

Self-harming patients
within
forensic psychiatric care

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Abbreviations

- CPT** *The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.*
- UN** *United Nations.*
- PO** *The Parliamentary Ombudsman.* The Swedish Parliament's supervisory power. Responsible for monitoring the Government, protecting the individual against abuse by governmental authorities and preventing the abuse of power by officials.
- CPTA** *The Compulsory Psychiatric Treatment Act (SFS 1991:1128).* The Swedish Act which contains the key provisions on compulsory psychiatric treatment and regulates, among other things, what types of coercive measures may be applied, the patient's rights and obligation of personnel.
- FPCA** *The Forensic Psychiatric Care Act (SFS 1991:1129).* The Swedish Act governing the treatment of persons sentenced for crimes committed under the influence of severe mental disorder. FPCA is a penalty for offences and is adjudicated by courts of general jurisdiction.
- PICU** *Psychiatric Intensive Care Units.* Highly specialised psychiatric care units for patients with in great need of care.
- IG** *Instrument of Government.* One of Sweden's four fundamental laws.
- FPC** *Forensic Psychiatric Clinic.* This clinic is mainly for patients convicted of crimes under the PCA but, to a certain degree, even compulsory care patients under CPTA.
- SHEDO** *Self Harm and Eating Disorders Organisation.* A non-profit organisation working with support, information, and opinions related to issues regarding self-harming behaviour and eating disorders.

Brief summary

Evidence suggests that an increasing number of young women with self-harming behaviour are under compulsory care in forensic psychiatric clinics in Sweden without being sentenced to forensic psychiatric care. Intentionally self-destructive acts are problems which have risen sharply within a ten-year period in Sweden, particularly among young women 15- 25 years of age (The National Board of Health and Welfare, 2009). Patients come to forensic psychiatry when general psychiatric care efforts have proved inadequate, and care in the forensic psychiatry is often regarded as an “emergency solution”. The care of these patients in forensic psychiatry is problematic from several aspects:

Forensic psychiatric care in Sweden is traditionally designed for men with criminal records. Women’s needs are in danger of being sidelined in an environment where women represent only about 10% of the incarcerated patients. Of these 10%, the majority are not sentenced to forensic psychiatric care, but instead are treated under Compulsory Psychiatric Treatment Act (CPTA), often because of self-destructive behaviour (The National Swedish Board of Health and Welfare, 2007a). To treat patients convicted of a crime together with self-destructive patients, risks not only leading to feelings of insecurity and stigma, but it also subjects the self-destructive patients to coercive and security measures which are not proportionate to their needs. This phenomenon was highlighted in Sweden in 2009, when it was revealed that in forensic psychiatric clinics mechanical coercive measures were used which are not permitted under Swedish law. In particular, focus should be aimed at the forensic psychiatric regional clinics in Sundsvall which, according to its website, has 12 places reserved for self-harming patients. The National Board of Health and Welfare’s enforcement unit in Umeå has, at least since 2003, been aware of the use of compulsory gloves and compulsory helmets at the clinic, but did not criticise the use of these coercive measures until December 2009, although the measures are not supported under Swedish law. Evidence in the form of, among other things, records and contracts entered into between patients and the treating staff also suggests that coercion is systematically used as retaliation for unwanted behaviour, such as deliberate self-destructive actions. The use of coercive measures such as compulsory gloves and long-term isolation in stimulus-free rooms as a means of punishment is contrary to Swedish as well as international law. The use of illegal coercive measures in clinics around the country, and the use of coercive measures as a means of punishment,

both exhibit the weaknesses in Swedish compulsory psychiatric care laws, but also weaknesses in government oversight of the facilities that are engaged in compulsory psychiatric care in Sweden, and in the handling of cases involving violations of the law in healthcare.

Introduction

In Sweden compulsory psychiatric treatment is regulated by two Acts: the Act on Forensic Psychiatric Care (FPCA) and Compulsory Psychiatric Treatment Act (CPTA). For further understanding, it is important to be aware of the difference between these two laws. Care under the Act on Forensic Psychiatric Care is given to a person who has been committed to forensic psychiatric care after having committed crimes under the influence of a severe mental disorder. For compulsory psychiatric treatment under the other Act, the Compulsory Psychiatric Treatment Act, the following conditions must be met:

Compulsory treatment may be given only if the patient is suffering from a severe mental disorder and, because of his or her mental condition and his or her personal relationships in general

- 1. has an essential need for psychiatric care, which cannot be met other than by the patient being sent to a hospital facility for qualified round-the-clock psychiatric care (in-patient compulsory psychiatric treatment), or*
- 2. the need to comply with specific conditions to be given the necessary psychiatric treatment (open compulsory psychiatric treatment).*

A prerequisite for care under this Act is that the patient is opposed to such care as stated in the first paragraph or, as a result of the patient's mental condition, there is substantial ground for the belief that the care cannot be provided with his or her consent.

Section 3, Act on Compulsory Psychiatric Treatment (SFS 1991:1128)

As a rule, these two groups of involuntary treatment patients are treated separately in different units or clinics. However, in 2009 the National Board of Health and Welfare* reported that every seventh forensic psychiatric patient was treated within general psychiatry in 2008, which meant 115 people in that year alone (National Board of Health and Welfare, 2009a). Highlighted, during the same year, was the fact that more and more patients with self-harming behaviour, and sometimes eating disorders, were forced into care in forensic psychiatric clinics, pursuant to the Compulsory Psychiatric Treatment Act. The attention of both phenomena led to significant reactions in the Swedish media (see, e.g. *Östgöta Correspondenten*, 2008, *Aftonbladet*, 2009, *Dagbladet*, 2009).

* The National Board of Health and Welfare is a Government agency under the jurisdiction of the Ministry of Social Affairs. The National Board of Health and Welfare has broad operations within social services, healthcare, health protection, disease control, and epidemiology. Among other things, it is incumbent on the National Board of Health and Welfare that its six enforcement units supervise care.

The compulsory treated patients in forensic psychiatry, who are supported by the Compulsory Psychiatric Treatment Act, are considered to be “particularly demanding” and care in forensic psychiatry is generally regarded as an emergency solution when general psychiatric efforts have proved inadequate. The indications are that more and more young women with self-harming behaviour as the main problem are sent to forensic psychiatric clinics without being sentenced to such care, and that at least two regional forensic psychiatric clinics have come to specialise in these types of patients.

