

## Psychiatric care/ Psychiatry and Patients Rights

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## Preface

In January 2002, The Hungarian Civil Liberties Union published a collection of studies on the legal rules which define patients rights on the one hand, and on their actual observance in practice on the other.<sup>1</sup> We tried to explore the extent to which efforts to make the individual's right to autonomy recognized in health care decisions are successful, whether the law protects the free choice of patients and whether the institutions designed to promote these aims succeed in translating them into reality.

The volume before the Reader is a document of continued inquiry along these lines. This time, the focus is on the legal devices incorporated in legal provisions on patients rights and the practice to which they have given rise. The discriminatory attitude to people with mental illness which is rooted in past practices and is maintained by prejudice requires even stronger efforts to secure patients rights fully.

Central to our inquiry is the question whether the legislator and the institutions which offer psychiatric treatment have themselves made the necessary efforts: whether they have created guarantees to keep the practice of psychiatric treatment within the bounds of the human dignity of patients and of the principle of treating persons as equals.

As psychiatric treatment and care are carried out not only in hospitals but also in social institutions, we paid attention to including in the discussion references to the practice carried on at these establishments. We also offer an account of the principles which underlie the functioning and actual practice of an institution at which patients are always treated on the basis of a court decision.

Budapest, April 2002

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<sup>1</sup> Patients rights – Rules and Practice, ed. Orsolya Heuer, published by HCLU, January, 2002.

## Psychiatric Treatment and Patients Rights

The rights of citizens in medical treatment are enacted in law in Hungary, a country which ratified the Council of Europe's Convention on Human Rights and Biomedicine (the Bioethical Convention).<sup>2</sup> These legal documents are major landmarks in the recognition of the individual's right to autonomy in health care settings. In what follows I will be focusing on rules which apply to psychiatric treatment in hospitals and the major amendments these rules have recently undergone.

Following the transition to democracy in 1989 the rules on the medical treatment of psychiatric patients were amended in 1994,<sup>3</sup> while the acceptance of comprehensive guarantees for patients rights came with the promulgation of the Health Care Act of 1997.<sup>4</sup> That the provisions on psychiatric patients were among the first to be revised is a circumstance explained by the fact of the ratification and promulgation of the European Convention on Human Rights in this country.<sup>5</sup> A number of important parts of the Hungarian legal regulations had to be brought into conformity with international human rights principles. Somewhat belated in international comparison, the changes which were then made affected the system of psychiatric provision, too. They gave narrower definition to the legal conditions of involuntary treatment and to its procedural guarantees.

Drafted in 1997, the new Health Care Act recorded not only the system of psychiatric services and the legal rules of the admission to it but also all patients rights related to health care provision in general. As far as the drawing up of a catalogue of patients rights is concerned, the Health Care Act followed the Amsterdam Declaration<sup>6</sup> of WHO, so we are now in a position to claim that the rights and entitlements listed in the Hungarian Act are in harmony with international standards. The Act includes a separate chapter dealing with rules which relate specifically to psychiatric treatment and the ways in which psychiatric treatment may be initiated.

### Forms of Psychiatric Treatment - Admission to the Hospital Ward

Psychiatric treatment at a hospital may begin in two basically different ways: it is either requested by the patient himself, or the patient is forced to undergo it against his/her wish. Involuntary psychiatric treatment is recognized as a possibility in most countries, but it is a measure whose application is made conditional upon a set of definite requirements and strict procedural guarantees. Involuntary treatment may be justified by the fact that the patient poses a danger either to him/herself in which case treatment is initiated in the patient's own interest, or the danger affects others, in which case treatment is initiated in order to protect society.

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<sup>2</sup> Convention of the Council of Europe on the Protection of the Rights and Dignity of the Human Being as regards the Application of Biology and Medicine signed on April 4, 1997 in Oviedo.

<sup>3</sup> Act LXXXVII/1994 on the modification of Act II/1972 on Health Care..

<sup>4</sup> Act CLIV/1997 on Health Care

<sup>5</sup> Convention on Human Rights and Fundamental Liberties, promulgated by Act XXXI/1993. (Henceforward "Convention".)

<sup>6</sup> WHO Amsterdam Declaration issued by WHO for the Promotion of Patients rights, 1994.

Let us first take a closer look at voluntary admission. The earlier Health Care Act, adopted in 1972,<sup>7</sup> determined only that anyone could request admission to a psychiatric ward and that the leading physician of the mental ward was competent to decide on the necessity of admission. Other details were being left unregulated. The 1994 amendment laid down further conditions: in addition to the patient's voluntary and autonomous decision it required that there should actually be a psychiatric illness and that treatment should be necessary. Decision about commitment to treatment remained with the head of the establishment, but a new rule was introduced stipulating that the necessity of treatment should be reviewed in 30 days by a court (the deadline is in some cases the 60th day).

When the 1997 new Health Care Bill was discussed, a heated debate arose about the question whether voluntary hospitalization should be reviewed by a court. Legislators insisted that court control over the reasons for, and the voluntariness of, requests was necessary to exclude the possibility of abuses. It seemed a justifiable precaution that approval by an independent body – a court – should be included in the arrangement to safeguard the condition of voluntariness. The psychiatric profession argued that submitting a voluntary patient to judicial control amounted to unjustified interference with the free choice by a competent person and therefore to an infringement of his personal rights. Legislators finally made a concession on this point, retaining the idea of necessary judicial control over voluntary treatment as a presumption, while at the same time reaffirming the right to autonomy of those applying for treatment in entitling them to protest against judicial review.

These rules apply to people who are in full possession of their decision making capacity and request admission to a hospital ward of their own accord. What about those whose competence is reduced to some extent? A request for admission to a health care facility may be made by their legal representative or, in the absence of one, some close relative. In such cases a court reviews, *ex officio*, the validity of consent and the question of the necessity of treatment.

We have mentioned the possibility that psychiatric patients may be committed to hospital treatment against their will. Under the 1972 Act anyone could be committed to treatment with reference to "mental illness" or on suspicion of mental illness based on the physician's opinion, if this was endorsed by the decision of the leading physician of the mental department. The idea of a conditional acceptance of psychiatric patients being forced to undergo treatment – if e.g. as a result of their mental illness they pose a danger to themselves or others – can be found in international documents. As in these cases they are subjected to a procedure which restricts their liberty, they have to enjoy certain basic

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<sup>7</sup> The head of the establishment notified the court at the time of the patient's admission. The notification was justified by the consideration that the court should be given some time to prepare for court review in case the treatment lasted as long as 30 or 60 days. (Cf. Dr. Éva Koczka, "A kóros elmeállapotú személyek pszichiátriai fekvőbeteg-intézeti kezelése elrendelésének és felülvizsgálatának szabályairól" (On the Regulation of the Hospitalization and Re-Examination of Mentally Disturbed Persons in Psychiatric In-Patient Establishments ), in: Medical Protection Hungary, 96/1: pp.14-16.

guarantees spelled out by the European Convention on Human Rights (henceforward "Convention"). "No one shall be deprived of his liberty save in the following cases (defined in 1/a-f of Article 5) and in accordance with a procedure prescribed by the law."<sup>8</sup> The Convention also states that the person deprived of his liberty should be speedily brought before a judge or some other official entrusted by law with judicial powers.<sup>9</sup> Legislation in force in Hungary until 1994 did not live up to these requirements. The beginning of hospital treatment was made conditional simply on the decision of the hospital's leading physician. It took several weeks for the judge to even get into contact with the patient and to check the legality of proceedings up to that time.

The 1994 amendment aimed at securing that a person can only be kept at a psychiatry ward against his will if an independent and impartial body – a court – has made a decision to that effect. A solution was found also to deal with cases in which a patient needs to be rushed to hospital without a prior judicial decision if his condition brooks no delay. This is called the emergency procedure.

In other words, a person could be committed to a psychiatric ward on account of his/her mental condition against his/her will only in case of immediate danger to himself or others, and if the danger could only be averted through immediate psychiatric treatment. Someone's mental state could only be judged by a physician and only a physician could initiate commitment. Under the rules accepted in 1994, the court had to be notified within 24 hours after the patient was taken to hospital. The court then was to decide within 8 days about the justifiability and legality of the involuntary hospitalization. Following this the court examined on every thirtieth day (every sixtieth in rehabilitation establishments) the necessity of continued treatment. An important guarantee was introduced by the rule that the court has to procure the opinion of a forensic psychiatric expert who is not taking part in the treatment. The idea that, if the specialist is to be independent, it is reasonable to require that he should not be someone who works at the same establishment as the physician treating the patient, or a senior physician at the institution, was raised in a critical analysis of mental health arrangements at the time.<sup>10</sup> The patient and his legal or authorized representative have to be given a personal hearing in the course of court proceedings. If the patient has no legal representative, the court appoints one for him.

In 1997 the legislator retained the previous rules relating to the emergency admittance and built new procedural rules as well as additional guarantees into the new Health Care Act. The judicial decision following emergency hospitalization has since had to be made not within 8 but 3 days, i.e. 72 hours, after the admittance to the hospital. In this way, speedy judicial decisions are made and abuses and unjustified hospitalizations are more quickly recognized. The new Health Care Act makes it possible also for the patients rights advocate to be authorized by the patient to represent him in the course of the judicial review procedure. At the same time, the rule that, if not represented, the patient will have a guardian *ad litem* appointed by the court for him, remained in force. In the interest of an effective representation procedure both the patients rights advocate and the

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<sup>8</sup> Convention, Article 5, Section (1).

<sup>9</sup> Convention, Article 5, Section (4).

<sup>10</sup> Cf. the paper by Dr Éva Koczka, see fn 7.

legal representative have to see the person they represent, to learn about the circumstances of commitment and to inform the patient about his/her rights in the course of the procedure. Information acquired from patients rights advocates reveals that they are not contacted with such requests despite the fact that their involvement in the proceedings might secure effective representation for those concerned.

The Methodological Circular issued by the Professional College of Psychiatrists<sup>11</sup> imposes a duty on the physician who perceives the emergency and requests commitment to record the commitment procedure. In conformity with the professional rule attached to the legal instrument, the physician not only has to issue a statement whether the endangering condition obtains but also has to describe the symptoms. This makes it possible for the court to judge in retrospect whether the involuntary hospitalization was really justified.

When the endangering condition does not require immediate steps, there is no good reason to make arrangements for taking the patient to hospital prior to a court decision. There has been a legal rule in Hungary since 1994 which provides that when there is no immediate necessity, those in need of psychiatric treatment should be taken to hospital on the basis of a court decision (compulsory treatment). In these cases it is a specialist physician of the psychiatric care establishment who initiates court proceedings. The judge then decides within 15 days whether to initiate compulsory treatment in an establishment.

Professionals – and this fact is discussed by the new Methodological Circular<sup>12</sup> – rarely take recourse to this procedure. The Circular only devotes a few lines to the existence of this type of procedure. The authors of the first Methodological Circular strongly support the idea that psychiatrists should opt for emergency commitment rather than the ordinary commitment procedure, because "it serves the patient's interests better". Psychiatrists who have been asked personally<sup>13</sup> have all referred to the dangers involved in a dragging on of the procedure.

Civil commitment based on a previous juridical decision is no doubt a lengthy procedure, but, on the other hand, this makes room for a more thorough examination prior to admission to the hospital. This offers a solution to cases in which the deteriorating state of the patient does not yet make immediate delivery to hospital an inevitable necessity, but treatment must begin to prevent the possibility of a severe and perhaps irreversible deterioration in his mental state. The procedure itself incorporates a great many more guarantees: the person concerned can tell his/her opinion in a more friendly "civil environment" before the court as opposed to a hospital, s/he has the chance to inform the decision makers about his/her circumstances and reasons for rejecting hospital treatment.

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<sup>11</sup> New Methodological Circular relating to Act CLIV/1997 on Health Care and its modification. In: *Psychiatria Hungarica* 2001, 16(4), pp.467-472.

<sup>12</sup> See previous note.

<sup>13</sup> Patients rights in Hungary – Rules and Practice, ed. Orsolya Heuer, published by HCLU, January 2002.

To make this type of judicial procedure an option actually taken by psychiatrists, it would be necessary to issue appropriate professional-methodological directives as well as to provide training both for physicians and for courts.

