SIVILOMBUDSMANNEN

VISIT REPORT

University Hospital of North Norway

26–28 April 2016

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1 The Parliamentary Ombudsman's prevention 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 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 who have been 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 those deprived of their liberty are given special priority.

In its endeavours to fulfil the prevention mandate, the Parliamentary Ombudsman also engages in extensive dialogue with national authorities, civil society and international human rights bodies.

[1] The Parliamentary Ombudsman Act Section 3(a).

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.

People who are derived of their liberty are more vulnerable in relation the prohibition against torture and ill-treatment. That is why the UN adopted an Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2007.

3 Summary

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited the psychiatric department at the University Hospital of North Norway (UNN) from 26 to 28 April 2016. The catchment area of the University Hospital of North Norway (UNN) comprises the counties of Nordland, Troms and Finnmark, and Svalbard. It also functions as the local hospital for 30 municipalities in Troms county and in Ofoten in Northern Nordland. The hospital offers a full range of specialist health services in the fields of somatic and mental health care and substance abuse treatment. The University Hospital of North Norway covers an area with a population of around 480,000 and it runs hospitals in several locations, including Tromsø, Harstad, Narvik and Longyearbyen.

The Clinic for Mental Health and Addiction Treatment consists of five departments: the psychiatric department, the substance abuse department, department South and department North, and the department for development, research and education. The psychiatric department is located at Åsgard in Tromsø. It comprises three sections: the emergency psychiatric section, the secure psychiatric section and the geriatric psychiatry section, with a total of eight units. The NPM visited the emergency psychiatric section and the secure psychiatric section, and the following units were visited: emergency ward North, emergency ward South, emergency ward Tromsø, the psychosis and substance abuse unit, and the secure psychiatric inpatient unit.

The NPM notified the hospital of the visit in advance, but not of the exact time when it would take place. The hospital submitted the requested documents both prior to and after the visit.

The visit started with a tour of all the units. Later on the first day of the visit, the NPM had a meeting with the clinic and department's management to present the Parliamentary Ombudsman's prevention mandate and the methods that would be used during the visit. Most of the committed patients who were available were offered a private conversation with the NPM. Interviews were also conducted with members of staff and the supervisory commission. Use-of-force records from all the units for 2015 and up to the time of the visit in 2016 were also reviewed. The visit lasted for three days.

The physical conditions in the secure psychiatric section appeared to be good, and the patients in the secure psychiatric rehabilitation unit who had agreements to this effect were permitted to go outside unaccompanied. The emergency psychiatric section, on the other hand, was in relatively poor physical condition. With the exception of emergency ward Tromsø, none of these units had direct access to a garden or ball game area, or to other areas where the patients could go outside unaccompanied. In emergency ward North, there were no curtains that could be drawn over the windows of the patient rooms.

There were no written procedures or overview of activities for patients at any of the units in the emergency psychiatric section. Nor did the clinic have an overview of how often the patients made use of the activities that were offered. The hospital's activity centre was closed down on 1 January 2016, and patients and staff said that few organised activities had been offered at the hospital since then. The units in the emergency psychiatric section stated that it was difficult to offer committed patients daily walks outdoors because of the staffing situation.

Administrative decisions on the establishment of compulsory mental health care, segregation, treatment without the patient's consent and the use of coercive measures are filed in electronic patient records. Separate record entries stating the grounds for each individual decision are also filed there. The grounds are not stated in the decisions themselves. Patients did not routinely receive record entries with the written grounds for such decisions together with the decision.

It was a consistent finding when reviewing use-of-force decisions and the medical grounds for the use of force that any attempts to use milder means were not documented.

The supervisory commission for the hospital meets every second week to consider complaint cases, to verify administrative decisions and carry out document control. The commission had not carried out welfare checks in 2015 and 2016. Nor were the wards routinely visited, and the patients were not offered an opportunity to speak to the commission when it was present at the hospital. No written information was 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.

It became apparent during the visit that there was uncertainty at all management levels about what patient injuries must be registered and reported. According to the management of the department and the units, there was uncertainty about whether patient injuries were actually reported, and thereby whether the procedure for identifying and registering patient injuries was complied with.

One case gave special cause for concern. It concerned a patient who was seriously injured when wrestled to the floor by staff in the inpatient ward. The injuries had to be followed up by medical personnel from outside the unit, but, despite the nature of the injuries, it was not noted in the records that the examining doctor followed up the patient's injuries. There was no report on the patient injury, neither in the hospital's internal system for registering patient injuries nor to the Directorate of Health or the Board of Health Supervision.

The supervisory commission stated that they had asked the management for information about patient injuries on several occasions. However, they had not received information about any injuries, although it had come to their knowledge, among other things through information in patient records, that such injuries had occurred.

In one case, repeated administrative decisions were made for committal pursuant to Section 3-3 of the Mental Health Care Act based on a provisional personality disorder diagnosis. According to the patient records, the responsible health professional considered the provisional diagnosis to indicate such a great change in the patient's behavioural pattern and ability to cope that this could be seen as corresponding to the Act's requirement for a serious mental disorder. No assessment was carried out, however, to establish whether the Act's requirement was met, despite the fact that the patient had been committed on the same grounds several times over a prolonged period.

One case was uncovered where a patient had been placed in restraints for six hours before a new duty doctor was informed. It appeared to be unclear what had happened in connection with the instigation of the restraint during the previous shift, and an administrative decision had not been made. Instead of ending the restraint or making a decision formalising the ongoing situation, the duty doctor noted in the patient record that this was left to the doctor who instigated the restraint and who came on duty the next day. The patient was placed in restraints for 25 1/2 hours in all.

The review of the patient records showed repeated instances of patients being held for brief periods without an administrative decision having been made. Some patients also told the team that they had experienced such holding as a punishment for behaviour that the milieu therapists did not like.

Some patients had been placed in restraints after having requested this themselves, despite the fact that coercive measures are not treatment measures and that the patient's consent does not constitute an independent legal basis for the use of coercive measures pursuant to the Mental Health Care Act Section 4-8.

Several sources in emergency ward North reported incidences of unnecessary use of force during the implementation of coercive measures. There were no procedures for training staff in placing patients in restraints at the psychiatric department. Nor were there procedures for training in or reflection about what effect the use of coercive measures can have on patients.

Next of kin are rarely or never informed about patients being placed in restraints. It emerged that there was no general procedure or guidelines at the clinic for the notification of next of kin.

The emergency psychiatric section did not offer voluntary follow-up interviews after the implementation of coercive measures. There were written procedures for the use of follow-up interviews in some of the units, but both patients and staff said that they were not normally complied with.

The supervisory commission pointed out that the hospital appeared to lack dependable procedures for registration in the use-of-force records. In addition, the supervisory commission remarked that some of the administrative decisions on the use of coercive measures were not entered in the records, only in the electronic patient records system (DIPS). In several cases, incomplete use-of-force records were signed by the supervisory commission without comment.

During the visit, it was observed that one patient was held in a prolonged segregation regime, mainly based on reports from the milieu therapists and without the assessments of the person responsible for the decision being stated.

Three of the units at the emergency psychiatric section had separate segregation units. None of them had direct access to the open air from the segregation units.

In emergency ward North, a room equipped with a restraint bed was part of the segregation unit. Placing the restraint bed in the segregation unit can increase the risk that the restraint bed will be used on segregated patients instead of milder means.

It was observed that patients were segregated in a separate room with members of staff sitting outside, with the door closed. This gave the impression that the patients were alone and without direct supervision for short or longer periods.

In the inpatient ward in the secure department, a large part of the ward was set aside as a segregation unit for one patient. At the time of the NPM's visit, the patient had been segregated continuously for around three and a half years. The administrative decisions were renewed every two weeks. Many of the decisions stated that the patient had not received the decision in writing, because 'too many "routine letters" are deemed to stress the patient'. The staff at the unit explained

that the patient could have a mental health condition that made it difficult for him to understand, at the moment when the decision was made, the decision to use force and the right to complain.

In an institutional culture, some characteristics and attitudes will represent a clear risk of ill-treatment. Internal cultures where staff have lost sight of the individual, 'us and them' attitudes, a culture of violence and use of force, and a culture of impunity can be mentioned in particular. The staff in emergency ward North were perceived as having several such unfortunate characteristics and attitudes.

The management is responsible for ensuring that the social identity and culture that develop among staff are in compliance with human rights and with fundamental rights such as patient safety and the inherent dignity of all human beings. When the management's attitudes and values are not clear or are not respected, there is a risk that cultures that permit abuse will develop. A clear lack of trust in the management was expressed by several members of staff during the visit. Several members of staff also pointed out that staff members were not looked after or followed up to any great extent if serious incidents occurred at work.

Recommendations

Physical conditions

- The hospital should ensure that the physical conditions in the emergency psychiatric section facilitate health-promoting therapeutic measures and prevent ill-treatment.
- All the patients should immediately be ensured the possibility of light screening at night.

