PRISONERS OR PATIENTS:

CRIMINAL PSYCHIATRIC DETENTION IN HUNGARY

MDAC Mental Disability Advocacy Center

HHC Hungarian Helsinki Committee

Introduction

This report is the outcome of a long dialogue between monitoring NGOs and administrators of the Juridical and Observational Psychiatric Institute (IMEI) in Budapest, Hungary, following a monitoring visit to that institution on the 17 and 18 December 2003. After this visit, monitors from the Hungarian Helsinki Committee (MHB) and the Mental Disability Advocacy Center (MDAC) held a meeting with Dr Albert Antal, the Director and Chief Physician of IMEI, as well as with other institutional physicians to share general observations and human rights issues which emerged during monitoring. Following this meeting, IMEI management investigated the issues raised and informed MHB of the results in a letter dated 22 December 2003. The letter is published as an addendum to this report.

The first version of this report was completed in April 2004 and shared with the Director of IMEI. The Director, Dr Albert Antal, sent detailed comments on the text on 12 May 2004. On the basis of these comments, MHB and MDAC amended the text in several places, and in July, sent the amended report to Major-General Dr István Bökönyi, Director General of the Hungarian Prison Service, who responded in a letter dated 9 August 2004. We also addend Dr István Bökönyi's full response to the end of this report.

Although responses from IMEI and prison administrators are included in full in addendums, in relevant sections of the report, their comments are also inserted in italics. This allows readers to see the diversity of opinion on certain issues from the point of view of human rights monitors as well as from the point of view of institution administrators.

Accordingly, the text consists of the following sections:

- The joint report of MHB and MDAC with inserted comments from the Director and Chief Physician of IMEI;

- The letter from the Director and Chief Physician of IMEI in relation to certain specific complaints; and

- The comments of the Director General of the Hungarian Prison Service in respect to the final report.

In addition to two concrete positive outcomes occurring as a result of the monitoring visit - modification of rules governing telephone contact between inmates and defence lawyers and the introduction of a complaints box system - a further positive development, according to information provided by the Director of the Health Department of the Hungarian Prison Service (Dr Katalin Heylmann), is that work has already begun within IMEI on the elaboration of patient risk-assessment guidelines.

1. Report on the monitoring visit

Members of the Hungarian Helsinki Committee (MHB) and the Mental Disability Advocacy Center (MDAC) made a joint visit to the Juridical and Observational Psychiatric Institute (IMEI) in Budapest, Hungary on 17 and 18 December 2003.

Members of the MHB team were: Dr János Somogyi (attorney), Ferenc Kőszeg, Dr Katalin Friedrich (attorney), Dr András Kristóf Kádár (lawyer), Iván Mándli (social worker) and Dr Anna Ungár (physician).

Members of the MDAC team were: Oliver Lewis (lawyer and Legal Director of MDAC), Dr József Kovács (expert in bioethics), Dr Kris Naudts (physician and psychiatrist) and Eszter Simor (social worker and Program Assistant of MDAC).

Cooperation of IMEI staff

The visit to IMEI ran less smoothly than other monitoring visits undertaken by MHB to other institutions within the Hungarian prison system. While this was due in part to the large size of the monitoring group, the particular character of the institution and its complex structure also played a role: IMEI's various departments are located in numerous buildings, and patients are also divided into several groups, based on legal status and on diagnoses.

On the first day of the visit, the monitoring team asked for internal documents governing the life of the institution (e.g. the house rules of the various departments). The team did not receive these, however, until the end of the second day. This made the gathering of information significantly more difficult (in view of the complex structure of the institution). In the monitors' experience, the provision of such documents has not proved problematic in other penal institutions.

[The monitors] have stated that the visit did not run smoothly. They primarily base this assertion on the fact that they did not directly receive at the beginning of their visit those internal documents which govern the life of the institution. According to our information, in every department inspected, the attention of the monitors was drawn to the fact that these documents were posted in the wards of the department. We agreed that the house rules would be handed over at the end of the inspection, and this handover took place at the pre-agreed time. Given the availability of the house rules, it is unclear as to why the Committee found it problematic that it was only on the second day that they received these documents in a form in which they could be taken away.

In certain departments, IMEI staff were helpful: we received the information we requested and they enabled us to talk to patients undisturbed. There was only one exception to the general willingness to cooperate – namely an older male nurse in the men's Neuro-psychiatric Department No. 1, who at 15:47 on 17 December 2003 was unwilling to show us the department's daily schedule because his "working shift had already ended."

I consider the communication problems which occurred in certain departments [...] very regrettable, since I could have been told about these immediately. The problem that was raised has been investigated, and the nurse has prepared a report. [...] It is difficult to understand why your report did not mention that the member of staff who was just finishing his work, instructed another nurse who was present to assist the members of the Committee in their work.

General Information

IMEI is the only high security psychiatric institution in Hungary for those subject to involuntary treatment (i.e. those who have committed violent crimes against other persons or crimes that have endangered public safety and where there is a danger that they may commit similar crimes in the future). These individuals are committed to a psychiatric institution and to IMEI specifically if the initial offence is one which is punishable by a period of at least one year.

Aside from individuals subject to involuntary treatment, other individuals also placed in IMEI are those sent for temporary involuntary treatment as well as prisoners experiencing mental disabilities and other individuals who have been referred by prison officials (for example, prisoners who are referred with suspected personality disorders).

The institution can accommodate 311 persons. At the time of the team's visit, 253 people were accommodated there.

After one year of involuntary treatment and with the permission of the Director and Chief Physician, a patient may be released on "adaptive leave," the aim of which is to prepare the patient for reintegration into society. "Adaptive leave" lasts at most 30 days and may be extended once. According to the rules of IMEI, a patient must spend "adaptive leave" with a caregiver who undertakes in writing to care for the patient. The Director and Chief Physician decides on the release of patients on adaptive leave, based upon the recommendation of the Adaptation Committee. Committee members include the Director and Chief Physician, the medical director, head physicians of the departments, the head of the clinical psychology department, the physician recommending adaptive leave, the heads of the institution's other non-medical departments, as well as IMEI's patients' rights ombudsperson. Adaptive leave may be granted on more than one occasion.

