Detention and Treatment of Sex Crime Offenders (in the Czech Republic)

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Part I:

Sexological Treatment in the Czech Republic

1.1 Introduction - Protective sexological treatment

The various categories of protective measures are set out in Title VI of the Penal Act[1]. Three kinds of such measures are distinguished: protective in-patient treatment, protective training (social re-training)[2], and seizure of property. „Protective measures constitute one category of penal law sanctions. Similarly to sentences, their purpose and objective is to protect the community, but in a specific manner which sets them apart from sentences.“ [3] The quoted comment underscores the fact that the Penal Act does not expressly define the purpose of protective measures; nevertheless, it can be argued that they are designed mainly to perform the preventative function, including isolation and treatment of the insane or those with a diminished degree of sanity. Another important feature is that protective measures „carry no moral condemnation of the act (and therefore, contrary to sentences, can be imposed even on individuals who have not been found guilty of a crime), and their imposition is not governed by the principle of proportionality between the sanction selected and the degree of dangerousness of the respective act.“ [4]

One of the four categories of protective treatment then, next to alcohol, drug and mental health programmes, is protective sexological treatment, which may be carried out as either in-patient or out-patient.

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1 Act No. 140/1961 Coll. as amended.

2 Applicable only to the youth.

3 Jelinek, J.-Sovak, Z.: The Penal Act and the Rules of Criminal Procedure with Comments and Court Cases, 16th edition, Linde, Prague 2001, p. 93.

4 Jelinek, J.-Sovak, Z.: The Penal Act and the Rules of Criminal Procedure with Comments and Court Cases, 16th edition, Linde, Prague 2001, p. 94.

1.2. Project / research methodology

The first stage of project implementation involved a detailed analysis of the existing legal framework including laws and subordinated legislation as well as methodology guidelines which are not binding legal regulations (the reason for conducting such a broad analysis was that legislation in this area is often outdated and incomplete: actual practice is guided by secondary legislation or methodological instructions).

The second stage consisted in developing structured questionnaires (one for patients under protective treatment, and another one for the staff of protective treatment facilities), and requesting and analysing internal guidelines and other internal regulations.

In the third stage, controlled interviews were conducted with patients and staff (including in prison service facilities) and all three types of questionnaires were filled in (i.e. questionnaires for patients under protective treatment, staff of the relevant wards, and convicted individuals for whom treatment has been proposed).

Stage four covered processing of questionnaires (all three types) and shortlisting key issues and problems in individual facilities and the system as a whole.

An advisory expert group was set up in step five who attempted to draft proposals for legislative change (either in the form of a legislative intent or a bill reduced to sections), and who may in the future recommend additional measures to improve treatment. In the final stage, proposals for specific systemic measures were produced.

The present report has been drawn up with particular focus on the final section, Proposals and Recommendations.

1.2.1. Project mission and objectives

The project mission is to improve the overall effectiveness of the protective sexological treatment system so that it is carried out under a legal framework which clearly defines the rights and responsibilities of patients and staff while improving patients' motivation and levels of protection of the community against dangerous sexual perverts.

Project goals:

- **To initiate an expansion of the network of facilities designed for protective treatment, and to exert positive influence over the stratification of these facilities so that patients with low motivation levels could, based on court decisions, be separated from those who are highly motivated for treatment.**

- **To help improve legal awareness of those undergoing or awaiting protective treatment. Enhancement of their legal knowledge.**

- **To improve availability of legal aid for individuals undergoing protective treatment while serving a term of imprisonment, and for individuals released from prison and awaiting treatment.**

- **To contribute to overall humanisation of facilities designed for protective treatment.**

- **To help create a legal framework that would define through a special law the rights and duties of individuals undergoing protective treatment, and the staff of protective treatment wards (possibly to initiate a Mental Health Act that could be shaped on the Polish model).**

- **To help minimize cases of restriction of personal freedom in facilities designed for protective treatment, and to help stop any degrading treatment in such facilities.**

- **To help improve the effectiveness of all types of protective treatment.**

- **To exert positive influence so as to increase the share of those who are placed on protective treatment already in prison, and to promote sentencing to probation combined with treatment or to fixed-term protective treatment only, wherever appropriate.**

- **To help improve levels of protection of the community against particularly dangerous sexual perverts and pathological aggressors, and to initiate introduction of new kinds of protective treatment to be carried out in special facilities that are secured against escape through building and technical adjustments.**

- **To initiate introduction of new kinds of protective treatment also in the out-patient (day-care) category.**

- **To help improve communication between courts, facilities designed for protective treatment and probation officers.**

- **To initiate a debate among professionals on the appropriateness of existing legislations for all types of protective treatment, and to exert positive influence over new legislative solutions in this sector.**

- **To strengthen the rights and position of patients with respect to decisions by health workers and courts regarding change in the type of treatment type or its termination.**

- **To initiate a debate about possibilities for improving the process whereby court-sworn experts and investigative, prosecuting and adjudicating bodies arrive at expert decisions concerning the appropriateness of imposing protective treatment, and improving the conditions in which such expert opinions are produced.**

- **To help improve youth protective treatment.**

- **To help health insurance companies become more reflective in their decisions about compensation for curative services of the fact that treatment of unmotivated patients is more difficult.**

1.3. Legal framework (current situation – problems, etc.)

In general, it can be argued that legislation in this sector is lacking in two ways. There is no integrated or umbrella law to regulate protective treatment. The second problem is tied to the first one: relevant legislation is fragmented, non-transparent and incoherent. It certainly fails to provide a clear legal perspective which could then be applied in practice. The resulting frequent need for improvisation concerns, for example, regulation of rights and duties of patients and medical staff. As regards the imposing and execution of protective treatment, our legal analysis focused mainly on the following pieces of legislation and other documentation:

- Penal Act, Law No. 140/1961 Coll.
- Rules of Criminal Procedure, Law No. 141/1961 Coll.
- Law No. 169/1999 Coll. concerning service of a term of imprisonment
- Law No. 293/1993 Coll. on serving custody
- Law No. 37/1989 Coll. concerning protection against alcoholism
- Law No. 20/1966 Coll. concerning care for the health of the people
- Law No. 82/1998 Coll. concerning liability for damage caused in the execution of public powers through a decision or incorrect official procedure
- Law No. 257/2000 Coll. concerning the Probation and Mediation Service
- Ministry of Justice Decree No. 37/1992 Coll. concerning rules of procedure for district and regional courts
- Ministry of Health Decree No. 187/1989 Coll. implementing the Law concerning protection against alcoholism and other drug addictions
- Ministry of Justice instruction No. 1100/98-OOD establishing the internal and office rules for district, regional and high courts
- Ministry of Justice instruction No. 27/2001
- Attorney General’s general instruction serial No. 1/2000
- Attorney General’s general instruction serial No. 6/2001
- Ministry of Justice communication No.1105/82-KO
- Constitutional Court judgment No. 299/1997
- Church and Religious Societies Act, Law No. 3/2002 Coll. concerning churches and religious societies
- Ministry of Health methodology measure LP-270-22.5.72

