FOLKETINGETS
OMBUDSMAND

Thematic Report on Psychiatry

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What has the theme led to?

Psychiatry was one of the themes for the monitoring visits in 2014 carried out by the Ombudsman in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

On the basis of his monitoring visits, the Ombudsman generally recommends that psychiatric wards continuously prepare and make active use of statistics on the use of force at unit level. The purpose of carrying out this statistical control of the use of force is to provide the institution management with information about patterns in and reasons for forcible measures undertaken in order to prevent and reduce forcible measures as much as possible.

The Ombudsman will discuss the follow-up on this general recommendation with key authorities. In addition, the Ombudsman will follow up on the issue during his monitoring visits.

The Ombudsman will discuss with the Ministry of Health the differences in the wards' possibilities of statistical control of data as regards the use of force.

The Ombudsman has asked the Ministry of Health whether it would be advisable to lay down guidelines for recommended standard house rules for psychiatric wards.

The Ombudsman has passed on information from psychiatric wards to the Ministry of Health about lack of feedback from the Danish Health and Medicines Authority on reports of the use of forcible measures.

The Ombudsman will discuss with the Ministry of Health the issue of enforcement of telephone restrictions at psychiatric wards where patients with and without such restriction are hospitalised.

The Ombudsman has sent this report to the Ministry of Health and to the Mental Health Services of the Regions of Southern Denmark, Central Denmark, North Denmark, Zealand, 'The Psychiatric House' (Psykiatrihuset) and the Capital Region of Denmark. The purpose is to notify the authorities of the report so that the authorities can include it in their deliberations concerning this issue.

Please read more about the Ombudsman's work on various themes in the appendix to this report.

Reasons for the choice of theme

By selecting the psychiatry theme, the Ombudsman wanted to check up on the conditions at institutions for adults within these areas:

- Conditions for patients with disorders relating to forensic psychiatry.
- Forced physical restraint within the psychiatric sector.
- Access to psychiatric wards.
- Activities for users with a psychiatric disorder.

The Ombudsman selects a number of general topics during his monitoring visits. For example, forcible measures and other restrictions, disciplinary measures and informal initiatives are included in the Ombudsman's general focus points during his monitoring visits.

The theme was selected in order to give the Ombudsman an increased insight into and to assess the conditions for forensic psychiatric patients during their hospitalisation, including forensic psychiatric wards. The Ombudsman was paying particular attention to the use of force, restrictions and limitations as regards the patients' rights at forensic psychiatric wards as well as ordinary wards.

In spite of ambitions of the opposite, the number of persons who were forcefully restrained rose from 2010 till 2012. The assessment of the Danish State Serum Institute on forcible measures within psychiatry from 2001-2013 shows that the number of immobilised persons was rising during 2010-2012 (1831 persons were immobilised in 2010, 1981 persons in 2011 and 1993 persons in 2012). Moreover, it also appears from the assessment that the increase continued in 2013 when 2084 persons were immobilised.

The coercive nature of the forcible restraint for the individual patient is emphasised in a judgment by the High Court of Eastern Denmark of 8 July 2014 (U2014.3300Ø) according to which unjustified immobilisation during admission to a forensic psychiatric unit must be considered as resulting in such intense physical and mental suffering that the restraint violates Article 3 of the European Convention on Human Rights. Article 3 prohibits torture and inhuman or degrading treatment or punishment.

The Ombudsman is also giving general priority to work and leisure time activities as far as the users' access to activities are concerned. Transfers between different sectors, for example discharge from a psychiatric ward to a private accommodation facility, is also one of the Ombudsman's overall focus points.

During his monitoring visits, the Ombudsman requested, among other things, information within these focus areas as to which extent users with a psychiatric disorder made use of the activities offered and how accommodation facilities experienced the residents' access to a psychiatric ward. The reason for asking these questions was that the Ombudsman during previous monitoring visits had been told that there may be problems within these areas.

