Norwegian Parliamentary Ombudsman

National Preventive Mechanism

Parallel report submitted by the Norwegian Parliamentary Ombudsman National Preventive Mechanism to the United Nations Committee on Economic, Social and Cultural Rights on the Occasion of its Consideration of Norway's Sixth Periodic Report at its 67th Session (17 February - 06 March 2020)

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1. About the Mandate of the National Preventive Mechanism

1. On 14 May 2013, the Norwegian Parliament, *the Storting,* voted in favour of Norway ratifying the Optional Protocol to the Convention against Torture, abbreviated OPCAT. The Storting awarded the task of exercising the mandate set out in OPCAT to the Parliamentary Ombudsman. In 2014, the National Preventive Mechanism (NPM) was established as a department under the Parliamentary Ombudsman to address this area of the Ombudsman's work.

2. The Parliamentary Ombudsman, represented by the NPM, has right of access to all places of detention and the right to speak in private with people who have been deprived of their liberty. The NPM also has right of access to all necessary information that is relevant to the conditions for people deprived of their liberty.

3. The NPM conducts regular visits to places where people are deprived of their liberty, such as prisons, police custody facilities, mental healthcare institutions and child welfare institutions. The visits can be both announced and unannounced. The NPM publishes a report following each visit, with a description of findings and potential recommendations to improving practices. Most of the reports are available in English, either in full or as a summary, on our website at

4. The NPM notes that the Committee in its List of Issues prior to submission of the sixth report of Norway requested information on the measures taken to follow up on reports of the NPM following its visits to psychiatric institutions.[1] The NPM takes this opportunity to thank the Committee for its awareness of our work.

5. The UN Convention against Torture states that torture and inhuman treatment are strictly prohibited and that no exceptions can be made from this prohibition under any circumstances. States that endorse the convention are obliged to prohibit, prevent and punish all use of torture and other cruel, inhuman or degrading treatment or punishment. According to the Convention, each State party shall 'ensure that its competent authorities proceed to a prompt and impartial investigation, wherever there is reasonable ground to believe that an act of torture has been committed in any territory under its jurisdiction'.[2] Norway ratified the Convention against Torture in 1986. The Prohibition against torture is set out in various parts of Norwegian legislation, including Article 93 of the Norwegian Constitution.

6. The NPM presents this submission to the Committee. It deals with issues arising in relation to women, children and persons with disabilities. Specifically, women in prison and challenges facing children and persons with mental health problems in child welfare homes, prisons and psychiatric institutions.

2. Women

2.1. Equality Rights of Women in Prison (Articles 2 & 3)

7. In 2016 the NPM published the report *Women in Prison - A thematic report about the conditions for female prisoners in Norway.* The report is available at www.sivilombudsmannen.no/en/news/prevention-torture/women-serve-under-worse-conditions-than-men/

[1] E/C.12/NOR/QPR/6, para. 28 (d).
[2] See the UN Convention against Torture, Article 12.

8. The purpose of this report was to highlight the challenging conditions female inmates face when serving sentences at Norwegian prisons. Since 2014, the NPM has visited most of the high-security prisons where women are serving sentences. This thematic report presents a knowledge base for action which is necessary in order to ensure that women deprived of their liberty receive equal treatment and the same protection as male inmates.

9. The report uses data the NPM obtained after visiting 14 prisons, of which eight held female inmates. We also conducted a survey amongst all Norwegian prisons and transitional housing facilities where female inmates serve their sentences.

10. The report shows that several elements of the sentencing conditions in high security prisons are worse for female inmates than those for men. International research supports the notion that with fewer women than men serving sentences prison administration, management, and prison facilities are organized and focused on the needs of men rather than women. Findings from the NPM's prison visits proves that there are several challenges that need to be addressed in order to improve the sentencing conditions for female inmates.

11. The NPM presents this report to the Committee in the hopes that it will inform your work. In the following paragraph we have listed our findings in the report for your convenience.

2.1.1. Findings in *Women in Prison* report

12. In reference to Articles 2 and 3 of the Economic, Social and Cultural Rights, the most significant findings in an equality rights perspective can be summarized in the following points below. However, as several of our findings are linked to the other areas of the Economic, Social and Cultural Rights, we have identified and added the relevant ESC Articles in each finding:

Article 2 - Non-discrimination

13. Women serving in mixed-sex prisons have an increased risk of unwanted attention or sexual harassment by male inmates.

