FOLKETINGETS OMBUDSMAND

5 February 2026

Thematic report 2025

Patients in departments of forensic psychiatry

Contents

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1. Introduction

The theme for the Ombudsman's monitoring visits (adults) in 2025 was the forensic psychiatric sector. During the year, the Ombudsman visited selected bed units in all of Denmark's eight departments of forensic psychiatry. The monitoring visits were carried out in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

During the monitoring visits, the Ombudsman especially focused on:

- The conditions intended to help ensure that patients with treatment orders and placement orders are not hospitalised in departments of forensic psychiatry for longer than necessary, including the rules on treatment plans and temporary leave.

- The written documentation in connection with forced immobilisations.

2. Result of the thematic visits

2.1. Main conclusions

- It is the Ombudsman's impression that both management and staff in the departments of forensic psychiatry generally focused on ensuring that hospitalisations of patients with treatment orders and placement orders are not extended longer than necessary and that deliberations about this were included in the work with the patients' treatment. There was also focus on the possibilities for temporary leave and on the access to requesting, to a relevant extent, that the State Prosecutor modify a treatment order or placement order.

- However, during the monitoring visits, the Ombudsman also received information about conditions indicating that there could be a risk of some patients being hospitalised for longer than there were grounds for from a treatment perspective, including challenges in the cooperation between the departments of forensic psychiatry and the municipalities in connection with discharge of patients to accommodation facilities.

- In the majority of the visited departments, there were examples of treatment plans, discharge agreements and coordination plans that lacked some of the information that they must contain according to the applicable rules.

- The monitoring visits generally left the impression that the visited departments focused on preventing and reducing the use of force.

- A review of a number of cases concerning forced immobilisation showed that there were examples that completion of use of force protocols and documentation of, among other things, permanent guards' records, carrying out of internal and external belt inspections and follow-up interviews did not take place in accordance with the applicable rules.

- Several of the visited departments used seclusion in own room without having obtained the patient's consent or without documenting the consent in accordance with the relevant applicable rules and practice.

2.2. General recommendations

The Ombudsman generally recommends that departments of forensic psychiatry

- ensure that treatment plans, discharge agreements and coordination plans contain the information required under the applicable rules

- have increased focus on ensuring quick, smooth and solution-oriented dialogue with the municipalities in connection with discharge of patients

- ensure that the patient record contains comprehensive documentation that the grounds for a forced immobilisation are present throughout the entire immobilisation period, and that the patient record, in cases where hand or foot straps are also used, contains separate grounds for starting and maintaining the use of those

- ensure that use of force protocols are completed in accordance with the rules, that the rules on permanent guards' duty to keep records and the rules on internal and external belt inspections are observed, including that an internal belt inspection is only postponed because a patient is sleeping if a medical assessment deems it harmful to wake the patient, and that an internal belt inspection that has been postponed because a medical assessment has deemed it harmful to wake the patient is carried out as soon as possible after the patient has woken up

- ensure that follow-up interviews are held and documented in accordance with the applicable rules and that it appears from the patient record if a patient does not want a follow-up interview – and, if so, why

- ensure that seclusion in own room is only used after the patient has given valid consent and that the patient's consent is obtained and documented in accordance with the relevant applicable rules and practice

The Ombudsman will discuss the follow-up on the general recommendations and a number of other matters and observations from the monitoring visits with the Ministry of the Interior and Health and the Ministry of Justice, among others. The Ombudsman will also follow up on the general recommendations during future monitoring visits.

Based on the monitoring visits, the Ombudsman has started several cases on his own initiative. Read more in item 6 below.

2.3. Background for choice of theme and focus areas

Patients admitted to departments of forensic psychiatry include people who have committed criminal offences but, due to a mental disorder or impaired mental development, cannot be sentenced to prison and who have instead been given a treatment order or placement order that involves a requirement or possibility of admission to a department of forensic psychiatry. The purpose of treatment orders and placement orders is, through treatment, to prevent the convicted person from committing new crime due to their mental disorder or impaired mental development.

In departments of forensic psychiatry, there can also be people sentenced to custody and remand prisoners, who are placed in a department of forensic psychiatry instead of a local prison (people in surrogate custody), including remand prisoners admitted for mental observation. There may also be people who have been charged with crime without being in remand custody and who have been admitted for mental observation as well as prison inmates who, due to their mental condition, cannot serve their sentence in a prison for short or long periods of time.

Patients in departments of forensic psychiatry are generally a vulnerable patient group, and they may, during their hospitalisation, be subjected to various types of force and coercion. Furthermore, patients with a treatment order or placement order may be hospitalised for a long time, and, in some cases, discharge presupposes a modification of their sentence.

The Ombudsman has previously investigated conditions for patients admitted to departments of psychiatry, including forensic psychiatry, for instance in connection with the 2021 monitoring visit on force and non-statutory interventions in the psychiatric sector.

