PUNISHMENT WITHOUT CRIME

THE INVOLUNTARY TREATMENT OF MENTALLY ILL OFFENDERS

Theses of Doctoral Dissertation (PhD)

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1. Introduction, Research Subject, and Methodology

"One must look into the mirror for a long time, often and for long, until one finally gets to know their true face. The mirror is not just a smooth silver plate, no, the mirror is also deep, like the mountain lakes, and whoever leans over it with great attention sees into the depths and always sees newer and newer depths (…)".[1] These thoughts by Sándor Márai are remarkable not only for their literary value. They aptly describe the essence of research carried out or to be carried out in the field of criminal sciences, while also serving as a reminder that there are few tools whose application as well as the way and quality of their application can reveal the current state of the era and our society, the advancement of its mentality or the lack thereof, with such relentless realism, much like a mirror, as criminal law does.

I found this particularly true during my research on involuntary treatment as a measure imposed on offenders who cannot be prosecuted due to their mental condition. According to András Szabó, "criminal law fulfills its role if (…) it does not attempt more than it is meant for: the punishment of crime".[2] Yet it is undeniable that certain legal institutions, such as involuntary treatment partially disrupt or at least challenge the classical conception of the role of criminal law. Ernő Friedmann saw the essence of "therapeutic punishment" precisely in the fact that it "does not retaliate against a crime but saves people for life".[3] These two statements clearly illustrate that applying sanctions to offenders whose criminal responsibility – and thereby the realization of the crime itself – is conceptually excluded, naturally leads to heated professional debates on the notion of "punishment without crime", raising both old and new questions to this day. Exploring these is especially justified in light of the double stigmatization, stemming from being subject to criminal proceedings and being classified as insane, as well as the marginalized position and limited advocacy capacity of those under involuntary treatment, which make them particularly vulnerable to potential violations in the course of the criminal procedure and law enforcement.

An overview of the historical development and the substantive, procedural, and enforcement-related aspects of the current regulation regarding the sanctioning of criminally irresponsible perpetrators reveals a long and far from concluded journey from the integration of insanity into criminal law by the Csemegi Codex, through the legal setting of major psychiatric disorders, to the (relative) harmonization with medical science; from the isolation of mentally ill offenders, through the recognition of the goal of treatment as equal, to declaring (hopefully not only theoretically) the primacy of that goal; from the workhouses and mental asylums, through the remand prison of Kőbánya, to the present-day

[1] MÁRAI Sándor: *Vendégjáték Bolzanóban*, Helikon Kiadó, Budapest, 2023. 235.
[2] SZABÓ András: A büntetőjog reformja – a reform büntetőjoga, *Jogtudományi Közlöny*, 1988/8. 523.
[3] FRIEDMANN Ernő: *A határozatlan tartamú ítéletek*, Athenaeum Irodalmi és Nyomdai Részvénytársulat, Budapest, 1910. 258.

Judicial Observation and Psychiatric Institute, which remains heavily influenced by the characteristics of penal institutions.

Considering the interdisciplinary nature of the research topic, I structured my dissertation upon the four-element concept of pathology in medical science, which is based on the tetralogy of etiology – pathogenesis – morphology – clinical aspects. The concept of pathology naturally presupposes the existence of a specific "disease" or disorder, which in the present case can be identified both in the mental state that provides grounds for involuntary treatment (subject to the fulfillment of additional conditions) and in the domestic regulation of the measure. Following this determination, the causes of the problem and the underlying trends must be examined as the representation of etiology[4]; in accordance with pathogenesis[5], the overview of the disputed issues becomes possible through dividing them into smaller, interconnected units; following the pattern of morphology[6], deficiencies manifested in the legal practice can be observed; and within the framework of clinical aspects[7], the functional impacts and discrepancies in law enforcement can be explored. As an addition to this, the analysis of historical precedents, the identification of key stages in the development of the measure held evident significance. Furthermore, regardless of the nature of the disorder in question, the presence of a "specialist", an external influencing and shaping factor, is always necessary to determine and constrain the further course of the "disease". In this case, such a role can be attributed to the European Court of Human Rights (ECtHR), the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), and (ideally) the domestic legislator as well as the Ombudsman.

