FOLKETINGETS OMBUDSMAND

Thematic report 2015
on individual support programmes
(’enkeltmandsprojekter’)

Doc. No. 15/01652/
EDS/SOS

What has the theme led to?

The treatment of persons in individual support programmes (so-called 'enkeltmandsprojekter' in Danish) was selected as a theme for the monitoring visits which the Ombudsman carried out in the adult social care sector in 2015 in cooperation with the Danish Institute for Human Rights and DIGNITY – Danish Institute Against Torture.

Individual support programme is an overall term for the special measures which the Act on Social Services provides for citizens with a behaviour so problematic that they cannot be accommodated in the normal social interaction at specialised residential facilities for people with, for instance, mental disorders or physical disabilities.

It was the Ombudsman's overall assessment that the staff at the institutions were generally reflective in relation to the many practical and ethical dilemmas of everyday life, and that they were development-oriented towards these particularly fragile citizens. The physical conditions for these citizens were good, and the (30) relatives and guardians with whom the Ombudsman and his team spoke during the visits expressed, with a few exceptions, great satisfaction with the conditions and with the staff's efforts.

However, the monitoring visits to the 14 institutions included in the Ombudsman's survey also showed that the staff encounter various dilemmas in their efforts to provide the best possible treatment for the citizens. These typically arise because the legislation does not allow the staff to use force to carry out measures which are necessary for the citizen or are in the best interest of the citizen, such as for instance a necessary health examination.

Following visits to two institutions, the monitoring visits also led to the Ombudsman opening own initiative cases on whether the provisions for the use of force in the Act on Social Services has been observed in specific instances.

And finally, the monitoring visits showed that in many instances of the use of force the responsible municipalities do not provide notification and guidance on channels of complaint, and that the responsible municipalities do not have a uniform practice on responding to the institutions' reports on the use of force.

Similar dilemmas are found in the children and young people social care sector.

The thematic report will be submitted to the Ministry of Social Affairs and the Interior and to the Ministry of Health so that the ministries can include it in their deliberations concerning the problematic issues. At a meeting between the Ombudsman and the Ministry of Health in January 2016, there was a preliminary discussion of the report's problematic issues regarding healthcare.

The thematic report has also been sent to the National Board of Social Services, the social supervision authorities and those institutions which the Ombudsman visited as part of the theme.

Reasons for the choice of theme

The purpose of the Ombudsman's monitoring of the social care sector is particularly to help ensure that society's most vulnerable citizens are treated with dignity and respect and overall in accordance with their rights.

At the time when individual support programmes were selected as one of the themes for the Ombudsman's monitoring visits in 2015, there had been media coverage of several cases in which citizens in individual support programmes had been victims of neglect of care and, in some instances, of unlawful use of force.

In Denmark, there are five social supervision authorities (one in each Region) which supervise social institutions. According to information which the Ombudsman received from the social supervision authorities, there were no systematic examinations of conditions for citizens in individual support programmes, and the supervision by these authorities of institutions in the social care sector is not directed specifically at these citizens but at the institutions in general.

On this basis, the Ombudsman decided in 2014 to assess conditions for these persons in his 2015 monitoring visits in the social care sector.

What did the Ombudsman do?

How was the investigation organised?

All information about social institutions can be found on the internet, through the Social Services Gateway. However, after the decision had been made to look into individual support programmes, it turned out to be difficult to identify such 'individual support programmes' ('enkeltmandsprojekter' in Danish) through the Social Services

Gateway or by searching on the internet, including the homepages of the individual municipalities. In addition, 'individual support programme' is not a uniform concept but will also be listed under such names as 'special measures', 'solo projects' or 'summer house projects'. The concept is not used in the Social Services Act either, and it has over time and in various contexts been defined in slightly different ways.

For use in his investigation of the sector, the Ombudsman chose the definition in the 2010 report "Tilbud til voksne med problemskabende adfærd" (Programmes for adults with behavioural problems (only available in Danish)) by the 'Vidensteam' (a group of experts under the National Board of Social Services), in combination with the definition used in the same Board's 2014 report "Særforanstaltninger – anbefalinger til god praksis for organisering, samarbejde og borgerinddragelse" (Special measures – recommendations for good practice in organisation, cooperation and user involvement (only available in Danish)). The first report can be found on the homepage of the 'Socialpædagogernes Vidensbank' (socio-educational workers' knowledge bank), while the latter can be found on the homepage of the National Board of Social Services.

