

Human Rights  
in  
Mental Health



**REPORT**

**REVIEW OF FORENSIC PSYCHIATRIC  
AND PRISON MENTAL HEALTH  
SERVICES IN UKRAINE**

December, 2015

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This publication is prepared within the framework of “Strengthening Capacities of the Ombudsperson’s Office” Project, Implemented by the United Nations Development Programme with financial support from the Ministry of Foreign Affairs of Denmark.

The opinions, attitudes, and assessments contained in the report do not necessarily reflect those of the United Nations Development Programme, other UN Agencies or the Ministry of Foreign Affairs of Denmark.



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## EXECUTIVE SUMMARY

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At the end of November 2015, a group of four foreign experts toured forensic psychiatric facilities in Ukraine to collect information that would help to develop good practice and lead to a plan of reform. The team worked under auspices of the Ukrainian Parliament Commissioner for Human Rights, and was accompanied by two staff members of the Ombudsman's Office. They spent time talking to senior managers and clinicians, front line staff and talking privately with patients.

The report describes finding units that operate as 'total institutions,' over controlling all aspects of patients' daily lives but failing to offer a wide or effective range of modern psychiatric health care. Patients are unoccupied and locked into their rooms for nearly the whole day. Their care is not individualized, not based on principles of recovery and rehabilitation and largely consists of medication, including the heavy use of older, sedating anti-psychotics. At the same time, hospital regimes are unnecessarily restrictive and depersonalizing. The use of separately managed, uniformed security guards also adds to an atmosphere of un-therapeutic, custodial control.

There is a great opportunity for Ukraine to acknowledge that its forensic psychiatric system urgently requires reform, with clear evidence and examples of how this can be successfully achieved. Hospitals do have some facilities with which they could deliver a wider range of multi-disciplinary treatment and staff who are keen to develop practice in line with the modern evidence base of psychiatry and international standards. The skills, goals and hopes of both patients and staff that currently are crushed by restrictive rules are there to be nurtured and developed. This would change the patient's experience of their time in hospital from a traumatic to a therapeutic one and establish a forensic health care system that safely rehabilitates mentally ill offenders and returns them to the community as productive members of society.

The report distinguishes issues and makes recommendations at three levels: the systemic, institutional and therapeutic. It is recommended that one or more pilot sites be identified by a tendering process to implement a reformed pathway of treatment from high security to out-patient treatment based on principles and models outlined within the report. This pilot site can be twinned with suitable facilities abroad and supported to develop as a national center of excellence in forensic health care.

Immediate changes to rules and regulations in the existing institutions are recommended to improve the care and lives of patients and working lives of staff. Finally, recommendations are made to develop the therapeutic interventions offered by the hospital's multi-disciplinary teams.

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## ASSESSMENT OF EXISTING FORENSIC PSYCHIATRIC SERVICES

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At the end of November 2015, a group of four foreign experts toured forensic psychiatric facilities in Ukraine, including the High Security Hospital in Dnepropetrovsk.<sup>1</sup> It was a multi-disciplinary group, comprising of a director of a forensic psychiatric hospital, a chief forensic psychiatric nurse, a prison director and an expert on Ukrainian mental health care services.<sup>2</sup>

Our mission was not to uncover abuses, but to collect information that would help to develop good practice and lead to a plan of reform. This report is the result of our visits. Although the paper provides a critical assessment of the current situation, it is intended to be a tool to be used to develop the existing system and bring it in line with international standards in forensic psychiatric practice.

We would like to take this opportunity to thank the directors of the facilities visited for their willingness to allow us to carry out our visit unobstructed, even though our arrival was officially unannounced and might have been perceived as an audit rather than an attempt to gather sufficient information on which to base well-founded recommendations for future development. We also thank them for the frank discussions during our visit and their willingness to discuss our “outsider’s view.” We fully understand any occasional feelings of discomfort, but hope our assurances of a positive approach and intent were accepted.

In the report “he” refers to both male and female patients.

### OVERALL ASSESSMENT AND INITIAL REMARKS

On entering the hospitals and speaking to staff and patients, it became clear to us that Ukrainian forensic psychiatric services represent “total institutions,” with a central focus on control and subordination. In such a situation, both patients and staff, including directors, become subject to a system, either maintaining the system as it is, or trying to perfect it by developing more rules and regulations to keep the patients under control.

Our way of operating was deliberately unconventional, but allowed us to gain a good inside view. We avoided long discussions about regulations, rules and operational issues with the hospital directors, but rather spoke to those involved in the services “at grassroots level”: the patients whom we met on their own wards, without any staff present and members of staff, without their superiors. Sometimes discussions were held in groups, sometimes individually. One of our team members in the mean time met with the director, allowing us to have a more complete view of the work of the hospitals.

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<sup>1</sup> The visit took place on November 15-22, 2015, and included visits to the following facilities: Dnepropetrovsk Special Psychiatric Hospital (strict regime); Dnepropetrovsk Oblast psychiatric Hospital (medium regime forensic department); Poltava Oblast Psychiatric Hospital (medium regime forensic department); Kiev Oblast Psychiatric Hospital in Glevakha (medium regime forensic department).

<sup>2</sup> For a short curriculum of the four experts see the appendix to the report.

What emerged was a heartbreaking picture of people lost in a system. Senior managers seemed to have also become lost in a labyrinth of rules and regulations, often citing legal obstacles as the main reason why things had developed this way and could not be readily changed.

At the same time, we met many staff members who voiced sincere concern for the situation in which their patients found themselves, who became emotional when going into details and who showed interest in doing things differently, if they could be allowed to do so. This gives hope that a different system can be built, one based on humanity and compassion, professionalism, a high standard of care for this specific group of patients and adherence to the main goal that should never be forgotten: to reintegrate these patients and return them to their loved ones as soon as they no longer pose a danger to others and themselves.