HCLU's experiences concerning involuntarily hospitalized persons warrant the claim that they are not given effective representation in the course of the procedure and are rarely aware of the legal opportunities that are open to them.

The law requires physicians to give patients full information during admission, inform them about their rights, the court procedure and its gist and the rights they enjoy in its course. It provides that information should not only be given orally but also in written form during the commitment procedure.<sup>14</sup> The psychiatric profession has not so far given any assistance to hospitals in compiling information brochures of this kind. It would be important to publish guidelines for hospital staff which would direct them clearly and identify the kinds of information they are supposed to give people in the course of admission and to make them available in written form so that the staff can study its content at any time later if, and when, the need arises.

#### On Treatment Decisions

The legal enactment of patients rights in 1997 was a major step forward. Although the old Health Care Act spoke of a duty incumbent on the physician to inform the patient and the desirability of obtaining the latter's consent, the content and extent of these desiderata were not appropriately spelt out and there were no legal means of enforcement.<sup>15</sup>

The patients rights enumerated in Chapter II of the new Health Care Act derive from the right to self-determination and to human dignity of persons who find themselves in a helpless state and therefore depending on the benevolence of others. Psychiatric patients must enjoy equal protection of the law with regard to such rights. General patients rights are to be respected during any kind of treatment, and psychiatric treatment is no exception. The legislator also introduced a few exceptions to allow for cases where deviation from the rule is permissible. Any patients right except the right to have access to medical files, may be limited when the patient is found to be in an endangering state, but only as long as necessary and to the extent justified by necessity. The Act lays emphasis on the rule that the human dignity of patients must not be violated even if they are in an endangering condition.

The right to medical treatment and to a highest possible degree of provision requires that modern forms of psychiatric services other than treatment in a hospital should be available to citizens. The latter continues to be the dominant form of provision.<sup>16</sup> The

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<sup>14</sup> Section (2) Article 191, Act CLIV/1997.

<sup>15</sup> Section (1) Article 45, Act II/1972 on Health Care: "The physician shall inform the patient he is treating...about the disease and the patient's state in an appropriate manner."

<sup>16</sup> The Health Care Act itself implies an attitude to treatment which clearly envisages treatment provided for psychiatric patients at a hospital to the exclusion of the special features of other forms of provision.



system of community psychiatry needs to be developed significantly so that patients in need of treatment will have a chance to recover in their own locality and to choose the form of service which best suits their needs.

The Health Care Act requires that psychiatric treatment should, whenever possible, be carried out in the patient's family or living environment and in the least restrictive ways possible. The activity of self-help organizations is also to be supported. A legally enacted duty not backed by a sanction has proved too feeble to effect institutional change: the 1999 amendment of the Act on Social Services made it obligatory for all municipal governments of localities with a population of over 20 thousand to establish day care centers for psychiatric patients, without assigning the additional funds necessary.<sup>17</sup> The time that have passed since the introduction of this piece of legislation has seen the emergence of only two such establishments in all Hungary. Several professional studies have been devoted to the necessity of transforming psychiatry.<sup>18</sup> The state has to secure both the legal environment and the necessary funds for the implementation of these necessary changes.<sup>19</sup>

The right to self-determination is described in the catalogue of patients rights as embracing the right to full information and informed consent. These rights may be temporarily limited during treatment. Information to be given immediately after commitment to an establishment may be legitimately omitted with psychiatric patients in an endangering condition while the condition lasts, but an attempt, at the very least, must be made to inform them immediately, and they are to be informed as soon as the endangering condition is over. Information must be given as fully as possible independently of the patient's competence. The physician must take into consideration the patient's level of education and age as well as his/her psychological state. Several studies have pointed out that the chances of recovery are better if the patient takes part in the process as a partner in possession of relevant information. According to a survey on psychiatric outpatients,<sup>20</sup> extensive information about side effects and about the therapeutic procedure have a direct effect on the patients' sense of contentment, which also gives nursing staff better chances to influence their recovery positively. The article based on the survey emphasizes and supports the importance of the training of therapists.

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<sup>17</sup> Act III/1993 On Social Services, Articles 75 and 87.

<sup>18</sup> "Reflektorfényben a honi pszichiátria" (A Highlight of Our Psychiatry), in: *Psychiatria Hungarica* 1997, 12(1), pp.45-50. "Röpirat a magyar pszichiátriáról" (A Pamphlet on Hungarian Psychiatry), in: *Psychiatria Hungarica* 1997, 12(1), pp.75-87. "Gondolatok a közösségi pszichiátriai ellátás fejlesztéséről (Reflections on Ways of Developing Community Psychiatry), in: *Psychiatria Hungarica* 1997, 12(5), pp.643-653. "A Pszichiátriai Szakmai Kollégium ad hoc bizottságának állásfoglalása a hazai pszichiátriai ellátás helyzetéről" (A Platform on the State of Hungarian Psychiatric Provision issued by the ad hoc Committee of the Professional College of Psychiatrists), in: *Psychiatria Hungarica* 1999, 14(2), pp. 218-224.

<sup>19</sup> According to a Professional College Platform issued in 2000 the drift toward more costly hospital care as opposed to out-patient treatment is a result of the financing scheme (under which an average in-patient in the psychiatry ward brings as much money as 75 patients taken care of on an out-patient basis). Cf. "A pszichiátriai járóbeteg ellátás helyzete és távlatai" (The State and the Prospects of Psychiatric Out-Patient Treatment), in: *Psychiatria Hungarica*, 2000, 15(6), pp. 713-716.

<sup>20</sup> Barak, Szor, Kimbi, Mester, Elizur: "Survey of patient satisfaction in adult psychiatric outpatient clinics", in: *European Psychiatry* 2001, 16:pp. 131-3.

The new Health Care Act makes the presumption that treatment and medical interventions may only be started upon the patient's consent. How does the right to consent actually fare during treatment? In voluntary treatment, the right to informed consent is conferred only on fully competent persons under Hungarian law. Incompetent persons are not entitled to decide in questions of treatment themselves, nor are those whose competence the court has deemed to be reduced. Since the amendment of the Civil Code in November 2001, courts have been empowered to declare a person to be of reduced competence only in specific decision making areas rather than in a general manner. If a person's right to self-determination is not limited by the court, s/he is free to give, or refrain from giving, consent to treatment, even if s/he is limited in his/her decisions concerning other matters such as finances.

If a person has been legally deprived of his/her right to make decisions, someone else will have to make the decisions for him/her. The first person to be asked to consent will be the one whom the patient appointed while s/he was still in possession of his/her full competence. It is this person who is most likely to capture the patient's choice and attitudes to his/her own life. The surrogate decision maker can be expected to rely on the patient's statements made while competent when giving consent. As a result of a most recent amendment to the Health Care Act, young people above 16 are now also allowed to make a statement in which they identify their chosen surrogate decision maker. If there is no surrogate decision maker appointed, their legal representative or a close relative is entitled to decide about interventions during treatment. It must be noted that under the law as it is at present surrogate decision makers are entitled to make decision only in cases of invasive interventions<sup>21</sup>. Thus e.g. medication may be administered by physicians to incompetent persons without consent.<sup>22</sup>

Of course, the recognition of the right to informed consent includes the possibility that it is up to the patients to determine what shall happen to their own bodies and lives, and so they must be free to choose between accepting or rejecting certain forms of treatment. Depending on the importance and consequences of the intervention, competent patients may deny consent, they may even issue a public statement, i.e. an advance directive for the future in case they become incompetent. On the basis of the legal rules competent psychiatric patients may also issue an advance directive which lays down certain procedures to be followed in case their state deteriorates.<sup>23</sup>

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<sup>21</sup> Act CLIV/1997 on Health Care, Article 3/m: "physical intervention which invades the patient's body through the skin, the mucuous membrane, or some orifice, excluding interventions which involve risks of negligible proportion to the patient."ing

<sup>22</sup> Act CLIV/1997 on Health Care, Article 16, Section (4).

<sup>23</sup> Complying with advance directives may occasion serious difficulty. When e.g. the patient knows that if his condition were to get worse, he would reject some effective medication or treatment and he therefore asks for its application in advance. When the worse condition sets in, he will completely reject the treatment in question. If the physician deems his patient to be competent at that time, he will have to accept his refusal to be treated (unless there is some over-riding consideration, e.g. a life hazard) etc.); alternatively, he may deem his patient to be incompetent, and then he will have to follow the advance directive and apply the effective treatment.

The importance of the principle of informed consent in medical research could hardly be overestimated as what we have there is new techniques which are just being introduced and which, therefore, involve a considerably higher degree of risk than established medical treatments. The new Health Care Act determines strict standards for medical experiments. The patient has to give consent to participation in the project in written form after full information both in speaking and writing. With incompetent patients or patients with reduced competence, the conditions are more severe. It is provided e.g. that the results to be expected from the research should directly serve the health of the subject of the research. At the same time, all that is required is the consent given by the patient's legal representative, next of kin or appointed surrogate decision maker. Hungarian law does not require that the patient's consent to involvement in the research should be acquired even if s/he is not fully competent.

In accordance with a ministerial decree the protection of the health and the personality rights of patients taking part in research<sup>24</sup> are to be secured. It is mandatory to appoint a physician who is not involved in the research as a participant to supervise these interests. This independent physician keeps regular contact with those participating in the research project, continuously provides information, examines complaints, but consent from the patient is not to be asked by him. Although this is a very advanced guarantee for the protection of the patient's rights, experiences of the Mental Health Interest Forum reveal that the name of the supervising physician is often not given to the patient, and the relevant rubric in the documentary sheet remains empty.<sup>25</sup> Involuntary psychiatric patients often come to depend on their physician greatly and thus it will hinge on the physician's decision how long the treatment will last and how far the patient's rights will be invaded.

A psychiatrist has recently discussed the importance of unbiased information for those participating in research. At an interest group forum János Füredi, a professor of psychiatry reported<sup>26</sup> that as head physician of a ward he requires that the independent physician not involved in the project should give the information and ask for the patient's consent. This expectation is in harmony with the international principles of medical research and it would be a great achievement to codify it in a legal instrument. In fact, Article 23 of the Helsinki Declaration makes exactly that demand. It provides that if the patient participating in the project is dependent on his physician who is heading the project, informed consent must be asked by a physician who is completely independent of the experiment.<sup>27</sup>

In order for a patient to be able to decide whether he wants to submit to further treatment it may be important for him to have access to his health care records. The Health Care Act stipulates the presumption that a patient has the right to access to his health care

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<sup>24</sup> Health Care Ministry Decree 11/1987 (VIII:19) on medical biological research, Articles 3 and 9.

<sup>25</sup> A spoken comment made at the "Taboo Afternoon" meeting organized by the Mental Health Interest Forum on February 11, 2002.

<sup>26</sup> Delivered at the event of the Mental Health Interest Forum mentioned in the previous note.

<sup>27</sup> Helsinki Declaration, Recommendations for Physicians Conduction Medical Biological Research on Humans, World Medical Association.

records, to inspect them and to have copies made of them. The Act introduces an exception with mental patients, making it possible for the physician in charge of treatment to withhold from the patient some of the data recorded during psychiatric treatment. This may be done for two reasons: either when getting to know certain details of the record is likely to jeopardize the patient's recovery, or when disclosure would violate the personality rights of a third person. A refusal to grant inspection must be recorded in writing and the patients rights advocate or the patient's legal representative must be notified.

The Professional College of Clinical Psychologists has issued a Statement<sup>28</sup> on the interpretation of the legal rule. This Statement has been most influential in helping psychologists to apply the provisions in practice and to decide debatable cases. In a comment on the interpretation of the Act, the Statement affirms that the Act, rather than giving the physician in charge of treatment full discretion to restrict access if his patient has some mental affliction, provides that cases must be decided on an individual basis. A detailed argument must be given to explain why exposure to the data is likely to endanger the patient's recovery. Nevertheless, the professional body of psychiatrists failed to elaborate methodological rules for psychiatrists in this area.