The Ombudsman's monitoring is particularly aimed at society's most vulnerable citizens. Some of the characteristics of the group of vulnerable citizens are that they usually have very few resources and that their rights may easily be put under pressure. This may also apply to users with a psychiatric disorder, including patients at a psychiatric ward.

What did the Ombudsman do?

In 2014, the Ombudsman selected psychiatry as one of the themes for his monitoring visits to institutions for adults. The theme was cross-sectional in the sense that conditions for users with a psychiatric disorder was relevant as regards the main part of the visits during the year. The theme was not only of interest when visiting psychiatric wards, but also when visiting accommodation facilities within the social sector as well as prisons.

The theme was divided into these topics:

- Conditions for forensic psychiatric patients:
    - In this context, the Ombudsman visited 10 general psychiatric units which often also included forensic psychiatric patients, and 21 units for forensic psychiatric patients only.
    - The Ombudsman asked the general psychiatric ward to provide him with information beforehand about
        - number of forensic psychiatric patients placed at an ordinary psychiatric ward within the last three years.
        - who made the decision to place a forensic psychiatric patient at a general psychiatric ward, and the criteria for reaching this decision.
        - how were staff members prepared for handling forensic psychiatric patients at an ordinary psychiatric ward.

  - The Ombudsman also asked the general psychiatric ward to state beforehand
    - whether the question of placing forensic psychiatric patients at a general psychiatric ward together with non-forensic psychiatric patients had been considered, including information about these deliberations.
    - possible consequences of placing forensic psychiatric patients together with non-forensic psychiatric patients, and numerical data which could clarify same (for example, increased use of force, increased number of removals from forensic psychiatric wards as well as satisfaction surveys).

- Forced immobilisation within psychiatry:
  - The Ombudsman visited 31 psychiatric units, including forensic psychiatric units.
  - The Ombudsman asked the psychiatric ward to provide him beforehand with the 3 latest cases on forced immobilisation at each unit (entries in coercive measures protocol and report of the follow-up sessions).
  - In connection with the cases on forced immobilisation, the Ombudsman asked the ward to state beforehand which information the institution management had received about these restraints, and whether the institution management had carried out an analysis of the restraints and subsequently implemented initiatives to prevent forced immobilisation and, if so, which type of initiative.
  - Prior to the visit, the Ombudsman's visiting team examined the cases about restraint based on a form focusing on whether essential selected procedure rules had been observed. The form is enclosed.
  - The Ombudsman investigated 54 entries in coercive measures protocols as regards restraint and reports, if any, of the subsequent follow-up session which had been undertaken after termination of the restraint.

- Access to psychiatric ward:
  - The Ombudsman requested relevant information beforehand about
    - for example, how had the accommodation facility experienced the residents' access to admission at a psychiatric ward within the last year.

        - whether it had become necessary for the psychiatric ward within the last year to reject citizens for other than medical reasons, for example due to capacity or security reasons.

- Activities for users with a psychiatric disorder:
    - The Ombudsman asked the institution to provide him with information beforehand about
        - the extent to which users with a psychiatric disorder made use of the individual offers of activity.
        - users, by name, who did not make use of or hardly ever made use of the activities offered.
        - how the institution motivated users who did not or hardly ever made use of the activities offered.

- The talks of the Ombudsman's team with the institution's management, staff, relatives and users also focused on the mentioned conditions within psychiatry.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act and as part of the Ombudsman's task of preventing exposure to for instance inhuman or degrading treatment of persons who are or may be deprived of their liberty, cf. the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

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. DIGNITY and the Institute for Human Rights contribute to the cooperation with special medical and human rights expertise, meaning that staff with this expertise participate in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

What did the Ombudsman find?

Based on the monitoring visits carried out, the Ombudsman noted the following, among other things:

- An overall impression that placement of forensic psychiatric patients at general psychiatric wards does not normally give rise to special difficulties for the wards. It could, however, be difficult for psychiatric wards, including forensic psychiatric wards, to maintain control of the patients' use of telephone when the ward comprised patients both with and without such restriction.

