FOLKETINGETS OMBUDSMAND

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Thematic report 2023

Children and young people in the psychiatric sector

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1. Introduction

Children and young people in the psychiatric sector was the theme for the monitoring visits (within the theme) in the children's sector that the Ombudsman carried out in 2023 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

Children and young people with a psychiatric diagnosis can be in a vulnerable situation. This is especially true for children and young people who need to be hospitalised in the psychiatric sector. In addition, the Mental Health Act allows for the use of various forms of force towards the children and young people. These conditions in particular formed the background for the Ombudsman's choice of theme for 2023.

In order to shed light on the theme, the Ombudsman carried out monitoring visits to 20 inpatient wards in a total of nine departments of child and adolescent psychiatry. The Ombudsman thereby visited all Denmark's departments of child and adolescent psychiatry where children and young people can be hospitalised. The monitoring visits especially focused on:

- Information for custodial parents
- Immobilisation etc. (immobilisation and use of physical force)
- House rules and 'seclusion in own room'
- Inclusion of children and young people.

2. What have the thematic visits shown?

2.1. Main conclusions

- The Ombudsman's general impression was – as during the monitoring visits in 2016 – that the children and young people were treated with care and respect and that the psychiatric departments provided a professional and committed service in connection with the treatment of the children and young people.

- The monitoring visits left the general impression that the departments were focused on ensuring that the staff were knowledgeable about the rules on force and that they were working on reducing use of force.

- Several departments did not consistently inform the parents of children and young people under the age of 15 about the possibility of waiving the right to decide on use of force or coercion towards their children.

- The departments' completion of protocols on use of force and record keeping could be improved.

- Follow-up interviews were in several departments not carried out or offered in accordance with the rules.

- There was a general focus on inclusion of the children and the young people regarding their treatment plans and on drawing up advance statements.

2.2. General recommendations

On the basis of the monitoring visits, the Ombudsman generally recommends that departments of child and adolescent psychiatry

- ensure that the mandatory review of forced immobilisations takes place in accordance with the time restrictions stipulated in the Mental Health Act, and ensure that deviation from this only takes place if a medical assessment deems it harmful to wake a sleeping patient and that such a decision is noted in the patient's record

- focus on record keeping in connection with use of force

- focus on carrying out follow-up interviews in accordance with the applicable rules.

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

Furthermore, the Ombudsman will discuss certain additional issues uncovered in connection with the monitoring visits with the Ministry of the Interior and Health. The issues concern the nature of a parental consent to use of force towards children and young people under the age of 15, cf. item 3.3, the scope for pooling follow-up interviews, cf. item 4.1.3.4, the power to make a decision to use physical coercion, cf. item 4.2.4, and the power to search patients, including the possibility for 14-year-olds to give personal consent to a search, cf. item 5.1.2.

Monitoring visits in recent years have indicated that there are certain challenges with regard to sector transfers between child and adolescent psychiatry on the one hand and municipalities and accommodation facilities etc. on the other hand, cf. below under item 7.1. In the Ombudsman's assessment, these challenges can affect whether children and young people with mental health problems receive the overall best support and treatment. The Ombudsman will therefore discuss this issue with the Ministry of the

Interior and Health and with the Ministry of Social Affairs, Housing and Senior Citizens.

The Ombudsman will also discuss the issue of certain departments' recruitment challenges with the Ministry of the Interior and Health, cf. item 7.3 below.

2.3. Background for the choice of theme and focus areas

The Ombudsman's monitoring is especially aimed at society's most vulnerable citizens. One of the characteristics of this group of citizens is that they often have very few resources and that their rights can easily come under pressure. This can for instance apply to children and young people in the psychiatric sector – not least to the children and young people who are hospitalised. The Ombudsman therefore has a general focus on conditions for this group of children and young people.

One of the purposes of the 2023 theme was – in comparison to previous monitoring visits to departments of child and adolescent psychiatry – to get updated information about conditions for children and young people in the psychiatric sector.

As part thereof, the Ombudsman wanted among other things to examine the information that the departments gave to the custodial parents on the possibility of refraining from deciding on use of force or coercion towards their children under the age of 15 and to examine the involvement and right to self-determination of the children and the young people.

In line with the Ombudsman's general focus areas, the Ombudsman also wanted to focus on the departments' use of immobilisation and physical force, including the conduct of follow-up interviews. In that context, the Ombudsman wanted to take a look at, among other things, the development in the use of immobilisation and physical force and at the departments' efforts to limit and prevent the use of these interventions.

Lastly, on the basis of experience from the adult psychiatric sector and new legislation on house rules in psychiatric departments, the Ombudsman wanted to uncover whether the departments' house rules were in accordance with the applicable rules and to shed light on the departments' possible use of 'seclusion in own room'.

The Ombudsman also visited a number of departments of child and adolescent psychiatry in 2016. In that connection, the Ombudsman gave a number of recommendations to the departments visited. The monitoring visits in 2023 have shown a need for the departments of child and adolescent

psychiatry to keep working on some of these themes, including record keeping and follow-up interviews.

