SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

Ålesund Hospital, Department for Hospital Psychiatry

19-21 September 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 Ålesund Hospital's psychiatry department on 19–22 September 2017. The hospital was notified in advance that the Parliamentary Ombudsman was planning a visit, but the date of the visit was not given.

Well-designed physical surroundings for patients are an important prevention measure. The wards visited had pleasant and open communal areas. The activity programmes offered at the hospital psychiatry department were unsatisfactory. Some of the patients in the emergency section were not given the opportunity to spend time outdoors every day. It was difficult to access outdoor areas, which was particularly challenging for patients in one of the emergency section's segregation units.

Several weaknesses were found in the hospital's practice in relation to administrative decisions to use coercion. Outdated templates were used that increased the risk of the person responsible for the decision not making assessments in line with applicable legislation. Several of the administrative decisions contained poor explanations of why the statutory conditions were found to be met. This particularly concerned segregation decisions and decisions regarding treatment without the consent of the patient. Among other things, whether the patient had been informed of the possible effects and side effects of the medication had generally not been documented, nor the degree to which the patient had been given the opportunity to influence the choice of type and dosage of medication. Patients did not receive the grounds for the decision in writing.

Two restraint beds were placed in the waiting room right beside the patient entrance to the emergency section and could make patients already in a vulnerable acute phase feel even more unsafe. Information was provided that gave cause for concern about whether the threshold for using mechanical restraints was too low and indicated that prolonged use of restraints was a challenge in the emergency section. A review showed that patients still often slept in restraint beds, and examples were found of patients not being released from the restraint beds during the night shift due to inadequate staffing. A review of the documentation indicated that there was an increased focus on documenting measures vis-à-vis patients placed in restraints. At the same time, the examinations were often somatic in nature rather than a review of whether the situation was still such that the coercive measure had to be upheld.

Information was provided during the visit that indicated that patients were sometimes locked up in their rooms without the person responsible for decisions being informed. Information also emerged that indicated that some cases of short-term manual control were not registered as administrative decisions.

In spring 2017, the Clinic for Mental Health Care and Substance Addiction Treatment in Møre and Romsdal health trust prepared an action plan to reduce the use of coercion. The action plan was partly implemented, but did not appear to have the full support of the organisation. Several of the measures were quite general in nature and targeted all forms of coercion. The action plan's ambition level did not seem to be very binding in relation to the use of coercion.

Many of the patients in the segregation units had little freedom of movement in practice and had to spend a lot of time in their rooms. This was due to a combination of the physical surroundings, capacity challenges and the way in which segregation was carried out.

The segregation units that the NPM visited were sterile and unattractive. Except for a bed, chair and table, the rooms were unfurnished and painted white. The two rooms that were originally common rooms for the patients in the emergency section's segregation units were used by other patients when necessary due to a high occupancy level. One of the segregation units had a separate isolation room. The room appeared to be unsuitable for patients, regardless of the situation.

The implementation of segregation measures seemed unplanned, and many of the patients felt lonely in the segregation unit. Voluntarily admitted patients had been segregated in the emergency section without it being documented that they had been informed about their right to discharge themselves from the institution. A decision on segregation in the emergency section was normally not extended beyond the maximum period prescribed by law of two weeks. However, in the reinforced rehabilitation section, there were instances of some very long-term decisions being made. For example, one patient had been segregated for more than 3.5 months in the course of a five-month period.

The hospital's practice of using electroconvulsive therapy (ECT) was also reviewed. A review of three cases showed that it had not been sufficiently documented whether the patients had given their informed consent. It was found that the hospital did not have a system for maintaining an overview of the number of ECT treatments administered on grounds of necessity.

