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The Parliamentary Ombudsman Norway

National Preventive Mechanism against Torture and Ill-Treatment

VISIT REPORT

Sørlandet Hospital, Kristiansand
7-9 September 2015

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1 The Parliamentary Ombudsman's preventive mandate

Based on Norway's ratification of the Optional Protocol to the UN Convention against Torture, the Parliamentary Ombudsman has been issued with a special mandate to prevent torture and other cruel, inhuman or degrading treatment or punishment.[1] The Parliamentary Ombudsman has established its own National Preventive Mechanism (NPM) in order to fulfil this mandate.

The NPM makes regular visits to locations where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits may be announced or unannounced.

Based on these visits, the NPM issues recommendations with the aim of preventing torture and other cruel, inhuman or degrading treatment or punishment.

The Parliamentary Ombudsman, represented by the NPM, has right of access to all places of detention and the right to speak privately with people deprived of their liberty. The NPM also has right of access to all essential information relating to detention conditions. During its visits, the NPM will seek to identify risks of violation by making its own observations and through interviews with the people involved. Interviews with detainees are given special priority.

The NPM also engages in extensive dialogue with national authorities, civil society and international human rights bodies.

2 Torture and ill-treatment

The prohibition on torture and other cruel, inhuman or degrading treatment or punishment is established in several international conventions that are binding on Norway.

The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the Convention against Torture), adopted in 1984, plays a central role in this connection. The same prohibition is also enshrined in the UN International Covenant on Civil and Political Rights (Article 7), the UN Convention on the Rights of the Child (Article 37), the UN Convention on the Rights of Persons with Disabilities (Article 15), and the European Convention on Human Rights (Article 3). Norway has ratified all these conventions.

3 Summary

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited the psychiatric hospital department at Sørlandet Hospital in Kristiansand on 7–9 September 2015. Sørlandet Hospital health trust is a district hospital for the inhabitants of Vest-Agder and Aust-Agder counties. It also functions as a local hospital for the municipalities of Lund and Sokndal in Rogaland county. The hospital offers all specialist health services in somatic and psychiatric health care and substance abuse treatment and has operations in several locations, including hospitals in Kristiansand, Arendal and Flekkefjord. The Clinic for Mental Health and Addiction Treatment comprises eight departments:

[1] The Act relating to the Parliamentary Ombudsman for Public Administration Section 3(a).

the psychiatric hospital department, the department of child and adolescent mental health, the outpatient clinic for psychosomatics and trauma, the department of substance abuse and addiction, and the district psychiatric centres in Aust-Agder, Solvang, Strømme and Lister. The psychiatric hospital department has facilities in both Kristiansand and Arendal.

The NPM's visit to Sørlandet Hospital was limited to six inpatient units at the psychiatric hospital department in Kristiansand: emergency units 6.1 and 6.2, psychosis units 4.1 and 7, secure treatment unit 4.2, and first-episode psychosis unit 2.1.

The NPM notified the hospital management in advance of a planned visit, but the exact time of the visit was not stated before the visit took place. The hospital submitted the requested documents both prior to and after the visit.

The visit began with an inspection of both emergency units and the secure treatment unit. Later on the first day of the visit, the NPM had a meeting with the department's management at which the NPM presented the Parliamentary Ombudsman's prevention mandate and the work methods for the visit. Interviews were then conducted with patients and the other inpatient units were inspected. The visit lasted for three days and concluded with a meeting with the department's management, at which preliminary findings were presented.

Most available committed patients were offered a private conversation with the NPM. Interviews were also conducted with staff members. The NPM also reviewed relevant documents. They included all use-of-force records for 2014 and 2015 up to and including the date of the visit. Documents were also requested that concerned the last three occasions on which restraint beds were used in each of the visited units that used restraint beds (4) before the hospital received notification of the visit.

The physical conditions in the different inpatient units appeared to be good. All of the inpatient units had access to outdoor areas, but the inpatient units situated on the ground floor (units 2.1, 4.1 and 6.1) did not have outdoor areas that were designed to enable patients who had been committed to go outside when they wanted.

The patients were informed both verbally and in writing about use-of-force decisions, but were not routinely given the grounds for the decision in writing. A review of documents concerning patients who had been subjected to the use of mechanical restraints showed a lack of agreement between documentation of attempts at less intrusive measures for some administrative decisions and record entries. Deficiencies were also found in the keeping of use-of-force records. The NPM did not find any written information posted in the inpatient units about rights in connection with the use of force, nor about the supervisory commission, the County Governor or the Parliamentary Ombudsman.

The NPM noted that the psychiatric hospital department had endeavoured to reduce the use of all types of force, including the use of coercive measures. A review of documents indicated that, in most cases, mechanical restraints were used for a few hours or for less than 24 hours. Two cases gave cause for grave concern. One case concerned a patient who had been placed in restraints and where the duration of the measure had been determined in advance without the person responsible for the decision continuously assessing the patient's situation and whether the criteria for the use of the

restraints still applied. In another case, an elderly patient with dementia was restrained for six hours, even though the risk of harm had passed.

The patients' next of kin were largely informed about the use of the coercive measures, so that their right to file a complaint etc. was safeguarded. In one case, however, two days elapsed before the next of kin was informed.

The psychiatric hospital department had initiated a system of voluntary interviews, so-called follow-up interviews, between patients and health personnel following the use of force. This is one of the measures the department hopes will reduce the use of all types of force. It emerged during the visit, however, that follow-up interviews were not always offered and that they were a source of distress for some patients who did not find them useful.

The NPM received feedback from several patients about the use of medication. Patients who had been forced to take medication largely perceived this as a negative experience.

All of the inpatient units had at least one segregation room or unit. The verandas in some of the segregation units did not give the patients a satisfactory feeling of spending time outdoors or did not sufficiently safeguard their privacy. The placing of the restraint beds in the segregation units was problematic because it could generate unnecessary fear or increase the risk of the restraint bed being used instead of less intrusive measures. The NPM found patients who were segregated in the segregation unit while the staff sat with the door closed in the main corridor outside. This practice, as it was observed during the visit, indicated that the segregation resembled full isolation.

The NPM was left with the impression that many patients wanted to spend more time outside, to have more physical activities and more active staff who could facilitate indoor activities.

The following recommendations are made on the basis of the NPM's visit:

PHYSICAL CONDITIONS

- The hospital should ensure that all committed patients have daily access to outdoor areas and that they as a general rule can use them when they want, with as few physical limitations as possible.

PATIENT RIGHTS

Administrative decisions

- Patients should always be informed both verbally and in writing about use-of-force decisions and about the concrete grounds for such decisions (the record entry). As a rule, the patient should not have to request access to his/her patient records in order to obtain information about the grounds for a decision to use force.

- Administrative decisions and record entries should contain thorough, correct and detailed information about the grounds for the use of coercive measures.

Opportunities to complain

- The hospital should ensure that information about patient rights, appeal bodies and the right to file a complaint is displayed and easily available in all inpatient units that receive patients who have been committed.

COERCIVE MEASURES

Improper use of coercive measures

- It should be ensured that decisions to use coercive measures are revoked as soon as the risk of harm has passed.

The use of coercive measures at patients' own request

- Coercive measures should not be used at the patient's own request unless the statutory requirements have been met.

Information to next of kin after the use of coercive measures

- The immediate next of kin should be informed at once about the use of coercive measures unless the patient objects.

Follow-up interviews

- The patient should be offered a follow-up interview about the use of the coercive measure, or, if relevant, the patient should be given an opportunity to talk to others who were not involved in the implementation of the coercive measure.

Use-of-force records

- The hospital should ensure that the use-of-force records always include the patient's name and personal ID number, the time when the coercive measure was initiated and discontinued, the grounds for the coercive measure and the names of both the duty doctor and the mental health professional responsible for the decision to use force. Any injuries to patients or staff must also be registered. Patients should be given an opportunity to submit comments to be enclosed with the use-of-force records, and they should have access to the use-of-force records concerning their particular incident.

SEGREGATION

Segregation records

- The hospital should ensure that all segregation records are standardised and contain information about the implementation of segregation measures, the degree of freedom of movement, any additional administrative decisions and other restrictions.

Design of segregation units

- The hospital should assess alternative segregated options for patients to spend time outdoors in addition to the verandas in inpatient units 4.1 and 6.2.

Restraint beds in segregation units

- Restraint beds should not be placed in the segregation units.

Location of staff

- Steps should be taken to ensure that segregation does not entail full isolation and that segregated patients are not kept separate from the personnel involved in implementing the segregation. The patient should therefore not be alone in the segregation unit while staff are outside in the corridor on the other side of a closed door.

Other restrictions during segregation

- Administrative decisions to limit contact with the outside world pursuant to Section 4-5 of the Mental Healthcare Act should not be made based on precautionary considerations or because it can be unpleasant for those affected.

CONTACT WITH THE OUTSIDE WORLD

Monitoring visits

- There should be no restrictions on telephone calls and visits unless strictly necessary and provided for by law.

SEARCHES

- The hospital should only search patients' belongings when there is a 'justifiable suspicion' that medicines, intoxicants, escape aids or dangerous objects are being introduced or stored, and an administrative decision should be made in such cases.

ACTIVITIES

- The hospital should strengthen the milieu therapy offered to patients who have been committed.

- The hospital should ensure that all committed patients have access to at least one hour of outdoor exercise and daily activities adapted to the patient's needs.

4 General information about the psychiatric hospital department at Sørlandet Hospital in Kristiansand

Sørlandet Hospital health trust is a district hospital for the inhabitants of Vest-Agder and Aust-Agder counties. It also functions as a local hospital for the municipalities of Lund and Sokndal in Rogaland county. The hospital offers a full range of specialist health services in the fields of somatic and psychiatric health care and substance abuse treatment. Sørlandet Hospital health trust covers an area with a population of around 290,000 people, and its activities are spread across several locations, including hospitals in Kristiansand, Arendal and Flekkefjord.

