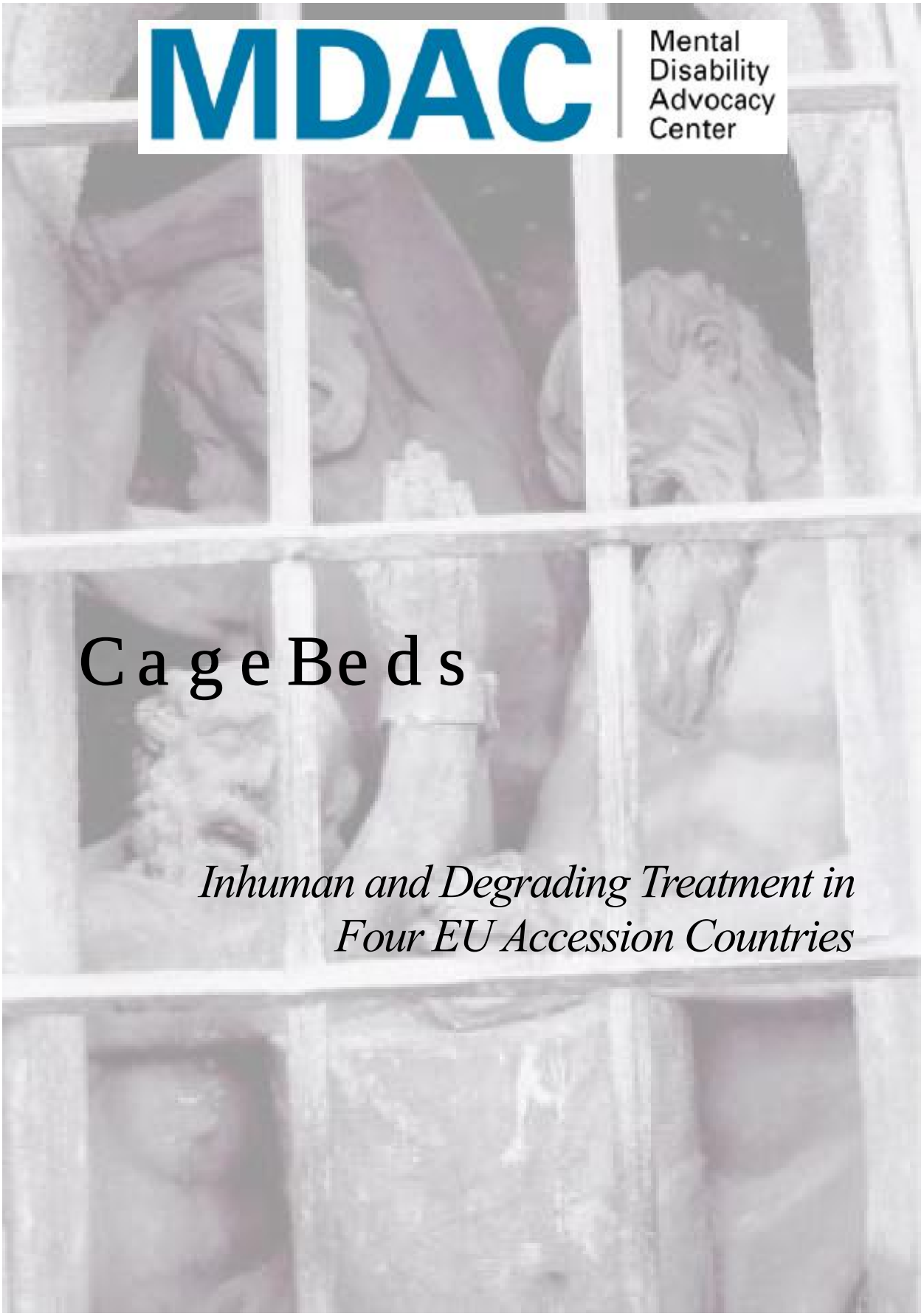

MDAC Mental Disability Advocacy Center

Cage Beds

Inhuman and Degrading Treatment in Four EU Accession Countries

The report has been translated into Czech, Hungarian, Slovak and Slovenian

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CAGE BEDS

Inhuman and Degrading Treatment or Punishment in Four EU Accession Countries

The **Mental Disability Advocacy Center** (*MDAC*) is an international organization that promotes and protects human rights of people with mental health problems and/or intellectual disabilities in twenty-eight countries of central and eastern Europe, the former Soviet Union, and central Asia. The goal of MDAC is to improve the quality of life for individuals by advocating public policies that respect human rights and promote community integration.

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Glossary and Terms

Cage Bed

A bed with a cage placed on top of it to enclose a person within the confines of the bed. Often, a distinction is made between cage beds, constructed only of metal bars, and net beds, constructed of metal frames and netting. Since the material with which it is constructed is of secondary importance, MDAC refers to both as cage beds. The European Committee for the Prevention of Torture (CPT) describes one cage bed in great detail: "The bed measured 2.08m x 0.93m, and was covered with a strong net, fixed on a tubular metal structure 1.26 m in height, an articulated opening with a padlock having been made on the left-side." MDAC found several types of cage beds during the course of its research. The most common style has an iron bar that can be raised and padlocked to confine a person within the bed. Another common type found my MDAC has iron bars that close horizontally rather than vertically.

Client

See ***user*** of psychiatric services

Consumer

See ***user*** of psychiatric services

Inhuman or Degrading Treatment or Punishment

As defined by the European Court of Human Rights: ill-treatment which arouses in the victim feelings of fear, anguish and inferiority, capable of humiliation and debasement and possibly breaking physical or moral resistance.

Intellectual Disability

Also referred to as "developmental disability," "learning disability" or "mental retardation". The World Health Organization defines this as a condition of arrested or incomplete development of the mind characterized by impairment of skills and overall intelligence in areas such as cognition, language, and motor and social abilities.

Mental Disability

An umbrella term referring to mental health problems and intellectual disabilities.

Mental Health Problem

Diagnosis of a psychiatric disorder according to internationally recognized diagnostic criteria.

Net bed

See ***cage bed***. A net bed is similar to a ***cage bed*** but instead of metal bars around the side and top of the bed, a net bed has netting, similar to the material used for fishing nets or rope. In this report, the term cage bed is used for both net beds and cage beds.

Restraint

The use of force or the threat of force for the purpose of controlling the actions of a person. A variety of devices and strategies may be applied to control a patient's behavior. Restraint can include chemical, physical or manual methods, and mechanical tools, such as cage beds.

Seclusion

The solitary detention of a person in a confined space. It also includes any situation in which a person is confined in a room on his /her own and the door cannot be opened by the person from the inside.

Social Care Home

Usually operated by the State, a long-stay residential institution typically for elderly people, people with mental health problems, intellectual disabilities, or substance abuse problems. They often also include residents referred to as "social cases" who may not (at least upon admission) fit into any of those categories.

Stigma

A mark of shame, disgrace or disapproval which results in an individual being shunned or rejected by others. The modern use of this word derives from the ancient Greek practice of burning or cutting a mark into the bodies of slaves, criminals, or traitors, to make visible something bad about the moral status of the bearer. The stigma associated with all forms of mental illness is strong but generally increases the more an individual's behavior differs from that of the 'norm.'

Survivor

The term currently carries at least two meanings: 'survivors of the psychiatric / mental health system'; and 'survivors of mental distress.' It can be used to describe persons who have survived human rights abuses under psychiatric care, those involuntarily placed in psychiatric care, as well as those no longer suffering from mental health problems. It also suggests the meaning of 'survivors' of adverse or traumatic life events generally – events that might be seen as bringing a person into contact with the mental health system in the first place.

User

It refers to a person who has used or uses psychiatric services. In Europe, 'users' of psychiatric services is more common; in Canada and the United States, people under psychiatric care are often referred to as 'consumers' or 'clients'. This term is used in this report interchangeably with ***client***, ***consumer***, and ***survivor***.

Acknowledgements

MDAC wishes to express its sincere gratitude to the many users and ex-users of psychiatric services in the Czech Republic, Hungary, Slovakia and Slovenia who agreed to share their experiences to make this report possible. For the exceptional generosity of MDAC's local partners who provided invaluable assistance and coordinated site visits, interviews and meetings, we are indebted.

In Hungary, Gábor Gombos of the Hungarian Mental Health Interest Forum (PÉF) shared his extensive knowledge of human rights in mental health institutions, arranged access to, accompanied MDAC researchers and provided translation in several institutions. Zsolt Bugarszki of the Soteria Foundation and PÉF assisted in arranging access to institutions and arranging meetings with government officials and translating interviews.

In the Czech Republic, Dr. Jan Pfeiffer of the Center for Mental Health Care Development (CMHCD) provided MDAC with background information and insights on Czech mental health services, coordinated site visits, interviews, meetings, provided logistical support and accompanied investigators to an institution and to meetings.

The Department of Social Services of the Ministry of Labour, Social Affairs and Family of the Slovak Republic arranged access to and officials accompanied MDAC researchers to several mental health facilities. Andrea Chorvathova, MDAC's local research assistant, coordinated logistics, interviews and meetings, translated interviews and gained the cooperation of several mental health NGOs throughout the country.

Nace Kovač and Mihael Gubenšek (MDAC local research assistant) of the Slovenian Association for Mental Health (ŠENT) were responsible for organizing all site visits, interviews, meetings, translation and providing logistical support.

MDAC staff was responsible for the research and production of this report. Field research was conducted and the report written by Susan Treadwell, MDAC Researcher, and Oliver Lewis, MDAC Legal Director, contributed to the ECHR legal section. All photos were taken by Matthew Treadwell.

Dr. Arman Vardanyan (MDAC Executive Director), Oliver Lewis and Clark Johnson (MDAC Advocacy Coordinator) provided extensive comments on multiple drafts of the report. The report was reviewed by Professor C. A. Gearty, Rausing Director, Centre for the Study of Human Rights, London School of Economics; Gábor Gombos of PÉF; Yonko Grozev and Krassimir Kanev from the Bulgarian Helsinki Committee; Professor Georg Høyer, Professor of Community Medicine, University of Tromsoe, Norway; Dr. Jan Pfeiffer of CMHCD; and Dr. Éva Szeli of Mental Disability Rights International, all of whose input greatly added to the content of the final report.

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Forward: Alvaro Gil-Robles, Commissioner for Human Rights, Council of Europe

I am extremely grateful for this opportunity to contribute a few small words to a report that itself speaks volumes. Its force is to provide at once a detailed illustration of the harrowing consequences of cage bed use and a blue print for its elimination, shining, as it were, both light on the problem and illuminating the way ahead.

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

That this process is already underway is due in large measure to the efforts of organizations such as the Mental Disability Advocacy Center to draw attention to areas of society all too often ignored. There is encouragement here. But what this report shows, above all, is the extent of the challenges ahead. And the need to overcome them quickly.

Alvaro Gil-Robles,

Commissioner for Human Rights

Strasbourg, May 2003

Executive Summary

In early 2003, MDAC along with the invaluable assistance of local partners in four EU accession countries (Czech Republic, Hungary, Slovak Republic and Slovenia), undertook research to provide a picture of the continuing prevalence of the use of cage beds, to discover how and why they are used, and whether there are any regulations governing their use. MDAC visited over 20 psychiatric wards of general hospitals or psychiatric hospitals and social care homes and interviewed users and ex-users of psychiatric services, mental health professionals, government officials and NGO representatives. MDAC research shows that in each of the countries under review, to varying degrees, cage beds are routinely used:

- to restrain people with severe intellectual disabilities who exhibit 'challenging' or 'difficult' behavior, sometimes for years;
- to restrain elderly people with dementia;
- to restrain psychiatric patients (in conjunction with chemical restraint);
- as a substitute for adequate staff levels or training;
- as a form of punishment or threat of punishment.

The rationalizations used to justify the continued use of cage beds to restrain people in psychiatric hospitals, which are under the authority of the Ministry of Health of each country, show a resistance to change on the part of the psychiatric establishment and deference to medical opinion on the part of policy-makers, content to maintain the status quo. In residential social care homes under the authority of Ministries of Social Affairs, where some of the most blatant examples of abuse can be found, lack of adequate resources, staff and training serve as the pretext for the continued use of cage beds.

This practice, whatever the justifications given, is in direct contravention of international standards, which hold that physical restraint should only be used for overcoming emergency situations where a person poses an imminent danger to him or herself or others. For any purpose, cage beds are inappropriate and unjustifiable. Furthermore, the interviews with users and ex-users of psychiatric services who have been subjected to placement in cage beds unmistakably show that whether proper procedures were followed or not, whether their restraint was ordered by a doctor or not, or whether they were kept in the cage beds for two hours or two weeks, the experience was invariably degrading, frightening, disempowering, and damaging. This denies their right to be free from inhuman and degrading treatment or punishment, which can no longer be ignored or denied.

Where international attention has focused on the use of cage beds in psychiatric institutions, States have taken only cursory steps to appease international criticism but no comprehensive solutions have been sought to ensure that no one has to suffer the indignity of being caged. MDAC has found that some people continue to spend most of their lives in cages and that these particularly vulnerable people, many of whom are stripped of legal competence, are in no position to defend themselves. States choose to take no notice as long as no outside attention is focused on the problem.

As these four nations prepare to join the European Union, they must demonstrate their commitment to observe the obligations under international law they have undertaken. The reluctance or refusal to end a practice, which has been internationally condemned and cannot be proven to be a recognized and acceptable component of care and treatment, casts doubt on that commitment.

Methodology

Objectives

This report is intended to document and raise awareness about the practice of using cage beds to restrain people in psychiatric institutions and social care homes in four EU accession countries (Czech Republic, Hungary, Slovak Republic and Slovenia) with the aim of eradicating their use. The use of cage beds in institutions for people with mental disability in Hungary was originally brought to the public's attention by various organizations.[1] The purpose of the present study is to ascertain the current situation regarding the use of cage beds, their purpose, and the extent of the regulation of their use in EU accession countries. MDAC discovered in preliminary research that they were in fact used extensively in the Czech Republic and Slovakia, and that they had been used widely in Slovenia, though no sources were certain whether they were still in use. Prior field research conducted by MDAC in other first wave EU accession countries revealed that, to the best of MDAC's knowledge, cage beds were widely used only in these four countries.[2]

One of the main objectives of MDAC's study was to discover what the perceptions of cage bed use were among clients and ex-clients of psychiatric services as well as mental health professionals in each country. The testimonies of the clients and ex-clients are of paramount importance in determining whether placement in cage beds constitutes inhuman and degrading treatment. The move towards creating social services which focus on consumer needs and the protection of rights and human dignity must begin with the sincere acknowledgement of the importance of their views and with recognition of the need for their active participation in formulating the policies and programs that affect them the most deeply.

Field Research

MDAC, in conjunction with local partner organizations, conducted human rights field missions in Hungary, the Czech Republic, Slovakia and Slovenia over a four-month period from February to May 2003. An MDAC researcher visited over 20 psychiatric institutions (including residential social care homes and psychiatric hospitals) with a photographer, where permitted,[3] and interviewed users and ex-users of psychiatric services, mental health professionals, mental disability and human rights NGO representatives, relevant Ministry officials and ombudspersons[4] using the highest standards of human rights documentation.[5] A standardized set of questions on cage bed and restraint use was formulated for site visits while interviews with users and ex-users were designed to allow them to speak freely about

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[1] Mental Disability Rights International (MDRI) published a report entitled *Human Rights and Mental Health: Hungary* in 1997 which highlighted the use of cage beds as a violation of international law; The European Committee for the Prevention of Torture (CPT) commented on the use of cage beds in psychiatric institutions in Hungary (1999) (later in Slovakia (2000) and Slovenia (2001)) and called for their withdrawal in each of its reports to the respective governments; in 2001, the Hungarian Mental Health Interest Forum (PÉF) released a report on a systematic study on the human rights protection of people in psychiatric social care homes in Hungary and found cage beds still in use in eight social care homes and called for the discontinuation of their use.

[2] It should also be noted that in field research conducted by MDAC in February 2003, cage beds were found in a psychiatric institution in Croatia.

[3] In all institutions where photographs were permitted, consent was sought from every individual photographed. All photos that appear in this report were taken during the research period from February to May 2003.

[4] See appendix 1 for list of institutions visited and parties interviewed

[5] The protocol followed conformed to the UN *Training Manual on Human Rights Monitoring* standards, specifically chapters 7 & 8 on information gathering and interviewing as well as drawing on standards developed by MDAC in *Human Rights Monitoring of Mental Disability Services: A Guide for Non-Governmental Organizations* (2002), unpublished.

their experiences. All interviews and site visits were recorded, transcribed, and are on file at MDAC. The site visits and interviews were conducted to give an indication of how cage beds are used in various institutional settings, the perceptions and justifications for their use, and whether any regulations exist for the restraint or seclusion of people with mental disability in psychiatric institutions.

Statistical data and relevant legislation were collected for each country. However, there are great variations between countries in the collection of statistics and availability of such data. The level of access to institutions and cooperation with relevant parties also varied from place to place. During preliminary research, it became evident that hospital and social care home directors enjoyed almost complete discretion in their decisions whether or not to allow independent observers. MDAC was denied permission to visit some psychiatric hospitals in Hungary,[6] the Czech Republic[7] and Slovakia.[8] MDAC only conducted site visits that were pre-arranged with the full knowledge that cage bed use was the subject of research.

There were enormous differences between institutions visited. A few were in relatively new and purpose-built facilities, with adequate staffing levels and a wide variety of meaningful occupational activities, while many others were situated in old, dilapidated former castles, with a serious lack of staff, resources and rehabilitative activities. Cage beds were found in institutions both old and new. MDAC notes that the management and staff of the vast majority of institutions visited seemed to be genuinely interested in providing quality care for their residents or patients. In the institutions visited, full cooperation was received from most staff members and MDAC was granted access to all areas of the buildings. There was also willingness to show documentation related to restraint use where it existed. One of the main reasons given for the refusal of permission to visit certain institutions was a fear of reprisal from the government, which it was believed would be more apt to place blame for the violation of human rights on heads of institutions rather than admitting its own culpability.

In an effort not to demonize the mental health professionals who continue to use cage beds or to deify those that have discontinued their use, individual institutions and staff members will not be identified in the text of this report. Furthermore, in order to respect the privacy and confidentiality of personal information of all clients and ex-clients of psychiatric services interviewed during this research, no names will be used. These interviews are on file with MDAC and have been coded to protect the privacy of these persons.