2.4. How did the Ombudsman proceed?

2.4.1. Material and information in connection with the visits

Prior to the monitoring visits, the Ombudsman received information from the psychiatric departments on a number of factors, and a copy of material on concrete incidents involving immobilisation and use of physical force.

Immediately prior to the monitoring visit, the Ombudsman informed the children and young people of the visit with a view to speaking with as many of them as possible. During the monitoring visits, the visiting teams had interviews with a total of 36 children and young people up to and including 17 and two young people aged 19.

In addition, the visiting teams spoke with parents of the children and young people (70 parents in total), with patient advisers (12 in total) and with department staff, and they collected information about the departments in connection with discussions with the departments' managements.

2.4.2. The legal basis for monitoring visits

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities in accordance with the Ombudsman Act and as part of the Ombudsman's work to prevent that people who are or may be deprived of their liberty are 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 of preventing degrading treatment etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The Danish Institute for Human Rights and DIGNITY contribute to the cooperation with human rights and medical expertise. This means, among other things, that staff with expertise in these areas participate on behalf of the two institutes in the planning, execution and follow-up regarding monitoring visits.

In addition, the Ombudsman has a special responsibility for protecting the rights of children according to the UN Convention on the Rights of the Child.

Generally, the Ombudsman's Special Advisor on Children's Issues participates in monitoring visits in the children's sector.

2.4.3. List of visits in 2023
On the Ombudsman' website, there is a summary of all monitoring visits in 2023, including the recommendations given to the individual departments of child and adolescent psychiatry: Completed visits in the children's sector in 2023

3. Information for custodial parents

3.1. The rules

Children and young people who have been admitted to a psychiatric department can be subjected to force. The force may consist of for instance belt restraint, manual restraint or treatment with tube feeding. By force is meant that there has not been given an informed consent to the measure.

3.1.1. The rules at the time of the monitoring visits
Until 1 June 2024, it was not considered force as defined by the Mental Health Act if a measure was carried out against the child's or young person's will but where the parents gave an informed consent on behalf of their child under 15 years of age. Instead, it was coercion and thereby meant a lapse of some of the legal rights under the Mental Health Act, such as the appointment of a patient adviser and access to complaint. Custodial parents therefore had to be informed that it was possible to refrain from deciding on use of force or coercion towards the child or young person under 15.

If the custodial parents did not wish to decide on use of force towards the child or young person under 15, it corresponded to no informed consent being given. As in other cases without an informed consent, it would therefore only be possible to put measures in place pursuant to the Mental Health Act if the Act's conditions therefore were met, and if this was the case, there was access to complaint and a patient adviser had to be appointed etc.

3.1.2. The rules per 1 June 2024
On 1 June 2024, an amendment of the Mental Health Act came into force[1]. According to the new rules – no matter whether the custodial parents have given informed consent or not – it is force if the child or young person under 15 has not given a personal informed consent. The purpose of the amendment of the Act is to ensure that patients under 15 have the same legal rights as patients who have turned 15, including access to complaint and to have a patient adviser appointed to them.

[1] Act No. 508 of 27 May 2024 on amendment of the Act on Use of Force in Psychiatry etc. (Strengthening of underage patients' rights, use of metal detectors, giving information to the police in connection with co-response to emergency call-outs to citizens etc.

It appears from the explanatory notes to the Act that informed consent from the custodial parents must be written down in the underaged patient's record. Furthermore, it must be written down if the custodial parents do not wish to give informed consent or waive the right to make a decision.

The Ombudsman's review of the material and information from the departments and reports in connection with the monitoring visits is – like item 3.2 below – based on the rules applicable at the time of the monitoring visits. The places – apart from item 3.2 – where the amendment will be especially important have been listed below.

3.2. The departments' information to custodial parents

The monitoring visits generally left the impression that there was a need for the departments to improve the information to the parents about the option of refraining from deciding on use of force or coercion towards their children under 15.

Eight of the nine departments thus stated that they informed the parents verbally about the possibility of refraining from making a decision but five of the eight departments did not impart this information consistently. One department generally did not give this information. A few departments handed out – sometimes according to a concrete assessment – written material about the possibility of refraining from making a decision. One department had written material about it available in the communal area.

In eight of the nine departments of child and adolescent psychiatry that the Ombudsman visited, the visiting teams spoke with parents of children and young people under 15. In seven of the eight departments, one or more parents of children and young people under 15 did not think or could not remember that they been informed that they could refrain from deciding on use of force or coercion towards their child.

The Ombudsman recommended to seven of the nine departments of child and adolescent psychiatry to (continue to) focus on ensuring that the required information be given to custodial parents of a child under the age of 15 about the possibility of waiving the right to decide on use of force or coercion towards the child.

Two departments stated that they would draw up written material about it which can also be used across the two Regions that the departments fall under.

3.3. The nature of a parental consent for use of force towards children and young people under 15

As mentioned above, the custodial parents of children and young people under 15 can waive the right to decide on use of force or coercion towards their child. In connection with examining the question of information about this, the nature of the consent that parents give to use of force gave the Ombudsman cause for further deliberations.