The Clinic for Mental Health comprises eight departments: the psychiatric hospital department, the department of child and adolescent mental health, the outpatient clinic for psychosomatics and trauma, the department of substance abuse and addiction, and the district psychiatric centres in Aust-Agder, Solvang, Strømme and Lister. The psychiatric hospital department has facilities in both Kristiansand and Arendal.

The NPM's visit to Sørlandet Hospital was limited to the psychiatric hospital department in Kristiansand. In Kristiansand, the psychiatric hospital department has seven inpatient units with a total of 73 beds. Each unit has a management team comprising one head of unit, one senior consultant and one specialist psychologist.

The NPM visited all the inpatient units except the geriatric psychiatry unit. The NPM visited the following inpatient units.

- *The emergency units (unit 6.1 and 6.2)* have 13 and 10 beds, respectively. The emergency units offer emergency care, assessment and diagnosis in connection with admissions on an inpatient basis. Conditions that are defined as emergencies pursuant to the Mental Health Care Act are mainly psychoses characterised by great distress and aggressiveness or destructiveness, severe anxiety and depressive reactions with a risk of suicidal tendencies,

and delirium. In addition to their emergency care function, units 6.1 and 6.2 receive patients from other units or district psychiatric centres when the patients' condition has deteriorated to the point where they cannot continue their stay at the unit in question. The units' treatment comprises medical treatment, milieu therapy, individual conversations, ECT treatment (electroconvulsive therapy) and family therapy. Unit 6.1 had 702 admissions and unit 6.2 had 390 admissions in 2014.[2]

- *Psychosis unit, the specialist unit for psychosis disorders (unit 4.1)* has twelve beds. The unit receives patients with serious mental illness combined with serious substance abuse problems or functional impairment who can at times pose a danger to themselves or others.

- *Psychosis unit, the unit for rehabilitation in connection with serious mental illness (unit 7.2)* has eight beds. The unit is a closed treatment and assessment unit for psychosis and takes inpatients. Most of the patients have been transferred from emergency departments, and more than half of the admissions are committals. The unit offers rehabilitation for patients with serious psychosis disorders such as schizophrenia, schizoaffective disorders and bipolar affective disorders. Most of the patients have been admitted to mental health institutions before, but the unit also has first-time inpatients over 35 years of age and assesses this patient group. The unit's patients are in the age group 23–65.

- *Specialist unit, the secure treatment and forensic psychiatry unit (unit 4.2)* has ten beds. The unit observes and treats patients whom the courts have sentenced to psychiatric treatment.

- *Specialist unit, the unit for first-episode psychoses (unit 2.1)* has ten beds. The unit offers assessment/diagnosis, a psychoeducational approach and treatment of first-episode psychoses and young adult patients with psychoses. There is a high proportion of patients with other concurrent illnesses, especially developmental disorders and substance abuse. The unit also takes outpatients.[3]

The Clinic for Mental Health has its own user council comprising representatives from Mental Helse Aust-Agder, Mental Helse Vest-Agder, LPP Grimstad/Aust-Agder, LPP Vest-Agder, A-larm, proLAR, the Kick-off environment connected to the department of child and adolescent mental health (ABUP), and WayBack. The psychiatric hospital department also has an experience consultant who incorporates user experience and user perspectives into the service.

In 2014, the psychiatric hospital department in Kristiansand[4] had 970 voluntary admissions, 172 admissions for compulsory observation,[5] 264 admissions for compulsory mental health care[6] and 15

[2] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, the psychiatric hospital department, Annual reports for units in the psychiatric hospital department 2014, pages 36 and 40.
[3] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, the psychiatric hospital department, Annual reports for units in the psychiatric hospital department 2014, pages 23 and 24.
[4] The admission figures broken down by the section under which patients were admitted were provided by the psychiatric hospital department.
[5] Sections 3-2 and 3-5 first paragraph of the Mental Health Care Act.
[6] Sections 3-3 and 3-5 first paragraph of the Mental Health Care Act.

admissions of patients sentenced to compulsory mental health care.[7] The number of committals was 231 per 100,000 in 2014.[8]

In 2014, the psychiatric hospital department at Kristiansand hospital[9] made a total of 78 administrative decisions concerning segregation.[10] In the same year, 107 administrative decisions to use of coercive measures were made,[11] of which 31 decisions concerned mechanical restraints, 33 decisions concerned short-acting medication, and 43 concerned short periods of holding patients. A total of 55 decisions were also made concerning treatment without the patient's consent,[12] of which 51 decisions concerned forced medication and four concerned forced nutrition.

5 How the visit was conducted

In June 2015, Sørlandet Hospital's management was notified that the NPM would visit in September. The date of the visit was not given.

Prior to the visit, the hospital submitted the requested documents, including the psychiatric hospital department's annual report, guidelines and statistics, nonconformity reports and copies of use-of-force records. Documents (administrative decisions, patient record entries and copies of use-of-force records) were also obtained for the last three occasions on which restraint beds were used before the hospital received notification of the visit in each of the four visited units where restraints were used. The NPM also obtained information from the supervisory commission.

The visit began with an inspection of emergency units 6.1 and 6.2 and secure treatment unit 4.2. The inspection included patient rooms, segregated sections, communal areas, outdoor areas and rooms with restraint beds.

Later on the first day of the visit, the NPM met with the department's management to present the Parliamentary Ombudsman's prevention mandate and the methods that would be used during the visit. The need for private interviews with patients was emphasised in particular.

On the first day, interviews were conducted with patients from emergency units 6.1 and 6.2. On the second day, the NPM inspected psychosis units 4.1 and 7.2 and interviewed patients from secure treatment unit 4.2 and psychosis unit 4.1. On the final day of the visit, NPM inspected and conducted patient interviews at first-episode psychosis unit 2.1 and carried out patient interviews at psychosis units 4.1 and 7.2.

Most committed patients were offered a private interview with the NPM. The NPM also interviewed voluntary patients who wished to be interviewed. The private interviews took place in the patient rooms or in consultation rooms connected to the inpatient units. The NPM particularly focused on

[7] Section 62 of the General Civil Penal Code.
[8] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, the psychiatric hospital department, Annual report 2014, page 9.
[9] The number of decisions concerning segregation, coercive measures and treatment without the patient's consent was provided by the psychiatric hospital department.
[10] Section 4-3 of the Mental Health Care Act.
[11] Section 4-8 of the Mental Health Care Act.
[12] Section 4-4 of the Mental Health Care Act.

patients who had been committed and/or experienced compulsory treatment or the use of coercive measures during their current or previous admissions.

Interviews were also conducted with staff members. During the visit, the NPM also reviewed use-of-force records from all inpatient units.

The visit concluded with a meeting with the department's management at which the preliminary findings were presented.

The hospital's management and other staff members were forthcoming throughout the visit. The NPM's information posters were posted in all the wards and the staff seemed to have been properly informed about the visit.

The following representatives of the Parliamentary Ombudsman participated in the visit:

- Helga Fastrup Ervik (head of the NPM, lawyer)
- Kristina Baker Sole (senior adviser, physician)
- Knut Evensen (senior adviser, social scientist)
- Johannes Flisnes Nilsen (adviser, lawyer)
- Ragnfrid Kogstad (external expert, professor of mental health care at Hedmark University College)

6 Findings and recommendations

6.1 Physical conditions

The physical conditions in the different inpatient units appeared to be good. All patient rooms were equipped with a bed and a wardrobe and had a separate bathroom. The rooms had windows and the doors could be locked from the inside. Among other things, each inpatient unit had a common living room, dining room and visiting room/consultation room. All duty rooms had windows with unobstructed views of the inpatient units.

Most inpatient units had spartan and institutional furnishings. Psychosis unit 7.2, however, was designed with a view to creating a less hospital-like atmosphere with the patients in focus. The corridor had pictures and sofa groups with tables and plants. The unit also had a small library with books, magazines, a DVD player and DVDs, and a cosy sofa group. The segregation unit at unit 7.2 was painted to create a good contrast between the floor, walls and ceiling, and it had an exit to a separate veranda with tables and chairs. Among other things, first-episode psychosis unit 2.1 had a music room with sofas, a TV, a piano and other instruments, and an activity room with a billiard table. The doors of the patient rooms open directly onto a common area.

All inpatient units had access to outdoor areas. The inpatient units situated on the ground floor (units 2.1, 4.1 and 6.1) did not have outdoor areas that were designed to enable committed patients to go outside whenever they wanted. Secure treatment unit 4.2, located on the first floor, had an exterior staircase down to a fenced-in garden which was partially screened from the road and other buildings. The garden had seats partly covered by a roof. The NPM was informed that the door to the garden was unlocked during the day and early evening every day. Emergency unit 6.2 and psychosis unit 7.2 had verandas with seats, but the doors had to be unlocked when a patient wanted to go outside. The

segregation units at emergency unit 6.2 and psychosis units 4.1 and 4.2 had small separate verandas, while the segregation units at emergency unit 6.1 did not have its own outdoor area (see section 6.5.2 on segregation).

The hospital informed the NPM that the gym had been closed for a year due to water damage after flooding. The gym will be repaired, but has not been reopened yet (see section 6.8 on activity).

Well-designed physical surroundings for patients are an important preventive measure. The physical conditions at the inpatient units should create a safe and health-promoting environment for patients so that treatment can be given in the most gentle and respectful manner possible.

Recommendation

- The hospital should ensure that all committed patients have daily access to outdoor areas and that they as a general rule can use them when they want, with as few physical limitations as possible.

6.2 Patient rights

6.2.1 Administrative decisions

At the psychiatric hospital department, it is the responsible mental health professionals who make administrative decisions concerning e.g. compulsory observation, compulsory mental health care, segregation, treatment without the patient's consent and the use of coercive measures. Decisions are recorded in the electronic patient records. They also contain notes giving the grounds for each individual decision. The administrative decision itself only states which statutory provisions have been considered and used as the basis for the decision and gives no specific grounds. Patients do not receive the written grounds for the administrative decision (the record entry) together with the decision, but have to request access to their patient records to see them. The Parliamentary Ombudsman has previously pointed out that this practice should be changed.[13] All patients should be informed of the grounds for use-of-force decisions both verbally and in writing in order to ensure that their rights are safeguarded and to prevent arbitrary use of force.

