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Report

**to the Finnish Government
on the visit to Finland
carried out by the European Committee
for the Prevention of Torture and Inhuman
or Degrading Treatment or Punishment (CPT)**

from 7 September to 18 September 2020

Strasbourg, 5 May 2021

CONTENTS

EXECUTIVE SUMMARY.....	4
I. INTRODUCTION	11
A. The visit, the report and the follow-up	11
B. Consultations held by the delegation and co-operation encountered	12
II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED.....	14
A. Police establishments	14
1. Preliminary remarks	14
2. Ill-treatment.....	15
3. Safeguards against ill-treatment	15
4. Conditions of detention	18
5. Remand detention in police establishments	20
B. Foreign nationals deprived of their liberty under aliens legislation	22
C. Prisons.....	26
1. Preliminary remarks	26
2. Ill-treatment.....	27
3. Conditions of detention	30
4. Health-care service.....	33
5. Other issues	37
D. Psychiatric Department of Helsinki University Hospital (Kellokoski).....	40
1. Preliminary remarks.....	40
2. Patients' living conditions.....	41
3. Staff.....	41
4. Treatment	42
5. Means of restraint.....	44
6. Safeguards	47

7.	Contact with the outside world	55
E.	State Residential Schools.....	56
1.	Preliminary remarks	56
2.	Material conditions and activities	58
3.	Treatment and care	60
4.	Staff.....	64
4.	Means of restraint.....	65
5.	Other issues	67
APPENDIX I LIST OF ESTABLISHMENTS VISITED BY THE CPT'S DELEGATION...		69
APPENDIX II LIST OF THE NATIONAL AUTHORITIES MET BY THE CPT'S DELEGATION		70

EXECUTIVE SUMMARY

During the 2020 periodic visit, the CPT's delegation examined the treatment and safeguards afforded to persons deprived of their liberty by the police (including intoxicated persons and remand prisoners held in police establishments) and the situation of remand and sentenced prisoners held at Oulu and Turku prisons, as well as of patients at the Psychiatric Department of Helsinki University Hospital (Kellokoski). It further visited Metsälä Detention Unit for Foreign Nationals in Helsinki and, for the first time, two juvenile establishments, Sairila and Sippola Residential Schools.

The co-operation received in preparation and throughout the visit was excellent at all levels, despite the exceptional circumstances in which the visit took place, due to the ongoing Covid-19 pandemic. However, the Committee must recall once again that the principle of co-operation between Parties to the Convention and the CPT also requires that recommendations made by the Committee are effectively implemented in practice. Although the CPT noted the tangible progress achieved in several areas, it is regrettable that a number of its long-standing recommendations remain unaddressed. This concerns in particular notification of custody and access to a doctor for persons in police custody, medical screening on arrival in immigration detention establishments, recourse to restrictions on remand prisoners' contact with the outside world and the impoverished regime for remand prisoners subjected to restrictions and prisoners segregated on security grounds, prison health-care services and legal safeguards for persons hospitalised and treated against their will in psychiatric establishments.

Police custody

As was the case during previous visits, the CPT's delegation heard no allegations of ill-treatment of persons detained by the police; on the contrary, most of the persons interviewed by the delegation, who were or had recently been in police custody, stated that the police had treated them in a correct manner. This is very positive.

The delegation further gained the favourable impression that access to a lawyer (including *ex officio*) for persons in police custody did not, in general, pose any particular problems in practice. By contrast, delays in notification of custody, another fundamental safeguard against ill-treatment, remained regrettably frequent and widespread and could last up to 96 hours despite the fact that the law only allowed such notification to be delayed for up to 48 hours.

Regarding access to a doctor, the situation was basically identical to that described in the report on the 2014 visit. While the police did not hesitate to call an ambulance if they thought the detained person's health condition so required, the absence of adequate health-care coverage in almost all police premises and, in particular, the lack of a systematic and routine medical screening on arrival at police prisons resulted in serious medical conditions going undetected and even, possibly, in deaths, especially in the case of intoxicated persons. The CPT once again makes detailed recommendations to address these shortcomings, also in view of the ongoing Covid-19 pandemic. Improvements are further recommended concerning the provision of written information to detainees on their rights.

Conditions of detention in police establishments were generally acceptable for the initial period of police custody (i.e. up to 96 hours). However, poor access to natural light was a problem in several police prisons visited, and some of the cells seen in Espoo, Kemijärvi and Pasila were in a rather poor state of repair.

Persons displaying signs of acute substance intoxication (referred to as “intoxicated persons” in the law) continued to be accommodated in police establishments. Nevertheless, custodial staff working in most of the establishments visited had received little (if any) specialised training in the care of this category of persons and in recognising the symptoms of conditions that could be mistaken for or complicate alcohol (or drug) intoxication. Moreover, due to overall staff shortages in most of the police prisons visited, there was also a lack of adequate supervision by custodial staff and insufficient (or inexistent) presence of health-care staff. The Committee calls upon the Finnish authorities to remedy these shortcomings.

Remand prisoners continued to be held at police establishments despite the fact that none of the police prisons visited offered suitable conditions for longer periods of detention. That said, the CPT welcomes the recent legal amendments aiming at shortening significantly the time spent in police prisons by remand prisoners (to 7 days’ maximum, as a rule) and the Finnish authorities’ plans to completely eliminate the practice of holding remand prisoners in police establishments.

Nevertheless, while the numbers of remand prisoners and their time of stay at police prisons had indeed been somewhat reduced since the CPT’s last visit, there were still occasions where remand prisoners had been held in totally inadequate conditions (e.g. in windowless cells at Espoo) for several months. To hold anyone for such a long time in cells without proper access to natural light (apart from a small opening in the roof) and, what is worse, under conditions akin to solitary confinement, could – in the Committee’s view – amount to inhuman treatment.

Foreign nationals deprived of their liberty under aliens legislation

The CPT welcomes that in practice, detention of unaccompanied minors is extremely rare in Finland, and that pursuant to amendments to the Aliens Act, unaccompanied minors younger than 15 can never be detained.

The delegation heard no allegations of ill-treatment of foreign nationals by staff at the Metsälä Detention Unit for Foreign Nationals.

Further, the Unit’s staff – who were well trained and who possessed appropriate multi-cultural and linguistic competences – displayed a generally positive attitude vis-à-vis the detained foreign nationals. The material conditions were generally adequate. That said, the ongoing absence of organised activities was a problem, especially for those detainees who spent lengthy periods (up to several months) at the establishment.

As regards health care, it is an improvement that the Unit now employed two full-time nurses. Nevertheless, the CPT invites the Finnish authorities to make efforts to ensure ready access to a nurse also on Sundays; further, someone competent to provide first aid should always be present at the Unit at night.

As previously, there was no systematic medical screening of newly arrived detainees (such a screening was systematically offered to foreign nationals, but it was not mandatory), which was obviously problematic in the context of the Covid-19 pandemic. The Committee is also concerned to note that access to psychological assistance and psychiatric care remained inadequate at the Metsälä Unit.

On a positive note, foreign nationals detained at the Metsälä Unit continued to have good possibilities to remain in contact with the outside world through receiving visits and making telephone calls, as well as sending and receiving letters. They were further provided with written information on their rights, including on the rights to legal assistance, to appeal and to make complaints.

Prisons

The CPT welcomes the measures taken to further reduce the prison population and in particular the final elimination of the long-standing problem of “slopping out” in Finnish prisons (with the closure of Hämeenlinna Prison as the last Finnish prison devoid of in-cell toilets).

In neither of the two prisons visited did the delegation receive allegations of ill-treatment of prisoners by custodial staff. On the whole, inmates interviewed by the delegation stated that they were being treated correctly by prison staff. That said, the CPT recommends that custodial staff be further encouraged to interact more with inmates and receive appropriate initial and ongoing training in this respect.

Inter-prisoner violence was not a major issue at Oulu Prison. By contrast, there had been several recent violent incidents at Turku Prison, some of them resulting in serious injuries. Despite genuine efforts to prevent and respond to violence between inmates, the situation was likely to deteriorate further due to the characteristics of the prisoner population, the shortage of qualified custodial staff and the prison’s increasing occupancy rate. The CPT again calls upon the Finnish authorities to take more decisive and proactive steps to prevent and stop inter-prisoner violence and intimidation. It further reiterates its long-standing recommendation to introduce effective procedures for recording and reporting injuries and for keeping reliable statistics on this phenomenon.

The number of prisoners in need of protection (so-called “fearful” inmates) had diminished since the 2014 visit. However, their segregation remains an issue of concern to the CPT, as these inmates continued to be subjected to extremely restrictive regimes, spending up to 23 hours per day locked in their cells, with no purposeful activities. While genuine efforts were being made to address this problem, the Committee remains of the view that more is required to provide adequate protection to this category of inmates, without resorting to isolation or use of regimes akin to solitary confinement. The CPT further recommends a more proactive approach by the prison health-care service towards these prisoners, particularly as regards psychological and psychiatric care.

Material conditions were generally excellent at Turku Prison and, despite the outdated infrastructure and the overall lack of space, still quite good at Oulu Prison (except for some “travelling cells” at Oulu Prison which were rather dilapidated and damp).

Further, inmates in both prisons were offered at least one hour of outdoor exercise every day, generally in sufficiently spacious and well-equipped yards. The only exception was a rather small and oppressive-looking exercise yard for remand prisoners on restrictions and other segregated prisoners at Oulu Prison.

The findings of the visit further indicate that the offer of activities in both prisons was rather limited. The worst situation was observed with respect to remand prisoners subjected to restrictions and other segregated inmates who spent the bulk of their time (up to 21-23 hours per day) locked in their cells. The CPT therefore makes detailed recommendations aimed at providing all prisoners with purposeful activities tailored to their needs.

It is a positive development that the responsibility for the prison health-care service had been transferred from the Ministry of Justice to the Ministry of Social Affairs and Health. However, a number of shortcomings remained in the field of prison health care. The CPT recommends in particular that the number of general practitioners and nurses be increased in both prisons and that someone qualified to provide first aid is always present, including at night. Further, the practice of custodial staff distributing medication to prisoners should finally be discontinued.

The Committee also calls upon the Finnish authorities to implement its long-standing recommendations to ensure that comprehensive medical screening of newly arrived prisoners is carried out systematically within 24 hours of arrival and to review the existing procedures for recording and reporting of injuries. Improvements are further recommended regarding adequate provision of psychiatric care and psychological assistance, in particular in view of the presence in both prisons of numerous inmates with mental health-related issues.

It is another serious matter of concern that 17% of posts for prison staff had had to be cut between 2006 and 2016 and that the budget of the prison service apparently did not allow for the recruitment of new staff. Not surprisingly, staff presence at both prisons was therefore clearly insufficient. Without significant progress in this area, it will also be impossible to implement the Committee's recommendations concerning the development of positive staff-prisoner relations, preventing and combating inter-prisoner violence and enlarging the offer of constructive out-of-cell activities.

Overall, most of the prisoners had good opportunities to stay in contact with their families and friends, including via the internet/e-mail, phone and video meetings. That said, the Committee recalls that all prisoners should benefit from a visiting entitlement of at least one hour every week and, with particular regard to remand prisoners under court-imposed contact restrictions, calls upon the Finnish authorities to ensure that all prisoners have regular access to a telephone.

The report notes positively that legal amendments had, amongst other things, shortened the maximum length of disciplinary solitary confinement from 14 to 10 days and fully abolished the sanction in respect of juveniles. Moreover, recourse to that measure was surrounded by appropriate safeguards and did not appear excessive in either of the prisons visited. It is further commendable that external complaints mechanisms continued to be well established and that prisoners generally knew and understood these mechanisms. Some improvements are once again recommended in relation to the internal complaints procedures.

Psychiatric institutions

As was the case during previous visits, the delegation received no allegations of any form of deliberate physical ill-treatment of patients by staff. Instances of inter-patient violence appeared to be rare and staff seemed generally to react promptly and adequately to such incidents.

It is further commendable that patients' living conditions at the hospital were very good and contributed to a positive treatment environment and that patients had good possibilities to maintain contact with persons close to them.

Patients who were allowed to move freely within the hospital's grounds also had frequent access to the open air and to a range of rehabilitative and recreational activities. However, some of the other patients were offered very few activities and they could usually only go to the outdoor yards for one hour per day or even less. The CPT recommends that these shortcomings be remedied.

Staffing levels at the hospital were generally sufficient. However, in particular in acute ward 10, the staffing situation was sometimes inadequate when patients with particularly challenging behaviour were present. Moreover, in some wards, many patients had very limited interactions with nursing staff and the staff-patient relations were generally rather distant or even tense. The Committee recommends that measures be taken to foster positive and trusting staff-patient relationships.

Electroconvulsive therapy (ECT) was applied rarely and surrounded by appropriate safeguards. That said, patients' written informed consent was usually not sought before resorting to this therapy. On a positive note, the provision of somatic care did not pose major difficulties.

It is further commendable that recourse to means of restraint was governed by detailed internal guidelines and the hospital's nursing staff regularly underwent training in applying manual control techniques. However, Kellokoski Hospital should increase its efforts to reduce the frequency of seclusion of patients and the duration of both seclusion and mechanical belt restraint. The Committee also recommends that every patient held in seclusion be subjected to continuous direct personal supervision by a qualified member of staff. Further, chemical restraint should be recorded as such in a dedicated register and in the respective patient's personal file.

As regards legal safeguards in the context of involuntary hospitalisation, the CPT has misgivings about the fact that patients could be held at a hospital against their will "under observation" without a formal reasoned and appealable written decision, for up to four days. It also noticed once again with concern that formal decisions to hospitalise a patient against his/her will were usually taken without the involvement of outside psychiatric expertise. The Committee further reiterates its recommendation that in the context of the review of involuntary hospitalisation of civil and forensic patients, involvement of an independent psychiatric expert be obligatory.

Administrative Court approvals of decisions to continue involuntary hospitalisation of a patient, as well as appeal procedures, still usually took several weeks and sometimes months. Ways should be found to reduce the length of these proceedings. The court approvals should further include individualised detailed reasoning and the patients concerned should have an effective right to be heard. The Committee also recommends that in the context of decisions made by the Finnish Institute of Health and Welfare regarding a forensic patient's involuntary hospitalisation (and its discontinuation), a personal hearing of the patient and the possibility for legal assistance be rendered mandatory. Further recommendations address the need for improvements concerning information provided to patients and the need for confidential complaints boxes.

As regards involuntary medical treatment, patients at Kellokoski Hospital usually had not been asked to consent to their treatment and generally felt that they had no possibility to refuse the treatment proposed to them. In this connection, the CPT once again reiterates the importance of distinguishing the need for involuntary hospitalisation from the need for a specific medical treatment. The need to reform the Mental Health Act in this respect was already underscored by the judgment of the European Court of Human Rights in the case of *X. v. Finland*, made in 2012. The Committee once again calls upon the Finnish authorities to address this issue with urgency.

State Residential Schools

In the two facilities visited, the CPT's delegation heard no allegations of any form of ill-treatment of juveniles by staff. On the contrary, many juveniles made positive comments on the caring attitude of the staff. In particular at Sippola Residential School, the staff's approach towards the juveniles was very supportive with frequent interactions aimed at relationship-building. Furthermore, inter-juvenile violence did not appear to be a major problem and whenever such incidents occurred, staff seemed to intervene promptly and adequately.

Material conditions at both facilities were very good, providing a friendly and homely atmosphere. The delegation further gained a generally positive impression of the daily regime offered to juveniles. Inside the living units, all juveniles could move freely and were in addition offered a wide range of educational and recreational activities. Most of the juveniles also had frequent access to the outdoor areas. However, at the special care unit at Sairila Residential School, juveniles were apparently sometimes only able to go outdoors for about half an hour per day. In the CPT's view, juveniles should be offered at least two hours' access to outdoor areas per day.

Practically all the juveniles at both facilities were considered as particularly vulnerable to one or several risks, such as drug use, becoming the subject of sexual exploitation and/or involvement in criminal activities. As regards drug addiction in particular, many juveniles continued using drugs during their stay at the schools. Nevertheless – and despite their serious concerns about the matter – the facilities had no effective means to prevent the juveniles from having practically unhindered access to the drug market since many juveniles could leave the school grounds unaccompanied. The CPT recommends that increased emphasis be placed on drug addiction treatment at both facilities and, as appropriate, at other substitute care facilities. Substitute care facilities should further be provided with effective means to protect the juveniles in their care from harm caused by drug use, sexual exploitation or involvement in criminal activities. The CPT asks to be informed, within three months, about the action envisaged in this respect.

It is another matter of concern that juveniles with severe mental health problems were frequently transferred back and forth between child welfare institutions and psychiatric hospitals as neither of the establishments felt that they could appropriately assist the juvenile. There is an obvious need for closer co-operation between the child welfare and health-care institutions.

The Committee is further concerned about the case of one juvenile it met at Sairila Residential School who had been diagnosed with hepatitis C, but apparently had not received treatment for the infection. Given the risks of the serious and irreversible long-term consequences of this disease, the CPT recommends that juveniles with hepatitis C always be assessed with a view to receiving direct-acting antiviral (DAA) treatment. It would like to receive confirmation, within three months, that such an assessment has been carried out in the above-mentioned case.

On a positive note, the juveniles at both facilities were cared for by an adequate number of well-qualified multi-disciplinary staff, including occupational therapists, social workers, psychologists, psychiatrists and qualified nurses.

An agitated juvenile could be placed as a measure of last resort in seclusion in a “calming down room”. Given the particular vulnerability of juveniles to the harmful effects of seclusion, it is commendable that the maximum length of seclusion had been reduced by law from 48 hours to 24 hours and in practice usually lasted for a much shorter time at both facilities. That said, juveniles were rarely seen by health-care staff in the context of seclusion. The CPT further recommends that the direct personal supervision of juveniles held in seclusion at both facilities (and, as appropriate, in other juvenile substitute care facilities) be increased in accordance with the relevant legislation.

Finally, the CPT welcomes the establishments’ emphasis on facilitating the juveniles’ contact with their families and other persons close to them. Juveniles could make daily phone calls and receive visits, and many juveniles were frequently granted home leave.

I. INTRODUCTION

A. The visit, the report and the follow-up

1. In pursuance of Article 7 of the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (hereinafter referred to as “the Convention”), a delegation of the CPT carried out a visit to Finland from 7 to 18 September 2020. The visit formed part of the Committee’s programme of periodic visits for 2020 and was the CPT’s sixth periodic visit to Finland.¹

2. The visit was carried out by the following members of the Committee:

- Marie Lukasová, Head of delegation
- Kristina Pardalos
- Arman Tatoyan
- Marika Väli.

They were supported by Borys Wódcz (Head of Division) and Almut Schröder of the CPT's Secretariat, and assisted by:

- Pétur Hauksson, psychiatrist, former Head of the Psychiatric Department at Reykjalundur Rehabilitation Centre, Iceland (expert)
- George Tugushi, lawyer and former Public Defender (Ombudsman) of Georgia (expert)
- Helena Karunen (interpreter)
- Kirsi Lammi (interpreter)
- Heli Mantyranta (interpreter)
- Katja Ranta-Aho (interpreter)
- Pia von Essen (interpreter).

3. The list of police, immigration, penitentiary, psychiatric and juvenile establishments visited by the Committee’s delegation can be found in Appendix I.

¹ See the full list of visits and their dates on the CPT’s website, <https://www.coe.int/en/web/cpt/finland>. All the Committee’s reports and responses of the Finnish authorities to date are in public domain, upon the authorities’ request and pursuant to the automatic publication procedure introduced by the Finnish authorities in 2016. According to this procedure, all documents related to CPT visits shall be published automatically, unless the Finnish authorities submit within two weeks a request to postpone (for a period of up to six months) the publication of the document concerned.

4. The report on the visit was adopted by the CPT at its 104th meeting, held from 1 to 5 March 2021, and transmitted to the Finnish authorities on 26 March 2021. The various recommendations, comments and requests for information made by the Committee are set out in bold type in the present report. The CPT requests the Finnish authorities to provide within six months a response containing a full account of action taken by them to implement the Committee's recommendations and replies to the comments and requests for information formulated in this report. As regards the recommendations in paragraphs 122 and 126 below, the CPT requests a response within three months.

B. Consultations held by the delegation and co-operation encountered

5. In the course of the visit, the delegation had consultations with Maria Ohisalo, Minister of the Interior, Malin Brännkärr, State Secretary at the Ministry of Justice and Saila Ruuth, State Secretary at the Ministry of Social Affairs and Health, as well as with other senior officials from the above-mentioned Ministries.

In addition, talks were held with Petri Jääskeläinen, Parliamentary Ombudsman and Pasi Pölönen, Deputy Parliamentary Ombudsman in their capacity as the Finnish National Preventive Mechanism (NPM).

A full list of the persons with whom the delegation held consultations is set out in Appendix II.

6. The co-operation received by the delegation in preparation and throughout the visit was excellent at all levels, despite the exceptional circumstances in which the visit took place, due to the ongoing Covid-19 pandemic. The delegation enjoyed rapid access to all the establishments visited (including those which had not been notified in advance), was promptly provided with all the requested information (including medical files) and was able to speak in private with all the detained persons it wished to interview. In addition, it received an impressive amount of documentation prior to and during the visit.

The Committee wishes to express its appreciation of the invaluable assistance provided before and during the visit by the CPT's Liaison Officer, Paulina Tallroth, and her colleague Tuuli Herlin, from the Ministry of Justice.