Article 10 - Protection of family

14. Female inmates risk having to serve their sentence in prisons in geographical locations far away from their children and families because of the low number of suitable prison places. This can be particularly challenging for female inmates with children who cannot travel unaccompanied.

Article 11 - Right to adequate housing

15. Several women's prisons are located in old buildings, dating back to as far as 1864. These buildings are unsuitable for the vulnerability and particular needs of female inmates.
16. Many women have significantly poorer access to outdoor areas and physical activities than men.
17. Some women risk having to serve in prisons with a higher level of security than their case indicates due to the limited number of prison places for women.

Article 6 - Right to work and Article 13 - Right to education

18. Women consistently have poorer access to real work training than men.

Article 12 - Right to health

19. Female inmates often have other health problems than men, and therefore need different health services. Access to female doctors is imperative and should always be offered as female inmates often have negative experiences with men in the past often linked to abuse. As such, women will have difficulty sharing health concerns with male doctors.
20. Mental health care for women in prison should be improved.
21. The substance abuse rehabilitation services offered to women are inferior to those offered to men.

2.1.2. Result of Report: Strategy Improving Sentencing Conditions for Women

22. In the follow up to our report *Women in Prison*, the Norwegian Correctional Service (*Kriminalomsorgen*, KDI) developed a strategy in June 2017 focused on improving sentencing conditions for female inmates.[3] The strategy includes 21 specific points of improvement within the following five areas:

- Women in prison shall be separated from men - organization and infrastructure
- Awareness of women who are serving sentences
- Accommodating sentencing practices for women
- Safety and vulnerability
- Competence on female inmates serving sentences

23. As of January 2020, the NPM is awaiting updated information on the results of the implementation of the strategy.

3. Children

24. In the period November 2016 - January 2020 the NPM has visited twelve group home facilities for children and youth in the ages of 12 - 18 years old. The facilities are approved for different types of placement; a) emergency residential homes for children in need of immediate care, and b) placement in accordance with sections 4-24 and 4-25 of the *Norwegian Child Welfare Act.* These sections allow for children and youth to be placed without their consent when specific conditions are met. Some of these latter facilities are mandated to rehabilitate children and youth with substance abuse and behavioral problems.

25. Summaries of the reports linked to each visit can be found in English on our website: https://www.sivilombudsmannen.no/en/visit-reports/

26. We note that it appears staff at group homes are making valuable attempts at addressing the challenges faced with operating facilities for children and youth placed in accordance with the *Norwegian Child Welfare Act.* Even so, regarding the Economic, Social and Cultural Rights our findings indicate some areas of concern which are highlighted below.

27. The NPM presents these findings to the Committee in the hopes that it will inform your work.

3.1. Mental Health in Child Welfare Homes (Article 12)

3.1.1. Use of force and restrictions applied in child welfare homes

28. We have found examples of several group homes making decisions on use of force, restrictions on freedom of movement and exclusion from community rooms and the use of electronic

[3] *Strategi for kvinner I varetekt og straffegjennomføring 2017-2020*, Kriminalomsorgen, 6.6.2017.

communications resulting in limited social interaction with other children and youth as a therapeutic method of addressing behavioural issues. These decisions are sometimes made as a standard routine upon admission to the facility, even if the law requires individual assessment for all forms of use of force.

29. Restricting access to electronic communication and social interaction are invasive decisions that increases the risk of inhuman and degrading treatment. The isolation that results from such restrictions can have detrimental effects on the development and mental health of children and youth. Further, using coercive measures against children and youth in a care facility setting is also very invasive. It is therefore imperative that these decisions are in accordance with legislative requirements, such as providing adequate reasons and ensuring that the decision is reviewed and that the opportunity to complain is made available.

30. The NPM has pointed to situations where child care homes are tasked with caring for adolescents with extensive mental health problems without having the required expertise to address the specific issues. We have noted that use of force appears to increase if mental health problems are not appropriately addressed.

31. Facilitating and providing proper health services tailored to the individual needs of the children and youth placed in the Child Welfare homes is an essential part of ensuring this group receives the care they are entitled to.

