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Inspection visit to the forensic psychiatric treatment department at the Viljandi Hospital Foundation Psychiatric Clinic

On 22–23 October 2020, advisers to the Chancellor of Justice inspected the forensic psychiatry treatment department at the Viljandi Hospital Foundation Psychiatric Clinic (hereinafter 'the department').

The department currently has considerably more staff than at the time of the Chancellor's previous inspection visit in 2015. There are more activity supervisors who organise work therapy and hobby activities for the patients. Every unit also has more carers on duty round the clock who are responsible for safety. Open communication between staff and patients was noticeable. The department's main building has been renovated; ventilation and the overall appearance of the wards has improved. Some patients have been transferred to the unit in another building, which has reduced overcrowding in the main building. Walking yards with sufficient space and sports and recreational opportunities left a positive impression.

Doctors maintain a thorough electronic treatment journal for each patient, also containing aggregate information about observations from other specialists. The department has well-organised documentation of extraordinary incidents. Also worthy of recognition is the work of nurses and carers in monitoring and documenting the condition of patients under restraint.

Patients in the department praised the helpfulness of the staff and affirmed that they were always able to approach a nurse or a carer with their concerns. Everyday problems are resolved swiftly. Patients praised good cooperation with attending doctors. Patients very much like participating in handicraft groups organised in the hobby house and in sporting activities. They were also satisfied with the food.

Patients must be ensured privacy in wards and during hygiene procedures. A patient must be able to lock the toilet door and video surveillance in patient washrooms and toilets is only allowed in order to prevent a risk associated with a specific patient. Furnishings in the department main building should be made cosier and window covers should be installed in wards.

Patients must be able to communicate with their next of kin without the presence of staff. The hospital should also enable patients longer telephone conversations and meetings with next of kin. Recreational and therapeutic options for patients on the second floor of the department main building should be diversified.

All instances of restraint in the department should be entered in the consolidated register, also recording the starting-time and end-time of applying means of restraint. A doctor's assessment on continuing to apply means of restraint must indicate why the patient continues to be a danger and needs restraint. Chemical restraint must be properly recorded.

It is positive that the medical committee assessing the patients' condition also includes doctors not related to the forensic treatment provider. However, sometimes the committee cannot make a proposal to terminate treatment because no suitable social welfare service exists for a patient. The department must always submit a motion to the court if the medical committee concludes that a patient no longer poses a danger and is able to live in a social welfare institution or that, instead of in-patient treatment, out-patient treatment may be prescribed for the patient. **The Chancellor calls on the Ministry of Social Affairs to make efforts so that in a situation where the criteria for application of forensic psychiatric treatment cease to exist a person is ensured the necessary social welfare service.**

In order to ensure safety, the staff at the forensic treatment department have established a number of rules and restrictions for patients which are not compatible with the applicable law. **The Chancellor understands that some of these restrictions are probably necessary and simply lifting them is not the best solution. The needs and condition of patients receiving forensic psychiatric treatment and the capacities of the hospital must be carefully analysed and subsequently the necessary rules laid down by law. Of course, amending the law or drawing up draft legislation is not within the capacity of Viljandi Hospital. Therefore, the Chancellor asks the Ministry of Social Affairs to pay attention to problems set out in the summary of the inspection visit. The Ministry, in cooperation with Viljandi Hospital, should analyse the situation and find solutions enabling the forensic psychiatric treatment service provider to ensure safety by lawful measures while also protecting patient rights.**

The forensic psychiatric treatment department at the Viljandi Hospital Psychiatric Clinic is the only place for referral of people for forensic treatment under a court order issued under § 86 of the Penal Code. The duration of treatment depends on a patient's recovery and whether the danger posed by them can be reduced (§ 86(3) Penal Code). A person may stay under treatment for years or decades. According to the activity licence, the forensic department has a capacity of 80 beds. During the inspection visit, 86 people were receiving treatment, ten of them women. No juvenile patients were receiving treatment.

Patients are divided between four sub-units of the department. The first floor of the department main building accommodates women as well as male patients in a less serious condition (SR1 unit). The second floor offers treatment for patients in a more serious condition and suffering from more challenging behavioural problems (SR2 unit) The SR2 unit also includes a block – separated from the rest of the unit – with two wards for patients suffering from very severe conditions and those with dangerous behaviour (the so-called isolated security unit). A little farther from the forensic psychiatric department main building is the third unit (SR3) to which patients are referred whose condition has improved and who are preparing to exit treatment. All units have spacious fenced walking areas. Handicrafts and other hobby activities are organised in the hobby house on the clinic premises and in activity rooms in the units.

The department's six psychiatrists are on duty on working days between 8−16. At other times, the on-call psychiatrist from the acute treatment department of the clinic can be called to the department if necessary. The departmental team has three psychologists, including one clinical psychologist and two social workers. Units in each department also employ carers, kitchen staff and cleaners. Recreational activities are organised by activity supervisors on working days both in units and in the hobby house.

The Chancellor's advisers and a healthcare expert (a psychiatrist) examined the rooms at the department, interviewed staff and patients, and examined documents.

1. Living conditions

The forensic psychiatric department main building has recently been renovated; the department's overall appearance and ventilation have improved significantly. The department is no longer as overcrowded as it was in 2015 (see the summary of the 2015 inspection visit). One wing of the clinic's long-term treatment department houses the SR3 unit, which had 20 patients on the day of the inspection visit. Most forensic psychiatric treatment patients were accommodated in single- to triple-occupancy wards. Some wards in the SR3 unit also accommodated four patients. Wards in the main building have the possibility to use the toilet and shower. The SR3 unit toilet and washrooms are in the corridor.

Ward furnishings were very different. In some wards, a patient's personal items could be seen as well as design elements adding cosiness (e.g. textile curtains). Some wards were extremely austere and also lacked certain mandatory furnishing elements (e.g. a table, chairs, bedside spot lighting). According to the hospital rules, only one personal television and radio set may be present in a ward for forensic psychiatric patients. Television can also be watched in the common room.

Many wards had no window covers. In some wards, patients covered windows with sheets of paper. Patients must be able to cover a window with a suitable window cover if they so wish. This protects against bright sunlight and also ensures privacy[1]. If curtains or a blind pose a danger to some patients, different solutions should be found. For example, a roller blind may be placed between window frames, or the like.

