FOLKETINGETS OMBUDSMAND

Thematic report

Force and non-statutory interventions in the psychiatric sector

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Contents

1. Introduction

During 10 monitoring visits to psychiatric wards in 2021, the Ombudsman investigated the use of various kinds of measures towards psychiatric patients. The investigation dealt with both forcible measures under the Mental Health Act and non-statutory measures.

Admission, stay and treatment in a psychiatric ward are generally voluntary, meaning based on informed consent from the patient.

However, forced admission to a psychiatric ward and forced treatment can take place under certain conditions under the rules in the Mental Health Act, which also allows for the use of particular forcible measures during admission such as manual restraint of the patient and belt restraints.

During the investigation of force under the Mental Health Act, the Ombudsman focused on whether the conditions for using force were observed and whether this was documented sufficiently. In addition, the Ombudsman investigated whether there was focus on preventing and reducing use of force.

In practice, patients in psychiatric wards can also be subjected to measures that are not regulated by the Mental Health Act. In some instances, such non-statutory measures appear in the ward's house rules. The Ombudsman's investigation focused on whether non-statutory measures in house rules or otherwise used in practice had the sufficient legal basis, including whether the measures constituted interventions that required valid consent from the patients.

2. General recommendations and follow-up

2.1. Force under the Mental Health Act

The psychiatric wards generally focused on preventing and reducing use of force, for instance through the initiatives that the Danish Health Authority recommend using in this connection.

However, several of the wards had not yet succeeded in implementing the relevant initiatives or in reducing use of force.

The Ombudsman generally recommends that the regions ensure continued focus on preventing and reducing use of force in the psychiatric sector.

The psychiatric wards generally focused on ensuring that the rules on force are observed. However, the Ombudsman gave recommendations to some wards that aimed to ensure that the rules on use of force are observed in practice. The recommendations especially concerned

- change of internal guidelines so they correspond to the rules on when forced immobilisation must stop and instructions to staff in this regard
- observation of time-related requirements to the medical evaluations of whether forced immobilisation is to be maintained
- ensuring that manual restraints do not last more than 30 minutes.

The Ombudsman generally recommends that the regions ensure focus on observing the rules on force.

As part of the monitoring visits, the Ombudsman's visiting teams reviewed some examples of records on forced immobilisation that did not contain sufficient documentation of compliance with the rules. Especially in regard to documentation that the conditions were met for maintaining forced immobilisation for more than a few hours.

Based on discussions with management in the psychiatric wards in question, the visiting teams did not find that the conditions had not been met for carrying out the specific forced immobilisations. Instead, the visiting teams pointed to a need to improve the documentation.

The Ombudsman generally recommends that the regions ensure focus on precise and comprehensive documentation in records on forced immobilisation – including in relation to the grounds for initiating and maintaining belt restraints – which observes the more rigorous requirements of Section 14(3) of the Mental Health Act in cases of restraint lasting more than a few hours.

Based on information from several of the psychiatric wards, the Ombudsman has also opened an own-initiative investigation of the Ministry of Health about the legal framework for private guards' use of force in psychiatric wards.

2.2. Non-statutory measures and interventions

The Ombudsman's visiting teams saw a number of examples of practices and rules in the wards' house rules that did not have authority in the Mental Health Act and where there was doubt whether the practices or rules could be maintained without statutory authority.

Prior to the thematic investigation, some of the examples had been dealt with in the Ombudsman's cases on non-statutory measures and interventions and

were discussed during meetings with the relevant ministry and Danish Regions. The cases are described in item 6.1.1 below.

Other examples, such as rules that the patients could not talk to each other about certain topics, had not been dealt with in the Ombudsman's cases or during meetings with the relevant ministry and Danish Regions prior to the thematic investigation. During a meeting in 2021 with the Ministry of Health, the Ombudsman spoke about these examples.

Since 1 January 2022, new rules in the Mental Health Act have made it possible to use some of the observed measures and interventions without obtaining the patient's consent in advance.

The Ombudsman generally recommends that the regions ensure that house rules and practices in the wards observe the applicable rules.