At the time of the monitoring, just one person was on adaptive leave. According to information provided by the Director and Chief Medical Officer, in 2003, adaptive leave was granted to three persons only.

The frequency of adaptive leave can only be examined in relation to the institution. Within the limited time available to them, the visiting Committee was not able to review the social circumstances of our patients (although we mentioned it several times), the way society views our patients and the changes in their families as a result of their criminal activities. The time that the Committee spent here was not sufficient

for us to analyse jointly the difficulties patients subject to involuntary treatment will have in adapting and rehabilitating.

According to information provided by the Director and Chief Medical Officer, approximately 80% of IMEI patients are subject to involuntary treatment because of indictments for murder or manslaughter. On average, they spend 4 to 6 years in IMEI. In 2003, 33 patients were released from the institution.

According to the Director and Chief Medical Officer, approximately 80% of the patients are under guardianship.

Staffing & Professional Resources

IMEI currently has 169 staff. Of these, 21 are doctors (including 15 psychiatrists) and one is a welfare assistant. Of the psychiatrists, six are on the national register of forensic medical experts. All of the staff in the institution work full-time. There are 70 nurses.

Monthly consultation sessions for doctors are held at IMEI. The main source of professional literature available to these psychiatric staff is the Acta Psychiatrica Hungarica, which rarely deals with forensic psychiatric issues, and, when it does, does so mainly in articles and case studies from the victim's (rather than the aggressor's) viewpoint. The only international journal which monitors could find at IMEI was the Hungarian edition of the JAMA Psychiatry Journal (Journal of the American Medical Association). IMEI staff have access to computers, but internet access is available on just one machine.

The provision of professional literature to the psychiatric staff is primarily a question of resources. Our colleagues have extensive experience in the field of forensic psychiatry in Hungary and within the institution's system do not necessarily have to follow the current literature. I would like to point out that forensic psychiatry differs primarily from general psychiatry in its legal regulation. There is no professional journal in Hungary that deals specifically with forensic psychiatry. In the institution, we receive the psycho-neurological and, the neuro-psychopharmacological professional journal. On our part, we consider it great progress that we have been able to implement and finance at least one connection to the Internet.

Physical Conditions

The physical infrastructure of IMEI is very poor in general. Different departments do not vary greatly in terms of the physical condition of either equipment or infrastructure. The Director and Chief Physician noted that, according to state plans, IMEI will be moved to a different building by 2008.

Most of the patients live in wards with between 4 and 9 beds (although there are also rooms accommodating smaller and larger numbers of beds). These bedrooms are dark and rather bare. But, conditions are no worse than in most penal institutions in Hungary. Since there are no bunk beds at IMEI, and patients subject to involuntary treatment are, in fact, free to move around in corridors and common areas, it might

be possible to say that, in terms of accommodation, patients are in a better situation than the majority of Hungary's prison population. Of course, as the Director and Chief Physician emphasized several times, residents of the institution are not prisoners but patients, and therefore the fact that they live in more pleasant surroundings than convicted prisoners is not, in itself, remarkable.

In the buildings, which are more than 100 years old, there are, naturally, some rooms that are darker and some that are colder and in certain cases lack decorations, but it is an exaggeration to state that this is the general situation. Our staff, in cooperation with the patients, ensure that the rooms have decorations. Our patients have the right to adapt their surroundings according to their own tastes. [...] The wards in Building I are by no means dark, since the windows have been replaced. Building III can be said to be dark, but the windows there cannot be changed because it is listed as a historic building.

During the day, patients wear a brown uniform resembling pyjamas. The observer team witnessed one case in which a patient asked one of the institution's employees for warmer clothes due to cold. The employee replied that there were no more warm clothes available for the patients. According to the judgment of the team, the patient's cell was, indeed, cold.

In 2003, we inspected and repaired the entire heating system. This was necessary because over the years there had been many problems with the heating. This year during the heating season, only rarely were there complaints that the heating in a given ward was not optimal, but in such cases steps were taken immediately to repair the heating system and blankets were issued from the stocks held in the departmental stores. It would be impossible to replace the entire heating system without remodelling the whole building. The complaint of the patient who said that he had not received warms clothes really makes no sense, since all patients across the board receive winter clothes appropriate for the season. [...]

It is difficult to appraise the statement that the patients wear a brown uniform resembling pyjamas both day and night. The clothing described in the report is the coercive uniform, the wearing of which is required by law. At the same time, we inform the respected Committee that it is not mandatory to wear the uniform at night; in our institution, the system is to wear "pyjamas" at night. It is undoubtedly true that our financial resources do not make it possible for us to provide our patients with the quality of uniform we would like.

Every department has a common room. These rooms are scantily furnished and bleak. Judging from the way they are furnished, they are used primarily for watching television. The common areas are unheated and smoky. Moreover, practically everywhere in IMEI, there is exceptionally dense cigarette smoke which, we believe, represents a hazard to both health and safety.

Indeed, we saw smoking not just in designated areas, but practically everywhere, including in rooms in the wards. One patient alleged that in the neuro-psychiatric department, smoking is only forbidden in the evening after patients are in bed. If this is true, then the practice does not comply with house rules provided to us (which strictly forbid smoking in wards of patients subject to involuntary treatment).

It is clear that smoking is strictly forbidden in the wards of the departments for patients subject to involuntary treatment. In the prison hospital area, where the ward doors are kept locked day and night, smoking is only possible in the wards. The establishment of smoking and non-smoking wards was carried out precisely on the basis of Section 4 of Decree 17/1999 (XI. 18.) of the Ministry of the Interior. [...] We would like to remark that the proportion of psychiatric patients who smoke is much higher than among other categories of patients, and so forbidding our patients from smoking would impair the feeling of well-being of those patients who do smoke. Of course, this does not mean that smoking is allowed everywhere.

Problems related to personal hygiene

Patients and staff both made statements to monitors which contradicted house rules in relation to bathing. In one department, according to staff statements, patients are allowed to use the showers every day, whereas the patients said that they were only allowed to use the showers on working days.