3.1.2. Preventing use of force and coercive methods

32. Although we have found several group homes to be working on preventing use of force and coercive methods with a focus on training and trauma-sensitive child welfare work, we have also registered that there is room for improving the systematic efforts to prevent use of force by working in cooperation with the children/youth themselves, and also, involving the children/youth in preparing treatment plans and decision-making.[4] Use of force can have a negative impact on the development and mental health of children and youth and it is therefore imperative that child care facilities work actively to prevent that such measures are used.

3.1.3. Use of police assistance to address behavioural issues

33. We have found lack of procedures and at times inappropriate involvement of police regarding children placed in group homes, specifically under sections 4-24 and 4-25 of the *Norwegian Child Welfare Act*. Involving police can increase the risk of coercive methods being used against the child/youth, and proper procedures need to be in place in order to prevent potential negative effects on the development and mental health of children and youth.

3.2. Educational Opportunities while in Child Welfare Homes (Article 13)

3.2.1. Lack of opportunity to attend school.

34. Education is fundamental to all development. Children and youth in group homes have the same right to education as other children. Findings from the NPMs visits indicate that there are challenges in providing relevant and adequate education for children placed in group homes. As a result, some children/youth are not attending school while placed in child care facilities and this is limiting their future opportunities to work and participate within their community.

[4] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), Para. 23.

4. Persons with Disabilities

4.1. Segregation in Mental Health Care Institutions (Article 12)

35. In 2018 the NPM published a report on *Segregation in mental health care institutions - risk of inhuman treatment*. A summary of the report is available at www.sivilombudsmannen.no/en/visit-reports/segregation-in-mental-health-care-institutions-risk-of-inhuman-treatment/

36. In the period between 2015 to 2018, the NPM visited twelve hospitals where patients are admitted for compulsory mental healthcare. During these visits, it was consistently found that many hospitals' use of segregation gave cause for concern.

37. The term segregation is defined as the patient being completely or partly removed from the other patients and only having contact with health personnel. Segregation, which can be implemented against the patient's will, takes place in the patient's room or in a segregation unit. A segregation unit consists of one or more rooms separated from the other parts of the department, normally with a door that can be locked. Patients in segregation units can be denied access to common areas and will normally not be able to have any social contact. It can be used both as a control measure to protect the patient or others against aggressive behaviour, or as a treatment measure where the idea is that reduced sensory impressions will calm the patient.

38. Norway is one of very few countries that has a special legal provision on the use of segregation as a coercive measure, in addition to isolation. Comparable practices in other countries have been assessed as isolation by human rights organisations and should only be used in acute emergency situations. The practice of segregation in Norway has some distinctive features. The measure is a combination of coercive measures and treatment, and the aim of the practice is thus unclear. The threshold for implementing segregation as a coercive measure is significantly lower than for implementing isolation and there is not a maximum set time limit. It is considered by some to be an effective treatment measure although there is little knowledge to support this.

39. The purpose of this thematic report was to provide a summary and elaboration of the Parliamentary Ombudsman's findings on the use of segregation from its visits to mental healthcare institutions. The findings are assessed on the basis of human rights requirements and standards, and discussed in light of history, research and public statistics.

40. The NPM presents this summary of the report to the Committee in the hopes that it will inform your work. In the following paragraph we have compiled the list of recommendations that the Parliamentary Ombudsman chose to make based on the findings in the report, in order to help prevent the risk of inhuman and degrading treatment.

4.1.1. Recommendations in Segregation Report

41. The recommendations listed below were given to the National Health Authorities (legislation and national expertise and overall governance) and to the Health Trusts and local mental healthcare departments in hospitals (humane use of segregation as possible):

To the National Health Authorities

Statistics

42. Prepare a national overview of the duration of segregation measures. Such an overview should also include information about geographical variations and, in particular, long-term measures.

Assessment of the legislation

43. Conduct an assessment of whether the legislation applicable to segregation is in accordance with human rights requirements and standards, and consider whether there is a need for special due process guarantees to avoid prolonged segregation.

Increase expertise in segregation

44. Consider national professional development projects on segregation, such as projects on humane and safe design of segregation units in mental healthcare institutions, less invasive methods for implementing segregation, and alternatives to segregation.

To Health Trusts and Local Hospital Departments

Implementation of segregation

45. Ensure that segregation is not implemented in a way that constitutes isolation and enable patients to have meaningful social interaction.
46. Ensure that further restrictions and force during segregation only takes place if there is a legal basis and it is strictly necessary and proportionate.
47. Implement special measures at the local level to avoid prolonged use of segregation.