Regarding the methodology, in addition to the relevant sources of law, I used selected works from the academic legal literature combined with certain related medical studies. A significant added value to introducing the review procedure of involuntary treatment was provided by my court research conducted in 2023 and 2024, through the personal observation of ninety-two proceedings. For the enforcement-related aspects, in addition to my visits to the Judicial Observation and Psychiatric Institute (IMEI), which serves as the place of implementation for involuntary treatment and is part of the prison system, the 2023 visit by the CPT and its 2024 report provided current grounding along with the Hungarian government's response. For the international chapter, my research with a *Fulbright* scholarship[8] in the United States in 2024 was crucial in presenting the operation of specialized courts handling cases of offenders with mental disorders and the "best practices" applied by them, as well as in assessing the potential for integrating these practices into the Hungarian legal practice. With the

[4] It examines the causes of the disease.
[5] It analyzes the course and mechanism of the disease.
[6] The observation of structural changes affecting cells, tissues, and organs.
[7] The analysis of the functional consequences of morphological changes.
[8] The completion of my dissertation was also significantly supported by the Rosztoczy Foundation, the Hungarian State Scholarship Eötvös, and the New National Excellence Program's Research Scholarship for Doctoral Students in Higher Education.

support of the University of California, Berkeley, I attended nearly two hundred seventy hearings in various counties of the state. In every chapter of my dissertation, I have emphasized proposals aimed at improving the current regulation and practice of involuntary treatment, while in the international section I placed focus on the expectations and requirements whose enforcement is fundamental for the lawful and fair application of the liberty-depriving measure.

2. The Substantive Criminal Legal Regulation of Involuntary Treatment *De Lege Ferenda*

An overview of the historical background reveals that several elements of the current regulation and practice of involuntary treatment – such as the requirement regarding the seriousness of the underlying criminal act and the perpetrator's danger to society deriving from the sanction's *ultima ratio* nature, the relevance of the necessity criterion concerning the (undetermined) duration of the measure, or the post-release supervision by a relative or state institution – had already developed, at least at the level of principles, under the scope of Act XLVIII of 1948, Act II of 1950 on the General Part of the Criminal Code, and the Penal Code of 1961. Even today, the conditions for imposing and terminating the measure are not solely determined by doctrines but are significantly shaped and refined by the evolving judicial practice.

After presenting the possible methods of determining criminal responsibility and its relation to the concepts of criminal and civil capacity and legal competence, I specifically addressed insanity as a biological cause potentially excluding (or limiting) criminal responsibility. I analyzed the legal and medical-scientific approaches to this condition, discrepancies between the two supported by my empirical research, and their manifestations in practice. I also discussed the need for the general use of the formal concept of "insanity" in the field of criminal sciences, which is filled with content by medical science – more precisely, expert practice – and the possible need to create a new expert methodological guideline. On the one hand, this is justified by the fact that even though the Criminal Code does not refer to specific types of mental disorders anymore, they continue to appear in other legal provisions, such as the Criminal Procedural Code (CPC), which stipulates that proceedings must be suspended if the defendant becomes "psychotic" after the commission of the criminal offense. On the other hand, such a guideline would make the applied expert methods and diagnostic criteria more understandable and verifiable for legal practitioners.

Beyond the concretization of the risk of recidivism as a prognostic condition in the relevant case law, it is advisable to refer to the need for standardized methods in expert assessments, the rather theoretical possibility of judges deviating from expert opinions, and the resulting tensions related to "experts' jurisdiction". Therefore, emphasis must be placed on aligning the conceptual frameworks of law and medical science and on providing legal practitioners with specialized training and knowledge. Regarding experts, legislative action is currently needed, since the former CPC stipulated that two experts must be involved in mental evaluations, whereas the new Code includes no such provision. In fact, the accompanying justification states that the legislator intentionally moved away from the former view, not considering the number of experts to be a criminal procedure-specific issue. However, it is noteworthy that this provision was not integrated into any other acts, such as the one on forensic experts, and is currently regulated only by a decree, which raises concerns due to its (even) easier modification and the lack of (sufficient) safeguards.

Regarding the criminal acts against the person that can serve as the basis for involuntary treatment – the listing of which among the Definitions of the Criminal Code pertains to the entirety of the Code –, a distinction may arise between those that involve actual use of force and those that entail threatening with its use. In my view – considering the *ultima ratio* nature of the liberty-depriving measure and the requirement of the severity of the underlying offenses that becomes evident from the current wording of the Code –, such acts should generally justify involuntary treatment only when actual violence arises. However, this restrictive interpretation that is more closely connected to the dogmatical and foundational principles of criminal law is not clearly supported by the Code's Definitions. Moreover, an example can be found in the Supreme Court's practice when it was stated that there can be no differentiation between an act committed with actual violence (against the person) and one with threatening thereof (robbery), so both should be considered violent offenses against the person for the purpose of applying the sanction. At the same time, the selective approach would not fall too far from the logic of the regulation, since e.g. all forms of domestic violence are listed among the violent crimes against the person in the form of referring to Section 212/A of the Criminal Code, however, it is hardly credible that misappropriating or concealing any assets from conjugal or common property (and thus causing serious deprivation to the victim) could serve as a basis for involuntary treatment. With regards to the Supreme Court's approach, not even this interpretation can be ruled out definitively, yet it appears neither realistic nor appropriate. I therefore support the position that involuntary treatment may be ordered for the offenses listed among the Code's Definitions, however, the court cannot apply them in an inconsiderate way without prior assessment; instead, the evaluation of the given act in the scope of the application of the measure shall be decided upon thorough consideration of the facts and circumstances of the case.