However it can be said that female patients tend to be a growing target group. The main reason for this is that the clinic has built a good reputation for care and treatment, for tradition and experience, of hard-to-care-for groups, namely (young adult) women with severe self-harming problems. (Söderberg, 2008)

Due to the lack of reliable statistics, it is unknown how common it is that self-harming patients are forced into forensic psychiatric care pursuant to the Compulsory Psychiatric Treatment Act. This may, to some extent, be explained by the difficulties in diagnosis and the definition of self-harming behaviour, which is not considered a separate disease or disorder but rather as a symptom which can occur with multiple psychiatric diagnoses. When the National Board of Health and Welfare, in 2008, investigated who was being held in compulsory psychiatric care, it found that 7% of the CPTA patients who were being treated in Sweden on 6 May 2008 were being treated at a forensic psychiatric regional clinic, and 14% in a county unit.* Of these, the majority had a diagnosis of schizophrenia (24 persons), 14 persons suffered from borderline personality disorder, and another 26 suffered from mixed diagnoses such as behaviour disorders, bipolar disorder, and other psychoses (National Board of Health and Welfare, 2009a). In another report from the National Board of Health and Welfare, it indicated that women, in total, represent approximately 10% of the patients in forensic psychiatric care clinics. Only a minority of these women are treated according to the Forensic Psychiatric Care Act, FPCA, instead most are cared for according to the Compulsory Psychiatric Treatment

* The units that care for forensic psychiatric patients can be divided into three levels of security. Regional care units have increased perimeter protection and thus can take care of most treatment of patients that require security. The next level consists of units at the county level, which have a slightly lower perimeter protection. The third level consists of general psychiatric units, where the care is carried out with the same level of security as for patients who were not sentenced (Government Official Report 2006:91).

Act, CPTA, often due to self-destructive behaviour and self-harming behaviour (National Board of Health and Welfare, 2007a).

No one knows just how many patients are cared for in forensic psychiatry according to the Compulsory Psychiatric Treatment Act mainly because they harm themselves. Nor is it possible to determine whether the phenomenon has grown over the years, even if SHEDO's organization as well as the forensic psychiatric clinics in Sundsvall's view is that this is the case (Söderberg, 2008).

The suitability of treating self-destructive compulsory psychiatric treatment patients in forensic psychiatric clinics

Treating patients against their will according to the Act on Compulsory Psychiatric Treatment or the Act on Forensic Psychiatric Care places great demands on ethics and the good quality of care. The National Board of Health and Welfare's inventory of the contents of the compulsory psychiatric care showed that compulsory psychiatric treatment patients in forensic psychiatry to a greater degree received both medical and psychological care input and rehabilitation (31%), while the corresponding figure in general psychiatry was 9% (National Board of Health and Welfare, 2009a). In general psychiatry, 41% of compulsory care patients received only medical treatment. Forensic psychiatric care may therefore in this respect be regarded as more favourable to compulsory psychiatric treatment patients than the general psychiatric care. A lack of resources in general psychiatry, lack of skill with similar circumstances, however does not constitute a justifiable reason for compulsory psychiatric treatment patients to be provided with care within forensic psychiatry. "Emergency solutions" that become part of the routine, risk delaying the resources and skills development within an area where such investments should take priority. Thus, the issue is what kind of conditions may constitute a good basis for what appears to be an increasingly established practice. However, the fact that severe self-harming patients are involuntarily cared for at forensic psychiatric clinics shows an insufficient exception to what should be a basic rule. Several uncertain factors also mean that it must be called into question whether the treatment of these

patients in forensic psychiatry can really be ethically and legally defensible. These factors are discussed under different headings below.

The forensic psychiatric environment, women and self-destructive behaviour

In principle, it can be called into question whether patients who are not sentenced to forensic psychiatric care, in general, should be treated at forensic psychiatric clinics. However, the compulsory psychiatric treatment patients treated primarily as a result of self-harming behaviour are subject to increased exposure since these patients are almost exclusively comprised of young women (the authors of this text are aware of only one man who, at the age of 15, was placed in compulsory care at a regional forensic psychiatric clinic in Växjö for self-harming behaviour). The self-harming women are forced into an environment which is traditionally designed for men with criminal records (The National Board of Health and Welfare, 2007a). The National Board of Health and Welfare wrote, in its report *Content of forensic psychiatric care* (2007a):

Many women place themselves into these systems without objection. They can create a spot in the group by making themselves “useful” (repairing men’s clothes, baking biscuits, etc.) or otherwise play on their femininity [...] the staff may appreciate this behaviour - and even encourage it - and therefore it works as a social lubricant in the system. One may unconsciously use women as “ornamental flowers”. They are planted sparsely, since this will engender a more pleasant atmosphere - men dress better, swear less, and so on. One visible sign of the women’s different role is the fact that the recreational activities provided are rarely adapted for women’s are rarely adapted for women’s development and needs. Simply put, one can say that women are likely to be considered, addressed and treated, as “deviant men” [...] One can say that the care, in the current situation, is not designed for female patients. (p. 31)

The Swedish healthcare system rests on “science and reliable experience”, which appears in both the Healthcare Act (SFS 1982:763) and partly in the Professions in Healthcare Act (SFS 1998:531). It should be noted that care of self-harming compulsory psychiatric treatment patients in forensic psychiatry is not evidence-based, to date there is no research on the care of this patient group in a forensic psychiatric setting. The knowledge which exists about self-harming individual groups shows that the care in forensic psychiatric clinics exposes this group to risks which in accordance with customary

precautionary principles, is not acceptable. There is no reason to believe that this group is a psychological or psychiatric homogenous group, but the surveys and scientific studies performed, in spite of everything, highlight their common connections. Numerous empirical studies suggest such a link between traumatic life experiences and self-harming behaviour/suicidal behaviour (Brodsky & Stanley, 2001). The National Board of Health and Welfare's report *Girls who harm themselves* (2004) reported that 24% of the 205 self-harming girls aged 14–19 were victims of physical abuse, 33% of psychological abuse, 27% of sexual abuse, and 37% of bullying. When you place severe self-harming patients in a forensic psychiatric environment there is a risk, in other words, in forcing victims to be cared for together with offenders. It should be obvious that this situation does not entail particularly good conditions for the patient to experience the security she is entitled to pursuant to Section 2a of the Health Care Act.