Due to the paucity of available data, the substantial number of institutions concerned, and the difficulty gaining access to them, this report is intended to provide a snapshot of the continuing prevalence of a practice that is legally impermissible and therapeutically unjustifiable. MDAC notes that there are a myriad of important issues, such as de-institutionalization, the system of guardianship, lack of social integration of people with mental disability, and involuntary detention, which are not touched upon in this report. Indeed, other forms of restraint or seclusion, which also constitute inhuman and degrading treatment, are also not assessed here, although they have garnered international attention in

[6] Psychiatrists at Debrecen Hospital and Koposvár Hospital were contacted to seek permission for a visit and MDAC was told that permission would have to be granted by the head doctor or director of the hospital, from whom no response could be received despite many phone calls and requests being sent.

[7] Jihlava Psychiatric Hospital, Kosmonosy Hospital, Opava Psychiatric Hospital, and Horní Beřkovice Psychiatric Hospital all refused to allow MDAC researchers to visit their institutions.

[8] The psychiatric department of Ruzinov General Hospital refused access to MDAC researchers.

the region recently.[9] These are all issues of serious concern in all of the countries examined as in all EU accession countries, but the sole focus of this report is the use of cage beds for people with mental disability in residential psychiatric institutions. MDAC finds this to be a grave enough abuse to warrant study on its own.

[9] Amnesty International, "Bulgaria: Far From the Eyes of Society," AI Index: EUR005/15/2002, documents ill-treatment, restraint and seclusion in psychiatric hospitals and social care homes in Bulgaria, which were found to include cages.

Introduction

In many parts of Europe in the late 1700s, the treatment of individuals with mental disability consisted of locking them away in large asylums and keeping them in chains. When Philippe Pinel, one of the fathers of modern psychiatry, freed the inmates of Bicêtre and Salpêtrière from their chains, it was a revolutionary idea, and many of his contemporaries thought he was unrealistic, and that people in mental institutions could not function in any capacity outside incarceration. Psychiatry has made tremendous steps in helping to improve the quality of life for many millions of people suffering from mental health problems through the centuries, but in many parts of the world, abuses in the name of treatment continue to endure. Over two hundred years after people with mental disability were first freed from chains, it is still possible to find them in cages.

In central Europe, cages with metal bars have largely been replaced by net beds, which are found by psychiatric professionals to be less objectionable. This distinction is, however, merely cosmetic, since the purpose and effect is exactly the same whether the construction is of metal bars or netting: to keep a human being in a cage. So, in speaking about these tools for physical restraint, the term cage bed will be used throughout the report.

MDAC is alarmed by the continued use of cage beds to restrain people with mental health problems and intellectual disabilities in psychiatric hospitals and social care homes in EU accession countries. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) described a cage bed as follows: "[t]he bed measured 2.08 m x 0.93 m, and was covered with a strong net, fixed on a tubular metal structure 1.26 m in height, an articulated opening with a padlock having been made on the left-side."[10] In 2003, the European Year of People with Disability, MDAC undertook research to uncover the nature of this practice in four central European countries: the Czech Republic, Hungary, Slovakia and Slovenia. These four nations will join the European Union (EU) on 1 May 2004. The Copenhagen Criteria, requirements for EU membership, stipulate that Member States will have attained "stability of institutions guaranteeing democracy, the rule of law, human rights and respect for and protection of minorities."[11]

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[10] Report to the Hungarian Government on the Visit to Hungary carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 5-16 December 1999 (Strasbourg, 29 March 2001), p. 53 ¶ 156.

[11] In June 1993, the Copenhagen European Council recognized the right of the countries of central and eastern Europe to join the European Union when they have fulfilled three criteria:

1) political: stable institutions guaranteeing democracy, the rule of law, human rights and respect for minorities;

2) economic: a functioning market economy;

3) incorporation of the Community *acquis:* adherence to the various political, economic and monetary aims of the European Union.

MDAC conducted human rights fact-finding missions in the Czech Republic, Hungary, Slovakia and Slovenia from February to May 2003 and found that cage beds are used to restrain people in psychiatric hospitals and social care homes throughout the countries visited. The restraint and seclusion of people with mental disability in psychiatric settings everywhere is a controversial and emotive topic, but there can be no doubt that the use of cages as a means of restraint is simply unacceptable. MDAC has found that people are placed in these cage beds for hours, days, weeks, or sometimes months or years. Through its research, MDAC found that two men in Slovenia have lived in these devices nearly twenty-four hours a day for at least the last fifteen years.

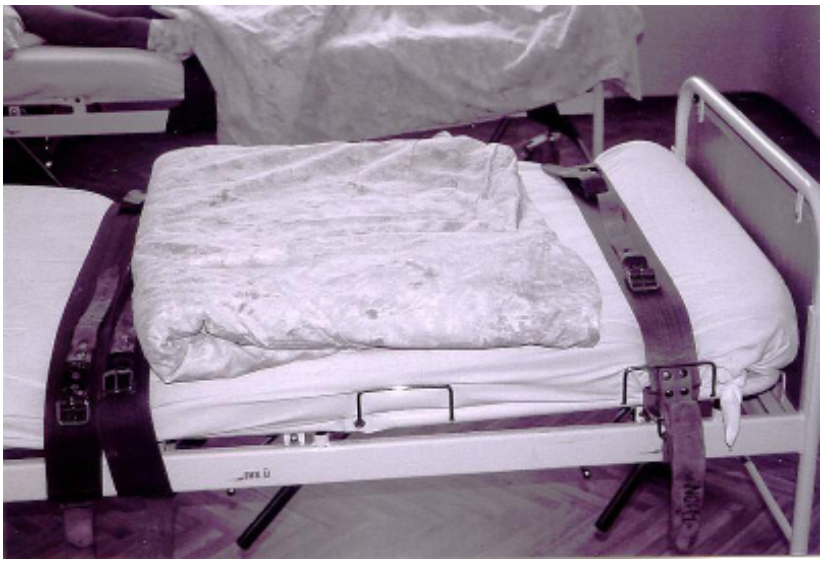
There is agreement among mental disability advocacy groups, human rights organizations, international professional psychiatric organizations, and many mental health professionals that the use of cage beds cannot under any circumstance be acceptable in modern psychiatry and that the practice should be abolished. The restraint of individuals in cage beds constitutes inhuman and degrading treatment, and as long as their use persists, these states are in violation of their obligations under domestic as well as international law.

This introduction is followed by a review of literature on the issue of restraint and seclusion and current efforts to end such coercive measures. This literature reveals that the use of cage beds is premised on misconceptions about appropriate means of providing safety and protection to psychiatric patients. The following section will broadly outline the international legal prohibitions on torture, or other cruel, inhuman or degrading treatment or punishment, and establish that the use of cage beds constitutes inhuman and degrading treatment.

The justifications for the use of cage beds will be shown as failing to meet international standards. Personal accounts will be used to illustrate the ill-effects that cage beds have on the individuals placed in them. The findings from MDAC's investigative research will then be given for each country, which will include: relevant domestic legislation and professional standards, an assessment of the current situation, regulation or oversight of the use of such restrictive measures, and lessons from institutions that have discontinued cage bed use. The final section will give conclusions, followed by recommendations to the States concerned.

These accession criteria were confirmed in December 1995 by the Madrid European Council, which also stressed the importance of adapting the applicant countries' administrative structures to create the conditions for a gradual, harmonious integration.

Restraint & Seclusion in Psychiatry



The restriction of an individual's personal liberty is a moral, ethical, legal and human rights issue. Restraint and seclusion are forms of incarceration, among the worst punishments a society can impose, and "should be used only as a last resort after all other reasonable means of control have failed."[12] Typically, it is viewed as "a last-ditch approach"[13] to manage aggressive or violent behavior, but in many instances, "with no real alternatives available, the last resort quickly becomes the first resort."[14] For a growing number of users, their family members and mental health officials in the US and Western Europe, the continued use of seclusion and restraint is a sign of treatment failure that highlights serious problems with mental health systems.[15]

According to one mental health professional, who administers a system of nine psychiatric hospitals where a 90% decrease in restraint use was achieved,[16] "Seclusion and restraint were symptoms of a whole approach to caring for patients. We felt that it was important to make it clear that these practices are not treatment interventions but treatment failures to be used only as a last resort." [17] He emphasized that mental health authorities "must look beyond particular strategies or techniques to the broader goal of helping consumers prepare to return to their communities and live independently."[18]

In theory, the sole purpose of restraint is to "enable staff to regain control of a potentially or actually dangerous situation by preventing the patient from harming him- or herself and moving them to a safe place where the crisis can be de-escalated."[19] In many cases, the use of coercive measures may actually escalate aggressive behavior and contribute to violence and injury. The guiding principle must be to try to resolve the underlying problems that lead to the use of restraint. There must be recognition that restraint and seclusion are not

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[12] Calfee, Barbara E., "Are You Restraining Your Patients' Rights?," *Nursing*, Vol. 18, Issue 5 (May 1988) p. 149.
[13] Zubeck, Pam and Eric Gorski, "Colorado Mental Health Institutions Investigate Use of Physical Restraint," *The Gazette*, Colorado Springs, Colo. (Monday, 10 October 1999).
[14] Mitchell-Pederson, Lynne, Elliot Fingerote, Colin Powell and Lois Edmund, "Avoiding Restraints: Why It Can Mean Good Practice," *Nursing*, Vol. 19, Issue 9, (September 1989) p. 71.
[15] "Seclusion and Restraint Debate Gains Momentum," *Networks* (Summer 1999), p. 3, available at: http://www.nasmhpd.org/ntac/networks/msm99.pdf.
[16] Stefan, Susan, "Perspectives From the Field: Legal and Regulatory Aspects of Seclusion and Restraint in Mental Health Settings," *Networks* (Special Edition, Summer/Fall 2002), p. 4, available at: http://www.nasmhpd.org/ntac/networks/SummerFall2002.pdf.
[17] "Focus on States: Pennsylvania Leads the Way in Reducing the Use of Seclusion and Restraint," *Networks* (Summer 1999), p. 4.
[18] *Ibid.*
[19] Wright, Steve, "Physical Restraint in the Management of Violence and Aggression in In-Patient Settings: A Review of Issues," *Journal of Mental Health*, Vol. 8, Issue 5 (October 1999) p. 468.

treatment, but rather "represent an emergency response to a treatment failure that resulted in an individual's loss of control."[20]

One mental health professional implores her colleagues to consider,

> *We were all inculcated at some early point in our training with the doctrine that the use of seclusion and restraint was necessary, therapeutic at times, and an acceptable part of a treatment plan. This training dies hard for some of us. But I ask every one of you to think about the following three questions without defense or emotion, just knowledge, intuition and logic.*
>
> *When does coercion beget anything but anger, learned helplessness or surface compliance? When does violence teach anything but passivity or more violence? How congruent is "recovery" with forced isolation or immobility?*
>
> *We know better and the time is now for change.*[21]

"This class of interventions [seclusion and restraint], which is marked by force, coercion, and violence and often results in trauma, has been accepted for decades as legitimate in behavioral health settings and derives from the erroneous belief that 'We must control the patients,'"[22] states a professional in mental health. This viewpoint is gaining ground in many parts of Europe, Australia and the US, particularly following widespread media attention on deaths related to restraint use in the US.[23] From campaigns to 'untie the elderly'[24] to creating restraint-free environments, many clients and professionals in mental health services are learning that it is possible to radically reduce the use of restraint and seclusion and thus to create more patient-centered care and a more humane environment for everyone.

> *In the past, facilities responded to deaths and injuries by trying to 'do restraints better.' However, the complexity of causes and factors relating to deaths and injuries in restraint makes this difficult, and a growing recognition of the traumatic effects of restraint on both patients and staff led a number of facilities and state agencies to make efforts to dramatically reduce the use of restraints. Their success was substantial and was consistently accompanied by a reduction in staff and patient injuries.* [25]

There is no evidence of the efficacy in using restraints in general, and cage beds specifically, as a means of preventing injury. One restraint reduction initiative led to a decrease in

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[20] "Improper Restraint or Seclusion Places People at Risk," United State General Accounting Office Report to Congressional Requesters, September 1999 as quoted in "Current Issues in Seclusion and Restraint," Office of the Ombudsman for Mental Health and Mental Retardation of the State of Minnesota, (12 December 2002) available at: http://www.ombudmhmr.state.mn.us/alerts/currentissuesonseclusionandrestraint.pdf.

[21] Huckshorn, Kevin Ann, "Message from NTAC," *Networks* (Special Edition, Summer/Fall 2002), p. 1.

[22] Hughes, Russell, "Replacing Control With Empowerment is a Proven Solution, *Networks* (Special Edition, Summer/Fall 2002) p. 17.

[23] Weiss, Eric, Dave Altimari, Dwight F. Blint and Kathleen Megan, "Deadly Restraint," *Hartford Courant* investigative series of articles (11-15 October 1998), available at: http://courant.ctnow.com/projects/restraint/day1.stm. The US Food and Drug Administration estimates that at least 100 deaths may occur annually from the improper use of restraints in institutions for people with mental disability. *See* FDA Backgrounder on Safe Use of Physical Restraint Devices, available at: http://www.fda.gov/opacom/backgrounders/safeuse.html.

[24] *See* Phillips, Charles D, Catherine Hawes and Brant E. Fries, "Reducing the Use of Physical Restraints in Nursing Homes: Will it Increase Costs?," *American Journal of Public Health*, Vol. 83, No. 3 (March 1993) p.343. This movement originated in the US and Canada in response to abuses reported in nursing care homes for the elderly.

[25] *See* Stefan, *supra* note 16, p. 4.

aggregate restraint use from 41% to 4% with no increase in serious injury and no need to increase the number of staff.[26]

MDAC research found that much of the current literature on restraint and seclusion emanates from the United States, where there is a movement to eliminate the use of coercive measures altogether. One possible reason for this was proposed in a US review of restraint and seclusion practices, which found that these measures were issues for debate in the United States, "where these controversial interventions are still used fairly regularly," whereas "in many parts of Europe, where seclusion and restraint are rarely utilized, they are no longer widely debated."[27] On the contrary, MDAC research found that restraint and seclusion are indeed still problems in many parts of Western Europe,[28] and that some studies have identified a need for comprehensive policies on restraint and seclusion.[29]

Negative Effects of Restraint on Patients and Caregivers

Restraint use is associated with numerous physical hazards, including pressure sores and limited mobility.[30] The psychological consequences can be equally, if not more, harmful. The use of physical restraints is commonly associated with increased mortality and morbidity[31] and can lead to a negative attitude toward treatment.[32] People have described the experience of being in restraints as emotionally devastating, frightening and humiliating,[33] and surveys of psychiatric service users suggest that restraint is invariably a "degrading and disempowering experience, often described as tantamount to rape."[34]

The psychological effects that restraint or seclusion can have on individuals have been called "iatrogenic trauma," meaning trauma caused by a physician or care-giver.[35] Coercive measures, which include restraint, "also foster dependency on the system for those who passively accept the process" and prevent the individual from "reaching his or her potential

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[26] Dunbar, Joan and Richard R. Neufeld, "Survey Finds Some Administrators Ambivalent Toward Restraint-Free Care," *Brown University Long-Term Care Letter*, 10421386, Vol. 7, Issue 4 (27 February 1995).

[27] Steel, Elizabeth, "Seclusion and Restraint Practice Standards: A Review and Analysis," (1 June 1999) Distributed by the US National Mental Health Association, Alexandria, Virginia.

[28] Minkowitz, Tina, "Report for the Quadrennial Review of the World Programme of Action on Disability," the World Network of Users and Survivors of Psychiatry, available at: http://www.wnusp.org/docs/wpa.html. The CPT expressed "concern about the frequent recourse in Danish psychiatry to physical immobilization of patients, which could last for several days, or even one week or more; on occasion, long periods of restraint were interrupted by brief periods without restraints." Available at: http://www.cpt.coe.int/en/states/dnk.htm. The CPT Report from their visit to Spain in 1998 also noted that restraint use for psychiatric patients in one prison, for periods of days or months amounted to ill-treatment, available at http://www.cpt.coe.int/en/states/esp.htm.

[29] *See* Välimäki, Maritta; Taipale, Johanna; Kaltiala-Heino, Riittakerttu, "Deprivation of Liberty in Psychiatric Treatment: A Finnish Perspective," *Nursing Ethics*, Vol. 8, Issue 6, (November 2001). *See also* Saloviita, Timo, "Challenging behavior, and staff responses to it, in residential environments for people with intellectual disability in Finland," *Journal of Intellectual & Developmental Disability*, Vol. 27, No. 1 (March 2002).

[30] *See* Mitchell-Pederson, *supra* note 14, p. 70, *see also* Watson, Roger, "Assessing the Need for Restraint in Older People," *Nursing Older People*, Vol. 14, No. 4 (June 2002) p. 31, *see also* "Elderly, confused patients tied up in hospitals," *Toronto Star* (18 November 2000), p. L102.

[31] *See* Phillips, *supra* note 24, p. 343. *See also*, Karp, Steven J., "Coercive Tactics are No Longer Viable Treatment Methods," *Networks* (Special Edition, Summer/Fall 2002), p. 13.

[32] *See* Taxis, J. Carole, RN C, MSN, MA, LPC, "Ethics and Praxis: Alternative Strategies to Physical Restraint and Seclusion in a Psychiatric Setting," *Issues in Mental Health Nursing*, Vol. 23 (2002) p. 158.

[33] *See* Phillips, *supra* note 24, p. 343.

[34] Leadbetter, David and Michael Budlong, "With Restraint…," *Community Care*, 03075508, Issue 1459 (13 February 2003).