Activation

- The hospital should improve patients' opportunities to participate in meaningful activities.
- The hospital should focus on improving milieu therapy measures in the emergency psychiatric section.
- The hospital should ensure that patients at the clinic are given access to daily outdoor exercise and physical activity.

Patient rights

Administrative decisions

- Patients should always be informed, both orally 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 or log in to the electronic patient records in order to obtain information about the grounds for a decision to use force.
- Administrative decisions and record entries should contain concrete and detailed information about the grounds for the use of force, and they should also contain information about attempts to use milder means.

Opportunities to complain

- The supervisory commission should ask the patient directly whether he/she wishes to speak with the commission.

- The sections should ensure that information about the supervisory commission, the County Governor and the Parliamentary Ombudsman is always prominently displayed and easily accessible to patients.

Patient safety

- The hospital should make sure that it has procedures in place that ensure that patient injuries are always reported and followed up internally and that the duty to report to the Directorate of Health and the Board of Health Supervision is complied with.
- The hospital should have procedures that ensure that health personnel responsible for treatment are responsible for following up patient injuries.
- The hospital should ensure that the supervisory commission is informed about serious incidents and patient injuries.

Administrative decisions concerning compulsory mental health care

The main statutory condition

- The hospital should make sure that procedures are in place that ensure that administrative decisions concerning compulsory mental health care are never made without it being documented that the main condition in the Act is met.

Coercive measures

Improper use of coercive measures

Mechanical restraints

- The hospital should take steps to ensure that procedures are in place that mean that an administrative decision is always made when coercive measures are used.
- Steps should be taken to ensure that everyone who is responsible for making administrative decisions on duty knows who is responsible for entering decisions in the patient records.
- It should be ensured that decisions to use coercive measures are revoked as soon as the risk of harm is no longer present and that decisions on the use of coercive measures are always based on an assessment of the situation at the time they are made.

Brief holding

- Steps should be taken to ensure that administrative decisions are always made concerning brief holding.

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 are met.

The exercise of coercion

- Coercive measures must be used in the most gentle and respectful way possible.
- The clinic should ensure that training and regular practice are given in the use of coercive measures. The training should also include understanding how patients can experience the use of force.

Information to next of kin after the use of coercive measures

- The patients' immediate next of kin should be informed at once about the use of coercive measures unless the patient objects. The hospital should ensure that procedures are developed for this and that all units comply with them.

Follow-up interviews

- Patients should be offered a follow-up interview about incidents involving the use of force.

Use-of-force records

- The hospital should improve the documentation provided in the use-of-force records, so that it always includes the patient's name and personal ID number, the time that the coercive measure was initiated and ended, the grounds for the coercive measure, the names of both the duty doctor and the person with professional responsibility for the decision to use force, and registration of any injuries to patients or staff.
- 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 relating to their own incident.
- The supervisory commission should ensure that it does not sign incomplete use-of-force records.

Segregation

Segregation decisions

- Steps should be taken to ensure that decisions on segregation are justified by concrete and independent assessments by the person responsible for the decision.

Design of segregation units

- The hospital should take steps to ensure that also patients who are segregated can go outdoors on a regular basis.

Restraint beds in segregation units

- Restraint beds should not be placed in segregation units.

Location of staff

- Steps should be taken to ensure that segregation does not entail 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.

Prolonged segregation

- If the patient's health condition is such that he/she is unable to receive the decision at the time when it is made, the patient should be re-informed when he/she is better able to receive and understand the information.

Institutional culture

Cultural risk factors in relation to torture and ill-treatment

- The hospital should initiate a process to ensure a shared culture where patients' safety, dignity and rights are promoted in all units in the emergency psychiatry section. Immediate measures should be taken to ensure that this is the case in emergency ward North in particular.
- The hospital should ensure uniform procedures for attending to staff after serious incidents.

4 General information about the Clinic for Mental Health and Addiction Treatment, the University Hospital of North Norway

The catchment area of the University Hospital of North Norway (UNN) comprises the counties of Nordland, Troms and Finnmark, and Svalbard. It also functions as the local hospital for 30 municipalities in Troms county and in Ofoten in Northern Nordland. The hospital offers a full range of specialist health services in the fields of somatic and mental health care and substance abuse treatment. The University Hospital of North Norway covers an area with a population of around 480,000 and it runs hospitals in several locations, including Tromsø, Harstad, Narvik and Longyearbyen.

The Clinic for Mental Health and Addiction Treatment consists of five departments: the psychiatric department, the substance abuse department, department South and department North, and the department for development, research and education. The psychiatric department is located at Åsgard in Tromsø.

The Parliamentary Ombudsman's National Prevention Mechanism (NPM) visited the psychiatric department in Tromsø. It comprises three sections: the emergency psychiatric section, the secure psychiatric section and the geriatric psychiatry section, with a total of eight units. Each unit is managed by a head of unit. The section for secure psychiatry is managed by a joint interdisciplinary team.

The NPM visited all the sections except for the geriatric psychiatric section, and the following units were visited:

- *Emergency ward North* has 13 beds. The unit is responsible for emergency care pursuant to the Specialist Health Services Act Section 3-1 and it admits patients over the age of 18. The unit offers emergency and crisis services, and specialised assessments and treatment. Its catchment area comprises the municipalities in Northern Troms and Finnmark.[2] The unit had 538 admissions during the period 1 January 2015 to 31 March 2016.
- *Emergency ward South* has 12 beds. The unit serves the inhabitants of Central Troms, Southern Troms and Ofoten and accepts patients who need to be admitted for the assessment and treatment of psychoses, severe depression, personality disorders or other acute crises. The ward is responsible for emergency care for patients over the age of 18 who have been committed pursuant to the Mental Health Care Act, and for those who need to be treated in a closed inpatient ward. The patients are assigned a treatment team consisting of a doctor and milieu therapists. According to the hospital, the treatment consists of a structured and safe environment, individual conversations, treatment with medication and network cooperation.[3] The unit had 501 admissions during the period 1 January 2015 to 31 March 2016.
- *Emergency ward Tromsø* has 10 beds. The unit is responsible for admitting patients with an acute need for psychiatric help in an inpatient ward, and it attends to the emergency care

[2] On UNN's website, see: http://www.unn.no/sykehusseksjon-nord/category23858.html.
[3] On UNN's website, see: http://www.unn.no/sykehusseksjon-sor/category23862.html.

function for its catchment area: Tromsø, Karlsøy, Balsfjord, Storfjord and Lyngen. Its area of responsibility includes assessment, treatment and care tasks. According to the hospital, the treatment consists of a structured, safe and predictable environment, individual conversations, treatment with medication and family and network cooperation.[4] The unit had 481 admissions during the period 1 January 2015 to 31 March 2016.

- *The psychosis and substance abuse unit* is an inpatient ward with 11 beds for patients with serious mental illnesses, for the most part psychotic disorders, and possible concurrent drug or alcohol problems. Their heath condition has led to serious functional impairment. The unit accepts patients from UNN's entire catchment area. The unit largely works in accordance with national professional guidelines for the assessment, treatment and follow-up of people with concurrent substance abuse and mental health problems and psychotic disorders, and other relevant guidelines, depending on the individual circumstances. The unit also emphasises cooperation with the patient's private and professional networks.[5] The unit had 43 admissions during the period 1 January 2015 to 31 March 2016.
- *The secure psychiatric inpatient unit* has six beds. The catchment area is Finnmark, Troms and Ofoten. The unit's target group consists of people diagnosed with a serious mental illness combined with behavioural or violence problems, people sentenced to compulsory mental health care pursuant to Section 39 of the General Civil Penal Code, and people who need to be assessed for the risk of violence problems that have not been clarified. The unit assesses the patients' resources and functioning in relation to everyday skills. It also offers treatment focusing on emergency care, stabilisation, diagnostic assessment and mapping of the risk of violence.[6] The unit had 15 admissions during the period 1 January 2015 to 31 March 2016.

[4] On UNN's website, see: http://www.unn.no/akuttposten/category19818.html.
[5] On UNN's website, see: https://unn.no/avdelinger/psykisk-helse-og-rusklinikken/psykiatrisk-avdeling/psykose-og-rusenheten-tromso.
[6] On UNN's website, see: http://www.unn.no/sikkerhetspsykiatri/category9973.html.

5 How the visit was conducted

In June 2016, UNN was notified that the NPM would visit during the course of the next eight weeks. The date of the visit was not stated.

Prior to the visit, the hospital submitted the requested documents, including guidelines and statistics, admission figures and nonconformity reports for the Clinic for Mental Health and Addiction Treatment. The clinic did not have an annual report for 2015. 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 five visited units.

The visit began with an inspection of the North, South and Tromsø emergency wards. Later the same day, the inspection continued at the secure psychiatric rehabilitation unit and inpatient unit, and the psychosis and substance abuse unit. The inspection included patient rooms, common areas, segregated sections, rooms with restraint beds, duty rooms and outdoor areas.