There are no universally applicable standards, procedures or criteria for compulsory treatment followed by the institutions that are engaged in compulsory treatment in Ukraine. As a result, both the conditions and the restrictions that are applied differ between hospitals. Treatment procedures and security restrictions, which should be applied in accordance with the security level enforced (ordinary, medium or strict), are not regulated and the decision of the court on the imposed level of security is based on legal, rather than medical criteria.

In fact, the duration of compulsory treatment is independent from the patient's condition, the dynamics of the disease or from the social risk caused by the patient. Rather, it is mostly related to the nature of the crime. None of the hospitals visited, including the high security one in Dnepropetrovsk, routinely use validated, evidence based instruments or methods to assess the risk of a recurrence of aggressive behavior. Very few hospital staff are specially trained in risk assessment and know how to use such tools.

### SYSTEMIC ASPECTS

Patients who have committed serious offenses and been found by a court to be "of unsound mind", are during their hospitalization treated at two or three medical institutions of differing levels of security before they return to society (where they may still undergo out-patient treatment). The patient does not have continuity of care. When stepping down to a lower level of security, the patient finds himself having to 'start again' rather than feeling he is making progress towards his discharge. Patients, even if they are willing to do so, cannot get involved in the process of their own treatment or make any impact on the length of their hospital stay.

Because of lack of space and appropriate staff, patients spend a large part of their time in bed, although the core of forensic psychiatric care is to help patients gradually return to normal life by gradually expanding their space from the bed to the ward, from the ward to the hospital department, and from the hospital department to the community. Therefore, it is important to create a well-organized and continuous treatment plan that involves not only medical professionals of various

specialties, but also the patients themselves actively striving to participate in their own progress. This would greatly help to reduce the length of their stay in psychiatric hospitals and improve the effectiveness of the treatment given.

A full clinical assessment must be based on the behavior of patients in a variety of situations: at work, during leisure activities, sports, education and work, in group therapy sessions and through frequent individual interaction with staff and psychiatrists. The level of security, limitations and individual care plan are then based on the assessment of the individuals' needs and risks.

At present, professionals who are not managed by the hospital administration maintain security in forensic hospital departments. Their activities are mostly guided by principles and guidelines of penitentiary rather than medical institutions. Security guards wear uniforms and carry special instruments or even weapons. As a result, clinical departments look more like prisons than medical therapeutic institutions. At the same time, the treatment process itself is not regulated by any agreed models of care, normative acts or legal documents. This situation of "two bosses" in one institution seriously obstructs the creation of a therapeutic environment.

From conversations with individual staff members, it appeared to us that neither orderlies nor security officers are adequately trained, either in mental health issues or in appropriate management of aggression. In some institutions patients complained that orderlies used physical force. Medication, most commonly in the form of aminazine was routinely used to sedate patients and as a punitive response to what was considered "inappropriate behavior" (some patients asserting that complaints could result in such punishment).

There is ample evidence that the length of stay of patients in the various security levels is not so much based on the actual mental state of the patient or a well-founded evaluation of his dangerousness. Rather, it is based on the idea that the patient needs to remain hospitalized at least for as long as he would have been imprisoned for the crime committed. In some cases, for example when incidents such as minor fights occurred in prison or for reasons that remained unclear to us, patients were kept longer than the applicable prison term. This situation is not only very damaging for the patients and their families, but creates an unhealthy environment for the staff to work in and deprives society of valuable parents, spouses and productive citizens.

### INSTITUTIONAL ASPECTS

Closed institutes such as the facilities we visited are at risk of becoming "total institutions" and are highly vulnerable to destructive tendencies. There is a huge difference in power between staff and patients. No matter in which part of the world the clinic or prison stands, it is necessary to be aware of tendencies such as unauthorized violence, antagonism between staff and patients, depersonalization (not considering the other as an equal, unique and valuable person) and corruption.

An effort to fight these tendencies by imposing a set of strict rules and regulations and maintain a punitive attitude towards any form of deviation does not solve the problem. Rather, it provokes people to become very creative in undermining the integrity of the institute. It is obvious that measures such as giving more medication as punishment, keeping patients in uncertainty about the length of their hospitalization and restricting them and refusing them the ability to fulfill their basic needs (e.g. going to the toilet when necessary; communication with relatives) cannot be called fair. Some patients mentioned physical abuse by orderlies, yet paradoxically others were glad of constant CCTV supervision on the ward as they said, “they cannot beat us unseen like they do in other parts of the hospital.”

We observed that the patients are kept almost disconnected from relatives and friends and are kept uninformed, docile, dependent and passive. The overwhelming majority had no idea what their rights were and said they had never been informed of them. They came with simple yet crucial questions that representatives of the Ombudsman’s Office promised to resolve.

The treatment these patients are subjected to is based on the assumption that they are incompetent and imminently dangerous. We challenge that presumption. We sat down with “dangerous” men in their cells, discussing their fates, hopes and desperations, without any anxiety or feeling of being in danger. Most men and women could very well explain their situation, what they did and how, and what they would do if they had the chance, either by being active inside hospital or after finally being allowed to go home. Most of the people we spoke to were intelligent and competent despite the fact that they are stuck in a totally dependent position. Their crime happened long ago, they do not cause incidents or violence and yet they are not challenged at all to function in more stressful and demanding situations such as work, therapy or sports. As a result, there is no mechanism that allows staff to assess whether the person is able to manage himself under normal circumstances in the community and whether the risk of an aggressive response to stress remains.