The UN International Covenant on Civil and Political Rights (UN, 1966), with which Sweden has undertaken to comply reads: "*Accused persons shall, save in exceptional circumstances, be segregated from convicted persons and shall be subject to separate treatment appropriate to their status as unconvicted persons*" (Part III, Article 10.2a). Consequently, there are obvious problems with the compulsory treatment of self-harming patients together with criminals sentenced to forensic psychiatric care. The authors submit that it is not possible to equate accused persons with women who are cared for according to the Compulsory Psychiatric Treatment Act, which makes exceptions to the above-stated rule even more remarkable and that the prevailing circumstances cannot be said to be exceptional.

When the presence of self-harming women in forensic psychiatric care was given attention during 2009, it led to a strong emphasis being placed on the very fact that women were being cared for together with men convicted of crimes. The fact that young women are over represented among self-harming patients and that women are a clear minority within the forensic psychiatric care in general, and to an ever increasing degree, are treated pursuant to the Compulsory Psychiatric Treatment Act rather than the Act on Forensic Psychiatric Treatment are naturally circumstances which warrant caution. There is no scientific evidence that there would be any therapeutic benefit for a young woman to be treated alongside a majority of men, usually older than themselves. On the contrary, it is suspected that the visual presence of these men may have a negative impact on young women, whose problems can include finding a healthy identity in interpersonal

relationships. It would be misleading to suggest that the care of self-harming women within forensic psychiatry would be risk-free as long as they were treated apart from those that it would be the most inappropriate for them to be with. Two shortcomings can be discerned in this reasoning. Firstly, the difficulty of effectively delivering the necessary differentiation is underestimated. The forensic psychiatric clinic in Sundsvall, which according to its website has 12 places reserved for self-harming patients, made an attempt in 2009 to treat compulsory psychiatric care patients separately in their own unit. However, the patients serious self-harming problems in combination with the clinic's treatment philosophy, that self-harming behaviour under no circumstances should be given attention, made the solution hardly successful since the patients were left only to help each other as the self-harm among the patients increased.

The difficulties in fully implementing a physical differentiation are not the only problem. The feeling of insecurity bears a real risk that the current group of patients cared for in forensic psychiatry, as well as the risk of stigmatisation, is only somewhat dependent on whether they have actual contact with forensic psychiatric care (FPCA) patients. The very knowledge of the fact that they are provided or will be provided care in a clinic for people who have committed serious crimes and that society views as a problem should constitute a significant risk for insecurity and stigma, a risk which no differentiation in the clinic can eliminate or significantly reduce. Something which also may be considered established is that people with self-harming behaviour typically have problems with themselves, such as poor self-esteem, feelings of inadequacy, and identity crises (The National Board of Health and Welfare, 2004). It raises the question of what signals are sent to these patients when they are placed involuntary into forensic psychiatric care. It is concluded that differentiation should be made even between the various branches of psychiatry.

I felt like a criminal and it feels like someone has stamped RPK [Forensic Psychiatric Clinic] on my forehead. Every time you come into healthcare after that they ask: "You've been in forensic psychiatric care and had compulsory psychiatric treatment, yes?" So shouldn't be the case that one feels hatred/anger for how one has to answer such a question.

Female, 25 years old, admitted to the forensic psychiatric clinic in Sundsvall

When I first came to admissions, I was terrified, frankly. I found it hard to see who was a patient and who was a member of staff. I sat with a male patient

who jumped into the microwave oven and asked me to sit with him and stroke his cheek and hold his hand. Then at the 93rd (patient care area) I sat with a rapist who later punctured another patient's lung with scissors. On the 96th, where I ended up, I was never afraid of the female forensic psychiatric care [FPCA] patients. The 96th was divided into female/male areas with a common smoking room and yard. I sat, amongst others, with a male patient who was sentenced for attempted murder and I had quite a lot of respect for him and felt uncomfortable in his presence. Actually the most uncomfortable thing was that you never knew what another person was convicted of.

Female, 29 years old, admitted to the forensic psychiatric clinic in Sundsvall

If I ever hear that I'm going back to Växjö or another clinic, I'll kill myself. I'll choose death over no life locked up in forensic psychiatric care. All I needed was someone to hold me and understand, and who could help me break it. Now I have a good psychologist and I'm going to do this. But they have stolen more than two years from me.

Female, 23 years old, admitted to the forensic psychiatric clinic in Växjö

Application of existing regulations

In principle, the authors have called into question the appropriateness of caring for self-harming compulsory psychiatric treatment patients in forensic psychiatric clinics. However, questions can also be raised regarding the quality of forensic psychiatric care these patients receive in practice, and whether existing regulations are really applied. A discussion is set out below regarding this, illustrated through the testimony regarding the circumstances and incidents at forensic psychiatric clinics which were collected in writing from 14 patients.

Coercion and proportionality

Units with activities engaged in healthcare pursuant to the Compulsory Psychiatric Treatment Act or the Act on Forensic Psychiatric Care are classified according to three different security levels: very high (level 1), high (level 2) and acceptable (level 3). The cumulative risk assessment of the patient is to be performed based on four aspects: risk of being helped to escape, escape-prone, prone to harming others, or prone to self-harm. The

main rule is that a patient being treated according to the Compulsory Psychiatric Treatment Act should be placed in a unit with an acceptable security level, level 3. Departure from the general rule can be made on special grounds, for example the patient showed aggressive behaviour or refused to participate in the planned psychiatric care measures. Lack of space in units with lower levels of security may never be deemed to be a special reason (The National Board of Health and Welfare, 2007b). Care of self-harming patients within forensic psychiatry is often defended because of these patients' need for protection and security, referring to their self-destructive behaviour. What distinguishes safety level 1 from level 3 is primarily the presence of exterior protection and perimeter protection (for example walls, locks, and fences), whereas level 1 requires a security system which can withstand assisted escape attempts and a advanced escape attempt. In a unit with security level 3 the only requirement is that there are routines for continued monitoring where the patients are located. Compulsory psychiatric treatment patients with self-harming behaviour, for obvious reasons, have types of security needs other than forensic psychiatric patients, so it is very doubtful whether the presence of outer and perimeter security can be considered as satisfying their specific needs for protection. Compulsory psychiatric treatment patients are inevitably negatively affected by security rules which apply in order to ensure that the forensic psychiatric patients, and the public's needs in relation to these patients which, among other things, include alarm arches in the entrance, the requirement of notification of visits one week in advance, and the recording of personal descriptions during periods of release. Due to lack of space, some compulsory psychiatric treatment patients have even been cared for in units customised for patients with specific restrictions regarding the use of telephones and thus, mobile telephones were not permitted.

