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Rights of Persons with Psychosocial Disabilities in the Czech Republic with regards to the Use of Restraints and Involuntary Treatment

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"We are people with impairments and those impairments clearly have an impact on how we live our lives. But the impairments are not the things which disable us,"

-Ian Macrae (Psychologist)

Table of Contents

List of Abbreviations

CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
EDF	European Disability Forum
EU	European Union
FRA	Fundamental Rights Agency
HUDOC	Human Rights Documentation
MPSV	Ministerstvo Práce a Sociálních Věcí (Ministry of Labor and Social Affairs)
MZD	Ministerstvo Zdravotnictví (Ministry of Health)
NPM	National Preventative Mechanism
SPMP	Společnost pro Podporu lidí s Mentálním Postižením (Society for the Support of Persons with Intellectual Disabilities)
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

Introduction

In recent years, the rights of persons with disabilities have been in the vanguard of policy developments and political discourse (Vrabková et al., 2023). Increased visibility of previously hidden rights violations in closed settings and internationally set standards for monitoring and compliance with human rights have contributed to this.

Significant progress has been made in this regard. With the adoption of a social model of disability, the root of the problem constituted by disability shifted from the individual to the society. Hereby, the responsibility to adapt was also transferred to society, rather than individuals needing to conform to societal standards, which their condition prevents them from achieving. To achieve this goal, deinstitutionalisation has been strongly advocated for as institutions continue to embody the medical model of disability, which fails to comply with human rights standards. A flagship achievement was the adoption of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2006, which entered into force in 2008. This document enshrined this paradigm shift, encompassing core principles of inclusion, participation, equality and dignity.

Nevertheless, elements of the medical model remain, not only due to societal barriers but also due to the medical aspect of certain disabilities. Psychosocial disabilities considerably fall under the field of psychiatry, which recognises the need to treat disorders that are socially disabling. In cases where the severity reaches a threshold of imposing behaviour that threatens the person or their surroundings, the manner in which situations are dealt with becomes less straightforward. The use of restraints and involuntary admission or treatment are two main measures taken under such circumstances that contradict the UNCRPD principles but continue to be administered under the justification of protection (CRPD, 2020 §103).

The Czech Republic's care system is characterised by its history under Soviet rule. This contributed to developing the care structure for persons with disabilities, with the centralisation of services, and institutions at the heart of it (Kubalčíková et al., 2017). Hence, deinstitutionalisation stalled in the Czech Republic, maintaining the continued practice of the use of restraints and involuntary admission and treatment of persons with disabilities. The CPT regulates these practices, as they are allowed under certain circumstances despite going against the principles of the UNCRPD. The regulation is imperative to ensure that such measures are only applied for protection and safety in imminently threatening cases. Hereby, the following thesis will look into how this is regulated, taking cases in the Czech Republic as the focus of

analysis, guided by the research question: "*To what extent is the legislation in the Czech Republic, regarding the use of restraints and practice of involuntary admissions and treatment of persons with psychosocial disabilities, in conformity with the normative framework and policy developments under the United Nations Convention for the Rights of Persons with Disabilities?*"

To address this question, the theoretical framework of the academic discourse regarding the social model of disability will be discussed, exploring the paradigm shift away from the medical model and how this has shaped the approaches to the rights of persons with disabilities. Furthermore, part of this model is also the policy push for deinstitutionalisation, prioritising inclusivity and integration by adapting society towards tolerance rather than segregating persons who are different. As this study is set in the context of the Czech Republic, the economic, political and social factors shaping the situation of persons with disabilities will also be delved into. Lastly, moving more concretely into the aim of this thesis, the discourse surrounding psychosocial disabilities within the social model of disability and the policy of deinstitutionalisation will be explored. The chapter on the legal framework will subsequently outline legislation on the level of the United Nations, European Union and the national level of the Czech Republic. The legal framework will then be applied to four cases from the ECtHR that processed cases dealing with the matter. To conclude, the theoretical framework, along with the legal framework and the illustrating cases, will build an objective understanding of the Czech legislation regarding the use of restraints and involuntary admissions and treatment of persons with psychosocial disabilities, to answer the aforementioned research question.

1. Theoretical Framework

In this preliminary research, the discourse on disabilities will be examined to establish the theoretical framework for the subsequent research. To begin, the paradigm shift from the medical model to the social model of disability will be discussed, after which the push for deinstitutionalisation will be examined from various angles of the existing discourse. Consequently, understanding the context approaches to disability in the Czech Republic will be explored after which the placement of psychosocial disabilities within this discourse will be evaluated. Based on this, the academic and societal significance of the research will be illustrated.

1.1 Social Model of Disability

Psychosocial disabilities have historically been approached through exclusionary treatment rather than rehabilitative and integratory inclusion, which is now the contemporary policy push (Vaďurová & Shmidt, 2019). The former characterises the medical model of disability, which fails to focus on sustainable recovery and empowerment due to its habit of emphasising diagnosis, lack of trust in the service consumers and paternalistic approaches (Byrne et al. 2016). Additionally, due to the seclusion of persons with psychosocial disabilities from society, this medical model fostered a culture of institutional care, which assumes a passive approach of protection compared to a more proactive approach of support and inclusivity (Šuľová, 2022).

The medical model sees disability as a deviation from the 'normal' hereby eliciting stigmatisation and discrimination. To quote Guevara (2021), it considers disability as a defect that needs treatment and as a personal problem rather than "a social reaction to natural human variation" (pg. 429). Institutions are a feature of the medical model with such approaches embedded in these closed settings, preventing any form of integration and inclusion into society (Ndlovu, 2021). Conversely, the social model assumes the position to tackle the societal barriers causing the disability. Price (2013) explains that mental disorders are medical phenomena, only becoming disabilities when the condition prevents full participation in society, hereby redirecting the focus on the social element.

The conditions for persons with psychosocial disabilities were therefore studied in the field of sociology within this paradigm, which over time then translated into legislative frameworks. The shift from the medical model can be brought back to various movements, including the anti-psychiatric movement fuelled by the push to eliminate life devoid of meaning after the Second World War, fuelling critiques of institutional life (Pilgrim & Rogers, 2008). Goffman (1961) elaborates on the institutional characteristics that result in such a life devoid of meaning in his essay collection on the social situation of mental health patients. Here, he illustrates dynamics such as fixed schedules, asserted social roles, and unbalanced power dynamics between patient and caregiver. Furthermore, the identities of patients are stripped, and any chance for development and empowerment is eliminated, which further feeds into a dehumanisation phenomenon of persons with disabilities, posing a serious risk of human rights violations. Šuľová (2022) elaborates on this point by providing examples such as a lack of respect for personal ownership and symbols of uniqueness and humanity. She also confirms Goffman's (1961) critique of routines and schedules, disregarding personal needs and

preferences. Furthermore, the concentration of all services in one institution results in bulk blanket treatment without individualised consideration for patients and residents. This element further engrains the dehumanisation of persons with disabilities, which cumulates in the lack of a human rights-based approach to persons with disabilities, especially those living in institutions.

Hereby, we arrive at the social model, which places disability in the social environment rather than it being an individual fault of the person with the disability (Ndlovu, 2021). This model reformed how states set up health care, social care, and various support mechanisms (Russo & Wooley, 2020). Normalizing difference and diversity is vital in overcoming the reluctance of inclusion, intolerance and persistence of homogenous attitudes. It allows for persons with disabilities to take on societal roles and become duty bearers as well as rights holders within the society through inclusion (Walmsley, 2006). Essentially, it defines disability as a social construct stemming from a normative framework with roots in egalitarian theory, tenanting that all humans are fundamentally equal and should be treated as such (Samaha, 2007).

Normalising differences in abilities and adjusting society to this diversity rather than trying to 'treat' and medicate persons with disabilities to conform to the societally set norm, is at the core of deinstitutionalisation. This is encapsulated in the social model of disability as it recognises individual disadvantage stemming from the intersection between personal traits and their social setting (Samaha, 2007). Hence, by loosening the rigidity of what 'normal' is, society can become more tolerant and malleable to adapt to human variation, hereby also breaking down systematic denial of equality for anyone that falls outside of this 'norm' (Vaďurová & Shmidt, 2019)

One of the outcomes of the paradigm shift, and probably the most significant one, was the adoption of the United Nations Convention on the Rights of Persons with Disabilities. This convention incorporates the social model of disability fostering social inclusion, non-discrimination, independent living and participation, imposing obligations on states to enforce mechanisms to foster conditions that permit an inclusive environment for persons with disabilities (Mladenov & Petri, 2020). This notably sparked the push for deinstitutionalisation through the realisation of institutions as breeding grounds for the medical model. Nevertheless, Samaha (2007) points to the missing link in adopting the social model of disability. Without dismissing the influence that societal perceptions of disability have on concrete change nor failing to recognise the mediated effect it may have had on decision-makers, the model does not set a solid enough normative basis on which legislation and policy can be built. In other

words, while applying the social model of disability can kickstart change, it does not guarantee social reconstruction. Societal intolerance is a barrier to integration, requiring the operationalisation of the social model of disability to be implemented in practice (Culham & Nind, 2003). Here, the developed legal framework comes into play as it sets standards for approaching the rights of persons with disabilities in a more conscious and proactive translation of the discourse into policy.

Hence, to conclude with reference to Mulvany (2000), the social model of disability should be used as a framework to approach policy while not disregarding the significant medical and political elements of the discourse. This ensures that necessary medical treatments and aid are still accessible to those who need them, which is a core element of the debates on deinstitutionalisation as it fundamentally influences how the process is handled and what is established as an alternative.

1.2 De-institutionalisation

De-institutionalisation stems from the paradigm shift concerning how disabilities are perceived, which can be accredited to the adoption of the social model of disability as outlined above. Lamb & Bachrach (2001) outline three components of de-institutionalisation: the release of persons from institutionalised settings into communities, diversion from institutional admission, and the development of alternative community services. The last of the three is the area that has encountered the most challenges by policymakers in terms of insufficient understanding of what deinstitutionalisation entails, resulting in a missing holistic legal and policy framework. Additionally, the institutional staff face a lack of resources to put the deinstitutionalisation action plans into practice. They further stress that this has led to unintended consequences for persons with severe psychosocial disabilities as they are left without structured care and assistance, leading to homelessness or criminality, which brings no benefits to the community. Therefore, care needs to be available for those who need it in a manner that complies with human rights standards and avoids the violating characteristics of institutions (Goffman, 1961; Šuľová, 2022).

It is important to discuss why deinstitutionalisation is necessary or pushed for in the first place. As Birtha (2020) outlines, institutions foster isolation of persons with disabilities rather than attempting to integrate and include them into society. It stems from the historical practice of denying persons with disabilities choice and control and creating legal barriers, which legitimises the use of institutions or practices within an institution that violate human rights

(Reid & Lattanzio, 2023). Šuľová (2022) further confirms these characteristics in her research and emphasizes the paternalistic approaches stemming from unbalanced power dynamics and learned passivity to specific behaviors by the staff of the residents due to their powerlessness.

It is important to realise the difference between moving from institutionalised settings to more community-based assisted living compared to merely dismantling institutions with no other measures to replace the assistance needed by persons with disabilities to integrate and live independently (Mladenov & Petri, 2020). Some persons with disabilities cannot live entirely independently and require assistance. This, however, also does not mean that efforts to integrate these persons should be disregarded. On the contrary, facilitated or assisted participation within community-based settings that are smaller and less isolated than institutions offer this alternative. An example would be increased accessibility to political participation, with voting stands being adapted to persons with disabilities or information being relayed in a more easily understandable format (Fundamental Rights Agency, 2024). For this reason, Mladenov & Petri (2020) advocate for the phrase 'transition from institutional to community-based care' rather than 'deinstitutionalisation' to clarify the objective of this initiative.