The same applies to staff. A very strict hierarchy exists in all the institutions we visited, and every decision on a patient’s care or management is taken or approved by the treating psychiatrist or director. The rest of the staff follow orders and do their best, but may become as institutionalized as their patients and lose interest in the unique personal stories and circumstances of their patients. Among the younger staff members, we noticed a strong desire to bring about change, however they would usually only nod their heads showing that they agreed with us and express themselves in a non-verbal way.

The Ministry appoints the hospitals directors and the composition of hospital staff is approved by the same Ministry of Health. However, the activities of the hospitals are controlled minute detail by the prosecutor’s office and the hospitals must perform their activities in accordance with the internal procedures of penitentiary institutions.

When communicating with the directors of the institutions, we detected a need for strategic planning and a clear lack of internal control, as well as the absence of any analysis of cost and performance. If a service lacks a clear strategy (vision, mission, and goals), then confusion and instability can be

expected. At the institutional level it is important that the goals of the service are clear and attainable. At the team level, a culture of cooperation should be emphasized (patient-focused treatment, an orientation to patient outcomes, mutual trust and respect., which is now very much absent.

Only clinical research and medical treatment plans are completed, little attention is paid to psychosocial support with no special staff appointed to deal with psychosocial aspects of care. The social rehabilitation and employment centers that operate in the hospitals we visited and which employ psychologists include psychosocial activity rooms that can be visited by only a very small number of patients. The patients' work is fragmented and inconsistent and therefore has little impact on the progress of treatment and the improvement of the patients' condition. The vast majority of patients are treated mainly through pharmacotherapy.

The grim environment, the beds placed side by side in the wards and barbed wire on the fence protecting the courtyard create an oppressive atmosphere, not to mention the fact that the patients are locked in their wards during a greater part of the day. Most sanitary units were worn and needed repair. The patients could not have free access to the bathroom whenever they needed it (especially at night). Patients who are treated under strict supervision conditions and are not free to leave the ward, should be able to use the toilet at any time.

### **Strict Regime: Special Psychiatric Hospital in Dnepropetrovsk**

Although our site-visit was supposed to be unannounced, it was apparent that the director had received advanced notice of our arrival. He explained that funding had not improved since previous inspections but that the hospital had hired additional staff through various grants. He felt that there was limited room for maneuver, given current staffing and money. We quickly split up in groups and while one of us spent the day discussing issues with the director, two teams ventured out to the wards, talking to patients and staff.

The SPH in Dnepropetrovsk is located in a building wholly unsuitable for its function. It is a stand-alone building on the grounds of a pre-trial prison, partially dating back to the nineteenth century, partially built some 25 years ago. The hospital is comprised of 12 clinical divisions that on the day of our visit held 709 patients (among them 83 women and 1 child). The child was treated in the adult department. The number of discharges usually number around 130 per year, but over the past year and a half some 230 patients have been discharged and moved on to medium-security wards elsewhere, an unusually high number possibly caused by increased attention from the Ombudsman's Office.

Although unsuitable and with the exterior of the building looking very dilapidated, the interior was well maintained and departments were clean. What we immediately noticed was the large number of staff in white coats roaming the corridors, while the patients were locked inside their rooms. The numbers on wards had been reduced in recent months and though many wards allowed for 120 beds each, most held around 80 patients.

There is only one high security forensic hospital in Ukraine, which therefore provides a service to the whole country. Patients are admitted only on presentation of a final court decision and a personal identification document. Every six months, the hospital submits a statement to the court regarding the continuation or termination of the compulsory treatment of a patient. The statement provides a conclusion of the psychiatrists' commission on the patient's mental state and recommendations for the conditions for further treatment. Nevertheless, and as indicated earlier, it remains unclear what criteria are used as a basis of the recommendations, since patients spend on average 5-8 years in the hospital. In most cases they are diagnosed with a chronic mental disorder and are provided only with pharmacological treatment. In practice, no psychological or social assistance is provided to the patients, there are no real individual treatment programs and patients spend most of the time in locked wards with metal doors.

The hospital has a procedure for examining patients' complaints but few are received. There is no confirmed information on the procedure for referral of patients. If necessary, patients are taken to other health care institutions for consultations but consultants are not invited to the hospital. No annual control of costs and performance efficiency takes place. The hospital also lacks an approved procedure for maintaining medical records. The procedure followed is similar to those in regular psychiatric hospitals, which is not adapted for specialized long-term treatment.

As indicated earlier, security workers have their premises in the hospital and wear military uniforms while on duty. Around 30 security guards work in the hospital simultaneously. During the day, the patients cannot freely leave their wards without being accompanied by a staff member; hallways are at all times watched by a security guard who wears a military uniform. He locks doors and lets the employees enter and exit the department. Security guards are not subordinate to the clinical head of the department.

In the event of danger or an incident, security guards call for help from additional guards by pressing an alarm button. Security workers are equipped with sticks and handcuffs that they are entitled to use at their own discretion, without the permission of a physician, yet only under extreme circumstances. However, there is no written procedure for the use of these special measures.

This guard service is very cost-inefficient, stigmatizing and without any doubt has a negative effect on the treatment of patients with mental illness. A security guard has the keys to the ward and it is he who decides when a patient should be admitted to the restroom and when not.

The functioning of the hospital is controlled by the district prosecutor's office. All subsidiary activities (catering, laundering, cleaning, repairs, etc.) are performed in the absence of any works contracts, services are provided by individuals (who are paid in cash). Support services are operated by a number of patients and such work is considered as work therapy.

