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LOCKED UP

– BUT NOT WITHOUT RIGHTS

A HANDBOOK ON HUMAN RIGHTS
IN SWEDISH COMPULSORY CARE

Published by Civil Rights Defenders and the National Association for Social and Mental Health (RSMH).

Civil Rights Defenders is an international human rights organisation that is politically and religiously independent. We defend people's civil and political rights and empower human rights defenders at risk.

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The National Association for Social and Mental Health (RSMH) is a membership organisation working to protect the rights of people with experience of mental illness through advocacy, peer support, and knowledge dissemination.

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FOREWORD

Together, the National Association for Social and Mental Health (RSMH) and Civil Rights Defenders are publishing this handbook in order to call attention to and strengthen the human rights of individuals who have been deprived of their liberty. The handbook focuses in particular on the context of compulsory psychiatric care.

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We want those who are or have been affected by compulsory care to know their rights. Knowing one's options can help reduce feelings of powerlessness. And no matter on what grounds you have been deprived of your liberty, you have certain inviolable rights. These include the right to have the grounds for detention reviewed by a court, the right to legal representation, the right to a good standard of care, and the possibility of being released when there are no longer valid grounds for detention.

Many feel that there is a lack of information about their rights in inpatient care. This is a serious issue, as it may negatively affect patients' well-being.

"Locked up – but Not Without Rights" is the result of a collaboration between RSMH and Civil Rights Defenders. In 2015–2018, we gathered knowledge and experiences from people who have been deprived of their liberty. We have investigated access to human rights, advocated for the improvement of the human rights situation in these institutions, and will continue to monitor what goes on behind locked doors in Swedish inpatient care.

In Sweden, you can be deprived of your liberty for various reasons and within a number of institutions. Among others, these include: Swedish Migration Agency detention centres, the prison and probation service, forensic psychiatric care, involuntary commitment of certain individuals with substance abuse problems, care of young persons, and compulsory psychiatric care.

If you find yourself in a closed institution, you are not alone. Every year, around 12,000 people receive care under the Compulsory Psychiatric Care Act (LPT). Around 1,600 people receive care under the Forensic Psychiatric Care Act (LRV). A majority of the roughly 1,000 people living in homes for young persons under the National Board of Institutional Care are being detained in accordance with the Care of Young Persons (Special Provisions) Act (LVU).

With the help of this handbook, we hope to spread knowledge, spark conversation, and effect change to ensure that the rights of persons in Swedish inpatient care are respected, and that the outside world is alerted when this is not the case. If you know your rights, you have a better chance of taking action in case something goes wrong.

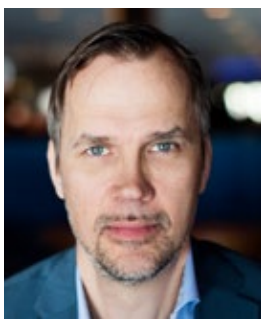

PHOTO: DAVID LAGERLÖF

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Sources: The above data concerning committed and detained persons was retrieved from the respective websites of the National Board of Health and Welfare and the National Board of Institutional Care in September 2018.

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PHOTO: KYLE GLENN/UNSPLASH

1 HUMAN RIGHTS

In this chapter, we review the human rights framework, international agreements, conventions, and the Swedish judicial system. The focus is on laws and regulations applicable in the context of compulsory care.

1.1 LOOKING BACK – A BRIEF HISTORY OF HUMAN RIGHTS

Laws regulating the detention of individuals on the grounds of mental illness have been around since as early as the 13th century. Since then, a lot has happened. In Sweden, compulsory care is now regulated through an interplay of Swedish and international legislation. The Swedish legislator does not alone get to decide about the content and interpretation of Swedish law. Sweden must also adapt to decisions and regulations from the EU, the Council of Europe, and the UN.

At the end of the Second World War, there was a strong desire to prevent the atrocities that had taken place from ever happening again. On 10 December 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights. The declaration outlines and defines our fundamental rights as human beings. It expresses a common will on the part of UN member states to work for the recognition of human rights, justice, and equality across the world. The declaration states that all human beings are entitled to these rights, without distinction of any kind. It is an issue of human dignity and how it can be protected.

1.2 CONVENTIONS

The main tool that the UN has for protecting human rights is international conventions. These are documents clarifying the meaning of our various rights. Conventions become legally binding on the states that choose to ratify them – that is, to sign and undertake to abide by them. National legislation must then be brought into alignment with the convention's requirements. The same applies to the application and interpretation of the law.

Over time, the UN has adopted a large number of conventions. Each clarifies our human rights within a specific area. Looking at the conventions adopted by the UN from the moment of its founding up until today, it becomes clear that the organisation has evolved significantly – from primarily dealing with the ramifications of war to working with issues of a different nature. These include the rights of, among others, children, women, and people with disabilities.

At the back of this handbook you will find a list of the conventions and other documents ratified by Sweden that contain provisions relevant to compulsory care. Any one situation may be governed by rights outlined in several different conventions.

A complete list of the conventions Sweden has ratified can be found on www.manskligarattigheter.se.

1.3 THE STATUS OF HUMAN RIGHTS IN SWEDEN

Contrary to what many believe, however, it is not possible to appeal to a convention in the same way as to Swedish law. This may seem strange. Indeed, human rights as they have been set down in declarations and conventions should be even be more important than the letter of Swedish law. They are, of course, but not in concrete situations.

In Sweden, we have a legal system referred to as dualist that is governed by a hierarchy of norms. This means that different laws have different weight. It also means that any convention Sweden ratifies must be entered into Swedish law in order to be of effect for the individual.

In order to understand the function of the UN and our human rights as well as the significance of conventions, we also need to explain the Swedish legal system.

1.4 THE SWEDISH LEGAL SYSTEM

The fundamental laws that comprise the Swedish Constitution trump all other Swedish legislation. The constitutional laws regulate the way the country is governed as well as many of our fundamental rights. For this reason, they are difficult to amend: before these laws can be changed, the Swedish Riksdag must decide on any amendment twice, and the decisions must be separated in time by a general election.

Other laws may not contain provisions in contradiction with the fundamental laws of the constitution.

Second in importance to the laws of the constitution are regular laws. These may have different structures and contain rights as well as obligations.

One law that outlines certain rights is the Act Concerning Support and Service for Persons with Certain Functional Impairments (1993:387) (LSS). Those covered by LSS are entitled to that which the law states, and may have their rights tried in court.

The Patient Act (2014:821), on the other hand, is a law outlining certain obligations. This law sets down the duties of healthcare providers, but as a rule patients cannot bring their case to court. Instead, patients can report a healthcare provider to the Patient Advisory Committee, the Health and Social Care Inspectorate (IVO), or the Parliamentary Ombudsmen (JO) if the applicable conditions are met.

Third in importance are government regulations.

Government agencies may issue directives, general advice, recommendations, and guidelines explaining a provision contained in a certain law or regulation.

Case law consists of previous judgments and decisions made by the courts. The higher the court that has made a certain decision, the more important the judgment is to the clarification of how the law is to be interpreted and applied.

In case of multiple, contradicting regulations, there are principles governing what provision takes precedence. Higher regulations take precedence over lower regulations, more recent laws over older laws, and special laws over general laws.

1.5 WHEN SWEDEN RATIFIES A CONVENTION

When a state ratifies – that is, accedes to – a convention, it undertakes to realise that which is set down in the convention. Among other things, the state must enact necessary laws. It must also take any other measures required to realise our rights as stated in the convention.

Another important principle is that existing Swedish law must be interpreted in accordance with the conventions Sweden has ratified.

In situations in which our human rights are not adequately safeguarded, the government has violated the agreements that Sweden has entered into with, for example, the UN, the EU, or the Council of Europe.

The UN has various committees overseeing countries' efforts to incorporate the conventions and guarantee the rights they set down. This happens through a review process carried out at regular intervals, usually every four years. Each review usually results in a series of recommendations and sometimes in criticism. The criticism and recommendations often lead to debate, enquiries, and legislative changes.

1.6 THE SPECIAL STATUS OF THE ECHR IN SWEDISH LAW

The European Convention for the Protection of Human Rights and Fundamental Freedoms is referred to in short as the European Convention on Human Rights (ECHR). It holds a special status in Swedish law. Since 1995, the ECHR is incorporated into Swedish law as the Law on the European Convention for the Protection of Human Rights and Fundamental Freedoms (1994:1219). It is also superior to all other laws in Sweden. The Instrument of Government, one of the fundamental laws of the Swedish Constitution, states that no other law may be passed that conflicts with the ECHR (2 ch 19 § RF).

Because the ECHR has been incorporated into Swedish law, it can be invoked in court. If your rights as set down in the ECHR have been violated, you can appeal against the violation in a Swedish court. Your case may subsequently be reviewed by the European Court of Human Rights; however, you must attempt to have your case tried within the Swedish legal system first. Even though the ECHR can be invoked in Swedish court, as of yet legal representatives and courts are not making full use of the convention. It is therefore important that you know it exists.

A complaint to the European Court of Human Rights cannot change what has already happened, but if the Court considers it a violation you may be entitled to damages and Sweden may be forced to change the law or procedure at fault. Sweden has been convicted in the European Court of Human Rights on several occasions.

When the European Court of Human Rights speaks on the correct interpretation of the ECHR through its judgements, it has an impact on how Swedish courts are to understand the convention when interpreting Swedish law.

Another important thing to note is that the European Court of Human Rights has ruled, in the case of Demir and Baykara v Turkey, that the ECHR shall be interpreted in the light of international law. This means that UN conventions impact our understanding of the content of the various provisions of the ECHR. For example, the UN Convention on the Rights of Persons with Disabilities states that a person must never be detained because of their disability. Article 19 of the same convention states that persons with disabilities have the right to living independently and being included in the community and that they are entitled to the support necessary to facilitate this right. These provisions are important to be aware of when invoking the provisions of the ECHR on the right to a free life.

Unlike the ECHR, UN conventions and declarations are not mentioned in the Swedish Constitution. Instead, these are international agreements that the government and parliament can enter on Sweden's behalf. Documents from the EU may have a different status in Swedish law. For example, while a directive from the EU sets out a number of objectives to be achieved by its member states, the latter are free to decide how to achieve these goals. A so-called decision is directly applicable, while recommendations are not legally binding on member states. In this handbook, EU documents of relevance to individuals in compulsory care will be outlined based on how they have been incorporated into Swedish law.

1.7 THE COUNCIL OF EUROPE

The Council of Europe is an intergovernmental European organisation fostering cooperation, established in 1949. The organisation comprises all the countries of Europe except Belarus. The Council of Europe was set up to facilitate the reconciliation of the European states after the Second World War. One of its tasks is to monitor issues of human rights, as well as torture and other inhuman or degrading treatment or punishment. In order to monitor the work of its member states, the Council of Europe has various commissioners and committees. One of these is the European Committee for the Prevention of Torture, which conducts visits to and careful investigations of institutions where persons are being detained. After such a review, the Committee for the Prevention of Torture issues a final report containing recommendations and sometimes criticisms. The Committee for the Prevention of Torture visited and reviewed Sweden in 2015.

PHOTO: CMDR SHANE/UNSPLASH

2 YOUR RIGHTS IN DETENTION

In this chapter, we review the legal grounds for detention, i.e. what is required under the ECHR and Swedish law. We explain your rights when being detained under the Compulsory Psychiatric Care Act (LPT), such as your rights to participation and information.

Article 5 of the ECHR states that "everyone has the right to liberty and security of person." This means that everyone has the right to move about freely within a country or to leave it. In some cases, restrictions may be imposed on this freedom. If so, there must be a legal basis and any act of detention must be in compliance with the law.

Article 5 also states that any person who is detained is entitled to take proceedings by which the lawfulness of their detention is decided speedily by a court of law. A person who has been wrongly detained has a right to compensation, should their detention be deemed unlawful.

2.1 LEGAL BASIS

According to Article 5 of the ECHR, no one shall be deprived of their liberty, except in the case of:

a) the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law,

b) the lawful arrest or detention of a person effected for the purpose of bringing them before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent them committing an offence or fleeing after having done so,

c) the detention of a minor by lawful order for the purpose of educational supervision or their lawful detention for the purpose of bringing them before the competent legal authority,

d) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants,

e) the lawful arrest or detention of a person to prevent their effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

The ECHR's Article 5 has its equivalent in Article 9 of the UN International Covenant on Civil and Political Rights. The United Nations Human Rights Committee, which oversees the implementation of the covenant, has adopted a comment on how Article 9 should be interpreted (Human Rights Committee, General Comment No. 35 Article 9: Liberty and Security of Person).