Some of the examples of rules and practices that the Ombudsman's visiting teams observed in the wards are not mentioned (expressly) in connection with the above-mentioned amendment of the Mental Health Act or in the related executive order. For instance, the patients could have their access to unhealthy food and drinks restricted. There were also examples where patients had restricted access to receiving visitors from the outside – such as relatives – or where the visits were being monitored. The Ombudsman will discuss the legal framework of these examples with the Ministry of Health.

In addition, the Ombudsman's visiting teams found that the intervention 'seclusion in own room' is used in several wards (for instance referred to as 'environmental seclusion', 'area restriction' or 'reflection time'). The intervention is generally characterised by a patient being isolated in his or her own room or another limited area with an unlocked door and possibly with members of staff standing guard outside the door. At the time of the monitoring visits, it had been clarified in the Ombudsman's Case No. FOB 2020-25 (in Danish at the Ombudsman's website) that such interventions could only be used with the patient's consent. Read more about this in item 6.1.

During six monitoring visits, the Ombudsman recommended that management ensure that no seclusion in own room (or other area restriction) takes place without the patient's consent.

The Ombudsman has subsequently opened an own-initiative investigation of a forensic psychiatric ward and the Ministry of Health about whether – after the above-mentioned amendment of the Mental Health Act on 1 January 2022 – there is authority to carry out seclusion in own room without the patient's consent.

In connection with consent to a non-statutory intervention, there are requirements for how consent is obtained and documented. For instance, the patients must be informed that they can at any time withdraw their consent, and staff must assess whether the patients are able to give consent. In a number of instances, the consent requirements were not met. This was the case both in relation to seclusion in own room and other interventions. During nine monitoring visits, the Ombudsman recommended that management ensure that consent to seclusion in own room and other interventions is obtained and documented in accordance with the relevant requirements set out in applicable rules and practices.

The Ombudsman generally recommends that the regions ensure that no non-statutory interventions are carried out without consent that has been obtained and documented in accordance with the relevant requirements set out in applicable rules and practices.

2.3. Follow-up

The Ombudsman's general recommendations in this thematic report are directed at the regions, including the psychiatric wards, which have the principal responsibility for the daily administration and handling of tasks in relation to the stated issues in the psychiatric sector.

However, the general recommendations are also directed at the Ministry of Health, which has the overall responsibility in the field.

The Ombudsman will discuss the follow-up of the general recommendations with the Ministry of Health and Danish Regions. The Ombudsman will also follow up on the general recommendations during future monitoring visits.

3. Basis for the choice of the investigation's theme

With the theme for 2021, the Ombudsman wanted to gain up-to-date knowledge of the conditions for patients admitted in the psychiatric sector with focus on use of force. The Ombudsman also wanted to follow up on the fact that monitoring visits during a period of time had revealed that various kinds of non-statutory measures and interventions appeared in house rules or were otherwise used in practice in psychiatric wards.

Force in the psychiatric sector constitutes a restriction in the patient's liberty and presupposes that it is necessary and proportional in the specific instance. Unnecessary force can constitute a violation of Article 3 of the European Convention on Human Rights on inhuman and degrading treatment.

As the result of an agreement in 2014 between the (then) Ministry of Health and Prevention and Danish Regions, each region entered into a partnership agreement with the Ministry, which led to common objectives that the number of patients subjected to forced immobilisation was to be halved in 2020 and that there was also to be a reduction in the overall use of force.

The Danish Health Authority's monitoring of force in the psychiatric sector in 2020 showed that the regions had generally succeeded in considerably reducing the number of persons who were subjected to belt restraints. However, the use of force had generally increased in the period since the agreement in 2014.

In addition, Denmark has been criticised by the European Committee for the Prevention of Torture (CPT) for the use of belt restraints, including especially long-term belt restraints, most recently in connection with a visit in 2019. In the autumn of 2020, the European Court of Human Rights delivered a judgment in a case against Denmark, where the Court found that a specific belt restraint episode in a psychiatric ward constituted a violation of Article 3 of the European Convention on Human Rights.

Furthermore, during a follow-up period regarding several monitoring visits to psychiatric wards, the Ombudsman had processed a number of cases about use of various non-statutory measures and interventions. The use thereof had been discussed during meetings with the relevant ministry – now the Ministry of Health – and Danish Regions.