Within this transition, Bugarszki et al. (2015) emphasise the risk of forming "segregated disability blocks" rather than proper integration. Lamb and Bachrach (2001) and McCarron et al. (2019) echo this in saying that deinstitutionalisation is a process that exceeds simply changing the location of where care is provided, but rather the manner in which it is provided. Hence, it is important to describe the various forms that alternative care systems can take. Bugarszki et al. (2015) pointed out the lack of a standard definition for community living or the alternative to institutions, to which the Society for the Support of Persons with Intellectual Disabilities (SPMP, 2024) in the Czech Republic offers a typology. Residential services, for example, would be targeted more on weekly daycare and support services within homes. Assistants are present, although only to support the persons with their plans. Another alternative is offered by outpatient services, which are more psychologically targeted by providing counselling and therapeutic workshops geared at practising skills needed for independence, such as communication and adaptation. Lastly, community-based services focus mainly on social integration, with assistance only facilitating independent living. Overall, self-sufficiency is the core aim of helping develop the necessary skills to sustain independent living. Although some persons will still require assistance or care, securing the assistance in an accessible manner while eliminating the fallbacks of the institutional culture is the goal to strive for.

This does not come without its challenges. Kock (2009) delves into the burden that caretaking puts on families regarding the care provided. Through unstructured interviews, families were asked to speak about their experiences. What came from this study was that the burden on the families exceeds the capabilities they have to provide adequate care, emphasising the need for resources and skills to be built up in families with members with psychosocial and intellectual disabilities. These implications affect the quality of family dynamics, emotional well-being, health, and financial resources. Herein, the respondents commented on various institutionalised settings being a positive relief factor as alternative and reliable support mechanisms. Nevertheless, these institutional settings took the form of group homes, which were more open and community based. This highlights the middle ground between forms of structured assistance without embodying a complete institutional culture.

Hence, while institutions within themselves bear a paternalistic culture that fosters power imbalances and often abuses this power, the complete abolishment of any such structured care system has proven not to be the best way forward. Structured care for facilitated independent living within assisted community settings allows for the middle ground between the medical element of disabilities that need attention and the social element that requires tolerance and adaptation by society.

1.3 The Czech Context

The context with regards to the situation of rights of persons with disabilities in the Czech Republic bears similarities with other countries that share the same history of being under Soviet rule up to 1989. It requires a multi-disciplinary approach to illustrate the various social, political, and economic drivers that collate into the existing legislative and policy frameworks. Institutional care is considered to be integral to welfare services in Eastern Europe. Therefore, the deinstitutionalisation process began later than most other European welfare states. While the completion of this process is not yet in sight, the beginnings can be traced to the denial of the old Soviet-style welfare model characterised by a state monopoly of care services and paternalistic attitudes (Kubalčíková et al. 2017). This also resulted in an attitude shift amongst policymakers.

Decentralisation is a prominent factor in the development of services into the form they take today. This occurred vertically, in terms of shared responsibility with the state, regions and municipalities, and horizontally in terms of functional divisions, which encompasses regulation, funding, monitoring and provision by different actors (Kubalčíková et al. 2017). However, a

limitation can be identified in financing mental health care systems, as Eastern European countries invest less of their GDPs in this field compared to Western Europe. Additionally, the mental healthcare system is relatively underfinanced compared to the physical healthcare system (Dlouhy, 2014). Without resources allocated to the 'transition from institutional to community-based care' (Mladenov & Petri, 2020), deinstitutionalisation poses the risk of being translated into practice in the sense of abolishing institutions without reinstating an alternative form of care. This alternative form, however, requires funds that are lacking, especially in the mental health care system, burdening the process of deinstitutionalisation due to the increase of resources needed to accomplish the process sustainably and comprehensively.

Furthermore, in terms of treatment and care given, the medical model of psychosocial disabilities prevails over the social model, which can be attributed to the remnants of the paternalistic care culture (Dlouhy, 2014). Nevertheless, notable progress has been made on a policy level despite it not yet being fully translated into practice. Referring to the European Social Network's (2013) model of the transition from the traditional welfare model to independent living, which in essence is parallel to the paradigm shift discussed above, the model recognises the role that national inclusion policies, the EU directives and funds as well as the UNCRPD played as drivers of change. This change has already produced tangible results concerning improvements.

Winkler et al. (2018) delved into an economic rationale for assessing deinstitutionalisation. He found in his study that the cost difference between resources spent for sustaining institutional care compared to community-based cases favours the latter. This is due to the greater picture of facilitated participation of persons with disabilities in the communities, contributing to the economy. This results in a cost-effectiveness calculation, which profits from social inclusion rather than institutional segregation while also complying with international human rights standards. Nevertheless, he notes in his conclusion that further research would be necessary to monitor the medical element of discharging persons from institutions, through which he highlights the need to retain the cost-effectiveness consideration in the discourse on disabilities without disregarding the medical aspects, especially of some psychosocial disabilities.

Staying in the field of economics, the marketisation of social care services is also an important factor to consider when understanding the Czech context. In a nutshell, the marketisation of social care services consists of market principles, such as a plurality of service providers, which is in line with decentralisation (Kubalčíková et al. 2017) and also of profit-oriented care delivery (Kubalcikova & Havlikova, 2016). Although the latter connotates potential negative

consequences on the rights of disabilities, it bears similar goals, such as the empowerment of service users. Nevertheless, as was discussed in the case of deinstitutionalisation, marketisation of social care needs to be taken with reserve, as too much competition between service providers, characterised by the profit drive, can take the focus away from the persons with disabilities relying on the care provided.

Hence, the above-mentioned social and political factors stemming from the remnants of the Soviet regime's care system, such as the centralisation of institutional care and paternalistic attitudes, the lack of resources allocated now, manifesting policy changes, and the economic drivers of change, all contribute to the greater picture contextualising the Czech Republic. These all feed into the understanding of why certain practices, such as the use of restraints or involuntary admission and treatment, are still permitted and how their use may sometimes overstep the carefully regulated permitting circumstances.

1.4 Psychosocial Disabilities

While the above topics are very important and provide the necessary basis for further analysis, it is also important to realise that there are some cases, especially with psychosocial disabilities, which need different and careful consideration. To reiterate an important point: mental disorders are conditions characterised by stagnated cognitive abilities or disruptive behaviours and various other psychological symptoms. Nevertheless, they only become intellectual or psychosocial *disabilities* when these conditions prevent full participation in society or put them at a disadvantage within a community due to these particular behaviours (Price, 2013).

Butler and Bowlby (1997) refer to embodied impairment as the interrelation between society and corporeality. When applying this embodiment to psychosocial disabilities, this becomes an embodied irrationality. The embodiment of irrationality also ties into the aforementioned point on differentiating between disorders and disabilities. Once the irrationality is embodied, it risks becoming disabling. This then opens the possibility of understanding 'sanity' outside of a biologically or medically deterministic manner and invites various other disciplines, such as sociology, law, politics, and economics, to shape the discourse on disability.

However, disability still has a medical component, which is very relevant to keep in mind in the more severe cases of mental disabilities without omitting the social structure which imposes the disability (McDermott & Turk, 2011). The push for deinstitutionalisation, despite its positive connotations, assumed a more equivocal character, especially concerning persons with

psychosocial disabilities in terms of integration and care (Grob, 1995). The integration becomes heavily dependent on the treatment and management of certain mental disorders. With the introduction of various pharmaceuticals, integration has become increasingly manageable; however, pharmacotherapy also brings the question of consent. Many persons with psychosocial disabilities refuse to medicate themselves, which arises most commonly from a lack of information and understanding of their personal condition (Schneider, 1999). This poses a barrier to the ability to fully participate in society, while forcible treatment would not be justifiable under such pretence. Hence, the medical elements and respecting the human rights-based social approach to disability come to odds with one another.

Within this balancing discourse, it is imperative to consider the degrees of severity of psychosocial disabilities. According to Price (2013), not all disorders are disabilities; nevertheless, arguably, not all disabilities lie in the lack of societal adaptation to persons with disabilities. There are medical diagnoses for several disorders listed in psychiatric classification systems, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Disorders that risk causing harm to others or themselves interfere with their ability to function in society. Here, then, the discourse on deinstitutionalisation becomes more polarised.

On the one hand, some authors argue that such conditions, even in severe forms, can be managed in an inclusive and accepting community-based environment with psychological support (Shanon, 1976). On the other hand, some authors identify such conditions as needing more structured treatment due to the risk assessment between societal freedoms and individual freedom. In other words, whether or not an individual's use of their freedom limits the freedom and safety of others. These voices are not heard as frequently anymore since the paradigm shift (Appelbaum, 1985; Morris & Kleinman, 2023). The arguments, however, lean heavily on criminal psychology and criminal law since crimes committed by a person with a severe mental disability are treated differently. The Czech Criminal Procedure Code (Act No. 40/2009 Coll), for example, in Section 47, establishes an alternative to waiving punishment for a crime committed by somebody of an unsound mind or limited legal capacity. This hereby acknowledges the medical element of psychosocial disabilities that constitute a disability rather than seeking societal explanations for disabling factors. Hence, adapting society to broaden conceptions of the 'norm' is surpassed by more vocal advocates for the medical model of the more severe psychosocial disabilities.

As it is determined that some instances of deinstitutionalisation pose a dilemma, the topic of involuntary admissions and treatment becomes relevant to investigate. Threats in this regard

are broader and more eventual as they involve leaving a person with a psychosocial disorder of varying severity to remain within the community in which the manifestation of the disorder causes the threat. On the one hand, involuntary admission is considered necessary in some cases to administer care and needs (Applebaum, 1985). On the other hand, however, it is argued that coerced and hereby not fully voluntary admission decreases the chances of further cooperation of the person admitted and instead increases anger and agitation, which can lead to worsening conditions, especially with regard to psychosocial disorders (Shanon, 1976). Seeing both sides of the argument, Monahan et al. (1995) argue for limiting the criteria under which involuntary admission and treatment are allowed. Over the years, this has been done and is reflected in the legislation at the international level by the guidance of the CPT (2017) as well as national legal frameworks, for example, in the Czech Republic through the Health Services Act (Act No. 371/2011Section 38 §1-2), outlining the permitting circumstances including when the person exhibits signs of mental illness and poses a threat to themselves or their surroundings.

Furthermore, maintaining the existence of various institutions and using restraints in cases of threat also comes into discussion. Here, unlike the discourse on involuntary admission and treatment, the threat is more immediate and requires a more interventionist and timely response. There is not as much of a polarised discourse on the topic; nevertheless, authors have weighed in on this practice's positive and negative aspects. Arguments against using restraints are on the prominent side of the debate, centred around autonomy and respect. Stilling (1992) refers to a cyclical occurrence of restlessness in patients with psychosocial disabilities, creating anxiety among staff, which in turn leads to them resorting to more authoritarian and coercive measures of control, such as the use of restraints. Nevertheless, this, in turn, leads to further erratic outbreaks triggered in patients due to feelings of helplessness. In other words, staff projects their feelings of frustration on patients. On the other hand, arguments for the use of restraints are limited to the absolute necessity to deal with the imminent threat to life or health (Birgili & İzan, 2019). As such, it is translated into the legislative framework both internationally (CPT, 2017) and nationally in the Czech Republic (Act No. 372/2011 Coll. Section 39 & Act No. 108/2006 Coll. Section 89).