7. That said, the Committee must recall once again that the principle of co-operation between Parties to the Convention and the CPT is not limited to steps taken to facilitate the task of a visiting delegation. It also requires that decisive action be taken to improve the situation in the light of the Committee's recommendations.

In this respect, the delegation has indeed observed progress in some areas, such as eliminating at last the practice of "slopping out" in prisons² and reducing the number and duration of placement of remand prisoners in police establishments ("police prisons").³

² See paragraph 36 below. This had been a long-standing recommendation by the CPT, ever since the Committee's first visit to Finland in 1992.

³ See paragraphs 22 to 24 below.

By contrast, several of the CPT's important long-standing recommendations have remained unimplemented e.g. those regarding notification of custody⁴ and access to a doctor⁵ for persons in police custody, those concerning medical screening on arrival in immigration detention establishments,⁶ those concerning recourse to restrictions on remand prisoners' contacts with the outside world⁷ and the impoverished regime for remand prisoners subjected to restrictions and prisoners segregated on security grounds,⁸ those concerning the prison health-care services⁹ and the legal safeguards for persons hospitalised and treated against their will in psychiatric establishments.¹⁰

The Committee wishes to emphasise that a persistent failure to improve the situation in the light of the CPT's recommendations could oblige it to consider having recourse to Article 10, paragraph 2, of the Convention.¹¹ The Committee trusts that the action taken by the Finnish authorities in response to this report will render such a step unnecessary.

⁴ See paragraph 13 below.

⁵ See paragraph 14 below.

⁶ See paragraph 30 below.

⁷ See paragraph 59 below.

⁸ See paragraph 46 below.

⁹ See paragraphs 48 to 54 below.

¹⁰ See paragraphs 95 to 99 and 104 below.

¹¹ "If the Party fails to co-operate or refuses to improve the situation in the light of the Committee's recommendations, the Committee may decide, after the Party has had an opportunity to make known its views, by a majority of two-thirds of its members to make a public statement on the matter."

II. FACTS FOUND DURING THE VISIT AND ACTION PROPOSED

A. Police establishments

1. Preliminary remarks

8. There have been no major changes to the legal and regulatory framework governing the detention of persons by the police since the 2014 visit. It should be recalled here that the maximum period of custody by the police of persons suspected of having committed a criminal offence is 96 hours.¹² Further, the police may, on their own authority, hold a person for a maximum of 24 hours in order to establish his/her identity or to protect him/her from an immediate serious danger to his/her life, bodily integrity, security or health (including due to alcohol intoxication).¹³ In addition, persons may be detained by the police for a maximum of 12 hours to protect public order¹⁴, and for up to 24 hours to prevent or eliminate a public disturbance.¹⁵

9. By contrast with the above, the delegation was informed at the outset of the visit by senior officials from the Ministry of the Interior that a major reform was underway of the Act on the Treatment of Persons in Police Custody (ATPPC, generally referred to as “Putkalaki”)¹⁶ providing a comprehensive legal framework for the treatment of persons detained by the police. A working group had been set up at the Ministry with the objective of preparing a new draft Act in the spring of 2021 and sending it to the Parliament thereafter. The main aim of the exercise was reportedly to cover in one legal act all different types and stages of detention by the police (including police custody) and – in the process – implement long-standing recommendations by the CPT and by the Parliamentary Ombudsman, *inter alia* those on the separation between the investigative and custodial functions of the police. **The Committee requests to be provided with updated information on the progress in the drafting and adoption of the new Act (and to receive, in due course, the text of the new law as adopted).**

As previously, the Finnish law (in particular, the Remand Imprisonment Act¹⁷ but also the ATPPC) allows holding remand prisoners in police facilities (“police prisons”),¹⁸ a practice criticised by the CPT in the past.¹⁹ The Committee will comment on this issue further in this report.²⁰

¹² Chapter 1, Sections 2 (2), 13 and 14 (1) of the Coercive Measures Act No. 450/87 (CMA). It is noteworthy that the police must request the competent court for remanding a detained person in custody “without delay and at the latest before noon on the third day from the day of apprehension” (Chapter 3, Section 4 of the CMA).

¹³ Sections 10 and 11 of the Police Act No. 493/95 (PA).

¹⁴ Section 14 of the PA.

¹⁵ Section 20 of the PA.

¹⁶ Act No. 841/06, in force since 1 October 2006.

¹⁷ Act No. 768/05, likewise in force since 1 October 2006.

¹⁸ “Police prisons” are police detention facilities (usually those with a bigger capacity and located in larger towns) designated by the Ministry of the Interior as establishments that may accommodate remand prisoners and staffed by specifically trained custodial officers.

¹⁹ See e.g. paragraphs 25 and 26 of the report on the 2014 visit (document CPT/Inf (2015) 25).

²⁰ Section II.A.5.

2. Ill-treatment

10. The delegation heard no allegations of ill-treatment of persons detained by the police; on the contrary, most of the persons interviewed by the delegation, who were or had recently been in police custody, stated that the police had treated them in a correct manner, both upon apprehension, during subsequent questioning and in the course of police custody.

Consequently, the conclusion reached by the CPT after the 2014 visit – namely that persons deprived of their liberty by the Finnish police currently run little risk of being subjected to deliberate ill-treatment – remains fully valid. This is most welcome.

3. Safeguards against ill-treatment

11. In the reports on its previous visits to Finland, the CPT has repeatedly made a number of recommendations and comments as regards safeguards for persons detained by the police. The Committee has placed particular emphasis on three fundamental rights, namely the right of detained persons to inform a close relative or another third party of their situation, to have access to a lawyer, and to have access to a doctor. As stressed by the CPT, these rights should be enjoyed by all categories of persons from the very outset of their deprivation of liberty (i.e. from the moment the persons concerned are obliged to remain with the police). It is equally fundamental that persons detained by the police be informed without delay of their rights, including those mentioned above, in a language they understand.

12. In the course of the 2020 visit, the delegation gained the impression that access to a lawyer (including *ex officio*) for persons in police custody did not, in general, pose any particular problems in practice; indeed, many detained persons with whom the delegation spoke confirmed that a lawyer had been present during the initial questioning by police officers and that they had been in a position to speak with their lawyer in a confidential manner. The Committee welcomes these positive findings.

13. By contrast, the delegation was concerned to observe that delays in notification of custody, another fundamental safeguard against ill-treatment, remained frequent and widespread and could last up to the maximum legal period of police custody (i.e. 96 hours),²¹ especially when the apprehended person was a foreign national without residence in Finland. **The CPT again calls upon the Finnish authorities to ensure that the relevant legal provisions concerning notification of custody (including, in particular, the maximum 48-hour time-limit for delaying the notification) are always implemented.**

²¹ Despite the fact that, according to the ATPPC, senior police officers (in practice, usually senior investigators in charge of the case) were only allowed to delay notification for a maximum of 48 hours as from the time of apprehension, and only “if such notification gives rise to a particular detriment to clearing up the offence”. The ATPPC also makes clear that any such delay must be duly reasoned, and the reasons recorded in the relevant documentation and communicated to the person concerned both orally and in writing.

14. Regarding access to a doctor for persons detained by the police, the situation observed during the 2020 visit was basically identical to that described in the report on the 2014 visit.²²

While the police did not hesitate to call an ambulance if they thought the detained person's health condition so required, the absence of adequate health-care coverage in almost all police premises²³ and, in particular, the lack of a systematic and routine medical screening on arrival to police prisons²⁴ resulted in serious medical conditions going undetected²⁵ and even, possibly, in deaths, especially in the case of intoxicated persons (see below).

In the light of the above, and especially given that police prisons still accommodate remand prisoners (see paragraphs 22 to 24 below), **the CPT calls upon the Finnish authorities to take steps to:**

- **improve access to a doctor and provide a 24-hour nursing cover at Pasila Police Prison;** such an ongoing presence of a nurse is in particular needed given the establishment's important capacity (60 places), its hybrid function as police detention facility (receiving criminal suspects, intoxicated persons and persons apprehended pursuant to the Aliens Act) and *de facto* remand prison (with some persons remanded in custody staying there for prolonged periods), and the large turnover with many detained persons being admitted at night;
- **improve significantly the access to a doctor and ensure regular presence of a nurse in all the other police prisons visited²⁶ (as well as, *mutatis mutandis*, in all other police prisons in Finland);**
- **ensure that all newly arrived detainees (and in particular remand prisoners) are medically screened, within 24 hours of their arrival at a police prison, by a doctor or a qualified nurse reporting to a doctor; as already stressed many times in the past, such a screening is essential, particularly to prevent the spread of transmissible diseases and suicides, and (in the context of prevention of ill-treatment) for recording injuries in good time.**

Further, **the Committee reiterates its recommendation that steps be taken to ensure that persons in police custody have an effective right to be examined, if they so wish, by a doctor of their own choice (in addition to any medical examination carried out by a doctor called by the police), it being understood that an examination by a doctor of the detained person's own choice may be carried out at his/her own expense.**

²² See paragraph 14 of document CPT/Inf (2015) 25.

²³ As previously, Pasila was the only police prison employing a part-time doctor and two nurses (who were absent at night and on weekends). None of the other police establishments visited had on-site medical staff, although in Espoo and Töölö police (custodial) staff could, if necessary, request assistance of doctors and nurses from a nearby municipal detoxification facility. Further, Vantaa police prison had a contract with a private company ensuring twice-weekly visits by a doctor.

²⁴ Such medical examination on arrival only took place if the person detained declared having a health problem and requested an examination, or when the receiving officer on duty suspected some health issue and informed the health-care worker (either on-site or, in most cases, an external one).

²⁵ Or only detected with a significant delay, sometimes after the person had been remanded in custody and transferred to a prison.

²⁶ See Appendix I.

The CPT also recommends that regular first-aid refresher courses be offered to all police officers working in detention areas of police prisons.²⁷

15. The aforementioned recommendation concerning initial medical screening gains an additional importance in the context of the ongoing Covid-19 pandemic.²⁸ In the police establishments visited, in addition to general precautions (availability of disinfectant gel, information for detained persons and staff, staff having been issued with masks), reception officers (who were not medically trained, apart from having followed a first-aid course) were now instructed to ask about any Covid-19 symptoms (and to watch out for such symptoms as cough and fever) and, in case of suspicion, call an ambulance or (in those rare establishments where a nurse was present or easily available) the nurse, who would perform a visual examination, check the person's temperature and oxygenation, and if needed, arrange for the person's transfer to a hospital.

While – according to the staff in the police prisons visited – there had been no confirmed Covid-19 cases amongst detained persons so far,²⁹ it is clear that the existence of a systematic screening upon arrival performed by a medically trained professional would represent an additional safeguard in this respect.³⁰ **The CPT would welcome the Finnish authorities' observations on this subject.**

16. While in general persons apprehended by the police received promptly some oral information, there still seemed to be occasional delays in the provision of written information on rights, especially in languages other than Finnish.³¹ The delegation also noted that not all of the persons interviewed in police prisons had received a copy of the information sheet to keep with them in their cell. Likewise, written information on house rules (including as regards access to a doctor) was found to be posted on the walls inside the cells in some,³² but by far not all of the police prisons visited. **The CPT recommends that steps be taken to remedy the above-mentioned deficiencies.³³**

²⁷ Staff in several police prisons visited told the delegation that they had received such training a while ago but had not recently taken part in refresher courses.

²⁸ Admittedly, at the time of the CPT's visit the epidemiological situation in Finland was relatively good, with the seven-day incidence of 18.3 new Covid-19 cases per 100.000 inhabitants as of the end of September 2020.

²⁹ There had reportedly been one case in Espoo, but amongst the staff, not the detainees.

³⁰ See also the Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (COVID-19) pandemic, issued on 20 March 2020 (CPT/Inf(2020)13), in which the CPT *inter alia* says that the relevant WHO guidelines must be respected and implemented fully in all places of deprivation of liberty.

³¹ At Turku police prison one of the officers on duty told the delegation that written information sheets in languages other than Finnish (e.g. Arabic, Bulgarian, English, Estonian, French, German, Italian, Latvian, Lithuanian, Persian, Polish, Romanian, Russian, Somali, Swedish and Turkish) were only provided on the detainee's request.

³² E.g. in Kemijärvi, Kuusamo and Raahe.

³³ See also See Article 3 of Directive 2012/13 of the European Parliament and of the Council of 22 May 2012 on the right to information in criminal proceedings (OJ L 142/1, 1 June 2012), <https://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2012:142:0001:0010:en:PDF>, which states as follows: “1. Member States shall ensure that suspects or accused persons are provided promptly with information concerning at least the following procedural rights, as they apply under national law, in order to allow for those rights to be exercised effectively: (a) the right of access to a lawyer; (b) any entitlement to free legal advice and the conditions for obtaining such advice; (c) the right to be informed of the accusation [...]; (d) the right to interpretation and translation; (e) the right to remain silent. 2. Member States shall ensure that the information provided for under paragraph 1 shall be given orally or in writing, in simple and accessible language, taking into account any particular needs of vulnerable suspects or vulnerable accused persons.”

4. Conditions of detention

17. At the outset of the visit, senior officials from the Ministry of the Interior informed the delegation that since the 2014 visit, 15 police prisons (out of the total of 50 police detention facilities in Finland) had been reconstructed or refurbished, including setting up separate health-care rooms, visiting premises, installing electricity and TV sockets in cells and improving exercise yards.

18. Indeed, the delegation's findings from the 2020 visit confirmed the assessment made during the CPT's previous visits to Finland, namely that conditions of detention in police establishments were generally acceptable for the initial period of police custody (i.e. up to 96 hours).

The cells seen in police establishments visited were of an adequate size for their intended occupancy (e.g. 8 m² to 12 m² for a single cell; 10 m² to 15 m² for a double) and suitably equipped (sleeping platforms with full bedding, a stool, a desk, a shelf, call system); further, ventilation and artificial lighting were generally acceptable. Most of the cells had sanitary annexes comprising a toilet and a washbasin, and some of these annexes were fully screened (e.g. in Espoo, Haukipudas, and in approximately half of the cells in Pasila); however, there were still some double cells without in-cell toilets in the latter establishment. That said, detained persons held in cells without sanitary annexes had ready access to decent communal toilets.

On the less positive side, poor access to natural light was a problem in several police prisons visited, especially in Espoo, Haukipudas, Pasila and Ylivieska. Further, some of the cells seen in Espoo, Kemijärvi and Pasila³⁴ were in a rather poor state of repair (e.g. walls covered in graffiti). **The CPT recommends that the Finnish authorities take steps to remedy the above-mentioned deficiencies.**

See also Article 4 of the same Directive:

“1. Member States shall ensure that suspects or accused persons who are arrested or detained are provided promptly with a written Letter of Rights. They shall be given an opportunity to read the Letter of Rights and shall be allowed to keep it in their possession throughout the time that they are deprived of liberty.

2. In addition to the information set out in Article 3, the Letter of Rights referred to in paragraph 1 of this Article shall contain information about the following rights as they apply under national law:

(a) the right of access to the materials of the case;

(b) the right to have consular authorities and one person informed;

(c) the right of access to urgent medical assistance; and

(d) the maximum number of hours or days suspects or accused persons may be deprived of liberty before being brought before a judicial authority.

3. The Letter of Rights shall also contain basic information about any possibility, under national law, of challenging the lawfulness of the arrest; obtaining a review of the detention; or making a request for provisional release.

4. The Letter of Rights shall be drafted in simple and accessible language. An indicative model Letter of Rights is set out in Annex I.

5. Member States shall ensure that suspects or accused persons receive the Letter of Rights written in a language that they understand. Where a Letter of Rights is not available in the appropriate language, suspects or accused persons shall be informed of their rights orally in a language that they understand. A Letter of Rights in a language that they understand shall then be given to them without undue delay.”

³⁴

E.g. cell no. 317 and no. 428.

19. Persons obliged to stay in police establishments in excess of a few days (including remand prisoners, see below) had daily access to suitable and clean showers, and were provided with a range of personal hygiene items. Further, hardly any complaints were received about the food served at these establishments, which invariably comprised at least one hot meal (often two).

20. Police establishments in Finland continue to be frequently used to accommodate persons displaying signs of acute substance intoxication (referred to as “intoxicated persons” in the PA). Special cells designed for this purpose were seen in all the police prisons visited. The size (between 10 m² and 20 m²) and equipment (washable mattresses, floor-level toilets with a drinking water tap, call system, CCTV) of these cells call for no particular comment. However, the delegation again noted that – with the exception of police officers employed at the Töölö facility (see paragraph 21 below)³⁵ – custodial staff working in the establishments visited had received little (if any) specialised training in the care of intoxicated persons and in recognising the symptoms of conditions that could be mistaken for or complicate alcohol (or drug) intoxication.

Due to overall staff shortages³⁶ in most of the police prisons visited (especially those located in the north of the country), there was also – as acknowledged by senior officials of the Ministry of the Interior met by the delegation at the outset of the visit – a lack of adequate supervision by custodial staff and insufficient (or inexistent) presence of health-care staff (see also paragraph 14). It was clear that notwithstanding the existing arrangements (such as the CCTV surveillance), deaths of intoxicated persons in police custody continued to occur.³⁷ In this context, the delegation was informed at the outset of the visit that new instructions, to be issued by the end of 2020 or early in 2021, would require custodial staff to personally and directly check the condition of every intoxicated person at regular and frequent intervals. **The CPT welcomes this development and would like to be informed of the details of the new instructions (including the precise frequency of obligatory checks) and of the date of their entry into force.**

Further, **the Committee calls upon the Finnish authorities to provide specialised training in the care of intoxicated persons (and in the recognition of conditions which could be mistaken for a state of intoxication e.g. internal bleeding or diabetes), to all police officers in Finland and to ensure systematic and rapid access to a nurse whenever intoxicated persons are held at police establishments. The CPT also recommends that more efforts be made to increase the presence and supervision by custodial staff.**³⁸ Furthermore, **the Committee invites the Finnish authorities to reconsider the option of conferring the care of intoxicated persons to health-care facilities.**

21. The delegation was informed that there were plans to close the Custodial Facility for Intoxicated Persons in Töölö; instead, intoxicated persons apprehended in Helsinki would be held at Pasila police prison. Indeed, the delegation observed that the first two floors of Pasila (50 cells) were being refurbished for this purpose.

³⁵ Who periodically received some on-the-job practical training dispensed by nurses working at the adjoining municipal detoxification centre.

³⁶ These staff shortages sometimes necessitated lengthy transfers of detainees to other establishments (as the delegation observed *inter alia* in Kemijärvi).

³⁷ According to the information provided to the delegation at the outset of the visit by senior officials from the Ministry of the Interior, there were on average 10 such deaths in Finland every year.

³⁸ It is noteworthy that, at the end of the visit, senior officials from the Ministry of the Interior informed the delegation of plans to recruit more custodial officers in police detention facilities. 40 new posts would be created in 2021 and the final objective was to have 200 more custodial officers throughout the country.

The Committee would like to receive more information on these plans, including the precise timing of the transfer, as well as whether it is also planned to transfer the experienced and trained custodial officers from Töölö to Pasila and reinforce the nursing staff at Pasila (to compensate for the loss of nursing assistance presently available at Töölö).

5. Remand detention in police establishments

22. As already mentioned in paragraph 18 above, none of the police prisons visited³⁹ offered suitable conditions for longer periods of detention, especially due to the absence of anything even remotely resembling an offer of activities (apart from access to TV/radio/DVD/computer games, as well as some books and magazines).

Further, none of the police prisons possessed genuine outdoor exercise facilities. The so-called “exercise yards” were mostly just bare larger (e.g. 25 m²) cells with a partial opening to the outside; some of them were malodorous (as they were essentially used just to smoke) and dilapidated, and the one in Espoo was partly flooded. It was hardly surprising that most of the interviewed remand prisoners told the delegation that they did not want to go to those yards.

23. In this context, the CPT notes as a positive development the recent amendments to the Coercive Measures Act and to the Remand Imprisonment Act⁴⁰ aiming at shortening significantly the time spent in police prisons by remand prisoners (to 7 days maximum, as a rule).⁴¹ Further, the delegation was informed by senior officials from the Ministry of the Interior of the Finnish authorities’ plans to completely eliminate the practice of holding remand prisoners in police establishments by 2025 at the latest.⁴²

The Committee calls upon the Finnish authorities to attach the highest priority to the implementation of these plans. Pending this, urgent steps must be taken to enlarge, refurbish and improve the design of outdoor exercise yards in police prisons.

24. The delegation indeed observed that the numbers of remand prisoners⁴³ and their time of stay⁴⁴ at police prisons had been somewhat reduced since the CPT’s last visit,⁴⁵ but there were still occasions where remand prisoners had been held in totally inadequate conditions (e.g. in windowless cells at Espoo) for several months.⁴⁶

³⁹ See the list in Appendix I.

⁴⁰ In force as from 1 January 2019.

⁴¹ Exceptions are still possible but require “weighty reasons” and an approval by a judge.

⁴² This would be achieved, at least in part, through the introduction of electronically monitored alternatives to remand imprisonment (intensified travel ban and house arrest).

⁴³ According to the statistics provided by the Ministry of the Interior at the outset of the visit, 2,017 remand prisoners had been held in police prisons in 2018 and 1,918 in 2019; the average daily number in 2019 had been 49.

⁴⁴ 10 to 14 days in the vast majority of cases.

⁴⁵ The number of remand prisoners in police prisons had been 2,314 in the year 2013 and the average stay 15 days; see paragraph 25 of document CPT/Inf (2015) 25.