4. Investigation method

4.1. How was the investigation organised?

The theme was investigated during 10 monitoring visits to psychiatric wards, where some of the visits included several units. The visits covered both units within the general and the forensic psychiatric sector, including the Maximum Security Unit (in Danish: 'Sikringsafdelingen') at the Department of Forensic Psychiatry, Region Zealand, where special rules apply.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to Section 18 of the Parliamentary Ombudsman Act and as part of the Ombudsman's task of preventing persons who are or who can be deprived of their liberty from being exposed to for instance inhuman or degrading treatment, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The Ombudsman's work to prevent degrading treatment etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. The Institute for Human Rights contributes with special human rights expertise. DIGNITY contributes to the cooperation with medical expertise. Among other things, this means that staff with expertise in these two fields from the two institutes participate in the planning and execution of and follow-up on monitoring visits.

4.2. How were conditions investigated during the monitoring visits?

In the opening letter for the individual monitoring visit, management in the visited psychiatric ward was asked for information on a number of factors and for copies of the material on the subject.

This concerned, among other things, statistical information about the use of various kinds of force, guidelines for use of force as well as protocols on force and records about a number of instances of forced immobilisation. In addition, the Ombudsman received the units' house rules and other information on the use of non-statutory measures and interventions as well as examples of documentation of a patient's consent to non-statutory interventions.

During the monitoring visits, management, staff, patients, patient advisers and guardian representatives, guardians and relatives were interviewed about conditions for the patients, including in particular the conditions that were in focus during the Ombudsman's visit in 2021.

5. Force under the Mental Health Act

5.1. Is there focus on preventing and reducing use of force?

5.1.1. Starting point of the investigation

The Ombudsman's visiting teams investigated whether there was focus on preventing and reducing use of force at the visited units.

The investigation used as its starting point the report 'Recommendations for reducing use of force towards people with mental disorders' (in Danish: 'Anbefalinger for nedbringelse af tvang for mennesker med psykiske lidelser'), published by the Danish Health Authority in January 2021.

In the report, the Danish Health Authority recommends, among other things, that the work with preventing or reducing use of force in the psychiatric sector be based on six so-called core strategies.

The six core strategies:

1. Management aimed at organisational changes
2. Use of data for information-based practice
3. Development of the staff's skills and professional knowledge
4. Use of force prevention tools
5. The patient's role in psychiatric wards
6. Use of debriefing techniques

The Danish Health Authority also recommends that compulsory admissions be prevented. This presupposes cooperation with actors outside the psychiatric wards.

Furthermore, the Mental Health Act contains rules on various initiatives in relation to the individual patient in order to prevent force, among other things. The visiting teams investigated whether these initiatives are used in practice.

Examples of initiatives in the Mental Health Act with the purpose of preventing force:

1. Advance statements
The patient must be asked about any statements of preferences in relation to treatment, including if use of force should become relevant.

2. Follow-up interviews
During a follow-up interview, the patient and staff go through their experience of the force used. The purpose is to prevent and reduce use of force towards the patient.

3. Discharge agreements and coordination plans
Agreements or plans must be made for certain patients who receive support under the Social Services Act. Actors that are relevant after discharge must be involved – for instance the patient, the psychiatric sector, the municipality and any support from social services. The agreements and plans must support a good transition to daily life after hospitalisation.

The visiting teams investigated the statistical development in the use of force in the visited psychiatric wards.

According to the Danish Health Authority, the national focus on halving the number of belt restraint episodes may lead to other forcible measures being used instead. The visiting teams looked at whether the development in the visited ward could indicate a substitution between forcible measures, for instance that belt restraints were replaced by long-term manual restraints or increased use of acute sedatives administered with force.

5.1.2. Result of the investigation

The Ombudsman's visiting teams found that the psychiatric wards generally focused on preventing and reducing use of force. The visited units had typically implemented, or were in the process of implementing, a number of the initiatives that the Danish Health Authority recommends using in the work with preventing and reducing use of force. However, several units had not yet succeeded in implementing the relevant initiatives or reducing use of force.

Generally, the wards pointed out that it required a cultural change, which took time to complete. Several of the psychiatric wards pointed to a lack of (permanent) staff and the patients' problems with drug abuse as some of the main causes of situations where force was necessary. The wards also pointed out that it is more often necessary to use force towards patients with externalising or boundary-crossing behaviour. In addition, the significance of the physical setting to the prevention of force was pointed out.