Later on the first day of the visit, the NPM had a meeting with the clinic and department's management at which the Parliamentary Ombudsman's prevention mandate and the methods that would be used during the visit were presented. The need for private interviews with patients was emphasised in particular.

On the first day of the visit, interviews were conducted with patients in emergency ward North.

On the second day of the visit, interviews were conducted with patients in emergency wards North, South and Tromsø, and the psychosis and substance abuse unit. Interviews were also conducted with patients and staff on nightshift in emergency ward North that day. On the third day, interviews were conducted with patients in the secure psychiatric inpatient unit and emergency ward Tromsø, and some remaining interviews were conducted with staff and patients in the other units.

Staff in all the units were also interviewed, as well as the heads of all the units, except for the psychosis and substance abuse unit. During its visit, the NPM also reviewed use-of-force records from all the units. A meeting was held with the supervisory commission for the hospital on the second day of the visit.

The visit was well prepared and organised by the hospital's management and staff. The NPM's information posters were posted in all the units and the staff seemed to be well informed about the visit.

A meeting was held three working days after the visit with the clinic and the department's management in order to discuss and clarify some important issues.

The following persons participated from the Parliamentary Ombudsman:

- Helga Fastrup Ervik (head of the NPM, lawyer)
- Aina Holmén, Senior Adviser, psychologist, PhD)
- Mette Jansen Wannerstedt (Senior Adviser, sociologist)
- Jonina Hermannsdottir (Senior Adviser, criminologist)
- Johannes Flisnes Nilsen (Adviser, lawyer)

6 Physical conditions

The physical conditions in the secure psychiatric section in Building 5 appeared to be good. Both the units were bright and well-maintained. The walls were painted in light colours, the rooms had curtains and sun-screening, and the interior furnishings gave the units a pleasant and less hospital-like ambience. The secure psychiatric rehabilitation unit had open doors, so that the patients could go out on their own by agreement.

Building 1 at Åsgård houses emergency wards North and South. The building showed clear signs of wear and tear.

Emergency ward North was on the second floor and had 13 beds. The unit consisted of a kitchen with pertaining dining room, living room/lounge, activity room, among other things with a piano, a smoking room with a balcony, a duty room, patient rooms and a segregation unit with two rooms, one of which was equipped with a restraint bed, and a lounge outside the two rooms. There is one shared bathroom and toilet for each two patient rooms.

The walls needed a new coat of paint and curtains were lacking for most of the windows. The bathrooms were poorly maintained and many of them lacked a shower curtain. In addition, the towel hooks and soap dispensers had been removed from the walls and not replaced.

There were no curtains that could be drawn across the windows despite the fact that it must be assumed that patients admitted in acute phases have a special need for sleep and rest. In the summer months, it gets very light in the patient rooms and during the period of midnight sun, there will be no light screening day or night. The head of the unit said that this was a problem for some of the patients and that black garbage bags were therefore taped over the windows during certain periods.

Emergency ward South was situated on the floor below emergency ward North and resembled it in design. The unit had a somewhat brighter appearance and showed less sign of wear and tear than emergency ward North. Except for two patient rooms, the bathrooms and toilets were shared by two patient rooms each. The unit had two common rooms in addition to a smoking room, medicine room and duty room. The ward did not have a separate segregation unit.

The patients in Building 1 did not have direct access to a garden or ball games area from the units, but there was direct access to a small smoking balcony. In another building in the same area, there was a gym and exercise room, but, according to patients and staff, it was not used much because of the staffing situation since the patients have to be escorted there by staff. The same applied to access to the open outdoor areas on the hospital grounds (see section 7 *Activation* for more details*).*

The psychosis and substance abuse unit was in Building 2. Like the other emergency units, the overall impression was that the unit showed signs of wear and tear. Except for the segregation rooms, the bathrooms and toilets were shared by two patient rooms each. They were all sparsely furnished, containing nothing to reduce the institutional impression.

Emergency ward Tromsø was situated in Building 6. It was a very run-down unit, and the NPM was informed that the unit was scheduled to move into newly refurbished premises during 2016. The ward had 10 beds. Except for two patient rooms with en suite bathrooms, the bathrooms and toilets

were shared by two patient rooms each. There was an atrium attached to the unit where the patients could take some fresh air. The door out to the atrium was locked and it was necessary to pass through the smoking room to get to it.

Well-designed physical surroundings for patients are an important prevention measure. The physical conditions in the inpatient units should create a safe and health-promoting environment for patients, so that treatment and care can be given in the most gentle and respectful manner possible. The physical conditions for the patients in the emergency psychiatric section were worrying and gave the impression that there was little understanding of how important the surroundings and facilitation are to patients who have been deprived of their liberty. The health situation of patients in emergency departments means that they have a particularly strong need for care and for being looked after in satisfactory and health-promoting surroundings.

Reference is made to the European Committee for the Prevention of Torture's (CPT) standards for psychiatric institutions:

> 'Creating a positive therapeutic environment involves, first of all, providing sufficient living space per patient as well as adequate lighting, heating and ventilation, maintaining the establishment in a satisfactory state of repair and meeting hospital hygiene requirements.'[7]

The CPT has also stated that:

> 'Patients should have regular access to suitably-equipped recreation rooms and have the possibility to take outdoor exercise on a daily basis.'[8]

Recommendations

- The hospital should ensure that the physical conditions in the emergency psychiatric section facilitate health-promoting therapeutic measures and prevent ill-treatment.
- All the patients should immediately be ensured the possibility of light screening at night.

[7] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 50, paragraph 34.
[8] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 51, paragraph 37.

7 Activation

Being able to participate in varied and meaningful activities and having access to outdoor and leisure activities outside one's own room is crucial to the mental and physical well-being of everyone deprived of their liberty.

Reference is made to the European Committee for the Prevention of Torture'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 regular basis.'[9]

In the UN Standard Minimum Rules for the Treatment of Prisoners (known as the Mandela Rules), it is stated that those who have been deprived of their liberty should be offered at least one hour of outdoor activity and that steps should be taken to facilitate exercise and recreation.[10] The Parliamentary Ombudsman has previously pointed out that the standard should not be lower for people deprived of their liberty in mental health care.

The clinic's management pointed out that priority was given to individual activation rather than organised joint activities. The clinic did not have an overview, however, of how often the patients made use of available activities. At the secure psychiatric section, activation was an important part of the treatment offered to patients, and it was individually assessed and followed up. There were no written procedures or overview of activities for patients at any of the units in the emergency psychiatric section. The units in the emergency psychiatric section stated that it was difficult to offer committed patients daily walks in the open air because of the staffing situation. Several members of staff in some of the wards pointed out that there were few organised activities and that they had recently been further reduced. The hospital's activity centre was closed down on 1 January 2016, and patients and staff said that few organised activities had been offered at the hospital since then. In several of the units in both the sections visited, it was also pointed out that less funding was available for organising outdoor walks, and that, among other things, the possibility of having the cost of bus tickets covered to participate in activities in the town had been reduced. The management justified this on the grounds that stays in the units were short. During the NPM's visit, however, there were several patients who had been staying for a long period in the emergency psychiatry section.

It is cause for concern when patients who have been deprived of their liberty may have to stay for weeks, and in several cases for many months, with few activities being available other than short walks in the hospital grounds when the staff have capacity. This situation was made worse by the lack of direct access to good outdoor areas from several of the units where patients could go unaccompanied (see section 6 *Physical conditions* for more details).

[9] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 51, paragraph 37.
[10] The UN Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules), adopted by the UN General Assembly on 17 December 2015, Rule 23.

Recommendations

- The hospital should improve patients' opportunities to participate in meaningful activities.
- The hospital should focus on improving milieu therapy measures in the emergency psychiatric section.
- The hospital should ensure that patients at the clinic are given access to daily outdoor exercise and physical activity.

8 Patient rights

8.1 Administrative decisions

It is the responsible mental health professionals in the psychiatric department who make administrative decisions concerning the establishment of compulsory observation, compulsory mental health care, segregation, treatment without the patient's consent, and the use of coercive measures. These decisions are stored in electronic patient records, which also contain separate record entries stating 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; it does not state specific grounds. Patients do not routinely receive the written grounds for such decisions (the record entry) together with the decision. The management stated that patients can see the grounds for the decision by requesting access to their patient records. The Parliamentary Ombudsman has previously pointed out that this practice should be changed.[11] Specific grounds must be given for an administrative decision in order to ensure that patients have a genuine possibility to exercise their right to complain. The decision shall both inform the patient about the legal basis for the measure and state concrete grounds for why it was implemented, in addition to providing information about the right to complain. All patients should be routinely informed, both orally and in writing, about the grounds for use-of-force decisions in order to ensure that their rights are safeguarded and to prevent arbitrary use of force. The Directorate of Health has recently stated that work is under way on a technical solution in the central patient records system that will ensure that the record entry is always printed together with the decision.