Article 14 of the UN Convention on the Rights of Persons with Disabilities also contains provisions on detention. It makes clear that a disability may never be the sole grounds for detention. Article 19 of the same convention outlines the right to live independently and be included in the community. Among other things, it states that the individual shall receive support to live independently and be able to choose their place of residence on an equal basis with people without a disability.

2.2 SWEDISH LAW

The ECHR makes clear that all forms of detention must have a basis in national law.

Detention in the Instrument of Government

The Instrument of Government states that all persons are protected from having their freedom of movement restricted or being detained (2 ch 8 § RF). However, this right may be restricted by law in order "to satisfy a purpose acceptable in a democratic society. The limitation must never go beyond what

is necessary" (2 ch 20 § RF). In this area, the Swedish Constitution is largely in line with the ECHR.

Detention under Swedish law

The national laws under which a person may be committed for compulsory care are as follows:

- LPT – The Compulsory Psychiatric Care Act (1991:1128)
- LRV – The Forensic Psychiatric Care Act (1991:1129)
- LVU – The Care of Young Persons (Special Provisions) Act (1990:52)
- LVM – The Care of Substance Abusers (Special Provisions) Act (1988:870)
- The Communicable Diseases Act (2004:168)

Within the context of LVU, youth service is a matter of both care and punishment as the result of a crime committed by a person who has not yet reached the age of criminal responsibility. Being subjected to compulsory care under the Communicable Diseases Act is very rare.

2.3 CRITERIA FOR COMPULSORY CARE UNDER LPT

As a prerequisite for care under the Compulsory Psychiatric Care Act, there must simultaneously be:

1) a severe mental disorder

2) an imperative need for care

3) a lack of consent

This is regulated in 3 § LPT.

Severe mental disorder

Severe mental disorder is a legal concept, the definition of which is found in legislative history and court rulings. It constitutes a state of mental illness of a dangerous nature and degree. What makes the condition severe may vary. Schizophrenia is by its nature a severe mental disorder, but the degree to which it is experienced does not typically mandate compulsory psychiatric care.

A person with a disability may not be detained solely on the grounds of their disability; it is against both international conventions and Swedish law. In order for a person with a disability to be committed for compulsory care, the criteria specified in the LPT must first be met.

The concept severe mental disorder primarily refers to conditions of a temporary psychotic nature. These are conditions involving a distorted perception of reality, with symptoms such as delusions, hallucinations, and confusion. This category may include various states of psychosis, depression with a suicide risk, personality disorders similar to psychosis, and certain other conditions such as crisis reactions that affect the level of mental functioning to such a degree that they take on a psychotic nature.

Alcohol- and drug-induced psychoses are included in the concept of severe mental disorder.

Imperative need for care

The second criterion for compulsory care is that there is an imperative need for care. Under Swedish law, this might mean that 24-hour and outpatient care is not sufficient, and that the patient needs to be treated on an inpatient ward. The criterion also stipulates a need for qualified medical care and supervision.

What does resisting care mean?

The third prerequisite for compulsory care is that there is no way to provide treatment other than against the patient's will. Otherwise, the very purpose of compulsory care – to induce the patient to participate in treatment voluntarily – is nullified.

According to the ECHR, you can be detained in order to receive care if you have a mental illness. However, both the European Court of Human Rights and the UN have clearly established that, as soon as less invasive measures are an option, compulsory care shall cease. The restriction of a person's human rights through coercion is not a question of receiving care; it is done against the patient's will. The aim of all compulsory care is to remove the necessity to restrict the individual's right to self-determination, bodily integrity, and freedom.

The objective of care and all care planning shall therefore be to induce the patient to participate voluntarily in the care they need. Difficulties arise when the patient does not have a true understanding of their need for care or does not believe that there is such a need at all.

The patient may be in favour of some forms of care, but not that which the treating doctor has deemed necessary. For example, the patient may be opposed to medication but would consider other forms of care.

The Patient Act contains provisions regulating the healthcare provider's obligation to inform the patient of the prognosis, recommendations, and possibility of choosing care options. It is important that healthcare providers explain and justify the care they offer, to help the patient gain trust in the healthcare services.

Another problem arises when the healthcare services do not offer alternative methods of treatment. For example, a patient may be receptive to care but not to medication specifically. If the doctor only prescribes medication, the healthcare provider may perceive the patient to be resisting care even though this is not the case. It is the healthcare provider's responsibility to explain and justify why only medication can be considered necessary care.

Through the legal prerequisite of a lack of consent, the legislator has therefore allowed for possible situations in which the patient consents to care but not to receiving the care that is deemed necessary. During the assessment of what constitutes necessary care in your case, as a patient you may sometimes demand a new medical assessment – a so-called second opinion. More information about the second opinion can be found in Chapter 5 of this handbook.

2.4 ON FORENSIC PSYCHIATRIC CARE

A person suffering from a severe mental disorder who has committed a crime may in some cases be sentenced to forensic psychiatric care. The prerequisites for this type of care are similar to those for compulsory psychiatric care.

Similarly, in the case of forensic psychiatric care, the administrative court must periodically decide whether to extend the period of treatment. Such a review shall, upon notification by the physician executive, take place every six months or at the request of the patient.

Forensic psychiatric care may be provided with or without a special discharge review order. If you have been sentenced to forensic psychiatric care with a special discharge review, the healthcare provider alone is not allowed to decide when you may be discharged. Instead, the discharge decision must be reviewed by the administrative court upon notification by the physician executive or at the patient's request.

Influence is an important piece of the puzzle

The provisions in the LPT about the healthcare provider's obligation to inform the patient of the prognosis, recommendations, and possibility of choosing care options are not always followed. The report "Lag utan genomslag" ("An act without impact") (2017:2) from the Swedish Agency for Health and Care Services Analysis concludes that the Patient Act is ineffective in securing patients' rights to information and participation.

It is important that healthcare providers explain and justify different methods of treatment and involve the patient, to help the latter gain trust in the healthcare services. In Civil Rights Defenders' and RSMH's experience, patients who feel powerless and like they have no influence over their own care also experience greater difficulty motivating themselves to participate in the proposed plan of treatment.

RSMH and Civil Rights Defenders are therefore advocating for the strengthening of patients' abilities to claim their rights in relation to care options, information, and participation, but also to ensure that healthcare institutions employ a human rights based approach.

PHOTO: JEREMY YAP/UNSPLASH

3 YOUR RIGHTS IN CASE OF COMMITMENT AND DETENTION

In this chapter, we review the regulations applicable in case of commitment or detention, as well as the requirements on medical assessments and decisions. Detaining someone for the purposes of compulsory care is one of the most severe interventions a person can be subjected to by society. The provisions governing who may be examined and detained for purposes of compulsory care are therefore detailed and clear, in order to minimise the risk of misinterpretation.

3.1 ISSUING OF A PSYCHIATRIC CARE CERTIFICATE

The standard commitment procedure requires the case to be reviewed by two doctors and is initiated by the issuing of a psychiatric care certificate after the patient has been examined (4 § LPT). If the patient is unwilling to participate in the medical examination, the doctor may decide in favour of detention (4 § LPT) and request police assistance in order to gain access to the patient (47 ch 1 § LPT).

In order for a doctor to be allowed to initiate a psychiatric care assessment, there must be reason to believe that the criteria for compulsory care are being met. The psychiatric care certificate must be written in direct connection with the examination and describe the patient's psychiatric history, current condition, mental and somatic status, and the reasons why compulsory care is deemed necessary.

Qualified to write a psychiatric care certificate are licensed doctors within the private or public healthcare sector, whose relationship to the patient does not present a conflict of interest.

3.2 COMMITMENT

Once a psychiatric care certificate has been issued, a decision is made on commitment for the purposes of compulsory care. This decision is made by a physician executive or an experienced specialist in psychiatry with a physician executive mandate.

By law, compulsory care may only be provided in psychiatric care facilities run by the county council. It is also in such an establishment that the decision on commitment shall be made once a psychiatric care certificate has been provided.

The decision must be made within 24 hours of the patient's arrival at a medical facility where compulsory care may be provided. A commitment order may only be issued if the physician executive determines that the criteria of the LPT are being met (6b § LPT).

A commitment order may not be based on a psychiatric care certificate older than four days, nor may the decision be made by the same doctor who issued the certificate. If the physician executive does not issue a commitment order, the treatment immediately becomes voluntary.

In connection with the issuing of a commitment order, or as soon as the patient is in a position to receive information, they shall be informed of the possibility to appeal against the decision.

3.3 DETENTION

If a patient who has been issued a psychiatric care certificate does not agree to remain in the medical facility pending a decision on commitment, the doctor on call may issue a detention order. A detention order prevents the patient from leaving the facility and is issued in accordance with 6 § LPT.

Detention for longer than four weeks

If the physician executive is of the opinion that treatment should last longer than four weeks, they must apply to the administrative court for continued compulsory care. The application must specify whether it relates to inpatient or outpatient compulsory psychiatric care.

After being reviewed by the administrative court, compulsory care may be provided for a maximum of four months from the date of the commitment order. After the four-month period, the administrative court may, upon the physician executive's application, allow an extension of compulsory care for up to six months at a time.

3.4 APPEALING AGAINST CONTINUED COMPULSORY CARE

The patient may appeal against the judgment issued by the administrative court. If so, the appeal must be sent to the administrative court. If the patient appeals against the judgment, the court must ensure that the case is reviewed speedily. The judgment must contain information on how, where, and when to appeal against the judgment.

PHOTO: BILDKOLL/MOSTPHOTOS

4 YOUR RIGHTS IN CASE OF POLICE TRANSPORT

In this chapter, we review the section of the Compulsory Psychiatric Care Act under which a doctor may request police assistance and the section of the Police Act regulating the use of coercion or force. The police may only use force in an emergency. Organisation and planning of police operations shall to the extent possible minimise the risk of a need for the use of force.

4.1 LEGAL BASIS

Under the ECHR, the police has an obligation to avoid the use of force and to apply non-confrontational methods in the first instance. If violence is used, it must be in accordance with the law and be both necessary and proportionate. Any use of force beyond what is necessary and proportionate is incompatible with the provisions of the ECHR.

The provisions of the ECHR shall be interpreted in the light of international law, such as the UN Covenant on Civil and Political Rights and the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Article 3 of the ECHR has its equivalent in Article 7 of the UN Covenant on Civil and Political Rights. However, the international convention of greatest significance to the interpretation of the ECHR's prohibition of torture, cruel

or degrading treatment is the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The European Court of Human Rights and the committees that monitor states' observance of these conventions have concretised the meaning of human rights in relation to the use of force by police.

In short, the police may only resort to violence when absolutely necessary; the use of force must be proportionate to the seriousness of the threat at hand and to the legitimate interests that are to be safeguarded. Organisation and planning of police operations shall to the extent possible minimise the risk of the use of force.

4.2 SWEDISH LAW

If a patient is aggressive or unwilling to present themselves at the medical facility, a doctor may request police assistance in transporting the patient to the medical facility (47 ch 2 § LPT).

Under Swedish law, there are certain requirements of proportionality and necessity. The Police Act states that a police officer shall "intervene in a manner that is justifiable in view of the object of the intervention and other circumstances." If coercion must be used, "the form and level of force used shall be limited to that required to achieve the intended result" (8 § the Police Act).

A police officer may only use force "if other means are inadequate and if it is justifiable in view of the circumstances" (8 § the Police Act). As further clarified by case law, 8 § the Police Act articulates the principles of necessity and proportionality. "The principle of necessity means that a police intervention may take place only when necessary for the deterrence or elimination of the danger or disturbance in question. The principle of proportionality means that the damage and inconvenience which the intervention may cause to an opposing interest must not be disproportionate to the objective of the intervention" (RH 1997:73).