The Ombudsman recommended to six wards that management ensure continued focus on preventing and reducing use of force. In addition, it was recommended that one ward ensure that valid and current figures for the use of force are available continuously and consider if there are grounds for setting specific objectives for reducing use of force.

At some wards, either the use of manual restraint, compulsory administration of sedatives or both had increased while the use of forced immobilisation had decreased.

Based on the obtained information and discussions with the relevant psychiatric wards, the visiting teams could not conclude that there had been a substitution of forced immobilisations with manual restraints (lasting more than 30 minutes) or compulsory administration of sedatives. Instead, these matters formed part of the basis for the recommendations to ensure continued focus on preventing and reducing use of force.

The Ombudsman did not recommend that management ensure the obtainment of advance statements or the drawing-up of discharge agreements and coordination plans. The mentioned initiatives are described in item 5.1.1. Some of the psychiatric wards stated that it could be difficult to

draw up advance statements immediately after admission, where the patients are usually feeling at their worst.

The Ombudsman gave a total of six recommendations about follow-up interviews; in two of them, it was recommended that management ensure that the patients are offered follow-up interviews. The other four recommendations concerned documentation of the follow-up interviews, among other things because it can be difficult to follow up on a held interview if there is no documentation of the contents of the interview.

5.2. Is there focus on ensuring compliance with the rules on force?

5.2.1. Starting point of the investigation

The Ombudsman's visiting teams investigated whether the psychiatric wards focused on ensuring that the rules on force are observed.

The Mental Health Act contains a number of rules that apply in all instances of force. For instance, force cannot be used until all possible alternatives have been tried in order to achieve the patient's voluntary cooperation. If less restrictive measures are sufficient, these must be used instead.

Also, according to the general rules, the patient's advance statement (see item 5.1.1) must be included in the assessment of what is least restrictive for the patient in a specific situation. For instance, according to the Ministry of Health, it cannot be argued generally that manual restraints are less restrictive than forced immobilisations.

In addition to the general rules, there are special conditions for the individual type of intervention. For example, forced immobilisations can as a rule only be used briefly and to the extent necessary in order to, for instance, prevent the patients from putting themselves or others at immediate risk of harm to body or health.

Furthermore, there are rules on re-evaluating whether or not to maintain long-term forcible measures. For example, forced immobilisations must as a rule be re-evaluated three times in every 24 hours. In addition, there are rules on external evaluations of the maintaining of forced immobilisations.

The purpose of several rules in the Mental Health Act is to ensure the patients' subsequent legal rights after use of force. Among other things, it is possible to complain, and a patient must be assigned a patient adviser to guide and advise the patient and to assist with submitting a complaint and carrying through the complaint process.

As part of the investigation, the visiting teams reviewed local guidelines on force and spoke with the psychiatric wards about how they follow up on cases where a patient complains about the use of force and where the ward's decision to use force is not upheld. The psychiatric wards also explained how it is ensured that staff are familiar with the rules. Lastly, information about records on forced immobilisations was included in this part of the investigation.

5.2.2. Result of the investigation

The visiting teams found that the psychiatric wards generally focused on ensuring compliance with the rules on force. Many wards focused on (supplementary) training and supervision of staff, updating internal guidelines and analysing the Psychiatric Patients' Board of Complaint's overrulings of use of force. The visiting teams also found that the patients were generally given information about use of force, assigned patient advisers and guided about the option to complain.

However, recommendations were also given in order to ensure that the rules on use of force are observed in practice. This is due to three matters in particular.

Firstly, several wards had local guidelines or action cards on when forced immobilisation should stop, which did not comply with the applicable rules. In addition, staff in some wards were unaware that care staff can stop forced immobilisation when it is no longer necessary to maintain it.

In four instances, it was recommended that management ensure that the local guidelines or action cards about force are updated so that they are in accordance with the applicable rules. In two instances, the Ombudsman recommended that management ensure that staff are instructed in the care staff's access to stop forced immobilisation. In one instance, the Ombudsman recommended that management ensure that it is determined as soon as possible whether a patient's restraints can be loosened when an external doctor has assessed that there are no longer grounds for immobilising the patient.