When the NPM requested that the hospital provide documentation of the use of coercive measures, the hospital discovered that, in one case, no administrative decision had been made. The hospital's management therefore requested all units to ensure that everyone who is responsible for making administrative decisions on duty is aware of who is responsible for entering decisions into the patient records. In connection with the visit, the NPM nevertheless found one more recent case in which no administrative decision had been made in connection with the use of a restraint bed.

The supervisory commission stated that it regularly advises health personnel against using standard texts in record entries that fail to provide a sufficient and specific description of how the statutory requirements for the use of coercive measures have been met in each case, including a specific description of which less intrusive measures have been used, how long they were used, and what the result was.[14]

[13] See the Parliamentary Ombudsman's report on the visits to Diakonhjemmet Hospital on 24–27 February 2015 and Telemark Hospital on 8–10 April 2015.

[14] Section 4-8 first paragraph of the Mental Health Care Act: 'Coercive means shall only be used when milder means have proved to be obviously futile or inadequate.' Sørlandet Hospital health trust, the psychiatric

Specific grounds must be given for an administrative decision to ensure that patients have the possibility to exercise their right to complain. The decision shall inform the patient about the legal basis for the measure and specific grounds shall be provided as to why it was implemented. It shall also inform the patients of the right to complain. A review of documents concerning patients who had been subjected to the use of mechanical restraints showed that some administrative decisions did not agree with the record entry about the same incident as regards documentation of attempts to use less invasive measures.[15] In one case, the record entry contained no information about less invasive measures having been attempted, even if the standard text concerning 'milder means' was included in the administrative decision. In another case, the person in charge documented that the less invasive measures mentioned had not been used, even if the standard text concerning 'milder means' was included in the decision. Contradictory information in administrative decisions and patient record entries can weaken patients' due process protection and possibilities of complaining.

Recommendations

- Patients should always be informed both verbally and in writing about use-of-force decisions and about the concrete grounds for such decisions (the record entry). As a rule, the patient should not have to request access to his/her patient records in order to obtain information about the grounds for a decision to use force.

- Administrative decisions and record entries should contain thorough, correct and detailed information about the grounds for the use of coercive measures.

6.2.2 Opportunities to complain

The supervisory commission's main task is to safeguard the due process protection of people who are given mental health treatment pursuant to Section 6 of the Mental Health Care Act. The supervisory commission is the appellate body for decisions concerning compulsory observation, compulsory mental health care, restrictions on contact with the outside world,[16] bodily searches and other searches,[17] seizures,[18] forced urine samples,[19] the use of coercive measures, segregation and transfer without consent.[20] In addition, the supervisory commission checks all administrative decisions concerning the implementation, upholding and termination of compulsory mental health care and verifies all administrative decisions after three months. Administrative decisions concerning involuntary medical examination[21] and treatment without the patient's consent can be appealed to the county governor. Efficient complaint schemes are important to safeguard patients' due process

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hospital department, Kristiansand S, administrative decision concerning the use of a coercive measure in accordance with Section 4-8 of the Mental Health Care Act: 'Milder means have been attempted, but proved to be obviously futile or inadequate.'

[15] Prior to the visit, the hospital was asked to submit documents concerning the three last cases where mechanical restraints had been used at each unit before the hospital was notified of the visit. The hospital was requested to provide copies of the use-of-force records, administrative decisions, medical grounds (patient record entries), patient record entries recorded during the patient's stay in the restraint bed and up to one day after the incident, and the outcome of the any complaint cases.

[16] Section 4-5 of the Mental Health Care Act.

[17] Section 4-6 of the Mental Health Care Act.

[18] Section 4-7 of the Mental Health Care Act.

[19] Section 4-7a of the Mental Health Care Act.

[20] Section 4-10 of the Mental Health Care Act.

[21] Section 3-1 of the Mental Health Care Act.

protection and prevent ill-treatment. The European Committee for the Prevention of Torture (CPT) has emphasised this in its standards for psychiatric institutions:

> '…as in any place of deprivation of liberty, an effective complaints procedure is a basic safeguard against ill-treatment in psychiatric establishments. Specific arrangements should exist enabling patients to lodge formal complaints with a clearly-designated body, and to communicate on a confidential basis with an appropriate authority outside the establishment.'[22]

> 'The CPT also attaches considerable importance to psychiatric establishments being visited on a regular basis by an independent outside body (e.g. a judge or supervisory committee) which is responsible for the inspection of patients' care. This body should be authorized, in particular, to talk privately with patients, receive directly any complaints which they might have and make any necessary recommendations.'[23]

The supervisory commission for mental health care in Vest-Agder meets every two weeks to consider complaint cases, control administrative decisions and any prolongations of administrative decisions, carry out document control and visit newly admitted patients. The staff asks the patients whether they wish to speak with the supervisory commission while the supervisory commission members are waiting outside the room. In the supervisory commission's estimate, around half the patients accepted the offer. The commission always has the opportunity talk to patients without the staff being present, either in separate visiting rooms or in the patient's room. If any staff members are present, it is because the patients themselves sometimes state that they want their contact person to be present. During the visit, the supervisory commission receives both written and oral complaints. In the supervisory commission's opinion, the department's staff members have a low threshold for phoning the supervisory commission to communicate complaints on behalf of patients.

The supervisory commission carried out seven unannounced visits to the psychiatric hospital department in Kristiansand in 2014 and two unannounced visits in the first half of 2015. During the unannounced visits, the supervisory commission reviewed use-of-force records and talked to patients. The supervisory commission wrote inspection reports that were collected in the commission's own archive. These reports were not sent to the hospital. Instead, the supervisory commission raised relevant matters in letters to the inpatient units. In the supervisory commission's experience, the inpatient units always gave thorough replies. In the inspection reports, the supervisory commission commented on physical conditions, activities and milieu therapy, the atmosphere at the units, education of next of kin, discharging patients to the municipalities, the sale of drugs in an outdoor smoking area, segregation and the use of restraint beds in patients' rooms, house rules, fire procedures and inadequate information in use-of-force protocols.[24]

[22] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 56, paragraph 53.
[23] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 56, paragraph 55.
[24] The supervisory commission for psychiatric hospitals in Vest-Agder, inspection reports from 2014 and the first half of 2015.

The supervisory commission stated that the matters it has identified during its regular visits every two weeks have largely been followed up through direct contact with the person responsible for the ward.[25]

The supervisory commission also has an annual meeting with the hospital's management at which both sides can raise matters for discussion. In January 2015, the supervisory commission raised the matters of individual plans and house rules with the management.

The NPM did not find any written information posted in the inpatient units about rights in connection with the use of coercive measures, nor about the supervisory commission, the County Governor or the Parliamentary Ombudsman. Information about the appeal bodies and the right to file a complaint should be displayed and easily available in all inpatient units to safeguard the rights of committed patients.

Recommendation

- The hospital should ensure that information about patient rights, appeal bodies and the right to file a complaint is displayed and easily available in all inpatient units that receive patients who have been committed.

6.3 Coercive measures

Coercive measures, which are regulated by Section 4-8 of the Mental Health Care Act, include mechanical restraints which hamper the patient's freedom of movement, including restraint beds, mobile restraints and clothing specially designed to prevent injury, detention for a short period of time behind a locked or closed door without a staff member present ('isolation'), single doses of short-acting medicines for the purpose of calming or anaesthetizing the patient, or briefly holding the patient ('holding').

According to the law, coercive measures shall only be used when absolutely necessary to prevent patients from injuring themselves or others, or to avert significant damage to buildings, clothing, furniture or other things. Coercive measures shall only be used when milder means have proved to be obviously futile or inadequate.[26] The Directorate of Health's comments to Section 4-8 of the Mental Health Care Act state that this means that coercive measures shall only be used when an emergency situation makes it necessary.[27]

According to the Clinic for Mental Health, administrative decisions concerning the use of coercive measures are made by the mental health professional responsible for administrative decisions, i.e. a senior consultant or specialist psychologist. The secondary on-call doctors have this responsibility outside ordinary working hours. If it is not possible to contact the responsible mental health professional immediately in an emergency, the person in charge at the unit, for example, the nurse in charge, doctor or psychologist on duty, can make a decision to use mechanical restraints or holding. Short-acting medication can only be prescribed by a doctor.

[25] Letter from the supervisory commission for psychiatric hospitals in Vest Agder to head of department Vegard Ø Haaland at the psychiatric hospital department, the Clinic for Mental Health, Sørlandet Hospital, 1 July 2015.
[26] Section 4-8 of the Mental Health Care Act.
[27] Circular IS-9/2012, page 76.

The hospital's information about coercive measures apply up to and including 1 July 2015. Emergency unit 6.2, psychosis unit 4.1 and secure treatment unit 4.2 have restraint beds and mobile restraints. The three last occasions on which mechanical restraints were used at emergency unit 6.2 were in June 2015, while the last three occasions in secure treatment unit 4.2 were in July 2013, November 2013 and May 2015. Psychosis unit 4.1 last used a restraint bed once in October 2013 and twice in March 2015.

First-episode psychosis unit 2.1 did not have a restraint bed, and mobile restraints were last used in June 2010. Emergency unit 6.1 did not have a restraint bed. The last three occasions on which mobile restraints were used were in July 2013, February 2014 and October 2014.

Psychosis unit 7.2 did not use mechanical restraints.

The psychiatric hospital department in Kristiansand stated that a total of 31 administrative decisions to use mechanical restraints in the form of restraint beds or mobile restraints had been made in 2014. Emergency unit 6.2 had the majority of occasions on which mechanical restraints were used, with 29 administrative decisions. The psychiatric hospital department also made 43 administrative decisions concerning holding in 2014. Administrative decisions concerning short-acting medication were made 33 times in 2014. Sørlandet Hospital stated that it does not use short-term detention behind a locked or closed door without a staff member present ('isolation') as a coercive measure. During the visit, however, circumstances were identified that could indicate that informal isolation was practised during segregation (see section 6.5.4).