All in all, the picture we observed was a very sad one. All patients were given medication, usually high dosages and often multiple medications at a time (the minimum being sedation with e.g. aminazine, which made them drowsy and was probably also meant to limit their sexual drive).

Patients are usually locked up for at least 20 hours a day, with one hour of “airing” in a caged courtyard and perhaps some time in the evening to watch television. Those in observation rooms had no time outside of their room, except for toilet and wash breaks. They have nothing to do, except smoke and read books, which in itself is difficult because medication makes reading sometimes impossible. Some of the wards had new fitness equipment. In one ward a patient was found to be using a fitness cycle, which looked very new indeed and a novelty both to him and to the staff.

On the whole there is no daytime activity program. We visited the rehabilitation center where two art groups were in progress but in our view the area could be much better used to activate the patients. There were examples of art and craft made by a hand full of patients, but no evidence that these were allowed on the wards or in patient’s rooms. All bedrooms were bare and had not been personalized in any way. A wired in radio system, when used, is only ever tuned to one, conventional music station. One patient complained that she wanted to learn English but was denied the right to have an MP3 player; however, nobody has suggested to her the possibility of using a written course rather than an oral one. Patients referred to only seeing their psychologist once every six months. The rehabilitation center also held a chapel room, but there was no provision for any religious observance other than Christianity.

Patients were escorted in groups once a week to a large, austere shower room where they are required to shower communally whilst observed by orderlies. This is degrading and undignified. Showers on wards could only be used by those patients who went to work. All the men had compulsory monthly short haircuts, adding to their uniformity and depersonalization. The patients were unnaturally quiet and passive.

Most of the patients have disability status, and thus receive a pension. This pension is administered by the hospital, yet all our efforts to understand the system of finance administration were in vain. When a group of competent outsiders have no ability to understand the system, how then can patients understand how much money they have available and how they can spend it? This issue is all the more important, as we saw in other institutions that a robust system can be developed easily and this particular hospital has repeatedly been accused of using patients’ pensions for their own purposes. It would be in the institution’s interest to prevent any of the air of suspicion that is now prevalent. It felt uncomfortable to see patients who are considered to be totally incompetent “voluntarily” spend their money on hospital furniture or even donate their pension to the hospital.

Patients have very little communication with the outside world as visits are rare and telephone communication is forbidden. Correspondence was carefully checked and censored. In general, the approach seemed to be to exclude all possibility for any transgression e.g. contacting a former victim or their family, yet this system of total control also excluded any possibility to test whether the patient could ‘stay on track’ and behave appropriately.

An important issue is that patients do not know their rights. There appear to be no leaflets, no lawyers who come regularly to consult the patients; no advocacy organizations that help them to find their way through the constant tension between restrictions and the need to prepare for life “on the outside”.

Patients stated that they had not been given the option of attending court when their case was reviewed. They said that they had not heard of the video conferencing equipment available in the rehabilitation center, which staff said had been used 22 times in total. In addition, patients are uninformed about their mental state, their diagnosis, the treatment plan, the medication they receive and the reasons why they are administered these medications. When visiting the library we suggested having some books available to patients on psychiatry but this was met with responses that this would only excite them and make their situation worse. In short – patients are kept uninformed and that very much adds to the air of a “total institution”.

The visit to this SPH was probably the most emotional part of our tour. Staff described interacting with patients to develop their social and life skills but we met many patients who had been crushed by the system, who were fully aware of their predicament, showed no sign of either mental illness or aggression, were intelligent and could formulate in detail what their situation was and their future would be. In most cases we had to overcome fear among the patients to enable them to talk; some voiced their fear that they would be given aminazine or an injection as a punishment for their willingness to talk.

### **Medium Regime: Dnepropetrovsk Oblast Psychiatric Hospital (Dnepropetrovsk); Poltava Psychiatric Hospital (Poltava); Kiev Oblast Psychiatric Hospital (Glevakha)**

Medium secure units are located within regular psychiatric hospitals. Patients are admitted in accordance with the final judicial decisions and most patients arrive from the high security hospital in Dnepropetrovsk. In individual cases, hospitalization under medium regime conditions is imposed directly by the court.

Although there was a difference in rules and the prevailing climate between the various institutes, in general they had the same regime as the SPH in Dnepropetrovsk in relation to daytime activities, treatment and rehabilitation. In short: a biological approach to treatment, no link between dangerousness and length of incarceration, no daytime activities and no rehabilitation program.<sup>3</sup> The main difference was the fact that patients were less scared to talk to us (except in Glevakha, where they directly asked us whether their willingness to talk would result in punishment), could watch television during evening hours (in one facility patients were allowed to have their private television in their rooms) and could use their private mobile phone (however only once a week and during predetermined hours). One unit did not allow access to mobile phones and only permitted local calls from the ward phone.

As a result of the current political situation, the number of patients in the Dnepropetrovsk oblast psychiatric hospital has been almost doubled (82 instead of 49). The department carries out its activities in accordance with internal work procedures approved by the director of the hospital. There is no long-term strategy and budget plans are drawn up on an annual basis. The department has an approved procedure for the lodging and examination of complaints, which is advertised in a visible place for patients. However, no complaints have been received over the last three years.

The department in Dnepropetrovsk is surrounded by two rows of security fencing. Inside the territory, there is a cage for a big, noisy watchdog, which was said to be the pet of the guards. Security is ensured by the state non-departmental guard service that is paid by the hospital on the basis of a contract. There are 4 workers in each shift; they wear uniforms, have handcuffs and can use tear gas in extreme situations. It is not specified what situations should be considered extreme, which leaves room for diverging interpretations.

