Uddrag af side 64 til side 67 om ”Ill-treatment” på psykiatriske institutioner i Danmark fra CPT's rapport fra 17. september 2014 om CPT's besøg i Danmark i februar 2014.

Report
to the Danish Government
on the visit to Denmark
carried out by the European Committee
for the Prevention of Torture and Inhuman
or Degrading Treatment or Punishment (CPT)
from 4 to 13 February 2014

Hent hele rapporten

”2. Ill-treatment

120. No allegations were received – and no other evidence was gathered – of deliberate physical ill-treatment of patients by staff at the three hospitals visited. On the contrary, the atmosphere at the hospitals was positive and the staff appeared to be dedicated and attentive. Nevertheless, at *Sct. Hans*, the delegation received a few complaints from patients that staff would occasionally overreact and that they resorted too quickly to physical force.

121. As regards the use of immobilisation in psychiatric hospitals, the CPT’s delegation noted a constructive attitude among its interlocutors, and an overall acknowledgement both by the central authorities and the staff in the hospitals visited of the need to reduce the resort to immobilisation (and coercion in general).

However, despite measures taken to tackle the frequent use and length of immobilisation in psychiatric hospitals, such as increased staff training and certain legislative amendments, there had been no reduction in the registered use of immobilisation in Denmark. On the contrary, the instances of immobilisation, and notably those of prolonged immobilisation (for more than 48 hours), has steadily increased and reached all-time peaks in 2012 and 2013 on a national level. The CPT therefore remains seriously concerned about the frequent and prolonged use of immobilisation in psychiatric hospitals.

For instance, at *Sct. Hans*, a patient had been immobilised five times for periods ranging from three to 38 days, for a total of 87 days and at *Amager*, one patient had been immobilised for 34 days. The CPT also received reports that psychiatric patients had been fixated to a bed for several months in different psychiatric hospitals pending their transfer to *Sikringen*. In one such case, a patient had been immobilised for more than 100 days at *Sct. Hans* (from 28 February to 11 June 2012).[73] Once at *Sikringen*, he had been restrained for a further one week upon his arrival and when the restraints were removed, he required training to walk properly again.

Moreover, at *Sct. Hans*, staff told the delegation that due to low staffing levels, patients could at times be immobilised when such a measure might have been avoided with higher staffing levels, and that for the same reason a patient who had been restrained for several months had not been released from the belts as often as his condition would have allowed. Clearly such a state of affairs is not acceptable.

In the CPT’s view, the duration of the actual means of restraint should be for the shortest possible time (usually minutes to a few hours), and should always be terminated when the reason for the use of restraint has ceased. The maximum duration of the application of mechanical restraint

should ordinarily not exceed 6 hours. As pointed out in the reports on the CPT's 2002 and 2008 visits to Denmark,[74] **the Committee considers that applying instruments of physical restraint to psychiatric patients for days on end cannot have any medical justification and amounts to illtreatment.**

122. According to Section 15 of the Mental Health Act, immobilisation is as a rule to be decided by a doctor. Only in emergency situations could a patient be restrained to a bed with an abdominal belt upon the authorisation of a nurse while the doctor has to be called immediately. During immobilisation, one staff member has to be permanently located near the patient (while as far as possible respecting his/her privacy).[75] The need for continuation of the measure of immobilisation has to be medically assessed at least four times a day in evenly-spaced intervals by a doctor. A second doctor has to authorise the continuation of immobilisation beyond 48 hours; however, such authorisation is thereafter obligatory only once a week.[76] In the Committee's view, a restraint approval based on the patient's physical and mental condition is of little value if it is several days old.