It was a consistent finding when reviewing use-of-force decisions and the medical grounds for the use of force that attempts to use milder means were not documented. The Mental Health Care Act Section 4-8 first paragraph states the following: 'Coercive means shall only be used when milder means have proved to be obviously futile or inadequate.' This wording is used as a standard text in administrative decisions on coercive measures at the psychiatric department at UNN. Such use of a standard text in record entries does not provide a sufficient and concrete description of how the statutory conditions for the use of force are met in individual cases. The grounds for the decision should contain a concrete description of what milder means have been used, how long they lasted and what the outcome was.

Recommendations

- Patients should always be informed, both orally 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 or log in to the electronic patient records in order to obtain information about the grounds for a decision to use force.
- Administrative decisions and record entries should contain concrete and detailed information about the grounds for the use of force, and they should also contain information about attempts to use milder means.

[11] See the Parliamentary Ombudsman's reports from its visits to Diakonhjemmet Hospital from 24 to 27 February 2015, Telemark Hospital from 8 to 10 April 2015 and Sørlandet Hospital, Kristiansand from 7 to 9 September 2015.

8.2 Opportunities to complain

The main task of the supervisory commission is to ensure due process protection for people who are being treated in the mental health care system pursuant to the Mental Health Care Act.[12] The supervisory commission is the appellate body for decisions concerning compulsory observation, compulsory mental health care, restrictions on contact with the outside world,[13] body searches and other searches,[14] seizures,[15] forced urine samples,[16] the use of coercive measures,[17] segregation[18] and transfer without consent.[19] In addition, the supervisory commission checks all administrative decisions concerning the implementation, upholding and termination of compulsory mental health care and verifies all decisions after three months. Administrative decisions concerning involuntary medical examinations[20] and treatment without the patient's consent[21] can be appealed to the County Governor. Efficient complaint arrangements are important to safeguard patients' due process protection and prevent ill-treatment. The CPT has emphasised this in its standards for mental health care 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 Åsgård Hospital Tromsø meets every second week to consider complaint cases, verify administrative decisions and any prolongations of such decisions, and carry out document control. The commission had not carried out welfare checks in 2015 and 2016. Nor were wards routinely visited, and the patients were not offered an opportunity to speak to the commission when it was present at the hospital.

In emergency ward South, information was posted about the patient ombudsman, while in emergency ward Tromsø there was a brochure about due process protection. However, the team did not find any written information posted in any of the inpatient units about rights in connection with the use of force, 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

[12] The Mental Health Care Act S. 6-1.
[13] The Mental Health Care Act S. 4-5.
[14] The Mental Health Care Act S. 4-6.
[15] The Mental Health Care Act S. 4-7.
[16] The Mental Health Care Act S. 4-7a.
[17] The Mental Health Care Act S. 4-8.
[18] The Mental Health Care Act S. 4-3.
[19] The Mental Health Care Act S. 4-10.
[20] The Mental Health Care Act S. 3-1.
[21] The Mental Health Care Act S. 3-3.
[22] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 56, paragraph 53.
[23] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 56, paragraph 55.

prominently displayed and easily accessible in all inpatient units to safeguard the rights of committed patients.

Recommendations

- The supervisory commission should ask the patients directly whether they wish to speak to the commission.
- The sections should ensure that information about the supervisory commission, the County Governor and the Parliamentary Ombudsman is always prominently displayed and easily accessible to patients.

8.3 Patient safety

The health service's job is to help patients. Sometimes, patients are nonetheless injured unnecessarily in their dealings with the health service.[24] Patient safety includes protection against violence and abuse while patients are receiving medical treatment.[25] An important part of this protection is facilitated by health institutions ensuring that procedures are in place for the documentation and reporting of injuries and for filing complaints. In order to guarantee patient safety, it is crucial that the health service takes steps to ensure transparency about errors and unintended incidents.

During the NPM's visit and the follow-up meeting with the management, it emerged that there was uncertainty among the management at clinic, section, department and unit level about what patient injuries are to be registered and reported. There was a procedure for identifying and registering patient injuries that the hospital sent to the NPM after the visit. There were no definite procedures for following up and dealing with such injuries.

According to the management of the department and the units, it was uncertain whether patient injuries were actually reported, and thereby whether the procedure was complied with. However, several members of staff stated that, in their experience, the reporting of patient injuries was not given priority. It was also stated that patient injuries in connection with uncontrolled behaviour were not reported. The supervisory commission also stated that it had asked the management for information about patient injuries on several occasions. The commission had asked for information about nonconformities and patient injuries, but it had not received information about any injuries, although it had come to their knowledge, among other things through information in patient records, that such injuries had occurred.

One case gave particular cause for concern. It concerned a patient who was seriously injured when wrestled to the floor by staff in the ward to which the patient was admitted. The injuries had to be followed up by medical personnel outside the unit. However, the medical follow-up was not registered in the patient's record despite the fact that the patient record stated that, in the days

[24] Patient safety can be described as protection against unnecessary injury as a result of the services performed by, or failure to provide services, on the part of the health service, cf. Kunnskapssenteret (2010): Mapping of the concept of patient safety. Memo.

[25] 'An undesirable incident is an unintentional injury or complication caused by treatment or care and not by the patient's illness,' cf. Mogensen & Pedersen (2003): Pasiendsikkerhed – fra sanktion til læring ('Patient safety – from sanction to learning'). Copenhagen: Munksgaard.

following the incident, the patient had repeatedly complained about pains relating to one of the injuries suffered.

The episode in which the patient was injured is only briefly mentioned in the patient's record, where it is described as uncontrolled behaviour. According to the patient record, it is unclear how the patient suffered the injuries. No administrative decision was made to briefly hold the patient despite the patient having been wrestled to the floor. Earlier the same day, another incident was recorded between the patient and staff that resulted in the patient being held for about five minutes. There was no administrative decision for this incidence of holding either.

There was no report on the patient injury, neither in the hospital's internal system for registering patient injuries nor to the Directorate of Health[26] or the Board of Health Supervision.[27]

The case is very worrying for several reasons. It is a matter of serious concern that force of this kind is used that can injure the patient in this way. It is also deeply worrying that the patient's injuries were not reported, neither internally nor to the competent authorities that deal with such injury reports. The fact that the unit has procedures for reporting patient injuries that are not complied with means that the patients are very vulnerable to possible abuses of power by the staff. This increases the risk of patients being subjected to ill-treatment (see also section 12 *Institutional culture*). The lack of information is also an obstacle to the clinic's management and the competent authorities taking necessary measures to learn from and prevent similar situations from recurring. According to information obtained during the NPM's visit, both the head of the unit and the head of the department were aware of the incident. When such incidents occur in an inpatient unit without being followed up by the management, this sends a strong signal to patients and staff that the clinic does not take responsibility for the patients' safety.

The incident also gives cause for concern about the medical follow-up of injuries to patients. Despite the nature of the injuries, it was not registered in the patient record that the examining doctor followed up the patient's injuries. Nor was the patient offered any form of follow-up interview after the incident.

Recommendations

- The hospital should make sure that it has procedures in place that ensure that patient injuries are always reported and followed up internally and that the duty to report to the Directorate of Health and the Board of Health Supervision is complied with.
- The hospital should have procedures that ensure that health personnel responsible for treatment are responsible for following up patient injuries.
- The hospital should ensure that the supervisory commission is informed about serious incidents and patient injuries.

[26] The Specialist Health Service Act Section 3-3.
[27] The Specialist Health Service Act Section 3-3a.

9 Administrative decisions concerning compulsory mental health care

9.1 The main statutory condition

In the Mental Health Care Act Section 3-3 (3), it is stated that the patient must be suffering from 'a serious mental disorder' in order for the condition for compulsory mental health care to be met. In the circular on the Act, guidance is provided about what mental states are covered by the main condition in the Act. Psychoses fall under the core area of the term, and certain other mental conditions are also covered. These can, for example, be serious eating disorders or personality disorders. It goes on to state: 'In the concrete assessment of whether a patient with such a disorder meets the main condition of the Act, emphasis must be placed on the patient's behavioural pattern, understanding of the situation, insight into his/her illness, ability to cope and any other mental symptoms.'[28] It is thus clearly stated that, for the Act's main condition to be met, the patient must be suffering to a serious degree from, for example, a personality disorder. In addition, the patient's behavioural pattern and ability to cope shall be emphasised.

In one case, repeated administrative decisions were made for committal pursuant to Section 3-3 based on a provisional personality disorder diagnosis. According to the patient records, the responsible health professional considered the *provisional* diagnosis to indicate such a great change in the patient's behavioural pattern and ability to cope that this could be seen as corresponding to the Act's requirement for a serious mental disorder. A thorough assessment was not carried out, however, to investigate whether the conditions in the Act were met. The case gave further cause for concern because it concerned a patient who was subjected to a number of committals based on the same provisional assessment over a period of several years. Nor had the periods of committal been used to clarify whether the patient's disorder actually met the Act's main condition for compulsory mental health care.