[35] *See* Cohen-Cole, Linn, "Restraint and Seclusion: Iatrogenic Trauma Comes Out of the Closet," *Networks* (Special Edition, Summer Fall 2002) p. 6.

for self-management and maximum independence."[36] There is now hard evidence showing that people who have been physically or sexually abused at earlier times in their lives can be retraumatized as a result of being restrained in inpatient psychiatric settings.[37]

The effects restraint has on caregivers also cannot be discounted. One study found that facilities with higher restraint and seclusion rates had higher rates of staff injury and lost staff time.[38] Research has also revealed that nurses involved in situations where patients had been placed in restraints suffered from anxiety, feelings of inadequacy, hopelessness, frustration, guilt, dissatisfaction and repugnance.[39]

Environments which favor control and order over collaboration and treatment can serve as a cause of aggressive behavior and violence. Coercive controls, which "directly manipulate body processes (physically or chemically), bypassing the patient's own thinking mechanisms, help to create a sense of helplessness and loss of control, which in turn can lead to increased levels of violence through its own violation."[40] In one study conducted in a forensic psychiatric setting, researchers found that just over 45% of all blows took place during the actual restraint process.[41] It also may be the case that "if staff are too busy to provide the level of contact with individual patients that they would prefer because of high levels of bed use and staff shortages, or if staff avoid certain highly disturbed patients because of the perceived difficulty and stress involved in interacting with them, then violence may be seen by some patients as an effective way of initiating contact with staff."[42]

Explaining Variance in Restraint Use

MDAC found a great deal of variation in the methods and use of restraint and seclusion in each of the countries studied, and even between institutions examined. In virtually all countries, the use of restraint has become part of routine hospital care, particularly when assisting in the management of difficult or challenging behavior.[43] One reason given by many directors and staff in institutions for the continued use of cage beds is that their institutions treat or house the most difficult or challenging patients or residents. But research over the last 20 years has consistently shown that restraint is largely a matter of institutional culture and not patient demographics.[44]

Studies have found wide variation in the use of seclusion and restraint among inpatient psychiatric facilities which could not be explained by patient demographics[45] and were not associated with a larger proportion of more severely ill patients treated in hospitals.[46] "The only factor that seemed to explain the difference was the attitude of the hospital administration toward the use of seclusion and restraint. That…stops the argument. The

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[36] Karp, *supra* note 31, p. 13.
[37] *See* "Seclusion and Restraint Debate Gains Momentum," *supra* note 15, p. 3.
[38] *See* "Current Issues in Seclusion and Restraint," *supra* note 20.
[39] *See* "Elderly, confused patients tied up in hospitals," *supra* note 30.
[40] Lewis, D.M., "Responding to a violent incident: physical restraint or anger management as therapeutic interventions," *Journal of Psychiatric and Mental Health Nursing*, Vol. 9, Issue 1 (February 2002) p. 58.
[41] Wright, *supra* note 19, p. 465.
[42] *Ibid*, p. 462.
[43] *See* Lewis, *supra* note 40, p. 57.
[44] *See* Stefan, *supra* note 16, p. 4. *See also* Välimäki, *supra* note 29.
[45] Study conducted by Robert Okin, M.D., former commissioner of mental health in Massachusetts and Vermont and now a professor of clinical psychiatry at the University of California at San Francisco and chief of psychiatry at San Francisco General Hospital, as in "Seclusion and Restraint Debate Gains Momentum," *supra* note 15, p. 5.
[46] *See* Välimäki, *supra* note 29, p. 525-526.

hospital's culture dictates whether, in what circumstances and how often seclusion and restraint interventions are used."[47]

It is also clear that environmental factors play a role in the differences between restraint and seclusion in institutional settings. Studies indicate that what is perceived as challenging or difficult behavior is less frequent and less severe in group homes than in large residential institutions, and that restraints are therefore used more often in institutions than in other forms of housing.[48] This is a clear indication that institutional culture plays a significant role in restraint use.

The lack of a clear (if any) policy on restraint use is also a major factor in explaining discrepancies. Due to its serious potential for abuse, the responsibility for clear policies on restraint goes beyond individual institutions. Where abuses are identified as system-wide and not merely isolated cases, a comprehensive policy to end those abuses is called for. It has been observed that "when administrators and leaders simply attend to and focus on the use of restraint as a treatment failure, restraint use drops."[49] And, in a growing number of institutions, policies to eliminate restraint use altogether have been successful. Again, this is not a function of the severity of patients' pathologies, but on institutional policies, staff training and a focus on creating client-centered and humane treatment.

Toward Restraint Elimination

The move toward a restraint-free environment in institutions for people with mental disability requires a comprehensive shift from a system of control to one of collaboration. In order for this shift to occur, strong leadership and accountability are required. States as well as institutional managers need to be accountable for this change to be effected, and the whole staff must be held accountable as well. "Values of respect and dignity must permeate the whole system and disrespectful behavior by staff must be confronted and changed."[50] The integral factors in facilitating this process are a combination of research, education, leadership and accountability.[51] The research to date shows significant evidence to disprove the belief of many mental health professionals and patients alike that restraint is a necessary part of psychiatric care that cannot be significantly reduced and/or eliminated.[52] There is also

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[47] According to Ira Burnim, staff attorney for the Judge David L. Bazelon Center for Mental Health Law in Washington, D.C., as in "Seclusion and Restraint Debate Gains Momentum," *supra* note 15, p. 5.
[48] *See* Saloviita, *supra* note 29, p. 27.
[49] Stefan, *supra* note 16, p. 8
[50] Karp, *supra* note 31, p. 15.
[51] *See* Taxis, *supra* note 32, p. 159.
[52] Lewis, *supra* note 40, p. 61.

a compelling body of literature available on the means taken by individual institutions or entire systems to move towards eliminating restraint and seclusion.[53]

Increasing Safety Through Restraint Reduction

The use of restraint is often justified as necessary to protect patients and maintain a safe environment. One of the most common reasons cited for the use of restraint in institutions is to protect older people from injury. A number of studies in institutions housing elderly people with dementia have shown that restraint use can be dramatically reduced or eliminated altogether without a corresponding increase in falls or injuries.[54] One such study indicated that, in the first year after the policy change, the use of physical restraints was cut by 97% with no increase in serious falls. "Not only did we virtually abolish physical restraints, but our use of pharmacologic restraints dropped by 39%," staff reported.[55]

The need to create a safe environment in mental health institutions is often highlighted as the primary reason for restraint or seclusion. "In an interconnected social setting like a hospital, if anyone is unsafe, all are unsafe. The environment cannot be safe for patients unless it is also safe for staff."[56] It should be obvious that aggressive behavior does not suddenly materialize without any cause. "Dogmatic, absolutist attitudes and provocative, authoritarian behavior of staff have been found to be associated with increased likelihood of assault and more experienced staff have been found to be less likely to be victims of assault than less experienced staff."[57]

One study indicated that "in over 50% of cases when coercive measures were deemed necessary, there had been a preceding act of control by one or more staff members which led to escalating behavior by the consumer, followed by more intrusive intervention by staff."[58] This underscores the need for staff training in de-escalation techniques and a shift from an environment of control to one of collaboration. Studies show that successful initiatives to

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[53] Some of the most common measures implemented at hospitals to reduce restraint use included consciousness-raising on the issues surrounding restraint and seclusion and consensus building among the staff. Enhanced training of staff in non-physical de-escalation in addition to standard training in how to use seclusion or restraint safely was often combined with sensitivity training to allow staff to see how patients might experience these interventions. Improved data collection procedures regarding staff initiation of seclusion or restraint also allowed the identification and control of specific individuals who over-used them. Other successful features included environmental alterations, such as the creation of 'quiet rooms' or 'relaxation rooms' where patients could go by themselves to calm down and encourage self-management. Another common and particularly effective initiative is the implementation of a de-escalation preference survey. This involves patients filling out a form on admission that itemizes a patient's preferences for how staff should respond when he or she becomes agitated. This involves patients in their treatment plans, reduces the potential for added trauma during a critical period, and acknowledges that there is no single method with which everyone can be de-escalated.

[54] Dunbar and Neufeld, *supra* note 26. *See also* Weintraub, D. and Spurlock, M, "Study Examines Impact of New Restraint Standards," *Brown University Geriatric Psychopharmacology Update*, Vol. 6, No. 4 (April 2002) p. 6, also reports that in 1999, a study on a psychogeriatric unit in an acute general hospital was conducted, which revealed a marked reduction in the number of restraint episodes in the year following the introduction of new restraint standards compared to the previous year (44 vs. 212 restraint episodes per 1,000 patient-days). There were also no notable differences observed for the number of total falls (18 vs. 21 falls per 1,000 patient-days) or serious falls (2 vs. 1 serious falls per 1,000 patient-days).
In Australia, a successful initiative to create restraint-free environments in aged-care facilities was reported by Susan Koch and Cheryl Lyon in "Case Study Approach to Removing Physical Restraint," *International Journal of Nursing Practice*, Vol. 7, Issue 3 (June 2001) pp. 156-161.

[55] Mitchell-Pederson, *supra* note 14, p. 67.

[56] Bloom, Sandra, "Creating Sanctuary," *Networks* (Special Edition, Summer/Fall 2002) p. 19.

[57] Wright, *supra* note 19, p. 462.

[58] Hughes, *supra* note 22, p. 17.

reduce restraint use, with a focus on the prevention of aggression through staff training in de-escalation techniques and the management of violence, contributes to a greater sense of safety and empowerment, and can reduce rates of injury of patients and staff alike.[59] In one hospital, 86% of staff who had been trained in verbal interventions, self-defense and manual restraint techniques, reported feeling more relaxed, comfortable, confident and able to handle violent incidents.[60]

Professional Opinions on Restraint Use

Some international societies of mental health professionals have made their positions clear on the use of restraint and seclusion. The World Psychiatric Association (WPA) issued its Declaration of Hawaii[61] on ethics in psychiatry in 1977, which states that the dignity and human rights of every patient must be respected in the course of receiving treatment.[62] Their Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill also holds that "persons have the right to professional, human and dignified treatment."[63] It recognizes that "involuntary intervention is a great infringement of the human rights and the fundamental freedom of a patient," and therefore calls for involuntary intervention to be "carried out with the least restrictive principle."[64] In 1996, the WPA revised some of its ethical standards in its Madrid Declaration, which states that, "Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient."[65]

The International Society of Psychiatric Nurses (ISPN) Position Statement on Restraint and Seclusion states "ISPN acknowledges that the use of seclusion and restraint is a clinical emergency and requires prompt coordinated attention."[66] It also endorses the "systematic

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[59] *See* Stefan, *supra* note 16, p. 4 who reports that the State of Pennsylvania pursued a policy aimed at dramatically reducing the use of seclusion and restraint in the state's nine psychiatric hospitals. According to data collected between 1994 and 1998, the number of hours of seclusion in those hospitals dropped by 91% and the number of incidents of seclusion fell by 60%. Later research showed that, in conjunction with the dramatic reduction in seclusion and restraint, staff and patient injury rates dropped by 74%. Taxis, *supra* note 32, reports on another study, a clinically based initiative in Texas which was started in 1998 when professional nurses on an 86-bed adult unit in a state psychiatric facility began to articulate concerns for the ethical dilemmas resulting from the restraining of patients. During the initial data collection period, the nursing staff voiced doubts of the possibility to reduce restraint use as well as concerns about the safety of the patients and staff if a program were implemented to reduce the use of restraint and seclusion. The entire process involved consensus building, consciousness raising, staff and patient education in de-escalation and problem-solving, environmental alterations, such as creating a room where patients could go to calm themselves down, and improvements in communication, administration and programs. The result of this effort was a "94% reduction in the incidence of restraint and seclusion." p. 160.

[60] *See* Wright, *supra* note 19, p. 466.

[61] Declaration of Hawaii, WPA approved in Vienna, Austria on 10 July 1983.

[62] *Ibid.* The text as it reads in the declaration is: "The psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group …"

[63] WPA Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill," adopted by the WPA General Assembly in Athens, (17 October 1989).

[64] *Ibid.*

[65] WPA Madrid Declaration on Ethical Standards for Psychiatric Practice, Approved by the General Assembly on 25 August 1996 and amended by the General Assembly in Yokohama, Japan in August 2002, available at: http://www.wpanet.org/generalinfo/ethic1.html.

[66] "ISPN Position Statement on the Use of Restraint and Seclusion," *Journal of Child and Adolescent Psychiatric Nursing*, Vol. 14, No. 3 (July-September 2001) p. 100.

investigation and utilization of alternatives to mechanical and chemical restraint"[67] and opposes all punitive measures."[68]

Professional Opinions on Cage Bed Use

Few mental health professionals or human rights activists outside central Europe are familiar with cage beds. For many, the very notion of placing human beings into cages of any sort is abhorrent, and even professionals within these four countries have described the practice as "medieval."[69] MDAC asked professionals in mental health to give their opinions on the use of cage beds.

Dr. József Kovács, head of the Department of Bioethics at Semmelweis University of Medicine in Budapest has directly addressed the singularly important question why cage beds are more unacceptable than other forms of restraint:

> *The problem of caged beds is, that they permit too much movement to protect patients from themselves, but too little movement for longer or semi-permanent use. They protect patients from themselves less than the standard forms of physical restraints, and allow patients less movement than the standard forms of seclusion. Thus they represent a mix between seclusion and physical restraint, having the disadvantages of both, but lacking their advantages. Since they are not useful, but create much suffering, I think that the claim, that they represent inhuman and degrading treatment is justified.*[70]

The Geneva Initiative on Psychiatry (GIP) "condemns the use of cage beds as inhumane and unnecessary," stated Prof Robin Jacoby, University of Oxford Department of Psychiatry and Chair of GIP.[71]

Dr. Mike Shooter, President of the Royal College of Psychiatrists of the UK and the Republic of Ireland stated:

> *Whatever their aim, be it the safety of the patient or others, the effect of caged beds is to dehumanize both those inside the cage and those looking after them. It reduces their relationship to that of prisoner and guard and can have no place in modern, therapeutic psychiatry. We have a duty to protect the rights of those made vulnerable by their disabilities. There can be no justification for violations that would be barely acceptable in battery-farmed animals.*[72]

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[67] *Ibid*, It also states that adults and children must be removed from restraints every 2 hours at a minimum. The ISPN also suggests that: "following any use of restraint and/or seclusion, patients should receive debriefing in clear words that they can understand from their primary caregivers. This intervention facilitates the following: symptom recognition, earlier de-escalation, and promotion of problem-solving and conflict resolution skills. Debriefing is necessary to minimize negative effects related to patients' experiences of being restrained and/or secluded." It also recommends that data on the clinical end points of restraint and seclusion be collected in order to identify patterns of use.

[68] *Ibid*, p. 102.

[69] Interview material from MDAC file # SI01-22-10 (26 March 2003) and #HU01-22-6 (6 May 2003).

[70] Kovács, József, "Ethical Problems of Physical Restraint in Hungary," Lecture delivered at the conference: The Uses and Abuses of Restraints, organized by the Massachusetts Office on Disability, Boston, Massachusetts (25 October 1999), reproduced with the permission of the author.

[71] Comment from an email communication, dated 28 May 2003.

[72] Statement received in an email communication, dated 6 May 2003.

The Use of Cage Beds as a Human Rights Violation

International Standards

All of the States included in this study have ratified a number of binding international treaties prohibiting inhuman and degrading treatment and punishment. Based on existing legal obligations of these States to protect human rights, the continued use of cage beds constitutes a violation of the right to be free from inhuman and degrading treatment and punishment. It is the duty of all States to take the necessary legislative, administrative, judicial and other measures to end such violations and prevent and punish acts in contravention of basic human rights.

The legal standard to determine what may or may not constitute inhuman or degrading treatment of all of the international legal instruments below takes into account the nature, purpose and severity of measures applied. In cases where a person's liberty is restricted, individual complainants are often deprived of any access to relevant documentation and so the burden of proof cannot rest solely on the victim and often lies with States to disprove allegations of a violation.[73] Abuses are difficult to prove and nearly impossible to document, since it is not only in the interest of psychiatric staff to downplay or obfuscate abuses, but many psychiatric professionals, nurses and staff of psychiatric institutions are so accustomed to conditions and practices that they fail to see anything wrong with them.[74] Based on the testimonies of those who have been placed in cage beds and professional opinions finding their use to be excessive and unnecessary, the use of cage beds can be shown to violate the

[73] The UN Human Rights Committee found in Communication No. 458/1991 alleging inhuman and degrading treatment against Cameroon in 1994, in point 9.2 that "As it has held on previous occasions, the burden of proof cannot rest alone with the author of a communication, especially considering that the author and the State party do not always have equal access to the evidence and that frequently the State party alone has access to the relevant information. Mr. Mukong has provided detailed information about the treatment he was subjected to; in the circumstances, it was incumbent upon the State party to refute the allegations in detail, rather than shifting the burden of proof to the author." CCPR/C/51/D/458/1991 (10 August 1994). In another communication of Irene Bleier Lewenhoff and Rosa Valiño de Bleier v. Uruguay, Communication No. 30/1978 (29 March 1982), U.N. Doc. CCPR/C/OP/1 at 109 (1985), point 13.3, the Committee states, "the State party has the duty to investigate in good faith all allegations of violation of the Covenant made against it and its authorities, especially when such allegations are corroborated by evidence submitted by the author of the communication, and to furnish to the Committee the information available to it. In cases where the author has submitted to the Committee allegations supported by substantial witness testimony, as in this case, and where further clarification of the case depends on information exclusively in the hands of the State party, the Committee may consider such allegations as substantiated in the absence of satisfactory evidence and explanations to the contrary submitted by the State party."
For the European Court of Human Rights, *see* Addo, Michael K and Nicholas Grief, "Does Article 3 of The European Convention on Human Rights Enshrine Absolute Rights?," *European Journal of International Law*, Vol. 9, No. 3 (1988), p. 515. *See also*, Ribisch v. Austria Application No. 18896/91, judgment 4 December 1995, where the Court developed the rule for the burden of proof that when a person is in the hands of public authorities, for instance in prison, and suffered bodily harm, it is for the State to prove that this bodily harm resulted from natural causes and was not inflicted by any agent of the State.

[74] Saloviita, *supra* note 29, p. 28, looked at staff responses to challenging behavior in 261 adult residents in a special care district in Finland and found that staff reported the frequent use of mechanical restraints and restrictive measures used as punishment, despite the anticipation that they would deny or hide such means because of their unacceptability in domestic and international law. *See also* McMahon, Maureen and Linda Fisher, "Achieve ED Restraint Reduction," *Nursing Management*, Vol. 34, Issue 1 (January 2003) p. 38, which reports that a significant number of nurses in one study indicated that restraint should continue beyond the time necessary for a patient to calm down.

fundamental right to be free from inhuman and degrading treatment and punishment under all of the international human rights treaties these States have ratified.

United Nations Treaty Mechanisms

Article 5 of the Universal Declaration of Human Rights reads: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[75] The same language is adopted in Article 7 of the International Covenant on Civil and Political Rights (ICCPR),[76] to which all of the States that are the subject of this study are parties. The ICCPR specifies that this right is non-derogable even in time of war or public emergency threatening the life of the nation. All four States concerned are also parties to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, a treaty which entered into force on 26 June 1987 and which highlights the elevated status of the right to be free from torture and other cruel, inhuman or degrading treatment. Indeed, the right is widely held as a peremptory norm and part of *jus cogens*, [77] or higher laws of paramount interest to the international community.

