitute one of the forms of ill-treatment, they are still used in the Czech Republic as legally approved

means of restraint at least at eleven psychiatric facilities. According to the complainant, the use of net-beds causes severe deprivation of personal liberty; great psychological pressure exerted upon the person; restraint and seclusion which worsens of the individual's mental health; humiliation; and often deprivation of food and water.

38. Given that the claims under both Articles have the same basis the Government shall present shared arguments, within which they shall express their opinion on specific aspects related to the individual rights.

A) GENERAL ARGUMENTS ARISING FROM INTERNATIONAL DOCUMENTS

(i) International obligations under the Charter and the Protocol

39. The right to protection of health under Article 11 of the Charter imposes a range of positive and negative obligations on the States. According to the Committee, the title of the article – "the right to protection of health" – makes clear that States' obligations under that provision are not solely limited to ensuring enjoyment of the right to benefit from any positive, proactive state measures enabling enjoyment of the highest possible standard of health attainable (such as ensuring equal access to quality health care). Nor are States' duties limited to the taking of those measures highlighted in Article 11 of the Charter. Rather, the notion of the protection of health incorporates an obligation that the State refrain from interfering directly or indirectly with the enjoyment of the right to health. According to the Committee, this interpretation of Article 11 is consistent with the legal protection afforded by other important international human rights provisions related to health (*Transgender Europe and ILGA Europe v. the Czech Republic*, no. 117/2015, decision of 15 May 2018, § 79).

40. As follows from the Committee's Interpretative Statement on Article 11 of the Charter, this right is closely related to the protection of human dignity and in that regard it complements the right to life under Article 2 and prohibition of inhuman or degrading treatment under Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms (Committee Conclusions 2005, Interpretative Statement on Article 11).

41. When assessing compliance with the obligations under Article 11 of the Charter the Committee takes into account reports of other human rights institutions monitoring the situation at psychiatric facilities, for example reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment ("the CPT") (Committee Conclusions 2005 on Article 11 § 1 of the Charter, Romania, 2005/def/ROU/11/1/EN).

42. In 2013, the Committee reviewed compliance with the Czech Republic's obligations under Article 11 § 1 of the Charter in the monitoring period from 1 January 2008 to 31 December 2011, and concluded that the Czech Republic complied with its obligations under Article 11 § 1 of the Charter (Committee Conclusions XX-2 of 6 December 2013 on Article 11 § 1 of the Charter, no. XX-2/def/CZE/11/1/EN).

43. Article 4 § 3 of the Protocol protects the right of elderly persons to social protection. This provision imposes an obligation on a State to adopt or encourage, either directly or in co-operation with public or private organisations, appropriate measures designed to guarantee elderly persons living in institutions appropriate support, while respecting their privacy, and participation in decisions concerning living conditions in the institution.

44. Article 4 § 3 of the Protocol includes, *inter alia*, the right to human dignity, right to appropriate care and services and the right to file complaints regarding acts or stay in an institutional facility [Committee Conclusions 2003, Slovenia (Article 23) and Committee Conclusions 2003, France (Article 23)]. When reviewing compliance with obligations under Article 4 § 3 of the Protocol the Committee also deals with conditions for the use of means of restraint.

45. When reviewing compliance with obligations under Article 4 of the Protocol in the period from 1 January 2008 to 31 December 2011 the Committee concluded that the Czech Republic had not complied with its obligations but only due to the level of the minimum pension having been manifestly inadequate and to insufficient protection against discrimination on grounds of age (Committee Conclusions XX-2 of 6 December 2013 on Article 4 of the Protocol, no. XX-2/def/CZE/23/EN).

46. Some of the rights under the Charter, including some of the components of the right to protection of health, are expected to be implemented progressively, in particular where the achievement of one of the rights in question is exceptionally complex and particularly expensive to resolve. Even in those cases the rights must be achieved within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources [*International Association Autism-Europe v. France*, no. 13/2002, decision of 4 November 2003, § 53; *Marangopoulos Foundation for Human Rights (MFHR) v. Greece, no.* 30/2005, decision of 6 December 2006, § 204].

(ii) International obligations under the Convention for the Protection of Human Rights and Fundamental Freedoms

47. The use of means of restraint may amount to ill-treatment within the meaning of Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention"). In order for ill-treatment to fall within the scope of Article 3 it must attain a minimum level of severity. The assessment of this minimum is, by the very nature of the matter, relative and depends on all the circumstances of the case, such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim. Further factors include the purpose for which the treatment was inflicted together with the intention or motivation behind it, as well as its context, such as an atmosphere of heightened tension and emotions (*Gäfgen v. Germany*, no. 22978/05, judgment [GC] of 1 June 2010, § 88).

48. As regards restraining belts the European Court of Human Rights ("the Court") has held that aggressive behaviour of an individual may require

recourse to the use of restraining belts, provided that checks are periodically carried out on the welfare of the individual so immobilised. Moreover, the use of such restraining measures must be necessary in the light of the circumstances and the duration of their use may not be excessive (*Wiktorko v. Poland*, no. 14612/02, judgment of 31 March 2009, § 55). Physical restraints can be used only exceptionally, as a matter of last resort and when their application is the only means available to prevent immediate or imminent harm to the patient or others and must be proportionate to such an aim (*Bureš v. the Czech Republic*, no. 37679/08, judgment of 18 October 2012, §§ 95 to 96).