After the visit, the hospital informed the Parliamentary Ombudsman that the clinic held regular meetings for responsible mental health professionals four to six times a year in order to discuss topics that illuminate various aspects of the interpretation of the Mental Health Care Act.

Recommendations

- The hospital should make sure that procedures are in place that ensure that administrative decisions concerning compulsory mental health care are never made without it being documented that the main condition in the Act is met.

[28] The Directorate of Health (2012): Circular IS-9/2012, page 37.

10 Coercive measures

Coercive measures, which are regulated by Section 4-8 of the Mental Health Care Act, include mechanical restraints that 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 being present ('isolation'), single doses of short-acting medicines for the purpose of calming or anaesthetising the patient, and briefly holding the patient ('holding').

Pursuant to the law, coercive measures shall only be used when absolutely necessary to prevent patients from injuring themselves or others, or to prevent 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.[29] The Directorate of Health's comments on 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'.[30]

The psychiatric department stated that, in 2015, a total of 163 administrative decisions had been made to use mechanical restraints in the form of restraint beds or mobile restraints. All the emergency units, as well as the psychosis and substance abuse unit and secure psychiatric inpatient unit, had access to restraint beds and mobile restraints. In the vast majority of cases, the use of mechanical restraints took place in emergency ward Tromsø and emergency ward North, which made 77 and 60 administrative decisions, respectively. Emergency ward South made 13 such decisions during the same period, while the psychosis and substance abuse unit and the secure psychiatric section made three and six such decisions, respectively, during the period. Administrative decisions concerning medicines with a short-term effect were made 146 times in 2015. During the visit, circumstances were uncovered that could indicate that informal isolation was practised during segregation (see section 11.4 *Location of staff*). Similarly, it was stated that there had been one case of short-term detention behind a locked or closed door without a staff member being present ('isolation') being used as a coercive measure in the secure psychiatric inpatient unit.

The Clinic for Mental Health and Addiction Treatment had developed a plan for increased voluntariness for 2014–2016.[31] The plan contained a long list of measures at different levels, such as improving user and next-of-kin participation, ensuring good quality and more knowledge about coercion, measures for improving documentation and data quality, dignified transport arrangements for the mentally ill, better cooperation between the municipal health service and the specialist health service, and the provision of good, appropriate buildings for people with serious mental illness. The clinic's dialogue agreement for 2014 stipulated the following concrete goals for reduced use of force:

- A 5 percent reduction in the number of committals to emergency wards compared with 2013.
- A reduction to 12 percent compulsory hospitalisations (N-005).

[29] The Mental Health Care Act Section 4-8.
[30] The Directorate of Health (2012): Circular IS-9/2012, page 76.
[31] The plan sent to the NPM was drawn up on 6 January 2014.

- A reduction of 10 percent in the number of administrative decisions authorising the use of coercive measures compared with 2013.

The clinic and department's management stated that some of the measures in the plan had been initiated, while others had yet to be implemented. There was uncertainty about whether the goals in the dialogue agreement for 2014 had been achieved.

The hospital's own statistics for the use of force in 2015 and 2016 clearly showed that there were large internal differences in the use of force between units at the clinic. There were particularly clear differences between the units as regards administrative decisions on segregation and on the use of mechanical restraints. This was true despite the fact that admission to the different units is governed by geographical criteria. Emergency ward North had high figures for administrative decisions on both segregation and mechanical restraints.

Reference is made to the European Committee for the Prevention of Torture's (CPT) standards for psychiatric institutions:

> 'It should be acknowledged that resort to restraint measures appears to be substantially influenced by non-clinical factors such as staff perceptions of their role and patients' awareness of their rights. Comparative studies have shown that the frequency of use of restraint, including seclusion, is a function not only of staffing levels, diagnoses of patients or material conditions on the ward, but also of the 'culture and attitudes' of hospital staff.'[32]

For further discussion of the importance of culture and attitudes, see section 12 *Institutional culture*.

Neither the clinic's nor the department's management appeared to have discussed the cause of these big differences. There was no plan to use the figures in further work on the reduction of coercive measures. The lack of visible follow-up of the coercion figures raises questions about the hospital's willingness to reduce the use of force. The supervisory commission stated that they were not aware of the department's statistics, and that they did not know about the large internal differences at the hospital as regards the use of coercive measures.

The European Committee for the Prevention of Torture (CPT) emphasises the decisive role of management in reducing the use of force:

> 'Reducing recourse to the use of restraint to a viable minimum requires a change of culture in many psychiatric establishments. The role of management is crucial in this regard. Unless the management encourages staff and offers them alternatives, an established practice of frequent recourse to means of restraint is likely to prevail.'[33]

During the visit, it was also evident that the clinic did not have a uniform practice for training in, or procedures for, the use of force. There were some big differences between the units as regards the content and extent of the training given, and as regards whether procedures were in place for debriefings of staff and follow-up interviews with patients. At the secure psychiatric inpatient unit,

[32] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 63, paragraph 54.
[33] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 63, paragraph 54.

debriefing interviews were always held with staff after such incidents, and the patients were offered follow-up interviews.

Emergency ward South had introduced the Brøset Violence Checklist (BVC) as part of its work on reducing the use of force. The BVC is a six-point checklist that aims to make it easier for health personnel to foresee violent behaviour in a short-term perspective and thereby prevent undesirable and dangerous behaviour. The unit's management stated that the checklist resulted in better reports and more targeted transfer of information between shifts and that it was perceived as an effective means of reducing the use of force. The measure underpins the practice of contacting patients at an early stage when they show signs of unrest or stress, and finding ways to remedy the situation.

The hospital largely satisfied the Norwegian Patient Register's criteria for the registration of coercive measures.

10.1 Improper use of coercive measures

10.1.1 Mechanical restraints

Prior to the NPM's visit, the hospital was asked to submit documents concerning the three last cases where mechanical coercive means had been used in the emergency unit and the secure units before the hospital received notification of the visit.[34] The review of the 15 cases in all found that, in one case at the emergency psychiatric section, the duty doctor was not informed at the start of the shift that a patient had been placed in a restraint bed. The patient had been in restraints for six hours before the duty doctor on the new shift was contacted. When the duty doctor tried to find out what had happened in connection with the restraint on the previous shift, this appeared to be unclear to the unit's staff as well. An administrative decision on the restraint had not been made and the record entry from the previous shift team contained little information. Instead of making an administrative decision formalising the ongoing restraint, the duty doctor noted in the patient record that this was left to the doctor who instigated the restraint and who came on duty the next day. The administrative decision was made on the day after the restraint was instigated. The patient was placed in restraints for 25 1/2 hours in all.

When a duty doctor becomes aware of an ongoing restraint situation for which no administrative decision had been made, he/she has a duty to ensure that this unlawful situation is brought to an end. This must be done either by releasing the patient from the restraints because the statutory conditions are deemed not to be met or by making an administrative decision on the use of force. It is also remarked that, according to the patient records, the restraint was initiated after the patient had been given 'an offer to be placed in a restraint bed'. See section 10.2 *Brief holding* for further recommendations in this context. The restraint bed was thus presented to the patient as a therapeutic measure, despite the fact that it is a coercive measure and shall not be used as part of treatment.

It is cause for great concern that a patient is restrained without an administrative decision on the use of force being made, and for further concern when the responsible doctor postpones assessing the situation and thereby prolongs the unlawful use of coercive measures. During use of a coercive

[34] The hospital was asked to provide copies of the use-of-force records, administrative decisions, medical grounds (patient record entries), patient record entries recorded during the time the patient was in the restraint bed and up to one day after the incident, and the outcome of the complaint case, if any.

measure, the patient's situation and whether the criteria for using the coercive measure are still met shall be assessed on a continuous basis. The use of coercive measures shall cease as soon as the risk of injury is no longer present.[35]

The Mental Health Care Act Section 4-8 emphasises that a decision on the use of coercive measures shall be made when 'this is absolutely necessary' in order to prevent the patient from injuring himself/herself or others. It is therefore cause for concern that several cases were found where the use of restraints had been decided in advance, i.e. the decision to restrain the patient was made on the basis of the patient's previous behaviour or where it had been decided to restrain a patient and the restraint was carried out despite the patient being calm and the situation being under control when the restraint was initiated. Several patients told of incidences of restraint being used as a punishment for behaviour or utterances that the milieu therapists or duty doctor did not like.

Recommendations

- The hospital should take steps to ensure that procedures are in place that mean that an administrative decision is always made when coercive measures are used.
- Steps should be taken to ensure that everyone who is responsible for making administrative decisions on duty knows who is responsible for entering decisions in the patient records.
- It should be ensured that decisions to use coercive measures are revoked as soon as the risk of harm is no longer present and that decisions on the use of coercive measures are always based on an assessment of the situation at the time they are made.