We would like to cite an example from the legal counseling hotline run by HCLU to illustrate the importance of the role professional guidance could play in stopping the practice that psychiatric patients are denied access to their medical files without any justification. A person turned to us asking for help in getting copies of the records of psychiatric treatment which he had undergone ten years earlier. The request for data was first rejected by the head of the psychiatric department, then by the director of the hospital. The first rejection was justified with reference to our client's psychiatric illness, in the second case the likely deterioration of his condition was given as a reason. Both justifications were against the law. The mere fact of psychiatric illness could not have been legitimately given as a reason to justify rejection. In addition, the applicant had not been seen or examined by the psychiatrists for ten years so they were not in a position to know even whether he was still suffering from a mental illness. How could they have possibly told without an examination that exposure to his health care data was likely to lead to a deterioration of his condition? We had to take the matter to court to help our client to get access to his data. The court ruled that the response of the hospital was against the law and ordered the hospital to make the data available to the former patient.

Let us conclude our discussion by trying to identify the means which the Health Care Act confers on psychiatric patients for enforcing their rights. Under the Health Care Act patients may seek assistance with ethical committees, in case of a conflict with the hospital may ask mediation, or place a complaint, to which the head of the establishment or of the maintaining institution is under a duty to reply in writing within 10 days. Patients may also seek help with the patients rights advocate whose very task implies special attention to be paid to the protection of the interests and rights of those who are in

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<sup>28</sup> "Statement of the Professional College of Clinical Psychologists on possible ways of restricting access to medical files (including records of psychological examinations)", in: *Psychiatria Hungarica*, 1998, 13 (6), pp. 735-736.

a vulnerable position. The Health Care Act supported this aim when it introduced the rule under which the patients rights advocate must be notified of any use of coercive measures and any restriction on access to health care data, and under which he is also entitled to represent the patient in civil commitment court proceedings. However, at the same time, the conditions under which the restrictions could be effectively checked, have not been created. First of all, during a survey we conducted in psychiatric departments, we found that despite the legal instrument and the prescription contained in the new Methodological Circular neither physicians nor patients rights advocates knew of the existence of this rule.<sup>29</sup> Secondly, and perhaps more importantly, even if the obligation to notify is observed, patients rights advocates are not normally in a position to initiate an inquiry instantly since they are present in the hospital only one day a week.

To sum up: The rights of psychiatric patients are enacted in effective legal instruments and their enforcement is aided by judicial procedure. Important and indispensable as the involvement of the court may be as a guarantee in decisions as regard commitment to treatment in an establishment, the actual practice shows that procedures are observed in a formal fashion and are thus capable of preventing only the gravest of infringements of rights. The efficacy of legal rules is undermined by the fact that patients do not get the information they need about the legal prescriptions which apply to them. Institutions which are designed to watch over the efficacy of patients rights lag behind in professional training, are poorly subsidized and, as a result, work in a formal fashion. While problems are rampant in psychiatric homes and thus the discussion about changing the circumstances goes on before the general public, infringements of rights in health care settings are not analyzed before the public and debates are carried through within the narrower confines of professional circles.

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<sup>29</sup> Patients rights in Hungary – Rules and Practice, ed. Orsolya Heuaer, published by HCLU, January 2002.

## On Conditions in Social Care Homes

Caring for psychiatric patients is an activity which is in need of transparent regulation both in the area of health care and in the sphere of social services. The social care given to psychiatric patients raises issues which are just as sensitive as any that one can identify in the provision these patients receive in health care.

A number of incidents publicized over the past few years and decades have drawn public attention to violations of rights in psychiatric homes. A number of investigations have been launched to find out about these cases and each has revealed serious problems and shortcomings. In her assessment of the situation in psychiatric homes, the Parliamentary Commissioner for Human Rights speaks of serious infringements of the right to liberty and personal safety in psychiatric homes. During a visit in 1999, the Committee for the Prevention of Torture<sup>30</sup> reached the same conclusion. The Rosenthal report<sup>31</sup>, which was very influential in the psychiatric profession, spoke very critically of the predominance of large establishments and the lack of communal forms of psychiatric care.

Both health care and social care institutions have their role to play in caring for psychiatric patients. In what follows we wish to explore the normative environment in which social care homes actually attend to this task today. Before coming to that part of our task, however, we would like to give a brief overview of the development of social care homes in Hungary.

### The History of Psychiatry in Hungary

In his book *Madness, Therapy and Stigma*, Péter Bakonyi<sup>32</sup> gives a detailed account of the emergence of the psychiatric profession and of the formation of social care homes in Hungary. Our summary is based on the facts collected in his book.

Until the end of the 18<sup>th</sup> century psychiatric patients received no care or treatment. There were no psychiatric hospitals, no psychiatric training, no specialists and no professional literature. Patients who had been cast out by their families used to hit the road, roam the country, drifting from village to village. Some of these people were lucky enough to be adopted by monasteries and various denominational establishments. Well-to-do families would place mentally disabled family members who had become a nuisance to them, in mental asylums abroad.

The first revolutionary transformation in psychiatry took place in the mid-19<sup>th</sup> century. It began with the formation of private institutions but soon the Governor would sanction the formation of state-run institutions as well. An increasing number of hospitals undertook

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<sup>30</sup> A committee founded by the International Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. Promulgated by Act III./1995.

<sup>31</sup> Mental Disability Rights International: Human Rights and Mental Health Care, Hungary) MDRI, Washington (1997).

<sup>32</sup> Péter Bakonyi, *Téboly, Terápia, Stigma (Madness, Therapy and Stigma)*, Szépirodalmi könyvkiadó, Budapest 1982.

to establish mental departments. From then on, people with mental disturbances were absorbed by these establishments as well as hospital wards.

From the early 20<sup>th</sup> century on a network of adopting families was established for psychiatric patients who did not need to be treated in hospitals (e.g. in Dicsőszentmárton, Balassagyarmat, Sátoraljaújhely, Baja and other places). Under this arrangement, adopting families cared for these people and provided them with activities. The placement of patients with families was organized by the physicians of the neurology and mental departments of hospitals.<sup>33</sup> “More than a quarter registered patients were kept in family care rather than in closed hospital departments” in 1930.<sup>34</sup> This arrangement was a more humane and more advantageous form of care than confinement in a closed institution or hospital ward. Families were encouraged to volunteer for this form of care by the financial support the government offered to them, and by the help these patients could give with small chores around the house.

The care given to these patients and their living conditions were periodically reviewed by a physician who visited the patient regularly. The ministry set and watched over standards which the living conditions of patients had to meet. To take an example, patients had to be accommodated in a room with a boarded floor. Physicians visiting patients were instrumental in spreading basic hygienic information, encouraging families to adopt habits such as using toothbrushes, clinical thermometers and building privies.

After World War II this institution of family care was completely dismantled, to be replaced by occupational therapy establishments and social homes for the mentally ill, mostly housed in what used to be country manors, mansions or barracks. These buildings were not appropriately converted or re-built for their new purpose. Such homes were established near country borders (in places such as Tompa, Zalaapáti, Búcsúszentlászló, Szentgotthárd). This fact was an additional hindrance to the socialization and integration of patients, who were placed in localities situated far away from their original place of abode (e.g. patients from Budapest were placed in the Szentgotthárd establishment, hundreds of kilometers from the Capital).

There were even several establishments which could not be reached by public transportation. This made leaving and visiting the facility extremely difficult. As years went by the number of state-run psychiatric homes increased while homes run by churches and denominations were dispersed.

There were forty mental social care homes in the country in 1980. Decision about the placement of patients was in the competence of local government officials instead of medical specialists. Patients already placed in homes were, as a rule, left without professional supervision for years on end and often even without skilled treatment. Medical tasks were attended to by the local district physician visiting the institution for

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<sup>33</sup> István Kappéter, “A pszichiátriai szociális otthonok meghatározóiról és jövőjükéről” (The Defining characteristics of Psychiatric Social Homes and Their Future) , *Psychiatria Hungarica*, 1994, IX. No.3., p.291.

<sup>34</sup> Bakonyi, op.cit. p.461.

one or two hours a week. One of the inmates in the Szentgotthárd psychiatric home had lived in the facility for twelve years before she was given a professional re-examination, which revealed that there was no reason to keep her in a psychiatric institute since she was not mentally ill.<sup>35</sup>

### Was the Functioning of these Social Care Homes Appropriately Regulated?

As the above example shows the rules relating to social care homes for the mentally ill included no effective guarantees against abuses, not even, as we have seen, against the possibility that someone could be committed to such an establishment for his whole life. Procedures which involved limitations of the basic rights of those concerned were regulated by decrees which included no standards on placement or the professional work done for which anyone could have been held accountable.

The introduction of new norms, forms of provision and methods in harmony with the principles of modern psychiatry was a step necessitated not only by the need for protection for basic rights but also by the inherent development of the profession itself. The new Act on Social Services was drafted to meet this challenge. Health care regulation was in a more advanced state in this area than social care regulation. Hospital treatment for psychiatric patients had been legally regulated as early as 1972<sup>36</sup>, but it was not until twenty years later that social care underwent similar legislative redefinition.

Enacted in 1993, the Act on Social Services<sup>37</sup> gave a unified formulation to norms relating to social homes and to other rules which regulate services offered as part of financial and personal care. The social sphere finally came under the scope of laws rather than being regulated merely by decrees. The promulgation of the Act restored to practical efficacy the constitutional principle that rules affecting fundamental rights and obligations are to have the status of laws<sup>38</sup>.

The Act on Social Services states that psychiatric homes should care for persons who do not need substantial psychiatric treatment, are not in a condition which poses danger to others, cannot be rehabilitated and are not capable of carrying on an independent life, and need permanent institutional inpatient care<sup>39</sup>. At the same time, no major progress was made in the creation of procedural guarantees against the kinds of abuse which are often found in the placement procedure.

### What Changes Did the Act on Social Services Bring in the Social Care Given to Psychiatric Patients?

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<sup>35</sup> Péter Hajnóczy, "Az elkülönítő" (Seclusion), *Valóság* 1975/10, p.88.

<sup>36</sup> Act II/1972 on Health Care, in effect until June 30, 1998.

<sup>37</sup> Act III/1993 on Social Services

<sup>38</sup> Parliament shall determine the fundamental rights and duties of citizens, their conditions and limits and the procedural rules for their enforcement. © Article 2, Act XI/1987 on Legislation.

<sup>39</sup> Act on Social Services Article 71. Effective until December 31, 2001.



Regrettably enough, relevant data point to the conclusion that the structure of social care provided for psychiatric patients has remained virtually unchanged in the past eight years since the introduction of the Act. Placement in long-term care homes remains the general rule as opposed to forms of communal care which is capable of promoting the integration of patients. Statistics relating to the year 2000 show that there were over 8000 people cared for on a long-term basis in in-patient homes in that year<sup>40</sup>. The number of people cared for is essentially the same as it was in 1993. Mental patients had to do without basic forms of care such as the provision of meals, family supporting services and assistance given in the home. Patients in need of help had no other choice than to apply for a place in a social care home. This resulted in a number of people having to go to live in a social care home who could have went on conducting their own lives with a little personal assistance. According to the data available for the year 2000 there were 61 long-term care psychiatric homes in the country.<sup>41</sup> 75 % of the patients committed to social institutions were living in crowded homes housing more than 1100 persons. An average of 139 persons were placed in one establishment, but there were (and still are) homes which house 4-500 persons. The home in Szentgotthárd is an extreme case with its 720 patients at the time of data collection.<sup>42</sup>

Efforts to phase out long-term placement in in-patient establishments as a dominant form of care have been reflected in amendments to the Act on Social Services. It was as a result of one of these amendments that the new institution of provisional homes was introduced. It was designed to provide provisional accommodation to patients leaving hospital until they become able to lead an independent existence. Launched in 1998, the first home of this kind<sup>43</sup> was not only the first but also the only one in the county until the end of 2000.<sup>44</sup> The only change during the three years since its inception is the decrease in the number of those who have had the chance to avail themselves of the services it offers.

Another amendment to the Act on Social Services required the establishment of group homes.<sup>45</sup> A group home is a small community which provides members with services tailored to their age, condition of health and ability to cater to their own needs. In these communities patients can lead their lives autonomously under conditions which include the provision he or she needs<sup>46</sup>. No data on the number of group homes for psychiatric patients established so far were available at the time this volume was completed. (Different sources offer different data, but it is beyond doubt that the total number of group homes across the country remains below 10). As group homes spread very slowly, there are very few patients who have the opportunity to use their services.