49. The Court considers that the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with. It is for the medical authorities to decide, on the basis of the recognised rules of medical science, on the therapeutic methods to be used, if necessary by force, to preserve the physical and mental health of patients who are entirely incapable of deciding for themselves and for whom they are therefore responsible. The established principles of medicine are admittedly in principle decisive in such cases; as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist (*Herczegfalvy v. Austria*, no. 10533/83, judgment of 24 September 1992, § 82).

50. The States are also required to make regulations compelling hospitals, whether public or private, and social services facilities to adopt appropriate measures for the protection of their patients' and clients' lives (*Calvelli and Ciglio v. Italy*, no. 32967/96, judgment [GC] of 17 January 2002, § 49; and *Nencheva v. Bulgaria*, no. 48609/06, judgment of 18 June 2013, § 111).

51. In the context of health and social services the Court has only expressed its opinion on the use of restraining belts [e.g. *Bureš v. the Czech Republic*, cited above; or *M.S. v. Croatia (no. 2)*, no. 75450/12, judgment of 19 February 2015]. It has not examined the compatibility of the use of net-beds with Article 3 of the Convention.

(iii) International obligations under revised CPT standards

52. Revised standards from 2017 [revised CPT standards of 21 March 2017, Means of restraint in psychiatric establishments for adults, CPT/Inf(2017), "the standards"] govern the use of means of restraint in psychiatric establishments for adults. In exceptional cases the standards allow the use of means of restraint if necessary (Article 1.1). Article 1.2 emphasises that means of restraint should always be applied in accordance with the principles of legality, necessity, proportionality and accountability.

53. Article 1.4 of the standards accentuates the *ultima ratio* principle, i.e. that the use of means of restraint must be used only as a measure of last resort and that restraints must be used for the shortest possible time.

54. As regards the use of net-beds, under Article 3.4 of the standards the States should prohibit their use completely.

55. In the report of 4 July 2019 on the visit to the Czech Republic from 2 to 11 October 2018 [CPT/Inf (2019) 23], the CPT notes, *inter alia*:

> "The CPT urges the Czech authorities to take the necessary steps, including on legislative level, to implement without further delay the Committee's long-standing recommendation to withdraw from service all net-beds in psychiatric hospitals in the Czech Republic (§ 106)."

56. In their response [CPT/Inf (2019) 34] to the CPT report, the Government noted, *inter alia*:

> "In an amendment to the Healthcare Services Act which is being prepared, the Ministry of Health plans to abolish the option of using net-beds as a means of restraint."

57. The Government provide details on the developments following that statement in § 117.

(iv) International obligations under the Convention on Human Rights and Biomedicine

58. Article 7 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine provide for the protection of people with a mental disorder:

> "Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health."

(v) Recommendation of the Committee of Ministers to member States Rec(2004)10 concerning the protection of the human rights and dignity of persons with a mental disorder

59. Article 27 governs seclusion and use of means of restraint and provides:

> "1. Seclusion or restraint should only be used in appropriate facilities, and in compliance with the principle of least restriction, to prevent imminent harm to the person concerned or others, and in proportion to the risks entailed.
>
> 2. Such measures should only be used under medical supervision, and should be appropriately documented.
>
> 3. In addition:
>
> i. the person subject to seclusion or restraint should be regularly monitored;
>
> ii. the reasons for, and duration of, such measures should be recorded in the person's medical records and in a register.
>
> 4. This article does not apply to momentary restraint."

(vi) Net-beds as viewed by the UN convention institutions

60. The right to health is protected also by Article 12 of the International Covenant on Economic, Social and Cultural Rights. The UN Committee on Economic, Social and Cultural Rights, in its General Comment No. 14 on the right to health (E/C.12/2000/4), similarly as the Committee, connects the right to health with human dignity (§ 3). The obligation to respect the right to health is interpreted as including a State's obligation to refrain from applying coercive medical treatments, unless on an exceptional basis for the treatment of mental illness. Such exceptional cases should be subject to specific and restrictive conditions, respecting best practices and applicable international standards (§ 34).

61. The right to health is to be realised progressively, but immediate effect applies to non-discrimination, the obligation to take steps towards the progressive realisation and the obligation to ensure the minimum essential levels of the right and the obligations to respect and protect (§§ 30 and 31; also the report by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health of 11 August 2014, A/69/299, § 10).

62. Although the UN Committee on Economic, Social and Cultural Rights has not expressed its opinion on the use of net-beds, their use was negatively viewed by several UN convention institutions, namely the UN Committee against Torture [Concluding observations on the sixth periodic report of Czechia of 6 June 2018, CAT/C/CZE/CO/6, §§ 32 and 33 (c)] and the UN Human Rights Committee (Concluding observations on the fourth periodic report of Czechia of 6 December 2019, CCPR/C/CZE/CO/4, § 26). Both committees recommended prohibiting their use.

(vii) Conclusion on implications of Article 11 § 1 of the Charter and Article 4 § 3 of the Protocol, as interpreted in the light of other international instruments, on the use of net-beds

63. The Government would note that the above summary of international human rights law shows that Article 11 § 1 of the Charter and Article 4 § 3 of the Protocol must be interpreted to the effect that the use of means of restraint at psychiatric facilities is possible if the following conditions are met:

- Legality, i.e. the use of means of restraint is governed by law,
- Necessity, i.e. the means of restraint must be used as *ultima ratio* and it must be used for the shortest possible time,
- Proportionality, i.e. preference given to the least restraining and least harmful measure, and
- Accountability, i.e. each restraint must be recorded.