Each unit has a fenced walking yard. In the yard, patients can smoke. One hour in the morning and one hour in the afternoon is designated for spending time outdoors. Walking takes place under supervision of carers.

The Chancellor has drawn the attention of the hospital to the fact that, in addition to the overall upkeep of the rooms, the well-being of patients can also be improved through a therapeutic environment. This means that the furnishings of a treatment facility include elements creating cosiness. The importance of a therapeutic environment was also emphasised by the expert involved in the inspection visit, who said that individuality and positive visual stimulation was lacking primarily in the SR2 unit and the isolated security unit.

Patients – especially those in long-term treatment – must be allowed to bring to the ward personal items of emotional value (e.g. family photos, books, mementos). Patients must also be created opportunities for safe storage of their belongings. At the same time, a person should have easy access to those belongings at will. This means that a safe at a nurse's desk or a wardrobe in the

[1] See e.g. the CPT 2015 visit to Serbia (para 156); the CPT 2016 visit to Latvia (para. 109).

hospital basement is not suitable for storage. A good solution would be to provide a lockable cupboard in the ward for each patient. This has also been recommended[2] by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). Every person in a ward should also have sufficient space (cupboard, shelves, etc) for keeping personal belongings and clothes.

Wards for long-term patients might be cosier than other wards. If a person themselves does not know how to make a room cosier, or they do not have any personal mementos to decorate the room, the staff must offer them assistance: for instance, choosing a poster or a painting together with the patient. A patient may be included in a handicraft group where they can themselves design something to decorate the ward. Due to their condition, patients might not understand how the living environment affects them. For this reason, it is the task of the staff to encourage and support patients in creating and maintaining a pleasant environment for themselves.[3]

The Chancellor understands that the behaviour of some forensic psychiatry patients might not enable safely creating a usual cosy atmosphere but alternative flexible solutions for this should be found. For instance, framed paintings can be replaced by murals or patients may be enabled to draw on the wall themselves (e.g. by turning a wall temporarily into a board, or the like). Some furnishings may also be portable (e.g. flowers, bean-bag chairs, and the like)

Patients in the SR2 unit must wear hospital clothes while patients in other units can use personal clothes if they so wish. Some patients do not like that the sign "SR" is written on their personal clothes with a marker. However, unmarked clothes may get mixed up at the laundry.

Overcoats of patients in the SR1 and SR2 unit are kept on clothes racks by the door to the yard. According to patients, jackets and some footwear are in shared use.

The hospital should also allow patients in the SR2 unit to wear personal clothes; outdoor clothes should not be in shared use. Based on international recommendations, the Chancellor has repeatedly said[4] that the rehabilitation process for patients in the psychiatric department can also be supported by allowing them to wear personal clothes and take items of personal value with them to the hospital.

Ward doors in the department main building still have large windows allowing others to see into a ward. The windows of washrooms on both floors of the main building are also uncovered, so that the inside of the bathrooms is also visible from the outside.

Patients in the SR3 unit have three consecutive toilet cubicles at their disposal; one of them is marked as a women's toilet. The toilet cubicles are not lockable, which reduces patient privacy. The CPT has emphasised[5] that female patients may be particularly vulnerable and, inter alia, they should be provided with toilets and washrooms which are protected and ensure privacy[6].

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[2] See para. 34;
[3] See e.g. the CPT 2016 visit to the Netherlands (para. 122); the CPT 2016 visit to Lithuania (para. 97); the CPT 2017 visit to Slovenia (para. 106).
[4] See e.g. the Chancellor's inspection visit of 27 October 2018 to the acute treatment department of Ahtme Hospital Foundation (see page 3 of the summary); the Chancellor's inspection visits of 7 November 2015 and 16 November 2015 to the forensic psychiatric treatment department of the psychiatric clinic of Viljandi Hospital Foundation (see page 10 of the summary); the CPT 2016 visit to Lithuania (para. 97); the CPT 2016 visit to Latvia (para. 110).
[5] See para. 122; see also the CPT 2012 visit to Croatia (para. 95).
[6] See also the Chancellor's inspection visit of 27 October 2018 to the acute treatment department of Ahtme Hospital Foundation (pages 2–3).

The Chancellor reiterates her recommendation given to the hospital in 2015 and asks to ensure the privacy of forensic psychiatric patients in wards and during hygiene procedures. It should also be ensured that restraint (in the observation room) is not visible to other patients. Furnishings in the forensic psychiatric department main building should be made cosier and window covers should be installed in wards.

2. Staff, information exchange, and security

In comparison to 2015, the forensic psychiatric treatment department has considerably more staff. Information exchange concerning patients is well organised. Every morning the departmental staff discuss the most important issues. Nurses keep a handwritten journal recording the most essential information which needs to be passed on to the next shift (nurses and carers). To ensure swifter information exchange, notices are also written on a large board in the staff room. More detailed information about a patient's condition and treatment is recorded in an electronic journal kept by doctors and nurses.

During the inspection visit, an impression remained that direct and open communication between the staff and patients was customary. Patients said that they dared and were able always to approach staff with their concerns; the staff are attentive and conflicts are noticed and swiftly intervened with. The attitude of psychiatrists and their readiness to listen to patients was also praised. Patients trust their attending doctor.

Responsibility for safety at the department mainly rests on carers. According to carers and nurses, the workload is heavy but the team is close-knit, with members helping each other whenever necessary. The situation becomes more complicated when a carer is accompanying a patient outside the unit (e.g. to a doctor's appointment). Dangerous situations have sometimes occurred, including assault by patients. As a rule, people are in forensic psychiatric treatment for a long time and the staff know the patients with more disruptive behaviour. However, assaults may also happen unexpectedly.

According to the staff, they have received diverse training on techniques for safe restraint as well as on behaviour of people with mental disorders. In connection with the spread of the SARS-CoV-2 virus, many planned training events were cancelled but the staff expressed the hope of being able to attend those training courses later. They attached particular importance to training on the behavioural specificities of people with mental disorders since this knowledge helps to remain calm while communicating with such patients.

The staff said that even though rest periods are scheduled during the working day, it is not always possible to use them. Nor do the staff have a separate resting room where they could go for a brief break. Although the unit has staff rooms, these are used by all the staff for eating as well as discussions. Therefore, the atmosphere there is not peaceful enough for having a rest.