This makes a set policy or legislative approach to de-institutionalisation challenging. Since disabilities come in such a broad spectrum of type and severity, each case needs an individualised approach.

1.5 Academic and Social Significance

Understanding the existing discourse on the social model of disability and deinstitutionalisation is important for it to translate into policy and practice effectively. Varying opinions on both highlight the challenges accompanying the implementation of policy into action. It is illustrated with regards to the use of restraints and involuntary admission and treatment as both these practices have an element of necessity stemming from the medical model of disability whilst also facing heavy critique derived from the social model of disability. The polarisation of opinions to a certain extent, but more importantly, the uncertainty of any one author on the topic due to exceptions and the need for individual case assessment, creates an identifiable gap to be addressed. Seemingly, the discourse remains stuck between policy developments and the socioeconomic reality of implementation (Kubalčíková et al., 2017).

While a significant amount of research has been conducted on these themes, when it comes to applying such practices to psychosocial disabilities in particular, as well as the overarching discourse on the paradigm shift and deinstitutionalisation, stances become controversial or uncertain. Examining controversial practices on a theoretical level is difficult. Hence, a legal analysis of concrete cases with reference to theoretical debates can overcome the challenge by combining specific circumstances of cases with generalised legal provisions to see to what extent they align. As the national legal provisions are largely fuelled by internationally set human rights standards, such as the UNCRPD, the reflection of these principles in practice and in the law can also be assessed. This can contribute evidence to the academic discourse, clarifying some uncertainties on the controversy of certain practices.

The necessity of practices such as the use of restraints or involuntary admission and treatment is recognised. However, acceptance is largely contested as the necessity seems derived from institutional characteristics rather than disorders (Stilling, 1992). It is therefore important to examine how this ambiguity of the source of justification is covered in the legislative framework that regulates institutions and practices within. This would allow the assessment of the extent to which the legal framework covers the reality of adopting the social model of disability and following the policy push for deinstitutionalisation. Furthermore, looking at cases can help identify the challenges and barriers in this regard to then feed back into the legislation and ameliorate the approach taken to dealing with persons with psychosocial disabilities in our society and ensure a human-rights based approach.

2. Methodological Framework

Drawing on preliminary literature, the research objectives are to understand how the legislation, specifically the rules and provisions regulating the use of restraints and practice of involuntary admission and treatment of persons with psychosocial disabilities in institutions, complies with the social model of disability and the policy push for deinstitutionalization. Furthermore, it is also an objective to understand relevant cases resulting from the human rights situation in the Czech Republic and how the state transposes obligations arising from the UNCRPD and the EU human rights legislation. Hereby, the following research question will be answered: "*To what extent is the legislation in the Czech Republic regarding the use of restraints and practice of involuntary admissions and treatment of persons with psychosocial disabilities, in conformity with the normative framework and policy developments under the United Nations Convention for the Rights of Persons with Disabilities?*".

The components of this research question are the relevant legal frameworks, which include the international framework under the UN, the EU and then the Czech legal framework. The Czech legal framework more specifically regulates practices generally covered by international treaties, such as the UNCRPD or the ECHR. Secondly, the other research component is the use of restraints and the practice of involuntary admissions and treatment, which will be examined using four relevant cases that were heard at the ECtHR.

The choice of these cases was made through purposive selective sampling, a non-probability sampling method, usually applied when the population of cases is diverse and broad. This enables focus on particular characteristics of cases (Rai & Thapa, 2015). Furthermore, the cases were also selected based on their thematic scope concerning the use of restraints and involuntary admission and treatment of persons with disabilities in institutions. This targets the gap between the extensive normative and policy framework on the one hand and the implementation of this in practice on the other. The cases are selected from the HUDOC database, as they allow an external analysis of Czech legislation and practice regarding their human rights obligations at the UN and EU levels. The bridge between the two is that while the Czech Republic is party to the UNCRPD, this is not a legally binding commitment. Nevertheless, the Czech Republic is legally bound to the ECHR, which complements various aspects of the UNCRPD (Chamon, 2020). The analysis of cases at the ECtHR, therefore, permits the indirect analysis of Czech transposition of the UNCRPD principles, but more importantly, the sufficiency in which human

rights, engulfed in the social model of disability and the policy push for deinstitutionalization, are protected at the national level.

The two hypotheses that will hereby be tested are firstly that *the legislation regarding the use of restraints and involuntary admission and treatment of persons with psychosocial disabilities does not fully reflect the normative framework being the social model of disability.* Secondly, it is hypothesized that *the Czech legislative framework does not fully transpose the policy principles of deinstitutionalization.* The use of restraints and involuntary admissions and treatments are elements of the paradigm shift, turning away from the medical model and replacing institutions with alternatives that refrain from resorting to such institutional practices. Hereby, the various components of the research question can be tackled to examine the overlap between the legislation and the social discourse and evaluate the extent to which psychosocial disabilities fit in this realm.

The thesis will assume a doctrinal method, which will look at cases against the Czech Republic at the ECtHR that deal with human rights violations, how the national legislation transposed these principles, and how the courts dealt with the cases. The research will also look at the nature of the legal rules and their development within the context of adhering to the principles outlined in the conventions and how the violations and the cases contributed to social and legislative change. More specifically, the IRAC method for legal analysis will be used for the cases (Bittner, 1990). This consists of first recognizing the legal issue, followed by the identification of the relevant legal rules, a synthesis of the two points analysed, and then, as referred to by Dunn (2015), concluding on the legal question posed, namely whether or not there was a violation of specific articles of the ECHR. This method incorporates a research and practice synthesis approach tailored to evaluating the impacts of existing public policies (Dunn, 2015). This means that the policy, or legislation, cannot be looked at exclusively and reduced to theory; it needs a concrete case for the analysis. For this reason, the four cases will illustrate and evaluate the legislation, followed by a discussion based on the theoretical framework presented above.

3. Legal Framework

3.1 International Legal Framework

Although disability has been mentioned in documents such as the Universal Declaration of Human Rights (UDHR), the first international human rights document, there was no standalone

document covering the multifaceted challenges and overcoming engrained issues regarding the rights of persons with disabilities. The United Nations Convention on the Rights of Persons with Disabilities was hereby adopted, to which most all states are party, as is the European Union itself. The ECHR also overlaps with various articles of the convention, allowing for it to be an additional safeguard for certain rights. These will be discussed below.

3.1.1.The United Nations

The UNCRPD is an international human rights treaty adopted in December 2006 and entered into force in May 2008. It covers civil and political rights, social and economic rights, and principles such as equal treatment and freedom from discrimination in a broad range of areas such as education, healthcare, and employment. All EU member states have signed and ratified the convention, including the EU as an institution itself. This is the first international convention that the EU has become party to, also becoming the first international organisation to do so (European Commission, 2011). In addition, 22 EU member states, including the Czech Republic, have also signed and ratified the optional protocol in 2019, establishing an individual complaints mechanism for the Convention.

As Celik (2017) rightly points out, the treaty not only brings to the surface core elements of human rights law, such as dignity and autonomy but also puts them into the very particular and relevant context of vulnerability and the accompanying necessity to ensure monitoring of the implementation of the convention. This topic extensively intersects with many other themes and human rights, such as participation in society through inclusion, non-discrimination, equal opportunity, accessibility, and freedom.

To go into more depth on the treaty, certain particularly relevant articles regarding deinstitutionalization, psychosocial disabilities, and, in general, the social model of disability will be highlighted. The preamble outlines the inherent dignity and equal rights of persons with disabilities, highlighting the need for inclusivity, protection and participation in society. These are then tackled through the various articles of the convention. Article 5 is on equality and non-discrimination, which calls for reasonable accommodation to be provided to ensure equal treatment and recognizes the need for active steps to be pursued to ensure compliance with this article. Article 8 further covers awareness raising, which intersects with the point made by Guevara (2021) and Samaha (2007) on normalizing disability, which enshrines the social model of disability as it fosters societal awareness and acceptance, which is the basis for integration. Article 9 then covers accessibility, with the aim of facilitating the independence of persons with

disabilities. Jumping forward, Article 19 explicitly covers independence, ensuring the right to live independently and be included in the community. Going back, Article 12 stirs the question of legal capacity, especially of persons with severe mental disabilities and therefore needs careful consideration. This needs to be considered together with Article 13, the right to justice, which seeks to remove all barriers to ensure access to legal proceeding as would be the deprivation of legal capacity.

The push for deinstitutionalization refers greatly to Article 14 on the liberty and security of a person. Arbitrary deprivation of liberty through forced admittance to an institution or security risks due to risk characteristics of institutions bears its legal basis here in the convention. Severe violations are covered by Article 15, which regulates the freedom from torture or cruel, inhuman or degrading treatment or punishment, which also has a more concrete and comprehensive base in the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. Furthermore, in Article 16 of the UNCRPD, freedom from exploitation, violence and abuse is also covered.

Article 25 covers the right to health, and it is important to note here that emphasis is put on treatment with informed consent. Due to the medical element of many disabilities, this becomes important to respect. Treatments and admission to healthcare facilities are human rights, but only if voluntary. This also connects to the aforementioned Articles 15 and 16, as non-consensual treatment will violate these other rights.

Finally, the convention outlines the right to an adequate standard of living and social protection, which frames the efforts as a collective task and an interdisciplinary one reaching into various aspects of life. The implementation of these articles internationally is monitored by the UN Committee on the Rights of Persons with Disabilities (Article 34), a body of independent experts to whom the parties to the convention need to periodically submit a report on the measures they take to implement the convention. In response, the committee issues recommendations to the parties to ensure the convention's implementation is better. This initiates a form of dialogue between the committee and the concerned party as information is gathered. The committee then issues a report every two years to the General Assembly and the Economic and Social Council on its activities and the situation of the state parties. The conference of state parties also allows for international dialogue and cooperation in implementing this convention.

3.1.2. European Union

The European Union has also ratified the convention, meaning that as a supranational entity, it must also uphold the obligations under the convention. Due to the structure of the EU, this cumulatively resulted in further legislative and policy action. The European Commission coordinated the implementation, and several mechanisms were implemented. To begin, the EU strategy for the rights of persons with disabilities is set for 2021-2030 to uphold equality, non-discrimination, access, independence, participation and respect. The European Commission supports member states in developing their own national strategies and action plans in line with the UNCRPD. Furthermore, endorsed by the Council, the EU framework on the implementation of the UNCRPD was established. Its members are the European Parliament, the European Ombudsman, the EU Agency for Fundamental Rights, and the European Disability Forum. This framework is based on Article 33(2) of the UNCRPD, which requires state parties to establish a framework to promote, protect, and monitor the implementation of the UNCRPD.

Lastly, in terms of further enforcement and implementation, the European Convention on Human Rights, although not covering specific provisions for the rights of persons with disabilities, ensures that all humans are treated equally, and their human rights are upheld. Unlike many other human rights documents, this is legally binding and has a supporting court that interprets the convention and processes applications against states that have violated the rights outlined in the convention. Such cases will be discussed below with regard to the violation of the rights of persons with disabilities to tie together the frameworks outlined. In particular, with regard to the thematic area of this thesis and the case studies, Articles 2, 3 and 5 will be of significance.