64. The manner and methods of health care provision at psychiatric facilities, including the use of means of restraint, as a component of the right to protection of health and the right of elderly persons to social protection are subject to progressive

realisation. The State is obliged to take measures towards the full realisation of both rights with measurable progress and to an extent consistent with the maximum use of available resources.

65. As discussed in detail below, the Government closely observe the developments in medicine and the developments in international law as regards the use of means of restraint and they react to both within reasonable time. The Government pay due attention to the issue and they consistently seek to improve the conditions of care at psychiatric facilities.

66. As regards specifically the use of net-beds and the view of this issue, the Government refer to the opinion of an expert society mentioned below (see § 112 below), that with the above principles being followed, even the use of a netted cage-bed can be the most appropriate and least restrictive measure for the patient. In the Government's opinion it is therefore not possible to find support in medical findings for the complainant's assertion that in all cases the use of netted cage-bed amounts to ill-treatment within the meaning of Article 3 of the Convention, violation of the right to protection of health protected under Article 11 § 1 of the Charter and violation of the right of elderly persons to social protection under Article 4 § 3 of the Protocol.

67. Nevertheless, the Government are aware of the constantly evolving international *soft law*, which especially since 2017 (see §§ 54 and 62 above) urges to refrain from using net-beds as means of restraint at psychiatric facilities.

68. On the other hand, the Government also refer to the fact that the Court has not yet had an opportunity to express its opinion on the use of net-beds.

69. Moreover, not even the Committee has expressed an opinion specifically on the use of net-beds, although it has had an opportunity.

When reviewing the Czech Republic's compliance with obligations under Article 11 § 1 of the Charter and Article 4 of the Protocol (see §§ 42 and 45 above) the Committee did not consider the issue of net-beds.

The Committee opted for a similar approach in 2017 for the 2012 to 2015 monitoring period in the cases of Slovakia (Committee Conclusions 2017 of 8 December 2017 on Article 23 of the revised Charter, no. 2017/def/SVK/23/EN), Austria (Committee Conclusions 2017 of 8 December 2017 on Article 11 §1 of the revised Charter, no. 2017/def/AUT/11/1/EN) and Hungary (Committee Conclusions 2017 of 8 December 2017 on Article 11 §1 of the revised Charter, no. 2017/def/HUN/11/1/EN), i.e. countries in which net-beds have been or are still used.

70. In the Government's opinion it is therefore not possible to find support in international law for the conclusion that the use of net-beds amounts in all circumstances to ill-treatment within the meaning of Article 3 of the Convention, violation of the right to protection of health protected under Article 11 § 1 of the Charter and violation of the right of elderly persons to social protection under Article 4 § 3 of the Protocol. On the contrary, as late as 2017 the Committee did not express an opinion against the use of net-beds.

71. Therefore the Government believe that Article 11 § 1 of the Charter and Article 4 § 3 of the Protocol cannot be interpreted as prohibiting, without any exceptions, the use of net-beds in 2020 or 2021 in some psychiatric facilities to a limited extent and under strictly defined conditions. In the Government's opinion, the State's obligation regarding the use of net-beds under those two provisions is that the State has to monitor the development of medical science and international law and has to react to them within a reasonable time and thus strengthen the fulfilment of the two rights protected by those provisions (see, *mutatis mutandis*, in obstetrics, *Dubská and Krejzová v. the Czech Republic,* nos. 28859/11 and 28473/12, judgment [GC] of 16 November 2016, § 189).

72. The Government are convinced that they comply with those obligations under the Charter and the Protocol thereto and are achieving measurable progress in this domain in a reasonable time. In the following parts of these observations the Government show in detail how—while considering the evolution of international law and medical science—they have continuously amended the regulations on and the practice in the use of means of restraint for the purpose of strengthening patients' rights to protection of health and elderly persons' rights to social protection and to boost safeguards against any negligence or abuse in the use of restraints. As early as 2007 that development resulted in the prohibition of the use of net-beds in social service facilities and in 2020 in a proposal for the prohibition of their use in health care facilities, which is now being debated.

B) ON THE EVOLUTION OF THE LEGISLATION

(i) Abolishing metal-bar cage-beds and net-beds in social care facilities

73. In response to international criticism regarding the use of metal-bar cage-beds (report of the Mental Disability Advocacy Centre[2] NGO and an appeal by the British author J. K. Rowling[3]) and net-beds [Report for the Government of the Czech Republic on the visit to the Czech Republic by the CPT from 21 to 30 April 2002, 12 March 2004, CPT/Inf (2004) 4, § 128], the Ministry of Labour, Social Affairs and Family issued in 2004 a methodological measure on the use of net-beds (see § 32 above), in which it prohibited the use of metal-bar cage-beds and limited the use of net-beds to exceptional cases only. Those were cases where the health and life of the restrained person was in danger and their use was always limited to the shortest time necessary. The methodological measure also introduced an obligation to record the use.

74. Further modification of the use of means of restraint in social care facilities took place in 2005 when the Act on Social Security was amended (see § 21 above). The use of measures restraining the movement of persons placed in those

[2] MDAC. Cage beds. *Inhuman and degrading treatment or punishment in four EU accession Countries* [online]. Budapest: MDAC, 2003, 62 pages. Available at: http://www.mdac.org/sites/mdac.info/files/English_Cage_Beds.pdf

[3] BBC NEWS. Rowling lambasts Czech caged beds [online] 2004. Available at: http://news.bbc.co.uk/2/hi/europe/3891189.stm

facilities was declared impermissible, except where necessary due to imminent danger to the health or life of those persons or the health or life of other persons, in which case restraints could be used for the time strictly necessary.