10.1.2 Brief holding

The review of the patient records showed repeated instances of patients being held for brief periods without an administrative decision having been made in some of the units. This was confirmed by staff in emergency ward North, who stated that the reporting of holding was inadequate, and that some members of staff regarded the holding of patients as part of the milieu therapy. This practice gives cause for concern. Some patients also told the team that they had experienced such holding as a punishment for behaviour the milieu therapists did not like.

Recommendations

- Steps should be taken to ensure that administrative decisions are always made concerning brief holding.

10.1.3 Treatment without the consent of the patient

The Parliamentary Ombudsman has previously stated that, all in all, there is cause for concern that the forced administration of antipsychotic drugs places patients at risk of inhuman or degrading treatment.[36]

[35] The Directorate of Health (2012): Circular IS-9/2012, page 141.

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.[37] 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.'[38] On 17 June 2016, the Government appointed a committee that is tasked with looking at the regulations and proposing amendments that meet the needs of today's and tomorrow's health and care services. The new regulations must underpin the goal of creating 'the patients' health service'. The committee will submit its recommendation by 1 September 2018.[39]

Because of the serious findings that were uncovered during the NPM's visit to UNN in areas such as patient safety, the use of coercive measures, segregation and a worrying institutional culture in parts of the clinic, it was decided not to give priority to reviewing how treatment without the patient's consent is practised.

10.2 The use of coercive measures at patients' own request

Some patients had been placed in restraints after having expressed a wish that this be done. It is important to emphasise that coercive measures are not treatment. The use of coercive measures at the patients' own request without the statutory requirements being met is therefore a practice that gives cause for concern. These may be patients who are trying to express a need for health care, care or security.[40] The 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.

For the same reason, patients should not be offered the option of being placed in restraints if they are experiencing a difficult situation. Several cases were found in which being placed in restraints was presented to the patient as a possible solution to a situation, and where it was up to the patient to consent. If the patient chose this option, an administrative decision was made and the restraint implemented. Similarly, cases were uncovered where a patient was asked to let the staff know when he or she was 'ready to be released from the restraints'. There is no legal basis for such practices in the Mental Health Care Act.

Recommendations

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

[36] See the Parliamentary Ombudsman's report following a visit to Sørlandet Hospital, Kristiansand from 7 to 9 September 2015.
[37] The Directorate of Health (2015): Assessment of the continuation of 'Improved quality – more voluntariness. A national strategy for more voluntariness in mental health care services (2012–2015).'
[38] The Directorate of Health (2015): Assessment of the continuation of 'Improved quality – increased voluntariness. A national strategy for more voluntariness in mental health care services (2012–2015),' pp. 22–23.
[39] See: https://www.regjeringen.no/no/aktuelt/utvalg-skal-forbedre-tvangsreglene/id2505055/.
[40] The European Committee for the Prevention of Torture (CPT), 2012: The use of restraints in psychiatric institutions, page 18, paragraph 9.

10.3 The exercise of coercion

It is a fundamental principle that a hospital shall be a safe place for both patients and staff. Reference is made to the European Committee for the Prevention of Torture's (CPT) standards for psychiatric institutions on the use of coercive measures:

> 'For the staff of a psychiatric hospital, it should be of the utmost concern that the conditions and circumstances surrounding the use of restraint do not aggravate the mental and physical health of the restrained patient.'[41]

And further:

> 'When recourse is had to restraint, the means should be applied with skill and care in order not to endanger the health of the patient or cause pain.'[42]

Several sources in emergency ward North reported incidences of unnecessary use of force when implementing coercive measures. Among other things, one patient had been placed in restraints with a pillow over the face and one patient had been placed in restraints naked. In addition, it was stated that it was mainly men who placed patients in restraints. There could be seven or eight nurses to one patient, who held different limbs while one sat astride the patient's chest or stomach. A female patient stated that this was a very difficult thing to experience based on her previous experiences.

Another patient was said to have been dragged along the floor by their arms into their room in front of other patients (see also section 12.1 *Cultural risk factors for torture and ill-treatment*)

The CPT underlines in general that patients against whom coercive measures are used should be dressed and not be exposed to fellow patients.[43]

There were no procedures for training staff in placing patients in restraints at the psychiatric department. Nor were there procedures for training in or reflection about what effect the use of coercive measures can have on patients.

Reference is made to the CPT standard for the use of coercive measures:

> '….training (is) essential and refresher courses need to be organized at regular intervals. Such training should not only focus on instructing health-care staff how to apply means of restraint but, equally important, should ensure that they understand the impact the use of restraint may have on a patient and that they know how to care for a restrained person.'[44]

Recommendations

- Coercive measures must be used in the most gentle and respectful way possible.
- The clinic should ensure that training and regular practice are given in the use of

[41] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 61, paragraph 47.
[42] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 62, paragraph 48.
[43] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 62, paragraph 48.
[44] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 62, paragraph 49.

coercive measures. The training should also include understanding how patients can experience the use of force.

10.4 Informing next of kin after the use of coercive measures

Information from patients, staff and heads of units confirmed that next of kin are rarely or never informed about patients being placed in restraints. It emerged that it is a goal in several units to cooperate with next of kin, including notifying them about the use of coercive measures, while other units only confirmed that next of kin are never notified. There was thus no overarching requirement or guidelines for notifying next of kin on the clinic management's part. The Parliamentary Ombudsman takes a serious view of this. The patient's immediate next of kin cannot exercise their right to complain if they are not informed in accordance with the law.[45] This type of practice weakens both the patients' due process protection and the rights of next of kin.

Recommendations

- The patients' immediate next of kin should be informed at once about the use of coercive measures unless the patient objects. The hospital should ensure that procedures are developed for this and that all units comply with them.

10.5 Follow-up interviews

Systematic use of voluntary conversations between the patient and health personnel after the use of force, a so-called follow-up interview, can be a means of preventing future use of force vis-à-vis the individual and the use of force in general.[46] At the same time, it is necessary to take into account that the degrading nature of coercion can result in such interviews being perceived as negative by the patient, who should therefore be able to choose whether they want to have a follow-up interview.[47]

The emergency psychiatric section did not offer voluntary follow-up interviews after the use of coercive measures. There are written procedures for the use of follow-up interviews in some of the units, but both patients and staff said that they were not normally complied with and that follow-up interviews rarely took place in practice. This was confirmed by the heads of the different units. The supervisory commission also pointed out that there was no practice for conducting systemised follow-up interviews in the psychiatric department.

[45] The Mental Health Care Regulations Section 27 third paragraph.

[46] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 61, paragraph 46.

[47] 'The patient shall be offered an interview or interviews afterwards, and the first interview should take place as soon as possible after the incident. The review should preferably be led by someone who was not involved in the incident. The head of section and person treating the patient are jointly responsible for ensuring that such interviews take place.' 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-ipsykisk-helsevern.

Recommendations

- Patients should be offered a follow-up interview about incidents involving the use of force.

10.6 Use-of-force records

The supervisory commission has pointed out that the hospital appeared to lack proper procedures for registration in the use-of-force records. The commission found deficiencies such as loose sheets and that the records were unsigned. In addition, the supervisory commission remarked that some of the administrative decisions on the use of coercive measures were not entered in the records, only in the electronic patient records system (DIPS). They therefore had to check both the records and DIPS to make sure that they had an overview of all administrative decisions.

At the NPM's meeting with the management, it was explained that priority was given to entering such decisions in DIPS and that this could be at the expense of registration in the use-of-force records. One of the doctors explained that, when he/she had forgotten to register a decision in the records and only entered it in DIPS, the supervisory commission had not commented on this. The doctor in question therefore did not see any point of registering the administrative decisions in the use-of-force records. This practice gives cause for concern. After the visit, the supervisory commission pointed out that it always reviews record entries in DIPS, which the hospital has stated are dependable sources for assessing administrative decisions on the use of force. Its view is thus that signing incomplete records is not cause for concern as long as it is clear from the commission's report that the decisions have been verified. However, as a result of inadequate records and doubt about where administrative decisions are to be registered, there is no dependable overview of the total number of administrative decisions, which makes the supervisory commission's work on safeguarding patients' rights more difficult. In addition, DIPS does not register the duration of the use of mechanical restraints, which further reduces the documentation on the use of coercive measures. This practice is also in conflict with the clinic's adopted plan for increased voluntariness, in which one of the measures is better documentation and data quality.

In several cases, incomplete use-of-force records were signed by the supervisory commission without comment. This is cause for concern because this body, which is tasked with safeguarding the patients' rights, thereby helps to legitimise a record-keeping practice that leads to an increased risk of ill-treatment.

Recommendations

- The hospital should improve the documentation provided in the use-of-force records, so that it always includes the patient's name and personal ID number, the time that the coercive measure was initiated and ended, the grounds for the coercive measure, the names of both the duty doctor and the person with professional responsibility for the decision to use force, and registration of any injuries to patients or staff.
- 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 relating to their own incident.

