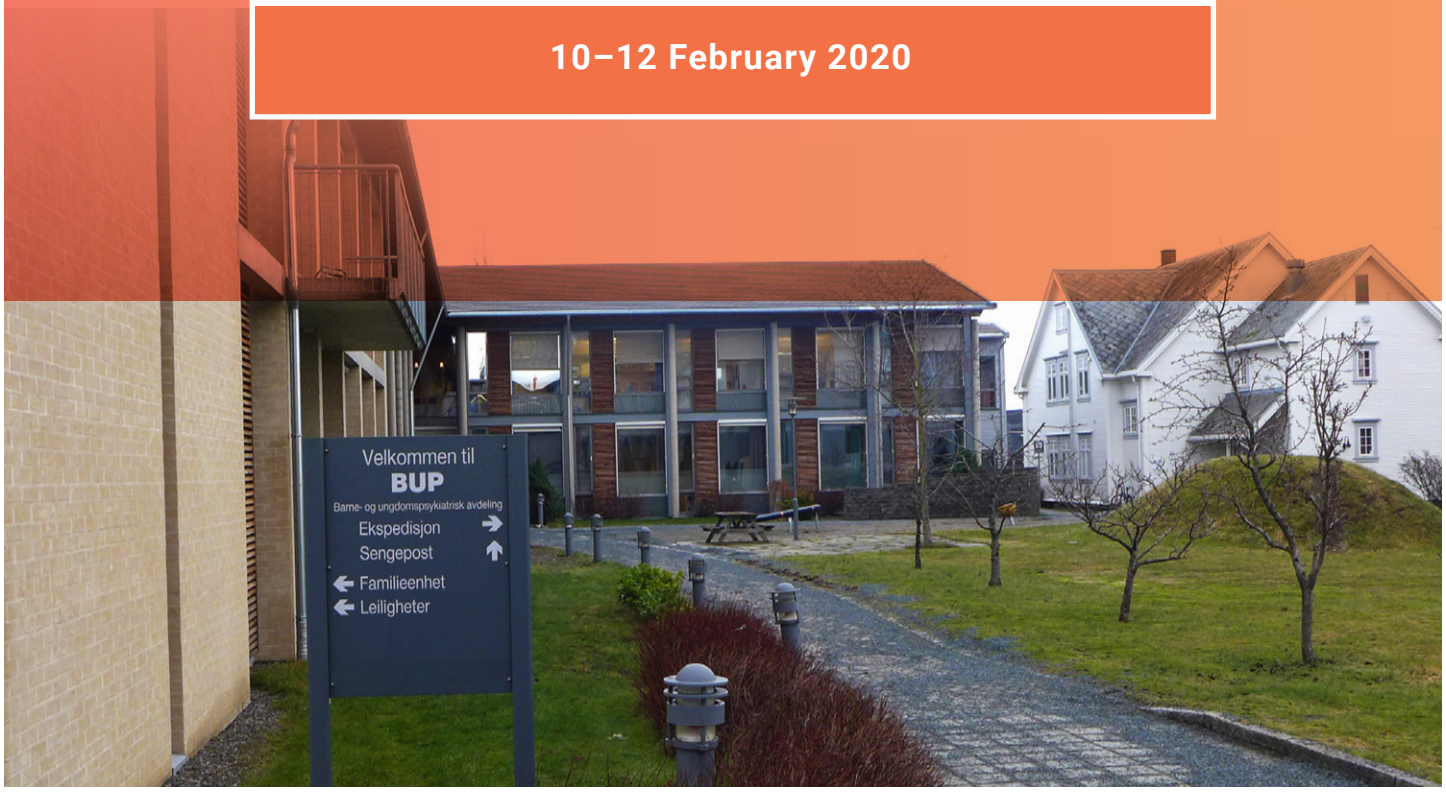
SIVILOMBUDSMANNEN
Norwegian Parliamentary Ombudsman

VISIT REPORT

SUMMARY AND RECOMMENDATIONS

BUP Inpatient unit, Levanger Hospital

10–12 February 2020



National Preventive Mechanism against
Torture and Ill-Treatment

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1 Torture and inhuman 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 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 endorsed all these conventions.

People who have been deprived of their liberty are vulnerable to violations of the prohibition against torture and inhuman treatment, which is why the UN adopted an Optional Protocol to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2002. Norway endorsed the Optional Protocol in 2013.