The UN calls attention to a lack of knowledge and the use of excessive force by Police

The UN Committee Against Torture has criticised Sweden for the repeated use of excessive force by Swedish police. And, in 2016, Sweden was criticised by the UN Human Rights Committee for not providing police officers with adequate training on how to reduce the use of excessive force and the treatment of persons with mental illness.

During the collaboration "Locked up – but Not Without Rights", RSMH and Civil Rights Defenders have been in ongoing contact with both committees, as well as with the Police Union and the Swedish Police Authority. We will continue working to ensure that police officers are better equipped to respond to persons with mental illness in a way that does not increase the risk of escalated violence.

Excessive force with a deadly outcome – the cases of Daniel and Sinthu

Civil Rights Defenders has also taken action on two separate cases illustrating major concerns regarding the police's treatment of persons with mental illness.

PHOTO: PRIVATE

Daniel died from a warning shot

One of the cases is about Daniel, who suffered a psychosis. He barricaded himself in his parental home in Lindesberg. His parents, who were concerned for his well-being, called for professional help. At the same time as medical personnel were dispatched, police were also sent to the scene. They were the first to arrive.

The police officers, who had not been trained in a low arousal approach, drew their weapons when they arrived at the scene. They perceived the situation as potentially dangerous. A shot was fired and hit Daniel, who died.

In a report that is now being reviewed by the UN Human Rights Committee, Civil Rights Defenders has established that the event could have been prevented if the police had waited for medical personnel to arrive or had been more competent in dealing with persons with mental illness.

Sinthu was subjected to violence in the Psychiatric Emergency Department

PHOTO: PRIVATE

The second case is about Sinthu, who had a psychotic disorder and was taken to Västerås Psychiatric Emergency Department for what his friends and family thought was a potential psychosis. A few hours into his treatment, something happened on the ward to upset Sinthu. He proceeded to seize an object that could be perceived as sharp and potentially dangerous. Staff called the police to the scene, to handle the situation. When the police arrived, Sinthu had locked himself in a room. Several police officers entered the room, using both a large amount of pepper spray and force. The police ceased to intervene when the officers deemed that Sinthu was no longer putting up resistance. He died in connection with the police intervention.

Civil Rights Defenders and Sinthu's family have criticised the prosecutor's handling of the preliminary investigation as well as the actions of the police.

PHOTO: ANDREY POPOV/MOSTPHOTOS

5 YOUR RIGHTS IN THE CONTEXT OF CARE AND CARE PLANNING

In this chapter, we review the healthcare guarantee as well as your right to emergency care, care in another county, and care planning. Included is a checklist for the care plan, which must be established as soon as a person is committed for compulsory care. The chapter includes sections on informed consent, the right to information about your state of health, and regulations concerning obtaining a new medical assessment, a so-called second opinion.

5.1 LEGAL BASIS

In Article 12 of the UN Convention on Economic, Social and Cultural Rights, states parties recognise the right of every person to enjoy the highest attainable standard of physical and mental health. The committee that monitors states' compliance with the convention has adopted a comment on how this right is to be interpreted in practice. Other conventions on human rights also contain similar provisions, including Article 25 of the UN Convention on the Rights of Persons with Disabilities and Article 24 of the Convention on the Rights of the Child.

This provision has no equivalent in the ECHR.

5.2 SWEDISH LAW

The Health and Medical Services Act (2017:30) (HSL) is a so-called framework law that contains basic provisions governing all healthcare services. It also regulates what the healthcare provider is obliged to offer you as a patient.

County councils and municipalities are independent from the state. They are responsible for ensuring that care is provided in accordance with HSL. The law stipulates what forms of care are municipal, including home healthcare and some outpatient care, as well as the forms of care for which county councils are responsible.

HSL also states that principals are responsible for ensuring that the care provided is good, safe, evidence-based, accessible, and of a high quality. The law does not specify precisely what types of care are to be provided.

The healthcare guarantee ensures care is not delayed

The Health and Medical Services Act sets down a healthcare guarantee (9 ch 1 § HSL). In accordance with the healthcare guarantee, a county council must offer care within a certain timeframe to persons under its responsibility. The healthcare guarantee includes an assurance that the individual shall be put in contact with a primary care provider, be allowed to see a primary or specialised care physician, and receive planned care within a certain timeframe.

Depending on the patient's needs, the patient shall be allowed to see a doctor at a primary care facility within no more than seven days and visit a specialist care centre within 90 days.

Your right to emergency care

If you are in need of immediate medical care, you have a right to receive it as soon as possible, no matter where you are in the country or your place of registration. This is stated in 8 ch 4 § HSL.

Your right to seek care in another county

If your own county council is unable to provide care in accordance with the healthcare guarantee, it must ensure that you receive care in another county and cover the costs (9 ch 2 § HSL). Even if this is not the case, patients may still opt for outpatient care, primary care, outpatient specialised care, or outpatient highly specialised care in other counties.

However, there may be referral requirements that must be followed in relation to outpatient specialised care in the county where the patient is seeking care or in their home county. The best course of action is to ask someone within the healthcare services in your county for advice on how to proceed. Either, you must be referred to another county or you can apply through self-referral, though your options may differ between counties.

Providers of care that is more costly typically require a referral. In the case of more expensive care, an advance approval or certificate from your home county is often needed to prove to the healthcare provider that your home county will cover the costs.

5.3 YOUR RIGHT TO A CARE PLAN

If you are the subject of a commitment order, a care plan shall be drawn up promptly. To the extent possible, the care plan shall be drawn up in consultation with the patient, in accordance with the Compulsory Psychiatric Care Act (16 § LPT) or the Forensic Psychiatric Care Act (6 § 2 par. LRV).

However, investigative measures may be required before a care plan can be established. In that case, a preliminary care plan should always be drawn up in connection with a decision on commitment for compulsory care (prop. 1999/2000:44 p. 79). If it is not possible to establish a care plan in consultation with the patient, the reason for this shall be stated in the plan in accordance with the National Board of Health and Welfare's Regulations and General Advice on Compulsory Psychiatric Care and Forensic Psychiatric Care (3 ch 4 § SOSFS 2008:18). Unless inappropriate, the patient's next of kin shall also be consulted (16 § 1 par. LPT).

Once a patient has been committed for compulsory care, a care plan shall be drawn up as soon as possible. This provision applies to both outpatient and inpatient compulsory psychiatric care as well as forensic psychiatric care (16 § LPT and 6 § 2 par. LRV).

The care plan must contain the information prescribed by the National Board of Health and Welfare (8 § FPRV). It shall form the basis for treatment of the patient in the acute stage immediately following commitment, and include the main features of the plan for further care (3 ch 3 § SOSFS 2008:18). The care plan shall provide an overall picture of the patient's medical, psychological, and social needs. In order that the purpose of compulsory

care may be achieved, the care plan shall also clarify the objectives of the different treatment measures and interventions (3 ch 5 § 1 par. SOSFS 2008:18).

The care plan checklist

It is important that the following information is included in the care plan in accordance with the National Board of Health and Welfare's Handbook with Information and Guidance on the Application of the Regulations of the National Board of Health and Welfare (SOSFS 2008:18):

- Date when the care plan was drawn up
- The patient has participated: yes or no. If no, why?
- Next of kin have participated: yes or no. If no, why?
- The patient has been informed of their right to a support person under 30 § LPT and 26 § LRV and has been informed of their rights under 48 § LPT and 30 § LRV
- Employment or work
- Next of kin and social network
- Children under the age of 18 whom the patient has custody of or is in close contact with
- Treatment contact within the healthcare services
- Whether the patient would like a contact person in accordance with 3 ch 6 § the Social Services Act (2001:453)
- Contact with the social services
- Interventions planned in accordance with the Social Services Act
- Trustee or custodian
- Personal representative
- Measures planned in accordance with the Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS) or the Assistance Benefit Act (LASS) (1993:389)
- Medical condition and need for treatment measures such as laboratory examinations, radiology, psychological assessment, assessment of activities of daily living, drug treatment, conversational therapy, or electroconvulsive therapy (ECT)
- Somatic health and potential dental needs: goals and objectives as well as planned and prior measures

- Substance abuse and addiction treatment needs: goals and objectives as well as planned and prior measures
- Nursing needs: goals and objectives as well as planned and prior measures
- Social needs, such as support to handle personal finances and contact with the authorities, contact with next of kin and one's employer, as well as support for next of kin
- Potential needs of children under the age of 18 whom the patient has custody of or is in close contact with: goals and objectives as well as planned and prior measures
- Potential need for intervention by the social services
- Need for patient education or other psychoeducational interventions: goals and objectives as well as planned and prior measures
- Risk assessment and risk management: dangerous to self or others, suicide risk, recidivism, and need for preventive measures. Where the danger persists: goals and objectives as well as planned and prior measures
- Whether the patient is allowed to leave the ward while remaining within the medical facility and its grounds
- Whether the patient is allowed to leave the medical facility and its grounds on certain conditions
- Outpatient compulsory psychiatric care and outpatient forensic psychiatric care as well as conditions for outpatient care
- Date to follow up on the care plan
- Results of the follow-up
- Review of the care plan
- The patient's thoughts on the outcome of the care plan
- Discharge and need for aftercare
- Outpatient contact and cooperation
- Follow-up of the care and support received by the patient

Reviewing the care plan

A care plan shall be reviewed regularly and revised as necessary (prop. 1999/2000:44 p. 79). According to the regulations of the National Board of Health and Welfare, the care plan must be reviewed as soon as there is a basis for establishing a plan for further care (3 h 3 § SOSFS 2008:18).

The physician executive is responsible for ensuring that a care plan is established, followed up, and reviewed by a doctor with relevant qualifications and experience (3 ch 6 § SOSFS 2008:18).

Under the Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act, it is the physician executive's responsibility to decide on or apply for inpatient compulsory psychiatric care or inpatient forensic psychiatric care, should the physician executive deem that the relevant prerequisites are being met.

In order for the physician executive to know whether a patient needs to be be readmitted for treatment, they must keep themselves informed about the patient's situation. Through contact with the patient, next of kin, any outpatient psychiatric care provider, and the social services, the physician executive can gain a continuous picture of the patient's developing illness and life situation. Notwithstanding requirements of confidentiality, information about a patient required for the performance of the physician executive's duties under the law shall be disclosed by the health and social services (43 § LPT). The provision also applies to compulsory forensic psychiatric care (24 § LRV).

If you are dissatisfied with your care plan

If a patient is not satisfied with their care plan, they should talk to the responsible doctor. As mentioned above, the care plan shall be drawn up in consultation with the patient (16 § LPT). In care planning, the patient's participation in and influence over the care provided shall be accommodated (3 ch 4 § LPT).

Moreover, medical treatment shall to the extent possible be delivered in consultation with the patient (5 ch 1 § the Patient Act). It is therefore desirable for the doctor responsible to draw up an individual programme of care together with the patient (prop. 1981/82:97 p. 50).

5.4 INFORMED CONSENT

Being subjected to compulsory care means that you have to remain on an inpatient ward, but it does not mean that the healthcare provider automatically has the right to give you medication or treatment under coercion. UN conventions distinguish between being detained and actually receiving care under coercion. Under Swedish law, it is in some cases, as

previously mentioned, legal to commit a person for inpatient care on a closed ward against their will, but this does not mean that the patient loses their powers of self-determination altogether.

According to international as well as Swedish law, the main rule is that all care requires consent. The Patient Act expressly states that care shall be provided with the patient's consent. However, the Patient Act does not stipulate how such consent is to be guaranteed.

The Compulsory Psychiatric Care Act both supplements and allows exceptions to the Patient Act, and it allows for involuntary medication and treatment in certain cases (see Chapter 6). However, this should be a last resort.

Sweden has received criticism on several points in this regard:

1. It is unclear what methods are used before resorting to coercion.
2. Coercion appears to be used routinely.
3. Consent is not documented.

The final point is particularly serious in the case of electroconvulsive therapy (ECT). One of the more common adverse effects of ECT is memory loss of a temporary or long-term nature. It can be difficult to remember the process in which ECT was accepted as a treatment option.

If there is no detailed medical record of how consent has been obtained, it becomes difficult for the patient to follow the process afterwards. As a result, the legal certainty of the patient is not protected and unnecessary suspicion may be cast on the psychiatric care services.

What does informed consent mean?

It is in the healthcare provider's interest to find a method of treatment that both the healthcare provider and the patient can agree on. A cooperative patient recovers faster.