The deliberations concerned firstly whether consent can be given to all uses of force that may arise during a hospitalisation (i.e. a general consent) or whether consent can only be given for specific situations which can be predicted or are expected (i.e. a specific consent). The background for the deliberations was that four of the nine departments stated that they – at least to a certain extent – used general consents obtained in the introductory part of a hospital admission as a basis for using force towards the children and young people.

Secondly, the Ombudsman's deliberations concerned the question of whether parents can give 'subsequent consent'. The background for this was that the monitoring visits showed that three of the nine departments tried to obtain a subsequent consent from the parents if it had not been possible to obtain consent prior to the measure.

In one department, the question of obtaining consent and giving information to custodial parents also gave rise to deliberations on whether parents under the Act on Parental Responsibility can give consent to use of force towards children and young people under 15 who are not covered by the Mental Health Act's scope of application. The background for the deliberations was that some of the children admitted to the department were hospitalised for diagnostic evaluation for for instance ADHD and were not covered by the Mental Health Act's scope of application. The department therefore obtained consent according to the Act on Parental Responsibility for handling of any conflicts.

The Ombudsman will discuss these issues with the Ministry of the Interior and Health.

4. Immobilisation etc.

4.1. Immobilisation

4.1.1. The rules
A patient who has been admitted to a psychiatric department can be the subject of forced immobilisation under the Mental Health Act. This also applies to children and young people.

In all actions concerning children, the best interests of the child shall be the primary consideration. This appears from the UN Convention on the Rights of the Child.

In addition, it follows from the general principles of the Mental Health Act that force must not be used until everything possible has been done to gain the patient's voluntary cooperation. Furthermore, use of force must be in reasonable proportion to what is sought to be achieved through use of force. Less invasive measures must be used if they are sufficient. Lastly, force must be carried out as gently as possible and with the greatest possible consideration so as not to cause unnecessary indignity or discomfort. Force must not be used to a further extent than what is necessary to achieve the intended aim.

IMMOBILISATION

What
Forced immobilisation must only be used for a short period of time and to the extent that it is necessary to prevent a patient from
1. exposing themselves or others to an immediate risk of incurring damage to body or health
2. persecuting or otherwise grossly harassing fellow patients or
3. committing vandalism of a not inconsiderable extent.

A patient can be forcibly immobilised for longer than a few hours when regard for the patient's or others' life, health or safety dictates it.

Who
Generally, the consultant psychiatrist makes the decision to forcibly immobilise a patient after seeing the patient, but in the absence of the consultant psychiatrist another physician can make the decision. If so, the consultant psychiatrist must review the decision as soon as possible.

In special situations, the nursing staff can decide on their own to immobilise a patient with a belt, but the consultant psychiatrist must then be sent for immediately.

How
Immobilisation may be carried out with a belt, hand and foot straps and gloves.

An immobilised patient must have a permanent guard. The permanent guard must make an impartial description of the patient's current condition and note his or her observations and the time of the observations at least every 15 minutes. The permanent guard must start a new record entry every hour.

Reassessments
A forced immobilisation must be reassessed by a doctor as often as conditions dictate, however at least three times in the course of 24 hours, distributed evenly over that time. The first reassessment must be carried out 4 hours at the latest after the decision to immobilise was made. Subsequent reassessments must be made with 10 hours between them at the most. The deadlines for reassessments do not apply if the patient is asleep and, according to a medical assessment, it is deemed harmful to wake the patient. The decision that it is deemed harmful to wake the patient must be noted in the patient's record.

If the forced immobilisation exceeds 24 hours, a specialist psychiatrist or a specialist in child and adolescent psychiatry who is not employed at the same ward, who is not responsible for the patient's treatment, and who is not subordinate to the treating doctor, must assess the question of continued immobilisation. The same applies after 48 hours, on the fourth day and then once a week as long as the immobilisation lasts.

Documentation, guidance on complaint etc.
Both forced immobilisation and immobilisation carried out against the minor's will but with parental consent must be recorded in the department's protocol on use of force. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

Furthermore, a patient who is forcibly immobilised must be given guidance on complaint and be notified, verbally and in writing, of the intended use of force and its details, background and purpose. In particularly urgent instances, the notification can be omitted but, if so, the grounds must be imparted subsequently. Following the amendment of the Mental Health Act, cf. item 3.1.2 above, the requirement of giving notification and guidance on complaint also applies to children and young people under 15 who do not consent to an immobilisation.

A patient who has been forcibly immobilised must be offered one or more talks (follow-up interviews). Children and young people under 15 whose parents have given consent to the treatment but who have not themselves

given consent must also be offered a follow-up interview. The same applies to the parents of the child or young person under 15. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

4.1.2. Extent of (forced) immobilisations

Prior to the visits, the Ombudsman obtained information on the number of forced immobilisations and immobilisations with consent from the custodial parent in the period 2020-2022. It appears from the information sent to the Ombudsman that the annual number of physical (forced) immobilisations varied a great deal between the departments in that period. They went from 0 up to 416 (forced) immobilisations in one year. No immediate correlation solely based on the departments' size and the number of (forced) immobilisations could be ascertained.