Article 2 is the right to life; states that deprivation of life will only be considered as inflicted in contravention of the article if resulting from the use of force which was absolutely necessary, outlining defence from unlawful violence as one of such instances. Article 3 outright declares that no one shall be subjected to torture or inhuman or degrading treatment or punishment. Article 5 is more elaborated on, providing the right to liberty and security. It outlines circumstances prescribed by law under which derogations are permitted. Relevantly, these include lawful detention when it is considered necessary to prevent the person from committing an offence or for persons of unsound mind, alcoholics, drug addicts or vagrants. The person must be informed promptly in an understandable manner, be entitled to take proceedings by which the lawfulness of his detention shall be decided, and release ordered if the detention is not lawful. In such a case, everyone shall have an enforceable right to compensation. Applied

to this research, this ‘detention’ would refer to involuntary admission, indicating that in cases of an offence committed or the person being of unsound mind, such admission would not violate Article 5.

3.2 The Czech Legal Framework

The Czech Republic does not have legislation specifically on mental health, resulting in a significant legal gap. The lack of specific laws for persons with psychosocial disabilities feeds into the aforementioned interpretative ambiguity in particular cases, which needs to be examined. This is relevant both academically and socially because of the need to protect persons in vulnerable situations and ensure their adherence to international human rights standards. Interpretative ambiguity of legal measures is also a limitation for the enforcement of the convention, which needs to be examined in relation to the current situation in the Czech Republic (Bartlett, 2014).

3.2.1 The Situation

The current standing of the framework and system for persons with intellectual and psychosocial disabilities in the Czech Republic is still largely rooted in institutional care. A telling statistic in this regard is that while the EU15 countries’ average hospital beds per psychiatric institution is 184.6, the Czech average is more than twice that high at 491.7 beds per institution (Krupchanka & Winkler, 2016). Furthermore, the last collected data available from the Czech Health Ministry shows that 60.6% of costs for psychiatric care are spent on inpatient care, while only 19.2% are on outpatient care and another 20.2% on pharmacotherapeutic care (MZD, 2020). This goes against the social model of disability previously discussed and looks rather at the medical aspects (Dobiášová et al. 2016). Nevertheless, it has been documented that between the years 2007 and 2022, the capacity for inpatient care has decreased by 29%, which points to progress in terms of deinstitutionalisation (MPSV, 2023)

Nevertheless, commendable efforts have been made to push the implementation of the convention further, such as integrating mental health centres. These are not institutions; instead, they act as a network of services within community settings and deliver services to those who need them (MZD, 2013). The network incorporates psychiatrists, psychologists, social workers, daycare centres, emergency teams and other more specialised workers or departments to prevent hospitalisation and assist integration within respective communities (MZD, 2017).

Approximately thirty of these centres operate in the Czech Republic, and the Ministry of Health set a target of one hundred (MZD, 2021).

The National Statistical Office also collects data on this; however, the last collection round was in 2018. Nonetheless, in 2023, they began a new round of data collection to better understand the living situation of persons with disabilities, their access to care and aid, whether their independence is facilitated by any tools or measures, what barriers they face, and where. This is in accordance with Article 31 of the UNCRPD, stating that all state parties need to collect disaggregated data on persons with disabilities. Furthermore, according to Article 35 of the UNCRPD, state parties must submit a report to the committee on progress and measures taken to implement the other articles of the convention and fulfil its aim.

Article 33(2) of the UNCRPD requires state parties to have a monitoring framework under a preventative mechanism. In the case of the Czech Republic, the Public Defender of Rights, the Ombuds Institute (Act No. 349/1999 Coll.) holds the National Preventative Mechanism mandate. Data on the situation of persons with disabilities is collected, after which the reports are publicly made available. The last one submitted was a quarterly review for 2024 and the annual report from 2023. Some of the main points raised here are as follows. First and foremost, progress on the state of deinstitutionalisation was reported. Due to the continued existence and reliance on institutions, the situation of persons still residing in institutions and whether their rights are being respected was also commented on here. Furthermore, barriers were investigated regarding communication and access, as well as the progress of the aforementioned deinstitutionalisation and the development of alternatives.

Furthermore, the Czech Republic is undergoing a psychiatric reform in which issues such as insufficient funding and resources, lack of political interest and lack of community care are addressed in the context of the push for deinstitutionalisation (MZD, 2013). The aforementioned integration of mental health centres is a flagship initiative within this reform as it assumes a multidisciplinary and, therefore, holistic approach to improving the circumstances that are part of the National Mental Health Action Plan 2020-2023.

Similarly, the Action Plan for transitioning social services to community-based care and greater individualisation of social services in the Czech Republic 2023-2025 (MPSV, 2023) also operates in the policy framework of deinstitutionalisation. It looks at action points to further integration, with the strategy being to focus, on the one hand, on legislation in terms of considering technical aspects of deinstitutionalisation, such as building a firm enough

community base to transfer residents into. Furthermore, individual approaches strived to deal with persons on a case-by-case basis, targeting all assistance provided to specific needs. Coordination is also emphasised due to the necessity of a multifaceted and holistic approach. Monitoring is another element of this action plan that is defined as needing further attention to understand the standing of the state of deinstitutionalisation and to evaluate it. On the other hand, non-legislative measures are also included in the action plan. Financial support is one strategic point to ensure the implementation of the deinstitutionalisation process. Furthermore, raising public awareness is another important element in building a community that hosts diversity and inclusion.

3.2.2 Legislation

There is no specific legislation on mental health in the Czech Republic. Hence, it is covered mainly under the Health Services Act (Act No. 372/2011 Coll.). This act covers services and conditions for provisions of health services. With regards to using restraints, Section 39 §1 provides an exhaustive list of restraints that are permitted, including the grip of a patient by medical staff, the use of belts or straps, net beds, seclusion room, protective jacket and psychopharmaceuticals. Section 39 §2 further emphasises that such restrictions can only be applied if the aim is to avert an imminent threat to life, and the method and duration should be proportionate and only in keeping with the threat at hand. In terms of involuntary admissions and treatment, the Health Services Act regulates informed consent in Section 38, stating that consent is not required under the circumstances that treatment was decided by a court (§1a.1) or if the person is a threat to themselves or their surroundings or shows signs of a mental disorder (§2).

Additionally, three other legislative documents are relevant to understanding compliance with the normative and policy framework set by the UNCRPD. These are the following: the Act on Social Services (Act. No. 108/2006 Coll.), the Civil Procedure Code (Act No. 99/1963 Coll.) and the Act on Specific Health Services (Act No. 373/2011 Coll,). With no specific legislation dedicated to this, the Ministry of Health had expressed the risk within the National Mental Health Action Plan that general provisions can allow certain issues to fall between the cracks. Nevertheless, the acts will be discussed specifically regarding the use of restraints and involuntary admission and treatment due to their relevance to the subsequent case analysis chapter.

First, the Act on Social Services (Act. No. 108/2006 Coll.) Section 89 also outlines provisions for the use of restraints. Section 89§1 provides that such measures may only be used in cases involving a threat to the health and life of the patient or others surrounding them and only if other efforts to avoid the threat have been unsuccessful (Section 89 §2). The mildest measure possible must be resorted to (Section 89 §3) but should be prevented from the beginning (Section 89 §4). After administering a restraint, the person's legal guardian must be informed (Section 89 §5), and a duly documented incident record must be produced (Section 89 §6). In 2018, however, a new recommendation, based on the recommendations of the CPT, was added, which prohibits using restraints as a systemic measure in the event of a staff shortage, for example.

Secondly, the Civil Procedure Code (Act No. 99/1963 Coll.) Section 191(a-g) outlines the proceedings on the admissibility of taking somebody in and keeping them in an institution. Upon involuntary admission, the court must be informed within 24 hours, which must then commence proceedings to establish the admissibility of the person concerned. If declared unlawful, the institution must release the person admitted; otherwise, they may remain institutionalised for up to one year before another court review. Involuntary admission or placement and involuntary treatment are not differentiated by law as a person involuntarily admitted, and their right to refuse treatment has not been considered. No specific provisions regulate involuntary psychiatric treatment for persons deprived of their legal capacity and under guardianship; however, the guardian's consent would be acceptable (FRA, 2009). After an amendment of this Act, now Act no. 402/2012, the approval of admission by a legal guardian is no longer taken as consent in lieu of the person being admitted.

Lastly, the Act on Specific Health Services (Act No. 373/2011Coll.) contains two controversial parts in this regard, as it outlines the conditions under which sterilisation and therapeutic castration are permitted. The former (Section 2 §12-16) is permitted in cases where the person has restricted legal capacity, which in some cases includes persons with certain disabilities (EDF, 2022). Further requirements, however, are also in place as safeguards, such as the need for a court agreement, the agreement of an expert commission composed of doctors specialised in urology and gynaecology, a clinical psychologist, and a lawyer. The justifications are usually medical reasonings and mostly in psychiatric institutions (EDF, 2022). Therapeutic castration (Section 3 §17-20) is legally performed on persons with paraphilic disorders which have manifested. This disorder, being socially disabling, is considered to be a form of psychosocial disability (Brown, 2023) and is hence treated with this intervention in severe and recurring

cases. Both these practices have been criticised by the CPT and the UNCRPD committee, with recommendations to abolish this practice. Hence, Act No. 373/2011 Coll. on specific medical services emphasised the need for written consent for such practice; nevertheless, as stated above, cases concerning persons with limited legal capacity still evoke critique despite measures to ensure safeguards (EDF, 2022).

The relationship between these provisions establishes a broad basis for safeguarding the rights of persons with psychosocial disabilities in institutions and encouraging institutionalisation to be the last resort. The two main provisions are the Health Services Act and the Social Services Act. The former aims to preventatively protect and systematically strengthen and develop the physical and mental health of persons and focuses more directly on patient's rights. Hence, it regulates the practices associated with achieving this aim. Since institutions are still at the heart of the healthcare system in the Czech Republic, this extends the act to regulating practices largely in healthcare facilities. The latter regulates the authorisation, execution, administration, and inspection of social service provision in terms of care in healthcare and asylum facilities, hereby bearing relevance to this research. Furthermore, the Social Services Act has a broader scope in the sense of ensuring the quality of various social services as well (CRPD, 2020 §45-47, 49-50). This contributes to the establishment of a reliable social and community basis for deinstitutionalisation efforts. Hence, the two provisions cover the health care facilities and social service institutions. It is important to cover both as with the paradigm shift away from the medical model; institutionalisation does not always mean hospitalisation, thereby extending the scope of facilities that need to be regulated.

The other two provisions mentioned, the Civil Procedure Code and the Act on Specific Health Services, are more particular and are only used in this paper as a complimentary provision rather than the basis of regulating institutions for persons with psychosocial disabilities. The Civil Procedure Code provides legal guidelines on involuntary admission in terms of the accompanying procedure rather than outlining in detail the conditions under which this would be permitted. These conditions are regulated by the aforementioned Healthcare and Social Services Acts. Furthermore, the Act on Specific Health Services, is mentioned here even more purposively due to its specific detailing of two practices: sterilisation and therapeutic castration. Being an institutional practice, it complements the two main regulations on the treatment of persons with psychosocial disabilities in institutions.

Complimentarily, the Code of Ethics (2017) established by the Czech-Moravian Psychological Association sets the normative standards, although not binding, for evaluating different power

dynamics and their impact on the person treated, respect, overcoming biases, equal rights, freedom, privacy, and other principles also found in the UNCRPD. This helps bring such rhetoric to the caretakers and professionals in the field to further embed a more human rights-based model of disability into the practice.

3.2.3 Monitoring and Implementation

Implementing the aforementioned legislative frameworks poses a new challenge as it requires resources and will. Furthermore, the critique of discrepancies between policymakers and professionals in the field comes to light, as certain legislation and policy action points stagnate in their enforcement due to barriers on the ground. Nonetheless, there are mechanisms in place that aim to bridge this gap.