While no definition of cruel, inhuman and degrading treatment is provided in any of these texts, it is instructive to look for guidance to the treaty bodies charged with interpreting the provisions and monitoring States' compliance with these treaties. The Human Rights Committee, established under the ICCPR, issued General Comment 20(44) on the implementation of Article 7. The Comment states, "the aim of the provisions of article 7 … is to protect both the dignity and the physical and mental integrity of the individual." It goes on to explain why no definition of the concepts is given. The Committee does not "consider it necessary to draw up a list of prohibited acts or to establish sharp distinctions between different kinds of punishment or treatment; the distinctions depend on the nature, purpose and severity of the treatment applied."[78] It goes on to add that, "prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by article 7."[79]

In 1991, the United Nations General Assembly adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles).[80] While not a legally binding document, these Principles provide a detailed description of minimum standards for the protection of mental disability rights under international law. Principle 9(1) requires that every patient have the right to "be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others."[81] The preservation and

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[75] General Assembly resolution 217 A (III) of 10 December 1948.

[76] General Assembly Resolution 2200A (XXI), 21 U.N. GAOR Supp. (no. 16) 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* 23 March 1976.

[77] The Vienna Convention on the Law of Treaties, concluded in Vienna 23 May 1969, *entered into force* 27 January 1980, UN Doc A/Conf 39/28, UKTS 58 (1980), 8 ILM 679, provides that a norm attain *jus cogens* status when it is (1) of general international law; (2) accepted by the States as a whole; (3) immune from derogation; and (4) modifiable only by a new norm of the same status.

[78] UN Human Rights Committee General Comment 20(44), Replaces General Comment 7 Concerning Prohibition of Torture and Cruel Treatment or Punishment, (Forty-Fourth Session, 1992) ¶ 4, available at: http://www.unhcr.ch/tbs/doc.nsf.

[79] *Ibid*, ¶ 6.

[80] General Assembly Resolution 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc. A/46/49 (1991).

[81] *Ibid*, principle 9(1).

enhancement of the autonomy of every patient while receiving treatment is required by Principle 9(4).[82]

Regarding the use of restraint and seclusion, Principle 11(11) states that:

> *Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.*[83]

Council of Europe Human Rights Provisions

European Convention on Human Rights and Fundamental Freedoms (ECHR) [84]

The Czech Republic, Hungary, Slovakia and Slovenia have signed and ratified the ECHR, an international legal treaty, which protects and furthers individual rights from infringement by States. The ECHR applies to all human beings within each country, including children, people without legal capacity, and people with mental disability. Decisions by the European Court of Human Rights, established by the ECHR, assist in fleshing out the content of the Convention so far as all Member States are concerned. Thus, the principles decided by the Court in the cases referred to below are applicable to all of the countries under review in this report.[85]

Article 3 of the ECHR reads: "*No one shall be subjected to torture or to inhuman or degrading treatment or punishment*." The prohibition is absolute. The Court has emphasised that such a fundamental right deserves no exceptions or limitations. States may not derogate from Article 3, which imposes a negative obligation on the State not to inflict torture, inhuman or degrading treatment or punishment on its citizens. It also creates a positive obligation on States to take measures to protect people from suffering such ill-treatment, whether carried out by State officials (such as in prisons, psychiatric hospitals or social care homes) or by private individuals or groups.

No cases involving cage beds have yet been brought to the Court, but the Court has stated that to be classed as "inhuman or degrading treatment or punishment," the act must arouse in the victim feelings of fear, anguish and inferiority capable of humiliation and debasement and possibly breaking physical or moral resistance.[86] In considering whether treatment is "degrading" within the meaning of Article 3, one of the factors which the Court considers is whether there was a positive intention to humiliate and debase the person concerned. However, the absence of any such intention does not conclusively rule out a finding of violation of Article 3.[87] Not every case of ill-treatment would be classified as an Article 3

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[82] *Ibid*, principle 9(4), which reads: "The treatment of every patient shall be directed towards preserving and enhancing personal autonomy."
[83] *Ibid*, principle 11(11).
[84] ETS 005, Rome, 4.XI.1950, signed in Rome on 4 November 1950, *entry into force* 3 September 1953.
[85] Article 1, ECHR.
[86] Ireland v. the United Kingdom judgment 18 January 1978, Series A no. 25, paragraph 167.
[87] Price v. the United Kingdom Application No. 33394/96, judgment 10 July 2001.

violation. The Court has held that ill-treatment must attain a *minimum level of severity* to fall within the scope of Article 3. The assessment of this standard is relative; it 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.[88]

As for medical treatment, States are obliged to protect the health of persons deprived of liberty (such as people in cage beds).[89] Further, lack of appropriate medical treatment may amount to treatment contrary to Article 3.[90] Treatment that has been authorized by a medical doctor would not usually be a violation of Article 3. The Court has acknowledged, "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."[91] There is no medical standard which legitimizes restraint in a cage bed as an acceptable form of treatment.

The Court has made clear that it "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 ECHR has been complied with. While it is for the medical authorities to decide, *on the basis of the recognized 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, such patients nevertheless remain under the protection of Article 3, the requirements of which permit of no derogation"[92] [emphasis added]. Further, the Court has said that alleged ill-treatment must "go beyond that inevitable element of suffering or humiliation connected with a given form of *legitimate* treatment or punishment" [emphasis added] to be deemed a violation of Article 3.[93] Again, there is no rule of medical science that recognizes cage beds as a legitimate form of treatment.

As to whether a person with a mental disability has to prove that he or she has suffered any specific harm, the Court has concluded that "[t]reatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able, or capable of, pointing to any specific ill-effects."[94] In respect of a person deprived of his or her liberty, recourse to physical force

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[88] Ireland v. the United Kingdom *supra* note 86, paragraph 162, *see also* Van der Ven v. The Netherlands Application No. 50901/99, judgment 2 April 2003 where the Court held that a violation of Article 3 had taken place due to the strict security regime of a high security prison where the applicant was held. No specific act of ill-treatment was found, rather the cumulative effects of the conditions of his detention were found to amount to inhuman and degrading treatment. Particular mention was made of frequent and systematic strip searches, which the applicant was forced to endure, which were found to be degrading and were found to cause the applicant to suffer from depression which was confirmed by psychiatrists' reports.

[89] Hurtado v. Switzerland, Comm. Report 8 July 1993, Series A no. 280, p. 16, § 79.

[90] Ilhan v. Turkey [GC] no. 22277/93, ECHR 2000-VII, § 87.

[91] Herczegfalvy v. Austria Application No. 10533/83, judgment 24 September 1992, reported at (1992) 15 EHRR 437, paragraph 82. Therefore a doctor would have to testify that it was medically necessary to use a cage bed for a particular person at a particular time. The victim would be able to claim that it was not medically *necessary*, and that alternative and less restrictive measures could and should have been used. The victim may use the expertise of other respected doctors, such as those whose comments appear in this report.

[92] *Ibid*, paragraph 82.

[93] Kudla v. Poland Application No. 30210/96, judgment 26 October 2000, reported at (2002) 35 EHRR 11.

[94] Keenan v. the United Kingdom Application No. 27229/95, judgment 3 April 2001, reported at (2001) 33 EHRR 38, paragraph 112.

which has not been made strictly necessary by his or her own conduct diminishes human dignity and is, in principle, an infringement of the right set forth in Article 3.[95]

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

The CPT was established under the Convention for the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (hereafter "the Convention")[96] to which all four States are parties. The body is charged with examining "the treatment of persons deprived of their liberty with a view to strengthening, if necessary, the protection of such persons from torture and from inhuman or degrading treatment or punishment."[97] The CPT has broad powers to investigate places of detention and interview persons deprived of their liberty. The two fundamental principles that govern relations between the CPT and parties to the Convention are co-operation and confidentiality.[98] As standard procedure, the CPT visits a State, prepares a report with findings and recommendations, and transmits that report to the State party to initiate a dialogue.

Substantive sections of CPT general reports have been reiterated in the CPT Standards to give clear advance indication to national authorities of its views on conditions of detention. On the issue of restraint in psychiatric institutions, the CPT Standards call for a "clearly-defined policy" which "should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control."[99] Regarding the use of mechanical restraint, it says "[i]f, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment."[100] "Prolonged" is an entirely subjective term, but the Standards clarify this point to state that, "The CPT has encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasize that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment."[101]

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[95] Tekin v. Turkey judgment 9 June 1998, *Reports* 1998-IV, pp. 1517-18, § 53.
[96] European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, E.T.S. 126, Strasbourg, 26.XI.1987, *entered into force* 1 February 1989, Chapter 1, article 1.
[97] *Ibid.*
[98] The CPT Standards, CPT/Inf/E (2002), Preface, p. 5, available at: http://www.cpt.coe.int/en/docsstandards.htm.
[99] *Ibid*, p. 52, ¶ 47.
[100] *Ibid*, p. 52, ¶ 48.
[101] *Ibid.*

The CPT is the only intergovernmental body to have commented on the use of cage beds in psychiatric institutions. In the countries examined where the CPT has found cage beds, it has called for their withdrawal.[102] As a non-judicial preventative body, the CPT's principal objective is to "assist States to realize the obligations they have assumed under Article 3 of the ECHR rather than determine whether it has been breached."[103] However, the Court has recognized the Committee's findings to be highly persuasive in reaching its decisions on violations of Article 3.[104]

[102] The CPT has called for the withdrawal of cage beds from Hungary (1999), Slovakia (2000), and Slovenia (2001). In its visit to the Czech Republic in 1997, no psychiatric institutions were visited.

[103] Barrett, Jastine, "The Prohibition of Torture Under International Law: The Institutional Organization," *International Journal of Human Rights*, Vol. 5, No. 1 (Spring 2001), p. 27.

[104] Peers v. Greece, Application no. 28524/95, judgment 19 April 2001, reported at page 11, paragraph 61, where the Court extensively cites findings of the CPT to rule that inhuman and degrading treatment resulted from poor conditions of detention. *See also* Van der Ven v. The Netherlands *supra* note 88.

Justifications for the Use of Cage Beds

Information on the use of cage beds – even in local languages – is exceptionally difficult to find.[105] The four countries under study all use cage beds, to varying degrees, but the justifications for their use are essentially the same everywhere. While many of the mental health professionals interviewed expressed dislike for cage beds, they could see no other means with which to deal with difficult situations as a result of inadequate resources, staff and training. MDAC found that incidents of aggression or violent behavior are reported as being very rare and instead, cage beds are used as protective measures and to manage what is perceived as "challenging" or "difficult" behavior.[106] Due to the factors named above, individuals with special needs are unable to be properly cared for and are instead, simply locked away. MDAC also found evidence that cage beds are used as a method of punishment or discipline: a clear violation of international standards.[107]

"If we had the possibility to have more staff and personal assistance for the clients and personal bedrooms, then their [cage bed] use would be quite minimal,"[108] said one nurse in a Czech social care home. Inadequate staff levels and overcrowding were given as major reasons for the use of cage beds in many of the institutions MDAC visited. In this particular social care home with a total of 300 residents, there was one nurse at night to care for 5 "family units," comprising 12 to 15 people each, or an average of one nurse for 65 residents.[109]

The institutions visited in Hungary had between 100 and 410 residents or patients, with typically one nurse to care for nine people during the day and one or two nurses to care for 30 to 100 individuals at night. According to one social care home director in Hungary, "statistically, if there are 2.6 staff persons for 50 residents then you can understand that cage beds are very easy to use and are simple tools."[110] One nurse in a social care home that has withdrawn cage beds said, "I think cage beds are very convenient. It makes life easier for the

[105] MDAC found references in these countries to people with mental disability being placed in chains, straitjackets, seclusion cells, and other mechanical restraints such as belts, but could scarcely find any mention of cage beds in any literature.
[106] Interview material from MDAC file #CZ01-22-1 (26 February 2003), #CZ01-22-3 (28 February 2003), #SK01-22-3 (10 March 2003) and #HU02-22-5 (6 May 2003).
[107] *See* CPT Standards, *supra* note 98, ¶ 48.
[108] Interview material from MDAC file #CZ02-22-5 (3 March 2003).
[109] Interview material from MDAC file #CZ02-22-4 (3 March 2003).
[110] Interview material from MDAC file #HU02-22-2 (20 February 2003).

staff."[111] A social care home director in Hungary said that one of the main reasons cage beds were used was because "staff wanted peace and convenience."[112]

MDAC found overcrowded conditions of up to 15 beds per room with too few staff members to adequately supervise residents or patients, where staff could see no alternatives to the use of cage beds. According to a representative of the Ministry of Health and Social Affairs of Hungary, proof that the use of cage beds is connected to overcrowding is that "all of the cage beds we found [during inspections] were not close to the nurses' stations … So they just left them there and didn't pay attention anymore because they found it to be a solution to lock them in."[113] With an adequate number of sufficiently trained staff to care for individuals with special needs, there would be "no need at all to have cage beds…"[114] she added.

The lack of adequate staff is not a sufficient excuse for the denial of fundamental human rights. Principle 14(1) of the MI Principles requires States to provide adequate resources to ensure "[q]ualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy…"[115] Further, there can be *no* justification under the ICCPR and ECHR for inhuman or degrading treatment. The prohibition of such ill-treatment is absolute and States must find alternatives.

Management of Aggressive or Violent Behavior

The principal reason stated for the use of cage beds was to manage aggressive or violent behavior. However, in virtually all of the institutions MDAC visited, incidents of aggressive or violent behavior were identified as being very rare, occurring "maybe once a decade," according to a nurse in a large psychiatric hospital in the Czech Republic.[116] In Hungary, one doctor reported that: "There were years when there was no aggression at all."[117] A social care home nurse said that she had never been struck in the forty years that she had worked at the institution, "even though I am a small woman," she added.[118] Another social care home in

[111] Interview material from MDAC file #HU02-22-1 (13 February 2003).
[112] Interview material from MDAC file #HU02-22-2 (20 February 2003).
[113] Interview material from MDAC file #HU03-23-2 (23 April 2003).
[114] *Ibid.*
[115] MI Principles, *supra* note 80.
[116] Interview material from MDAC file #CZ01-22-1 (26 February 2003).
[117] Interview material from MDAC file #HU01-22-6 (6 May 2003).
[118] Interview material from MDAC file #HU02-22-5 (6 May 2003).

Slovakia with one cage bed reported that it was used "only for cases when clients became a danger to themselves or others" and that it had not been used so far this year and in ten instances in 2002.[119]

The determination of what constitutes aggressive behavior is highly subjective and underscores the potential for abuse with cage beds. One former psychiatric hospital patient in Slovakia explained that she was placed into a cage bed for "a few days" for "shouting and crying."[120] There is also evidence to show that the restraint process itself can lead to assault or injury of staff or patients.[121] As one nurse in the Czech Republic confirms, "Sometimes a patient may bite or scratch someone while he or she is being restrained but cases of attacks or injuries are very rare."[122] In any event, the standard that applies in cases where an individual poses a danger to him or herself or others, is given by the CPT. It states that where physical restraint is necessary, after initial non-physical efforts fail, it should be limited to manual control.[123] Additionally, the MI Principles require that every patient have the right to the least restrictive or intrusive treatment possible.[124] Cage beds do not meet that standard.

Protection from Injury

With cases of aggressive or dangerous behavior being rare, cage beds are primarily used "not because the residents were dangerous but rather to protect the residents from something," [125] said one social care home director in Hungary. In a geriatric ward of a psychiatric hospital in Slovakia, one doctor said that cage beds were locked "for patients who are very confused at night and want to go to the toilet. They can fall and break a hip. For this reason, these patients are closed in bed only at night."[126] Another doctor concurred:

> *We use it mainly for psycho-geriatric patients who are unable to follow instructions and they are restless. They move all the time and when you use some drugs, they often have problems with stability and you can avoid some serious injuries when the patients are in the bed. On the other hand, when you put these patients into these kinds of beds, only during the night, they can sleep if they can't get out. If you do not use this kind of restraint, they are always trying to walk. They do not sleep.*[127]

It is highly unlikely that anyone, involuntarily restrained, would be lulled into a sleepy sense of tranquility by being confined in a cage bed. This doctor went on to add that cage beds were used "combined with psycho-pharmacological drugs."[128] If a person is chemically restrained because of his or her sleeplessness or agitation, their placement in a cage bed seems all the more inappropriate and unnecessary. Moreover, justifying the use of cage beds to prevent injuries from falls defies all the evidence that shows that facilities can reduce or eliminate restraint without any corresponding increase in injury from falls and that restraint may contribute to injury more than reducing it.

The justification of cage bed use to protect individuals from harming themselves is also unfounded and inappropriate. In a Hungarian social care home, a special cage bed with high

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[119] Interview material from MDAC file #SK02-22-5 (10 March 2003).
[120] Interview material from MDAC file #SK03-21-2 (30 April 2003).
[121] *See* "Restraint & Seclusion" above.
[122] Interview material from MDAC file #CZ01-22-1 (26 February 2003).
[123] *See* CPT Standards, *supra* note 98, ¶ 47.
[124] See MI Principles, *supra* note 80, principle 9(1).
[125] Interview material from MDAC file #HU02-22-2 (20 February 2003).
[126] Interview material from MDAC file #SK01-22-3 (10 March 2003).
[127] Interview material from MDAC file #SK03-22-14 (13 March 2003).
[128] *Ibid.*

metal bars but not enclosed on top was recently built to restrain a female resident who became highly "aggressive" and prone to self-injury during epileptic seizures. How placement in a metal cage could prevent her from injuring herself was not explained. A representative of the Ministry of Health, Social and Family Affairs in Hungary also acknowledged this fact, saying: "The only thing that cage beds can prevent is having contact between two people: the one in the cage bed and another one. It is not prevention from self-injury."[129]

Punishment

Although prohibited by domestic law in Hungary, "there is a role for cage beds as punishment" one patient's rights advocate who oversees five hospitals told MDAC.[130] Since there are no effective mechanisms for control or oversight to ensure that the law is obeyed, cage beds are used as disciplinary measures. A nurse in a social care home in Slovakia openly admitted that "it is punishment for them to go to the cage bed and they are afraid of it."[131] By all accounts heard by MDAC, nursing staff was fully aware of the fear that placement in cage beds elicited in patients or residents. A former patient recounted "patients spoke to each other when someone started to become aggressive. They said, 'Please be quiet. … Don't do this because they might put you in a cage bed.'"[132] During one visit to a Czech psychiatric hospital, a doctor asked a young man to tell MDAC researchers what he had done that caused him to be put in a cage bed. The man simply replied, "I was naughty." Clearly there was the perception of the use of the cage bed as a punitive device. The use of cage beds as punishment is particularly cruel and violates the CPT's guidelines on restraint use which categorically state that physical restraints "should never be applied, or their application prolonged, as a punishment."[133]

Whatever the reasons cited, the continued use of cage beds is unjustifiable. Their use violates international professional standards on restraint and disregards clear evidence showing that restraint can be anti-therapeutic and physically as well as psychologically damaging. Furthermore, the use of cage beds constitutes inhuman and degrading treatment, a fundamental human rights violation, which cannot be justified under any circumstance.