Preventing segregation

48. Implement measures in consultation with patients to prevent the use of segregation, including preparing alternatives to segregation.

Special requirements for staff

49. Ensure that staff who work in the segregation units meet high ethical awareness requirements relating to the use of force, and how to prevent the use of force.

The physical design of segregation premises

50. Implement measures to ensure that premises used for segregation are designed in a humane manner that avoids sensory deprivation.
51. Restraint beds should not be placed in the segregation units.

Due process protection in connection with segregation

52. Ensure that decisions on segregation are justified by concrete and independent assessments by the person responsible for the decision.
53. Ensure that a treatment plan for segregation is prepared, as far as possible in consultation with the patient. A treatment plan should contain therapeutic treatment, adapted activities, and daily opportunities for spending time outdoors, as well as a plan to end the segregation measure.

4.2. Other Findings in Mental Health Care (Article 12)

54. In addition to the issues relating to the use of segregation in mental health care institutions as mentioned above in 4.1. we would like to point out the following areas of concern in connection with mental health care and Article 12 of the ESCR. These issues are linked to findings we have made following visits to twelve mental health care institutions in the period 2015-2018.

55. Summaries of the reports linked to each visit can be found in English on our website: https://www.sivilombudsmannen.no/en/visit-reports/

56. The NPM presents these findings to the Committee in the hopes that it will inform your work.

4.2.1. Use of Mechanical Restraints

57. Coercive measures in mental health care are regulated by Section 4-8 of the Norwegian *Mental Health Care Act*.[5] These include mechanical restraints such as restraint beds, mobile restraints and clothing specifically designed to prevent injury, detention for a short period of time behind a locked or closed door without a staff member present ('isolation'), single doses of short-acting medicines for the purpose of calming or anaesthetizing the patient, or briefly holding the patient ('holding').

58. Norwegian law requires that coercive measures only be used when absolutely necessary to prevent patients from injuring themselves or others, or to avert significant damage to buildings, clothing, furniture or other things. Further, it is a requirement that other less restrictive measures have been unsuccessfully attempted, meaning that coercive measures must only be used in emergency situations when absolutely necessary.[6]

59. The use of mechanical restraints in the form of restraint beds is widespread at mental health care institutions and the NPM has found inconsistencies in its practice. External factors such as management, institutional culture and the availability of activities to patients, appear to significantly influence the practice of how and when restraint beds are used.

60. Use of a restraint bed is a very invasive measure and the risk of ill-treatment increases with the length of time a patient is kept in restraints. Proper training of health personnel is important to avoid injury to patients when put in restraints and involving police when strapping patients to a restraint bed can be very problematic.

61. We have recommended that mental health hospitals ensure that patients' dignity and welfare are safeguarded when restraint beds are used. Due process rights of patients need to be respected, ensuring that the procedural requirements for decisions are followed and that records are kept in accordance with the law. In addition, a patients' right to appeal and contact with a lawyer needs to be safeguarded. Decisions to use coercive measures must not be prolonged beyond the period strictly necessary for its designated purpose.[7] As example, the NPM has criticized situations where patients are left sleeing while in restraints.[8] Patients admitted to mental health care institutions are in a vulnerable situation and thus treatment of this group requires special attention to ensuring legal requirements are fulfilled when using coercive methods such as restraints.

4.2.2. Forced Medication

62. According to the *Mental Health Care Act* section 4-4 patients admitted under compulsory mental health care may be subject to involuntary treatment when certain requirements are fulfilled. Involuntary treatment often involves the prescription of neuroleptic drugs, ingested as pills or administered by injection and may involve the use of force.[9] The law requires that treatment

[5] Lov om etablering og gjennomføring av psykisk helsevern (psykisk helsevernloven), referenced hereinafter as *the Mental Health Care Act*.
[6] *Mental Health Care Act*, section 4-8 and the Directorate of Health's comments to Section 4-8 of the *Mental Health Care Act*, Circular IS-9/2012, page 76. See report Sørlandet Hospital, Kristiansand, 7-9 September 2015.
[7] See example Akershus University Hospital, Department for Emergency Psychiatry, 2–4 May 2017 and University Hospital of North Norway, 26-28 April, 2016.
[8] See example, report on Ålesund Hospital, Department for Hospital Psychiatry. 19-21 September 2017.
[9] Note that Section 4-4 also permits that nutrition be given without the consent of the patient, as part of the treatment of a patient with a serious eating disorder, provided that this is considered to be an absolutely necessary choice of treatment.

without the patient's consent only be done when an attempt has been made to obtain consent prior to treatment, or it is obvious that consent cannot or will not be given.

