Visit Report

Psychiatric Ward of Akureyri Hospital
Inpatient Unit

24 May 2022

OPCAT monitoring of facilities where persons deprived of their liberty reside

Summary

The Althingi Ombudsman visited the Psychiatric Ward of Akureyri Hospital for the purpose of OPCAT monitoring on 24 May 2022. The Ombudsman's inspection focused on the Inpatient Unit of the Psychiatric Ward, where some patients may be held against their will. In this instance, the Ombudsman did not announce the exact arrival time in advance.

The Psychiatric Ward of Akureyri Hospital is the only specialised psychiatric ward outside the capital area. The Inpatient Unit of the hospital's Psychiatric Ward provides both 24-hour and outpatient services. The main function of the unit is to ensure the safety of people in acute mental distress and to provide appropriate care and nursing. However, various types of therapeutic work are also carried out there. In 2021, 197 persons were admitted to the Inpatient Unit in a total of 273 instances, most of them staying in the unit for 2-5 days. The vast majority of patients are admitted on their own volition, but those who dwell there against their will are either kept there on the basis of involuntary commitment or deprivation of legal competence under the Act on Legal Competence. In 2021, only one patient, or about 0.6% of those hospitalised, was involuntarily committed. During the 26-year period 1996-2021, there were 164 involuntary commitments to the ward, representing 0.6% to 5.6% of those admitted per year.

For OPCAT inspections, it may be necessary to examine the legal basis on which individuals have been deprived of their liberty and which specific legal framework applies to their detention. The operations of the Psychiatric Ward of Akureyri Hospital are part of public health and hospital services, and are subject to various laws and regulations providing for these services. The Act on Legal Competence accords a person committed involuntarily the right to receive advice and support from a counsellor of persons involuntarily committed. The doctor or nurse on duty must notify the counsellor of the involuntary commitment as soon as possible. In this regard, the Ombudsman recommends that the Hospital ensure that the notification to the counsellor is always made as soon as possible, and that staff are provided with adequate education about the role of the counsellor. The Hospital is directed to provide patients committed involuntarily with adequate information about their right to advice and support in a clear and accessible manner and in a language that the person understands. Furthermore, it must ensure that the implementation of involuntary commitment accords with the provisions and purpose of the Act on Legal Competence, to ensure that such cases are put through the correct legal channels. In this regard, attention is drawn to the fact that the Act on Legal Competence provides for certain steps in connection with involuntary commitment, with the procedure becoming more extensive with each step to ensure the legal security of the person committed involuntarily.

In a previous report on a visit to three closed psychiatric wards at the hospital Kleppur, part of the National University Hospital, the Ombudsman made recommendations and suggestions to the authorities concerning the lack of a clear legal framework for the use of force, coercion and other interventions impinging on the rights of patients in psychiatric wards. These recommendations and suggestions were reiterated in the report on the visit to the Acute Psychiatric Ward on Hringbraut. In light of the fact that the issues are being acted on through certain channels in the Ministry of Health, these recommendations are not repeated specifically in this report. Despite the fact that, as indicated above, a clear legal basis may be lacking for the specific criteria followed by the Inpatient Unit of Akureyri Hospital concerning interventions, coercion and the use of force in the Unit, nothing was found during the visit to indicate that patients are subjected to inhuman or degrading treatment in the Unit. On the contrary, it could generally be concluded from the visit that the administrators and staff of the Unit respect patients and seek their consent and co-operation. The report does emphasise, however, that

this does not alter the Ombudsman's previous conclusion that the uncertainty concerning the legal authorisations of staff in this respect is unacceptable.

The report addresses the recommendation to Akureyri Hospital, as appropriate in consultation with the National University Hospital, the Directorate of Health and the Ministry of Health, that it analyse which decisions within the Hospital comprise administrative decisions that are subject to the rules of the Administrative Procedures Act. In this regard, special consideration must be given to decisions involving more than the specifics of the treatment of the patient in question and any kind of interference in privacy, coercion or the use of force. The Hospital is also directed, as appropriate in consultation with the same parties, to analyse what measures comprise treatment measures, on the one hand, and security measures or other measures, on the other.

The Psychiatric Ward of Akureyri Hospital has no special security team, specially trained to respond to and take defensive action against violence, as in the psychiatric wards of the National University Hospital. If difficult incidents occur or when it is evident that a patient needs coercion, such as during medication administration or transportation, assistance is requested from the police or a security company responsible for specific security-related tasks under a contract with the Hospital. In this context, and in accordance with comments from other supervisory bodies, the recommendation is addressed to Akureyri Hospital to stop the practice of involving security guards, who have not received the required training, in the subduing of patients, and to review its procedures with intention of limiting as much as possible the involvement of the police in subduing patients and transferring them between institutions.

