Punished and isolated: disabled prisoners in Norway

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Serving a sentence has two purposes in Norway; it is a punishment for a crime and it is considered as an opportunity for rehabilitation to prevent repeated crime. This presupposes that all prisoners have access to activities and common rooms in the prisons. Interviews with prisoners with hearing or mobility impairments showed that accessibility is a problem in many prisons. The experiences of prisoners with hearing or mobility impairment show that lack of awareness and preparedness for their situation causes isolation as well as a decline in physical and mental health. Some prisons had cells partially adapted for prisoners with disabilities – and these were mostly located in high-security units. A majority of Norwegian prisons have some experience with disabled prisoners, but there are no systems for knowledge accumulation or sharing within the Norwegian Correctional Service. Lack of accessibility also deprived some disabled prisoners of their legal right to progression of the conditions for serving their sentences, and they served under more severe conditions for longer periods than non-disabled prisoners. Due to the lack of accommodation and access to health care and rehabilitation measures in prisons, they run the risk of serving a sentence without access to rehabilitation.

Keywords: sentence; prisons; rehabilitation; isolation

A correctional service on two pillars

Under the prison and penal policies of the Nordic countries, going to prison itself is considered as the punishment for crime (Kriminalomsorgen 2013), and the prison conditions 'can then approximate to life outside as far as possible' (Pratt 2008a, 119). Norwegian prisons are part of this penal ideology, and serving a sentence in Norway has two purposes: it is a punishment for a crime a person has been found guilty of, while it is also considered as an opportunity for personal rehabilitation to prevent repeated crime in the future (Hammerlin 2008). When a person serves a sentence, s/he meets a two-sided correctional service. On one side, there are curfews, restrictions, security measures and control mechanisms that limit the freedom of the inmates. On the other side, there is a continuous focus on opportunities and participation in education, work and other activities. These activities are organized both to resemble a regular daily rhythm outside the prison (cf. the policy that considers deprivation of freedom, not the prison conditions, as the punishment for crime), and with the aim of building up resources in the inmates, which will help them to avoid new criminal actions when released from prison (cf. the goal of rehabilitation). An intention of implementing these activities is also to prevent the
mental and physical harm that prisoners may suffer as a result of isolation as well as strict limits and surveillance of regular life activities in a prison.

The number of persons with various impairments or disabilities in Norwegian prisons is not known, and there is no systematic knowledge on the level of this group of prisoners’ access or lack of access to various rehabilitation activities in prisons. The focus in this article is on how disabled prisoners experience access (or lack of access) to various activities and services in prisons. On the basis of these experiences, we ask whether disabled prisoners risk serving sentences under more severe conditions than other (non-disabled) prisoners.

Existing knowledge

A search for literature and previous research on disabled prisoners in Norway showed that some knowledge existed on prisoners with mental disorders and cognitive, intellectual or medical impairments in Norwegian prisons, and that these groups are both over-represented and underserved (Friestad and Hansen 2004; Hartvig and Østberg 2004; Ministry of Justice 2009; Rasmussen, Almvik, and Levander 2001; Rua 2009; Sivilombudsmannen 2010; Stortingstingsmelding 37 (2007–2008); Søndenaa 2009). The knowledge about prisoners with sensory and physical impairments was more scarce. The overall lack of references may serve as an indicator that there has been little focus on prisoners with sensory or physical disabilities in Norway or in the Nordic countries. Studies from the USA indicate that people with hearing loss are over-represented in correctional services, and receive poorer service than other prisoners (Miller, Vernon, and Capella 2005; Vernon and Greenberg 1999). It is not possible, however, to assume uncritically that the same is the case in Norway, since the correctional services and the systems of justice are different in these two countries (Pratt 2008a, 2008b). Newspaper reports in the USA and UK reveal that prisoners with disabilities are subjected to discriminatory and exclusionary mechanisms in prisons. Many of these stories are about how the correctional institutions commit offences because the prison conditions degrade and deprive disabled prisoners of their integrity (Casciani 2009; Doyle 2009; Quinlan 2010; The Telegraph 2009). A couple of similar stories were also found in Norwegian newspapers (Tangnes 2003; Tjersland 2005).