Regulations regarding number of showers allowed is missing from the house rules of certain departments (although weekly and daily schedules do contain provisions in regard to this). We recommend that the minimum number of showers allowed should be reconsidered and should be stated clearly in house rules with reference to daily schedules for detailed regulations (similar to the way in which, for example, the house rules prescribe a daily one-hour walk for remand patients as well as for patients who are being held on suspicion of having personality disorders).

In most departments, the showers are in an exceptionally bad condition. One patient complained that there was hot water only in the afternoons. Another patient in the women's neuro-psychiatric department claimed that staff watch patients while they were taking showers. Once again, the house rules issued with respect to patients subject to involuntary treatment do not regulate whether staff observation during shower time is allowed or not. In the other two sets of house rules – *argumentum a contrario* – it is stated that nurses may only watch prisoners while they are shaving. Institutional rules issued with respect to patients subject to involuntary treatment must regulate what licence the nurses have in this issue.

Both the daily and weekly schedules contain the shower times. In the departments for patients subject to involuntary treatment, there are showers every day. In the departments for referred patients, there are showers during the week. On non-working days, for security reasons, there are indeed no showers here.

In the departments for patients subject to involuntary treatment, there is a central mixer tap, so that the psychiatric patient cannot scald himself, even accidentally. We reject the patient's allegation that they only get hot water in the afternoons, since only hot water can flow from the showers. In accordance to the instruction from the Director of the Hungarian Prison Service, during the summer we ensure weekend showers and, indeed, several showers a day, in view of the very hot weather.

Treatment

According to information from IMEI doctors, 80% of the patients suffer from schizophrenia. Treatment consists mainly of drug therapy.

One psychiatrist told the observer group that the majority of patients receive new atypical anti-psychotics [most receive risperidon (risperdal), while a smaller number receive olanzapin (zypraxa)]. A smaller proportion of patients, however, receive traditional anti-psychotics, which represent outdated modes of drug therapy and often have severe side effects.

On admission to IMEI, 70% of patients are started on depot drug therapy*, for the first time in their lives. Typically, patients receive a combination of haloperidol and clozapine, supplemented by depot neuroleptics. Only a few patients are treated with atypical neuroleptics.

The side effects of psychiatric treatment (especially sedation and weight-gain) were noticed in numerous patients. Some of these side effects are offset by anti-cholinergic treatments (which, however, produce further side-effects). To monitor side-effects (primarily in the case of clozapine), blood tests are regularly administered to patients. The majority of patients we spoke with found side-effects worrying, particularly excess weight and the related risk of diabetes (in the men's Psychiatric Rehabilitation Department No. 1, nearly 10% of patients suffer from diabetes) and increased risk of heart and vascular problems accompanying weight-gain.

The treatment of patients is based on professional norms, the patient's condition and the doctor's judgement. In our institution, in the majority of cases, the opinion and experience of the patient are also instrumental in the determination of the treatment. We consider it doubtful that any of our colleagues would have declared that the majority of their patients received the so-called atypical anti-psychotics. These drugs are prescribed if this is justified by the patient's condition and the experience gained from the patient's treatment. Financial reasons do not make it possible for every patient to receive atypical anti-psychotic drugs. It is with particular and genuine curiosity that we received the Committee's conclusion that our treatment protocol is based 70% on the use of depot neuroleptics.

It seems that the professional consultant invited by the Committee did not bear in mind which drugs are classified by the psychiatric profession – whether within Hungary or elsewhere – as being among the atypical – i.e. second generation – anti-psychotics (e.g. Clozapine). The professional consultant did not draw the Committee's attention to the fact that one of the problematic side effects of the above-mentioned atypical anti-psychotics is an increase in weight and a sedative effect. So, the statement that the professional diagnoses are not in accordance with the current recognised literature reflects a subjective conclusion which seeks to find fault with our therapeutic protocol.

The use of anti-psychotics is a professional stipulation. According to the prevailing professional view, a psychotic patient must be treated with anti-psychotics. Similarly, based on professional stipulations, maintenance treatment must be continued

* Depot drug therapy refers to depot injections which are anti-psychotic drugs suspended in vegetable oil and given directly into the muscle of the buttock, where they form a pocket of the drug to be absorbed slowly over time. According to professional literature, depot antipsychotic injections should not be routinely prescribed, and should not be given to a patient who is also taking anti-psychotic medication orally.

after the acute psychosis has passed. During the continued treatment, because of the change in drugs, certain risk factors must be checked regularly. For example, instructions for the use of clozapine prescribe blood tests at set intervals. Therefore, this is not a matter of "luck", but rather the complete implementation of professional specifications. The high number of diabetic patients which the Committee became aware of and which it described as "worrying" is, similarly, subject to professional and systematic screening examinations.

Our colleagues are aware that obesity and diabetes are risk factors, as the Committee also mentioned. In the above, we have stressed that based on the recognised professional data, clozapine and olanzapin, quetiapine (modern anti-psychotics) represent greater risks in this area as regards weight gain and diabetes.

The monitoring team met a patient who complained that he had received a drug against his will, a side-effect of which was excess salivation. He said that because of taking this drug, he was incapable of thinking clearly or preparing appropriately for his upcoming court case.

Amongst the atypical anti-psychotics, the effect which clozapine has on the muscarine receptor often causes salivation as a result. Naturally, the Committee is not required to know all of the information which a psychiatrist is required to know. The Committee's findings do not refer to any impartial facts indicating medical complaints that even lay examiners could have noticed. Similarly, it is part of the field of psychiatry that "the ability to think clearly" is not necessarily a function of the psychiatric drug treatment, but rather partially a symptom of the specific endogenous mental illness.

Patients did not have access to information (information booklets, posters) about the diagnosis of illnesses, nor about the varieties of treatments for mental disorders.

We would like to state that we comply fully with the requirement to provide information that is laid down in the Health Act and which forms part of our medical activity. If the members of the Committee had asked them, then the majority of our patients, depending on their mental capacity, would have given exact information about their illnesses, their treatment and which side-effects they should look out for and immediately report to the staff treating them.