The medium security forensic department of the Poltava oblast psychiatric hospital is located in a separate building which has a perimeter surrounded by a fence and hired external security guards. The guards wear uniforms and carry tear sprays. The patients can leave the department on very rare occasions; medical consultations and even court hearings are organized on the premises. The grounds include a big courtyard and a sports square for outdoor games that have not been used since a patient managed to escape. Despite the fence, guards and the big space around the building all windows of the department are barred, which seems to be an unnecessary and repressive measure.

The patients can ask a nurse to buy them some goods. They give their bankcard to the nurse and ask them to buy the requested items. However no procedure for these matters exists in writing and this raises many doubts, as the patients also have to tell the nurse their PIN codes.

Poltava had a small area to which women patients could be admitted. Whilst this had separate sleeping and washing areas, it would be hard for the unit to be therapeutic for what would be only one or two women, perhaps with histories of victimization by men. Staff did not seem to recognize how difficult it would be for vulnerable women to live in such close proximity and in such a minority with men.

The medium regime forensic department in the Kiev oblast hospital in Glevakha served fairly good food, according to the patients, while another gave obviously too little and persuaded patients to help keep the wards clean in exchange for extra food rations (the patients were clearly emaciated and some even too weak to get out of their beds). In Glevakha, patients wore pajamas and had no regular day clothes, while in the others, normal clothing was allowed. Notably, the patients claimed they had to purchase the pajamas themselves.

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## ASSESSMENT OF EXISTING FORENSIC PSYCHIATRIC SERVICES

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In general, however, in all the institutions we visited, patients were allowed only one hour in the outside air a day (in one facility more extensive freedom of movement to work in the grounds had been severely restricted after a patient escaped, and thus dozens of patients had been punished because of the action of one). In one facility patients were not allowed out during weekends or when it rained or froze (the pretext being that patients had no coats or umbrellas).

In two units, security only entered the unit if called but on one a security guard stood and watched the ward corridors. These security guards brought with them practices that increased the repressive atmosphere, such as the kenneling of a dog in the unit grounds and carrying a baton and CS spray on their belts.

Two wards had extensive CCTV within the building. In these units, one nurse was allocated to watch the camera feeds, taking them away from patient contact.

Some of our observations can provide you with an idea of the conditions under which patients live for up to five years or more:

- Staff reported that psychologists run social skills and adaptation groups and that nurses can lead discussion groups on movies or books. A variety of sporting possibilities were listed. However patients described that it is not possible to study, work, engage in sport, do creative activities, garden, cook, walk freely on the ward or in the garden during the day;
- In one hospital it was not allowed to sit on the bedcover of the bed, neither was it allowed to cover your head with a blanket, in spite of the fact that a light would remain on in the room throughout the night;
- No personal objects are allowed on the walls, and in most facilities patients can only have a book, a pen and a bottle of water next to their beds;
- Patients can only use their telephone and buy groceries when the psychiatrist decides that it is allowed;
- In one hospital patients had to stand still next to the beds when the psychiatrist makes his rounds or when there is a visit. They are forced to wait until the staff say they can do otherwise;
- In one facility the dentist did not use anesthesia, in another the equipment belonged in a museum. In general, it seemed that the quality of materials used was very low and it was impossible to get false teeth when needed;
- Patients cannot go to the library themselves but have to wait for the librarian to visit the ward. Patients buy their own food products (a necessity considering the bad quality of food provided by the institution) and buy their own pajamas or books and journals (all according to predetermined

lists). In one facility patients were donating pension funds “voluntarily” to sponsor furniture such as bedside cabinets or other items needed by the facility.

- One unit had access to an excellent activity area with comfortable facilities for group work, exercising, music and art activities. Despite having a busy schedule of activities on display, it did not seem a heavily used area and patients from the medium secure unit were very unlikely to attend.

### THERAPEUTIC ASPECTS

None of the hospitals we visited had a treatment strategy. They focused on supporting the treatment of mental disorders and the observation of somatic conditions. Patients are not prepared for re-integration into society. During their treatment, patients not only fail to acquire new skills but also lose those social skills that they had before hospitalization. During such inpatient treatment, they have not had the chance to adapt to society and are thus forced to live in psycho-neurological “social care institutions” or to return to the hospitals where they feel safer.

The internal organization of the treatment departments is generally poor and they do not have enough professionals to deliver therapeutic processes. None of the facilities had available positions for social workers (the only exception being Glevakha, which had one on staff) and psychologists have no special clinical knowledge to work with forensic psychiatric patients. Nursing staffing levels varied but appeared adequate, all units reporting that they had no nursing vacancies but that recruiting sufficient medical staff was difficult.

Individualised treatment of forensic psychiatric patients should be based on individual treatment plans that specify treatment goals, treatment methods, and the distribution of the staff’s responsibilities. Treatment plans should also record the dynamics of the patient’s condition and review the prescribed medicines. The probability of the recurrence of aggressive behavior should be determined on a regular basis.

During interviews staff described a reasonable range of therapeutic activities that were open to patients. This did not, however, correspond to the patient accounts of their time on the unit or the available evidence of activity.

Nurses described their role in passive terms as an observer of behavior who would then contact medical or psychology staff to provide interventions if needed. They do receive regular training but this seemed to mostly consist of sessions on physical health care.

Very low levels of aggression or self-harm were reported which is a positive although unfortunately attained by the total control measures described above. Sexuality was not generally recognized as a need or risk area, though one service acknowledged the existence of masturbation.

Services had a system in place to assess each patient's level of disability. After completing these levels of assessment, the disability level is categorized for individual patients. Each level of disability is associated with a pre printed treatment plan with physical, medical, occupational, social and work related activities to be implemented which can be ticked off on the plan once completed. This was the nearest to an individualized multi disciplinary treatment plan that we saw in the patient's documentation. It is a positive step but was not in place for all patients' and not truly individualized.