⁴⁶ Two remand prisoners at Espoo had been held under such conditions since 6 and 9 months respectively. Also in other police prisons (e.g. in Haukipudas) the delegation noted prolonged stays of remand prisoners (up to two months).

To hold anyone for such a long time in cells without proper access to natural light (apart from a small opening in the roof) and, what is worse, under conditions akin to solitary confinement,⁴⁷ could – in the Committee’s view – amount to inhuman treatment.

⁴⁷ The two aforementioned remand prisoners at Espoo police prison were subjected to restrictions (on association and contact with the outside world). See more on the subject of restrictions in paragraphs 46 and 59 below.

B. Foreign nationals deprived of their liberty under aliens legislation

25. There had been no major changes to the legal framework for immigration detention since the 2014 visit. As previously, foreign nationals could be deprived of their liberty by the police or the Border Guard if it was necessary to establish their identity, to prevent them from committing an offence and/or to secure their deportation.⁴⁸ They had to be brought before a judge within 96 hours of the moment of their apprehension⁴⁹, and a continuation of their detention required a judicial decision, which had to be reviewed subsequently every two weeks.⁵⁰ Detention of foreign nationals continued to be limited to up to 6 months; however, this time-limit was extendable for up to 12 months.⁵¹

Under the Aliens Act⁵², the deprivation of liberty of foreign nationals in police and Border Guard establishments should be an exception, only when the detention unit for aliens (see below) is temporarily full or if the person is apprehended far away from the detention unit; in this case, detention in a police establishment may not last more than 4 days and the person concerned must be brought before a judge within 24 hours from apprehension.⁵³ As for Border Guard establishments, the detention of persons pursuant to the Aliens Act is possible for a maximum of 48 hours.⁵⁴

Consequently, whenever it is deemed necessary to deprive a foreign national of his/her liberty pursuant to the Aliens Act, he/she should as soon as possible be placed in a detention unit.⁵⁵

26. One important legal development since the CPT's last visit concerns the detention of unaccompanied minors. Pursuant to the new wording of the Aliens Act, unaccompanied minors younger than 15 can never be detained. Those aged between 15 and 17 may only be detained for the shortest possible period (72 hours renewable once) necessary to prepare and secure their deportation, after the final negative decision on their asylum request. The delegation was informed by senior officials from the Ministry of the Interior that in practice, detention of unaccompanied minors was extremely rare.⁵⁶ This is to be welcomed.

⁴⁸ Pursuant to Section 121 of the Aliens Act (AA), No. 301/2004, in force since 1 May 2004.

⁴⁹ Section 124 (2) of the AA.

⁵⁰ Section 128 of the AA.

⁵¹ Section 127 of the AA.

⁵² Section 123 (3) of the AA.

⁵³ The delegation was told at the outset of the visit that, due to a significant drop in the number of apprehensions since the start of the Covid-19 pandemic and to the fact that Finland's both detention units were far from being filled to capacity, detentions of foreign nationals pursuant to the AA in police and Border Guard establishments were exceptional and – if they did take place – detention periods were very short (24 hours maximum in the case of the police, a few hours maximum in the case of the Border Guard).

⁵⁴ Sections 36 and 62 of the Border Guard Act No. 578/2005, in force as from 1 September 2005.

⁵⁵ As referred to in Act No. 116/2002 on Detention Units and the Treatment of Foreign Nationals Placed in Detention, as well as in Section 123 (2) of the AA. Detention Units are run by the Finnish Immigration Service, a Government agency subordinated to the Ministry of the Interior.

⁵⁶ Four cases in 2017 (for 1 to 3 days), two cases in 2018 (each time for just a day), four cases in 2019 and one case so far in 2020 (until 1 September).

27. It is to be stressed that the delegation heard no allegations of *ill-treatment* of foreign nationals by staff at Metsälä Detention Unit for Foreign Nationals (the only immigration detention facility visited during the 2020 periodic visit⁵⁷). Further, the delegation observed that the Unit's *staff* – who were well trained⁵⁸ and who possessed appropriate multi-cultural and linguistic competences⁵⁹ – displayed a generally positive attitude vis-à-vis the detained foreign nationals. Incidents of *inter-detainee violence* appeared to be very rare and were well handled by the management and staff of the Unit.

28. Overall, the CPT has no critical remarks to make as regards the *material conditions* at Metsälä Detention Unit,⁶⁰ which were further improved by the fact that (since the start of the Covid-19 pandemic) the establishment had received less detainees and was operating well below its official capacity of 40; at the time of the 2020 visit there were 20 foreign nationals at the Metsälä Unit.⁶¹ As a result, everyone who wished so could have a room for themselves.

There were only two minor deficiencies: some of the washing machines (that foreign nationals could use to wash their clothes) were broken and the shelter in the exercise yard had just very recently been damaged during a storm. **The Committee recommends that these deficiencies be eliminated.**

29. As previously, detained foreign nationals could move freely within the accommodation areas⁶² and had access to the Internet, television programmes in many languages, DVDs, books and magazines.

That said, the persisting absence of organised *activities* was a problem,⁶³ especially for those of the detainees who spent lengthy periods (up to several months) at the establishment. Although the average stay at the Unit was said to be approximately 10 days, there were a few foreign nationals who had stayed there for almost 2 months and one had been there for over 3 months.

The CPT recommends that further efforts be made to develop the offer of activities, in the light of these remarks.

The delegation also noted that some of the workout machines in the gym (accessible for 5.5 hours each day) were out of order. **The Committee invites the Finnish authorities to address this problem.**

⁵⁷ Finland has two detention units, the other one situated in a former prison in the small village of Konnunsuo (Joutseno) in the region of Karelia (some 20 km from the town of Lappeenranta and approximately 15 km from the Russian border). It was visited by the CPT in 2014, see paragraph 33 of document CPT/Inf (2015) 25.

⁵⁸ The 22 counsellors were mostly educators and social workers by training and the ten security officers were former prison guards or custodial police officers, having undergone additional training before taking up their duties.

⁵⁹ Over half of the staff had an immigrant background and staff members spoke more than 20 languages.

⁶⁰ See the general description in the reports on previous visits, especially in paragraph 42 of the report on the 2008 visit (document CPT/Inf (2009) 5) and in paragraph 32 of the report on the 2014 visit (document CPT/Inf (2015) 25).

⁶¹ One difference with the 2014 visit was that Metsälä now accommodated only single adult men; women, families and juveniles were sent to Joutseno Detention Unit.

⁶² They had keys to their rooms.

⁶³ Admittedly, counsellors did occasionally organise bingo tournaments, cooking classes, table tennis and table football competitions, movie projections on a large screen, etc.

30. As for the *health care*, there had been an improvement as the Unit now employed two full-time nurses⁶⁴ (permitting a daily presence of a nurse until 6 p.m., except on Sundays).

While welcoming this, **the CPT invites the Finnish authorities to make efforts to ensure ready access to a nurse also on Sundays; further, steps should be taken to ensure that someone competent to provide first aid (which should include being trained in the application of CPR and the use of defibrillators) is always present at the Unit at night.**

As previously, there was no systematic medical screening of newly arrived detainees (such a screening was systematically offered to foreign nationals upon arrival, but it was not mandatory), which was obviously problematic in the context of the Covid-19 pandemic. Admittedly, the Unit's management had set aside (in the formerly unused office space) a special "quarantine area" for newly-arrived foreign nationals coming from "risk countries", where they would spend 14 days apart from other detainees; the area would also be used to accommodate any detainees with Covid-19 symptoms, while awaiting the test results. Detainees were also provided with written information on Covid-19 in several languages, and were asked to use the sanitizer and to try to observe a safe distance (2 metres) from each other while indoors. Masks and tests would only be used in respect of symptomatic persons (both detainees and staff), in accordance with the national sanitary guidelines. This notwithstanding, **the Committee calls upon the Finnish authorities to put in place as a matter of priority a prompt and systematic medical screening for all newly arrived foreign nationals at Metsälä Detention Unit. Reference is also made here to paragraphs 14 and 15 above.**

In this context, **the CPT would like to receive more detailed information about new instructions and a protocol on medical screening on arrival, which had reportedly been adopted in August 2020 but the implementation of which had been delayed (due to the pandemic) until autumn 2020.**

31. The Committee is also concerned to note that access to *psychological assistance* and *psychiatric care* remained inadequate at Metsälä Unit. In particular, there were still no regular visits to the facility by a psychiatrist or a psychologist. Quick access to psychiatric care (through a transfer to a psychiatric hospital) was only provided in acute situations. For non-urgent consultations the procedure was cumbersome and time-consuming as it required two subsequent referrals (from the nurse to the GP, then from the GP to the psychiatrist). **The CPT reiterates its recommendation that steps be taken to ensure adequate access to psychological assistance and psychiatric care for foreign nationals at Metsälä Detention Unit.**

⁶⁴ Who, unlike in the past, could devote their whole attention to the foreign nationals detained in the Unit (as the adjoining open reception centre for asylum seekers had been closed).

32. As for *contact with the outside world*, foreign nationals detained at the Metsälä Unit continued to have reasonably good possibilities to receive visits,⁶⁵ make telephone calls (including with their own mobile phones) and send and receive letters. Further, as before, detainees were provided with *written information* (available in a large number of languages) on their rights, including on the right to *ex officio* legal assistance, to appeal and to send confidential *complaints* to outside bodies.⁶⁶ External *monitoring* was carried out by staff of the Parliamentary Ombudsman's Office in their capacity as the NPM.⁶⁷

33. While visiting Metsälä Detention Unit, the delegation was told of the existence of plans to close the establishment and replace it with a new purpose-built facility after 2022 (i.e. after the current lease contract for the existing premises expires). **The Committee would like to receive, in due course, more detailed information about these plans.**

Further, the CPT wishes to stress that the **recommendations made in respect of Metsälä Detention Unit in paragraphs 29, 30 and 31 above should be considered as applicable *mutatis mutandis* to Joutseno Detention Unit.**

34. The delegation also visited the Border Guard Unit at Kuusamo Border Crossing Point which had two clean, well-lit and ventilated *holding cells* measuring some 8 m² each. The cells had no furniture and had reportedly never been used so far, any apprehended persons being taken – after initial questioning – to the police or Border Guard offices in Kuusamo, and then if necessary to the police prison.

The delegation noted that there was a lot of *information* in different languages available on the rights of apprehended persons (including the right to *ex officio* legal assistance and to submit a complaint) as well as on the asylum procedure. Online or phone *interpretation* services were available in case of need. Border Guard officers told the delegation that they would always ask apprehended persons about any *health issues* and would watch for external injuries and – in the current context – for any Covid-19 symptoms. In case of any suspicion of health-related problems, they would call an ambulance and (in the case of suspicion of Covid-19) use masks and give a mask to the apprehended person.⁶⁸

⁶⁵ Visits (up to 45 minutes at a time) were unrestricted in frequency, the only requirement being to fix a time in advance and provide identification details of the visitors. After having been suspended for a while due to the Covid-19 pandemic, visits were authorized again but under adapted conditions (using a spacious and well-ventilated room, detainees and visitors being required to wear masks, use the sanitizer and observe 2 metres of distance).

⁶⁶ Detainees could use a special (locked) complaint box or could send complaints online or through their lawyers.

⁶⁷ The Unit's staff told the delegation that the NPM representatives visited the establishment approximately once a year (the most recent visit having taken place in December 2019).

⁶⁸ Posters and leaflets about Covid-19, in several languages (including Russian) were displayed in a visible manner on the premises.

C. Prisons

1. Preliminary remarks

35. The CPT's delegation carried out first-time visits to two prisons, in Turku⁶⁹ and in Oulu.

Turku Prison was a purpose-built closed-type establishment brought into service in 2007. Located at the outskirts of Turku and occupying a large area (comprising *inter alia* two main detention blocks, the administration building and a large activities/classrooms/workshop compound), it had a capacity of 255 and was, at the time of the visit, accommodating 269 adult prisoners (approximately 20% being foreign nationals) including 41 women; it was thus officially overcrowded, essentially in the women's units.⁷⁰ 85 of the inmates were on remand and there were 22 prisoners sentenced to life imprisonment (including two women).⁷¹ Adjacent to the prison was Finland's main psychiatric hospital for prisoners, with which it shared the secure outer perimeter (but which had a separate management).

Oulu Prison, located in the centre of town, was – by contrast – a very old establishment (opened in 1885) although it had undergone major reconstruction (including the addition of a new open-regime block) in 1995. Occupying a relatively small area, it had the official capacity of 86 and was accommodating 74 adult inmates at the time of the visit (approximately a fifth of them female), most of whom (some 65%) were on remand; the remaining sentenced prisoners were as a rule serving short sentences and were not considered as presenting a security risk. Similar to the situation observed in Turku, there was some temporary overcrowding in the female units.⁷²

36. At the outset of the visit, senior officials from the Ministry of Justice and the Criminal Sanctions Agency (CSA) informed the delegation of the various already taken or planned legislative, organisational and other steps affecting the prison system since the CPT's 2014 visit.

Among others, measures had been taken to further reduce the prison population,⁷³ including the introduction of two additional measures alternative to remand imprisonment (an intensified travel ban and house arrest with electronic monitoring), enlargement of the catalogue of community sanctions (especially for young offenders, aged below 21 at the time of the offence) and the adoption of amended provisions facilitating early release (especially for repeat offenders serving long sentences). The Committee welcomes these measures.

⁶⁹ The CPT had visited the old Turku Prison, now closed, in 2003 (see paragraphs 62 and 68 of document CPT/Inf (2004) 20).

⁷⁰ The delegation was told that this was temporary, due to the partial closure of Hämeenlinna Prison which was due to reopen shortly, after a thorough reconstruction (the new prison was indeed opened in the beginning of November 2020). See also paragraph 36 below. It is noteworthy that this excess female prisoner population did not result in the living space per prisoner being reduced to an unacceptable degree (see also paragraph 41 below); some of the women had to share a (normally single) cell but most of them were accommodated in the disciplinary cells which were not supposed to be used for the purpose of "normal" accommodation but which nevertheless offered adequate material conditions (see also paragraph 60 below).

⁷¹ Life-sentenced prisoners were not segregated from the rest of the prisoner population.

⁷² Two female prisoners had to be accommodated in the "travelling cells" (see paragraph 42 below).

⁷³ At the time of the 2020 visit (as of 1 September) the prison population stood at 2,691 (as compared with approximately 3,100 during the 2014 visit). This represented an incarceration rate of 49 inmates per 100,000 of national population. On 1 January 2020, the total official capacity of the prison system was 2,878.

In addition, the temporary ban on enforcement of prison sentences (due to the Covid-19 pandemic) had the effect of reducing the prison population by approximately 400; but the ban had been lifted as from 31 July 2020 and the prison population (especially the fine defaulters) had started slightly growing again.

Regarding the prison estate, the delegation's interlocutors were first of all pleased to announce that the long-standing problem of "slopping out" in prisons⁷⁴ had finally been eliminated, with the closure of the last Finnish prison devoid of in-cell toilets (Hämeenlinna Prison).⁷⁵ The delegation was also informed of the ongoing extensive prison construction programme (five of the six prisons currently under construction being meant to replace old existing establishments); among others, a new open prison (capacity 60) had been brought into service in Jyväskylä and the new closed women's prison in Hämeenlinna (capacity 100) was to open in the end of September or early October 2020. A new open prison in Kerava (capacity 136) was scheduled for opening in October too. More long-term projects included the construction of a new prison in Oulu (with 100 places),⁷⁶ two other new closed prisons with 100 places each by 2023 and the extension (160 additional places in a new annex) of Vantaa Prison (planned to be completed by 2025).

The CPT welcomes the elimination of "slopping out" in Finnish prisons and invites the Finnish authorities to pursue their programme of modernisation of prison estate; in this context, the replacement of the current Oulu Prison by a new establishment should be a priority.⁷⁷ The Committee would like to be provided with an update on the implementation of the above-mentioned programme in the Finnish authorities' response to this report.

2. Ill-treatment

37. The delegation received no allegations of ill-treatment of prisoners by custodial staff in the penitentiary establishments visited. On the whole, inmates interviewed by the delegation stated that they were being treated correctly by prison staff. The delegation did observe though that in general custodial staff did not interact much with prisoners, spending a lot of their time in their control rooms and limiting their contacts to responding (via interphone) to inmate's requests.

At the outset of the visit, senior CSA officials told the delegation that instructions had been issued encouraging prison staff to interact more with inmates, in accordance with the principle of dynamic security.⁷⁸

⁷⁴ I.e. a situation where, in order to comply with their needs of nature, inmates were obliged to resort to buckets placed in their cells.

⁷⁵ The old prison had to be closed urgently in the autumn of 2018 because of serious technical and security-relevant issues. Female prisoners were transferred to other prisons (including Turku and Oulu Prisons, see paragraph 35 above) pending the completion of the new prison in Hämeenlinna (see below).

⁷⁶ See also paragraph 42 below. This was a joint project with the Ministry of the Interior, also aiming at accommodating in the new prison remand prisoners currently held in "police prisons" in the region.

⁷⁷ See paragraphs 42 and 45 below.

⁷⁸ Dynamic security is the development by staff of positive relationships with prisoners based on firmness and fairness, in combination with an understanding of their personal situation and any risk posed by individual prisoners (see Rule 51 of the European Prison Rules, <https://rm.coe.int/european-prison-rules-978-92-871-5982-3/16806ab9ae>, and paragraph 18.a of the Recommendation Rec (2003) 23 of the Committee of Ministers of the Council of Europe to member states on the management by prison administrations of life sentence and other long-term prisoners, https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805dec7a). Dynamic security also implies an adequate offer of constructive activities, see paragraph 47 below.

In the light of the delegation's findings during the 2020 visit, **the CPT recommends that these efforts be intensified and accompanied by appropriate initial and ongoing staff training.**⁷⁹

38. Inter-prisoner violence was not a major issue at *Oulu Prison*. Sporadic verbal altercations between inmates could occur but such incidents were responded to quickly by staff and inmates concerned placed in different units without any possibility of contact with each other. This was made easier by the fact that, as already mentioned in paragraph 35 above, Oulu Prison was essentially a remand facility and most of the prisoners did not associate much, except within their small units.

By contrast, there had been several recent violent incidents at *Turku Prison*, some of them resulting in serious injuries.⁸⁰ Management and staff tried their best to prevent and respond to violence between inmates, but – according to the establishment's Director – it was not an easy task given the characteristics of the prisoner population (with many gang members)⁸¹ and the shortage of qualified custodial staff.⁸² The Director expressed the view that the situation was likely to deteriorate further as the prison's population was increasing again after the temporary halt to the enforcement of prison sentences due to the Covid-19 pandemic (see also paragraph 36 above) and it was difficult to recruit qualified staff.⁸³

The Committee wishes to stress once again that the duty of care which is owed by the prison authorities to prisoners in their charge includes the responsibility to protect them from other prisoners who might wish to cause them harm. **The CPT again calls upon the Finnish authorities to take more decisive and proactive steps to prevent and stop inter-prisoner violence and intimidation.**⁸⁴ **The management and staff of Turku Prison must exercise continuing vigilance in order to make sure that no case of inter-prisoner violence and intimidation goes unnoticed, and make use of all the means at their disposal to prevent such cases. This will depend greatly on having an adequate number of staff present in detention areas and in facilities used by prisoners for activities.**⁸⁵

⁷⁹ See also paragraphs 55 to 57 below.

⁸⁰ Staff informed the delegation of two incidents in 2020, in which inmates had sustained serious injuries. In one case, a prisoner had been hit on his neck with a broken lamp and had sustained life-threatening injuries requiring urgent hospitalisation; in another incident, an inmate was stabbed in his eye with a pen (he underwent surgery and his eye could be saved). Further, there had been approximately 10 other incidents in 2020, with less severe injuries.

⁸¹ Staff estimated that approximately 10% of all prisoners were declared gang members, mostly "traditional" motorcycle gangs but also the United Brotherhood (a Finnish gang – which had united the previously existing gangs called Natural Born Killers, Rogues Gallery and M.O.R.E. – involved mainly in drug trade, financial crimes and security services), whose members had reportedly remained active in the prison despite the "official" announcement of cessation of activity in January 2020 (see https://yle.fi/uutiset/osasto/news/united_brotherhood_gang_says_it_is_shutting_down/11145648). According to the management of Turku Prison, gang members constantly attempted to put in place an unofficial criminal hierarchy and to operate a system of extortion vis-à-vis fellow inmates (e.g. charge them for free telephone calls, force them to smuggle drugs inside the prison, etc.). The management's response included frequent transfers of such prisoners between the units (or to other prisons).

⁸² See paragraph 56 below.

⁸³ See paragraph 56 below.

⁸⁴ See also the relevant case law of the European Court of Human Rights, especially in *Premininy v. Russia* (application No. 44973/04, judgment of 10 February 2011, paragraphs 87 – 90) and in *Gjini v. Serbia* (application No. 1128/16, judgment of 15 January 2019, paragraph 77).

⁸⁵ See also paragraphs 47 and 57 below.

39. An additional general problem – affecting the prison system as a whole – was that, in the absence of effective procedures for the recording and reporting injuries (see paragraph 51 below) and, consequently, the absence of reliable statistics, the prison administration had no accurate picture and no proper overview of the extent of the phenomenon of inter-prisoner violence (given that inmates who were victims of such violence often refused to make an official complaint).⁸⁶

The Committee recommends that steps be taken to eliminate this systemic *lacuna*; reference is also made here to the recommendation in paragraph 51 below.