Secondly, a long time could pass between the medical evaluations of whether or not to maintain belt restraints (belt inspections). The visiting teams saw many examples where 11 to 17 hours would pass between these re-evaluations. According to the rules applying at the time, the doctor should carry out three belt inspections that should be distributed equally over the course of 24 hours.

During seven monitoring visits, the Ombudsman recommended that management ensure that new medical evaluations of the question of

continued forced immobilisation are carried out in accordance with the applicable rules. In one instance, it was recommended that management ensure that external medical inspections are carried out in connection with long-term immobilisations.

After a legislative amendment on 1 January 2022, the Mental Health Act now states how much time is generally allowed to pass between two belt inspections.

Thirdly, management in the psychiatric wards and the visiting teams discussed compliance with the applicable guidelines about the use of manual restraints. One ward stated that they do not use manual restraints at all unless the patients specifically requested this in, for instance, their advance statement. A different ward generally viewed manual restraints as less restrictive than forced immobilisations. Some wards used manual restraints for more than 30 minutes.

In three instances, it was recommended that management ensure that long-term manual restraints lasting more than 30 minutes are avoided, and in one instance, it was recommended that management ensure that short-term manual restraints only take place after a specific assessment, which takes into account the patient's advance statement.

The Ombudsman also gave a few recommendations to ensure documentation of complaint guidance or to ensure systematic follow-up of overrulings by the Psychiatric Patients' Board of Complaint and to make staff aware of the practice.

In addition, during several monitoring visits, the visiting teams were informed that the wards used private guards. The guards would typically intervene if the patients exposed staff to violence. In some cases, the guards could use physical force towards the patients. The Ombudsman did not give recommendations to the visited psychiatric wards but has opened an own-initiative investigation of the Ministry of Health about the legal framework for private guards' use of force in psychiatric wards.

5.3. Is there documentation for compliance with the rules on force?

5.3.1. Starting point of the investigation

The Ombudsman's visiting teams investigated whether there was documentation for compliance with the rules on force.

As part of the investigation, the visiting teams reviewed two to four protocols on force from each psychiatric ward concerning forced immobilisation with belt and possibly straps and gloves along with relevant records. The material

was compared with the rules in the Mental Health Act and related executive orders and guidelines as well as practices from the courts and the Psychiatric Patients' Board of Complaint.

What is the purpose of documenting forcible measures?

Documentation of forcible measures such as forced immobilisation serves several purposes. The documentation can thus form the basis of analyses and follow-up of specific episodes with force and thereby be part of the work with preventing force. In addition, documentation ensures that the patients or their representatives can get an insight into what happened. Documentation can also support compliance with rules and be included in cases with complaint bodies and the courts, which determine if a measure is justified.

See more about the duty to take notes at the Ombudsman's website (in Danish) and more about data on forcible measures and analysis of the individual forcible measures at the Danish Health Authority's recommendations for reducing force for people with mental disorders (in Danish).

In practice from the Psychiatric Patients' Board of Complaint and the courts, there are several examples that insufficient documentation of for instance the patient's dangerous behaviour has been significant when forced immobilisations are overruled.

5.3.2. Result of the investigation

The received documentation was not reviewed in order to assess whether there were grounds for criticising the individual forced immobilisation. On the contrary, the documentation was reviewed with the preventive purpose of ensuring partly that no force is carried out that does not meet the requirements of the Mental Health Act, partly that the documentation lives up to the requirements of the Act.

The visiting teams saw a number of examples of records on forced immobilisations not containing sufficient documentation that the forced immobilisations complied with the rules.

There were a few examples of insufficient documentation that the patients were at risk of harming themselves or others upon immobilisation. For

instance, one record stated that the patient 'lay down calmly' when the patient was immobilised.

Furthermore, there were examples where there were no separate grounds for using wrist or ankle straps and maintaining the use of these.

In addition, there were a number of examples of insufficient documentation for maintaining immobilisation lasting more than a few hours. According to Section 14(3) of the Mental Health Act, a patient can only be immobilised by force for longer than a few hours when so prompted by the consideration of the patient's or others' life, health or safety.

For example, a patient was described as 'prone to anger', 'verbally aggressive' and 'having many needs'. Another patient was described as 'clearly angry and verbally aggressive – turns up radio loudly and lies with the back to me and facing the loudspeaker directly. Then orders me to leave.' There were also several examples where it was taken into account whether the patient was able to make an agreement on for instance cooperating with staff when it was to be assessed whether the patient's forced immobilisation could stop, among other things. Management stated that an assessment is made of how dangerous the patient is in all cases.

