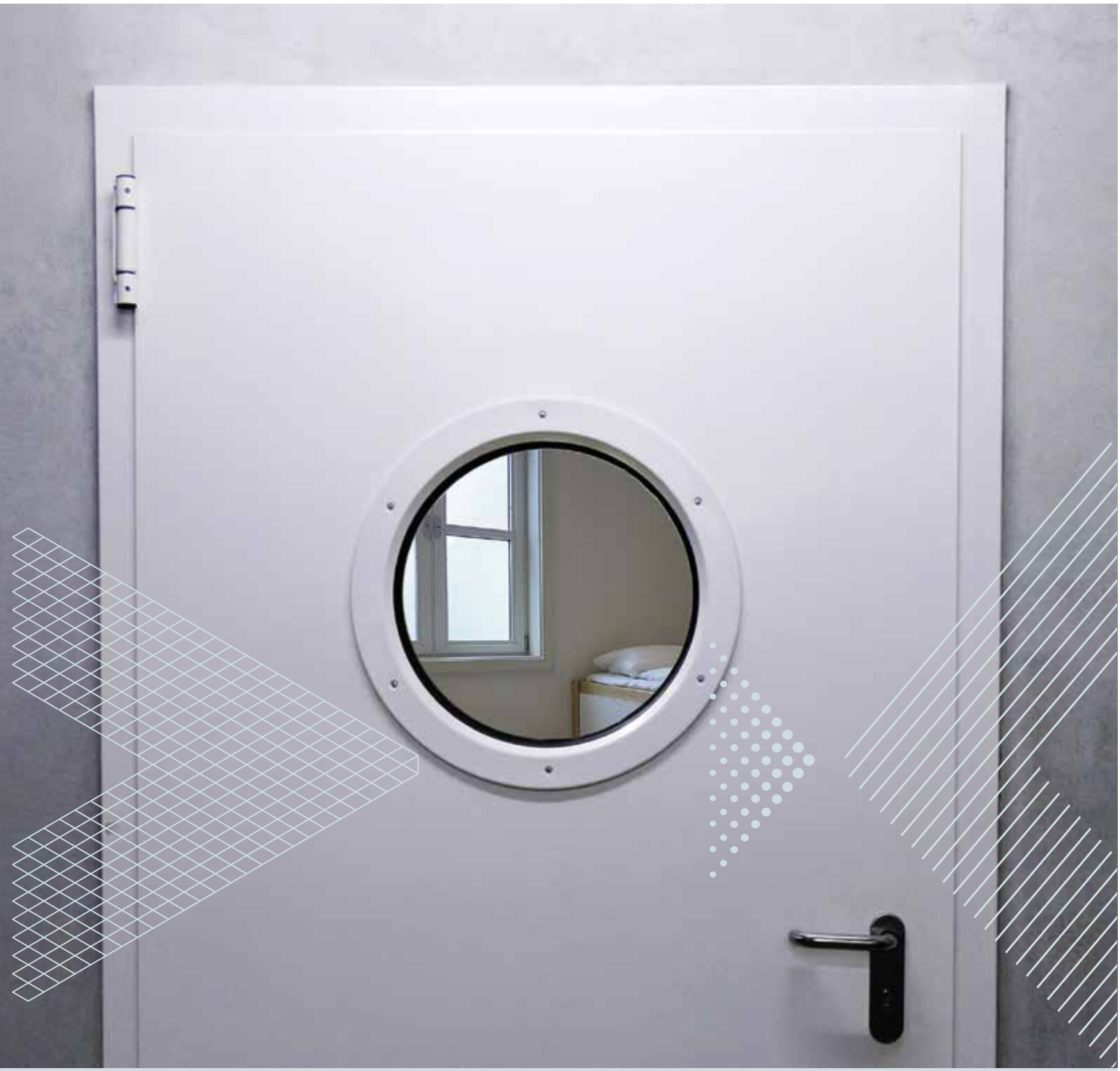

Summary and recommendations 2018

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SEGREGATION IN MENTAL HEALTH CARE INSTITUTIONS – RISK OF INHUMAN TREATMENT

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Summary of segregation report

In the period between 2015 and 2018, the Parliamentary Ombudsman's National Preventive Mechanism has visited 12 hospitals where patients are admitted for compulsory mental healthcare. During these visits, it was consistently found that many hospitals' use of segregation gave cause for concern.

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

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

In a historical perspective, segregation emerged as a method of treating agitated patients that was more humane than isolation, which was no longer considered an expedient therapeutic method. In general, the development of the segregation method took place in the field of nursing. From 2001, a separate administrative decision had to be made on segregation in accordance with the Mental Health Care Act Section 4-3. Psychiatrists and psychologists who are responsible for making administrative decisions concerning segregation, however, learn little about segregation in their specialisation.

Although the figures are uncertain, public statistics and surveys indicate that the use of segregation has increased significantly in the period from 2001 to 2016. The use of isolation has also increased in recent years. Guidelines from the national health authorities have probably contributed to segregation becoming such a key measure.

Public statistics have also shown that some patients are subject to many decisions on segregation during a year. This could lead to these patients spending many months in total in segregation. The figures also indicate that there are significant geographical variations in the number of administrative decisions on segregation.