As described above, most of the patient's day was idle, with long periods of inactivity in locked rooms. No units allowed patients to have leave outside the unit, either in the grounds of the hospital or into the community, which can be considered as a key component of rehabilitation that need not wait for a transfer to general conditions. Treatment was in the form of medication, with a heavy reliance on Aminazine, though newer atypical medication was available and also in use. Aminazine brings a high risk of serious side effects and safer, less debilitating alternatives are readily available. The prevailing therapeutic approach did not reflect the language of recovery, of dignity and respect, individualized care or psychosocial rehabilitation.

One of the key issues that needs to be addressed is a lack of clarity regarding the roles and functions of the hospital management, the security provided by the Ministry of Internal Affairs (at the Dnepropetrovsk SPH) and the procuracy.

The directors of all institutions we visited responded to our critical remarks by referring to restrictions and rules imposed by procuracy organs, or as the result of complaints by advocacy groups (e.g. that patients are not allowed to work because it would be a form of forced labor). Whether this is used as a pretext to not change current practice, or is really a crucial obstacle is not for us to determine. What is clear to us is that a forensic psychiatric hospital is a medical establishment and not a penitentiary service, that patients are there for treatment and not for punishment, and that the director of the institution and his staff should have full control over the function of the facility of which he has been put in charge. Unless this fundamental paradigm shift is implemented, all attempts to reform the system will be unsuccessful.

The current situation in the forensic psychiatric institutions we visited constitutes a form of systemic ill treatment and is incompatible with the international laws and conventions signed and ratified by Ukraine, with its desire to become part of the European region. It is not only in the interest of the patients and their families that this system changes fundamentally, but also of the population as a whole. The government has the duty to protect its citizens against acts of violence committed by persons with mental illness. The current system fails at all levels; it does not treat properly, it does not rehabilitate and it does not seek to reintegrate as a means to protect society.

Treatment of forensic psychiatric patients should be seen as an independent courtordered medical process that should be organized by the executing specialized health care institutions. It would be optimal, if a consistent process of patient treatment and monitoring took place in one medical institution with all levels of supervision (strict, medium, ordinary) and if subsequent outpatient treatment were provided in accordance with individual treatment plans. In this way it would be much easier to train and specialize the staff and ensure continuity of the treatment process. However, at the moment patients who are subject to court-ordered involuntary treatment are eventually treated under regular supervision conditions in regular psychiatric units. Their treatment is not specialized, which causes a lot of inconvenience to both the patients and the staff of hospitals.

Our recommendations are based on a number of basic assumptions that should be kept in mind continuously:

1. Respectful and compassionate human interaction
2. Choice and taking responsibility through information and education
3. Excellent (medical) treatment and care
4. Healthy food, drinks and activity

5. Complementary care and a purpose/quality of life
6. Humanized technology
7. Architecture and environmental support for health and healing
8. Friends, family and community have a positive role
9. Client satisfaction and experience
10. Motivated and satisfied employees

### SYSTEMIC RECOMMENDATIONS

Considering the above, we recommend implementing the following systematic changes in forensic psychiatric service delivery in Ukraine:

1. Guarantee independence of psychiatric assessment, treatment and advice from interference by procuracy or other governmental or non-governmental bodies., Establish an adequate monitoring system under the auspices of the Ombudsman for Human Rights to make sure human rights in facilities are guaranteed and patients receive the treatment to which they are entitled. There should also be a system requiring and making available independent second opinions where patients lack capacity to consent to treatment or who do not agree with their treatment plan. The system must be absolutely transparent about the rights, rules and obligations of both patients and staff. It must establish sufficient control mechanisms to avoid abuse e.g. the use of patient pensions for other reasons than personal needs of the patients; nepotism; and bribe-taking;
2. Instead of working on a complete review of all legal regulations and legislations, provide the opportunity to start a pilot project in the course of which a new model of forensic psychiatric service is developed and implemented. This should include all levels of security, where the main objective is to create a therapeutic climate in which the patient can actively use his energy and talents in the process of recovery and a return to society. The unit should be based on a recovery approach with its model of care based on patient need, i.e. for care to be delivered close to a patient's home, for patients to be able to move between levels of security as needed, for security level and restrictions to be based on individualized risk assessment and for continuity of care by a stable clinical team. Men and women should be cared for in single sex units, tailored to meet their different presentation and needs.

The pilot should be started on the basis of a tender procedure, through which existing facilities or new mental health facilities can propose their services on the basis of a long term development plan. Such a plan will help determine whether there is sufficient knowledge and enthusiasm for

such an undertaking, sufficient spacing and staffing and sufficient political support from local authorities;

3. Evaluate this pilot through an ongoing scientific research program under the auspices of the Institute of Psychiatry of the Ministry of Health of Ukraine. The ultimate goal of the pilot is to function in future as a center of excellence for the rest of the country, e.g. to train personnel in other facilities, to develop research programs, participate in international studies and become a source of knowledge and expertise in forensic psychiatry for Ukraine;
4. Establish a twinning program between this pilot site and the national forensic psychiatric hospital of Lithuania in Rokiskis, which went through a similar process of reform over the past 12 years and which can provide a perfect setting for on-the-job training of personnel from the new pilot facility. In addition, training can be provided by selected forensic psychiatric facilities in The Netherlands and the United Kingdom who have experience in working in this part of the world and under challenging conditions.