With the theme for 2025, the Ombudsman wanted to gain up-to-date knowledge on the conditions for patients admitted to departments of forensic psychiatry in general, including the use of and prevention of force, among other things.

The Ombudsman also wanted to investigate the departments of forensic psychiatry's work ensuring that patients with treatment orders and placement orders are not hospitalised for longer than necessary, and the monitoring visits thus focused on those patients' conditions in particular.

As part of the theme for 2025, the Ombudsman also wanted to visit the departments for people in surrogate custody, which the regional councils were able to establish effective from 1 January 2022.

2.4. How did the Ombudsman proceed?

2.4.1. Material and information in connection with the visits
Prior to each monitoring visit, the Ombudsman received written information and material from the visited departments for elucidation of the focus areas for the visit, including examples of treatment plans, forced immobilisation cases, house rules etc.

During the monitoring visits, the visiting teams received more details on the written information during interviews with management and staff. In addition, the visiting team spoke with 115 patients and in total 92 relatives, legal guardians or social guardians.

The visiting teams were also shown relevant parts of the visited departments, including patient rooms, visiting rooms and activity rooms.

2.4.2. The legal basis for monitoring visits
The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to 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 OPCAT is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. 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 those fields from the two institutes participate in the planning and execution of and follow-up on monitoring visits.

2.4.3. List of visits in 2025
On the Ombudsman's website, there is a list of monitoring visits to institutions for adults in 2025, including the thematic visits, and the recommendations given to the individual institutions (www.en.ombudsmanden.dk, under About

the Ombudsman, Monitoring activities, Monitoring visits to institutions where citizens live, Monitoring visits according to UN rules, Monitoring visits to institutions for adults in 2025).

3. Patients admitted to departments of forensic psychiatry – special focus on patients with treatment orders and placement orders

As mentioned in item 2.3, there are a number of different patient groups in the departments of forensic psychiatry.

In the majority of the forensic psychiatric units that the Ombudsman visited, most patients had either a treatment order or a placement order, and, as mentioned in item 2.3, the Ombudsman focused especially on the conditions for those patients in connection with the theme for 2025. However, several of the conditions mentioned below are also relevant to other patient groups.

Patients with treatment orders or placement orders who are admitted to departments of forensic psychiatry must be offered a coherent hospitalisation process that does not stretch longer than absolutely necessary.

It is the responsibility of the Prosecution Service to ensure that treatment orders and placement orders are not maintained for longer and to a greater extent than necessary.

The departments of forensic psychiatry's work ensuring that people with treatment orders and placement orders are not hospitalised for longer than necessary takes place through treatment plans and leave plans, among other things. Therefore, in connection with the monitoring visits, the Ombudsman focused on the visited departments' preparation of treatment plans and the extent and nature of the patients' leave, among other things. The Ombudsman also focused on the visited departments' preparation of discharge agreements and coordination plans for the patients and the cooperation with the municipalities in connection with discharge.

3.1. Treatment plans

The rules on treatment plans are set out in the Mental Health Act (Consolidation Act No. 1045 of 18 September 2024), the Guidance Notes on Force (Guidance Notes No. 9257 of 19 March 2023 on Use of Force etc. in the Psychiatric Sector) and the Guidance Notes on, among other things, Chief Consultants' Responsibility towards Patients with a Treatment Order or an Outpatient Psychiatric Treatment Order (now Guidance Notes No. 9873 of 28 August 2025).

A treatment plan must be prepared for all patients who are admitted to a department of psychiatry. The treatment plan must be prepared no later than one week after the admission, and a copy of the plan must be given to the patient, unless the patient declines it. There are also a number of requirements for the contents of the treatment plan.

Prior to each monitoring visit, the Ombudsman received and reviewed – typically three – treatment plans from the visited department. The majority of the treatment plans concerned patients with treatment orders or placement orders, but the Ombudsman also received treatment plans for people in surrogate custody, among others. The review showed that there were shortcomings in several treatment plans in the majority of the visited departments.

In five departments, several treatment plans lacked some of the information that is mentioned in the section on treatment plans in the Guidance Notes on Force. This included information about the treatment's expected duration and information about any involvement of relatives.

In seven departments, one or more treatment plans for patients covered by the Guidance Notes on Chief Consultants' Responsibility towards Patients with a Treatment Order or an Outpatient Psychiatric Treatment Order lacked some or most of the information mentioned in the Guidance Notes. This included what degree of observation from healthcare staff that the patient needed and an assessment of the patient's risk of committing new crime. Several of the visited departments stated that the information appeared in other places, for instance in the patient record.

The Ombudsman recommended that seven of the visited departments ensure that treatment plans contain the information required under the applicable rules.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that treatment plans contain the information required under the applicable rules.