The Compulsory Psychiatric Care Act (SFS 1991:1128) is very clear on the issue of *proportionality*:

*Coercive measures in connection with care under this Act may be used **only if they are proportionate to the purpose of the measure**. If less restrictive measures are sufficient, they should be used. Force must be exercised as gently as possible and with the utmost focus on the patient. [Emphasis added] (SFS 1991:1128; Section 2a)*

When one examines the everyday lives which women in compulsory psychiatric treatment and self-harming behaviour encounter within the forensic walls, a number of situations soon appear in which the idea of proportionality takes a back seat to familiar routines and patterns. The transport of prisoners, personal descriptions, limitations in visitor opportunities, limitations on telephone use, and the walking through alarm arches, most probably does not stand in reasonable proportion to the purpose which the law so clearly requires.

The first thing I encountered when I came to the forensic psychiatric clinic, was the 5-metre high grey concrete wall which surrounded the clinic (which incidentally, I could see outside my window every day for 10 months as a reminder that I was locked up and would never get out of here). When we arrived, I had to take off all of my own clothes and put on an x number of sizes too big, men's grey sweat suit, two socks without elastic, and then I was taken to the admissions department which more than anything resembles a prison environment. I was shown to my room, a cold grey-painted room without any furniture except a steel bed which was secured to the wall and appeared to come from the '70s.

Female, 29 years old, treated at the forensic psychiatric clinic in Sundsvall

Prisoner transport with three monster sized guards. They frisked me; I cried and hugged my cuddly toy animal hard between my fingers until my knuckles were white. They tell me just to take it very easy. I swallow my fear, my knees are buckling but I think that I can't show any signs of weakness. The medication makes me easy to handle. I hear them talking to each other about the risk of escape has been judged to be very high. I think, I hardly have the energy to stand up. The guards place me at the back of the bus, with bars on all the windows and between the back seat and the driver. This is a nightmare, a real horror film.

Female, treated at the forensic psychiatric clinic in Sundsvall

Unregulated coercion

The regional forensic psychiatric clinic in Sundsvall writes, on its website: “Regarding the self-destructive patients, great importance is placed on the responsibility for the patient's life being placed back on the patient. Specifically, this means that any possible self-destructive acts may not be magnified and become part of treatment and conversations. Extra supervision is therefore very unusual and is only used in extreme emergencies”. Even patients state that extra supervision is not used but rather testify to

the wide use of isolation, compulsory gloves, and other forms of coercion. The relevant clinic's decision to use mechanical restraints rather than increased monitoring with the help of staff to guarantee the safety of self-destructive patients is problematic in relation to the National Board of Health and Welfare's guidelines: "*If the patient, through aggressive or disruptive behaviour, seriously disrupts the care of other patients he or she may be separated, i.e. kept isolated from the other patients [...]. One must first question if the personnel actions can achieve the same purpose as the isolation measures would achieve*" (National Board of Health and Welfare, 2009a).

Every citizen is constitutionally protected against forced physical intervention (Instrument of Government, Chapter 2, Section 6). "Physical violation" refers primarily to physical force used against the human body, but includes medical examinations, minor surgery such as blood sampling, and similar operations which fall under the concept of physical inspection. This protection against all forms of forced physical intervention may be limited only by law and only to meet the purposes which are acceptable in a democratic society (Instrument of Government, Chapter 2, Section 12). Later in the same text it appears that restrictions of this kind may be made, among other things, with regard to "*protection of life, personal safety, or health*" (Instrument of Government, Chapter 8, Section 7, first sentence). The restrictions relating to coercive measures which are of interest to the current patient group are found in the Compulsory Psychiatric Treatment Act. This law permits, under special conditions, two forms of mechanical constraint: belt restraint and separation/seclusion. These coercive measures are used within forensic psychiatry as well as in general psychiatry. However, it has been shown that other mechanical restraints are found in forensic psychiatric clinics around the country, and probably even in general psychiatry to some extent. Decisions from the National Board of Health and Welfare and testimony from patients testify to compulsory gloves (leather bags which lock into place around the wrists with a key), waist belts (leather belts thrown around the waist to which the wrists lock at an adjustable length), helmets (described by patients in the forensic psychiatric clinic in Sundsvall as being like a rugby helmet with grids which cannot be removed, and by patients in Växjö as "a plastic helmet covered with a bandage so it looked as if she had only had a bandage but then, when we felt it, it was hard as stone"). All of these coercive measures lack legal support. In the Government Bill on Compulsory Psychiatric Treatment and Psychiatric Care (SFS 1999/2000:44) it states:

According to the Government's view, a patient's freedom of movement should not be restricted in any way other than by using a belt or similar device. There is no reason, from a treatment point of view, by change of Section 19 of the Compulsory Psychiatric Treatment Act (CPTA) to make it possible for patients freedom of movement to be restricted by other means, such as the so-called straitjacket or handcuffs. (p. 84)

The only possible exception which can be identified concerns the right of self-defence: *"This necessity occurs when danger threatens life, health, property, or other essential interests protected by law"* (The Criminal Code, SFS 1962:700, Chapter 24, section 4, second paragraph). Coercive measures in other words may not be used for any purpose other than by means shown by applying the provisions of the law on compulsory psychiatric treatment, except in emergency situations where the paragraph on self-defence may be invoked. Against this background, it is very difficult to see how the systematic use of compulsory gloves in the forensic psychiatric clinic in Sundsvall could be justified. The patients that have worn compulsory gloves in Sundsvall claim that the gloves have probably been used at the clinic since the 1950s. Patients have been forced to wear compulsory gloves from a few hours to several months at a time, usually as a consequence of self-harming behaviour. The paragraph on self-defence cannot be invoked and all patients suggest that the gloves are removed temporarily during toilet visits and meals, but then locked on the wrists again.