The healthcare expert participating in the inspection visit pointed out that construction-related specifics of the forensic psychiatry department main building render ensuring safety rather difficult. Long narrow corridors where a large number of patients congregate are places with potential for conflict. Despite creating an additional SR3 unit, the forensic psychiatric treatment department still has too many patients and their placement in smaller units is almost impossible in view of people's character and problems. Although it is possible to accommodate patients with the

most challenging behaviour in the isolated security unit, thus alleviating security problems in larger units, this does not offer a comprehensive and durable solution.

The Chancellor acknowledges the hospital's efforts in ensuring security in the forensic psychiatric treatment department. It is positive that security is based primarily on open and direct communication between staff and patients and on staff team work. Security problems caused by construction-related features of the building can only be resolved by creating a modern architectural solution corresponding to the needs of forensic psychiatric patients and staff. Staff training must definitely continue and, until such training is precluded by the epidemiological situation, necessary support for new team members must be ensured. The staff must be ensured rest breaks and people must be encouraged to use them. Creating a staff resting area in the units should be considered.

3. Video surveillance

All units in the department have video surveillance. In observation rooms and in the isolated security unit, the toilet and washroom are also under constant video surveillance. In the SR1 and SR2 unit, the so-called medical isolation facility is also under video surveillance, except the toilet and the washroom. The video feed can be viewed at the nurse's desk and recordings are preserved for three months.

Most patients know in which rooms of the department video surveillance is used as well as its extent. Patients said that the staff had not notified them of the application of video surveillance in the toilets of the observations rooms but they had noticed a camera in the corner in the ceiling of the toilet. Some patients said that video surveillance annoyed them.

The Chancellor understands that video surveillance helps the staff to obtain a better overview of what is happening in the department and enables swift intervention if necessary. Yet when ensuring security the patients' right to privacy must also be taken into account and, as a rule, video surveillance in wards, toilets and washrooms should be avoided.

The Chancellor has previously said that use of video surveillance in the toilet of the department seriously interferes with a patient's right to privacy. The Chancellor has also repeatedly[7] drawn the attention of hospitals to the fact that use of video surveillance must proceed from the principles of the European Union General Data Protection Regulation and has emphasised that video surveillance of a person during hygiene procedures must be justified on a case-by-case basis. Placement in an observation room or the isolated security unit cannot automatically involve video surveillance of the toilet, but its need must be assessed based on the condition of the patient placed there.

Constant video surveillance of a toilet might not be necessary because medical staff can enter the toilet in the event of a reasonable suspicion (e.g. a patient stays unusually long in the toilet and does not reply when asked). The need to maintain video surveillance of the washroom and toilet must also be reassessed after a reasonable interval. Such serious interference with a person's privacy must be as brief as possible in view of the patient's condition.

[7] See e.g. the Chancellor's inspection visit of 9 November 2019 to the psychiatric clinic of Pärnu Hospital Foundation (para. 2); the Chancellor's inspection visit of 5 May 2018 to the department of children and young people of the Psychiatric Clinic of Tartu University Hospital Foundation (para. 2).

The expert participating in the inspection noted that use of video surveillance in a toilet is an extremely strong measure and the department should find a technical possibility to blur a patient's private procedures on the monitor. The same has been recommended by the CPT in its reports.[8]

A patient must be notified of the application of video surveillance in their ward and the toilet. It is the duty of the staff to explain to a patient the reasons for video surveillance of the ward and toilet and also record this information in the medical file. Ensuring overall security in the department is not a sufficient reason for video surveillance of a patient's toilet.

The Chancellor asks to ensure that video surveillance of forensic psychiatric patients takes better account of patients' right to privacy. In the event of video surveillance of a patient's toilet, a technical solution should be found to blur the area of a patient's hygiene procedures on the monitor.

4. Communication and meetings with next of kin

Every unit has rooms where patients can meet with visiting next of kin. Due to lack of space, in the SR3 unit the intermediate corridor in front of the unit has been adjusted for meetings with visitors, with tables and chairs brought in for this purpose. Up to 30 minutes is prescribed for a visit. A longer visit is possible only exceptionally. A unit staff member is always present during a visit.

Patients can make phone calls to their next of kin. One call a week is allowed and the precise time is agreed with a patient. Calls can be made either from the phone in the department or from a personal mobile phone. The length of a call is up to five minutes. Next of kin can also call a patient on the departmental phone and in that case the number of calls per week is not limited. Someone from the staff is always present during a call.

Patients said that they would prefer to speak with their loved ones so that no staff is listening in on conversations. They also expressed the wish to have more time for phone conversations because no detailed discussion can take place within five minutes to obtain sufficient information about the life of their next of kin.

According to the staff, they need to be present during phone calls to see how the conversations affect a patient's condition. The staff conceded that they have had to intervene in conversations, for instance, when a patient becomes agitated or their description of what happens in the department does not correspond to the reality according to the employee's judgement. Documents revealed that in some cases a patient receives a phone call but due to their condition they are not called to the phone. Documents did not indicate whether a patient is later informed of the call. Documents also recorded an incident where a patient's anxiety was caused by a prohibition on calling their next of kin outside the time designated for calls.

The Chancellor understands that allowing visitors to forensic psychiatric patients and arranging use of a phone by patients places an additional burden on departmental staff and may sometimes also endanger security, for example if a visitor brings a dangerous item to a patient. At the same time, it is absolutely necessary that people in forensic psychiatric treatment maintain contact with the world outside the hospital.[9]

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[8] See e.g. the CPT 2015 visit to Germany (para. 109); the CPT 2016 visit to the Netherlands (para. 107); the CPT 2018 visit to Norway (para. 55); the CPT 2018 visit to Greece (para. 66).

[9] See also the CPT standards. Involuntary placement in psychiatric establishments. CPT/Inf(98)12-part (para. 54).