Also worthy of consideration is a modest and thoughtful expansion of the underlying offenses to include certain acts with objectively greater gravity[9] as reflected in the ranges of their penalties. This can be particularly relevant for certain aggravated forms of offenses, the specific integration of which among the relevant acts would not be inconsistent with the current structure of the regulation either, considering that the lawmaker used the same logic, for instance, in terms of mutiny. Instances may include the aggravated forms of illegal entry into private property, particularly when the person who enters into or remains in the home or other property or the confines attached to such of another person

[9] In view of the violent acts against the person listed among the Definitions, the "minimum" of the gravity of the act can typically be considered to be punishability with imprisonment of up to three years.

does so by force and qualifying circumstances occur, e.g. displaying or carrying a deadly weapon (which is punishable with imprisonment of one to five years); the larceny of motor vehicle, which may be committed by force (and also carries one to five years of imprisonment); or coercion on the part of the authorities, especially in criminal cases.

By contrast, incorporating less severe offenses, especially the frequently disputed public nuisance or harassment into the regulation of a measure currently involving undetermined deprivation of liberty, thus making it one of the most drastic sanctions in the legal system, is highly questionable. It is undeniable that there is a gap in the legislation as these acts cannot be grounds either for involuntary treatment or for forced medical treatment under the Health Care Act – which can be ordered if other statutory requirements for involuntary treatment are fulfilled, but, if the perpetrator was criminally responsible the punishment would not be more than one year of imprisonment – however, this discrepancy should primarily be addressed by potentially expanding the scope of forced medical treatment rather than extending or blurring the boundaries of the liberty-depriving sanction. Conversely, with regards to proposals aimed at reducing the scope of the offenses listed among the Definitions, I take the view that the current provision already offers an adequate response in the form of the final statutory criterion, the hypothetical judicial decision by stipulating that if the offender was punishable, the judge would impose imprisonment of more than one year, which evidently goes beyond the penalty range prescribed by the Code and offers the court far wider discretion even in comparison to other European countries.

The most controversial aspect related to this requirement is the evaluation of the offender's "hypothetical guilt". While the list of violent crimes against the person solely entails intentional acts – which is appropriate in the context of involuntary treatment given that the risk of recidivism is only meaningful in such cases –, the consideration of offenses endangering the public can be debatable. Public endangerment, evidently the most fundamental act in this category, is explicitly punishable under the Criminal Code both when committed intentionally or negligently. Besides, legal literature tends to include interference with works of public concern, which may also be committed intentionally or negligently. A peculiar issue arises: while the nature of the liberty-depriving measure suggests that it should be applied only in the most serious cases, with other possibly non-criminal solutions being used elsewhere, it is the statutory regulation itself that implies the opposite, namely, including both intentional and negligent conduct. This is somewhat mitigated by the character of the offenses, which entails outstanding danger to society and by the fact that judicial decisions must be based primarily on the objective sentencing factors. I note, however, that setting out eligible offenses in a statutory form would be possible in the same way as the lawmaker determined the considerable violent crimes against the person and criminal offenses that endanger the public (or involve the use of arms) for the acts of terrorism.

One of the most striking elements in the currently sketchable picture and one again in need of restoration in Hungary is the provision concerning the duration of the measure in question. It is not only justified but also necessary to reinstate the relatively determined duration of the measure in line with fundamental principles related to the deprivation of liberty in the law enforcement system, the requirement of *nulla poena sine lege (certa)*, proportionality, and especially the expectation that the measure should not result in a more severe legal disadvantage on the perpetrator than any criminal penalties, and that insane offenders should not (basically) find themselves in a less favorable position by virtue of an acquittal and the imposition of the measure than a sane defendant.[10] Today, however, a view persists that the undetermined nature of the sanction is sufficiently justified by the goal of protecting the society and the aim of treatment. This would mean, though, that the legislator is not merely declaring the primacy but indeed the exclusivity of these objectives and values over the fundamental rights of the individual, failing to regulate even the most crucial limits of interference with such rights at the legislative level. It cannot be ignored that criminal legal provisions in the service of the rule of law must reconcile the protection of society and the fundamental rights of individuals in a manner that respects human dignity, equality before the law, and humanitarianism. Legal certainty and the additional principles of constitutional criminal law must accompany any sanction throughout its entire "life cycle" from its creation, through the establishment of its framework and imposition, to its execution. As the regulation in force between 2010 and 2013 on the relatively determined duration demonstrated, it is indeed possible to create a solution that allows the treatment of offenders who remain dangerous to society for life if necessary – but not within the system of law enforcement anymore – while also adequately integrating criminal legal safeguards into the application of the measure. This way, the medical and legal approaches are not getting into conflict, and the relevant provision does not compel professionals of either field into unjustified yet inevitable internal contradiction.