Punishment

In the third Article of the European Convention (2003) it states that: *"No one shall be subjected to [...] degrading treatment or punishment"*, and in the fifth Article of the United Nations Universal Declaration on Human Rights (2009) the wording is identical: *"No one shall be subjected to [...] degrading treatment or punishment"*. According to the Compulsory Psychiatric Treatment Act (SFS 1991:1128, Section 19), the strapping down of patients with a belt should only be used to protect the patient from themselves, alternatively also other people from being injured. Separation/seclusion should only occur if it is necessary due to the patient's aggressive or disruptive behaviour which seriously hampers the care of other patients (Section 20). The same Act states, as previously mentioned, that coercive measures must be proportionate to the aim of the action (Section

2a). The strong prohibition against punishment, which applies in both Swedish and international law, gives reason to question the use of coercive measures, once again with particular focus on the forensic psychiatric clinic in Sundsvall. Even greater evidence has emerged that mechanical restraints in the current clinic were not only used as protective measure but as a method to condition against dysfunctional behaviour. In the Swedish investigative TV programme, *Kalla Fakta*, which aired in October 2009, among other things, two contracts were presented signed between a patient and her care-taker (see, Appendices 1 and 2). In the contract the patient had, among other things, committed herself to discontinue her self-harming behaviour. A violation of the contract would immediately lead to the patient being forced to wear compulsory gloves for at least three months, which later also took place. The National Board of Health and Welfare has also directed criticism against two cases of isolation because, it “prescribed” the separation of patients, notwithstanding that this may never be resorted to as a method of treatment (National Board of Health and Welfare, 2009c, d). The understanding that the clinic in Sundsvall resorted to coercive measures in the treatment and/or punishment of patients is strengthened by several patient stories which were communicated to the authors:

It felt like extreme coercion and negligence were the methods they supported and carried out. It was not by healing through conversations and socialising that one would stop your sick behaviour; rather it was in order not to be punished [...]. I harmed myself in the unit - the consequences - I was sentenced to wear compulsory gloves for a week. I was shocked at this, in my opinion, an unnecessarily long period of time [...]. When in my desperation, despite the gloves, I succeeded in harming myself, it was time to be strapped down with the belt. I think I lay there four hours. Now I had a staff member present, but really not. They made it very clear that he was sitting there just because the law said so, not for my sake. He sat with his back to me and read his book. He did not try to have any conversation. It was sad, many thoughts circling around in your head when you're is strapped down, it's nice if one gets to vent a little and maybe move forward in one's thoughts.

I thought that it was all over this time, but no. I still had isolation. I don't remember now how many hours it lasted. I think it was six hours. Six total unnecessary hours.

Female, 46 years old, admitted to the forensic psychiatric clinic in Sundsvall

There are nice staff members when you're feeling good, otherwise they're very mean. They bully and so on. Asking for leave from the clinic is not even discussed before February or next year. They are very hard if you harm yourself [...]. I cut myself on Monday and ended up in the isolation room for 19 hours. It was really horrible.

Female, 17 years old, admitted to the forensic psychiatric clinic in Växjö

If you harm yourself in any way you have to put on gloves with locks. Then you are locked in an isolation cell. At the forensic psychiatric clinic there are no extra supervision like there are in general psychiatry. You get to wear a rugby helmet with grids on it, if you try to throw yourself against a wall. The idea is that you should not receive any external stimulus. Therefore one lies down, sometimes strapped in, on a bunk in a white, cold room. Psychiatric intensive care units are oceans apart compared to this cell. I lie there alone for three days. Sometimes I hear the key rattling in the lock, I was besides myself with the thought of some company.

Female, 25 years old, admitted to the forensic psychiatric clinic in Sundsvall

Human rights

The United Nations Declaration on Human Rights is universal and applies to everyone. In the fifth article of the Universal Declaration it states that no one “*No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment*” (UN, 2009). The corresponding text is also found in the United Nations International Covenant on Civil and Political Rights, Part III, Article 7 (UN, 1966). In the Convention Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (UN, 1984) the term torture is defined as:

*any act by which **severe pain or suffering, whether physical or mental, is intentionally inflicted** on a person for such purposes as obtaining from him or a third person information or a confession, **punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.** [Emphasis added] (Part I, Article 1.1)*

*The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as the “CPT”), is called upon through visits to examine how the detention of people within, for example, prisons and psychiatric clinics, are treated. The Committee’s purpose is to strengthen these persons’ protection against torture and inhuman or degrading treatment or punishment (Council of Europe, 1987). The CPT has published a document, *The CPT Standards*, which clearly highlights*

a number of conditions which are relevant in this context (CPT, 2006). On page 58, paragraph 48, the Committee writes: “*physical restraints have been applied for a period of days; the Committee must emphasise that such a state of affairs **cannot have any therapeutic justification and amounts, in its view, to ill-treatment***” [Emphasis added]. The CPT thereby rejects all use of physical restraint over several days and sees this invariably as neglect. A good number of patients at the regional forensic psychiatric clinic in Sundsvall have said that they have worn compulsory gloves for several days and up to three months at a time. The measure has repeatedly been defended by the representatives of the clinic, something that seems very contradictory in relation to the CPT’s statements. In addition, the Committee also describes that coercive measures which may not be used at all in psychiatric care, which are totally inappropriate for the purpose, and should only be regarded as degrading: “**Handcuffs, metal chains and cage-beds clearly fall within this category; they have no rightful place in psychiatric practice and should be withdrawn from use immediately**” [Emphasis added] (CPT, 2006, p. 64, paragraph 40). The Government expresses, in Government Bill 1999/2000:44 that a patient’s freedom of movement should not be restricted other than in the ways already permitted by the Compulsory Psychiatric Treatment Act (CPTA), for example with so-called straitjackets or handcuffs (p. 84). Against this background, the authors of this paper question what separates handcuffs and shackles from compulsory gloves, so much so that the later locking device, unlike the former, can be said to be an acceptable method of compulsion, although it has no legal basis. Finally, the CPT believes that separation/seclusion is a measure of constraint which should be phased out and, as much as possible, be avoided. They stress that the separation should be applied strictly, continuing for as short a time as possible, and be regularly reassessed. Emphasised in particular is “*the existence of appropriate human contact; the need for staff to be especially attentive*” (CPT, 2006, p. 58, paragraph 49). Here, also, there is reason to take a look at the forensic psychiatric clinic in Sundsvall, where patients pointed out the deliberate lack of human contact during isolation and the strapping down of patients with a belt (see above quote of “Female, 46 years old” and “Female, 25 years old” under the heading “Punishment”).