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<sup>40</sup> Yearbook of Social Statistics 2000, Section 7, Ch.14, Központi Statisztikai Hivatal, Budapest.

<sup>41</sup> Yearbook of Social Statistics, Sect. 9, Ch.14..

<sup>42</sup> Based on a paper read out by Andrea Bácskay (Central Office of Statistics, Social Statistics Department) on May 24, 2001. (The data relate to the year 1999).

<sup>43</sup> Section c, paragraph (3) Article 8 of Act III/1993, the version of social legislation presently in effect.

<sup>44</sup> Yearbook..., Sect. 9, Ch. 14.

<sup>45</sup> Act III/1993, Article 85/A in its present form.

<sup>46</sup> The conditions for the implementation of this form of care are to be secured gradually, but the final deadline is December 31, 2009.

If we cast a glance at the health care system which caters to the needs of mental patients we find similar proportions between in-patient and outpatient arrangements. Health care settings offering outpatient care accounted for no greater share of the care available to patients than a decade earlier. The most recent figures available on the number of patients cared for in out-patient clinic are from the year 1999. There has been no significant change in the number of patients recorded in out-patient clinic in the past ten years (128.952 persons were registered in 1999). This fact underscores the earlier statement that placement in a hospital continues to be the dominant form of psychiatric care and that outpatient treatment has not come to the fore. In 1999 the greatest number of people in out-patient care were recorded in the capital city, but the proportion of patients in relation to the population of the particular locality was the highest in Csongrád, Baranya and Nógrád county rather than in the capital.<sup>47</sup>

Those who fail to get into health care have no other choice than to apply for placement in a social care home. The main findings of the investigations of the Parliamentary Commissioner for Human Rights in 1996 came as a real shock to the public: there is no network of social care for psychiatric patients in Hungary, there are no provisional homes, protected jobs, protected hostels, day and night sanatoriums.<sup>48</sup> On the whole, these statements are still true.

#### On the Functioning of Psychiatric Homes

The executive orders on the application of the Social Services Act stipulate strict conditions for the running of psychiatric homes. They include regulations on such details as furnishings and equipment, the phasing of care and the rights of those cared for. A particular institute is given a permanent license if it meets the conditions set by the law; if not, it will be given a provisional license until it comes to meet the conditions. Most social care homes have not been able to acquire a permanent license. In 2000, 50% of these establishments were still running on a provisional license.<sup>49</sup>

Public administration authorities are empowered to close down establishments with serious defects.<sup>50</sup> These powers have never been used. The authorities tend rather to opt for changing the license of the defective facility from permanent to provisional and allowing it to remain in operation given a public interest in offering provision. In the recent past, an establishment was found which offered care for psychiatric patients without a license from the relevant authorities, although this was certainly an exception.<sup>51</sup>

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<sup>47</sup> Yearbook..., 1999, Sect. 9. Ch.4.

<sup>48</sup> The Reality of the Human and Civil Rights of Patients in Psychiatric In-Patient Establishments and Psychiatric Homes, 1996, p.80.

<sup>49</sup> Taken from the paper "Life in the Establishment as Expressed in Figures" read out (in Hungarian) by Mrs Károly Tokaji (Head of the Statistical Department of the Central Office of Statistics) at the conference "The Quality of Life" held on May 24, 2001.

<sup>50</sup> The Government decree 188/1999 referred to here has been in effect as of December 31, 1999. Within a year from the decree's taking effect offices of public administration had to examine a number of establishments – including psychiatric ones –to check whether they lived up to professional requirements.

<sup>51</sup> Based on Mrs Károly Tokaji's paper, see note 20.

More determined action on the part of authorities would be very much desirable since establishments lag behind reasonable expectations both in terms of furniture and equipment and the personal qualities of their staff. If we confine our attention to one single aspect, e.g. furnishings and equipment, almost every single facility shows signs of serious shortcomings. This is by no means surprising as the buildings were not originally designed for the purpose of housing patients under treatment and care. Most buildings are old ones in bad need of rehabilitation. The Parliamentary Commissioner has seen a building which she deemed unfit for human living let alone for the purpose of professional care for mental patients.<sup>52</sup>

Another factor which substantially determines the quality of the professional work done in psychiatric homes is the fact that the profession is unwilling to recognize this form of care as its own task. As long as the attitude of professionals remains unchanged and as long as they continue considering only provision given in health care establishments as a legitimate part of psychiatric activity, the standards of work done in psychiatric homes will fall far below those of the care provided in health care establishments and such as can be reasonably expected. A statement of the Professional College of Psychiatrists,<sup>53</sup> commenting on a fatal incident in a psychiatric home is illustrative of the attitude of the profession: “The establishment – the psychiatric home – has, regrettably enough, received no appropriate help from anyone including, most notably, the psychiatric profession.”<sup>54</sup>

Our discussion has so far focused on the defective functioning of psychiatric homes, the effete control exercised by the authorities, the shortcomings of equipment and personnel, financial difficulties and the detached attitude of the psychiatric profession. In what follows I would like to add another shortcoming to the list, one that is responsible for much of the inefficacy found in the observance of quality requirements and in the respect for the rights of those cared for, and this is the lack of civil control.

Civil organizations should be given the opportunity to visit inpatient homes, to give expression to their experiences and report them to maintainers or other authorities, and to submit their criticism, proposals or comments, petitions etc. at competent authorities. Such civil organizations could also be instrumental in helping those in care to assert their rights. In fact, it was the original intention of the legislator to put an end to practices in the running of establishments which deviate from the rules and to protect the rights of those in care, so it is hardly understandable why no steps have been taken so far to build up a network of civil control.

### Who Really Decides on Placement in a Social Care Home?

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<sup>52</sup> Following the ombudsman’s criticism the maintainer decided to close up the home and its patients were transferred to a new home in Füzasabony opened in 1997. Cf. *The Reality of the Human and Civil Rights of Patients in Psychiatric In-Patient Establishments and Psychiatric Homes*, 1996, p.31.

<sup>53</sup> The College is active as an advisory body to the Minister of Health.

<sup>54</sup> Quoted from a report delivered by dr. Attila Szűcs at the College session held on February 13, 2001.

Almost a year after the promulgation of the Act on Social Services, Parliament adopted comprehensive amendments designed to make it more appropriate to its purposes. Some of the amendments were conceived with the aim of dealing with the human rights aspects of admission to social care homes. The question we wish to explore next is whether or not the new rules are more effective in protecting the rights of patients in social care homes.

There are several reasons which support the changes. Admission to psychiatric homes can be applied for by the patient or his/her legal representative. Admission is most often requested by the guardian rather than the patient him/herself. It is an open question whether the guardian's decision matches the patient's wishes, and whether the former acts in good faith and with due care.

It is worth making a digression on the difference, if any, between the rules of admission to health care facilities, on the one hand, and to social care homes, on the other. In the social sphere, the extent to which the rights and interests of patients are taken into consideration in the course of the admission procedure have not received attention. It has been taken for granted that placement in a social care home is a service which is sought on a voluntary basis. Since the patients themselves have almost never been willing to apply for admission to a psychiatric social care home, competent authorities tend to take recourse to the institution of guardianship. The majority of those involved were under guardianship anyway: these tend to be people who have repeatedly been treated in a hospital, and court proceedings for placement under guardianship will have been started in their case before it came to consider whether long-term inpatient treatment in a psychiatric home would be the right solution for their problems. Those who did not yet have a guardian at the time, were quickly assigned one by the authorities. The provisional or *ad litem* guardian then signed the application for the patient. Over the years, thousands of people whose decision making capacity has never been examined by a court found themselves committed to social care homes upon the request and with the agreement of a provisional guardian whose act of will decided the course of their lives for good.

Legal rules restricting commitment to involuntary medical treatment involving a restriction of freedom, as we have said, began to be introduced in the early 1990s. Over the years several changes have been introduced, which have contributed to increased observance of the rights of psychiatric patients.<sup>55</sup>

The institution of involuntary commitment in the social sphere was introduced by the 2001 amendment of the Act on Social Services. In a document submitted for the Parliamentary debate HCLU argued that none should be obliged by a court decision to

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<sup>55</sup> Court review is to be initiated within 24 hours after admission. The court will deliver a decision concerning involuntary treatment. To make the decision, the court needs to give the patient a personal hearing, who is secured a representative during the procedure. The court reviews its own decision every thirtieth or, as the case may be, every sixtieth day. One of the most important functions of the patients rights advocate is to protect the rights of patients, etc. .

avail himself of a social service.<sup>56</sup> The Bill was not designed to involve an impartial body – the court – in the procedure of committing an incompetent person through a proxy decision made by a guardian. Its aim was to provide for the possibility of committing in a social care home a fully competent individual. In what follows we will take account of the rules of commitment to psychiatric homes in the wake of the said amendment to the Act on Social Services and compare them with the rules on hospital treatment.

The basic differences between the two forms of provision – caring in a social home as opposed to psychiatric treatment in a hospital – can be summarized as follows.

– A patient can only be committed to mandatory hospital treatment if he is in an endangering or immediately endangering condition. Hospitals engage in medical treatment and a patient is obliged to submit to it if he is in a condition which poses danger to himself or others.

Mandatory commitment to a social care home cannot be justified by the patient's endangering condition since by the law no patient in an endangering condition is allowed to be admitted to a social care home. Commitment to such an establishment is made mandatory for any person unable to look after himself properly even with somebody's help or if there is nobody on whom the person in question could rely for such assistance.

– If a patient is treated in a hospital against his will, the court reviews the necessity of treating him every thirtieth day of his commitment. This kind of independent judicial control is not available in the social home setting despite the fact that commitment to such an establishment is often for an entire life in contrast to hospital treatment which normally lasts for not more than a few weeks or months. In the social sphere the patient does not have the opportunity to appeal to an impartial body for a remedy to his complaints.

– If voluntary admission to the hospital is requested by the patient's legal representative rather than the patient himself, the court is to review the validity of the request, and the sufficiency of the reasons for treating the patient in hospital. In cases when someone requests the patient's admission to hospital against the patient's will, a judge examines whether the legal representative's decision violates any of the patient's rights and interests.

Judicial control is absent from the procedure of placement in social homes despite the fact that with most psychiatric patients it is the legal representative, not the patient himself, who requests admission. Admission to a social home follows a procedure which is completed in the absence of judicial intervention. A statement from a physician and a signature from the guardian are sufficient for the placement to go through. The court should be authorized in such cases to examine whether admission is voluntary and whether there has been any abuse involved in the admission request. Since what is at stake is long-term placement, it would be equally reasonable for the medical expert's

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<sup>56</sup> HCLU Statement Series No. 16, published by HCLU, July 2001.

opinion to be based on an examination carried out by a committee rather than one single physician.

We can conclude that the legal regulation fails to provide for any guarantees against commitment without the patient's consent. Indeed, the new rules have added to the number of cases in which patients may be committed to social care homes against their will. The decisions made by courts apply to persons of full competence. Courts may decide on mandatory commitment of persons who do not seek admission to a psychiatric home and have the requisite decision making capacity. The amended Act on Social Services –unlike the Health Care Act – includes no provisions on the rules of court procedure, on hearing to be given to the patient, on his representation and on any review of the decision.

The room for action is extremely narrow for those who want to refuse institutional care in the first place or to leave the establishment where they are committed. In the future not even persons of full competence will have the freedom to refuse the services of a social care home as long as they have been committed to the institute on the basis of a court decision. If, by contrast, the person in care lacks full competence, he can only leave the establishment with his guardian's agreement.

A review of the necessity for continuing institutional care is carried out every second year. The decision is met by a committee of a number of physicians. If the committee finds that the patient no longer needs institutional provision, it proposes that the committing organ and the director of the establishment take the necessary steps. We find in the Act no rule relating to the manner in which the review is to be carried out in the case of patients committed to the establishment as a result of a court decision. Careful reading of the Act suggests, however, that it is either up to the committee of physicians or to the director of the establishment to initiate with the court a procedure of annulment of the commitment decision. The law is equally silent on what happens if they fail to make this step.

The Amendment provides for the possibility that the person in care, if competent, or his legal representative, if he is not, initiate a review process. Persons under guardianship are not allowed to request review themselves, not even once a year, so they are at the mercy of their guardian's will in this respect also.