The continued lack of knowledge about disabled prisoners was the backdrop when the Fafo Institute received a grant from the Fritz Moen research fund. The project was granted permission for research by the Norwegian Social Science Data Services/Data Protection Official for Research and the regional offices of the Norwegian Correctional Service to identify prisons that currently had prisoners in the target group, and conduct semi-structured interviews with these prisoners about personal experiences from life in prisons. The research project showed that most prisons had some experience with disabled prisoners, that the accommodation for these prisoners was fortuitous and that they were denied access to common activities and individual services (Haualand 2011).

How many, where and who are they?

The Norwegian Correctional Service did not provide any information about or for disabled prisoners on their websites or when we called them asking for information, and referred to regional or local offices and institutions. The way the regional and local staff discussed disabled prisoners also revealed the very relative as well as fluid concept of disability. The initial and general question to the officers about whether they had any
experience with prisoners with impairments, disabled prisoners or disability in the prisons
where they were in charge was not readily understood by all. When the researcher used
more specific and also more popular concepts like ‘hard of hearing’, ‘blind’ or
‘paralyzed’, some officers were able to identify and give information about prisoners
within the target group of the research project. The officers could sometimes only
remember specific challenges related for example to meals or transport between floors
without elevators, or they talked about prisoners who were considered shy or ignorant
until the officers found out they had a hearing loss. A preliminary conclusion was that to
the extent any knowledge existed, it was local and based on personal experiences in each
prison. There had been no attempts to systematize or accumulate this knowledge for
future use.

Given the difficulties many of the officers we talked to had in identifying or
remembering prisoners in the research project’s target group, it is likely that the actual
frequency of disabled prisoners or prisoners with impairments is higher than the numbers
presented here. Out of a total of 44 registered prisons and transition/half-way housing in
Norway, there were 21 institutions where one or more prisoners who had challenges
related to either sight, hearing or mobility served during the period the mapping was done
(March–April 2010). In addition to these 21 institutions, officers in 8 prisons said there
had been prisoners with one or more impairments earlier. Several prisons reported that
they had prisoners with impairments with some frequency, but could not specify how
often. This shows that challenges related to adapting prisons to prisoners with
impairments are not only restricted to a few institutions, and one must expect that the
majority of prisons sooner or later have to deal with this group of prisoners.

Number of inmates with sensory or physical impairments

The 21 institutions which reported that they had one or more prisoners with impaired
sight, hearing or mobility at the moment of contact identified a total of 25 prisoners with
one of the three specified impairments who were currently serving sentences. Some
prisons had more than one prisoner with some kind of hearing, seeing or mobility
impairments. Twelve of these were deaf or had hearing loss, thirteen had some kind of
physical impairment and one person was partially sighted. One person had both a
physical impairment and hearing loss. The figure will necessarily vary from month to
month, as new prisoners come in and others are released. Since only one prisoner with
partial sight was identified, we decided to focus on hearing loss or physical impairments.
With only one potential partially sighted informant, it would be difficult to form an idea
of the general application of his experiences. Further, there were no women in this
sample, which also reflects the overall low percentage (8%) (Kriminalomsorgens sentrale
forvaltning 2011) of women serving sentences.