The use of segregation is a controversial field because there is little knowledge that attests to it having a positive effect. Patient studies indicate that the coercive elements of segregation are stronger than and more isolation-like than treatment purposes would indicate.

Norway is one of very few countries that has a special legal provision on the use of segregation as a coercive measure, in addition to isolation. Comparable practices in other countries have been assessed as isolation by human rights organisations and should only be used in acute emergency situations. The practice of segregation in Norway has some distinctive features. The measure is a combination of coercive measures and treatment, and the aim is thus unclear. The threshold for implementing segregation as a coercive measure is significantly lower than for implementing isolation, and it is also considered an effective treatment measure despite there being little knowledge to back this up. Segregation measures can also be implemented for a long time, without any set upper time limit.

The Parliamentary Ombudsman's findings have shown extensive use of segregation in most of the hospitals visited. Segregation was an integral part of the treatment regime at some of them, and a large proportion of the available beds were in segregation units.

Several of the wards the Ombudsman has visited had a culture characterised by boundary setting, correction of undesirable behaviour, and a strong focus on order that could trigger conflicts and segregation decisions. The Parliamentary Ombudsman's visit also found that inadequate options for engaging in meaningful activities and spending time outdoors can trigger segregation decisions.

The segregation premises generally looked very bare, and are commonly referred to by members of staff and patients as being prison-like. The rooms often have no furnishing apart from a bed and sometimes a table and a chair. These items of furniture are often heavy to move or bolted to the floor. The rooms often lack a homely feel and are painted white with no decorations or pictures on the walls. Many rooms had windows with film that made it completely or partly impossible to look out of.

In general, the segregation units do not adequately safeguard patients' dignity. The bare design of the segregation premises is often justified as a security precaution. In the Ombudsman's opinion, such a view of security is problematic. Research does not support the notion that a lack of furnishing prevents violence and destruction. On the contrary, research indicates that humane design can contribute to reducing the use of force. Another contention is that the patients' sensory impressions should be limited. However, the patients' experience indicates that the bare design reinforces the impression of segregation being a form of punishment. The Parliamentary Ombudsman's visits found that many of the institutions have a low awareness of the potential negative effects of a lack of sensory impressions. Both the Parliamentary Ombudsman's findings and research in the field indicate that measures should be implemented for more humane design of segregation premises. Many of the segregation units also had restraint beds and isolation rooms, which further adds to the sense of segregation being a punishment.

A key finding is that segregation is often carried out in ways that in reality are equivalent to isolation, or which clearly resemble isolation. Many patients spend a lot of time alone in bare rooms, often with little contact with the staff.

The Parliamentary Ombudsman has observed that physical restraint is incorrectly considered as a part of the segregation that does not require an administrative decision to be made regarding the use of force. The Parliamentary Ombudsman also found that the implementation of segregation is often characterised by strict rules, unclear treatment content, and a lack of opportunity to spend time outdoors every day or participate in adapted activities. Examples were also found of segregation measures being used for a very long period of time. Some patients are segregated for several months or, in exceptional cases, years. Furthermore, administrative decisions on the use of segregation were often inadequately documented, without a precise description of why segregation was considered necessary.

According to human rights standards, there are clear limitations on the right to use isolation-like measures in the health service. The use of segregation, particularly if upheld over long periods of time, in an invasive manner with a low degree of freedom of movement, meaningful human contact and self-determination, can constitute a risk of violation of the prohibition against inhuman and degrading treatment. Insufficient knowledge makes using segregation as a treatment measure appear problematic. Segregation as a control measure is also problematic because it provides for a considerably lower threshold for the use of force than that provided for in human rights requirements and standards.

The Parliamentary Ombudsman calls for a greater focus on finding alternatives to the current practice of segregation. Former professional development projects and findings from visits have shown that it is possible to find alternative and less invasive segregation methods that do not entail being confined to a segregation unit. It is also important to prevent patients becoming socially isolated. The report points to the need for special measures to be implemented to avoid long-term segregation, and to acquire an overview of the duration of segregation at a national level.

On the basis of the findings in the thematic report, the Parliamentary Ombudsman has chosen to make recommendations to help prevent inhuman and degrading treatment. The recommendations are intended for the national health authorities, health trusts and local hospital departments.

Recommendations of the segregation report

On the basis of the findings in the thematic report, the Parliamentary Ombudsman has chosen to make recommendations to help prevent the risk of inhuman and degrading treatment. The recommendations listed below are intended for two different levels of authority: The recommendations regarding legislation, greater national expertise, and overall governance are intended for the national health authorities, while the recommendations concerning as humane use of segregation as possible are intended for the health trusts and local hospital mental healthcare departments.

11.1 To the national health authorities

Statistics

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

Assessment of the legislation

› carry out an assessment of whether the legislation that applies to the use of segregation is in accordance with human rights requirements and standards, both as regards the right to use segregation as a treatment measure and as a control measure. The need for special due process guarantees should also be considered to avoid prolonged segregation.

Increase expertise in segregation

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

11.2 To health trusts and local hospital departments

Implementation of segregation

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

Preventing segregation

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

Special requirements for staff

› ensure that staff who work in the segregation units meet high ethical awareness requirements relating to the use of force, and that they are knowledgeable about how to prevent the use of force.

The physical design of segregation premises

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

Due process protection in connection with segregation

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

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