The Amendment introduced, after the model of patients rights advocates under the Health Care Act, the establishment of the office of advocates for the rights of persons in care. The powers of these advocates, however, are rather weak, even in comparison with those of patients rights advocates. The advocate has no right to proceed at the request of the person in care in matters relating to his placement in social care home, the cessation of institutional care or his transfer to a different establishment. The same applies to a request for review. Persons in care who are not fully competent are, as we have seen, excluded from this. The advocate is not empowered to help them in such matters, either. These restrictions make it completely impossible for the person in care to receive help from the advocate in matters relating most closely to the care he receives at the establishment.

## Did the Act Come to Include New Forms of Care?

Another question which is worth exploring in light of the amended Act on Social Services is whether the amendments have given rise to any shifts from institutional care to communal provision.

Amendments over the past ten years repeatedly targeted regulations relating to long-term inpatient facilities. This indicates an effort on the part of legislation to transform the structure of the social establishments by stopping the oppressive predominance of inpatient facilities by legislative means.

Over the past few years, advances made in modern psychiatry have led, in many countries, to efforts to shift the emphasis from hospital-centered professional services to community care.<sup>57</sup> The reduction in the number of hospital beds in Hungary has strongly affected psychiatric wards, but there has been no parallel expansion in the area of communal forms of care.

In the wake of the Amendment adopted in 2001 several changes will come into force which may be conducive to new arrangements for providing those in need with the support their state requires in their own homes rather than in establishments. The amendments define the principles of community psychiatry and fortify arrangements for community care. The avowed aim is to support the autonomy of the persons who need care, to develop their abilities or, if this is not possible, to support them in keeping their skills on the level where they already are.

One had to reckon also with the fact that budgetary constraints impose heavy restrictions upon the scope of the provision hospitals are able to offer. The reduction in the number of beds affect psychiatric wards heavily. This adds to the urgency of developing communal forms of care: people leaving the hospitals cannot be left without provision. The amendments definitely make a plea for the necessity of community services, making it incumbent on local authorities to make arrangements for effective psychiatric services in the community and to assist those in need to get access to the service.

New services are to be made available for people with mental illness from 2003 on, including such as the provision of meals, the accessibility of family support centers and the provision of personal assistance. The availability of community care may help reduce the number of patients who are admitted to social care homes against their will because they are left without help of any other kind in looking after themselves. Thus the number of those who are given basic provision may increase significantly, reducing the

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<sup>57</sup> There have been efforts in Hungary – some of them preceding the binding provisions of the Act on Social Services – to make a variety of arrangements for communal care part of the services offered by psychiatric provision. The health care facilities of the VIIth district of the capital tried e.g. to make arrangements for a cooperation between clinical departments, out-patient surgeries, daytime hospital services and psychiatric nursing services.

predominance of forms of provision in hospitals and long-term placement in huge institute. If maintainers fulfill their duties of provision in harmony with the law, community care may give effective assistance in providing for patients, and the process conducive to the phasing out of commitment to social homes may slowly get started.

## Summary

The purpose of this study was to pinpoint the shortcomings of the system of social services for the mentally ill in general and the grave concerns to which social care homes give rise. We wanted to provide an account of the extent to which psychiatric homes live up to the requirements one can make on institutional care in terms of human rights and professional standards. We examined whether there had been any legislative steps toward the phasing out of the oppressive predominance of huge inpatient institution and toward creating less restrictive, community services. The only way to secure recognition for the right of the mentally handicapped to decide for themselves, and for their human dignity is to phase out overcrowded social care homes and to build up locally accessible services instead.



## Restraint within the Bounds of the Law

A few months ago a fire in a psychiatric home claimed the life of a young man. Once again, this tragic incident brought into sharp focus the question of instruments of restraint applied in psychiatric institutions. The young man was burnt alive in his padlocked caged bed, without even a slim chance to get out. There were no staff nearby.

The necessity of imposing limits on means of restraint through regulations was not raised until 1997, almost ten years after the transition to democracy in 1989, the year when the Health Care Act was finally reformulated. This area had not been legally regulated until then, and accepted methods of restraining psychiatric patients had been left undefined even in Methodological prescriptions disseminated among professionals. This situation prevailed despite the fact that it was routine everyday practice both in hospitals and in psychiatric homes offering long-term treatment, to apply physical and chemical means as well as seclusion to control psychiatric patients .

## On the Legal Rules Regarding the Application of Coercive Measures

Before embarking on a recapitulation of legislation presently in effect on restraint, I would like to make a short digression. It is remarkable that the rules on so-called compulsory or involuntary treatment, i.e. treatment against the patient's will, were re-drafted by the Hungarian Parliament as early as 1994. This was done in an effort to bring national legislation in line with international human rights norms acknowledged across European states. In accordance with the norms enunciated in the Human Rights Convention of the Council of Europe the issuing of orders for involuntary treatment in an institution was made conditional on judicial proceedings.<sup>58</sup> This step was justified with reference to the principle that involuntary treatment in an institution involves restricting the patient's personal liberty, and this may be allowed only within the bounds of the legal guarantees defined by the Convention. The fact that the patient is deprived of his/her liberty in the interest of his/her own health in a health care institution does not automatically place the matter within the exclusive competence of the medical profession. Commitment to a psychiatric institution must be subject to procedural safeguards of the same kind as any other kind of involuntary commitment.

The legislator stopped at this point, however. No consideration was given to the inference that if involuntary commitment to a psychiatric institution must be subjected to legal constraints, then so must the restraint of freedom within the walls of psychiatric institutions. What made this omission particularly awkward was that in Hungary, as it is widely known, psychiatric patients were often confined in caged beds, rendered unable to move by being tied down and, in certain social care homes, kept under tortuous and often humiliating conditions for years.

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<sup>58</sup> "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful." European Convention on Human Rights,, Article 5, Section 4. Hungary ratified the Convention on November 5, 1999.

The legislative amendments adopted in 1994 ushered in new conditions. Under the new rules decisions on the necessity, or otherwise, of psychiatric treatment were now to be made by a judge whenever the patient himself/herself had refused to consent to treatment. It should not be overlooked, however, that the judge's powers are restricted to decide whether treatment should be administered at all. They do not include the power to approve of particular means of restraint applied in the course of actual treatment. Even more importantly, means of restraint are used not only against involuntary patients treated on the basis of a judicial decision: they are also applied to voluntary patients. Thus, the same reasons that demand judicial decision on involuntary commitment, demand judicial intervention in the administration of involuntary treatment, too. This conclusion is the more compelling that restraint is never applied against psychiatric patients for reasons of health care but exclusively in response to conduct which is deemed dangerous.

When the issue of restricting freedom of movement appeared on the agenda in 1997 as part of the new Health Care Act then in preparation, the psychiatric profession seemed to be divided on it. Some supported the initiative. Those accepting the necessity of regulation saw legal constraints not only as safeguards for individual rights, demanded by the rule of law but also as a means conducive to the humanization of professional practice. Others were against legal codification of permissible restraint, concerned about stigmatizing psychiatry as a branch of the medical profession where coercive measures are applied against patients while restraint is applied to patients in non-psychiatric treatment, too, e.g. when the patient is likely to behave in ways which would put the success of treatment to risk.

The rules about techniques of restraint were finally formulated in the context of the right to human dignity, in the general chapter on patients rights. They were defined as emergency measures designed exclusively to avert the danger to the physical integrity of the patient or of other persons.

The scope of these rules includes all patients and all health care providers. The legislators did not address the question whether such rules, formulated in fully general terms, would be sufficient to enforce respect to law in the specific area of psychiatric institutions. The only specific rule enunciated stated that coercive measures may be lawfully initiated only against a patient whose behavior poses a danger, and required that the administering of such a measure is to be approved by a physician within two hours.

### On the Instruments of Restraint

The use of caged beds has been under attack by organizations which protect the interests of psychiatric patients and legal defense organizations at professional fora as well as before the wider public. After an inspection initiated by the mayor of Budapest in a psychiatric home run by the municipal council of the Capital although itself located in the countryside, a local daily published photographs which showed two naked women locked up in a caged bed. Video materials recorded by the documentary group called "Black

Box” in the early 1990s showed a room in a psychiatric home which contained nothing but a row of caged beds with persons in them who, as was revealed, had been there for several years.

Flaring up from time to time, the controversy about the use of restraint in psychiatric homes has centered on caged beds as one of the hotly debated issues. Although the use of this instrument has become a symbol of inhumane treatment, to the present day there is no prohibition – no binding legal or professional norm – against it, despite the fact that the Constitutional Court has drawn the attention of legislation to the use of such instruments as a possible source of grave infringements of rights.

Article 3 of the European Convention on Human Rights prohibiting torture, inhuman and degrading treatment is the definitive norm for the regulation of means of restraint.<sup>59</sup> The same prohibition is confirmed by Section 2 of the Article 54 of the Hungarian Constitution. These international and constitutional norms were appealed to by the Constitutional Court when it subjected the relevant provisions of the Health Care Act to constitutional review.

In its decision delivered in October 2000 the Court found the legal conditions for restraint – that the patient’s behavior poses danger or immediate danger – to be in conformity with the requirements set by the Constitution. At the same time, it stated that “arbitrary restraint on liberty” means not only restraint imposed with no justification at all: arbitrariness might also result from a state of affairs in which there are no legal provisions to limit the choice of restraining measures to be administered.<sup>60</sup>

The Health Care Act allows use of restraint only in cases of the strictest necessity, and confines their continuance within the minimum of time justified by necessity. The Constitutional Court declared these prescriptions to be abstract norms designed to promote the principle of “proportionality and necessity” – as such, they are not sufficient to limit the application of restraints to the constitutionally permitted domain. According to the Court, the missing legal guarantee would be a categorical ban on all methods that fall under the concepts of torture, and cruel, inhumane or degrading treatment.

The Constitutional Court found the Parliament guilty of a constitutional omission, and appealed for remedying it by re-casting the conditions of restricting personal liberty in such a way as to give effect to the above-mentioned prohibition.

### The Use of Caged Beds Violates an International Obligation

During its visit to Hungary in 1999, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (henceforward “Committee”) visited psychiatric institutions. The Committee is an international agency monitoring the observance of the European Convention for the Prevention of Torture and Inhuman or

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<sup>59</sup> According to Article 3 “No one shall be subjected to torture or to inhumane or degrading treatment or punishment.”

<sup>60</sup> Constitutional Court Decision 36/2000(X.27.).

Degrading Treatment.<sup>61</sup> Its tasks include examining treatment applied to persons who are deprived of their freedom.

In the psychiatric institutions it visited, the Committee saw patients who were kept in caged beds. The Committee found this practice a grave violation of rights, and it requested the Hungarian authorities to take instant measures, urging them to phase out the use of caged beds in psychiatric institutions without further delay.<sup>62</sup>

The stance taken by the Committee – as regards both the demand for instant steps and the gist of their subsequent report – made it plain that phasing out caged beds without delay in all types of psychiatric institution was a matter which would be judged in terms of international obligations.

After the Committee had made these points clear in several ways, the Ministry of Social and Family Affairs took steps toward the phasing out of caged beds. It sent out a Circular, urging the maintainers of psychiatric homes to put an end to the use of caged beds. As a result, the number of caged beds was significantly reduced in social care homes.

When the Ministry turned to psychiatric social care homes in 2000 to gauge the extent to which caged beds were actually used, 30/% of those replying reported the use of this kind of instrument. The actual proportions may be safely assumed to be higher as the figures were based on voluntary communications. A year later the Mental Health Interest Forum, a civil organization, reported on an investigation of its own which revealed that “there had been an obvious decrease in the number of caged beds used in psychiatric homes”.<sup>63</sup> The investigating group had seen caged beds in eight of the 52 psychiatric homes it had visited, including one in which it had seen as many as 12.<sup>64</sup>

Did the Constitutional Court’s Decision Result In Stricter Legal Conditions on Restraint?