In connection with this proposal, I analyzed the potential dilemmas arising in the legal practice to which the legislator made a rather vague reference in the reasoning of the Criminal Code when abandoning the relatively determined duration and which were addressed in the Supreme Court's 1/2011. Decision on Criminal Legal Uniformity. The idea of the applicability of involuntary treatment only on those occasions when the hypothetical judicial decision would entail executable imprisonment for the offender may occur both for the undetermined and the relatively determined sanction, which, despite being a logical requirement, presumably does not require separate legislative specification. Besides, the question arises how to assess those cases in which an underlying act for the measure is committed in concurrence with another one that is excluded from the considerable offenses for the application of the sanction, and the (hypothetical) imposition of imprisonment of more than one year would only be

[10] I add that even in the case of reinstating the relatively determined duration of involuntary treatment, an individual who is criminally irresponsible will not be in the exact same position as a sane perpetrator, since when determining the upper limit of the measure, only the penalty prescribed for the underlying criminal act is taken into account; in contrast, for an offender who is criminally responsible, the court would consider the rules on the mitigation of punishment and any mitigating circumstances arising in the case when determining the length of the custodial sentence for the same act. I do not, however, consider this particularly problematic given that the measure must be terminated immediately, even before reaching the upper time limit, if it is no longer necessary.

possible based on the rules of cumulative sentences. This was obviously distinguished from the rather theoretical cases (considering the severity of the underlying offenses) in which more than one qualified act is committed, but the statutory requisite would still be met only due to the multiple counts of offenses and cumulative sentences. This distinction is supported, among others, by the conjunctive nature of the criteria for involuntary treatment, which must therefore be interpreted collectively and in light of their interrelation. It is worth noting that, in the context of active repentance, the Criminal Code expressly regulates a similar situation: the provision shall also apply in connection with multiple counts of offenses, where e.g. the criminal offense against life, physical integrity or health is considered decisive. This approach can be considered grounded from the perspective of the aim to enable the broader reparation for the damage caused by the offense and serves as an example that the arrangement regarding the scope of the applicability of cumulative sentences pertaining specifically to given provisions of the General Part of the Criminal Code is no stranger to the logic of the regulation. However, based on the principle that deprivation of liberty can only be applied as a last resort an opposing conclusion can be drawn in the situation in question. In my opinion, it is therefore necessary to distinguish between criminal acts according to whether they can, by their nature, independently serve as a ground for the application of involuntary treatment.

In determining the starting date of the relatively determined measure, the potential inclusion of coercive measures plays a significant role. After evaluating their liberty-depriving nature and their possible execution in the IMEI, I still consider the commencement of the actual treatment as decisive, according to which solely involuntary preliminary treatment shall be included along with the appropriate integration of this rule into the law. This is supported by the fact that both the six-month deadline for conducting the review procedure and the one established as a condition for adaptation leave are calculated from the start date of the execution of involuntary preliminary treatment. The emphasis on the effective initiation of the treatment is also reflected in the provision of the Law Enforcement Code (LEC) which allows the time spent in another medical institution to be included in the duration of the period of involuntary preliminary treatment, whereas the monitoring of the perpetrator's mental condition at IMEI prior to the coercive measure cannot be considered.

In determining the upper time limit of the measure, the assessment of multiple counts of offenses is particularly relevant. Taking into account the upper limit of the applicable punishment for the gravest of the multiple offenses and the corresponding legislative regulation of the issue is justified when reinstating the relatively determined duration. Furthermore – in contrast with previous judicial practice –, it shall be stipulated by law that the special, more lenient sentencing rules in the General Part of the Criminal Code for juvenile offenders also apply when determining the maximum duration of the measure in order to prevent unjustified disparities between sane and insane individuals within this category of offenders. It must also be noted that if a legal question arises in the judicial practice that remains unresolved or ambiguous, the interpretation more favorable to the perpetrator must be followed. It should be added that, where the measure is imposed under the special sentencing rules resulting in a shorter maximum than that applicable to adults for the same act, and treatment remains necessary thereafter, the civil psychiatric system must – and should – ensure continued care and treatment, just as in the case of adults.

Evidently, when reinstating the maximum term for the sanction, the question occurs whether the upper time limit should apply to involuntary treatments ordered before the amendment's entry into force. Contrary to the approach taken in the Supreme Court's 1/2011. Decision, I take the view that the answer must be confirmatory. The principles of *nulla poena sine lege*, humanity, fairness, and the prohibition of discrimination all require this stance. The *nulla poena sine lege* principle is unavoidable with regards to the execution of the measure (both in its type and extent) for which the legal practice has provided a number of examples in the form of similar modifications of other sanctions. For instance, the duration of placement in a reformatory institution, which had previously been an undetermined sanction, was set by the legislature in 1995 to a term of one to three years. A similar situation occurred when the maximum duration of community service work was reduced from a hundred to fifty days in 1997. Upon the entry into force of these amendments, the term of all placements in a reformatory institution became determined, and any portions of community service work previously imposed beyond fifty days were not enforced. Concerns of humanitarianism and fairness arising from the uncertainty of the undetermined sanction also go against allowing severely discriminatory differentiation among the individuals in question based solely on whether their involuntary treatment was ordered before or after the entry into force of the more favorable regulation.