- The supervisory commission should ensure that it does not sign incomplete use-of-force records.

11 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.[48] Segregation can take place in the patient's own room or in 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 also applies during segregation. Patients must be informed about their right to discharge themselves from the institution.[49]

Based on a systematic review of literature about Norwegian segregation practice, there is little evidence-based knowledge about the effect of segregation in Norway.[50] Segregation was nonetheless extensively used at UNN, and for prolonged periods for some patients. A total of 245 administrative decisions on segregation were made at the clinic in 2015, and emergency ward North made a higher number of such decisions than the other emergency wards.

11.1 Segregation decisions

During its visit, the NPM found a practice relating to administrative decisions on segregation that gave cause for concern. It was observed that one patient was held in a prolonged segregation regime, mainly based on reports from the milieu therapists. It is cause for concern that such segregation is continued for long periods without the assessments made by the person responsible for the decision being clearly stated as the grounds for the decision. Segregation is a major intervention in a person's private life. The longer someone is subjected to segregation, the more intrusive the measure is. In addition, it is emphasised that segregation puts patients who do not have next of kin around them in a particularly vulnerable situation.

Recommendations

- Steps should be taken to ensure that decisions on segregation are justified by concrete and independent assessments by the person responsible for the decision.

[48] The Mental Health Care Act Section 4-3.
[49] The Directorate of Health (2012): The annotated version of the Mental Health Care Act and the Mental Health Care Regulations, IS-9/2012, Chapter 3, Section 18, page 132.
[50] Norvoll R, Ruud T, Hynnekleiv T. (2015). 'Skjerming i akuttpsykiatrien' ('Segregation in emergency psychiatry'). Tidsskrift for Norsk Legeforening, 135, pp. 35–39.

11.2 Design of segregation units

There were dedicated segregation units in emergency wards North and Tromsø, and in the psychosis and substance abuse unit, as well as in the secure unit. Emergency ward South stated that it had made a conscious decision not to set aside a special area for a segregation unit in order to have more ordinary patient rooms available.

In emergency ward North, the segregation unit was at the far end of the corridor. It consisted of three patient rooms in all and one room with a restraint bed. The innermost part of the segregation unit consisted of two patient rooms, an anteroom/small lounge with two chairs and a small table, and a room with a restraint bed. There was a separate bathroom in the innermost area, with a steel toilet and shower. The outermost area comprised a common room with a small kitchen, dining table and sofa and table. The bathroom for the rooms in this part of the segregation unit had a normal porcelain toilet. There was a separate smoking room for the segregation unit. There was also a small duty room/personnel room from which staff could observe both parts of the segregation unit through glass. The segregation unit had a sterile appearance, with no pictures on the walls or other elements that could help to foster a secure atmosphere. There was no possibility of direct access to the open air from the segregation unit.

Emergency ward Tromsø had two rooms adapted for segregation. The patient room had an anteroom and smaller room attached, with two chairs that staff could use. The shower and toilet were attached to these two rooms. Like the rest of the department, these segregation rooms were very run-down. There was no direct access to fresh air from these rooms.

At the psychosis and substance abuse unit, the segregation unit was being refurbished. It consisted of a bedroom, a living room and bathroom and it could be furnished in accordance with requirements. It also had a separate entrance, so that it was not necessary to enter via the common room in the ward. This was in order to facilitate the treatment of patients with perinatal psychosis. There was no direct access to fresh air from this unit.

See section 11.5 *Prolonged segregation* for a description of the segregation unit in the secure psychiatric inpatient unit.

Recommendations

- The hospital should take steps to ensure that also patients who are segregated can go outdoors on a regular basis.

11.3 Restraint beds in segregation units

In emergency ward North, the segregation unit included a room equipped with a restraint bed. Segregated patients were thereby just a few steps away from the restraint bed, which was located in the innermost part of the unit. This could create an impression of segregation as a means of control rather than as a way to ensure calm 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. Placing the restraint bed in the segregation unit can increase the risk that the restraint bed will be used on segregated patients instead of milder means. In addition, it could give rise to unnecessary fear in patients who are aware

that an intrusive means of coercion is so near at hand. The location of restraint beds in the segregation unit seems problematic.

Reference is made in this connection to the clinic's own statistics for the use of coercive measures, where emergency ward North scores very high for the use of mechanical restraints; see section 10 *Coercive measures.*

Recommendations

- Restraint beds should not be placed in segregation units.

11.4 Location of staff

It was observed during the visit that patients were segregated in a separate room with members of staff sitting outside, with the door closed. This practice was also confirmed by several members of staff and patients in the different units in the emergency psychiatric section. This gave the impression that the patients were alone and without direct supervision for short or longer periods. The door could also be closed, so that personnel, from the outside, could prevent a patient from leaving the room.

The Directorate of Health has issued an interpretation of the Mental Health Care Act's provisions on the use of segregation in a case that concerned the segregation of a patient in a separate room in a segregation unit.[51] In this case, the health personnel sat outside a door that was ajar. The health personnel had a dialogue with the patient through the door opening. The Directorate of Health stated that the segregation measure must be deemed to be isolation, and, among other things, it stated:

> 'However, the personnel and the patient were in separate rooms, and the nature of the physical separation and the (assumed) intention of keeping the door *between* the patient and the personnel closed if using physical force if required, indicates that the patient was subjected to de facto isolation.'[52]

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

[51] 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', (Legal interpretation – the Mental Health Care Act – The use of segregation or isolation and procedures for referring patients to forced observation and involuntary mental health care'), 11 October 2015.

[52] 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', 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, when the hospital implements segregation measures pursuant to the Mental Health Care Act Section 4-3 in a number of inpatient wards, '[it is not] permitted for a patient to be kept separate from personnel taking part in implementing the segregation. This means that the Mental Health Care Act has been violated.'

Recommendations

- Steps should be taken to ensure that segregation does not entail 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.

11.5 Prolonged segregation

In the inpatient ward in the secure department, a large part of the ward was set aside as a segregation unit for one patient. The segregation unit consisted of a bedroom and a living room, plus a separate bathroom. The doors leading out to the department were usually open, but a large table was placed in such a way that it filled the door opening. The table was used for social activities such as card games, but the main reason for its placement was to serve as a buffer between staff and the patient in the event of sudden uncontrolled behaviour. A separate outdoor area with a small garden and a reinforced stairway had been built in connection with this unit, with a special entrance/exit for this patient.

In some instances of uncontrolled behaviour, the patient was locked in the segregation unit without any staff being present, in accordance with an established procedure. The patient could be kept locked up for up to two hours. In such cases, an administrative decision on isolation was made. The doors to the innermost unit had inlaid glass and an opening, so that the staff could be outside and communicate from there. At the time of the NPM's visit, the patient had been segregated continuously for around three and a half years. The decisions were renewed every two weeks and the decision records were signed by the supervisory commission. In reality, the patient had lived in the segregation unit for several years, with very limited possibilities for contact with the outside world. The regulations do not place any limit on how long a patient can be segregated, and a patient can therefore live in isolation from everyone except treatment staff for years. This is problematic, however, in relation to the risk of ill-treatment.

It was apparent from many of the administrative decisions concerning segregation, mechanical restraints and isolation that the patient had not received the decision in writing, because 'too many "routine letters" are deemed to just stress the patient'. It is difficult to understand how information about the basis for a decision on coercive measures can represent an additional burden for a patient who has been placed in restraints or segregated. On the contrary, good written and verbal information about why the decision was made could contribute to a follow-up interview about the use of force (see section 10.5 *Follow-up interviews).* The staff at the unit explained that the patient could have a mental health condition that made it difficult for him to understand, at the moment when the decision was made, the decision to use force and the right to complain. In such situations, endeavours should be made to provide the information as soon as the patient's condition has changed, so that the patient has a real chance to understand that segregation and coercive measures are measures that there must always be grounds for.

In order to safeguard the patient's due process protection and possibility of complaining about decisions, the patient should be informed both in writing and verbally when a decision is made. In

principle, therefore, it gives cause for concern that the same person who makes the decision considers that the patient is incapable of having the written decision presented to him. This constitutes a risk of ill-treatment in that the patient is denied the possibility of receiving information about the grounds for the decision, which will form the basis for a complaint.

Recommendations

- If the patient's health condition is such that they are unable to receive the decision at the time it is made, the patient should be informed again when they are better able to receive and understand the information.