The decision of the Constitutional Court made it incumbent on Parliament to redraft rules on restraint in such a manner that they would exclude the application of methods which amount to an infringement of human dignity. Actually, an amendment had been adopted by Parliament already before the Court’s decision. In 1999 the requirement of periodical review of a patient under restraint was enacted into law. This provision rules that the patient’s condition and physiological needs have to be reviewed periodically and

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<sup>61</sup> European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (Strasbourg, 1987). Hungary joined the Convention, which it promulgated in Act III. 1995.

<sup>62</sup> Report to the Hungarian Government on the visit to Hungary carried out by CPT from 5 to 16 December 1999 (March 2000) I. Introduction E.8.

<sup>63</sup> Gábor Gombos, Eszter Kismódi, Katalin Pető, *The Human Rights of Patients in Social Care Homes for the Mentally Ill*. Published by the Mental Health Interest Forum in 2001. Some statements in the report written by the members of the legal defense organization reveal that gross violations of human rights still occur. They report finding a naked boy in his caged bed in one institution and another boy locked in his caged bed in another. The latter’s nurse told them the boy had been locked up almost continuously for six years. His case bears testimony to the survival of the practice of applying restraint as a way of personal nursing, as it were, rather than as a provisional means for averting danger.

<sup>64</sup> *Ibid.* p.30.

recorded. Parallel to this progressive move, however, the same amendment made a step backwards in that it made possible to record, in emergencies, the directive for the application of such measures *ex post facto*. This drove a possible “leak” in an important guarantee.

HCLU submitted a Statement for the upcoming parliamentary debate on the draft amendment in March, 2001. The Statement proposes that restraint is to be limited by rules which are couched in specific terms. It is not enough to enunciate a general ban on cruel and inhumane treatment. A list of permissible means of restraint must be set up, and those means the application of which counts as cruel and inhumane treatment must be spelt out concretely. The law must put an end to abuses of control in psychiatry. Unless this is achieved, debates about the legality or illegality of the application of particular means are bound to flare up time and again.<sup>65</sup>

In the reasoning attached to its decision, the Constitutional Court itself drew attention to the fact that listing permissible means in a legal instrument would not be an exceptional solution. The Police Act, e.g., lists instruments – tear gas, nets, handcuffs – which may be applied if the conditions specified in the law obtain. Similarly, the Health Care Act itself features a list of permissible techniques of reproduction.<sup>66</sup> Despite all this, however, the Parliament kept to the draft submitted by the Government, and rested content with prohibiting the application of inhumane measures in general, without giving a more precise definition of means, techniques and procedures.<sup>67</sup>

The law as amended by the legislative process, although was supposed to put an end to a state of constitutional omission, failed to exclude arbitrary restraint. As if to make matters even worse, the amendment further extended the discretionary powers of those in the position to give directives for applying restraint to at least one specific category of patients – namely, psychiatric patients. Before the amendment, restraint was judged permissible if it was justified by the need to protect the patient’s or others’ health or physical integrity. Under the amended legislation restraint may be justified with reference to the aim of breaking resistance in the course of treatment, too.<sup>68</sup>

### The Psychiatric Profession on Restraint

In April 2001, the Professional College of Psychiatrists issued a Methodological Circular on “Conditions of the Application of Means and Modes of Restraint “.<sup>69</sup> This document aims at preventing the emergence situations which involve danger. It imposes on the profession a duty to provide for appropriate conditions in terms of equipment and personnel, to organize training courses with the further aim of preventing situations from arising in which the application of restraining measures is inevitable.

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<sup>65</sup> On the amendment o the Health Care Act see HCLU Statement Series No.15.

<sup>66</sup> Article 166 of Act CLIV/1997 on Health Care.

<sup>67</sup> Section (2) Article 11 of Act XXXIV/2001.

<sup>68</sup> Section (2) Article 192 of Act CLIV/1997 on Health Care.

<sup>69</sup> Methodological Circular to supplement Act CLIV/1997 on Health Care and its amendment. In: *Psychiatria Hungarica*, Vol.16, No.4, 2001, pp.467-472.

There is one respect in which the Circular of the Professional College proves to be utterly conservative: it fails to specify a list of permissible forms of restraint. The following two pronouncements are all the Circular says about the subject:

“Physical restraint consists in the limitation of the patient’s freedom of movement or in his isolation. Medication necessary to restrain the patient counts as chemical restraint only if it is administered against the patient’s will. “

This definition provides psychiatrists with no action-guiding standards. It fails to specify permitted as against impermissible instruments of restraint (such that conflict with the ban on inhumane treatment – see caged beds).<sup>70</sup>

Besides physical and chemical means of restraint, the Act also mentions biological and psychological techniques as possible means of restraint. These notions, however, are not further interpreted either by the Act or the Methodological Circular issued by the professional college. We are thus left uncertain as to those biological and psychological means by which a patient is permitted to be forced to stop behaving in a threatening manner.

There is a statement in the Circular which is likely to lead to legal disputes: It says that the legal rules on restraint do not apply when a helpless or disturbed patient is restrained in his/her freedom for the purpose of preventing an accident. The framers of the Circular may be presumed to have intended to define certain techniques which are applied routinely against elderly patients such as barring the side of beds with planks, fastening patients to chairs with sheets etc. – out of the law’s range of application. In my view, the Professional College transgressed its competence at this point and erred into the prohibited area of arbitrary legal interpretation. The legislator allowed restraints of freedom to be applied only in emergencies arising in the course of care administered to psychiatric patients, and subjected even such interventions to conditions set by the law. It is difficult to see how this law could be reconciled with the routine practice of keeping elderly patients tied to chairs in the corridors of psychiatric care homes. Could this be seen as falling outside the scope of applying restraint? Are we really to lay it at the discretion of the staff of psychiatric institutions to decide how they are going to treat elderly patients with no potential for causing danger, freed from the limitations imposed by the law?

#### A Methodological Recommendation for the Social Care Homes for Psychiatric Patients

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<sup>70</sup> The professional college of British psychiatrists has elaborated a strategy for its members which is based on a detailed account of instruments and techniques of restraint and the training which is made a precondition of their application. The strategy includes clear statements concerning acceptable and unacceptable methods of restraining patients. These professional prescriptions are periodically updated. See “Strategies for the management of disturbed and violent patients in psychiatric units”, Royal College of Psychiatrists, Council Report CR 41, March 1995.

The Ministry of Social and Family Affairs published its “Guidelines for the Treatment of Patients in an Endangering Condition” in the first half of 2001.<sup>71</sup> The primary aim of the Guidelines was to remove ambiguities from the description of the means of restraint that were to be applied to such patients. They reveal an underlying approach informed by notions which are central to a humane and integrative conception of psychiatry. In addition to spelling out some general steps, they emphasize the need for a plan of action which is tailored to the individual case and the particular kind of emergency. They require that after the application of the coercive measure to a patient the tension created in other patients is to be eased and the series of events they may have witnessed is to be evaluated with them. A sample documentary sheet is attached to the Guidelines which features a summary of the efficacy and effects of the means of restraint applied.

The Guidelines also give a more detailed account of methods of restraint than the Methodological Circular. They define techniques of fastening and the instruments such interventions require. They define caged beds as an inhumane instrument, incompatible with international standards and a potential grave danger to the person restrained.<sup>72</sup>

Can we say, then, that the use of caged beds is, at long last, put under a ban in Hungary? There are two reasons against answering that question in the positive. One is that the Guidelines are addressed only to social care homes, they do not apply to hospitals and outpatient clinics that are supervised by the Ministry of Health. They thus reach out only to a limited number of psychiatric patients. The other reason is that the Guidelines, being what they are, i.e. a professional recommendation, have no legal binding force.

Nevertheless, this first step taken by the Ministry of Social and Family Affairs marks a significant change in the situation. When the Ministry addressed the maintainers of psychiatric homes and urged them to phase out the use of caged beds, the number of caged beds in actual application decreased significantly. The publication of the Methodological Guidelines can also be expected to exert considerable pressure on social care homes to stop the practice. To make this happen, it would be necessary to monitor the actual outcome of any action taken to make these necessary changes materialize. Besides the professional authorities, patients rights advocates and independent civil organizations could also have an important role to play in weeding out the use of caged beds and other unlawful practices of restraint.

#### What Can the Patients rights Advocate Do Against Abuses?

The Health Care Act rules that patients rights advocates employed by hospitals should receive a copy of the records of every case of restraint applied. The office of the patients rights advocate is a government office in health care settings which is maintained by the government with the aim of furthering the effective enjoyment by patients of the rights

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<sup>71</sup> Módszertani útmutató az egyes szociális intézményekben végzett ápolási-gondozási tevékenységhez (Methodological guidelines for the nursing and caring activities carried out in some social care institutions.) Periféria Füzetek, 2001/1. Published by the Institute for National Social and Family Policy of the Ministry of Social and Family Affairs.

<sup>72</sup> Ibid. p.30.

that are secured for them by the law. Advocates are to pay special attention to groups of patients who are in a helpless condition or situation, such as psychiatric patients. Experiences show, however, that patients rights advocates have difficulty in taking concrete action on behalf of patients under restraint.

Let me offer, by way of illustration, a case which became known to HCLU through its counseling hotline. A woman telephoned us to seek help on behalf of her friend. The friend had spent several days in a state of anxious indecision about what she should do and finally presented for psychiatric treatment. After a few days she left the hospital only to be taken back against her will. Following this, she was submitted to heavy drug treatment and tied to her bed by the chest and limbs. That is how she was found by her friend when the latter came to visit her. The visitor asked for an explanation and was told that it was necessary to keep her friend tied down because otherwise she would keep getting up and trying to leave, which was dangerous as she was dizzy from the drugs. Dissatisfied with the state of affairs and its medical justification, the woman looked for a way to remedy the situation. She went to see the patients rights advocate and asked him what he could do to stop these measures. The advocate assured her of his sympathy but told her that because her friend was at the closed mental department which he could hardly enter, he was unable to render effective help in a matter involving her.

Given the conditions under which the patients rights service is run at present, this is more or less what one could have anticipated. There is no patients rights advocate in hospitals who could be contacted any time during the day. They are only available for a few hours on one particular day of the week. Patients rights advocates have not had appropriate training either before or since the introduction of the institution. One advocate is often in charge of the affairs of two or three, sometimes four, hospitals.

Yet, even until the patients rights advocate service comes to be appropriately recognized and its advocates come to acquire proper training, there are a few things that could be done to address the problem at the institutional level. The law confers on the advocates not only the task of providing help but also of taking a record of any anomalies in the functioning of the health care institution at which they are active. They would be acting wholly within these legal entitlements if they described abuses they experience in the course of restraint and reported them to the leadership or the maintainers of the institutions.

### On Civil Control over Psychiatric Institutions

I was working on the present study when a report published in a daily newspaper caught my attention.<sup>73</sup> There had been an accident in a social care home for the mentally ill in the countryside. One of the persons affected by the accident was a boy who had been kept isolated both from the company of the other mental patients and from the outside world. The HCLU decided to pay an official visit to the institution to see the conditions prevailing there. To be granted entry to the premises and see them from the inside, we

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<sup>73</sup> Rémtörténetek egy gyermekotthonból (Horror Stories from a Children's Nursing Home), Magyar Hírlap, December 18, 2001.



first had to request permission from the relevant authorities of the church which runs the social care home. We were denied permission to enter, under the pretext that the case was already being investigated as a result of the news published, and that therefore our visit was inopportune. Our next request for a later date for a visit has not been answered at all.

In the late 1990s the Parliamentary Commissioner for Human Rights conducted investigations in several social care homes for mentally disabled persons. Her experiences led her to make a proposal for the building up of a framework of civil control over the institutions concerned.<sup>74</sup>

During its visit at the end of December 1999, the Committee against Torture strongly criticized the legal arrangement allowing only maintainers and local public health authorities to conduct investigations in caring homes. In its report to the Government the Committee called on Hungarian authorities to make arrangements for control over psychiatric institutions to be exercised by outsiders, requiring specifically that in addition to unimpeded access to the institution for the inspecting organization, the inmates should also be secured the opportunity to turn to the organization with their complaints and requests.<sup>75</sup>

In the autumn of 2000 the Government sent a bill to the Parliament for redrawing the Act on Social Services. The bill enunciated clear guidelines to be followed by a new type of psychiatric provision system and committed itself to institutional reform. It initiated steps to reduce the dependence of those in care. HCLU submitted a Statement to the legislature for the discussion of the bill. In this Statement, we drew attention to the absence of any provision for civil control from the draft which otherwise included a number of undoubtedly promising changes. We proposed that organizations protecting the interests of psychiatric patients and mentally disabled persons should be allowed to volunteer for the task. Under this proposal the maintainer of the psychiatric institution would choose one among these organizations and entitle it to inspect the social care home and talk confidentially to those in care. In return it would undertake an obligation to send a report of its findings to the maintainer.<sup>76</sup> The parliamentary discussion, however, failed to lead to amending the bill in this sense.