A doctor may prescribe that patients considered a danger to themselves and/or others be placed in a secure area of the Inpatient Unit. In this regard, the recommendation is made that Akureyri Hospital establish a proper channel for decisions on detention in a secure area, in accordance with the Administrative Procedures Act, so that it is formal and registered and the patient informed about complaint and appeal channels. The recommendation is also made that Akureyri Hospital seek ways to ensure access to outdoor exercise for all patients on a daily basis, to the extent possible, and to ensure that debrief of patients following the use of force is recorded. The suggestion is also made that the Hospital consider whether there is reason to review its record keeping, as appropriate in consultation with the National University Hospital, to ensure that statistics on the use of force and other serious incidents in the Inpatient Unit can be easily retrieved. Finally, the recommendation is made that Akureyri Hospital ensure that patients deprived of their liberty are informed that they can request a physical examination, for example following the use of force or violent incidents, including with regard to alleged injuries or accusations thereof, and that records indicate this has been taken care of.

The Inpatient Unit of the Psychiatric Ward of Akureyri Hospital was formally opened in March 1986 in its current premises, which were intended to be temporary. The facilities and environment of the Unit are generally neat and clean. An assessment by the Directorate of Health discussed in the report states that the Unit is still in temporary facilities, which reflect their age and do not meet today's requirements. The report therefore presents various recommendations and suggestions in this regard. Among other things, it recommends that the Minister of Health examine and assess whether the building that currently houses the Inpatient Unit satisfies the requirements made for its activities and scope. The recommendation is directed to Akureyri Hospital that it examine whether an outdoor activity area could be provided for the Unit, in particular in consideration of patients who are not trusted to leave the Unit. Suggestions are also directed to the Hospital concerning securities issues in sanitary facilities in the secure area and the lack of a visiting space or other space where patients can deal with personal affairs in privacy, in particular in the case of patients sharing rooms.

Patient participation in daily activities is part of their rehabilitation. It was revealed during the Ombudsman's visit that occupational therapy for inpatients takes place in the Outpatient Unit. This means that patients committed involuntarily, who are not trusted to leave the Unit, do not have access to occupational therapy. Furthermore, the patients placed in the secure area naturally have no access to group work in the Inpatient Unit or occupational therapy in the Outpatient Unit. In that regard, the recommendation is addressed to Akureyri Hospital to seek ways to ensure that patients who are not allowed to leave the Unit have appropriate activity and rehabilitation, as far as possible given their condition, including patients staying in the secure area.

During the Ombudsman's visit, it was noted especially that the vast majority of the staff in the Inpatient Unit are healthcare professionals. It also attracted the special attention of the Ombudsman and staff that the administrators and staff of the Inpatient Unit appear to be making every effort to limit any kind of intervention and coercion towards patients in the Unit. In this regard, however, recommendations are directed to Akureyri Hospital in connection with self-defence courses attended by staff, in light of the special considerations that apply to physical subduing of patients with mental disabilities.

Patient access to effective complaint and appeal channels is a significant factor in preventing inhuman or degrading treatment in mental health institutions. In this regard, the recommendation is made that Akureyri Hospital review its current procedure in the Inpatient Unit for providing information to patients and their relatives to ensure that they are informed about complaint and appeal procedures, both inside and outside the hospital, in an easy-to-understand format and in a language they understand. Information provision to staff of the Unit also needs to be improved, and education provided on patients' complaint and appeal routes inside and outside the hospital, including what procedures apply when such complaints and appeals are made and in which channels they should be placed. Furthermore, on their role in guiding patients and, as the case may be, their relatives in this regard.

Finally, the report draws attention to a specific problem on the borderline between law enforcement and the healthcare system, of which the Ombudsman has become aware, in the case of individuals whom the police need to deal with but who are struggling with mental health problems, sometimes related to drug abuse. These cases do not always concern persons suspected of a criminal act, as they may either be in some situation where the police feel they need to intervene or where the persons themselves contact the police. It can be concluded from information obtained by the Ombudsman on a visit to the Northeast Iceland Commissioner of Police, that the police do not feel that these persons belong in police cells and in fact their placement there may threaten their health and well-being. Furthermore, that in Akureyri there is a lack of social remedies for individuals struggling with drug addiction. Suggestions of the administrators of the Psychiatric Ward of Akureyri Hospital on these matters point out that even though it is not considered appropriate to keep these persons in police cells, they do not necessarily belong in healthcare institutions. Thus, special measures may need to be established, such as through the co-operation of different services. The report emphasises that it is not up to the Ombudsman to decide how to solve the above-mentioned problem, but that it is unacceptable that persons in police custody who are visibly in need of healthcare or other services are staying in police cells and do not receive appropriate treatment. In this regard, there is a need for consultation and co-operation between institutions and ministries responsible for law enforcement and healthcare and possibly, as the case may be, social affairs.

The Ombudsman will continue to monitor the development of these issues, but requests that Akureyri Hospital and other authorities to whom recommendations or suggestions are directed, report on their responses to the report by 1 July 2023.

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