Because of the difficulties in identifying persons in individual support programmes and their residential facilities, the Ombudsman asked the five largest municipalities and five randomly picked municipalities, evenly distributed geographically, to state which persons the municipalities had decided to give special assistance in the form of individual support programmes. The persons should meet the following conditions:

- The person must be staying at a residential facility or be in a comprehensive programme for which the overall rate for 24 hours is at least DKK 5,000 (all inclusive).
- In addition, the person must be an adult (+18 years) with a permanent functional impairment. The functional impairment must be due to mental retardation, late onset brain damage and/or autism spectrum disorders or other fundamental development disorders.
- The person must also exhibit problematic behaviour which requires a staffing level of at least 1:1.

On the basis of the information received from the 10 municipalities, the Ombudsman selected 14 institutions to visit. The visited institutions appear in appendix 1.

The institutions were picked so that they covered all parts of Denmark and all three types of ownership, meaning private (3), municipal (9) or regional (2). The visits to the

14 institutions included a total of 79 persons who were covered by the above-mentioned definition.

What was examined during the visits?

During the visits, the Ombudsman focused especially on the following conditions:

- Use of force, including number and procedures
- Other interventions vis-à-vis the users
- Physical conditions for users, including their developmental activities
- Relationship between users and staff, including the issue of violence and intimidation (both users towards staff, users towards other users, and staff towards users)
- Relationship between users and their relatives/guardians, including the way in which the institution endeavours to maintain/improve the relationship
- Healthcare services for the users, including the institution's medicines management

How were conditions examined?

Prior to each visit, the Ombudsman asked the institution for information about a number of factors, partly about the institution's overall circumstances and partly about the users included in the visit.

In addition, the institution was asked for a brief statement (a total of no more than three pages) on the following issues: 1) how the institution prevented that the users ended up in inhuman and degrading situations, 2) which significant, problematic incidents the institution had experienced within the last 12 months, 3) what professional (not financial) main challenges the institution had faced in 2015, 4) how the users' access to medical services was organised, and 5) the institution's use of substitute staff (when did the institution use substitute staff, to what extent, and what were the substitute staff's qualifications).

Lastly, the municipalities responsible for the users in individual support programmes (the acting authority) at the relevant institution was asked to forward the three most recent reports from the person-centred supervision which the municipality had carried out regarding the user.

The responsible social supervision authorities were invited to participate in each monitoring visit. In this context, the Ombudsman asked the social supervision

authorities to state whether the authorities had found cause for notifying the placing municipalities in connection with the authorities' supervision of the institutions. The social supervision authorities participated in the large majority of the Ombudsman's monitoring visits.

During the visits, the Ombudsman's monitoring team had talks with the institution's management, staff (including health care personnel), relatives and guardians and with the residents. The monitoring teams had talks with 30 relatives, of whom 13 were guardians, and with 15 residents. It was not possible to have a conversation with most of the 79 residents, either because they did not have any language or because they had difficulties to such an extent that a conversation with strangers would affect their mental state negatively.

The monitoring visits were carried out as part of the Ombudsman's general monitoring activities pursuant to section 18 of the Ombudsman Act and as part of the Ombudsman's task of preventing exposure to for instance inhuman or degrading treatment of persons who are or may be deprived of their liberty, cf. the Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

The Ombudsman's work to prevent degrading treatment, etc. pursuant to the Protocol is carried out in cooperation with the Danish Institute for Human Rights and with DIGNITY – Danish Institute Against Torture. DIGNITY and the Institute for Human Rights contribute to the cooperation with special medical and human rights expertise, meaning among other things that staff with this expertise participates in the planning and execution of and follow-up on monitoring visits on behalf of the two institutes.

What did the Ombudsman find?

As mentioned above, it was the Ombudsman's overall assessment that the institutions' staff were generally reflective in the many practical and ethical dilemmas of everyday life, and that they were caring and development-oriented towards these particularly fragile citizens. The physical conditions for these citizens were good, and the (30) relatives and guardians with whom the Ombudsman and his team spoke during the visits expressed, with a few exceptions, great satisfaction with the conditions and with the staff's efforts.

Dilemmas

More than half of the visited institutions stated that there were residents for whom it was very anxiety-triggering to have to go to the dentist, doctor's or to the hospital to have a filling put in or to have their teeth cleaned, to have blood samples taken or to undergo other examinations and operations. These residents were often without any language and had a developmental age of between 2 and 4 years of age. They were consequently unable to understand the necessity of consenting to the treatment or examination. Procuring consent from guardian or relatives was not a problem in this context, according to information from the institutions and the relatives. The problem was that the resident physically resisted in connection with necessary examinations or treatment.