75. In 2007, the Act on Social Services came into force (see § 22 above), which completely abolished the use of metal-bar cage-beds and net-beds in social service facilities. The Act also laid down strict conditions under which it is possible to interfere with personal liberty of clients of social service facilities. The Act emphasised that restraints may be applied only in cases of imminent danger to their own health or life or the health or life of other persons, such being only for the time strictly necessary and sufficient to avert the imminent danger to their health or life. The Act provides for the obligation to use the least restrictive measure, but only when the use of verbal calming down, diversion of attention, effective active listening or distraction was not effective and the restricted person was informed. As regards the hierarchy of means of restraint, the Act lays down that at first it is possible to use physical holds and only then place the person into a room designed for secure stay, or upon the decision of a physician and in the physician's presence to administer medicines.

76. Compliance with section 89 of the Act on Social Services is monitored by inspectors of social service provision and violation of that section with the use of means of restraint contrary to the law is considered to be a minor offence for which a fine of up to CZK 250,000 (approximately EUR 9,144) can be levied.

(ii) Evolution of regulations governing the use of metal-bar cage-beds and net-beds in psychiatric facilities

77. Further to the international criticism mentioned above (see § 73 above), in 2004 the Ministry of Health issued an instruction to withdraw immediately all metal-bar cage-beds found in psychiatric facilities.

78. The first methodological measure aimed at psychiatric care was issued in 2005 (see § 28 above).

79. In 2009, the Ministry of Health adopted the second methodological measure (see § 29 above).

80. On 1 April 2012, the Healthcare Services Act came into force. It also provided for the use of means of restraint (see § 8 above). Section 39 contained a closed list of permitted types of means of restraint, including placing the patient in a netted cage-bed, and laid down the conditions of their use, specifically the condition of necessity, i.e. that they are applied only for as long as necessary, and the condition of legitimate aim, i.e. that the aim is only to avert imminent danger to the life, health or safety of the patient or other persons. The Act also imposed an obligation on healthcare facilities to inform the patient about the reasons for the use of the restraint and to inform the patient's statutory representative. The patient's movement could be restrained only where indicated by a physician, but for exceptional cases provided for in section 39(3)(d) of the Healthcare Services Act (see § 8 above). During restraint, the patients had to be under the supervision of

health professionals and measures had to be taken to prevent damage to the patients' health. Another obligation was to keep records of individual uses of restraints. Where the patient's movement was restricted during treatment the health care provider was obliged to notify the court within 24 hours.

81. On 14 March 2013 and 1 January 2014, two amendments to sections 39 and 40 of the Healthcare Services Act came into force. They lifted the obligation to notify the court of the patient's restraint when the patient consented to restraint within 24 hours from the use of the means of restraint (see § 13 above), and extended the range of persons informed to include the legal guardian (see § 16 above).

82. On 31 May 2017, an extensive amendment to the Healthcare Services Act came into force (see § 19 above), which reacted to the judgment in the case of *Bureš v. the Czech Republic* (cited above) in which the Court held that Article 3 of the Convention had been violated on the ground of the way, conditions and progress of the use of restraining belts on the applicant at an alcohol recovery unit. The amendment prohibited the use of net-beds in alcohol recovery units. It also made the conditions for the use of means of restraint more stringent when it laid down that the selected restrictive measure had to be used only as a measure *ultima ratio* and that the least restrictive measure had to be used given the circumstances of the case. The amendment extended the range of the information that was recorded in the records of the use of restraint to include the reason for its use and also imposed an obligation on all providers to keep central records of the use of restraints, stating the numbers of uses of the restraint. This wording of the provisions concerned is still in force.

83. The adoption of the third methodological recommendation of the Ministry of Health on 20 April 2018 was crucial (see § 30 above). The recommendation elaborates on the statutory provisions and sets out the details of the process of applying means of restraint. It is recommended to inpatient care providers to draw up a risk management plan for high-risk patients to prevent life-threatening situations. The recommendation emphasises that means of restraint cannot be used as a means of prevention or punishment, not even due to operational inadequacies such as lack of staff or the camera system not working. As regards information given to the patient, the recommendation specifies that if it is not possible to inform the patient on an ongoing basis about the reasons for restraints due to his health, the patient shall receive the information immediately after the restraint is removed in the form of a therapy session.

The recommendation also specifies the maximum duration of restraint; in cases of net-beds it is 12 hours from the placement, and at the end of this period a physician must reassess the grounds for the continued use of the means of restraint.

The recommendation, similarly as the statutory provisions, emphasises the need for supervision by health professionals while in the case of net-beds the supervision must be continuous. Over the duration of the restraint the patient's personal needs, and also thermal and light comfort and prevention of any complications are attended to. The recommendation emphasises that personal

hygiene and other personal needs are performed outside the netted cage-bed if the patient's health condition allows.

It is prohibited to apply inhumane practices when using restraints and it is necessary to respect the patient's dignity and privacy; therefore the patient should be visually separated from other patients and protected from unwanted contact by other patients.

The methodology specifies more precisely the record keeping and it also recommends to the facilities to draw up their own internal rules and to train the healthcare staff regularly.