At this pilot, the conditions should be created that would eventually be applicable to all of forensic psychiatric services in Ukraine, provided the pilot turns out to be successful. In practice, it means that the following steps should be implemented:

- Admission and release from the institution is decided by courts based on an independent psychiatric risk-assessment. It should be a decision of the director of the institute, advised by the psychiatrist, to place a patient on a ward with a different security-level.
- The medical staff (psychiatrists, nurses, occupational therapists, social workers etc.) as well as the support personnel and facility management should be trained in multi-disciplinary teamwork, case management and in implementing a more patient-orientated approach. Of special concern are the orderlies and the security personnel, who deal with patients on a face to face basis and have little training, either in the basics of mental illness or aggression management. All should go through a selection procedure and receive adequate training. Inappropriate physical violence should be banned and lead to immediate investigation and, if founded, dismissal and referral to the police.
- Security and treatment personnel should both be under the full authority and responsibility of the director of the facility. He should be responsible for the selection of security personnel and ensure their adequate training. He is responsible for assuring that mechanisms are in place to prevent excesses and abuse of power. Security personnel must be based off-ward, not armed with weapons or dogs and respond only in the event of incidents. They should have more discrete uniforms and not wear military uniforms or combat fatigues.

The economic and social benefits of this different approach should be monitored in terms of a shorter and less expensive length of stay, the active involvement of patients, possible profits from work and less dependence on state-pensions and - last but not least - the prevention of emotional and material damage to their children and families as a result of their unacceptably long incarceration.

## INSTITUTIONAL RECOMMENDATIONS

Irrespective of whether a pilot forensic psychiatric facility will be established, a number of measures should be implemented at the existing facilities without any delay. These are meant to improve the quality of life for patients but, as a consequence, will also greatly improve the working conditions of the staff members:

1. Contact with the outside world should be facilitated as much as possible. It must be possible for patients to phone their family. They should be able to meet their families in a more “normalized” situation, for example in the underused therapyrooms with nice chairs and couches. It should be made possible for patients to use email in a safe and controlled way (e.g. through [www.prisonmail.eu](http://www.prisonmail.eu)). In the current situation in Ukraine it would enable patients from the DNR/LNR and the Crimea to communicate with their families, with whom currently no communication is possible;
2. Provide patients with space to use their energy and to develop skills. Let them work, exercise, cook, learn and contribute to the institution’s wellbeing and climate. Allow them to play football or other sports, and let them build their own sport facilities and gardens: the wards are full of plumbers, painters, drivers, hobby-farmers, electricians and constructors whose skills are unused and gradually become obsolete. A Patients’ Council, with representatives elected by patients to represent their views and meet with management should be introduced.
3. To work towards modern standards of psychiatry, services should reduce the number of patients cared for in one bedroom. Patients must be encouraged to personalize their bed space. Units should minimize blanket rules and restrictions and eliminate hair cutting by rote and increase choice and the ability for patients to decide things such as what radio station can be listened to. Patients should be allowed televisions and radios in their rooms (if the individual’s risk is assessed as appropriate) and all patients should have access to newspapers, books and games. Nurse run groups should be developed on wards and patients let out of rooms during the whole day. Patients with mental illness should be cared for in separate units to those with a learning disability or dementia. Treatment should be directed exclusively to cure or safely manage the mental illnesses that cause danger to patients and others. Doctors should be very hesitant in using heavy medication: it makes people drowsy, sick and passive and can be a serious obstacle on the road to recovery.
4. Leadership in the institution should focus on increasing the competence of the staff as much as possible. Nurses and psychiatrists need to be trained to make and execute individual, multidisciplinary treatment plans, which can effectively treat illness and risk, diminish the negative effects of incarceration and support recovery and rehabilitation. Staff should be empowered, the role of nurses, social workers and occupational therapists should be greatly enhanced and instead of patrolling the

floors to maintain strict security, staff should engage with the patients as much as possible.

## THERAPEUTIC RECOMMENDATIONS

To ensure the effectiveness of compulsory treatment, it is necessary to make a gradual transition from the biological treatment model to a considerably more effective biopsychosocial (BPS) one. In this way, not only the treatment of illness but also the proper functioning of patients in the community after treatment in hospital may be secured.

To adopt this method of treatment, a continuous therapeutic process should be organized not solely by a psychiatrist but by a multidisciplinary team composed of a psychiatrist, a psychologist, nurses, a social worker, and, if required, other specialists.

Treatment in forensic psychiatric hospital has to include a wide range of therapeutic, rehabilitative and recreational activities, including proper pharmaceutical and medical treatment. It has to involve the reduction of symptoms of illness as well as the reduction of crime risk. Rehabilitative–psychosocial employment should prepare patients for independent life when they return to their families. Social employment therapy as part of an integrated rehabilitation program should help the patient to discover motivation, develop learning and communication skills, help acquire specific skills and improve selfconfidence. During hospitalization patients have to be provided with conditions for improvement, i.e. learning, vocational training or professional rehabilitation and acquisition of new skills which will be helpful in their future life.

The expert team would also like to propose a number of specific recommendations:

1. Audits of prescribing practice and the use of anti psychotic medication should be undertaken by pharmacy staff to compare results against high dose and best practice guidelines. This should include measuring the use of Aminazine and lead to an action plan to eliminate its use. Aminazine injections are erratically absorbed and released. Oral and IM doses are sedating and lead to side effects. Drugs such as lorazepam and promethazine should be used for the short-term management of acute agitation.
2. Nurses should develop their own assessment process and documentation.
3. Each patient should have an individualized multi-disciplinary care plan, created with the patient and laying out the contribution of each profession to help the patient reach his goals.
4. Nurses should use a side effects rating scale with their patients, such as the LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale)
5. A formal reflective practice group should be run for ward teams each month.
6. It should not be a blanket rule that most patients are observed when showering or using the phone. This should only be done if individually assessed as necessary

7. Nursing staff should take part in escorting patients when patients are taken out of the ward. More patients should be able to access the wider hospital grounds rather than only ward yards.
8. Nurses should have more freedom to give extra, as needed medication and be appropriately trained and supported to help them develop that role.
9. Nurses should introduce regular group work on their wards, such as a morning community meeting and news and music groups.
10. The multi-disciplinary team should keep joint notes in which all staff record their interactions with patients.
11. Patients who are progressing well should be able to use unescorted ground and community leave without staff escorts, as part of their preparation for discharge.