Finally, I analyzed the question of the repeated application of the measure when the perpetrator commits another criminal act after the relatively determined involuntary treatment has been ordered (by final judgement). In such cases, applying the sanction again cannot be excluded in principle: the execution of both measures could proceed parallelly up to the shorter term, and thereafter continue until the longer duration expires. I note that, although the legislator perceived difficulties in these instances, Act LXXX of 2009 that introduced the relatively determined term already included a provision on "concurrence" by stipulating that the period of probation of suspended prison terms shall apply concurrently. The regulation of this in the Criminal Code – pertaining to the relatively determined measure – is also justified.

3. Proposals Concerning the Review of Involuntary Treatment

In order to present a relatively detailed picture, it was essential to outline both the regulatory background and the current practice of the review and enforcement of involuntary treatment. Regarding the review, a conceptual change occurred with the entry into force of the new CPC, jurisdiction over the procedure was transferred to the sentencing judge, and the lawmaker introduced the pertaining rules into the LEC instead of their continued integration into the CPC among special procedures, which has given rise to both formal (legislative drafting) and substantive issues, such as the appropriateness of single-judge proceedings instead of decisions being made by a chamber. The first and last comprehensive empirical research on review procedures in Hungary was conducted by the Mental Disability and Advocacy Center (MDAC), with its results published in 2004. From the perspective of nearly twenty years, a comparative study based on a similar yet expanded methodology and framework – conducted through the personal observation of court hearings – appeared both timely and justified.

Besides the presence of experts (and the treating physician) at the hearings, the legal representation of individuals under involuntary treatment – referring to which the ECtHR's case law has distinguished the mere appointment of the defense counsel from the provision of effective legal assistance – as well as the duration of the proceedings, my analysis covered the nature of the underlying criminal acts, the starting point of the measure (including involuntary preliminary treatment when applicable), and in light of my proposal to reinstate the relatively determined duration of the measure, the question whether at the time of the review the duration of involuntary treatment exceeded the statutory maximum of imprisonment prescribed for the (most serious) offense committed. Additionally, I examined the most commonly occurring mental disorders serving as a basis for the finding of insanity, along with the opinions issued by the IMEI and the court-appointed experts in relation to the review procedures, particularly those additional criteria that, in practice, are attached to the termination of the measure.

Among my findings, I would highlight that violent crimes against the person were overwhelmingly dominant (97%), particularly crimes against life, limb, and health: homicides and battery accounted for 68% of these cases. Both the IMEI (in the medical report) and the appointed experts provide opinions on the (potential) existence and nature of mental disorders in the patients. The subtypes of schizophrenia appeared in 71% of the individuals, with paranoid schizophrenia being the most common. The widespread use of involuntary preliminary treatment was reflected in the fact that 83% of the patients under review had previously been subject to this coercive measure. For approximately 14% of the subjects, the duration of the measure equaled or exceeded the upper limit of imprisonment for the most serious offence they had committed. These findings are in line with previous academic standings that the lack of preparedness in the civil psychiatric system and its presumed inability to care for those discharged from IMEI after the expiration of the relatively determined term cannot serve as a sufficient argument against setting an upper time limit for the sanction. Although the number of affected individuals is not extraordinary, the violation of rights and interests they face due to the extended deprivation of liberty within the law enforcement system is nonetheless striking.

While the online hearing of patients during the COVID-19 pandemic was a logical and effective substitute for their in-person presence, upon the significant reduction of medical risks, it would be worth considering to follow the practice of hearing the subjects in person, specifically at the IMEI – a progressive approach I observed during my court traineeship (in 2017) –, which could contribute not only to the more grounded judicial decision-making through direct experience but also to more effective communication between the treated persons and their legal representatives.

I also addressed the need for control mechanisms and an established set of criteria regarding the discretionary decision by IMEI's chief executive physician on whether patients can appear in court, as well as the possibility of involving court-appointed experts in such decisions. The lack of guidelines, justification requirements, and legal remedies regarding the patients' fitness for appearance creates room for arbitrariness while their participation in the trial is a fundamental procedural safeguard. Besides, it would be advisable for the IMEI to provide detailed reasoning for its position, primarily documented in the medical report. Given the medical nature of the issue and the fact that court-appointed experts provide opinions closer in time to the review date, it would be a realistic solution for the court to address the question to them whether the individual is fit to appear in court, which could serve as the basis for participation in the trial (or the lack thereof).