Large group therapy sessions—attendance at which is voluntary—are not supplemented with individual psychotherapy, which might help patients better address mental health problems. During the two-day monitoring visit, the team noticed that most patients spent most of their day unoccupied—either simply shuffling up and down the corridors or sitting or lying on their beds.

I am truly sorry if, in connection with the Committee's inspection, we were not able to continue our psychotherapeutic activity in all of our departments during the inspection. At the same time, we inform the Committee that in accordance with the regulations of psychotherapy, there would not have been any possibility to inspect the group and individual therapy sessions anyway. Similarly, in our current system, in accordance with professional regulations, we primarily use individual and small group psychotherapy of an educational nature. The result of this is that with some of our patients, with appropriate treatment, we are able to gain the patients' cooperation, in-

form them about their illness and teach them how to live with their illness. Contrary to the Committee's professional psychiatric opinion, our staff continually assist patients in "coping with mental problems".

Very few patients have any real contact with their families (not necessarily the fault of the institution). However, the extremely restricted use of the "adaptive leave" might be a tool for greater contact, were it approved by IMEI authorities more often.

On a positive note, we can highlight the fact that, during our visits, doctors and nurses communicated with patients in a friendly tone and were open to patients' questions and complaints. Nurses appeared to be constantly available to the patients.

We are glad to hear that the members of the Committee consider the relationships between the staff and the patients to be friendly, but for us this is natural and, we hope, is generally the case in civilian hospitals as well.

As in penal institutions generally, security is also one of the most important considerations at IMEI. In the context of involuntary treatment, where the use of restraints is severely restricted, the monitoring team observed that in order to avoid possible aggression and violence, staff rely primarily on the effects of sedative medications. With the emphasis on sedation, there is less attention to achievement of a beneficial treatment combination (which might involve greater use of talk and occupational therapy and fewer sedatives, for instance).

It follows from the penal nature of the institution that security is, indeed, an important consideration. We do not know, however, on what basis the Committee members drew the conclusion that this is one of the most important in a psychiatric institution. It is not the danger, but rather the professional rules already detailed above, that determine the treatment with drugs. The use of restraints is legally regulated. The Committee, in its professional statement that "a more beneficial combination for the patient, [is one] involving more occupational therapy and less drugs" is, in general, correct, but let us not forget the professional rule that the continuing treatment in our institution is carried out in accordance with professional prescriptions and with the appropriate dosages of drugs. Professionally, it is incorrect to imagine that in connection with continuing treatment, the quantity of drugs can be significantly reduced by combining them with psychotherapy and sociotherapy. It seems that the Committee is not aware of the fact that while supplementing drug treatment with educative therapy can reduce the chances of relapse, the effective dosage must still be given. Our institution, therefore, uses this combination in its professional protocol.

All non-drug therapy is voluntary (i.e. drug therapy is the only treatment which is given involuntarily). If a patient wants to spend the whole day in bed, he/she may do so. Visits to the departments are made daily by departmental doctors and twice weekly by the head doctor of any given department. Monitors did not receive any information as to whether multi-disciplinary team discussions are ever held by these doctors, nor as to whether, in specific cases, detailed case discussions are held.

We believe that multidisciplinary team discussions are necessary, if justified by the patient's condition. In view of the fact that this is a daily routine and that we did not receive a question about this, it is natural that the Committee is not informed about this.

Our institution has several consultants at its disposal (a dermatologist, an ophthalmologist, a neurosurgeon and a neurologist dealing with electro-physiology), while amongst our staff there are those with specialist qualifications in internal diseases, infectology, anaesthesia and gastroenterology.

The predominance of drug therapy appears to contradict information which the Director and Chief Physician disclosed in his letter of 22 December 2003. Replying to issues raised by the monitors, the director of the institution wrote that in 2003, IMEI spent 41% less on drugs than equivalent civilian institutions. This could, however, be due to use of older (and therefore less expensive) anti-psychotics. Without details of the stock of drugs and a detailed comparison, it is difficult to draw any conclusion from this otherwise striking cost differential.

Reintegration (educational and occupational) activities

The predominance of drug therapy and the limited use of other forms of therapy is also connected to the problem of lack of alternative (educational, occupational) activities in the institution. At the meeting concluding the monitoring visit, IMEI administrators were offended with an observation (made by the MDAC consulting psychiatrist) that aside from drug therapy, the institution offered no other regular therapy, and that the range of other reintegration-oriented activities and programmes was very narrow. In response to this observation and with the intent to illustrate that "the patients can choose every week from among a large number of programmes," the Director and Chief Physician attached to his letter of 22 December 2003 a list of programmes organised by the psycho-pedagogical department.

In that 13-point list, however, there are relatively few programmes meeting the specific needs of IMEI inmates. In fact, only the psycho-pedagogical programmes under the heading of "psychotherapy-driven activities" can be regarded as such (small groups for the intellectually-disabled, creative therapy study circle, group activities on lifestyle themes). Other activities— for example free religious practice, availability of newspapers for patients, organising field trips so patients can sometimes eat outside the institution and the organisation of family or personal visits—cannot really be viewed as "therapeutic" programmes. Patients (and indeed everyone held in custody) are entitled to the provision of such programmes by national law. In fact, cultural programmes offered (recital competitions, festivals in May and June, St Nicholas celebrations) are no different from those in other penal institutions (the only exception is a mixed-sex disco on Fridays).

It is also doubtful whether one can describe as therapeutic so-called "work" activities (which inmates of other institutions also do) that serve to keep the institution running, such as cleaning, serving food, carrying food, washing up, et cetera. One possible exception is the maintenance of the district council's children's summer camp, since this activity is carried out outside the institution, offering the opportunity to maintain some contact with the outside world, and thereby serving some kind of therapeutic aim in preparing patients for reintegration.

In our judgement, every activity has therapeutic value!