To be able to exercise self-determination and give consent, the patient must be provided with the necessary information about available options and their possible effects. The Patient Act states that the patient shall receive information (3 ch the Patient Act), and that this shall happen before the patient gives consent (4 ch 2 § the Patient Act).

In order for the patient to be able to give informed consent, it is also a requirement that the patient actually understands the information they have received. The information provided shall be adapted to the recipient's age, maturity level, experience, linguistic background, and other individual capacities (3 ch 6 § the Patient Act).

Appropriate measures shall be taken to ensure that persons with disabilities have equal access to information and communication in order to be able to make independent choices in accordance with Articles 3 and 9 of the UN Convention on the Rights of Persons with Disabilities. Children with a disability shall be offered tailored support in order to be able to exercise their right to express their opinion in accordance with Article 7(3). The person providing the information shall to the extent possible ensure that the recipient has understood the content and meaning of the information provided.

The information shall be provided in writing, if necessary in light of the individual capacities of the recipient or if they ask for it (3 ch 7 § the Patient Act).

Finally, informed consent must be freely given. This means that the patient must be free to choose, that is, not subjected to coercion or in such a position of dependence that any freedom of informed choice becomes a mere illusion.

Your right to information about your state of health

A psychiatric patient shall receive information about their state of health; the available methods of examination, care, and treatment as well as which ones are recommended; the support available to persons with disabilities; when they can expect to receive care; the expected course of care and treatment; significant risks of complications and adverse effects; as well as aftercare and methods for preventing illness or injury (3 ch 1 § the Patient Act). However, as long as the healthcare provider complies with the law and offers good care, it is not possible to demand other forms of care than what is being offered.

Under the Patient Act, the patient shall also be informed about the possibility of choosing treatment option, a permanent medical contact, healthcare provider, and provider of publicly funded healthcare; obtaining a new medical assessment; and receiving a permanent healthcare contact (2 § the Patient Act).

The patient shall also receive information about the healthcare guarantee and the possibility of obtaining details from the Swedish Social Insurance Agency about seeking medical care in other countries within the European Economic Area (EEA) or Switzerland (SFS 2016:658 the Act amending the Patient Act).

5.5 YOUR RIGHT TO A SECOND OPINION – A NEW MEDICAL ASSESSMENT

If you are not satisfied with your medical assessment, you may in some cases be entitled to a new medical assessment – a so-called second opinion from another doctor (8 ch 1 § the Patient Act). To be entitled to a new medical assessment, you must have a life-threatening or particularly serious illness or injury. If so, you shall be given the opportunity to obtain a new medical assessment within or outside your own county.

What counts as "a life-threatening or particularly serious illness or injury" is determined on a case-by-case basis. "Life-threatening" refers to consequences in the short term, i.e. not the fact that certain diseases may risk shortening your life by a few years in the long term (prop. 1998/99:4 p. 48). There are no further instructions on how these criteria are to be understood or applied in the context of compulsory psychiatric care.

There is no law preventing the healthcare services from helping you to receive a new medical assessment in certain situations, even though the conditions for the county council's obligation to provide a second opinion are not being met (prop. 2013/14:106 p. 80).

The person responsible for you as a patient shall inform you and your next of kin of the possibility of receiving a new medical assessment (6 ch 6 § PSL and 3 ch 2 § p 2 the Patient Act). Details about the information provided to you or your next of kin shall be recorded in your medical chart (3 ch 6 § p 5 PSL).

If you would like a new medical assessment you can ask your doctor or someone else working at the healthcare centre where you received your assessment. If granted a second opinion, you will usually receive a referral to another specialist care centre where the new assessment is made. It is the county council or region where you are registered that covers the cost. It will also pay for the trip if you need to travel to another county.

Your doctor shall assist in making your medical records and other documentation available, to provide the doctor making the new assessment with access to the documentation necessary to consider available treatment options (prop. 1998/99:4 p. 31). If the new medical assessment leads you to prefer a different treatment option, your wishes must be respected, provided that the chosen treatment is consistent with scientific research and proven experience and that the treatment can be considered justified in relation to the disease or injury in question and the cost of treatment (8 ch 1 § 2 par. the Patient Act).

If the healthcare professional responsible does not consider a new medical assessment warranted, they should carefully explain and justify their decision to you, and in certain cases to your next of kin. The decision, and your opinion in case you do not agree, shall be recorded in your medical chart (3 ch 6 § p 5 and 3 ch 8 § PDL).

If you have been denied a new medical assessment and you are not satisfied with the decision, you should convey your wishes to the healthcare provider in the first instance. You may, for example, speak to the head of operations. In some cases, there may be a patient representative at the hospital that you can turn to. You may also contact the Patient Advisory Committee (preferably after speaking to the healthcare provider), which can facilitate a dialogue between yourself and the healthcare provider.

It is not possible to demand a new medical assessment in court. Neither is IVO able to affect your chances of receiving a second opinion. If the decision to deny you a medical assessment has caused medical harm, IVO may aim criticism at the healthcare provider. If you have suffered medical harm, you may also make a claim to Landstingens Ömsesidiga Försäkringsbolag (“the county councils’ mutual insurance company”) (LÖF).

The Healthcare Guide 1177 provides information about obtaining a new medical assessment – a so-called second opinion – on its website.

The inquiry's proposal of a right to a second opinion

In 2012, a government inquiry into psychiatric legislation proposed that the government should task the National Board of Health and Welfare with drawing up guidelines on what counts as "a life-threatening or particularly serious illness or injury." Among other things, the inquiry found that ECT as a treatment constitutes such a serious interference with the patient's physical integrity, with known adverse effects, that it should come with a right to a new medical assessment. Another example provided by the inquiry is when a person has been taking the same drug for a very long period without any lasting improvements to their mental health (SOU 2012:17 p. 410 ff.). However, the inquiry's proposal was never implemented.

The lack of guidance on how to apply the provision on a new medical assessment to persons in compulsory psychiatric care has been criticised, both by the National Board of Health and Welfare (prop. 2013/14:106 p. 81) and by the government inquiry into psychiatric legislation (SOU 2012:14 p. 410). As of yet, this criticism has not led to any action.

Psychiatric care must not mean a deterioration in health – your right to somatic care during compulsory care

Civil Rights Defenders and RSMH have received calls from individuals with questions about the right to somatic care for persons in compulsory psychiatric care.

Not infrequently, the call concerns a person being treated for mental illness who feels that they may in fact be experiencing psychological symptoms caused by physical injuries. Sometimes, it concerns a person suffering from mental illness who is given medication that is causing harm to their physical condition. On a

few occasions, the call has concerned a patient who simply feels that they are not getting the somatic care they need.

What all of these cases have in common is a concern that the patient's physical health is not being taken seriously. According to the Health and Medical Services Act, all care must be good and safe. This means that psychiatric care must not impair the patient's physical health.

You thus have a right to receive adequate care for your physical health while being subjected to compulsory care, especially if the period of compulsory care is longer. It is also the case that neglecting physical pains while administering compulsory psychiatric care may constitute inhuman and degrading treatment and be contrary to human rights. Often, the healthcare provider must balance competing interests and decide whether the patient is in adequate physical condition to receive the necessary physical care. However, if the patient is in a position to receive care, it must be provided. If necessary, the transport unit of the Swedish Prison and Probation Service may provide assistance to ensure safety at the request of the psychiatric care provider.

The balancing act is equally precarious when it comes to medication with detrimental effects on the patient's physical health. In this case, the healthcare provider must balance the medication's beneficial effects on the patient's psyche against its potential consequences for their physical health. If there are no other options, even potentially high-risk medications may become necessary. If so, it must be justified and subject to review, however.

Several people have also contacted RSMH stating that, when seeking somatic care, they were referred to a psychiatric care provider on the grounds that they are suffering or have previously suffered from mental illness. Being denied somatic care by the healthcare services solely on the grounds of having or being perceived to have a psychosocial disability may constitute discrimination. More information can be found in the chapter on discrimination.

PHOTO: LINDA WEICHSELBRAUN

6 COERCIVE MEASURES

In this chapter, we review the provisions concerning coercive measures such as detention, commitment, body searches, isolation, and the use of restraints. There is also information about your options before and after the issuing of a commitment or detention order. Coercion shall be used with as much leniency as possible and with the greatest possible consideration for the patient. If less invasive measures would be sufficient, they shall be used. The final sections of the chapter offer guidance on how to report situations where you feel that you have been subjected to unnecessary coercion.

6.1 LEGAL BASIS

The coercive measures that may be used when a person has been committed for compulsory care are governed by Swedish law, but also by Articles 3 and 8 of the ECHR.

Article 3 of the ECHR states that "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." It has its equivalent in Article 7 of the UN Convention on Civil and Political Rights, Article 37 of the Convention on the Rights of the Child, and Article 15 of the UN Convention on the Rights of Persons with Disabilities.

However, the international document of greatest significance to the interpretation of Article 3 of the ECHR is the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Sweden

has ratified the Optional Protocol to the UN Convention against Torture. In addition to the Optional Protocol, a special subcommittee has been set up. The Subcommittee on Prevention of Torture (SPT) has the right to visit facilities where persons are being detained in the countries where the Optional Protocol has entered into force. The subcommittee's reports and recommendations to each state are public documents and may offer guidance on how both the UN Convention against Torture and Article 3 of the ECHR ought to be interpreted in a specific case.

Article 3 of the ECHR is also complemented by the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. It establishes a European Committee for the Prevention of Torture (CPT), which monitors the convention and inspects places where persons are being detained. When the committee has conducted a visit, it writes up a report and issues comments on the state's or a certain institution's compliance with the convention. The committee's recommendations are also important for our understanding of what the ECHR's prohibition on torture, cruel, or degrading treatment means in practice.

In brief, coercion may only be used when absolutely necessary, and the act of coercion must be proportionate and permitted by law. All forms of excessive force or coercion are incompatible with the provisions of the ECHR.

The European Court of Human Rights has clarified that only treatment or punishment characterised by a significant severity or ruthlessness may fall under Article 3. In view of this, the concepts "inhuman" and "degrading" are to be interpreted restrictively. If an act or treatment that may be perceived as inhuman or offensive is not covered by Article 3, it may be covered by the privacy protections in Article 8 and thus remain incompatible with the provisions of the ECHR.

6.2 SWEDISH LAW

The Instrument of Government states that "everyone shall be protected in their relations with the public institutions against any physical violation" (2 ch 6 § RF). Any exception to this provision must have a basis in law. The Compulsory Psychiatric Care Act and the Forensic Psychiatric Care Act contain provisions allowing for the use of coercion when a person is subjected to compulsory care. Different types of coercion may be used depending on whether you have been issued a commitment or detention order, or if no such order has been issued.

As an overarching principle, all forms of excessive force as well as unnecessary or disproportionate coercion are prohibited. This is also made clear in Swedish law.

Coercive measures may only be used if they are proportionate to the objective (2a § LPT and 2a § LRV). If less invasive measures would be sufficient, they shall be used. Coercion shall be used with as much leniency as possible and with the greatest possible consideration for the patient.

All coercive measures must be carefully documented in the patient's medical chart and, where appropriate, in the decision records (the Patient Data Act 2008:355). These decisions cannot be appealed.

From the patient's perspective, it is also important that all prior measures, taken in order to avoid the need for coercive measures, are recorded. This allows you to follow the course of events in hindsight.

Coercive measures prior to a detention order

Acts of coercion necessary to prevent the patient from leaving the section of the care facility where the patient is to remain may be used for the purpose of maintaining order at the facility or ensuring safety of care (6 § LPT). Such coercion may be used prior to the issuing of a detention order. However, a qualified doctor must have issued a psychiatric care certificate before you can be prevented from leaving the ward.

The law does not clearly specify the types of coercion that may be used. Instead, healthcare professionals must rely on provisions in the Penal Code concerning impunity in case of distress or self-defence and lawful authority, when they are forced to intervene against a patient. If other measures are not sufficient, the provisions give healthcare professionals the right to intervene with force. This may include physical coercion, such as restraining a patient who wants to leave the care facility or who is attacking other patients or staff (prop. 1999/2000:44 p. 115).