3.2. Temporary leave

The rules on temporary leave for patients with treatment orders and placement orders are set out in the Executive Order on Temporary Leave (Executive Order No. 1492 of 5 December 2024 on Off-Grounds Privileges etc. for Persons Admitted to a Hospital or an Institution under a Criminal Sentence or a Decree of Dangerous Behaviour). The Executive Order states that the chief consultant may give permission for some specified types of leave for patients with treatment orders and placement orders, while it is the State Prosecutor who decides on leave in other cases. According to the

Executive Order on Temporary Leave, decisions on permission for leave must take into account socio-pedagogical and treatment-related considerations, the risk of abuse of the leave and the consideration for enforcement of the law. Special rules apply to patients who are, among other things, in surrogate custody and patients who are placed in the Secure Department of Slagelse Psychiatric Hospital (Sikringsafdelingen).

In connection with the monitoring visits, the visited departments explained how temporary leave was used in connection with treatment and rehabilitation of patients with treatment orders and placement orders. The visited departments typically used a step-based model with a gradual increase in the access to move freely, provided the previously granted leave took place satisfactorily and the patient's condition was stable. Normally, the patients started getting access to move around on the grounds of the department (for instance the department's garden). Then, the patients got permission to leave the department's grounds. First to the grounds immediately outside the department, the nearest shopping opportunity or similar. In the beginning, it was normally brief accompanied leave, after which the duration could be gradually increased, and permission could also be given for unaccompanied leave for up to three hours.

Several of the visited departments stated that temporary leaves were rarely cancelled due to lack of staffing, but leaves could be postponed until, for instance, later in the day.

Based on the visiting teams' interviews with patients, staff and management, it was generally the Ombudsman's impression that the visited departments focused on the possibilities for leave and on leave being used as an element in the overall treatment, including in relation to practising skills that would be necessary in connection with discharge.

Four of the visited departments stated that the State Prosecutor, who decides on unaccompanied leave for more than three hours (possibly overnight), had a practice of granting the first leaves of this type on the condition that the patient be under supervision by a relative or similar. This meant that it was more difficult for patients without relatives or close persons or patients without contact to relatives to get permission for this type of leave, and, according to the visited departments, there was a risk that this would affect the duration of the hospitalisation, since it was more difficult for those patients to document their skills and progress. One of the visited departments stated that, if a patient had no relatives that could accompany the patient on leave for more than three hours, the staff would accompany the patient instead, which was resource-demanding and meant, among other things, that those leaves could not take place overnight. Another department stated that the

staff in one unit had started to arrange overnight trips to holiday houses in order for the patients to be able to document their skills.

The Ombudsman will discuss this in connection with the follow-up discussions on the theme with the relevant authorities.

3.3. Modification or revocation of sentences

The rules on modification, including mitigation, or revocation of, among other things, treatment orders and placement orders are set out in the Criminal Code (Consolidation Act No. 1145 of 5 November 2024) and in the Director of Public Prosecutions' Circular on Mentally Abnormal Offenders (now Circular No. 10075 of 1 April 2025).

As mentioned above, it is the responsibility of the Prosecution Service to ensure that treatment orders and placement orders are not maintained for longer and to a greater extent than necessary. For this purpose, the State Prosecutor generally obtains a statement from the department of forensic psychiatry once a year on the need for maintaining the treatment order or placement order. However, it is the court that decides if a treatment order or placement order is to be revoked or modified, including mitigated.

The chief consultant responsible for treatment may – like the patient themselves and the patient's social guardian – request a modification of a treatment order or placement order. The request is presented to the State Prosecutor, who brings the question before the court.

All the visited departments stated that the State Prosecutor carried out the annual hearings on the need to maintain treatment orders or placement orders. The visited departments were also aware of their access to – between the annual hearings – request the State Prosecutor to bring the question of modifying a treatment order or placement order before the court if the visited departments did not find that there were grounds for maintaining it. The majority of the visited departments stated that they had requested one or more modifications of sentences within the last year.

3.4. Discharge agreements and coordination plans

The rules on discharge agreements and coordination plans are set out in the Mental Health Act, the Executive Order on Use of Force Protocols (Executive Order No. 1079 of 27 October 2019 on Use of Force Protocols and Records, Registration of and Reports on Force, Discharge Agreements and Coordination Plans in Psychiatric Wards), the Guidance Notes on Force and the Guidance Notes on Registration (Guidance Notes No. 9256 of 19 March 2023 on Registration of Force in the Psychiatric Sector).

In connection with discharge from a department of forensic psychiatry, discharge agreements or coordination plans must be made for patients in the target group. The purpose of discharge agreements and coordination plans is to help ensure, among other things, that the patient continues their treatment.

A discharge agreement can only be made if the patient cooperates in entering into the agreement. If a patient does not cooperate in entering into a discharge agreement, a coordination plan must be made instead. There is no difference in the required contents of discharge agreements and coordination plans, which both concern the treatment-related and social support for the patient after discharge.