Most notable is the ombuds institution, referred to as the public defender of rights. This institute holds the mandate of the national preventative mechanism (NPM), which is an obligation for all state parties to the UNCRPD under Article 33. Concretely, all state parties must designate focal points within the government for matters relating to the convention's implementation, including an independent mechanism to promote, protect and monitor the implementation. Under this mandate, the Czech Ombuds Institute can conduct unannounced and ad hoc visits to all institutions or closed settings with the right to access documents and to speak with residents and staff. The importance of unannounced visits must be highlighted to ensure a true picture of the situation within an institution is created. Usually, however, aside from ad hoc visits, the ombuds institute usually sets an annual plan determining which institutions will be visited based on findings from previous visits and complaints received. In cases where a violation of an article of the UNCRPD is found, they issue recommendations to the institution to make amends. Here, the advisory body on the rights of persons with disabilities provides more specialised insights within the ombuds institute. Nevertheless, if the violation amounts to a crime, it is referred to competent authorities to investigate further.

All of the laws, acts, policies, and mechanisms outlined above will be further looked into through an application on a case, by which an analysis will also be developed. Nevertheless, overlapping the international framework with the Czech legal framework, it becomes apparent that provisions of the UNCRPD are not fully or transparently implemented and transposed in the law. Despite monitoring mechanisms, concrete legislative change is needed to support the reforms occurring in practice.

4. Case Studies

In this chapter, four cases will be examined in order to reach a more comprehensive analysis of how the Czech Republic's legislation and practices adhere to international and supranational legislative and policy frameworks. They concern a range of topics such as involuntary administration, restraint measures, forced medication, coercion and legal capacity presented in the order of the judgments made. These cases showcase the times the state, through its transposition of the UNCRPD, failed to uphold the convention's principles and articles, which are also reflected in the ECHR.

4.1 The Cases

4.1.1 Case of Bureš v. the Czech Republic

The applicant, born in 1985 and residing in Brno, has a psychosocial disability. On the 9th of February 2007, the applicant unintentionally overdosed on Akineton, a medication used to treat most commonly Parkinson's and other movement disorders. This medication had been prescribed to the applicant by his psychiatrist. The abuse of this medication, however, can cause central nervous disturbances such as severe states of confusion, delirium or hallucinations. In the applicant's case, this mental state led to him leaving his flat dressed only in a sweater. After being stopped by the police, assuming he was a drug addict, he was brought to the Brno-Černovice Psychiatric Hospital by ambulance. When admitted, he was examined by a doctor who attested to not having found any injuries on the applicant's body, and after being transferred to the sobering-up centre, another doctor, also confirmed that there were no injuries on the applicant.

On the morning of the next day, the applicant was transferred to the Intensive Psychiatric Unit. The admission record here states that he had 'visible abrasions on the front of his neck, both wrists, and both ankles, caused probably by friction against textile, and abrasions of an unspecified different type on his knees' (§9). He complained about his treatment; however, no action was taken. Five days later, a neurologist conducted an examination of the applicant's condition and found that he had suffered severe paresis, a condition in which muscle movement becomes impaired due to the administered straps, due to which he began intensive treatment at the Rehabilitation Unit.

According to the applicant, he was strapped to a bed with leather straps. During this, two male nurses kneeled on his chest and verbally abused him. Due to insufficient blood circulation caused by the straps, the nerves in his arms were damaged, leading to the paresis. The Government submitted a record which also outlined the events. It was noted that the applicant was intoxicated upon admittance and strapped to bed at 20:10. At 22:00, he was unstrapped, but at 04:30, he attacked a nurse and was strapped again and once more at 06:30, following destructive behaviour. At 07:15, he was moved to the psychiatric hospital.

The applicant remained in the hospital involuntarily until the 13th of April. This, however, resulted in confusion and the inability to take care of himself after his release, for which reason he voluntarily returned the following day and remained there until July 1st, 2007. These circumstances bring about the legal question of whether or not there was a violation of Article 3 of the European Convention on Human Rights which reads: "No one shall be subjected to torture or inhuman or degrading treatment or punishment". This covers the themes of involuntary admission and treatment and the use of restraints.

Legal Rules

To better understand the development of the circumstances, the relevant legal rules in the Czech Republic need to be reiterated to assess the lawfulness of the use of restraints. The Health Services Act had still not been in place here; however, the Act on Social Services (Act. No. 108/2008 Coll.) Section 89 also outlines conditions under which the use of restraints may be permitted, which requires the presence of a threat to health and life. These acts in this regard do not contain any contradicting or different guidelines and hereby act to reinforce one another as the former applies to healthcare facilities and the latter to any social service facility including in healthcare. The ruling also referenced Guideline no. 1/2005 of the Journal of the Ministry of Health; however, it stipulates that restraints on patients in psychiatric facilities be used only as a last resort when necessary to protect the patient. Important is that it may not be used as a facilitator for treatment. Furthermore, if the cause of erratic behaviour is unidentifiable and therefore cannot be removed and the benefits outweigh the risks, such measures may also be permitted. It is explicitly stated that it may not be used as a punishment. The patient in restraints also must be checked on a regular basis, and records of all this need to be kept.

Looking at the international and supranational legal standards, the UNCRPD outlines in Articles 15 and 16 freedoms from torture or cruel, inhuman or degrading treatment and freedom from exploitation, violence and abuse, respectively. However, it does not specify what

constitutes violence or such treatment providing a margin of appreciation to the interpretation of these clauses by the state parties. Nevertheless, the EU framework establishes a more comprehensive and definitive interpretive base.

The ECHR states in Article 3 that "no one shall be subjected to torture or to inhuman or degrading treatment or punishment," which restraints and involuntary admission can amount to. The CPT (2017) has assessed this right in greater detail and issued standards on the use of restraints that reflect the same conditions required in Czech legislation: legality, necessity, proportionality, and accountability.

The Application and Analysis

As outlined above, there are many sources to draw from, as this phenomenon has been addressed in the legislation. It is the implementation and interpretation of these laws that becomes challenging. Despite listing conditions under which both involuntary treatment and the use of restraints may be permitted, this results in a subjective analysis of the situation.

The legality of these actions in the Czech Republic will be analysed by applying the Czech legislative framework to the facts of the case. With regards to the Social Services Act, the use of restraints is only permitted in cases where the resident poses an imminent threat to life, and the method and duration should be proportionate to the threat at hand. Examining the facts of the case, it is noted that restraints were not used as a last resort, and requirements for the administration of restraints, such as consistent monitoring and surveillance, were not complied with. Furthermore, upon being admitted, he had not shown signs of aggression that would justify the use of restraints and not by any means the proportionality aspect. The restraints were so tight that they caused pain and suffering; the applicant explained he thought he could suffocate. Additionally, this treatment had long-lasting effects, which once again counters the proportionality element of the regulation on administering restraints. The second time he was strapped has a more justifiable basis for the use of restraints, as he attacked a nurse after being unstrapped for the first time. Nevertheless, this attack can be linked to his treatment by the nurses; hence his outburst being triggered by unwarranted institutional practices.

The government, however, maintains that the nurses were not state agents, so accountability cannot be brought upon the state. Secondly, such intervention was necessary to protect the applicant's health. In terms of the former argument, despite not being a state agent, they perform a state duty due to the state's responsibility for anyone deprived of liberty. In terms of the latter,

the necessity clause, the threat posed needs to be examined. Despite the applicant's inappropriate behaviour due to his mental state, he was not violent during transport and admission; however, he was allegedly restless. This still, however, does not constitute a threat imminent enough to resort to the use of restraints. After he was unstrapped, he attacked the nurse, which then led to his restraining again. This time, although the threat was present, the reasoning for this erratic behaviour could be identified and removed, which, according to the aforementioned Guidelines of the Journal of the Ministry of Health, then does not constitute a justification for the use of restraints as there were other venues possible to treatment. Hence, domestic guidelines were also not complied with.

Conclusion

From this analysis, it would be concluded that there was a violation of Article 3 of the ECHR. First of all, resorting to restraints was not justified by the necessity and threat of the applicant and the situation. Secondly, the administration of the restraints resulted in pain and suffering as well as long-lasting effects due to negligent surveillance and monitoring of the applicant's condition while restrained. The court argued alike and made the judgement unanimously that there had been a violation of Article 3 of the ECHR

4.1.2 Case of Dvořáček v. the Czech Republic

The applicant was diagnosed with Wilson's disease, which is an accumulation of copper in the body resulting in impairment and changes in character traits. He also suffered from hebephiliac disorder, a form of paedophilia, which was a result of his illness rather than primarily a sexual deviation. Due to this condition, the applicant had been prosecuted multiple times for crimes against children under 15 years of age and in 2002, he was sentenced to imprisonment. He was hospitalised to undergo protective treatment but underwent mostly outpatient care. His legal capacity was restricted with his mother appointed as his legal guardian. One of the criminal proceedings was suspended due to his not being criminally responsible at the time of the offence; however, he was ordered by the District Court to undergo institutional protective sexological treatment instead because the applicant refused pharmaceutical treatment despite the psychiatrist insisting that without such intervention, he may be dangerous. The circumstances of this institutionalisation of the applicant are the subject of the complaint.

The applicant refused to be castrated as well as continuing to refuse medication, for which reason institutionalisation was seen to be the permanent solution. Eventually, the applicant

agreed to pharmaceutical treatment; however, after a few months of the treatment, he complained about its effects, and after deliberation on the applicant's mental state and the testimony from the Psychiatric hospital, the District Court agreed to outpatient sexological treatment. Here, however, the applicant claimed that his illness had worsened during the hospitalisation and that he now suffered from mental problems, fear of the hospital, castration, humiliation and loss of dignity. Furthermore, he claimed that the pharmaceutical treatment only deprived him of his active sexual life but did not make the sexual desires go away. An expert agreed that, indeed, such treatment without a comprehensive approach, including psychotherapy and social care, would not result in progress in his condition.

By request of the applicant's mother, an expert opinion was issued on the state of the applicant's illness, where it was concluded that his illness had progressed. The expert also stated that the treatment he received during his hospitalisation was ineffective because the aim was suppressing sexuality rather than eliciting change and also because the applicant did not cooperate. Hence the expert concluded that in the case of paedophilia, outpatient protective treatment is insufficient, and the castration or sexual sedation is the only treatment "which would ensure public safety and allow the complainant to live outside the medical facility" (§19). After further incarceration for new charges, the District Court agreed for him to continue outpatient care.

The applicant complained to the ECtHR that the hospital did not provide him with adequate care, subjected him to forced medication and involuntary treatment as well as applied psychological pressure to force consent to castration. He could not seek remedy there because there was no complaint mechanism in the institution where he was hospitalised. Hence, the legal question arises of whether there was a violation of Article 3, the prohibition of torture, and Article 13, the right to an effective remedy.

Legal Rules

The legal rules applicable to this case on the national level are derived from, first and foremost, the Health Services Act Section 38 §1-2, which apply in their procedural directives. The medical staff had the obligation to inform the applicant about his admission and treatment and obtain his consent before proceeding. Only under the circumstance of the person showing signs of mental illness or intoxication could this be derogated from which applied to the circumstances. Nevertheless, due to the criminal charges against the applicant, it is necessary to consider further criteria.