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## PLAN OF ACTION

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### PRE-PHASE: THREE MONTHS

During this phase, the outcome of our assessment and recommendations should be discussed with all stakeholders both in separate and collective settings. It would be important to give adequate feedback to our hosts, who in spite of the fact that our visit was unannounced and they had no legal basis to refuse access, provided us with the opportunity to talk to patients and staff and did their best to accommodate our wishes. It would be desirable to meet with policy makers to make them aware of the situation at hand; to talk to potential donors who might be willing to provide the funding to develop the intellectual exchange and organize the necessary training and supervision by experts willing to help Ukraine to reform its forensic psychiatric service.

### PHASE 1: SIX MONTHS

Our suggestion is to organize a tender among Ukrainian mental health care institutions interested in being the site for a pilot of a state-of-the-art forensic psychiatric service involving all three levels of security: strict regime, medium regime and general regime, as well as rehabilitation and resocialization services. The facilities tendering should provide a long-term plan of how they would like to develop these services, what the final outcomes would be and how they plan to meet the basic requirements of the tender. In our view, the pilot site (one, preferably two) should receive maximum support both from the Ukrainian government and foreign organizations. They should be twinned to the Rokiskis facility in Lithuania and one or more institutions e.g. in The Netherlands and the United Kingdom. They should be provided with external material and intellectual support. However, this would only be possible if they would be willing to meet the requirements carefully formulated along the lines outlined in this report.

### PHASE 2: 24 MONTHS

In the following two years, the pilot site(s) should implement their development plan. On a regular basis, policy makers, professionals and the non-governmental sector should be invited to seminars where progress is reported upon, problems and obstacles are discussed and solutions sought. It is important that the current culture of secrecy is replaced by one of transparency, without the omnipresent fear of being exposed, criticized or replaced.

### PHASE 3: 12 MONTHS

On basis of the outcomes of the pilot phase, all Ukrainian legislation in Ukraine related to forensic psychiatric practice should be reviewed and brought in line with the new approaches.

**Mr. Frans Douw** (1955) has been General Director of four Penitentiary Institutions in the province North Holland, The Netherlands: Amerswiel (house of detention and open and closed regimes for women), Zuyder Bos (long term sentences, life sentence), Westlinge (open and half open) and Schutterswei (for short sentences). He retired at the end of November 2015. Frans Douw was from 1998 until 2005 Director of the Forensic Observation and Treatment Unit (FOBA) of the Dutch Prison System in Amsterdam, which carries out clinical psychiatric crisis interventions for all prisons. Before he was head of a department of Pieter Baan Centrum, Utrecht, the Dutch Forensic Psychiatric Clinic for Clinical Pre-trial Assessment. Frans Douw is Chairman of the board of the Foundation of Recovery and Return which provides a forum to all participant in the process of crime, punishment, recovery and return. Frans Douw is also visiting professor at Nyenrode Business University and in 2014 he became member of the board of Dutch Cell Dogs.

**Dr. Gavin Garman** is a mental health nurse from the UK with a doctorate in psychology. He has 18 years professional experience in forensic psychiatry, including wide experience of service development work and the strategic planning, creation and expansion of forensic psychiatry services. He is currently the Head of Nursing for nine forensic units and five prisons, acting as professional lead for nurses and responsible for ensuring the multi disciplinary care provided is of a high quality. He has worked for the Council of Europe in Turkey and Georgia and with NGOs in Croatia and Moldova. He has published on the topics of managing forensic services, the care of women forensic patients and patient involvement.

**Dr. Algimantas Liausedas**, a psychiatrist by profession, is director of the Rokiskis psychiatric hospital, the only forensic psychiatric institution in Lithuania. The hospital has all three security levels and an extensive rehabilitation and resocialization department. Before becoming director of the facility in 2003, he worked in Vilnius as a psychiatrist, last being head of a department at the Vilnius psychiatric clinic in 2001-2003. In the course of his twelve years as director of Rokiskis psychiatric hospital he implemented a dozen projects funded by the Dutch Ministry of Foreign Affairs, the European Union and the Lithuanian government focusing on forensic psychiatric services, occupational and social rehabilitation, vocational rehabilitation, increasing staff qualifications, and the development of social services. Dr. Liausedas is a board member of the Association of Hospital Management and the Lithuanian psychiatric Association, and a founder member of the Association of mental health management.

**Prof. Robert van Voren** (1959) is Chief Executive of the NGO "Human Rights in Mental Health- FGIP", an international foundation for mental health reform. In that capacity he has worked in Ukrainian mental health for the past 25 years. He is also Professor of Soviet and Post-Soviet Studies at the Vytautas Magnus University in Kaunas (LT) and the Ilia State University in Tbilisi (GEO), and teaches in Kyiv at the Grinchenko and Shevchenko Universities. He is currently Vice-President of the World Federation for Mental Health (WFMH). He is Honorary Fellow of the British Royal College of Psychiatrists and Honorary Member of the Ukrainian Psychiatric Association.





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