Based on the UN and Council of Europe’s Human Rights Conventions, it can therefore be argued that parts of the care forced on patients, especially in the forensic psychiatric clinic in Sundsvall, are to be characterized as inhuman and degrading treatment, and probably even as torture according to the UN’s definition of the term. Hypothetically,

these forceful types of coercion and punishment could be part of the good results by which the clinic defends the care of self-harming patients but which in this case were achieved by methods which are not compatible with current laws and conventions.

And I can partly agree with, most of them get “healthy” and stop harming themselves. But I don’t think it always has to do with feeling better, rather that one simply stops because to harm yourself at a forensic psychiatric clinic means that you will be punished in one way or another and never get out of there. I myself stopped harming myself openly and hurt myself on the sly instead and then when I got out it started up again.

Female, 33 year old, admitted to the forensic psychiatric clinic in Sundsvall

I’ve been thinking today how one gets out of here, I have also asked but of course there is no answer. Strong arguments are good to have, but except for that I think, and this is bad, one simply must smile and look happy, and absolutely not show any feelings except happiness and only endure it for an undecided time. It’s not long-term thinking at all, and they want us to think in the long term, but I have a hard time seeing this as an environment for treatment. It’s hard to be so dependent, and at such a disadvantage, and one cannot protest.

Female, 22 year old, admitted to the forensic psychiatric clinic in Sundsvall

Care of minors

Although it may be thought of as rare, there are young patients (under 18) being treated according to Compulsory Psychiatric Treatment Act in forensic psychiatric clinics. The authors of this text have personal knowledge of at least five young patients who were placed in one of the country’s forensic psychiatric clinics during the 2000s. In August 2003, two young women with self-harming behaviour died in a fire, in a regional forensic psychiatric clinic in Växjö, which was started by a patient convicted of arson. The two fatalities were in the care of the clinic according to the Compulsory Psychiatric Treatment Act. In an interpellation written by Göran Gunnarsson (2003), a case is described in which a 15-year-old girl was placed into a regional forensic psychiatric clinic in Vadstena. The Head of Operations at the regional forensic psychiatric clinic in Sundsvall also confirmed, in a newspaper interview, that young patients have been treated at the

clinic (*Östgöta Correspondenten*, 2008). This is the case despite the fact that the United Nations Convention on the Rights of a Child, Article 37 c, states that:

Every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action. [Emphasis added]

The Authority's conduct

The National Board of Health and Welfare is a Government agency governed by the Ministry of Social Affairs which, among other things, is responsible for overseeing healthcare. The National Board of Health and Welfare's mission is governed by several different legal texts and, in this context, the following are of particular interest: the Act on Professional Healthcare Field (SFS 1998:531) the Profession with Health Services and Regulation (SFS 2009:1243) with instructions for the National Board of Health and Welfare. In the last-mentioned Act, it is clear that the National Board of Health and Welfare shall monitor the activities in relation to quality, safety, and the rights of individuals (Section 8.1). The importance of gender issues in the investigation of the business is paramount, where women's and men's different terms in particular should be taken into account (Section 7.3). The National Board of Health and Welfare's aim is to prevent injuries and eliminate hazards in healthcare, as well as support and review both the business and the health and healthcare personnel's actions (Professional Healthcare Field Act, SFS 1998:531, Chapter 6, Section 3).

In 2003, the National Board of Health and Welfare's Enforcement Unit in Umeå investigated a matter involving a self-harming patient in the regional forensic psychiatric clinic in Sundsvall, in which the patient was isolated remarkably frequently and for long periods of time. The National Board of Health and Welfare's decision found that the patient had to wear both compulsory gloves and a helmet, but no criticism was made against the use of these coercive measures, even though there was no legal basis (National Board of Health and Welfare, 2003). Unauthorised mechanical coercive measures have subsequently appeared in repeated individual reports to the National Board of Health and

Welfare and a review decisions from such, but none of these decisions led to any criticism. In terms of the National Board of Health and Welfare's abovementioned mission, this lack of criticism is remarkable. As previously established, compulsory helmets or compulsory gloves, in the Compulsory Psychiatric Treatment Act, should be regarded as illegal restraints. If the National Board of Health and Welfare becomes aware that someone has violated a provision relating to activities under their supervision, they are required to take action and, if necessary, submit a complaint for prosecution (the Professional Healthcare Field Act SFS 1998:531, Chapter 6, Section 12). The National Board of Health and Welfare also has the authority to ban the operation of all or part of a clinic. This can be done either if the business does not improve performance on the points the Board has previously requested in an investigation, or promptly if there is a danger to the patients' lives, health or personal safety (Act on Professional Healthcare Field, SFS 1998:531, Chapter 6, Sections 15- 16). In addition, if the National Board of Health and Welfare considers there are grounds against healthcare professionals for disciplinary sanctions, probation, or revocation of licences, they must notify the Medical Responsibility Board,* HSAN. If the person against whom disciplinary sanctions are brought can be deemed to be reasonably suspected, in the performance of their job, of a crime for which a jail sentence may be prescribed, the National Board of Health and Welfare must submit a complaint for prosecution (Act on Professional Healthcare Field, SFS 1998:531, Chapter 6, Sections 18-19). The use of mechanical coercion which is not covered by the Compulsory Psychiatric Treatment Act should be classified as illegal detention, a crime which can carry a sentence of between one and ten years' imprisonment (Criminal Code, SFS 1962:700, Chapter 4, Section 2).