When the prisoners had been localized, a selection of informants was made on the
basis of impairment, level of prison security and geographical location. Based on the
contact with prisons with previous experience with disabled prisoners and the researcher’s
personal network, two former prisoners were also included in the shortlist of preferred
informants. When the invitation letters were sent out to the prisoners by way of the
prisons, some had already been released, and it was not possible to find a replacement
within the time limit for the project. Among the prisoners who actually received the
letter with a request for interview, all but one sent a positive response. During the visits to
the prisons (related to the interviews with the informants), some officers were also
The eight prisoners who were interviewed had served or were serving sentences lasting from three months to thirteen years, and were serving at all security levels. Some had served more than once, and some had also served in more institutions than one, and at different security levels. Primarily, experiences related to hearing or mobility impairments were discussed with them. This research project cannot of course indicate the quantitative occurrence of the problems met by this group of prisoners, but the individual experiences are recurrent as well as symptomatic. Despite the quite small number of informants, there are at least two reasons to believe that their experiences are valid to illustrate a general lack of attention towards prisoners with disabilities in Norwegian prisons. First, their independent, yet concurrent experiences are from a large proportion of Norwegian prisons, and the informants had spent a considerable amount of days in prisons in several regions and at various security levels. Next, several informants additionally take medicines in order to reduce pain or maintain functionality. The procedures related to medication reveal a similar lack of systematic communication and measures to reduce disabling barriers and procedures in prisons. Even though the number of informants is small, they represent one-third of the identified prisoners with sensory or mobility impairments at the moment of contact, and all had stories about isolation, lack of access or fortuitous attention to their challenges from the prison staff and officers. Some had more severe experiences than others in terms of isolation or lack of access. These will be highlighted most frequently in this article, since the purpose here is to show how lack of attention to the situation of prisoners with disabilities may jeopardize their health as well as their rights as prisoners. This is not to say that the informants with the more ‘moderate’ experiences did not face isolation or reduced activities in the prisons. Some of these had less severe disabilities or served in open units, which sometimes enabled them to develop strategies to compensate partially for their lack of immediate access. Such strategies were not as readily available to prisoners with more severe disabilities or prisoners in units with more restrictions and higher security levels.

**Living conditions**

The focus of the interviews with the prisoners was primarily on accommodation and accessibility in prison, but they were also asked about social background, including family life, employment experience, education, housing, how long they had lived with a disability and (ab)use of drugs if any. These questions were designed in line with similar issues in previous studies by Statistics Norway and a survey on living conditions and mental health among inmates in Norwegian prisons (Friestad and Hansen 2004). Previous studies have shown that there is an accumulation of low-standard living conditions among inmates as well as among disabled people (Friestad and Hansen 2004; Ramm 2010; Ramm and Ottes 2013). The unemployment rates are higher, educational and income levels are lower and general health is poorer in both groups. The trial or reasons for serving sentence were not planned topics for the interviews, but some mentioned the sentence when they discussed the lack of congruence between the offence and the harsh conditions they experienced when serving their sentences.

The general impression is that the interviewees represented a relatively resourceful group. Four of those interviewed had some kind of mobility impairments, while five were deaf or hard of hearing (one belonged to both groups). Most were a few years older than their fellow prisoners (the informants were between about 35–65 years old). Half of them interviewed about their experiences with disability accommodation and accessibility in the prisons where they worked, but individual prisoners were not discussed with them.7
had no history of drug abuse (other than alcohol), two had previously long periods of drug abuse and two had episodes of drug use. All but one had a good relationship with (parts of) the family, and said they had had a good upbringing with involved parents, and absence of violence or other abuse. Six had completed secondary education, three of these had some kind of education beyond this level and one had completed college education. Earlier employment ranged from scattered work, longer periods of regular employment or self-employment. Several of the respondents indicated that they saw themselves as relatively resourceful compared to most other prisoners, both because of higher age and more life experience, better living conditions, better education and general knowledge and fewer (psychological) injuries and problems because of substance abuse. This probably also affected their willingness to participate in the study, and how they think about how they have been treated in prison. This could also indicate that they have made the officers and/or prison staff aware of the challenges they face. Other disabled prisoners may not have the same level of consciousness about the barriers they face, and are perhaps more likely to be ignored or made less visible than those who were interviewed. The informants represented a broad range of experiences. To some of them, a combination of both personal therapy and health services as well as general adaptation of the prison facilities was important to maintain functionality, while some were more concerned about health or medical services than accommodation or accessibility or vice versa.

Experiences of disabled prisoners

Therapy and health services

In Norway, the general health authorities are also responsible for providing health service in prisons. This is called the import model and is partly justified by the need to separate the responsibility for protecting and serving prisoners from the authorities that are responsible for punishment, that prisoners shall be given health services according to individual needs after an individual evaluation and that professional assessments should provide the basis for these services. (Sosial- og helsedirektoratet 2004). It is expected that the health and medically required therapy should be maintained during sentence, and that prisons have to prepare for continued access to such services for prisoners with a chronic health problem.