40. Segregation and even isolation of the so-called “fearful”⁸⁷ (as well as “violent” or “difficult”) inmates also remained an issue of the CPT’s concern. At the outset of the visit, senior officials from the Ministry of Justice and the CSA told the delegation that the number of prisoners in need of protection had diminished since the 2014 visit.⁸⁸ Reportedly, this had mainly been due to the overall decrease of prison population but also to the more adapted infrastructure⁸⁹ of newly-built prisons.

Nevertheless, in both prisons visited, especially in Turku,⁹⁰ there was still a number of such prisoners⁹¹ and they continued to be subjected to extremely restrictive regimes, spending the bulk of their day (up to 23 hours) locked in their cells, with no purposeful activities. While genuine efforts were being made to address this problem,⁹² the Committee remains of the view that more efforts are required to provide adequate protection to this category of inmates, without resorting to isolation or use of regimes akin to solitary confinement.

The CPT calls upon the Finnish authorities to ensure that prisoners in need of protection (and other prisoners segregated because they are considered to be violent or otherwise “difficult”) have effective access to purposeful activities. In order to make this possible, staff presence should be increased in the relevant prisoner accommodation areas, especially in the closed units.⁹³

⁸⁶ On the other hand, whenever an official complaint was made, there generally was a proper and duly documented police inquiry (as the delegation could observe at Turku Prison, where there had been 11 such inquiries between 1 January and 1 September 2020).

⁸⁷ Referred to as “pelokas” in Finnish. Those were the inmates who were – for a variety of reasons – afraid of other prisoners and who were accommodated separately on their own request.

⁸⁸ While in 2014 the average daily number of “fearful” prisoners had been approximately 103 (i.e. some 4.7% of the total population of inmates in closed units/prisons), in 2019 that number had done down to 75 (i.e. some 3.8% of the total population in closed units/prisons).

⁸⁹ New prisons having a modular structure permitting to create smaller living units of a variable size (according to the needs) and thus to better separate potential victims and perpetrators.

⁹⁰ While, according to the Director, there was only one “official” “fearful” inmate at Turku Prison at the time of the delegation’s visit (who was *de facto* in solitary confinement), staff estimated that up to approximately half of the prisoners refused to participate in group activities – and for at least some of those inmates the reason was that they were afraid of their fellow prisoners.

⁹¹ Also in Oulu there were ten “fearful” prisoners (out of the total of 74 inmates at the time of the visit).

⁹² E.g. in Turku prisoners belonging to certain (potentially) vulnerable categories (Roma, sex offenders, etc.) were placed apart from others and staff were told to pay particular attention to them whenever they were in “risky” situations where contact with other prisoners was possible (e.g. on the way to/from outdoor exercise).

⁹³ See also paragraph 57 below.

Moreover, a proactive approach by the prison health-care service towards prisoners on protection is required, particularly as regards psychological and psychiatric care.⁹⁴ There should be an individual assessment of their needs at regular intervals and, where appropriate, transfer to another prison and/or to an appropriate treatment facility should be considered. Both such a proactive approach and such an individual assessment are at present not sufficiently developed in Finnish prisons.

3. Conditions of detention

a. material conditions

41. Material conditions were generally excellent at Turku Prison, which was a modern purpose-built establishment⁹⁵ in a very good state of repair and cleanliness. Inmates were accommodated in bright and airy single-occupancy cells measuring approximately 12 m² (not counting the surface of the fully-screened sanitary annexes with a toilet, a washbasin and a shower),⁹⁶ which were well furnished (a bed with full bedding, a desk, a chair, a chest and shelves) and often personalised with posters, pictures and plants. A lot of additional equipment (for coffee and tea making, fans, fridges, etc.) was in evidence. Further, prisoners had access to fully equipped kitchens (where they could prepare any extra food items purchased in the prison shop), washing machines and, once a week, to a sauna.

42. Despite the outdated infrastructure and the overall lack of space, material conditions were also quite good at Oulu Prison,⁹⁷ except for some of the “travelling cells”⁹⁸ which were rather dilapidated and humid.

The Committee notes the Finnish authorities’ plans to build a new prison in Oulu (see paragraph 36 above and **invites them to implement these plans as soon as possible. Pending this, steps must be taken to improve material conditions in the “travelling cells”.**

⁹⁴ See also paragraphs 53 below.

⁹⁵ The Director pointed out that the management and staff of the old Turku Prison (see paragraph 35 above) had been amply consulted when architectural plans for the new prisons were being drawn.

⁹⁶ As already mentioned in paragraph 35 above, a few of the cells in women’s units were temporarily accommodating two prisoners each, which was still acceptable according to the CPT’s minimum standards (see document CPT/Inf (2015) 44 “Living space per prisoner in prison establishments: CPT standards”, <https://www.coe.int/en/web/cpt/living-space-prisoners>).

⁹⁷ Cells (all single occupancy) measured between 10 and 15 m² (including – except in the open women’s unit – a fully screened sanitary annexe) and were well lit and ventilated. The equipment consisted of a bed with full bedding, a desk, a chair or a stool, a chest and a shelf. Prisoners also had access to kitchenettes (located in the units), to well-appointed communal toilets (unrestricted for inmates accommodated in cells without toilets), showers (at least twice a week) and to the sauna (once a week).

⁹⁸ Some of these cells (normally used to accommodate prisoners in transit, for a week maximum) were larger, e.g. a cell measuring some 60 m² and containing three bunk beds.

43. Inmates in the two prisons visited were offered the opportunity to take at least one hour of outdoor exercise every day (including on weekends). The exercise yards were generally sufficiently spacious, many of them being fitted with basic sports equipment, as well as provided with some means of rest; further, in case of rain or snow prisoners were provided with adapted clothing and shoes.

The only exception to this generally favourable situation was the rather small and oppressive-looking exercise yard (with no sky view) for remand prisoners on restrictions and other segregated prisoners at Oulu Prison.

The CPT recommends that ways be sought to provide those prisoners with better outdoor exercise possibilities, including with access to the establishment's 3 larger open-air exercise yards (used by the rest of the prisoner population).

b. regime

44. As already mentioned in paragraph 35 above, Turku Prison had extensive high-standard premises for activities (workshops⁹⁹ and classrooms¹⁰⁰) which were nevertheless (as acknowledged by the management and staff) rather underused at the time of the visit,¹⁰¹ mainly due to staff shortages.¹⁰² There were more prisoners willing to work and study than the establishment could provide, and so for the great majority of inmates¹⁰³ the main distractions (apart from reading,¹⁰⁴ watching TV, listening to the radio, playing computer and board games) were the visits to the gym¹⁰⁵ and the possibility to play billiard or table tennis during their association time (up to 3 hours per day).

45. Some very limited activities were also available at Oulu Prison, though the offer was severely restricted by both the lack of space and the profile of the prison (primarily a remand facility with a big prisoner turnover). Only eight prisoners had a job in a small carpentry workshop and one additional inmate worked as a cleaner. Some individual tuition was offered to young prisoners (aged below 21) who had missed their general education,¹⁰⁶ and upon request the prison allowed inmates to follow (online) distance classes. Other than that, possibilities for distraction were similar to those in Turku (reading, TV/radio, computer and board games, access to the large gym once a week and to smaller gyms 3 times a week).

⁹⁹ Metal, carpentry, upholstery, sewing, bookbinding.

¹⁰⁰ General primary and secondary education was dispensed, as well as vocational training (metal and woodwork) for some 40 inmates in total.

¹⁰¹ The workshops employed some 40 inmates while there was place for at least 60.

¹⁰² See paragraph 56 below.

¹⁰³ Approximately 200 out of 267.

¹⁰⁴ The prison had a large library with some 15.000 volumes.

¹⁰⁵ There was a large central indoor gym, available a few times a week but only for inmates from more open units, and small gyms in the units (with workout machines), accessible 3 times a week.

¹⁰⁶ Staff told the delegation that such tuition was usually provided by teachers from the nearby secondary school, either in person or online, to between six and ten inmates at any given time.

46. In both establishments visited the worst situation was observed with respect to remand prisoners subjected to restrictions¹⁰⁷ and other segregated inmates (on security grounds,¹⁰⁸ including the “fearful” ones¹⁰⁹).

Inmates from these categories spent the bulk of their time (up to 21 – 23 hours per day) locked in their cells, with no or hardly any organized activities and very little association (between 30 minutes and 3 hours each day, only with other inmates from the same category).

47. In the light of the remarks in paragraphs 44 to 46 above, **the CPT recommends that further efforts be made in order to provide all prisoners in the establishments visited with purposeful activities tailored to their needs (including work, vocational training, education and targeted rehabilitation programmes). Regarding, more specifically, remand prisoners subjected to restrictions, the longer the restrictions continue, the more resources should be made available to ensure that the prisoners concerned benefit from a programme of purposeful, and preferably out-of-cell, activities and are offered at least two hours of meaningful human contact every day (and preferably more).**¹¹⁰

As for sentenced prisoners segregated on security grounds,¹¹¹ the Committee wishes to stress that the existence of a satisfactory programme of activities is just as important – if not more so – for those prisoners: it can do much to counter the deleterious effects upon prisoners’ mental health and social skills of living in the bubble-like atmosphere of their small unit. Prisoners concerned should, within the confines of their detention units, enjoy a relatively relaxed regime by way of compensation for their severe custodial situation. They should be able to meet their fellow prisoners in the unit and be granted a good deal of choice about their activities (thus fostering a sense of autonomy and personal responsibility). **The CPT recommends that measures be taken to offer prisoners segregated on security grounds, at Turku Prison and elsewhere, structured programmes of constructive activities, preferably outside the cells, based on individual projects intended to provide prisoners with appropriate mental and physical stimulation.**

Regarding the “fearful” prisoners, reference is made to the remarks and recommendation in paragraph 38 above.

¹⁰⁷ Turku Prison was accommodating some twenty remand prisoners on restrictions, including approximately ten whose regime was so restricted that it resembled solitary confinement (see also paragraph 59 below).

¹⁰⁸ There were two such inmates in solitary confinement at Turku Prison, one of them sentenced to life imprisonment for a terrorist offence and the other who had committed a severe assault on a fellow inmate (see paragraph 38 above) and had attempted on several occasions to attack the staff; a further six sentenced prisoners could only associate with each other in their small unit and were not allowed to go to the workshops/classrooms. Typically, such prisoners were declared and active gang members with a history of violent behaviour (including vis-à-vis the staff).

¹⁰⁹ See paragraph 40 above.

¹¹⁰ See also paragraph 59 below.

¹¹¹ The delegation spoke with some of those prisoners and examined their files at Turku Prison, and was satisfied that the decisions regarding their placement were well documented and duly reviewed every 30 days, and that the relevant procedural safeguards were observed (in particular the right to be heard, access to legal assistance, written information on the grounds for the measure and on the avenues of complaint).

4. Health-care service

48. The Committee notes as a positive development the transfer, in 2016, of responsibility for the prison health-care service from the Ministry of Justice to the Ministry of Social Affairs and Health. This has had a positive impact on the health care staff's professional independence, skills improvement and career advancement, the oversight of the quality of care¹¹² and the continuity of care (before, during and after imprisonment).

49. However, as observed by the delegation during the 2020 visit, the above-mentioned transfer of responsibility did not appear to have brought about tangible improvements in prisons, as regards health-care staffing levels¹¹³ and presence (especially at night¹¹⁴ and on weekends¹¹⁵) and access to doctors (in particular specialists,¹¹⁶ including dentists¹¹⁷).

As previously, the burden of providing health care to prisoners rested primarily with the nurses who – although well qualified and experienced – could not be expected to replace doctors. The delegation also noted that medication (including psychotropic drugs) continued to be distributed by non-medical custodial staff, a practice criticized many times in the past.¹¹⁸

The CPT recommends that the health-care staff resources (general practitioners and nurses) be increased in both prisons visited. In particular, there should be at least the equivalent of a full-time general practitioner at Turku Prison. Further, steps should be taken to improve access to specialists, including to a dentist at Oulu Prison. The Committee also calls upon the Finish authorities to ensure that someone qualified to provide first aid (preferably a nurse) is always present, including at night, in the prisons visited (and, as applicable, in all the other penitentiary establishments). The current, highly questionable, practice of custodial staff distributing medication to prisoners should finally be discontinued.

The CPT would also like to receive confirmation that a replacement has been found for the general practitioner currently on long-term sick leave at Oulu Prison.

¹¹² By the National Supervisory Authority for Welfare and Health (Valvira).

¹¹³ Turku Prison (population 269) had seven full-time nurses and two part-time GPs (one coming 3 times a week and the other twice a week). As for Oulu Prison (population 74), the health-care staff team consisted of two full-time nurses and a GP visiting 3 times a week (however, the doctor had taken long-term sick leave a week before the visit and no replacement had yet been found at the time of the delegation's visit).

¹¹⁴ I.e., in fact, after 4.30 p.m.

¹¹⁵ Unlike in Oulu, there was some limited presence by nurses at Turku Prison on Saturdays and Sundays.

¹¹⁶ Especially at Turku Prison, the delegation heard several complaints about delays of access to the GP (reportedly up to 3 weeks) and even longer waiting times (up to 3 months) to see specialists such as an ophthalmologist or a gynaecologist; the latter was also confirmed by one of the staff members who stated that sometimes private consultations were arranged to avoid such excessive delays, but those were expensive. Waiting times of up to 3 months to see a specialist were also not uncommon at Oulu Prison. Regarding access to a psychiatrist, see paragraph 53 below.

¹¹⁷ While the delegation heard no complaints about dental care at Turku Prison, inmates in Oulu had to experience long delays because there was no dentist there (prisoners had to be sent to Pelso Prison, approximately 100 km away, which took a week minimum to arrange); only in real dental emergencies could inmates be taken to see a dentist at Oulu University Hospital.

¹¹⁸ See e.g. paragraph 77 of the report on the CPT's 2014 visit (document CPT/Inf (2015) 25).

50. Despite the CPT's long-standing recommendations on this subject, the delegation observed in both prisons that medical screening on arrival (consisting essentially of a questionnaire, without a proper medical examination) was still often delayed by up to 72 hours.¹¹⁹ In this context, **the Committee calls upon the Finnish authorities to take effective and energetic steps to ensure that a comprehensive medical screening of newly arrived prisoners is carried out systematically within 24 hours from arrival.**¹²⁰

51. The CPT is also disappointed by the fact that its repeated recommendations concerning the recording and reporting of injuries observed on prisoners have remained largely unimplemented; in particular, injuries were usually poorly recorded and were not reported unless the prisoner concerned consented to this. There was thus a real risk that some medical evidence of ill-treatment (or inter-prisoner violence) could be lost because the inmate concerned would be afraid to consent, and therefore ill-treatment (or inter-prisoner violence) would remain undetected.

Consequently, **the Committee once again calls upon the Finnish authorities to amend the relevant legislation and review the existing procedures in order to ensure that whenever injuries are recorded which are consistent with allegations of ill-treatment made by a prisoner (or which, even in the absence of allegations, are indicative of ill-treatment or inter-prisoner violence), the report is immediately and systematically brought to the attention of the competent authorities (e.g. the police and/or the prosecutor), regardless of the wishes of the prisoner. The results of the examination should also be made available to the prisoner concerned and his or her lawyer; the health-care professional should advise the prisoner concerned that the writing of such a report falls within the framework of a system for preventing ill-treatment (and inter-prisoner violence) and that the automatic forwarding of the report does not substitute for the lodging of a complaint in proper form.**¹²¹

The CPT also wishes to recall that any record drawn up after such an examination should contain:

- (i) **an account of statements made by the person which are relevant to the medical examination (including his/her description of his/her state of health and any allegations of ill-treatment or inter-prisoner violence);**
- (ii) **a full account of objective medical findings based on a thorough examination;**
- (iii) **the doctor's observations in the light of i) and ii), indicating the consistency between any allegations made and the objective medical findings.**

The record should also contain the results of additional examinations performed, detailed conclusions of any specialised consultations and an account of treatment given for injuries and of any further procedures conducted.

¹¹⁹ It is to be stressed nevertheless that the CPT has no concerns regarding the screening and treatment for transmissible diseases (HIV, TB, hepatitis B) in the prisons visited. Regarding Covid-19, see paragraph 52 below.

¹²⁰ See also paragraph 14 above.

¹²¹ Reference is also made here to more detailed standards contained in the substantive section of the CPT's 23rd General Report ("Documenting and reporting medical evidence of ill-treatment"), in particular in paragraphs 73 to 82 (document CPT/Inf (2013) 29, <https://www.coe.int/en/web/cpt/medical-evidence-ill-treatment>).

The recording of the medical examination in cases of traumatic injuries should be made on a special form provided for this purpose, with "body charts" for marking traumatic injuries that will be kept in the medical file of the prisoner.

In addition to this, all injuries should be photographed in detail and the photographs kept, together with the "body charts" for marking traumatic injuries, in the prisoner's individual medical file. This should take place in addition to the recording of injuries in the special trauma register.

52. The aforementioned somewhat superficial character of the initial medical screening and the insufficient presence of health care staff were particularly problematic during the Covid-19 pandemic. Although both prisons visited were considered (by the management) as "Covid-19 free" at the time of the visit (as were apparently all the other penitentiary establishments), having in place proper screening procedures and securing a sufficient health-care staff presence at all times would no doubt be beneficial in case of a possible worsening of the epidemiological situation in the country in general¹²² and in the prisons concerned in particular. With this in mind, **reference is made once again to the recommendations in paragraphs 49 and 50 above.**

In both penitentiary establishments visited general preventive measures had been taken in the context of the Covid-19 pandemic, such as the provision of written information (in different languages) to inmates and staff, encouraging inmates to keep a safe physical distance whenever possible, and providing sanitizer and masks to staff and inmates.¹²³ If staff observed any inmate displaying symptoms suggestive of Covid-19 (or if a prisoner reported such symptoms to the staff), the prisoner concerned would be placed in medical isolation and a PCR test would be performed as quickly as possible; while awaiting the outcome of the test, all contact persons would be quarantined.¹²⁴ Prisoners returning from outside the establishment (e.g. from a prison leave or from court) were systematically quarantined and tested as well.¹²⁵

All in all, the measures taken so far appeared to be adequate at the time of the visit.¹²⁶ However, should the epidemiological situation deteriorate, further steps might be required. In this context, **reference is made to two statements issued by the Committee on this subject,¹²⁷ including on the importance of increasing staff resources and improving significantly the medical screening upon admission (as well as Covid-19 testing of newly-arrived prisoners).**

¹²² It is noteworthy that, compared with the situation at the time of the visit (see paragraph 15 above), the epidemiological situation had indeed worsened in the months following the visit. At the time of drafting of this report (early February 2021), the latest available figures (as of the end of January 2021) suggested a seven-day incidence of 47 new Covid-19 cases per 100.000 inhabitants.

¹²³ Only in confirmed or suspected (especially symptomatic) cases, in accordance with the national sanitary guidelines.

¹²⁴ One of the women's units at Oulu Prison was under quarantine when the delegation visited the establishment, but this was lifted the following day after the test results came negative.

¹²⁵ Three of the "travelling cells" at Oulu Prison (see paragraph 42 above) had been set aside for this purpose.

¹²⁶ Apart from the above-mentioned deficiencies in terms of medical screening and health-care staff presence.

¹²⁷ "Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (Covid-19) pandemic" (document CPT/Inf (2020) 13, issued on 20 March 2020, <https://www.coe.int/en/web/cpt/-/covid-19-council-of-europe-anti-torture-committee-issues-statement-of-principles-relating-to-the-treatment-of-persons-deprived-of-their-liberty->) and "Follow-up statement regarding the situation of persons deprived of their liberty in the context of the ongoing Covid-19 pandemic" (document CPT/Inf (2020) 21, issued on 9 July 2020, <https://www.coe.int/en/web/cpt/-/covid-19-cpt-issues-follow-up-statement>).

53. As regards the psychiatric care¹²⁸ and the psychological assistance,¹²⁹ both remained very problematic, as acknowledged by senior officials met at the outset of the visit and by the management and staff in the prisons visited. This was of particular concern given the presence in both prisons of numerous inmates with mental health-related issues.¹³⁰

At the time of the visit, there were two ongoing research projects concerning mental health in prison, one run jointly by Riihimäki Prison and Tampere University, another by Valvira and Helsinki University. **The CPT would like to be informed, in due course, of the outcome of these projects and – in particular – of any concrete measures taken or envisaged in consequence.**

On a more local level, **the Committee recommends that regular visits by a psychiatrist be ensured at Oulu Prison and that the frequency of the psychiatrist's regular visits to Turku Prison be increased.**¹³¹

Further, **the CPT recommends that all the vacant posts for psychologists be filled in both prisons visited.**

54. Inmates' addiction to substances (mainly alcohol and drugs) remained a major challenge for the prison health-care services in Finland. In this context, the delegation noted that a drug-free unit existed at Turku Prison,¹³² offering opioid agonist therapy,¹³³ rehabilitative programmes and prospects to advance to a more open regime, to early release and further rehabilitation after release. No such dedicated unit existed at Oulu Prison, which was rather understandable considering the profile of the establishment (essentially for remand prisoners) and the generally short average periods inmates spent at Oulu Prison.¹³⁴ That said, some counselling was reportedly offered to prisoners in need by a specialised nurse (see paragraph 53 above) although the delegation was not in a position to discuss it with her on the day of the visit and at least two of the interviewed prisoners told the delegation that they would have wanted to receive help with their addiction problem but that it was not possible in practice. **The Committee would like to be provided with more detailed information on this subject.**

¹²⁸ There was no psychiatrist at Oulu Prison (if required, reliance was had on online consultations or inmates could be transferred to the Psychiatric Hospital for Prisoners in Turku). Turku Prison employed a psychiatrist occupying 80% of a post and visiting the establishment three times a week.