- The Ombudsman noticed that the contents of the wards' house rules varied significantly and that the authority for several of the rules could be in doubt. Furthermore, in many cases the house rules did not state the consequences of breaking the house rules.

- There was a difference in the individual wards' possibilities of statistically monitoring the use of force to find possible connections and patterns as well as reasons for the force used towards the patients.

- The investigation of cases regarding forced immobilisation showed that the wards had a number of difficulties within the field, especially regarding obligatory investigation of the use of restraint and the completion of subsequent sessions.

- The Ombudsman was informed that psychiatric wards did not receive any feedback from the Danish Health and Medicines Authority on the reports regarding coercive measures which the wards had sent to the Authority.

Forensic psychiatric patients in general psychiatric wards

A number of psychiatric wards stated that placement of forensic psychiatric patients did not generally give rise to special difficulties for the wards. This was because forensic psychiatric patients were patients with a psychiatric disorder just like the other hospitalised patients and that possible problems depended on the individual patient. One ward stated that forensic psychiatric patients affected the wards' atmosphere.

For the sake of the objective of the remand, the police can oppose that a remand prisoner has telephone conversations. Forensic psychiatric patients with another non-custodial sentence may also be subject to telephone restrictions.

The monitoring visits to psychiatric wards indicated that it can be difficult for the wards to uphold the telephone restrictions in cases where a forensic psychiatric patient with

telephone restrictions is hospitalised together with patients without such restrictions at a psychiatric ward, including a forensic psychiatric ward, to which forensic psychiatric patients are also admitted.

The difficulties may vary. Some psychiatric wards were unable to ensure enforcement of telephone restrictions.

One ward stated, for example, that the ward checked whether remanded patients borrowed other patients' mobile phones. At the same time, the ward assumed that this happened. Another ward informed us that it commonly occurred that remanded patients threatened other patients into lending them their phones. The ward informed the police that the ward was unable to ensure that telephone restrictions for remanded patients were enforced. In order to ensure that such restrictions were enforced, the patients in question would need to be transferred to a proper forensic psychiatric ward.

A third ward informed the Ombudsman that difficulties may arise as regards forensic psychiatric patients' access to various means of communication since many of these patients were subject to telephone, visit and internet restrictions whereas ordinary patients had access to same. It could be difficult for the staff to enforce this and required close attention on the forensic psychiatric patients.

Other wards enforced telephone restrictions by simultaneous restrictions on other patients who were not subjected to such restrictions.

Accordingly, the Ombudsman was informed during a visit that forensic psychiatric patients with telephone restrictions resulted in restrictions also on forensic psychiatric patients without such restrictions as regards, for example, the use of a mobile phone. A ward stated that mobile phones were always confiscated from the patients because the ward's patients always included patients subject to telephone restriction. Patients without telephone restrictions could ask for permission to make a phone call by using a mobile phone in the visiting room. These patients were also allowed to use the ward's coin-operated telephone.

The Ombudsman will discuss the issue of enforcement of telephone restrictions with the Ministry of Health.

House rules at psychiatric wards

Pursuant to the Danish Mental Health Act, written house rules must be available to the patients at every psychiatric ward. The house rules must be handed out to the patient upon admission.

Prior to his monitoring visit to a psychiatric ward, the Ombudsman requests a copy of the house rules of the units he visits.

House rules must contain general rules regarding the patients' opportunities for activities during admission such as, for example, rules of access to making phone calls and permission to receive visits.

The monitoring visits to psychiatric wards indicated that the contents of the wards' house rules varied greatly, and that doubt might arise as regards the authority for some of the rules.

The Ombudsman received information about examples of various house rules which included the following, among other things:

- On admission all patients are body-searched and in cooperation with the patient, the staff checks the luggage brought along.

