Visit Report

Landspítali – The National University Hospital of Iceland
Acute Psychiatric Ward 32C

29-30 September 2021

Summary

The Althingi Ombudsman visited the psychiatric ward of the National University Hospital (NUH) on Hringbraut on 29 and 30 September 2021. In this instance, the Ombudsman's examination was directed at the Acute Psychiatric Ward 32C, a psychiatric intensive care unit for acutely ill patients. The examination concerned in particular the legal framework for involuntary commitment and the legal status of patients, as well as the facilities in the ward.

The Acute Psychiatric Ward 32C handles the reception, diagnosis and treatment of individuals with serious mental illnesses who because of their illness are considered dangerous to themselves, their environment or others. This is a closed ward where patients can be detained against their will, either on the basis of involuntary commitment or deprivation of legal competence under the Act on Legal Competence. Some patients also stay there at their own request, although this group of patients is in the minority. The ward has ten beds; four for women and four for men, as well as two beds for patients in recovery. During the period from the end of August 2020 to the end of August 2021, there were 322 admissions to the ward.

As a general rule, medical treatment may not be administered without the patient's consent. The commitment and treatment of patients in an acute psychiatric ward against their will is therefore a deviation from the principle of the patient's right to self-determination. No person may be deprived of his/her liberty except as authorised by law. In this connection, the Ombudsman makes, among other things, a recommendation to NUH to ensure that it is clear to staff and patients on what legal basis patients are admitted and that procedures and information provision to patients who are admitted voluntarily to the ward take into account their legal status. Furthermore, that restrictions on fundamental rights are relevant and do not exceed what is necessary. Recommendations and suggestions are also addressed to the Minister of Justice, concerning the clarity of the legal authority for treatment of persons deprived of legal competence in mental health institutions and the possibility for persons deprived of their liberty to have a decision on their commitment in a psychiatric ward reviewed.

The report also recommends that the Minister of Justice examine the substantive requirements of the Act on Legal Competence for involuntary commitment and assess whether there is a need to have the Act state more clearly that involuntary commitment on the grounds of mental health problems is unauthorised unless a mental illness calls for such deprivation of liberty and other less severe remedies are out of the question, such as when persons present a danger to themselves or when their lives or health would otherwise be endangered. Recommendations are also made to NUH to ensure that involuntary commitment cases follow appropriate legal channels. Suggestions and recommendations are also made to the Minister of Justice in connection with the involvement of a consultant physician in the District Commissioners' decisions on involuntary commitment, including the setting of rules in this regard.

The Act on Legal Competence states that the Minister of Health may set further rules on providing information on the legal status of a person in involuntary commitment; however, such rules have not been set. Given disclosures on certain flaws in information provision to patients in this respect, the Ombudsman directs the suggestion to the Minister of Health to consider whether there is cause to set further rules on providing information on the legal status of persons in involuntary commitment, in accordance with the legal authorisation to this effect.

Under the Act on Legal Competence, a person in involuntary commitment has the right to enjoy the advice and support of a special counsellor in connection with the hospital stay and treatment there. With reference to previous suggestions in this regard, as well as information that emerged during the examination that in some cases knowledge of the counsellor's role was lacking, the Ombudsman recommends that the Minister of Justice set rules on counsellors of those committed

involuntarily. The ombudsman also directs recommendations and suggestions to the hospital on procedures and information disclosure in connection with the counsellors' role. A suggestion is also made to the Minister of Justice concerning the poorer legal status of persons deprived of their legal competence in this respect. The recommendation is made that the Minister of Health issue a regulation on advice and support following involuntary commitment, to accord with the statutory obligation to this effect.

The report suggests the Minister of Justice consider whether there is cause to re-examine rules on appeals to the courts concerning 72-hour and 21-day involuntary commitment, with the aim of giving a person committed involuntarily a more realistic possibility of obtaining a substantive review of the decision. A suggestion is also made to NUH regarding the provision of information to staff on the role of lawyers and their access to their clients.

A legal decision on deprivation of liberty does not automatically result in restricting other fundamental rights, such as the right to respect for private life. Any restriction on the right to private life must be based, among other things, on statutory authority and the requirement of necessity. As previously stated in the Ombudsman's report regarding the visit to three closed psychiatric wards at Kleppur psychiatric department, there is no clear legal authority under Icelandic law to apply various types of interventions, coercion and the use of force on patients in mental health institutions. In this connection, the Ombudsman reiterates previous recommendations and suggestions to the Minister of Health and Minister of Justice to ensure that such measures are defined and an appropriate statutory framework provided, if it is the will of the government and the parliament to have such measures that require special legal authority used on patients in closed psychiatric wards.