2 The Parliamentary Ombudsman's prevention mandate

As a result of Norway's ratification of the Optional Protocol to the UN Convention against Torture in 2013, the Parliamentary Ombudsman was 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 regularly visits locations where people are deprived of their liberty, such as prisons, police custody facilities, mental health care institutions and child welfare institutions. The visits can be both announced and unannounced.

The Parliamentary Ombudsman 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 Parliamentary Ombudsman also has right of access to all necessary information that is relevant to the conditions for people deprived of their liberty.

The risk of torture or ill-treatment occurring is influenced by factors such as legal and institutional frameworks, physical conditions, training, resources, management and institutional culture.[2] Effective prevention work therefore requires a broad approach that does not exclusively focus on whether the situation complies with Norwegian law.

The Parliamentary Ombudsman's consideration of factors that constitute a risk of torture and ill-treatment is based on a wide range of sources. During its visits, the Ombudsman examines the conditions at the institution through its own observations, interviews and a review of documentation. Private interviews with those who are deprived of their liberty are a particularly important source of information, because they have first-hand knowledge of the conditions at the institution in question. They are in a particularly vulnerable situation and have a special need for protection. Interviews are also conducted with the staff, management and other relevant parties. Documentation is also obtained to elucidate the conditions at the institution, such as local guidelines, administrative decisions on the use of force, logs and health documentation.

After each visit, the Parliamentary Ombudsman writes a report describing its findings and recommendations for preventing torture and other cruel, inhuman or degrading treatment or punishment.

The reports are published on the Parliamentary Ombudsman's website and the institutions visited are given a deadline for informing the Ombudsman about their follow-up of the recommendations. These letters are also published.

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

[1] Section 3 a of the Parliamentary Ombudsman Act.

[2] See the UN Subcommittee on Prevention of Torture (SPT), The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 30 December 2010 CAT/OP/30/6.

3 Summary

The Parliamentary Ombudsman's National Preventive Mechanism visited the inpatient unit at Levanger Hospital's Child and Adolescent Mental Health Care Services (BUP), 10–12 February 2020. The unit was not notified of the dates in advance.

The most important finding during the visit was that the unit provided a safe and caring environment for children and adolescents in situations of vulnerability. The culture of the institution was characterised by a high level of openness, respect and care. The way the children were cared for is an example for other mental health facilities to follow. The inpatient unit chose not to be approved for involuntary admission. This had several positive consequences for the care the children and adolescents received. The inpatient unit had made significant efforts to avoid physical structures with a strong security focus, sterile environment and locked doors. Instead, the focus of the institution was on the type of services and follow-up offered to the children to encourage them to participate in therapy. The exit doors were unlocked.

The facilities were well maintained with bright colours, pleasant décor and a home-like atmosphere. Several of the adolescents expressed that they had not expected an inpatient unit at a mental health facility to be so cosy. We learned that management had made a conscious choice to facilitate a better sense of well-being by providing a more pleasant environment. The unit had a good selection of activities on offer, including a gym. The unit also organised voluntary activities and the youth were able to participate in deciding what activities that were made available. The adolescents also had opportunities to meet friends and family outside the inpatient unit. The inpatient unit also had its own school in proximity to the facilities. Family members expressed that the school was a positive measure, and that it cooperated well with the local schools of the adolescents.

The unit provided the children and youth with adequate information on their rights, daily routines, and details on the treatment they would be receiving. Our findings indicate that the opinion of the children and adolescents were generally heard, and they were able to participate in decisions of importance to them. This applied to their treatment as well as to daily tasks and the facilitation of visits and activities. Children also had the opportunity to give feedback on how they had experienced their stay. This is a good practice for learning how children and adolescents experience hospitalisation.

One area for improvement identified was a need for common guidelines on how to prevent abuse and assault in the inpatient unit, or how to deal with suspicions of such cases. Staff members stated that these were things they had not really discussed, although the unit did have simple routines for preventing abuse and assault from occurring. There were no findings during our visits that indicated that abuse or assault had taken place.

Since 2013, Levanger Hospital has maintained cooperation with child welfare services, which permits commitment of children to the inpatient unit by an emergency decision with legal authority in the the Child Welfare Act. A total of 19 children and youth have been placed in the unit, pursuant to this Act between 2017 and 2019. Staff at the unit felt that these admissions had generally been unproblematic. This arrangement is an interesting measure for ensuring that children cared for by the child welfare services with complex needs receive better and more personalised assessment and health care.