Erik is a prisoner who needs regular physical therapy to prevent deformation of his legs and back. Before he was sentenced to prison, he went to a physiotherapist several times a week. When he started to serve his sentence, it took five months before he saw a physiotherapist again, and since then he has had therapy at intervals of several weeks between each appointment. Due to the lack of therapy and an inappropriate wheelchair, Erik fears his feet have been permanently fixed in a wrong position:

I’ll survive this. My concern is not that I’m sitting here, but I fear I’ll never come back to the level I used to be, I am very afraid of that. (Erik, wheelchair user, high-security prison)

For people like Erik, access to therapy is not about recovering from an immediate disease, but about preventing further functional decline. To prevent loss of function, treatment must be preventative and must be repeated continuously to have the desired effect.

Some are also dependent on medication to reduce pain (often after injury), or assistance from health care personnel to maintain personal hygiene. Kåre tells about his experience with access to medication in prison:
When I came here, they asked me about my regular medicines. I said I used a few light sleeping pills and some diazepam which I use only when I have spasms, but only to a small extent. I tried to get an arrangement to get them as emergency medicine, so I could take them when I needed to, like I do outside. But that was not possible. So I had to take them every day. In the beginning when I arrived, I said, okay, I’ll take them every day. So the first three months I was here I got more diazepam and stimuli than I’ve taken in the last five years. So finally, I had to say stop. They did not work anymore. But the nurses thought I could not stop, I had to cut down gradually, because they thought I certainly had become dependent. But I just stopped right away, said that’s enough. After I complained about this practice, I have not been allowed the diazepams I initially asked for. It’s all or nothing. (Kåre, wheelchair user, high-security)

The prison regulations were given priority over Kåre’s actual medical needs. Bjørn is another prisoner with a back problem who could not get the pain killers he needed in order to sleep, because he had to take them during daytime office hours. Both Kåre and Bjørn became victims of the conflict between health and security, as the prison regulations do not allow them to manage their own medication. Their experiences confirm what Rua (2009) also documented; the prison doctors are often left alone with the responsibility for care of prisoners, and some doctors in Rua’s study said if the prisoners’ health care needs are in conflict with the prison’s security regulations, they often let safety issues come before health.

It is not only strict guidelines that prevent access to the necessary preparations but also that lack of communication between different levels within the Correctional Service may preclude access to essential medicines, as Erik experienced:

I was promised that everything would be in place in advance. The court and the prosecutor guaranteed that my health would be taken care of. When I came here, no one knew anything. I use a lot of different medications, and I have diabetes, quite severe diabetes. And it took several days before I got insulin, several days before I got my supply in place. (Erik, wheelchair user, high-security prison)

The guidelines for health services to inmates in prison allow for self-administration of drugs unless separate administration can cause serious harm or cause problems with regard to quiet, order and security in prison (Sosial- og helsedirektoratet 2004). Diazepam, like Bjørn’s morphine-based pain killers, are potentially addictive drugs, and the prisons’ reluctance to let these informants manage their own medication can be related to the advice in the guidelines. One informant said he had observed inmates with epilepsy who had been deprived of their medications for the same reason, and the result was that people fell on the stairs and fell asleep in the shower.

Inmates who require long-term and coordinated services from the public health services have the right to an individual plan, just as they have outside the prison. But none of the informants who had such a plan before serving sentence experienced that this was followed up in prison. As a consequence, their health conditions had worsened considerably:

I have what they call an individual plan at home. But here I just have to follow the rules like everyone else. That’s what I get as a response when I ask for the plan. The guidelines say I am entitled to individual treatment, and have a legal right to special health care. But when I tell the guards, they don’t pass on the information to the health service, so I just sit here and no one does anything about it. My personal contact officer was almost shocked when he saw what I look like now. (Erik, wheelchair user, high-security prison)
A common experience among the informants who need physical therapy, either to maintain mobility or as part of rehabilitation after injury, is that therapy and the frequency have declined dramatically after they started serving sentence. A recurring problem seems to be that it takes too long before proper therapy is arranged, and when and if therapy eventually is resumed, the frequency is considerably reduced compared to the frequency outside prison. It seems that these prisoners find themselves in a grey zone between the responsibility of the health authorities and the responsibility the prison facilities have to follow up medical advice. The prison doctor is often only available for short periods and is not responsible for the distribution of drugs or for general conditions in prison. The nurses at the health office in the prison must follow up on the recommendations from the prison doctor, but must also deal with the security regulations, which may be in conflict with the doctor's prescriptions. Added to this, there are limited staff resources, which may have a severe effect for people who need extensive medication, or medicines outside office hours. One officer said he expected the health service would take care of the prisoners whose health cannot be ensured in prison. In the prison where he works, a disabled prisoner struggled to be heard, because the prison management did not follow up advice from the doctor on medical treatment. This is a sign of a fragmented health care in prisons which may affect disabled inmates particularly severely.

Accessibility, accommodation and communications

Few prisons give prisoners with disabilities an opportunity to serve their sentence under conditions that are equivalent to non-disabled prisoners. In some prisons, a few measures had been taken to improve accessibility, but the informants suggested that the effort is done piecemeal. The cells may be partially accessible for a wheelchair user, but common areas may not be accessible at all. Deaf and hard of hearing prisoners may be able to enter common rooms, but may still not be able to interact or socialize with fellow prisoners.

In the cells

Several informants (especially those serving sentences in high-security prisons) mentioned that the calling systems in the cells were problematic. This system is used by the prisoners when locked inside the cells to call guards. In cells without a bathroom or toilet, the calling system is used to call a guard when a visit to the bathroom is necessary, and may also be used for other acute needs. Depending on how the prison is built, the guards will come to the door and talk to the inmates through a hatch, or reply via intercom. Håkon and Jan, who are deaf, had no problems with pushing the button at the calling box, but could not use it properly, since they were not able to hear the response, or to make themselves understood. This was not only problematic for them but also gave the guards more work, since they had to walk up to the cell to see what was needed every time.

Erik could use the wall mounted calling system when sitting in the wheelchair, but if he fell on the floor, he had no chance of calling for help:

Between 20.30 and 07.15 hours in the morning the doors are locked. At home I have a remote control safety alarm that I just press if something happens, but I cannot use it here. The guards think the calling system here is enough. I’ve tried to explain to them that if I … during a transfer from chair to bed, if I fall between, I just lie there until someone comes. But they simply tell me it does not happen. (Erik, wheelchair user, high-security prison)
An employee in the prison where Erik is serving his sentence said that there was a separate cell with a call system equipped with a light signal when a guard had been alerted, especially constructed for inmates with hearing loss. The attempts to make the prison more accessible are fragmented, and do not safeguard all groups.

Erik’s prison is one of the few prisons with any kind of customized cells for wheelchair users in the Correctional Service region. However, he did experience that the bathroom was partially inaccessible. He could enter it, but the shower and sink were fitted too high up for him to reach them properly. Due to the ill-fitted bathroom, Erik had trouble with maintaining his personal hygiene. At home he had some help from home care services when taking a shower. In prison, he received no such help:

As for personal hygiene – I need some help, and I do not get that here. I have not showered in six months. Well, I have used soap, water and a cloth for the most essential parts. (Erik, wheelchair, high-security prison)

A similar case has been reported in Norway earlier (Tangnes 2003). Both in Erik’s case and in the case in the newspaper, there had been both a lack of available personnel and lack of accessibility. Because of incorrectly fitted bathrooms, prisoners in wheelchairs needed help to use the bathrooms, but this help was not made available due to inadequate staffing in the prison. When the basic personal needs are neglected for such long times, this can hardly be characterized as an unfortunate slip, but is rather a result of a serious failure of the system.