Very many patients in the forensic psychiatric treatment department have broken relationships with their family and next of kin even before being committed for treatment. Some patients have never had a family relationship. For this reason, it is even more important to support patients' communication with their next of kin where those relationships do exist and next of kin show interest in how a patient is doing. It is especially important to ensure sufficiently close contact of a patient with their children and spouse or partner. Naturally, the child's best interests must be given primary consideration in organising contact between a patient and children.[10]

Communication with next of kin is encouraged by rooms adjusted for visits. Visits and phone conversations should take place regularly and be of sufficient duration so that patients can spend meaningful time and have meaningful conversations with their next of kin. It is positive that the forensic psychiatric department main building has visiting rooms. However, their furnishings are rather austere and might not be suitable for meetings with a child. Visiting rooms have no toys for smaller children or equipment necessary for shared activities (e.g. a play corner, drawing equipment).[11]

The duration of phone calls allowed for forensic psychiatric patients is too short to enable a meaningful conversation. In the recommendations sent to the prison, the Chancellor has noted that a phone call with a duration of up to ten minutes once a week is not sufficient to maintain social ties and in particular family ties with next of kin. For example, the CPT has given a positive assessment[12] of an arrangement in a Danish hospital where patients could have private telephone conversations in their rooms twice a day with a call duration of up to 20 minutes. Nor had the hospital imposed any limitation on the frequency of visits by next of kin. A visit may last for up to four hours.

When setting the length of visits, it should be taken into account that the psychiatric clinic at Viljandi Hospital is currently the only forensic psychiatric treatment service provider in Estonia. This means that a patient's next of kin may live far from the hospital. So a 30-minute visit may seem too short in comparison to the time spent to reach the hospital. This creates the risk that no one comes to visit a patient, which, in turn, may lead to disruption of family ties.

Patients must be enabled privacy during telephone conversations and during meetings. If hospital staff are present during a conversation between a patient and their next of kin, the patient's right to inviolability of private life is violated (§ 26 Constitution of the Republic of Estonia). Video surveillance is used in the room designated for phone calls and meeting visitors. As a result, the staff of the forensic psychiatric treatment department can monitor what is going on in the room from a distance. In that case, the confidentiality of conversations between a patient and their next of kin is ensured while medical staff maintain an opportunity to intervene if the situation so requires (e.g. the behaviour of the patient or visitor becomes dangerous).

The Chancellor reiterates the recommendation to ensure privacy in communication with next of kin for patients of the forensic psychiatric treatment department. Patients should also be enabled longer telephone conversations and meetings with next of kin. Visiting rooms could be cosier and also adjusted for meetings with children.

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[10] Child Protection Act § 5 clause 3, § 21.

[11] See additionally the Chancellor's inspection visit of 13−15 March 2017 to Tallinn Prison (para. 6.2); K. Žurakovskaja-Aru. Lapse õigus *vs.* võimalus suhelda vangistuses vanemaga – vanglavälisest suhtlemisest ümberpööratuna (The rights of the child vs. an opportunity to remain in contact with a detained parent – a reverse view on communication outside prison). *Juridica*, 2015.

[12] See para. 167.

5. Treatment and therapy options and recreational activities

Based on documents, it may be concluded that patients' health is monitored and documented thoroughly and several specialists deal with patients, including activity supervisors who organise activity therapy and other activities. Patients said that if they need to they could talk to their attending doctor about their grievances and progress of treatment, and a nurse is also always present in the department to resolve urgent issues (e.g. in case of pain or mood swings).

According to the expert participating in the visit, forensic psychiatric patients were offered opportunities for modern psychiatric treatment (both pharmacotherapy as well as different psychological and psychosocial interventions). According to the expert's assessment, the use of medicines corresponded to patients' condition.

However, opportunities for patients in the SR2 unit and in the isolated security unit to participate in activity therapy are insufficient and should be expanded. The expert conceded that organisation of activity therapy is currently impeded, among other things, by lack of suitable rooms.

The CPT has repeatedly underlined that therapy is an essential part of psychiatric treatment.[13] The European Court of Human Rights has noted that even though every patient's situation is unique, as a rule the relevant treatment must include quick alleviation of symptoms as well as a comprehensive therapeutic strategy to prevent deterioration of a patient's health.[14]

The SR1 and SR2 units of the forensic psychiatric treatment department have activity rooms where an activity supervisor organises recreational activities for patients. In the activity room it is possible to play board games, use a computer (without an internet connection), draw, and the like. Group activities also take place there: thematic conversation groups, film viewing and dance events. Activity rooms are open for use by patients on working days (09.15–15.45) and when an activity supervisor is present.

On the days of the inspection visit, the activity supervisor at the SR2 unit had fallen ill. No replacement could be found, so that it was not possible to use the activity room. Many patients in the SR2 unit spent time by walking in the corridor of the unit, some patients were lying in bed in their ward and a few were watching television. Activities for patients are organised by an activity supervisor and in the event of the supervisor's absence activities are simply cancelled. According to staff, carers and nurses have no possibility to supervise patients' hobby and recreational activities.

The Chancellor has recommended that, in order to expand people's options for recreational activities, during the daytime patients could be allowed to go to the activity room at the acute treatment department of the psychiatric hospital. For patients in the SR2 unit of the forensic psychiatric treatment department, the activity room is also the only place to spend time meaningfully. For this reason, it should also be possible to use the room when an activity

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[13] See e.g. the CPT 2007 visit to Estonia (paras 105–108); the CPT 2014 visit to Georgia (paras 143–149); the CPT 2015 visit to Sweden (para. 112).

[14] See also an overview of ECtHR case-law emphasising the necessity of access to appropriate therapies: Maria Sults, Käti Mägi. Süüteo toime pannud vaimse häirega inimese kinnipidamiseks sobivad asutused: olukord Eestis ja põgus ülevaade mõningatest Euroopa Inimõiguste Kohtu lahenditest (Appropriate Authorities for Detaining a Person with a Mental Disorder Who Has Committed an Offence: Situation in Estonia and a Brief Overview of Some Decisions of the European Court of Human Rights). *Juridica* 2020/1.

supervisor falls ill or is on holiday. Patients could also be in the activity room under supervision of carers or nurses. Opening the activity room for patients at weekends could also be considered.

Patients in the SR1 and SR3 units go to the hobby house at the psychiatric clinic in smaller groups according to schedule; the hobby house is generally open on working days (10.00–16.30). In the hobby house, it is possible to engage in handicraft, there is a sewing machine and a wood workshop. In the room it is possible to prepare food and canned food and practise other skills needed for independent life (cleaning, dishwashing). The hobby house also has a small exercise room where group training takes place twice a week. Patients may also use the room for individual training. Once a week an Estonian language class takes place in the hobby house.

Patients said that the activities organised in the hobby house have become an important part of their life and they long for re-establishment of the pre-restrictions schedule to be able to go to the hobby house every working day. Although the unit also has an activity room, the opportunities offered by the hobby house are more varied. In the units, patients usually spend time by reading newspapers and books, watching television, listening to the radio, walking, and lying in bed in their ward.