12 Institutional culture

12.1 Cultural risk factors in relation to torture and ill-treatment

In institutions that are authorised to deprive people of their liberty, there will always be an imbalance of power between the management and staff, on the one hand, and residents of the institution, on the other. At a hospital where patients are committed, the patients are dependent on the staff if their daily needs are to be met and fundamental rights respected. The imbalance of power between staff and patients creates vulnerability to abuse and violations of human dignity and fundamental rights. This vulnerability is further increased at institutions that are largely shielded from public access, such as institutions providing compulsory mental health care. It is therefore particularly important that institutions where people are deprived of their liberty make active endeavours to promote values, attitudes and a shared culture that are in accordance with the right to be treated humanely and with dignity.[53]

The culture at an institution primarily comprises the prevailing values, attitudes and perceptions among the staff; their attitudes to what is important in the unit, how problems are solved and what kind of behaviour is acceptable.[54] The culture will be reinforced by employees' perception of the management's acceptance or engagement.

In an institutional culture, some characteristics and attitudes will represent a clear risk of ill-treatment. This applies in particular to internal cultures where staff have lost sight of the individual and where 'us and them' attitudes, a culture of violence and the use of force and a culture of impunity from sanctions and punishment have developed.[55]

If members of staff stop seeing each patient as an individual, but treat them like objects or as representatives of a group (for example based on diagnosis, gender or age), this creates distance. In such cases, human relations can easily be weakened and a risk of ill-treatment arises. Research shows that 'us and them' attitudes in agencies that exercise power can result in the use of force.[56] In prisons, it has been found that such attitudes among staff generally lead to a higher stress level among inmates.[57]

A culture of violence and the use of force develops where the prevailing attitude is that violence is normal or necessary. This will often be the case in places where the staff perceive control to be an

[53] The UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Article 10. See also the Scottish Human Rights Commission (2009): Human Rights in a Health Care Setting: Making it Work for Everyone. An evaluation of a human rights-based approach at the State Hospital.
[54] PRI and APT (2013): Institutional culture in detention: a framework for preventive monitoring.
[55] PRI and APT (2013): Institutional culture in detention: a framework for preventive monitoring.
[56] Terrill et al. (2003): Police culture and coercion, *Criminology,* 4, pp. 1003–1034. See also Norvoll & Husum (2011) *Som natt og dag? – Om forskjeller i forståelse mellom misfornøyde brukere og ansatte om bruk av tvang* ('Like night and day? – About differences in understanding between dissatisfied users and staff on the use of force'), Arbeidsforskningsinstituttet, which states that: 'Several studies show that groups of personnel in hospital wards (especially those where control cultures prevail) are characterised, among other things, by a wish on the part of the staff to maintain a distance to the patients. […] This contributes to a creating a view among staff of the patient as "the other" and significantly different from themselves.' (page 10)
[57] Liebling (2007). 'Why prison staff culture matters' in *The culture of prison violence,* Byrne, Taxman and Hummer (eds.), Allyn and Bacon, page 105.

overarching priority. Such a culture will flourish even more where the staff do not believe that they have alternative means available or lack knowledge about other ways of dealing with conflicts.

When staff commit violations without being held accountable, we can speak of a culture of impunity from sanctions and punishment. Places where members of staff typically cover things up for each other, or do not report injustices that are committed, contribute to maintaining such a culture. A culture of impunity from sanctions and punishment is allowed to develop when the management of the institution does not actively intervene against abuses of power. If the management tacitly accepts injustices, this sends a strong signal that such practices can continue without having any consequences for those involved.

Reference is made to the European Committee for the Prevention of Torture's (CPT) standards for psychiatric institutions:

> 'Psychiatric patients should be treated with respect and dignity, and in a safe, humane manner that respects their choices and self-determination. The absence of violence and abuse, of patients by staff or between patients, constitutes a minimum requirement.'[58]

12.1.1 Emergency ward North

During the visit, the NPM found a clear 'them and us' attitude in emergency ward North. Several examples were found of individual patients being talked about in ways that seemed to be dehumanising. Some of the personnel group expressed suspicion about the intentions and behaviour of the patients. Similar attitudes to society at large were also found in the unit. Several of the patients reported offensive, sexualised and degrading utterances and attitudes that resulted in them feeling unsafe or inferior when they were with certain members of the personnel group.

Deprivation of liberty means that it is not possible for these patients to protect themselves from staff members' presence or to avoid being the butt of negative or degrading comments. This is serious. Such incidents were entered in patient records in several cases and, in some cases, had developed into incidents of uncontrolled behaviour with subsequent holding and restraint. The supervisory commission stated that, when reviewing administrative decisions on the use of force, there appeared to be examples where the use of force was occasioned by confrontational behaviour on the part of staff. In one patient record, the duty doctor had noted that the patient's experiences with the milieu therapists should be reported to the person responsible for treating the patient. It must therefore be assumed that this was known among the treatment group.

It also emerged that, in emergency ward North, holding for brief periods was repeatedly used without an administrative decision being made (see, among other things, section 8.3 *Patient safety*). The visit left the impression that some of the staff regarded holding as part of the milieu therapy. In addition, several patients experienced being placed in restraints and holding as punishment for behaviour the staff did not like, instead of it being used as a last resort to prevent injury to the patient or others. A clear majority of both staff and patients stated that, in their experience, reducing the use of force was not a goal in the ward. Several sources provided information about unnecessary use of force in contact with patients, and several members of staff regarded certain colleagues as

[58] The European Committee for the Prevention of Torture (CPT), CPT Standards, CPT/Inf/E (2002) 1 - Rev. 2015 English, page 58, paragraph 37.

being very concerned with control and having power over the patients (see also section 10 *Coercive measures*).

Reference is also made to the CPT:

> 'It should be acknowledged that resort to restraint measures appears to be substantially influenced by non-clinical factors such as staff perceptions of their role and patients' awareness of their rights. Comparative studies have shown that the frequency of use of restraint, including seclusion, is a function not only of staffing levels, diagnoses of patients or material conditions on the ward, but also of the 'culture and attitudes' of hospital staff.'[59]

It also emerged that patients have been injured in encounters with staff, both in holding situations (see section 8.3 *Patient safety*) and while being placed in restraints. There were no procedures for registering such injuries, and the perception was that these incidents were not followed up in relation to those involved.

A sharp distinction was also described between staff on the nightshift and staff on the day and evening shifts. The nightshift staff were a fixed group of personnel, nearly all men, who almost exclusively worked nights. The staff themselves emphasised that there was little communication between the nightshift and the rest of the staff, and it was pointed out, among other things, that meetings and training were not organised to any great extent in a way that enabled nightshift staff to participate. Several of the nightshift staff stated that they did not feel they were understood by the management, but at the same time that they could largely perform their duties as they themselves wished. Both the management of the unit and several members of the treatment group and milieu therapists stated that, in their view, most incidents involving patients being placed in restraints took place at night, although it was also pointed out that figures that could confirm this were lacking.

12.1.2 Management

The management is responsible for ensuring that the social identity and culture that develop among staff are in compliance with human rights and with fundamental rights, such as patient safety and the inherent dignity of all human beings. When the management's attitudes and values are not clear, are not respected or are seen as supporting a negative culture, the risk of cultures being allowed to develop that permit abuse increases strongly. Surveys of cultures among staff in institutions where deprivation of liberty takes place also show that socialisation in the direction of negative attitudes largely depends on the employees' perception of whether they will be held accountable. A perception that staff will be held accountable for abusive practices, on the other hand, has a strong socialising effect in the positive direction. In the same way, it has been shown that, where there is a lack of common values promoted by a clear management, this will in itself create an increased risk of abuse.

During the visit, we found few examples of the management of emergency ward North or the management at higher levels in the organisation having addressed unfortunate attitudes among staff as described above (see, among other things, section 12.1.1 *Emergency ward North*). A clear lack of trust in the management was expressed by several members of staff during the NPM's visit.

[59] 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 63, paragraph 54.

It was found that there was a clear lack of insight into and will on the part of the management at all levels to address the causes of the big differences in the use of force between the units in the emergency psychiatric section, and to ensure good procedures for registering patient injuries (see, among other things, section 8.3 *Patient rights* concerning a serious patient injury that was not reported or followed up despite the management being aware of it). Such lack of a clear will on the management's part to do something about the use of force may have been interpreted by staff as acceptance of their attitudes and practice.

It was consistently found in the emergency psychiatric section that clear written routines were lacking for important procedures and that there were big differences between the units in terms of practices and procedures. There were also big differences between the sections as regards written procedures. Among other things, there were no common procedures in the emergency wards for the training of new employees and for carrying out follow-up interviews after the use of coercive measures (for more details, see section 10 *Coercive measures*).

Several members of staff also pointed out that staff members were not looked after or followed up to any great extent if serious incidents occurred at work, or if someone was injured during working hours.

In light of these risk factors and findings made during the visit to UNN, the Parliamentary Ombudsman takes a serious view of the conditions in emergency ward North in particular, and points out that responsibility for changing these conditions primarily rests with the management.

Recommendations

- The hospital should initiate a process to ensure a shared culture where patients' safety, dignity and rights are promoted in all units in the emergency psychiatry section. Immediate measures should be taken to ensure that this is the case in emergency ward North in particular.
- The hospital should ensure uniform procedures for attending to staff after serious incidents.