Access to and participation in common areas

In order to participate in general activities in prisons, the common areas must also be accessible. These areas include arenas for leisure activities, like dining, cooking, TV rooms and fitness studios, as well as areas for education and work. To reduce the mental harm that may result from isolation, prisoners are expected to participate during common time (hours when the cells are open). Denial of access or participation in common activities may be used as punishment for prohibited or disturbing behaviour, but only for a limited time, and isolation as punishment is regulated by the Execution of Sentences Act. Almost all the informants had experienced various kinds of isolation, however, as a consequence of lack of access or attention to their situation. Although a cell may be (partially) accessible, dining areas can be located on another floor or in another building. This restricts prisoners with mobility impairments, who may have to eat their meals in solitude when the other prisoners gather in the dining room. Lack of snow clearance in the wintertime is another cause of seasonal isolation from common dining or activity areas. Kåre, a wheelchair user who needs a regular workout to maintain the strength in his back, was denied access to training facilities. His cell, which was adapted for wheelchair users, was located in a high-security department in the prison, while the training facilities were in a semi-open department. The only reason for serving in a high-security department was because the accessible cell was located there, but the prison nevertheless required a guard to follow him to the workout rooms in the semi-open department. Due to limited personnel resources, the prison could not provide a guard as often as Kåre needed to do his workout programme. As with the intercom systems, the lack of accessibility to training facilities was a cause of isolation as well as extra work for the guards.
Communications

Accessibility is not just about access to the physical environment but also about the ability to communicate with other people. Håkon had no trouble following the daily routines and carrying out his tasks or participating in common dining, but he could not participate in conversations with the other inmates or guards:

I was alone a lot, and did not experience that the officers showed any concern. They treated hearing and deaf alike. I could see that the others were chatting with each other during working hours, for example, and there were a lot of comments and small talk, but I could not hear anything. (Håkon, deaf, former inmate)

When Håkon was treated like just another inmate, he was placed at a disadvantage compared to the other prisoners. The common activities that are arenas for social interaction and communication became sites that reinforced the sense of loneliness for Håkon. Jan, another deaf prisoner, said that if he was to participate on equal terms, there should be an interpreter available during common time, from the moment the doors are opened, and until they are locked in again. A sign language interpreter could have made Jan more equal to the inmates, and he would then have had some access to the social interaction taking place when the cell doors are unlocked. When he served his sentence, he pushed the prison to request interpreters for various common social activities. The prison did not know who would be responsible for paying the fees, so it took quite some time before an interpreter was allocated to him. When an interpreter was hired for the weekly entertainment activity, this became his only opportunity to communicate freely during the week, so the interpreter’s role was different from the intended role:

When I finally got an interpreter, I did not bother to follow what was happening; it was just so important to have someone to talk to. Someone I could talk to about things. Get my thoughts out. Just signing, and signing to someone. Communicating. I could of course just sit and watch the interpreter translating what the other people said, but then I would not say anything myself. If only there had been just one more deaf prisoner, it would have been much easier, since I could talk to him sometimes. That would have been okay. (Jan, deaf, former inmate)

All the deaf and hard of hearing informants talked about lack of access to information. Two hard of hearing informants had developed strategies to learn about common information, either from other prisoners or from the guards. It was a prerequisite, however, that they had some residual hearing, and were aware that there was information they needed or missed. Håkon said it took quite some time before he learned about the various activities and work places in the prison:

When I arrived here, I just sat there, I did not know anything. Not until a couple of weeks later, I learned that I could apply for a job, and I was able to find the forms I needed to fill in to get advice. There should have been an arrangement when you come into the prison, that the people who work here must give you information about the rights and opportunities you have, so that also we who are deaf get some information. But the attitude was like ‘this is your responsibility; you have to find out what we’re doing here’. People must ask the others what to do, find things out for themselves. That’s not good enough. We cannot hear what other people say. We’re only left to ourselves. (Håkon, deaf, former inmate)

Håkon was extra vulnerable to loneliness, and could possibly have benefited greatly from a volunteer visitor, but he did not learn about this possibility until after he had been
released. He is quite sure he missed the information about the volunteer visitor programme since he could not hear. This could easily have been arranged by the prison at no cost, but lack of awareness was probably a barrier. A personal officer, who had been in charge of deaf and hard of hearing prisoners, mentioned that the TV in the common room could be a problem. The remote control is generally not available to the prisoners but is required to view subtitles. The officer was able to make an arrangement so only the deaf prisoners could use the remote. This was quite a simple action, which also shows that adaptation does not need to be particularly demanding. Recognition of the problems is required, however, and commitment to solve them.