According to the staff, allowing patients from the SR2 unit to the hobby house would be complicated since many items and tools are used in activities there which may be a danger to a patient from the SR2 unit. Many patients in the SR2 unit also need individual supervision, whereas activities in the hobby house take place under the guidance of an activity supervisor and usually in a group.

According to the staff, patients staying in the isolated security unit adjacent to the SR2 unit can participate in group activities organised once a week in the activity room. At other times, patients in the isolated security unit are offered individual activities. During the inspection visit, there was one patient in the security unit (the unit has two single-occupancy wards) who had not participated in therapy for a long time. According to the staff, the patient refuses to participate in the activities offered and a pastoral counsellor for individual conversations is being sought for them.

The CPT has stressed[15] that patients whose long-term segregation from others is justified must be ensured therapy, meaningful recreation and human contact. Mere daily hygiene and eating cannot be considered therapeutic activities. If a patient refuses treatment and therapeutic activities the reason for refusal must be identified.

According to the expert participating in the inspection visit, the patient placed in the isolated security unit of the forensic psychiatric treatment department is ensured modern pharmacological treatment and psychiatric consultations but the patient is seldom included in joint activities and their therapeutic options are very limited, which may slow down their rehabilitation.

The work of the medical team and activity supervisors at the forensic psychiatric treatment department with patients deserves recognition. The Chancellor asks to find opportunities to diversify therapeutic and recreational options for patients in the SR2 unit and the isolated security unit. During the daytime, patients should be able to spend time in the unit activity room. Supplementing the types of therapeutic options should be considered, for instance music and art therapy could also be offered.

[15] See paras 150−168.

6. Applying and documenting means of restraint

The SR1 and SR2 units have two observation rooms used both for seclusion and for mechanical restraint. What takes place in the observation room can be viewed directly through the glass from the nurse's desk. In addition, there is a separate ward, the so-called medical isolation facility, for isolating from others patients with symptoms of infection. According to the staff, the door to this ward is locked only when a secluded patient within the meaning of the Mental Health Act is staying there. If necessary, means of restraint can also be applied in the isolated security unit. The SR3 unit also has one observation room.

During the inspection visit, one patient in the SR2 unit had been placed in the seclusion room (§ 14(2) clause 4 Mental Health Act). In the other seclusion room in the SR2 unit there was a patient in respect of whom the so-called regime No 5 established under the hospital rules had been applied. There were no mechanically restrained patients in the department.

The guidelines for applying means of restraint in the psychiatric clinic emphasise that staff applying means of restraint must have completed the required training. The guidelines also deal with the hygiene and provision of meals for a restrained patient. This is positive.

The psychiatric clinic at Viljandi Hospital has a central electronic register on application of means of restraint. This provides a good overview of restraint applied in the forensic psychiatric treatment department. However, it does not reflect the starting-time and end-time of every instance of application of means of restraint. In some cases, the duration of restraint has been noted in the field for explanations but it is impossible to get a general overview of the duration of restraint.

The CPT has emphasised that combining instances of application of means of restraint in a single register provides hospital management with an oversight of the extent of their occurrence and enables measures to be taken, where appropriate, to reduce their incidence. The entries in the register should include the time at which the measure began and ended, the circumstances of the case, the reasons for resorting to the measure, the name of the doctor who ordered or approved it, and an account of any injuries sustained by patients or staff. Patients should be entitled to attach comments to the register, and should be informed of this entitlement.

Patient-related documentation concerning application of means of restraint is included in a patient's electronic medical file. It is difficult to find the necessary information in the documentation. If continued restraint of the same patient is documented in different forms, the hospital's information system does not enable a quick overview of the circumstances related to restraint. The staff at the department admitted that it is not easy to find the necessary information in the documents concerning a completed instance of restraint.

The hospital offers training for staff on safe application of means of restraint. According to the staff, a carer is always present with a mechanically restrained patient and a nurse checks and documents the patient's condition.

Risk incident reports showed that sometimes medication needed to be administered to a patient to calm them down but the patient themselves refused to take the medication. Administration of medication by use of force was not interpreted as chemical restraint. Nor were some of the episodes of application of means of restraint described in risk incident reports reflected in the consolidated register of restraint.[16]

[16] E.g. the risk incident taking place on 22 February 2020 at17.20.

Based on international recommendations, the Chancellor has drawn the attention of hospitals to the fact that administration of medication prescribed by a doctor 'in case of necessity' to alleviate a patient's symptoms of agitation in a situation where the patient themselves refuses to take the medication must be treated as chemical restraint and documented accordingly.

Documents allow the conclusion that nurses at the forensic psychiatric treatment department have described the condition of a restrained patient with required frequency and the entries made by nurses are detailed: they deal with a patient's condition, hygiene procedures as well as medication administered. However, a psychiatrist's reasoning justifying the need for continuing restraint is scant and often it is not clear from the reasoning how exactly the patient continued to pose a danger.

The Chancellor emphasises once again that a psychiatrist's assessment of the need for applying means of restraint constitutes a basis for serious interference with a patient's rights. Therefore, it is necessary that the doctor's assessment should be documented with sufficient precision as only then does it enable the justification for restraint to be retrospectively assessed if necessary.

The Chancellor asks that it should be observed that all instances of restraint in the forensic psychiatric treatment department are also recorded in the consolidated register. The register on application of means of restraint in the psychiatric clinic should also reflect the starting-time and end-time of application of restraint. The doctor's assessment of continuing application of means of restraint must reflect the justification as to why restraining the patient needs to continue and how exactly the patient poses a danger. Chemical restraint must be properly recorded.

7. Medical committees

It is good to note that the department has taken into account the recommendations by the Chancellor in the summary of the 2015 inspection visit concerning the activities of the medical committee periodically assessing the condition of forensic psychiatric patients. The medical committees are more independent since they also include psychiatrists not working in the forensic psychiatric treatment department. According to the expert participating in the inspection visit, the working arrangements of the committees and assessments about the need for continuation of forensic psychiatric treatment are comprehensive and rely on recognised psychiatric assessment models. Members of the committee meet with a patient personally. They also request information from specialists dealing with a patient daily (nurses, carers, activity supervisors).