My research experiences abroad, particularly observing hearings at special courts for mentally ill offenders (mental health courts) in the USA – which share several features with Hungarian review procedures – revealed several best practices that could effortlessly be implemented domestically. Informing judges by relevant professionals in the form of organizing professional consultations before the reviews; prior consultation between defense attorneys and the represented persons together with providing sufficient information to them during the proceedings; as well as the expectation of experts' participation – possibly online – in the hearings are (or could be) such crucial elements of the reviews that support sound judicial decision-making and advance key issues such as ensuring a protective background, a placement in a social care institution after the discharge of the patient in a timely manner.

Mandating the presence of experts at the hearings by law is particularly relevant when their opinion contradicts that of the IMEI regarding the possibility of releasing the offender. Without their presence, neither the patients nor their lawyers have any opportunity to question them, which hinders effective legal representation and advocacy. In case the judges intended to address questions to them, they would be forced to adjourn the hearing. Requiring expert participation poses no significant obstacles, since it can be arranged online – similar to current practices for patients – without involving additional financial or infrastructural burdens for the justice system.

From the perspective of effective legal representation, I consider it essential that appointed lawyers exercise the right of appeal in accordance with the Code of Ethics of the Hungarian Bar

Association when the represented person appeals against the judgement, or their intent is clearly directed toward this. Along with placing greater emphasis on the professional conduct of defense attorneys, a formal complaints mechanism tailored to psychiatric patients should be established. Individuals must also receive adequate, understandable, and accessible information about the proceedings and their rights.

While I agree that establishing a protective background through social care institutions or relatives after the termination of involuntary treatment and years of deprivation of liberty in the IMEI is crucial to ensure patients' long-term stability and reintegration, a clear contradiction exists between the requirement narrowly defined by statute and the universal application of this criterion in the experts' practice. The LEC only prescribes for severely ill or incapacitated patients to be taken home or, if necessary, to be placed in an appropriate medical institution or in a specialized care institution providing personal care, with the required measures to be taken by the chief executive physician of IMEI. Even though the law suggests that this condition should be examined on a case-by-case basis, experts are applying it to every situation by linking it to the risk of recidivism, with the reference that reoffending in terms of a similar criminal act may only be excluded if a protective background exists. If the general application of this criterion is indeed indispensable (due to its inseparable intertwinement with reducing the risk of recidivism), the pertaining regulation must also reflect this. I note that this would be more realistic if the regulation incorporated such a safeguard as the determination of the maximum possible duration of the sanction, which could to some extent offset the more restrictive condition attached to the termination of the measure.

However, it is still a significant issue that individuals undergoing involuntary treatment often remain in the IMEI for months, or even years, beyond the point at which the Institution would deem their discharge justified, solely due to the lack of available places in social care homes. While the ECtHR accepts that national authorities are entitled to condition the release of a treated individual on the availability of a certain level of supervision, and may thus defer discharge until such arrangements are in place, this is only compatible with the European Convention on Human Rights if the delay is not unreasonably prolonged and if the legal system provides adequate safeguards against such excessive delay. In this context, it is worth mentioning that applications submitted on behalf of all individuals for whom the IMEI recommends discharge and placement in a social care home – but also a substantial portion of applications submitted to social care homes in general – explicitly request priority access to available spaces. According to the Act on Social Administration and Social Benefits, when a request for priority placement is made, the head of the institution determines the justification for the claim and, in cases of multiple claims, decides on the order of fulfillment. A lasting solution to this issue could only be achieved if the increasingly urgent need to establish an adequately capacitated institutional network was exceptionally not sacrificed to the – at least in this field – continuously cited counterargument of insufficient funding.

In my own research, out of 92 hearings, the court terminated the involuntary treatment of 11 offenders. Among those affected, the proportion of individuals who had a statement of acceptance from a relative was similar to those who were placed in a social care institution. According to the information provided by the IMEI to the CPT, the waiting time for admission to a social care home is at least one year, often longer, and following the Committee's visit in 2023, 27 individuals were awaiting placement. This situation – which has also been acknowledged by the Hungarian government – raises the issue of detention without legal basis. Furthermore, it poses a serious challenge for both the patients and the staff of the Institution by negatively affecting the therapeutic relationship and patient motivation. In 2023 and 2024, likely not completely unrelated to these findings, a significant increase was observed in the number of discharges from the IMEI compared to data from previous years.

4. Recommendations Concerning the Execution of Involuntary Treatment

Stepping out of the courtroom and into the IMEI, which is a regular subject of recurring criticism due to its "prison within a prison" character, the fundamentally Janus-faced status of involuntary treatment as a liberty-depriving yet therapeutic sanction and those subjected to it as detainees and patients becomes unmistakably evident. This duality is echoed by the outer walls reinforced with barbed wire and the open-door ward system within the building; by the application of coercive measures as defined in the LEC alongside pharmaco- and psychotherapy; and by the alternating roles of the psychologists and nurses employed at the Institution, who at times replace their white coats with uniforms. While the former Decree No. 36/2003. (X. 3.) on the implementation of involuntary treatment and on the responsibilities and operation of the IMEI regulated the Institution's legal status, this is conspicuously absent from the currently applicable Decree No. 13/2014. (XII. 16.) – it is only the Institution's founding charter and its organizational and operational regulations that provide guidance – , therefore, it would be advisable to (re)establish the IMEI's legal status through statutory regulation.