A review of four cases where ECT had been administered on grounds of necessity in the period 1 January 2016–22 September 2017 showed that the patients' conditions were deemed to be serious. There seemed to be an awareness of the ethical dilemmas that arise when ECT is administered without informed consent. The review also uncovered weaknesses in the documented assessments of whether the requirements for treatment on grounds of necessity had been met. In several of the cases, treatment with drugs was not relevant because this was seen as having contributed to or even led to the serious condition. It was not clear why other treatment measures were not sufficient to prevent an acute risk to the patient's life or health. In several of the reviewed cases, ECT was administered on grounds of necessity several times. There was little documentation of the assessments made explaining why the requirements for treatment on grounds of necessity were still met.

The patients generally described the staff in positive terms such as kind and caring. At the same time, information emerged from both patients and staff members about cases where less invasive means could have been used rather than coercion. Staff members talked about cases where restraints had been used for longer than strictly necessary and where staff insecurity was a contributing factor. Fear and insecurity among the staff constitutes a clear risk of disproportionate use of force.

Conversations with staff at the reinforced rehabilitation section indicated that they had a good culture of ethical reflection on the use of coercion and were highly aware of what causes conflict when patients are deprived of their freedom and autonomy. There was a considerable potential for learning across wards, particularly as regards the establishment of a safe atmosphere with as little use of coercion as possible. At the time of the visit, there was limited exchange of experience.

Findings made during the visit showed that the local police had been called out several times in 2017 to assist with security matters at the hospital psychiatry department. Information also emerged that the police sometimes acted as guards in the segregation units and that they usually arrived in

uniform. Other situations were also described in which it can be questioned whether the situation indicated that the police should have been involved.

At the emergency section, the arrival brochure had been changed after the supervisory commission pointed out that the confiscation of patients' mobile phones was not permitted. The old arrival brochure, which stated that the department would keep the patients' mobile phone during their stay, was nevertheless still to be found in the emergency section wards during the visit.

The supervisory commission was not in the habit of walking around the ward to talk to the patients. Although the staff seemed to encourage patients to contact the supervisory commission and assisted them in doing so, such a practice increases the risk of the supervisory commission not uncovering censurable conditions or of not meeting the most vulnerable patients.

Recommendations

Physical conditions and activities

- 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.
- All patients, including patients in segregation units, should be guaranteed at least one hour outdoors every day with adequate opportunities for physical activity.

Decisions on use of coercion

- The department should implement measures to ensure that the person responsible for the decision systematically considers whether all the statutory conditions are met when making an administrative decision on the use of coercion.
- Administrative decisions on the use of coercion 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 patients receive written administrative decisions with the grounds for the coercive measure unsolicited.

Use of coercive measures

- Further measures should be implemented to ensure that the use of mechanical restraints ceases as soon as the risk of harm is no longer present.
- The department should ensure that all staff members are familiar with the statutory requirements for the use of isolation and short-time manual control of patients, and that the measures are always registered as an administrative decision.

Segregation

- The decision memo should always contain a concrete description of the factual background for the segregation decision.
- No patients should stay in the isolation, regardless of the situation or the length of the stay.
- The department should take action to ensure that patients are not segregated in a way which in reality is equivalent to isolation.

Treatment without the consent of the patient

- The department should implement measures to ensure that the assessment and documentation of treatment without consent satisfactorily safeguard the patients' legal protection.

Electroconvulsive therapy (ECT)

- Measures should be taken to ensure that the patient always receives thorough information about the treatment both orally and in writing, and that the main information provided is entered in the records.
- The department should ensure a sufficient overview and documentation of each individual case where ECT is administered 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.

Institutional culture

- The department should implement measures to create a common culture and increase the staff's sense of security and reduce the need to use force.

The role of the police in connection with measures implemented on the wards

- The department should review, in consultation with the police, its practice regarding police assistance on wards.

Patient involvement and information

- The department should implement measures to ensure the systematic involvement of the patients in connection with the use of coercion during their stay.
- The department should quality-assure all information material and house rules in the section to ensure that no restrictions are imposed without a legal basis.

Complaints and supervision

- The supervisory commission should regularly visit the wards to ensure that the patients' welfare and rights are safeguarded.

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