Here, the ECtHR referred to the Code of Criminal Procedure (Act No. 140/1961 Coll.), which was used at the time to establish the relevant national law and practice. Since then, however, the Code of Criminal Procedure has been updated and is now found as Act No. 40/2009 Coll. Nevertheless, in this regard, both still cover the fundamentals of the ruling. In Section 26 of Act No. 40/2009 Coll. diagnosis of a mental disorder at the time of committing the act means the person cannot be held criminally responsible for the act. Nevertheless, this only applies insofar as the illness obstructs the ability to recognise the illegality or control their actions. Furthermore, both acts cover the concept of protective detention or treatment. This is the updated act referred to in Section 47, which provides a waiver of punishment for the simultaneous imposition of protective treatment or protective detention. This is used in the cases of the offender being in a state caused by a mental disorder aimed at improving the offender's condition while protecting society.

Furthermore, the Act on Specific Health Services Section 3 §17-20 permits the practice of therapeutic castration on sex offenders, including individuals diagnosed with a paraphilic disorder. This did not manifestly occur in this case. However, the applicant claimed that he was pressured into consenting to this treatment in order to quell his sexual desires and eliminate the risk of repeat transgressions.

The applicant brought complaints based on Article 3, claiming he was subjected to ill-treatment. The ECHR guide explains that Article 3 is only to be applied to cases where the ill-treatment attains a minimum level of severity. This determination is relative and depends on the circumstances of the case.

The Analysis and Application

One recommendation that can be drawn from this case is there needs to be a more standardised and regulated reaction in terms of such offences and crimes as the applicant was being moved in and out of the institution, and no comprehensive treatment was administered from the start to deal with his condition. This resulted in disruptions of the treatments and a lack of a comprehensive treatment plan tackling the disorder not only chemically but also psychosocially to facilitate better chances of treatment and reintegration into society.

The key dispute here is the involuntary treatment of the applicant and the lack of a free basis upon which consent can be granted. As mentioned above, involuntary admission and treatment are not distinguished between in the law, so the same act applies. Being given the limited choice

between surgical castration, pharmaceutical treatment, or indefinite detention can constitute a form of coercion; nevertheless, it was noted that treatment of some kind constituted a medical necessity. Despite this, none of the evidence pointed to the treatment of the applicant so severe that it would constitute a violation of Article 3.

Furthermore, to fall back on the national legislation, the elaboration on criminal liability is of value. While the applicant's past crimes are not subject to this particular case of his treatment, they raise an important element to understanding the Czech Republic's alleged violation of Article 3 of the ECHR. Important to note is that a court order of protective treatment does not constitute consent to treatment. Nevertheless, this relates to a broader discourse of dealing with persons with psychosocial disabilities, which not only hinder their participation in society but actually pose a threat. This is how the court also argued the medical necessity of a form of treatment. Hence, the scope of the application can be put into question here as the intention to subject the applicant to ill-treatment is not present, and the authorities operated under the dilemma of treating the applicant's condition and protecting society from the manifestations of his disorder.

Conclusion

Hence, the facts of the applicant's admission and treatment within the institution, although bordering on coercion, did not amount to a violation of Article 3 because of the lack of substantial evidence, procedural flaws at the national level rather than substantial ones, and the lack of severity. The court also argued that the information available did not violate Article 3 of the ECHR.

4.1.3 Case of Červenka v. the Czech Republic

The applicant had a behavioural disorder caused by alcohol as he was an alcoholic and repeatedly experienced alcohol withdrawal delirium (delirium tremens). He was stripped of his legal capacity and assigned a public guardian. However, after instances such as causing disturbance at night, urinating on the building stairs, mistreating animals or yelling at passers-by, the applicant's parents could no longer take care of him, so the public guardian recommended placement in an institution. Although the applicant did not want to go, he agreed eventually. Around a month later, however, he disagreed with his placement and contacted several authorities, including his public guardian, who dismissed his complaint.

The applicant claims he was being held in the social care home against his will. He signed a letter of attorney allowing for a lawyer from the Mental Disability Advocacy Centre to represent him and demanded his release. However, the social care home director claimed that the applicant's placement was legal because of the deprivation of legal capacity and his public guardian having consented to it. As a reaction to this, the applicant's lawyer requested the District Court to issue a decision on the lawfulness of the admission. With the request being dismissed, the lawyer turned to different courts. However, the power of attorney was not accepted because the applicant was deprived of his legal capacity, not allowing such a power transfer. Eventually, however, after these appeals and rejections, the public guardian agreed to the applicant's release. The applicant maintains that he had been deprived of his liberty against his will by his placement in the social care home. This hereby calls for the question of whether Article 5, the right to liberty and security, had been violated.

Legal Rules

A member of the CPT also comments on involuntary admission to psychiatric establishments (Kmecová, 2024), as it issued standards for such practice. Such a measure, which derogates from the fundamental principle of the right to liberty (Article 5 ECHR), must again be based on clearly set laws.

In the Czech Republic, involuntary admissions and treatment are regulated by the Health Services Act Section 38 §1-2, outlining exceptional permitting circumstances regarding consent. Further, this permits involuntary hospitalisation in cases of exhibiting signs of mental illness and being a threat to themselves or their surroundings.

Cases involving limited legal capacity are governed by the Code of Civil Procedure (Act no. 99/1963), which stipulates that a special representative should be appointed in cases of conflict of interest between the person deprived of legal capacity and their legal guardian. However, an amendment of this act, now Act no. 402/2012, states that an admission approval by a legal guardian may not substitute consent of the person being admitted and relies on court approval and having heard objective medical expert opinions. This amendment had, however, not yet been in place at the time of the admission, making the approval legally sound at the time.

Lastly, the article in question, Article 5 of the ECHR, stipulates circumstances under which a person may be deprived of their liberty. In this case, it relates to §1(e), under which detention of persons of unsound mind, alcoholics, or drug addicts is permitted. However, the person must

be informed, given the opportunity to defend himself, and provided with legal assistance to do so.

The Application and Analysis

With regards to the involuntary admission of the applicant, it is only permitted by the Health Service Act in cases where the person poses a threat to themselves or their surroundings or when their legal capacity is limited. The government argued that this had been the case, citing the harassing and disruptive behaviours and once the applicant's condition had improved, he had been released, and the measures were in keeping with the principle of necessity. Furthermore, however, regarding the amendment, the involuntary admission must be in accordance with national legal standards, which in this case stipulate court notification, review and approval, which was not done in this case, leading to a procedural breach.

Moreover, despite filing numerous complaints and requests to review the decision, dismissing appeal requests and not recognising the power of attorney the applicant conferred upon a lawyer resulted in an unlawful decision to approve the admission. The key problem here was found to be the lack of provisions at the national level to provide an effective solution and remedy and, hence, also find the measure lawful. While the law outlines conditions that need to be met for admissions to psychiatric hospitals, there is less regulation for admissions to social care homes. Therefore, the applicant's argument was that his being held in the social care home was based on the powers that had been granted to his guardian rather than based on a thorough evaluation of his mental state. Furthermore, the applicant claimed that due to no improvement in his condition before and after being institutionalised, his placement in the social care home had been for the guardian's convenience, following complaints from neighbours rather than the best solution for treatment, leading to an arbitrary deprivation of liberty.

The government argued that due to the continuous complaints from neighbours, the inability of the applicant's parents to take care of him, and his medical history of alcoholic dementia, his case required intervention. Furthermore, as mentioned above, due to the lack of concrete regulations for admissions into social care homes, there is no sound basis to evaluate the necessity of the applicant's admission.

Again, with reference to the specifications of derogation permittance of Article 5 of the ECHR, the applicant was not granted a proper defence due to his deprivation of legal capacity and his absence during the decision made under the consent of his guardian. Hence, structural issues

with the deprivation of legal capacity arise as the applicant was stripped of independence in terms of filing a complaint via transfer of power of attorney to a lawyer and having courts dismiss his requests for review. Cumulating in the guardian's decision to admit the applicant into the social care home, the applicant was deprived of his physical liberty without possessing the legal capacity to remedy this act.

Conclusion

Hereby, it would be concluded that there was a violation of Article 5 of the ECHR because of the unlawfulness of the court decision and the procedural flaws concerning the applicant's deprivation of legal capacity, which restricted his ability to apply for an appeal and contest the involuntary admission to the social care home. Furthermore, the lack of regulation for admissions to social care homes created an uncertain basis for justifying the decision. The court also argued that the decision by the national court for deprivation of liberty was not lawful and therefore made a unanimous judgement stating there was a violation of Article 5 of the ECHR.

4.1.4 Case of V v. the Czech Republic

The applicant's brother (P.Z) was the subject of this case, suffered from paranoid schizophrenia. On the evening of November 5th, 2015, the emergency was called by a member of P.Z.'s family, as he had become aggressive, threatening other family members. He was taken to a hospital, by which time he had calmed down and agreed to be administered an antipsychotic medication. The next morning, he began to grow restless, so the nurses began to prepare an intensive care room, which consisted of a solid metal door and a bed with magnetic straps to restrain aggressive patients. Following a verbal altercation with staff, P.Z. began to exhibit destructive behaviour, breaking furniture and doors. An orderly tried to intervene, to which P.Z. reacted by pushing him to the ground and beating him, trying to strangle him with a fire hose. This behaviour was attributed to being a defence as he only began growing restless when he found out he was being moved to a seclusion room. A police emergency line was called, who intervened immediately, forcing P.Z. to the ground. Due to his strength, the police officers could not restrain him, so deeming that all conditions for using a taser had been met, they resorted to the use of force.

The firing of the taser was done several times as P.Z. continued to resist. Eventually, however, his arm was partially immobilized, which allowed the nurse to administer a tranquiliser. After the injection, P.Z. was turned around and had no palpable pulse, so the resuscitation efforts

began; however, 45 minutes later, he was pronounced dead due to cardiac arrest. Criminal proceedings were initiated for negligent homicide; however, the constitutional court dismissed the case as manifestly ill-founded as the authorities had not breached their statutory obligations and the actions had been based on sufficient reasoning. Hence the question arises whether there was a violation of Article 2, the right to life and Article 3, the prohibition of torture, of the ECHR.

The Legal Rules

This case primarily looks at the regulation of the use of physical restraints, referring to the grip of the medical staff and the police officer, the use of a taser as a form of subduing P.Z. and finally, the administration of chemical restraint. According to both the Health Services Act and the Social Services Act, the conditions to use restraints, which is the threat of imminent threat to life, were met. Nevertheless, the Social Services Act further elaborates that other efforts must have been taken first and been unsuccessful, finally resorting to the mildest measure. In the 2018 revision of the act, the added amendment stipulates the prohibition of using restraints as a systemic measure. Furthermore, again referencing the Health Ministry's Guideline no. 1/2005, if the cause of the erratic behaviour can be identified and removed, the use of restraints should not be permitted.

The CPT (2017) had issued recommendations in this regard, due to the urgent need for more regulated administration of restraints. First of all, the ultimate goal should be to avoid the use of restraints, which the preparation of the seclusion room before the altercation did not comply with. Moreover, psychiatric establishments need to have a specific policy on restraint covering under which circumstances they may be used, the means, and supervision as well as staff training, which became difficult to regulate under these circumstances due to the external intervention of the police. Nonetheless, the same regulations need to be applied to all public authorities because they are bound by certain internationally agreed-upon human rights standards despite the context of occupation.

The Application and Analysis

According to these laws and the facts, the incident began when P.Z. was being prepared to be transferred into a seclusion room used to restrain aggressive patients before circumstances explicitly called for this. Hereby, the cause of the erratic behaviour can be rooted in this. Instead of attempting to ameliorate the situation by eliminating the cause of the aggression, being his

unjustified transferral to a seclusion room, the reactionary aggressive behaviour served as the basis for the further use of restraints. To begin with, the reliance on the seclusion room as a preventative practice exhibits the systemic nature of resorting to restraints, which, as was the case with P.Z., became the cause for agitation.