We are also of the opinion that in the institution we provide our patients with a wide-ranging socio-therapeutic programme which is perhaps more extensive than those offered in civilian psychiatric practice. The psycho-pedagogues carry out their work in teams in our patients departments, under the direction of the departmental head physician and in coordination with the attending physicians, the psychologist and the nursing staff. In addition to their daily administrative tasks and their work involved in helping certain patients maintain social contact with the outside world, they also run the various activities listed in the attachment to the Director's letter. They organise different cultural and sports events. They do this in such a way that each educator is responsible for around 50 – 60 mental patients. Day after day, they have to deal with and sort out the patients' worries, problems, correspondence, visits etc. In Hungarian prisons, the number of prisoners to each educator is the same. Since we are dealing with patients subject to involuntary treatment, this ratio can be regarded as being much worse. Given these circumstances, the quantity of programmes listed earlier is even more noteworthy,

In our opinion, all of the activities listed in the Director's letter of 22 December are of therapeutic value, since even if something is required " by law" it can have a therapeutic effect. In a similar way, the carrying out of work related to the running of the institution is also of therapeutic value. This in no way differs from the work therapy activities carried out in civilian institutions, and which are, on the contrary, declared to be a form of social therapy. We also note that if we are already comparing institutional practice with the programmes offered by other penal institutions, the fundamental differences lies not in what a programme is called, but rather in the use of the educational tools and methods employed. This corresponds to the "particular" needs of those placed in the IMEI.

Risk Assessment

Doctors in IMEI do not have established professional guidelines to assess risks which might emerge from an involuntary patient population. IMEI does not have a written policy on risk assessment. And, even though risk assessment is an important concept in forensic psychiatry, on the basis of discussions with IMEI psychiatrists, the concept did not appear to be in use at all within the institution.

Monitors did note that IMEI psychiatrists use a few general and easily applicable principles when preparing cases for the annual judicial review of involuntary treatment. The psychiatric member of the monitoring group, however, observed that IMEI doctors appear to base their risk and relapse assessments on random empirical experience rather than on facts that have been gathered and systematised scientifically. This psychiatrist added that compounding this issue in Hungary, is the lack of medium secure units and community psychiatry to enable reintegration of forensic patients. Continuity of treatment remains an insoluble task for the authorities.

We were similarly surprised by the Committee's mention of a lack of "risk assessment" – a term which presumably conforms to modern terminology.

We believe that our activity, by virtue of the laws in force, involves continuous risk

assessment. The fact that we do not call it as such follows from the wording of the law. We regret that the Committee considers that our colleagues' many years of experience are just "random" and "empirical". We readily accept data published in the literature in connection with the danger to society of the "criminally psychiatrically" ill which is of a non-empirical nature. If the Committee thought that we could establish general critera which would address the justifiability of involuntary treatment while ignoring the patient, his personality, his illness and his social environment, then we consider it very doubtful.

It is our unchanged opinion that, in the terminology of the Committee, that risk assessments of patients can only be made on an individual basis, taking into account the facts of the particular case. The inadequacies of psychiatric provision in Hungary do not lie within our competence.

There were also no apparent written guidelines on how to deal with aggressive patients. We did not receive any statistics in writing, but the management said that in the past 20 years there had been only two serious incidents in which staff had been physically attacked. This small number appears surprising, given the histories of those treated in the institution. Treatment with powerful sedatives offers one possible explanation.

There is nothing that needs to be put down in writing as regards the dangerous situations provoked by aggressive patients. There are nationally-accepted professional guidelines regarding the therapeutic possibilities in this regard. There is no need for institutional professional guidelines. Such situations must be tackled on the spot and this general rule applies not only to us, but to any civilian psychiatric department as well. The fact that there have only been two serious incidents over the past twenty years bears testimony to the therapy we carry out, which is aimed at preventing aggression. It is malicious and incorrect to suggest that this low level of aggression is obviously the result of the sedative effect of treatment with powerful drugs. On this basis, it has not even occurred to the Committee that this is the result of the outstanding treatment provided by the staff.

Restraints

According to Paragraph (a) of Section 84/A of the Act on Penal Institutions, only limited physical restraint (partial or full restriction of movement) may be used with patients (and only in those cases defined in the Act). The use of other restraint measures, which can be used with other kinds of prisoners, is forbidden. Also applicable in the case of IMEI patients are the provisions of the Health Act, which limit the restriction of personal freedom in any way (by physical, chemical, biological or psychological means or procedures) to those people "diagnosed with a mental disorder who are dangerous" or "whose behaviour poses an immediate danger" [a difference in Hungarian law]. Only the attending physician can order the use of restraints. As an exception, in specifically justified cases, a specialised nurse can also order temporary restraint, but must immediately inform the physician, who must approve the restraint within two hours. In the absence of this approval, restraint must be ended immediately.

In IMEI, restraint usually involves tying a patient to a bed and administering anti-psychotics. Generally, an order to thus restrain a patient is made by a physician, but a nurse can also prescribe restraint (on the condition that the physician approves this within two hours). It appeared to monitors that the professional restraint guidelines applicable to the institution had not been adopted.

In the list of appendices to house rules issued to those patients subject to involuntary treatment, a guide on the use of personal restraint in healthcare institutions was indicated. Despite our requests, however, we did not receive a copy of this appendix (though other appendices, such as those dealing with fire safety and safety at work, were afforded to us). We are therefore not in a position to judge whether IMEI patients have received satisfactory information regarding restraint regulation.

The decisions relating to personal restraint in healthcare are determined in the Health Act and in the Act on Penal Institutions. Our institution has never needed any rules deviating from these, nor would any other such rules be allowed by law.

In the IMEI, the carrying out and documentation of personal restraint in healthcare is performed precisely as prescribed by the Health Act referred to above. Amongst the other regulations it is even required that we send a copy of the restraint documentation to the public prosecutor who provides legal supervision over us. [...] The guide is not just an appendix to the house rules that we display there as one of a list of the house rules. The handing over of the guide is attested by a signed acknowledgement of receipt, which everyone signs when they receive the guide. The handing over of the house rules is also carried out in writing in a similar way.

Suicide risks

A separate section of IMEI accommodates patients under observation because they have attempted or threatened to commit suicide. In this section, suicide watches are arranged as follows: two convicted prisoners from the Budapest Prison are placed in each ward, and they keep an eye on the IMEI patients to ensure that no acts of self-harm are committed. These prisoners, who are performing “prison work” tasks for payment, do not receive any special training and they have no right to take any direct action; they only have a reporting obligation.