(iii) Control mechanisms

84. The Government would further note that individual remedies using which the patient can contest unlawful use of means of restraint, and forms of supervision and other control mechanisms monitoring the situation in psychiatric facilities were introduced into the legal order. They both constitute important guarantees against any negligence or abuse of the restraints.

a) Individual remedies

Complaint

85. Persons who were placed in a netted cage-bed can lodge a complaint against that placement under sections 93 *et seq*. of the Healthcare Services Act (see §§ 10 and 33 above). The complaint can also be lodged by the patient's statutory representative, legal guardian, a person authorised by the patient, or a person of kith and kin. In that regard it must be emphasised that the statutory representative and legal guardian are informed without undue delay about the placement in a netted cage-bed (see § 8 above). The health care provider must publish the information on the possibility of lodging complaints in a publicly accessible place in the psychiatric facility and on its website (see § 10 above).

86. The complaint must be considered within 30 days of the date of its receipt. If the complainant disagrees with the manner the complaint was handled, they can lodge a complaint with the competent administrative authority (see §§ 10 and 33 above).

87. In case of doubts as to compliance with the proper procedure in the provision of health care services or in the event that personal injury to the patient is claimed and the complaint is not manifestly ill-founded, an independent expert is appointed. The expert can propose the appointment of an independent expert panel, or the panel can be appointed in cases in which the expert does not possess sufficient expertise. The panel must be appointed always for assessment of whether the patient's death resulted from personal injury, provided that the complaint is not manifestly ill-founded. The administrative authority must handle the complaint within 30 days, or 90 days if an independent expert is appointed, or 120 days in cases that are referred to an expert panel.

88. Where the administrative authority finds errors, it orders the provider to adopt remedial measures, including the time limit for compliance, or it files a report with the competent chamber to initiate disciplinary proceedings.

Action for the protection of personal rights

89. A person against whom means of restraint, including a netted cage-bed, was used can bring an action for the protection of personal rights if they believe that this was an unlawful interference with their dignity or personal liberty, seeking through the action that such interference be ceased and the consequences of the interference be eliminated, including the award of pecuniary satisfaction. In this action it is also possible to seek compensation for any personal injury or death caused by the use of means of restraint, including netted cage-bed (see § 25 above).

b) Supervision and other control mechanisms

Supervision

90. Under the Healthcare Services Act the regional authorities are competent to inspect health care providers and thus check their compliance with the conditions for the provision of health care services. The overseeing authority verifies and checks the reasons for the use of means of restraint using its own observations, structured interviews with the staff, the patient concerned or other patients, and inspection of relevant medical records; the authority also checks whether the patient for whom the use of means of restraint was indicated was supervised. The outcome of checks is recorded in findings, in which the authority can hold a violation of regulations and impose remedial measures.

National preventive mechanism

91. The public defender of rights (ombudsperson) has the role of a national preventive mechanism (see §§ 23 and 24 above) and therefore visits psychiatric facilities as well. For that purpose the defender has a wide range of powers (see § 24 above). After visiting a facility the defender draws up a report in which it informs about their findings and they can also formulate recommendations or propose remedial measures. The facility concerned is invited to provide observations on the report and should the defender find the response insufficient they inform a superior authority or the public. The defender proceeds in the same way in cases where the facility does not respond to the report and recommendation or where it did not comply with its obligation to co-operate.

92. To date, the public defender of rights has carried out dozens of visits to psychiatric facilities and published reports on those facilities on its website.[4]

[4] https://www.ochrance.cz/?id=102650

(iv) Conclusion

93. It is evident from sub-paragraphs (i) to (iii) that the regulations governing the use of means of restraint have undergone considerable development since 2004, reflecting the evolution of both international law and the medical science.

94. In health care services, the use of means of restraint is currently provided for in a law and the specifics are set out in detail in methodological recommendations of the Ministry of Health. The statutory provisions include a closed list of permitted means of restraint and impose strict conditions for their use, namely the principle of necessity in section 39(2)(a) and (b) of the Healthcare Services Act and the principle of subsidiarity and proportionality in section 39(2)(c) of the Healthcare Services Act.

95. Another important obligation is that to inform the patient about the reasons for the restraint and the further steps and also to inform the patient's statutory representative, or legal guardian. The methodological recommendation also emphasises that it is impermissible to use means of restraint as a form of punishment or as a preventive measure. The psychiatric facility must keep records of each individual restraint and if the patient does not give sufficient consent, the facility must notify the court of such restraints.

96. Moreover, the law regulates the numbers of health professionals who must be present in psychiatric facilities and also sets their minimum technology and equipment (see §§ 26 to 27 above). The purpose of setting these standards is, *inter alia*, to minimise the need to resort to the use of means of restraint.

97. In addition, the currently debated amendment to the Healthcare Services Act removes net-beds from the list of permissible means of restraint in health care facilities (see § 117 below).

98. Patients who were placed in a netted cage-bed contrary to the regulations have an opportunity to contest the placement. There are also regular inspections of and visits to psychiatric facilities.

99. In social services, metal-bar cage-beds and net-beds were abolished. Similarly as in the case of health care facilities there has also been considerable progress in the regulations governing the use of other means of restraint.

100. Therefore the Government are convinced that at present, the legal order sufficiently regulates the conditions for the use of means of restraint and thus it complies with Article 11 § 1 of the Charter and Article 4 § 3 of the Protocol. In the Government's opinion the above described evolution illustrates the progressive realisation of the right to protection of health and the right of elderly persons to social protection (see §§ 46 and 62) within a reasonable time.