[129] Interview material from MDAC file #HU03-23-2 (23 April 2003).
[130] Interview material from MDAC file #HU01-23-1 (9 April 2003).
[131] Interview material from MDAC file #SK02-22-9 (11 March 2003).
[132] Interview material from MDAC file #SK03-21-3 (30 April 2003).
[133] CPT Standards, *supra* note 98, ¶ 48.

Testimonies

The testimonies of people interviewed by MDAC on their personal experiences of being placed in cage beds, reveals very similar stories of fear and humiliation. These interviews show that the use of cage beds is perceived by those placed in them as inhuman and degrading and cannot under any circumstance be justified or considered therapeutically necessary.

MDAC found a lack of knowledge about the traumatic effects of caging among mental health care professionals during its research. One hospital director was so oblivious to the damage that cage beds can inflict on persons confined within them that it was suggested that "maybe it would be better to have them [cage beds] in different colors."[134] For those who have never been involuntarily caged, it is difficult to know what the experience is like for someone who has. One doctor expressed the viewpoint that cage beds were preferable to restraint with straps, seclusion, or chemical restraint.[135]

Since 'there is no way to ethically fill the gap between using involuntary physical restraint and experiencing it, those who use it, will usually never experience it. So they cannot know how it feels.'[136] Asked about the potential for abuse of cage beds, one doctor told MDAC that in his 28 years in the profession, he had never seen any abuse.[137] On the other hand, according to one former patient who has been locked in a cage bed, "Anything in psychiatry can be abused but cage beds are an abuse in themselves."[138]

Often, the airing of grievances or alleging that a right has been violated of those with mental disability takes place in an environment where stigma against them is used to cast doubt on and invalidate their experiences. "Psychiatric patients are discredited before even speaking; their ability to claim their own reality denied; their civil rights limited…. The victim's task of establishing that restraint and seclusion constitute psychiatric abuse of traumatic proportions…must occur against a backdrop of almost hopeless disparity of credibility."[139]

In her capacity as a patients' rights advocate, one former patient said that she had heard "many patients complain about it [placement in cage beds]" and commented that, "generally, patients do not want to talk about cage beds because it is a very bad experience and very degrading for them."[140] Despite this and the fact that many people tend not to question the medical treatment imposed on them,[141] in most interviews conducted by MDAC, individuals felt that their placement in cage beds constituted a breach of trust by their caregivers. The personal experiences of those who have been put in cage beds leaves no room for doubt about the suffering and humiliation they cause to those confined within them.

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[134] Interview material from MDAC file #CZ01-22-3 (28 February 2003).
[135] Interview material from file #SK03-22-14 (13 March 2003).
[136] Kovács, *supra* note 70.
[137] Interview material from MDAC file #SK03-22-14 (13 March 2003).
[138] Interview material from MDAC file #SI03-21-2 (26 March 2003).
[139] Cohen-Cole, *supra* note 35, p. 6.
[140] Interview material from MDAC file #SK03-21-2 (30 April 2003).
[141] Lewis, *supra* note 40, p. 59.

> *People who have been in cage beds always tell the same story: they felt like animals. People were thrown in there and left for 12, sometimes 24 hours. These people were thirsty because they were sedated and would have to use the toilet facilities. When they shouted, no one answered. They had no choice but to soil themselves, which was another humiliation.*[142]

The sentiments expressed by this ex-user of psychiatric services were shared by a number of individuals interviewed. MDAC also found that people who have been confined to cages spend much longer than 24 hours in them. A former psychiatric service user in the Czech Republic communicated his experience to MDAC:

> *I would like to try, at least to outline objectively the problem of cage beds from a psychiatric patient's point of view, who has experienced it himself.*
>
> *First, I would like to start with my own experience, which happened in the fall of 2000. During my stay at a psychiatric hospital ..., where I voluntarily asked for professional help, I was confronted in this way: without any consultation on the treatment procedure or therapy, I was put in one of these cages, where they forced me to stay for about a week. The feelings are very hard to describe, although I will probably never forget and the fear caused by it will stay with me forever, it was a mixture of betrayal, fear, humiliation, powerlessness and hopelessness…"*[143]

Speaking to a former psychiatric service user, MDAC asked what her opinion on cage beds was. She responded, "I am definitely against them because I have experienced it and I know how awful it is to be locked up. You feel like you would rather kill yourself than be in there for several days."[144] She explained that while she was in a cage bed, she watched another woman die in another cage bed in the same room. "In the evening they [staff] just came, took the body and let me out." The testimonies of three different users in three different countries described similar experiences of being forced to witness another person's death while locked in a cage bed.[145]

"When you just look at the bed, especially when the net is up, it looks innocent," explained a woman in the Czech Republic. "But when a person is locked in there, it is quite different. Sometimes people want to go to use a bathroom and they cannot. So they pull up their mattress and go to the bathroom through the iron bars."[146] A former patient in the Slovak Republic shared her experience with MDAC:

> *It was about one week after I had my baby. I was in a manic state and I was put in the hospital. I received sleeping pills. I don't know how long I slept. When I woke up I went to the lobby. I met a nurse there but I was confused and unable to tell her what I wanted. After that the nurse asked another nurse and an orderly to come over. They wanted to give me more sleeping pills but I refused. They wanted to give me an injection, which I also rejected. I jumped on the floor. After that, they gave me an injection and put me in a cage bed.*[147]

She was not a danger to herself or anyone else. She went on to explain:

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[142] Interview material from MDAC file #SI03-21-2 (26 March 2003).
[143] Anonymous Statement received by MDAC from a psychiatric ex-user and member of NGO, on file with MDAC #CZ03-21-5 (28 February 2003).
[144] Interview material from MDAC file #CZ03-21-4 (28 February 2003).
[145] *Ibid*, Interview material from MDAC file #SI03-21-1 (25 March 2003), Interview conducted at a psychiatric hospital in Hungary (9 April 2003).
[146] Interview material from MDAC file #SI03-21-1 (25 March 2003).
[147] Interview material from MDAC file #SK03-21-3 (30 April 2003).

> *When I woke up, I had to go to the bathroom. They wouldn't allow me to go. I shouted for about 30 minutes. After that I had to do it in the cage bed like an animal. Of course I had trouble going to the bathroom since I had just had a baby ... After that I had to stay in the cage bed and they didn't change the bedding or the mat even though it was dirty. They didn't want to let me out and also refused to clean the mattress.*[148]

Regarding the supervision received, she added:

> *They saw me but they didn't come. They didn't talk to me. Later a nurse came and told me I could go to dinner. I asked her if I would have to return to this smelly bed and she answered that I had no right to ask that question. So they didn't allow me to go to dinner even though they wanted to let me go before just because I asked a question. After one and a half hours when they saw that I was quiet and just crying because I felt helpless, they let me out."*[149]

During the same hospitalization, she was placed in a cage bed on another occasion. She said, "I had to … go to the bathroom very often at night. After about the third time, the nurse saw me and asked another nurse to help her put me in the cage bed again, without any reason. I was not aggressive. I was not crying or shouting. I didn't wake up other patients."[150] A former psychiatric patient in Hungary told of the same experience of being placed in a cage bed for getting up twice at night to use the toilet. "I have claustrophobia," he explained. "There was nothing to urinate in so I had to scream to get attention to go to the bathroom. I spent one full day in there [the cage bed] but there was no mention made in my medical record."[151]

The only interviews conducted by MDAC of individuals placed in cage beds were with former psychiatric hospital patients who invariably described their experiences highly negatively. But many social care homes and hospitals reported that cage beds were mainly used for people with severe intellectual disabilities who exhibited 'challenging' or 'difficult' behavior and were rarely aggressive or violent. Due to the nature and severity of their disabilities, no testimonies from such individuals could be obtained. Yet, it is these individuals whom MDAC has found are sometimes kept in cage beds for years. There is no doubt that these individuals suffer from the same adverse physical and psychological effects, regardless of whether they are able to communicate their feelings or not.

[148] *Ibid.*
[149] *Ibid.*
[150] *Ibid.*
[151] Interview material from MDAC file #HU22-21-10 (13 February 2003).

Hungary

The State of Mental Health Care

Hungary is a higher middle-income group country according to World Bank 2000 criteria, with a total population of 10 million.[152] The proportion of health budget to GDP is 5.3%, 8% of which is spent on mental health care.[153] Government sources estimated that there are between 600,000 and 1 million persons with disabilities, or 6 to 10 percent of the population.[154]

Unlike the other countries under review, Hungary has one Ministry, the Ministry of Health, Social and Family Affairs, which is responsible for all psychiatric establishments, both hospitals and social care homes. Statistics show a total of 10,078 psychiatric beds.[155] According to the Hungarian Central Statistical Office, there were 74,338 residents in 1,230 social care institutions under the direct authority of municipal governments in 2001 (the most recent year for which data is available). The populations housed in these facilities include the "aged, psychiatric patients, addicts, handicapped children and adults, homeless persons and others."[156] As is widely acknowledged, it is routine to find mixed populations of residents in most institutions.

According to the World Health Organization, "collaboration between government departments [in Hungary] on mental health issues is not strong and the nongovernmental organizations are relatively weak, as well as lacking experience in collaborating with governmental agencies."[157] There are few "modern forms of outpatient and half-way institutions."[158] This leads to the hospitalization of "social cases" or people with chronic mental health problems for many years as they wait to enter social care homes. The waiting lists for social care institutions are frequently long, and many people spend their entire lives in such institutions. A new Health Act came into effect in 1997, and while there is no special law on mental health, the Health Act contains a chapter on mental disorders and their treatment.

Domestic Legislation and Standards

The Constitution of Hungary states in Chapter XII, Article 54(2) that: "No one may be subjected to torture, or to cruel, inhuman or humiliating treatment or punishment." Chapter I, Article 7 also provides that: "The legal system of the Republic of Hungary accepts the generally recognized principles of international law, and shall harmonize the country's domestic law with the obligations assumed under international law."

The legislation on mental health issues, including the protection of human rights for people with mental disability, generally conforms to international standards, but enforcement

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[152] World Health Organization (WHO) *Atlas Country Profiles on Mental Health Resources 2001*, Geneva, WHO/NMH/MSD/MDP/01.3, p. 321 available at: http://www5.who.int/mental_health/download.cfm?id=0000000243.

[153] *Ibid*, p.321.

[154] US State Department Human Rights Report, Hungary 2002 also mentions that the use of cages was criticized by MDRI and PEF, available at: http://www.state.gov/g/drl/rls/hrrpt/2002/18369.htm.

[155] Hungarian Ministry of Health Statistical Summary 1999, available at: http://www.eszcsm.hu/eum/english/adatgy-eng.htm.

[156] Hungarian Central Statistical Office, available at: http://www.ksh.hu/pls/ksh/docs/index_eng.html.

[157] "Mental Health in Europe," Country Reports from The WHO European Network on Mental Health (2001), p. 36.

[158] *See* WHO Atlas Country Profiles, *supra* note 152, p. 322.

mechanisms are either absent or very weak. On restraint use in psychiatry, the Health Care Act (1997), Section 10(4) stipulates that:

> *[A] patient's personal freedom may be restricted by physical, chemical, biological or psychological methods or procedures exclusively in case of emergency, or in the interest of protecting the life, physical safety and health of the patient or others. Restriction of the patient may not be of punitive nature and may only last as long as the cause for which it was ordered exists.*[159]

Chapter X, which deals specifically with psychiatric patients, provides even more detailed guidance on the use of restrictive measures:

> *192. §(1) Only a patient who exhibits dangerous or immediately dangerous behavior shall be restricted in his personal freedom in any manner whatsoever. The restriction shall only be maintained, and shall only be employed to the extent and in the manner that is absolutely necessary to avert the danger.*[160]

In 2000, the Hungarian Constitutional Court ruled on a case concerning the use of cage beds to restrict freedom of movement included in the Health Care Act. The Court's opinion was that the Parliamentary provision for the restriction of an individual's freedom was unconstitutional. Its failure to set up the provisional conditions for the restriction of freedom of movement was found to violate constitutional provisions. The Court ruled that "arbitrary" restriction of freedom can exist not only where lack of conditions for such restriction are given but also when the *means of restriction* are not delimited in concrete legal provisions. The Court did not, however, specifically deal with whether the use of cage beds to restrict one's liberty could be considered unconstitutional.[161]

Cage Beds in Hungary

Hungary was the first country to have the use of cage beds denounced in a number of influential reports. The first in 1996, by Dr. Katalin Gönczöl, Hungary's then Parliamentary Commissioner for Human Rights, reported on human rights protection in five social care homes in Hungary and criticized the use of cage beds. International attention to cage bed use in psychiatric institutions in Hungary was raised by Mental Disability Rights International's (MDRI) report *Human Rights and Mental Health: Hungary* in 1997. MDRI found the use of cage beds to "create unnecessary suffering on the part of people with mental disabilities." It also found that the use of cage beds "constitutes inhuman and degrading treatment under the ICCPR and ECHR."[162]

Two years later in 1999, the CPT visited Kenessey Albert Hospital and Ludányhalászi Social Care Home in Hungary and called for the immediate withdrawal of cage beds from all psychiatric institutions. The elimination of cage beds in Hungary has still not been achieved, almost four years later. In addition to the standard protocol for CPT proceedings described in the preceding section, in exceptional circumstances the CPT may make immediate

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[159] Hungary Act CLIV of 1997 on Health, promulgated on 23 December 1997, available (English) at: http://www.eum.hu/eum/english/CLIV/chapter1-2.htm#ch2.
[160] *Ibid*, Chapter 10, Section 192, available at: http://www.eum.hu/eum/english/CLIV/chapter10-.htm#ch10.
[161] PÉF, "The Human Rights of Patients in Social Care Homes for Mentally Ill 2001," unofficial translation of Constitutional Court Case (36/2000 (X.27)AB provision).
[162] MDRI, *Human Rights and Mental Health: Hungary* (March 1997) p. 27.

observations under Article 8, paragraph 5 of the Torture Convention[163] to hasten communications and action to redress situations of major concern. In 1999, the CPT made such immediate observations on the issue of cage beds:

> *...the CPT wishes to stress that placement in facilities such as net-beds cannot be considered, in modern psychiatric practice, as a valid method of intensive care for residents in a state of agitation. Further, such an approach could lead to abuses. At the end of the visit, the delegation invoked Article 8, paragraph 5, of the Convention and requested the Hungarian authorities to ensure the immediate withdrawal from service of all such net-beds throughout the country. It asked to receive a report on the action taken in response to this request within three months.* [164]

In the Hungarian Government's Response to the CPT Report, it was stated that a Methodological Note had been issued on "Guiding Principles for Nursing and Caring Activities in Homes for Patients with Addictive or Psychiatric Disorders." This Methodological Note was issued by a working group set up by the Hungarian Psychiatric Society for the sole purpose of drafting the Note.[165] It includes a chapter guaranteeing the rights and interests of patients and expressly forbids the use of cage beds, but only in social care homes for psychiatric patients.[166] As a recommendation with no legal enforceability, there is nothing to legally compel institutions to withdraw cage beds from use.

The Ministry conducted a survey on "measures, methods, and means of restraint" in 1999 "in all institutions for psychiatric patients."[167] The Government of Hungary was forthcoming in detailing the measures taken to comply with the CPT recommendations and admitted that a total of 31 cage beds had been found in 7 counties and in two Budapest institutions. The Government took the further measure of instructing county governments to send a circular to institutions requesting that cage beds be removed.[168] Despite these measures, the eradication of cage beds has yet to be achieved in social care homes for psychiatric patients. It is clear that in order to eradicate cage beds from all psychiatric institutions, national legislation prohibiting their use will be required.

MDRI's report, detailing conditions of residents in psychiatric institutions living in cage beds, had a profound influence on the withdrawal of cage beds from many psychiatric institutions. One doctor, head of a psychiatric department at Kenessey Albert Hospital, who was against cage bed use said that following the report, "[the staff] witnessed the

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[163] The text reads: "If necessary, the Committee may immediately communicate observations to the competent authorities of the Party concerned." European Convention on the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *supra* note 95, Article 8 (5).

[164] CPT Report on Hungary, *supra* note 1, p. 53 ¶ 157.

[165] Response of the Hungarian Government to the Report of the CPT on its Visit to Hungary from 5 to 16 December 1999 (Strasbourg, 29 March 2001) p. 38, ¶ 75, available at: http://cpt.coe.int/documents/hun/2001-03-inf-eng.pdf.

[166] Hungarian Ministry of Health and Social Affairs, "Guiding Principles for Nursing and Caring Activities in Homes for Patients with Addictive or Psychiatric Disorders," unofficial translation, states that possible means or tools to manage violent behavior include psychological de-escalation, pharmacotherapy, separation of the patient, and restraint, and that "cage beds cannot be enumerated among these means!" It also states that the placement of a person in a cage bed violates the person's personality rights, norms on the application of coercive measures, constitutes inhuman and degrading treatment under international law, and can be dangerous to a patient's life. It states that cage bed use cannot be accepted as a means of detention, corporal punishment, or part of normal hospital treatment, p. 20.

[167] Government of Hungary Response to CPT Report, *supra* note 165, p. 36, ¶ 74.

[168] *Ibid*, p. 38, ¶ 75.

international criticism imposed on the hospital so no one opposed the removal of the last cage beds."[169]

A Mental Health Interest Forum (PÉF) report, entitled *Human Rights of Patients in Social Care Homes for Mentally Ill*, a systematic survey of all 52 social care homes for people with psychiatric diagnoses in Hungary, found that eight institutions still used cage beds in 2001. The Ministry conducted its own research in 2001, corroborating PÉF's findings. The Ministry found that a total of 19 cage beds were still being used in social care homes for psychiatric patients. What is largely unknown are the conditions in the roughly 160 social care homes for about 24,000 people with intellectual disabilities in Hungary.[170] This is cause for alarm since a representative from the Ministry said that a "larger number of cage beds were found in homes for people with intellectual disabilities" and that of the 19 cage beds found in institutions for psychiatric patients, "only two were used for psychiatric users and 17 for people with intellectual disabilities."[171]

The great deal of attention placed on social care homes for people with mental disability and on the use of cage beds in particular has made gaining access to any psychiatric facility for research purposes particularly difficult.[172] All the sites MDAC was able to visit had removed cage beds, except a psychiatric ward of a general hospital. The lessons to be learned from the staff and residents of these institutions that have withdrawn all cage beds are highly constructive, and they should be used as a resource to assist other facilities in doing the same.