Some of those under suicide watch alleged that the convicted prisoners, using their prerogative, acted as if they were the bosses of patients under observation. At mealtimes, the prisoners sit at the table, and those under suicide watch can only sit down once the prisoners have finished eating.

Although we understand that the use of prisoners to observe patients is due to the lack of available nursing staff, we draw attention to the fact that some people sent to IMEI are on remand. In the case of remand prisoners in particular, the current suicide watch procedure breaches Section 119 of the Act on Penal Institutions, according to which remand prisoners must be separated from convicted prisoners.

The IMEI runs a separate department for those held on remand and convicted prisoners. Within this department in the “observation wards” prisoners are employed to

provide a warning function that complements our technical systems.

The use of the so-called "ward leaders" is, indeed, a measure that we have been forced to take. In order to replace them, we would need to employ at least 20 more staff to undertake this task alone.

We constantly monitor the behaviour of the prisoners, and so this forced measure does not result in these prisoners assuming positions of power. If we notice anything like that, we immediately dismiss them and take immediate disciplinary action against them.

Contact with the outside world

House rules issued to patients provide for visits from children under the age of 14 once a month, subject to prior permission. We believe that the legality of this restriction is questionable. According to Section 84, paragraph (4) of the Act on Penal Institutions, the rights of patients to maintain relationships (including visiting rights) laid down in Section 11 of the Health Act, can only be restricted in accordance with the Act on Penal Institutions. This latter Act, however, contains only the restriction that patients subject to involuntary treatment can receive visitors no more than once per week. The restriction on visits by children under the age of 14 thus cannot be derived from the Act on Penal Institutions.

In connection with the maintenance of contacts, the sections of the laws referred to do lead to the conclusions drawn in the report. However, because of the limited resources available to the IMEI, we could only solve the problem by making visits more infrequent. Namely, at present there is the possibility for monthly visits by children under the age of 14, by using the visiting room of Budapest Prison. In practice, it is not possible for us to use this room more often. We would only be able to arrange more visits by children by using our own visiting room (pavilion). This, however, would be at the expense of visits to those subject to involuntary treatment. We would not be able to ensure weekly visits to those subject to involuntary treatment. In view of the importance of visits by children under the age of 14, these visits are handled under the direction of the psychologist. This, however, cannot currently be solved, given the lack of staff and visiting rooms. Naturally, we agree with the Committee's recommendation, but for this we would need to build new premises and take on extra staff.

Equally problematic house rules concern the regulation of contact with lawyers. These rules elaborate times when referred patients may meet their lawyers (from Monday to Thursday between 9.00am and 3.00pm; and on Fridays between 9.00am and 12.30pm). Amongst the group of referred patients, some may be prisoners held on remand, to whom Section 244 of Decree 6/1996 (VII. 12.) of the Ministry of Justice applies. Section 244 states that verbal communication may take place between those held on remand and their lawyers at any time during the office hours of the institution, and indeed outside these hours as well if the discussion with the lawyer is necessary in order to carry out a procedural action.

Similarly illegal, in our judgment, is the house rule which states that those subject to temporary involuntary treatment and those held on remand can only phone their

lawyers once a week (in addition to the five minutes' of telephone calls which are provided to everyone). According to Section 135, paragraph (3) of the Criminal Proceedings Act, defendants held on remand cannot be restricted in the exercise of their procedural rights. The right to a defence is one of the most important procedural rights, of which the right to contact with a lawyer is an integral part (especially in the case of those deprived involuntarily of their freedom). According to the Criminal Proceedings Act, it must be ensured that the accused can contact his lawyer. An accused person held on remand can only be subjected to restrictions that ensue from the nature of the criminal proceedings or which are necessitated by the arrangements within the custodial institution.

In our view, it thus follows that if someone held on remand wishes to contact his lawyer and if this does not disturb the arrangements within the institution to a disproportionate extent (for example, he does not demand contact with his lawyer several times a day), then he should be provided with the opportunity to do so.

(The institution did not issue us with the rules related to the use of phones by patients, so we are not able to express an opinion about the telephone rules).

Telephone contact with a lawyer can greatly influence the condition of the referred patient. Since I agree with the Committee's recommendation, I have amended the access to telephones and have ensured that daily use of the telephone is made possible.

Grievance Procedures

Several patients reported that their complaints did not reach the appropriate person. The Director and Chief Medical Officer replied to this allegation with the following: "The patients may turn at any time to me or to my deputy, whether this be orally or in writing in a sealed envelope. No one has ever been adversely affected by taking such a step, and I categorically reject the suggestions made in connection with this."

All three sets of house rules issued to us include information about the grievance procedure. According to house rules issued to patients, patients can forward their complaints and comments in letters in sealed envelopes to the Director and Chief Physician by handing the sealed envelope to an instructor who will then pass it on to the Director. However, if the subject of the complaint is that instructor, the patient will not necessarily want the instructor to handle it.

House rules issued to those patients referred by prison officials and to those that have been admitted via the neuro-psychiatric department do not even mention the possibility of making a complaint in a sealed letter; instead, the patient must fill in a request sheet and hand this over personally to the instructor. Here is it even more questionable as to whether the process is appropriate if the complaint happens to concern the instructor.

We therefore believe that it is worth considering whether, as in other penal institutions, IMEI should make it possible for patients and prisoners to place complaints into sealed "Director's" complaint boxes.

In connection with the complaints procedure, we would like to remark that any referred patient or patient has the right to request a hearing with the Director and Chief Physician or his deputy. Given this, it is not easy to understand the conclusion that "in the case of a complaint forwarded by an instructor this process might not be satisfactory if the complaint relates to that same instructor." In this way, it is a flawed approach because the referred patient or the patient in his letter will simply request that the Director and Chief Physician listens to him personally and thus the actual complaint will only become known at the time of the hearing. In practice, those making complaints present their petitions in this way. Naturally, if the seriousness of the complaint merits it, then it will be recorded in writing (as an official report with a description of the events etc. written by the patient himself).