Coercive measures prior to a commitment order

Förutom det tvång som får användas för att hindra någon att lämna Except for acts of coercion with the purpose of preventing someone from leaving the ward pending a detention order, all other forms of coercion prior to a commitment order require that a detention order has been issued.

Body search prior to a commitment order

Body searches prior to the issuing of a commitment order are regulated by the Compulsory Psychiatric Care Act (6 § LPT).

After a detention order as been issued, but prior to a commitment order, a patient may be searched or subjected to a superficial strip search as part of checks for such items as dangerous goods or narcotics. The process is regulated by the Prohibition of Certain Goods Dangerous to Health Act (1999:42) and by the Doping Criminal Act (1991:1969).

As an involuntary patient, you may not carry narcotics, alcoholic beverages, other doping substances, syringes or needles that can be used for injection into the human body, or other objects specifically associated with substance abuse or other handling of narcotics.

The same applies to property that may be used to harm oneself or others, or that may be detrimental to the healthcare services or to order at the care facility (21 § LPT). If such property is found, it must be disposed of or destroyed (24 § LPT).

Body search after a commitment order

Body searches after the issuing of a commitment order are regulated by the Compulsory Psychiatric Care Act (23 § LPT). Healthcare professionals may also, if necessary, search or subject a patient to a superficial strip search after the issuing of a commitment order. This measure is carried out in accordance with the above description of body searches prior to the issuing of a commitment order, and aims to check whether the patient is carrying any of the prohibited property previously mentioned (21 § LPT).

The inspection may also be carried out to confiscate any electronic communications services that the patient is not allowed to possess. If necessary in order to maintain safety at the healthcare facility, or in the case of inpatient compulsory psychiatric care subject to a higher security classification, the healthcare provider may also introduce general entry checks. This means that patients who enter the ward or facility are searched for objects that the involuntary patient may not possess (23b § LPT).

If necessary in order to maintain safety at an inpatient forensic psychiatric facility or ward subject to a higher security classification, the healthcare provider may also decide that all persons who enter the facility or ward

must be searched (i.e. subjected to a general entry check) in accordance with 8b § LPT.

Your rights in connection with a body search or superficial strip search

Body search: An examination of any clothing or other items that a person may be carrying, as well as bags, packages, and other items they may be bringing.

Superficial strip search: An examination of the visible parts of the naked body as well as the armpits, hair, and soles of the feet.

These measures may not be taken routinely and must be justified on a case-by-case basis. Ideally, two staff members shall be present during the search.

A body search or superficial strip search order cannot be appealed.

According to the ECHR, any interference with a person's private life must be necessary and proportionate. If you believe that a body search has constituted an interference of a significantly more severe nature than there may have been grounds for, you should raise this with your healthcare provider or physician executive in the first instance, as they are required to receive your complaints and opinions. You should also contact the Patient Advisory Committee and report the incident to the Health and Social Care Inspectorate (IVO). All sexual advances in connection with a body search are inadmissible and should be reported to the police.

Use of restraints prior to a commitment order

The use of restraints prior to the issuing of a commitment order is regulated by the Compulsory Psychiatric Care Act (6 § LPT). Prior to the issuing of a commitment order, a person may only be subjected to short-term belt restraints for up to four hours. There must be an immediate danger that the patient may cause serious harm to themselves or others. Decisions can be made by a licensed doctor. If a decision to use belt restraints has been made prior to the issuing of a commitment order, the physician executive shall make a decision on whether or not to issue a commitment order soon after. Healthcare professionals must be present for the entire duration that the patient is subjected to belt restraints.

If the regulations are breached, you may report the incident. See section 6.3 below.

Use of restraints after a commitment order

A person may also be restrained using a belt or similar contraption after the issuing of a commitment order, if there is an immediate danger that the patient may cause serious harm to themselves or others (19 § LPT and 5 § LRV). A decision on this shall be made by the physician executive. Healthcare professionals must be present for the duration that the patient is subjected to restraints. As a general rule, restraints may only be used for a short period of time. The use of restraints for more than four hours require special reasons as well as a personal examination by the physician executive. As soon as the decision as been made, the use of restraints for more than four hours must be reported to IVO. If the patient is being restrained for more than 72 hours, a new form with additional information must be sent to IVO.

In order to discontinue the ongoing use of restraints, a decision by the physician executive is required. Decisions can be made via telephone, based on information provided by staff.

Isolation prior to a commitment order

Isolation means that a patient is denied contact with other patients, usually by being confined to their own or a separate room. Isolation prior to the issuing of a commitment order is regulated by the Compulsory Psychiatric Care Act (6 § LPT).

After a detention order has been issued, but prior to a commitment order, a decision on isolation can be made by a licensed doctor. A decision on isolation concerning a patient committed for compulsory care can only be made by the physician executive.

Prior to the issuing of a commitment order, a patient may only be subjected to shorter periods of isolation of up to eight hours. As a prerequisite for isolation, the patient must be exhibiting a level of aggressiveness or severely disruptive behaviour that constitutes a significant impediment to the care of other patients. During isolation, the patient must be monitored continuously. Decisions can be made by a licensed doctor. It is important to document who has or have been responsible for the continuous monitoring of the patient in their medical chart.

If the regulations are breached, you may report the incident. See section 6.3 below.

Isolation after a commitment order

A patient may also be kept isolated from other patients after the issuing of a commitment order, but only if it becomes necessary because the patient is exhibiting aggressive or disruptive behaviour that significantly impedes the care of other patients (20 § LPT and 5 § LRV). Isolation may only be used in an emergency when other measures are not sufficient or appropriate. The purpose of isolation is to protect the other patients. A decision on isolation is valid for up to eight hours. After that, the patient must undergo a personal examination by the physician executive before a new decision can be made. The duration of the isolation may be extended through a new decision by up to eight hours.

In case of special reasons, a decision on isolation may be valid for a fixed period exceeding eight hours. The provision is applicable to certain extreme cases in which the patient's situation is so serious that isolation must last for a period longer than a few days. This should only be necessary in certain exceptional cases (prop. 1990/91:58 p. 261). Such a decision may only be valid for up to 72 hours. It is the physician executive who makes decisions on isolation. If a patient is being kept in isolation for more than eight consecutive hours, IVO must promptly be notified.

If the patient is being confined to a secluded space but which has an open door, this also falls under the legal definition of isolation.

During isolation, the patient must be monitored continuously by healthcare professionals.

Involuntary treatment prior to a commitment order

Involuntary treatment administered after a detention order as been issued, but prior to a commitment order, is regulated in the Compulsory Psychiatric Care Act (6a § LPT).

Involuntary treatment in the form of involuntary medication or feeding may be administered when there is a serious and imminent danger to the patient's life or health. In other words, prior to the issuing of a commitment order, involuntary medication may not be administered solely for the purpose of calming the patient in order to prevent them from becoming violent and harming others.
Decisions on administering medication against the patient's will must be made by a licensed doctor. Involuntary medication means that the patient receives medication while under restraint, usually by intramuscular injection.

Long-acting medications should not be used in the acute stage before a decision on commitment has been made.

Involuntary treatment after a commitment order

Involuntary treatment administered after the issuing of a commitment order is regulated in the Compulsory Psychiatric Care Act (17 § LPT). Like the forms of involuntary treatment that may be administered prior to the issuing of a commitment order, involuntary medication or feeding may also be administered after the patient has been committed for compulsory care. As a starting point, treatment options shall be discussed in consultation with the patient. If appropriate, next of kin shall also be included in the conversation. The physician executive may decide that treatment and medication shall be administered against the patient's will, if the physician executive considers it necessary in order to achieve the purpose of care.

Measures such as involuntary injections or medication should be reserved for emergency situations only, as they can be perceived to violate the patient's integrity. It is the doctor's responsibility to ensure that all other possibilities for a patient in need of treatment to receive care and accept medication have been exhausted.

Informal coercion

Sometimes, if a patient does not voluntarily agree to be admitted, they may face the risk of receiving medication or other treatment by coercion. As a result of more or less explicit pressuring, the patient may feel that they have no real choice. In such situations, many patients agree to things they would not have consented to if not for the looming threat of coercion. These types of situations are referred to as informal coercion.

A literature review of perceived coercion yields a hierarchy of different types of pressuring:

1. *Persuasion:* An appeal to reason (but often also to emotion), based on arguments about risks and benefits. The patient's arguments are taken into account and answered.
2. *Exploiting a personal relationship:* A personal relationship is used to influence the patient, who may be emotionally dependent on the treatment provider and reluctant to disappoint them.
3. *Using a bait:* It is suggested that the patient will receive additional support or services if they agree to participate in the proposed treatment.

4. *Threats:* It is suggested that support and services may be withheld or that the use of coercion will be considered if the patient does not go along with the treatment.
5. *Coercion:* The patient is forced to undergo treatment against their will with the help of compulsory care legislation

Source: Szmukler, George and Paul S. Appelbaum (2008) "Treatment Pressures, Leverage, Coercion and Compulsion in Mental Health Care," Journal of Mental Health, 17:3, 233–244.

The line between factual information and more direct attempts at influencing the patient is not always easy to pinpoint. The patient's own experience of the events is likely to be the best indicator. While it may be the intention of staff to provide information, the patient may feel like they have no choice in the matter.

6.3 REPORTING INJURIES, MEDICAL HARM, AND IRREGULARITIES IN CONNECTION WITH COERCIVE MEASURES

If healthcare professionals fail to comply with the regulations, patients or next of kin may make a complaint to the Parliamentary Ombudsmen (JO). A complaint can also be made to the Health and Social Care Inspectorate (IVO), which examines incidents where a patient's integrity and self-determination have been severely affected.

JO and IVO can criticise the healthcare facility. Normally, neither JO nor IVO are able to investigate complaints relating to circumstances dating back more than two years.

If you have suffered medical harm, you may also be entitled to compensation from the Landstingens Ömsesidiga Försäkringsbolag ("the county councils' mutual insurance company") (LÖF).

If you have suffered injury from medication, you may contact the Swedish Pharmaceutical Insurance (LFF) to have your case reviewed. The Patient Advisory Committee can provide information on where to turn and how to write a complaint. By law, every county in Sweden has its own Patient Advisory Committee.

The Patient Advisory Committee can also facilitate a dialogue with the healthcare provider.

Better care, less coercion

In 2013, SKL and the National Board of Health and Welfare published a report indicating that the use of coercive measures could be reduced with the help of systematic efforts. According to the report, it is in large part a question of avoiding coercive measures by using low-impact methods and other ways of working. If most coercion is avoidable through preventive measures, it raises the question of whether coercion is at all necessary.

The European Committee for the Prevention of Torture has criticised Sweden for its seemingly routine use of coercive measures. The UN Committee on the Rights of the Child and Committee on the Rights of Persons with Disabilities have also criticised Sweden for excessive use of coercion. The Committee on the Rights of the Child is of the view that coercion against children should be prohibited.

In other words, the state should channel more resources into preventing staff from resorting to coercive measures in all cases where it is not strictly necessary. ”För barnets bästa? Utredningen om tvångsåtgärder mot barn i psykiatrisk tvångsvård” (”For the good of the child? An inquiry into coercive measures against children in compulsory psychiatric care”) SOU 2017:111 offers suggestions on how to reduce the use of coercion against children.The inquiry has been put out for consultation, but the legislative process is slow. Civil Rights Defenders and RSMH are continuing to work on the issue as it affects both children and adults.

If you have been subjected to unnecessary coercion

Civil Rights Defenders and RSMH have received numerous calls from individuals who feel that they have been subjected to coercion to a degree far beyond what may be considered necessary.

Sweden has also received strong criticism from the UN regarding its use of coercion and restrictions. As an example, the UN Committee on the Rights of the Child has criticised Sweden for its use of various forms of coercion against children in compulsory care and asked Sweden to completely ban the use of belt restraints and isolation against children.

If you have been subjected to coercion that you consider unnecessarily severe, you should ask your legal representative to look into whether the European Court of Human Rights or the various monitoring committees have issued statements on similar cases. Swedish law shall be interpreted in the light of international law, and conditions in Sweden may not be contrary to the ECHR.