Lack of progression

Two of the informants served their sentences in a high-security unit only because these units were partially accessible to them as wheelchair users. Had they not been wheelchair users, they probably could have served in a semi-open unit, as is the case for Erik:

The only reason that I am in this prison is that very few prisons have accessible cells. I have no long sentence, or severe offence, so I could very well serve in a semi-open unit. So it’s all about that accessible cell. (Erik, wheelchair user, high-security prison)

There is at least one prison with wheelchair-adapted cells in every Correctional Service region, but most of them are placed in high-security prisons. Wheelchair users who are sentenced to prison for less than two years, and who according to the Execution of Sentence Act could be considered for imprisonment in lower security units, loose this opportunity because of lack of accessible cells in these units. This practice is confirmed by an officer in a high-security prison with wheelchair-adapted cells:

Officer: The regional office sends us a list of sentences that fit our profile; it depends on the length of sentence. Not all these should serve here. But, at a regional level, there are very few cells for disabled people, in particular wheelchair users.

Researcher: So people who could be considered for serving in prisons with lower security measures serve here, simply because this prison is the only prison with accessible cells? Officer: That is right.

The Execution of Sentence Act (§ 14 e) states that any transfer to more restrictive serving conditions than is necessary for security, should as far as possible, be of a temporary nature and measures should be taken to reduce the burdens on inmates (Ministry of Justice 2000). To the wheelchair users, the restricted conditions for serving a sentence were not of a temporary nature. They were more restricted than necessary for security and there are few indications that any special measures were taken to reduce the burdens on these inmates.

Punishment without rehabilitation?

The experiences of the informants presented in this article show that prisons fail to make rehabilitation activities (work, education, group activities) accessible to disabled prisoners. In consequence, these prisoners’ ability to participate in rehabilitation programmes and other activities in prison is severely limited. Further, the prisoners who relied on regular therapy or needed medicines outside the health office hours experienced harm to their health. Only a small group of prisoners have been interviewed, but they tell stories
that have common elements across various prisons and Correctional Service regions. The experiences of the interviewed prisoners testify to random, arbitrary and inadequate adaption for and attention to prisoners with disabilities in Norwegian prisons. This study is not exhaustive, but it shows clearly that the Correctional Service lacks procedures and resources to secure the needs and rights of disabled inmates.

As a consequence of lack of accessibility, prisoners with disabilities are more likely to experience isolation than other inmates. Gamman (1995) showed in a study that fully or partially isolated inmates had more health problems than non-isolated prisoners, and that the condition of those with somatic illnesses was worsened during isolation. Securing access to common activities is thus an important task for the prisons. Prisons must work to counter the possible negative effects of isolation, by arranging common activities and encouraging participation in them. Both in terms of security levels for serving sentences and isolation, disabled prisoners are frequently, and without formal decisions, subject to practices that are considered a strain on the general prison population. These practices are limited by law (Ministry of Justice 2000). The informants in this project are not primarily exposed to isolation as a result of formal decisions, but because of lack of preparedness and attention to their situation. Due to lack of accessibility, not only do these prisoners risk serving under conditions that isolate them from common life in prisons, but they may also have stricter security measures imposed on them than their offence indicates.

Some prisoners experience poor access to necessary medicines, while other informants were told they had to take medicines at particular hours every day (other times than when they should be taken for best effect) in order to get them at all. This can be considered an example of forced medication, where regulations are in conflict with the actual medical needs of the person using medication. In a discussion paper for a seminar at the UN High Commissioner for Human Rights on disability, torture and other degrading treatment, it is pointed out that in many countries, legislation and legal practice may be a severe obstacle for persons with disabilities to be able to refuse or object to medical treatment (United Nations High Commissioner for Human Rights 2007). The experiences of some informants confirmed that this also is the case in Norwegian prisons.