Process of Elimination

Two years after the CPT called for the removal of cage beds from all psychiatric institutions in Hungary, a fire was started in Törökszentmiklós Social Care Home in November 2000, and a man, who was placed in a cage bed almost every night was killed. Everyone else in the social care home was able to escape, but because he was locked in the cage, the staff was unable to save him. It took this event to convince the management of the institution to stop using cage beds entirely. In the opinion of the head nurse of the institution who has worked there for forty years:

> *When I started working here and the building was constructed, there were no cage beds and I wasn't even aware of such equipment. It was simply beyond my imagination. But after the first cage bed was purchased, it became routine. We had them and used them. Now that we do not have any cage beds again, we can see that it is possible to live and work without cage beds and I simply think that it is a stupid piece of equipment. But if you have them you use them.*[173]

The most common reason given for the withdrawal of cage beds from use in the social care homes visited is that orders were received from a higher authority. One social care home director told MDAC, "I spent many years as a head nurse and I hoped I could have the confidence from the staff in making the decision to remove the cage beds, but many of them just thought I went crazy and forgot how difficult it was to care for the patients. If the office of the Public Authority (municipal government) had not required it, I couldn't have removed the cage beds on my own." She went on to add that in a national meeting of social care home directors in 2002, "someone asked them to express their opinions on whether social care

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[169] Interview material from MDAC file #HU01-22-6 (6 May 2003).
[170] Interview material from MDAC file #HU03-23-2 (23 April 2003).
[171] *Ibid.*
[172] Out of five psychiatric hospitals to which MDAC sought access, only two allowed a visit to proceed.
[173] Interview material from MDAC file #HU02-22-1 (13 February 2003).

homes could function without cage beds. The majority said 'no,' but surprisingly at the same time, the number [of cage beds] has decreased. The reduction is perhaps not due to a change in cage beds [themselves] but on requirements."[174]

The Ministerial Guidelines, prohibiting cage bed use in psychiatric social care homes, are insufficient without monitoring and oversight to ensure that the guidelines are followed. "When we started to investigate the system," reported a ministerial representative, "there was a small institution for people with intellectual disabilities with 150 residents that had 14 cage beds. When they found out about the visit, they immediately removed them and after that they stopped using them. They didn't change anything but they found out that they didn't need them. They used them without any sense. The only thing they did was move the 14 people closer to the nurses' station. They were originally put in cage beds because of disturbing behavior and just because of the proximity to the nurses, they found they could handle the situation."[175]

Staff in each of the social care homes that have withdrawn cage beds from use said that it was necessary to do so in a gradual process so that both staff and residents who had become accustomed to their use could acclimate to a cage-free environment. After the Ministerial guidelines were issued, the approach of one home was to organize a meeting for the nurses and inform them about the guidelines and the protocols which must be adopted. This facility also trained selected nurses in manual restraint techniques to manage aggressive or violent behavior. When the new director of one social care home decided to withdraw cage beds, he met with staff members from each department, explained his position and listened to the opinions and concerns of the staff to build consensus.[176]

Where there is a lack of adequate staffing and training on alternative methods of dealing with difficult or challenging behavior, the withdrawal of cage beds may cause resentment among staff members whose cooperation is imperative in creating a safe environment. One social care home director said, "Among the older staff members, you always find some who will say that 'for 100 years, I worked this way, so why should I change?"[177] Asked what the largest obstacles to a complete elimination of cage beds were, a Ministry representative said, "I think there are two main obstacles: attitude and education. It is most important to have the appropriate number of educated staff in the system."[178]

Without the support of the staff and destruction of cage beds, as opposed to their placement in attics or basements, there is always the potential for their reinstitution when the staff feels they have no alternatives. MDAC found that in one social care home, all of the "net beds" were removed but a new cage bed was introduced. This cage bed was specifically built for a young woman who has severe intellectual disability and epilepsy. The director of the institution described it as "a special bed" which is "a kind of cage but not a traditional one since she is able to stand up." The director added, "I think this bed looks terrible, like a cage in a zoo. … The biggest problem with this cage bed is that I cannot guarantee that only that woman with seizures is placed in the bed."[179] The need for a clear legal prohibition, and enforcement of such a prohibition on the removal of cage beds from these institutions is essential.

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[174] Interview material from MDAC file #HU02-22-2 (20 February 2003)
[175] Interview material from MDAC file #HU03-23-2 (23 April 2003).
[176] Interview material from MDAC file #HU02-22-5 (6 May 2003).
[177] Interview material from MDAC file #HU02-22-2 (20 February 2003).
[178] Interview material from MDAC file #HU03-23-2 (23 April 2003).
[179] Interview material from MDAC file #HU02-22-2 (20 February 2003).

Accountability and Monitoring

There is a patient's rights ombudsperson for every hospital in Hungary, but frequently, one person is assigned to visit several facilities. MDAC has found that this system fails to protect people with mental disability, partly due to the lack of training in psychiatric issues given to these ombudspersons. One patients' rights ombudsperson explained that all hospitals are required by law to inform the ombudsperson of every instance of restraint used, but that this is rarely observed.[180] A system of ombudspersons for social care homes was supposed to have been started in January 2003, but at the time of writing, had yet to be established.[181]

The director of the Hungarian Civil Liberties Union, a human rights NGO which has done extensive work on patients' rights issues in Hungary, reported that while conducting research, they were denied permission to visit eight out of the ten psychiatric hospitals to which they sought access. MDAC was denied access to one psychiatric hospital because a doctor stated that the psychiatric department was undergoing renovation and did not want to allow a site visit for that reason.[182] In other cases, psychiatrists who were contacted replied that the approval of the hospital director was required and for various reasons, these directors were never available.[183] It is obvious that in order for human rights to be protected, independent monitoring is required, particularly in the cases of individuals who are most vulnerable to abuse.

There must be mechanisms put in place to enforce the right to be free from ill-treatment, such as placement in cage beds, in all psychiatric settings. On the elimination of cage beds, one director stated, "The major problem is that the law can't be enforced."[184] While they are necessary, legal obligations without enforcement mechanisms can be equally hollow. The Hungarian government must be held accountable for ensuring that fundamental rights of persons with mental disability are protected. There are individuals within institutions, the mental health profession and within the government who would like to see the end of cage bed use but the State must bear the responsibility for a comprehensive change to occur.

[180] Interview material from MDAC file #HU01-23-1 (9 April 2003).
[181] Interview material from MDAC file #HU03-24-1 (12 February 2003).
[182] Békéscsaba Hospital Psychiatric Ward
[183] Psychiatrists at Debrecen Hospital and Koposvár Hospital were contacted to seek permission for a visit and MDAC was told that permission would have to be granted by the head doctor or director of the hospital, from whom no response could be received despite many phone calls and requests being sent.
[184] Interview material from MDAC file #HU02-22-2 (20 February 2003).

Czech Republic

The State of Mental Health Care

The Czech Republic is a higher middle-income group country based on World Bank 2000 criteria, with a total population of 10.26 million. The proportion of health budget to GDP is 7.6%, and of that total 3% is spent on mental health.[185] According to a study conducted by the Center for Mental Health Care Development (CMHCD), an NGO based in Prague, there are 38,391 beds for people with mental disability in nearly 500 social care institutions in the Czech Republic under the authority of municipal governments directly and the Ministry of Social Affairs indirectly. The Ministry of Health is responsible for approximately 10,000 beds in 22 psychiatric hospitals and an additional 1,400 beds in psychiatric departments of general hospitals.[186]

Social care in the Czech Republic is described as "insufficient" by the WHO, due mainly to "a lack of communication among the different providers."[187] There is inadequate care for people with chronic mental health problems, stemming from the "lack of priority given to this area" and the "lack of coordination between health and social care,"[188] which results in long waiting lists for placement in social care homes. The goals and reforms that have been achieved in mental health care were formulated by the Commission of the Psychiatric Society of the Czech Medical Association and published in 1997 as *Psychiatric Care in the Czech Republic – Programme Document and Mental Health Care Policy.* The majority of work in providing community services is done by various NGOs.[189]

Domestic Legislation

The Czech Republic has elevated human rights norms to a higher law status. Article 10 of the Constitution, concerning international human rights treaties, states that "Ratified and promulgated international accords on human rights and fundamental freedoms, to which the Czech Republic has committed itself, are immediately binding and are superior to law."[190] There is no specific legislation on mental health, but regulation of mental health is covered by the Law on Health Care for the Population (Act. No. 20/66 Coll.). A new Health Care Act is currently being debated to replace the existing Act from 1966 but at present, there is no legal regulation on the use of restraint in psychiatry.[191] Following the CPT visit in 2002, the Ministry of Health asked the Psychiatric Association to draw up quality standards to include guidelines on restraint use.[192]

Cage Beds in the Czech Republic

There has been little attention placed on the use of cage beds in psychiatric institutions in the Czech Republic. The CPT report on its visit to the Czech Republic in 2002 has not yet been made public. In their previous visit in 1997, no psychiatric institutions were visited and so no mention was made regarding the use of cage beds. The visits conducted in 2002 included one

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[185] *See* WHO Atlas Country Profiles, *supra* note 152, p. 298.
[186] APEL Study, results shared with MDAC by CMHCD in an email communication dated 13 February 2003.
[187] WHO Regional Office for Europe, "Health Care Systems in Transition Summary: Czech Republic," 2002, p. 5, available at: http://www.who.dk/document/Obs/CZHsum112002.pdf.
[188] *Ibid,* p. 6.
[189] Mental Health in Europe, *supra* note 157, p. 20.
[190] Constitution of the Czech Republic, Constitutional Act No. 1/1993 Coll. of the Czech National Council of 16th December 1992, as amended by Acts No. 347/1997 Coll., 300/2000 Coll., 448/2001 Coll., and 395/2001 Coll. Chapter 1, Article 10, available in English at: http://www.psp.cz/cgi-bin/eng/docs/laws/constitution.html.
[191] Ministry of Health of the Czech Republic, http://www.mzcr.cz/data_e/c6/lib/20-1966.doc.
[192] Interview material from MDAC file #CZ03-23-1 (27 February 2003).

psychiatric hospital and one social care home for juveniles with mental disabilities. The report will not be released until the government of the Czech Republic authorizes it.

CMHCD conducted a study on the protection of human rights in psychiatric hospitals in the Czech Republic, which will be made public in June 2003. It found that in Jihlava Psychiatric Hospital, 60 out of 600, or 10% of the total bed capacity are cage beds. In 2002, 416 people were placed into cage beds. In Kosmonosy Hospital, which has approximately 500 beds, 430 people were placed into cage beds; while in Opava Psychiatric Hospital, cage beds were used to restrain 20 people last year. According to the findings of this study, cage beds are widely used in psychiatric hospitals. MDAC was denied permission to visit any of the above hospitals.

All of the institutions MDAC visited had some internal regulations on restraint use. Officials at facilities that have such internal regulations are able to admit that abuses may occur elsewhere. "This is true that cage beds can be abused and it depends on each particular institution and how they work out rules for their use," said one nurse in a psychiatric hospital.[193] Another nurse admitted, "Before when there were no rules, sometimes the staff was tempted to use them [cage beds] just to have an easier time."[194]

However, in each of those particular institutions, MDAC found cases of individuals kept in cage beds for practically the entire day - every day - except when they needed to use the toilet. In one of these institutions, MDAC was told that in addition to the 17 or so cage beds throughout the facility, there were also two "small beds for very young children with nets to prevent these children from getting out." We were also told "these two cots don't have locks."[195] Despite these assurances, inspection revealed one of these "cots" to have metal bars and a padlock on the door. Inside was a seven or eight-year old boy with severe intellectual and physical disabilities, who was receiving no therapy and had no supervision. In one psychiatric hospital, MDAC found three men kept in cage beds in an acute intensive care ward, two of whom spend most of their time in these cages. [196]

Even where there are rules governing the use of physical restraints, cage beds are often not subject to the same regulations as other tools, such as fixation with straps or the use of straightjackets. "It is not as closely watched because there are some patients who have been here for years and it is known that they need a cage bed," MDAC was told by one nurse, "so they are not watched every hour. For sure, they get more attention than other patients. But with straps, patients are watched much more closely."[197]

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[193] Interview material from MDAC file #CZ01-22-1 (26 February 2003).
[194] Interview material from MDAC file #CZ02-22-5 (3 March 2003).
[195] Interview material from MDAC file #CZ02-22-4 (3 March 2003).
[196] Interview material from MDAC file #CZ01-22-2 (26 February 2003).
[197] *Ibid.*

At a psychiatric hospital, MDAC was told, "The use of restraints is prescribed by a doctor. There are internal regulations for these standards worked out by doctors and nurses. They specify under which conditions and how restraints can be used. Up to now, we cannot do without them, especially without cage beds. We try to use them minimally… with intellectually disabled children at night it is for 8 hours. With psychotic patients, it can be for several days, but children are taken out to use the bathroom but always accompanied by a member of the staff."[198] As can clearly be seen by this example, "minimally" is a wholly subjective and relative term, since the CPT has stated that it views the placement of individuals in restraint for a period of days as sufficient to constitute ill-treatment.[199]

There was a complete lack of recognition among many staff members of these institutions in the Czech Republic that the use of cage beds as everyday beds for residents or patients, kept in rooms with normal beds, could be considered inappropriate. The CPT has stated that the placement of cage beds in rooms with normal beds creates a degrading situation.[200] In two of the institutions visited, cage beds were used as everyday beds for some of the patients or residents. One director explained, "Some of our clients have absolutely normal beds, some of them special, and only 18 of them [are] cages."[201] During one visit, MDAC was told that the patients were not kept in the cage beds during the day but only at night. As we toured one building of a hospital housing boys with the most severe disabilities, MDAC found an adolescent boy alone in a room, locked in a cage, much to the staff and director's chagrin.

"You can see that it's not possible to do without the cage beds…. But there are no 'cage' beds, only net beds,"[202] said one director. In another institution, MDAC was told "Right now two clients are in cage beds during the day. These two clients are taken out of the cage beds during the day for some time when there is some free staff available to supervise."[203] The negative effects that placement in cage beds could have on individuals were hardly considered. In one director's opinion, "I am not very happy with cage beds in terms of hygiene and we would like to use more modern devices but we don't have enough money. Cage beds are not secure enough … It's difficult to clean them."[204]

Without any attention on the use of cage beds as a human rights violation in Czech institutions, there have been few major changes in their use. A disability rights advocate recounted what he had seen in one social care home in 1984. "At that time they used many cage beds. It is sad to say, but it looked like a zoo and the people there didn't behave like human beings."[205] In 2002, a former Ministry of Social Affairs employee visited a social care home where she saw "real cage beds" as opposed to "net beds." She said, "They were awful.

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[198] Interview material from MDAC file #CZ01-22-3 (28 February 2003).
[199] CPT Standards, *supra* note 98, p. 52, ¶ 48.
[200] Report to the Government of the Slovak Republic on the visit to Slovakia Carried out by the CPT from 9 to 18 October 2000, (Strasbourg 6 December 2001) p. 50, ¶130.
[201] Interview material from MDAC file #CZ02-22-4 (3 March 2003).
[202] Interview material from MDAC file #CZ01-22-3 (28 February 2003).
[203] Interview material from MDAC file #CZ02-22-5 (3 March 2003).
[204] Interview material from MDAC file #CZ01-22-3 (28 February 2003).
[205] Interview material from MDAC file #CZ03-21-2 (4 March 2003).

It looked awful. There were 3 cage beds in a room and the people couldn't stand up. One woman kept destroying her mat so she had no mattress but just iron bars. They had spent 99.9% of their lives in cages."[206]

Even the death of a young girl in a cage bed has not prompted calls for their removal from this particular institution or any other. In a February 2003 issue of *Respekt*, an influential Czech journal, the death of 14-year-old Adriana in a social care home was reported. She was put in a straitjacket and locked in a cage bed almost every night, according to the director of the institution. On the night of July 20, 2002, one of the iron bars of the bed fell on her and she later died in the hospital.[207] MDAC visited this institution and spoke to the director about this incident, inquiring what measures had been taken following her death to prevent similar incidents. He told us that over 1 million Czech Crowns (approximately 32,000 Euro) had been spent to replace all of the old cage beds with newer models. No measures were attempted to withdraw cage beds from use.[208]

A director of one social care home that no longer uses cage beds expressed a very different opinion on the necessity of cage beds. In this large institution with over 200 residents, cage beds were removed eight years ago. Asked how staff manages aggressive or violent behavior without cage beds, he responded, "This is what individual care is all about. The staff should know the client so well that they can predict a possible attack and prevent aggression." This director seemed impervious to staff fears about the removal of cage beds during his tenure. "I simply threw them away," he said. Regarding staff reactions to his decision to remove cage beds, "They were not very happy," he said, "but I'm not here for them."[209]

Accountability and Monitoring

No legislation or regulations exist on the national level to deal with the use of restraints in the Czech Republic. As mentioned above, the Czech Republic has legal obligations, both domestic and international, to protect the human rights of all of its citizens. This requires, in part, that independent mechanisms for monitoring and oversight be established to ensure that the rights of people with mental disability are protected. Principle 14(2) of the MI Principles obliges States to inspect every mental health facility, with sufficient frequency to "ensure that the conditions, treatment and care of patients comply with these Principles."[210] The Ministry of Social Affairs has begun an initial inspection program that was carefully designed with the cooperation of all mental health stakeholders. The major flaw with this system is that no institutions are compelled to take part in these inspections. Participation is completely voluntary[211] and those institutions with no interest in improving the quality of care or human rights protection of their clients can continue to use abusive practices unchecked. If the Czech Republic is to meet its obligations under international standards, it must enact legislation to compel all mental health institutions to undergo regular inspections with the aim of protecting the rights of the facility's clients.