Involuntary treatment applied in the absence of criminal responsibility is undoubtedly an ambiguous sanction within the criminal justice framework, however, criminal proceedings – despite their potential to criminalize or stigmatize – can, in principle, offer additional safeguards for offenders with mental disorders, which (when consistently implemented and enforced) constitute a substantive argument in favor of maintaining the current regulatory structure. Nonetheless, the question whether this line of reasoning remains equally valid with respect to the enforcement of such measures within the penitentiary system is a subject of recurring debates. I consider it reasonable to further integrate the IMEI into the healthcare system along with the necessary security measures maintained or newly established, and emphasis should be placed primarily on aligning the Institution more closely with the healthcare organizational framework and reinforcing its hospital-like character. Additionally, the closure of the National Institute of Psychiatry and Neurology (OPNI) in 2007 as a part of the "healthcare reform" has had lasting repercussions on the civil psychiatric system, ranging from reductions in bed capacity through decreased funding for outpatient psychiatric services to a persistent shortage of qualified personnel. In light of these issues, reopening the OPNI is also a matter worthy of consideration.

In its report published in 2024, the CPT pointed out that the issue of relocation despite its repeated recommendations and a number of commitments by the Hungarian government remains unresolved and has not lost its relevance considering the requirements of modern psychiatric care. It cannot be overlooked, however, that unlike the previous reports on the IMEI, this document also contained significant positive observations regarding specific developments implemented at the Institute and the variety of therapies made available to patients. Nonetheless, a substantive and ongoing concern regarding the Institute's operation and therapeutic environment is the broader provision of accommodation for patients in smaller units. Achieving this by dividing the existing wards would be essential for safeguarding the treated persons' right to human dignity, enforcing the prohibition of inhuman treatment, and facilitating the timely fulfillment of the purpose of the measure.

The CPT specifically deemed the IMEI unsuitable for the treatment of mentally disordered juvenile offenders and urged their placement in a different institution. The Hungarian government, however, rejected this proposal with an argument of questionable robustness that, according to the provisions of the LEC, the IMEI is the only facility where involuntary treatment can be carried out, claiming that its infrastructure and staff are adequate for achieving the therapeutic goal. Yet, as supported by my research, the overwhelming majority of patients under involuntary treatment are adults, the IMEI's system was fundamentally designed with their treatment and needs in mind, and (on some occasions) the Institute lacks both the material conditions required for the treatment of juveniles and the specialized staff trained for this specific purpose. In the relevant legal literature, it has also been raised repeatedly that the needs and rights of this group of offenders would be better aligned with their protection if treatment was provided in a civil psychiatric institution.

The situation of patients within the IMEI is fundamentally defined by two main aspects: the enforcement and protection of their rights, and the application of restrictive means and certain coercive measures against them. Whether viewed from an international perspective through the provisions of conventions, resolutions, and recommendations, the expectations reflected in ECtHR case law, as well as the state practices presented in my dissertation, or from the standpoint of domestic regulatory and enforcement trends, there is a discernible shift towards the strengthening of patients' rights and a persistent, though at times seemingly fragile, effort to establish (criminal) legal safeguards to protect individuals with mental disorders and reduced ability to assert their rights and interests. In connection with certain rights afforded to patients, it is necessary to place greater emphasis on the requirement of accessible, comprehensible, and, where needed, repeated provision of information given that (according to the CPT's observations) patients are regularly unaware of some of their rights. Among these is a particular feature of treatment, which is not without ambiguity and contradiction in the practice of involuntary treatment, namely, that while the patient obviously cannot refuse the treatment as a whole, the right to refuse certain methods and the interventions intended to be used extend to those subjected to involuntary treatment as well. For these cases, it is justified to create a statutory requirement of obtaining a second medical opinion (from a psychiatrist not involved in the patient's treatment) if the individual objects to a particular intervention.

In terms of the restrictive means, the requirements articulated in international legal instruments, the ECtHR's case law, the guidelines of the CPT, as well as in domestic legislation play a significant role orienting, among others, the permissible duration of such measures, the exercise of (in-person) professional oversight of their application, the provision of clear and comprehensive information to patients, and the establishment of accessible complaint mechanisms for those affected. One of the most striking deficiencies regarding the execution of involuntary treatment is the lack of compliance with these expectations. From both the patients' rights and the data protection perspective, the electronic surveillance of the treated persons raises concerns due to its general application within the wards (not targeted at specific individuals) as well as to its use during mechanical restraint, which, even in cases of staff shortages, cannot substitute for continuous personal supervision. It shall also be noted that, consistent with the CPT's findings from 2010, prison officers at the IMEI continue to lack specialized training in working with psychiatric patients – although the Training, Continuing Education and Rehabilitation Centre of the Hungarian Prison Service includes components addressing the management of inmates with psychological and mental disorders in its curriculum –, so this area also seems to be in need of further development.