63. There is a further legal requirement that the probability of the medical treatment given without consent will result in a positive outcome. In September 2017 stricter requirements were introduced in order to ensure due process rights for patients faced with involuntary treatment.

64. Forced medication represents a significant invasive measure against a person's integrity and personal autonomy. Treatment outcomes for involuntary treatment with neuroleptic drugs is unclear and increasingly contentious, particularly regarding its long-term effects.[10] It is well-documented that neuroleptic drugs may have harmful side-effects, in some cases serious and irreversible. Forced medication constitutes an exception to the fundamental principle of consent to health care. Based on its potentially serious harmful side-effects the NPM has voiced concern that mental health care patients are exposed to risk of inhuman or degrading treatment.

65. The NPM has found during its visits that many patients report experiences of humiliation and distress as well as unwanted or painful side-effects from forced medication. Staff, particularly at emergency hospital wards, voice their concern that treatment plans for patients increasingly consist only of prescription drugs. Such practice is not in line with human rights standards.[11]

66. A consistent finding by the NPM is that the written records of administrative decisions of involuntary treatment often does not contain adequate information to determine whether the intervention was in accordance with the legal requirements. Records often lack information that the doctor in charge engaged in genuine efforts to enable the patient to influence the treatment. Another finding is that many patients do not receive sufficient information about the expected effects and potential side-effects. Based on its findings, the NPM is concerned that fundamental principles of legality, necessity and proportionality are not respected in practice, and that persons with mental health problems are not receiving an appropriate standard of care.

4.2.3. Electroconvulsive Treatment (ECT)

67. In 2017, the NPM examined the practice of using ECT without consent at mental health care hospitals. Electroconvulsive therapy (ECT or electroshock therapy) is a treatment whereby short, low-voltage electric shocks are administered to the patient's brain. The effects of ECT is highly debatable amongst experts, and questions remain concerning the value of its use and potential harmful effects.[12]

68. Administering ECT without consent is prohibited in Norway, however, there is an opportunity to apply this treatment without consent on the grounds of 'necessity', meaning in situations where it is deemed necessary to sustain life. Findings made by the NPM during several visits in 2017 highlights that patients are subject to a high risk of inhuman or degrading treatment in these situations.

[10] In Norway, a decision of treatment without the patient's consent may have a duration of three months at a time.
[11] CPT, Involuntary placement in psychiatric establishments, Extract from the 8th General Report of the CPT, published in 1998, CPT/Inf(98)12-part, para. 37.
[12] Aslak Syse, Gyldendal Rettsdata annotated version of the Mental Health Care Act, Section 4-4, last revised on 5 November 2016.

69. The NPM notes that in its Concluding Observations to Norway in 2013, the UN Committee on Economic, Social and Cultural Rights recommended Norway to abolish its practice of administering ECT without consent.[13] Following a country visit to Norway in 2015, the Council of Europe Commissioner for Human Rights questioned whether administering ECT on the basis of the legal principle of necessity was in keeping with human rights standards.[14] The Commissioner also highlighted the importance of obtaining an accurate overview of the scope of ECT therapy, and making it publicly available.

70. In a letter to the Ministry of Health and Care Services in June 2016, the Directorate of Health questioned whether the principle of necessity provides a sufficient legal basis, pointing out that repeated treatments are required for ECT to be effective.[15] The Directorate recommended that the use of ECT on basis of necessity be considered further by the Committee appointed by the government to conduct an overview of the regulation of coercion in Norwegian legislation (*Tvangslovutvalget*). The Committee submitted its recommendations in September 2018.[16]

71. In June 2017 the Norwegian Directorate of Health published national guidelines on the use of ECT. It was emphasised that it is only relevant to consider administering ECT on the basis of necessity in situations where a patient with a serious mental disorder is in an acute situation, and there is an immediate and serious risk to the patient's life or health.[17]

72. In the NPM's opinion, the current application of the principle of necessity as an independent legal basis for administering ECT without consent is problematic. The main reason for this is because of the Norwegian Constitution's requirement that any invasion against an individual by the authorities must be founded in law.[18] This requirement becomes even stricter depending on the seriousness of the invasive measure.[19]

73. During visits in 2017 the NPM has identified cases where mental health professionals have discovered patients suffering serious cognitive side effects following ECT therapy, including memory loss of the treatment occurring. Patients who had undergone ECT based on necessity were also subject to other invasive coercive measures during treatment, such as the use of a restraint bed for the administration of ECT. The NPM also found examples where the use of force had escalated following ECT therapy based on necessity.