- On admission or transfer to the unit, belongings are checked and a possible body search is carried out in order to remove objects which may harm the patient or others. The confiscated objects are kept in a locked safe and will be returned upon discharge or transfer.

- As a main rule, patients have access to the computers available at the communal areas. A private computer requires permission by the unit management and it must not be possible to link up the computer to a network.

- Visits to the unit must be planned so that the staff are informed about the visit the day before. Visits take place in the purpose-built visiting rooms. All visits will be supervised for security reasons. Objects that visitors wish to bring into the unit will be checked.

- The following objects, among other things, must not be taken into, brought along to and are not allowed in the unit:
    - Mobile phones.
    - Money.
    - Letters to or from the patient or fellow patients.

- Incoming parcels and mail are opened by the staff together with the patient. However, this does not apply to mail from a public authority. If the patient opposes these guidelines, the parcel/letter will not be handed out.

- Patients with telephone restrictions are only allowed to make phone calls to public authorities. Other patients are allowed to make one phone call during day shift and one phone call during evening shift. The patient pays for the phone calls himself. The phone call must not last longer than 10 minutes. If the connection fails upon the first call, an extra call is allowed. After this, the patient is not allowed to make further phone calls during this shift. If patients have no money in the bank, no phone calls are allowed. Phone calls to lawyer, patient counsellor or social security guardian are free of charge. Incoming calls are accepted without limitation, but regards for other patients must be taken. In case of misuse, the arrangement can be made more strict/cancelled. Likewise, a limitation of calls may be imposed for treatment purposes.

- For security reasons patients are not allowed to stay in other patients' rooms.

The received house rules gave rise to various recommendations.

The Ombudsman recommended, for example, that the management upon a review of the house rules was aware of not imposing restrictions without the requisite authorisation.

One visiting team pointed out that similar conditions were described differently in house rules of the various units at the same psychiatric ward. The visiting team recommended that the management considers standardisation of the contents of the house rules. Some of the wards had started working on harmonising the house rules.

House rules must also include general rules of the consequences of non-compliance with the house rules.

During most of his monitoring visits in 2014, the Ombudsman's visiting team found that the house rules did not state the consequences of non-compliance with the house rules. Consequently, the visiting team recommended in many cases that the wards ensure that these consequences were stated in the house rules.

The review of the house rules and the discussions during the monitoring visits led to the Ombudsman asking the Ministry of Health during his annual meeting with the Ministry whether it would be appropriate to prepare instructions for standard house rules. The Ministry will consider the matter.

The wards' possibility of statistically supervising the use of force

In connection with his monitoring visits to psychiatric wards in 2014, the Ombudsman was provided with a wide range of information about the use of force at the various wards. The Ombudsman was, among other things, informed of how the wards carried out statistical supervision of the use of force.

Data on the use of force enable the wards to identify possible connections, patterns in and reasons for the coercive measures towards the patients. The wards can make use of this knowledge in order to systematically reducing the use of force. In this way, the wards are able to statistically supervising the use of force and act to a relevant extent.

Therefore, the Ombudsman recommends that psychiatric wards prepare and make active use of statistics about the use of force at unit level on a continuous basis. The purpose of doing so is aimed at providing the management with information about possible patterns in and reasons for the coercive measures exercised in order to prevent and reduce coercive measures as much as possible.

The monitoring visits showed that there is a difference as regards which possibilities the individual wards have as to statistical supervision of the use of force, and how these possibilities are used.

It was, for example, impossible for one ward to collect statistical data on the use of force at unit level whereas other wards were given this possibility. The ward – without this possibility – stated that the ward would probably be able to collect statistical data at unit level approx. 3 months later.

One ward stated that it was not possible for the management to extract figures as to duration of belt fixation. The units themselves were also unable to prepare systematic surveys of the use of force divided into type, times, staff, etc. However, these figures could be provided by the Region. A project enabling the units themselves to prepare figures for an analysis of possible causal connections was on the way. It had not until recently become possible for the ward to collect individual figures on the use of force at the individual units from the Region. Another ward stated that statistics were prepared centrally and that it was an unresolved task of the individual units to make more systematic use hereof.