¹²⁹ Turku Prison had only one psychologist occupying 80% of a post, while there were 3 posts for psychologists foreseen. The situation was (even) worse at Oulu Prison where the psychologist's post had been vacant for a long time; meanwhile, the prison had hired a third nurse (specialized in mental care and addictions) who also replaced the social worker (on long-term sick leave).

¹³⁰ According to the management and the health-care staff with whom the delegation spoke, approximately 80% of all inmates in Turku Prison and approximately 70% in Oulu Prison were on some type of psychiatric medication.

¹³¹ Something that should not (*a priori*) be excessively difficult to achieve, given the existence of the Psychiatric Hospital for Prisoners right next door to Turku Prison (see also paragraphs 35 and 53 above).

¹³² With 15 prisoners at the time of the visit.

¹³³ Available options included methadone, buprenorphine (Buvidal in injections) or buprenorphine and naloxone (Suboxone orally). If a prisoner received treatment before coming to the prison, he/she could continue the same treatment.

¹³⁴ As a rule, prisoners who needed and wanted help with their addiction problems would be offered such assistance once transferred to the establishment where they were supposed to serve their sentences.

5. Other issues

55. At the outset of the visit, the delegation was informed by senior officials from the Ministry of Justice and the CSA that, due to financial constraints, 17% of posts for prison staff had had to be cut between 2006 and 2016. It remained the case during the 2020 visit that the budget of the prison service did not allow recruiting new staff, as apparently most of the resources were absorbed by the ongoing prison (re)construction programme (see also paragraph 36 above) and the development of new electronic records (the so-called “client information system”).¹³⁵

56. Unfortunately, the negative consequences of this state of affairs were conspicuous in the two prisons visited.

At *Turku Prison* (capacity 255), the delegation was told that the number of prison staff posts had been cut from 248 in 2007 to 180 at the time of the 2020 visit, and there could be as few as four custodial officers present in the whole detention area at night, which – as acknowledged by staff – would have been totally insufficient in case of any incident.¹³⁶ The situation was better during the day time, with up to 11 officers effectively present per block (one to three per floor, each floor accommodating 40 to 60 prisoners), but the staffing levels were still insufficient to fully ensure inmates’ access to association and organised activities.¹³⁷ This was exacerbated by the fact that, due to the severe deterioration of prison staff training (again, because of financial constraints), the establishment had been obliged to recruit untrained staff; approximately 20% of custodial staff had been recruited without any prior theoretical training and had taken up their duties after merely 3 days of practical in-service training. The Director explained to the delegation that attempts were being made to ensure that at least one experienced and well-trained custodial officer could be present on every shift on each floor, as otherwise untrained and inexperienced custodial staff would have to interact with challenging inmates, many of them (as already mentioned in paragraph 38 above) being active gang members with a history of violent behaviour. Unsurprisingly (as also stressed by a staff trade union representative with whom the delegation spoke), the situation was a source of constant stress for custodial staff, made even worse by significant accumulated overtime.

Staffing situation was in theory somewhat better at *Oulu Prison* (capacity 86),¹³⁸ but in reality, staff presence was totally inadequate because custodial officers were engaged in escort duties in addition to their normal tasks. The Director told the delegation that sometimes there was only one custodial officer present on each floor as other colleagues were away escorting inmates to/from police prisons, to/from courts, hospitals, etc. As was the case in *Turku*, recruiting qualified prison staff was reportedly extremely problematic.

¹³⁵ The budget for this new records system had apparently “exploded” from the initially planned 13 to 37 million EUR and the system was still not operational.

¹³⁶ See paragraph 38 above.

¹³⁷ See paragraph 44 above.

¹³⁸ With eight custodial staff present during the day but only four at night (after 4.30 p.m.).

57. **The CPT recommends that the Finnish authorities ensure, including by providing adequate financing, that there is enough duly trained staff (especially custodial officers) in all prisons, including at Turku and Oulu Prisons.** Indeed, without truly significant progress in this area, it will be impossible to implement the Committee's recommendations concerning the development of positive staff-prisoner relations (see paragraph 37 above), preventing and combating inter-prisoner violence (see paragraph 38 above) and enlarging the offer of constructive out-of-cell activities (see paragraph 47 above).

58. Regarding contact with the outside world, the delegation was informed at the outset of the visit of extensive amendments to the Imprisonment Act and Remand Imprisonment Act passed in 2015, providing *inter alia* access to the Internet/e-mail to inmates, to private mobile phones (in open prisons)¹³⁹ and to video meetings (through VoIP). As previously, inmates were allowed one 45-minute visit per week and offered the opportunity for an additional 3-hour family visit¹⁴⁰ every few months.¹⁴¹ A temporary ban on visits, due to the Covid-19 pandemic, had ended in June 2020. It is noteworthy that while the ban was in force, prisoners without restrictions could make additional phone calls and had access to extra video meetings.

That said, the delegation observed that short-term visits continued, as a rule, to take place in closed-type facilities (with a plexiglass separation). It is to be recalled here that, according to the CPT, the rule should be inversed, open visiting facilities being the norm. **The Committee reiterates its recommendation that the current practice be reviewed so as to ensure that closed-type visiting facilities are used only to the extent and for the time justified by any threat (e.g. of smuggling illicit substances or other prohibited items, or the necessity to prevent the spread of transmissible diseases) that the prisoners concerned (or their visitors) effectively represent.**

59. As already mentioned (see paragraph 46), both prisons visited were accommodating remand prisoners with court-imposed restrictions, including on contacts with the outside world.¹⁴² The delegation noted that some of those prisoners had been prohibited from receiving visits and/or making/receiving phone calls for prolonged periods (frequently for 4 to 6 weeks, in a few cases for up to 6 months and even, in one case, 9 months).

The CPT wishes to stress once again that all prisoners, including remand prisoners, should have access to a telephone. This principle is enshrined in the European Prison Rules.¹⁴³ If there is a risk of collusion, particular telephone calls can be monitored. It also recalls that all prisoners (whether sentenced or on remand), irrespective of the regime, should benefit from a visiting entitlement of at least one hour every week. **The Committee calls upon the Finnish authorities to ensure, including through legislative amendments, that this is always the case.**

¹³⁹ There were pay phones in every unit in the prisons visited and prisoners could use them every day (for at least 10 minutes, often longer).

¹⁴⁰ Also referred to (on male units) as a "father and child" visit. In addition, sentenced prisoners could be granted a prison leave.

¹⁴¹ Prisoners had to make a request for such visits, which were as a rule granted unless the prisoner concerned had a record of poor behaviour during preceding family visits.

¹⁴² E.g. there were eight remand prisoners on full restrictions at Oulu Prison at the time of the visit and, according to the staff, every day between 15 and 30 inmates on partial restrictions (e.g. visits and calls allowed with the closest family but not friends).

¹⁴³ Rules 24 and 99.

60. The aforementioned 2015 amendments to the Imprisonment Act and to the Remand Imprisonment Act had also shortened the maximum length of disciplinary solitary confinement from 14 to 10 days and removed from both laws the obligation to consult health care personnel before placing a prisoner in solitary confinement (a “fit for punishment” certificate). Further, disciplinary solitary confinement could no longer be applied in respect of juvenile inmates. These changes are to be welcomed.

Recourse to disciplinary solitary confinement did not appear excessive in either of the prisons visited,¹⁴⁴ and conditions in disciplinary cells were very good in Turku¹⁴⁵ and adequate in Oulu.¹⁴⁶ The disciplinary procedure contained appropriate safeguards, including the right to be heard, to call witnesses and the possibility of appeal the sanction in court.¹⁴⁷ In short, the situation in this respect was fully satisfactory for the CPT.

61. As regards complaints’ procedures, the Committee is pleased to note that *external* complaints’ mechanisms continued to be well established; further, in the two prisons visited the delegation gained the impression that prisoners generally knew and understood these mechanisms and were making use of them.¹⁴⁸

The issue of concern that had remained from the previous CPT’s visit to Finland (in 2014) was related with the *internal* complaints’ procedure, namely there were still no complaint boxes and internal complaints were not systematically recorded and followed up. In this connection, **the Committee reiterates its recommendation that prisoners be enabled to make written complaints at any moment and place them in a locked complaints box located in each accommodation unit. All written complaints should be registered centrally within a prison before being allocated to a particular service for consideration. In all cases, internal complaints should be processed expeditiously (with any delays duly justified in writing) and prisoners should be informed within clearly defined time periods of the action taken to address their concerns or of the reasons for considering the complaint inadmissible or unjustified. In addition, statistics on the types of internal complaints made should be kept as an indicator to the management of areas of discontent within the prison.**

Regarding the independent monitoring of prisons, this was performed on a regular basis by the Parliamentary Ombudsman (and his staff), in his capacity as the NPM.¹⁴⁹

¹⁴⁴ At Turku Prison there had been 42 disciplinary sanctions (of all kinds, not only solitary confinement but also warnings, reprimands, etc.) in 2019 and 23 in the period between 1 January and 1 September 2020. At Oulu Prison, there had been 43 sanctions in 2019 and 19 between 1 January and 1 September 2020. The average duration of disciplinary solitary confinement was of 2 to 3 days.

¹⁴⁵ E.g. the bright and airy cells at Turku Prison measured 12 m² each and were equipped with a bed with full bedding, a table, a stool and a fully screened sanitary annexe; there were also a few more secure cells for inmates suspected of possible self-harm tendencies (with a sleeping platform, a mattress, a pillow and a blanket, as well as a secure stainless toilet and a washbasin). Inmates placed in these cells could take an hour of outdoor exercise each day, in dedicated yards measuring some 30 m².

¹⁴⁶ Oulu Prison had no dedicated cells for disciplinary solitary confinement: if needed, two of the “travelling cells” could be used for this purpose (see paragraph 42 above) and TV sets would be taken away from the cells for the duration of the sanction.

¹⁴⁷ The right to appeal had been reinforced by the said 2015 amendments: a provision had been added making it clear that the prison’s administration must inform the prisoner in writing of the grounds of the sanction and his/her right to appeal.

¹⁴⁸ For example, the Ombudsman had received some 50 complaints from prisoners in the period from 1 January to 1 September 2020, in relation with Covid-19 measures in prisons (such as temporary bans on visits).

¹⁴⁹ The last visit to Turku Prison had taken place in 2019, and to Oulu Prison approximately 3 years before.

D. Psychiatric Department of Helsinki University Hospital (Kellokoski)

1. Preliminary remarks

62. Administratively, the Ministry of Social Affairs and Health is responsible for the general planning, direction and supervision of mental health care while the Regional State Administrative Agencies, guided by the National Supervisory Authority for Welfare and Health (“Valvira”), are in charge of the operational planning, direction and supervision of mental health care within the regions. The practical organisation of health care services (including mental health) is carried out by the municipalities.

63. The main law governing psychiatric care in Finland is the Mental Health Act (*mielenterveyslaki*).¹⁵⁰ In addition, the status and the rights of patients - including patients with mental health disorder - are stipulated in the Act on the Status and Rights of Patients (*potilaslaki*).¹⁵¹

Since the CPT’s 2014 visit, several attempts have been made to introduce new legislation aimed at strengthening patients’ rights on the one hand and specifying the criteria for restricting their rights on the other hand. The last such attempt to adopt a “Client and Patients Law” (*asiakas- ja potilaslaki*), failed in 2018 at the end of the previous legislative period.¹⁵²

The delegation was informed by the Finnish authorities at the outset of the visit, that a new working group was about to be set up in order to continue these works as of autumn 2020. **The CPT would like to be informed about the further progress made in the drafting of new legislation regarding patients’ rights and restrictive measures in health care establishments.**

64. The CPT visited for the first time the Psychiatric Department of Helsinki University Hospital at Kellokoski (hereinafter “Kellokoski Hospital”). The hospital, situated 40 km north of Helsinki near the village of Kellokoski, had been founded in 1915 and was relocated to a newer hospital building in the vicinity in 2019. It accommodates forensic and civil patients - including many long-term patients and treatment-resistant patients transferred from other (regional and state) psychiatric hospitals. It also carries out court ordered forensic assessments. In 2019, 161 patients in total had been admitted to the hospital. Patients stayed at the hospital on average for 117 days (2019), but many considerably longer. One patient had been held at the hospital for 15 years.

The linear-shaped five-storey hospital building comprises six closed mixed-sex wards connected by a central staircase.¹⁵³ With a capacity of 120 beds, the hospital was fully occupied at the time of the visit, accommodating 21 women and 99 men. Juveniles were generally not admitted to the hospital.

¹⁵⁰ Act No. 1116/1990.

¹⁵¹ Act No. 785/1992.

¹⁵² The draft had been designed to comprehensively regulate rights and restrictions for persons in various health and social care institutions by defining different criteria e.g. for forensic and civil patients with mental health disorder, for persons with learning disabilities, substance dependent persons and for elderly persons with memory impairment.

¹⁵³ In addition, there is an open ward which accommodates long-stay forensic patients in the process of preparing their discharge.

The majority of patients had been diagnosed as suffering from (paranoid) schizophrenia or schizo-affective disorders, sometimes combined with personality disorders or substance dependence.

65. The delegation was informed that the Ministry of Social Affairs and Health plans to construct a new psychiatric hospital with a forensic department in Helsinki until 2025. **The CPT would like to receive information about the further progress in this respect.**

66. During the visit, the delegation received no allegations of any form of deliberate physical ill-treatment of patients by staff. That said, concerning prolonged application of belt restraint, reference is made to paragraph 83 below.

A few accounts of inter-patient violence were reported to the delegation. However, the delegation gained the impression that staff generally reacted promptly and adequately to such incidents.

2. Patients' living conditions

67. The living conditions at the hospital were very good, contributing to a positive treatment environment. Patients were accommodated in spacious and adequately furnished single or double rooms which had good access to natural and artificial light and were clean and in a good state of repair. In addition, the communal sanitary facilities (toilets, showers) were well maintained and clean. Patients also had access to pleasantly furnished communal areas with open kitchens on their wards (equipped with TV sets and computers with internet access) and every patient had a locker for his/her personal belongings.

3. Staff

68. The staff complement at Kellokoski Hospital (with its 120 beds) comprised in addition to the director ten full-time medical doctors, who were all general psychiatrists, forensic psychiatrists or trainee psychiatrists. In addition, there were four psychologists, four social workers, 18 occupational therapists, 143 qualified nurses (including 56 mental health nurses) and 11 assistant nurses.

During the day shifts, four to seven nursing staff members were present on each ward. At night, two or three nursing staff members were present on each ward, one doctor was present in the hospital and another one was available on call.

69. While the staffing levels on most wards appeared to be sufficient for the number of patients and care required, the staffing situation on ward P10, which accommodated some of the most challenging patients, appeared to be sometimes inadequate.¹⁵⁴ This was mainly due to the fact that in addition to the eight regular beds, this ward comprised all of the hospital's six seclusion rooms, which were also the only rooms where mechanical restraint was applied to patients. If one or several particularly challenging patients were present – and in particular when they were placed in seclusion or even under mechanical restraint - the ward staff had many additional tasks and could barely provide quality care for the other patients. To ease their burden in such situations, an additional nursing staff member was at times assigned to this ward, but reportedly not for all shifts. This appeared to be insufficient. **The CPT therefore recommends that the possibilities to (temporarily) reinforce nursing staff presence on wards accommodating particularly challenging patients at Kellokoski Hospital be reviewed.**

70. Patients had two or three designated nurses in charge of their care who were supposed to be their primary contact persons. This is a commendable concept.

However, it transpired from interviews that on some wards (mainly on wards P10 and P20) many patients' relations with staff, including with their designated nurses, were rather distant or even tense. Several patients told the delegation that they had very few interactions with staff and felt that staff were not interested in them and/or sometimes acted in a disrespectful manner. Staff were seen by a number of these patients mainly as their "custodians", responsible for ward security rather than care. As regards wards accommodating particularly challenging patients, this may at least partly be due to the ward staff's heavy workload (see preceding paragraph). Nevertheless, there was an obvious need for increased emphasis on fostering positive and trustful staff-patient relationships.

The CPT recommends that decisive measures be taken to foster positive and trustful nursing staff-patient relationships at least at some wards of Kellokoski Hospital. In this context, reference is also made to the recommendation made in the preceding paragraph.

4. Treatment

71. It is commendable that comprehensive individual treatment plans were drawn up for all patients upon their admission and that they were regularly reviewed by a multi-disciplinary team. In this context, the patients' views were also noted.

72. As regards access to the outdoor areas, many of the patients were allowed to move around freely, alone or accompanied by family members, also outside the hospital building. The other patients could go to one of the two secure outdoor yards¹⁵⁵ at the back of the hospital building via the hospital's central staircase (or by using the elevator), when accompanied by staff. Access to these yards was coordinated for patients from different wards in shifts which usually lasted 30 minutes, in principle twice per day for each ward.

¹⁵⁴ At ward 10, five nursing staff members were normally present during the day shifts and three at night.

¹⁵⁵ The yards were large fenced outdoor areas with greenery and equipped with benches, tables and some shelter against inclement weather.

That said, some patients told the delegation that on some days access to the outdoor yards was granted for less than one hour or occasionally not even offered at all.

In the CPT's view, patients with mental health disorder should generally, health permitting, benefit from unrestricted access to outdoor areas during the day, unless treatment activities require them to be present on the ward. The CPT acknowledges that the current architecture of Kellokoski Hospital makes it difficult to enable patients to access the secure yards freely, as the yards are not directly accessible from the wards (which requires patients to be accompanied by staff).

Therefore, the Committee recommends that the necessary steps are taken at Kellokoski Hospital to ensure that patients' access to the outdoor areas is considerably increased. The aforementioned aim of generally unrestricted access to outdoor areas during the day should further be taken into account for the design of new psychiatric hospitals, including the one planned to be built in Helsinki in the coming years (see paragraph 65 above).

73. The programme of therapeutic activities at Kellokoski Hospital included individual and group therapy sessions with a psychologist, a substance abuse group, music therapy sessions and work therapy (e.g. packaging).

In addition, a range of rehabilitative and recreational activities was offered to those patients, who were allowed to move freely in the hospital's grounds. They had access to a gym, a sauna, a swimming pool and crafts workshops, could join a sports or a cooking group, go for walks outside or help (on a voluntary basis) maintain the hospitals green outdoor areas. This is commendable.

However, the offer of rehabilitative and recreational activities was much more limited for those patients whose movements were restricted. An occupational therapist and/or a physiotherapist offered activities at least on some wards several times a week or took patients to the gym. Some patients could also join an activity group, e.g. the cooking group. However, a number of patients spent most of their time in the common ward areas (or their rooms), watching TV, playing board games or using the internet. In this connection, several patients claimed that they felt bored and that there were very few activities offered to them. **The CPT recommends that the treatment of all patients – including those whose movements are restricted - comprises a wide offer of therapeutic, rehabilitative and recreational activities. As an absolute minimum, every patient should be offered the opportunity to participate in organised activity every day and should be motivated by staff to participate.**

74. As regards the frequency of psychiatric consultations, a number of patients from different wards (including acute wards) told the delegation that they were met by their psychiatrists only once or sometimes twice per month or even only once in two months. A few patients also said that the meetings with their psychiatrists sometimes lasted only a few minutes. In this context, a few patients alleged that the doctors' weekly entries in the individual files concerning the patient's mental state were not always based on meetings with them but presumably on information received from nursing staff (with whom a number of them had rather poor relations, see paragraph 70 above).

Given the profile of the patients, many of whom suffered from severe mental disorders - some of which were at an acute stage - the frequency (and possibly sometimes the duration) of meetings with the psychiatrists would not appear to be particularly high.

The CPT encourages the management of Kellokoski Hospital to increase the time medical staff spends in direct personal contact with patients, with the aim of developing trusting therapeutic relationships, facilitating co-operation and reviewing the patients' treatment plans. Experience has shown that this would very likely also contribute to decreasing the need for coercive measures. Reference is further made to the recommendation in paragraph 70.

75. The delegation was informed that the hospital resorted rarely to electroconvulsive therapy (ECT), and only applied as a last-resort measure to treat life-threatening conditions.¹⁵⁶ Physically, it was carried out at a nearby somatic hospital¹⁵⁷ and recorded in a register on involuntary treatment measures.¹⁵⁸ However, the patients' written consent was generally not sought before resorting to this therapy.

The CPT reiterates its recommendation that steps be taken at all psychiatric hospitals in Finland to ensure that patients' written informed consent is always sought before resorting to ECT (and that this be reflected in the relevant documentation).

76. The arrangements for somatic care did not pose major difficulties. Consultations with external general practitioners were offered at the hospital once a week, and specialist care was provided at a nearby health care centre.

5. Means of restraint

77. In reaction to violent behaviour, patients could be subjected to manual control (holding), mechanical restraint in a fixation bed, seclusion or chemical restraint.

78. The hospital had detailed internal guidelines on restraint measures, including "involuntary administration of medication" (which would in practice include chemical restraint). Further, apart from chemical restraint (see paragraph 88), all incidents of restraint measures were recorded as such in a central register on involuntary measures and in the patients' individual medical files.