74. The NPM has also found several cases of ECT being administered based on necessity although it was unclear whether the legal requirements were fulfilled, as example questions of whether other

[13] UN Committee on Economic, Social and Cultural Rights, Concluding Observations – Norway, 13 December 2013, E/C.12/NOR/CO/5.
[14] Report by Nils Muiznieks, Commissioner for Human Rights of the Council of Europe, following his visit to Norway, 19 to 23 January 2015, CommDH (2015) 9.
[15] The Directorate of Health, Concerning use of ECT in grounds of necessity, letter of 4 July 2017 to the Ministry of Health and Care Services.
[16] On 17 June 2016, the Government appointed a legislative committee to conduct an overall review of the regulation of coercion in the health and care services sector. The committee was chaired by professor Bjørn Henning Østenstad.
[17] The Directorate of Health (June 2017): National guidelines for the use of electroconvulsive therapy (ECT), page 26–28.
[18] Article 113 of the Norwegian Constitution.
[19] See, *inter alia*, Norwegian Supreme Court Reports Rt. 1995 p. 530 and Rt. 2001 p. 382.

means to securing the patient's health were attempted. In some cases, there was lack of documentation to indicate that other treatment options had been attempted or considered prior to using ECT.

75. In most cases, ECT based on necessity was repeated over several days or weeks. One patient underwent twelve ECT treatments over a period of one month. The basis for this treatment was an apparent ongoing acute risk. However, the records indicate that the patients' condition was not in an acute state during this entire time period and it is therefore questionable whether the legal criteria was fulfilled.

76. The evolving administration of ECT based on necessity appears to have developed a practice that has resulted in a circumvention of the purpose of the legislators' decision to prohibit the use of ECT without consent.

77. The Committee appointed by the government to conduct an overview of the regulation of coercion in Norwegian legislation (*Tvangslovutvalget*) has recommended that the use of ECT be regulated by law as an emergency measure to be used to sustain life. It is recommended that the use of ECT only be used on patients who have not resisted the ECT treatment and who do not possess the competence to make a decision. It is suggested that patients should have the opportunity to make a declaration of reservation against future ECT treatments. This declaration will need approval by a Board (*Tvangsbegrensningsnemda*).

78. The Parliamentary Ombudsman has provided input to the Committee that it is necessary that the lawmakers conduct an assessment of factors impacting the proportionality and necessity of using ECT without consent as a treatment therapy. This assessment should include whether the treatment is necessary to sustain life and how opposing interests and arguments should be considered and determined.The Parliamentary Ombudsman has also stated that the lawmakers conduct an assessment of the prohibition against torture and other inhuman and degrading treatment and its impact on ECT treatment without consent. The basis for this evaluation should be focusing on the threshold set for ECT use and whether this is in accordance with current knowledge trends and research and todays international legal developments.

4.3. Solitary Confinement in Norwegian Prisons (Article 12)

79. In 2019 the NPM published a *Special report to the Storting on Solitary Confinement and Lack of Human Contact in Norwegian Prisons*. The report is available at www.sivilombudsmannen.no/en/news/prevention-torture/special-report-on-solitary-confinement-and-lack-of-human-contact-in-norwegian-prisons/

80. The purpose of this report was to make the Storting, aware of the risk of violation of the prohibition against torture and inhuman treatment that isolation in prison entails.

81. Norwegian authorities have for several years been criticized internationally for the use of solitary confinement in Norwegian prisons. As recently as in June 2018, the UN Committee against Torture expressed great concern about the extent of prolonged isolation and said that the conditions for use of solitary confinement were not sufficiently clear. In the same year, the European Committee for the Prevention of Torture (CPT) visited Norway and recommended in its report that inmates held in isolation should be offered structured activities and have meaningful human contact on a daily basis. The committee was particularly concerned about the isolation of inmates with mental health problems.