PHOTO: KAITLYN BAKER/UNSPLASH

7 YOUR RIGHTS IN CASE OF RESTRICTIONS

For patients in compulsory or forensic psychiatric care, there are provisions that may, under certain conditions, allow for interference with the individual's private life. In this chapter, we review the legal basis for restrictions on information and correspondence in inpatient institutions. This includes monitoring of mail and letters, as well as restrictions on electronic communications such as telephones and computers. We look at statements issued by the Parliamentary Ombudsmen (JO) and others on the inspection of patients' rooms.

7.1 LEGAL BASIS

Both national and international law contain provisions safeguarding the individual's right to privacy. Article 8 of the ECHR consists of three parts: respect for the private life of the individual, respect for the family life of the individual, and the right to protection of home and correspondence.

Under the Instrument of Government, Swedish law may not be applied if contrary to provisions in the ECHR. These, in turn, are to be interpreted in light of international law.

Article 8 of the ECHR has its equivalent in Article 17 of the UN Convention on Civil and Political Rights. The UN monitoring committee for the convention has adopted a comment on how Article 17 should be interpreted:

General Comment No. 16 – Article 17, The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation.

The individual's right to protection against interference with their privacy is also enshrined in Article 22 of the UN Convention on the Rights of Persons with Disabilities. Article 17 further clarifies the protection of the individual's privacy, stating that "Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others."

Children's rights

The right of the child to protection of their private life is enshrined in Article 16 of the Convention on the Rights of the Child and Article 7 of the UN Convention on the Rights of Persons with Disabilities.

Children's right to privacy must always be looked at from both a holistic and a child perspective. The right to privacy enshrined in the Convention on the Rights of the Child is complemented by the following rights: the right of children to express their opinion, the best interests of the child as a primary consideration, the right to a family life, and the right to protection against attacks on their honour.

The Convention on the Rights of the Child also contains several articles relating to the detention of children relevant to the interpretation of Article 8 of the ECHR. These include Articles 9, 16, 20, and 25.

7.2 SWEDISH LAW

Restrictions on Article 8 of the ECHR may only be imposed in the manner provided for in Article 8(2), that is, in accordance with the law and as is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Monitoring of mail

For patients in compulsory or forensic psychiatric care, there are provisions that may, under certain conditions, allow for interference with the individual's private life. These provisions can be found in the Compulsory Psychiatric Care Act (LPT). In accordance with the Forensic Psychiatric Care Act (LRV), these provisions shall also apply in the context of inpatient forensic psychiatric care (8 § LRV).

The physician executive may decide that mail received by a patient is to be inspected in order to verify that it does not contain certain prohibited property (22 § LPT). This includes items such as narcotics, alcoholic beverages, other intoxicants, or property that may harm the patient or someone else, or be detrimental to the healthcare services or to order at the care facility (21 § LPT). If mail arrives containing property that the patient is not allowed to possess, it may be confiscated.

The inspection of mail may not extend to the written contents of letters or other documents.

In this context, "mail" may refer to letters, parcels, or similar items that are intended for sending.

The physician executive may decide to monitor mail to a certain patient if it is necessary for the care or rehabilitation of the patient or to avoid injury to others (22a § LPT). For this purpose, the physician executive may open, inspect, and withhold items of mail from the patient. A decision to withhold items of mail may only be made if the care or rehabilitation of the patient may otherwise be hindered or to prevent injury to others. It may, for example, become necessary in order to break a destructive pattern of behaviour caused by the patient's medical condition or to prevent threats and harassment towards others.

Mail from a patient to a Swedish authority, lawyer, the patient's public counsel, or an international body authorised to receive complaints from individuals shall be forwarded without prior inspection.

A decision on monitoring of mail may never be taken collectively for a group of patients or a certain ward. In each individual case, an overall assessment of the conditions for the decision must be made. It may never be used as punishment.

Prior to a decision to monitor a patient's mail, it must be shown that the patient has abused their right to communicate with the outside world or that there is a well-founded reason for such an abuse being likely. The patient's current mental state and past behaviour shall be taken into account. Moreover, such a decision does not allow for consistent monitoring of all items of mail. Instead, it means that no further decision is needed for the opening, inspection, and withholding of individual letters during the period that the decision remains valid.

The principle of proportionality set out in the LPT and Article 8 of the ECHR applies to all decisions on monitoring of mail (2a § LPT). This means that the inspection of the contents of an item of mail must not be more invasive than is necessary in relation to its purpose. It also means that the inspection shall, to the extent possible, only be carried out by a certain person or certain persons.

During the opening and inspection of an item of mail, the patient should be present. Yet it is not clear from legislative history what "should" really means in this context. JO offers some guidance on the issue. In JO's decision 3890-1999, a forensic psychiatric unit had inspected items of mail without the patient's participation. The unit's own procedures for inspection of mail made clear that such checks must not take place in the patient's absence. JO noted that the incident had been contrary to the unit's procedures, but did not offer any further criticisms.

Decisions on monitoring of mail may be valid for up to two months but may also apply to shorter periods and shall be reviewed on an ongoing basis. When the conditions for the decision are no longer being met, it shall immediately cease to be valid. The period of restriction or monitoring may be extended by up to two months at a time through a new decision (23 § LPT). The law does not specify an absolute limit. Prior to each decision, a new assessment must be made, the necessity of the measure must be reviewed, and the interference must be deemed proportionate (Article 8 of the ECHR and 2a § LPT).

The patient shall be informed that the decision may be appealed to the administrative court.

Electronic communications

Chefsöverläkaren får besluta att inskränka en patients rätt att använda The physician executive may decide to restrict a patient's right to use electronic communications services (20a § LPT). This refers to services that require one party to transmit signals to another party via an electronic communications network, such as to a telephone or computer.

Prior to a decision to restrict a patient's right to use electronic communications services, it must be shown that the patient has abused their right to use such services or that there is a well founded reason for such an abuse being likely. The patient shall also be informed that the decision may be appealed to the administrative court.

Inspection of the patient's room

A patient may not be in possession of certain prohibited items as specified by the LPT, including narcotics, alcoholic beverages, syringes, and in some cases other property that may harm the patient or others, or be detrimental to the healthcare services or to order at the care facility (21 § LPT). The healthcare provider has a responsibility to ensure that order and safety are maintained at the care facility, and inspections of patients' rooms may become necessary to fulfil that responsibility. Inspections of patients' rooms are thus allowed upon suspicion that the patient is in possession of a prohibited item. The inspection shall be carried out without violation of the patient's bodily integrity.

If a prohibited item is found, it shall be confiscated. It is not possible to appeal against a decision on confiscation.

The legislative history of LPT does not indicate under which circumstances an inspection of a patient's room may be carried out or not. However, JO has issued a statement on this matter in Protocol 4090-2001. The case concerned the inspection of a patient's room at a forensic psychiatric facility upon suspicion that the patient had smuggled unauthorised items into the room. According to JO, the inspection of a patient's room is by definition to be considered a house search (2 ch 6 § RF).

In general, the protection against house searches and similar interference is not absolute, and can be limited through provisions laid down by law or with authorisation by law (2 ch 12 § RF).

However, any restriction may only be imposed to serve purposes acceptable in a democratic society.

The healthcare provider is responsible for care management and ensuring that order and safety are maintained at the care facility. According to JO, inspections of patients' rooms may thus be a necessary step in fulfilling that responsibility.

PHOTO: MANOP PHIMSIT/MOSTPHOTOS

8 DISCRIMINATION

In this chapter, we review the prohibition of discrimination at the international, European, and Swedish level.

8.1 LEGAL BASIS

According to the Swedish Academy Dictionary, to discriminate is "to subject a particular person or group to unjust treatment." It is a relative concept, meaning that it may only be understood in the act of comparison, i.e. when related to something else, such as the treatment that a person should have received or that someone else did receive.

The prohibition of various forms of discrimination is enshrined in a large number of international, European, and Swedish laws. As a principle, it is fundamental to the individual's ability to access their human rights.

The ECHR also prohibits discrimination in relation to the rights enshrined in the ECHR or any of its protocols.

8.2 SWEDISH LAW

The Swedish protection against discrimination is found in the Instrument of Government, and further specified in the various anti-discrimination laws, including the Discrimination Act (2008:567) which specifically prohibits discrimination in the context of the healthcare services, the social services, and the social security system.

The forms of discrimination prohibited by law are direct discrimination, indirect discrimination, lack of availability, harassment, sexual harassment, and instructions to discriminate. The grounds of discrimination included in the prohibition are gender, transgender identity or expression, ethnicity, religious or other beliefs, disability, sexual orientation, and age.

The prohibition of discrimination set down in the Discrimination Act is applicable to the following areas of society:

- Work
- Education
- Labour market policy initiatives and employment services without a public service mission
- Starting or running a business
- Professional qualifications
- Membership in certain organisations
- Goods, services, and housing (outside of private and family life)
- Public gatherings or events (e.g. concerts, markets, or fairs)
- Healthcare
- The social services, mobility service, and housing adaption grants, as well as the social security system (i.e. the services offered by the Swedish Social Insurance Agency)
- Unemployment insurance
- Student finance

In the case of mental illness, it is considered a disability if the illness is recurrent or chronic. This means that you are covered by the prohibition of discrimination regardless of whether you feel that you have a disability or not.

Even if your mental illness is not recurrent or chronic, you may still be covered by the protections in the Discrimination Act. If, for example, you are being denied somatic care because your healthcare provider knows or believes that you have a psychosocial disability, this may count as discrimination.

As a person with a psychosocial disability, you may be treated differently for reasons unrelated to your disability. Being treated differently on the basis of other grounds of discrimination is also prohibited.

8.3 IF YOU HAVE BEEN SUBJECTED TO DISCRIMINATION

If you feel that you have been subjected to discrimination, there are a number of places to turn to, including the Equality Ombudsman – a government agency working toward a society free from discrimination – or one of Sweden's anti-discrimination agencies. Anti-discrimination agencies provide legal advice and support to people who feel they have been subjected to discrimination. They also work to educate and shape public opinion on discrimination issues in local and regional contexts. You should turn to the anti-discrimination agency closest to your place of residence or where you experienced discrimination.

Proof of discrimination within the healthcare services

Outlined below are a number of court cases where the court has decided that an organisation must make individual assessments and not assume that, for example, all persons with a mental illness are a certain way or can only manage certain things. Despite the fact that patient advisory committees often receive complaints about treatments and interactions with the healthcare services, there are very few cases concerning disability as grounds of discrimination in the context of healthcare. For this reason, the cases below are not specifically related to compulsory care. Instead, the aim is to illustrate what may count as discrimination.

One case concerns a woman who sought help over a tingling sensation in her arm. The woman suffered from both electrical hypersensitivity and fibromyalgia. When she sought medical treatment for the tingling in her arm in the autumn of 2009, the doctor told her that all of her problems were psychological and that she needed psychotherapy. She left the healthcare centre without receiving an examination. The woman reported her doctor to the Equality Ombudsman, who entered into a settlement agreement with Kalmar County Council. As a result, the woman received SEK 60,000.

In another illustrative case of discrimination in the context of healthcare, a doctor was assessing the potential illness or disability of two patients of an ethnic origin other than Swedish. The purpose was to provide a psychiatric co-assessment in their long-term sick leave cases. After two visits, the doctor issued a psychiatric opinion which, according to the Equality Ombudsman, was based on generalising views about the patients' ethnicity and not on their actual individual state of health.

Stockholm District Court sentenced the doctor to pay SEK 60,000 in damages to the man and the woman for the violation. From the judgment, we can learn that a healthcare professional's assessment must always be made on the basis of the individual and that all forms of generalisation are prohibited by law.

Sources: Kalmar County Council, case NOTE 2009/1877, settlement 201-06-07; and Stockholm District Court, case no. T 25395-06 and T 16183-06, judgement 2009-12-10.

PHOTO: JASON BAXTER/MOSTPHOTOS

9 YOUR RIGHT TO SUPPORT

In this chapter, we review your right to receive support in the form of a support person or contact person. There are two sections outlining the provisions concerning custodians and trustees, as well as how to appeal against decisions on custodian- or trusteeship.

Many municipalities offer personal representatives. They can provide information about care, rights, and support available to persons with mental disabilities or who suffer from recurring mental illness.