After repeated pressure from both the media and private individuals, as well as following information regarding a pending Parliamentary Ombudsman notification, the National Board of Health and Welfare's Enforcement Unit in Umeå, in the Autumn of 2009, chose to examine the regional forensic psychiatric clinic in Sundsvall for compliance with the Compulsory Psychiatric Treatment Act. The assessment was based on three cases of patients from whose medical records the following deficiencies were identified:

* HSAN, the Medical Responsibility Board, is an independent Government agency which examines questions of disciplinary sanctions and the withdrawal and recovery of medical licenses and regarding healthcare professionals.

- Decisions on indefinite compulsory measures
- Decisions on unlawful coercion
- Decisions on coercive measures if necessary
- Coercive measures taken without the issuing physician documenting the decision
- Decisions on coercive measures in advance
- Decisions on extension of coercive measures in advance
- Decisions on coercive measures without personal investigation
- Incomplete records regarding decisions

In addition, it was found that compulsory gloves were used as means of punishment orders, and that contracts were drawn up between the treating staff and patients in compulsory psychiatric treatment pursuant to which a breach of contract would lead to patients being forced to wear compulsory gloves for at least three months (National Board of Health and Welfare 2009e, see Appendix 2). The deficiencies found by the National Board of Health and Welfare in its investigation were extensive and by no means minor, but despite this fact, no notification was made to The Medical Responsibility Board or to the public prosecutor, as required by law (1998:531, Chapter 6, Sections 18-19).

In December 2009, the authors of this document made two complaints to the Parliamentary Ombudsman, whose responsibility is to oversee Governmental agencies, protecting individuals against abuse by governmental authorities and preventing abuse of power by officials. One notification was directed to the forensic psychiatric clinic in Sundsvall, while the second concerned the National Board of Health and Welfare's Enforcement Unit in Umeå. On 18 January 2010, the two complaints were dismissed with reference to the criticism that the National Board of Health and Welfare's conclusion addressed in December, at least six years after the National Board of Health and Welfare first became aware of the practice of compulsory gloves (National Board of Health and Welfare, 2009e). The authors found the basis for the decision strange and contacted the Parliamentary Ombudsman with a request for clarification of the justification for the decision taken. The administrative official then declared that the Parliamentary Ombudsman is not an authority, in the normal sense, but has the status of a special regulatory body. Thus, the provisions of the Administrative Procedure Act (SFS

1986:223) on the Authority's handling of cases are not applicable in the Parliamentary Ombudsman's activities. Thus, a Parliamentary Ombudsman is not required to open an investigation, but will decide whether a complaint shall be dismissed, removed from procedure, forwarded to another authority for investigation, or admitted for further investigation. This follows from Section 19 of the Instructions for the Parliamentary Ombudsman Act (SFS 1986:765). The Parliamentary Ombudsman decides in each case to what extent the reasons for his or her position need to be developed in the decision. Therefore, the Parliamentary Ombudsman has absolute power to decide which cases should be included for review and is not required to justify the decisions made, and the applicant does not have party status in the case.

In May 2007, the Government decided to give the National Board of Health and Welfare the assignment of examining the use of illegal coercive measures in psychiatric compulsory care and to make proposals for action. The examination was to be reported in the autumn of 2008, and aimed at enhancing the legal rights of patients under compulsory treatment (Ministry of Health and Social Security, 2007). Nearly one year later, in April 2008, the Government decided to change the National Board of Health and Welfare's assignment. Rather than examining the use of illegal courses of action, the assignment was changed to focus on education and information to health professionals about the applicable regulatory framework for involuntary treatment and coercive measures. The decision was justified by the fact that taking inventory of unlawful coercive measures was associated with great difficulties and that the Board's personnel resources could be better exploited through education (Ministry of Health and Social Security, 2008). In light of the foregoing, it can be stated that the outcome of this training effort has been highly unsatisfactory. The Agency, whose mandate it is to protect the patients' rights and ensure their safety during treatment, through failure to act, has given its blessing to the compulsory care conducted around the country and contributed to the current patients' vulnerability and tremendous legal uncertainty.

Discussions

Although there are no statistics on how many patients are under compulsory treatment in forensic psychiatric care, mainly because of severe self-destructive behaviour, the

evidence suggests that these patients are often treated at regional forensic psychiatric clinics, particularly in Sundsvall or Växjö, which both consider that they have built up a specialisation for self-harming patients. Of the 14 patients from whom the authors of this paper have collected information, eleven patients had been treated in Sundsvall (one of them has also been treated at the county clinic in Östersund for several years, one has been under the care of the regional clinic in Växjö for a few years, one has been cared for at the county clinic in Huddinge for some months, and another one has been cared for at the regional clinic in Vadstena for a shorter period of time). Another two have been cared for in Växjö and one in Vadstena. Thus, public perception of the care of these patients in forensic psychiatric clinics is based on primarily the care which is offered in Sundsvall and, to some extent, in Växjö. None of the patients whom the authors have contacted have failed to level criticism at the care they received within forensic psychiatry (when asked if they thought that the staff had the skills to handle their problems, twelve replied unequivocally “No”, while two did not answer the question), but a few of them have been able to highlight good elements. Primarily, these good elements have related to the importance of boundaries and structure, relief over avoiding constant “threat of discharge”, and the fact that their self-harming behaviour actually declined over the duration of the treatment at the forensic psychiatric clinic. Among the 9 patients who were discharged at the time the data was collected was discharged, the duration of treatment varied between 5 months and 4 years within forensic psychiatry. The average treatment time for the nine discharged patients was 1 year and 10 months. Another patient who was cited in this document, died in 2007 after a nearly seven-year long stay within forensic psychiatric care.

Since some patients in the regional forensic psychiatric clinic in Sundsvall in April 2009, sounded the alarm about their situation through the media, action was taken at the relevant clinic. A unit intended only for compulsory psychiatric treatment of patients was established, and patients witnessed a tendency to increased caution where coercive measures were used. However, these changes proved not to be persistent and care has once again been described as unlawful. The initial differentiation between patients cared for according to the Compulsory Psychiatric Treatment Act and the Act on Forensic Psychiatric Care do not exist any longer, since many female patients with self-harming behaviour were once again transferred to units intended for care under the Forensic Psychiatric Care Act. After the National Board of Health and Welfare criticised the use of

compulsory gloves, isolation has become increasingly more frequent as a reprisal for self-harming behaviour. Isolation patients are subject to isolation periods of a few hours up to six days, this in a stimulus-free room furnished with a bed with belt straps, a toilet and a metal sink. The only window is tinted to prevent being able to see out, and the patients in isolation have no human contact.