While in several European countries a legal institution comparable or related to involuntary treatment allows for the possibility of "conditional release", in Hungary this function is ostensibly fulfilled by the adaptation leave, which, however, is being applied with increasing restrictiveness based on the current pieces of experience. In the majority of cases, the absence of a suitable and willing caregiver constitutes the main obstacle to granting adaptation leave, thereby significantly narrowing the scope of its application, while the temporary, supervised release from the IMEI would be crucial in facilitating reintegration into society. It is therefore necessary to examine how the opportunity could be extended to a broader group of patients, provided other conditions are met, potentially even within institutional settings considering especially the fact that affected individuals are also likely to be placed in alternative institutional environments after the termination of involuntary treatment. Furthermore, the former regulation explicitly listed the members of the Adaptation Committee (whose recommendation forms the basis of the chief executive physician's decision on adaptation leave), including the representative of patient rights. In contrast, the current legislation constitutes a regression in terms of legal safeguards as it merely provides that committee members are appointed at the discretion of the chief executive physician, and the IMEI's representative of patient rights is only an invited (potential) participant whose presence is not mandatory. I consider it advisable to reinstate the mandatory participation of the representative of patient rights in order to promote the enforcement of the rights and interests of those under involuntary treatment.

A similarly remarkable deficiency in connection with the current law enforcement is the absence of a system for aftercare, despite the fact that several other countries attribute particular significance to this element, primarily to prevent recidivism. One shall only consider the example of Germany where further treatment is provided within the framework of outpatient care and supervision by probation services; or Austria, France, the Netherlands, and Portugal where specialized clinics and accommodation facilities have been established exactly for this purpose; even Japan where rehabilitation coordinators play a key role. In Hungary, such a system could most feasibly be created through the involvement of probation officers. Naturally, this would to some extent alter the traditional concept of probation with supervision as a supplementary measure linked to other sanctions, nonetheless, the Criminal Code already provides precedent for such an extension, e.g. its applicability related to conditional prosecutorial suspension. The suitability of this measure is demonstrated by its dual objectives: the prevention of reoffending and the facilitation of social reintegration, including contributing to the creation of necessary conditions and supporting the development of essential social skills. It would be worth considering organizing preparatory and informational sessions and training for probation officers to ensure the creation and maintenance of effective cooperation with this special group of individuals. Although the annual number of terminated involuntary treatments is negligible in comparison to the caseload of probation officers, the expansion of staffing is warranted in view of the already existing overload. In practice there is also a recurring demand for discharged patients to be subject to a mandatory requirement to participate in outpatient treatment at the regionally competent psychiatric care institution – which could be implemented, for instance, as a rule of conduct within the framework of the probation with supervision –, since without continued (pharmacological) therapy, their condition is unlikely to remain stable and the risk of recidivism increases significantly.

In relation to the implementation aspects of my proposal to reintroduce the relatively determined duration of the sanction, I note that both the LEC and Decree No. 13/2014. (XII.16.) contain (transitional) provisions on how to proceed in cases where the maximum possible term of the measure has elapsed, specifically addressing the scenario in which psychiatric treatment is still deemed necessary after the termination of involuntary treatment, thus they may serve as appropriate ground when re-introducing the relatively determined duration as well. Should further treatment be justified – a situation that, as confirmed by both previous analyses and my own research, applies to a relatively small number of patients – the duty could be transferred to the civil psychiatric system provided that appropriate security mechanisms are in place.

5. Closing Remark

The remaining and at the same time most fundamental question is: what picture does the current regulation of substantive criminal law, procedure, and enforcement present to our society – as the mirror mentioned in the introduction – regarding the treatment of particularly vulnerable individuals suffering from mental disorders? The effort to create a balance between the necessary safeguards of the liberty-depriving measure and the protection of society accompanies and continuously shapes the application of the sanction, serving as a reminder that every community is defined as much by the humanity it enforces as by the cruelty it tolerates, and by the rights it upholds as by those it allows to fade into the far-from-benign obscurity of neglect. It may not be an overstatement to assert that this picture reveals countless depths filled with plays of light and shadow, much like the human mind itself. And these depths are as timeless as Foucault's truth: man and madmen are more closely linked than they could ever have been in the powerful animal metamorphoses illuminated by the burning mills of Bosch; they are joined by the impalpable link of a reciprocal truth.[11]

[11] FOUCAULT, Michel: *History of Madness*, Routledge, London – New York, 2006. 529.