Prior to each monitoring visit, the Ombudsman asked to receive three discharge agreements and three coordination plans.

Sikringsafdelingen stated that the patients were only discharged to other departments of forensic psychiatry and that therefore no discharge agreements or coordination plans were made.

The review of the discharge agreements and coordination plans that the Ombudsman received from the seven other visited departments showed that the use of discharge agreements and coordination plans varied. Three of the visited departments stated that they only used coordination plans while two of the visited departments stated that they primarily used discharge agreements. The background for this was discussed with the visited departments, and the matter will be part of the Ombudsman's follow-up discussions on the theme with the relevant authorities.

The review of the discharge agreements and coordination plans also showed that several of them contained shortcomings in six of the visited departments. The discharge agreements and coordination plans did not in all cases contain the information required under item 8 of the Guidance Notes on Force. For example, it was not clear to what extent the patients had cooperated or had been sought to be involved in the work with the discharge agreement or coordination plan and who were supposed to react if the agreement or plan was not observed. Likewise, the time of reassessment of the discharge agreement or coordination plan – and who was responsible for this – did not appear.

The Ombudsman recommended that six of the visited departments ensure that discharge agreements and coordination plans contain the information required under item 8 of the Guidance Notes on Force.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that discharge agreements and

coordination plans contain the information required under the applicable rules.

3.5. Cooperation with the municipalities

Patients can be discharged to, for instance, their own residence – possibly with support – or they can be discharged to an accommodation facility. The municipality assesses whether a patient must be granted an accommodation facility. The municipality also finds a suitable accommodation facility where the patient can be offered a place.

During the monitoring visits, the visited departments explained their cooperation with the municipalities in connection with discharge of patients. A few of the departments described the cooperation with the municipalities in connection with discharge of patients as well-functioning, while other departments stated that the cooperation with the municipalities could be difficult. A few of the visited departments stated that specific cooperation agreements had been entered into with the municipalities.

Some of the visited departments found that the municipalities' granting and finding of suitable accommodation facilities for the patients could take time – in some cases a long time – among other things because it could be difficult for the municipalities to find and then to get a place in specialised accommodation facilities. According to the visited departments, the departments and the municipalities could for instance also have different assessments of whether an accommodation facility was suitable for the patient, and, according to the visited departments, sometimes a patient did not want to be discharged, or the patient needed or wanted a slow transition to the accommodation facility.

Several of the visited departments stated that they were in contact with and wanted dialogue with the municipalities on what type of accommodation facility and what support measures the patient – according to the visited department's experience and assessment – needed after discharge in order to reduce the risk of relapse, including worsening the patient's mental condition, substance abuse or crime. The visited departments thus wanted to avoid that the treatment-related results achieved during the patients' often long hospitalisation were lost after discharge, for instance as a result of the patients being offered a place at an accommodation facility that was not suitable for the patients in the departments' opinion. Furthermore, several of the monitoring visits left the impression that the visited departments were unclear about the division of responsibility between the departments and the municipalities, for instance in relation to the assessment of whether a specific accommodation facility is suitable for the patient.

It appeared from the material that the Ombudsman received prior to the monitoring visits that the majority of the visited departments had refrained from discharging patients because, in their opinion, there would not be enough support measures or there was no suitable residence or suitable accommodation facility to discharge the patients to. There had thus, according to the visited departments, been examples of patients who, for that reason, had been hospitalised for longer than there were grounds for from a treatment perspective.

The Ombudsman recommended that the managements of two of the visited facilities, which experienced difficulties in the cooperation with the municipalities in connection with discharge, sought to enter into cooperation agreements with the relevant municipalities on discharge of patients admitted to departments of forensic psychiatry.

In the light of the information that the departments of forensic psychiatry and the municipalities can have different assessments of the need for or suitability of accommodation facilities and support measures and that this may affect the duration of the patients' hospitalisation, the Ombudsman generally recommends that the departments of forensic psychiatry have increased focus on ensuring quick, smooth and solution-oriented dialogue with the municipalities in connection with discharge of patients.

The information on the visited departments' cooperation with the municipalities, including in connection with discharge of patients to accommodation facilities, and the impression that the departments were unclear about the division of responsibility between the departments and the municipalities in that connection, will be part of the Ombudsman's follow-up discussions on the theme with the relevant authorities.

3.6. Summary

Patients with treatment orders and placement orders are generally characterised by many of them being hospitalised for a number of years.

The monitoring visits focused on the duration of the hospitalisations, including the planning of the patients' treatment, what the visited departments did to ensure that the hospitalisations were not longer than necessary and whether the departments could point to conditions where, in their opinion, there was a risk of delaying the patients' discharge – and, if so, what conditions.