Based on discussions with the relevant psychiatric wards, the visiting teams did not find that the conditions for carrying out the specific forced immobilisations had not been met. Instead, the visiting teams pointed to the need to improve documentation.

During nine monitoring visits, the Ombudsman recommended that management ensure focus on precise and comprehensive documentation in records on forced immobilisation – including in relation to the grounds for initiating and maintaining belt restraints – which observes the more rigorous requirements of Section 14(3) of the Mental Health Act in cases of restraint lasting more than a few hours.

6. Non-statutory measures and interventions

6.1. Measures and interventions in house rules and practices

6.1.1. Starting point of the investigation

During monitoring visits to psychiatric wards in 2014 and the following years, the Ombudsman was made aware that there were large differences in the contents of rules on measures and interventions towards patients in the wards' house rules. For instance, the rules could entail that the patients had restricted access to mobile phone or visits. In the Ombudsman's opinion,

there could be doubt as to the legal basis for several of the rules in the wards' house rules and practices.

In continuation of the monitoring visits, this gave the Ombudsman occasion to open several cases about non-statutory measures and interventions. The Ombudsman also discussed these issues with the relevant ministry – now the Ministry of Health – and Danish Regions.

In the Ombudsman's Case No. FOB 2020-43 (in Danish at the Ombudsman's website), it was found that some interventions did not have authority in the Mental Health Act, for instance routine searches of the patients. In addition, there was doubt as to the legal basis for other measures and interventions such as restriction of patients' access to mobile phone and visits. Therefore, the Ministry – then the Ministry of Health and Senior Citizens – would work to create a clear legal basis so that in future there would be no doubt as to the framework for implementing restrictions in house rules in the psychiatric wards. In continuation of this, the Ministry of Health informed the regions in March 2021 that they were to adjust the house rules so they no longer contained rules on measures and interventions without authority or with doubtful legal basis, and that the adjustment could not wait for a precision of the legal basis in the Mental Health Act.

In the above-mentioned Case No. FOB 2020-25 (in Danish), the Ombudsman considered so-called 'seclusion in own room' (also referred to as 'environmental seclusion', 'area restriction' or 'reflection time'). The intervention is generally characterised by a patient being isolated in his or her own room or another limited area with an unlocked door and possibly with members of staff standing guard outside the door.

The Ombudsman stated that he agreed with the Ministry of Health and Senior Citizens that requiring a patient to stay in his or her own room without the patient's consent must be considered a forcible measure without authority in the Mental Health Act. The intervention could only be implemented with the patient's consent.

In Case No. FOB 2016-32 (in Danish at the Ombudsman's website), the Ombudsman stated that there was no authority for restricting patients' access to buying unhealthy food.

In connection with the monitoring visits in 2021, the visiting teams investigated if non-statutory measures included in house rules or otherwise used in practice had a legal basis, including if the non-statutory measures comprised interventions presupposing that the patients had given valid consent to them.

6.1.2. Result of the investigation
The visiting teams saw a number of examples of measures in the wards' house rules and practices that did not have authority in the Mental Health Act. Since those measures could constitute interventions towards the patients, it was doubtful whether they could be used without statutory authority, cf. the above-mentioned Case No. FOB 2020-43 (in Danish) about interventions without authority in the Mental Health Act.

The psychiatric wards stated that the observed measures and interventions were typically used to ensure order and safety in the wards and to benefit the treatment of the individual patient. For example, patients could have restricted access to their mobile phone so that the patients did not expose themselves in a demeaning manner, damage their relationship with relatives or suffer serious financial harm.

The wards also pointed to the fact that there could be a need for routine searches of patients and visitors to the wards to ensure that the patients did not get access to drugs in the ward.

As mentioned above, in March 2021, the Ministry of Health informed the regions that house rules about certain measures and interventions without authority in the Mental Health Act or with a doubtful legal basis were to be adjusted and that the adjustment could not wait for any precision of the legal basis in the Mental Health Act. Therefore, the Ombudsman recommended that nine psychiatric wards change the house rules and practices so that they reflected the rules applicable at the time.