Some decisions of the medical committee indicated that, according to doctors' assessment, forensic psychiatric treatment could have been discontinued or replaced with out-patient forensic psychiatric treatment if the person had been guaranteed a place in a social welfare institution corresponding to their needs. The condition of some patients had been assessed by the Social Insurance Board and they were in a queue for the 24-hour social welfare service. According to staff explanations, the hospital does not wish to release a forensic psychiatric patient before it is clear that appropriate support for them is guaranteed in the social system. Many patients need assistance and guidance even after leaving treatment so as to be able to maintain the improved health condition achieved as a result of teamwork by the forensic psychiatric treatment department.

According to the Minister of Social Protection regulation, people referred to the special care service from forensic psychiatric treatment are given priority in the queue for the service. It seems that despite their priority status, people have to wait for a long time for the appropriate service because care homes offering the special care service do not have sufficient vacancies.

Forensic psychiatric treatment restricts a person's freedom of movement and constitutes an extremely serious interference with fundamental rights. For this reason, forensic psychiatric treatment can last only until a person's recovery or until the danger posed by them ceases to exist (§ 86(3) Penal Code). A healthcare provider must submit a motion to the court for termination of forensic psychiatric treatment if, according to the medical committee's assessment, a patient has recovered or the danger posed by them has decreased to the extent that they can live in a social welfare institution.

The Chancellor understands the hospital's concern and sense of responsibility for its patients. Resolving the problems of the social welfare system is not within the competence of a forensic psychiatric treatment provider. However, it is not acceptable that the shortcomings of the social welfare system are given as justification for a person's unfounded detention.

The Committee of Ministers of the Council of Europe has said in its recommendation[17] that involuntary treatment in a hospital may continue only as long as is unavoidably necessary and the state must make available appropriate aftercare services.

The CPT has considered it deplorable that a person must stay in involuntary treatment in a psychiatric hospital only because the state has no appropriate support for the person outside the hospital environment. In recommendations sent to states, the CPT has asked that such a situation be avoided.[18]

If the medical committee concludes that a person no longer needs forensic psychiatric treatment, this essentially means that the patient has recovered or/and their behaviour no longer poses a danger. At the same time, the person may still need continued support in everyday activities and in complying with the treatment scheme which may require their referral to a social welfare institution or/and application of out-patient forensic psychiatric treatment instead of in-patient treatment.

The Chancellor asks the forensic psychiatric treatment department to always submit a motion to the court if the medical committee concludes that a patient would be able to live in a social welfare institution or may be transferred from in-patient to out-patient treatment.

8. Restrictions imposed to ensure security in the forensic psychiatric treatment department

Every person referred for forensic psychiatric treatment poses a danger to themselves and society due to their mental condition. This means that patients in the forensic psychiatric treatment department are presumed to be persons exhibiting risky behaviour and suffering from serious psychiatric disorders. Naturally, accommodating and treating such patients and arranging their communication, etc., is more complicated than organising accommodation and treatment for other patients. The staff of the forensic psychiatric treatment department must ensure safety in the department every day. At the same time, legal possibilities for ensuring safety in a forensic psychiatric treatment department are not much different from the possibilities available to other hospitals, which may be problematic.

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[17] Council of Europe. Committee of Ministers. Recommendation No REC(2004)10 concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory Memorandum, Art. 24.
[18] See e.g. the CPT 2012 visit to Portugal (para. 122); the CPT 2016 visit to Italy (para. 123); the CPT 2017 visit to Albania (para. 49).

To ensure safety, a psychiatric hospital may apply means of restraint on a person behaving dangerously. With a view to ensuring safety, the law also lays down a list of substances and items whose possession is prohibited while receiving in-patient psychiatric treatment. The hospital staff are allowed, in the event of a reasonable suspicion, to examine a person's belongings and seize any prohibited items.

Under the forensic psychiatric treatment regulation, a healthcare provider must take physical and organisational safety measures to reduce the risk of commission of dangerous acts and prevent arbitrary departure of a patient from the department or ward block.

The Chancellor emphasises that under § 11 of the Constitution of the Republic of Estonia restrictions on fundamental rights must arise from a law. In a regulation, on the basis and within the limits of delegated powers clearly conferred by a law, the requirements of a law may be further refined but serious restrictions on fundamental rights may only be laid down by a law. For example, the preconditions and the procedure for applying means of restraint is laid down by a law while the frequency of monitoring the condition of a patient subjected to restraint is regulated by a ministerial regulation. On this basis, the forensic psychiatric treatment regulation alone does not entitle a forensic psychiatric treatment service provider to restrict patients' fundamental rights (e.g. the right to property) more extensively than laid down by the Mental Health Act.

At a hospital accommodating people with dangerous behaviour or where other security risks occur, it is necessary to temporarily restrict the fundamental rights of people staying in the institution. It must be clear to a person whose rights are restricted under what legal grounds that decision was made and how it can be challenged.

The Chancellor understands how complicated it is in a forensic psychiatric treatment department to cope with and prevent patients' aggressive, self-harming or other dangerous behaviour. However, in a state governed by rule of law, measures for ensuring security and restricting the rights of people in treatment, as well as the preconditions for their application, must arise from a law. This is not a mere formal requirement: difficult ethical issues related to dealing with people in forensic psychiatric treatment must be debated and clarified by the Riigikogu as the people's representative body. A hospital may not be placed in a situation where the only choice is between different violations of the law.

In the context of welfare institutions, the CPT has said[19] that in establishing restrictions any limitations automatically applicable to everyone in the institution should be avoided as much as possible. The primary consideration should proceed from risks related to a specific person.

Locking doors of wards for the night

In the SR1 and SR2 units and in the isolated security unit, the doors of patient wards are locked for the night so that the patients themselves cannot exit the wards. According to the staff, ward doors are kept locked from the beginning of 'lights out' until the morning (22.00–07.30) and some patients themselves ask that the door of their ward be locked even earlier because they are concerned about their safety. Wards have staff call buttons but there is no button by every patient's bed. Patients have different opinions about locking the wards. Some feel safer thanks to this while others dislike this kind of arrangement.

[19] See para. 158 et seq.

