**Isolation-like segregation in mental health care**

*A key finding from the visits carried out in 2017 was that a number of mental health care institutions practised extensive segregation of patients. Patients were often segregated in unsuitable premises, with very limited opportunity for human contact and activity. The Ombudsman expressed concern on several occasions that this measure, in practice, resembled isolation.*

**What is segregation?**

Segregation is restriction of patients’ freedom of movement and self-determination that exceeds the level otherwise defined for compulsory mental health care. A segregation measure is, in part, considered a treatment measure and, in part, a measure to shield other patients.

Segregation is regulated in Section 4-3 of the Mental Health Care Act, and means that the patient is kept completely or partly segregated from other patients and from personnel who do not take part in the examination, treatment and care of the patient. Segregation can take place in the patient's own room or in a special segregation unit. The responsible mental health professional can decide to segregate a patient for treatment purposes or out of consideration for other patients.

Norway is one of the few countries that uses segregation as a form of treatment, which is in principle distinct from isolation.[[1]](#footnote-1) Isolation is defined in the Mental Health Care Act as a coercive measure where the patient is detained behind a locked or closed door without a staff member present, while segregation requires close follow-up by the health personnel present.

A systematic review of literature in 2015 concluded that there was little knowledge of the effect of segregation in Norway.[[2]](#footnote-2) Patient studies indicate that the coercive elements of segregation are stronger than and are perceived as being more isolation-like than treatment purposes would indicate.[[3]](#footnote-3)

**Human rights standards and Norwegian legislative amendments**

As segregation entails further restriction of patients' already limited freedom of movement and self-determination, it constitutes an encroachment on patients’ right to privacy pursuant to Article 8 of the European Convention on Human Rights (ECHR). Segregation must therefore have a legal basis, and it must be necessary and proportionate in each case. In cases where a person’s autonomy is already limited, the European Court of Human Rights (ECtHR) takes a strict view of measures that further limit people’s autonomy.[[4]](#footnote-4) The implementation of segregation measures that provide so little opportunity for human contact that they, in practice, constitute isolation pose a high risk of inhuman and degrading treatment. Human rights standards in mental health care stipulate that isolation cannot be regarded as a therapeutic measure, but only a coercive measure.[[5]](#footnote-5) Coercive measures must only be used as a last resort and if they are the only way of preventing patients from inflicting harm to themselves or others. The UN Convention on the Rights of Persons with Disabilities has recommended that member states discontinue the use of isolation in legislation and in practice.

**The scope of segregation**

The use of segregation was extensive in a number of the hospital departments visited by the NPM. Segregation appeared to be an integral part of the treatment regime at some of them, in that a large proportion of the available beds were in segregation units. At one hospital, the number of beds in the segregation units accounted for almost 30 per cent of all beds. Such a high proportion of segregation beds in itself entails a risk that the threshold may be low for using segregation.

It was consistently found that the grounds for administrative decisions on segregation were inadequately documented. The grounds given for segregation being considered necessary were often not sufficiently detailed, and the inadequate grounds also made it difficult for patients to have the administrative decisions reviewed in connection with complaints. The review showed that the administrative decisions often made reference to agitated behaviour, treatment purposes etc., without this being linked to concrete incidents or circumstances. A number of patients were subject to segregation to prevent them from embarrassing themselves in relation to the other patients, often referred to as ‘bringing shame on themselves'. Given that the patients were committed, there often appeared to be a low threshold for acceptable behaviour. Unlawful measures were also identified, such as the routine segregation of substance abuse patients without individual assessments. Other measures, such as the segregation of voluntarily admitted patients in cases where it was not documented that the patient had been informed about their right to discharge themselves, is also problematic. In a number of decisions, no reference was made to whether segregation was implemented as a treatment measure in the interest of the patient or out of consideration for other patients. The findings make it clear that segregation is a difficult mix of use of force and treatment. The fact that there were restraint beds in several of the segregation units visited reinforced the impression of segregation being a coercive measure.

**Physical conditions in the segregation units**

Segregation measures were often implemented in dedicated segregation units. They consistently had a sterile feel, and the staff and patients at several of the units visited referred to them as being prison-like. The patient rooms were generally painted white with no decoration or pictures on the walls. The rooms had no furnishing apart from a bed and sometimes a table and a chair. It is not clear why all the rooms are furnished with a minimum of furniture and sensory impressions. Recent research does not support the assumption that segregation rooms with a minimum of furnishing reduces mental symptoms or violent behaviour. At one of the hospitals, the doorknobs on the inside of the doors to patient rooms were difficult to open, particularly for patients with shaky hands as a result of the side effects of medication or somatic conditions.

In a number of the units visited, the conditions in the segregation unit made it difficult to attend to all the patients’ needs, particularly when it was fully occupied. Some of the premises were cramped and inflexible, which made it difficult to be near the patients without appearing invasive. Noise and commotion could lead to increasing unrest and, in some cases, the patients being aggressive towards the staff. Restraint beds in the segregation units increased the risk of patients perceiving segregation as unsafe.