The Ombudsman was informed of several incidents when it had finally been necessary for the staff to use force to restrain the resident so that the required treatment, blood sampling or examination could be carried out. Some institutions had chosen to report such uses of force as non-statutory use of force to both the placement municipality and the relevant social supervision authority.

A couple of institutions stated during the Ombudsman's monitoring visit that they had informed the Ministry of Social Affairs a few years ago of the non-statutory uses of force with a view to having the Ministry look into the issue.

In most situations where force had been used, the resident had been restrained for a short time, until the sedation worked or the blood sample had been taken. However, the Ombudsman's monitoring team was also informed of a few incidents when the use of force had been more extensive. In one case an institution had an incident when a younger resident during a nature walk had had a serious fall. The fall had resulted in one of the resident's legs being broken in several places. None the less, the resident had attempted to run away on his broken leg, and the staff member had had to restrain the resident on the ground for quite some time before the paramedics came to the rescue.

In the hospital, the resident had resisted treatment and kicked out with his broken leg which was to be operated on and put in a cast. In order to ensure that the resident received the required treatment, several members of the institution's staff had to restrain him. The responsible authority had subsequently carried out a very thorough analysis of the incident with a view to the institution learning from the experience.

The media has mentioned some instances where a resident had resisted medical examination and where those medical examinations had not been carried out using coercion. The lack of medical examination had meant that the resident had not received the necessary treatment and had consequently died.

Both management and staff at the institutions visited by the Ombudsman knew that the use of force in such situations had no authority according to the Social Services Act or the Health Act.

Management and staff encounter the dilemma in situations where it is not possible, despite pedagogic efforts, to achieve a voluntary acceptance of a necessary treatment or examination but where the treatment or examination is required in order to ensure that the resident's medical condition does not deteriorate. The Social Services Act does not give the authority to use force in these situations but in the assessment of the institution, omitting examination or treatment does constitute neglect of care towards the resident.

Section 126 of the Social Services Act lists several conditions to be met in order for emergency use of force to be considered lawful. Section 126 stipulates as follows:

> **"Section 126.** The municipal council may decide to use physical force in restraining a person or leading a person to another room where
> 1) there is an imminent risk that the person may cause substantial injury to himself/herself or other persons, and
> 2) it is absolutely necessary in the given situation."

In many health treatment situations, such as teeth brushing, orthodontic treatment or measuring blood glucose level for the adjustment of diabetes medication, there is in the institutions' opinion no basis for the use of physical force according to section 126 of the Social Services Act. On the other hand, failure to carry out such health treatments can – especially over time – constitute a neglect of care.

Section 19 of the Health Act allows non-consensual medical treatment in certain strictly limited situations. Section 19 stipulates as follows (unofficial translation):

> **"Section 19.** If a patient, being temporarily or permanently unable to give informed consent or being under the age of 15, is in a situation where immediate treatment is necessary for the patient's survival or for a more long-term improvement of the patient's chance of survival or for a significantly better

> outcome of the treatment, a healthcare professional can start or continue a treatment without the consent of the patient or of the custodial parent, next of kin, or guardian."

Forced treatment is carried out on the grounds of *jus necessitates* in order to prevent grave injuries to the patient, cf. i.a. Mette Hartlev et al., Sundhed og Jura (2013), page 148 f. (only in Danish) and item 134 of Practice Note to the Social Services Act on the Use of Force and other Infringements of the Right of Self-determination towards Adults, including Pedagogic Principles (Practice Note No. 8 of 15 February 2011, only in Danish).

There are no regulations in the Danish Health Act on the use of force to avoid neglect of care.

The resident's encounters with other people outside the institution

The Ombudsman was informed several times that during excursions outside the institution, persons in individual support programmes may run into situations with outside persons where it may be necessary, due to the residents' behaviour, to pull the residents away to avoid physical confrontations. However, these situations may not present an obvious risk of significant bodily injury and there is therefore no authority to use force towards the resident pursuant to section 126 of the Social Services Act.

The Ombudsman's monitoring team was also informed of incidents where residents had subjected themselves to degrading situations by undressing in public. Nor in these situations do the regulations in the Social Services Act allow the use of force to lead the resident away.