Another example of violation of personal integrity is when a prisoner is denied the opportunity to take care of personal hygiene. In a survey of the conditions in Parkhurst prison in the UK, two similar conditions were revealed, which resulted in major media coverage in the British press in 2009 (Casciani 2009; Doyle 2009; The Telegraph 2009). When the report of the project this article is based on was released, the Norwegian Centre for Human Rights also included the problematic situation for disabled prisoners in their report to the European Committee for Prevention of Torture or Degrading Treatment or Punishment, and wrote in the report that in:

this connection it is pertinent to note that Norway signed the UN Convention on the Rights of Persons with Disabilities in 2007. In signing the treaty, Norway has accepted an obligation not to defeat the object and purpose of the treaty prior to its entry into force. (The Norwegian Centre for Human Rights 2011, 8–9).

Also, the Anti-Discrimination and Accessibility Act, which aims to prevent discrimination on the basis of disability, states that ‘Direct and indirect discrimination on the basis of disability is prohibited’ (Ministry of Justice 2008, section 4), but the lack of preparedness and routines in prisons shows that prisoners are discriminated on the basis
of disability. Hence, there is good reason to ask whether the Norwegian Correctional Service also violates the Anti-Discrimination and Accessibility Act.

There is reason to believe that for prisoners with disabilities, conditions while serving sentences are more severe than for non-disabled prisoners. Some also serve under considerably harsher conditions than those they have been sentenced to in court, with less proportionality between the offence and the sentence than intended. In certain cases, the conditions for serving a sentence are serious violations of their personal integrity. Disabled prisoners risk serving under conditions that are practically and personally stressful, as well as ethically and legally questionable. In consequence, disabled inmates are often subject to punishment without rehabilitation, which is a violation of what is perceived as the purpose for sentencing people in Norway.

Notes
1. Pratt (2008a, 2008b) has defined this policy as ‘Scandinavian Exceptionalism’. Not only are the conditions in Scandinavian prisons considerably better than in prisons in most other countries in the world, but the level of imprisonment is also considerably lower. This article is written in a Scandinavian context, and is anchored in a Scandinavian view on prisons and the dual purpose of prisons (punishment and rehabilitation) embedded in the penal policy in these countries.
2. The approach to impairment and disability (and the relationship between these) in this article may be positioned in a critical disability studies tradition, where the problems faced by disabled people are conceptualized as emerging in a relationship between impairment and oppression. This approach is partially in opposition to the material approach in the social model of disability as well as the individualized medical approach (Corker 1999; Vehmas and Watson 2014).
3. We asked specifically that at least one of the impairments that was possible to identify by others should be related to sight, hearing or mobility. The terms we eventually used were (in Norwegian); ‘tunghørt’, ‘døv’, ‘blind’, ‘svaksynt’, ‘halt’, ‘bruke rullestol eller stokk’ and more. Not all of these concepts are considered as good or correct professional language, but they worked to make the officers identify and/or remember target prisoners, and the concepts were also used spontaneously by some officers when they discussed their experiences with disabled prisoners. We asked specifically that at least one of the impairments that was possible to identify by others should be related to sight, hearing or mobility. Some of the identified prisoners had more than one impairment, which possibly also intersected in terms of practical challenges.
4. Overgangsbolig.
5. The average number of prisoners serving sentence at a given time was 3704 in 2010 (Kriminalomsorgens sentrale forvaltning 2011).
6. The researchers did not know the identity of these prisoners, only their existence and some very superficial knowledge about their impairment or disability, like ‘wheelchair user’, ‘has hearing aids’, ‘problems with walking’ and so forth.
7. The officers were informed about the purpose of the interviews, and gave informed consent to use quotations from the interviews, based on oral information about the intentions. No personal information about or from the officers was collected.

References
The Execution of Punishment Act 2000.