Many of the segregation premises visited did not have direct access to outdoor areas. The patients therefore had to be accompanied out of the segregation units by staff, but this was contingent on staff being available. In practice, many patients were not able to spend time outdoors every day.[[6]](#footnote-6)

Many patients also had limited freedom of movement. A number of the segregation units did not have common rooms. Some of the hospitals had segregation units with access to a communal living room. A high occupancy rate in the segregation units meant that the patients often had to share the time spent in the living room, and were assigned ‘living room time’. As a result, the patients had to spend a lot of time in their rooms. At one hospital, beds had been placed in the common rooms in the segregation unit to increase capacity.

**Implementation of segregation creates sense of isolation**

One key finding was that segregation measures were implemented in ways that meant that the intervention clearly resembled isolation or had to be considered isolation.

At some hospitals, written procedures or informal practices were identified that indicated that blocking a patient’s door for a few minutes was regarded as ‘part of an administrative segregation decision’. Such coercive measures constitute isolation pursuant to Section 4-8 of the Mental Health Care Act, and can only be implemented in situations where they are absolutely necessary.

Patients in segregation units spent a lot of their time alone in their room with little contact with the staff. Segregation was often practised by patients being told to stay in their rooms, but without the door being closed. A number of the patients found such verbal messages humiliating, and said that they felt lonely and needed someone to talk to. Where the staff were during segregation varied. A member of staff often sat outside the door of the patient’s room, generally with the door slightly ajar or closed. In some places, segregation was practised by the patient being left alone in the unit with the door to the common area left open. The patients were then asked to stay in their own rooms as much as possible, while the staff sat in a spot in the common area, from where they could see into the segregation unit. It appeared to be uncommon for the staff to be together with the patient, although the legislation on segregation requires close follow-up and contact with health personnel.

A review of the documentation indicated that segregation was carried out in an unsystematic manner. The hospitals had not set out in writing how they expected segregation to be implemented, such as what kind of treatment and activities the measure was to include. There was no differentiation between segregation for treatment purposes or out of consideration for other patients. At one hospital, the procedures merely consisted of a list of the objects that were not to be found in a segregation room. With few exceptions, segregated patients had little opportunity to engage in activities adapted to their interests and level of functioning. They also had limited access to entertainment such as radio, music and reading materials, and many patients said they were bored. The lack of such entertainment was said to be based on the need to limit sensory impressions, but nor were they made available to other segregated patients. The Ombudsman has pointed out that it is the responsible mental health professional’s duty to ensure that segregation measures are not more invasive than strictly necessary.

Findings indicate that many segregation measures are in effect over a long period of time. Pursuant to current legislation, segregation can be maintained for up to two weeks at a time, and for some patients, segregation is extended a number of times. Some patients were subject to segregation over many months. If segregation is maintained over a long period of time without any change in the circumstances that led to segregation being considered necessary, this may indicate that the patient requires a different form of treatment.

Research on isolation in prison has shown that limiting human contact, sensory impressions and self-determination can be harmful to health.[[7]](#footnote-7) Segregation, particularly if it takes place over a long period of time, poses a risk of inhuman or degrading treatment. Mental health care institutions should therefore give particular consideration to the risk of harmful effects of isolation in their practice.

1. In Denmark, Section 18 d-f of the Psychiatry Act gives institutions the right to practise individual segregation and lock doors in the unit. Announcement No 1160 of 29 September 2015 regarding the act on use of force in psychiatric care (the Psychiatry Act). [↑](#footnote-ref-1)
2. Norvoll, R., Ruud, T., Hynnekleiv, T. (2015). Skjerming i akuttpsykiatrien ('Segregation in emergency psychiatry’). The Journal of the Norwegian Medical Association, 135, pages 35–39. [↑](#footnote-ref-2)
3. See note above. [↑](#footnote-ref-3)
4. Munjaz v United Kingdom, Application no. 2913/06, 17 July 2012, section 80: ‘...when a person’s personal autonomy is already restricted, greater scrutiny [will] be given to measures which remove the little personal autonomy that is left.’ [↑](#footnote-ref-4)
5. CPT, ‘Means of restraint in psychiatric establishments for adults (Revised CPT Standards)’ 21 March 2017, page 2. Also see the recommendation of the Council of Europe’s Committee of Ministers, Rec (2004) 10, Article 27 no 1: ‘Seclusion and restraints should only be used (...) to prevent imminent harm to the person concerned or others, and in proportion to the risk entailed.’ In an international context, ‘seclusion’ mainly appears to mean that the patient is locked in a room alone. [↑](#footnote-ref-5)
6. By comparison, according to the Mandela Rules, Rule 23 No 1, prisoners shall have at least one hour of exercise in the open air daily. In a number of its reports, the Parliamentary Ombudsman has pointed out that patients in mental health care should also have the opportunity to spend time outdoors every day. [↑](#footnote-ref-6)
7. For a summary of research findings, see Sharon Shalev, A Sourcebook on Solitary Confinement, LSE/Mannheim Centre for Criminology 2008. [↑](#footnote-ref-7)