A number of wards were able to extract various statistics on the use of force at unit level.

Some of the wards were able to link statistics on the use of force together with statistics within other fields.

As an example, one ward's database system made it possible to combine data on the use of force with data on, among other things, absence due to illness, medicine management (both at unit level and for the individual patient) together with patient aggression measurements. The patient aggression measurements provided detailed information about date, time of day and type of aggression, whereas data on the use of force showed date and time of the day. Thus, possible causal connections were clarified this way.

Another ward used statistics showing times during the day or week when there was a more frequent use of fixation and whether coercive measures were linked to less experienced staff.

During a monitoring visit, the management stated that it was impossible to extract statistics as regards the extent to which the staff (specified by name) had participated in the coercive measures undertaken.

The visiting teams gave various recommendations to the wards regarding statistical supervision of the use of force.

For example, a visiting team recommended to a ward to keep statistics on the use of force, also at unit level, with statement of time, enabling an analysis of possible patterns in the use of force.

It was also recommended that a ward continued to work on accessing data on the use of force, thus enabling the management to make analyses to detect possible patterns in order to improve prevention of the use of force.

During a monitoring visit, a visiting team emphasised that analyses and supervision of the use of force should be based on a secure statistical foundation and not on intuition.

The Ombudsman will discuss with the Ministry of Health the differences in the wards' ability to supervise the use of force.

Cases about forced immobilisation

A patient admitted to a psychiatric ward can be forcefully restrained pursuant to the Danish Mental Health Act.

Forced immobilisation may only be used when deemed necessary in order to prevent the patient from exposing himself or others to possible danger of harming body or health, to prevent the patient from persecuting or in any other way grossly abusing other patients or committing acts of vandalism to a not inconsiderable extent. Furthermore, a patient who for safety reasons asks for physical restraint will be restrained if a physician consents. The psychiatric ward is only allowed to use belt, hand and foot straps as well as gloves to immobilise the patient.

The Danish Mental Health Act stipulates a number of procedural rules which must be observed when a patient is physically restrained. The rules include special legal rights guarantees. The Danish Mental Health Act has been changed in some respects. As an example, the rules have been changed with regard to the minimum required frequency of a renewed medical assessment. The changes come into force as of 1 June 2015.

All psychiatric wards must have a coercive measures protocol. The ward's staff must enter the use of physical restraint in the protocol in accordance with the rules regarding which information the staff must enter in the protocol.

The Ombudsman examined 54 entries in the coercive measures protocol such as fixation on the basis of the form enclosed with this report. The visiting teams informed

the various wards about the outcome of the examination to a relevant extent and provided relevant recommendations.

The consultant psychiatrist is responsible for forced immobilisation not being used to a further extent than necessary. Moreover, the Danish Mental Health Act foresees that forced immobilisation must be reassessed at set intervals. Thus, if a patient must continue to be restrained as often as conditions necessitate it, a new medical assessment must be undertaken, however at least 4 times a day. The 4 times must be undertaken regularly after a decision on forced immobilisation has been made. The date for the new medical assessment must appear from the coercive measures protocol.

The examination of the entries in the coercive measures protocols indicated, among other things, that in a number of cases it did not appear from the coercive measures protocol that a new medical assessment had been undertaken evenly 4 times a day as to whether the patient should continue to be physically restrained.

As an example, according to a coercive measures protocol a patient was physically restrained with a restraint belt from 28 August 2013 at 23.15 pm until 29 August 2013 at 12.45 pm without a new medical assessment. Another example from the protocol showed that a patient fixated with a restraint belt was medically assessed on 25 September 2013 at 10.00 am, and that the next medical assessment was undertaken on 26 September 2013 at 10.00 am.