And lastly, situations where the resident suddenly wants to run away were mentioned. Such situations may quickly escalate to present real danger to the residents who may wander into high-traffic areas, as these residents are far from being safe in traffic.

According to the Social Services Act, staff are only allowed to use pedagogic measures in such situations. However, according to information received by the monitoring team, there were several times when the pedagogic efforts were not sufficient and that persons in individual support programmes had been exposed to verbal or physical reactions which had had a great negative impact on them.

Several institutions therefore expressed a wish for more extensive authority to intervene concerning this group of citizens in escalating situations. It was stressed that the wish was solely based on a regard for the best protection of and care for these citizens.

In some of the conversations with relatives/guardians, the relatives/guardians expressed the spontaneous wish that the institutions would, far more than was actually the case, use force in order to avoid that the citizen was exposed to degrading or extremely unpleasant situations.

The resident's encounters with other residents at the institution

In institutions with more than one resident in an individual support programme, the institution will often attempt to create a social contact between these residents or with other groups at the institution who are also mentally impaired but who are not in an individual support programme. It sometimes happens in such social situations – often quite unpredictably – that an individual support programme resident may start to scream or destroy furniture and equipment or hit out at the other residents. Such behaviour is very anxiety-provoking for the other residents present.

The dilemma for the staff is that the care they wish to provide for the residents cannot be put into practice by leading the resident with the anxiety-provoking behaviour out of the room by use of force, such as taking the resident by the arm. As mentioned above, the Social Services Act's regulations on the use of force presuppose that "there is an imminent risk that the person may cause substantial injury to himself/herself or other persons" and that "it is absolutely necessary in the given situation". It may therefore be some considerable time before the institution staff, using only pedagogic means, manage to get the resident with the anxiety-provoking behaviour or the other residents out of the room. According to the institutions, such incidents trigger anxiety in the residents which may take days or longer to wear off.

On this background, some institutions and certain relatives/guardians expressed the view that it would benefit both the anxiety-provoking resident and the other residents if the use of force was permitted in a limited form in these situations.

The resident and transport

Several institutions used an H-harness with a magnetic catch when transporting the resident in the institution's bus. The resident would be able to open ordinary safety

belts, and this could cause serious problems with regard to traffic safety because the resident would grab or hit the driver. The dilemma arises when the resident has been strapped in the H-harness willingly but subsequently wants to be released from it. The resident cannot do so on his or her own when an H-harness is used. Thus, the resident is restrained by the harness against his or her will.

The regulations of the Social Services Act do not allow such a restraint. Nor would the consent of a guardian mean that it would be lawful to restrain the resident against his or her will. This follows from both the above-mentioned guidelines and of the legislative history of the Guardianship Act.

At a couple of the institutions, the Ombudsman's monitoring team was informed that a municipality with the acting authority for a resident had given permission to use the H-harness. On these occasions the monitoring team stated that in the Ombudsman's opinion, such permissions could not be given under the provisions of the Social Services Act.

At those institutions where the Ombudsman's monitoring team was informed of the use of an H-harness with a magnetic catch, the resident's guardian/relatives were informed thereof and concurred therein, according to the institutions.

The monitoring team's talks with guardians/relatives on the use of the H-harness indicated that these did not consider the use of the H-harness to be a problem and that they could not think of any other solution.

The resident and personal safety equipment

A few of the residents included in the investigation suffered from epilepsy or had such poor motor function that they were prone to falling with resulting fall injuries. In one instance, this had resulted in a massive concussion, and in another, a skull fracture.

The institutions use, among other things, safety helmets for the residents in order to avoid such injuries. However, in certain instances the residents do not wish to wear the helmet. The provisions of the Social Services Act do not allow using force to make the resident wear the helmet. The institutions with residents who needed a safety helmet informed the Ombudsman's monitoring team that the resident's wish not to wear a helmet was always respected.

Naturally, the institutions tried to compensate for the risk of injury to the resident by staff always being very close to the resident in such situations in order to be able to catch the resident in time. However, it did worry the staff greatly that they were not able to fully safeguard the resident from the serious accidents which did happen from time to time.

Relatives of residents needing a safety helmet expressed to the monitoring team their frustration that the legislation was so designed as to make it impossible to force a resident to wear a helmet in situations involving serious risks.

Own-initiative cases

There were factors at two of the institutions which gave the Ombudsman cause to raise concrete own-initiative cases.

One of the visited institutions said that when transporting a resident in the institution's vehicle, they used an H-harness with a magnetic catch which the resident could not get out of without help. Furthermore, the resident was fitted with a walking harness – by all accounts voluntarily – when the staff went for a walk with the resident.