It was the Ombudsman's impression that both management and staff in the departments of forensic psychiatry generally focused on ensuring that hospitalisations of patients with treatment orders and placement orders are not extended longer than necessary and that deliberations about this were included in the work with the patients' treatment.

As stated above, the visited departments also pointed to various conditions that may affect the duration of a hospitalisation. An example of this, as mentioned in item 3.2, is the State Prosecutor's practice of, in the beginning, granting unaccompanied leave for more than three hours on the condition that the patient be under supervision by a relative or similar. In addition, as mentioned in item 3.5, the visited departments have stated that, in some cases, it could take the municipalities a long time to find a place at an accommodation facility.

Discussions during the monitoring visits thus uncovered various factors, which, according to the visited departments, could affect the duration of the hospitalisations and which indicated that, in some cases, there were patients with treatment orders or placement orders that could risk being hospitalised for longer than there were grounds for from a treatment perspective. However, it was not possible within the framework for the monitoring visits to clarify and investigate the dynamics further. The information will therefore also be part of the Ombudsman's follow-up discussions on the theme with the relevant authorities.

4. Use of forced immobilisation in departments of forensic psychiatry

Patients admitted to a department of forensic psychiatry may be subjected to different types of force if the conditions in the Mental Health Act have been met. The force may consist in, for instance, forced medication, manual restraint and forced immobilisation.

It is considered force if the patient does not give informed consent. The rules also state, among other things, that force cannot be used before everything possible has been done to achieve the patient's voluntary cooperation. If a less intrusive measure is sufficient, it must be used.

According to the Mental Health Act, patients must, in connection with the admission talk, have the opportunity to state any preferences in relation to the treatment, including in relation to force, if use of force should become relevant during the hospitalisation (so-called advance statements). If it is not possible to obtain an advance statement upon admission due to the patient's condition, it must be obtained as soon as possible thereafter.

All the visited departments focused on obtaining advance statements from the patients upon admission – or as soon as possible thereafter if the patients' condition did not make it possible upon admission.

The monitoring visits also generally left the impression that the visited departments focused on preventing and reducing the use of force, including forced immobilisation. As part of this work, the data for the use of force and the types of force used were reviewed frequently and regularly, and specific cases of use of force were reviewed and analysed. There were also interdisciplinary discussions about prevention of force, individual action plans were prepared in order to reduce the use of force in relation to specific patients, and there was focus on supplementary training of the staff.

Prior to each monitoring visit, the Ombudsman received statistical information about the use of force in the visited units in the last three years. Some of the visited departments had succeeded in reducing the use of force during the period. The visited departments that had not reduced the use of force explained the background for this in connection with the monitoring visits.

4.1. Generally on forced immobilisation

The rules on forced immobilisation are set out in the Mental Health Act, the Executive Order on Force (Executive Order No. 1075 of 27 October 2019 on Use of Other Force than Deprivation of Liberty in Departments of Psychiatry) and the Guidance Notes on Force. The same rules apply for patients admitted to a department of general psychiatry as to a department of forensic psychiatry. However, the Mental Health Act and the Executive Order on Force contain some special rules on ambulatory forced immobilisation that only apply to patients at Sikringsafdelingen – which are not dealt with in this thematic report.

Forced immobilisation normally means restraining a patient to a bed/cot with a belt placed across the abdomen. In some cases – together with the use of a belt – arms and legs may be restrained using hand or foot straps, and gloves may be used.

Forced immobilisation may take place, for instance, if the patient puts themselves or others in immediate danger of harm to body or health. The Mental Health Act – with appurtenant Executive Orders and Guidance Notes – contains a number of requirements, including documentation requirements, if a patient is forcibly immobilised.

Prior to each monitoring visit, the Ombudsman received and reviewed a number of the visited department's most recent forced immobilisation cases. The Ombudsman reviewed the cases with a preventative aim and in order to assess whether the rules imposing requirements for the written documentation in connection with a forced immobilisation were met.

4.2. Completion of use of force protocols

The rules on use of force protocols are set out in the Executive Order on Use of Force Protocols and in the Guidance Notes on Registration.

When forced immobilisations are carried out, some information must be added to the use of force protocol. This includes the time of the commencement and cessation of the intervention, the grounds for the intervention, the prescribing chief consultant's name, names of the involved staff members, the time of a renewed assessment of the forced immobilisation and the grounds for maintaining the forced immobilisation.

The review of the received use of force protocols showed that several of the visited departments' completion of the protocols could be improved. For instance, there were examples where the use of force protocols did not contain the names of the involved staff members, and it was impossible to identify the staff members with certainty in any other way. There were also examples of internal belt inspections (cf. below in item 4.5), which had been postponed because the patient was sleeping, being registered in the use of force protocol as a completed belt inspection, of inconsistencies between the time indications for the belt inspections in the use of force protocol and the patient record, and of belt inspections having been registered only in the patient record and not in the use of force protocol.