82. This special report uses data from the NPM's findings relating to solitary confinement as a result of visiting 19 high-security prisons in the period 2014-2018.

83. This report demonstrates that solitary confinement is extensively used in Norwegian prisons. At least one in four inmates are held in their cells for 16 hours or more on weekdays, and for even longer on weekends. Despite the broad consensus that solitary confinement and lack of human contact can cause serious harm and must be limited this practice appears to be increasing. In order for Norwegian authorities to fulfil their state responsibility, it is essential to coordinate measures to reduce the use of solitary confinement. In the present situation, Norwegian authorities do not comply with international human rights standards, and individuals are suffering under the detrimental effects of isolation.

84. The NPM presents the Special report to the Committee in the hopes that it will inform your work.

4.3.1. Findings in Solitary Confinement Report

85. In the following, we hereby provide you with the findings in the special report, and the recommendations that the Parliamentary Ombudsman chose to give to the Storting (4.3.2.).

- Lack of reliable information about the use of solitary confinement in Norwegian prisons

86. A review of data and statistics show that there is a lack of reliable overview of the extent of solitary confinement in Norwegian prisons with significant margins of error linked to the available data. Accordingly, authorities do not have reliable information to consider measures to reduce the use of solitary confinement and limit its harmful effects. It is highly censurable that, more than 20 years after the Standing Committee on Justice requested such data, it does not exist. The data used in this report must therefore be understood to be minimum estimates throughout.

- Extensive use of solitary confinement and restrictions on association with other inmates

87. Solitary confinement and restrictions on association with other inmates are widely used in Norwegian prisons. Part of this practice is in contravention of human rights standards, specifically when an inmate is placed in solitary confinement not as a result of behaviour but as a result of practical or financial challenges within the prison, such as lack of staffing or lack of adequate building facilities. These challenges are linked to the absence in Norwegian legislation of rules that entitle inmates to at least eight hours out-of-cell time a day and to pursue meaningful activities in locations conducive for social interaction. The threshold for using solitary confinement is low in Norwegian legislation; Solitary confinement may be used as a control measure when necessary to maintain 'peace, order and security'. This does not reflect that solitary confinement must only be used in exceptional cases. The high number of inmates placed in isolation by-choice (self-isolation) gives cause for concern. There is a lack of targeted effort to prevent isolation caused by fear and insecurity among inmates. Self-isolation is in general not based on administrative decisions and is therefore not reflected in available data. Findings show that several inmates are held in isolation for months, sometimes years.

- Lack of follow-up and supervision of inmates in solitary confinement.

88. In general, inmates in solitary confinement have very little meaningful human contact. Most often, correctional staff are the only people who have contact with these inmates. The imbalance of power between staff and inmates means that staff cannot replace the human contact that can be achieved by associating with other inmates. Inmates in solitary confinement have very limited possibilities of pursuing meaningful activities, and they are often left to spend their time outdoors

alone in small exercise cells. Limited follow-up by staff means that inmates in solitary confinement are exposed to the risk of inhuman or degrading treatment.

- Particularly vulnerable inmates

89. Some inmates are particularly prone to being placed in solitary confinement and more vulnerable to the detrimental effects of isolation than others, such as those with severe mental health problems, young age, war or other past traumas and language problems. We found a lack of awareness of these risk factors in many prisons. We have observed inmates whose functional abilities have gradually deteriorated in most areas while in solitary confinement. Some of them clearly had an unmet need for health care. We have also met inmates who have chosen solitary confinement because they felt the communal sections to be unsafe. This gives grounds for concern considering the risk isolation entails for the cognitive development of young individuals and their possibility of being reintegrated into society. It is often difficult to get inmates with mental health problems admitted to specialist health care institutions. In some cases, they are discharged from psychiatric inpatient wards after a brief stay without receiving treatment and returned to prison where they continue to be held in solitary confinement.