The institution believed that the municipality acting for the resident, which also owned the institution, had given permission to use the H-harness, and that the use of the walking harness could be based on regards for the staff's occupational health.

The Ombudsman asked the responsible municipality for a more detailed account of any decisions made by the municipality regarding the use of the H-harness and the walking harness, including the legal grounds for the decisions.

The Ombudsman has not concluded his processing of this case.

At another of the visited institutions, a special alarm/door opener with delayed action was used in a resident's room. This special door opener was meant to prevent the resident from getting out of the room without the knowledge and active follow-up by the staff, thus getting herself into a situation where she could be a risk to herself or to others.

It appeared from the material which the institution had sent the Ombudsman that the municipality acting for the resident seemed to have given the permission in 2013 and that the permission had been extended indefinitely in connection with the

municipality's preparation of the 2014 action plan for the resident. The precise statutory authority did not appear from the 2013 decision, and the action plan did not state on which grounds the municipality had decided that the measure should be extended indefinitely.

On that basis, the Ombudsman asked the municipality acting for the resident to give a more detailed account of the grounds for the decision and for extending it indefinitely.

The Ombudsman has concluded this case. He concurred with the assessment in the municipality's consultation response that there was no statutory authority to give an indefinite permission to the alarm/door opener in question. The Ombudsman therefore found it to be regrettable that there had for a period of time been such measures in place for the resident without the necessary authority.

Reports on forcible measures, notification and guidance on complaint

During the visits, the Ombudsman's monitoring team in particular discussed emergency uses of physical force pursuant to section 126 of the Social Services Act with the accommodation facilities. The following concerns such uses of force.

Reporting of forcible measures

Section 136 of the Social Services Act states the rules for the reporting of forcible measures. The provision says as follows:

> **"Section 136(1).** Admission to special accommodation facilities under section 129 and any forcible measures taken, including in connection with measures under sections 125-128, shall be registered and reported by the facility to the municipal council responsible for the resident's placement at the facility, cf. section 9 and 9b of the Act on Legal Protection and Administration in Social Matters, and to the municipal council responsible for supervising the operation of the facility, cf. section 148a of this Act or section 2 of the Act on Social Supervision. Is the resident concerned in the report placed at a municipal or regional facility, that facility shall in addition inform the municipal or regional operator of the forcible measure.
> *(2)* The municipal council shall draw up action plans in accordance with section 141 for persons in relation to whom the measures referred to in subsection (1) hereof are implemented."

This provision is further clarified in section 9 of the Executive Order on forcible measures and other restrictions in the right of self-determination of adults and on special safety measures for adults and the duty to accept persons in the accommodation facilities covered by the Social Services Act (Executive Order No. 392 of 23 April 2014), and in the Practice Note by the Ministry for Social Affairs and the Interior on the Use of Forcible Measures and other Infringements of the Right of Self-determination of Adults, including Pedagogic Principles (Practice Note No. 8 of 15 February 2011), item 107.

In 2012, the Ministry for Social Affairs and the Interior issued Practice Note on the Use of Forcible Measures in connection with Persons with a Substantial and Permanent Impairment of Mental Function – for the use of Public Officials. On page 33 of the Practice Note, the process for the treatment of reports on the use of forcible measures is described in more detail. From this it appears, among other things, that the accommodation facility shall send the report to the municipality with a duty to act for the resident and to the social supervision authority and that the municipality with a duty to act for the resident shall make a decision on the lawfulness of the measure and provide the resident with guidance on channels of complaint. There are, however, no provisions in the Social Services Act or in the above-mentioned Executive Order that say that the municipality with a duty to act shall make a decision regarding the lawfulness of the measure or provide the resident with guidance on channels of complaint.

The Ombudsman's visits showed that all the accommodation facilities – according to their own statements – send all reports on forcible measures to the municipality responsible for the resident's action plan and to the relevant social supervision authority. A number of municipal facilities also send all reports to their owner municipality, just as the regional facilities send all reports to the region. All facilities were aware that the social supervision authorities were not obliged to give any feedback concerning the individual report.

The visits also revealed that none of the visited institutions receive any feedback to all of their reports on forcible measures sent to the municipalities responsible for the residents' action plans.

The visits also showed that for the three different types of institution (private, municipal and regional) there was also a difference in the extent to which, and from which body, the institutions received feedback on their reports on use of force.