On that basis, the Ombudsman recommended that five of the visited departments ensure that the use of force protocol does not imply that a belt inspection has been carried out while the patient was sleeping, since that cannot be the case. The Ombudsman recommended that two of the visited departments ensure that it is possible to identify the staff members involved in a belt restraint, and that two of the visited departments ensure that there is consistency between the use of force protocol and the other patient records.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that use of force protocols are completed in accordance with the rules.

4.3. The duration of and grounds for maintaining a forced immobilisation

According to the Mental Health Act, a forced immobilisation can only take place briefly, meaning for a few hours. However, a patient may be forcibly immobilised for longer than a few hours if there are significant grounds for continuing the forced immobilisation, including the consideration of the patient's or another person's life, mobility or safety. There are time limits for when a renewed medical assessment of the forced immobilisation must take place (so-called belt inspection); cf. item 4.5 and 4.6 below. If hand or foot straps are used, the renewed medical assessment of the forced

immobilisation must take into separate account the continued use of the straps.

In the cases that the Ombudsman received from the visited departments, the forced immobilisations lasted between three hours and 11 days.

In the review of the cases where the forced immobilisations lasted longer than a few hours, there were several cases where it could be questioned whether the description of the basis for maintaining the forced immobilisation to the full extent documented that the conditions for maintaining the immobilisation were met. For instance, this applied in cases where the immobilisation was maintained in order to see a certain (more) stable period and to see if the patient could cooperate. There were also examples where no separate grounds were stated for starting or maintaining immobilisation using straps.

On that background, the Ombudsman recommended that seven of the visited departments ensure increased focus on the patient record containing comprehensive documentation for the maintaining of forced immobilisation for the whole period of immobilisation. The Ombudsman also recommended that three of the visited departments ensure increased focus on the patient record containing separate grounds for starting and maintaining immobilisation using straps.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that the patient record contains comprehensive documentation that the grounds for a forced immobilisation are present throughout the entire immobilisation period, and that the patient record, in cases where hand or foot straps are also used, contains separate grounds for starting and maintaining the use of those.

4.4. The permanent guard's records

The rules on permanent guards and the records the guard must keep are set out in the Mental Health Act and the Guidance Notes on the Duty of the Permanent Guard to Keep Records for Patients Forcibly Immobilised with Belt Restraints (Guidance Notes No. 9285 of 4 March 2022).

A patient who has been forcibly immobilised with belt restraints must have a permanent guard. During the forced immobilisation, the permanent guard must make an objective description of the patient's current condition and keep records on their observations at least every 15 minutes.

A review of the forced immobilisation cases that the Ombudsman received prior to the monitoring visits showed, among other things, that all eight of the

visited departments had cases where the permanent guard had not kept records at the stated intervals.

On that background, the Ombudsman recommended that all eight of the visited departments ensure increased focus on the permanent guard keeping records at least every 15 minutes on the current condition of the person being forcibly immobilised.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that the rules on permanent guards' duty to keep records are met.

4.5. Internal belt inspections

The rules on internal belt inspections are set out in the Mental Health Act, the Executive Order on Force and the Guidance Notes on Force.

For the duration of a forced immobilisation, renewed medical assessments must be made of the question of the continued use of the forced immobilisation (belt inspection) as often as conditions allow, however at least three times in 24 hours distributed evenly. The first reassessment must take place no later than four hours after the decision to use forced immobilisation has been made. Subsequent reassessments must take place with no more than 10 hours in between.

If the patient is sleeping when a reassessment of the forced immobilisation is to take place, the patient must as a rule be woken so the doctor can make the reassessment. A belt inspection can thus not be made on a sleeping patient.

If the doctor assesses that it is harmful to the patient's condition to wake the patient, the doctor may decide not to wake the patient. The decision must be noted in the patient record, and the doctor must be summoned as soon as the patient wakes up, so the reassessment of the forced immobilisation can take place.

The review of the forced immobilisation cases that the Ombudsman received prior to the monitoring visits showed that, in the majority of the visited departments, there were examples where internal belt inspections were not carried out in accordance with the rules.

In the majority of the visited departments, there were examples of patients who were sleeping and were not woken when an internal belt inspection was to be carried out. In several cases, it did not appear from the patient record that it was deemed harmful to wake the patient. There were also several examples of patients who had subsequently woken up and had been awake

for some time without an internal belt inspection being carried out before the patients fell asleep again. Lastly, there were examples where an internal belt inspection was not carried out until some time after the patient had woken up (in one case up to seven hours).

Based on the review of the forced immobilisation cases, the Ombudsman recommended that four of the visited departments ensure increased focus on compliance with the rules on internal belt inspections. Of those, it was also recommended that three of the departments ensure increased focus on belt inspections only being postponed because a patient is sleeping if there is a medical assessment that it would be harmful to wake the patient.