79. As regards manual control techniques, all nursing staff underwent training in reacting to actual or potential aggression (including yearly refresher courses) and no complaints were received from patients concerning the application of holding techniques. This is positive.

80. Mechanical restraint could be applied to patients in two of the seclusion rooms (see paragraph 84) which were each fitted with a fixation bed (6-point belt restraints).

¹⁵⁶ In application of paragraph 22b of the Mental Health Act.

¹⁵⁷ Reportedly always with anaesthesia and muscle relaxants and administered by specially trained staff.

¹⁵⁸ The director explained to the delegation that ECT was always registered as involuntary when it was considered necessary from the medical point of view, even if the patient agreed.

81. Mechanical restraint was usually ordered by the ward doctor and in emergency cases by nurses who immediately called for a doctor to attend. The doctor thereafter saw the patient about three times per day to review the need for continued fixation. In cases of prolonged fixation, the director's deputies were also sometimes informally consulted. Throughout the measure, the patients concerned were under permanent direct personal supervision¹⁵⁹ by a member of staff. This is commendable.

82. The Committee further gained the positive impression that efforts were made to reduce recourse to mechanical restraint at Kellokoski Hospital. In 2018, it had been resorted to in 57 cases, in 2019, in 45 cases and in the first four months of 2020 in eight cases (at the hospital which had 120 beds).

83. Mechanical restraint was usually applied for periods of about one hour up to one or two days and on several occasions for much longer.¹⁶⁰ The longest instance of mechanical restraint in 2019 had lasted in one exceptional case for 27 days¹⁶¹ and in the first four months of 2020 seven days.

The CPT acknowledges the fact that the hospital accommodates a very specific patient population, many of whom display particularly challenging behaviour. However, in the CPT's view, the duration of belt restraint should be minutes rather than hours. Mechanical restraint for days on end could easily be considered as amounting to ill-treatment.¹⁶²

The CPT recommends that the management of Kellokoski Hospital further increases its efforts to reduce the duration of mechanical restraint. In case of an exceptional prolongation of mechanical restraint beyond a period of a few hours, the measure should be reviewed by a psychiatrist at short intervals. Consideration should be given in such cases and where there is repetitive use of mechanical restraint to the involvement of a second doctor.

84. The hospital had six seclusion rooms which were sufficient in size (between 8 and 13 m²) bright, well-ventilated, clean, and equipped with a mattress on the floor (or, if used for fixation, with a fixation bed). Four of the rooms were equipped with a toilet and washbasin and there was a separate toilet facility in the corridor for patients accommodated in one of the rooms without toilet.¹⁶³ All the rooms were also monitored by a CCTV camera and had a functioning call bell.¹⁶⁴

¹⁵⁹ Usually in a small annex room with the door open to the seclusion room in which the patient is placed.

¹⁶⁰ For instance, mechanical restraint was applied for more than two days in 2018 six times, in 2019 five times and in the first four months of 2020 once. The median period of mechanical restraint had lasted in 2018 for 14 hours and 10 minutes, in 2019 for 3 hours and 7 minutes and in the first four months of 2020 for 22 hours and 35 minutes.

¹⁶¹ The patient was subsequently referred to a state forensic hospital, as Kellokoski Hospital had found itself unable to release her from the restraints.

¹⁶² See judgement of the European Court of Human Rights in *Aggerholm v. Denmark*, Application No. 45439/18, issued on 15 December 2020, paragraphs 84 and 114.

¹⁶³ There was also a shower in the corridor for patients held in a seclusion room.

¹⁶⁴ While placed in a seclusion room, patients could generally wear their personal clothes.

However, the CPT has misgivings about the fact that the general appearance of the seclusion rooms was carceral. The rooms were equipped with heavy iron doors with hatches and three massive bolts for locking, as are used for isolation cells in prisons. Such a design is not conducive to a positive treatment environment and is unnecessary in a psychiatric hospital. **The Committee encourages the Finnish authorities to take these considerations into account, including for the design of the new psychiatric hospital planned to be built in Helsinki in the coming years** (see paragraph 65).

85. Seclusion was ordered by the ward doctor who usually visited the patient thereafter about twice per day. As was the case for mechanical restraint, the director's deputies were apparently sometimes informally involved in the reviews of longer lasting seclusion measures.

The CPT attaches particular importance to the direct personal supervision of patients held in seclusion, which should maintain the therapeutic alliance with the patients and provide them with assistance. At Kellokoski Hospital, patients in seclusion were - in addition to CCTV surveillance¹⁶⁵- usually visited by health care staff about six times per day and sometimes mainly to deliver the meals. This is clearly insufficient.

The Committee recommends that every patient held in seclusion be subjected to continuous direct personal supervision by a qualified member of staff. The staff member may be outside the patient's room (or in an adjacent room with a connecting window), provided that the patient can fully see the staff member and the latter can continuously observe and hear the patient. Clearly, video surveillance cannot replace continuous personal staff presence.

86. Moreover, the Committee has misgivings about both, the high frequency and the length of resort to this measure at Kellokoski Hospital. In 2018, patients had been placed in seclusion on 284 occasions (at the hospital which had 120 beds), in 2019 on 215 occasions, and in the first four months of 2020 on 60 occasions. The measure had been applied to patients in 2018 for a median duration of 21h30min, in 2019 for a median duration of 22h30min, and in the first four months of 2020 for a median duration of 1 day and 4 hours.¹⁶⁶ The longest instance of seclusion had lasted in 2019 for 14 days and in the first four months of 2020 for 33 days.

Given the possible detrimental effects of seclusion on the patient concerned, the CPT would like to reiterate its view that seclusion, as any other means of restraint, should always be a measure of last resort and should be terminated as soon as the patient has calmed down. The Committee has serious doubts as to whether seclusion of patients for several days is justifiable.

The CPT therefore recommends that the management of Kellokoski Hospital further increase their efforts to reduce the frequency and duration of seclusion of patients.

¹⁶⁵ A staff member was designated in each case to permanently observe the patient via the CCTV monitor.

¹⁶⁶ Patients were placed in seclusion for more than two days in 2018 50 times, in 2019 48 times and in the first four months of 2020 eleven times.

87. The delegation further gained the impression that after the end of a restraint measure (seclusion or fixation), a debriefing with the patient frequently took place as required by the hospital's internal guidelines. However, a few patients who had been subject to a restraint measure in the past, claimed that no debriefing had taken place and some also said that they had perceived the restraint measure as a punishment. The latter might indicate the need for a more thorough debriefing, clearly explaining the reasons for the measure. **The CPT encourages the management of Kellokoski Hospital to pay increased attention to engaging with each patient who has been subject to a restraint measure in a meaningful and thorough debriefing.**

88. The use of chemical restraint was decided by the ward doctor. Regrettably, it was neither recorded in a dedicated restraint register¹⁶⁷, nor noted as a restraint measure in the patient's medical file,¹⁶⁸ thus making it difficult for the delegation - as well as for the hospital's management and any other monitoring body or inspection - to obtain a clear overview of the frequency of its use. **The Committee recommends that every application of a restraint measure, including chemical restraint, be recorded as such in the respective patient's personal file and that a dedicated register on the use of chemical restraint be created, in all psychiatric establishments.**

6. Safeguards

a. involuntary hospitalisation and its review

89. The procedure for involuntary hospitalisation of a civil patient is described in the Mental Health Act. An outside doctor, usually a general practitioner, makes a "referral for observation" to a hospital (on a so-called "M1" form) if he/she believes that the preconditions for a person's involuntary hospitalisation are likely to be met.¹⁶⁹ At the hospital, the patient is met by another doctor, usually a psychiatrist, who also assesses whether these preconditions are likely to be met. If this doctor approves and the patient does not agree to stay voluntarily, the patient is kept at the hospital under observation.¹⁷⁰

¹⁶⁷ Statistics were kept about "involuntary administration of medication" (58 instances in 2019) and it was explained to the delegation that this number mainly referred to the administration of rapid acting tranquillisers. Nevertheless, this cannot replace a dedicated register on recourse to chemical restraint.

¹⁶⁸ Apparently, the medicine doses administered were noted in the patient's medical file, but not as a "chemical restraint" measure.

¹⁶⁹ Sections 9, 9 a and 8.

¹⁷⁰ Section 9 c.

At the latest on the fourth day of the observation, a treating doctor must assess the patient and note, supported by well-founded reasoning, whether he/she believes the preconditions for involuntary hospitalisation are met (by filling in an “M2” form). In that context the patient must be heard. Usually on the same day, a doctor superior to the treating doctor - the psychiatric director or his/her proxy - takes the formal administrative decision on involuntary hospitalisation (“M3” form), based on the patient’s file and the two assessments made by the aforementioned doctors (without meeting the patient).¹⁷¹ If he/she concludes that the preconditions for involuntary hospitalisation are met, the patient is held at the hospital for as long as the preconditions are considered to be fulfilled.¹⁷²

This decision can be appealed.¹⁷³ Further, the patient can at any time request an assessment by an external doctor *of his/her own choice* regarding the need for his/her hospitalisation. However, in this case, the patient has to bear the costs of the assessment¹⁷⁴ which certainly has a dissuasive effect for many patients. **The CPT would like to be informed if, in the context of the initial hospitalisation decision, patients also have the possibility to be assessed by an independent outside psychiatrist (not necessarily of his/her own choice) free of charge.**

90. The CPT has misgivings concerning the described holding of patients at a hospital “under observation” which prevents them from leaving the hospital for up to four days. This deprivation of liberty is usually not based on a formal decision in writing (or based on comprehensive medical documentation) but is apparently simply noted in the patient’s medical file. Nor do the patients concerned receive a written copy of any decision to deprive them of their liberty. This makes it practically impossible for the patient to file a reasonable appeal against the measure.

These misgivings concern likewise cases when hitherto voluntary patients are prohibited from leaving the hospital to be taken under observation (retention procedure).¹⁷⁵ Also in these cases, the *de facto* deprivation of liberty of the previously voluntary patients - for up to four days - appears not to be based on a formal decision in writing.

The Committee therefore recommends that the Mental Health Act be amended so as to ensure that any deprivation of liberty of patients with mental health disorder– including taking them under observation - be based as from its outset on a formal decision in writing, accompanied by comprehensive reasoning and information about appeal avenues; in this context, patients should receive a copy of the decision.

¹⁷¹ It is noteworthy in this context that at least at Kellokoski Hospital, the M2 statement and the M3 decision could be seen as one single assessment and were indeed practically always congruent (including with literally identical reasoning). This was confirmed by the hospital’s director who explained that the assessment made by the treating doctor (in the M2 form) and the decision made by the senior doctor (M3 form) were closely interlinked due to the supervising senior doctor’s own influence on the decisions made concerning the patient’s treatment and the treating doctor’s M2 assessment.

¹⁷² Sections 10 and 11.

¹⁷³ Section 24 of the Mental Health Act.

¹⁷⁴ Section 12 c of the Mental Health Act.

¹⁷⁵ Section 9c and 13 of the Mental Health Act.

91. The documentation examined by the delegation at Kellokoski Hospital revealed that the treating doctors' assessments (M2 form) were usually accompanied by reasoned diagnostic information¹⁷⁶ and that the formal decision on involuntary hospitalisation (M3 form) included by default detailed information on appeal possibilities (including addresses), patients were asked to sign¹⁷⁷ these decisions and received a copy. This is positive.

92. However, in more general terms, the CPT remains concerned about the effectiveness and adequacy of the current safeguards against arbitrariness of involuntary hospitalisation of both newly admitted and, in particular, the above-mentioned retained patients (see paragraph 90).

In both cases, decisions on involuntary hospitalisation are taken by a hospital doctor, usually without involvement of outside psychiatric expertise. In the case of newly-admitted patients, the initial referral to the hospital is made by an outside doctor (albeit usually not a psychiatrist),¹⁷⁸ while a voluntary patient who is already at the hospital can be retained even without any involvement of outside expertise.¹⁷⁹

Indeed, patients could – after the end of the observation period – file an appeal against the formal hospitalisation decision to the Administrative Court or, request an assessment by an external doctor of their own choice, at their own cost.¹⁸⁰ However, patients with mental health disorder are often particularly vulnerable; they are frequently marginalised, lacking support and resources and are already dependant on the hospital where they are placed. In this context, conditioning the possibility of an independent review of involuntary hospitalisation on the patient's own initiative may in many cases *de facto* prevent the patient from benefitting from that important safeguard.

The Committee would like to emphasise that hospitalisation against the patient's will is a drastic measure which seriously infringes a person's right to liberty. In order to provide the patients concerned with appropriate protection against potential arbitrariness in decision-making, the procedure for ordering involuntary placement should offer effective guarantees of independence and impartiality as well as of objective psychiatric expertise. The CPT considers it therefore highly advisable that the actual hospitalisation decision should be effectively reviewed by an independent body, assisted by independent psychiatric expertise and competent to revoke the involuntary hospitalisation. This could, for instance, be a court (or another authority) which decides based on a hearing (which preferably takes place at the hospital). In this context, the patient should have the effective right to be heard and be entitled to legal assistance. Such is indeed the practice in many European countries.

The CPT invites the Finnish authorities to review the current system of safeguards regarding involuntary hospitalisation of patients with mental health disorder, with the aim of providing both retained and newly admitted patients with effective safeguards in the light of these remarks.

¹⁷⁶ However, as mentioned above (footnote ...), the reasoning in the senior doctors' decisions (M3 forms) was word-for-word identical with the statements made by the treating doctors (M2 forms), in all files examined by the delegation.

¹⁷⁷ The patient's refusal to sign (and possible reasons for it expressed by the patient) was usually testified by signature of an additional staff member.

¹⁷⁸ See paragraph 89.

¹⁷⁹ Informally by the treating doctor and, after up to 4 days of observation, supported by a formal decision of his/her superior (on the M3 form), see paragraph 89 and footnote 171.

¹⁸⁰ See paragraph 89.

93. It is recalled that the review of an involuntary hospitalisation decision takes place in the case of a civil patient before the end of the first three months and subsequently after further six months, by the doctor who took the initial placement decision (M3 form).¹⁸¹ For a prolongation of an involuntary hospitalisation beyond nine months, the initial hospitalisation procedure must be started again.¹⁸²

For forensic patients, the involuntary hospitalisation decision must be reviewed before the end of the first six months by the hospital's psychiatric director (or his/her proxy). He/she can subsequently prolong the involuntary hospitalisation for another six months. After that, the initial hospitalisation procedure must be started again.¹⁸³

The decisions to continue involuntary hospitalisation (M3 forms) must further be submitted for approval to the Administrative Court (see paragraph 96).¹⁸⁴ In the context of the approval (and appeal) procedures, patients also have the possibility to be represented by a lawyer.

94. As regards the involvement of an external psychiatric opinion in these reviews, the Mental Health Act has stipulated since 2014 that an expert in psychiatry "not attached to the treating hospital" should be involved in the "M3" decision on continuation (or discontinuation) of the involuntary hospitalisation if the patient so wishes. The hospital must inform the patient of this possibility. If the patient refuses, the refusal and any reason given by the patient must be recorded and included in the documents to be submitted to the Administrative Court.¹⁸⁵

At Kellokoski Hospital, the delegation gained the positive impression that patients were systematically informed about the possibility to request an external expert opinion and a number of patients had also made use of it.

While recognising the above-mentioned legal provisions as a step in the right direction, the CPT recommended in its 2014 report that the involvement of an independent expert should not depend on the wishes expressed by the patient, but rather be obligatory. In their reply, the Finnish authorities expressed the view that the patient should be given the possibility to refuse such an external opinion.¹⁸⁶

The CPT acknowledges the Finnish authorities' respect for patients' choices. However, as pointed out above, the Committee considers the obligatory involvement of an external psychiatric opinion to be an essential safeguard against possible arbitrariness in decision-making concerning involuntary hospitalisation. This applies to the review of such decisions in the same way as to the initial decision to hospitalise a patient against his/her will. A positive obligation is necessary because persons held at a psychiatric hospital against their will are not always confident enough, nor are they always in a position to appreciate whether it is necessary, to insist in the involvement of an external opinion.

¹⁸¹ Sections 12 (1), 12 (2) and 11 (2) of the Mental Health Act.

¹⁸² Starting with an external referral (M1 form) by an external doctor as described above, according to Section 12, paragraph 2 and Sections 9 and 10 of the Mental Health Act.

¹⁸³ Starting with a hospitalisation order issued by the Finish Institute for Health and Welfare according to Section 17 (2) of the Mental Health Act.

¹⁸⁴ Section 12 (1) of the Mental Health Act.

¹⁸⁵ Sections 12 a and 12 b of the Mental Health Act.

¹⁸⁶ CPT/Inf (2015) 33, page 58.

The CPT therefore reiterates its recommendation that the Mental Health Act be further amended so as to provide, in the context of the review of involuntary hospitalisation of civil and forensic patients, for the obligatory involvement of a psychiatric expert who is independent of the hospital in which the patient is placed.

95. As mentioned above, the decisions on continuation of involuntary hospitalisation of civil and forensic patients also require the approval of the Administrative Court. The court's approval decision is taken by a board of two legal members and one doctor, usually a psychiatrist (with each of the three board members having one vote in the case of disagreement). This is commendable.

96. That said, the CPT has repeatedly expressed its concern about the length of the respective court proceedings. Despite the legal provision that the court proceedings related to involuntary hospitalisation must be dealt with "with urgency",¹⁸⁷ the Administrative Court approvals examined by the delegation at Kellokoski Hospital during the 2020 visit still usually took several weeks and sometimes months.¹⁸⁸ The same also applies to appeal procedures initiated by the patient. Apparently, patients had sometimes already been discharged from the hospital by the time the court had approved (or rejected) their involuntary hospitalisation.

The Finnish authorities, in their reply to the CPT's 2014 report, argue that the long procedures are *inter alia* caused by the necessity to give – in the administrative court procedure – the parties involved time to submit their views in writing and, sometimes by problems related to the service of notice.¹⁸⁹ Nevertheless, the value of a court approval or appeal procedure is significantly diminished if the ruling is only delivered several weeks or more after the commencement or continuation of a patient's involuntary hospitalisation.

The CPT therefore recommends that the Finnish authorities take further effective steps – including, if necessary, at legislative level – to ensure that the court approvals and appeal procedures of civil and forensic involuntary hospitalisation decisions are carried out within reasonable timescales.

97. In the past, the CPT had also had doubts as to whether the court reviews were carried out in a thorough way. Indeed, during the 2020 visit, each and every court approval¹⁹⁰ examined by the delegation consisted of identical wording stating that the legal requirements for the patients' extended hospitalisation were being met. In the Committee's view, each court approval should be substantiated by written individual reasoning, which would not only avoid a certain appearance of "rubber-stamping" but also, more importantly, allow the patient to either comprehend the rationale behind the approval, or to file a well-argued appeal to the Supreme Administrative Court.

¹⁸⁷ Section 26 of the Mental Health Act.

¹⁸⁸ According to the information received from the Ministry of Social Affairs and Health, the average length of respective court proceedings in 2019 was 1.7 months.

¹⁸⁹ CPT/Inf (2015) 33, pages 60 to 61.

¹⁹⁰ The delegation was told that if the court rejected the involuntary hospitalisation decision, the court ruling would indeed contain individual reasoning.

98. Furthermore, while patients were usually heard in the context of an appeal procedure initiated by themselves, they were still very rarely heard during the regular court approval procedures concerning the continuation of their involuntary hospitalisation.¹⁹¹

The CPT recommends that the Finnish authorities take effective steps to ensure that the court approvals of civil and forensic involuntary hospitalisation decisions include individualised detailed reasons explaining the rationale behind the ruling. Further, it reiterates its recommendation that patients with mental health disorder should have an effective right to be heard in person when the court approves (or rejects) the lawfulness of their continued involuntary hospitalisation. To make such hearings meaningful, it is essential that the respective court hearings are carried out within appropriately short timescales (see recommendation made in paragraph 97).

99. As regards the discharge procedure for forensic patients in particular, the hospital's psychiatric director's (or his proxy's) decision to discontinue a forensic patient's involuntary hospitalisation requires the approval of the Finnish Institute of Health and Welfare (THL).¹⁹² THL can either confirm the decision to discharge the patient or, if it considers that the conditions for involuntary hospitalisation are nevertheless still being met, order (the continuation of) the person's involuntary hospitalisation.¹⁹³

THL generally forms its opinions on the need for involuntary hospitalisation based on reports from the patient's treating doctor and from the hospital's psychiatric director (the latter usually not having examined the patient in person) as well as on other information from the patient's file. In this context, it is a matter of concern for the Committee that the Finnish Institute for Health and Welfare takes its respective decisions without meeting or hearing the patient concerned (nor having any legal representative present).

In order to preserve the patient's interests in the decision-making process, the CPT recommends that a personal hearing of the patient and the possibility for legal assistance be rendered mandatory in the context of decisions made by the Finnish Institute of Health and Welfare regarding a patient's involuntary hospitalisation (including its discontinuation). The institute's rules and, if necessary the legislation, should be amended accordingly.

b. involuntary treatment

100. As regards involuntary medical treatment of patients who are hospitalised against their will, the CPT must once again reiterate the importance of distinguishing the need for involuntary hospitalisation from the need for a specific medical treatment. As already explained several times in the past, at least since its visit in 1998, the Committee has serious misgivings that involuntary hospitalisation continues to be construed by Finnish law as automatically authorising medical treatment regardless of the patient's will, as the law does not differentiate between involuntary hospitalisation and involuntary treatment.