The psychiatric hospital department had prepared a list of prioritised measures to reduce the use of all types of force in the department, including coercive measures.[28] These measures emphasised systematic efforts, competence-raising, user participation and communication. The department's own assessment was that a majority of the prioritised measures had been implemented in full or to a significant degree.

According to the psychiatric hospital department, the use of restraint beds in emergency unit 6.2 has seen a downward trend in the past five years in terms of the number of administrative decisions (50 decisions in 2010, 29 in 2014), the number of minutes (20,100 minutes in 2010, 13,771 minutes in 2014), and the number of patients (38 persons in 2010, 22 persons in 2014). However, it is noted that the numbers seem uncertain in light of the fact that the time the coercive measures were terminated was not always recorded (see section 6.3.1).

6.3.1 Improper use of coercive measures

Prior to the visit, documents (decisions, record entries and copies of use-of-force records) were obtained for the last three occasions on which restraint beds were used in each of the four visited units where restraints were used.

A review of documents, as well as of the use-of-force records for 2015, indicated that, in most cases, mechanical restraints were used for periods of a few hours or for less than 24 hours.

Two cases gave cause for grave concern. One concerned a patient who had been placed in restraints on a Thursday and where it was decided on the following day, Friday, that the patient would remain

[28] The list sent to the NPM was last revised on 1 July 2015.

in restraints until Monday. The record entry written on Friday states the following: 'The patient will remain in restraints until Monday, when the undersigned will assess the situation.' It was stated in the entry that the plan was for the patient to be transferred to an adjacent unit the following Tuesday. On Monday, a new administrative decision was made to uphold the coercive measure until the transfer to the adjoining unit the next day.

The coercive measure was not entered in the use-of-force record after Sunday morning, even if it was upheld for a further two days. Neither the administrative decision made on Monday nor the time the use of restraints was terminated on Tuesday were entered in the records. It was therefore unclear whether the patient was still wearing mobile restraints during transport to the adjoining unit, or whether they had been removed prior to the transfer. However, it was stated that shortly after transfer to the new unit, the patient was in the common area together with other patients, behaving in a calm and friendly manner.

During use of a coercive measure, the patient's situation and of whether the criteria for using the coercive measure are still met shall be assessed on a continuous basis. The use of coercive measures shall be terminated as soon as the risk of harm has passed.[29] In light of the statutory requirements, the use of coercive measures where the duration of the measure is decided in advance seems clearly problematic. The duration of the measure (five days) gives further reason for concern, and reference is made to the fact that the CPT states the following in its standards for psychiatric institutions:

> 'The CPT has on occasion encountered psychiatric patients to whom instruments of physical restraint have been applied for a period of days; the Committee must emphasise that such a state of affairs cannot have any therapeutic justification and amounts, in its view, to ill-treatment.'[30]

Furthermore, it is worrying that the patient was restrained for several days with reference to the fact that the patient was eventually to be transferred to another unit. The documents in the case gave reason to question why the patient was not transferred sooner, and whether speeding up the transfer could have prevented several days of restraint use.

In another case, mobile restraints were used on an elderly patient with dementia for six hours. The patient in question had been administered short-acting medicine and had been held for 45 minutes as a result of being highly confused and acting out vis-à-vis the staff. During the long-term holding, which was carried out in the patient's bed by two staff members of the opposite sex, the patient stated that the holding was invasive and offensive. The patient was then placed in mobile restraints, also in the patient's own bed. According to the record entry, the patient calmed down immediately after having been restrained. The mobile restraints were nevertheless not loosened, nor were attempts made to loosen them. The patient record stated that the patient 'had slept well after being restrained, so we chose not to loosen them'. However, no attempts were made to loosen or remove them when the patient woke up and more medication was administered before the patient went back to sleep. The evaluation entry stated that the restraints were not removed until after the shift changeover, while the patient was still sleeping. The use-of-force protocol lacked a clear calculation of the duration of the holding and restraints use. It is also pointed out that the patient was admitted

[29] The Directorate of Health, The Mental Health Care Act and the Mental Health Care Regulations with comments, IS-9/2012, Chapter 3, Section 26, page 141.
[30] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 54, paragraph 48.

pursuant to Section 3-3 of the Mental Health Care Act, despite the fact that the requirement for a serious mental disorder was not met. This error was corrected on the following day, when an administrative decision was made pursuant to Section 4A-5 of the Act relating to patient and user rights.

The case raises ethical issues regarding the use of coercive measures in dementia care. It is also emphasised that the use of coercive measures shall be terminated as soon as the risk of harm has passed.

Recommendation

- It should be ensured that decisions to use coercive measures are revoked as soon as the risk of harm has passed.

6.3.2 The use of coercive measures at patients' own request

There were also some cases where the patients themselves wanted to be placed in restraints. In these cases, an administrative decision was made and the patients were informed about their right to complain. However, coercive measures are not a treatment measure, and the use of coercive measures at patients' own request without the statutory requirements being met is therefore a practise that gives cause for concern. These patients may try to express a need for health care, care or security.[31] A patient's consent does not constitute an independent legal basis for the use of coercive measures under Section 4-8 of the Mental Health Care Act. Using coercive measures at the patient's own request can also entail a risk of misinterpreting or abusing the patient's consent.

Recommendation

- Coercive measures should not be used at the patient's own request unless the statutory requirements have been met.

6.3.3 Information to next of kin after the use of coercive measures

The patients' next of kin were mostly informed about the use of restraints so that their right to file a complaint etc. was safeguarded. In one case, however, two days elapsed before the next of kin was informed. The record entry in the case was written on a Saturday: 'The undersigned has not phoned to inform the next of kin about the incidents today. The undersigned discussed this with the head of unit who was in charge during daytime today, and he had not contacted the next of kin either. We agreed that it can wait until Monday. The patient's mother usually comes to visit every Monday at 18, and we agreed that she can be informed then.' The patient's next of kin cannot use their right to complain when they are not informed, and a delay in informing the next of kin weakens the rights of both the patient and the next of kin.

Recommendation

- The immediate next of kin should be informed at once about the use of coercive measures unless the patient objects.

6.3.4 Follow-up interviews

A voluntary interview between the patient and health personnel after the use of coercive measures, a so-called follow-up interview, can be a means to prevent future use of coercion vis-à-vis the

[31] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), 'The use of restraints in psychiatric institutions', CPT (2012) 28, page 18, paragraph 9.

individual and the use of coercive measures in general.[32] At the same time, it is necessary to take into account that the offensive nature of the use of coercion can result in the patient perceiving such interviews as negative.

The psychiatric hospital department has introduced voluntary follow-up interviews after compulsory observation, after compulsory mental health care and after all other types of coercion (Sections 4-3, 4-4, 4-5, 4-6, 4-7, and 4-8).[33] This is one of the department's prioritised measures to reduce the use of coercion. However, during the visit it emerged that follow-up interviews are not always conducted. It also emerged that the interviews were a source of distress for some patients who did not find them useful.

The NPM was made aware of one case where a patient was not permitted to talk about the experience of coercive measures with a fellow patient. If this is the case, it is a practice that gives cause for concern.

Recommendation

- The patient should be offered a follow-up interview about the use of the coercive measure, or, if relevant, the patient should be given an opportunity to talk to others who were not involved in the implementation of the coercive measure.

6.3.5 Use-of-force records

The use of coercive measures, including administrative decisions, the professional grounds for administrative decisions and continuous monitoring notes are recorded in the electronic patient records. The use of coercive measures are also registered in hand-written use-of-force records available at the inpatient units. The use-of-force records lacked some information, such as patient names, the start date and termination date for the use of coercive measures, and the duration of holding and the use of restraints. Sometimes, the use of mechanical restraints were recorded as 'complete fixation' or 'mobile restraints' only, while sometimes, more extensive information was provided, such as 'mobile restraints w/the left arm fixated,' 'moved r/arm and leg fixation to the left side' or 'freeing leg again item 1'. The information provided about the reason why coercive measures were used was frequently sparse; for example, the entry often said 'agitated' or 'acting out' without giving further details. The staff's written comments in one of the use-of-force records revealed professional disagreement about whether holding carried out in connection with the injection of medicine without the patient's consent (Section 4-4 of the Mental Health Care Act) should be entered in the records of the use of coercive measures pursuant to Section 4-8 of the Mental Health Care Act.

The supervisory commission regularly reviews use-of-force records as part of its welfare controls. Shortcomings in the keeping of the use-of-force records are discussed with the management at the

[32] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 61, paragraph 46. Follow-up interviews with patients are also described in the procedure 'Mekaniske tvangsmidler – bruk i psykisk helsevern' ('Mechanical restraints – use in mental health care'), version 1.0 published by Helse Bergen health trust. The procedure is available at http://www.helsebiblioteket.no/microsite/fagprosedyrer/fagprosedyrer/mekaniske-tvangsmidler-bruk-i-psykisk-helsevern.

[33] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, Follow-up interview after the use of coercive measures – the Clinic for Mental Health, General document, document ID number II. KPH.FEL.2.2-36, revision 3.01, adopted on 2 July 2015.

unit in question. It is good that the supervisory commission communicates directly with the units if there are shortcomings in the records. However, some of the handwritten use-of-force records were so unsystematic and incomplete that it could be challenging for the supervisory commission to identify the patients who are most at risk. In some cases, incomplete use-of-force records (including records lacking time of termination) were signed by the supervisory commission without comments.

The CPT's standards for psychiatric institutions state that patients should have the opportunity to submit comments to be enclosed with the use-of-force records and should be informed about their rights. Patients should also be given access to the use-of-force records concerning their own incident if they so wish.[34]

Reference is also made to the CPT's standards about what factors the use-of-force records should document.[35]

There is no electronic registration or reporting system for administrative use-of-force decisions in Norway. This has previously been discussed in the NPM's visit reports concerning Diakonhjemmet Hospital and Telemark Hospital, and is a matter that will be followed up in relation to the Directorate of Health.