C) RELEVANT DOMESTIC PRACTICE

101. The facts described in the collective complaint rely in part on data gathered by the complainant further to written requests for information (Annex no. 1 to

the collective complaint), and in part on information gathered during visits to psychiatric facilities conducted by the complainant (section II.C of the collective complaint): the Kosmonosy Psychiatric Hospital (§§ 23–24, 34–36 and 39 of the collective complaint), the Opava Psychiatric Hospital (§§ 25–28 and 38 of the collective complaint), the Bohnice Psychiatric Hospital (§ 29 of the collective complaint), the Lnáře Psychiatric Hospital (§ 30 of the collective complaint), the Opařany Children's Psychiatric Hospital (§ 31 of the collective complaint) and the Klatovy Hospital's Psychiatric Department (§§ 32–33 and 37 of the collective complaint).

102. The Government note that the visits to these facilities were conducted in 2013 and 2014, i.e. six to seven years ago. In this respect, the Government note that since the complainant's visits, the legislation governing the use of restraints has significantly progressed (see §§ 82 and 83 above). The Government also note that practice has also significantly moved forward, as to-date four[5] out of the six psychiatric facilities are no longer using any net-beds. Although in 2019 the Lnáře Psychiatric Hospital still had three net-beds, they were not used a single time in that year.

103. Thus, the complainant's allegations of facts as to the conditions and the practice in these psychiatric settings are no longer true to a large extent and do not reflect the current developments in the law and the significant progress made at most of these facilities.

104. The Government value the activities of the complainant organisation as a representative of the civil society in this domain and consider its activities to be an important form of public control over the conditions in psychiatric settings. The patients' testimonies, as narrated in the collective complaint, are very serious, but the Government consider it to be necessary to emphasise that the reliability thereof cannot be verified as they mostly do not rely on facts established by a court of law, or by monitoring bodies such as the CPT or the ombudsperson. Although the collective complaint does in part rely on the CPT report, these are conclusions from a visit conducted in 2014 (§§ 24 and 25 of the collective complaint). Moreover, these allegations only refer to two facilities (the Kosmonosy Psychiatric Hospital and the Dobřany Psychiatric Hospital), that have both ceased using net-beds.

105. As to the statistical data presented by the complainant in Annex no. 1 to the collective complaint the Government note that some of these figures are outdated or inaccurate (see §§ 4–6 above). The Government therefore consider it to be more relevant to refer to current data presented in the Enclosure herewith.

106. As follows from the enclosed data, out of 46 inpatient psychiatric facilities 32, i.e. the vast majority (70%) do not have any cage-beds at all.

107. It should also be emphasised that out of 14 facilities that do have them, three do not use the net-beds: in the Lnáře Psychiatric Hospital and in the Alber-

[5] The Kosmonosy Psychiatric Hospital, the Opava Psychiatric Hospital, the Bohnice Psychiatric Hospital, and the Opařany Childrens' Psychiatric Hospital

tinum psychiatric ward no restraint took place in 2019 and in the Psychiatric Hospital in Písek the netted cage-bed has not been used at all during the monitored period. Thus, net-beds have been used by less than a quarter (24%) of the psychiatric facilities.

108. In 11 facilities that have net-beds and use them, their numbers differ. The data collected shows that the majority of facilities have less than four net-beds and half of them have less than three.

109. As to the reduction in the numbers of net-beds, three out of the nine facilities that have cage-beds and provided the Government with data for the period from 2017 to 2019, or 2020, have reduced their number. In none of the remaining six facilities has the number of net-beds increased during the period.

110. As to the number of uses, out of the 11 facilities that continue using net-beds, four have reduced the number of uses,[6] in five facilities, the trend could not be determined; during the monitored period, in one year the number rose and in another year it declined. Only in two facilities did the number of uses rise during the monitored period.[7] In one of them, the Liberec Regional Hospital, the rise was very small; a netted cage-bed was used once in two months on average.

111. In the Government's view, the above shows that the number of net-beds and the number of their uses are gradually being reduced.

D) NET-BEDS FROM MEDICAL DOCTORS' PERSPECTIVE

112. According to the Psychiatric Society of the Czech Medical Association of J. E. Purkyně, a professional society of medical doctors, pharmacists and other personnel of health care and related fields working towards the development of psychiatry, net-beds are used for patients with cognitive disorders during disorientation episodes and unrest in the evening and during night time, usually as part of adaptation difficulties at the beginning of hospitalisation. The change of environment sometimes exacerbates disorientation in these patients, with subsequent tension accompanied by psychomotor agitation with a risk of injury and frequent hetero-aggressive behaviour towards other patients and personnel. Placement in a netted cage-bed can make it easier to induce sleep and minimise the risk of injury without the need for increased doses of tranquillisers. High doses of psychotropic medication present a substantially greater risk for the patient in terms of prognosis and of the development of complications due to excessive sedation.

113. According to the head of the Psychiatric Clinic of the Brno University Hospital, there is a category of patients (in particular patients with organic disorders

[6] The Psychiatric Clinic of the 1st Faculty of Medicine, Charles University, and of the General University Hospital, the Psychiatric Hospital in Jihlava, the Psychiatric Clinic of the University Hospital in Plzeň and the Psychiatric Clinic of the University Hospital in Brno

[7] The Psychiatric Hospital in Havlíčkův Brod and the psychiatric ward of the Regional Hospital in Liberec

– especially deliriums and serious behavioural disorders accompanying serious syndromes, and cases of dementia) for whom placement in a netted cage-bed bed is the safest and least harmful option. Other options are restraining the patient in their bed using straps, which strongly restricts the patient's movements and moreover, can result in the patient's mental state deteriorating. That, in turn, requires higher doses of medication, which can have adverse effects and presents the risk of somatic complications (in particular, pressure ulcers, or deep vein thrombosis, etc.). Discontinuing the use of net-beds could cause greater discomfort and greater health risks (mental and somatic) for some categories of patients than using such cage-beds while complying with all the measures that are systematically used when physically restraining a patient. It seems that it is important to have a sufficient range of various means of restraint so that the most suitable one can be used for each patient.