Reports from the Parliamentary Commissioner of Human Rights and Hungarian as well as international organizations testify to the fact that psychiatric institutions in Hungary

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<sup>74</sup> “The minister of Public Welfare, however, did not accept the recommendation to regulate civil control by a ministerial decree...”. Report on the activities of the ombudsman for civil rights and his general deputy in the year 1997 (Office of Parliamentary Commissioner of Human Rights, 1999) p. 131. Having had all his proposals turned down by the minister, the Ombudsman turned to Parliament for support in his efforts to make room for a role in controlling certain institutional activities to be fulfilled by civil organizations. She received no support. After a series of exchanges of letters with the minister the ombudsman revoked his proposal three years later. Comprehensive Report NO. II. on the observance of the human and civil rights of patients in psychiatric in-patient establishments and psychiatric homes (April 2000, p.56.)

<sup>75</sup> Committee for the Prevention of Torture (CPT) Recommendations, C. Psychiatric Establishments, 4. “Steps to be taken to ensure that all psychiatric establishments in Hungary – including care homes for psychiatric patients – are visited, on a regular basis, by an independent outside body responsible for the inspection of patients’ care.”

<sup>76</sup> “On the New Rules for Psychiatric Homes”, HCLU Statements No.16, July 2001.

regularly engage in practices of restraint which are seriously at variance with the modern understanding of psychiatric treatment and with the norms of international law. Such practices are deployed not only as an emergency measure to divert dangerous behavior but are also applied against certain patients as a routine part of care. The Government has, no doubt, taken steps to drive back severe abuses, but to make these measures effective it is necessary to systematically monitor any progress made in the area.

### On the Importance of Prevention and Training

Our discussion so far focused on the present stage of regulation and control aimed at relegating the application of restraint to the realm of last resort measures. I would like to conclude the present study by taking account of means applied to prevent threatening and offensive behavior.

Our first task is to understand properly the situations which enhance the risk of aggressive manifestations. We might begin by pointing out that the view according to which there is a simple causal relationship between mental illness and aggressive behavior is mistaken. Violent behavior is not a direct manifestation of the psychopathology of the mentally disturbed individual. It is a result of an interaction between several factors and a series of events. Cases of aggressive behavior on the part of mentally handicapped persons are therefore to be interpreted in the context of social and environmental factors rather than simply in light of the individual's affliction.

The patient's aggressive outburst is always preceded by some episode occurring between the patient and one or two or several other persons. We must come to recognize that these episodes are, more often than not, acted out in overcrowded institutions in which the individual's autonomy does not extend over minimal matters such as how to schedule one's day, whether to withdraw rather than to stand leaning against the wall of a corridor. Patients generally do not have the minimal privacy that every human being needs when washing or relieving oneself. They share a room with others, not having a single minute they could spend alone. They are bored, there being no organized and meaningful activities around. They do not get their money from the ward and are thus prevented from buying themselves cigarettes, and when they complain to the staff about this situation, they are likely to be reprimanded rather than given a decent hearing.

Caught in the rising spiral of the frustrations experienced, the patient is likely to be unable to deal with his/her aggression. It is small wonder that it will burst out in the end. We must become fully aware of this if we are to be able to make effective steps toward change. Environmental factors which tend to evoke aggressive responses include the size of personal space available, the scope of personal belongings, comfort, and peace and quiet. As far as activities are concerned, the lack of choice and opportunities, the monotonous repetition of days without outstanding events and the dull predictability of such a framework of day-to-day existence only tend to reinforce the same process. The overall effect is enhanced by the indifferent attitude, or even provocative behavior, on the part of staff, and the lack of attention and understanding patients have to experience.

For all these reasons, it is of crucial importance carefully to investigate the chain of events which lead to restraint. Such investigation could help identify the factors – inherent in the environment, the quality of care afforded and interpersonal exchanges – which tend to lead up to outbursts of aggression in patients. Psychiatric institutions should have detailed plans of action for the prevention and treatment, if need be, of aggressive outbursts in patients. The report delivered by the Committee Against Torture criticized the lack of such a written policy in psychiatric institutions and urged authorities to remedy this omission.<sup>77</sup>

The training of staff along these lines is another necessity. Training must not be restricted to one or two appointed members of personnel but be extended to all. Appropriate training could make the staff aware of the physical, psychological and sociological factors which have a potential for evoking threatening and endangering behavior, and could teach them how to prevent outbursts of aggression. Training could also make them aware of techniques for evading confrontation<sup>78</sup> and teach them how to deal with aggressive outbursts with the help of skilled and effective techniques for holding down and holding back.<sup>79</sup>

## Conclusion

In the absence of such measures, legal rules are bound to bear fruit very slowly.

What is needed is that every institution should elaborate a detailed plan of action – a written policy – for preventing aggressive outbursts which as a rule lead to restraint, and for providing special treatment for persons in care who are in an endangering condition. Actual restraint must come as a last resort. It has to be recorded in reports and these reports must be periodically evaluated and summarized, and their implications must be spelt out. A curriculum for relevant training courses must be worked out and an underlying system of the ends, methods and proper functioning of these training courses must be elaborated. Last but not least, arrangements must be made which enable civil society to exercise, through independent organizations of its own making, outside control over the observance of patients' rights and the running of institutions within the bounds of the law.

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<sup>77</sup> Committee Report III. Recommendations, C. Psychiatric establishments, 4. "...a clear written policy to be established...as regards the use of means of restraint...".

<sup>78</sup> Andrew A. McDonnell, "Diffusing violent situations: low arousal approaches", in: *British Journal of Therapy and Rehabilitation*, Vol.6, No.2, February 1999.

<sup>79</sup> McDonnell-Dearden-Richens, "Staff Training in the Management of Violence and Aggression", in: *Mental Handicap*, vol. 19, September 1991.

## Compulsory treatment

In what follows we wish to discuss a form of compulsory psychiatric treatment which is carried out for special reasons and under special institutional settings. A directive for compulsory treatment can not be issued by an institution belonging to the state-run health system: it is confined to institutions which form part of the administration of justice and are housed within the area of a penal establishment. The establishment in question is the Forensic Institute for the Observation and Treatment of the Mentally Ill, and the people treated there against their will are mostly persons who have committed some violent crime as a consequence of which the court has ruled that they should undergo compulsory treatment rather than being punished since they fail to meet one of the criteria of criminal liability – they fail to command full decision making capacity. Compulsory treatment in their case is justified by the aim of remedying the disease which lead to the reduction or complete absence of decision making capacity or competence and of preventing dangerous conduct from occurring in the future.

The question whether an agent is competent is crucial for his act to qualify as a criminal act and for making the agent accountable for what he has done. To be punishable for a crime, the agent has to be fully competent. There is no criminal liability without competence, nor is there any punishable wrongdoer in the absence of competence. States of reduced competence include minority, duress, threat, and “mental disorder”.

### What are the Conditions for Compulsory Treatment?

In order for a directive for compulsory treatment to be legally valid, several conditions have to be met. The lack of competence has to derive from a mental disorder and the criminal act has to fall within a certain category of criminal offense. The danger that the same person is likely to commit similar acts in the future is a further important condition.

The court’s finding that the person concerned has committed the criminal act and lacks competence is not a pre-condition for a ruling that the agent must undergo compulsory treatment. Such a ruling can be made during criminal proceedings already. For the procedure to start, it is sufficient to have the opinion of a forensic medical expert making it likely that the proceedings will end by finding reason to initiate compulsory treatment. The conditions so far referred to are formulated in the Penal Code as follows:

Article 24, Section 1 of the Penal Code states: “A person who commits the act in an abnormal mental state - specifically in a state of mental illness, of developmental disability, dementia, a confused mental state or personality disorder - which makes him incapable of recognizing the consequences of his act or of acting in accordance with these consequences, is exempted from punishment.”<sup>80</sup>

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<sup>80</sup> Act IV/1978 on the Penal Code.

According to Article 74 of the Penal Code compulsory treatment, ordinary or provisional is to be ordered if the doer has committed a violent act against a person or a criminal act which poses a threat to the public and is not punishable on account of his mental state provided that a prison sentence exceeding a year would have to be imposed by the court.

A further condition on the initiation of compulsory treatment or provisional compulsory therapy is the existence of some ground for supposing that the doer is likely to commit a violent act against a person or a criminal act which causes danger to the public.

According to Article 98 of the Act on Criminal Procedure<sup>81</sup> provisional compulsory treatment is to be initiated if there is good reason to conclude that the culprit's state makes it necessary.

One of a number of court decision relevant to these legal provisions states that compulsory treatment cannot be initiated in cases of actual bodily harm and negligent delinquency. Another instructive principle recorded in court decisions is the statement that mental disorder is to be understood relative to the time when the act is committed. If mental disorder set in at a time after the act, the procedure has to be suspended, or even stopped.<sup>82</sup>

#### Decision on the Necessity of Compulsory treatment

An examination of the culprit's mental state falls within the competence of psychiatry. Decision making capacity cannot be ascertained without a medical expert opinion obtained from a psychiatrist. Legal rules presently in force require the participation of two psychiatric experts for a valid examination of competence, but final decision is in the court's discretion. If the experts propose compulsory treatment for the person arrested and the court orders this, then arrest is lifted, the culprit is acquitted, but he is committed to compulsory treatment.

Experts are to give an opinion on the mental state of the accused at two different times. They have to tell whether the accused was in an insane state of mind or was suffering from a personality disorder at the time of committing the act, or whether this state hindered him in recognizing his act or its consequences. Secondly, they have to tell whether at the time of the examination there was a danger that the person examined would commit a similar criminal act in the future. If the answer to either of these questions is in the negative, and the court upholds the opinion, compulsory treatment may not be initiated.

In other words, it may happen that the doer is found to have lacked capacity at the time of his committing the act but is found to pose no danger to society in the future, perhaps he

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<sup>81</sup> Act I/1973 on Criminal Procedure.

<sup>82</sup> Court Decisions, 1992, 747.

is mentally in order and therefore requires no therapy. In such a case the accused has to be released, and criminal proceedings against him have to stop.<sup>83</sup>

This is only a possibility. We do not know of any particular instance in which neither a punishment was inflicted nor compulsory treatment initiated against the doer of a criminal act of the appropriate kind. Relevant data – which are rather scarce – show that the length of time spent in compulsory treatment is proportional with the seriousness of the offence committed rather than with the doer's state of mind. In contrast to compulsory treatment initiated in state-run health care, compulsory treatment initiated in the context of criminal punishment usually extends over a long period of time and has, as we shall see later, much in common with confinement as applied in criminal punishment. Thus compulsory treatment, while a curative measure in terms of its justifying reasons and purposes, is characterized both in regulation and its actual practice by a combination of two elements: treatment and punishment.

If the conditions of compulsory treatment, ordinary or provisional are lacking, and if committing the accused to therapy or care seems necessary “on the judgment of the authorities” (in the stage of investigation, the stage involving the prosecutor's office or in the stage of court proceedings), a psychiatric outpatient clinic or the health authorities of the district of residence of the accused is to be contacted. This is what is known as a “measure to prevent crime”.<sup>84</sup> The legal rule gives no guidance concerning the identity of the authority which is to decide on the necessity of therapy and provides no means for the person concerned to protest or appeal against this decision. At present, we have no information as to the steps which are taken in actual daily practice, but it does not seem a very bold conclusion to maintain that the vagueness of regulation and the pull of inertia inherent in established customary practices result in significant and unjustified disadvantages for the person concerned.