Several departments pointed out that a large number of the (forced) immobilisations over recent years were concentrated on a few patients and were for the majority connected with severe self-harm or eating disorders.

Generally, the visits left the impression that the departments were focused on preventing and reducing use of forcible measures towards the patients. In that context, the departments gave a relevant account of various initiatives, for instance an increased focus on the patients' advance statements, subsequent review of specific situations involving use of force and managerial awareness of the issue.

4.1.3. Examples of specific (forced) immobilisations

Both forced immobilisation and immobilisation carried out against the minor's will but with parental consent must be recorded in the department's prococol on use of force. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

In connection with the monitoring visits, the Ombudsman obtained information on the departments' most recent uses of (forced) immobilisation, including protocols on use of force, the permanent guard's record entries and minutes from the follow-up interview. The Ombudsman received material concerning a total of 30 cases on forced immobilisation and a total of 12 cases on immobilisation with consent from the custodial parent.

The review of the material concerning the specific cases formed a basis for discussions between the visiting teams and the visited facilities during the monitoring visits. The main themes of these discussions appears below under items 4.1.3.1- 4.1.3.4.

4.1.3.1. Mandatory assessments

It follows from the Mental Health Act that – for the duration of a forced immobilisation – a renewed medical assessment of whether or not to continue the forced immobilisation is to be carried out as often as conditions dictate or at least three times in the course of 24 hours, distributed evenly over that time. The first assessment must be made 4 hours at the latest after the decision to use forced immobilisation has been made. Subsequent assessments must be made with 10 hours between them at the most. The above-mentioned time intervals do not apply if the patient is asleep and, according to a medical assessment, it is deemed harmful to wake the patient. Find more details under item 4.1.1 above.

The review of the received material showed that there were examples in three departments of the mandatory assessment of forced immobilisations not being carried out in accordance with the Mental Health Act's framework therefore. Furthermore, two of these departments were not aware that the time restrictions stipulated in the Mental Health Act can only be deviated from if a medical assessment deems it harmful to wake a sleeping patient, and that such a decision must be noted in the patient's record.

On that background, the Ombudsman recommended the three departments to ensure that the mandatory assessment of forced immobilisations takes place in accordance with the stipulations of the Mental Health Act. Furthermore, the Ombudsman recommended two of these departments to ensure that deviation from the time restrictions stipulated in the Mental Health Act only happens if a medical assessment deems it harmful to wake a sleeping patient, and that, if so, such a decision must be noted in the patient's record.

The Ombudsman generally recommends that it is ensured that the mandatory reassessment of forced immobilisations takes place in accordance with the time restrictions stipulated in the Mental Health Act and that deviation from this only takes place if a medical assessment deems it harmful to wake a sleeping patient and that, if so, such a decision is noted in the patient's record.

4.1.3.2. Permanent guard

A patient who has been immobilised with a belt must have a permanent guard. During the forced immobilisation, the permanent guard must make an impartial description of the patient's current condition and note his or her observations and the time of the observations at least every 15 minutes.

On the basis of the received material and the information received during the monitoring visits, the Ombudsman recommended one department to focus on documenting that there is a permanent guard for immobilisations, including

that a record entry is made every 15 minutes in accordance with the rules of the Mental Health Act.

4.1.3.3. Record keeping
Pursuant to the Mental Health Act, all information on, among other things, forced immobilisation and immobilisation against the minor's will but with consent from the custodia parent must be entered into the department's protocol on use of force. There are rules on what information must be entered into the protocol on use of force[2]. In addition a number of other data must be added to the patient's record, including information about follow-up interviews and the permanent guard's notes.

The review of the material received in connection with the monitoring visits showed that there is room for improvement in the departments' completion of protocols on use of force and record keeping. Thus, the Ombudsman recommended eight departments to have (continued) focus on record keeping.

The basis for the recommendations varied between the departments but several recommendations concerned the entering of the names of the involved staff members in the protocols on use of force and insufficient documentation for follow-up interviews.

The Ombudsman generally recommends that the psychiatric departments focus on record keeping in connection with use of force.

4.1.3.4. Follow-up interviews
After any kind of forcible measure, the patient must be offered one or more talks (follow-up interviews). The same applies to minors under 15 whose parents have consented to the treatment but where the minor has not given personal consent. The same applies for the minor's parents. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

A follow-up interview must include a number of specific subjects, for instance how the patient experienced the forcible measure and the patient's assessment of how force could have been avoided in the concrete situation. The aim of the interview is to shed light on the patient's and staff's perception of the situation that led to use of force with a view to preventing further use of force and perhaps carry out force in another way in connection with future forcible measures. Minutes of the interview must be made afterwards and

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[2] Executive Order No. 1079 of 27 October 2019 on protocols on use of force and records, recording and reporting use of force, and discharge agreements and coordination plans in psychiatric departments, and Guidance Note No. 9256 on recording use of force etc. in psychiatry.

entered into the patient's record. If the patient does not want a follow-up interview, it must be entered into the record together with the reason for the refusal.