114. Thus, the Government are of the opinion that based on the experience of psychiatrists, net-beds can be the safest and least restraining means of restraint for some groups of patients as they allow the patient relatively free movement (unlike straps) and resting on a mattress with linen (unlike the seclusion room). However, their use must comply with the above principles of legality, necessity, proportionality and accountability (see § 63 above).

E) RECENT DEVELOPMENTS

(i) Reform of psychiatric care

115. The Psychiatric Care Reform Strategy was published on 8 October 2013. The strategy sets out seven goals:

1) Increase the quality of psychiatric care through a systemic change in the organisation of the provision thereof;
2) Reduce the stigmatisation of the mentally ill and psychiatry in general;
3) Increase the users' satisfaction with psychiatric care provided;
4) Improve the efficiency of psychiatric care thanks to early diagnosis and identification of hidden mental illness;
5) Increase the success rate of mentally ill people's full integration within society (in particular by improving the conditions for their employment, education and housing, etc.);
6) Improve the interconnection between health care, social and other support services, and
7) Humanise psychiatric care.

116. The implementation of the strategy is divided into three phases. Currently, until 2023, the first phase,[8] which includes initiation and creating conditions, is under way. It includes activities and projects required for

[8] http://www.reformapsychiatrie.cz/proc_reformujeme/

the proper setting of the conditions for launching the various implementation projects during the implementing phase. The second phase will include most implementation projects in all areas, including interdepartmental coordination activities, legislative changes and other projects not financed from EU funds. The third phase will include the evaluation of each area and of the implementation projects in order to prepare in detail and launch the next phase of the reform.

(ii) Planned prohibition of net-beds in health care facilities

117. In response to the developments in international law, in particular the revised CPT standards, and in compliance with its promise (see § 56 above) the Ministry of Health has drafted an amendment to the Healthcare Services Act, which repeals section 39(1)(c), thereby removing net-beds from the list of permitted means of restraint.

118. On 18 August 2020 the amendment was sent to the interdepartmental commenting procedure, which was completed on 15 September 2020. At present, the comments are being discussed.

119. The amendment is expected to come into force on 1 January 2022.

OVERALL CONCLUSION

120. The Government are convinced that as the legislation on and the practice of using net-beds in the Czech Republic evolve as above outlined, the right to the protection of health and the right of elderly persons to social protection enshrined in Article 11 § 1 of the Charter and Article 4 § 3 of the Protocol are being progressively realised in a reasonable time.

The legislation governing the use of means of restraints adequately reflects the human rights commitments under international law: it provides sufficient safeguards against misuse and defines strict criteria which must be met when exceptionally resorting to the use of a netted cage-bed. The evolution of the legislation since 2004 has responded to the development in medical science and international law. The use of net-beds has been prohibited in social services; in health care services, an amendment to the Healthcare Services Act, which entirely prohibits the use of net-beds as a means of restraint in health care facilities, is currently being debated.

The vast majority of psychiatric facilities no longer have net-beds at this point. The overall number of net-beds is declining and the number of uses is not on the rise.

PROPOSED DECISION OF THE COMMITTEE

121. In the light of the above, the Government of the Czech Republic in their observations on the collective complaint at hand propose that the Committee holds that Article 11 § 1 of the Charter and Article 4 § 3 of the Protocol have not been violated.

Vít A. S c h o r m
Agent of the Government
signed electronically

ENCLOSURE

Statistical data on the numbers of net-beds and uses thereof

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ENCLOSURE

Number of net-beds in all psychiatric facilities

Psychiatric facility	Number of net-beds				
	2020	2019	2018	2017	Note
PRAGUE					
1. Psychiatric Hospital in Bohnice	0	1	1	1	
2. Psychiatric Clinic of the 1st Faculty of Medicine, Charles University, and General University Hospital	2	N/A	N/A	N/A	
3. Psychiatric Ward, Military University Hospital Prague	0	0	0	0	
4. Child and Youth Detox Centre; Hospital of the Sisters of Mercy of St Charles Borromeo	0	0	0	0	never had any
5. Children's Psychiatric Clinic of the 2nd Faculty of Medicine, Charles University, and Motol University Hospital	0	N/A	N/A	N/A	
CENTRAL BOHEMIAN REGION					
6. National Institute of Mental Health	0	0	0	0	
7. Psychiatric Hospital in Kosmonosy	0	0	N/A	N/A	
VYSOČINA REGION					
8. Psychiatric Hospital in Jihlava	N/A	3	4	11	
9. Psychiatric Hospital in Havlíčkův Brod	N/A	12	12	12	
10. Children's Psychiatric Hospital in Velká Bíteš	0	0	0	0	never had any
11. Psychiatric Hospital in Jemnice, PATEB s.r.o.	0	0	0	0	
PLZEŇ REGION					
12. Psychiatric Hospital in Dobřany	0	0	0	0	none since 2013
13. Psychiatric Clinic of the University Hospital in Plzeň	2	N/A	N/A	N/A	
14. Psychiatric Ward, Klatovy Hospital	9	N/A	N/A	N/A	