Moreover, the documentation examined by the delegation showed that in the case of a patient who had been continually immobilised for a period of 34 days at *Amager*, authorisation in writing by a second doctor had only been provided twice during the whole period. Indeed, staff were of the opinion that only one such authorisation was required, even if the patient was restrained for more than a month. **Existing legal safeguards must be rigorously enforced.**

123. The second doctor's authorisation was usually provided by a psychiatrist from a different ward within the same hospital. In case of disagreement between the treating and the second doctor as to the need for continuing the immobilisation, the law provides that the treating doctor's opinion prevailed.[77] In the Committee's view, such a disagreement is a serious matter and should automatically lead to a referral to a third authority for a decision. An independent scrutiny should not rely on the second doctor's or the patient's ability and willingness to appeal.

124. The release of an immobilised patient from belt restraint could be authorised by a nurse without consulting a doctor. This is positive, as it helps avoid the measure lasting longer than is absolutely necessary. However, the legislative amendments do not explicitly stipulate that the application of immobilisation should stop as soon as the danger of harm has passed[78] and no maximum duration for immobilisation has been introduced. From the documentation examined, the delegation found that patients were frequently immobilised for 47 hours. The frequent termination of immobilisation just before the requirement for the second doctor's assessment may raise questions as to the genuine necessity of applying the measure for the whole 47 hours. Moreover, at *Amager*, staff told the delegation that the release of a patient from immobilisation depended inter alia on the situation on the ward, such as the presence of other particularly demanding patients, staffing levels and the female/male staff ratio on the shift. Such a state of affairs, if accurate, would not be acceptable.

125. The CPT again calls upon the Danish authorities to review the legislation and practice of immobilising psychiatric patients and in particular to ensure that immobilisation with a belt:

- **is only used as a last resort to prevent risk of harm to the patient or to others;**
- **is applied for the shortest possible time (usually minutes rather than hours) and is always terminated as soon as the danger of harm has passed; the maximum duration should ordinarily not exceed six and under no circumstances exceed 24 hours;**
- **is never applied or its application prolonged due to a shortage of staff;**

- is subject to regular review by a second doctor in case of an exceptional prolongation of immobilisation beyond the six hours limit, and thereafter at reasonably frequent intervals; and that in cases of disagreement between the treating and the second doctor about the prolongation of immobilisation, the matter be automatically referred to an independent third authority for decision. The same procedure should apply if the use of mechanical restraint is repeated within 24 hours following the termination of a previous measure of restraint.

126. All instances of immobilisation were recorded in the hospitals visited in a special protocol regardless of the length of their application and the measure was according to staff applied out of the sight of other patients. However, two patients at *Amager* and *Sct. Hans* met by the delegation stated that they had each witnessed another patient being restrained. **The CPT trusts that the Danish authorities will ensure that immobilisation does not take place in view of other patients.**

Further, patients at *Sct. Hans* and *Sikringen* were regularly offered a debriefing after having been subjected to immobilisation. At *Amager*, this was still not systematically the case, but the delegation was assured that a regular debriefing would be introduced in the near future. **The CPT would like to receive confirmation that this is the case now.**

127. The CPT was informed that the police were occasionally called to the closed wards at *Amager* and *Sct. Hans* to help staff in dealing with agitated patients. In their response of 21 May 2014 to the preliminary observations made by the CPT's delegation, the Ministry of Health explained that such interventions occurred at *Sct. Hans* on average every second month and at *Amager* every third month, and that police used force in these situations only once in two or three years. Nevertheless, **in the CPT' view, hospital staff should be sufficient in number and appropriately trained to handle violent situations without recourse to the police.**

128. In at least one case at *Sct. Hans*, a police intervention apparently involved the application of pepper spray inside a hospital ward. According to the medical documentation, police had dispersed pepper spray in a patient's face after he had succeeded in freeing himself from their grip and subsequently handcuffed him. The patient claimed that due to being handcuffed he had had difficulties to wash his eyes in order to relieve the symptoms of the spray and that he then suffered from sore eyes for several days. In the CPT's view, it is totally inappropriate for pepper spray to be used in a hospital setting. Its use could only be justifiable in a life-threatening situation.
The CPT recommends that the Danish authorities take the necessary action to ensure that pepper spray is only ever authorised inside a hospital when there is a real risk of threat to life."