9.1 SUPPORT PERSON

If you are receiving compulsory psychiatric care, forensic psychiatric care, or if you are being kept in isolation under the Communicable Diseases Act, you have a right to a support person. The right to a support person also applies in the context of psychiatric or forensic psychiatric outpatient care. The physician executive is obliged to inform the patient of their right to a support person (30 § LPT and 26 § LRV).

A support person acts as a companion to a patient in compulsory care – someone to talk to who is completely independent of the healthcare services. If the patient wishes, the support person has a right to participate in administrative court hearings.

However, a support person may not replace healthcare professionals, assume responsibility for the patient's finances, or act as a legal representative.

All support persons are bound by professional secrecy and may not tell others about the patient or any other patients they see as part of their role.

The Patient Advisory Committee assigns cases and appoints a support person at the request of the patient or upon notification from the medical facility where the patient has been committed. When a patient is discharged, they may keep their support person for up to a month, after which the support person can stay in touch as a contact person.

9.2 CONTACT PERSON

There are various provisions giving individuals the opportunity or right to a contact person. A contact person can assist with social contacts, participate in leisure activities, and provide support and advice in everyday life.

If you have a disability, you can apply for a contact person through your municipality, either under the Act Concerning Support and Service for Persons with Certain Functional Impairments (LSS) or the Social Services Act (SoL). You do not need to know under which law you are seeking to exercise your right; the social welfare officer keeps track of that.

A contact person acts as a friend and companion to an adult or young person with some form of intellectual, physical, mental, or neuropsychiatric disability. Having a contact person is free of charge.

Contact person for children and young persons

Children and young persons may be entitled to a contact person and/or contact family under these provisions. Under the Social Services Act, children and young persons may also receive a contact person for other reasons, such as if their social network is limited and:

- the parents are in need of relief.
- the child or young person needs additional adult contacts.
- the parents are struggling with issues such as addiction or mental instability.

If a person is over the age of 15, they can give consent and request a contact person on their own behalf. If the person is under the age of 15, a contact person may only be appointed with the consent of their guardian. An application for a contact person is made to the social services within the municipality. Typically, it is the social worker at the social services office for children and young persons who decides whether this type of support can be helpful to the child and their family. First, the social worker conducts an investigation in accordance with the Social Services Act to assess the need for a contact person.

9.3 PERSONAL REPRESENTATIVE

Many municipalities offer personal representatives. They can provide information about care, rights, and support available to persons with mental disabilities or who suffer from recurring mental illness.

A personal representative works on behalf of the individual and is completely independent of other authorities. They support individuals who tend to have a lot of contact with healthcare, social, and rehabilitation services or other social actors. A personal representative becomes a bit like a personal coordination centre. They are there because many people with mental disabilities or more severe mental illness are dealing with a large number of contacts and considerable needs, but cannot always be expected to cope or know when and where to turn to get help.

A personal representative is a voluntary and free service, and is not available in all municipalities. You therefore have to call the municipality where you are registered to ask whether there is a personal representative who can support you in your everyday life.

9.4 CUSTODIANS AND TRUSTEES

In some situations, you may need help managing your finances, safeguarding your rights, and making sure that things are running smoothly in life. If so, you can apply to the chief guardian in your municipality for assistance from a custodian or trustee.

A custodian or trustee is a person who is paid a fee to assist you with such tasks as paying bills, applying for benefits, or getting additional support from society. They can help you make your living situation, welfare, and spare time

function as smoothly as possible. The tasks of the custodian or trustee are governed by your needs. You have the option to suggest who you would like as your custodian or trustee, but they must be approved by the chief guardian.

Custodians are only assigned to persons who would like one, on a voluntary basis.

Trustees are assigned to persons who need more extensive support, and where a custodian is not sufficient or the person who needs it does not consent. A decision on providing a trustee can thus be made against the individual's will if there are clear reasons for doing so. Because trusteeship involves imposing certain limitations on your independence – on your autonomy – it is considered a very restrictive measure. Decisions on providing a trustee should thus be made with caution. From an international perspective, it is doubtful whether the Swedish form of trusteeship is permissible.

Contact your municipality if you would like to apply for a custodian or trustee, or receive more information.

9.5 APPEALING AGAINST CUSTODIAN- OR TRUSTEESHIP

If you are dissatisfied with a decision on custodian- or trusteeship, you may lodge an appeal. The decision should state where, when, and how to appeal against it.

If you are dissatisfied with your custodian or trustee, or would like a new one, you should turn to the chief guardian in your municipality. The chief guardian supervises custodians and trustees. If the Guardian Committee does not help you, you can contact the County Administrative Board to enquire whether the chief guardian has acted wrongly.

PHOTO: CHRISTIANA RIVERS/UNSPLASH

10 YOUR ROLE AND RIGHTS AS NEXT OF KIN

In this chapter, we review your role and rights as next of kin with regards to visits, transparency, and participation in the care of your close relative.

Being next of kin to a person in compulsory care can be difficult. In some cases, it can be both a relief and a curse.

A person who is worried about their close relative may have a need for transparency. At the same time, it is not certain that it will be granted as there may be other interests that weigh more heavily.

The first one is the patient's right to privacy and integrity. Without the patient's permission, a ward cannot tell you whether the person is on the ward or not.

If they have been deprived of their liberty, however, the healthcare services may, when expressly asked, confirm that the patient is on the ward. Yet the healthcare services may not share other details without the patient's consent, as is regulated by the Public Access to Information and Secrecy Act (2009:400) (OSL).

Informing next of kin that a person is on a particular ward, even if the patient has not given their express consent, is to some degree a safeguard to protect the rule of law. It would not be reasonable for the healthcare services to

be able to lock people up without informing anyone of whom and on what grounds.

In accordance with OSL, a commitment order under the Compulsory Psychiatric Care Act is a public document, but the same is not true of detention orders and psychiatric care certificates.

The other interest that may be balanced against the participation of next of kin is the healthcare provider's obligation to ensure good and safe care, to the extent that it is in conflict with the close relative's wishes. Examples may include situations in which a next of kin is upsetting the patient or making them less susceptible to care, being far too assertive to a point where patient safety is threatened, or arguing for treatment that is inappropriate because it lacks evidence.

In accordance with LPT, next of kin should be allowed to participate in care planning as long as it is not inappropriate. When a family member or close relative with a history of mental illness is admitted for psychiatric care, next of kin often have knowledge that can help the healthcare services gain more insight into the patient's identity, history, and needs. Gaining access to such information may even be a prerequisite for the ability of the healthcare services to provide good and safe care.

Visits by next of kin

Next of kin are typically entitled to visit the ward during visiting hours, but that opportunity may become subject to restrictions. There may also be specific guidelines on different wards that relatives must comply with out of respect for other patients' integrity.

Subject to a decision, patients may have to undergo a body search upon commitment under the Compulsory Psychiatric Care Act (LPT). As a rule, next of kin cannot be forced to do the same. However, staff have a right to deny visitors access if they refuse to leave bags, outerwear, and other packaging outside the ward. If necessary in order to maintain safety at an inpatient forensic psychiatric facility or ward subject to a higher security classification, the healthcare provider may also decide that all persons who enter the facility or ward must be searched (i.e. subjected to a general entry check) in accordance with 8b § LPT.

PHOTO: MICHAEL ERHARDSSON/MOSTPHOTOS

11 YOUR RIGHT TO LODGE A COMPLAINT OR APPEAL

In this chapter, we review your right to lodge a complaint and to appeal against decisions on detention and compulsory care. We explain what appeal instructions are, which decisions and measures may be appealed, and which care measures may not be appealed. Here, you will find more information about public counsel, legal counsellor, lawyer, and representatives.

At the end of the chapter is an article about a study in which Civil Rights Defenders has mapped legal processes responding to cases of deprivation of liberty. The study concludes that it is very rare for the administrative court to rule against the physician executive's assessment.

It is important to know your rights, including your right to appeal against certain decisions. The Compulsory Psychiatric Care Act should be made available and clearly visible to patients in the medical facility.

11.1 LEGAL BASIS AND SWEDISH LAW

According to Article 13 of the ECHR, all persons shall have access to an effective remedy if their rights as set forth in the convention are violated. This means that there should be a possibility to complain about violations of the provisions of the ECHR, to appeal against a decision, and to have it reviewed.

Swedish complaint procedures in the context of both psychiatric and somatic care are largely regulated in accordance with the same system, regardless of whether the matter concerns compulsory care. If you are dissatisfied, you should turn to your healthcare provider in the first instance. The ward or clinic at the hospital has an obligation to investigate events that have resulted in a patient being mistreated. It shall take the measures necessary to avoid it happening again, in accordance with 3 ch 3 § the Patient Safety Act (2010:659).

In the second instance, you should turn to the head of operations at the healthcare facility where you have been treated. If the healthcare provider does not take action, you may contact the Patient Advisory Committee. For cases of a particularly serious nature, you may also turn to IVO. Persons in compulsory care may have their application reviewed by IVO even if they have not turned to their healthcare provider or to the Patient Advisory Board first (which is not the case in the context of other forms of care).

If you are the victim of a crime committed by another inmate or by staff, or if you believe that staff have committed an act of misconduct, it is also possible to turn to the police. The crime of official misconduct, as set down in 20 ch 1 § the Penal Code (1962:700), can only be committed by a public official whose work involves the exercise of public authority. This includes police officers and healthcare workers in their professional capacity. Official misconduct may involve disregard of the law, gross disregard of applicable guidelines, or other serious incidents.

Many of the persons who have contacted RSMH have opinions about the way they have been treated by staff. Poor treatment is problematic because it falls within a grey area of what is and is not permitted by law. If, for various reasons, staff are unable to treat people adequately, this is always inappropriate and deeply problematic. Yet it is difficult to lodge a complaint against. You should always report such matters to the Patient Advisory Committee, however, so that they receive information about how patients feel they are treated by staff.

Appealing against a decision

Under general administrative law, all decisions relating to the exercise of public authority must include appeal instructions explaining whether the decision can be appealed, and, if so, when, where, and how to lodge your appeal.

Under Swedish law, patients have a right to appeal against the following decisions and measures:

- Commitment orders – such an appeal is also considered to include a request to cease compulsory care
- Rejection of request to cease care
- Rejection of request to go outside the care facility
- Restriction on the use of electronic means of communication
- Decision on monitoring of mail from a patient
- Destruction or sale of property (see 24 § LPT)
- Withdrawal of permission to go outside the area of the care facility
- Conditions for outpatient compulsory psychiatric care

Care measures that may not be appealed:

- Involuntary medication
- Belt restraints
- Isolation
- Body searches and superficial strip searches

If you feel that you have been wrongly subjected to one of these measures, you should contact the Patient Advisory Committee or IVO. The Patient Advisory Committee does not make medical assessments of its own and does not issue opinions on whether the healthcare provider has acted wrongly. Instead, the committee's aim is to help patients and healthcare providers better understand each other so that such wrongs can be overcome. You can also report the incident to IVO, who will investigate your complaint. If IVO exposes shortcomings, it may criticise the institution or initiate an individual case against a specific person whose actions have been found wanting. IVO may also initiate a supervisory case concerning the clinic you have reported. It is important to remember that a complaint to IVO is a public document that can be accessed by anyone, unless classified.

11.2 WHEN ARE YOU ENTITLED TO A PUBLIC COUNSEL?

In certain situations, you not only should but must have legal support according to law and conventions. Such is the case when a person is suspected of having committed a crime, or in connection with applications to extend compulsory care. A public counsel is a person who safeguards your interests in a case and offers support during the proceedings. It is the responsibility of the court or authority handling your case to ensure that you are assigned a public counsel. A public counsel is typically a legal counsellor or a lawyer. A legal counsellor is a person with a law degree. However, only a person who has been admitted as a member of the Swedish Bar Association may call themselves an lawyer. A legal counsellor may apply to become a lawyer after at least three years of qualified legal practice and passing the Swedish Bar Examination. Some legal counsellors choose not to apply for membership in the Swedish Bar Association even though they are qualified. So it can be difficult to determine who is good and who is not.

However, if you are dissatisfied with your lawyer, you can turn to the Disciplinary Committee of the Swedish Bar Association

11.3 INFORMATION ABOUT THE APPEALS PROCEDURE AND LEGAL REPRESENTATION

If you are receiving care under the Compulsory Psychiatric Care Act, the physician executive shall, as soon as your condition permits, ensure that you are informed of your right to appeal against certain decisions (32 § and 33 § LPT). You shall also be informed of your right to a representative or counsel, as well as your right to be assigned a public counsel (38 § LPT). The Compulsory Psychiatric Care Act should be made available and clearly visible to patients in the medical facility (48 § LPT). These provisions are also set down in the Patient Act.

