SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Akershus University Hospital, Department for Emergency Psychiatry

2-5 May 2017

National Preventive Mechanism against
Torture and Ill-Treatment

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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 given a special mandate to prevent torture and other cruel, inhuman or degrading treatment or punishment.[1] To fulfil this mandate, a special unit known as the National Preventive Mechanism (NPM) was established in the Parliamentary Ombudsman's office.

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

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

The Parliamentary Ombudsman, represented by the NPM, has right of access to all places of detention and the right to speak privately with people deprived of their liberty. The NPM also has right of access to all essential information relating to detention conditions. During its visits, the NPM seeks to identify risk factors for violations through independent observations and through conducting interviews with the people involved. Interviews with persons deprived of their liberty are given special priority.

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

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

2 Summary

The Parliamentary Ombudsman's National Preventive Mechanism (NPM) visited the emergency psychiatric department at Akershus University Hospital (Ahus) on 2–4 May 2017. The hospital was notified in advance that the Parliamentary Ombudsman was planning a visit, but was not informed of the date of the visit.

The six wards under the department for emergency psychiatry were housed in an older building on the hospital grounds. The wards' communal areas were nicely furnished, but the building showed signs of wear and tear and the reception area did not give newly arrived patients or visitors a positive first impression. A number of patients had limited opportunity to spend time outdoors, particularly patients subject to restrictions on being outdoors and patients in the segregation units. There was no direct access to outdoor areas from the communal areas or segregation units.

The department employed two physiotherapists who offered both individually adapted physical activity and weekly activities for all patients. Other than that, the range of activities available to patients was limited, and there were no alternatives for patients who did not wish or were unable to participate in physical activity.

A review of administrative decisions and protocols submitted to the NPM relating to the use of force in the department found that there were weaknesses in the documentation of the use of force. The concrete grounds for each decision, and particularly decisions regarding medical treatment without the consent of the patient, were not specific enough and partly based on the wrong conditions. The patient's right to receive the administrative decision was not adequately safeguarded, and the patients were not routinely given the concrete grounds for the decision.

At the start of 2017, the unit had initiated a project to ensure the correct and reduced use of force, and planned to focus more on the scope and variation in the use of mechanical restraints in particular.

A review found that there had been a reduction in the number of times mechanical restraints had been used in the past year. The staff had received training to ensure that patients were restrained in the safest and gentlest way possible. However, conversations with patients who had been placed in restraint beds indicated that many patients did not feel well taken care of while being placed in restraints. It was also worrying that many patients had been strapped to a restraint bed for longer periods of time, in some cases for more than a day. In some of these cases, it was poorly documented what assessments had been made and what attempts had been made to use less invasive means or release the patient. Several staff members and patients felt that the use of restraints sometimes continued after the situation that necessitated their use had ended.

Findings made during the visit indicated that patients had sometimes been confined to their room without an administrative decision on isolation being made. It was also found that the threshold for writing administrative decisions on holding of patients was too high, because it was believed that it was unnecessary to write down and record short-term holding of patients even if they objected to the holding.

The segregation units were relatively spacious, and the patients could move around between different rooms within the segregation unit. Segregated patients had limited opportunity to spend

time outdoors, including engaging in outdoor physical activities. Furthermore, the practice of regulating the time patients spent in their own rooms and in the segregation unit's living room through daily plans seemed to take little account of the conditions similar to isolation that can arise if the patient is obliged to remain in their own room too much while staying in a segregation unit.

The forced medication figures showed that considerably more administrative decisions had been made in the past year. What arrangements the medical personnel had made to facilitate patient involvement, and what information the patient had received about expected effects and possible side effects, were poorly documented.

In the period from January 2015 to the end of February 2017, the department had performed ECT on eight patients on grounds of necessity. Based on the information provided about the use of ECT on such grounds, several of these treatments seem problematic in relation to the requirements for grounds of necessity.

Many of the patients had limited opportunity to go outside the department. This also included voluntarily admitted patients. Several of the patients stated that they did not understand the background for these limitations. Staffing challenges were given as one important reason for why it was not possible to accompany patients outside.

Many patients reported that they were treated well at the department. Many patients stated that most of the staff were nice to patients, and that they were well looked after. However, several staff members and patients pointed out that some of the staff had an authoritarian or patronising attitude.

One ward in particular stood out as having had a poor working environment for a long time, with too few nurses or other staff with relevant professional backgrounds, and a high staff turnover. Several patients in this ward stated that they felt unsafe. Findings also indicated difficulties with control of and signs of subcultures among some of the department's nightshifts.

There were no posters or information brochures available in the wards about patients' right to file a complaint to the supervisory commission, the County Governor or the Parliamentary Ombudsman. There seemed to be a general attitude among the staff that information about this could unsettle involuntary committed patients in particular. There was also little user participation clearly reflected in the department at system level. No one with user experience was directly involved or employed by the department, and the user representatives in the hospital's user committee had little experience and knowledge of the department.

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

Physical conditions and activities

• The hospital should consider the extent to which the physical surroundings, especially the outdoor areas at the emergency psychiatry department, are conducive to creating a safe environment for treating patients in times of crisis.

• The department should, in consultation with the patients, ensure a varied range of activities adapted to the individual patient's level of functioning and interests.

Administrative decisions and records in connection with the use of force

• The department should ensure that individual and concrete proportionality assessments are carried out for all decisions on the use of force.

• Administrative decisions on the use of force should contain concrete grounds that make it possible to see how the applicable statutory conditions have been taken into account in the case at hand.

• The department should ensure that an administrative decision is made as quickly as possible in connection with the use of force and that a decision is never backdated.

• The department should ensure that patients receive written administrative decisions with grounds unsolicited.

Use of coercive measures

Use of mechanical restraints

• The department should ensure that patients' dignity and welfare are safeguarded when restraint beds are used, and that the right to contact a lawyer and the appeal bodies is safeguarded.

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

Use of isolation

• The department should ensure that an administrative decision on isolation is always made if the measure means that the patient is isolated.

Use of short-term holding

• The department should ensure that an administrative decision is always made when a patient is subjected to holding.

Use of segregation

• The department should ensure that conditions similar to isolation do no arise under segregation when the patient is obliged to stay in their room.

Use of ECT on grounds of necessity

• The department should review its procedures for use of ECT on grounds of necessity in order to ensure that patients are not subjected to an unlawful practice.

Restrictions on the right to leave the department

• All patients should have the opportunity to spend at least one hour outdoors every day with adequate opportunities for physical activity, including patients in the segregation units.

• The department should ensure that voluntarily admitted patients are not unlawfully subjected to restrictions on the right to leave the department.

Institutional culture

• The department should ensure that the staff have professional backgrounds and a common culture that minimise the risk of inhuman treatment.

Patient rights and user involvement

• The department should ensure that good information about patient rights and user organisations is available to all patients.

• The hospital should ensure greater user participation in the running and development of the department.

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