According to the decree of the Minister of Justice [36/2003. (X.3.) IM], if the level of understanding required for management of patients placed in IMEI is permanently absent and the patient does not have a guardian, his or her interests are to be represented by the patients' rights ombudsperson (Section 5, paragraph (5)). The patients' rights ombudsperson, according to the same decree (Section 9, paragraph (1), point (g)), is also a member of the "Adaptive Leave" Committee. It would be useful to specify in a regulation how Sections 30-33 of the 1997 CLIV Act on Heath (the Health Act) can be exercised under the specific circumstances of involuntary treatment. In this instance, it appears desirable, for example, that the patients' rights ombudsperson should, in accordance with the Health Act, be able to call the attention of the director of IMEI to any illegal practices which he or she has noticed, as well as to any other inadequacy.

The comments in respect of the patients' rights ombudsperson are correct in respect of the fact that Decree No. 36/2003 of the Ministry of Justice places extra duties on the ombudsperson, in addition to those laid down in the Health Act. Nevertheless, to our knowledge, the rights and responsibilities of the patients' rights ombudsperson are also regulated by a separate decree by the Ministry of Health, Social and Family Affairs. However, it is unclear as to why different rules should apply to the patients' rights ombudspersons working in in-patient institutions carrying out involuntary treatment, and those ombudspersons working in other in-patient institutions. The right of the ombudsperson that was concretely mentioned is in force in our institution, because of the law.

Other complaints

At the end of the visit, members of the monitoring group related these issues in detail to the management of IMEI. On 22 December 2003, the Director and Chief Physician gave a detailed written response to issues raised. We publish this letter below.

2. Specific issues and general questions raised

(letter of Dr Albert Antal)

Dear Mr. Kőszeg,

In respect to the questions raised during your visit to our institution on 17 and 18 December 2003, I would like to give you the following information:

1. Cs. K. […] convicted prisoner

(According to his account, he had been released.)

I. Sentence of the Szabolcs-Szatmár-Bereg County Court:

Sentence No. […]

7 months in prison

Conditional release authorised on 25 November 2003.

II. Sentence of the Nyíregyháza City Court

Sentence No. […]

6 months in prison

Sentence reduced by 25% for good behaviour. Will be released conditionally on 1 March 2004

Having fulfilled full sentence will be released on 13 April 2004.

(He is currently fulfilling his sentence).

III. Sentence of the Nyíregyháza City Court

[...]

7 months in prison

Sentence reduced by 25% remission for good behaviour. Will be released on 22 September 2004.

Having complete full sentence, will be released on 13 November 2004.

2. T.B. [...] held on remand

[...]

The person with whom he indicated he would like to get contact is his sister-in-law A. B., who lives at […]

According to the telephone information service, there is no landline telephone at the given address. The mobile phone companies are not able to give any information either.

With the inmate, we wrote a request to the Miskolc City Court, the court acting in the case.

In this request, he asked for permission to get into contact with his sister-in-law by letter.

We sent the request with our support to Miskolc on 19 December 2003. Today, T.B. was transferred back to the Borsod-Abaúj-Zemplén County Penal Institution.

We have informed the Penal Institution about the case.

3. A.N. […] held on remand

- would like to send a parcel to his child
- would like to be placed in a non-smoking ward room
- does not know his defence counsel
- is being examined for a duodenal ulcer
- The name of his defence counsel is Dr M. Sz. […] (the prisoner has been informed of this).
- He has a chronic duodenal ulcer which has lasted for several years. We have booked him for an examination.
- On the basis of the attached declaration, the referred patient does not wish to send a package to his child.
- He has been placed in a non-smoking ward.

4. Cs. P. […] patient subject to involuntary treatment (does not know the telephone number of his guardian).

The guardian's name is: L.B. (professional guardian), telephone number: [...]

We have drawn the patient's attention to the fact that he can buy a phone card with his deposited money and in this way he can get in touch with his guardian.

5. NF L. Ny. […] convicted prisoner under treatment (painful joints)

In connection with his complaints, we have recommended further tests. The referring doctor will act in connection with this. Today, the patient was transferred back to the institution from which he had been sent.

6. J. K. […] convicted prisoner under treatment (adjustment of medication). (Is in a ward with a lot of people).

The patient is placed in a 10-bed room where there are currently seven people. He is receiving drug treatment for his medical problems.

7. In the Neuro-psychiatric Department, several patients complained that the injections were painful.

In the presence of the medical director and the departmental director, I personally examined the patients who had received injections. In no case did I find any kind of lesions that would have been the result of an improperly administered injection.

At the same time, I drew the attention of the department's nursing staff to the importance of complying fully with the rules for giving injections.

8. For 18 years, our institution has been monitoring the costs and use of drugs so that we can compare our use of drugs with that of other institutions.

In 2001, we spent 41% less on drugs than similar civilian institutions. Looking back over the last 18 years, this can be said to be the average annual situation.

9. I attach the list of activities, other events and study circles organised by the Psycho-pedagogical Department. As this shows, the patients can choose from amongst a wide range of programmes every week.

10. I attach the Clinical Psychology Department's letter on methodology.

11. The patients can turn to me or to my deputy at any time, either in writing in a sealed envelope, or orally.

No one has ever been adversely affected by taking such a step.

I categorically reject the suggestions made in connection with this.

In the points above, I have responded to the problems which you and your colleagues raised.

We consider that the continuation of your work is also in our interests and we shall fully support this in the future as well.

Budapest, 22 December 2003

Yours sincerely,

Dr Antal Albert PhD

Director and Chief Physician.

3. Dr István Bökönyi's letter

Dear Chairman,

I have received the information regarding the report prepared following your visit to the Juridical and Observational Psychiatric Institute.

In connection to the contents of the report, I would like to make the following comments:

The very respected representatives and experts of the Hungarian Helsinki Committee, together with the delegates of MDAC – presumably guided by the best of intentions – have endeavoured to examine a great many issues in a fairly short period of time in IMEI. It is my conviction that you were only able to study a cross-section of the activities in IMEI. Presumably, this is the reason why only a small proportion of the findings in the report are based on accurate facts. In no way do I wish to dispute your analysis of the situation with regard to the IMEI building and the objective conditions. I, too, am well aware of the building's technical state and the overcrowded conditions, but together with my colleagues, I am making strenuous efforts to change these. This is demonstrated by the high-standard renovation of Department IV, the refurbishment of the showers as well as the continual implementation of improvements, both small and large. The development plan for the prison service covering the period 2003-2008, which was approved in the Government Decision 2147/2002. (V. 10.), specifically includes the provision of modern accommodation in IMEI in 2007-2008. Naturally, putting this into practice depends upon funding from the central government budget.