¹⁹¹ In the regular review procedures, patients can be heard by the court upon request, but only if this is not considered by the court to be manifestly unnecessary.

¹⁹² At THL, the respective decisions are taken by a special Forensic Psychiatry Board (*oikeuspsykiatrinen lautakunta*).

¹⁹³ Section 17 (2) of the Mental Health Act.

In this context, the Committee has repeatedly recommended that the Finnish authorities introduce a procedure whereby patients are placed in a position to give their free and informed consent to medical treatment. This could for example be done by asking the patients to sign a special form with information about the suggested treatment measures. However, Section 22b (3) of the Mental Health Act still stipulates that the treating doctor “decides on the treatments and examinations that are given, regardless of the patient’s will” and also on “holding or tying down the patient [...] for the period of a treatment [...]”.¹⁹⁴

101. At Kellokoski Hospital, many patients told the delegation that they had not been asked to consent to their treatment and felt that they had no possibility to refuse the treatment proposed to them.¹⁹⁵ Several patients also said that they believed that refusing their medication would lead to being injected by force and some said that they had themselves experienced forced medication. Further, a patient’s refusal of treatment did not result in an external independent psychiatric review as to whether a particular treatment could be provided against the patient’s will.

Moreover, apart from the general absence of a formal appeal avenue (see below), patients at Kellokoski Hospital were generally also not aware of a possibility to complain against an involuntary treatment measure (see paragraph 106).

102. As regards the possibility to formally appeal against a specific treatment measure, it is recalled that the need to reform the Mental Health Act in this respect is underscored by the judgment of the European Court of Human Rights in the case *X. v. Finland*.¹⁹⁶ The court considered the respective patient’s situation as being aggravated by the fact that a care order issued for the involuntary hospitalisation also contained an automatic authorisation to treat the patient, even against her will, without an immediate judicial appeal possibility. Eight years after the judgment, no such appeal possibility exists in Finland and the judgment still remains unimplemented in this respect.

103. Therefore, **the CPT once again calls upon the Finnish authorities to introduce at all psychiatric establishments in Finland, without further delay, a procedure whereby patients’ free and informed consent to treatment is actively sought and every patient capable of discernment is given the opportunity to refuse treatment or any other medical intervention. The relevant legislation should be amended so as to stipulate the fundamental principle of free and informed consent to treatment, as well as to clearly and strictly define exceptional circumstances that may cause any derogation from this principle.**

The relevant legislation should be further amended so as to:

- require an external psychiatric opinion in any case where a patient does not agree with the treatment proposed by the hospital's doctors;**

¹⁹⁴ An exception to this rule is stipulated in Section 22b (2) for “psychosurgical or other treatments that seriously or irreversibly affect the patient’s integrity. For them, the patient’s written consent is required, unless the measure is necessary to avert a danger to the patient’s life”.

¹⁹⁵ The delegation was informed by the hospital’s management that written consent had only been sought in a few “difficult cases”.

¹⁹⁶ *X. v. Finland*, application No. 34806/04, judgment issued on 3 July 2012, paragraph 220.

- provide patients with the possibility to appeal against a proposed treatment to an independent outside authority, to benefit from legal assistance to that end and to receive the respective ruling within an appropriately short timescale;

It should further be ensured that the patient's consent or refusal is in any case recorded prior to its commencement. As regards informing patients about avenues of complaint, reference is made to paragraph 105.

- c. other safeguards

104. Information brochures were available for each ward, explaining in comprehensible language the house rules and the ward's daily schedules. Regrettably, they were not available in foreign languages. In addition, a national-level patient information brochure - which existed in at least eight languages - described the involuntary hospitalisation procedure and patients' rights, including their rights to make appeals and to complain to different complaint bodies (see following paragraph).

That said, a number of patients interviewed by the delegation claimed that they had not seen a copy of these brochures and/or had generally not received comprehensive information upon admission.

It also appeared that patients who did not speak Finnish sometimes had great difficulties in communicating with staff and therefore at times did not understand what was happening on their ward, e.g. when patients were called to go to the outdoor yard.

The CPT therefore recommends that steps be taken to ensure that in all psychiatric hospitals in Finland, oral and written information setting out the hospital's routines and patients' rights is systematically provided to all newly-admitted patients (and their families). To this end, information brochures should be available in an appropriate range of languages. Patients unable to understand the brochure(s) should receive appropriate assistance.

Further, steps should be taken to enable staff to communicate on a daily basis with all patients, including those who do not speak Finnish, and provide them with the information relevant for them. Consideration should be given to making use of interpretation services.

105. An effective complaints procedure is a basic safeguard against ill-treatment in psychiatric establishments. In this connection, it is commendable that psychiatric hospitals in Finland have designated Patients' Ombudspersons assigned to inform patients about their rights and assist them with filing complaints (and formal appeals) when needed.¹⁹⁷ At Kellokoski Hospital, information boards and some of the above mentioned information brochures available at the wards provided the Patients' Ombudsperson's contact details.¹⁹⁸

Written complaints could generally be addressed internally to the hospital's director or otherwise to the Regional State Administrative Agency, the Parliamentary Ombudsman or the Chancellor of Justice.

¹⁹⁷ This role is usually performed by one or two staff members (e.g. social workers) who act as ombudspersons in addition to their regular tasks.

¹⁹⁸ Patients could either call a phone number for Finnish speakers or one for Swedish speakers.

Many patients knew of some of the avenues of complaint, in particular of the possibility to contact the hospital's Patients' Ombudsperson, but some others claimed that they did not. Further, at least some patients seemed not to know how to complain directly and confidentially to an outside body (if they wanted to complain without involving the hospital's Patients' Ombudsperson). A few patients also told the delegation that they were generally lacking trust in the usefulness of making complaints.¹⁹⁹

The Committee recommends that the Finnish authorities take the necessary measure to ensure that at Kellokoski Hospital and in all other psychiatric establishments in Finland patients are systematically informed about all available complaint avenues, verbally and in writing, accompanied by the contact details of the respective complaint bodies.

In addition, **confidential complaint boxes should be available on each ward (to be opened only by specially designated persons, and in confidence).**

7. Contact with the outside world

106. The delegation gained a positive impression of patients' possibilities to maintain contact with persons close to them. Patients could generally retain their mobile phones and also had free access to internet. They could receive visits every day, usually until 6 or 6.30 p.m. (and later by arrangement) in a dedicated visiting facility or in visit rooms on their wards.

At the time of the CPT's visit, the visiting possibilities for the patients' next-of-kin had been restricted due to the Covid-19 pandemic. This meant that visits were only allowed from family members and could last indoors only 15 minutes (outside the building much longer). This appeared to be a reasonable temporary solution.

¹⁹⁹ In the first eight months of 2020, 28 complaints (by 16 patients) had been filed at the hospital.

E. State Residential Schools

1. Preliminary remarks

107. For the first time in Finland, the CPT visited two educational facilities where juveniles were deprived of their liberty, *Sairila State Residential School* and *Sippola State Residential School*.

State residential schools are closed, State-run²⁰⁰ institutions holding children and young persons based on the decision of municipal social services. The reasons for their placement are usually escalated problems resulting from drug addiction, conduct disorders, school or home absconding, suicidal or self-destructive tendencies and/or criminal behaviour. State residential schools generally accommodate children and young persons of up to 21 years of age in the most difficult life situations and with very challenging symptoms, after other foster placements have failed to address their situation effectively. Finland has a total of five state residential schools with 126 places in all.

108. The placement and stay of a juvenile in so-called “institutional substitute care” is regulated by the Child Welfare Act (*Lastensuojelulaki*).²⁰¹

A minor can only be taken into substitute care as a measure of last resort and when such placement is considered to be in his/her best interests if:

- (1) his/her health or development is seriously endangered by lack of care or other circumstances in which he/she is being brought up, or
- (2) he/she seriously endangers his/her health or development by abuse of intoxicants, by committing an illegal act other than a minor offence or by any other comparable behaviour.²⁰²

The placement decision is taken by a senior social welfare officer in the juvenile’s home town (or his/her qualified proxy) after the social worker in charge of the minor has prepared the case, unless the minor’s custodian or the minor aged 12 years or more opposes the placement. Otherwise, the placement decision is made by the administrative court.²⁰³ Such placements are generally unlimited but must be terminated when the need for taking the minor into substitute care ceases to exist (unless this would manifestly not be in his/her interests).²⁰⁴

In urgent cases, an emergency placement can be ordered by the above-mentioned senior social welfare officer or his/her qualified proxy, if the minor is in immediate danger or otherwise in need of urgent placement in substitute care. It can last for up to 30 days and exceptionally up to 45 days (the latter only with the agreement of the minor’s guardian and the minor being over 12 years of age) and can be extended by the administrative court by up to 60 additional days.²⁰⁵

²⁰⁰ They operate under the guidance and supervision of the National Institute for Health and Welfare (THL) and the Finnish National Agency for Education.

²⁰¹ Sections 49, 40 and 57.

²⁰² Section 40.

²⁰³ Sections 13 and 43.

²⁰⁴ Section 47 (1).

²⁰⁵ Sections 38 and 13.

109. The treatment of minors in substitute care institutions has been subject of a wide public debate²⁰⁶ in Finland in recent years and legislative amendments have subsequently been made and are underway.

In March 2019, the Ministry of Social Affairs and Health appointed a working group in charge of reforming substitute care for minors who require intensified care. The group was tasked, amongst other things, with identifying the necessary measures for providing minors in substitute care with appropriate mental health and substance abuse services and with reviewing the legal provisions concerning restrictive measures in substitute care.

In this context, several amendments to the Child Welfare Act entered into force on 1 January 2020. They shortened, *inter alia*, the maximum length of seclusion and specified the rules concerning the individual treatment plans for minors in substitute care (see paragraphs 131 and 120).

On 4 September 2020, the above-mentioned working group launched a comprehensive report accompanied by a draft government proposal for amended legislation on the reform of child welfare services.²⁰⁷ Amongst other things, the report recommends securing preventive substance abuse services for juveniles and lowering the threshold for their access to mental health services (see also paragraphs 122 and 125 below).

The CPT would like to be informed about the further progress in the ongoing reform of child welfare services as regards the treatment of juveniles who are deprived of their liberty.

110. Sairila State Residential School (hereinafter “Sairila”) is located in a green residential area by a lake, 8 km east of the city of Mikkeli in southern Finland. It started operating in 1962. Since then, the buildings have been renovated several times and new buildings have been added. At the time of the visit, the facility comprised six units – for four to five juveniles each – in several one-storey houses. They included one standard regime unit, four “demanding care” units and one “special care” unit (see paragraph 115). One “demanding care” unit was for girls only, while the standard regime unit was exclusively for boys. All other units accommodated boys and girls together.

The main building, comprising the canteen, offices and therapy rooms, was undergoing a comprehensive reconstruction at the time of the visit, which was planned to be finalised in spring 2021. With an official capacity of 25 places, the school had one free place on the first day of the visit. The six girls and 18 boys who had been placed at the facility were between 14 and 17 years old and many of them had come from faraway municipalities.²⁰⁸ Most juveniles stayed at the school for at least three months and frequently longer, often until they finished compulsory education.

²⁰⁶ The debate focussed amongst other things on the qualification of staff and restrictive methods used in juvenile institutions.

²⁰⁷ The report and the government proposal can be found here (in Finnish): [Lastensuojelun vaativan sijaishuollon uudistamistyöryhmän loppuraportti - sosiaali- ja terveysministeriön verkkopalvelu](#)

²⁰⁸ While the delegation was visiting, some of the juveniles were on home leave and a few had absconded.

111. Sippola State Residential School (hereinafter “Sippola”), is located in a remote area in the village of Sippola, 30 km from the town of Kouvola in southern Finland. It opened as a boys’ “rearing facility” for the first time in 1909. Since then, the buildings have been converted, modernised and renovated several times. In addition to the historic wooden two-storey administrative building, it comprised five living units in smaller individual houses scattered around the institution’s vast grounds, including two standard regime units (one for boys and one for girls), one “demanding care” unit for boys and two “special care” units for boys and girls together. At the time of the visit, construction works were underway for two new “special care” units, planned to be finished in summer 2021.

The facility – with likewise 25 places – had no free place available at the time of the visit. The nine girls and 16 boys who had been placed at the institution were between 13 and 17 years of age, originating from all over Finland.²⁰⁹ As was the case in Sairila, juveniles usually stayed at the school for at least three months and frequently longer, often until they finished comprehensive school.

112. The delegation received no allegations of any form of ill-treatment by staff at either of the facilities. On the contrary, at both facilities, the delegation heard several positive comments on the caring attitude of the staff. In particular at Sippola, relations between staff and juveniles appeared to be very positive and the delegation observed the staff’s supportive approach towards the juveniles with frequent interactions aimed at relationship-building.

Inter-juvenile violence did not appear to be a major problem and whenever such incidents occurred, staff seemed to intervene promptly and adequately.

2. Material conditions and activities

113. Material conditions at both facilities were very good, providing a friendly and home-like atmosphere. The living areas were in a good state of repair and clean. Every juvenile had his/her own personalised room which was of sufficient size (11 m² or more), adequately furnished, well ventilated and had good access to natural light. All rooms at Sairila and most rooms at Sippola had their own separate sanitary annexe (toilet and washbasin, some also with a shower), and a sauna was available on each unit. The common areas in each unit comprised open-plan kitchens, a dining table, sofas and television sets. In addition, both facilities comprised schoolrooms, hobby-workshops, a gym and a sports hall, a canteen and a well-equipped sports ground.

114. Apart from the standard regime units, juveniles could also be placed in “demanding care” or “special care” units.

The concept of “demanding care” units had been introduced recently at both schools in order to provide intensified care for minors with particularly demanding needs. A greater presence of (multi-disciplinary) staff allowed for a more individual approach and the regime was slightly stricter than in standard regime units. Such placements were usually not limited in time.²¹⁰

²⁰⁹ Also at Sippola, some of the juveniles were on home leave at the time of the visit, and a few had absconded.

²¹⁰ As “demanding care” is so far not regulated by a specific legal framework, the general provisions on substitute care apply to it.

Placement of a minor in a “special care” unit is a restriction measure regulated in the Child Welfare Act.²¹¹ “Special care” units provide for a stricter regime, including restrictions of free movement outside the living unit and frequently also restrictions on contact with certain persons, as well as intensified individual care enabled by increased staff presence. Such placements can be ordered, if necessary, for minors as of 12 years of age whose behaviour poses a serious risk to their own growth and development or health, and who cannot be otherwise treated. A placement under “special care” is temporary, it can usually last up to 30 days and for extremely pressing reasons up to 90 days.

115. The delegation gained a generally positive impression of the daily regime offered to juveniles. Inside the living units, all juveniles could move freely and were in addition offered a wide range of educational and recreational activities.

116. As regards access to the outdoor areas, several juveniles at both facilities were under formal movement restrictions.

In accordance with the law, such restrictions can be ordered by the facility’s director (or a staff member appointed by him/her) for up to seven days, or by the juvenile’s personal social worker in the juvenile’s home municipality for up to 30 days, when it is necessary to protect him/her from behaviour that could seriously harm him/her (see also paragraph 124).²¹² The restriction orders specified for each individual juvenile where, both inside and outside the facility’s perimeter, he/she could move alone or accompanied by staff.²¹³

117. Juveniles in standard regime and demanding care units of both facilities, who at the time were not under movement restrictions, generally had free access to the open air and were also allowed to leave the facilities’ grounds unaccompanied in their free time. In Sairila, this meant that they could also go alone to the nearby city of Mikkeli.²¹⁴

The generally free movement of the juveniles, including outside the facility,²¹⁵ had in Sairila been introduced only two weeks before the CPT’s visit, after the previous, stricter practice²¹⁶ had reportedly been criticised by the Parliamentary Ombudsman as lacking in legal grounds.

For the juveniles in standard regime and demanding care units who at the time were under movement restrictions, access to the outdoor areas was more limited. Their possibilities to go outside usually depended upon staff availability and the delegation gained the impression that sometimes less than two hours per day were offered.

²¹¹ Sections 71 to 73.

²¹² According to Section 69 of the Child Welfare Act.

²¹³ At Sippola, 15 juveniles had been under a movement restriction in the first eight months of 2020 (in a total of 33 cases) and at Sairila 18 juveniles (in a total of 65 cases).

²¹⁴ Juveniles would for instance go there by bicycle or arranged to be being picked up by someone by car.

²¹⁵ The juveniles’ freedom of movement was nevertheless restricted insofar as when they were not returning from an outing they were searched by the police and brought back to the facility.

²¹⁶ Previously, juveniles could only leave the facility unaccompanied when they had been informally assessed as sufficiently stable and not at risk of using drugs or engaging in other dangerous or criminal behaviour.

In the special care units, juveniles were generally under movement restrictions which would usually last for the length of their placement in special care.²¹⁷ They could normally go outside one or several times per day accompanied by staff (e.g. for playing football). However, at the special care unit at Sairila, the delegation was told that apart from access to a small secured terrace,²¹⁸ juveniles could occasionally go outdoors for only about half an hour per day.

In the CPT's view, juveniles should be offered at least two hours' access to outdoor areas per day. **The Committee therefore recommends that the management of Sairila State Residential School (and, as appropriate, other juvenile substitute care facilities) take the necessary steps to ensure that this precept is implemented in practice.**

118. In the mornings, juveniles generally attended either primary or lower secondary school lessons in small groups and one juvenile at Sippola attended a vocational training course outside the institution.

In the afternoons, the juveniles from standard regime and demanding care units were offered a wide range of leisure activities (e.g. handicrafts or a music group) in well-equipped workshops,²¹⁹ could play various team sports in a sports hall and had access to a gym. Additionally, they could play card and board games, make phone calls, use computers²²⁰ or participate in preparing meals in their units.

The offer of group activities for juveniles placed in special care units was more limited due to the obligation to keep them separate from juveniles from other units. However, in addition to outdoor access they could use a gym several times per week for about one hour every time and could play card and board games with staff, watch television, use computers²²¹ or participate in preparing meals.

In addition, frequent excursions were organised by all units, e.g. fishing, swimming, playing ice-hockey or going to a restaurant.

3. Treatment and care

119. Individual care and development plans had been prepared for each juvenile and were regularly updated. Based on the new legal provisions in force, a new and more detailed form for these individual plans was about to be introduced at the time of the visit. The new forms require, amongst other things, specifying concrete objectives for different aspects of the juvenile's life (e.g. general management of everyday life, family and other relationships, physical and mental health status) and describing the necessary measures to attain the objectives. This is commendable.

²¹⁷ According to Section 71 of the Child Welfare Act.

²¹⁸ Juveniles had access to a small terrace which was secured with mesh and bars where they could e.g. play table football or lift weights.

²¹⁹ For instance, Sippola had a pottery workplace, Sairila had a photographic laboratory, and both schools had a music studio available for the juveniles.

²²⁰ Internet access was partially restricted. For instance, juveniles had no access to social networks.

²²¹ Internet access was partially restricted for them as well.

In addition, each juvenile had two contact persons amongst the staff (at Sippola) or a “personal team” (at Sairila)²²² appointed to him/her. Regular team meetings²²³ were held to evaluate the juvenile’s development. It is also positive that, at most of these meetings, the juveniles concerned could be present for at least part of the meetings.

120. According to the information received at both schools, practically all the juveniles were considered as particularly vulnerable to one or several risks, such as (continued) drug use, becoming the subject of sexual exploitation and/or involvement in criminal activities.

121. As regards drug addiction in particular, the large majority of juveniles had already arrived at the institutions with a history of drug use. One or several staff members in each of the facilities had been trained on substance use issues, some juveniles received treatment for substance use disorders in outpatient clinics and urine tests and room searches were carried out upon suspicion of drugs.

However, many juveniles (mainly in the standard regime and demanding care units) continued to use drugs during their stay at the schools. The directors of both institutions and the Ministry of Social Affairs and Health were well aware and seriously concerned about this problem (see paragraph 110). At Sairila in particular, where many juveniles had only recently been permitted to leave the premises unaccompanied – and where juveniles could reach the nearby city in their spare time²²⁴ – staff members feared an imminent rise in the juveniles’ drug consumption.²²⁵ Apparently, many of the juveniles were too vulnerable to move freely outside the facility as they required a longer period free of drugs for any addiction treatment to have a sustainable effect.

Despite that situation, the facilities had no effective means to prevent the juveniles from practically unhindered access to the drug market since many juveniles could leave the school’s grounds unaccompanied (see paragraph 118). Only the social worker in the juvenile’s home municipality could impose longer movement restrictions (above 7 and up to 30 days), or placement in a more secured special care unit (which rarely had free places). Reference is also made in this respect to paragraphs 117 and 115.

²²² The “personal team” consisted of the juvenile’s contact instructor, a special worker (psychologist, addiction treatment worker, psychiatric nurse or social worker) and his/her contact teacher.

²²³ At Sairila, the “personal team” plus, if necessary, other staff members concerned, usually met once or twice a month (and in the special care unit every week) to discuss issues of care and treatment. At Sippola, the situation of each juvenile in standard regime or demanding care units was discussed in a weekly meeting by their unit staff and in addition several times a year by a multi-disciplinary team (comprising the director and also other staff members who worked with the juvenile, e.g. his/her teacher). The situation of juveniles in special care units was evaluated every week by a multi-disciplinary team which also included the psychologist and social worker(s).