As a state institution, the National University Hospital is a government authority in the legal sense. With regard thereto, previous recommendations to the hospital are reiterated regarding the need to analyse which of its decisions comprise administrative decisions. Certain perspectives also need to be considered when deciding when measures used on patients are, on the one hand, treatment measures and, on the other hand, safety measures or other measures. Furthermore, the hospital must obtain patients' consent for interventions as treatment; if consent is not available, a formal decision must be made on compulsory treatment, taking care to ensure that both the relevant documenting and procedure comply with law. When a measure involves a decision on a patient's right or obligation, in the meaning of the Administrative Procedures Act, the rules of administrative law on procedure and legal certainty must be observed and care taken to ensure that the case file demonstrates this.

The report recommends that NUH apply a procedure for follow-up on patients after the use of force, insofar as possible, and review ward rules and the implementation of interventions towards patients, with regard to assessment of their necessity in each individual's case. Various recommendations and suggestions are also directed to the hospital in connection with other interventions, such as restrictions on outdoor activities, phone access, hospital clothing and the involvement of police in transport and overpowering of patients.

The premises of the acute psychiatric ward were renovated in 2013 and the facilities there are generally good and neat. The report does, however, set out various recommendations and suggestions in this regard, including in connection with windows, outdoor facilities, ventilation, tableware, activity and visiting rooms and certain safety issues in the environment of patients and staff. The hospital is also advised to assess whether the activities and leisure available to patients give adequate consideration to their needs and seek ways to improve these, especially with regard to persons who remain in the ward for longer periods.

There was no indication otherwise than that the work atmosphere on the acute psychiatric ward was generally good. The visit did reveal, however, a shortage of professionally trained staff and some staff turnover among general employees. In this connection, it is pointed out that high staff turnover and associated inexperience among staff, as well as understaffing, can affect patient care and increase the likelihood of coercion being applied.

International supervisory bodies have emphasised the importance of having effective procedures for complaints and appeals in preventing degrading treatment in mental health institutions. In this connection, it is recommended that NUH review its current rules and procedures on the ward so that patients, and as the case may be their families, receive information about routes for complaints and appeals within and outside the hospital in an easy-to-understand format. Provision of information to staff about patients' routes for complaints and appeals and the procedures concerning them also needs to be improved.

The Patients' Rights Act provides, among other things, for patients to be informed of significant rules and practices that apply at the institution. In this context, it is recommended that NUH see to it that ward rules are generally made known to patients in the acute psychiatric ward, in a language they understand, both in writing and orally. The hospital is therefore asked to follow up on plans to prepare a booklet to hand out to patients explaining, among other things, the ward's activities, the rights of persons admitted there and ways to have decisions reviewed.

Satisfactory record-keeping in connection with deprivation of liberty is a basic aspect of protection against ill treatment and a premise for persons deprived of liberty to seek to enforce their rights. In this connection, a recommendation is made to NUH to have follow-up procedures involving staff and patients after the use of force properly recorded. The hospital is also advised to take into consideration other perspectives on record-keeping that appear in the report in the review of the ward's documentation system currently underway.

It was pointed out during the Ombudsman's visit that a lack of appropriate accommodation could lead to patients remaining on the acute ward for longer than necessary. There are lengthy waiting lists for long-term places in psychiatric wards and a lack of accommodation for patients after hospitalisation. In this connection, the suggestion is made that NUH and the Minister of Health seek ways to shorten waiting lists of long-term psychiatric wards so that the deprivation of liberty of patients is not more onerous than necessary at any given time. The report also reiterates previous recommendations and suggestions to the Minister of Social Affairs, made in the Ombudsman's report on the visit to three closed wards at Kleppur, to consult with municipalities on how to make patients' deprivation of liberty no more lengthy and burdensome than treatment providers consider necessary.

The Ombudsman will continue to monitor the development of these issues, and requests that the National University Hospital and other authorities to whom these recommendations or suggestions are directed provide an account of actions taken in response to the report by 15 September 2022.

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