The comment in your report about the patients' uniforms does not really make sense. The patients placed in IMEI are provided with suitable clothing: firstly, the clothing meets the hospital conditions; secondly, those subject to involuntary treatment are provided with day-time clothing that is suitable for the season and pyjamas for the night time. It is possible that, on occasion, clothing of the right size might not be available, but we make sure that the missing items are supplied as soon as possible.

Those subject to involuntary treatment may not smoke in the wards. Separate smoking areas have been designated for them. In placing other referred patients, taking account of Section 4 of the Ministry of Justice Decree No. 17/1999. (XI. 18.), we provide either smoking or smoke-free wards. Section 5 of the above-mentioned decree lays down certain restrictions on the staff, but as with Section 6, this does not affect the wards.

In connection to bathing, I can inform you that in my circular letter dated 3 September 2002, I ordered that prisoners placed in cells without hot water taps should be able to shower at least twice a week. Those in IMEI subject to involuntary treatment can shower once a day, which is, moreover, a programme of therapeutic value. Other wise referred patients can also shower once a day, although it has undoubtedly happened that on a few occasions, weekend showers were missed because of staffing problems.

It follows from the particular circumstances of IMEI that the services provided to patients living there can only be effective with certain restrictions. This obviously does not provide an excuse for not fulfilling the responsibilities related to the patients' rights, such as keeping patients appropriately informed and providing them with the highest standard of healthcare.

I am convinced that the specialists at IMEI endeavour using all possible means to fulfil their statutory duties and to provide total care for the patients placed there, in spite of the fact that the physical conditions are far from ideal.

The assessment of the therapeutic methods used does not fall within my competence but according to my information, they are being carried out in accordance with professional protocols and their work merits recognition. For decades there has been regular professional supervision carried out by the Ministry of Health and experts designated by the Professional College of Psychiatrists and specialists sent from the National Public Health and Medical Officer Service (ÁNTSZ), and they have declared the professional work carried out in IMEI as an achievement worthy of respect.

The examination carried out by the Chief Public Prosecutor's Office also judged the operation of the IMEI to be legal.

Not just Hungarian experts, but also foreign experts regularly visit the institution within the framework of exchange trips. Experts from the Netherlands have declared their desire to develop a joint psychotherapeutic programme. They have also indicated their intention to take part in the research carried out in IMEI (in connection with suicide and addiction illnesses). Every year IMEI is visited by legal and medical students, candidate psychologists, students from the Police College, social workers, benefactors and staff from civilian psychiatric institutions in groups of 30-35. In the past 5 years, 10 dissertations have been on the subject of involuntary treatment and how it is carried out. The candidates have spent a long time in the institution, which has allowed them to study the given topic in depth.

Your report emphasises shortcomings in the treatment and condemns the educational programmes, yet on the part of the above-mentioned experts and candidates, there has never been a single case in which such concerns have been raised.

IMEI staff take part in graduate and post-graduate training, forensic medical science and forensic psychiatric teaching as well as in practical training, which is carried out at IMEI, as are professional examinations.

At the various Hungarian congresses over the last 5 years, IMEI staff have represented their specialist field, giving 50 presentations, while their scientific work has appeared in more than 50 written articles. Within the framework of a competitive application system, they have won the right to take part in the training of specialist nurses.

It is my view that IMEI provides patients placed there with a wide-ranging socio-therapeutic programme, which exceeds that offered in civilian psychiatric practice and which places emphasis on individualised treatment.

Risk-assessment as a self-standing concept similarly does not make much sense in the context of IMEI. Risk analysis and the measurement of risk can only be done

on an individual basis. The tools for this are personal knowledge of the patient and experience gained in the course of individualised therapy. In view of the fact that experts at IMEI place great emphasis on this, their opinions can in no way be regarded as random, although they can, justifiably, be called empirical. The fact that in twenty years, there have only been two aggressive actions is not surprising, but is rather the result of professional treatment.

Restraint use is determined not by professional guidelines but by legal requirements.

The observation and supervision by convicted prisoners of those who have attempted to commit suicide and those who are at risk of suicide is unquestionably a temporary forced solution. Their duty is limited to the timely reporting of any danger, in order to prevent self-harm. Unfortunately – with the large number of patients requiring treatment – we cannot place a member of staff beside every patient as risk of suicide. Thus, the placing of convicted and remand prisoners together did happen, although only in a few cases. In such cases, we immediately alerted the appropriate prosecutor, who took note of the fact. We are continually looking for a suitable method and procedure to regulate this issue in a more effective way. At present, a committee comprising outstanding experts is carrying out research this area.

The comments made in connection with the visit are, in part, legitimate. It is true that children under the age of 14 can visit only once a month. This is because the IMEI building does not have the necessary facilities. These visits must therefore take place in the designated area of the Budapest Prison and the prison cannot offer any more time slots. We are examining the possibility of bringing this form of contact into line with the legal regulations and looking at how this might be achieved.

The timing of meetings with lawyers is guided by the IMEI's office and hospital arrangements, with particular attention being paid to organised healthcare and other programmes.

IMEI is obliged to facilitate telephone calls with lawyers, depending on the practicalities. This is only supplementary to the weekly contact with the lawyer, since the patient can correspond and talk personally to his/her lawyer. I accept your recommendation regarding a director's complaint box and I have already ordered its introduction.

In conclusion, I would request that before publishing the report, you and your colleagues kindly weigh the situation, the recognised work and responsibilities of the management and the specialists at IMEI, as well as the process which, as part of the ongoing healthcare reforms, will, hopefully, create better conditions at IMEI.

Budapest, 9 August 2004

Yours sincerely,

Major-General Dr István Bökönyi