The Ombudsman asked to receive the minutes from the follow-up interviews in the cases on (forced) immobilisations that the departments had sent prior to the monitoring visits.

The review of the forwarded material compared with the information that the visiting teams received during the monitoring visits showed that in a number of instances, follow-up interviews were not held or offered in accordance with the applicable rules.

The Ombudsman therefore recommended five departments to (continue to) focus on follow-up interviews – including with parents of children and young people under 15 – being held in accordance with applicable rules on interviews following cessation of forcible measures and coercion in psychiatric departments.

The Ombudsman generally recommends that the departments focus on carrying out follow-up interviews in accordance with the applicable rules, cf. also below under item 4.2.3.2 on follow-up interviews.

It appears from the guidance note on use of force[3] that a follow-up interview must take place as soon as possible after the forcible measure has ended. More than one forcible measure can be discussed at the same interview if the measures were part of the same episode, for instance forcible detention, manual restraint and sedation on the same day or multiple administrations of sedatives within a 24 hour period.

In connection with the monitoring visits, the Ombudsman became aware of several incidents where forcible measures over a longer period (days, up to one month) were 'pooled' and the patient was offered one single follow-up interview to discuss them all. These were quite a large number of forced immobilisations in connection with an extended period of compulsory treatment with daily instances of forced tube feeding.

In the light of this, the Ombudsman will discuss the scope for 'pooling' follow-up interviews with the Ministry of the Interior and Health.

4.1.4. Knowledge of rules etc.

Children and young people admitted to the psychiatric sector must be treated with dignity, consideration and in accordance with their rights. To ensure this,

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[3] Item 7 in Guidance Note No. 9257 of 19 March 2023 on use of force etc. in psychiatry.

it is crucial that staff are familiar with the rules that apply to use of (forced) immobilisation of the children and young people. Written guidelines can in this connection provide support and help in the daily work.

During the monitoring visits, the visiting teams got the general impression that the departments were focused on ensuring that staff – for instance through training – were familiar with mental health legislation and the most gentle way of carrying out forcible measures.

However, the Ombudsman found cause to recommend one department to ensure that new staff receive relevant training on conflict management within a reasonable time after they are hired and two other departments to ensure that staff receive training in the rules on (forced) immobilisation and physical coercion towards children under the age of 15.

The Ombudsman also gave a few recommendations concerning the departments' written guidelines, including to ensure that the guidelines are in accordance with the applicable rules.

4.1.5. Forced immobilisation extending longer than 30 days

The consultant psychiatrist is responsible for ensuring that a forced immobilisation extending more than 30 days is reported to the Patient Safety Authority.

Prior to the monitoring visits, the visiting teams asked to receive any reports of this nature. All nine departments stated that they had not had such reports.

4.2. Use of physical force

4.2.1. The rules

The Mental Health Act also allows the use of physical force in certain situations towards a person who is admitted to a psychiatric department. This also applies to children and young people.

Physical force must be carried out in accordance with the general principles of the Mental Health Act, cf. above under item 4.1.1.

USE OF PHYSICAL FORCE

What
A patient in a psychiatric department can be restrained and with force, if necessary, be led to another place in the hospital if it is necessary in order to prevent the patient from

1. exposing themselves or others to an immediate danger of incurring damage to body or health
2. persecuting or otherwise grossly harassing fellow patients or
3. committing acts of vandalism of a not inconsiderable extent.

Documentation, guidance on complaint etc.
Physical force, including when physical force is carried out against the minor's will but with parental consent, must be recorded in the department's protocol on use of force. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above. The circumstances surrounding the physical restraint must also be described in the patient's record.

A patient who has been the subject of physical coercion without parental consent must be given guidance on complaint and be notified, verbally and in writing, of the intended use of coercion and its details, background and purpose. In particularly urgent instances, the notification can be omitted but, if so, the grounds must be imparted subsequently. Following the amendment of the Mental Health Act, cf. item 3.1.2 above, the requirement of notification and guidance on complaint applies, regardless of whether there is parental consent or not, if the child or young person under 15 does not consent to the restraint.

A patient who has been the subject of physical coercion without parental consent must be offered one or more talks (follow-up interviews). The same applies to children and young people under 15 whose parents have consented to the treatment but who have not given personal consent. The same applies to the parents of the child or young person under 15. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

4.2.2. Extent of the use of physical force

Prior to the visits, the Ombudsman obtained information about the number of uses of physical coercion (without parental consent) and about physical force towards children and young people under 15 against their will but with consent from the custodial parent in the period 2020-2022.

It appears from the information sent that the annual number of uses of physical force varied a great deal between the departments in the period. Thus, the number varied from 3 uses of physical force in one year in one department to 833 in one year in another department. No immediate correlation solely based on the departments' size and the number of uses of physical force could be ascertained. Eight of the nine departments had both uses of physical coercion without consent and physical force with consent from the custodial parent in the period. The last department had solely carried out physical force with consent from the custodial parent.