The three visited private-owned institutions received highly fluctuating feedback from the municipalities with acting authority to their reports on use of force. The private accommodation facilities send their reports to the municipality with acting authority and to the social supervision authority.

Most of the visited municipality-owned institutions received feedback from the owner-municipality to all reports concerning the municipality's own residents but often not for the citizens who were not the municipality's own residents. For some municipalities, however, the system was similar to the system described below for the regions. In those instances, the institution received feedback from the owner-municipality also to the reports regarding citizens who were not the municipality's own residents but often not from the citizen's own action plan municipality.

All regional institutions received feedback from the region to all reports, as a system has been established in the regional institutions to the effect that all reports on the use of force shall be sent not only to the action plan municipality but also to the region. According to the regional institutions' information, some of the action plan municipalities did not provide the institutions with any feedback.

All the institutions expressed a wish for feedback from the action plan municipalities to reports on the use of force. However, the institutions did not know if there was a duty on the part of the action plan municipality to give feedback on each individual report. In the institutions' opinion, feedback would strengthen the cooperation between the institution and the action plan municipality which would in many instances be a clear benefit for the citizens.

The Ombudsman will discuss the uneven practice in this field and the institutions' wish for feedback to reports on the use of force with the Ministry of Social Affairs and the Interior.

Notification and channels of complaint

Section 133 of the Social Services Act stipulates the channels of complaint for, among other things, the use of force in an urgent situation, pursuant to section 126 of the Act.

In a case published in the Ombudsman's Annual Report for 2014, 2014-2, the Ombudsman has criticised, among other things, that a municipality's decision on the use of a door opener for a resident at an institution was not notified to anyone. In the Ombudsman's opinion, the resident's spouse ought to have been informed of the

decision. The Ombudsman also stated that both the accommodation facility and the municipality should have observed the rules on, among other things, registration and reporting of and follow-up on the use of the door opener.

As mentioned above, the Ministry of Social Affairs and the Interior has specified in its Practice Note on the Use of Forcible Measures in connection with Persons with a Substantial and Permanent Impairment of Mental Function that the action plan municipality shall provide guidelines on appeal when restrictive measures have been used.

The Ombudsman's visits to individual support programmes showed an uneven practice as to whether guardians, relatives or others with the right to complain are notified when the use of force has taken place, and whether they receive guidance on the channels of complaint.

In some instances, the contact between the accommodation facility and the guardian/relatives was good, and the facility would for instance notify the guardian/relatives of the restrictive measure over the phone, but without any guidance on channels of complaint. The accommodation facilities generally did not know whether the action plan municipality gave any guidance on appeal to those with a right to complain.

In other instances, the accommodation facility saw to it that guardians/relatives were notified in writing and given guidance on channels of complaint.

In yet other instances, certain owner municipalities saw to it that guardians/relatives were notified when a restrictive measure had been carried out and gave them guidance on channels of complaint. In those instances, however, the accommodation facility had no knowledge of whether or not guardians/relatives of citizens from other municipalities than the owner-municipality received notification and guidance on channels of complaints.

The visiting team's talks with guardians/relatives showed that the majority received notification (via the telephone or in connection with visits) from the accommodation facility of a restrictive measure.

The talks also showed that only very few – according to their own memory – had received notification and guidance on channels of complaint from the action plan municipality concerning the restrictive measure.

The Ombudsman will discuss the uneven practice in the sector with the Ministry of Social Affairs and the Interior with a view to ensuring that relatives, spouses, guardians, etc. can in practice utilise the channels of complaint according to section 133(3) of the Social Services Act.

Copenhagen, 12 May 2016

Jørgen Steen Sørensen

Danish Parliamentary Ombudsman

Appendix 1

The Ombudsman's visits to individual support programmes in 2015

Institution	**Date**	**Number of residents**
"Damsgaarden"	25 March	1
"Udviklingsprojektet De 2 Gårde"	9 April	5
"Birkekrattet"	10 April	1
"Atterbakken"	28 April	1
"CAS 2"	29 April	3
"Sødisbakke"	19 and 20 May	25
"Sølund"	3 and 4 June	18
"Solkrogen"	17 June	3
"Behandlingscenteret Hammer Bakker"	18 June	6
"Ørum Bo- og aktivitetscenter"	27 August	3
"Hyldgården"	28 August	3
"Stokholtbuen"	2 September	6
"Rønnegård"	17 September	3
"Solvognen"	21 September	1
Total of 14 institutions		**79 residents**