- Solitary confinement in security cells or restraint beds

90. The use of security cells and restraint beds involves a significant deprivation of senses and a risk of harmful effects on health. Our findings include several examples of situations where the use of security cells can have an extremely negative impact, even after a relatively short time. We also found that it takes too long before inmates receive help to get out of unhygienic and degrading conditions. Findings from our visits show that inmates do not receive the help they need from prison to bring their confinement to an end as soon as possible. Inmates can thus be held in security cells for longer than strictly necessary. Training and guidelines are lacking on how staff should follow up inmates to ensure their welfare and as brief a stay as possible. It is particularly censurable that individuals in an acute life crisis and who wish to harm themselves are placed in a security cell without satisfactory follow-up. The risk of harm is greater where inmates are confined due to mental crisis. Inmates who are strapped to a restraint bed risk being traumatised in an acute life crisis. Close follow-up is therefore necessary. Despite the risk of both mental and physical harm associated with the use of security cells and restraint beds, the *Execution of Sentences Act* and its Regulations do not contain any requirements for staff supervision. Inadequate procedures and unclear systems for record keeping make the prisons' internal control of practices difficult and prevents oversight bodies and the Parliamentary Ombudsman from carrying out control functions.

- Lack of follow-up of inmates in solitary confinement by health services

91. Our findings show widely varying practices between different prisons regarding follow-up of inmates in solitary confinement by the prison health services. One reason for the varying practice is because the organisational structure of the health service is different in each prison. Our findings indicate that the Norwegian regulatory framework and practice concerning daily medical supervision of inmates in solitary confinement are not in accordance with international human rights standards. We have found several cases where inmates, some suffering from severe health problems, have been held in solitary confinement for a long period of time without being attended to by medical personnel. There is a need for significant increased knowledge and training of medical personnel charged with the task of caring for inmates in solitary confinement.

- Lack of supervision (oversight) and complaints mechanism

92. The supervisory regime is not in line with the standards set out in the European Prison Rules and the Nelson Mandela Rules. The fact that Norway lacks adequate prison inspection regimes has major consequences for safeguarding and controlling the conditions for inmates in solitary

confinement. The prison health service, which plays an important role in relation to inmates in solitary confinement, is also not subject to regular oversight.

- Lack of mechanisms to prevent solitary confinement

93. There is a need to strengthen the work of the Correctional Service in order to prevent situations and incidents that trigger solitary confinement. The current regulatory framework does not give the Correctional Service a duty to focus on systematic prevention. The current legislation falls short of meeting Norway's commitments under international law to prevent situations that entail a risk of torture or other cruel, inhuman or degrading treatment or punishment.

4.3.2. Recommendations in Solitary Confinement Report

94. In order to ensure that inmates in Norwegian prisons do not suffer isolation that can entail violation of the prohibition against torture and other cruel, inhuman or degrading treatment or punishment, the Parliamentary Ombudsman issued the following recommendations to the Storting to request that the Government implement the following measures:

- Ensure reliable and publicly available data on the extent of solitary confinement in Norwegian prisons.
- Establish a national standard to ensure that inmates have the possibility of associating with others for at least eight hours every day and are offered meaningful activities.
- Amend the provisions of the Execution of Sentences Act to ensure that a) solitary confinement is only used in exceptional cases and for as brief a period as possible, b) follow up of all inmates in solitary confinement is in accordance with human rights standards.
- Submit a proposal for a statutory or regulatory duty to prevent the use of solitary confinement in prisons.
- Strengthen the Correctional Service's supervisory regime by defining a legal mandate that ensures systematic and regular supervision in accordance with international human rights standards.
- Ensure that common professional guidelines are drawn up to ensure satisfactory follow-up of inmates in solitary confinement.
- Prepare a plan for closing down or adapting prisons that are not tailored for association between inmates.
- Revise the national guidelines to health and care services for inmates, to ensure that detrimental effects of isolation are identified and that inmates in solitary confinement receive follow-up.
- Establish by law that the health service is responsible for following up inmates in solitary confinement, so that inmates seen by medical personnel on a daily basis.
- Ensure that prison health services are provided with enhanced knowledge relating to inmates' special health issues, solitary confinement and the detrimental effects of isolation.

4.3.3. Result of Report: Committee Hearing in January 2020

95. The NPM would like to bring to the Committee's attention that as a result of the findings in the special report, the Norwegian Storting held a special hearing on January 14, 2020, on the issue of solitary confinement inmates are faced with in Norwegian prisons. The NPM appreciates the attention the Storting has given this matter and hope it will result in an improvement of solitary confinement in Norwegian prisons.

5. Concluding Remarks

96. The above information is intended to provide the Committee with an overview of those issues that the NPM considers important to address during Norway's upcoming review. The NPM remains at your disposal to provide any additional information that the Committee deems necessary.