In addition, the Ombudsman recommended that six of the visited departments ensure that an internal belt inspection that has been postponed because a patient is sleeping is carried out as soon as possible after the patient has woken up.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that the rules on internal belt inspections are observed, including that an internal belt inspection is only postponed because a patient is sleeping if a medical assessment deems it harmful to wake the patient, and that an internal belt inspection that has been postponed because a medical assessment has deemed it harmful to wake the patient is carried out as soon as possible after the patient has woken up.

4.6. External belt inspections

The rules on external belt inspections are set out in the Mental Health Act, the Executive Order on Force and the Guidance Notes on Force.

If a forced immobilisation lasts for more than 24 hours, a doctor who is a specialist in psychiatry or in child and adolescent psychiatry – and who is not employed in the psychiatric unit where the forced immobilisation takes place, is not responsible for the patient's treatment and is not subordinate to the treating doctor – must assess the continued use of forced immobilisation (so-called external belt inspection).

A renewed external belt inspection must be carried out if the forced immobilisation lasts for more than 48 hours, and another external belt inspection must be carried out on the fourth day. After that, an external belt inspection must be carried out once a week.

The external belt inspection must be carried out no later than on the day when the time limit expires. If the time limit expires late in the evening or at night, the external doctor must be summoned so that the external belt inspection can be carried out the following morning.

The review of the forced immobilisation cases that the Ombudsman received prior to the monitoring visits showed, among other things, that there was one case where an external belt inspection was not carried out after 24 hours because the patient was sleeping – and that the external belt inspection was still not carried out the following morning. In another case, where a belt restraint lasted 3.5 days and nights, there was no external belt inspection after the forced immobilisation had lasted for more than 48 hours.

Based on the review of the forced immobilisation cases, the Ombudsman recommended that the managements of two of the visited departments ensure that external belt inspections are carried out in accordance with the applicable rules.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that the rules on external belt inspections are met.

4.7. Follow-up interviews

The rules on follow-up interviews are set out in the Mental Health Act, the Executive Order on Follow-up Interviews (Executive Order No. 1093 of 11 September 2015 on Interviews Following Cessation of Forcible Measures and Coercion in Psychiatric Departments) and the Guidance Notes on Force.

Following the cessation of a forcible measure, a patient must be offered one or more interviews (so-called follow-up interviews), which must take place as soon as possible. Follow-up interviews seek, among other things, to elucidate how the patient experienced the force used and the reason the force was used, the patient's assessment of how force could have been avoided and how similar situations can be prevented.

The purpose is to find out the patient's and the staff's experience of the situation that led to the use of force in order to give the patient a greater understanding of the reason why it was deemed necessary in the situation to use force and in order to prevent and reduce the use of force towards the patient. Minutes of the interview must be recorded, and it must appear from the patient record if – and, if so, why – the patient did not want a follow-up interview.

The review of the forced immobilisation cases that the Ombudsman received prior to the monitoring visits showed, among other things, that there were a number of cases where follow-up interviews had not been held, and it did not appear from the patient record that the patient did not want a follow-up interview.

The Ombudsman recommended that five of the visited departments ensure that it appears from the patient record if the patient does not want a follow-up interview.

In the light of this, the Ombudsman generally recommends that the departments of forensic psychiatry ensure that follow-up interviews are held and documented in accordance with the applicable rules and that it appears from the patient record if the patient does not want a follow-up interview – and, if so, why.

5. Other matters

During the interviews with the visiting team, several patients and relatives spoke about matters from the patients' everyday lives, including matters with special significance due to the duration of the patients' hospitalisation.

One matter that was mentioned was the food, which in two of the visited departments – according to the departments and the patients in those departments – contained additional energy and protein because it was intended for patients with somatic illnesses (enriched food).

Many patients admitted to departments of forensic psychiatry receive medication, including antipsychotic medication, during their hospitalisation, which may, as mentioned, last for quite some time. The medication may lead to weight gain because it reduces the feeling of fullness and the metabolism. Therefore, several of the patients who said they had experienced significant weight gain were dissatisfied with the serving of enriched food.

The Ombudsman will include this matter in the follow-up discussions on the theme with the relevant authorities.

6. Own-initiative cases

Based on the monitoring visits to the departments of forensic psychiatry, the Ombudsman has found grounds for starting several own-initiative investigations.

6.1. House rules of departments of forensic psychiatry

The rules on house rules are set out in the Mental Health Act and in the Executive Order on House Rules in Departments of Forensic Psychiatry (Executive Order No. 205 of 7 February 2022).

All departments of psychiatry, including forensic psychiatry, must have written house rules that are available to the patients. The house rules must contain general rules on the scope of the patients' activities during the hospitalisation, for instance rules on smoking and visits. In addition, the house rules must contain a description of what types of restrictions and limitations, as described in the Mental Health Act, that may occur in the department, for instance restriction or limitation of the access to mobile phones, computers or similar communications devices, specified books, magazines, social media or websites.