Recommendation

- The hospital should ensure that the use-of-force records always include the patient's name and personal ID number, the time when the coercive measure was initiated and discontinued, the grounds for the coercive measure and the names of both the duty doctor and the mental health professional responsible for the decision to use force. Any injuries to patients or staff must also be registered. Patients should be given an opportunity to submit comments to be enclosed with the use-of-force records, and they should have access to the use-of-force records concerning their particular incident.

6.4 Treatment without the consent of the patient

6.4.1 Findings from the visit

The psychiatric hospital department in Kristiansand informed the NPM that 51 administrative decisions concerning forced medication and four administrative decisions concerning forced nutrition were made in 2014. The staff was of the opinion that the clinic has a strong focus on user participation and that therapists cooperate with patients who object to medical treatment by trying alternative measures and medication that is more acceptable to the patient in question.

The NPM received feedback from several patients about the use of medication. Some patients did not take or had stopped taking medication, and others took medication voluntarily which they felt

[34] Reference is made to a letter from Diakonhjemmet Hospital to the Parliamentary Ombudsman of 25 November 2015 in which the hospital informs the Ombudsman that the use-of-force records will be scanned and enclosed with the patient records. Any comments the patient may have regarding the incident will also be scanned and enclosed. Reference is also made to a letter from Telemark Hospital of 19 November 2015 in which the hospital states that any comments the patient may have to the use-of-force records will be scanned and enclosed with the patient records.

[35] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 55, paragraph 50 and page 63, paragraph 52.

was effective and gave few side effects. However, patients who had been forced to take medication mostly had negative experiences described as e.g. 'terrible', 'horrible' and 'torture'. Several patients referred to unpleasant side effects such as headaches, lethargy and weight gain, a deterioration of their illness with more hallucinations and confusion. Some patients said that the medication did not help them. One patient had lost trust in the staff after having been forced to take medication. Another patient consented to taking medication under pressure to avoid an administrative decision of forced medication. Another patient was told that he would be forced to take medication indefinitely.

6.4.2 National legislation

Pursuant to Section 4-4 of the Mental Health Care Act, patients under compulsory mental health care may be examined or treated without consenting subject to more detailed conditions. Such treatment includes medical treatment without consent in the form of tablets or an intramuscular injection. According to the Act, examination and treatment without the patient's consent may only take place when an attempt has been made to obtain his or her consent, or it is obvious that consent cannot or will not be given. Furthermore, Section 4-4 defines stringent requirements regarding the effectiveness of medication:

> 'Medication may only be carried out using medicines which have a favourable effect that clearly outweighs the disadvantages of any side effects.'

The standard of proof that the treatment will be effective for the individual patient shall also be strictly interpreted. According to the Mental Health Care Act, compulsory treatment measures 'may only be initiated and implemented when there is a great likelihood of their leading to the cure or significant improvement of the patient's condition, or of the patient avoiding a significant deterioration of the illness'.[36] In the preparatory works to the Mental Health Care Act, the former Ministry of Health and Social Affairs discussed the relationship between treatment measures without the consent of the patient and Article 3 of the European Convention on Human Rights (ECHR). The Ministry was of the opinion that a strictly professional justifiability requirement, a requirement for thorough preparatory examinations and a requirement for 'great likelihood' that the compulsory treatment will have a positive effect will safeguard against violations of ECHR Article 3.[37]

The Mental Health Care Act does not give patients diagnosed with a serious mental illness the same right to refuse treatment as other patients. The right to refuse treatment is considered a part of the fundamental right to health set out in the UN's International Covenant on Economic, Social and Cultural Rights (CESCR) Article 12.[38] Objective and reasonable grounds are required in order for differential treatment to not constitute discrimination. The right to equal treatment and protection against discrimination follows from Article 98 of the Norwegian Constitution and several international human rights conventions. Norway's ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2013 has led to extensive discussions about whether the mental health care legislation can be upheld in its current form.

[36] Section 4-4 third paragraph last sentence of the Mental Health Care Act.
[37] Proposition No 11 to the Odelsting (1998–1999) chapter 8.4.6.
[38] See the CESCR Committee, General Comment No 14, 'The right to the highest attainable standard of health', 11. August 2000, E/C.12/2000/4, paragraph 8.

6.4.3 Prevailing international law

The discussion has concerned whether, or to what extent, CRPD allows special legal authority for coercive measures for persons with a disability, i.e. whether a lower threshold for coercion applies compared with other people. In particular, this concerned the scope of Article 12 on equal recognition before the law and legal capacity, Article 14 on the right to liberty and security of the person, Article 15 on freedom from torture or cruel, inhuman or degrading treatment or punishment, Article 17 on protecting the integrity of the person, and Article 25 on the right to health. Thus far, the practice of the expert committee mandated to interpret the convention (the CRPD Committee) has been based on compulsory treatment that is fully *or* partially based on psychosocial disability being in violation of the CRPD's prohibition on torture and inhuman treatment set out in Articles 15, 16 and 17, as well as Article 12. In its concluding observations for Denmark, the Committee recommended that:

> '…the State party amend its laws and regulations in order to abolish the use of physical, chemical, and other medical non-consensual measures, with regard to persons with psychosocial disabilities in institutions'.[39]

The UN Committee on Economic, Social and Cultural Rights (the CESCR Committee) has expressed a similar opinion and, in 2013, it recommended that the Norwegian authorities:

> '… incorporate into the law the abolition of the use of restraint and the enforced administration of intrusive and irreversible treatments such as neuroleptic drugs and electroconvulsive therapy.'[40]

**Other UN bodies have not adopted a clear position,[41] or their views on compulsory treatment allow for the possibility of continuing the practice, subject to strict due process protection guarantees.[42]

The prevailing international law has thus not been finally clarified. However, there is little doubt that the trend is moving towards an increased focused on autonomy and non-discrimination of people with disabilities. The question of whether coercion in mental health care constitutes a discriminatory

[39] The UN Committee on the Rights of Persons with Disabilities (the CRPD Committee), concluding observations for Denmark, 29 October 2014, CRPD/C/DNK/CO/1, paragraph 39. See also the CRPD Committee's concluding observations for Sweden, 11 May 2014, CRPD/C/SWE/CO/1, paragraph 36: 'The Committee also recommends that the State party ensure that all mental health services are provided with the free and informed consent of the person concerned.' See also the CRPD Committee's General Comment No 1 on CRPD Article 14, 11 April 2014, CRPD/C/GC/1, paragraph 42, among others.

[40] The UN Committee on Economic, Social and Cultural Rights (the CESCR Committee), concluding observations for Norway, 13 December 2013, E/C.12/NOR/CO/5, paragraph 19. See also the UN Working Group on Arbitrary Detention, 'Basic Principles and Guidelines on Remedies and Procedures on the Right of Anyone Deprived of His or Her Liberty by Arrest or Detention to Bring Proceedings Before Court', 6 July 2015, A/HRC/30/37, guideline 20, paragraph 106 b); the UN Special Rapporteur on the right to health and on the rights of persons with disabilities, joint statement of 10 October 2015.

[41] The UN Special Rapporteur, Report to the UN General Assembly, 'Torture in Healthcare Settings', 1 February 2013, A/HRC/22/53, and the Special Rapporteur's 'Response by the Special Rapporteur to the Joint Statement from the American Psychiatric Association and the World Psychiatric Association', 22 January 2014.

[42] Among the latter is the UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT); see the document 'Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on the rights of persons institutionalized and medically treated without informed consent', adopted at the Committee's 27th session on 16–20 November 2015.

practice is increasingly the topic of critical discussion on the basis of general legal requirements for necessity and proportionality rather than diagnose-based criteria.[43]

Norwegian authorities have submitted a declaration of interpretation that expresses the view that the convention permits 'compulsory care and treatment of people, including measures initiated to treat mental illness, when the circumstances necessitate such treatment as a final resort and the treatment is subject to due process protection guarantees'.[44] This has been criticised by, among others, the Equality and Anti-Discrimination Ombud, which was tasked with monitoring Norway's compliance with CRPD when Norway ratified the convention.[45]

6.4.4 The seriousness of the encroachment

Forced medication entails a very serious encroachment on an individual's personal integrity and the autonomy of one's own body, thoughts and feelings. The knowledge base for concluding that forced treatment with antipsychotic drugs has a positive effect in the treatment of serious mental illnesses appears unclear and disputed, especially as regards long-term effects ('maintenance treatment'). Medical expert environments are increasingly critical of the quality of research studies.

The Centre for Medical Ethics has stated that:

> 'There is no research evidence to support the claim that compulsory treatment has positive effects, and we know that coercion in the mental health services clearly has harmful effects.'[46]

The Norwegian Medical Association has also stated that it may be necessary to further examine the need for forced medication, particularly for young people, among other things seen in relation to alternative forms of treatment and the serious potential consequences of forced medication.[47]

It seems to be well documented that the use of antipsychotic drugs is associated with many side effects, which can in some cases be serious and irreversible.[48] The side effects can be psychological, such as 'emotional blunting', reduced libido or apathy. Metabolic side effects can include strong weight gain, glucose intolerance and increased cholesterol levels. Patients can also experience motor side effects, such as uncontrolled muscular spasms (acute dystonia), stiffness of muscles and joints similar to that seen in patients with Parkinson's disease, involuntary body movements, particularly in the face (tardive dyskinesia), and extreme tingling and restlessness (akathisia). Possible links between antipsychotic drugs and mortality have also been pointed out.

All in all, there is cause for concern that the forced administration of antipsychotic drugs puts patients at risk of inhuman or degrading treatment.