As described above under item 4.1.2, the visits generally left the impression that the departments were focused on preventing and reducing the use of forcible interventions towards the patients. Several departments pointed to a general downward trend in the use of physical force. A few patients could have a major impact on the overall number of uses of physical force per year.

4.2.3 Examples of concrete uses of coercion

Uses of physical coercion (without parental consent) and physical force towards children and young people under 15 against their will but with consent from the custodial parent, must be recorded in the department's protocol on use of force. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

In connection with the monitoring visits, the Ombudsman obtained information on the departments' most recent uses of both types of use of force, including use of force protocols and minutes from the follow-up interviews. The Ombudsman received material concerning a total of 28 cases on use of physical coercion without parental consent and a total of 32 cases on use of physical force with consent from the custodial parent. The material came from all nine departments (however, from one department, only cases on the use of physical force with parental consent).

The review of the material concerning the specific cases formed a basis for discussions between the visiting teams and the visited facilities during the monitoring visits. The main themes of these discussions appear below under items 4.2.3.1- 4.2.3.2.

4.2.3.1 Record keeping

Similar to what appears above under item 4.1.3.3, mental health legislation contains rules on what information must be recorded in the protocol on use of force and the patient's record in connection with a use of physical coercion, including use of physical coercion with parental consent.

The review of the cases received by the Ombudsman showed that the departments' completion of protocols on the use of force and record keeping

with regard to the cases on the use of physical coercion can be improved. Thus, the Ombudsman recommended eight of the nine departments to have (continued) focus on record keeping.

As stated under item 4.1.3.3, the Ombudsman therefore generally recommends that the psychiatric departments focus on record keeping in connection with use of force.

4.2.3.2 Follow-up interviews
After any kind of forcible measure, the patient must be offered one or more talks (follow-up interviews). The same applies to minors under 15 where the parents have consented to the treatment but where the minor has not given personal consent. The minor's parents must also be offered follow-up interviews. Find more details under item 4.1.3.4 above. This applies also after the amendment of the Mental Health Act, cf. item 3.1.2 above.

The review of the received material in the cases on use of physical coercion, including physical coercion with parental consent, gave the Ombudsman cause to recommend five departments to have a (continued) focus on carrying out follow-up interviews in accordance with the applicable rules following cessation of forcible measures and use of coercion in psychiatric departments. This also applies to follow-up interviews with parents of children and young people under 15.

The Ombudsman therefore generally recommends that the departments focus on carrying out follow-up interviews in accordance with the applicable rules, cf. also above under item 4.1.3.4 on (forced) immobilisation.

4.2.4 Knowledge of rules etc.
As described above under item 4.1.4 on (forced) immobilisation, the visiting teams got the general impression during the monitoring visits that the departments were focused on ensuring that staff – for instance through training – were familiar with mental health legislation and the most gentle way of carrying out forcible measures. This also applied in relation to the use of physical force.

The discussions regarding the use of physical coercion thus gave no occasion for recommendations apart from those mentioned under item 4.1.4.

There was cause during two monitoring visits to discuss who can make the decision to use physical force towards a patient. The reason for the discussion was that the Mental Health Act does not regulate the issue of the decision-making power. On the other hand, it appears from the Executive

Order on Recording Use of Force[4] that when physical force has been used, ‘the name of the prescribing/attending physician’ must be entered into the protocol on use of force and it appears from the Guidance Notes on Recording Use of Force[5] that the name of the prescribing physician must be recorded in Chart 3.

The Ombudsman will discuss the issue of decision-making power in relation to use of physical coercion with the Ministry of the Interior and Health.

5. House rules and seclusion in own room

5.1. House rules

5.1.1. The rules
All psychiatric departments must have written house rules.

The house rules must contain the department’s general rules on for instance order and behaviour. They must also contain a description of what prohibitions and restrictions may occur in the department and what measures may be implemented with a view to avoiding repetition of behaviour in contravention of implemented prohibitions and restrictions.

HOUSE RULES

Contents
The house rules must contain general rules on what the patients can and cannot do during their admittance. This can for instance be rules on smoking and visiting.

The house rules must also contain a description of the prohibitions or restrictions that can occur in the individual departments. The possible prohibitions and restrictions may for instance concern:

- Access to mobile phone, pc or similar communication equipment
- Sexual congress between patients in the department
- Access to specific books, magazines, etc.
- Access to using specific social media etc. and specifically stated websites.

[4] Executive Order No. 1079 of 27 October 2019 on protocols on use of force and records, recording and reporting use of force, and discharge agreements and coordination plans in psychiatric departments.

[5] Guidance Note No. 9256 of 19 March 2023 on recording use of force etc. in psychiatry.

Prohibitions and restrictions must not be used before everything possible has been done to obtain the patient's voluntary cooperation, and the measures must be in reasonable proportion to what is sought to be achieved by these means, and they must not be used to a wider extent than necessary in order to achieve the intended goal.

The house rules must also contain a description of the measures that may be implemented in the department with a view to avoiding repetition of behavior in contravention of implemented prohibitions and restrictions.