Restrictions and limitations must not be used towards a patient before everything possible has been done to obtain the patient's voluntary cooperation. Restrictions and limitations must also be in reasonable proportion to the aim, and they must not be used to a further extent than necessary to achieve the intended aim.

Prior to the monitoring visits, the Ombudsman obtained the visited departments' house rules. In that connection, the Ombudsman became aware that the house rules – in addition to general rules on the scope of the patients' activities – also contained a number of restrictions and limitations that, according to the house rules, applied generally to the patients and did not presuppose a decision made in relation to each patient to start the relevant restriction or limitation.

On that basis, the Ombudsman has started an own-initiative investigation of the Ministry of the Interior and Health in order to clarify, among other things, whether such general restrictions and limitations towards the patients can be established in the house rules. The case is still pending.

6.2. Seclusion in own room (area restriction)

Seclusion in own room (area restriction) means that a patient is isolated in their own room or another restricted area with an unlocked door, possibly with a staff member standing guard outside the door.

The Mental Health Act does not contain rules on seclusion in own room. However, the Act does contain rules on personal seclusion, meaning that the patient can move freely in the unit, but there is constantly one or more staff members in proximity to the patient – also when the patient is in their own room.

In the case FOB 2020-25 (in Danish on the Ombudsman's website), the Ombudsman stated that he agreed with the (now) Ministry of the Interior and Health that seclusion in own room can now only be used based on a concrete medical assessment with a treatment or safety-related aim and with the patient's consent. The Ombudsman also stated what it takes in practice

before a valid consent to seclusion in own room can be said to exist and what information must appear from the patient record, according to the Ombudsman.

On 19 May 2025, a political agreement was made on an overall 10-year plan for the psychiatric sector (2020-2030). In that connection, it was agreed that it must be possible for the staff in the psychiatric sector to use area restriction – meaning to decide where the patient must stay. The agreement describes under what circumstances and in what way area restriction can be decided and must be re-assessed. However, according to the agreement, the necessary legislation is not expected to take effect until 2026-2027.

During six monitoring visits, the visiting teams received information that seclusion in own room had been used either without consent or without documentation in the patient record of the matters relating to the information to the patient and the patient's consent and ability to make decisions that are mentioned in the case FOB 2020-25.

For example, during the visits, information appeared about cases where patients were told to stay in their own room without the staff having obtained the patient's consent. In other cases, instructions to stay in their own room had been a consequence of a lack of compliance with other instructions from the staff, for instance about smoking times.

The Ombudsman recommended that six of the visited departments ensure that consent for seclusion in own room is obtained and documented in accordance with the relevant applicable rules and practice.

On that basis, the Ombudsman generally recommends that seclusion in own room is only used after the patient has given valid consent and that the patient's consent is obtained and documented in accordance with the relevant applicable rules and practice.

Furthermore, the Ombudsman has started an own-initiative investigation of the Ministry of the Interior and Health and asked the Ministry whether the Ministry finds grounds for taking any action to ensure that there is sufficient clarity in the psychiatric sector about the legal position concerning use of seclusion in own room until – as part of the political agreement of 19 May 2025 – rules may be established on area restriction. The Ombudsman concluded the case on 3 December 2025 after the Ministry of the Interior and Health on 28 November 2025 – based on the Ombudsman's consultation letter – had contacted the regions about the framework for the use of seclusion in own room until separate legislation is in place.

6.3. Special departments for people in surrogate custody

With an amendment of the Mental Health Act, which took effect on 1 January 2022, the regional councils became able to establish departments for people in surrogate custody.

Chapter 5 b of the Mental Health Act contains special rules for people in surrogate custody. It appears from those rules that, if a department has been established for people in surrogate custody, the chief consultant may, in order to ensure order and safety – without a warrant – decide on, among other things, opening and control of post and examination of rooms or belongings. The chief consultant may also decide to restrict or limit the possibility of bringing, possessing or having at their disposal mobile phones, among other things.

In three of the visited departments, there were special units for people in surrogate custody. In the three units there were – in addition to the people in surrogate custody – also patients with other grounds for placement than surrogate custody, including patients with treatment orders or placement orders. The patients who were placed in a unit for people in surrogate custody – without being in surrogate custody – had in common that they were subjected to limitations in relation to their access to making telephone calls and going online, which they would not be subjected to if they had been placed in a general forensic psychiatric unit.

On that basis, the Ombudsman has started an own-initiative investigation of the Ministry of the Interior and Health in order to clarify the interpretation and application of the provisions of Chapter 5 b of the Mental Health Act. The case is still pending.

Sincerely,

Christian Britten Lundblad