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[43] See in particular Anna Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective', *Human Rights Law Review*, 2014, 14, pp. 459–498.
[44] Proposition No 106 to the Storting (2011–2012)
[45] The Equality and Anti-Discrimination Ombud, CRPD 2015, 'Ombudets rapport til FNs komité for rettighetene til mennesker med nedsatt funksjonsevne - et supplement til Norges første periodiske rapport' ('the Ombud's report to the UN Committee on the Rights of Persons with Disabilities – a supplement to Norway's first periodic report'), page 20 ff.
[46] The Centre for Medical Ethics' consultation submission to the Paulsrud committee's Norwegian Official Report NOU 2011:9.
[47] The Norwegian Medical Association's consultation submission to the Paulsrud committee's Norwegian Official Report NOU 2011:9.
[48] See NOU 2011:9, pp. 113–114 with further references.

6.4.5 Need for further examination

In an evaluation made in summer 2015, the Directorate of Health concluded that endeavours to reduce coercion in mental health care have been unsuccessful, despite clear objectives and a national strategy.[49] The Directorate of Health recommended that the Ministry of Health and Care Services initiate a revision of the Mental Health Care Act and stated that: 'The revision should include rules relating to the establishment and implementation of compulsory care and examine more closely the right to use compulsory medical maintenance treatment in particular.'[50] The Parliamentary Ombudsman will follow up this matter with the health authorities.

6.5 Segregation

The responsible mental health professional can decide to segregate a patient for treatment purposes or out of consideration for other patients. Segregation means that the patient is kept fully or partially separate from other patients and from personnel who do not participate in the examination, treatment and care of the patient.[51] Segregation can take place in the patient's own room or a special segregation unit. If segregation takes place in a segregation unit, an administrative decision must be made for segregation in excess of 12 hours, and the decision can be made for a period of up to two weeks at a time. For segregation in the patient's own room, an administrative decision must be made if the segregation is maintained for more than 24 hours. Administrative decisions concerning segregation and prolongation of segregation can be appealed to the supervisory commission.

Segregation can also be used for patients under voluntary mental health care, but this requires the patient's consent. A patient under voluntary mental health care cannot be detained or otherwise prevented from leaving the institution if he/she so wishes. This includes during segregation. Patients must be informed about their right to discharge themselves from the institution.[52]

According to a systematic review of literature about Norwegian segregation practice, there is little evidence-based knowledge about the effect of segregation in Norway.[53] However, the hospital stated that it saw a growing need for segregation. At the same time, it was emphasised that segregation was used for as short periods as possible.

6.5.1 Segregation records

A review of the segregation records[54] showed that patients were segregated for periods lasting between one day and six weeks, but it was difficult to confirm the precise duration of the segregation in all cases, since the termination date and time was not always entered in the records. Four patients

[49] The Directorate of Health, 'Vurdering av videreføring av "Bedre kvalitet – økt frivillighet. Nasjonal strategi for økt frivillighet i psykiske helsetjenester (2012–-2015)"' ('Assessment of whether to continue the strategy "Improved quality – reduced coercion. National strategy for reduced coercion in mental health services (2012–2015)"'.

[50] The same note, pp. 22–23.

[51] Section 4-3 of the Mental Health Care Act.

[52] The Directorate of Health, The Mental Health Care Act and the Mental Health Care Regulations with comments, IS-9/2012, Chapter 3, Section 18, page 132. Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, Segregation – guidelines, Guideline, ID number II. KPH.FEL.2.2-37, revision 1.01, adopted on 22 January 2014.

[53] Norvoll R, Ruud T, Hynnekleiv T. 'Skjerming i akuttpsykiatrien' ('Segregation in emergency psychiatry). *Tidsskrift for Norsk Legeforening* (The Journal of the Norwegian Medical Association) 2015; 135:414 – 5.

[54] Segregation records for units 4.1, 4.2, 6.1, 6.2 and 7.2 for 2015 up to and including the time of the visit.

had been subject to several segregation decisions during the course of several months, and for two of them, the segregation decision had been prolonged immediately after the first decision expired.

In some cases, the records lacked clear grounds for the segregation (in one case, for example, the grounds were given as 'patient's mental state'). The practice also varied in terms of how the content of segregation measures was registered and whether other administrative decisions concerning restrictions were also registered. In psychosis unit 7.2., the segregation measures were described in relation to the patient's freedom of movement and access to objects/media, such as 'segregated at segregation unit with personnel present. [Not] receive letters and parcels. [No] visits other than family. Inspection of belongings and body search'. In emergency unit 6.1, however, the segregation measures were only described as 'segregation Section 4-3' or 'segregation in room' in all cases. One segregation decision was also found to not be registered in the records. Different registration practices and inadequate information in the segregation records made it difficult to maintain a good overview of the extent of segregation measures. This is important, among other things because the records provide the basis for the supervisory commission's welfare control.

Recommendation

- The hospital should ensure that all segregation records are standardised and contain information about the implementation of segregation measures, the degree of freedom of movement, any additional administrative decisions and other restrictions.

6.5.2 Design of segregation units

All inpatient units had a segregation room or segregation unit and emergency unit 6.1 had two segregation units. There were some differences between the segregation units at the different inpatient units, but a typical segregation unit comprised a room with a bed and a sitting room with a chair or sofa, and a small hallway with a chair. Some segregation units had a window that offered a direct view of the bedroom or sitting room from a room outside that was part of the segregation unit. Most segregation rooms seemed very spartan, without pictures on the walls or other elements to create a safe atmosphere, with the exception of some magazines. The segregation unit at psychosis unit 7.2, however, was painted in calming yet contrasting colours on the walls and ceiling, see below. All the segregation units were equipped with a clock.

The two segregation units at emergency unit 6.1 had exits to the hospital's outdoor area through locked doors from the unit's main corridor. The doors to the segregation units from the unit's corridor had frosted glass, and chairs were placed in the corridor so that the staff could sit right outside the doors of the segregation units. One of the segregation units was in the quietest end of the inpatient unit. The other segregation unit was located in the intersection between two wings, and was also next to the main entrance and registration room. The patients in this segregation room could therefore be exposed to quite a lot of noise. The windows in the segregation room next to the main entrance had frosted glass to protect the patient's privacy, but they also obstructed the patient's view.

Patients in the segregation unit in emergency unit 6.2 had access to a small separate veranda. However, the veranda had a roof and Plexiglas windows that did not give a satisfactory feeling of being outside. The veranda was a fenced-in part of the unit's big common veranda, which made it

look like a glass cage. The other patients could see into the veranda, and the patient's privacy was thus not fully protected.

The segregation unit at psychosis unit 4.1 had direct access to a small veranda without a roof, but with high wooden walls to prevent people from looking in. The veranda was dark and offered no view of the scenery or surroundings. Nor was there a satisfactory exercise area for patients.

Psychosis unit 7.2 had a segregation unit with a veranda overlooking the garden. The walls in the segregation unit were painted to create a good contrast between the floor, walls and ceiling. The unit also had big windows with a view and a lot of daylight. The segregation unit in unit 7.2 was the only one built to ensure that the staff had unobstructed views of the anteroom and sitting room from the corridor.

Recommendation

- The hospital should assess alternative segregated options for patients to spend time outdoors in addition to the verandas in inpatient units 4.1 and 6.2.

6.5.3 Restraint beds in segregation units

Psychosis unit 4.1 and emergency unit 6.2 had rooms equipped with restraint beds as part of the segregation units. This means that patients who were segregated in these units were only a few steps away from the restraint bed in the room adjacent to the segregation room. This created the impression of segregation as a means of control rather than as a way to ensure peace and security. In this context, it is emphasised that segregation is not a coercive measure, cf. Section 4-8 of the Mental Health Care Act. Patients' knowledge that an invasive means of coercion is so close can seem threatening and create unnecessary fear. The close proximity of the restraint bed in the segregation unit can increase the risk that the restraint bed is used instead of less invasive measures in relation to segregated patients because it is easily available. The location of restraint beds in the segregation units seems problematic.

Recommendation

- Restraint beds should not be placed in the segregation units.

6.5.4 Location of staff

Prior to the visit, the NPM received information about cases where patients subject to segregation decisions were segregated in their own room with the door closed and staff members sitting outside the door to prevent the patient from leaving the room. During the visit, the NPM found patients who were segregated in the segregation units while staff members sat with the door closed in the main corridor outside. The reason given for this was that the patients themselves wanted to be alone, or that this was done for treatment purposes. However, the segregation units were designed so that the staff could be present in the units without being in the same room as the patient if the patient wanted to be alone. However, it was the NPM's impression during the visit that the patients were spending most of the day alone and without direct supervision in the segregation unit. Even if the doors between the segregation units and the corridors were unlocked, the doors were closed and the personnel outside could prevent the patient from leaving the segregation unit.

The Directorate of Health has provided an interpretation of the Mental Health Care Act's provisions on the use of segregation.[55] The case concerned the segregation of a patient in the patient's own room in a segregation unit while health personnel were sitting outside, talking to the patient in question through a door that was slightly ajar. The Directorate of Health's assessment was that this segregation measure constituted isolation. Reference is made to the Directorate of Health's assessment of the case: 'However, the personnel and the patient were in separate rooms, and the nature of the physical separation and the (assumed) intension of keeping the door *between* the patient and the personnel closed using physical force if required, indicate that the patient was subjected to de facto isolation.'[56]

On this basis, it is pointed out that the staff members' location outside the segregation units, as observed during the visit, indicated that the segregation resembled full isolation.

Recommendation

- Steps should be taken to ensure that segregation does not entail full isolation and that segregated patients are not kept separate from the personnel involved in implementing the segregation. The patient should therefore not be alone in the segregation unit while staff members are outside in the corridor on the other side of a closed door.