Only in exceptional cases were adolescents who acted aggressively admitted involuntarily to an inpatient unit for adults, with locked doors. Youth were then placed in a separate unit at the adult

clinic, located in a new, modern building within walking distance of the inpatient unit for children and adolescents. Over the past three years (2017–2019), a total of 18 adolescents under the age of 18 had been admitted to the adult unit. Four of these were younger than 16 years. A review of these cases indicated that the children had been closely followed up by staff at the BUP inpatient unit. Most of these stays were brief.

Depriving children of their liberty in a facility with adults is problematic according to UN Convention of the Rights of the Child, unless this is determined to be in the best interests of the child. Child and adolescents who were hospitalised in an adult acute psychiatric ward without their consent were placed in a shielded unit, separated from the adult patients. This shielded unit appeared to be new and was designed for vulnerable patients. Several children did find it distressing to be placed in the same unit as adults with mental illnesses. It is also unfortunate for children to be isolated from their peers. The Ombudsman notes that the best interest of the child must be assessed in each individual case, but that the opportunity for contact with peers is important for all children and adolescents. Exceptions from this should only occur in extraordinary circumstances and for as brief a period as possible, when maintaining contact with peers is not a safe and justifiable option.

No decisions were made on the coercive use of mechanical restraints, isolation or short-acting drugs at the BUP inpatient unit between 2017 and 2019. The unit had no mechanical restraints or isolation rooms. Nor were there any decisions regarding segregation, although they did have rooms that could be used for this. None of the children we spoke with had experienced coercive methods, and no decision were made on coercive methods in 2019. Our findings, and the fact that there had been few cases of coercive methods, indicates that the unit had been successful in preventing the use of these.

No decisions were made on the use of coercive treatment involving medication or nutrition for children and adolescents from 2017 to 2019. There were incidents where children under the age of 16 were required to accept treatment against their will. However, the unit was restrictive in its use of antipsychotic medications. It was disclosed that adolescents over the age of 16 could be offered voluntary tube feeding. Offering voluntary tube feeding carries the risk that nutrition by tube feeding could become normalised for patients with eating disorders. Tube feeding should only be offered as part of a comprehensive treatment programme. We therefore asked the inpatient unit to consider whether it was responsible to offer voluntary nutritional measures in the form of tube feeding.

The inpatient unit had no written house rules. We found no unlawful informal house rules but did recommend that the hospital provide better documentation to explain why there was a need for routine inspections of the adolescents' luggage upon arrival. The unit facilitated visits from family and friends during the stay. None of the adolescents we spoke with during the visit had experienced restrictions in the use of their mobile phones.

Our findings indicate that the staff were highly aware of the fact that they had to speak with the children and adolescents alone, to discuss what they could tell their parents and others. The adolescents we spoke with said that they felt safe and that they trusted the staff. We were told that the staff was good at creating a safe space to talk, without everyone having to know everything. All the parents we spoke with stated that they felt well taken care of as next of kin. They also felt that their children had been treated well during the admission process, and praised the staff for this.

A good system was established for complaints and control measures at the inpatient unit, which was adapted to the special needs of children. Both the unit and the supervisory commission had routines to ensure that the complaints by children who were opposed to the hospitalisation were quickly

addressed. This complies with relevant human rights standards. The local supervisory commission actively checked to ensure the proper legal protection for children and adolescents. They appeared to maintain a proactive and child-friendly approach.

3.1 Recommendations

Protection and safety

- The inpatient unit should prepare common guidelines aimed at reducing the risk of violence, abuse, and sexual assault against children and adolescents. It should facilitate regular discussions on these topics among staff members.
- The inpatient unit should look at alternative measures, to avoid transferring children and adolescents to the adult psychiatric inpatient ward, to the extent this is possible,.

Use of coercive measures

- The inpatient unit should assess its practice of offering voluntary tube feeding, based on the requirements for professional responsibility.

Right to privacy

- The inpatient unit should provide documentation to explain why routine inspections of the rooms and possessions of children and adolescents, are necessary and proportional.
- The inpatient unit should ensure changes in the written procedures on the use of mobile phones to reflect the changes in practice, and to prevent misunderstandings among the staff.

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