The measures must be in reasonable proportion to the behaviour for which prohibitions or restrictions have been implemented and must not be used to a wider extent than necessary in order to achieve the intended goal.

Information
The house rules must be available for the patients and must be handed out in connection with the admission to the department.

5.1.2. The departments' house rules
Prior to the monitoring visits, the Ombudsman asked the departments to send him house rules for the wards included in the monitoring visits. The Ombudsman received house rules from all departments (and wards).

The visiting teams received the general impression that the departments went through the house rules with the children and the young people and (possibly) their parents in connection with admission and handed out a copy to the children and young people. In several departments, the house rules were also available in the communal areas of the wards.

On 1 January 2022, new regulations on house rules in psychiatric departments came into force[6]. The regulations mean, among other things, that the house rules must contain a description of what prohibitions and restrictions may be implemented in the department and a description of what measures may be implemented with a view to avoiding repetition of behaviour in contravention of implemented prohibitions and restrictions. Review of the house rules sent to the Ombudsman showed that two departments had not yet revised their house rules in accordance with the relevant amended regulation. However, the Ombudsman noted in connection with the two monitoring visits that the wards' house rules were being revised in order to bring them in line with the applicable regulation.

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[6] Act No. 2618 of 28 December 2021 on amendment of the Act on Use of Force in Psychiatry etc. (House rules in psychiatric departments, security checks in forensic psychiatry, special rules for people placed in surrogate custody etc.).

It appeared (with variations in wording) from several of the house rules received by the visiting teams that the departments did not compensate for loss or theft of money or valuables during the hospitalisation. With reference to Danish law's general rules on damages, the Ombudsman therefore recommended four departments to consider whether the wording of the house rules' paragraphs on compensation was true. In addition, the Ombudsman recommended one of the departments to consider whether its house rules' stipulation of a limitation in the access to going outside the ward after violation of the house rules was in accordance with Section 2 c of the Mental Health Act on measures that can be implemented by the department.

Practice for searching patients was discussed with all departments. The discussions did not give cause for recommendations but one department indicated that the Mental Health Act's rules on searches were not very consistent with occupational health and safety legislation. The Danish Working Environment Authority had thus indicated that all patients should be searched, as dangerous objects in the department could constitute a danger to staff. In another department, there were discussions of 14-year-olds' access to giving their own consent to personal searches if staff could not obtain consent from the custodial parent in time.

The Ombudsman will discuss both issues with the Ministry of the Interior and Health.

5.2. Seclusion in own room

5.2.1. The intervention and conditions therefore

In connection with previous monitoring visits to psychiatric departments, the Ombudsman has found that the intervention 'seclusion in own room' is used in several places. Other names for this sort of intervention is 'environmental shielding', 'area restriction' and 'reflexion time'.

Seclusion in own room is generally characterised by a patient being isolated in his or her own room or another delimited area with an unlocked door and possibly with members of staff standing guard outside the door.

The intervention is not statutory, and its use without consent from the patient must be considered a coercive measure without authority in the Mental Health Act. It is thus a condition for using the intervention that the patient gives voluntary consent to it, that the consent is based on sufficient information and that the patient has decision-making capacity. Find details in Case FOB 2020-25 (in Danish only, on the Ombudsman's website).

5.2.2. Use in the visited departments
For use in the preparation of the monitoring visits, the visiting teams asked the departments to state whether the departments use seclusion in own room and, if so, to send a copy of any written guidelines in that respect or, alternatively, an account of the use of the intervention, including of how they obtain and document consent. The subject was also discussed during the monitoring visits.

Several departments stated that they use seclusion in various ways in their daily work. The departments pointed to for instance personal shielding pursuant to the Mental Health Act, shielding as a healthcare professional concept that stipulates the observation frequency, and various voluntary measures. However, all nine departments stated that they do not use seclusion in own room in the sense that is mentioned above under item 5.2.1 and that is described in Case FOB 2020-25 (in Danish only, on the Ombudsman's website).

Two departments stated that they had previously used seclusion in own room as defined in Case FOB 2020-25 but that they did not do so any longer.

6. Inclusion of children and young people

6.1. The rules

According to Article 12 of the UN Convention on the Rights of the Child, a child has the right to be heard.

The Mental Health Act has a number of provisions aimed at involving the patients in their own treatment during a hospitalisation.

INCLUSION OF CHILDREN AND YOUNG PEOPLE

Treatment plan
All persons being admitted to a mental health department must have a treatment plan. This is the responsibility of the psychiatric consultant.

The patient must be involved and heard about the contents of the plan.

The treatment plan must be drawn up at the latest within one week from the time of admission.

The treatment plan is a part of the patient’s record.

Advance statements
In connection with the admission interview, the patient must be heard about any statement of preferences in relation to treatment, including in the case of force being considered (advance statements).

Any advance statements on the part of the patient must be entered into the patient's record and to the widest possible extent included in the treatment plan.