6.5.5 Other restrictions during segregation

Restrictions on contact with the outside world

The inspection, interviews with patients and a review of relevant documents showed that some segregated patients were also subject to administrative decisions imposing restrictions on their contact with the outside world pursuant to Section 4-5 of the Mental Health Care Act (see also section 6.6). The purpose of some of these administrative decisions was to protect patients in an acute phase of a psychosis from 'embarrassing themselves'. Furthermore, one record entry stated that 'there may also be a basis for limiting contact with the next of kin if contact with [the patient in question] becomes burdensome for them...' and another record entry stated that 'one protects the next of kin from the discomfort of seeing [the patient in question's] condition'. The Parliamentary Ombudsman has previously considered this matter in a complaint case concerning a patient's right to phone contact with the immediate family and the media.[57] In that case, the Parliamentary

[55] The Directorate of Health's communication with Stavanger University Hospital, 'Lovfortolkning – Lov om psykisk helsevern – Bruk av skjerming eller isolasjon og rutiner ved henvisning til tvungen observasjon og tvungent psykisk helsevern' ('Interpretation – the Mental Health Care Act – The use of segregation or isolation and procedures for referring patients to compulsory observation and compulsory mental health care'), 11 October 2015.

[56] The Directorate of Health's communication with Stavanger University Hospital, 'Lovfortolkning – Lov om psykisk helsevern – Bruk av skjerming eller isolasjon og rutiner ved henvisning til tvungen observasjon og tvungent psykisk helsevern' ('Interpretation – the Mental Health Care Act – The use of segregation or isolation and procedures for referring patients to compulsory observation and compulsory mental health care'), 11 October 2015, page 2. See also the letter from the County Governor of Rogaland to Stavanger University Hospital, Helse Stavanger health trust, 'Avslutning av tilsynssak – Stavanger universitetssjukehus – pliktbrudd' (Closing of investigation – Stavanger University Hospital – breach of duty'), 23 June 2015. The County Governor found that the Hospital's implementation of segregation measures pursuant to Section 4-3 of the Mental Health Care Act in several wards did '[not] allow for keeping the patient segregated from the personnel involved in implementing the segregation. This means that the Mental Health Care Act has been violated.'

[57] The Parliamentary Ombudsman, case 2011/248.

Ombudsman found that the Act did not allow for limitation of the patient's contact with the outside world based on what appeared to be precautionary considerations. Reference is also made to the Directorate of Health's circular on the Mental Health Care Act: 'The right to communicate is so important that it is not a sufficient basis for adopting restrictions that the communication entails some discomfort for the people affected.'[58] Reference is also made to the UN Convention on the Rights of Persons with Disabilities:

> 'No persons with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence or other types of communication. Persons with disabilities have the right to the protection of the law against such interference or attacks.'[59]

It gives cause for concern that patients who have been committed, who already have limited contact with other patients and staff members during segregation and are therefore particularly vulnerable, have their contact with the outside world restricted.

Recommendation

- Administrative decisions to limit contact with the outside world pursuant to Section 4-5 of the Mental Healthcare Act should not be made based on precautionary considerations or because it can be unpleasant for those affected.

Restrictions within the segregation unit

The psychiatric hospital department prepares individual plans for the implementation of segregation, and these plans are enclosed with the patient records. Such a plan 'can describe, for example, time spent indoors and outdoors, meals, conversations, fresh air and physical activity, smoking, the use of stimuli such as music and computers, communication with the outside world, telephone calls, visits and hygiene. As far as possible, the plan must be prepared in cooperation with the patient, cf. Section 15 of the Mental Health Care Regulations'.[60] In addition, a follow-up interview is conducted with the patient and any next of kin after the segregation has been terminated (see also section 6.3.4).

On the basis of inspections, interviews with patients and a review of relevant documents, the NPM formed the impression that the patients mostly did not have access to a TV, radio, music, computer and other activities during segregation. It gives cause for concern if segregated patients are routinely subjected to such restrictions. The patients have no real possibility to consent or object to these restrictions, and since no administrative decision is made in these cases, they have no possibility to complain. Reference is made in this context to the fact that restrictions shall be limited to what is absolutely necessary.[61]

[58] The Directorate of Health, The Mental Health Care Act and the Mental Health Care Regulations with comments, IS-9/2012, Chapter 3, Section 4-5, page 68.
[59] The UN Convention on the Rights of Persons with Disabilities, Article 22 No 1.
[60] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, Segregation – guidelines, Guideline, ID number II. KPH.FEL.2.2-37, revision 1.01, adopted on 22 January 2014.
[61] Section 4-2 first paragraph of the Mental Health Care Act.

6.6 Contact with the outside world

In principle, patients in closed mental health institutions have the right to free and unmonitored communication with the outside world on a par with the rest of the population. This applies to communication in the form of telephone calls, letters and visits etc. In principle, these rights apply regardless of whom the patient is communicating with. Restrictions on rights against the patient's will requires a basis in law in accordance with the principle of legal authority. Such legal authority is provided in the Mental Health Care Act Section 4-5.[62] The provision stipulates strict conditions for imposing restrictions, a fixed time limit in the second paragraph and clear case processing rules. An administrative decision must be made by the responsible mental health professional, the decision must be recorded without undue delay, and it may be appealed to the supervisory commission. The provision must be seen in conjunction with the other rules set out in Chapter 4 of the Mental Health Care Act, particularly Section 4-2, which concerns protection of personal integrity. Restrictions and coercion 'shall be limited to what is absolutely necessary', cf. Section 4-2 first paragraph. Restrictions on the right to express oneself and maintain contact with the outside world must also be warranted by law and sufficient grounds must be provided in order for such restrictions to be in line with Norway's human rights obligations.[63]

The Clinic for Mental Health has common house rules for all units which include rules for contact with fellow patients and the outside world.[64] Mobile phones, tablets and computers are allowed on all wards. According to the house rules, patients may not visit each other's rooms. Reference was made to several serious incidents in the units as a result of visits to patients' rooms and to this restriction being based on consideration for patients' safety. Visits from friends and next of kin could take place in the patient's room or a visiting room.

6.6.1 Phone use

A document review identified one instance where an administrative decision was made to restrict a patient's contact with the outside world in accordance with Section 4-5 of the Mental Health Care Act. The grounds given for the administrative decision were that '[the patient in question] talks on the phone while under the influence of medication and gives the partner incorrect information about own condition, treatment and other patients at the unit, among other things. [The patient in question] has also phoned the police and the emergency number 113 to report similar matters'.

Pursuant to Section 4-5 second paragraph of the Mental Health Care Act, the right to use a phone can be restricted 'insofar as this is necessitated by strong considerations related to the treatment or

[62] See the second and fourth paragraphs of the provision.

[63] Freedom of expression is protection by Article 100 of the Norwegian Constitution. However, the third paragraph states that 'Clearly defined limitations to this right may only be imposed when particularly weighty considerations so justify in relation to the grounds for freedom of expression'. Prior censorship etc. is in principle prohibited, but may be permitted in institutions, cf. the fourth paragraph. Freedom of expression is also protected by Article 10 (1) of the European Convention on Human Rights (ECHR), with the right to encroach on such freedom set out in Article 10 (2). ECHR Article 8 protects the right to private and family life, home and correspondence. Furthermore, the UN International Covenant on Civil and Political Rights protects the freedom of expression in Article 19 and correspondence etc. in Article 17. The provisions of this convention were incorporated into Norwegian law in the Human Rights Act of 21 May 1999 No 30, and take precedence over any other legislative provisions pursuant to Section 3 of this Act.

[64] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, House rules for the inpatient units, the Clinic for Mental Health, General document, document ID number II. KPH.FEL.2.4-24, revision 2.00, adopted on 16 September 2014.

welfare of the patient or strong consideration for a closely related person.' The preparatory works to the Mental Health Care Act[65] emphasise that a lot is required for restrictions to be permitted:

> ''In order for restrictions on the right to communicate to be adopted, the considerations must be so strong that they approach the criteria for applying the principle of necessity. In the Ministry's view, the norm shall be free right of communication for patients in institutions for compulsory mental health care. Restrictions shall therefore be kept at an absolute minimum.'[66]

In this case, the administrative decision concerning the restrictions seems not to be based on as strong considerations as required by law.

Another committed patient was subjected to restrictions on phone use without an administrative decision being made. The patient's treatment plan stated that 'the staff shall know who the patient is calling and dial the number for [the patient in question] and be present while [the patient in question] is on the phone... the patient is not to contact the staff or therapist by phone'. Such an encroachment on the patient's autonomy requires an administrative decision pursuant to Section 4-5 of the Mental Health Care Act.

6.6.2 Monitoring visits

Several sources confirmed that visits were monitored by staff members present in the room in cases where a risk of substance abuse or of drugs or alcohol being introduced to the institution was suspected. Administrative decisions were not always made in such cases.

When there is a justifiable suspicion that an attempt will be made to bring medicines, intoxicants, dangerous objects etc. into the institution, an administrative decision can be made to open and inspect the patient's letters, and any objects that are found can be seized pursuant to Section 4-7. Section 4-5 second paragraph of the Mental Health Care Act only authorises restrictions on the right to receive visits 'insofar as this is necessitated by strong considerations related to the treatment or welfare of the patient or strong consideration for a closely related person.'

The Mental Health Care Act Chapter 4A on safety measures in regional secure treatment facilities states that it can be decided that visits must take place with personnel present if there is a risk of escape, serious violence, introduction of medicines, intoxicants, escape aids or dangerous objects, or if there is a risk of attacks on the patient. However, there are no corresponding provision in the Act concerning other wards.

Therefore, any restrictions on the right to receive visits on ordinary wards must be based on the considerations set out in Section 4-5 second paragraph. As mentioned, a lot is required for these requirements to be met. Suspicion of the introduction of medication and intoxicants may perhaps be regarded as 'strong considerations related to the treatment' which may justify restrictions on the

[65] Proposition No 11 to the Odelsting (1998–1999) page 114.

[66] This is also followed up by the Ministry of Health and Care Services' circular on the provision (Circular I-10/2001, page 35): 'A lot is required to justify restrictions on the right to communicate. Pursuant to the text of the second paragraph, strong considerations related to the treatment or welfare of the patient or strong consideration for a closely related person are required. It is a matter of qualified requirements for exceptions, requirements that approach the criteria for applying the principle of necessity. The requirements are partly related to the patient's own situation and partly to the situation of the family or a closely related person.'

right to receive visits in some cases, but in such case, the compliance with the conditions of the Act must be further specified and an administrative decision must be made.