²²⁴ See also paragraph 118. The delegation observed itself that, at the time of the visit, many of the juveniles without movement restrictions were absent during the afternoons, reportedly going to the city on their own (rather than engaging in various organised activities offered by staff).

²²⁵ At Sairila, the previous director had resigned shortly before the visit, apparently in disagreement with the recent lifting of the informal movement restrictions. At least one other staff member told the delegation that he/she was also planning to resign, for the same reason.

122. To sum up, it is clear that much more emphasis on drug addiction treatment is needed at both facilities, including individual treatment programmes and motivational work to engage the juveniles in respective therapies. Moreover, to make drug addiction treatment effective, and also to prevent other individually identified risks for the juveniles from materialising (e.g. the risk of becoming the subject of sexual exploitation²²⁶), the schools must be provided with the necessary pedagogical means to protect the juveniles under their responsibility. In this connection, the CPT would like to emphasise that the authorities are obliged to ensure that the juveniles' right to physical integrity is effectively protected (including from harm caused by drug consumption or by another individuals).

The CPT recommends that the Finnish authorities take the necessary measures, including at legislative level, to ensure that:

- **at Sairila and Sippola State Residential Schools (and, as appropriate, at other juvenile substitute care facilities) increased emphasis is placed on drug addiction treatment, including individual treatment programmes and motivational work to engage the juveniles in respective therapies;**
- **substitute care facilities be provided with effective means to protect the juveniles under their care from harm caused by drug use, sexual exploitation or involvement in criminal activities.**

The Committee further trusts that these precepts will be taken into account in the context of the ongoing reform of child welfare services.

The CPT would like to be informed, within three months, about the action envisaged.

123. In this connection, the delegation was told at both establishments that the decisions of the social workers in the juveniles' home municipalities to either restrict a juvenile's free movement outside the facility or to end a movement restriction (see paragraph 117) sometimes did not correspond to the assessments made by the State Residential Schools' multi-disciplinary teams, including those of the juvenile's treating psychologists and psychiatrists. This might be related to the fact that some of the social workers had very little contact with the juvenile concerned and met them rarely, sometimes only once or twice a year.²²⁷

The schools' staff on the other hand interacted with the juveniles concerned on a daily basis, had seen his/her recent development (and had an awareness of what was generally going on in the facility) and thus seemed to be well placed to determine the appropriate degree of freedom of movement. **The Committee encourages the Finnish authorities to take these precepts into account when deciding on the necessary measures as recommended above.**

²²⁶ One case of such exploitation was revealed to the delegation.

²²⁷ Many of the juveniles had come from municipalities far away from the facility in which they were placed and the delegation was informed by the authorities that the social workers concerned often also had very heavy workloads which made it difficult for at least some of them to keep in close contact with the juveniles. Reportedly, there was also a high turnover amongst these social workers.

124. As regards mental health problems, the large majority of the juveniles at both facilities had been prescribed psychotropic medication²²⁸ and many had already stayed at a psychiatric hospital for treatment. The delegation was informed that due to the countrywide reduction of places in psychiatric hospitals, more juveniles with severe mental symptoms – who were often particularly difficult to treat and/or very self-destructive – were now being sent to state residential schools. This had resulted in an increased demand and long waiting lists for the few places in the special care units.

It is another matter of concern that juveniles with severe mental symptoms were frequently transferred back and forth between child welfare institutions and psychiatric hospitals as neither of the establishments felt that they could appropriately assist the juvenile. There is an obvious need for closer cooperation between the child welfare and health-care institutions to ensure that juveniles with severe mental health symptoms receive appropriate care.

The Ministry of Social Affairs and Health was fully aware of the issue and the above-mentioned working group has made proposals in its report to address the problem (see paragraph 110). **The CPT encourages the Finnish authorities to resolutely pursue their efforts to address the above-described problem effectively. Reference is further made to the request for information in paragraph 110.**

125. Health-care staffing levels appeared to be generally appropriate at both facilities. At Sippola, they comprised, in addition to the director,²²⁹ two physicians (working 1.5 and 2 days per week respectively and more if needed), two psychologists (working 2 and 4 days respectively and more if needed) and one full-time qualified nurse. The full-time psychiatrist had just started his parental leave for a total of six months. Due to difficulties in finding a replacement, the facility had arranged for a psychiatrist from Turku²³⁰ to be available for consultations by video-call twice a week. The management were aware that this was not an ideal situation and assured the delegation that if the arrangement turned out impractical, they would continue to seek a better solution.

At Sairila, a psychiatrist came in for consultations for about 12 hours a month. The facility further employed one full-time psychologist and three qualified nurses. One of these nurses was a psychiatric nurse and addiction therapist.

Whenever it was considered necessary at either of the facilities, an ambulance was called or medical consultations with doctors (including gynaecologists) outside the school were arranged. Several juveniles at both facilities also had regular appointments with psychiatrists at outpatient clinics.

²²⁸ For instance, at Sairila, 77% of the juveniles had been prescribed neuroleptics, many of them at full doses, and some were also prescribed other psychotropic medication. In one unit at Sippola, three of the juveniles were under full anti-psychosis doses of neuroleptics, indicating serious mental disorder.

²²⁹ The director was a psychiatric nurse and social worker with a Master of nursing science.

²³⁰ 300 km from Sippola.

126. The Committee is concerned about the case of one juvenile who had been diagnosed, according to the juvenile's personal file, with hepatitis C, but apparently had not received treatment for the infection. Treatment for hepatitis C is readily available and given the risks of the serious and irreversible long-term consequences of this disease, a juvenile with hepatitis C should be assessed with a view to receiving direct-acting antiviral (DAA) treatment. **The CPT recommends that these precepts are implemented in practice in all substitute care facilities. It would further like to receive confirmation, within three months, that an assessment for direct-acting antiviral (DAA) treatment has been carried out in the above-mentioned case.**²³¹

127. During the visit, one juvenile at Sippola who had been tested for a Covid-19 infection due to flu-like symptoms was waiting for her test result. While waiting, she had been suspended from attending school, but the delegation observed her associating normally with other girls in her unit (including physical contact). In order to prevent the spread of the infection to other juveniles and/or staff, measures should be taken to ensure that juveniles in substitute care facilities who are suspected of having a Covid-19 infection reduce their social contacts to the absolute minimum for the short time until the test results are known and keep a physical distance from other persons. **The Committee trusts that these precepts are implemented in practice in all juvenile substitute care facilities in Finland.**

4. Staff²³²

128. Staffing levels at both state residential schools appeared to be satisfactory. According to the countrywide standard, instructors – many of whom were also Bachelors of social services and/or qualified nurses – were employed on a staff-juvenile ratio of 1.3 in the standard regime units (1.3 instructors per one juvenile), 1.8 in demanding care units and 2.0 in special care units. Each instructor was assigned to a specific living unit in order to foster relationship-building with the juveniles of that particular unit.

At Sairila, three or four instructors were present in the standard regime unit on weekdays during the daytime,²³³ four to six in each of the demanding care units and four to seven in the special care unit. On weekend days, four instructors were present in the special care unit and two in each of the other units. At night-time, a total of at least six night-watchmen were always present for all the units. In addition, the facility employed an occupational therapist.

At Sippola, four to six instructors were present in each of the standard regime units on weekdays during the daytime, five or six in the demanding care unit and four to six in each of the special care units. On weekend days, most units were usually staffed with four instructors and the special care units with one or two more. At night-time, there were one or two watchmen present per unit. In addition, the facility employed two full-time social workers.²³⁴

²³¹ The case was highlighted to the facility's director during the visit.

²³² Other than health-care staff (discussed in paragraph 125).

²³³ The shifts were overlapping (the morning shift usually lasted from 7 or 8 a.m. to 4 p.m. and the afternoon shifts from late morning or noon until 10 p.m.) and fewer staff were present in the mornings when juveniles were at school.

²³⁴ One of the social-worker posts was vacant at the time of the visit.

Each of the facilities further employed six teachers and several school counsellors (four at Sairila and six at Sippola) for school education.

In this context, the CPT also notes positively that at Sippola, staff were offered monthly external supervision sessions which enjoyed active participation and at Sairila, an external trauma therapy centre offered training concerning the treatment of persons who had experienced violence.

4. Means of restraint

129. In reaction to violent behaviour by a juvenile, staff occasionally used manual holding techniques to prevent harm of other persons and/or the juvenile. In this connection, staff at both institutions received regular training in professional manual holding techniques and no complaints were received from juveniles regarding their application.

130. At both facilities, an agitated juvenile could also be placed as a measure of last resort in seclusion in a “calming down room”.²³⁵

The Child Welfare Act provides that the juvenile can be secluded from other juveniles as a measure of last resort if he/she poses a danger to him/herself or for other reasons “related to his/her life, health or safety”. It should never be applied as a punishment and must be terminated as soon as possible.²³⁶ The delegation gained the impression that such placements were not excessively frequent.²³⁷

Given the particular vulnerability of juveniles to the harmful effects of seclusion, it is further positive that, according to the new legal provisions in force, the maximum length of seclusion has been reduced from 48 hours as previously to 24 hours. The measure can initially last up to 12 hours and may, if necessary, be extended once by another 12 hours.²³⁸ These limits were respected in practice at both facilities.²³⁹

The law further provides that the juvenile should undergo a medical examination at the start, during or after seclusion “if necessary”, and before the decision on continuing seclusion (beyond 12 hours) is taken “unless this is manifestly unnecessary”.²⁴⁰ The delegation found that in practice, juveniles were rarely seen by health-care staff in the context of seclusion.

²³⁵ Each of the establishments had two such rooms which were sufficiently large (between 8 and 11m², including the toilet area) and equipped with a thick mattress, a toilet, a washbasin and a CCTV camera (with the toilet area duly excluded).

²³⁶ Section 70 (1) and 61a.

²³⁷ At Sairila, 12 juveniles had been placed in seclusion in 2019 (in a total of 14 cases) and 13 juveniles (in a total of 25 cases) in the first eight months of 2020. At Sippola, 17 juveniles had been placed in seclusion in 2019, and the same number in the first eight months of 2020 (in 52 and 54 cases respectively).

²³⁸ Section 70 (1) and (2).

²³⁹ According to the documentation examined, seclusion at Sairila usually lasted between one and three hours and very rarely for as long as 12 hours. At Sippola, the delegation was informed that seclusion frequently lasted only about 30 minutes and was rarely applied for 12 hours or longer.

²⁴⁰ Section 70 (4) of the Child Welfare Act.

In the CPT's view, the placement of any juvenile in a calming-down room should be immediately brought to the attention of a member of the health-care staff in order to allow him/her to look after the health-care needs of the juvenile concerned. This is even more important given the frequent occurrence of mental health problems amongst the juveniles concerned (see also paragraph 125).

The CPT recommends that steps be taken at Sairila and Sippola State Residential Schools (and, as appropriate, in other juvenile substitute care facilities) to ensure that placement in a calming-down room is applied in compliance with the requirements set out in this paragraph; the relevant legislation should be amended accordingly.

131. The CPT welcomes that the law stipulates that throughout the seclusion measure a – in each case specially appointed – “child safety officer” must supervise the minor “by being in the same room or in the immediate vicinity so that he/she has access to the secluded minor”. The minor must also have access to the staff member. He/she must receive adequate care throughout the measure and must have the opportunity to speak with the staff member.²⁴¹

Regrettably, this was not implemented in either of the facilities. While being held in the seclusion room, the juveniles were, according to staff, constantly supervised via CCTV. In addition, the delegation was told that at Sairila, staff went to see the juvenile in the seclusion room once or twice per hour. At Sippola, staff reportedly entered the seclusion room in some cases less than once per hour.

The CPT recommends that the direct personal supervision of juveniles held in seclusion at Sairila and Sippola State Residential Schools (and, as appropriate, in other juvenile substitute care facilities) be increased in accordance with the relevant legislation. CCTV cannot replace direct personal supervision.

132. After the end of a seclusion measure, it is essential that a debriefing takes place with the juvenile in order to explain the reasons for the measure, restore the staff-juvenile relationship and discuss how to prevent future eruptions of violence and subsequent seclusion. At Sairila, the delegation gained the impression that such debriefing took place regularly. Also at Sippola, the management emphasised that a debriefing with the juvenile's contact staff member must be carried out systematically. However, the delegation heard allegations that in practice, debriefing did not always take place or was not always carried out thoroughly.

At both facilities, the delegation also heard accounts of juveniles who had been subject to seclusion and had perceived the measure as punishment for minor breaches of rules (rather than as a security measure). A few juveniles also alleged that seclusion was not always terminated as soon as he/she had calmed down.²⁴² This might be an indication that a more thorough debriefing is needed which clearly explains to the juvenile the reasons for the measure.

The CPT encourages the management of Sippola and Sairila State Residential Schools to stay vigilant in ensuring that thorough debriefing with the juveniles always takes place after the end of a seclusion measure.

²⁴¹ Section 70 (2) of the Child Welfare Act.

²⁴² The Child Welfare Act clearly stipulates that restrictive measures (such as seclusion) should not be applied as punishment and must be terminated as soon as possible (Section 61a).

133. On rare occasions,²⁴³ police officers were called to either of the facilities to assist in dealing with particularly agitated or violent juveniles.

The CPT has doubts regarding the practice of calling police officers into juvenile institutions to manage violent situations. The institutions' staff are in charge of maintaining order within the institution and should be able to control a violent outburst by one or more juveniles. **The CPT would like to receive the Finnish authorities' comments on this matter.**

5. Other issues

134. As regards juveniles' contact with the outside world, the CPT welcomes the establishments' emphasis on facilitating the juveniles' contact with their families and other close persons. When considered necessary for protecting the juvenile (or other persons), the juvenile's contact with his/her parents or certain other persons could be formally restricted for a few days or weeks and up to one year at a time.²⁴⁴

Juveniles who had no contact restriction could use their own mobile phones in their free time or were provided with a phone for daily use if needed.²⁴⁵ Juveniles who were under a contact restriction²⁴⁶ could nevertheless make phone calls to specified persons (from a personal contact list), at Sippola for at least 30 minutes per day and at Sairila apparently for about 15 minutes per day.

All juveniles could further receive frequent visits from their families or sometimes from other close persons (unless contact with the person concerned had been formally restricted). At both schools, accommodation was available for visitors who wanted to stay overnight, given that many of them came from other parts of the country. In addition, juveniles from the standard regime and demanding care units at both facilities were frequently granted home leave with the permission of the responsible social worker in their home municipality.

135. The delegation further gained the positive impression that the juveniles received upon their admission appropriate information on their rights and the institutions' daily routines. In addition to the verbal information provided to them, information brochures were available in each living unit.

136. The information brochures also informed the juveniles about relevant avenues of complaint. They generally encouraged juveniles to talk to staff about their concerns (e.g. to their contact staff member) or to the facility's director, and informed them that staff would assist them with appealing against formal decisions concerning them (e.g. the placement at the facility or movement and contact restrictions). Juveniles could further complain confidentially to the municipal social workers in charge of their case or the municipal social ombudsmen²⁴⁷ (both in their home municipalities), as well as to the Parliamentary Ombudsman and the Chancellor of Justice.²⁴⁸

²⁴³ According to the information received, this happened at both facilities about once or twice a year.

²⁴⁴ Sections 62 and 63 of the Child Welfare Act.

²⁴⁵ Each juvenile received a credit of 10 € per month for phone calls.

²⁴⁶ At both schools, less than half of the juveniles had a contact restriction. In each facility, 12 juveniles had been under contact restrictions in the first eight months of 2020 (at Sippola in a total of 27 cases and at Sairila in a total of 26 cases).

²⁴⁷ *Sosiaaliamies*.

²⁴⁸ <https://okv.fi/en>

While juveniles seemed generally aware of at least some of the avenues of complaint, the delegation met at both facilities a few juveniles who claimed that they would not know how to complain confidentially to an independent outside body.

The CPT encourages the Finnish authorities to remain vigilant and ensure that juveniles held at substitute care facilities are well aware of all avenues of complaint available to them.

APPENDIX I

LIST OF ESTABLISHMENTS VISITED BY THE CPT'S DELEGATION

Establishments under the responsibility of the Ministry of the Interior

Police Detention Facility Espoo
Police Detention Facility Haukipudas
Police Detention Facility Helsinki (Pasila)
Police Detention Facility Kemijärvi
Police Detention Facility Kuusamo
Police Detention Facility Mikkeli
Police Detention Facility Raahe
Police Detention Facility Turku
Police Detention Facility Vantaa
Police Detention Facility Ylivieska

Töölö Custodial Facility for Intoxicated Persons, Helsinki

Metsälä Detention Unit for Foreign Nationals, Helsinki

Border Guard detention facility at Kuusamo Border Crossing Point

Establishments under the responsibility of the Ministry of Justice

Oulu Prison
Turku Prison

Establishments under the responsibility of the Ministry of Social Affairs and Health

Sairila Residential School
Sippola Residential School
Psychiatric Department of Helsinki University Hospital, Kellokoski.

APPENDIX II

LIST OF THE NATIONAL AUTHORITIES MET BY THE CPT'S DELEGATION

A. Ministry of Justice

Ms Malin BRÄNNKÄRR	State Secretary
Mr Ari-Pekka KOIVISTO	Director General, Department of Criminal Policy and Criminal Law
Ms Marianne MÄKI	Head of Crime Prevention and Sanctions Unit
Ms Paulina TALLROTH	Government Counsellor, CPT Liaison Officer
Mr Juho MARTKAINEN	Senior Ministerial Adviser, Legal Affairs
Ms Minna PIISPA	Ministerial Adviser
Ms Tuuli HERLIN	Senior Specialist
Mr Jussi MÄKINEN	Senior Specialist, Council of Europe Coordinator

Criminal Sanctions Agency

Mr Arto KUJALA	Director General
Ms Riitta KARI	Development Director
Ms Gabriella ADLERCREUTZ	Director of Internal Audit
Mr Ari JUUTI	Director of Security
Ms Heli TAMMINEN	Head of Legal Division
Mr Sami PELTOVUOMA	Senior Specialist
Ms Kati SUNIMENTO	Senior Specialist
Ms Satu RAHKILA	Senior Specialist
Ms Hannele SVANSTRÖM	Lawyer, Data Protection Officer
Ms Katri JÄRVINEN	Director of Criminal Sanctions Region of Southern Finland
Mr Jaakko JOKINEN	Assistant Director of Vantaa Prison
Ms Susanna SCHUGK-LAULUMAA	Assistant Director of Riihimäki Prison
Mr Tero UURANMÄKI	Assistant Director of Helsinki Prison
Mr Hannu KIEHELÄ	Director of the Training Center for Prison and Probation Personnel

B. Ministry of the Interior

Ms Maria OHISALO	Minister of the Interior
Ms Emilia LAAKSONEN	Special Adviser to the Minister of the Interior
Mr Tero KURENMAA	Director General, Police Department
Ms Minna HULKKONEN	Director General, Migration Department
Mr Harri SIVULA	Ministerial Adviser
Mr Jarkko NIEMINEN	Senior Specialist, Police Department
Ms Satu KASKINEN	Senior Specialist, Migration Department
Ms Marja AVONIUS	Specialist, International Affairs Unit

National Police Board

Mr Konsta ARVELIN	Chief Superintendent
Mr Jussi KIISKI	Superintendent
Mr Hannu PIETILÄ	Superintendent

Border Guard Headquarters

Ms Tuire METSO	Chief Superintendent
Ms Sanna PALO	Chief of Legal Division
Mr Max JANZON	Senior Officer

Finnish Immigration Service

Mr Olli SNELLMAN	Head of Section, Reception Unit
Mr Mikael LAURINKARI	Director, Helsinki Detention Unit (Metsälä)

C. Ministry of Social Affairs and Health

Ms Saira RUUTH	State Secretary
Ms Laura LINDEBERG	Special Adviser to the Minister
Ms Riitta-Maija JOUTTIMÄKI	Senior Ministerial Adviser, Legal Affairs
Ms Jaana HUHTA	Senior Ministerial Adviser, Legal Affairs
Ms Helena VORMA	Senior Ministerial Adviser, Medical Affairs
Ms Susanna HOIKKALA	Ministerial Adviser
Ms Soila KARREINEN	Senior Medical Officer
Ms Seija VILJAMAA	Senior Specialist
Ms Jenna UUSITALO	Legal Adviser

National Institute for Health and Welfare

Mr Matti SALMINEN	Director, State Residential Schools
Mr Jussi KORKEAMÄKI	Director, Health Care Services for Prisoners
Ms Merja MIKKOLA	Development Director, State Services

Supervisory Authority for Welfare and Health (VALVIRA)

Ms Marita RAASSINA	Senior Officer
Ms Sari VUORILAMPI	Senior Officer
Ms Reija KAUPPI	Legal Officer
Ms Leena KINNUNEN	Senior Officer
Mr Risto HEIKKINEN	Senior Officer

D. Office of the Parliamentary Ombudsman

Petri JÄÄSKELÄINEN	Parliamentary Ombudsman
Pasi PÖLÖNEN	Deputy Parliamentary Ombudsman
Ms Iisa SUHONEN	OPCAT-Coordinator, Principal Legal Adviser
Mr Juha HAAPAMÄKI	Principal Legal Adviser
Ms Anu RITA	Principal Legal Adviser
Mr Tapio RÄTY	Principal Legal Adviser
Ms Lotta HÄMEEN-ANTTILA	Senior Legal Adviser