At that point, the threat to life and health was imminent, and various attempts were made to restrain him prior to the police being called. Nevertheless, according to the Ombudsman, the police had not exhausted these before resorting to the use of a taser. Furthermore, according to the report by the Ombuds institution, the imminent threat had, at this point, subsided, meaning that the proportionality was askew. Nevertheless, the resort to the use of force and restraint by the police once again confirms the above, that there is a presence of a systemic nature of such approaches, which highlights the problematic nature of institutional culture. Furthermore, a comprehensive guiding framework on the steps that need to be taken, as well as the cooperation between the medical staff and the police, was lacking. Appropriate training of the police was also missing due to the absence of understanding on how the tasering may elevate the risks of P.Z.'s mental and physical health condition, as well as the situation of vulnerability he was in. Important also to note was that as P.Z. had been admitted to a psychiatric hospital, the staff should have been equipped to deal with such erratic behaviour, as the court found it not to be uncommon.

Article 2 of the ECHR, which is the subject of this case, is not considered to be violated if the use of force, which was absolutely necessary, outlining defence from unlawful violence. The unlawful violence comes under question here, however, as P.Z. was clearly not of sound mind to comprehend the illegality of his violence against the staff, nor to control it, which arguably allows for the omission of the consideration of legality and liability for his actions (Code of Criminal Procedure Act No. 40/2009 Coll.)

Conclusion

From this analysis, due to negligence resulting in the death of the applicant's brother, it can be concluded that there was a violation of Article 2 of the ECHR. Despite not being an intentional deprivation of life, due to negligent following of procedure, the actions of the hospital staff and police officers resulted in the death of the applicant's brother. This negligence directly relates to the culture behind the use of restraints as it continues to be applied preventatively as part of systemic practice. Patient awareness and anticipation of such practices result in agitation, which is then used as justification to proceed with such practices. The court also argued that negligence

and lack of preparation for such incidents resulted in P.Z.'s death and therefore made the judgement that there was a violation of Article 2. In cases of extreme outbursts of behaviour, proper preparation needs to be ensured for the staff to react appropriately and, despite more severe measures being applied, still protect the health and safety of all.

4.2 Application of the UN Convention on Rights of Persons with Disabilities

The above was an analysis of cases heard before the ECtHR on violations of the ECHR. Nevertheless, as these cases concern persons with disabilities, an analysis based on the UNCRPD is also relevant. The manner in which the Czech public healthcare actors handled the cases in question with regard to the supporting legislation will be examined in lieu of the relevant articles of the UNCRPD to evaluate the extent to which the legislation transposes these principles and safeguards the rights of persons with disabilities.

To begin, Article 12, the equal recognition before law, relates to the legal capacity of persons with disabilities. It specifies that state parties shall take all appropriate measures to provide persons with disabilities support to exercise their legal capacity. This was exhibited in the case of Červenka v. the Czech Republic. The deprivation of liberty of the applicant resulted in his inability to seek justice, and his right to support to do so was clearly violated as even his appointing a power of attorney was not accepted by national courts. This impedes the respect of Article 13, the right to justice, as well, as it creates a precarious situation for persons with psychosocial disabilities to articulate their concerns and seek justice and compensation for their damage.

Furthermore, Article 14, the right to liberty and security, aligns very clearly with Article 5 of ECHR, indicating also a similar analysis. Involuntary admissions and treatment, again in the cases of Dvořáček v. the Czech Republic and Červenka v. the Czech Republic, called to question the extent to which this went against Article 14 of the UNCRPD. The article outlines that deprivation of liberty must be lawful and cannot be justified by the existence of a disability alone. In neither of these cases was this the reason, as both applicants had posed a disturbance as their disorder was manifested. In the case of Dvořáček v. the Czech Republic, the threat was imminent due to his paraphilic disorder, and this was also recognised by the court. Hence the involuntary admission of the applicant would not have gone against Article 14. In the case of Červenka v. the Czech Republic, there was less of a threat present, which had also been acknowledged by the ECtHR, resulting in a judgment of no violation of Article 5 of the ECHR and inferably also under Article 14 of the UNCRPD.

Article 15 and Article 16 cover freedom from torture or cruel, inhuman or degrading treatment or punishment and freedom from exploitation, violence and abuse, respectively. The former is also specifically encompassed by Article 3 of the ECHR. These articles come into question in the Bureš v. the Czech Republic case as the use of restraints had not been warranted, and other related elements, such as the length and force of restraint, were also disproportional, amounting to cruel and inhuman treatment. Furthermore, in the case of V. v. the Czech Republic, excessive force used to restrain P.Z. also amounted to a violation of Article 15 and Article 16 in terms of violence. Concretely, Article 16 calls on State parties to take appropriate measures to prevent all forms of violence and abuse by ensuring appropriate forms of assistance and support. This, however, requires resources, which the institution in the case of V. v. the Czech Republic did not have. Such negligence then also amounted to a violation of Article 10 of the UNCRPD, the right to life.

Finally, Article 25 of the UNCRPD, the right to health, highlights the requirement of health professionals to provide care of the same quality to persons with disabilities, including on the basis of free and informed consent. The case of Dvořáček v. the Czech Republic illustrates the inconsistency of Czech legislation regarding this provision while also highlighting the associated dilemma. The Specific Health Services Act still permits sterilisation and therapeutic castration under circumstances and only voluntarily agreed to. Nevertheless, this becomes blurry in practice, as exhibited in the case of Dvořáček v. the Czech Republic. The applicant here claimed that he was being pressured into undergoing such a procedure in order to be released from the institution, which takes the ‘free’ element of informed consent away. Limited cognitive capacity then also interferes with the objectivity of the regulations making it a precarious provision. This dilemma was also referred to with regard to the ECHR as there is a need to balance the need for treating a certain disorder that, in its manifestation, becomes threatening to the person or their surroundings and respecting the free and informed consent element of Article 25 of the UNCRPD. Further analysis of the cases with regards to the theoretical framework as well, will be discussed below.

4.3 Analysis

By examining the four cases, certain gaps in the Czech national legal provisions or practices allowing certain institutional treatments could be identified. It becomes apparent through these cases that there needs to be a comprehensive bridge between legislation and practice. While it

is inhumane to restrain persons in institutions, there are circumstances which arguably compel staff to behave in a particular manner and take certain actions.

While on one hand, mental disorders do not all constitute a disability, and those that do, are arguably due to societal inflexibilities and inabilities to adapt to various needs due to the preservation of the norm (Price, 2013), there are also medical elements to disorders that result in the necessity of intervention for protective purposes (Appelbaum, 1985). It is on this basis that conditions permitting certain measures and actions are included in the legislation, as is, for example, the use of restraints and involuntary admission and treatment. Nevertheless, it becomes challenging to regulate the conditions of necessary intervention due to the possible subjectivity of defining the severity of threats that then constitute this necessity.

To begin dismantling this, the four cases were chosen to highlight the scales of severity and allow for an illustration of 'necessity'. To begin, the cases dealing with involuntary admission and treatment will be analysed. In the case of Dvořáček v. the Czech Republic, for example, the threat was obvious due to the sex offender charges against him clearly making his condition threatening to his surroundings. The threat posed to his surroundings reaches a notable threshold as the offence constituted a crime. Without legal capacity, however, the applicant could not be held legally responsible for his acts, therefore the treatment of his condition was the protective measure instilled to mitigate this threat.

Similarly, although to a lesser extent, the case of Červenka v. the Czech Republic also involved a threat due to his alcoholic dementia causing public disturbances such as yelling at people or urinating in the hallways. Such public disturbance arguably did not constitute a justifiable threat to admit the applicant against his will. Although evoking fear in people in his surroundings, there were no accusations of harm to health or life.

In the two cases above, both these applicant's conditions were chronic, also making the threat so. Therefore, the conditions called for a more long-term and comprehensive treatment and an opportunity to attempt rehabilitation and integration into society. Nevertheless, in the case of both, this was refused by the applicants, posing a difficult situation to balance between the severity of the threat posed by the person and the respect for human rights by international and national legal standards. Since, in the case of Dvořáček v. the Czech Republic, the threat posed by his paraphilic disorder amounted to a threat severe enough to justify the involuntary admission and treatment, the ECtHR found no violation of Article 3. The pressure to consent to taking medication or surgical castration, did not amount to the minimal level of severity for

being classified as ill treatment, considering the circumstances. On the other hand, in the case of Červenka v. the Czech Republic, the involuntary admission could not be justified by the threat of public disturbance caused by the manifestation of the applicant's disorder. These two cases hereby exhibit that despite the legislation outlining 'threat' vaguely and rationally, this threat can be evaluated by the harm caused by the applicants in order to proceed accordingly.

In terms of the use of restraints, the threat and necessity condition for the justification of using restraints can be analysed by the other two cases. In the case of Bureš v the Czech Republic, the applicant's state of mind was a result of an accidental overdose; although the public indecency and intoxication were reason enough to admit him, the use of restraints was not warranted by the circumstances as the threat was not proportionate to the measures taken to restrain him. The applicant only grew restless after having been restrained, indicating that this seemed to be a trigger to aggressive behaviour. This exhibits the problem found in institutions that are closed settings. Restraints are used systemically and as a first resort preventatively, which is not justifiable. Preventative use results in a trigger for restlessness and threatening behaviour, which can then justify the use of restraint. Nevertheless, the person's rights violation occurs in the first instance of restraint. The reliance on the use of restraints systematically highlights the problem of lack of staff and the consequent lack of capacity to approach events reactionarily, resulting in the preventative use of such measures (CPT, 2015).

These issues, such as the lack of resources and the lack of staff and training, make it difficult to deal with unforeseen challenges and behaviour that come up. This was exhibited by the case V. v the Czech Republic, as the immediate resorting to the use of force and restraints illustrates the engrained elements of the medical model of disability. The use of restraints and involuntary admission or treatment reflects the paternalistic elements of institutions, which manifest in violations of the rights of persons with disabilities. To immediately resort to such measures further reflects the ambiguity of the regulatory tools and the absence of training of staff to administer more human rights-compliant practices in institutions, which can then also facilitate a more comprehensive grasp on disorders. P.Z., upon admission, had been calm; it was only when the seclusion room was prepared for him that he became aggressive. The aggressive behaviour then constituted a threat large enough to use restraints; however, the preparation of the seclusion room was not legitimised and eventually became the trigger for the violent outburst. Again, to reiterate, making it seem like the systematic resorting to coercive measures provoking unwanted behaviours, before they become necessary.

This dilemma falls into the paradigm shift towards the social model of disability. Referring to the above, the first hypothesis can be addressed, stating that *the legislation regarding the use of restraints and involuntary admission and treatment of persons with psychosocial disabilities does not fully reflect the normative framework being the social model of disability*. Reflecting on this is not as straightforward. Arguably, the legislation is sufficient as it outlines an exhaustive list of conditions under which restraints and involuntary admission and treatment are permitted. Nevertheless, in practice, the application of this legislation stagnates due to practical issues such as the lack of resources. Despite the goal being deinstitutionalisation, during the transition period and for the cases which require structured care, it remains important to impose further regulations and to tackle the accompanying issues that proliferate the misuse of certain permitted acts (Birgili & İzan, 2019). The report issued by the CPT (2015) to the Czech government noted that understaffing is a core issue in the persistence of institutional practices. It further pointed to the reliance on the use of police officers to help in the use of restraints due to this staff shortage; nevertheless, due to a lack of understanding of particular disabilities and disorders, this becomes difficult to regulate in an ethical manner. Furthermore, there is also a lack of training on the application of the social model of disability and deinstitutionalisation. This is illustrated by the persisting remnants of the medical model approach of staff (MZD, 2020). This, however, is not acknowledged in the legislation. In order for the provisions to be declared sufficient, the circumstances need to be reflected meaning that the insufficiency of resources needs to be addressed. The hypothesis could be rejected under the condition that institutions have sufficient resources to implement the existing legislation, but in itself the legislation fails to bridge the gap between the provisions and the application itself by taking into consideration the reality within institutions and is therefore accepted.