Section 4-6 of the Mental Health Care Act also authorises inspection of a patient's room after a visit when there is a justifiable suspicion that medication, intoxicating substances etc. have been brought into the institution, without the visit itself being monitored.

The NPM found decision templates where restrictions on the right to 'receive visits, 'use the telephone', 'receive letters and parcels' and 'send letters and parcels' had been ticked, cf. Section 4-5. However, sufficient grounds for these restrictions were not provided in the pertaining record entries. In one record entry, for example, the restrictions were only described as follows: 'the patient does not have access to a computer with internet access on the ward. The mobile phone has been confiscated. [The patient in question] can contact the lawyer and immediate family by further agreement.' In another record entry, the restriction was merely described as 'the patient's mobile phone has been confiscated and is kept on the ward'. The staff also monitored both these patients' visits, without this being specially described or grounds being given.

On this basis, the Parliamentary Ombudsman finds that the strict conditions for restricting telephone calls and visits set out in the Mental Health Care Act have not been satisfactorily complied with. Nor were administrative decisions made in relation to all restrictions, and some of the decisions that were made were inadequate. This makes it difficult, sometimes impossible, for patients to appeal these administrative decisions.

Recommendation

- There should be no restrictions on telephone calls and visits unless strictly necessary and provided for by law.

6.7 Searches

Section 4-6 of the Mental Health Care Act authorises inspections of patients' room and bodily searches of patients. The statutory requirement is that there must be a 'justifiable suspicion' that medicines, intoxicants, escape aids or dangerous objects are being introduced or stored. If the conditions are met, an administrative decision must be made. The requirement for a 'justifiable suspicion' means that there must be concrete grounds for the suspicion, for example concrete tips about the introduction of a dangerous object, intoxication, aggressive behaviour or behaviour that gives grounds for suspecting suicide plans.

The psychiatric hospital department only has guidelines concerning visits and searches for the secure treatment unit. Emergency units 6.1 and 6.2 and the closed psychosis units 4.1, 4.2 and 7.2, however, practise routine searches of luggage upon admission despite the department being familiar with the statutory requirements. The department and clinic are of the opinion that the Mental Health Care Act does not provide sufficient protection for their patients or for a safe workplace for the staff. In the department's experience, dangerous objects have been found among patients' belongings in cases where there was no concrete suspicion to justify searching the luggage. The department

continues to ask its closed inpatient units to systematically search the luggage of all admitted patients for the purpose of ensuring that no dangerous objects are introduced.[67]

The practice in the emergency units and the closed psychosis units is to ask the patients for permission to search their luggage. In most cases, the patients agree to this. In cases where patients do not give their permission and there is a strong suspicion that they are attempting to introduce unwanted/dangerous objects, an administrative decision is made to search the luggage. In some cases, the luggage is stored in a locked room until the patient leaves.

The secure treatment unit had special procedures for bodily searches and other searches.[68] The purpose of this was to ensure that patients, next of kin and visitors could not bring dangerous objects, escape aids, medicines or intoxicants in or out of the unit, and to ensure a satisfactory working environment. All patients and visitors were searched and routinely had to walk through a metal detector. In addition, they were requested to present any objects and articles they wished to bring into the unit to the staff unsolicited. Beyond this, the staff could go through the luggage/clothing by means of searches and a hand-held metal detector. This arrangement was based on voluntary participation and cooperation. If a patient objected to the inspection or search, or if there was a justifiable suspicion, the responsible mental health professional could make an administrative decision, cf. Sections 4-6 and 4-7 of the Mental Health Care Act. If visitors did not consent or if there was a justifiable suspicion, the staff could refuse visits to the unit without giving any further grounds. Visitors were informed about this in a separate document and by means of a sign near the entrance.

The NPM is aware that several mental health institutions consider searching all patients and luggage on arrival to be a necessary measure to ensure the safety of the patients themselves, their fellow patients and the staff. At the same time, ECHR Article 8 (2) states that the need for security in an institution must be weighed against the individual's right to protection against encroachments that violate their integrity. Through the adoption of Section 4-6 of the Mental Health Care Act, the Norwegian authorities have explicitly defined the threshold for carrying out searches. Pursuant to the applicable regulations, patients' belongings may not be routinely searched on arrival. Nor does the patient's consent form an independent basis for carrying out a search under Section 4-6 of the Mental Health Care Act. The NPM refers to its previous visit reports[69], in which it is stated that hospitals are not currently authorised to carry out routine searches.

The Ministry of Health and Care Services have distributed proposals for amendments to the Mental Health Care Act for consultation. The proposed amendments would extend the right to implement control measures to prevent the introduction of medication, intoxicants, dangerous substances, dangerous objects and means of escape.[70] The consultation deadline was 8 January 2016.

[67] Sørlandet Hospital, the Clinic for Mental Health, the psychiatric hospital department Kristiansand, letter from head of clinic Oddvar Sæther to the Board of Health Supervision in Vest-Agder, 2 October 2013.
[68] Sørlandet Hospital, the Clinic for Mental Health and Addiction Treatment, Entries, exits and visits at the secure treatment unit, General document, ID number II.KPH.PSA.2.4-1, revision 1.00, adopted on 2 July 2014.
[69] The Parliamentary Ombudsman's reports on the visits to Diakonhjemmet Hospital on 24–27 February 2015 and Telemark Hospital on 8–10 April 2015.
[70] See https://www.regjeringen.no/no/dokumenter/hoyring---forslag-til-endringar-i-psykisk-helsevernloven--kontroll-for-a-hindre-innforing-av-legemiddel-rusmiddel-skadelege-stoff-farlege-gjenstandar-og-rommingshjelpemiddel/id2457523/

Recommendation

- The hospital should only search patients' belongings when there is a 'justifiable suspicion' that medicines, intoxicants, escape aids or dangerous objects are being introduced or stored, and an administrative decision should be made in such cases.[71]

6.8 Activities

Prior to the NPM's visit, the psychiatric hospital department submitted information about the activities available to the patients. Examples of activities include drives, fishing trips and walks in the woods, a music group, cooking and exercise. Emergency units 6.1 and 6.2 prepare an individual activity plan for each patient on the basis of his/her treatment plan. Patients at the other inpatient units are offered both individual and joint activities in accordance with the individual patient's treatment plan and treatment goals. All patients at secure treatment unit 4.2 can choose one activity outside the hospital per week, and the unit organises regular drives for all patients with possibilities for barbecuing, swimming or fishing. In addition, individual activities are organised for long-term patients in secure treatment unit 4.2 in cooperation with the next of kin. These activities may include overnight stays. Patients at first-episode psychosis unit 2.1 can participate in weekly classes on topics relating to substance abuse and psychiatry. Psychosis unit 7.2 offers a weekly bowling trip, fishing trips or walks in the woods twice a week, a weekly session with a physiotherapist and joint football practice with other units. Patients can also schedule individual sessions with a physiotherapist. In addition, unit 7.2 had an activity room where patients could participate in arts and crafts activities. Psychosis unit 4.1 offered far less activities, and only organised one joint activity a week (wood chopping in the woods), and participation in this activity was limited to four patients each time.

The hospital's gym had been closed for a year due to extensive water damage after flooding. Some units used a gym in the basement of building 7 as a temporary solution. However, many patients and staff members missed the hospital's gym. At the time of the visit, the head of the psychiatric hospital department did not know when the gym would be reopened.

Reference is made to the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment's (CPT) standards for psychiatric institutions:

> 'Psychiatric treatment should be based on an individualised approach, which implies the drawing up of a treatment plan for each patient. It should involve a wide range of rehabilitative and therapeutic activities, including access to occupational therapy, group therapy, individual psychotherapy, art, drama, music and sports. Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis; it is also desirable for them to be offered education and suitable work.'[72]

The staff also motivates patients to participate in activities by posting information about the activities on notice boards, giving verbal reminders, motivational conversations, rewards and purchasing necessary equipment and clothes. The units also plan activities and prepare the staff. Nevertheless, the visit left the impression that patients in many of the inpatient units did not have

[71] See the letter of 15 October 2014 from the Directorate of Health to the supervisory commission for the University Hospital of North Norway (UNN), section 1, final paragraph, concerning the requirement for recording 'without delay'.

[72] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 51, paragraph 37.

many activities during the course of a normal day. Most patients found that they did not have much to do and spent a great deal of time alone with their thoughts. Many patients wanted to spend more time outside, to have more physical activities and more active staff who could facilitate indoor activities. The supervisory commission confirmed that patients complained that they were bored, especially in the afternoon and evening.[73]

Psychosis unit 4.1 organised eight short smoking breaks. In addition, individual outdoor activities were facilitated. It was unclear whether all patients were given the opportunity to participate in outdoor activities every day. Reference is made e.g. to the fact that a *minimum* requirement for one hour of outdoor activity per day applies to all inmates in Norwegian prisons who, like patients under compulsory mental health care, are deprived of their liberty. The importance of daily outdoor activities for all patients is emphasised by the CPT, most recently in the committee's report after a visit to the Czech Republic in April 2014.[74]

Recommendations

- The hospital should strengthen the milieu therapy offered to patients who have been committed.

- The hospital should ensure that all committed patients have access to at least one hour of outdoor exercise and daily activities adapted to the patient's needs.

[73] The supervisory commission for psychiatric hospitals in Vest-Agder, inspection report of 22 December 2014.
[74] The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), Report to the Czech Government on the visit to the Czech Republic from 1 to 10 April 2014, http://www.cpt.coe.int/documents/cze/2015-18-inf-eng.pdf,
section 155: 'The CPT wishes to stress that, as a matter of principle, every patient, unless there are clear medical contraindications, should be offered at least one hour of outdoor exercise every day and preferably considerably more, and under no circumstances should daily outdoor exercise be prohibited for such patients as an informal sanction'.

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