If it is not possible to obtain an advance statement from the patient in connection with the admission interview, the reason for this must be entered into the patient's record. The advance statement must be obtained as soon as possible thereafter.

If the patient's advance statement is deviated from, it must be entered into the patient's record together with the reason for the deviation.

6.2. The departments' inclusion of children and young people
Prior to the monitoring visits, the Ombudsman asked the departments for material on inclusion of children and young people.

The monitoring visits left the impression that the departments endeavoured to include the hospitalised children and young people. This applied both in everyday life in the departments and in relation to the treatment of the children and young people.

Based on the forwarded material and the discussions with management, staff, parents and the children and young people, it was the visiting teams' assessment that the departments did draw up treatment plans. The visiting teams also found that the treatment plans were predominantly drawn up on time and following at least attempts to involve the patients, and that there was attention on drawing up advance statements for the patients.

On that background, the monitoring visits did not give cause for recommendations concerning involvement of children and young people. However, one department was recommended to focus on record keeping, including in connection with drawing up advance statements.

7. Other issues

7.1. Sector transfers
Both in 2021, where the theme for the monitoring visits by the Ombudsman's Children's Division was children and young people in secure residential

institutions, and in 2022, where the theme was small private accommodation facilities for children and young people, the issue of cooperation with the child and adolescent psychiatric sector was discussed. Both years, there were institutions which stated that they experienced challenges in the cooperation with psychiatric emergency services. At a meeting following the monitoring visits in 2021, the Ombudsman informed the, then, Ministry of Social Affairs and Senior Citizens of the challenges that the institutions had stated they experienced in this respect.

Similarly, in connection with the monitoring visits to the psychiatric departments, the Ombudsman has discussed the issue of sector transfers. In that context, the majority of the psychiatric departments pointed to challenges in sector transfers between the departments and municipalities or accommodation facilities.

Several departments indicated that the lack of suitable places in accommodation facilities was a challenge, as it meant that fully treated patients could not be discharged and thereby took up beds in the children and adolescent psychiatry sector. Some departments also mentioned that the lack of relevant support following an admission in the psychiatric sector could be a challenge and result in readmissions, just as a long diagnostic process before the child or young person came to the psychiatric sector worsened the situation for the child or young person and for the rest of the family. One department stated that they saw that some children and young people who were admitted from accommodation facilities were discharged by the accommodation facilities during the admission. This meant that the children and young people did not know where they would live when they came out of hospital. There were also children and young people who did not receive any visits from their accommodation facility during the admission.

A few departments also mentioned implemented initiatives intended to counter sector transfer issues. Concretely, this concerned a closer cooperation with a specific accommodation facility and the establishment of a mobile team which could be a sounding board for the patients' accommodation facilities in connection with a concrete form of hospitalisation.

The completed monitoring visits did not give a full picture of the sector transfer issues that occur in practice or the reasons for the problems in this respect. But in the Ombudsman's opinion, they indicate that the challenges described – both by the psychiatric departments and by the social institutions during previous monitoring visits – may be important to whether or not children and young people with psychiatric issues receive the best overall support and treatment. The issues described should therefore in the

Ombudsman's opinion give the responsible authorities in the field cause for deliberations.

In this context, the Ombudsman will discuss this issue with the Ministry of the Interior and Health and with the Ministry of Social Affairs, Housing and Senior Citizens.

7.2. Use of guards

In connection with two monitoring visits, the visiting teams noticed that the departments use external guard personnel. The departments stated that the guards are only used in special circumstances and only to ensure the staff safety.

On that background, the departments were informed that the Ombudsman's Monitoring Department had opened an own-initiative case on the legal scope for use of force by private guards in psychiatric departments, and that the departments would be informed of the result of the case.

The departments have subsequently been informed of the result of the investigation (Case FOB 2024-12 in Danish only, on the Ombudsman's website). In this investigation, the Ombudsman found that actual exercise of authority in the form of the use of physical force is covered by the requirement for express statutory authority in connection with delegation to private parties. This also applies in instances where the decision to use physical force is made by the authority and the private guard 'solely' participates in the use of force under instruction from the authority. Section 17(1) of the Mental Health Act does not contain the power to delegate use of force or coercion to private parties.

7.3. Recruitment

Three departments have pointed to recruitment as a main challenge in the profession. The departments point to the cause therefore being, among other things, geographical reasons and that it is evening, night and weekend work.

The Ombudsman will discuss the issue with the Ministry of the Interior and Health.

Sincerely,

Niels Fenger

THE OMBUDSMAN'S THEMATIC REPORTS
Every year, the Ombudsman carries out a number of monitoring visits within a specific theme. The most significant results of the monitoring visits are summarised and communicated in a thematic report, which the Ombudsman writes in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture. The thematic reports are made public on the Ombudsman's website and are sent to the relevant authorities so that those authorities can include them in their deliberations. The Ombudsman also informs Parliament of the reports.

BASIS FOR THE OMBUDSMAN'S MONITORING ACTIVITIES
The monitoring visits are 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 that persons who are or who can be deprived of their liberty are 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. The Institute for Human Rights contributes with 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.