As discussed above, deinstitutionalisation is a major component of adopting the social model of disability. Although supporting the integration process accompanying deinstitutionalisation by moving persons with disabilities into community-based care settings is beneficial, there are certain conditions where the person may become a threat to themselves or their surroundings, in which case intervention is needed (Birgili & İzan, 2019). Hereby, the second hypothesis can be addressed. This states that *the Czech legislative framework does not fully transpose the policy principles of deinstitutionalization*. Although progress was made, especially highlighting the statistics provided by the MZD (2020), there are still some barriers to further adhering to this policy push due to the remnants of the medical model in institutions and the first resort in cases involving psychosocial disabilities still being the use of restraints and involuntary admission and treatment in cases deemed necessary. However, due to the range of severity of

particular cases, complete deinstitutionalisation is difficult to visualise and aim for. Moving towards this for cases in which threat is absent is commendable and beneficial to all. However, for certain cases, even if extraordinary, there must be additional measures, monitoring, reporting and documentation of instances where human rights violations occur under the justification of protective and preventative necessity (Birgili & İzan, 2019). Therefore, similarly to the first hypothesis, despite the legal and policy framework supporting deinstitutionalisation being in place, their implementation is halted by structural challenges such as the lack of resources. Nevertheless, due to the different conclusions of the national court and the ECtHR, in three of the four cases, it can be deduced that, once again, the legislation does not transpose the principles of deinstitutionalisation fully as it fails to recognise the practical barriers in applying the rules and regulations hereby once again accepting the hypothesis.

To conclude on the hypotheses, the legislation fails to account for limitations and barriers faced by institutions to follow through with the provisions. First of all, it is important to recognise the lack of staff leading to professional burnout which also affects the approaches taken by staff to residents (Stilling, 1992). Furthermore, as previously mentioned, complete deinstitutionalisation is not a goal for the near future, indicating the imperative need for staff training and preparation in institutions and all actors involved (V. v the Czech Republic). Secondly, the lack of comprehensive and established alternatives to institutional care leads to the argued necessity of involuntary admissions and treatment of persons with psychosocial disabilities that pose a threat to the public. Erratic behaviour and irrational reactions are common for certain psychosocial disabilities, so adequate training and resources must be available to deal with such cases in a human-rights-compliant manner, and the legislative and policy frameworks need to reflect this.

5. Evaluation

In order to evaluate the strength of the analysis provided above, a brief reflection on the research will be presented. An identifiable limitation of this research is that the cases refer to very specific circumstances under which certain practices were resorted to, and the analysis hereby faces an obstacle to generalisability. Nevertheless, this limitation also pointed to the reality of this topic, as every case is particular, calling for careful evaluation of the specific circumstances under which measures were used. Legislation can only regulate the general context; human rights training and sufficient resources establish a preparation to react appropriately with regard to the UNCRPD principles.

Nonetheless, without a broader sample, it becomes difficult to draw definitive conclusions from the points of discussion. On the one hand, the social model of disability and the push for deinstitutionalisation are based on progressive notions, which, however, require a significant number of resources to follow through with. Ideally, community-based alternatives to institutions would be established to abolish the intuitional and systemic practices that often induce aggressive behaviour and worsen psychosocial conditions (Stilling, 1992). With abundant resources, however, this is difficult to achieve, resulting in the persistence of institutions and institutional, systemic culture alongside it.

On the other hand, there are arguments standing by the opinion that through treatment in or outside of institutions, through psychotherapy or pharmacotherapy, disorders can be regulated to eliminate the risk posed to the public (Shanon, 1976). If the disorder manifests into harassment or a threat, despite the lack of criminal liability for some persons with psychosocial disabilities, provisions such as protective detention or treatment offer a substantive solution. Nevertheless, these are remnants of the medical model of disability, seeing ‘treatment’ as the only option way to ‘fix’ the individual condition rather than mobilising a more social and rehabilitative approach to provide care and help. Despite critiques by the CPT, even its own regulations permit such measures in certain cases posing an imminent threat, nevertheless stress the need for more regulation and monitoring in this regard due to the relative interpretation of permitting circumstances (Kmecová, 2024).

Hence, the disparity between the human rights standards, the legislation and the reality is noticeable, resulting in the precariousness of regulating these measures. This uncertainty stems from particularities of circumstances, combined with structural and material barriers to resolve underlying issues. Further research could look exactly at these circumstances. Although issues such as lack of resources and staff had already been identified here (CPT, 2015), further research on the ombuds institutions' reports of cases, the institution’s reports on the use of restraints and involuntary admissions and treatments could reveal that more practical side of the socio-legal approach taken here. Hereby, the particularities of the situations in which restraints or used or persons are involuntarily admitted or treated can be better understood to evaluate how the legislation could bridge the gaps between the provision and the implementation.

Conclusion

Drawing on the analysis above, the research question guiding this thesis can be addressed. Both hypotheses, one that the legislation regarding restraints and involuntary admission and treatment fails to reflect the social model of disability, and the second that the legislation does not fully comply with the policy push for deinstitutionalisation, contribute to the identifiable insufficiencies in the legislation. This is exhibited by the ECtHR decisions on unjust rulings of courts at the national level, which were permitted by the existing legislation. Hence, the legislation has practical gaps that need to be addressed for it to be in full conformity with the normative framework and policy developments under the UNCRPD.

The challenge of balancing between protection from threats caused by psychosocial disabilities and ensuring compliance with human rights standards continues to pose a dilemma. Arguably, there are certain circumstances which cannot fully be handled in compliance with the social model of disability or the push for deinstitutionalisation. While maintaining this as the ultimate goal, regulation of these exceptions needs to be considered. This is covered by the various acts in the Czech legislation. Nevertheless, the allowance of the practice in some form has been shown to open the practices to be used as a first resort. The cases analysed confirmed Stilling's (1992) findings that such practices, when unjustified, trigger patients into states under which the use of restraints, for example, can be legitimised. It further also feeds into a cycle of staff attitudes and burnout further resulting in negative projected behaviours. This hereby calls for stricter regulation of the practice.

Nonetheless, stricter regulation also will not help without addressing structural issues such as insufficient staffing, inadequate funding and human rights training (CPT, 2015). Without securing material and methodological support for institutions in their current practices and moving towards community-based alternatives, compliance with human rights standards will continue to be challenging despite the legislative framework reflecting state obligations.

Due to the particularities of each situation, formalistic approaches fall short of ensuring full human rights compliance for persons with disabilities, especially in institutional settings. Naturally, legislation cannot tackle every unexpected circumstance when dealing with persons with psychosocial disabilities. Nevertheless, individualised, case-by-case approaches can be encouraged. This is generally regulated by the present legislation, and with human rights training, extraordinary circumstances can also be dealt with and prepared for. For this to be implemented in practice however, there are several additional measures that can be taken.

A targeted focus on comprehensive treatment of persons with psychosocial disabilities, which would address both medical and social components of disabilities, is imperative. Hereby, principles such as societal integration and inclusion, enshrined in the motto “Nothing about us without us,” can be achieved. Participation at all stages of combatting challenges is essential. Without the input of the persons the legislation and policy affect, key points risk being omitted, and stagnation of the implementation of the UNCRPD principles is sure to follow.

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Abstract

The rights of persons with disabilities have recently been at the forefront of policy developments. This paper focuses on psychosocial disabilities and aims to highlight the intersection of the medical elements of various disorders and the structural factors in society that make the disorder disabling. From a legal perspective, the challenge of balancing between protection from threats caused by psychosocial disabilities and ensuring compliance with human rights standards continues to pose a dilemma. The Czech care system is characterised by remnants of the Soviet care system. This has caused the implementation of the social model of disability and efforts for deinstitutionalisation to face challenges. The Czech Republic has, therefore, faced criticism for the remaining institutions and practices within, such as the use of restraints and involuntary admissions and treatments. To better examine this, a legal analysis of four cases processed at the European Court of Human Rights against the Czech Republic found that while the legislation, for the most part, transposes international human rights standards well, the application of these laws faces difficulties due to insufficient resources and persisting negative attitudes to persons with psychosocial disabilities. Arguably, there are certain circumstances which cannot entirely be handled in compliance with the social model of disability or the push for deinstitutionalisation. While maintaining this as the ultimate goal, regulation of these exceptions needs to be considered to ensure that legislation and resources suffice to implement international human rights standards.

Key Words: Psychosocial Disabilities, Use of Restraints, Involuntary Treatment and Admission, Czech Republic, Deinstitutionalisation, Social Model of Disability

Abstrakt

Die Rechte von Menschen mit Behinderungen sind in letzter Zeit in den Vordergrund der politischen Entwicklungen gerückt. Dieses Papier befasst sich mit psychosozialen Behinderungen und soll die Überschneidungen zwischen den medizinischen Elementen verschiedener Störungen und den strukturellen Faktoren in der Gesellschaft, die die Störung zu einer Behinderung machen, aufzeigen. Aus einer rechtlichen Sicht stellt sich die Herausforderung, ein Gleichgewicht zwischen dem Schutz vor Bedrohungen durch eine psychosoziale Behinderung und der Gewährleistung der Einhaltung von Menschenrechtsstandards zu finden, weiterhin ein Dilemma dar. Das tschechische Betreuungssystem ist durch Überbleibsel des sowjetischen Betreuungssystems gekennzeichnet. Dies hat dazu geführt, dass die Umsetzung des sozialen Modells der Behinderung und die Bemühungen um eine Deinstitutionalisierung auf Herausforderungen stoßen. Die Tschechische Republik sieht sich daher mit der Kritik an den verbleibenden Einrichtungen und den darin angewandten Praktiken konfrontiert, wie z. B. dem Einsatz von Zwangsmaßnahmen und unfreiwilligen Einweisungen und Behandlungen. Eine juristische Analyse von vier Fällen, die vor dem Europäischen Gerichtshof für Menschenrechte gegen die Tschechische Republik verhandelt wurden, ergab, dass die Gesetzgebung die internationalen Menschenrechtsstandards zwar größtenteils gut umsetzt, die Anwendung dieser Gesetze jedoch aufgrund unzureichender Ressourcen und der anhaltenden negativen Einstellung gegenüber Menschen mit psychosozialen Behinderungen auf Schwierigkeiten stößt. Es gibt bestimmte Umstände, die nicht vollständig mit dem sozialen Modell der Behinderung oder dem Bestreben nach Deinstitutionalisierung in Einklang gebracht werden können. Auch wenn dies das ultimative Ziel ist, muss eine Regelung dieser Ausnahmen in Betracht gezogen werden, um sicherzustellen, dass die Rechtsvorschriften und Ressourcen ausreichen, um internationale Menschenrechtsstandards umzusetzen.

Schlüsselwörter: Psychosoziale Behinderungen, Anwendung von Zwangsmaßnahmen, Unfreiwillige Behandlung und Einweisung, Tschechische Republik, Deinstitutionalisierung, Soziales Modell der Behinderung