The Chancellor's advisers also visited the forensic psychiatric treatment department in the evening and were convinced that all the wards at the department were already locked at 21.30. **The wards of the** forensic psychiatric **treatment department were also locked for the night in 2015 and the Chancellor then pointed out that this was not compatible with the law.** The legislation regulating forensic psychiatric treatment has not been amended in the meanwhile, so the Chancellor's position remains the same.[20]

Long-term isolation of a dangerous patient

The psychiatric clinic at Viljandi Hospital applies five treatment regimes. Creation of the fifth regime arose from the necessity for the forensic psychiatric treatment department to ensure the security of staff and patients during the treatment of a patient exhibiting permanently dangerous behaviour. During the inspection visit, the fifth regime was applied in respect of two patients, one of whom was in the isolated security unit and the other in an observation ward.

The fifth regime essentially means a patient's transfer to the isolated ward block or to an observation ward which they exit only while accompanied by several staff members. A patient subject to the fifth regime does not have contact with other patients. Additionally, the person may be subject to other restrictions decided by the treatment team. For example, a patient is under constant video surveillance (including in the toilet), they are searched after walks and visits, their ward may be searched without the patient's presence, a patient must wear hospital clothes, restrictions are imposed on a patient's visits, etc.

The Mental Health Act enables restricting the freedom of a patient in a certain situation, i.e. in the event of applying involuntary treatment or prescribing in-patient forensic psychiatric treatment, the person must stay in hospital. If certain preconditions are met, it is possible to apply means of restraint listed in the law to a patient. To apply these restrictions, the law lays down a specific procedure and imposes the duty to assess continuation of use of a measure with a certain frequency. These measures safeguard a patient from arbitrary restrictions.

The law does not lay down the restrictions involved in applying the fifth treatment regime in the forensic psychiatric treatment department. This means that applying such measures is not lawful.

Section 2 clause 4 of the forensic psychiatric treatment regulation can be interpreted so that, in finding a suitable unit for a patient, a treatment institution may proceed from the severity of the patient's illness and the danger posed by their behaviour. This is also done in the forensic psychiatric treatment department; for instance, patients are transferred from one unit to another. Under the current regulatory framework, a patient's complete isolation is only possible when applying a means of restraint laid down by law, i.e. placement of a patient in a seclusion room or under mechanical restraint.

In an exceptional situation, it may prove to be unavoidable that a patient behaving dangerously must be separated from others for a longer period than in the case of placement in a seclusion room from a few minutes to several hours. The expert participating in the inspection visit noted that the hospital's actions in coping with a challenging patient are understandable even though they might

[20] About the issue of locking wards of psychiatric patients, see also: the CPT 2015 visit to Germany (para. 129); the CPT 2016 visit to the United Kingdom (para. 139).

not be compatible with the law. CPT reports[21] refer to practice in some countries where psychiatric hospitals are allowed to segregate a patient from others for a longer period if certain preconditions are met. The CPT has not ruled out application of this measure but has pointed out that the reasons for isolating a patient must be clear and the necessity for extending the measure must be assessed periodically. The hospital staff must also make efforts aimed at being able to bring the patient back to the ordinary department as soon as possible.[22]

Imposing restrictions on communication in the forensic psychiatric treatment department

The internal rules of the department allow only close relatives and guardians to visit patients and communicate with them by telephone. Next of kin are understood as including parents, grandparents, brothers, sisters, children, and spouse. Information boards in the units display the telephone numbers of several state agencies, as well as information that meetings with a lawyer are possible.

Documents revealed that the letters of at least one patient addressed to private individuals were not sent by the hospital but were instead forwarded to the patient's guardian. The justification given was that, according to the hospital's assessment, the message in the letters may incite commission of dangerous acts.

Patients said that some of them considered restrictions on communication imposed by the hospital as unfair. Some patients mentioned that they would like to communicate with people from a social welfare institution where they previously lived and where they hope to return in the future. Some wanted to call their acquaintances.

According to the staff, restrictions on contact are necessary to ensure security in the department and protect others from disturbing behaviour by patients. For instance, forensic psychiatric patients have made bomb threats by phone. Some next of kin have asked that the hospital not allow a patient to call them. Contact with friends involves the risk that an agreement is reached to assault the staff.

Naturally, the hospital is entitled to impose a reasonable time and place for visits and phone calls in its internal rules. Visitors can also be required to comply with rules of behaviour ensuring security (e.g. not to come to the department while intoxicated and not to bring prohibited items). However, a forensic psychiatric treatment service provider is not entitled to restrict the range of people with whom a patient wishes to communicate because this interferes with the patient's right to inviolability of private life (§ 26 Constitution). A patient themselves is entitled to refuse to meet a visitor or accept a phone call.

Paragraph 3.1. of the explanatory memorandum to the Act on amending the Mental Health Act (86SE) does mention an example of a possibility to impose a restriction on a patient's contacts under § 9^1(2) of the Mental Health Act but this example is misleading since § 9^1 of the Act does not deal with imposing restrictions on contact but only provides a basis for restricting the fundamental right to property. This means that the law does not enable restricting a patient's range of contacts.

[21] See e.g. the CPT 2011 visit to Norway (para. 93); the CPT 2014 visit to Finland (para. 105); the CPT 2016 visit to the United Kingdom (paras 150−168); the CPT 2019 visit to Denmark (paras 174−178).

[22] Periodic assessment of the condition of a patient subjected to the fifth regime is carried out in the forensic psychiatric treatment department and an independent external expert is involved. However, since the relevant treatment regime is not lawful in essence, the summary will not analyse the arrangements for periodic assessment in more detail.

The Riigikogu has not enabled a forensic psychiatric treatment service provider to restrict patients' contacts while relying on the hospital's own risk assessment or security risks. **Thus, restrictions on contact imposed by the hospital and disrupting patients' correspondence contravene the law.**

Even when a guardian has been appointed for a person, this does not mean that the guardian is authorised to decide with whom and how a ward may communicate, i.e. impose restrictions on the ward's contacts. The guardian's duties are set out in the court order on guardianship[23] and, as a rule, these duties include representing a person in transactions and organising health and social services necessary for the ward (§§ 206, 207 Family Law Act).

If a patient's phone calls or letters are disturbing for the addressee, that person may seek a restraining order against that forensic psychiatric patient which may also include a prohibition on phone calls.

If hospital staff suspect that a patient may use contact with next of kin and friends to plan offences with their help then the police should be notified so they can initiate proceedings and monitor calls and correspondence if necessary.