The difficulties MDAC faced in gaining access to Czech psychiatric institutions are reportedly not uncommon. The Czech Commissioner for Human Rights reported that he was denied permission to visit a psychiatric hospital in the southern Czech Republic on the

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[206] Interview material from file #CZ03-23-3 (5 March 2003).
[207] Bartova, Eliška, "Us from an Institution," unofficial translation, *Respekt* (12 February 2003).
[208] Interview material from MDAC file #CZ02-22-4 (3 March 2003).
[209] Interview material from MDAC file #CZ02-22-2 (27 February 2003).
[210] *See* MI Principles, *supra* note 80.
[211] Interview material from MDAC file #CZ03-23-2 (5 March 2003).

grounds he had no right to 'disrupt' the lives of the patients.[212] Particular mention should be made of one psychiatric hospital outside Prague that refused access to MDAC for the purposes of conducting its research. It was reported by three different organizations working in the field of mental disability rights that this was perhaps the institution in the Czech Republic with the most abusive regime.[213] MDAC finds these allegations to be highly credible and calls on the Government of the Czech Republic to investigate and take measures to redress the abuses that may be taking place.

[212] Interview with Jan Jařab (3 March 2003) where he explained that Brno Psychiatric Hospital had denied him permission to visit.

[213] Horní Beřkovice Psychiatric Hospital refused permission for MDAC researchers to visit and was reported by Svaz Pacientu, CMHCD and Kolumbus to be one of the hospitals with the most abusive regimes in the Czech Republic.

Slovakia

The State of Mental Health Care

The country is a higher middle-income group country, based on World Bank 2000 criteria, with a population of 5.38 million. The proportion of health budget to GDP is 8.6% and 2% of the total health budget is spent on mental health.[214] There are 4,834 psychiatric beds situated in five large long-stay psychiatric hospitals and 1,594 beds in 25 psychiatric wards in general hospitals under the authority of the Ministry of Health.[215] As of December 2001, Slovakia had a total of 439 social care institutions with a capacity of 30,385 beds and 29,505 residents, administered by municipal governments with oversight from the Ministry of Labour, Social Affairs and Family.[216]

Slovakia is undergoing a transformation of its entire health care system, devolving authority to catchment areas or municipal authorities, with units of 100,000 to 150,000 inhabitants.[217] There is no mental health legislation, and care is based on constitutional principles and general health care laws.[218] Psychiatry is the worst paid among all branches of medicine.[219] The national health insurance policy does not provide for social workers or clinical psychologists to work as members of a team with psychiatrists and nurses in outpatient facilities.[220] The WHO describes the present state of mental health care as "insufficient and even backward, not only in comparison to the rest of the developed world, but also compared to physical health care in the country."[221]

Domestic Legislation

Chapter II on Basic Rights and Freedoms, Part 1, Article 11 of the Slovak Constitution reads:

> *International treaties on human rights and basic liberties that were ratified by the Slovak Republic and promulgated in a manner determined by law take precedence over its own laws, provided that they secure a greater extent of constitutional rights and liberties.*[222]

Article 16(2) employs similar language to international instruments, stating: "No one must be tortured or subjected to cruel, inhuman, or humiliating treatment or punishment."

Section 38(6) of the Act on Health Care 1994 describes procedures for involuntary detention and restraint for patients in hospitals.

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[214] *See* WHO Atlas Country Profile 2001, *supra* note 152, p. 372.
[215] *See* Mental Health in Europe, *supra* note 157, p. 76.
[216] Statistical Office of the Slovak Republic, available at: http://www.statistics.sk/webdata/english/srsic02a/contents.htm.
[217] *See* Mental Health in Europe, *supra* note 157, p. 76.
[218] 277 Act by the National Council of the Slovak Republic of 24th August 1994 on health care, unofficial translation.
[219] *See* Mental Health in Europe, *supra* note 157, p.78
[220] *Ibid*, p. 77.
[221] *Ibid*, p. 78.
[222] Constitution of the Slovak Republic, (3 September 1992) as amended on 14 July 1998 and 14 January 1999, available at: http://www.government.gov.sk/VLADA/USTAVA/en_vlada_ustava.shtml.

> *The health institution is obliged to notify the Court, even in the case that the patient displaying symptoms of psychiatric disorder or suffering from mental disease has been admitted with the agreement of the Court, and, in cases in which it – during treatment – turned out necessary to limit his (the patient's) free movement. Until the decision of the Court is taken, only such diagnostic and therapeutic intervention can be carried out which are inevitable for immediate life saving or preventing major deterioration of patient's health or in order to ensure the protection of the patient's surroundings.*[223]

There are no standards on the use of restraint measures throughout all hospitals in Slovakia, but the psychiatric association is currently preparing standards for care.[224]

Cage Beds in Slovakia

Following its visit to Slovakia in 2000, where the CPT delegation found cage beds in Vel'ký Biel and Okoč social care homes, it reported that "the situation of some of the residents placed in net-beds … can only be described as execrable."[225] It stated that net-beds should cease to be used.[226] The CPT's opinion on the acceptability of cage bed use was restated in a later paragraph of the report that reads:

> *On the specific issue of net-beds, the CPT has made clear that it considers they are not an appropriate means of dealing with residents or patients in a state of agitation; it has recommended that they cease to be used as a tool for managing such persons. Similarly, more suitable means than net-beds can be found to ensure the safety of persons with impaired mobility or nocturnal disorders.*[227]

A response to the CPT Report was issued by the Government of Slovakia at the end of 2001. It stated that the Ministry of Health's chief specialist on psychiatry, in cooperation with the Ministry of Labour, Social Affairs and Family drew up a "Professional Guideline for Regional Authorities and Social Service Establishments concerning the use of Netbeds for Residents with Mental Disorders and/or Behavioral Disorders Placed in Social Service Establishments."[228] The guidelines state that restraint may only be ordered by a physician and that documentation must be taken for every instance of restraint use, including the time it was started, when it ended, and the reason for its use.[229] One reason given in the Government's response for the continued use of cage beds in social care institutions was the failure of the Ministry of Health to create "specialized institutions for persons suffering from mental and behavioral disorders whose health condition warrants the placement in such institutions."[230]

It seems that the CPT and the Slovak government reached an impasse on the issue of the acceptability of cage beds. In the government's response to the CPT report, it was stressed that, "According to the Health Ministry's chief specialist on psychiatry, net-beds constitute a

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[223] Act on Health Care of the Slovak Republic, *supra* note 218, section 38(6).
[224] Interview material from MDAC file #SK03-22-14.
[225] CPT Report on Slovakia, *supra* note 200, ¶ 97.
[226] *Ibid*, ¶ 103.
[227] *Ibid*, ¶ 127.
[228] Response of the Slovak Government to the CPT Report on its visit to Slovakia from 9 to 18 October 2000 (6 December 2001), p.46.
[229] "Professional Guidelines for Regional Authorities and Social Service Establishments Concerning the Use of Net-Beds for Residents with Mental Disorders and/or Behavioral Disorders Placed in Social Service Establishments," unofficial translation.
[230] Response of the Slovak Government to the CPT Report, *supra* note 228, p. 47.

more humane means to manage a patient than other means."[231] Meanwhile, the CPT report stated:

> *While, in their reply of 16 January 2001, the Slovak authorities indicate that the use of net beds in social services facilities is "not justified", it appears that guidelines have been issued for their use in those very facilities. The guidelines in question provide that net-beds may only be used for "clients ... whose placement in such beds is indicated due to their severe mental disorder or disease, resulting in endangerment of such clients or of their environs.*
>
> *The CPT does not concur that net-beds are an appropriate means of dealing with residents or patients in a state of agitation. It recommends that net-beds cease to be used as a tool for managing such residents. If it proves necessary to separate aggressive, agitated, disturbed, or autistic residents, they should be placed in suitably equipped rooms of an adequate size. Residents temporarily placed in such facilities should benefit from adequate human contact. Similarly, more suitable means than net-beds can also be found to ensure the safety of persons with impaired mobility or nocturnal disorders (e.g. disorientation/sleepwalking).*[232]

A government official who co-authored the guidelines said, "social services cannot do anything against a patient's will. … I think that in social institutions there is no place for cage beds." She added, "They should only have patients who don't need to be restrained. It is not their role to solve situations when people need cage beds. It is really a question for hospitals for health care and not for social institutions because they cannot restrict a user's freedom."[233] While accompanying MDAC researchers on a site visit to one social care home, this official stated, "This home is not a health institution and it doesn't have the right according to the constitution to restrict personal freedom."[234] However, the guidelines issued from the Ministries of Health and Social Affairs state just the opposite. They provide that restraint can be used for residents of social care homes under the guidelines described above.

There is no information available on the number of social care homes or psychiatric hospitals that use cage beds, and accurate information on the number of cage beds in individual institutions is also difficult to acquire. One representative of the Ministry of Social Affairs reported that a social care home visited by the CPT still had four cage beds at the time of her visit several months ago.[235] When MDAC visited this institution, researchers were shown a large room holding five empty cage beds and were told by the director that there were a total of seven.[236] When MDAC conducted a visit to this institution in May 2002, there were seven cage beds found in this same room, all were full and some with naked women held inside.[237] In an interview with the social services department in one municipality, responsible for oversight and monitoring of all social services in the region, no one could tell MDAC researchers how many or which institutions used cage beds.[238]

Social care homes are not health institutions and some are visited by doctors just once or twice a month.[239] This poses a great difficulty for homes to follow the Ministerial Guidelines

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[231] *Ibid*, p. 47.
[232] CPT Report to the Government of Slovakia, *supra* note 200, p. 41, ¶ 103.
[233] Interview material from MDAC file #SK03-23-1 (19 February 2003).
[234] Interview material from MDAC file #SK02-23-1 (10 March 2003).
[235] Interview material from MDAC file #SK03-23-2 (19 February 2003).
[236] Interview material from MDAC file #SK02-22-12 (13 March 2003).
[237] MDAC site visit conducted in May 2002.
[238] Interview material from MDAC file #SK03-23-3 (12 March 2003).
[239] Interview material from MDAC file #SK03-23-1 (19 February 2003).

to only permit restraint when ordered by a physician.[240] The result, not only in Slovak social care homes, is that a psychiatrist frequently advises social care home staff in which cases and for which clients cage beds can be used. A physician is not consulted every time a cage bed is used but can look at the documentation after the fact, to approve whether the measure was necessary and appropriate.[241] In many cases, it is questionable whether psychiatrists are consulted about every instance of restraint used in the social care homes they visit. At one institution, MDAC was told, "We have recommendations from a psychiatrist for another three patients in case of aggressive behavior or hysteria or posing a danger to themselves or others. It is allowed to pacify them in a cage bed for the necessary time."[242]

In one relatively new, purpose-built social care home for men with moderate to severe mental disabilities, MDAC found one client kept in a cage bed almost all of the time. It was explained by a nurse that, "He takes your hand and shows you that he wants to be inside the cage bed and he shows you that he wants to close it because he feels safe inside."[243] There was no mention of *why* this resident feels safer inside the cage bed, or what treatment or therapy he is receiving to alleviate this fear. There is one cage bed in this new institution, but the director said that prior to the institution's opening three years ago, it was clear that other patients used to be put in cage beds.[244] In another social care home, we were told by a government representative, "There are 4 cage beds but they are not used every day. There used to be one client who was in the cage bed all the time. Now he doesn't want to be in it anymore. There has been a change in the amount of time they are used. Now, he just uses it at night and it is not locked anymore. The cage beds are regularly used with two clients but they are not locked."[245]

After their statement that one client was kept in a cage bed "all the time," two representatives of the central government responsible for this institution were asked what measures had been taken to ensure that abuses could no longer take place. They responded: "We don't agree that it was abused before." They continued, "We didn't agree with the CPT report because we didn't think it was true."[246] One of the representatives added, "If someone wants to be in a cage bed, it is something that the client chooses and it is the best way for them."[247] Here again, the fact that a client would *want* to be placed in a cage bed, and the questions that raises about the lack of therapy and the quality of care in the institution itself, did not appear important to the representatives.

The CPT's visit to Slovakia included two social care homes but no psychiatric hospitals. Asked how the CPT report influenced restraint practices, one doctor, who works in psychiatric hospital, replied, "The CPT report wasn't a problem. There haven't been any changes."[248] By all accounts, the use of cage beds in psychiatric wards of general hospitals or psychiatric hospitals is pervasive.[249] MDAC could not discover information on any

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[240] *Ibid.*
[241] Interview material from MDAC file #CZ02-22-4 (3 March 2003), #SK02-23-4 (14 March 2003), #SK02-22-12 (13 March 2003), and #SK02-22-9 (11 March 2003).
[242] Interview material from MDAC file #SK02-22-9 (11 March 2003).
[243] *Ibid.*
[244] Interview material from MDAC file #SK02-22-8 (11 March 2003).
[245] Interview material from MDAC file #SK02-23-5 (14 March 2003).
[246] *Ibid.*
[247] *Ibid.*
[248] Interview material from MDAC file #SK03-22-14 (13 March 2003).
[249] All interviews conducted pointed out that cage beds were widely used in psychiatric hospitals in Slovakia. The teaching hospital still uses cage beds, according to the head doctor there.

psychiatric wards or hospitals that do *not* use cage beds.[250] According to a Ministry of Social Affairs official, "The Ministry of Health still thinks that cage beds are the best tools for controlling patients."[251] While potential for abuse was admitted for social care homes, MDAC found unwillingness among Slovak mental health professionals to admit that abuses could occur with cage bed use in hospitals as long as there was professional oversight.

Process of Elimination

After the Ministerial guidelines on restraint use in social care homes were issued, it appears that the most abusive practice of keeping residents locked in cages for days, weeks and months ceased in many facilities. Two of the social care homes visited by MDAC reduced the number of cage beds they had, and one eliminated them entirely. The only residential facility visited by MDAC without cage beds decided to withdraw their three cage beds in October 2002 based on the recommendations of the Ministry. On staff reactions to the decision to remove the cage beds, the head health nurse said: "The staff was afraid. But they have adjusted. They are sometimes afraid when a client becomes aggressive but we have individual consultations."[252]

After receiving scrutiny from the CPT, some institutions found that residents who had been kept in cage beds semi-permanently could make great progress. For clients who had been kept in cage beds for most of their time, "We just changed the system of work," explained one director. "We have more staff and more individualized care for difficult clients. Some of the clients who were unable to communicate before can now take care of themselves."[253] However, this social care home still has seven cage beds. Asked why they haven't withdrawn them altogether, the reason given was that there were seven "difficult" clients and they needed to keep all seven cage beds in case all seven of these residents became aggressive or violent at the same time.

MDAC found a general disbelief among mental health professionals, policy-makers, and some users that psychiatric institutions in Slovakia could function without cage beds. In the words of a Ministry of Social Affairs official, "these social care homes are very old buildings and there is no possibility to reconstruct them and there are no alternatives to cage beds to manage a room with special walls or something other than cage beds."[254] In reality, there are many alternatives to the use of cage beds, which the examples of institutions in similar situations clearly show. The Government of the Slovak Republic must comply with its international obligations by ending the inhuman treatment of people placed in cage beds rather than offering empty rhetoric and rationalizations.

Accountability and Monitoring

There is no independent system of monitoring or oversight of institutions for people with mental disability in Slovakia. However, visits to social care institutions are conducted by local governments as well as the Ministry of Social Affairs. "The direct responsibility is with the founders of each institution, mainly the local governments. The central government used to have the authority to monitor. Elected local governments now have responsibility,"[255]

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[250] The only psychiatric hospital MDAC was able to visit had many cage beds. In reports from users and ex-users, it was discovered that four other hospitals use cage beds and no report that MDAC received suggested otherwise.
[251] Interview material from MDAC file #SK03-23-1 (19 February 2003).
[252] Interview material from MDAC file #SK02-22-7 (10 March 2003).
[253] *Ibid.*
[254] Interview material from MDAC file #SK03-23-1 (19 February 2003).
[255] *Ibid.*

reported an official from the Ministry.[256] "After the CPT visit, the government issued regulations to conduct inspections at least once a year to every institution," said one local government representative. "We usually make 2 visits a year."[257] The exact purpose and quality of these inspections was doubtful according to one director. "Unfortunately, all oversight and control is focused on money."[258]

At one social care home, the director and two governmental representatives were asked whether there was any independent monitoring from NGOs on the protection of human rights. One of the government officials responded, "There is no monitoring because NGOs can't inspect this institution. They can come to visit but not to inspect. Generally we have some civil control because whenever people come to repair something in the building or to bring food or when anyone comes from outside, they can see what it is like here."[259] To which the director added, "There is natural monitoring. People can see this institution. There are regular visitors every week like people who bring milk."[260] While this is no doubt true, it is rather unlikely that this "natural monitoring" regime is aware of human rights standards or is looking for rights violations that may be occurring in the institution.

[256] *Ibid.*
[257] Interview material from MDAC file #SK03-23-4 (13 March 2003).
[258] Interview material from MDAC file #SK02-22-8 (11 March 2003).
[259] Interview material from MDAC file #SK02-23-6 (14 March 2003).
[260] Interview material from MDAC file #SK02-22-15 (14 March 2003).

Slovenia

The State of Mental Health Care

Slovenia is a higher income group country according to World Bank figures. It has a population of 1.99 million. The proportion of the total health budget to GDP is 9.4%. There are no budget allocations specifically for mental health, nor are details about mental health spending available.[261] Slovenia had 810 beds in psychiatric hospitals under the authority of the Ministry of Health in 1997 (the most recent year for which data was available), which is an almost 80% increase since 1995.[262] There were 12,346 people in retirement homes and combined social welfare institutions and 1,713 in special social welfare institutions under the Ministry of Social Affairs in 2001.[263]

Domestic Legislation and Standards

Article 8 of the Slovenian Constitution states: "Laws and regulations must comply with generally accepted principles of international law and with treaties that are binding on Slovenia. Ratified and published treaties shall be applied directly." Article 18 of the Slovenian Constitution prohibits torture and inhuman or degrading punishment or treatment. Slovenia has no mental health legislation, a fact that has been repeatedly criticized by the Human Rights Ombudsman's office.[264] There is no legislative regulation on restraint use.

Cage Beds in Slovenia

Psychiatric institutions in Slovenia largely removed cage beds from use in the mid-1990s. In its initial research, MDAC heard several reports that cage beds had been eradicated entirely from institutions for people with mental disability. In its report to the government of Slovenia on visits conducted in 2001, the CPT found cage beds in both psychiatric institutions visited, Hrastovec-Trate Social Care Home and Maribor General Hospital's Psychiatric Department. In fact, MDAC found that most psychiatric hospitals and social care homes for psychiatric patients have withdrawn all cage beds but that they have not been completely eliminated.