The management of the ward informed the visiting team that the management would raise the issue at once and impress the rules on the staff. Furthermore, the management intended in future to include measures of rule compliance in the coercive measures protocols in the management information system.

If a forced immobilisation lasts longer than 48 hours, an external physician must assess whether the patient must continue to be physically restrained. That the physician is external means that he or she is not employed by the psychiatric unit where the physical restraint takes place, that he or she is not responsible for the patient’s treatment and that he or she is not a subordinate to the physician in charge of the patient’s treatment. The external physician must be a specialist consultant in psychiatry. Should disagreement between the external physician and the physician in charge of the patient’s treatment arise, the assessment of the physician in charge of the patient’s treatment will be decisive.

Subsequently, the external medical assessment must be repeated once a week as long as the patient is physically restrained. Time of the external medical assessment must be entered in the coercive measures protocol. The consultant physician must immediately after expiration of the 48 hours and after the expiration of the subsequent periods of 7 days ensure that an external physician is called in to make the assessment.

The examination of the coercive measures protocols showed, among other things, that on a few occasions the external medical assessment had not been stated in the coercive measures protocol.

In one case, a forced immobilisation lasted 92 days, 21 hours and 15 minutes from 6 January 2014, 14.15 pm until 9 April 2014, 11.30 am. According to the coercive measures protocol, the fixation was assessed by an external physician on 8 January, 26 February and on 12 and 19 March 2014. After the first external medical assessment, 49 days passed before the next external medical assessment. The third external medical assessment took place 2 weeks later, whereupon 7 days passed before the fourth external medical assessment. Hereafter, no further external medical assessment took place according to the coercive measures protocol until the forced immobilisation ended 21 days later.

The management of the ward informed us during the monitoring visit that there was no doubt that external medical assessments had been undertaken. The physicians had informed the management that the 48-hour assessment had been entered in the coercive measures protocol, and that it was not customary practice to enter the subsequent external assessments in the coercive measures protocol – instead, these assessments would be entered elsewhere. The management informed the visiting team that the management would emphasise that the subsequent external assessments should be entered in the coercive measures protocol.

One visiting team recommended that the management in accordance with its statements initiated measures to ensure that applicable rules regarding completion of the coercive measures protocol were observed. During another monitoring visit, recommendation to follow up was given to the management as well as a recommendation to focus on discipline regarding completion of the coercive measures protocol.

When, for example, a forced immobilisation ends, the patient must be offered one or more follow-up sessions as soon as possible. The follow-up session is to clarify the

patient's and the staff's perception of the situation leading to the forced immobilisation. The intention of having such a session is to prevent the use of additional force and possibly to carry out force differently in the future. The report of the session must be registered.

The Ombudsman received reports of the subsequent sessions which had been carried out after the termination of the 54 forced immobilisations.

Subsequent follow-up sessions had not been held in a number of cases.

The examination of the reports regarding subsequent follow-up sessions indicated, among other things, that in a number of cases the reports did not clarify the staff's perception of the cause of the forced immobilisation.

During some of the monitoring visits, the management stated that it would discuss the issue of follow-up sessions and emphasising on the rules.

Feedback on reports of the use of force

During monitoring visits, the Ombudsman was also informed that psychiatric wards did not receive any feedback from the Danish Health and Medicines Authority on the reports sent to the Danish Health and Medicines Authority regarding the use of force. The Ombudsman took up the issue with the Ministry of Health. The Ministry stated that the Ministry would discuss the issue with the Danish Health and Medicines Authority.

Copenhagen, 1 June 2015

Themes for monitoring visits

Every year, the Ombudsman selects one or more themes for the year's monitoring visits in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The selection of a definite theme depends especially on where an additional monitoring effort is required. The Ombudsman often selects a narrow topic such as placement in solitary confinement cell under the Prison and Probation Service. At other times, the Ombudsman selects broad themes such as institutions for adults and treatment of alcohol and drug abuse.