Imposition of protective treatment in general is regulated by Section 72 of the Penal Act to the effect that protective treatment is imposed by courts on offenders whose sanity was diminished at the time of perpetrating the offence, and it is imposed by courts where they believe that correction of the offender and protection of the community will be

better secured in this way than through a sentence of imprisonment. A necessary condition, however, is that the offender did not, even as a matter of negligence, bring about their condition of diminished sanity under the influence of an addictive substance. In addition, a court may impose protective treatment where it considers, with regard to the offender's health condition, that the aim of the sanction can be achieved even through a combination of a shorter sentence with protective treatment. Furthermore, protective treatment can be imposed in the following three instances:

a) where the perpetrator of an otherwise criminal offence is insane and therefore not criminally liable, and his stay outside confinement is dangerous,
b) where the perpetrator committed an offence in a condition that was brought about by a mental disorder, and his stay outside confinement is dangerous, and
c) where the perpetrator who indulges in addictive substance abuse committed an offence under the influence of such a substance or in relation to its abuse; in this case, the court will not impose protective treatment if it is clear that the objective cannot be achieved for reasons relating to the perpetrator as an individual.

Protective treatment can be imposed in addition to other sanctions or even in case of discharge. Where protective treatment is imposed in conjunction with a custodial sentence, treatment will usually commence upon arrival to prison. In other cases, protective treatment is usually served in a health care facility. However, where it can be expected with a view to the nature of the disease and treatment possibilities that out-patient care would meet the objective, the court may order this type of treatment or additionally transform a treatment order from in-patient to out-patient or vice versa. When institutional (in-patient) protective treatment is imposed, the imprisonment order will indicate the facility to which the convicted person is to be delivered after release from prison. Where a term of imprisonment is not sufficiently long to meet the objectives of treatment, the court can rule that treatment should continue either in an institutional or out-patient facility. Protective treatment will last as long as may be required to meet its objectives. Release from protective treatment is decided by courts. Where the circumstances that caused the imposition of protective treatment cease to exist before treatment starts, the court will release the offender from having to undergo treatment.

Institutional protective treatment is served in a specified health care facility relevant to the territory in which the patient is resident or abiding.

When imposing out-patient protective treatment, it is necessary for the court to pre-discuss the patient's admission with the relevant out-patient facility.

Protective treatment during imprisonment

is imposed, at the same time as the imprisonment order is sent out, by the presiding judge who decided the case in the first instance. In this case, the protective treatment order and its annexes are sent directly to the prison rather than the health care facility. At the same time, the prison is notified as to which health care facility the convict should be delivered to upon release from prison if he needs to continue treatment after having completed his term in prison. To this end, the prison will also receive two duplicates of the protective treatment order for the health care facility relevant to the prisoner's place of abode.

In-patient protective treatment:

two copies of an in-patient protective treatment order together with a duplicate of the judgment of protective treatment are sent out by the presiding judge to the health care facility relevant to the place of residence or abode of the person who is to undergo treatment. Based upon agreement with the health care facility administration, the presiding judge determines the treatment commencement date. At the same time, he notifies the health care facility administration that transformation of in-patient to out-patient protective treatment or release from protective treatment under the conditions set forth in the Penal Act (Section 72, Subsection 5) is possible only on the basis of a final and conclusive judgment of a court in whose district protective treatment is carried out, and he requests that the court be immediately notified should reasons for any of those steps arise. In addition, he asks the health care facility to inform the

court which imposed protective treatment as to whether or not the individual upon whom protective treatment was imposed arrived upon the set day to begin treatment.

The presiding judge calls on the persons upon whom protective treatment was imposed to arrive at the relevant health care facility on the set date. If the person is legally incapacitated, the court shall call on that person's statutory representative. If the person not dangerous to the community, they can be granted the time required for taking care of their affairs. If they fail to appear for in-patient protective treatment on the set day or if they are dangerous to the community, the presiding judge asks the police headquarters relevant to person's place of residence (abode) to deliver them to the health care facility. In-patient protective sexological treatment is provided by selected psychiatric hospitals where sexological wards are set up for that purpose. Patients who are incapable of staying in such wards are offered individual care in the psychiatric hospital ward where they are hospitalised.

Out-patient protective treatment:

two copies of an out-patient protective treatment order together with a duplicate of the judgment of protective treatment are sent out by the presiding judge to the health care facility relevant to the place of residence or abode of the person who is to undergo treatment. Based upon agreement with the health care facility administration, the presiding judge determines the latest starting date for treatment. At the same time, he asks the health care facility administration to raise a proposal with their district court for changing the treatment to in-patient if the patient refuses to submit to protective treatment or if his further stay outside confinement turns out to be dangerous or if it is later established that due to the nature of the disease and the treatment options, the purpose of treatment cannot be met in the out-patient format. The court also notifies the health care facility that release from protective treatment is possible only under the conditions set out in Section 72, Subsection 5 of the Penal Act (i.e. when the purpose of protective treatment has been achieved or is found impossible to achieve) and based on a final and conclusive judgment by a district court having local jurisdiction over the given health care facility. The health care facility is also requested to inform the court that imposed protective treatment whether the concerned person reported for treatment within the set time. The presiding judge calls upon the person on whom protective treatment has been imposed to report to the respective health care facility no later than the set deadline. At the same time, the judge is obliged to notify that person of the consequences of failing to do so. If that person is legally incapacitated, the presiding judge will proceed through their statutory rep. Protective out-patient sexological treatment is provided by sexology wards of NsP category III or possibly by sexology consulting rooms at psychiatric wards of polyclinics of category NsP III or category II, depending on the client's place of residence. Sexology wards cooperate in its provision with NsP II category psychiatric wards at polyclinics within agreed scope, particularly with a view to the better connection the latter have with the patient's social environment.

1.4. Problems identified in the area of respect for fundamental human rights and freedoms in the course of protective sexological treatment

As for procedural aspects, our analysis focused on identifying problems in imposing, executing and transforming protective treatment. What we regarded as problematic was mainly non-compliance with valid legislation, with a special focus on observance of patients' fundamental human rights. Where a relevant regulation is missing, we will strive for its initiation.

Our key criticism from this point of view concerns the lack of a uniform piece of legislation to cover implementation of protective treatment, resulting in regimes that can often be seen as unlawful with respect to Article 4 of the Charter of Fundamental Rights and Freedoms.

Another marked deficiency is the lack of regulation over legal assistance and its poor availability to clients.

1.5. Social welfare for persons in protective sexological treatment (legislation, lack thereof, financial provisions for patients)

As regards social or financial provision for patients in protective sexological treatment, based on our search of legislation and experience gained in institutional sexological care facilities, we conclude that this provision is rather insufficient.

The first major problem is that patients are mostly admitted for protective treatment straight from prison, in the accompaniment of the Prison Service of the Czech Republic or Police of the Czech Republic. These patients thus have no chance to register with the relevant Job Office or file an application for a social care benefit in their community. Moreover, unless the person worked in prison, he is not entitled to sickness benefit.

One option to provide at least minimum funds to these patients is to file a written application for a social care benefit with their municipal or local authority.

Another alternative is to apply for disability pension. It is common practice for medical advisers at the relevant social security administration to recognise patients in protective treatment as fully disabled. The frequent problem is, however, that not all of the patients meet all the statutory requirements for the granting of a disability pension.

If the patient finds himself recognised as fully disabled but without entitlement to a pension, he will usually stop receiving social care benefits from the relevant municipal or local authority because he is regarded as fully disabled and provided for through hospitalisation in care facility, which is funded from the patient's health insurance.

This results in growing indebtedness of patients, who find themselves stuck in a vicious circle (paying up the cost of criminal proceedings and the cost of imprisonment). This is also why they frequently stop contributing to health insurance.

The clients' need to procure personal care products, clothes, etc. thus remains more or less unresolved. Patients are largely dependant on help form their families (who are often not interested in maintaining contact with them, however). This unsatisfactory situation has been criticised also by the expert group.

1.6. Findings from field research (client questionnaires, management questionnaires, opinion poll)

Two types of questionnaires were produced within our project: one for patients with a protective sexological treatment order (including questionnaires for those who are still awaiting PT), and another one for the staff of these facilities (this questionnaire focuses, among other things, on construction and technology aspects and material equipment of wards and other premises used for treatment). When sending out letters of request for filling in our questionnaires, we also asked for any internal rules or other internal guidelines of the relevant wards, which we then analysed.

As for persons serving a term of imprisonment, we conducted structured interviews with a total of 17 prisoners with a protective sexological treatment order (Valdice: 4 people, Rynovice: 6 people, Kurim: 3 people, Mirov: 4 people).

As regards persons under protective sexological treatment, an in-depth interview was carried out with a total of 31 clients (treatment facility in Havlickuv Brod: 5, Kosmonosy: 7, Prague-Bohnice: 5, Opava: 4, Dobrany: 3, Brno: 3, Horni Berkovice: 4).

As for the staff questionnaire, we received a total of 8 filled in questionnaires (Dobrany, Havlickuv Brod, Sernberk, Prague-Bohnice, Kosmonosy, Brno, Opava, Horni Berkovice).

1.7. Institutional provisions for protective sexological treatment

In-patient and out-patient protective sexological treatment facilities fall under the charges of the Ministry of Helath. Within the Czech health system, in-patient protective sexological treatment can be provided in the following health care facilities:

• Havlickuv Brod	sexology ward capacity: 26 beds
• Kosmonosy	22 beds
• Dobrany	12 beds
• Sternberk	no specialised ward, 6 patients under treatment
• Opava	28 beds
• Brno	24 beds
• Horni Berkovice	20 beds
• Prague-Bohnice	40 beds, 20 patients under treatment

The total identified capacity for all the facilities is 172 beds. Voluntary treatment is also offered by sexology wards in all of the above.

1.8. Protection of potential victims of persons under protective treatment

As regards patients indicated for radical sexological treatment who have long refused to submit themselves to treatment, we believe they should not be placed in facilities which lack relevant building and technical adjustments. Furthermore, we believe that the standard regime should not apply to these patients. Nor should they be allowed to go for walks outside the asylum premises until their attitude to treatment has changed. According to reports from heads of psychiatric hospitals, such patients currently total 11 people. As we were unable to obtain data from some hospitals, the actual number can be expected to be slightly higher.

The following approach which is wholly unacceptable by all standards has been described to us in several hospitals: what matters to police bodies when prosecuting the criminal offence of obstructing the execution of an official decision is whether or not the patient has neglected treatment e.g. by escaping from the hospital. If the patient receives medication only once a week and his escape lasted say only three days (after which he returned on his own), the police will not proceed with the case on the grounds that no criminal offence has been committed and there are no other appropriate means of addressing the matter. Relying on the opinion of hospital staff and on interpretation of law, it can be concluded, however, that for the facts of a crime to be achieved in this case, the very fact of escape (and a breach of internal hospital rules) is relevant rather than the fact that medication regime has not been neglected.

It is mainly the police forces who often tend to underplay such cases and refuse to proceed with them if the patient did not offend during the escape. It would seem desirable in this respect to pay more attention to police training and stress the potential danger from such escapes to particularly vulnerable groups within society (children and women).

1.9. Legal status and legal certainties of medical personnel

As there is currently no statute to regulate protective treatment, the staff of psychiatric hospitals acting as treatment providers have no legal certainty as to the degree of possible restrictions on patients and their rights as part of the treatment regime. No rights and duties are laid down by law, and as a result, medical staff are frequently blamed by patients themselves for violating their rights. Legal uncertainty in respect of these issues is highly undesirable, and the present situation should change radically with the adoption of a law on the execution of protective treatment.

With regard to the special nature of the work and to patient structure, it would also be desirable to define a different status for the staff of mental hospital wards providing protective treatment that would, unlike their present status, be separate from that of standard medical personnel. Statutory regulation is highly desirable.

1.10. Expert group

The group met in Prague on 24 February 2003. The meeting was attended by five heads of specialised sexology wards (two of whom are members of an inter-departmental committee for protective treatment at the Ministry of Health), workers from the Prison Service and an official from the legislative department of the Ministry of Justice of the Czech Republic as well as other workers from the health sector.

The experts and workers from the Counselling Centre mainly discussed a proposal for an amendment to the Rules of Criminal Procedure, presented to them at the meeting by a representative from the Ministry of Justice. Under Section 106, the proposed amendment introduces a new institution under protective measures: security detention. Courts could impose this protective measure upon individuals who are not criminally liable due to insanity and upon offenders whose condition when committing an offence was caused by mental disorder and whose further stay outside confinement is dangerous, and upon offenders who repeatedly offended under the influence of an addictive substance. The experts recommended even at the meeting that the text of the bill reduced to sections should expressly mention not only mental disorder but also sexual deviation, which is not included in the international classification of mental disorders. The experts agreed that facilities that would be providing security detention should fall under the Ministry of Health. A project has now been approved to construct a new sexological treatment building in the psychiatric hospital in Brno – Cernovice. The facility will have the necessary construction and technical features to provide for security detention. The expert group also agreed that training of future staff should be secured in advance. A majority of experts were not happy with the work of certified experts responsible for proposing protective treatment. Heads of wards were sceptical about protective treatment during imprisonment with regard to transformation of treatment to out-patient or its termination while the patient is still in prison. They argued that it is impossible to test the patient's behaviour outside confinement in his communication with family and friends. There was unanimous agreement as to the unsatisfactory regulation of financial and social provision for patients during treatment. A majority of the experts subscribed to the idea that adoption of a law on the execution of protective treatment is necessary. A minority opinion was voiced that the rights and duties of patients and medical staff can be sufficiently regulated through secondary legislation.

Heads of wards expressed their unhappiness with the work of investigating, prosecuting and adjudicating bodies in situations where a patient is obstructing treatment. They criticised those bodies for their lax, alibistic and often slow decisions. They also pointed out flawed and inappropriate legislation under which protective treatment orders are directed to health care facility rather than patients, which is contrary to common practice in the EU member states. The expert group also pointed out that a specialised treatment facility for young sexual deviates is non-existent in the Czech Republic.

1.11. Building and technical security features for protective sexological treatment

None of the facilities we visited is sufficiently secured through building and technical features against patient escapes.

1.12. Protective sexological treatment regime

All of the facilities we visited jointly apply the group therapy regime. In our opinion, this situation is not adequate as the Czech Republic lacks any facilities specialising, for example, on treatment of patients with organic brain damage or intellectual deficiencies nor patients who have been imposed two protective treatments.

Equally inappropriate is the fact that the regime differs from one hospital to another (not in terms of medical specialisation, but rather as a result of the lack of unifying legislation and non-compliance with international conventions for the protection of human rights). This results e.g. in situations where a patient has been transferred and comes across an entirely different regime concerning the use and possession of a mobile phone, frequency and conditions

for walks inside and outside the hospital premises, a different system of credit points, etc. Again, the introduction of a unifying piece of legislation is more than desirable.

1.13. Detention facilities (current situation, outlook, opinions)

The current vision for detention facilities as reflected in the proposed amendment to the Rules of Criminal Procedure (cf. chapter immediately below) presupposes the construction of one specialised institutional care facility with the capacity of approx. 150-180 beds in stage I. The current plan is to locate the facility within the premises of the Brno-Cernovice psychiatric hospital.

Before a court decides on placement in this facility, the patient should be observed and diagnosed following his stay in a medical facility; there is no way an out-patient examination should be sufficient.

In this respect, an urgent need for special training for the personnel of this facility arises. The expert group have agreed that the staff should have previous experience from the prison environment and minimum work experience should be three years. Therefore training should start as soon as possible or rather should have begun already.

Whether „security detention“ is shaped according to the proposed draft Penal Act and Rules of Criminal Procedure or along the lines proposed by the Ministry of Health (creation of a special institutional care facility in Brno-Cernovice for „differentiated protective treatment“ in the Ministry of Health terminology), it can be expected this will be – or should be – connected with a consolidation of legislation with respect to the rights and duties of patients and staff. What is clear is that such rights and duties must be laid down in special legislation (in the order of a statute).

1.14. Intentions of the Penal Act (impact on protective treatment policy)

The recodification of penal law which is now under way will, if adopted in the envisaged form, have a quite substantial impact also on protective sexological treatment and its implementation.

The legislative department at the Ministry of Justice are now preparing the draft Penal Act and Rules of Criminal Procedure reduced to sections also taking into account that current regulation of protective treatment is unsatisfactory and insufficient.

The most important change being proposed is the introduction of the institution of „security detention“, to be imposed under the above draft when „the perpetrator of an otherwise criminal offence that would show the features of a very serious crime is not criminally liable due to insanity, his stay outside confinement is dangerous and it cannot be expected, with a view to the nature of the disorder and the purpose of protective treatment, that the protective treatment imposed would lead to sufficient protection of the community) – cf. Section 106, Subsection 1 of the draft.
„A court may do so with regard to the offender’s personality and with a view to his past life and his circumstance also where

a) when committing the crime, the offender was in a condition caused by mental disorder, his stay outside confinement is dangerous and with a view to the nature of his mental disorder and the purpose of protective treatment, that the protective treatment imposed would lead to sufficient protection of the community
b) the offender has already been committed to prison twice for at least one year for intentional crime committed under the influence of an addictive substance or in relation to its abuse, and it cannot be expected that the purpose of protective treatment and sufficient protection of the community could be achieved.

(3) Security detention may be imposed by courts separately in case of discharge or in conjunction with a sentence.
(4) Security detention shall be carried out in a special detention institution under top security.
(5) Security detention shall last for as long as required by its purpose. At least once in every two years, the court shall review whether the grounds for continuing security detention still persist.

(6) Security detention may be additionally transformed by a court to in-patient protective treatment and vice versa.
(7) The court shall drop security detention where circumstances which served as a basis for its imposition have ceased to exist before the detention begins.“

This key provision thus proposes the creation of „detention institutions“ the need for which has been voiced by a large part of the expert public for many years.

A major deficiency in the proposed legislative text to regulate protective treatment is that if interpreted narrowly, it would de facto exclude patients suffering from sexual deviations. The proposed wording in each case only mentions crime committed in a condition caused by „mental disorder“. The proposal needs to be amended so as to include also crimes committed in a condition caused by a „sexual deviation“ which, from a medical perspective (and according to the international disease classification) is not a mental disorder.

The Counselling Centre for Citizenship/Civil and Human Rights has filed a motion to this effect with the Ministry of Justice legislative department.

The intentions of the draft and the bill reduced to section envisage introduction of the term „security detention“. We believe, in agreement with a proposal by the Council of the Government of the Czech Republic for Human Rights’ Committee for Prevention of Torture and Other Inhumane or Degrading Treatment or Punishment, that the term „detention“ (laying aside) may lead to the mistaken idea that there is no need to work with these patients and that treatment is impossible. We therefore propose that the term „security detention“ („zabezpecovaci detence“ in Czech) be replaced with the term „protective detention“ („ochranne zadrzovani“) which, in Czech, is free of the above connotations.

1.15 Cooperation with investigating, prosecuting and adjudicating bodies (Police, Prosecuting Attorney Offices, Courts)

Current legal provisions regarding obstruction of protective sexological treatment are contained in Section 171, Subsection 1, letter d) of the Penal Act. He who „commits a serious act in order to obstruct the purpose of protective treatment or protective training (social re-training) imposed by a court or otherwise, and especially by means of escaping, substantially impedes the execution of such a decision“ shall be punished by being committed to prison for up to 6 months or with pecuniary punishment.

This legal provision expressly mentions escape from an institutional care facility as grounds for criminal liability. It can be argued that each escape lays the ground for penal liability and should therefore be reported to the investigating, prosecuting and adjudicating bodies. As regards other forms of obstruction, they would have to reach a similar degree of gravity as escape.

In theory, the draft is fairly clear and unproblematic. From a practical point of view, however, many problems arise in whose light the draft appears deficient. One cannot expect a law to define all the different kinds of obstruction, yet the general wording of this provision seems inappropriate.

An altogether different issue is the poor response from investigating, prosecuting and adjudicating bodies with regard to reported instances of protective treatment obstruction. In practice, there have been frequent cases of zero response from the Police of the Czech Republic, while the Prosecuting Attorney Offices usually respond after a delay.

As for the issue of obstructing the execution of an official decision, a frequent problem in case of out-patient treatment is the fact that patients will fail to respond to letters asking them to report for treatment or they will deliberately change their address, thus impeding delivery.

In this context, the unsatisfactory situation with respect to treatment orders has to be mentioned. The order is addressed to the health care facility rather than the offender as would be usual in other countries. A change in the current procedure should become part of the upcoming amendment to Rules of the Criminal Procedure.

This issue is linked to the unnecessary complexity of investigation of cases where protective sexological treatment was never launched: the physician or the facility have to prove that they sent the relevant notice tot he patient, which is costly in terms of times and finance.

1.16. The youth

As regards youth treatment, a specialised health care facility is lacking, and at least one new ward serving the whole country should be allocated. At present, it is virtually impossible to place a youth with a protective treatment order in a health care facility. To admit youth patients for voluntary treatment is also impossible.

1.17. Certified experts: their intervention in the criminal proceedings and imposition of protective treatment (problems and improvement options)

While conducting our investigations as part of the project, we largely came across negative assessment of certified experts' work. Criticism was levelled at them both by patients under imposed PT and by medical facility staff. The reasons for their critical comments are as follows.
Patients themselves claim that the examination took place while they were in custody and the expert usually only came to see them once. In some cases, an additional examination takes place during their single visit to a hospital. Cases of an opinion being produced based on a one-hour interview with the patient are not rare. Besides, opinions tend to basically copied over and over for patients with previous protective treatment orders.

Another problem is the repeatedly confirmed experience of patients and medical facilities that opinions are produced by psychiatrists who lack qualification in sexology. Members of the expert group supported this view when they said that expert committees that should work in different regions are not functional and currently not even operational (or unestablished). Such medical expert committees should be addressing life-long education of experts and possible sanctions against those who have erred in their work. One of the likely causes for these problems is the fact that the Certified Experts and Interpreters Act [5] is rather outdated. There is no way of sanctioning experts for poor opinions, experts registered with the Ministry of Justice are virtually impossible to recall, etc.

Some members of the expert group have also criticised the criteria (and the formal and informal educational requirements) for adding a certified expert to the list.

Medical staff have proposed the creation of one forensic psychiatric facility (with an estimated capacity of approx. 150 beds) where imposition of protective treatment would be decided only after long-term observation of the patient. (Similarly to the Dutch TBS clinics [6]). Their recommendation is to apply this requirement to all cases where a decision about imposing protective treatment or protective detention is being made.

Also highly problematic is the certified experts approach to improving motivation of the accused person to cooperate by giving an inaccurate representation of the proposed protective treatment and telling them that if PT is imposed, they will get a lower sentence or that the protective treatment will last only three months, for example. According to our findings, the average length treatment imposed for an indefinite period of time is 12.4 months. This has been confirmed by both medical staff and patients. During our research, we repeatedly came across cases of patients who had been misled to believe that after release from prison, their freedom will not be restricted and they will simply come for out-patient examination or treatment once in a while.

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5 Law No. 36/1967 Coll. concerning certified experts and interpreters.

6 See below.

1.18. Protective treatment and imprisonment: protective treatment while in prison

The legal provision which allows for protective treatment during imprisonment (only in cases where PT was imposed in conjunction with an unconditional sentence of imprisonment) is contained in the Rules of Criminal Procedure, Section 351, Subsection 1. In this regard, the law speaks of „treatment“, and it is inadmissible from this point of view to speak of some sort of „preparation for treatment“ (this view is shared by a part of the expert public, while the expert guarantor now regards such treatment as mere „preparation for treatment“ even though no such regime is recognised by law).

Thus even though the Rules of Civil Procedure provides for protective treatment during imprisonment, only ward has been established within the Prison Service in the Kurim prison. The ward is designed only for convicts placed in especially guarded prisons. No solution has been sought so far for prisons under supervision and top security prisons.

The Kurim ward is not designed to serve the youth either (currently, there is no civilian medical ward where the youth could undergo treatment).

The Kurim unit suffers from a lack of staffing resources. There is no full-time psychiatrist-sexologist.

The Prison Service General Headquarters are inclined to introduce a similar ward in a top security prison but they say that the opening of such a ward is hampered by a lack of qualified psychiatrists-sexologists. Financial remuneration is also an issue: in a civilian or private facility, they can earn a lot more than the prison can offer (and in civilian establishments, they mostly work with patients who are highly motivated).

Employment of convicts who are undergoing treatment in the ward is also problematic. Frequently it is the impossibility to work that prevents many patients from reporting for treatment while in prison.

What must likewise be seen as a grave fact is that due to the medical handicap, the entire ward is contaminated within the prison community and humiliated by others. This can also be a reason why treatment in prison is refused, as recorded for several patients within our research. Sufficient measures need to be adopted (e.g. greater isolation from the rest of the prison population) so that these prisoners are not degraded and endangered by their fellow prisoners nor by the prison staff.

From a long-term perspective and as a comment that is worth considering in future legislative work, we propose that under certain conditions and to a certain degree, reporting for treatment should always be obligatory still in prison.

The outcomes, evaluation, and in general the full documentation of treatment carried out in prison handed over to the civilian facility where treatment is continued does not always meet the expected standard of quality. This is one of the factors which lead to the experts‘ perception of a mere „preparation for treatment“.

One must be highly critical of the fact that the prison ward is unable to offer treatment to patients who committed the gravest crimes and are therefore committed to a top security prison. Yet it is precisely on these patients who are potentially the most dangerous that the focus on their immediate, timely and effective treatment in the interest of the community should be the most accentuated. Not treating them or not motivating them for more radical sexological treatment may create high levels of risk that they will re-offend while under protective treatment in a civilian health care facility.

Some experts do not recommend termination of in-patient treatment or its transformation to out-patient while the patient is still in prison, arguing that it is impossible to properly test the patient in relation to his family and the external environment and his behaviour there. In case of some patients with low motivation levels who at the same time refuse the sexological treatment that has been indicated for them, we believe that such testing is dangerous and may end tragically.

The fact that no out-patient treatment is available to prisoners must also be noted as inappropriate.

1.19. Protective treatment in civilian health care facilities

We have the following critical comments concerning protective treatment carried out in civilian health care facility:

- Treatment regimes in all of the facilities. There is no specialisation within the Czech Republic. Yet this kind of treatment is not suitable for all patients.
- Treatment facilities are unsecured or secured entirely insufficiently through building and technical adjustments against escape.
- The hygienic standard in some facilities is inadequate (identified deficiencies include windowless bedrooms, mould in common rooms and bathrooms, walk-through bedrooms, etc.).
- Voluntary patients are treated alongside with patients under a protective treatment order.
- Relocation of uncooperative and unmotivated patients to wards with a more restrictive regime within the hospital is problematic.

- The rules – the credit point system change as treatment goes on. Patients and professionals object that rights and duties under PL are not defined by law.
- While patient structure is assumed to be more or less the same, the length of treatment varies greatly from one facility to another (from a minimum of 6 months to a maximum of 23 months, with an average of 12.4 months)

1.20. Problematic items in the internal guidelines and credit point system of sexological treatment regime

The list of items for which positive credit can be granted is about one half of the inventory of items for which negative credit can be levied (a ratio of 11.5 : 25.8, based on data from four hospitals). Our findings thus show that punishment is more extensive than praise and positive motivating for treatment. Negative credit points are levied e.g. for the following.

- verbal attacks at staff or fellow patients
- porušení abstinence (přestože nemají uloženu OL protialkoholní nebo toxikologickou)

Also problematic are the following facts:

- Upon arrival at a treatment facility, the patient is assigned to a group where he is not granted any leave for two weeks.
- On some day, no visitors are allowed in the hospital ward.
- The punishment for concealing a mobile phone is to downgrade the patient to the admission group which is the most restrictive.
- Bullying and physical assault can be punished with anything from – 5 points to downgrading the patient to the admission, most restrictive group (this is a wide range, creating space for subjective assessment)
- When a patient is granted vacation, he must find a substitute to do his cleaning duty.
- When a patient is granted disability pension, he is obligated to repay financial assistance which he received in the past from the community fund.
- Patients must report their mobile phone numbers to the nurse room.
- Patients must not have their car even in front of the hospital. If they are found in breach, they are punished by downgrading to the admission group.
- If a patient does not report on his fellow patient smoking in the bedroom, he is punished by getting no leave for a week.
- The directive requirement and claim that every patient is obliged to submit unconditionally to any medical order is problematic.
- It is patients‘ duty to inform doctors about violations of the rules by other patients.
- Patients are obliged to suffer blood and urine collection to identify prohibited substances. Refusal to comply is classified as a positive test result.
- Patients are not allowed to use their own radio, record player or other electronic equipment.
- A patient’s haircut must correspond with their photograph in their ID.
- Patients are not allowed to draw at their discretion on money deposited with the hospital administration. The limit is 300 CZK and can be reduced by CZK 10 per each negative credit point.
- Patients must bear their money on them.
- After admission to a ward, the patient usually walks around in his pyjamas for two weeks.
- A patient can be placed in the second best group immediately after having undergone testicular pulpectomy (castration).
- Playing dice or cards in the ward is prohibited.
- Patients are prohibited from using gambling machines while on leave outside the hospital.

- Patients are banned from keeping dangerous objects (weapons, explosives, acids, etc.) in the ward.
- Repeated abuse of alcohol by a client is classified as obstructing the execution of protective treatment.
- The fact that there is a position of head of the bedroom, who is responsible for order in the bedroom, can introduce a hierarchy of superiority and inferiority among patients, and invoke the feeling that this is a semi-military establishment.
- Patients' use of mobile phones is restricted to a period from 7 pm to 9 pm.
- The guideline whereby entry into locker rooms, examination room and offices of medical personnel is allowed only upon invitation seems to be inadequate.
- Patients have the right to receive visitors only from amongst their next of kin. Their partners and girlfriends may visit them only after consultation with the attending doctor or psychologist. Children up to 15 years of age are not allowed in the ward

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Additional points of criticism relate to the following areas:

- On the list of items for which positive credit points can be gained, activities related to cleaning chores heavily out-numbered those which are connected with psychotherapy (the ratio was 2:1).

- In case of proven theft, the ward staff are authorised, in the presence of a member of the self-governance, to carry out a complex check of all patients, their personal property and the entire ward.

We find the above issues problematic firstly because we believe that some of the restrictions and duties can clearly be imposed only on the basis of statutory provisions, and some are inappropriate because they create space for subjective assessment and abuse in the sense of arbitrary prolongation of treatment by medical staff or by patients.

1.21. Statistics and other data provided by head physicians

Our investigation was carried out between 1 October 2002 and 31 March 2003 in eight psychiatric hospitals given below:

- Dobrany
- Havlickuv Brod
- Sternberk
- Bohnice
- Kosmonosy
- Brno - Cernovice
- Opava
- Horni Berkovice

Other relevant findings:

- The combined capacity of all of the above sexological wards is 172 beds.
- The number of patients at the time of our investigation was 132.
- The average time of in-patient protective sexological treatment per patient in the period from 1 January 2001 until questionnaires were filled in is given below:

Sternberk:	6 months
Opava:	8 months
Kosmonosy:	10 months
Dobrany:	8-12 (average estimated by us: 10) months

Havlickuv Brod:	12 months
Brno:	14 months
Horni Berkovice:	16,5 months
Bohnice:	23 months

The average time of treatment for all of the hospitals is 12.4 months.

- The number of recorded patient escapes from wards is 6.
- A list of attorneys was available to patients at only one ward.
- Only ward sees patients' rights to defence and accessibility of legal aid for patients as inadequately secured.
- Only two wards expressed satisfaction over financial remuneration of medical personnel.
- At the time of our study, 23 patients in seven wards, or 17.4 per cent of all patients were unmotivated and obstructing treatment (one hospital provided no data about the number of unmotivated patients).
- IN all of the eight wards, there were 11 patients, or 8.3 per cent of the total who were refusing testicular pulpectomy that had been indicated for them.

1.22. Information gained from patients under imposed protective treatment in psychiatric hospitals

- Interviews with a total of 31 patients were carried out under this project (Dobrany - 3, Havlickuv Brod - 5, Sternberk - 0, Bohnice - 5, Kosmonosy-7, Brno - 3, Opava - 4, Horni Berkovice – 4). 10 patients out of these are not interested in treatment.
- Sixteen patients, or more than 50 per cent have stated that they were only seen by a certified expert in psychiatry or sexology once during detention, 6 patients reported 2 visits, 2 patients 3 visits, and 3 patients said they had not been seen at all, while the rest do not know.
- Eight patients see their treatment as highly needed, 11 as needed, 5 as useless, and 7 as completely useless.
- Six patients were not aware of the possibility to undergo protective treatment in prison during imprisonment. One patient would have been interested in being treated while in prison, but he did not know how and were to apply. Fourteen patients applied for protective treatment in prison, but their applications were denied. Only one patient was accommodated. Four patients knew about this option, but were not interested to undergo treatment while in prison.
- Eight patients did not know how, when and with whom they can apply for transformation of protective treatment to out-patient or for its cancellation.
- Nine patients did not know what the assessment (review) procedure was for requests for cancelling or changing PT to out-patient treatment.
- Three patients complained of being badly treated by the medical personnel.
- Patients raised the following critical comments (and requests for changes) on internal ward guidelines:

more frequent leave, more freedom, fewer bans, being allowed more frequent contact with their families, they wanted to be able to attend therapy despite a ban imposed for a violation of internal guidelines, a more moderate regime, cancellation of the duty to report every thirty minutes while on leave, more opportunities to work in the hospital, better alternatives for spending leisure time, extend time for meals beyond 10 minutes, improve communication with staff, reopen the visitors' room to enable intimate visits, being allowed free use of their mobile phones, reduce staff powers in some areas, prevent frequent theft, extend TV watching time – currently until 10 pm, more personal free time, unhappiness about length of treatment not being kept – patient says he is prevented from starting out-patient treatment, hoping for a change in staff's arrogant behaviour toward patients, request that patients be allowed to spend their leave outside the hospital premises right from the beginning of treatment.

1.23. Information gained from interviews with convicts upon whom protective treatment was imposed in prisons

- 17 prisoners were interviewed
- Twelve convicts were aware of the possibility to undergo protective treatment while in prison, and eight would have been interested in treatment already in prison.
- Out of the five convicts who did not know they could undergo protective treatment in prison, four would have been interested in this option.

Part II:

Sexological treatment – the Dutch example

2.1. Legislative framework (history)

The Dutch Penal Code form 1881 contained no provisions concerning treatment with particularly dangerous aggressors apart from sections which mention insane offenders who should be placed in psychiatric asylums. In 1911, a new code was adopted and the years 1925-1928 saw the implementation of „detention under the authority of the government“ (terbeschikkingstelling van der Regering). TBR was used in cases of criminally liable individuals whose recognizing function was weakened or they were psychologically disturbed at the time of the crime. TBR made it possible for courts to impose, alongside with a sentence of imprisonment, the duty to undergo treatment in a government health care facility for at least two years with potential for unlimited prolongation.

In 1988 TBR was replaced with TBS (terbeschikkingstelling). As part of this reform, the conditions for imposing detention changed and have been more stringent ever since. Also the rights of individuals in imposed detention were extended and specified.

Application of TBS requires assessment of the offender‘s criminal liability: TBS can only be imposed where the perpetrator is free of any criminal liability or his criminal liability is reduced. If the perpetrator is recognised as free of criminal liability (e.g. in cases where he was insane at the time of the offence), TBS alone may be imposed. In cases where criminal liability was only reduced, TBS is imposed alongside with a sentence. In such instances TBS will be imposed if a serious crime (such as physical abuse, rape, murder or sexual abuse) was committed in connection with a mental disorder or illness or if a particular combination of the offence committed and mental disorder is found to be a potential hazard in terms of the offender's future behaviour. In these cases, TBS is served after the sentence was completed.

2.2. Conditions for imposing TBS in cases of partial liability for an offence

In such cases, in order for TBS to be imposed, the following criteria have to be met: the offender suffered from a mental disorder or mental under-development at the time of the offence(s) for which the applicable sentence is imprisonment of at least 4 years (the prison sentence of min. 4 years need not actually be imposed – only the possibility of such a judgment is required).

TBS is imposed where this is necessary in order to secure the safety of others, public order or property. A previous conviction is not a pre-condition.

2.3. Protective mechanisms

Before TBS can be applied, a personal assessment of the offender must be produced. This is done by a group of experts in multiple fields, of which two or more must specialise in behavioural science: one has to be a psychiatrist, and the other one is usually a psychologist. The offender is examined from several perspectives including his criminal liability or its degree, his dangerousness, type of mental disorder and possibilities for treatment or correction.

An important difference from the earlier mechanism (the above-mentioned TBR) is that under TBS, offenders with partial criminal liability may refuse the examination. In that event, the offender will be convicted with no resort to TBS.

2.4. Duration and extension

TBS can be imposed for a maximum of two years. After this time has lapsed, a review is undertaken and TBS can be prolonged by another one to two years. In case of non-violent crimes, TBS can be prolonged by a maximum of 4 years. IN cases where TBS followed after acts aimed against the bodily integrity of one or more individuals and its extension is required for the protection of other people's safety, the prolongation can be unlimited. Since 1988, an additional examination by a psychiatrist and a psychologist has been a pre-requisite for extending TBS.

The average duration of TBS is reported to be 4 years, and after spending this period in a psychiatric hospital, the patient remains in community treatment for some more time.

2.5. Treatment under TBS

Before arrival for treatment in a medical facility, the patient goes through a clinical examination. Since 1952, such examinations are conducted at the F. S. Meijers Institute, Utrecht. Here the effective possibilities for treating a given patient are examined and the most appropriate facility for him and his particular treatment is determined. The criteria for the eventual placement are the assessed level of mental disorder, nature of the offence committed, risk of escape, the risk the offender represents for public safety, and availability of treatment in the respective facility (the last criterion being the most important one). The examination usually takes six weeks.

Possible and available forms of treatment include psychotherapy, medication and physical therapy, social therapy and other methods such as non-verbal, creative, expressive and movement therapy. Except where this is precluded by special safety or medical reasons, a majority of patients live in some kind of home groups.

Treatment under TBS usually starts in conditions which are comparable to imprisonment and under serious restrictions which are relaxed over time and if treatment is successful, the patient will be released into the community in the end. Release on probation is gradually applied, at first with supervision by a specialist probation officer, and later without this supervision.

Individuals detained under TBS are placed in nine top security forensic clinics. Each of these has a capacity of 85-90 patients, but some may also receive offenders who are not criminally liable. Recently, overfilling has been a problem which resulted in cases of people waiting for TBS in prison for up to two years. New clinics were built and the number of beds increased.

When their treatment under TBS is over, the patients are released but they do not always regain full freedom: there is currently a debate about setting up additional forensic psychiatric clinics, half-way houses and other facilities that would serve as support to TBS clinics.

Also discussed at present is the issue of patients whose treatment has been completed but without success. There are proposals to set up treatment facilities for the placement of long-term patients who are regarded as uncurable and who are unlikely to be ever let out of confinement.

2.6. Sexual deviation

No special treatment programmes are available for sex offenders. They are treated in top security clinics designed for TBS. Sexual aggressors represent approx. 30 per cent of patients placed on the basis of TBS.

These patients are treated in Dr.S. van Mesdag facilities in Chroningen, Veldzich Clinic, Balkburg, Dr. Henri van der Hoeven Clinic, Utrecht, Pieter Baans Centre, Utrecht, Professor Pompe Clinik, Nijmegen, and the Oldenkotte hospital, Rekken.

Out of the total of seven facilities, three are government-run and four are private.

Treatment time for sexual aggressors is 6 years, or two years longer than for other patients.

2.7. „Patient's advocate"

A „patient's advocate" is available free of charge to individuals placed in psychiatric asylums, including those placed on the basis of TBS. Although employed by the asylum, the advocate is independent of the management. He or she is an expert in patient rights and never acts without the patient's knowledge or consent. Advocates themselves have no executive power, they do not decide complaints, etc. These are decided by a complaints committee in each facility. Advocates help patients draw up their complaints and may support them during hearings on their complaints. They will also advise patient about any issues related to their stay in the treatment facility.

2.8. Conditional discontinuation of treatment

A court may decide that treatment under TBS should be conditionally suspended. In such cases, the patient will be discharged from the facility and his discharge is conditional upon continuation of (out-patient) treatment or adherence to treatment procedures. Those who violate the terms expose themselves to the risk of forced re-admission.

Placement under TBS must be seen within the wider context of legislation which regulates the status of those suffering from mental illness and those who have been placed in health care establishments involuntarily.

These issues are covered by the Psychiatric Facilities Act form 1992 (the BOPZ Act).

This law regulates involuntary placement and involuntary treatment of individuals suffering from mental disease in psychiatric hospitals. This detailed system can serve as a role model or inspiration for Czech regulators with regard to the planned establishment of detention facilities as well as potential regulation of the rights of those placed involuntarily, setting up the function of patient advisers or the use of enforcement tools, consenting to treatment, etc.

2.9. Collaboration with a foreign NGO

During our work on this project, we established contact and cooperation with an NGO abroad that deals with similar issues.

The NGO is Mental Disability Advocacy Center Budapest (MDAC), an international group that specialises in protecting and advocating the rights of people with mental disorders altogether in 28 countries of Central and Eastern Europe, ex-USSR and Mongolia. MDAC's objective is to improve the quality of life for these people through helping promote respect for human rights and social integration.

Part III:

Proposals and recommendations

3. Proposals and recommendations

- **We recommend that protective detention be enshrined in law as a new protective measure. This measure would be enforced, based on a court decision, on patients who have committed a serious crime, are free from criminal liability due to insanity, and at the same time, are dangerous to the community, as well as patients who are dangerous to the community and have been treated unsuccessfully in the past or have been obstructing treatment and refuse more radical sexological therapy that has been indicated fro them.**

- **We recommend adoption of a law concerning the execution of protective treatment.**

- **We recommend the setting up of a specialised nation-wide facility for youth treatment.**

- **We recommend that all patients convicted to an unconditional sentence of imprisonment start getting treatment straight away after their arrival in prison.**

- **We recommend that in some cases of less serious crimes, protective treatment should precede imprisonment and the length of treatment (or its significant portion) be counted toward the sentence.**

- **We recommend that in case of protective alcohol or drug treatment, patients who have been sentenced to imprisonment should be allowed to have the sentence replaced with the duty to undergo treatment in a civilian facility.**

- **We recommend that in case of particularly dangerous sexological patients who have repeatedly and long-term (for at least a year) refused radical therapy indicated for them, where a court decides about PT, it should be obliged to rule that the patient must be placed in a protective detention facility or other facility that will be better secured against escape than existing protective treatment facilities through building and technical adjustments and the applied regime.**

- **We recommend that half-way houses be set up for homeless patients with effective participation from the government because letting such patients „out in the street“ is highly problematic and poses great risks of further re-offending.**

- **We recommend that the various credit point allocation systems in treatment regimes be adjusted so as not to violate any laws or other legal norms that may be superior to laws. Furthermore, we recommend that these systems be adjusted so as to prevent patients to wilfully prolong their treatment: a gross violation of the regime will effectively put the patient at the beginning of treatment.**

- **We recommend changing laws and regulations to the effect that protective treatment is imposed upon the patient rather than the health care facility.**

- **We recommend to strengthen the staffing of wars so that intensive treatment can continue throughout weekends.**

- **We recommend that patients with other types of protective treatment should not be placed in the above-discussed wards. Even placement of voluntary patients in these wards is problematic.**

• Where out-patient treatment follows after in-patient sexological care, we recommend that this should take place in the same ward where the patient was treated in the past.

• We recommend that immediately after arrival at the ward, patients be instructed in writing about the procedure of a review for the transformation of treatment to out-patient or cancellation of treatment, including information about how and where patients may apply.

• We recommend that patient be allowed to apply for conditional release from in-patient PT provided that they will continue to submit themselves properly to out-patient treatment.

• We recommend improving levels of awareness among convicts about possibilities for undergoing PT while in prison and about other issues related to the treatment process, transformation of treatment to out-patient or its cancellation.

• We recommend that the Ministry of Health and health insurance agencies should review compensation for services and increase the number of credit points earned for tasks associated with patient treatment.