In addition, the visiting teams saw examples of rules and practices that were not part of the Ombudsman's previous cases on non-statutory measures and interventions and that had not been discussed with the Ministry of Health or Danish Regions. For instance, this included rules that the patients could not speak to each other about certain topics. During a meeting in 2021 with the Ministry of Health, the Ombudsman mentioned these examples. The Ombudsman's previous cases on non-statutory measures and interventions are mentioned above in item 6.1.1.

An amendment of the Mental Health Act of 1 January 2022 made it possible to implement some of the observed measures and interventions without obtaining the patient's consent in advance.

However, it is still not possible to for instance review patients' mail regularly or search patients without suspecting that there is medicine, drugs or dangerous objects in the ward. Special rules apply at the Maximum Security Unit, forensic psychiatric wards and wards for people placed in surrogate custody.

In addition, the Ombudsman's visiting teams saw examples of rules and practices that were dealt with in the above-mentioned Case No. FOB 2016-32 and FOB 2020-43 (in Danish). For instance, the patients could have their access to unhealthy food and drinks restricted. There were also examples of patients having restricted access to receiving visitors from the outside – such as relatives – or where the visits were monitored. These examples are not (expressly) referred to in the mentioned amendment to the Mental Health Act or the related executive order.

Furthermore, the visiting teams found that the intervention 'seclusion in own room' is used in several wards (for instance referred to as 'environmental seclusion', 'area restriction' or 'reflection time'). The intervention is generally characterised by a patient being isolated in his or her own room or another limited area with an unlocked door and possibly with members of staff standing guard outside the door. At the time of the monitoring visits, it had been clarified in the Ombudsman's above-mentioned Case No. FOB 2020-25 (in Danish) that such interventions could only be used with the patient's consent.

During six monitoring visits, the Ombudsman recommended that management ensure that no seclusion in own room (or other area restriction) takes place without the patient's consent.

The Ombudsman has subsequently opened an own-initiative case against a forensic psychiatric ward and the Ministry of Health about whether – after the above-mentioned amendment to the Mental Health Act of 1 January 2022 – there is authority to carry out seclusion in own room without the patient's consent.

6.2. Is consent being obtained and documented in accordance with applicable rules?

6.2.1. Starting point of the investigation
In Case No. FOB 2020-15 and FOB 2020-25 (in Danish at the Ombudsman's website), the Ombudsman established how staff should obtain and document patients' consent to interventions in the form of transitioning from having their doors locked at the Maximum Security Unit and seclusion in own room.

In connection with the visits in 2021, the visiting teams reviewed records on consent to seclusion in own room or other non-statutory interventions and compared the records with the requirements of valid consent to seclusion in own room etc. The visiting teams also discussed the matters with the psychiatric wards' management, staff and patients.

When is there valid consent for seclusion in own room and other non-statutory interventions?

- The consent must be voluntary and must not have been given under force or threats of force.
- The consent must be based on comprehensive information. As a minimum, information must be given on the following – though without implying that such information is necessarily comprehensive:
  - the contents and meaning of the agreement, including the agreement's consequences (that the patients cannot leave their room or a limited area without prior agreement with the staff)
  - the treatment or safety-related purpose of the agreement
  - the fact that the agreement only applies because the patient has given consent and that the patient can withdraw the consent at any time.
- The information must be given in such a way and to such a degree that the patient – to the extent necessary – understands the contents and meaning of the information.
- Staff must have assessed the patient's ability to make decisions.
- The patient must have access to discuss his or her consent with a patient adviser or guardian representative.

6.2.2. Result of the investigation

The Ombudsman's visiting teams found that no valid consent was obtained to seclusion in own room and other interventions in many cases.

Several psychiatric wards stated that seclusion in own room was used for instance in critical situations when it was not possible to obtain consent from the patient. For example, it could be initiated in order to avoid forced immobilisation of the patient.

The wards also pointed out that there could be instances where consent could not be obtained to for example seclusion in own room because the patient was too unwell to relate to this question.

During nine monitoring visits, the Ombudsman recommended that management ensure that consent to seclusion in own room and other

interventions is obtained and documented in accordance with the requirements set out in applicable rules and practices.

Yours sincerely,

Niels Fenger