The information should be visible, accessible, and adapted to the persons at the facility. It must thus be made available both orally and in writing, and shall also be repeated if necessary.

Many feel that there is a lack of information about their rights on an inpatient ward, which is a serious issue as it exacerbates feelings of powerlessness and may negatively affect patients' well-being. Not being able to read up on what is happening when you need it also leads to less predictability.

If you do not speak Swedish, the information shall be provided to you through an interpreter or other support on the ward. If you feel that you have not received this information, you should ask the medical staff or your doctor in the first instance. If it is still not provided to you, you should contact your Patient Advisory Committee.

11.4 A NOTE ON SWEDISH COURTS OF LAW

In Sweden, there are essentially two legal pathways. The first one is through the general courts, which deal with criminal and civil cases. The general courts consist of the district courts, the courts of appeal, and the Supreme Court.

Then there are the administrative courts, which include the administrative courts, the administrative courts of appeal, and the Supreme Administrative Court. They review cases concerning compulsory care. In addition, there are also specialised courts, including the Labour Court and the migration courts.

The role of the court in cases concerning detention

In different types of proceedings, the court has – through the judge – different powers. In cases of compulsory care, the court has an obligation to ensure that the matter is sufficiently investigated before a decision can be made on continued compulsory care.

If there is not sufficient evidence to make a decision on compulsory care, the court shall either request more evidence and ensure that the investigation is complemented or make a decision that the person should no longer receive compulsory care.

The court shall also ensure that proceedings take place within the time specified, that counsel is available, and that all parties are heard. If there is a need for an interpreter, the court shall provide it. Finally, the court shall ensure a fair trial.

When the Administrative Court Makes a Decision on Compulsory Care

If your doctor is of the opinion that compulsory care needs to continue in the form of outpatient or inpatient treatment, the doctor must apply to the administrative court. In the administrative court, a professional judge and three lay judges usually adjudicate the case after a jurist has given a report, i.e. an oral presentation.

During the report, the physician executive and the jurist give an account of the facts of the case and applicable law.

By law, an additional doctor attached to the administrative court, a so called medical expert, shall also give an opinion on the need for and form of continued care. The opinion of the medical expert is intended to act as a procedural safeguard, ensuring that the court's decision is based on the assessment of more than one doctor. This increases the administrative court's capacity to make an objective assessment.

After the report or the oral proceedings, the court deliberates. This means that the judges discuss the case and reach a decision. If they disagree, there is a vote. The professional judge and the three lay judges each have one vote.

Sometimes, the judgement is delivered orally immediately after the deliberation. However, standard practice is to deliver the judgment later, on a date set by the administrative court. The court always notifies those concerned of the judgment. Information on what to do if you are dissatisfied with the decision, how to lodge an appeal, and the timeframe within which you may do so shall be included with the decision. You always have a right to attend the court hearing. However, if you would like to do so, it is important that you consult your legal representative who will be familiar with both the court process and relevant regulations.

11.5 APPEALING AGAINST A DETENTION ORDER

An administrative court judgement concerning deprivation of liberty may always be appealed. The court's judgment will explain how and when to appeal against the decision.

It shouldn't be the physician executive's sole decision – but it almost always is

During the collaboration on "Locked up – but Not Without Rights", Civil Rights Defenders and RSMH have gathered experiences from persons who have been deprived of their liberty for purposes of compulsory care. It is the experience of many of those who have reached out that legal proceedings concerning detention are all but a chimera, and that the decision still rests with the physician executive. This experience is further confirmed by a study conducted by Civil Rights Defenders.

During the autumn of 2017, Civil Rights Defenders reviewed all judgements issued by the administrative courts in Luleå, Linköping, and Malmö in order to investigate the extent to which the courts carry out independent assessments of the patient's need for continued compulsory care or a transition between inpatient and outpatient care. The courts were specifically selected with the purpose of achieving a geographical spread.

The survey showed that all three administrative courts make extensive use of standard wordings in its findings in cases under both the Compulsory Psychiatric Care Act (LPT) and the Forensic Psychiatric Care Act (LRV). These wordings consistently refer to the physician executive's assessment or to the medical investigation presented by the physician executive, without further specifying the circumstances.

The survey concluded that it is very rare for the administrative court to rule against the physician executive's assessment. It is also very rare for the medical expert to express an opinion that deviates from the physician executive's.

Among the LRV cases, none of the 131 reviewed judgments issued by Linköping Administrative Court indicated a difference of opinion between the doctors, or between the doctors and the administrative court.

In Luleå Administrative Court, the medical expert and physician executive expressed differing opinions in only in one out of 33 cases. Among the reviewed LRV cases brought before Malmö Administrative Court, the court went against the physician executive's assessment in only one out of 56 cases.

A similar pattern could be discerned among LPT cases. Civil Rights Defenders and RSMH are working to improve these circumstances.

What can you do to help?
Alert your representative to the situation in the courts, so that they can observe and demand the objectivity of the medical expert when assessing your case.

You can ask your representative to underline the importance of providing clear reasons for the decision. Standard wordings consisting of routine references to the physician executive's assessment make it difficult for the patient and their representative to appeal against a decision, as it is not clear on what grounds a decision to continue compulsory care has been made.

PHOTO: MICHAEL ERHARDSSON/MOSTPHOTOS

12 INTERNATIONAL DOCUMENTS IN FORCE IN SWEDEN

The following is a list of documents to which Sweden has acceded and that contain provisions relating to compulsory care. Any one situation may be governed by rights outlined in several different conventions.

All of the conventions that Sweden has ratified can be found on www.manskligarattigheter.se.

Documents from the UN					
Document	**Signed**	**Ratified**	**In force in Sweden**	**Reservation**	**Prop.**
International Convention on the Elimination of All Forms of Racial Discrimination, 1966-03-07	1966-05-05	1971-12-06	1972-01-05		1970:87
International Covenant on Economic, Social and Cultural Rights, 1966-12-16	1967-09-29	1971-12-06	1976-01-03	Article 7 (d)	1971:125
International Covenant on Civil and Political Rights, 1966-12-16	1967-09-29	1971-12-06	1976-03-23	Articles 10(3), 14(7) and 20(1)	1971:125

International Covenant on Civil and Political Rights, 1966-12-16					
	Signed	**Ratified**	**In force in Sweden**	**Reservation**	**Prop.**
Optional Protocol on Individual Right of Complaint to the International Covenant on Civil and Political Rights, 1966-12-16	1967-09-29	1971-12-06	1976-03-23	Article 5 moment 3	1971:125
Convention on the Elimination of All Forms of Discrimination against Women, 1979-12-18	1980-03-07	1980-07-02	1981-09-03		1979/80: 147
Optional Protocol on Individual Right of Complaint to the Convention on the Elimination of All Forms of Discrimination against Women, 1999-10-06	1999-12-10	2003-04-24	2003-07-24		2002/03: 19
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1984-12-10	1985-02-04	1986-01-08	1987-06-26		1985/86: 17
Convention on the Rights of the Child, 1989-11-20	1990-01-26	1990-06-29	1990-09-02		1989/90: 107
Convention on the Rights of Persons with Disabilities, 2006-12-13	2007-03-30	2008-12-15	2009-01-14		2008/09: 28
Optional Protocol to the Convention on the Rights of Persons with Disabilities, 2006-12-13	2007-03-30	2008-12-15	2009-01-14		2008/09: 28

Documents from the Council of Europe					
Document	**Signed**	**Ratified**	**In force in Sweden**	**Reservation**	**Prop.**
European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), 1950-11-04	1950-11-28	1952-02-04	1953-09-03		1951:165
Protocol No. 1 (ECHR), 1952-03-20	1952-03-20	1953-06-22	1954-05-18		1953:32
Protocol No. 4 Securing Certain Rights and Freedoms Other Than Those Already Included in the Convention and in the First Protocol, 1963-09-16	1963-09-16	1964-06-13	1968-05-22		1964:87
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (Convention Against Torture), 1987-11-26	1987-11-26	1988-06-21	1989-02-01		1987/88:133
Protocols No. 1 and 2 (Convention Against Torture), 1993-11-04	1994-03-07	1994-03-07	2002-03-01		
European Charter for Regional or Minority Languages, 1992-11-05	2000-02-09	2000-02-09	2000-06-01	Sweden's regional and minority languages are Sami, Finnish, and Meänkieli	1998/99:143

Documents from the Council of Europe					
Document	**Signed**	**Ratified**	**In force in Sweden**	**Reservation**	**Prop.**
European Framework Convention for the Protection of National Minorities, 1995-02-01	1995-02-01	2000-02-09	2000-06-01	The national minorities in Sweden are Sami, Sweden Finns, Tornedalians, Roma, and Jews	1998/99: 143
European Social Charter, 1961-10-18	1961-10-18	1962-12-17	1965-02-26	The charter does not contain any provisions on the right of reservation	1962:175
European Social Charter (revised), 1996-05-03	1996-05-03	1998-05-29	1999-07-01		1997/98: 82
European Convention on the Exercise of Children's Rights, 1996-01-25	1996-01-25				
Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Appli-cation of Biology and Medicine, 1997-04-04	1997-04-04				

Documents from the Council of Europe					
Document	**Signed**	**Ratified**	**In force in Sweden**	**Reservation**	**Prop.**
Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, 1998-01-12	1998-01-12				
Council of Europe Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse, 2007-10-25	2007-10-25				
Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence, 2011-05-11	2011-05-11				

ABBREVIATIONS AND KEY TERMS

BrB – Penal Code (1962:700)

FB – Parental Code

FPL – Administrative Court Procedure Act (1971:291)

HD – Supreme Court

HFD – Supreme Administrative Court

HSL – Health and Medical Services Act (2017:30)

HäL – Act on Detention (2010:611)

JK – Chancellor of Justice

JO – Parliamentary Ombudsmen

KvaL – Act on Correctional Treatment in Institutions (1974:203)

LPT – Compulsory Psychiatric Care Act (1991:1128)

LRV – Forensic Psychiatric Care Act (1991:1129)

LRU – Forensic Psychiatric Assessment Act (1991:1137)

LSPV – Act on Preparation of Inpatient Psychiatric Care in Certain Cases (1966:293)

LSS – Act concerning Support and Service for Persons with Certain Functional Impairments (1993:387)

LUL – Young Offenders (Special Provisions) Act (1964:167)

LVM – Care of Substance Abusers (Special Provisions) Act (1988:870)

LVU – Care of Young Persons (Special Provisions) Act (1990:52)

NJA – Nytt juridiskt arkiv (“New legal archive”)

OSL – Public Access to Information and Secrecy Act (2009:400).

Prop. – legislative proposal

RB – Code of Judicial Procedure

RF – Instrument of Government

SFS – Swedish Code of Statutes

SOU – Swedish Government Official Reports

SOSFS – National Board of Health and Welfare’s Code of Statutes

SiS – National Board of Institutional Care

SoL – Social Services Act (2001:453)

MONITORING, SUPERVISORY, AND COMPLAINTS BODIES

BO – Ombudsman for Children

CPT – European Committee for the Prevention of Torture

DO – Equality Ombudsman

European Court of Human Rights

European Court of Justice

UN Committee on the Rights of the Child

UN Committee on Economic, Social and Cultural Rights

UN Committee on the Elimination of Discrimination against Women

UN Human Rights Committee

UN Committee on the Rights of Persons with Disabilities

UN Committee on the Elimination of Racial Discrimination

UN Committee Against Torture

JK – Chancellor of Justice

JO – Parliamentary Ombudsmen

JO OPCAT Unit

IVO – Health and Social Care Inspectorate

LÖF – Landstingens ömsesidiga försäkringsbolag (“the county councils’ mutual insurance company”)

Patient Advisory Committee (there is one in each county, contact the one in the county where you received care)

Sweden’s Anti-Discrimination Agencies


CIVIL
RIGHTS
DEFENDERS


RSMH
RIKSFÖRBUNDET FÖR SOCIAL OCH MENTAL HÄLSA