Lists of prohibited items

According to the procedure established by the Viljandi Hospital psychiatric clinic, patients receiving in-patient treatment may not possess dangerous items or substances, which have also been listed in § 9^1(1) of the Mental Health Act. On top of this, the forensic psychiatric treatment department has established a list of items which the hospital believes are dangerous for forensic psychiatric patients to possess, and next of kin are also not allowed to send these to patients in parcels or hand over during meetings. For example, patients are prohibited to possess a pencil, sharpener, or powdered tea. It is prohibited to send or bring to patients several liquids (juices, and the like), home-made food, bread rolls, etc. The list is based on § 9^1(2) of the Mental Health Act which allows prohibiting a person under in-patient psychiatric treatment to possess substances or objects which due to the patient's state of health pose a risk to the patient's own life or health or to the life or health of others or considerably endanger the inviolability of private life of persons under treatment.

The Chancellor has drawn the attention of the forensic psychiatric treatment department to the fact that restrictions on possessing items imposed under § 9^1(2) of the Mental Health Act must be based on assessment of the state of health of a specific patient. The explanatory memorandum to the Act on amending the Mental Health Act (86SE) states that § 9^1(1) of the Mental Health Act lays down a list of substances and items which are definitely prohibited while in the case of imposing restrictions mentioned in § 9^1(2) of the Act a healthcare provider must proceed from a specific patient on whom the restriction is set[24].

According to explanations by staff, restrictions are necessary to prevent substances and items with which patients may harm themselves or which otherwise endanger security in the department from reaching the department. For example, alcohol is added to juice brought by next of kin or cash is hidden in home-cooked food. The staff conceded that this is done only by a few visitors whose

[23] See also the Supreme Court Civil Chamber order of 19 April 2017 No3-2-1-32-17 (para. 14); Supreme Court Civil Chamber judgment of 17 December 2020 No 2-17-1453.
[24] See also the Supreme Court Special Panel order of 18 November 2013 No 3-2-4-1-13, para. 8.

risk behaviour is known to the staff. As a rule, patients' next of kin have not tried to bring something dangerous to the department. There are many patients in the units and they stay in treatment for a long time. Therefore, the risk exists that patients with prison experience influence others and demand that their next of kin bring prohibited items to the department. For this reason, the staff believe that different treatment may lead to conflicts since due to their health condition many patients find it difficult to understand why exactly they have been targeted by restrictions. Although patients' risk behaviour varies, it is safer if rules on prohibited substances and items apply uniformly to all patients.

The Chancellor concedes that the duty of a healthcare provider set out in § 9^1(2) of the Mental Health Act to assess additional restrictions on the right to property individually with regard to each patient might not be appropriate in the context of provision of forensic psychiatric treatment. As a rule, patients are in a psychiatric hospital voluntarily and their behaviour does not pose a danger, so that additional restrictions on possession of items are rather an exception, agreed with a patient and imposed for a short period. People referred to forensic psychiatric treatment are those who pose a danger due to their behaviour and mental condition. With that in mind, in the case of forensic psychiatric patients, an overall ban on use of certain items in addition to the substances and items listed in § 9^1(1) of the Mental Health Act would probably be justified but the current law requires an individual risk assessment and individualised reasoning with regard to each patient in order to impose the relevant restrictions. This means that the list of prohibited items drawn up by the forensic psychiatric treatment department and which applies to all patients regardless of their health condition and individual risk assessment contravenes the law.

The Chancellor understands the department's concerns about security but the law does not distinguish forensic psychiatric patients from others in terms of restricting psychiatric patients' right to property. **Thus, according to the law, establishing additional restrictions on possession of property must proceed from the individual health condition of each psychiatric patient and a corresponding risk assessment.**

Sanctions applied in the forensic psychiatric treatment department

According to the department's internal rules, in the event of intentional violation of internal rules restrictions may be imposed on a patient, such as a ban on possession of a personal radio or television set, a ban on possession of tea, coffee, smoking, receipt of goods, visits, phone calls.

According to the staff, sometimes it is necessary to influence a patient's behaviour with a restriction because otherwise they would not comply with the rules. At the same time, the staff conceded that in the case of many patients the additional restrictions did not have the desired effect because, due to their health condition, they are unable to control their behaviour. The most frequently used sanction is reduction of the daily cigarette allowance or removal of a television set from the ward for a certain period. Both nurses and carers may decide on application of a sanction.

Patients said that additional sanctions had been imposed on some of them or they had been threatened with imposition of additional sanctions. There have been instances where a patient was committed to a seclusion room and, additionally, their daily cigarette allowance was reduced. Patients have heard how a patient violating the rules is told that if the violation continues they would be deprived of the possibility to smoke. However, the patients did not mention restrictions on phone calls or visits.

The Mental Health Act does not allow applying restrictions or penalties against patients who violate hospital rules. **Forensic psychiatric treatment providers have no legal basis to apply disciplinary measures against patients.**

If a patient's behaviour becomes dangerous due to their health condition, it is possible to apply means of restraint (§ 14 Mental Health Act). The CPT has emphasised that applying means of restraint for the purpose of punishment is prohibited.[25] The CPT is of the opinion that punishing psychiatric patients for violating hospital rules is questionable since the patient's behaviour depends on their health condition and problems should be resolved through therapeutic intervention, not punishment. The CPT has recommended states to abandon applying disciplinary sanctions to psychiatric patients.[26]

The Chancellor has also drawn attention to the fact that imposing contact restrictions on a person with a mental disorder receiving treatment or a social welfare service for violating the institution's rules is not lawful. Nor is it allowed to threaten patients with potential restrictions.[27]

I expect feedback from Viljandi Hospital to the recommendations by 1 October 2021 at the latest if possible.

Ülle Madise

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[25] CPT standards. Means of restraint in psychiatric establishments for adults. CPT/Inf(2017)6, (para. 1.6); see e.g. the CPT 2017 visit to Slovenia (para. 120).
[26] See e.g. the CPT 2016 visit to Germany (para. 126); the CPT 2016 visit to the Netherlands (para. 113); the CPT 2017 visit to Poland (para. 136); the CPT 2019 visit to Portugal (para. 114).
[27] See the Chancellor's inspection visit of 5 May 2018 to the department of children and young people of the Psychiatric Clinic of Tartu University Hospital Foundation (page 6); the Chancellor's inspection visit of 17 January 2019 to Valkla Home of AS Hoolekandeteenused (page 5).