### The Review of Compulsory Treatment

Compulsory treatment has to be reviewed at the end of the sixth month and, then, of the first year after commitment, and every year after that. Four months prior to the annual review, the director of the establishment sends a resumé of the diagnosis to the court. The legal rules make it incumbent upon the leading physician of the establishment to indicate to the court if the conditions for compulsory treatment no longer obtain, if “there is no reason to fear that the person concerned will commit a new crime which may give rise to a need to initiate compulsory treatment for him”. The public prosecutor, the spouse of the person concerned, his/her legal representative, defense counsel or the director of the establishment are entitled to request an extraordinary review, which, however, may be ignored if it has not yet been six months since the previous review.

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<sup>83</sup> If the doer lacks capacity at the time he is called to accounts, criminal proceedings may not be started (cf. Article 13 of the Act on Criminal Procedure) or proceedings already in progress must be stopped, or the doer is to be acquitted. Lack of capacity at that stage counts as a reason which excludes or annuls punishability.

<sup>84</sup> Act on Criminal Procedure, (3) Article 117.

A psychiatric patient who is being treated in a health care establishment has his/her case automatically reviewed every thirty days, and has the right to be heard in the review process. A person under compulsory treatment is undergoing a more severe restriction of his/her liberty and his/her case is reviewed less frequently than that of a person treated in a hospital which belongs to ordinary health care. This gives rise to a need for even stronger guarantees that the court will not take a decision without giving him/her a personal hearing. The Act on Criminal Procedure states that the person under compulsory treatment has to be given a personal hearing, if possible, in the review procedure. If we look at the actual practice, however, we find that this is not the general rule. We might wonder what could have lead to such a result.

Permission for the person under compulsory treatment to appear before court is given by the leading physician of the Forensic Medical Institute.<sup>85</sup> If the physician decides is against the patient's appearance before the court, there is no room for complaint, appeal or any kind of legal remedy, nor does the physician have any legally imposed duty to support the decision with reasons. As a result, the head of the Institute has a choice between the cumbersome option of shouldering the substantial costs of taking the patient to court (vehicles, personnel, time etc.) or the more convenient option of sending a written opinion.

It would be rather reasonable to modify the relevant legal instrument<sup>86</sup> with a view to making it possible that the leading physician's decision against the patient's appearing before the court should be open to revision and appeal. This decision might not only influence the result of the court review, but it would also reduce the extent to which patients are exposed to the procedure. (It is worthy of note that while the earlier legal rule used to make the leading physician's decision a precondition of appearance before any authority, the decree in effect at present makes only appearance before the court conditional on such a decision.)

While the judges who decide on the necessity of treating involuntary psychiatric patients in ordinary hospitals appear personally at the scene of treatment, judges who conduct reviews of persons in compulsory treatment hardly ever go to the Forensic Medical institute personally. Since the person in compulsory treatment cannot as a rule appear in the court, procedures usually go through without a personal hearing and decisions are made on the basis of written opinions. A review in a courtroom usually lasts 5-10 minutes. The occasional presence of the person concerned does not make much of a difference to this pattern of events. Attorneys are usually assigned to patients *ex officio*. They are not usually well-informed enough about the case and meet their clients in the courtroom for the first time. Proceedings are routine-like and superficial.

There are two principles which underlie the Hungarian Law on Criminal Procedure: verballity and directivity. This means that the procedure must be conducted through personal hearings of the participants and conclusions must be drawn from directly examined evidence . Any violation of these principles is a matter which affects

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<sup>85</sup> Decree 11/1979 on the execution of punishments and measures, (4) Article 84/A.

<sup>86</sup> Decree 11/1979 on the execution of punishments and measures, (4) Article 84/A.

international obligations. The Hungarian Republic ratified the European Convention on Human Rights<sup>87</sup> almost ten years ago. The obligations enunciated in this Convention are legally binding on states who are party to it, and court decisions reached in accordance with them have the force of precedent. Article 5 of the Convention states that “Everyone has the right to liberty and security of person.” It was a violation of this article that the Strasbourg court found in *Winterwerp v. Holland* case. The Court held that every person committed to an otherwise closed mental establishment is entitled to take proceedings and must be secured a hearing. This is one of the most basic guarantees one must have attached to proceedings by a court.

### Everyday Life in Compulsory Treatment

People committed to compulsory treatment are taken to a specific establishment, the Forensic Institute for the Observation and Treatment of the Mentally Ill (FIOTMI). The FIOTMI is located within the walls of the prison in Kozma street, with 311 beds recorded, It is headed by a leading physician who is at the same time a commanding officer of law enforcement. The establishment is financed by the Health Insurance Fund to an extent dependent on the number of beds on the basis of a financing contract. There are also appropriations for FIOTMI in the law enforcement budget. The FIOTMI is presently functioning on a provisional license because it does not meet the architectural and professional minimum standards set by the 2001 decree of the Health Minister. Under an agreement based on legislative provisions, public health and epidemiological supervision over the inmates used to be administered by the Surgeon General’s Office (SGO) The codification adopted in 1999 put an end to this. Considering the conditions under which inmates have to be accommodated, this task can be appropriately performed only under conditions of increased and unceasing supervision. Law enforcement agencies, however, lack the adequate financial means and professional staff to do so themselves.

Rules on patients rights which are set out in the Health Care Act for patients under psychiatric treatment in health care settings<sup>88</sup> apply to those in compulsory treatment as well. Other legal instruments, however, allow for substantial exceptions from these legal prescriptions.<sup>89</sup> As a result, those in compulsory treatment, ordinary or provisional live in what are practically prison conditions despite the presumption that the provisions of the Health Care Act apply to persons in compulsory treatment, too.

A client of HCLU, presently in compulsory treatment, reported that on being committed to provisional compulsory treatment he had to hand over his phone card and had not been able to phone anyone since then. He had been given no reason to justify the measure up to the time we talked to him. Our lawyer wrote a letter requesting the director of FIOTMI to put an end to this unlawful state of affairs, referring to the recommendation of the

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<sup>87</sup> Act XXXI/1993 on the promulgation of the European Convention on Human Rights and Fundamental Liberties signed on November 4, 1950 in Rome and its eight rotocols.

<sup>88</sup> 11/1979 Decree, section (2) Article 84.

<sup>89</sup> Rules which deviate from some provisions of the Health Care Act are recorded in Decree 11/1979 on the execution of punishments and measures, and Ministry of Justice Decree 9/1979.



Parliamentary Commissioner of Human Rights, which had been accepted by the director, and to the legally enacted right of patients to maintain contacts.

#### A Selection from the Statements of the Parliamentary Commissioner of Human Rights

The Parliamentary Commissioner of Human Rights inspected the working of FIOTMI and reported that it was contrary to the norms set out in legal instruments and to the fundamental principles of medical treatment. She described the conditions prevailing at FIOTMI as virtually prison conditions and expressed her opinion that this state of affairs undermines the efficacy of medical treatment.<sup>90</sup>

Inmates in FIOTMI are not allowed to talk to their visiting relatives without supervision (by a female nurse, a male nurse and a prison guard), all their outgoing letters are checked while incoming letters being checked at random. Despite the prescriptions in the Health Care Act, which should prevail in this area of compulsory treatment, keeping contact with the outside world (friends, relatives etc.) is severely limited and is poorly regulated.

The situation so far described has recently been slightly modified by an amendment to the legislation on law enforcement which provides for in detail the patient's right to keep up contacts.<sup>91</sup> The new regulations, however, still limit this right severely. Persons in compulsory treatment have to wear a uniform. They can keep contacts in ways which remind one of prisons rather than hospitals: the person in compulsory treatment can meet only persons approved of by the establishment and his relatives as well as all his letters and parcels are checked. Contact is limited in other ways as well: not only is the range of persons allowed to visit them is regulated by the establishment but so is the frequency of visits. A person in compulsory treatment is allowed to see visitors once a week and to receive a parcel and telephone once a week.<sup>92</sup>

The amendment affected also the conditions under which coercive measures may be applied.<sup>93</sup> During her visit the Parliamentary Commissioner of Human Rights witnessed numerous incidents in which inmates were physically coerced. This is inhuman and degrading. Inmates are routinely tied down, locked in (seclusion is applied well beyond the necessary extent as a form of punishment), and the leading chain is also used every day. (The information brochure issued by the management describes the use of the leading chain as a security measure rather than a punitive one.) Equally contradictory to the Health Care Act, relatives are not notified of applications of coercive measures. The amendment brought with it moderate improvement in this regard, too. Under the new rules only limited physical restraint (e.g. holding with the hand) may be applied, which

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<sup>90</sup> Office of Parliamentary Commissioner Reports 3041/1998 and 1042/1999.

<sup>91</sup> Section (3) Article 12 of Act XXXIV/2001 on the obligations of employees in specialist health care and the modification of certain laws affecting health care.

<sup>92</sup> Decree 11/1979 Article 84.

<sup>93</sup> Section (4) Article 12 of Act XXXIV/2001 on the obligations of employees in specialist health care and the modification of certain laws affecting health care.

means that punitive measures (e.g. seclusion) or more severe means of restraint are now under a ban.

Reports by the Parliamentary Commissioner of Human Rights state that the situation of persons under provisional compulsory treatment is worse even than that of persons under ordinary compulsory treatment. Both the restrictions imposed under pretrial arrest and those imposed under ordinary compulsory treatment apply to these persons. An indication of the severity of their situation is the fact that they may be kept in solitary confinement without any justification, explanation or notification.

### Summary

Relevant legal instruments state that compulsory treatment is designed to treat people rather than to punish them. Although the law determines that the rights of psychiatric patients in health care settings are to guide the treatment of persons under provisional and ordinary compulsory treatment, a consultation of either the legal provisions or of the ongoing practice reveal that, in fact, the rules and procedures of imprisonment are applied to them. Legislation confers broad powers on the director of FIOTMI both as regards placement and treatment, as well as communication with the world outside. Established practices involve substantial violations of patients rights enumerated in the Health Care Act. The principles of the verbatim and of conclusions based on directly examined evidence are hardly observed in the course of review.

The power of the authorities to take measures with the aim of preventing crime are also a source of problems. With such power at hand, they can put suspects in an awkward position for no serious reason at all. For example, they can notify the outpatient psychiatric care center of the district where the person suspected of crime resides, and no legal provisions are there to regulate and limit such a move. It depends completely on the authorities whether they undertake such a measure.

In light of practical experience, provisional compulsory treatment is the most severe and most restrictive of coercive measures. Persons under provisional compulsory treatment are dealt with according to the rules on custody and ordinary compulsory treatment. Custody is itself a measure of restraint carried out under strict conditions. The situations created by it are made more severe by the procedures applied in compulsory treatment which are, in addition, virtually unregulated. Established practices emphasize the more severe aspects of both measures. To take an example from the experience of HCLU, an accused subjected to compulsory treatment could not leave his cell for over 4 months where he had been put with three others. The actual practice of provisional compulsory treatment defies not only the provisions enunciated in the Health Care Act but even the minimal rights of inmates serving their prison sentences.

The legal rules on compulsory treatment show signs of poor regulation and legal uncertainty. The provisions of the Health Care Act, a legal instrument which is couched in general terms, are offset by the lower level decrees and directives, and this circumstance is further aggravated by the fact that these latter fail to follow any regular

pattern and give rise, as a consequence, to chaotic practices. It would be necessary to redraft both the substantive and procedural rules relating to compulsory treatment so as to render them detailed enough to suit practical needs and to bring them in harmony with the Health Care Act and the aim of treatment.

The actual practice of reviewing both kinds of compulsory treatment also leaves much to be desired, primarily because the practice of completely omitting a vital stage – a personal hearing given to the person concerned – has become firmly established. The requirement of directness can only be identified at the level of principles rather than practice. Established “business routines” tend to assert themselves, the decision and “recommendation” of the leader of FIOTMI defines the outcome of the review procedure.

The regulation on compulsory treatment and the functioning of FIOTMI receive very little public attention. One or two special incidents occasionally emerge into public notice, but the reports that are issued about them hardly ever go into the details of the consequences, the rights of the culprit and the conditions under which he receives treatment. The FIOTMI is an establishment which is shut off against the outside world both physically and socially. It is partly as a result of this state of complete isolation that civil organizations protecting the rights of psychiatric patients have not conducted any surveys in this establishment. There are hardly any official data and statistics available. This alone would require a comprehensive survey of the area to be undertaken, were it not for the problems analyzed above which keep haunting it.