The CPT reiterated its views on the acceptability of cage beds in its report to the Slovenian government, saying, "The CPT is of the opinion that net-beds are not an appropriate means of dealing with residents or patients in a state of agitation. It recommends that net-beds cease to be used as a tool for managing such persons as soon as possible." Additionally, "at both establishments, the persons placed in net-beds could be seen by other residents/patients and potential visitors. Such a situation was said by patients to be degrading. Further, in the CPT's opinion, this could also affect the psychological state of the other residents/patients."[265]

In the Slovenian Government's Response, it reported that "Slovenian Recommendations and Guidelines for the Application of Special Safety Measures in Psychiatry were adopted and published in May 2001 in the Slovenian psychiatric publication *Vice Versa* (ISS 1318-5761), edited by the National Professional Collegiate Body for Psychiatry and the Institution for the

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[261] *See* WHO Atlas Country Profiles, *supra* note 152, p. 375.

[262] *Statistical Yearbook of the Republic of Slovenia 1997*, 9.1, p. 166, available at: http://www.sigov.si/cgi-bin/spl/zrs/leto97/index.html.

[263] Slovenia in Figures 2002, Statistical Office of the Republic of Slovenia, available at: http://www.sigov.si/zrs/slo/slfig02/slfig02.pdf.

[264] Ombudsman Annual Reports from 1996-2001 all heavily criticize the Slovenian government for failing to enact mental health legislation.

[265] Report to the Slovenian Government on the visit to Slovenia carried out by the CPT from 16 to 27 September 2001 (Strasbourg, 18 December 2002) p. 50 ¶ 130.

Development of Slovenian Psychotherapy, Ljubljana."[266] The guidelines state only that the use of cage beds is "being abandoned" and that cage beds are used for the isolation of patients who are violent or demonstrate highly disorganized behavior. The guidelines do not prohibit their use except with suicidal patients.[267] The Government also informed the CPT of a national research project to evaluate the changes in clinical practice following the abandoning of cage beds.[268]

The move away from cage beds was initiated after a fire in Ljubljana Psychiatric Clinic, in which one woman locked in a cage bed was killed. With 400 beds, Ljubljana Psychiatric Clinic is the largest psychiatric hospital in Slovenia and serves as the teaching university hospital. It also has the only closed ward for more difficult or aggressive patients in all of Ljubljana. The fire was started on 15 October 1991 in a room with four occupied cage beds, by a patient who smuggled matches into the bed. The nurse and orderly were able to save three of the patients, including the woman who started the fire, but were unable to save the fourth woman. The incident took place at around 3:30 in the morning when there was only one nurse on duty to care for 3 wards containing about 100 people.[269]

MDAC found that cage beds remain in at least two psychiatric hospitals and one social care home. At one hospital, it was reported that they were simply unable to remove the remaining cage bed because it was fixed to the floor.[270] In the other, the head doctor/director simply found nothing objectionable about the use of cage beds. "We use cage beds for patients with dementia or people in alcoholic delirium, occasionally," he said. The doctor told MDAC that the cage beds were used for a "small number of patients, most frequently … at night for patients with dementia who lose their orientation and fall from their beds and can get some new injuries. Frequently, patients just sleep in them. They are not closed. In fact, if we have patients who can fall and need special care, it is a safe place."[271]

To clarify, the doctor was asked, "Are the cage beds closed and not locked or just left open because it seems that patients would be able to fall out of bed if the net were open?" to which he responded: "You know the answer." An MDAC researcher tried to explicate, "So they are closed but not locked." Again, the response was, "You know the answer. It is just logical. Sometimes other people can imagine that we are dealing with beasts here, locked up. They are not beasts. They are patients." It is evident from this conversation that cage beds were not solely used as restraint measures to deal with aggressive or violent behavior in emergency situations, a violation of the Slovenian professional guidelines on restraint which this doctor was himself involved in drafting.[272] Asked whether another doctor who no longer used cage beds in his hospital knew of any instances of abuse with cage beds he replied, "If I look at a part of the population of [geriatric] patients with severe dementia who are severely agitated, not violent but who could harm themselves if not cared for constantly, of course these patients were regularly put in cage beds."[273]

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[266] Response of the Slovenian Government the Report of the CPT on its visit to Slovenia from 16 to 27 September 2001 (Strasbourg, 18 December 2002), p.58.
[267] *Vice Versa*, (2001) unofficial translation.
[268] Response of the Slovenian Government the Report of the CPT, *supra* note 266, p. 59.
[269] Unofficial translations of articles in Slovenian daily newspapers, *Delo* (17 October 1991) and *Dnevnik* (16 October 1991) and magazine *Jana,* no. 43 (30 October 1991).
[270] Telephone Interview with Director (27 March 2003).
[271] Interview material from MDAC file #SI01-22-3 (22 March 2003).
[272] *Ibid.*
[273] Interview material from MDAC file #SI01-22-10 (26 March 2003)

In the only social care home in which MDAC found cage beds still in use, there were two men, ages 40 and 45 who live all their lives in cage beds. They both have severe intellectual as well as physical disabilities. They are kept in diapers and pajamas most of the time. One man was transferred from a social care home for children when he turned 18 and will most likely be institutionalized for life. The other was sent to the social care home when his family could no longer care for him. They have spent at least the past 15 years living in cages, reported the director of the institution.[274]

The director tried to remove the cage beds from use but found that the staff could not handle these two residents in any other fashion so three cage beds were returned from the attic: two for these men and another for a resident who reportedly just sleeps inside the cage.[275] On 25 April 2003, MDAC sent a letter of concern regarding this situation to the Committee Against Torture, the UN body responsible for oversight of States' compliance with the Convention Against Torture or Other Cruel, Inhuman or Degrading Treatment or Punishment. In May 2003, the Council of Europe's Commissioner for Human Rights, Alvaro Gil-Robles took the matter up with the government during his visit to Slovenia, after sending members of his delegation to visit the institution.

Process of Elimination

The initiative to remove cage beds from the teaching hospital in Ljubljana in March 1998 was that of the then director and President of the Association of Slovenian Psychiatrists. Discussing why he decided to do away with cage beds he explained, "There was no knowledge how to deal with violent people, particularly in admission wards. In order to abolish cage beds you need to educate staff in dealing with violent patients."[276] According to this psychiatrist, "The majority of patients put in cage beds have delirium tremens. Violent behavior is quite irregular with them. These people are not violent. They just need more intensive care and are not to be left alone."[277]

The doctor went on to say, "There are two problems with cage beds. First, it looks like a cage and the person inside looks like an animal. I constantly told people to try to imagine one of their loved ones in a cage bed. The problem is that staff forgets that there is a person in the cage bed. Lots of people were forgotten." He recounted the tragic fire as such an example. He pointed out another potential danger with the use of cage beds, "Sometimes people manage to untie the netting and hurt themselves with the net."[278] A doctor at one psychiatric hospital verified the reality of this danger, telling MDAC about a man who attempted to hang himself with the netting on the cage bed.[279]

The experiences of the institutions that have withdrawn all cage beds from use should be highlighted. In the case of one psychiatric hospital where cage beds were removed several years ago, one doctor said, "The staff was very anxious about it but now they see that they don't need them."[280] In addition, the director who decided to remove the cage beds stated, "After two or three months [when the cage beds were removed], no one knew that there were no cage beds in the hospital. … If you talk to young colleagues who came after the cage beds

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[274] Report on visit conducted by MDAC local research assistant, file #SI-22-11 (17 April 2003).
[275] Interview material from MDAC file #SI02-22-11 (17 April 2003).
[276] Interview material from MDAC file #SI01-22-10 (26 March 2003)
[277] *Ibid.*
[278] *Ibid.*
[279] Interview material from MDAC file #SI01-22-9 (26 March 2003).
[280] *Ibid.*

were removed, they would question why they were ever used."[281] Asked how much persuasion was necessary to convince other hospital directors to follow this example, he said, "[I]t didn't take much persuasion. Directors couldn't continue using a practice that teaching universities stopped using."[282]

Research on restraint use was done by the Ministry of Health in 1998-1999. In Ljubljana Psychiatric Clinic, where cage beds continued to be used during the first year of the study, it was found that once cage beds were withdrawn, the number of patients who were restrained decreased dramatically from every third patient to every seventh the following year. There was also a striking reduction in the number of hours patients were restrained.[283]

In one large social care institution that removed cage beds following the CPT visit in 2001, the transition was explained as being very simple. "We had 2-3 cage beds but they were removed because we didn't use them. They were used about twice a year."[284] On how aggressive or violent behavior is managed, the director explained, "We only use physical restraint. There was professional training in Ljubljana for two techniques. A few staff members went to the training in Ljubljana and then they trained other staff members."[285] Other methods used to prevent such aggression are "special soft rooms for relaxation with special lights and music. Every patient has an individual program with what kind of music they like."[286]

The importance of having adequate numbers of and appropriately trained staff cannot be underestimated. In the well-staffed teaching hospital, the former director said, "The training of the existing staff was enough to remove cage beds. The number of staff is not the problem. We have enough nurses to sit with patients in fixation straps. There is a pressure to use restraint for as short a time as possible if you need to attend to other patients."[287]

This is an important point since, in each of the countries examined, the use or discontinuation of the use of cage beds cannot be explained by staff numbers or crowded conditions alone. Institutional culture and policy play more substantial roles in explaining the frequency of the use of restraint and seclusion than patient demographics or staff levels.

Accountability and Monitoring

There is no independent system of inspection for psychiatric facilities in Slovenia. The office of the Human Rights Ombudsman, established in 1995, regularly visits places of detention including psychiatric hospitals. The Ombudsman's Annual Report in 2000, mentions the use of beds with netting but states that their use is "only justified in exceptional circumstances."[288] MDAC found that there is oversight for involuntary detention cases where judges from local courts regularly visit hospitals. But as social care homes are not considered places of detention, as residence should be strictly on a voluntary basis, there is no body, which regularly oversees conditions in social care homes. There is a need for an independent body to inspect and monitor psychiatric institutions to ensure that the rights of those in the facilities are protected.

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[281] Interview material from MDAC file #SI01-22-10 (26 March 2003).
[282] *Ibid.*
[283] Interview material from MDAC file #SI01-22-9 (26 March 2003).
[284] Interview material from MDAC file #SI02-22-5 (24 March 2003).
[285] Interview material from MDAC file #SI02-22-4 (24 March 2003).
[286] *Ibid.*
[287] Interview material from MDAC file #SI01-22-9 (26 March 2003).
[288] Republic of Slovenia Human Rights Ombudsman *Annual Report 2000*, p. 25-26.

Conclusions

This report documents the use of cage beds, a particularly inhuman and degrading form of restraint, in the Czech Republic, Hungary, Slovakia and Slovenia. In the European Year of People with Disability, MDAC has found that some people spend most of their lives in a locked cage bed. This practice has been allowed to persist despite international condemnation and calls for the complete withdrawal of cage beds. This situation must be immediately remedied to protect the fundamental right of people to be free from inhuman and degrading treatment.

No evidence can substantiate the effectiveness of or need for cage beds in psychiatric institutions. On the contrary, a wealth of research exists showing that restraint in general is physically and psychologically damaging and simply unnecessary in most instances. People who have been subjected to placement in cage beds testify that the experience was invariably frightening, disempowering, damaging and degrading.

The European Convention on Human Rights, a treaty, which all four countries have ratified, categorically prohibits inhuman and degrading treatment or punishment. There can be no exceptions. United Nations treaties, which have also been ratified by these States – including the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights – also provide absolute prohibitions on such violations.

The European Committee for the Prevention of Torture has called for the discontinuation of cage bed use, but these governments have taken insufficient steps to comply with international standards. No comprehensive solutions have been sought to spare people the indignity of being caged. Cage beds constitute inhuman and degrading treatment or punishment, contrary to international law. Their use must end in order for these States to comply with their binding international legal obligations.

As these four countries enter the European Union next year, EU governing bodies should be aware that some of its new citizens will be confined inside padlocked cage beds. MDAC calls on these governments to immediately observe their obligations under international law to protect every person's right to be free from inhuman and degrading treatment, to be freed from cage beds.

Recommendations

MDAC calls on the Governments of the Czech Republic, Hungary, Slovakia and Slovenia to immediately:

- Prohibit the use of cage beds through legislative and administrative measures
- Monitor the implementation of such a prohibition and make the results public
- Provide for independent inspections - including non-governmental organizations of users of psychiatric services - to monitor human rights in institutions for people with mental disability
- Institute mandatory human rights training for all personnel of institutions for people with mental disability
- Implement the CPT's guidelines on "Means of Restraint" (See *Appendix 2*) in all institutions for people with mental disability
- Implement a system for the central collection of statistics on restraint and seclusion and make this data public

To the Government of Hungary

- Institute training for patients' rights ombudspersons on monitoring institutions for people with mental disability and standards for restraint
- Fully implement the recommendations of the CPT report of 1999 regarding "psychiatric establishments"

To the Government of the Czech Republic

- Ensure that the newly established inspection system for social services is compulsory for all social service facilities
- Investigate allegations that the regime at Horní Beřkovice Psychiatric Hospital may constitute ill-treatment
- Authorize the publication of the CPT report of 2002

To the Government of Slovakia

- Fully implement the recommendations of the CPT report of 2000 regarding "social services homes"

To the Government of Slovenia

- Make the results of the research on restraint and seclusion in psychiatric hospitals public
- Fully implement the recommendations of the CPT report of 2001 regarding "psychiatric establishments"

Appendix 1: Site Visits and Interviews

Sites Visited

Hungary: Soteria Day Center, Törökszentmiklós Social Care Home, Debrecen Social Care Home, Délpesti Hospital Psychiatric Department, Budapest Social Care Home, Ludányhalászi Social Care Home, Kenessey Albert Hospital Psychiatric Department.

Czech Republic: Bohnice Psychiatric Hospital, Terezin Social Care Home, Opařany Children's Psychiatric Hospital, Slatiňany Social Care Home.

Slovakia: Michalovce Psychiatric Hospital, Rakovec Social Care Home for Women, Jablon Social Care Home, Bardejov Social Care Home for Men, Kompa Day Center, Banska Bystrica Daily and Weekly Care Center, Vel'ký Biel Social Care Home for Women, Okoč Social Care Home, Medvedov Social Care Home.

Slovenia: Ormož Psychiatric Hospital, Vojnik Psychiatric Hospital, Hrastovec-Trate Social Care Home, Dutovlje Social Care Home, Ljubljana Psychiatric Clinic, ŠENT Day Center and Group Home, Lukavci Social Care Home.

Interviews Conducted

Hungary: Éva Bódy of the Ministry of Health and Social Affairs; Judit Fridli of the Hungarian Civil Liberties Union; Zsolt Bugarszki of Soteria Foundation; and Zsuzsa Simon, Patients' Rights Ombudsperson

Czech Republic: Dr. Václav Filec of the Ministry of Health, Kristýna Čermáková and Milena Johnová (formerly) of the Ministry of Social Affairs; Jan Jařab, Government Commissioner for Human Rights of the of the Czech Republic; Vlasta Hirtová of the Open Society Foundation, Luboš Olejár and Josef Mrázek of Svaz Pacientu; Jiří Vencl, Dr. Jan Hutař, and Martina Přibylová of the Czech National Disability Council; Radek Prouza and Anna Kachlikova from Kolumbus; Eliška Bártová, Journalist with *Respekt*

Slovakia: Viera Tomanová, Jozefina Vlckova and Martina Konečná of the Ministry of Labour, Social Affairs and Family; Dr. Pětr Nawka of Integra Association for Mental Health; Marcela Barová from Open the Door, Open Your Heart (ODOS); Lubos Olejar of Premeny; Dr. Peter Breier of the League for Mental Health; Dr. Viera Záhorcová from the Association for Supported Employment; Lívia Kosťová of the Banská Bystrica Municipal Government Social Services Department; Jana Švorcová from the Bratislava Municipal Government Social Services Department; Libusa Hubinova, and Bozena Mareckova from the Regional Office of Social Services of Bratislava; and Ingrid Baumannová of the Slovak Helsinki Committee

Slovenia: Dr. Slavko Ziherl of Ljubljana Psychiatric Clinic; Ivan Šelih of the Office of the Human Rights Ombudsman; Suzanne Oreški of Altra; and Tanya Lamovec and Vinko Zalar of Paradoks

Appendix 2: Excerpts from CPT Standards

European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) "Substantive" sections of the CPT's General Reports,

VI. Involuntary placement in psychiatric establishments

Extract from the 8th General Report [CPT/Inf (98) 12], pages 52-53

E. Means of restraint

47. In any psychiatric establishment, the restraint of agitated and/or violent patients may on occasion be necessary. This is an area of particular concern to the CPT, given the potential for abuse and ill-treatment.

The restraint of patients should be the subject of a clearly-defined policy. That policy should make clear that initial attempts to restrain agitated or violent patients should, as far as possible, be non-physical (e.g. verbal instruction) and that where physical restraint is necessary, it should in principle be limited to manual control.

Staff in psychiatric establishments should receive training in both non-physical and manual control techniques vis-à-vis agitated or violent patients. The possession of such skills will enable staff to choose the most appropriate response when confronted by difficult situations, thereby significantly reducing the risk of injuries to patients and staff.

48. Resort to instruments of physical restraint (straps, strait-jackets, etc.) shall only very rarely be justified and must always be either expressly ordered by a doctor or immediately brought to the attention of a doctor with a view to seeking his approval. If, exceptionally, recourse is had to instruments of physical restraint, they should be removed at the earliest opportunity; they should never be applied, or their application prolonged, as a punishment.

The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.

49. Reference should also be made in this context to the seclusion (i.e. confinement alone in a room) of violent or otherwise "unmanageable" patients, a procedure which has a long history in psychiatry.

There is a clear trend in modern psychiatric practice in favour of avoiding seclusion of patients, and the CPT is pleased to note that it is being phased out in many countries. For so long as seclusion remains in use, it should be the subject of a detailed policy spelling out, in particular: the types of cases in which it may be used; the objectives sought; its duration and the need for regular reviews; the existence of appropriate human contact; the need for staff to be especially attentive.
Seclusion should never be used as a punishment.

50. Every instance of the physical restraint of a patient (manual control, use of instruments of physical restraint, seclusion) should be recorded in a specific register established for this purpose (as well as in the patient's file). The entry should include the times at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff.

This will greatly facilitate both the management of such incidents and the oversight of the extent of their occurrence.

Appendix 3: Excerpts from MI Principles

Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

Adopted by General Assembly Resolution 46/119 of 17 December 1991

Principle 1 *Fundamental freedoms and basic rights*

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.

…

Principle8 *Standards of care*

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

Principle 9 *Treatment*

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

…

1. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

Principle 11 *Consent to Treatment*

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

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