SOUTHERN BOHEMIAN REGION					
15. Psychiatric Hospital in Lnáře	N/A	3	3	3	
16. Psychiatric Hospital in Písek	N/A	1	1	1	
17. Psychiatric Ward, České Budějovice Hospital	0	0	0	0	none since 2005
18. Children's Psychiatric Hospital in Opařany	0	0	0	0	closed in June 2012
19. Psychiatric Hospital in Červený Dvůr	0	0	0	0	
20. Psychiatric Ward, Tábor Hospital	0	0	0	0	
LIBEREC REGION					
21. Psychiatric Ward, Regional Hospital in Liberec	2	N/A	N/A	N/A	
USTECKÝ REGION					
22. Psychiatric Hospital in Horní Beřkovice	0	0	0	0	
23. Psychiatric Hospital in Petrohrad	N/A	4	5	5	
24. Psychiatric Ward, Masaryk Hospital in Ústí nad Labem	0	0	0	0	never had any
25. Psychiatric Ward, the Most Hospital	0	0	0	0	
26. Children's Psychiatric Hospital in Louny	0	0	0	0	
KARLOVY VARY REGION					
27. Psychiatric and Psychotherapy Ward, Ostrov Hospital	0	N/A	N/A	N/A	
HRADEC KRÁLOVÉ REGION					
28. Psychiatric Clinic of the University Hospital in Hradec Králové	0	N/A	N/A	N/A	
29. Centre for the treatment of addictions in Nechanice, a part of the Psychiatric Clinic of the University Hospital in Hradec Králové	0	N/A	N/A	N/A	
30. Psychiatric Ward, Nové Město n. Metují Hospital	0	0	0	0	none since 2012

PARDUBICE REGION					
31. Psychiatry and Psychotherapy Ward, Svitavy Hospital	N/A	0	0	0	
32. Psychiatric Ward, Pardubice Regional Hospital	N/A	4	4	N/A	
33. Psychiatric Ward, Albertinum, expert treatment centre in Žamberk	N/A	1	2	3	
OLOMOUC REGION					
34. Psychiatric Clinic, Olomouc University Hospital	N/A	2	2	2	
35. Psychiatric Hospital in Šternberk	0	2	2	2	
36. Psychiatric Ward, Olomouc Military Hospital	2	N/A	N/A	N/A	
MORAVIAN-SILESIAN REGION					
37. Psychiatric Ward, Ostrava University Hospital	0	0	0	0	none since 2012
38. Psychiatric Hospital in Opava	0	0	0	none since April 17	
39. Marianne of Orange Psychiatric Hospital	0	0	0	0	none since 2013
40. Psychiatric Ward, Hospital & Policlinic in Havířov	0	N/A	N/A	N/A	
41. Private Psychiatric and Psychosomatic Clinic in Třinec	0	0	0	0	never had any
ZLIN REGION					
42. Psychiatric Hospital in Kroměříž	0	0	0	0	
SOUTHERN MORAVIAN REGION					
43. Psychiatric Clinic of the University Hospital in Brno	N/A	N/A	N/A	N/A	
44. Psychiatric Hospital in Brno	0	N/A	N/A	N/A	
45. Psychiatric Ward, Znojmo Hospital	0	0	0	0	
46. Psychiatric Ward, Brno Military Hospital	0	0	0	0	

Legend: N/A, information not provided or the facility does not have the information

Number of uses of net-beds in the psychiatric facilities that have such beds to date

Psychiatric facility	Number of uses of net-beds/number of patients		
	2019	2018	2017
1. Psychiatric clinic of the 1st Faculty of Medicine, Charles University, and General University Hospital	17	31	N/A
2. Psychiatric Hospital in Jihlava	160/37 (cage-bed uses) + 5/3 (cage-bed uses and therapeutic seclusion)	305/62 (cage-bed uses) + 2/2 (cage-bed uses and therapeutic seclusion)	312/50 (cage-bed uses) + 3/3 (cage-bed uses and therapeutic seclusion)
3. Psychiatric Hospital in Havlíčkův Brod	148/71	128/72	101/68
4. Psychiatric Clinic of the University Hospital in Plzeň	14	28	32
5. Psychiatric Ward, Klatovy Hospital	50	24	38
6. Psychiatric Hospital in Lnáře	0	2	2
7. Psychiatric Hospital in Písek	0	0	0
8. Psychiatric Ward, Regional Hospital in Liberec	98	95	86
9. Psychiatric Hospital in Petrohrad	98/20	109/25	51/18
10. Psychiatric Ward, Pardubice Regional Hospital	22	16	20
11. Psychiatric Ward, Albertinum, expert treatment centre in Žamberk	0	1	1
12. Psychiatric clinic, Olomouc University Hospital	100 (cage-bed) + 1 (cage-bed and straps) + 36 (cage-bed and seclusion room) + 4 (cage-bed, straps and seclu-sion)	63 (cage-bed) + 2 (cage-bed and straps) + 33 (cage-bed and seclusion room)	244 (cage-bed) + 2 (cage-bed and seclusion room)
13. Psychiatric Ward, Olomouc Military Hospital	25/9	38/7	12/4
14. Psychiatric Clinic of the University Hospital in Brno	2/2	25/12	34/17

Legend:

The table shows the numbers of times that net-beds were used to restrain a patient. Where the facility provided figures on the number of patients, they are stated in the format “number of uses/number of patients”. In some cases, several types of restrains were used simultaneously; in these cases each figure is stated separately and the combination of restraints is given in parentheses. N/A is written in cases where the facility did not provide the information because it did not have it.