The crimes which were committed, and are still being committed, are against the laws and conventions on human rights and should be regarded as so egregious that they must be investigated, not only by the authorities, who have the duty to monitor healthcare, but also by the judiciary. This is necessary in order to give redress to the affected patients who have been caused, perhaps, lifelong suffering, not only from their underlying illness but as a result of the reception and treatment they experienced at the forensic psychiatric clinics in Sweden, a country that considers itself at the forefront in relation to both psychiatric care and human rights.

SHEDO Society, Lund, 17 May 2009, by

Sofia Åkerman, President
Thérèse Nilsson, Vice President
Linus Broström, PhD

Revised in November 2009, and in March 2010, by

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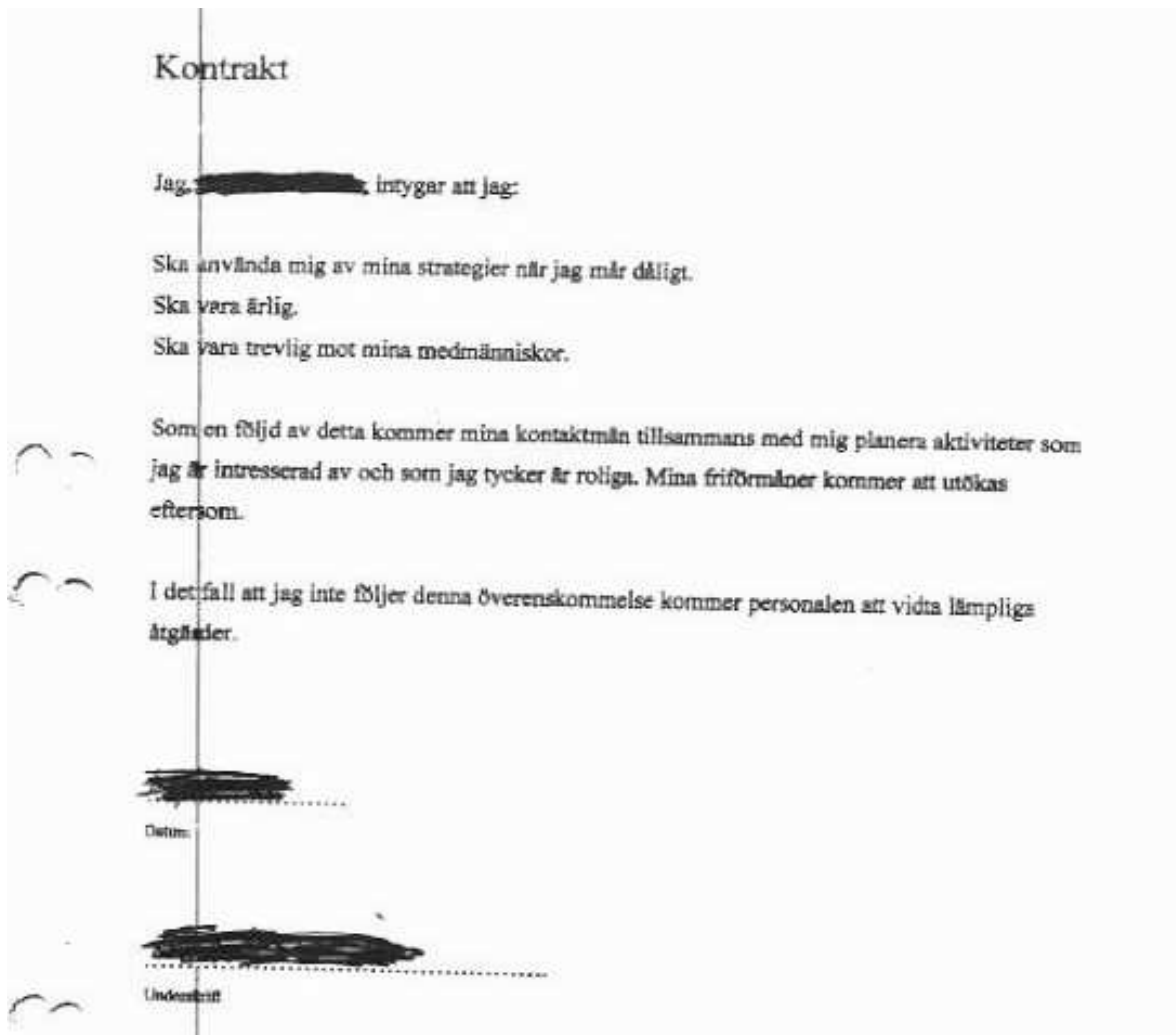
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CONTRACT

I, N.N., certify that I:

Shall use my strategies when I am not feeling well.

Shall be honest.

Shall be nice to my fellow human beings.

As a result of this, my contact person together with me, will plan activities in which I am interested and that I think are fun. My liberty privileges will be increased over time.

In the event that I do not comply with this agreement, the staff will take appropriate action.

Date

Signature

Kontrakt

Härmed intygar jag, [REDACTED], att jag skall upphöra med mitt självdestruktiva beteende. Jag ska inte heller ljuga för personal eller manipulera medpatienter.

Fortsatta självdestruktiva handlingar, lögn eller manipulerande skall direkt leda till handskar i minst tre månader samt indragen utgång med personal.

Jag ska använda mig av de strategier jag arbetat fram tillsammans med mina kontaktpersoner.

[REDACTED]
Datum

[REDACTED] [REDACTED] [REDACTED]
Signatur

CONTRACT

I, N.N., hereby certify that I shall stop my self-harming behaviour. I will not lie to the staff or manipulate fellow patients.

Continuing self-harming acts, lying, or manipulating will directly lead to compulsory gloves for at least three months, and the suspension of periods outside with staff.

I shall use my strategies that I have worked out together with my contact person.

Date

Signature