The themes enable the Ombudsman to include current topics in the monitoring visits and to undertake an in-depth investigation of certain issues and to gain experience of practice, including best practice.

A principle aim of the carrying out of monitoring visits during that particular year is to clarify and investigate the themes of the year in question. In consequence of this, the main part of the annual monitoring visits are undertaken in institutions where the topics are relevant.

Thematic Reports

At the end of the year, the Ombudsman reports on the outcome of the monitoring visits during the year in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

The themes are especially reported in separate reports on the individual topics. The Ombudsman sums up and communicates the most important results of the themes in the reports.

General recommendations

The outcome of the themes may be general recommendations to the authorities such as, for example, a recommendation to draw up a policy for the prevention of inter-user violence and intimidation.

General recommendations are based on the Ombudsman's experience within the specific field. Such recommendations would normally be given to specific institutions during previous monitoring visits.

In general, the Ombudsman will discuss the follow-up on his general recommendations with key authorities. Furthermore, the Ombudsman will follow up on his recommendations during the monitoring visits.

The general recommendations are aimed at having a preventive effect. The reason for the preventive work within the monitoring area is based on the Ombudsman's task as National Preventive Mechanism pursuant to The Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.

The thematic reports are published on the Ombudsman's website www.ombudsmanden.dk. In addition to this, the Ombudsman also submits the reports to the relevant authorities so that the authorities can include the reports in their deliberations regarding the various sectors.

Coercive Measures Form

Case No.: _____

General information

Patient's age at commencement of fixation : _____

Patient gender: …….. ☐ Man ☐ Woman

Forensic psychiatric patient ☐ Yes ☐ No ☐ No information

Measure

Belt: …….. ☐ *– Duration: _____ days _____ hours*

Wrist straps: ……..... ☐ *– Duration: _____ days _____ hours*

Foot straps: ……. ☐ *– Duration: _____ days _____ hours*

Decision

Who decided fixation with belt:

The physician (section 15(1)) …… ☐ Nursing staff (section 15(3)) …… ☐

- Presented to the physician …….. ☐

- How long before the physician made a decision? _____ days _____ hrs

Who took the decision to use hand straps and/or foot straps:

The consultant psychiatrist (section 15(2)): ……. ☐

Another physician due to the consultant psychiatrist's absence (section 4a): ……. ☐

- Presented to the consultant psychiatrist …….. ☐

- How much time passed before the consultant psychiatrist made a decision? _____ days _____ hrs

Reasons for fixation:

"exposing oneself or others to likely risk of getting hurt …" (section 14(2)(i)) …….. ☐

"harassing or otherwise grossly abusing other patients" (section 14(2)(ii)) ……..…… ☐

"commits extensive acts of vandalism" (section 14(2)(iii)) ……... ☐

Consent (section 23 of the Consolidated Act on Coercive Measures) ……. ☐

Watch

Permanent watch (section 16) …….. ☐ Yes ☐ No ☐ No information

Regular medical assessments

Times of renewed medical assessment (section 21(4)) – *"at least 4 times a day, regularly undertaken during the day"*

- W*ere the times set with regular intervals during the day?* ☐ Yes ☐ No

Times of assessment undertaken by an external physician (section 21(5-6)) – *"after 48 hrs and repeated once a week")*

Information about possible disagreement between the external physician and the physician in charge:

Follow-up session

Has a follow-up session been carried out (section 4(5)): …… ☐ Yes ☐ No ☐ Offered

Does the follow-up session reflect **the patient's** perception as regards the reasons that led to fixation (section 1(2) of the Consolidated Act on follow-up sessions) …… ☐ Yes ☐ No

Does the follow-up session reflect **the staff's** perception as regards the reasons that led to fixation (section 1(2) of the Consolidated Act on follow-up sessions) …… ☐ Yes ☐ No

Remarks

For example, the use of gloves, (section 14(1)) and immobilisation of minors or immature 15-17-year-olds with the consent of the custodial parent, but against the will of the minor/the immature juvenile: